

Leadership and Better Patient Care: Managing in the NHS

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Executive Summary

The NHS National Leadership Council Website¹ (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)

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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.

Leadership and Better Patient Care: Managing in the NHS

1 Leadership, organisation and the NHS

1.1 Leadership

What is currently known about leaders and leadership? The ongoing attempt to identify the characteristics necessary for effective leadership over recent years has been described as an 'obsession' studied more extensively than almost any other characteristic of human behaviour (Higgs, 2002; Tourish, 2008). Alimo-Metcalfe, Alban-Metcalfe et al. (2007) in their comprehensive review of the literature, show that formal studies of leadership date back (at least) to the beginning of the 20th century. They propose, that despite changes in the way leadership has been studied and the underlying epistemological stance taken by the researchers, *"in all cases, the emphasis has been on identifying those factors that make certain individuals particularly effective in influencing the behaviour of other individuals or groups and in making things happen that would not otherwise occur or preventing undesired outcomes"* (p. 2). As *"many have pointed out, that in spite of the plethora of studies, we still seem to know little about the defining characteristics of effective leadership"* (Higgs, 2002, p.3). Even so this has not appeared to quell the appetite for pursuing an ideal of leadership, impelled by the changing demands of organisations echoed across public sector institutions such as the NHS. These changes are in part the result of technological advancements which impact upon clinical practices, demographic changes both of which have altered the strategic, structural and financial profile of health (and social) care (Tierney, 1996).

The tantalising questions remain though about what those factors might actually be and the significance of the context to 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).

But in addition, or conversely, the context, culture, climate and/or structure of an organisation each have an impact on the performance of the people who lead in it (Carroll, Levy, & Richmond, 2008; Goodwin, 2000; Michie & West, 2004).

Focusing on the relationship(s) between 'leadership' and context has revitalised contemporary research particularly through the development of qualitative research, discursive and social constructionist epistemologies (Grint, 2005; Uhl-Bien, 2006) although it is unclear at this stage how far a connection might be developed between this research and its applications, for example in health care services (Fambrough & Hart, 2008).

In what follows in this chapter we explore the changing ways in which leadership has been conceptualised over the past fifty years, particularly focusing on how it has and *might* be operationalised in the NHS (particularly although not exclusively in a *hospital* context) .

1.2 Background and introduction to the study

The NHS Modernisation Agency Leadership Centre (NHSMALC) website³ had originally suggested that effective leadership is a key ingredient in modernising today's health care services. In its own words:

Effective leadership and management in the healthcare system are key drivers in patient experience. Governance and good environments matter to patients, their visitors and carers and staff.

But how might effective leadership be achieved and sustained? The NHS Leadership Centre commissioned a number of leadership initiatives (Larsen et al., 2005). The NHS Institute for Innovation and Improvement (2005) *NHS Leadership Qualities Framework*⁴ emphasised the *situational* nature of leadership and indicated the circumstances under which different leadership qualities will take precedence.

These comprise fifteen contextualised qualities covering a range of personal, cognitive, and social characteristics arranged in three clusters which are set out in Figure 1:

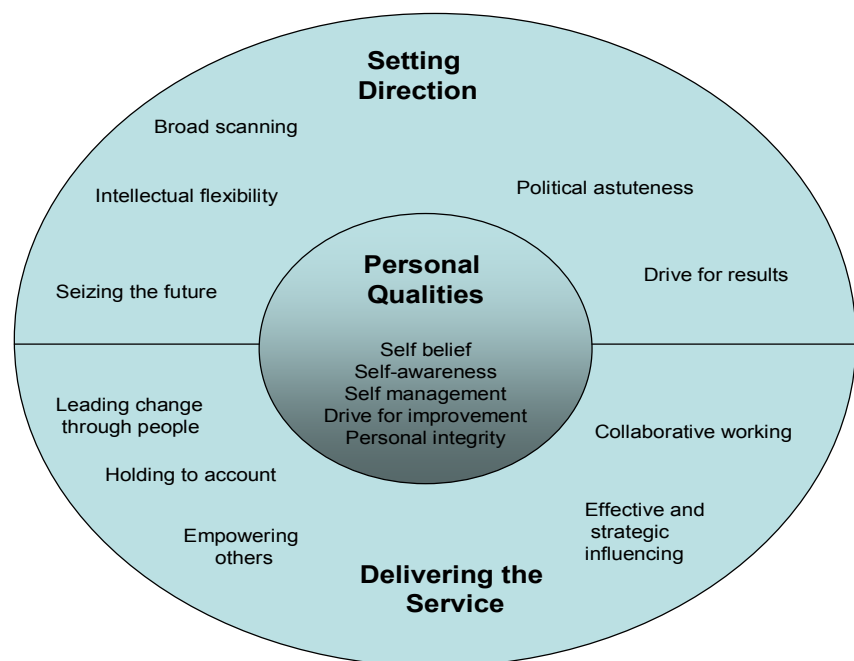
³ <http://www.dh.gov.uk/en/managingyourorganisation/leadershipandmanagement/index.htm>

⁴ <http://www.nhsleadershipqualities.nhs.uk/>

- *Personal Qualities*
- *Setting Direction*
- *Delivering the Service*

Thus, a competent leader enables development in an organisation that is goal directed, geared to developing processes and systems and enables staff at all levels to plan effectively and efficiently towards agreed goals (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Figure 1. The NHS Qualities Framework



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However, these same authors underscore the point that there is something beyond leadership competency that needs to be addressed, particularly in a changing and complex context such as an NHS Trust. *That is that a leader is someone who encourages and enables the development of an organisation in a culture based on integrity, transparency and valuing others. Leaders also need to question, think critically as well as strategically* (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Since the publication of the *NHS Leadership Qualities Framework* in 2005 all efforts have been directed to recognising and discussing leadership qualities and making strides towards their implementation. In 2008 Clare Chapman, Director General of the Department of Health's Workforce declared:

*Leadership is all about creating value for customers and citizens whilst also making work worthwhile for staff. This sounds incredibly straight forward - but it requires courage and resilience, and commitment throughout the entire piece*⁵

David Nicholson the CEO of the NHS in the report *Inspiring Leaders: Leadership for Quality* (January 2009) building on Darzi's *NHS Next Stage Review*⁶ stated:

It is imperative that we align what we are doing on leadership with what we want to achieve on quality. This is what I call leadership with a purpose.

Over the past year, the Department of Health has worked extensively with the NHS and other stakeholders to determine how best to foster talent and leadership development, and it is clear that there is a great deal of enthusiasm for a more systematic approach.

Spotting and developing confident leaders is a priority for us all if improving quality is our shared purpose. This guidance represents our best collective thinking to date. I invite you to use it and contribute to its improvement as we learn how to bring leadership centre stage over the coming months.

Nicholson and his team have charged the Strategic Health Authorities with finding gaps in leadership and systematically nurturing talent across the whole of the NHS. Clearly, the enthusiasm of successive senior officers in

⁵ DH_083353.

⁶ www.dh.gov.uk/en/Healthcare/Highqualitycareforall/index.htm

government and the NHS has been to link effective leadership with good service delivery and patient care as the primary outcome.

1.2.1 Leadership and Better Patient Care in this Study

This rhetoric and confidence about the type of leadership that best suits the NHS from those who lead it gave us pause for thought (Milewa, Valentine, & Calnan, 1998; Mueller, Sillince, Harvey, & Howorth, 2004b). 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 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 aims were overall to seek out the meanings and perceptions of relationships between (effective) 'leadership' and (better) 'patient care' and how leadership is transmitted across organisations to impact upon service delivery, taking account of the mixed methods and specific social science and systemic approaches that the investigatory team proposed. This inevitably has brought certain issues to the fore and (possibly) obscured others.

Our starting point therefore was to hold the NHS model of leadership in mind while calling on our own specific strengths as academics, from a range of social science and methodological backgrounds, to take a cross section of Trusts, clinical specialties, services, staff grades and patient needs, and to observe the *processes of leadership* in everyday working life. From this we proposed it should be possible to determine the ways in which leadership, NHS organisations and patient care were socially and discursively constructed so that links between leadership and patient care might be explored.

In Chapter One we outline some of the important contemporary social science and organisational thinking on leaders and leadership and explore the links between this and the NHS perspectives.

In Chapter Two we set out the innovative methodologies employed to investigate and analyse the research questions. This is followed in Chapter Three with the detailed procedures used for data collection.

The results are presented across four separate chapters. Chapter Four provides the analysis of what leadership means and how it is experienced by staff and patients (Christensen & Laegreid, 2003; Fairhurst, 2005).

Chapter Five presents the results of the Organisational Climate Survey (OCS) (Stringer, 2002). In Chapter Six, open systems theory and the concept of the 'organisation in the mind' are introduced particularly focusing upon the transmission of leadership across organisations. The relationship

between leadership, authority and emotion is discussed in Chapter Seven and in Chapter Eight the role of gender relations and their impact on leadership are reviewed (Begun, Hamilton, Tornabeni, & White, 2006; Ford, 2010; Telford, 2007).

Chapter Nine covers definitions, explanations and experiences of patient care and particularly how it relates to leadership by NHS staff and patients (Begun et al., 2006; Disch, Edwardson, & Adwan, 2004).

Finally in Chapter Ten we summarise our findings, make recommendations and draw conclusions.

Appendices provide copies of the research instruments, additional statistical results and the relevant NRES information.

1.3 Theoretical Approaches to leadership

Leadership research and theory is prolific with the consequence that numerous, frequently overlapping, models of leadership are available to agencies attempting to analyse or train leaders (and indeed managers, as until relatively recently little distinction was made between these two categories, see e.g. Kotter, 1996). Over the past fifty years leadership theories have shifted through different points of focus from the 'trait (or 'great man') approach in the 1940s, through the 'behavioural' perspectives in the 1950s whereby some styles of behaviour were seen as being more or less influential on potential followers. Then since the 1960s and 1970s the focus has been upon 'situational' leadership based mostly upon Fiedler's 'contingency' theory which proposed that different leadership styles were needed for different situations (see Alimo-Metcalfe, Alban-Metcalfe, et al. 2007; Western, 2008 for further details). During the 1970s and 1980s leadership research, albeit prolific, had reached an all time low in terms of its perceived contribution to theory and added value to knowledge for practice, so that as Cummings (1981 p. 366, quoted in a review by Bryman, 2004) asserted:

As we all know, the study and more particularly the results produced by the study, of leadership has been a major disappointment for many of us working within organisational behaviour.

Bryman unpicked the implications of the phrase Cummings used "as we all know" noting that it was "simultaneously sweeping and damning" (2004, p. 730). Bryman also picks out Miner's (1975) suggestion for temporarily abandoning the concept because of its limited utility in helping us understand organisational behaviour. *Why had leadership research reached this nadir during those decades? Why has there been a more recent upsurge of interest in leadership again almost to the point of saturation?*

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Bryman in his review suggests, that the renewed confidence and interest in the study of leadership has come from improved measurement and analytic techniques, greater use of meta-analysis so that more systematic reviews could be compiled, the emphasis on *transformational leadership* and *charismatic leadership* which have provided a fulcrum for the area of research, more and better cross-cultural studies and greater diversity in the types of leadership and organisational contexts that have been studied.

A factor that may also have contributed to the idea that leadership research continues to be fruitful is that a greater diversity of methodological approaches have been added and Bryman's review specifically focused on the value added by qualitative research.

Towards the end of the 1980s and beyond, thinking about the meaning(s) of leadership came to take greater precedence than in the previous two decades, possibly because of a perceived dearth of leadership *per se*.

These deliberations cast light onto the:

- *interactions between leaders and followers* and organisational cultures (Avolio, Gardner, Walumbwa, Luthans, & May, 2004; Lewis, 2000; Schilling, 2009)
- the *management of emotion* (George, 2000; Lewis, 2005; Pescosolido, 2002)
- the *processes* of leadership (Collinson, 2005; Dopson & Waddington, 1996; Vangen & Huxham, 2003)

Even so, or perhaps because of the use of qualitative approaches and related conceptualisation, Alvesson and Sveningsson (2003) were able to entitle a recent paper arising out of their study of leadership in a research and development company: "*The great disappearing act: Difficulties in doing 'leadership'*".

By this they meant that during their study they were able to identify how the existence of the label 'leadership' led to an assumption that the concept had an empirical reality. However the results of their work indicated that leadership might be better explained as a *process or series of processes of interaction*. This conclusion raises questions about mainstream thinking on leadership which presumes observable and possibly measurable characteristics (Alvesson and Sveningsson, 2003, p. 361; see also Ford, 2010).

Most recently there has been reconsideration and development of ideas about leadership in context taking account of the relevance of some earlier studies of organisations (e.g. Lewin, 1947) and open systems theories (see

Chapter Six; Laughlin and Sher, 2010) and new epistemological positions (e.g. Ford, 2010).

In our study, as a consequence of these recent critiques of leadership research and the result of methodological innovation, we approached the concept of 'leadership' as not necessarily a property of one individual (although it can be) or of one specific role, such as Clinical Director or a service manager, but rather we identified leadership as a *process* occurring within a group, organisation or collectivity that *imagines, wills and drives change* (Gabriel, 2004; Gronn, 2002).

1.3.1 Dimensions of Leadership and their Value for the NHS

Leadership, *as a practice*, has been on occasions constructed as 'a beautiful or rarefied ideal' an idea which has little use in the real world particularly as it has been suggested there are at least 350,000 definitions of leadership in the academic literature (Pye, 2005; Tourish, 2008; Western, 2008). *The question for this report is how to identify the literature on leadership and organisation with the most relevance for the contemporary NHS.*

Most discussed in theory and in practice over the past two decades has been the idea of *transformational leadership* (Bass, 1985) a model to explain ways in which a leader can be identified or trained to demonstrate the qualities that enable her/him to *perform beyond expectations*. The phrase 'transformational leadership' was coined originally in 1973 by Downtown but did not gain impetus until 1978 when Burns published his book, *Leadership*, which highlighted the *relationship* between leaders and followers (Burns, 1978).

Until then, as shown above (see Bryman, 2004) there had been little by way of a breakthrough in applicable knowledge. Burns (1978) demonstrated a *psychological* difference between an exchange relationship - where followers respond to leaders because of rewards they might receive - and one in which they respond to leaders who transform their attitudes and behaviours through inspiration and/or charisma (Bass, 1985; Yukl, 1999; Rafferty and Griffin, 2004). Transformational leadership then, is concerned with emotions, values and ethics, standards and long term goals which include assessing followers' moves and satisfying their needs (Currie & Lockett, 2007; Day, Gronn, & Salas, 2006; Eagley & Johannesen-Schmidt, 2003; Northouse, 2004).

Recognition that transformational leadership is not simply an individualistic model but one that *teams* can display (Day et al., 2006; Gronn, 2002; Sivasubramaniam, Murry, Avolio, & Jung, 2002) has shifted the

concentration from individual leaders per se to a more diffuse and distributed model of leadership and organisation context.

1.3.2 What constitutes transformational leadership?

Bass (1985) highlighted several characteristics of *transformational (or transformative) leadership* that allow followers and leaders to achieve far beyond their expectations. These are not discrete categories but given the significance placed upon the ideas behind transformational leadership in the scientific and training literature it is worth outlining the basic ideas behind these characteristics/types which have been identified as:

- Charismatic leadership
- Inspirational motivator
- Intellectually stimulating leadership
- Considerate leadership

Charismatic leadership

Bass (1985) proposed that "*charisma is a necessary component of transformational leadership*" (cited in Yukl 2002, p.261) and that charismatic leaders are endowed with exceptional personal qualities that attract followers. Charisma, a word derived from the Greek, means "*divinely inspired gift*" and is thought to give people the ability to perform miracles or predict the future (Yukl 2002, P. 241).

It is for this reason that charismatic leaders are often regarded as "*visionary, a futuristic, or a catalyst for change*" (Murphy 2005, p. 131; see also Bass 1985; Bennis & Nanus, 1985). Due to their rare personal qualities charismatic leaders are able to convey their visions to their followers in a clear and concise manner allowing them to visualise what they could achieve in the future if they worked together towards a common goal. As the leader's vision is normally realistic yet optimistic, it empowers the followers granting them greater self-esteem, encouraging and inspiring them to achieve the vision (Bennis & Nanus, 1985; Northouse, 2004; Yukl, 2002).

Inspirational motivator

Through their charisma, transformative leaders have the ability to inspire their followers through words of profound wisdom, or at least is what is *perceived* to be profound wisdom, such as with the case of Jim Jones⁷ in the USA or more positively President Obama who has reformed health care and banking legislation in the USA against the odds. Transformative leaders are

⁷ In 1978 Jim Jones persuaded more than 900 members of his People's Temple in Jonestown, Guyana to commit mass suicide.

excellent communicators which allow them to turn their visions into reality. Many use emotional and optimistic speeches to inspire their followers. They usually lead by example and often become role models to their followers who are in awe of their moral and ethical character. Many followers try and emulate their leaders' good qualities and are confident that their leaders will make just decisions on their behalf leading them to a prosperous future (Kellerman, 2004; Rafferty & Griffin, 2004).

Intellectually stimulating leadership

Transformational leaders have the ability to captivate their audience making the most mundane speeches and events interesting. They encourage their followers to be innovative, challenging the status quo and their own values and beliefs (Northouse, 2004). They also encourage their followers to solve problems and take an active role in the organisation, thus enhancing their self-worth and self-esteem, increasing their job satisfaction and productivity.

Considerate leadership

Transformational leaders are often also considerate leaders who are adept at performing mentoring or advisory roles to support their followers' emotional needs (Hiller, Day, & Vance, 2006; Rafferty & Griffin, 2004). Such leaders listen carefully to their followers' needs and desires, empathising with them during difficult periods. Being empathetic also builds a strong bond between leader and follower and thus a strong reciprocal relationship (Simpson & French, 2005).

It is important to note though, despite the wide take-up of transformational leadership as a conceptual model and a *practice*, that there remains uncertainty about the ambiguity of subdivisions and distinctions between elements in the model. Theoretical distinctions between 'charisma' and 'inspirational motivation' have become blurred over time and some theorists have suggested that elements of transformational leadership might also be identified as *transactions* (see Rafferty and Griffin, 2004 for a discussion of the implications).

Further concerns have been raised about how transformational leadership can take place in organisations, particularly public service ones, which are constrained by government initiative and targets and localised regulatory and normative pressures (Currie & Lockett, 2007; McNulty & Ferlie, 2004). However, it may also be that professional staff (rather than leaders/managers) in contexts such as health care, may in fact be more transformational than might be predicted because of their long-term commitment to the organisational goals (McGuire & Kennerly, 2006).

Most recently the notion that transformational leaders are very much 'engaging' leaders has been proposed (Alimo-Metcalfe, Alban-Metcalfe et al, 2007; Alban-Metcalfe & Alimo-Metcalfe, 2009; Macy & Schneider, 2008).

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One further comment here concerns the role of *gender* in styles of leadership and its consequent impact on organisational transformation (Fletcher, 2004; Mandell & Pherwani, 2003). There is evidence that (whether displayed by a woman or a man) feminine styles of leadership may be more related to engagement, emotional and social intelligence and distributed leadership, which may be important for complex organisations such as the NHS (see below).

1.4 Leadership, organisation and emotion at the turn to the 21st Century

Models of leadership and organisation theory have evolved over time and leadership and organisational structures and cultures are intrinsically linked in the literature. Leadership, if it is to motivate, innovate and move organisations to change, has to have an *emotional dimension* and, thus, effective leaders have a clear *emotional agenda* (as well as a strategic and structural one) which is particularly acute in services such as the NHS which is working to serve people's health care needs (Ashforth & Humphrey, 1995; Bolton, 2000; Pye, 2005).

Exploring organisations and leadership at the level of 'emotion' has become contested territory, as recognition, that organisations and their leaders need to take account of emotional engagement (Alban-Metcalf & Alimo-Metcalf, 2009; Vince & Broussine, 1996) at all levels of the work place, has emerged. Prior to the 1980's, organisational literature had been dominated by cognitive orientation (George, 2000) which favoured the rational, 'masculine' and scientific explanations of organisations and their leaders. This notion therefore ignored the (so called) irrational and 'feminine' characteristics of emotion, which were deemed detrimental to productivity and success. At that time emotions were regarded as the culprits that distort an individual's perceptual and cognitive faculties and therefore should be kept under control (Alvesson & Sveningsson, 2003b; Clarke, Hope-Hailey, & Kelliher, 2007; Dasborough, 2006; de Raeve, 2002; Ford, 2006).

As social and occupational psychologists began to study the effects of positive and negative moods on decision making, job satisfaction, choice of work-based activities and organisational climate, however, (Isen & Means, 1983; Rafaeli & Sutton, 1987, 1989) 'emotion' as part of organisational life gained impetus once again. This resurgence coincided with leadership theorists studying how moods and emotions could effect the quality of leadership (George, 2000).

It is possible to trace a rough trajectory from the 'hard nosed' scientific management, with the organisation perceived as a 'machine' in the early twentieth century, through towards a more humanistic, emotional and

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sometimes even spiritual way of thinking about contemporary leadership and organisational metaphors towards the twenty-first century, all of which are potentially transformational, not simply to the individuals concerned, but to the organisational dynamics.

Hochschild's (1983) *The Managed Heart* has been credited with being one of the earliest examples of research into emotions and organisational settings (Ashkanasy, Hartel, & Daus, 2002). She looked particularly at the airline industry and how airline cabin crew managed their emotions for dealing with difficult passengers and to promote a particular airline image. She termed this emotional management '*emotional labour*' (Hochschild, 1983).

Since this publication, the study of emotions in organisations has increased (Ashkanasy et al., 2002) with academics concentrating on key concepts such as emotional labour, emotional intelligence, mood analysis and Affective Events Theory (AET) and most recently a return to psychodynamic understanding of organisations and groups (see Ford, 2010; Schwarz, 1990). Since the 1990's a plethora of literature has emphasised the role of emotional concerns in private sector organisations such as the airline industry (Hochschild, 1983; Taylor & Tyler, 2000; Tyler & Abbott, 1998), service sector (Crang, 1994), merchant banking (McDowell & Court, 1994; Pugh, 2001), law (Harris, 2002) and image consultancy (Bryson & Wellington, 2003; Wellington & Bryson, 2001).

However, emotionality in the public sector was mostly neglected until 2000's when a surge of literature began to be published analysing the NHS (Allan & Smith, 2005; Bolton, 2000; Cummings, Hayduk, & Estabrooks, 2005a; Hunter, 2005; Lewis, 2005; McCreight, 2005; McQueen, 2004; Michie & Gooty, 2005; Michie & West, 2004; Smith, 1992) and the fire service (Archer, 1999; Scott & Myers, 2005; Ward & Winstanley, 2006; Yarnal, Dowler, & Hutchinson, 2004).

1.4.1 Emotional labour, leadership and patient care

Hochschild differentiates between emotional labour and emotional work or 'face-work' (Goffman, 1967). Emotional work has been described as the effort we put into presenting and representing our feelings as well as into feeling what we ought to feel (see Fineman, 2003). For example, a person ought to feel happy at a wedding and sad at a funeral and if their emotions do not match these expectations then a person must perform emotional work to display the appropriate emotion. This is sometimes difficult as people struggle to disguise their true emotions and perform the socially acceptable emotion.

When a person's emotions are appropriated and performed for commercial gain it is known as *emotional labour*. Hochschild states that emotional labour occurs in many occupations. However, she believes it to be more

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prevalent in service industries, such as the airline industry, where workers' emotions are sold as part of a commercial package⁸. Employees working in service industries must be skilled at managing their emotions and facial expressions in order to project the correct emotion to the customer (Crang, 1994; Lewis, 2005). This often means that employees have to suppress their own emotions in order to perform and display emotions that are suitable for commercial gain and in alignment with the organisations' image (McDowell and Court 1994).

Surface acting allows the employee to make up an outward gesture (Hochschild, 1983), to perform emotions that are not actually felt. In contrast, deep acting means that the employee can suppress or become estranged from their true feelings and *actually feel the emotions* that the employer wants them to display. *"One finds that the performer can be fully taken in by his own act, he can sincerely be convinced that the impression of reality which he stages is the real reality"* (Goffman 1990, p.28).

In the NHS, positively managed emotions *could* lead to better patient care, greater patient satisfaction and a relaxed and professional organisational climate (Amendoldair 2003; Bolton 2003). Lewis (2005) highlights how nurses in a special care baby unit appropriately managed their emotions to create a professional organisational climate, in which to offer quality patient care to special needs babies and emotional support to their parents. Lewis suggests that a nurse's job is sometimes very stressful and emotionally destabilising, especially when a baby dies. Nurses need to be conscious of their own emotions and regulate them to prevent causing further distress to the parents by displaying a professional demeanour (Bolton 2001).

However, managing emotions in this way, particularly if they are not felt, comes at a psychological and emotional cost and the whole process would be problematic without attending to emotional intelligence.

1.4.2 Emotional intelligence, leadership and patient care

The 'discovery' of emotional intelligence (EI), despite on-going valid critiques (see below) marked a turning point in contemporary organisational theories and approaches to leadership because of the tradition that emotions represent a threat to rationality – a view that has been widespread particularly in North America and North Western Europe (Fambrough & Hart, 2008; Western, 2008).

⁸ For a critical analysis of Hochschild's dichotomy of emotional labour and work see Bolton 2000 and Bolton and Boyd 2003.

Mayer and Salovey (1995), who conceived the idea of emotional intelligence, defined it as the ability to manage and understand one's own and other people's emotions in a consistent way so as to reflectively promote emotional and intellectual growth. Goleman (1996; 1998) who popularised the concept, identified emotional intelligence as a set of competencies, redefined and restated by George (2000) as follows:

- The expression and appraisal of emotion
- Enhancing cognitive process and decision making
- Emotional knowledge
- Managing emotions

These characteristics appear to have much in common with the rhetoric of transformational qualities of leadership although in many ways EI has become a management 'tool' rather than a critical model. To this end (apparently) Goleman (Goleman, 2000; Goleman, Boyatzis, & McKee, 2001) focused on 'styles' and 'performance' which seem far away from the 'heady' descriptions below of qualities of emotional intelligent leadership, which refer to feelings, empathy and creativity.

The expression and appraisal of emotion

An emotionally intelligent person will be able to understand their own and others' feelings and able to empathise, which may enable them to be manipulative for better or for worse.

Enhancing cognitive processes and decision making

Having emotional intelligence allows a person to use emotion to be creative, solve problems, make decisions and flexible plans for themselves and on the behalf of a group. An emotionally intelligent leader will be able to judge their mood and make decisions accordingly. If the person is in a negative mood this may mean choosing to wait until such negative episodes have past in order to make a comprehensive decision.

Emotional Knowledge

Emotionally intelligent people understand how other people may be affected by their negative moods and therefore may take care not to spread bad feeling around the group.

Managing Emotions

Many leaders are able to manage their followers' emotions as well as their own, but as indicated below, developing the qualities required to manage emotions effectively is highly complex and more about processes than style or performance (Fambrough & Hart, 2008; Hughes, 2005). As Fambrough and Hart argue 'emotional intelligence' has passed into common use among organisational leaders with little recognition of the way it has been identified

as problematic. *What has been so attractive about EI to leaders in health care organisations?*

The idea of emotional intelligence captured the imagination of some training NHS staff as a means to improve staff relationships and enable clinicians to empathise with their patients (Allan & Smith, 2005; Cummings et al., 2005a; McQueen, 2004; Amendolair 2003, Luker et al 2002). McQueen (2004) reflecting on the 1960's when health care workers were encouraged to hide their emotions from their patients, for the sake of maintaining a professional role, suggests that in recent decades this view of nursing has changed and health care workers frequently display emotions to illustrate their commitment to patient care (Williams 2000). McQueen suggests that emotionally intelligent nurses are important for building strong patient-nurse relationships (Conger and Kanungo 1987 and (Lewis, 2005). Nurses with high Emotional Intelligence are able to build rapport quickly with their patients through communication and interactive skills (Schutte et al 2001).

McQueen (2004) also states that "*emotional labour calls upon and engages*" emotional intelligence (2004, p. 103). In order for patients to feel cared for nurses have to constantly *perform* positive emotions and behaviours such as warmth, friendliness and consideration. However, when confronted with a 'difficult' patient nurses may experience negative emotions such as frustration, irritation or anger. The nurses must be emotionally intelligent enough to identify their emotions and then perform emotional labour to submerge the negative emotions in favour of more positive emotions (Bolton 2003).

While EI *per se* needs to be understood more critically (Fambrough & Hart, 2008), the introduction of emotional management and engagement by leaders (and others) in health care organisations needs further scrutiny (see below); despite the best efforts of some management gurus emotion is a fact of personal, interpersonal and organisational life particularly when considering what it means to deliver patient care.

1.4.3 Beyond emotional intelligence

Interest in EI has continued to grow among management and organisational academics with a focus on how to measure it – the conclusions generally indicating the need for caution in measures to predict or to establish baselines for its development among managers (Conte, 2005). The conflation of managerial skills as listed by Mintzberg (Mintzberg, 1973) cited in Riggio and Reichard, (2008) which included the ability to 'deal' with subordinates, 'empathize' with top-level leaders and establish and maintain social networks, alongside managing emotions as a leader, have come to be known as 'people skills'. These are clearly represented in the NHS leadership qualities framework and vital for managing in any organisation (see Figure 1).

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1.4.3.1 Social intelligence (SI) and leadership

In 2006, taking account of advances in neurological psychology, Goleman (Goleman, 2006) proposed that because humans are *designed* for social connection, rapport and supportive emotional interactions enhance performance of managers and leaders. He listed these qualities under the umbrella of 'social intelligence' and identified four dimensions:

- *Synchronization* – whereby matching moods lead to a sense of rapport
- *Attunement* – listening fully
- *Social cognition* – understanding how people interact
- *Social facility* – finding it easy to interact with others

While some people have little difficulty meeting these criteria and mastering their social intelligence, others (such as Narcissists, Machiavellian and Psychopathic types), Goleman argues, do not have the capacity for social intelligence, and thus he proposes a means of *selecting* effective leaders by testing these qualities. This model albeit individualistic has something to offer through extending the theoretical underpinnings of 'people skills' and emphasising the importance of taking followers and colleagues seriously in decision-making.

Following EI and SI in bringing management/organisational theories together with developments in psychology, particularly cognitive neuroscience and evolutionary psychology, is the reconsideration of the role of intuition in understanding leadership and organisational behaviours (Sadler-Smith, 2008). Sadler-Smith brings the idea of the 'gut feeling' into the foreground to explore the influence of this sense upon decision-making particularly under pressure (e.g. many emergency clinical decisions rely on the clinician's instinct of whether the patient should be operated on, admitted to hospital, whether to call for support).

It seems that while there is a continuing trend towards an evidence-based understanding of leadership, success there is also an emergence of features of human life that are difficult to explain and measure, although all the proponents cited above stick to the view that these characteristics are scientifically explicable and measureable despite challenges from both positivist and critical social constructionist positions (Ashforth & Humphrey, 1995; Conte, 2005).

1.4.3.2 Affective Events Theory (AET)

AET predicts that specific features of work (e.g. autonomy) have an impact on the arousal of emotions and moods at work that, in turn, co-determine job satisfaction of employees. AET further proposes that job satisfaction is

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an evaluative judgement that mainly explains cognitive-based behaviour, whereas emotions and moods better predict affective-based behaviour. The results support these assumptions (Jürgen, van Rolf, Fisher et al., 2006). Ashkanasy et al (2002) suggested that AET has two important messages for leaders in an organisation.

- Followers' emotions are heavily influenced by their leaders' emotions and therefore leaders must minimise the 'hassles' that they place on their followers in order to increase job satisfaction and performance. Short-term negativity can be tolerated without much impact on the team or organisation.
- However, if negative events persist it will affect followers' moods leading to negative emotions, poor performance, reduced job satisfaction and in the case of the NHS, (possibly) to poor quality patient care. It is therefore suggested that leaders need to give followers positive feedback regularly to "*ameliorate the daily hassles experienced by employees*" procuring positive behaviours such as team spirit and self-worth (Dasborough 2006, p. 165 ; Weiss & Cropanzano, 1996). The connections between the moods of individuals and their performance may be understood better in terms of emotional engagement between leaders and followers on both conscious and unconscious levels (see below).

1.5 Distributed leadership

The academic study of distributed leadership, that is when at various levels leadership (or influence) behaviour, identity, role and responsibility are distributed to more than one individual or group of individuals, has been at the forefront of much social scientific leadership research over the past ten years (Buchanan, Addicott, Fitzgerald, Ferlie, & Baeza, 2007; Day, Gronn, & Salas, 2004; Gronn, 2002; Mehra, Smith, Dixon, & Robertson, 2006a). The implication of this interest in distributed leadership is, that organisations have changed and previous models - including the charismatic, 'hero' leader and the 'command and control' organisational structures - are dysfunctional in a context where organisational change is rapid and diversification of strategic leadership and management essential (Butterfield, Edwards, & Woodall, 2005; Dent, 2005; Goodwin, 2000). In a competitive, diverse and divergent environment leadership needs to be distributed, in order to enhance democratic governance, thus enhancing legitimacy and increasing survival chances (Currie et al., 2009).

Distributed leadership also implies that organisations where it is practiced have (relatively) flat hierarchies with diverse service needs and expertise across all sectors of the organisation (Huffington, James, & Armstrong, 2007). This model applies to hospitals and primary care settings, where

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distinct professional groups each have their own standards of excellence, while at the same time sharing goals of competence and quality related to the service they provide to patients and how they interrelate to other organisations.

With this shift in focus of many leadership practices and leadership studies the definition of such leadership has been proposed as:

".. a status ascribed to one individual, an aggregate of separate individuals, sets of small numbers of individuals acting in concert or larger plural-member organisational units" (Gronn, 2002, p. 428).

Gronn suggests also that when leadership is distributed it may be that the duration of that influence is limited, perhaps (structurally) to a single project and therefore (psychologically) distributed leadership might mean having to 'give up' leadership as well as take it up (Huffington et al., 2007). Furthermore, according to Gronn (2002) the most common understanding of distributed leadership, witnessed by the growing number of references to it in the research and policy literature, is that it applies to numerous people across an organisation taking some degree of a leadership role or responsibility.

More importantly, Gronn identified distributed leadership as *concerted action* meaning that there are many roles comprising a 'leadership complex' with at least three potential forms:

- *collaborative modes of engagement* which arise spontaneously in the workplace. This suggests that leadership practice is 'stretched over' the context of the organisation and not a function of those in managerial roles such as matron or clinical director. However, if the matron, clinical director and other colleagues who share ideas for change or particular activities they *may "pool their expertise and regularise their conduct to solve a problem after which they may disband"* (Gronn, 2002, p. 430).
- the *intuitive understanding* that develops as part of a close working relationship among colleagues. These relationships tend to happen over time when organisation members come to rely on each other and develop a close working relationship, to solve problems or bring about change and others might be involved in a 'framework of understanding'.
- The variety of *structural relations* and institutionalized arrangements which constitute attempts to regularize distributed action. Thus, for example, if there were dissatisfaction with existing arrangements for particular practices, a team of 'equals'

might emerge to find ways to improve or change the problematic practices.

All of these are apparent particularly, but not exclusively, in Trust Three (the FT) as exemplified in Chapters Four and Nine in particular.

Gronn argues the importance of examination of these different forms of concerted action to understand where influence (and thus leadership and power) might lie in any organisational context. Emotionally, however, these different models of distributed leadership suggest the impact of these structures and practices at a deeper level (Gabriel, 2004) particularly around authority (Halton, 2007; Hirschhorn, 1997) competition (Morgan, 2006) rivalry and envy (James & Arriba, 2005; Stein, 2005)

1.6 Organisational Culture, Climate and Contexts

As introduced above, post-industrial (or even 'post-modern') organisations (Burrell, 1988; Fineman, Sims, & Gabriel, 2005) and networked (Balkundi & Kilduff, 2006; Goodwin, 2000) organisations are changing rapidly and the NHS is clearly among these. Changes in the NHS take place at a number of levels, emerging from the direct policy dictates from central government to become local initiatives. Moreover, the NHS has become increasingly team (and indeed multi-disciplinary team) based over the past two or three decades so that knowledge, influence and leadership for transformation and change are not only moving from a top-down to bottom-up model, but as indicated, to a distributed model which involves lateral influence (Begun et al., 2006; Day et al., 2006; Ferlie & Shortell, 2001).

The type of leadership that is supported and promoted in any organisation and the related concept of the organisational structure depends on and impacts upon organisational climate and culture.

Although research undertaken on organisational *climate* and organisational *culture* comes from different epistemological traditions, since around 1990 the literature and concepts referring to both have been overlapping and/or complementary (Schneider, 1990; Schneider, 2000) and increasingly the terms are used interchangeably (Ashkanasy et al. 2000).

It is, however, generally accepted that 'climate' is a logical extension of what was originally conceptualised as 'psychological' climate, that is, shared psychological meanings in an organisation; so that *organisational* climate is an aggregation of those individual perceptions of a work-place context (James, Choi et al. 2008).

Organisational culture on the other hand has its origins in anthropology and human relations (see Davies, Nutley and Mannion, 2000; Scott, Mannion et

al. 2003). Organisational psychologist Edgar Schein's (1985/2004) ideas about organisational *culture* as a pattern of *shared basic assumptions that have worked well enough and adapt to the external environment and serve internal integration*⁹, is one of the most frequently quoted definitions. Schein takes a systems theory approach to understanding organisations and his work has been built upon by himself and others to develop a variety of typologies which underpin measures of both organisational culture and climate (see Albino-Metcalf, Alban-Metcalf et al. 2008 for a comprehensive overview of this literature).

Organisational climate, with its origins in traditional psychology is *typically* "... the only domain of organisational research that simultaneously examines perceptions of jobs, groups, leaders, and organisational attributes and thus has the unique capacity of being able to decipher common denominators and latent relationships that are not available to those who study only specific domains such as perceived equity" (James et al., 2008, p.27). We therefore made a decision to use a measure of *climate* as a backdrop to this mostly qualitative study, in order to 'triangulate' with our findings on leadership and patient care.

However, we found a competing strand of interest in the measurement of organisational *culture* (e.g. Davies, Nutley and Mannion, 2000; Scott, Mannion, Davies and Marshall, 2003) which more frequently seems to attend to health care settings than studies of climate albeit with some notable exceptions (Dawson, Gonzalez-Roma, Davis and West, 2008).

1.6.1 Emotion and the unconscious in organisations

Organisational climate and/or culture cannot be discussed without acknowledging that organisations are places where both the intellect and emotion are called into play in order to achieve organisational goals and as we have made clear, emotions are intrinsic to service delivery and leader-follower engagement in the NHS. Emotional engagement, while available to human consciousness, also takes place at an unconscious level (Gabriel, 2004; Hugh, 1986; Lyons-Ruth, 1999; Morgan, 2006; Willmott, 1986), and anxiety or stress is particularly salient when having to care for and make potentially life-saving decisions for patients (James & Huffington, 2004; Menzies¹⁰¹¹, 1970).

⁹ A paraphrase.

The ideas that characterise transformational leadership models, such as 'charisma', 'influence', 'inspiration' 'thoughtfulness' and 'consideration', have intellectual roots beyond contemporary management theory and training. They are more closely related to group and organisational theories with late 19th and early 20th century origins (De Board, 1978; Gabriel, 2004) from which much contemporary organisational theory has emerged.

The first significant attempt to analyse group behaviour made at the start of the 20th Century by Le Bon (1917/1920) whose book *The Crowd* illustrated his observation that individuals in a large group can demonstrate a 'collective mind' which emerges when people are bound together in some way. McDougall's book *The Group Mind* (1922/2009) and Sigmund Freud's *Group Psychology and the Analysis of the Ego* (1921/1922) also focused on what would subsequently come to be recognised as unconscious group processes. Freud developed Le Bon's and McDougall's ideas in the context of psychodynamic theory, arguing that the binding force of the group derives from the *emotional* ties of the members, which are expressions of their libido or drive.

Studies of (and human 'experiments' about) group psychology, taking some of this perspective on board, flourished after the Second World War conducted and further developed by psychiatrists in the newly formed NHS. In Britain the work of Wilfred Bion, Tom Main, Maxwell Jones and others led to innovations in both group psychotherapy and the study of organisations. Bion's work on group relations and dynamics which contributed to the development of the Group Relations Training Programme (GRTP) at the Tavistock Institute in 1957 evolved into the Leicester Conferences with other organisations using this model across the world (Miller, 1993). However contemporary knowledge and understanding continues to reflect back upon this early work.

What was learnt during this period about group dynamics and group relations represents an important dimension in the understanding of contemporary organisations and the relationship between leaders and followers. We develop this further in Chapter Seven in particular. It is important to note how the intellectual journey from work on emotional labour to social intelligence and intuition has so far largely neglected to explore the extent to which unconscious processes remain part of the emotional context of human social interaction (Allan and Smith, 2005, p. 21).

¹¹ Isabel Menzies is sometimes referred to as Menzies-Lyth. Her work has been reprinted several times with each name used.

In a hospital environment it is inevitable that negative events such as death occur (see Lewis for discussion on the impact of death on nurses in a special care baby unit taking an 'emotional labour' approach). When death does occur nurses may display emotions (consciously and unconsciously) such as anxiety and fear (Allan & Smith, 2005; Obholzer & Roberts, 1994; Allan 2001; Smith et al 2003). Obholzer asserts that "[he] believes that many of the organisations' difficulties that occur in hospital settings arise from a neglect of the unconscious psychological impact of death and near-death on patients and staff" (1994, p.171). He explains that hospitals are sites where anxieties about social taboos such as death are *contained*, that is that staff and the organisation overall takes away the anxiety and the responsibility for care from the relatives. Patients and staff are socialised to believe that hospitals are institutions where illness is treated and that medical knowledge and practice is infallible. This is illustrated by patients who contend that doctors possess God-like qualities and have the ability to heal all ailments. When death does occur, medical staff and the patient's relatives may feel *duped* by the institution they believed would save their loved one.

At the turn of the 19th to the 20th Centuries psychoanalytic ideas were seen to have something new and important to say, not only about the psychology of the individual and the role of the individual unconscious, but about *unconscious processes when people converge in groups and crowds* as shown above. From psychoanalytic theory we take up ideas again today specifically about the relationships which exist between followers and leaders, made explicit in the paradigm shift from transactional to transformational leadership. Working together and accepting or resisting influence comes not only with an observable set of behaviours and measurable emotions, but with unconscious and 'secret' ones including dependency, envy, power, anger, authority and emotional contagion, which may be either conscious or unconscious but have important consequences for behaviours (Burke et al., 2006; Simpson & French, 2005; Stein, 2005; Whitely, 1997). In Chapter Seven for example we see examples of where two senior managers find themselves unable to influence despite their senior roles, legitimacy and operational power. As Gabriel (2004) has argued "*emotions are no simple side-effects of mental life*" as "*emotion lies at the heart of human motivation*" (p.215).

One key feature of caring for sick patients, managing change and the social context of the NHS Trust then, is the ways in which clinicians and managers manage their anxiety which is fundamental to working in any health care setting. In the section that follows below, we demonstrate how psychoanalytic thinking explains how individual psychology and unconscious defence mechanisms link to the ways in which human beings work in groups and organisations.

In Chapter Nine we attend in more detail to the anxieties involved in obstetrics and more generally on the emotions involved in care of the elderly. In anticipation of these we present the theoretical material in some detail immediately below in this chapter.

1.6.2 Clinicians' anxiety and patient care

To conceptualize anxiety we draw on object relations theory, the branch of psychoanalysis associated with Melanie Klein (1959) and, in particular, the work of scholars who applied object relations to an understanding of groups (Bion, 1961) and organisations (Jaques, 1952; Menzies, 1970; Klein, 1987; 1983) hypothesising that an infant responds from the earliest time to the withdrawal of the maternal breast by experiencing a powerful anxiety of a 'persecutory nature'. Being unable to grasp the separation from the breast intellectually, the infant, unconsciously, feels as if every discomfort were inflicted by hostile forces. A fundamental *splitting* takes place, whereby an object is experienced as two separate objects, one entirely good and one totally bad. Thus there is a good breast (which is always present and nourishing) and a bad breast (withdrawing and denying), a good mother and a bad mother.

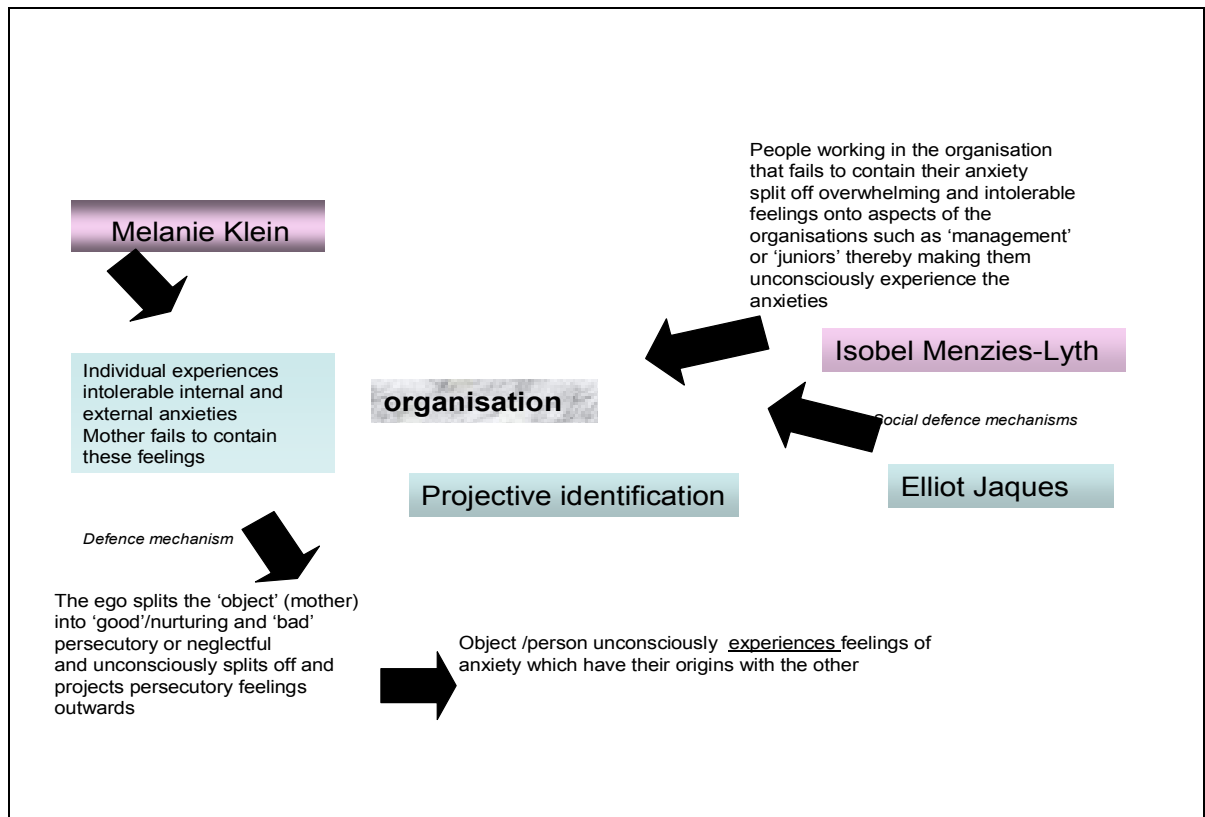
This is a pattern repeated in clinical settings, where patients routinely refer to a 'good nurse' and a 'bad nurse' and, almost identically, clinical staff referred to some patients as 'a good patient' and to others as 'a bad patient' (see Chapter Nine for an example of this). Splitting according to Klein extends in the child's own self – those aspects of him/herself that she cannot bear are projected outwards ("It is not I who is angry/fearful/envious; it is you"). Again this is a phenomenon observed many times in clinical settings. Frustration, discomfort and pain are experienced as persecution from hostile forces and their concomitants (e.g. hate) become destructive impulses which *are still operative in later life*, especially in times of stress and crisis.

Splitting and projection then are seen as fundamental *defences against primitive anxieties* by the object-relations school of psychoanalysis. Within this tradition, objects are not external entities but are shaped by phantasies¹² and feelings, they are *introjected* and projected, they split into good and bad and they constantly define and re-define the ego (or self). Object relations theory has found numerous important applications in the theory of organisations, primarily through the works of Jaques (1952) and Menzies Lyth (1960; 1970) in the UK, and more recently, Hirschhorn (1988), Gould (1993), Diamond (1993), Schwarz, (1990), Schwarz and Clore (2003) among others. Notable among these applications is the

¹² 'Phantasies' spelt in this way refers to those in unconscious experience.

treatment of *the whole organisation as an object which is liable to become incorporated in psychic reality* and towards which the individual may develop relations akin to early relations with significant objects from her environment and hold the 'organisation in the mind' (Armstrong, 2005) which we will discuss in more detail in the context of evidence from the study in Chapter Six.

Figure 2. Social Defences against Anxiety in Organisations



Menzies-Lyth, whose 1960 classic study of nursing staff occupies a privileged position in this literature, was driven by her initial observation that nursing work is highly anxiety-producing. She argued that nurses confront many different emotions from patients and their relatives - gratitude for the care they offer, admiration, envy for their skills and resentment stemming from forced dependence. Such projections create strong feelings in the nurses themselves:

The work situation arouses very strong and mixed feelings in the nurse: pity, compassion and love; guilt and anxiety; hatred and resentment of patients who arouse these strong feelings; envy of the care given to the patient. (Menzies-Lyth, 1988 , p. 46)

Faced with such an emotional cauldron, many nurses re-experience infantile persecutory anxieties, from which they seek to defend themselves, through

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the familiar mechanisms of projection, splitting and denial. Menzies-Lyth's important contribution was to establish how an organisation's own bureaucratic features, its rules and procedures, rotas, task-lists, paperwork, hierarchies and so on, in short '*the system*' acts as a support for the defensive techniques. By allowing for 'ritual task performance', by depersonalizing relations with the patients, by using organisational hierarchies, nurses contained their anxiety. Yet, in Menzies-Lyth's view, such organisational defences against anxiety were ultimately unsuccessful:

The system made little provision for confronting anxiety and working it through, the only way in which a real increase in the capacity to cope with it and personal maturation would take place. As a social defence system, it was ineffectual in containing anxiety. (Menzies-Lyth, 1991, p. 363)

The system's inadequacy in Menzies-Lyth's study is evidenced by its failure to train and retain nurses, the chronically low morale, high levels of stress and burn-out and absence of work satisfaction. By contrast, institutional health is testified not only by performance and output indicators, but also by morale indicators, and individual feelings of growth and maturation. Social defences against anxiety, then, are self-defeating. Instead of *containing* anxiety, they exacerbate it, just as neurotic symptoms far exacerbate the patient's malaise instead of containing it. Since Menzies-Lyth's pioneering work, some attention has been paid to how to support nurses and enable them to contain their emotions, without resorting to depersonalizing social defences. Yet, there is ample evidence that many nurses today continue to struggle with modest support against powerful anxieties (Theodosius, 2006; 2008). It is striking that no single study has sought to examine whether doctors face similar types of anxieties as nurses, whether they resort to similar psychological defences and the extent to which these defences function effectively across different individuals. In Chapter Nine we see evidence that doctors too appear to react similarly when faced with intolerable anxieties.

1.7 Developing our approach to leadership and the NHS

Studies of leadership and organisations such as the NHS clarify that diverse disciplinary perspectives have come together and separated more than once over the past century. The relationship between organisational and social context over that time has impacted on both practices of leadership and empirical and theoretical changes. In the 21st century the rules of scientific management or leader as therapist no-longer apply, and the rapid changes in organisations such as the NHS brought about by economic and technological imperatives, have left many who engage in leadership

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discourses, for practical and academic purposes, moving between the transformational and the post-heroic positions.

We now consider theoretical perspectives, ideas and practices that can potentially be brought together to good effect in this study for the benefit of patients and those who work for their good within the NHS, focusing on some of the recent debates which explore the context of leadership and the place of distributed leadership as they apply to NHS contexts.

1.7.1 The base-line:

- It is now widely acknowledged that organisations, their leaders and followers come together in a highly *emotional context*. How can those who lead and work in such organisations take account of the role of emotion while not being 'emotional' (i.e. making unfair and irrational decisions)? Understanding this is vital for enabling management and leadership particularly in a complex institution which has patient health, safety and care at its cutting edge (Morgan, 2006) .
- The NHS, individual Trusts and Units within these Trusts are constantly engaging staff in *change* (which may be evolutionary and/or politically driven) and which may be motivational and/or stressful or resisted (McNulty & Ferlie, 2002). This further demands emotional and social intelligence and engagement from leaders and followers (Bovey & Hede, 2001).
- The primary *tasks* and related *roles* might conflict at various points as these changes impact emotionally and intellectually on staff performance and service delivery (Zoller & Fairhurst, 2007).
- Organisations have to have leaders but leadership is not necessarily always the province of a small group of individuals but depends on the structure and demands placed on the organisations and the tasks required at any one time (Currie et al., 2009; Day et al., 2006; Harvey, 1989; Michie & West, 2004).
- An emotional context requires attention to both conscious and *unconscious* dimensions of human interaction and power relationships which may come into play in organisations which comprise multiple professional disciplines, different grades of role and people from diverse cultures, sexualities and gender (Ford, 2006; Gabriel, 2004). Acknowledgement of the importance of anxiety, envy, competition, anger and the emotional ties between people needs to be taken into account (see Figure 3 below).

Two models of leadership are therefore examined in this study (see Figure 3 below):

- First, *inspirational and transformative (or engaging) leadership* which has attracted much recent attention in that its absence was seen as a critical factor behind the failure of many organisational innovations. In this approach, leadership hinges on leaders' ability to communicate effectively, relate emotionally with their followers and develop a vision that is both attractive and achievable. The role of transformational leadership then is to lead an organisation towards change and thus some elements of transformational leadership are essential for understanding the practices and needs of the NHS (Alban-Metcalf & Alimo-Metcalf, 2009).
- The second relevant dimension is *distributed leadership* (sometimes called *dispersed, distributive, collective, or supportive 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). A *distributed leadership* approach is consistent with Bailey and Burr's (2005) research on successful NHS Trusts, which states:

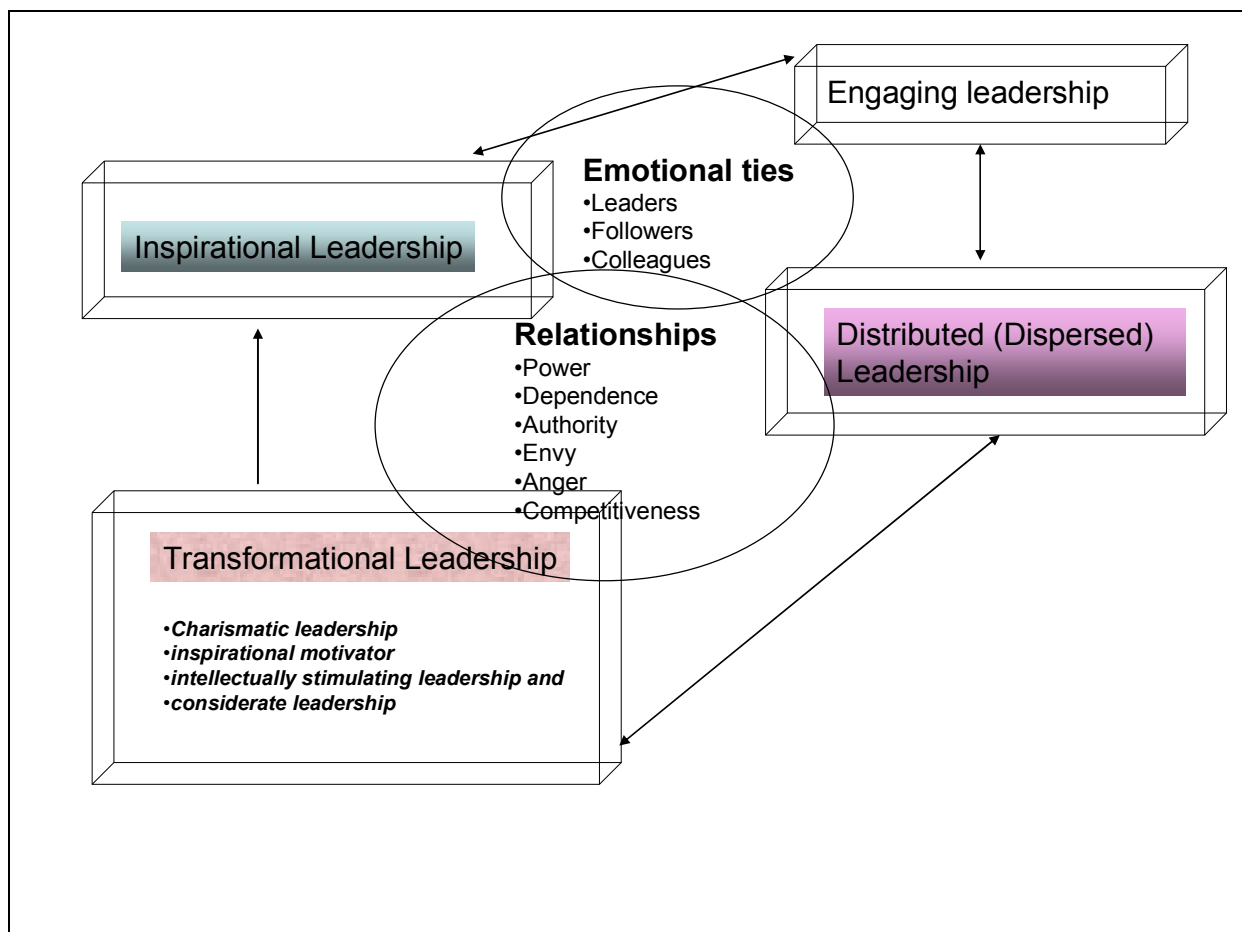
In contrast to the individual, heroic leader concept, leadership is seen in terms of the influence processes that contribute to the collective and individual capacity to work effectively. This idea of collective and distributed leadership is closely associated with the emergence and special requirements of 'new' organisational forms generally and the NHS in particular it is consistent with the agenda for devolved decision – making, empowerment of the frontline, de-centralisation, inclusion and such initiatives as 'Leadership at the Point of Care'.

Thus, distributed leadership is seen by Bailey and Burr (2005, p. 14) as directly linked to patient care.

A combination of these two models might now be seen as 'engaging' leadership as described by Alimo-Metcalf, Alban-Metcalf et al. (2007) and this combination will be explored further in our analysis of the (qualitative) data in particular.

Furthermore the model of the post-industrial/postmodern and or networked organisation will be 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).

Figure 3. Leadership Styles, Followership and Emotion



1.8 Conclusion

In an organisation like the NHS there are opportunities for leadership at all levels, as well as opportunities for success and unforeseen consequences leading to failure. Leaders in the NHS are involved *transformationally* in responding to policy initiatives and government demands, but the NHS is also an organisation that relies on the knowledge, skills and abilities of all its people – leaders and followers.

It would seem that *transformational/engaging and distributed leadership* are particularly useful conceptual resources to deploy in the context of the National Health Service, where a workforce of different ethnic, cultural and

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class backgrounds caters to the needs of a similarly diverse patient population.

Following Alimo-Metcalfe, Alban-Metcalfe et al (2007) "*an engaging 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'*" (2008, p. xi).

As part of the conceptual framework we develop, it is clear that the *emotional links* between individual staff, groups of staff and staff and patients need to be privileged as they play out at various organisational levels. Implicit therefore is that emotions above and below the surface (conscious and unconscious) are taken into account if the leader/follower and staff/patient relationships are to be understood and improved.

2 Aims and Methods

2.1 Introduction

The research questions in this study centre on identifying:

- (a) processes by which leadership is transmitted through health service organisations to effect the delivery of health services, and
- (b) how features of the organisation, the leader, and the service influence these processes.

The focus of this study was to explore the relationship(s) between (good) leadership in NHS organisations and (good) patient care. This demanded consideration not only of leadership characteristics, qualities and styles but the ways in which NHS organisational climate and culture interacted with individual practices and identities of those who worked in them and were patients. The overall plan was, thus, to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery. This research further sought to expand existing knowledge by exploring the following questions.

1. First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
2. Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

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3. Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

2.2 Aims and Objectives

We separated these overarching research questions into aims and objectives thus:

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients;
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts on service delivery;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted through health care organisations to affect service delivery, posits *organisational climate* as one feature of the organisation that could positively or negatively affect the quality and delivery of health services.
- To learn how different stakeholders (specifically, patients, nurses and professions allied with medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care.
- To identify how the need for change in service delivery is identified and what drives the need for change.

2.3 Methods

This multi-method study therefore uses a mixture of qualitative and quantitative methods to enable and support an innovatory approach to examining the psycho-

social and psychodynamic factors intrinsic to the meanings and processes of leadership, organisation and patient care.

Qualitative research methods now have a strong and long-standing profile in social science, particularly sociology and anthropology. But over recent years they have become increasingly relevant in social psychological research.

Furthermore nursing research (Finlay & Ballinger, 2006; Kerr, 2002) and most recently even health services research have begun to take evidence emerging from qualitative methods seriously. Perhaps this began with a series of papers in the British Medical Journal in 1995. Pope and Mays for example leading on this series aptly titled their paper *Reaching the Parts other Methods Cannot Reach* (Pope & Mays, 1995). Noteworthy from this point onwards is that there is no 'one' qualitative method of either data collection or analysis and we draw on several traditions and styles in this study which are outlined below.

Unlike health services research *per se*, but akin to critical social science, there is a powerful tradition in organisational research that has taken account of the diverse nature and intrinsic value of qualitative methodologies to understanding the life of organisations (see for example Cassell and Symon, 1994; Ybema et al., 2009)

What counts of course is choosing methods which meet the demands of the research hypothesis or overarching questions. We thus began from the premise that 'leadership', 'patient care' and 'organisational change' are not objective facts but social or discursive constructions. By this we mean that these concepts are constructed through discourse, i.e. a coherent system of statements which constructs an 'object' (Parker, 2002). In other words, talk about leadership is the process by which leadership is constructed (and thus recognised) as something that happens in organisations such as the NHS.

To capture these constructions we used a range of methods:

- focus groups;
- a survey-based questionnaire including a standardized measure of Organisational Climate;
- ethnographic 'shadowing';
- observations of social places, formal and informal and meetings;
- analysis of 'stories' of leadership collected through in-depth interviews.

2.4 Capturing the data

In what follows we present the outline plans for capturing, managing and analysing the data to meet our aims although as shown in Chapter Three not all of our goals were achieved.

We focused upon three NHS Trusts with at least one being a Foundation Trust specifically to explore whether any variations in the qualities of leadership, organisation and patient care could be distinguished. An

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investigation of three Trusts was considered to be manageable within the time frame and other resources available for the project.

Within each Trust we chose two distinct 'units' to study. We conjectured these would probably to be defined by clinical speciality or site (bearing in mind that many Trusts are organised across more than one hospital/physical space).

We conducted focus groups, an organisational climate survey, story-telling interviews and ethnographic work (observations and shadowing) across these six units with staff and patients.

We employed two researchers¹³ to carry out the majority of this work, but some members of the investigatory team also took an active part in the process.

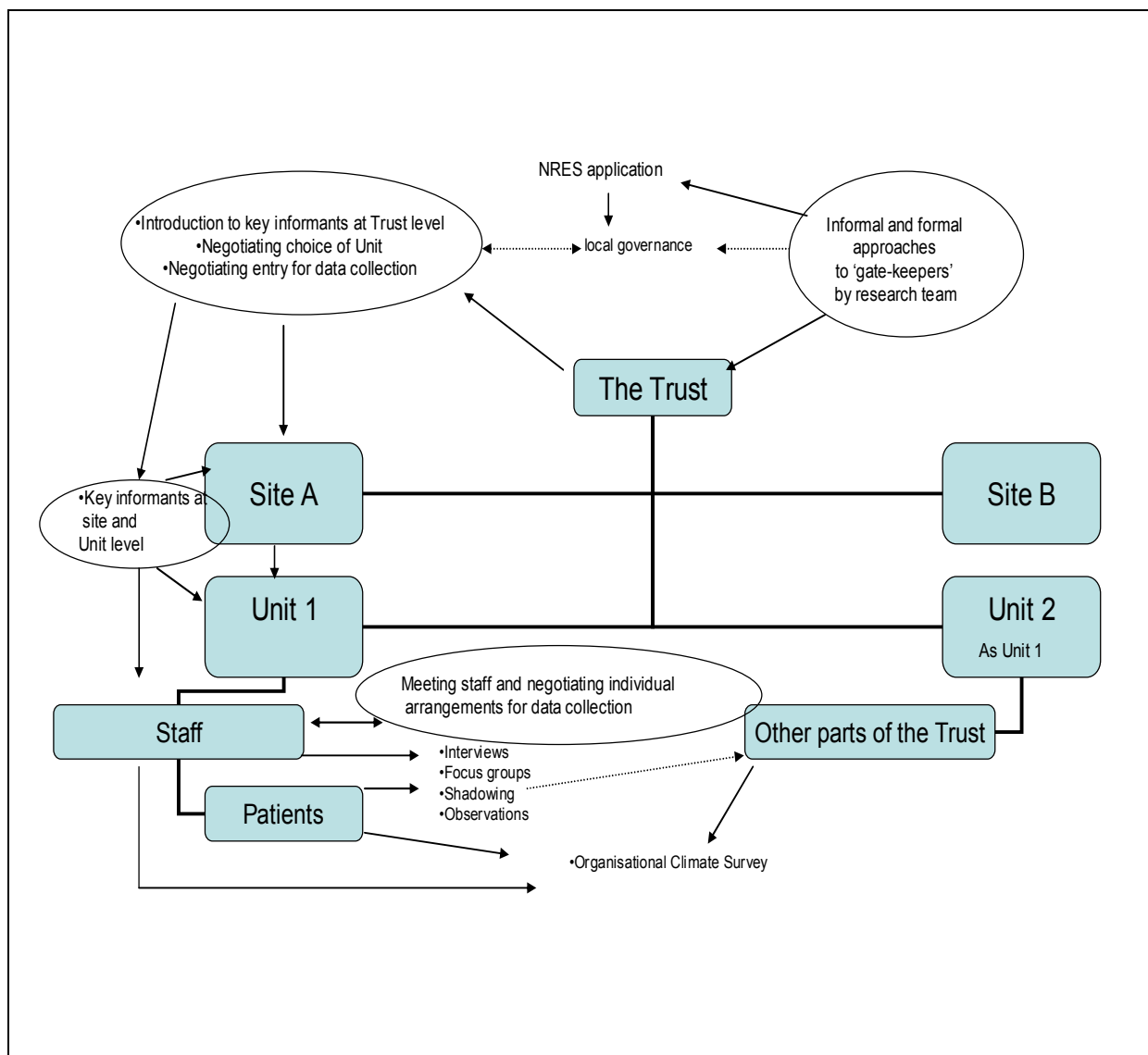
The qualitative data would by necessity and designed be analysed using a variety of methods:

- a. Thematic analysis (TA)
- b. Critical Discourse Analysis (CDA)
- c. Narrative analysis

Each of these approaches to data analysis, again by necessity and design, was subject to nuances of interpretation, intrinsic to their nature.

¹³ In the event three researchers were involved because of maternity leave and cover.

Figure 4. Access Pathways, Sampling Procedure and Data Collection Process



2.5 Sampling

The Trusts

Sampling the Trusts was decided according to three criteria that:

- they were each different from each other in the image they projected (on their web-sites, in terms of their physical style,

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locality, size and community) and that the sample had to include one Foundation Trust.

- they were in easy reach of London (for practical purposes as the study team were based in London and Surrey).
- we were able to gain access via personal contacts in R & D or senior management (the 'gatekeepers').

The Units

Sampling of the Units in each of the Trusts was achieved through negotiation with the gatekeepers and/ or key informants recommended by the gatekeepers with the intention that a balance might be struck between:

- the specific academic interests of the research team (for example the PI is particularly interested in Obstetrics and Gynaecology services).
- some degree of opportunity for comparison between Trusts, so that if possible some similar Units might be compared across the Trusts.
- and (possibly most influential) the concerns of the gatekeepers and other senior Trust staff.

The Sites

All three Trusts selected for an initial informal approach were on more than one site although the selection of study unit determined whether or not the data was collected on more than one site.

Individual Participants (staff)

Individual participants were to be selected on an 'informed' volunteer basis. That is that via a process of meetings with key informants and presentations to staff-groups individual staff would hear about the study and be offered the opportunity to participate. For those who were not involved in the meetings or presentations a staff e-mail list was used to communicate information about the study and request volunteers to participate in interviews and focus groups. The intention to meet the study aims was to ensure participation from a variety of staff groups and levels of seniority.

Individual Participants (patients)

Patients were to be recruited for interview either by the staff directly caring for them or by the researchers themselves once the staff of each unit had become familiar and accepted the presence of the researchers.

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Survey Respondents (staff)

The Organisational Climate Survey (OCS) was to be administered within the Units that were the focus of the study and, if possible, across other Units in the Trusts. The circulation was to be achieved either through e-mail or through internal mail depending on negotiation with the relevant gate-keepers.

Survey Respondents (patients)

Patients who might complete the patient version of the survey were to be recruited by staff and/or researchers if staff permitted the researchers 'on the ground' access.

Observations and 'Shadowing' (staff and patient-staff interactions)

These methods would require the participants to be familiar and comfortable with the presence of the researchers and familiar with the ongoing research process and also be prepared to co-operate. The rules for engagement in the activities would then be made on a strategic (i.e. the staff and / or situation that would yield the richest source of information) and a pragmatic basis (i.e. the possibility of the situation yielding important data regarding leadership, organisational culture and climate and patient care).

2.6 Ethical considerations

There are clearly considerations about confidentiality and anonymity in all data collection which involves human participants Easily identified in this study (and thus in the NRES application) is the matter of the safe keeping of the raw data including completed questionnaires, any identifying characteristics of these questionnaires, digital recordings, transcripts from focus groups and interviews and the researchers' field notes. It is important to note that this is not necessarily as simple to do as it is to describe particularly because a team of investigators, the researchers themselves and some 'casual' clerical staff ¹⁴all had different types of access to the data.

The solution was to have a shared drive set up by the computer centre at Royal Holloway, University of London (RHUL) on the main site at Egham which could only be accessed by specified investigators identified by the PI. Additionally there was an access pass-code to read the transcripts and the SPSS file.

¹⁴ The sheer volume of data made it necessary to use more than one person to input the data and transcribe the recordings. Two people other than the researchers were engaged to work on this although both were employees of RHUL who knew the importance of keeping the data safe.

Another ethical consideration specific to this project was that because the staff were discussing leadership and being asked to give examples of good and bad leadership, as well as examples of effective and poor patient care, it was inevitable that:

- they would be talking about *other* members of staff. These other staff could not be told that they had been talked about (by definition) leaving them unable to provide their version of the story or aware of the fact they had been discussed.
- the researchers would therefore be 'holding' some knowledge of others which would be 'data'. This fact drew attention to the ethical and empirical complexities of working in an organisation in which data is being collected on human interactions and relationships.

As patients' experiences and views and staff's views of patient care were also part of this investigation, similar issues applied.

Finally, frequently overlooked but nonetheless very important consideration was given to the fact that participants' time should not be wasted. We were confident in the design and our experience as investigators supporting and managing the researchers (who themselves were experienced in this kind of study) that the study was robust enough to adapt to the vagaries and quirks of 'real life' and that the outcome would be valid and add value to existing knowledge.

2.7 Methods of data collection and research instruments

As described above a mixture of qualitative and quantitative methods were used to ensure a full picture of leadership in the organisations to be studied. Collecting data in applied settings, where the participants are also engaged on a day-to-day basis is demanding work which is challenging for researchers involving persistence, social skills, the ability to develop rapport, clarity of purpose combined with flexibility, the skill of 'thinking on your feet' and making practical judgements about what is feasible at any one time. For example, if plans had been set for an interview with a staff member who was then called away for an important work matter, the researcher could arrange other potential participants or be prepared to engage in a period of systematic observation.

Immediately below we describe the methodologies we chose to employ to conduct our investigations which will be described in greater detail where appropriate in the context of specific case studies.

2.7.1 Focus groups

Focus groups, once the province of market researchers, in common with in-depth interviews, are now a popular method of collecting psycho-social data in the area of health research (Nicolson & Anderson, 2003; Nicolson et al., 2008) having gained recognition in social science overall as a robust way of eliciting “*shared and tacit beliefs, and the way these beliefs emerge in interaction with others in a local setting*” (Macnaghten and Myers, 2004, p. 65 in Seale et al) (p.8). In other words focus groups represent a means of gathering a sense of how those who work in an organisation share a sense of their ‘organisation in the mind’ (Armstrong, 2005) which may be mutually accepted, challenged or undermined by the perceptions of colleagues. Focus groups also enable the researchers to check out the quality and effectiveness of the communications themselves between members of the Unit or as Morgan (1998) suggests “*Focus groups are fundamentally a way of listening to people and learning from them* (1998, p. 9).

The process involves one or two researchers meeting with between four and eight participants who share a common situation and the guide lines for the discussion focus on key topics (see Appendices). One researcher takes notes although both are empowered to guide the discussion which is also digitally recorded. One benefit of this means of data collection is that through discussion among peers issues or perspective upon certain issues are brought into focus which might have escaped previous research authors and the researchers themselves (Morgan, 1998).

The *focus group guide* employed a similar structure to the *Interview Guide*.

2.7.2 Organisational climate

The Organisational Climate Questionnaire (OCQ) designed by Stringer (Litwin & Stringer, 1968; Stringer, 2002) also called ‘The Leadership Questionnaire’, was specifically designed to produce a scale to measure leadership in the context of climate albeit in a business rather than NHS setting. To complement the mostly qualitative methods of data gathering and analysis, we developed a questionnaire for staff and patients across the Trusts and used (a slightly adapted form of) Stringer’s measure of leadership and organisational climate, with the expectation that our results might also be linked to other studies undertaken with this measure, which had been used to examine management and leadership in organisations.

It identified six dimensions of organisational climate: *structure, standards, responsibility, recognition, support* and *commitment*, and uses eighteen leadership practices (three for each dimension) to capture how people feel about their jobs, how they are managed, and how things work in a particular organisation. Because this scale is designed to give practical

indicators on how to improve performance, many of the leadership measures are based on management practices, which are equally important to the overall success of an organisation. In general, however, each leadership practice measure is based on the premise that leaders care about arousing the motivation of members in the organisation (Stringer, 2002). The OCS was adapted from to fit a model relevant to NHS Staff working in a hospital setting and another version was adapted to be used with Patients (see Appendices).

2.7.2.1 Measurement tool: Stringer's OCS – Leadership and Organisational Climate

Stringer (2002) defines organisational climate as the "*collection and pattern of the environmental determinants of aroused motivation*" (p. 9) and he takes motivation to be central to the development of his climate questionnaire predominately based on the work of McClelland-Atkinson's framework with regards to intrinsic motivators of work related-behaviour: the need for achievement (nAch), the need for power (nPow), and the need for affiliation (nAff).

Stringer noted that specific dimensions of climate appear to have a predictable impact on motivated behaviour and can be measured and managed by those in senior positions accountable for organisational performance.

The six distinct dimensions identified and measured are:

- 'Structure'
- 'Standards'
- 'Responsibility'
- 'Recognition'
- 'Support'
- 'Commitment'

The statistical data was entered into an SPSS file to seek frequencies, correlations and to explore significance levels of differences and similarities between and within groups of respondents.

2.7.3 The survey structure and items

The survey is structured in two parts:

Part 1: measures *Organisational Climate* or how people perceive the work environment.

Part II: measures *Management Practices* or how people see their own managers behaving.

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Part 1:

This part consists of twenty-four items grouped into the six dimensions - 'structure', 'standards', 'responsibility', 'recognition', 'support' and 'commitment' - designed to measure how people feel about their work environment using a 4 point Likert scale. The directions ask the participants to describe the kind of working climate that has been created in their organisation (defining 'organisation' as the smallest work unit relevant to the participant).

Descriptions of the dimensions are as follows:

1. **'Structure'** pertains to the clarity of roles, responsibilities, accountability and expectations. According to Stringer this is more of a managerial than a leadership issue and one which is more practical than inspirational. It reflects the employees' sense of being well organised and of having a clear definition of his or her roles and responsibilities. *"structure is high when people feel that everyone's job is well defined and is low when there is confusion about who does which tasks and who has decision-making authority"* (Stringer, 2002, p.65).

The following items measure 'structure':

- The jobs in this organisation are clearly defined and logically structured.
- In this organisation, it is sometimes unclear who has the formal authority to make decisions.
- In some of the projects I've been on, I haven't been sure exactly who my boss was.
- Our productivity sometimes suffers from a lack of organisational planning.

2. **'Standards'** is about the need to achieve targets and reach goals. It is the drive to achieve and improve, it includes the 'commitment' and persistence to follow through on set targets. This dimension measures the feeling of pressure to improve performance as well as the degree of pride employees have in doing a good job. When interpreting this measure, high 'standards' indicate that people are always looking for ways to improve performance, whereas, a low score reflects lower expectations for performance.

The following items measure 'standards':

- In this organisation we set very high 'standards' for performance.
- In this organisation people don't seem to take much pride in their performance.
- Around here there is a feeling of pressure to continually improve our personal and group performance.
- Our management believes that no job is so well done that it couldn't be done better (Stringer, 2002, p.65).

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3. **'Responsibility'** is about taking ownership of the work and results which are obtained. Ideally people will be motivated to achieve results and take ownership over these. Where managers delegate and encourage responsibility, workers are more likely to feel a sense of 'responsibility'. It reflects employees' feelings of 'being their own boss' and not having to double-check decisions with others. A sense of high 'responsibility' signifies that employees feel encouraged to solve problems on their own. Low 'responsibility' indicates that risk taking and testing of new approaches tend to be discouraged (Stringer, 2002; p.66).

The following items measure 'responsibility':

- We don't rely too heavily on individual judgment in this organisation almost everything is double checked.
- Around here management resents your checking everything with them if you think you've got the right approach you just go ahead.
- You won't get ahead in the organisation unless you stick your neck out and try things on our own.
- Our philosophy emphasises that people should solve their own problems themselves.

4. **'Recognition'** relates to the relationships between one's performance and associated rewards, as well as broader sense of approval or disapproval of an individual's efforts. It indicates employees' feelings of being rewarded for a job well done. This is a measure of the emphasis placed on reward versus criticism and punishment. High 'recognition' climates are characterised by an appropriate balance of reward and criticism. Low 'recognition' means that good work is inconsistently rewarded (Stringer, 2002, p. 66).

The following items measure 'recognition':

- In this organisation the rewards and encouragements you get usually outweigh the threats and criticisms.
- There is not enough reward and 'recognition' given in this organisation for doing good work.
- We have a promotion system here that helps the best person rise to the top.
- In this organisation people are rewarded in proportion to the excellence of their job performance.

5. **'Support'** is the degree to which there is a sense of warmth and team work, within which the individual feels that they are 'backed up' by others. This will determine the amount of trust and respect amongst team members. It reflects the feelings of trust and mutual 'support' that prevails within a work group. 'Support' is high when employees feel that they are

part of a well-functioning team and when they sense that they can get help (especially from the boss) if they need it. When 'support' is low, employees feel isolated and alone. This dimension of climate has become increasingly important for today's e-business models in which resources are severely constrained and a premium is placed on teamwork (Stringer, 2002, p.66).

The following items measure 'support':

- You don't get much sympathy in this organisation if you make a mistake.
- When I am on a difficult assignment, I can usually count on getting assistance from my boss and co-workers.
- People in this organisation don't really trust each other enough.
- I feel that I am a member of a well-functioning team.

6. **'Commitment'** reflects employees' sense of pride in belonging to the organisation and their degree of 'commitment' to the organisation's goal. Strong feelings of 'commitment' are associated with high levels of personal loyalty. Lower levels of 'commitment' mean that employees feel apathetic toward the organisation and its goals (Stringer, 2002, p. 11).

The following items measure 'commitment':

- Generally, people are highly committed to the goals of this organisation.
- People here feel proud of belonging to this organisation.
- People don't really care what happens to this organisation.
- As far as I can see, there isn't much personal loyalty to the organisation.

Part II:

This part asks the participants to describe the practices of their managers. Using the same six dimensions as in Part I, participants are given eighteen statements which describe the way a manager might perform her or his duty and the respondents are asked to indicate how much he or she agrees with each of the statements. Here a 5 point Likert scale is used.

Once again the six dimensions are used to assess perceptions of managers' practices:

1. 'Structure'

- Establishing clear, specific performance goals for subordinates' job.
- Clarify who is responsible for what within the group.
- Making sure tasks and projects are clearly and thoroughly explained and understood when they are assigned.

2. 'Standards'

- Setting challenging performance goals and 'standards' for subordinates.
- Demonstrating personal 'commitment' to achieving goals.
- Giving subordinates feedback on how they are doing on their job.

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3. 'Responsibility'

- Encouraging subordinates to initiate tasks or projects they think are important.
- Expecting subordinates to find and correct their own errors rather than doing this for them.
- Encouraging innovation and calculated risk in others.

4. 'Recognition'

- Recognizing subordinates for good performance more often than criticizing them for poor performance.
- Using 'recognition', praise and similar methods to reward subordinates for excellent performance.
- Relating the total reward system to performance rather than to the other factors such as seniority or personal relationships.

5. 'Support'

- Being supportive and helpful to subordinates in their day to day activities.
- Going 'to bat' for subordinates with superiors when the manager believes their subordinates are right.
- Conducting team meetings in a way that builds trust and mutual respect.

6. 'Commitment'

- Communicating excitement and enthusiasm about the work.
- Involving people in setting goals.
- Encouraging subordinates to participate in making decisions.

Leadership question

We also asked a single question to capture directly how satisfied an employee is with the leadership they receive from their immediate supervisor. It was a simple statement: *I am satisfied with the quality of the leadership I receive from my immediate manager* which we measured using a 4 point Likert scale.

2.7.4 Ethnographic observations and 'shadowing'

Ethnographic observations and shadowing are especially useful to organisational research because they allow people to *physically* express their inner thoughts, and put ideas into *observable action*, all of which would be inaccessible through the survey or structured interview questions.

Ethnographic observation (often referred to as *participant observation*) has its roots in anthropology but has become increasingly deployed in sociology, cultural and social geographies. In the field (which in this case is a Unit in an NHS Trust) the researcher's aim is to "*understand how the cultures they are studying 'work'*" that is, to grasp "*what the world looks like*" to the

participants in the context being observed (Delamont, 2004, p. 206). In this study observation and shadowing opportunities were (mostly) formally set up and pre-arranged. However, the researchers, through taking their roles as interviewers, focus group leaders and having an every-day presence with key informants, gate-keepers and participants, were able to immerse themselves in the lives and atmosphere of each of the Trusts and Units providing evidence about the processes of leadership and patient care as well as 'climate' (Bloor, 2001; Goffman, 1961).

Shadowing involved the same conceptual framework as ethnographic observation in that the aim was to understand what the world looks like from the perspective of the staff member being shadowed as well as the worlds of the other staff and patients that they engaged with in the course of their work (Czarniawska, 2008; McDonald, 2005). It involved meeting the participant (usually) at 8 am and for one or two days accompany them including at break times until the participant went home. In Trusts where there was more than one site and/or when the nature of the day's work involved meetings outside the hospital (as in nearly every case) then the researcher spent time in a car with the participant and if agreed the conversation was digitally recorded as an *aide memoire* for the field notes. The participant was able to withdraw at any time, or for a period of time, across the shadowing period.

Thus the sense of 'what the Unit world looked like' was recorded in field notes which were then discussed with the other members of the team (who had some familiarity with the relevant part of the Unit/Trust) in a context where the researcher could be reflexive and explore the 'silent space' of the 'ethnographic self' (Coffey, 1999). The researcher's notes and expressed thoughts were then discussed with other members of the team, some of whom were familiar and others not so with the specific context (Barry, 2003). A similar approach was used to discuss the interview material because even though the interviews were digitally recorded and transcribed verbatim, this did not account for the reflexivity that took place following the interview itself and on transcribing and reading the transcript, and therefore featuring in the analysis (Nicolson, 2003).

In this context there was concern to capture the emotional content and atmosphere of the organisations. This meant that ethnographic methodologies were implemented to analyse the emotionality of the interactions (verbal and non-verbal) between patient and practitioner. It was through these observations that the use and importance of the researcher's *body as a 'research instrument'* became palpable, especially for understanding the emotions emerging out of the interactions between patient, relatives and practitioner(s). This process has been proposed as the antithesis of taking for granted that emotion should be removed from

ethnographic investigation and that in fact the research process is highly emotive and far from an emotionally barren terrain (Bondi, Davidson, & Smith, 2005).

As the researcher collects data they move through a continuum of emotions from the euphoric highs of excitement at starting a new research project, sense of achievement and pride as they begin to make contacts and collect initial data, perhaps trepidation, fear and nervousness as they meet new participants or research settings through to the depths of despair, isolation and frustration as the research process (inevitably at times) becomes chaotic and messy. However, these emotions are often neglected, regarded as unimportant to the overall research process and abandoned in the writing up phase. We use these frequently neglected emotions and feelings as part of, and beneficial to, the project as representing a rich source of data.

By being more attentive to their emotions and bodily senses ethnographers also become more sensitive to their environment and their participants thus gaining a greater awareness of what they are observing. In recalling a sound, smell or feeling the ethnographer is able to open up their mind's eye to re-visualise the interaction with greater clarity and accuracy making it more likely that an accurate representation of what was observed will be recorded.

2.7.5 In-depth semi-structured and 'story-telling' interviews

In-depth semi-structured Interviews: Over the past fifteen years this method of qualitative data collection has become increasingly common in health services and health research in general (Pope and Mays, 1995; Kvale, 1996; Grbich, 1999) consistently a method of choice for identifying perceptions, meanings and experiences of dynamic and complex concepts such as 'leadership' and 'patient care' (Rubin and Rubin, 1995; Denzin and Lincoln, 1998; Rapley, in Seale et al, 2004).

The use of such interviews has led to increased levels of sophistication in the interpretation of qualitative in-depth data in the context of historical, cultural and political frameworks demonstrating that in-depth semi-structured interviews (and more generally qualitative research) have capability beyond simply adding rich description to statistical evidence (see Denzin and Lincoln, 2002; Willig, 2008).

Story-Telling: One of the explicit aims of the interviews was to collect a number of stories to reflect critical experiences in the organisations' past and present life. In the field of organisational studies, there is now an extensive literature of how to use stories told by organisational participants

as windows into organisational culture, politics and numerous other phenomena (Gabriel, 2000; Hannabuss, 2000).

The inclusion of story-telling in the context of the in-depth interview increases the scope for making sense of data in ways that delve deeply into the respondents' perceptions and meaning of the *processes* of leadership and patient care. Story-telling also increases the validity of the interview through the use of reflexivity, and positioning the events and 'atmosphere' of the stories in the context of the organisational analysis.

Of particular relevance to this study, stories can instigate insights into the processes of positive or negative social and organisational change and leadership which involves the management of meaning and emotions, both of which rely heavily upon the use of stories, allegories, metaphors, labels and other narrative devices.

The study of *organisational stories* is particularly relevant in health care settings that are liable to unleash strong emotions and fantasies. Hence, hospitals are rich grounds for collecting stories, as numerous researchers have recognized (Kleinman, 1988; Frank, 1998; Greenhalgh, 2002; Hurwitz, 2006; Mattingly, 1998). Storytelling permeates everyday clinical practices and "*medical professionals find ways to 'routinize' their practice and thus, metaphorically at least, bring the unruly and frightening world of illness under control*" (Mattingly 1998, p. 277).

The *interview schedule* (see Appendices) therefore was designed to elicit information on the participant's view of 'leadership' and 'patient care' through 'stories' to provide examples in their opinion that constituted good and poor leadership and good and poor patient care through 'critical incidents'.

As the interviews were semi-structured and in-depth they relied to a great extent on the interviewing skills of the researchers and their ability to establish rapport and consequent willingness of the participants to engage in the process. The early pilot interviews therefore were unlikely to influence the details of the interview schedule itself although the early interviews were planned to enable the research team to identify the best *strategies* to engage participants in the task.

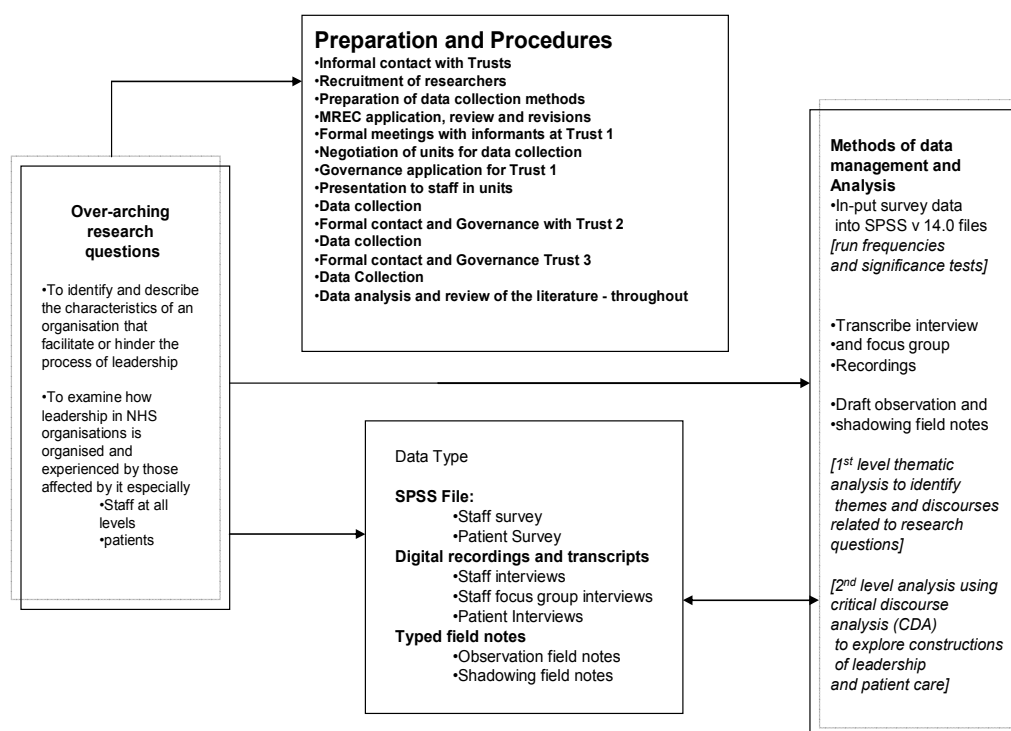
2.8 Data Management

The interviews and focus groups were digitally recorded and transcribed verbatim. The transcripts stored on a password protected Word file (initially on the researchers' PCs but subsequently on the secure shared drive described above) and sound recordings stored on audio files (password protected on the PC of the PI and not on the shared drive).

The OCS data was entered and stored on an SPSS file, password protected and placed on the secure shared drive.

Fieldwork notes from observations and shadowing were similarly password protected stored on the shared drive once they had been prepared by the individual researchers.

Figure 5. Outline of Study Procedures and Methods



2.8.1 Data Analysis

There are effectively therefore three categories of data.

1. Qualitative data representing verbatim 'talk' (digital recordings/transcripts) of interviews and focus groups.
2. Qualitative data from observations, shadowing and other field notes. These were subjective accounts of observations, perceptions, emotions and meanings given to the field work by one researcher. This may have been following discussion with the other researcher on occasions when that person had had access to the same raw

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material. Discussion with another member of the investigatory team (frequently but not always the PI) also took place following the first drafting of the field notes in order to clarify the meanings given to specific behaviours and relate theory and data.

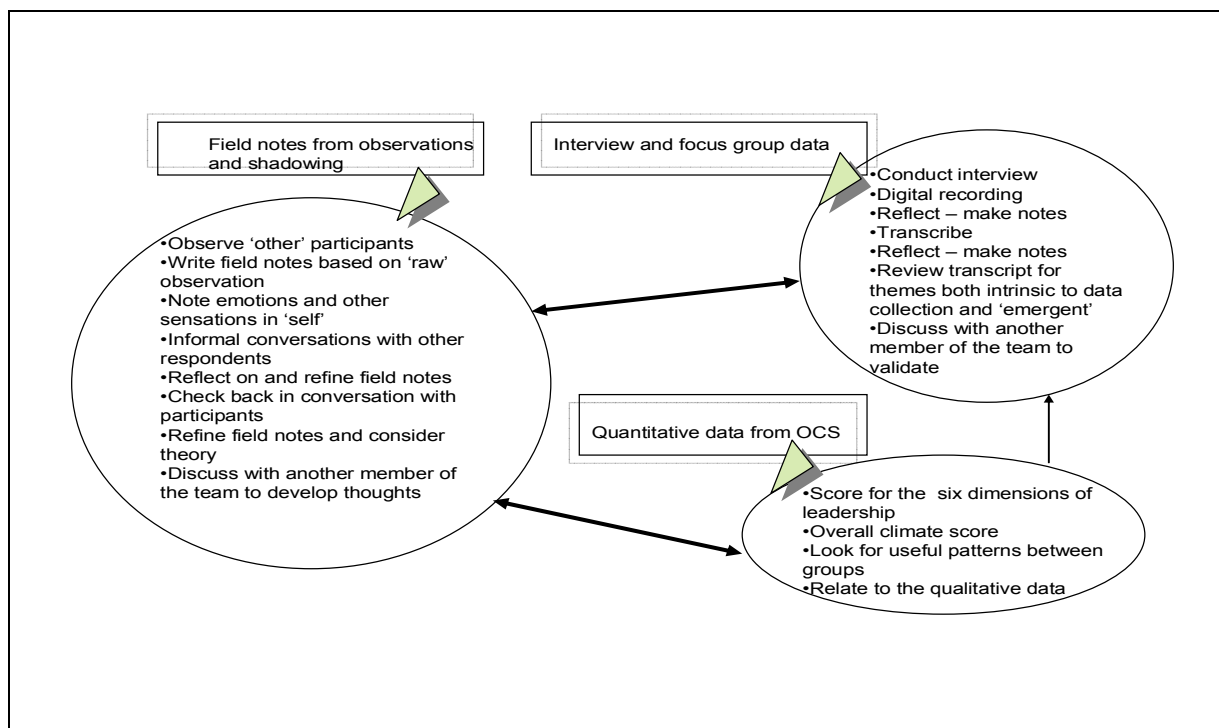
3. Statistical data from the OCS.

2.8.2 Thematic Analysis (TA)

The transcripts and field notes were examined initially for relevant extracts related to the main themes ('leadership', 'organisation' and 'patient care').

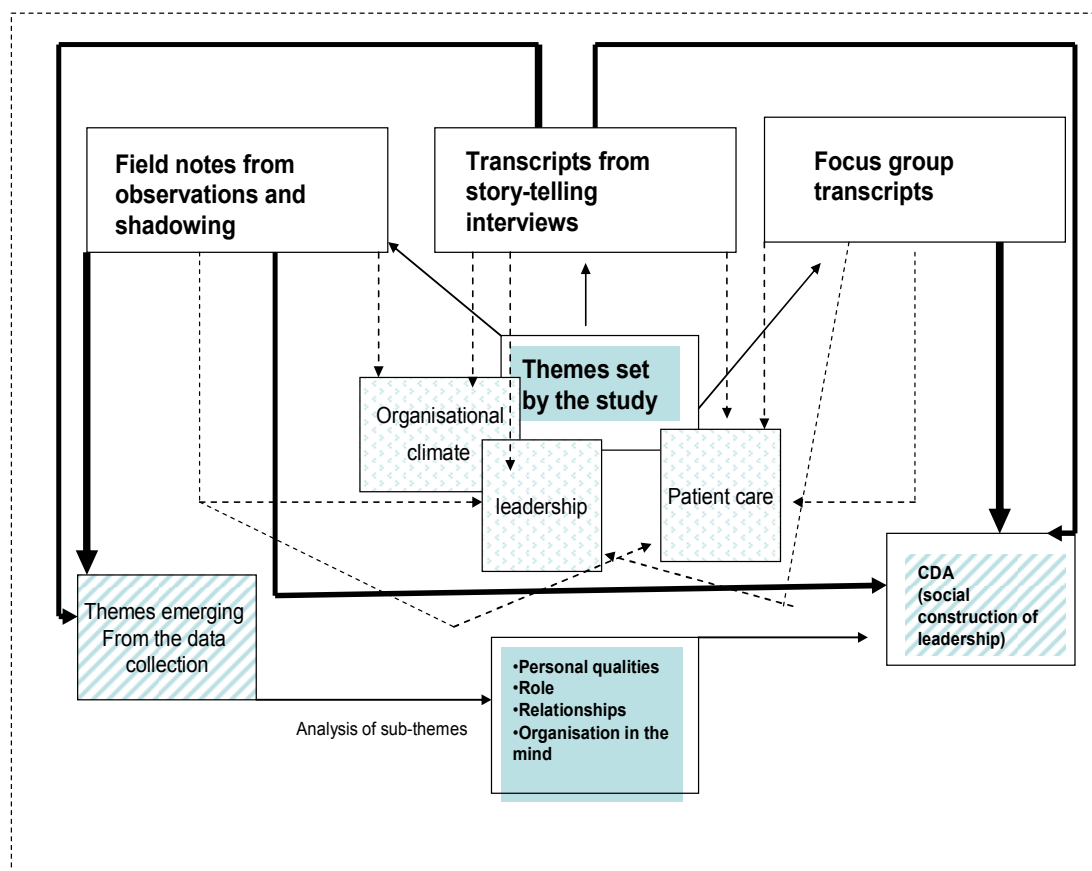
Sub-themes were then to be identified, some of which are likely to relate closely to the previous research literature on leadership and organisational climate, although it is likely that each organisation will demonstrate particular issues that were more difficult to anticipate at the outset.

Figure 6. From data collection to data analysis



Data relating to these themes and sub-themes was to be collated on Word files and where deemed relevant to the study aims, analysed further using the following methods – Discursive Psychology, Critical Discourse Analysis and Narrative Analysis. All these approaches focus on language and the way language is used to construct key concepts (e.g. the organisation) but there are different nuances to each perspective each of which adds an important dimension to the analysis of this data.

Figure 7. Thematic to CDA with Narrative analysis



2.8.3 Discursive Psychology, Discourse Analysis and Critical Discourse Analysis (CDA)

Hepburn and Potter (2004) argue convincingly and with justification that DA has evolved to have several iterations over recent years. One common feature though has been that 'discourse' (i.e. what is said) and 'context' are difficult to separate and it is the ways in which context is worked into the analysis of discourse that distinguishes the character of DA deployed in a particular piece of analysis.

The thematic analysis was a starting point from which to focus in upon the close readings of the texts, which related to the processes of leadership and patient care, as it represents a flexible and clear way of identifying what is emerging from the data and points a way forward with more detailed analysis (Braun and Clarke, 2006)

We argue that leadership is a social construction and there is a growing body of literature providing evidence to support this view. There has also been a recent focus in organisational research and theory to specify an Organisational Discourse Analysis (ODA) (Pritchard, Jones and Stablein, 2004) which involves four approaches i.e. *Narrative*, *Foucauldian*, *Linguistic* and *Deconstruction* which in turn are influenced by a *reflexive awareness* of the organisational culture in which the research is being conducted.

Pritchard et al, (2004) argue further that the exact methodology and approach to the data depends on the 'researcher position' in the organisation being studied. In other words this approach *benefits* from the subjectivity of the researcher's interpretation of what processes mean and specifically from researcher reflexivity about their 'take' on a situation and set of interactions.

To qualify this method of analysis further, a discursive approach means that language is represented not so much as an objective truth but as a means of *constructing* what might be understood (Parker, 1992; Coyle, 2007).

Particularly relevant in this study, in which participants are asked to tell stories and provide evidence to support what is good and bad about both leadership and patient care (and implicitly the organisation in which these actions take place), is discursive psychology (DP) that highlights how "*descriptions of events are bound up with doing actions, such as providing justification for actions and blaming others*" (Hepburn and Potter, 2004, p. 169).

Thus Critical Discourse Analysis (CDA) sees language as a *social practice* and thus considers carefully the context in which language is used (see

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Wodak, 2004). CDA is related to the notion that *power is negotiated through language*. This is particularly apposite in a study of leadership in organisations. Even more so CDA is 'abductive' so that a constant movement between theory and empirical data is needed which suits ethnographic methods such as shadowing and observations enabling the researcher to test out their ideas as they progress with the data collection, and the attempt to understand how cultures work and how the research participants make sense of and experience their worlds.

2.8.4 Narrative Analysis

Narrative approaches to data analysis have been able to cut through the great complexity of the NHS - the intense emotions, positive and negative, it evokes among most of its stakeholders (e.g. Rooksby, Gerry & Smith, 2007; Bryant, 2006; Iedema et al., 2009; Brown et al., 2008; Elkind, 1998; Brooks, 1997). These studies have, for example, addressed power issues in the doctor-patient relationship, exploring communication in a consultation situation. In these analyses, the patient's 'subordinate' narratives have often been neglected or taken over by the doctor's privileged 'medicalizing' discussion (Mattingly, 1998, p. 12; see also Radley, Mayberry & Pearce, 2008). However, there is also a recognition that many of these narratives are co-constructed by patient and physician (Mattingly, 1998, p. 43; Kirkpatrick, 2008); exploring solely the patient voice in isolation and presuming that doctors will at all times occupy a dominant position in this relationship may be missing half of the story - the doctor's experience. As Mattingly (1998) points out, *"[h]ealers too, may be able to give a different kind of voice to their practice when they describe their work in narrative terms rather than the flattened prose of biomedical discourse"* (p. 14).

As a genre, narrative psychology is thriving (Smith & Sparkes 2006). There has been talk of the 'narrative turn in psychotherapy and psychiatry' (Brown, Nolan, Crawford & Lewis, 1996), and Crossley (2003a & 2003b) for example argues strongly for a 'perspective that retains a sense of both psychological and sociological complexity and integrity' noting that narrative psychology is concerned with 'coming to grips with how a person thinks and feels about what is happening to her' (2000, p. 6). She employs a phenomenological framework to explore narratives of 'the voice' of 'the mentally ill' (Crossley & Crossley 2001) and the experience of temporal elements and self/identity of people living with serious illness (HIV, cancer; see also Söderberg, Lundman & Norberg, 1997). Narrative research in health care has also been used to study the lived experience of patients (see for example Hemsley, Balandin & Togher, 2007; Hök, Wachtler, Falkenberg & Tishelman, 2007) and an emerging genre of 'narrative based medicine' seeks to make use of stories in developing a fuller understanding of illness experiences (Launer, 2003; Taylor, 2003; Greenhalgh, 1999).

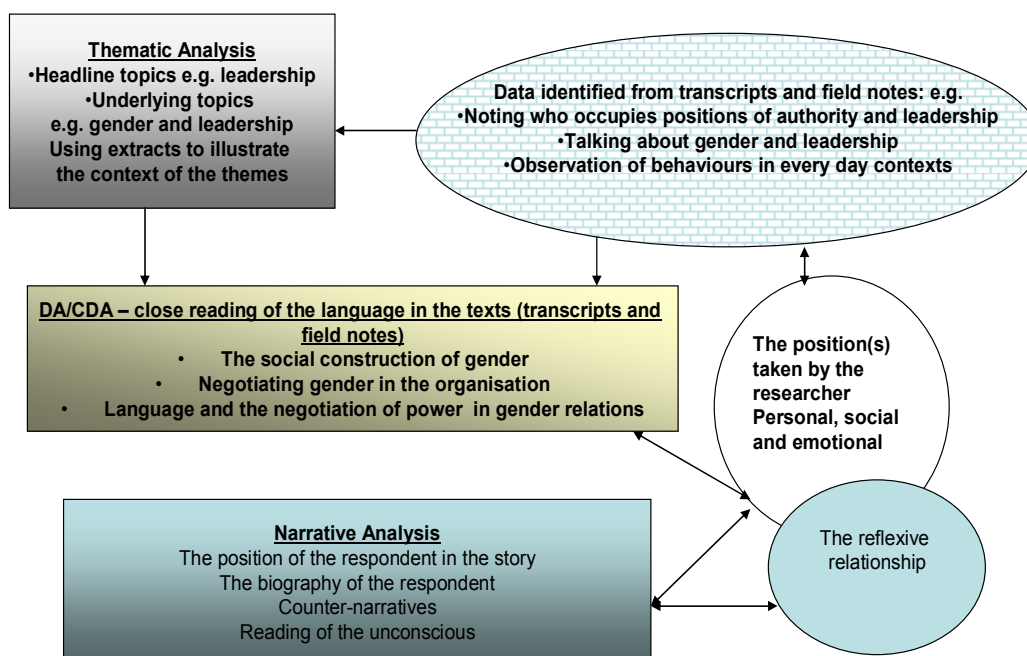
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Narrative based medicine is not merely an insightful way of doing research, but may have powerful policy implications. As Overcash (2003) argues, "*narrative methods are an effective research option that can lead to enhanced patient care*" (p. 179). While interpreting narratives can enhance the possibilities of integrating evidence-based research findings with individual illness experiences, and Winterbottom and colleagues (2008) suggest numerous courses of further research on why and how narratives may influence medical decision making.

Narrative analysis, as with DA, has been approached differently by academics from a range of disciplines so that the ideas surrounding the analysis of *narratives* (or stories told in a sequence) have a variety of emphases. The strength of taking the narrative approach over DA /CDA *per se* is that the 'subject' of the story (the narrator) retains a central role (Crossley, 2007). This can be seen in some detail in subsequent chapters particularly where the accounts of ethnographic observations and shadowing are highlighted where the 'story' becomes that of the researcher herself and with the stories unfolding through the interviews.

Furthermore the narrative analysis places the respondent's story as part of their own *identity construction* which lends an important dimension to the relationship of the story-telling to the teller. Particularly interesting here is Andrews' (Andrews, Sclater-Day et al., 2004) approach which focuses specifically on the elements of stories "*that lie in tension with the ones we are socialised to expect*" (2004, p. 97) or what she calls 'counter-narratives'. Researchers such as Hollway and Jefferson, 2002; Gough, 2003; Sclater, 2004; Allcorn, 2004 and Gabriel, 2004 and 2005, take on board the role of the interlocutor in positioning themselves in their story while considering some of the unconscious and emotional elements both of the story being told and the way that the relationship between the researcher and respondent plays out to construct and limit the story that is told. This dimension is particularly important in the context of this study where emotions are rife at least in part because of the high pressure (exacerbated to some extent by the changing political initiatives directed towards NHS institutions) and the particular nature of the work in caring for ill people (see for example Menzies-Lyth 1960).

Figure 8. Levels of qualitative data analysis e.g. 'gender'



2.8.5 Statistical Analysis

The data from the OCS was coded and in-putted into an SPSS v 14.0 file and significance tests were run (see Chapter Five for the full details).

3 Research Procedure

3.1 Introduction and Overview

The nature of this study, much of which involved the researchers immersing themselves in the 'world' of the participants, meant that it is not possible to provide an authentic *sequential* account of the procedure of data collection except possibly for the administering of the OCS (Organisational Climate Survey).

The bulk of the study, as identified in Chapter Two, comprised multiple methods of collecting different types of data across three Trusts, six Units and five sites.

3.1.1 Negotiating Access

The study took place across a three year period. Negotiation of access was complicated as indicated, although in itself a valuable procedure which occurred at several levels and helped to increase the richness of the team's understanding of leadership, patient care and the context of each organisation.

- Negotiating access began from the 'notional' level while writing the grant application whereby the investigatory team needed to identify whether a project with this design was in fact feasible. We thus made informal inquiries via personal contacts.
- More formal contacts were made once the project was confirmed with the intention to achieve verbal agreement about access for planning the NRES application.
- Following that we met to formalise the details with key informants (i.e. senior clinicians and managers) who had been identified in the previous stage.
- Once we had achieved a favourable NRES review, we pursued local governance applications with the help of the key informants.

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- These stages were managed by approaching one Trust at a time although during the latter part of the study some overlapping negotiations and governance were necessary.
- Part of the formal stage of negotiation concerned consideration of which *Units* could/would form the focus for the study. This was very much two-way but also serendipitous with suggestions from the team of investigators moderated by whichever senior clinical staff the key informants considered would be amenable to 'hosting' the study.
- The key informants then identified opportunities for the team to present the project to staff in the selected Units in 'educational half days' or 'staff meetings' depending upon the local structures.
- These formal presentations only took place in Trusts One and Three however. The procedure in Trust Two (because of the culture, location and structure) was on the basis of a 'tour' (which with permission was digitally recorded) organised by a senior nurse manager so the researchers, one of the co-investigators and the PI could meet various key nursing and medical staff across one of the Trust sites.

Once all that had been achieved it was the researchers on the whole who managed the day-to-day negotiations about who could and would agree to take part in the various elements of the study. This was complicated because of the day-to-day patterns of staff, changes in staff roles, particularly at senior levels, shift patterns and the sheer numbers of staff who may or may not have been aware and willing to allow access to, say, a particular meeting or team for observation or interviews.

Figure 9. Procedures and time-line

	2006/7	2008	2009
Winter	<ul style="list-style-type: none"> •Recruit and prepare researchers •Informal contact with 3 Trusts 1 and 2 •Informal visits to Trusts 1 and 2 •Develop research instruments •Prepare COREC/NRES application •MREC presentation and revisions •MREC approval •Start to review literature on leadership 	<ul style="list-style-type: none"> •Arranging formal contacts with Trust 2 (on 2 sites) •Visit to Site A •Further data collection in Trust 1 •Patient interviews 	<ul style="list-style-type: none"> •Researcher begins maternity leave and new researcher inducted into the team •Data collection in Trust 2 Site 2 •<u>[difficulties gaining access to staff list in Trust 2 for survey]</u> •Presentation to staff in Trust 3 (Unit 1) •Distribution of staff survey (individually handed out) in Trust 3
March - June	<ul style="list-style-type: none"> •Formal meeting with Trust 1 R & D director •Governance application •Formal meetings with senior staff to negotiate units for study •Unit based meetings and introductions •Presentation at educational half day on Unit 1 (obs & gyn) of Trust •Pilot interviews •Pilot staff survey 	<ul style="list-style-type: none"> •Formal meeting in Trust 2. Tour of Site A •Visit to Site 2 •Governance for Trust 2 •Informal meetings •Data collection begins in Trust 2 •<u>Trust 1 staff in Unit 1 return surveys to PI saying they won't give them out</u> 	<ul style="list-style-type: none"> •<u>[further difficulties gaining access to staff list in Trust 2 for survey – now due to key staff transfers]</u> •Preparation and presentation of invited paper to SDO conference in June •Paper preparation and further conference presentations
Summer	<ul style="list-style-type: none"> •Organise, send out and in-put data from staff survey in Trust 1 •Observations and interviews with key staff •Presentation to Unit 2 •Focus groups and interviews on Unit 2 	<ul style="list-style-type: none"> •Application for extension to project (successful) 	<ul style="list-style-type: none"> •Put staff survey on Trust 2's 'intranet' with information about how to complete and return •E-mail staff in Trust 3 who had not received a staff survey •<u>[a low response in both cases]</u>
Autumn	<ul style="list-style-type: none"> •Data collection •Data in-putting from staff survey •Patient survey given to staff on Unit 1 to distribute 	<ul style="list-style-type: none"> •Preparation of journal paper 1 •Further review of literature •Governance for Trust 3 •Identifying key contacts in Trust 3 •Negotiation about Unit 1 (Care of the Elderly) 	<ul style="list-style-type: none"> •Journal paper 1 (anxiety) being revised for publication •Journal paper 2 in preparation (gender) •Journal paper 3 (in preparation) leadership and 'territory') •Presentation prepared and delivered to NHS Surrey and Borders conference •Final draft report

3.1.2 Time frame and Participation of Investigators

We negotiated the formal details of access consecutively in order to make the process manageable. Most data was collected by the researchers (Dr. Fox, Dr. Lokman¹⁵ and Ms. Rowland) although the PI and other investigators made the initial contacts, met with key informants, contributed to the presentations and conducted some of the interviews and focus groups and (Profs. Gabriel and Nicolson, Dr. Heffernan and Mr. Howorth). The PI (Nicolson) and at least one of the researchers was present at all initial meetings with the gate-keepers and key informants.

3.1.3 NRES review

This was prepared and submitted at the end of 2006 and the PI, one of the researchers (Lokman) and another member of the investigation team (Gabriel) attended the appointment with London-Surrey Borders Research Ethics Committee in January 2007.

Annual reports were submitted to the NRES subsequently as required.

3.2 Sample characteristics

The three Trusts, selected as stated above in Chapter Two were each very different from each other, not only in formal terms (size, budget, location and organisational structures) but also informally and culturally and this influenced the 'access pathways'. Thus for example in Trust One our informal and then formal contact was with the R & D director (also a senior clinician) and assistant R & D director, who introduced us to the CEO, the clinical directors and senior nurses.

In Trust Two we had begun with meeting the CEO at the 'notional' phase who then retired in the meantime. This meant starting again with delayed local governance and to accomplish this, we were directed towards a senior clinical manager who then changed their role and location which meant dislocation of our planned procedures.

Trust Three involved a personal contact initially who was directly involved as a clinician in one of the Units who then arranged for us to have a

¹⁵ Dr. Lokman worked on the project for over two years and Dr. Fox took her place.

meeting with another senior clinician who in turn arranged for us to give a presentation to the Care of the Elderly/Geriatric Unit. From there we sought a second Unit for Study independently through contacts made during the course of working in the first Unit.

Trust 1 (One site only) a DGH (District General Hospital)

The Research and Development director here suggested the Units for study to be:

- Unit 1, Obstetrics and Gynaecology
- Unit 2, Cardiology

We were happy with his suggestions, and the staff was generally co-operative and supportive of the researchers.

The Trust itself covers two sites but the choice of these Units meant that all data was collected from one site. This was helpful because it meant the researchers and some of the investigators could spend time familiarising ourselves with the layout of the Units and the Trust site and become familiar 'faces' so that gaining consent from respondents was made easier than it would have been if the researchers and the study itself had to be presented as 'new' on each occasion.

While the study was taking place there were many fears expressed among the staff at all levels that the site we were investigating would become the less powerful with the other site taking over many of the executive functions. While the study team were collecting data on this site however this did not happen and the general 'morale' has improved so that the Trust is currently applying for Foundation Trust statusⁱ.

Self-Description of the hospital

The site we studied had 400 beds and a range of acute care services, including an Accident and Emergency department. It is situated in 52 acres of Green Belt parkland within 40 – 60 minutes of London. Originally it was built to serve casualties of the Second World War. Over the years, the hospital has been rebuilt, developed and extended to include maternity services, a departmental and clinic area, and a new theatre complex. In the early 1990s, the X¹⁶ Wing, which includes a Postgraduate Education Centre and modern well-equipped wards, was opened. A new building for the Accident & Emergency, ITU and Orthopedic Unit opened in the summer of 1998. In addition, comprehensive HIV and genitourinary medicine services are provided in a dedicated building.

¹⁶ We have used 'X' to ensure anonymity.

Obstetrics and Gynaecology

The study territory for this Unit¹⁷ comprised the labour ward, postnatal ward, a general outpatient clinic a dedicated ante-natal clinic and the Maternity Services Administration. The unit offered midwife care for home births, one to one care, water births and there was always a consultant obstetrician available and compared to other local hospitals it gained a score of 3/5 which was joint top score.

Cardiology

This Unit studied comprised one in-patient ward, the Medical Assessment Unit (MAU) and the Critical Care Unit.

In addition we spent time in the Management Suite where five interviews also took place of the CEO, Clinical Director, the Director and Deputy Director of R & D and a middle-ranking manager.

Observations also took place in public and eating spaces and shadowing involved walking around the hospital between different specialty wards and administrative departments.

Trust 2 (2 sites)

The Trust was one of the biggest DGHs in London with 4,200 staff. It had had a history of problems in its financial management and the quality of care but recent information on the web-site and confirmed by the CEO made it clear that:

The Care Quality Commission, the organisation that regulates health care nationally, has awarded the Trust a rating of excellent for the quality of services we provide to our local population. This is the highest possible performance rating in the 2008/09 Care Quality Commission annual national assessment report.

It seems that problems with the financial management remain although improvement had been noted.

The structure and organisation of Trust 2 differed significantly from Trusts 1 and 3. Trust 2 comprised two sites (recently combined into one Trust where one was a teaching hospital) which were at least eight miles apart and it

¹⁷ There were other parts of the Maternity Services at Trust 1 that were not observed directly.

was difficult to travel between one and the other on public transport other than using more than one bus or travelling in and out again from London. The journey by car varied from about thirty minutes upwards depending upon traffic.

Physically the two sites were very different. Site A was a relatively new building designed (as one researcher stated) to look like a motel or contemporary hotel. The other, B, was a traditional middle height rise built in the 1970s on a green site and appeared far more formal with long corridors and many signs to departments. Site A was more 'angular' and you could not walk very far without having to turn a corner which presented a very different 'feel'.

It was not possible, particularly in Site A to select a discrete specialist Unit (unlike Trust 1). Site A focused on acute medicine and care of the elderly and there were no formal divisions in where patients were treated as either in-patients or out-patients. So an older person with 'geriatric' health related problems could be in a bed next to a much younger person. We have identified a Unit as a Site in the case of this Trust. We found it equally difficult to 'pin down' a specialty in Site B as well.

At Site B we collected data from acute medical specialties, obstetrics and gynaecology and therapies (the latter being both physical and psychological).

This was in part because senior management at Site A (who were our key informants and 'gatekeepers') introduced us to staff they considered amenable. Thus for purposes of the study we had to identify Site B as our second Unit. Despite the introductions we managed, via snowballing, to find a range of participants who demonstrated many different view points.

To summarise then in Trust 2 the study was carried out in the following two Units which we have identified as follows:

- Site A / Unit 1 (Acute Medicine; Care of the Elderly)
- Site B / Unit 2 (Acute Medicine; Obstetrics and Gynaecology; Therapies)

We also interviewed a Clinical and Nursing Director both of whom worked across both sites and senior managers including the CEO and deputy CEO.

It became clear very early on that there was intense rivalry, even animosity between the two sites and some of this is explored in later chapters.

Trust 3 (2 sites)

Trust Three, in central London, is a long established hospital and a Foundation Trust with connections to a prestigious medical school. Travel

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between the sites took about twenty to thirty minutes by public transport. 9,000 staff are employed by the Trust with 1,100 beds available across the Trust at any one time.

- Unit 1 (Care of the Elderly, Acute Medicine)
- Unit 2 (Therapies)

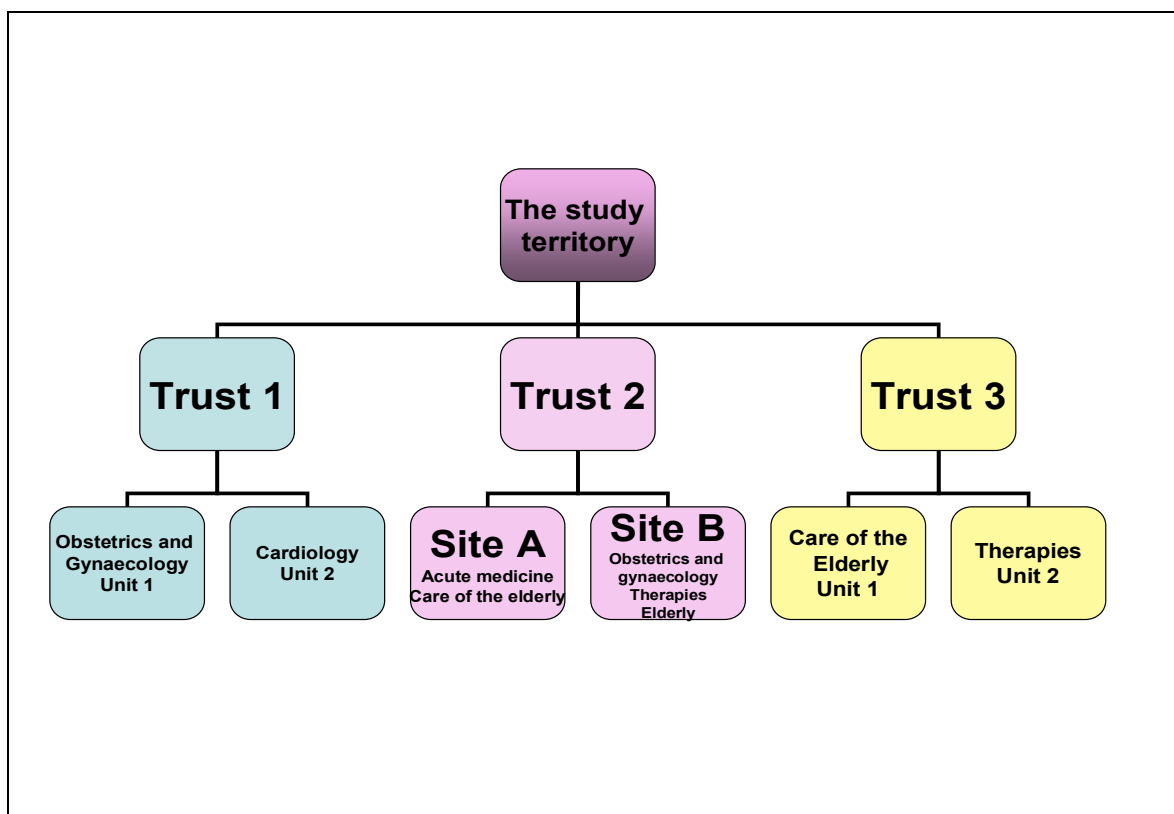
Unit 1 is described on the web-site thus:

Geriatric medicine specializes in the diagnosis and management of common symptoms and diseases in older people, particularly:

- *problems with mobility*
- *falls*
- *continence*
- *difficulties with looking after oneself*

Unit 2 (therapies) which included physiotherapy and psychological therapies spanned both the sites and covered many clinical departments and extended to primary care services especially local GP practices as well.

Figure 10. Participating Trusts and Units



3.2.1 Response rates (qualitative approaches)

It is difficult to identify an accurate response rate for the qualitative components (the majority) of the study because the sampling was conducted in an opportunist manner in many cases – i.e. whether someone agreed to take part in an interview or focus group if the researchers were on site and made a serendipitous approach.

As stated in Chapter Two, much of the qualitative data was collected by virtue of the researchers 'being there' in the right place at the right time and therefore gaining the trust of potential participants. In many cases the researchers were introduced to a member of staff who suggested ways in which other respondents might be accessed. Methods included personal introductions, using e-mail lists or sometimes a staff member knowing what was happening asked the researchers if they might participate in the study.

Overall the majority of staff approached to participate agreed to do so, although circumstances sometimes prevented it (e.g. one focus group was cancelled in Cardiology due to a patient emergency and one observation was cut short because the consultant refused to have the researcher in the ward round, although they had been observing on the ward before the consultant arrived having been given permission by the nursing staff).

Although the key staff across all three Trusts agreed to support the researchers in gaining access to patients for the OCS and interviews, the patient form of OCS was anonymously returned to the PI by someone at Trust 1 saying they did not want patients to participate in that exercise¹⁸.

It proved impossible to administer the patient OCS in the other two Trusts also, because the staff said in advance they were too busy to help and the researchers had difficulty in making contact with individual patients who were always either in busy wards or with a member of staff. Thus interviews and observations were conducted, with patients' consent, during shadowing.

The OCS for the staff is discussed fully in its own right in Chapter Five.

3.2.2 Individual participants

Respondents were either NHS staff or patients so by definition there were elements of uncertainty about whether they would be available at appointed

¹⁸ We sought advice but in line with the NRES review participants could withdraw their consent at any time so we did not feel free to pursue this further.

times and whether (as acknowledged in the NRES consent form) they choose to drop out at any time, even after having agreed to take part.

As shown below in Table 1, forty six respondents took part in in-depth story-telling interviews, thirty nine took part in focus groups. During twenty six days of shadowing of key staff, numerous other staff and patients were involved in data collection and similarly, during the eleven and a half days of observations on wards and in administration areas across the Trusts.

In addition, ten patients consented to be interviewed in depth and, again more staff were involved in the eight meetings that were observed and an introductory walking tour with a staff member in one Trust involved additional staff and patients in the study.

Each of these data collecting encounters represents a different unit of study and a different 'order' of data.

The nature of the study required a commitment of between 30 minutes (for completion of a survey or a short interview) up to two days, in the case of 'shadowing', of respondents time. Most respondents' contributions to the study, however, took about 90 minutes although this also represented an important commitment of their time (and energy).

Table 1. Qualitative Data Collection

Table 1. Qualitative Data by modes of collection							
	Interviews		Focus groups	Shadowing (staff and patients)	Ethnographic observation	Patient interviews	Other meetings and visits
Trust	N = men	N= women	N = Group (n = participants)	N = days	N = days		
1	13	19	5 (15)	5	9	10	4
2	5	9	3 (24)	8	3 x .5 + 1	0	2
3	4	8	0 (0)	13	0	0	2
Totals	22	26	8 (39)	26 days	11.5 days	10	8

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3.2.3 OCS (Organisational Climate Survey)

Trust 1

The staff survey

An administrator in Trust 1 provided a staff list (name and location) from which a random sample (35%) was identified using the SPSS software version 14 providing a list of 939 potential participants from staff across the Trust (including and beyond the Units participating in the main data gathering). The questionnaires were all individually addressed and sent through internal mail.

Of these 223 (24%) individuals returned a completed questionnaire, although ten blank surveys were returned with a note that the intended recipient had left the trust and one said they were unable to read English (1). Thus the final number of participants for Trust 1 was 210.

The patient survey

In Trust 1 we gained agreement from the senior staff on the two study Units (Obstetrics and Gynaecology and Cardiology) that they would arrange wherever possible for patients to complete the patient version of the OCS and would arrange for the researchers to collect the completed forms.

However the full batch of uncompleted patient questionnaires was sent back to the PI at the College several weeks later with an anonymous note stating that the staff did not wish to administer these to the patients. We were unsure how to proceed after this because ethically, although the survey was directed to the patients, the staff had completed consent forms and had copies of participant information sheets, and were aware that they (staff) could withdraw from the study at any time. We considered that this constitute an ethical dilemma for the team.

The researchers made other attempts to hand out the questionnaires directly to patients but found that while some patients were prepared to consent to being interviewed and almost all consented to having a researcher present during patient/doctor/nurse meeting it was not looking possible to obtain a valid sample of questionnaire returns.

Trust 2

Trust two was organised across two distinct sites and although the senior staff work across both sites, as will be made clear from Chapters Three and Four below, each site is very different in its organisation. We initially

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approached the senior staff on Site A first about how to distribute the questionnaires and they referred us to Human Resources on Site B who were the only people with access to a staff list. We did not get any acknowledgement from HR despite several attempts including one visit to the head of HR from one of the researchers. He said he would get back in touch once he had checked whether he could release this list but he did not and we considered there was little more we could do to pursue this particular approach.

The PI then contacted the senior nurse manager, who had been one of our original gatekeepers, for help but found that she had left for another post.

Following the abortive attempts to contact HR (or anyone else who might have been able to help) a PA in one of the many departments we contacted suggested that there was a staff intranet which went out once a week with an 'update' section with news for staff across the Trust. The PI made contact with the editor of this site who agreed to include an electronic version of the OCS.

Consequently, the questionnaire was included on this web-site, with a preamble (adapted from the NRES participant information sheet) on two occasions. However it only produced one reply. We made one final attempt via the PA of the CEO to contact HR for a staff list to no avail.

What was interesting and perplexing though was, that there was no difficulty obtaining a commitment from staff across the Trust to participate in an interview or focus group which was much more time consuming and personally revealing.

By the time we were ready to collect the patient survey data at Trust 2 we already recognised the problems with the responses from the staff. Also, by contrast, we had established the effectiveness of eliciting patient data from the shadowing and observations. We therefore made a decision to focus on this approach to data collection from patients rather than pursue more blind alleys.

Trust 3

In Trust 3 the early signs were that there was no overarching administrative structure from which we could obtain a staff list and nobody we asked could advise on the best way to gain that information. However we did have some 'local' e-mail addresses of the staff in the Units and therefore we e-mailed the OCS to staff on the two study Units and obtained 13 replies all together.

3.2.4 Participant characteristics

There were 224 respondents who completed and returned the questionnaire, of which 77% were women (n = 172) and there were 23% men (n = 49). These included from Trust 1 (n = 210, 93% of respondents), Trust 2 (n=1, 0.4%) and Trust 3 (n= 13, 5.8% of respondents).

The mean age was 46 years, standard deviation 11.1. The majority of respondents were married (62.7%), with a further 7% cohabiting. Twenty percent of respondents were single and almost 10% divorced. The majority of respondents were White (72%), the next biggest group were Asian (18%) and other ethnic minorities such as Black (6.5%) and Oriental (3%) consisted of much smaller groups.

Pay level: most of the respondents had a salary of less than £20k (44.3%) or between £20k- £40k (38.8%). A much smaller percentage (5%) earned between £60k and £90k and a further 2.3% of respondents had a salary exceeding £90k.

3.2.5 Professional demographics

The majority of respondents had been working in the NHS for over 5 years (68%), with a further 26% for between 1-5 years. Only 5.8% reported less than one year's service.

3.2.6 Stability within individual Trusts and Units:

Most respondents had been employed by the same hospital for over 5 years (56%) and another 34% had worked there between 1-5 years. The rest (10%) had been employed by the hospital for less than a year.

Most respondents reported working for the same Unit for over 5 years (45%), a further 43% reported working there for 1-5 years and only 12% reported service of less than 1 year. A similar pattern was seen in terms of length of time in same job. However the majority in this case had been working at the same job for between 1-5 years (45%) and slightly less (41%) had been working in the job for over 5 years. Another 12% had been employed in the same job for less than one year.

3.2.7 Role:

The majority of respondents were nurses, 31%. 13.5% of respondents were managers; 11% consultants/doctors/physicians. Other allied professionals, such as scientists and psychologists made up 10% and support staff made up a further 6%. Clerical staff and 'other' staff (such as porters, maintenance) made up a further 13% each.

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3.3 Data Analysis

This was conducted in the manner described in Chapter Two and the results are discussed separately in the following chapters each of which when relevant provides more context to the conceptual framework and analysis in the substantive area of focus.

3.4 Conclusion

The diverse nature of each of the organisations studied provided valuable information about the different kinds of challenges that different leaders at all levels might face in different institutions across the NHS.

Staff at senior level (particularly non-clinical managers) moved around within and between Trusts. During the course of conducting our study some key gate-keepers and participants left the Trust, others joined and yet others moved position and role even during the relatively short time we collected data there.

In some cases mergers had just taken place or were expected. This was experienced by some as opportunities and others as threats, but in all cases it meant structural reorganisation, staff being re-assigned or choosing to leave for another post.

This has to be taken to be part of the changing face of the NHS overall and central to the culture and climate of the participating Trusts, and can no doubt be generalised to every NHS Trust across the country. In what follows, we have used our different strategies for data capture to examine the relationships between leadership and service delivery in this fluid and (potentially) exciting context.

4 Leadership in the NHS

4.1 Introduction

In any organisation:

Leadership is needed to pull the whole organisation together in a common purpose, to articulate a shared vision, set direction, inspire and command

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commitment, loyalty, and ownership of change efforts (Huffington, 2007, p. 31).

and

Leadership would be easy to achieve and manage if it weren't for the uncomfortable reality that without followership there could be no leadership except, perhaps for the delusional sort. (Obholzer, 2007, p. 33).

In this chapter we examine the ways in which leadership is defined, exercised, experienced and transmitted taking account of how far leadership is perceived as pulling the organisation together to pursue the common purposes of patient care and the relationship between leaders and followers.

We specifically:

- Explore how leadership is defined by different stakeholders and what they see as determining its quality;
- Seek to begin to understand how leadership is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients through examining the data from focus groups and story-telling interviews;
- Using the same data sets, explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted.

4.2 How is leadership defined by different stakeholders and what do they see as determining its quality?

We start this particular exploration with a *thematic analysis* of the qualitative data to identify what themes emerge from the definitions, while also making interpretations using *CDA* and *narrative analysis*. In so doing we pay attention to what Gough has termed 'emotional ruptures' (Gough, 2004) in the text which serve to illuminate some of the subordinated or unconscious information in the stories of the respondents and the subjectivity of the narrator (Frosh, 2003; Frosh, Phoenix, & Pattman, 2003; Hollway & Jefferson, 2000).

In Chapter One we proposed that 'leadership' as a concept has been subjected to continuous scrutiny and moved through different theoretical and paradigmatic iterations. The NHS has identified the qualities it requires in a leader and the role that NHS leaders (at all levels) are expected to strive towards (see Figure 1). We therefore inferred that respondents, imbued in the culture, would focus on 'transformational' or 'distributed'

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explanations and definitions about leaders and leadership because these models are embraced by the style of the coaching and training on offer.

4.3 Definitions

Respondents distinguished between 'leader' and 'leadership'. A 'leader' was described and defined in diverse ways including as:

Obviously strong minded and opinionated (Administrator, T, 2¹⁹).

Particular personality traits - need to be - to have integrity, ((1²⁰)) to ((1)) be clear, err to be facilitative, to have energy to listen, erm, to negotiate, ((2)) to make decisions (Senior Non-clinical Manager, T, 2).

... making sure that you're the person who is erm keeping the team focused getting them to achieve those goals looking at different ways of working (Senior Clinician, Trust 3).

These definitions suggest diverse ways of thinking about the idea of 'leader', indicating that commonality of stakeholder views should not be taken for granted. The qualities a leader has to have are determined in these definitions through having opinions, being strong-minded while also having integrity. A leader also needs to be able to facilitate actions, negotiate and keep the team focused towards the achievement of its goals supporting team-work.

4.3.1 Defining leadership

Leadership in this first definition below was about a formal role and implicitly hierarchical rather than distributed:

I don't think there is anything magical about good leadership. It is about establishing what the organisation wants to do and allowing people to get on and do it (Recently retired CEO with clinical background, T2).

This respondent, who had occupied a senior position, saw the structure and strategic direction of the organisation as fundamental to what works as leadership which was not 'magic'.

¹⁹ In some cases we are able to identify the Trust but where there is any chance of a breach of confidentiality we adjust the 'credit' to ensure anonymity.

²⁰ Where the transcription has included double brackets it denotes pauses timed in seconds.

The following respondent expresses it differently suggesting that it means different things to different people on the one hand, while also being an imponderable (possibly even magical):

Leadership is like love, we all know it exists, but you can't actually prove it, you can't define it, and it comprises of lots of different things that people do, if you demand evidence for everything...you will get rid of leadership eventually (Senior Clinician, T2).

This clinician seems to take distributed leadership for granted in that it is about 'lots of different things that people do'. A warning is expressed it appears, though, that trying to *show* leadership exists across the organisation (perhaps rather than residing in designated roles) might ultimately destroy the possibility of leadership. Following Gronn (Gronn, 2002) this might be a way of suggesting that through concerted action leading to conjoint agency, leadership might not be so obvious (as in the first definition immediately above) but it might be more effective in a hospital where there are different qualities needed to lead in different activities.

Resonating with the view above that a leader has to have integrity, is the view from one leader's experience:

I learnt that it's very important thing for leadership... to not lie, not hide anything and just tell them the reality and be true to yourself, and that's really important (CEO, Non-clinical).

There is an immutable relationship between the leader and the follower. Being true to oneself and honest towards followers must be fundamental to the emotional engagement or attachment between leaders and followers. The significance of emotional engagement as well as emotional and social intelligence was high on many respondents' agendas for determining leadership quality:

... leadership is about having, or being able to demonstrate at any level a coherent vision for where you're trying to go and getting people getting there (Nursing Manager, T 2).

[Leadership in the NHS] is a people focused, leadership job (Senior Non-clinical Manager, T3).

.. it's not always leading from the front (Senior Clinical [therapies] Manager, T 3).

While the leader needs to have vision, these definitions imply that vision alone does not determine how leadership can be exercised or experienced. Leadership will not work unless the leader engages the followers with that vision.

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If leadership fulfils an organisational role ('establishing what the organisation wants') then can it also be 'people focused'? If good leadership is about transparency and honesty is there an assumption that it has not always been so or may not be so at some future time? What does this imply? Does leadership have an 'indefinable' quality' or set of characteristics that work within a specific context but may not be transferable as 'skills'?

Leadership presents dilemmas for the maintenance of personal integrity ('tell them the reality and be true to yourself'), it is a 'job', it requires 'vision' and flexibility and most importantly it seems it is about focusing on people.

4.4 How is leadership in NHS health care organisations exercised and experienced by those affected by it?

Respondents talked about the *role* of the leader as central to the practice of leadership in the organisation. Leadership was understood to be intrinsically linked to particular tasks/goals while necessarily engaging with the followers who had to implement much of these tasks and achieve the goals. There was a sense that many respondents held an idealised view about leadership in their own Trust. Sometimes though the reality for them fell short of expectations because the person occupying that role failed to live up to their hopes.

For example, as the following extended extract illustrates:

.. one of the things about the leadership and management of this Trust is first of all clinical leadership is strong in most places. The clinical directors here have general clout and they are not just figureheads .. and the other bit I think - relationships between general managers and clinicians on the whole are much more positive here than other Trusts (Senior Clinician).

This proposes that strong leadership among clinicians (distributed both horizontally and vertically via the clinical grouping) enables managers to deliver the service to patients. However, this does not in itself identify the characteristics of the links between strong leadership and service delivery.

For many respondents leadership is exercised at least in part through each leader's personal characteristics (good and bad). Almost without exception when asked about the qualities that make a leader, and to 'story' their own explanations, respondents placed a degree of emphasis on the characteristics of an 'ideal type'. The following exemplifies this:

Most important quality is the communication. Being able to listen - hear what is being said and to deliver that--what they want to say, so that it is heard by all. That it be quite quick thinking, being able to develop an idea

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and roll it out, umm being able to think on their feet as well, because sometimes you get things that turn up and you have to deal with it there and then, umm, reasonably personable so people will confide in that person, um also strong so that when things are tough they can um deal with them (Clinical Midwifery Manager, T1).

The comprehensive but daunting picture of how leadership is exercised described above, represents an ideal of distributed leadership as *concerted action* (Gronn, 2002). This type of leadership is exercised through being able to communicate – to listen and to express clearly (so as to be ‘heard’) how action will be taken. ‘Rolling out’ the idea again suggests taking peers and followers along with you and being ‘personable’, so people will confide in that person, further indicates the ability to take the views of others into account calling for both emotional and social intelligence (Amendolair, 2003; George, 2000; Goleman, 2006; Lopes, Grewal, Kadis, Gall, & Salovey, 2006; Riggio & Reichard, 2008). In this model, the multifaceted communications rely on the ability to use the information to think quickly and be strong under ‘tough’ circumstances.

However, in the next extract (from a non-clinical manager) the ideal type of leadership is represented by responding to short and medium term organisational goals (Buchanan, Fitzgerald et al., 2005; Riccucci, Meyers, Lurie, & Han, 2004).

Erm, I think leadership is about erm, encouragement. It is about showing people direction in which you as an organisation and them as individuals engage in. I think it's incredibly important especially in an organisation like the NHS where there are lots of different groups of people and lots of different objectives - sort of daily ones, monthly ones more long term, and you have quite a clear sort of vision of where you're going and I think that the good leaders in the NHS show that, and examples of bad leadership are where that is not so defined. (Middle Manager, T2).

This suggests a *transactional* model of leadership, whereby the good or effective leader offers ‘encouragement’ to the followers in return for people accepting the practices of the wider organisation (Bass, Avolio, Jung, & Berson, 2003; Eagly and Johannesen-Schmidt, 2003)

4.4.1 Exercising leadership through their organisational ‘role’

Leadership is experienced by some as being exercised through the legitimated role. Organisational role in the leadership discourse equates with the leader’s professional position as the respondent below shows clearly:

Who would be a leader to me? I think there's a number of different areas, there's your direct line manager, who's the clinical leader of your department. Who's who in this structure there's line managers above them, and above them and so on. There would be people you would look to within your own specialty clinically who are more experienced than you ((2))²¹ in certain areas, to ask for advice, erm ((1)) and similarly in an academic environment ((1)) there are other people there who have more experience that you would want to take advantage from or advice from. ((2)) And in the wider circle, national or international leaders in the field who are so expert at those things that you also turn to. (Medical Consultant, T3).

While the formal roles and organisational hierarchical structures are taken seriously by this respondent, there is also a clear vision of leadership being exercised through concerted action in collaborations that arise *spontaneously* where clinical and/or experience is valued and sought within this respondent's speciality and sometimes *intuitive* leadership (Day, Gronn, & Salas, 2006; Pearce, 2004). However, there is also a sense that this respondent experiences leadership through the institutionalisation not only of formal roles locally, in the organisation itself, but through the structural relationships with those who are seen as experts in a much wider networked context (Pearce, 2004). This version of leadership is particularly important in that it demonstrates that leadership can be both experienced and exercised beyond the boundary of the organisation and the NHS, based on knowledge and expertise originating outside these systems.

Respondents frequently combined personal qualities with their understanding of the leadership role, particularly related to taking responsibility as part of that role:

It's quite difficult, I mean I think taking responsibility (4) making sure that things happen that are supposed to happen, or don't happen that aren't supposed to happen (3) um.., (6) that's it. (Clinical Medical Consultant, T1).

Not everyone saw leadership in this way. This respondent is talking about their own experience of being in a role in which then 'buck' frequently stops and thus by definition they are in the role of leader.

The exercise of leadership through being a 'role model' (Trevino, Hartman, & Brown, 2000) where qualities of leadership were displayed was important for some:

The leaders that I've worked for and have wanted to follow ... push something in me that says 'I want to be like them' or I completely support

their vision of where they're going or you know so I want to follow that person and I want to do the best that I can do for them because I believe in them and their vision. (Head of Non-Medical Clinical Team, T3)

This explanation has a flavour of heroic or charismatic leadership, although not as a quality that resides in a specific person necessarily, but one that resides in a relationship that 'fires' up both leaders and followers (Klein & House, 1995). Even though the idea of the charismatic leader has been at least partly consigned to the history of the late 20th century organisation, it has not disappeared and needs further thought particularly in an organisation such as the NHS where changes are sometimes rapid and stressful (James, 1999) and internal culture needs to be taken into account (Dopson & Waddington, 1996; Tourish & Vatcha, 2005).

4.4.2 The relationship of the 'leader' to 'followers': how leadership is experienced

While leadership is the focus of the professional and political debates about the NHS and other organisations, until recently, relatively little attention has been paid to followers' experiences of leadership (Avolio et al., 2004; Howell & Hall-Merenda, 1999; Lewis, 2000; Schilling, 2009). From the perspective of a manager taking the position here as 'follower' looking 'upwards' in the organisation:

I think it's, it's providing, you know direction and to lead and that's a leader's main job in my mind. And (2) that's .. what they say for leadership, you must have followers. If nobody's following you, what you are saying then? you are not a good leader. So that's a good, you know, test for a leader to evaluate themselves. That's what they are saying and what they are trying to achieve. Are people behind them or not? If they are not behind the leader there's something wrong with that. (Middle Non-clinical Manager)

From the perspective of a junior doctor taking the 'followership' position:

I think in order for you ... well in my opinion a leader, I have to be able to kind of respect them. If I don't respect or kind of have faith in what they do, then it's, it's a personal authority, so in order, you know in order for me to do that I have to believe in what they say. I mean, I might not always agree with them in my opinion but at the end of the day I have to be able to respect them enough and for them to have certain authority, someone who's probably experienced and gained that knowledge, so yeah. (Junior doctor)

For leadership in the NHS to be exercised effectively then there has to be an engagement between the leader and the followers (Macy & Schneider, 2008) and to understand fully how the engagement takes place, a degree of

emotional engagement and/or attachment to the leader and the organisational vision is fundamental (Riggio & Reichard, 2008; Rubin, Munz, & Bommer, 2005; Vince & Broussine, 1996).

The failure to take followers with you is made explicit here from the perspective of one (designated) leader:

A: I was forced upon them...

Q: that's what I was going to ask. So presumably there was a lot of resentment I guess?

A: Yes.

Q: And how does it manifest itself?

A: Erm, non-cooperation, making life difficult for you sometimes, people talking about erm ((2)) sort of criticising you behind your back and erm playing silly games behind your back that makes management of other people more and more difficult. Erm you know, and yet we sort of have to fight another battle to win hearts and minds, when we, you know, don't really have the time to do that, we have got to have our focus on doing what we are meant to do, which is to manage patients and to manage our beds properly.

This extract from the interview with someone whose role it is to lead change is revealing. The respondent recognises that he is not taking people with him and in his view, the followers appear to eschew co-operation. He also believes they are mocking him and that that mockery is contagious. He may or may not be able to evidence this, but that it is in his mind is potentially detrimental to his experience of leading in his organisation (Stein, 2005). Furthermore, instead of looking at himself, this respondent wants to push the blame for the leadership failures onto the followers (in other words he engages in splitting described in Chapter One) (Klein, 1975; Segal, 1973). Such a process is diametrically opposite to leadership studies that identify authenticity and trust between leaders and followers as being one of the basic qualities for leadership (Avolio et al., 2004; de Raeye, 2002; Novicevic, Harvey, Ronald, & Brown-Radford, 2006).

There is also some evidence of concerted action here, distributed among those who were leaders of the *resistance*, which is not necessarily against the values of the organisation in any negative way, but may be seen as upholding important principles and challenging change (or a particular form of leadership) that might be perceived as counteracting these important values (Collinson, 2005; Zoller & Fairhurst, 2007).

Trust is one important quality in the way leadership is exercised and experienced by followers and developing trust is essential if changes in

practice are to be implemented (Bass & Steidlmeier, 1999; Hunter, 2005). So, for example, 'engaging' with others involves trust:

Yeah definitely there are some good examples of where it's obvious that people have been able to engage lots of different kinds of people in different groups and I think they've done that just by sort of making relationships with them in the first place and then when it comes to having to lead them and be influential then you can see that those relationships are already there and then they can call on that you know, that sort of that trust or that sort of relationship that they've got (Middle Non-clinical Manager, T2).

The same respondent continued with a specific example that aptly demonstrates the links between all the three sub-themes.

Yep, I think Florence who is our head of [a non-clinical department] .. I think she is a very good example of what I'm talking about in terms of her job. And her role relies a lot on other people. Erm so as a personality she is a very responsible person, she gets on with everybody and you can really see how that works for her because when she needs somebody to do something or she needs people to listen they are going to because they have got a good relationship with her and she has taken time to build relationships when it is perhaps not necessary.

To summarise so far - *good* leadership in the NHS is understood by staff at various levels as:

- Taking responsibility
- Being 'given' authority by the followers
- Getting on with the people in the organisation
- Taking time to build relationships
- Being trusted by followers
- Winning hearts and minds
- Having a vision for the organisation
- Taking colleagues with you

4.4.3 Patients' perspectives on how leadership is exercised

While there were several things held in common (particularly 'trust' and 'taking responsibility') with the staff, patients unsurprisingly, considered leadership from a different position, based upon how they themselves had experienced a specific episode of care. One woman, who had had a previous bad experience in the same Trust in which she was now a patient, said:

Well somebody taking responsibility really for erm you know your care, erm especially. I keep going back to the same example but you know someone being responsible for not reading through my notes and if someone had taken that leadership erm and actually said 'right I'm going to look through

these notes', you know they would have obviously seen what they had to see and so basically yeah I think there is a lack of leadership.

The emphasis was on wanting the leader to take responsibility for patient care in contrast to poor practice whereby notes were not read. It was taking responsibility, and reassuring the patient that they were taking responsibility, that could be experienced by patients as good leadership.

Another patient similarly suggested that in their exercising of leadership, the clinical staff need to make sure that they were seen to be acting in the patients' best interest. For example:

When they're explaining their-selves, they do explain their-selves and what they're thinking. And they do tell me like the 'ifs' and 'buts' blah blah blah about this certain thing, but then one says something and [another] one says something else but they do explain themselves and what they're on about.

Also, another patient indicated that there needed to be one person who held overall responsibility for service delivery:

I don't know how it works hierarchy wise, whether there's like a top doctor or whatever, whoever it is somebody really needs to, you know, take a really ((2)) be sort of, you know, held responsible.

It is perhaps worth noting that the patients overall focused on the role of clinical leadership but saw that as being practiced by an individual rather than in a distributed form. There was a general view that individuals needed to be accountable and accountability equated with leadership.

4.5 What are the characteristics of an organisation that facilitate, or hinder, the process of leadership?

Leadership happens in a context and that context can facilitate or hinder leadership processes (Currie et al., 2009) and the influences of the organisation are particularly acute when the environment is changing rapidly (Goodwin, 2000; Michie & West, 2004) as in the NHS.

One respondent felt they no longer knew 'who was who' in the leadership hierarchy but considered it didn't really matter:

..., here is this model that says here is the Board and here is the chief exec and here is whoever else is up there. And there's this, this and this ... and [a colleague suggested] shouldn't we be transparent all the way through and shouldn't everything link? and I thought, this came up somebody legitimately asked the question that people here need to know what is happening here. Why? Why? I don't care. (Clinical Physiotherapist, T3).

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One senior Occupational Therapist, in the same Trust, on the other hand felt that knowledge of the organisation was important to facilitate leadership at every level so that when:

... people feel they are working as part of an organisation that's working for something, as part of a team and are appreciated and valued as part of that and are working for someone as well who feels what they are doing is worthwhile, I think that patient care will be of better quality.

This respondent was also convinced that supervision was part of the process by which an organisation facilitated both leadership and good practice in patient care. *"I have once a month supervision, like set time for supervision so I think that is really good."*

Furthermore, supervision and informal contact with peers facilitated effective distributed leadership which impacted across the organisation: *".. you can go to people informally, your peers erm whenever it's quite flexible like that and even if you're a senior like me you think 'hang on I don't know if I'm on the right track here so am I missing something?' You can just go and speak to you team about it or one of our colleagues downstairs or whatever if you want to.*

More dramatically a senior clinical leader suggested that leadership is facilitated in 'moral' organisations:

A²²: So one thinks they are better than the other, so the seven deadly sins basically...pride, the other one is gluttony, which means excess...one can never have enough, for the sake of it, and then just goes beyond, you know, one million, two million, you know, which kind of greed isn't it...excess basically, and also rushing is in there, doing things too fast. A good system will reduce its workload, yeah? The NHS has a thing of needing to do more and more, erm anyway, I don't know whether you find this useful or not, so greed, gluttony, there's rushing, and then jealousy, which is really envy, which is really competition.

Q: Yeah

A: You need to get rid of competition, and I will tell you in a moment what could replace it, which is basically team work, team work and kindness; how you get on with each other...anger is on the list. Anger is, is blame, and the opposite is blame free culture.

Q: Yeah

²² Q = question, A = answer.

A: Or forgiveness if you want, so you need to forgive mistakes, and you know you will be forgiven...and, erm...erm...next one is laziness, that's obvious, that's hard...people either have it or not, but laziness is joylessness, you need to make sure people enjoy it, and diligence, yeah? So there needs to be something in place of ...and we have that now with trust away days and things like that, but you have to have somebody dedicated to making people understand it's about having fun

Q: Yeah, yeah

A: working is about having fun...yeah? And then its... which comes really from up here, it's just an, an, yeah, can't have enough...which is also, it's also, the opposite is erm...do not take more than you can, do not take more than you need...and that is quite a moral stand ground, more than you need...for everyone

Q: Yeah

A: and if you employ that rule, then the whole organisation becomes so successful that there's masses of money left over ... Everything works well...the problem is everyone doesn't understand that, and believe in that, and then there's a difficulty...so that's moral high ground, very moral high ground, but if you go along those, you actually have all the features of leadership.

For this respondent the organisation needs to focus on patient care, treating patients *and* staff with 'kindness'. This is counter in his view to the process of setting targets for service delivery and organisational growth (or survival) and thus competition between organisations and competition between individual staff or staff teams, which is a force that (it seems) promotes the wrong kind of leadership (Kuokkanen & Katajisto, 2003; Sambrook, 2007). Furthermore, supportive teamwork and 'forgiving' mistakes and preventing the 'blame game' enhances socially and emotionally intelligent leadership distributed responsibility across the organisation and enhancing the culture and climate (Riggio & Reichard, 2008) .

Another senior medical leader and manager (T3) reinforced this idea:

I think the ethos within the hospital, is one that encourages people to develop and grow, and deliver good quality care, you know, so, I mean I think wherever it comes from it is enabled within this organisation, and it works very effectively. One of the features that enables that to happen...it's firstly being an organisation that attracts good people to want to work here in the first place. So you get high quality people applying for the position, be it in medicine, or managing, or nursing or any of the other professions By and large, we're fortunate in that. And that's partly due to the reputation, and partly due to the [location] but I think the ethos that comes

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from the leadership makes it desirable to be here. Erm...so it attracts the right people in, it then enables, it doesn't put the brakes on, it doesn't try to control people too much.

Thus, organisational performance and culture/climate were 'enabled' through a cycle of encouragement, good practice, reputation and a supportive and 'hands-off' approach to leadership. This suggests concerted action, leader/follower engagement and emotionally supportive behaviours at all levels. That the physical location of the hospital is attractive is perhaps but one factor in this equation, although a central location makes it possible to draw on a wide range of staff as opposed to a location which is in a small town or distant suburb.

It is not just features of the organisation itself that impact on leadership. Organisations reflect changing discursive constructions of leadership and the values that underlie what it means to be effective as a leader in that place at that time (Ferlie & Shortell, 2001; Lansisalmi, 2006; Michie & West, 2004; Scott, Mannion, Davies, & Marshall, 2003). As demonstrated in Chapter One theories of leadership have developed and different approaches have become significant at different times as witnessed by the shift from promoting and studying transactional, charismatic and heroic leadership styles to the contemporary emphasis on forms of distributed, networked and transformational leadership (Bryman, 2004; Butterfield et al., 2005).

One dramatic change over the past twenty and more years has been the image of the medical consultant in the public psyche. Thus the 'heroic' leadership of Sir Lancelot Spratt has been firmly (it seems) replaced by the team work in the TV series *Casualty* or *Holby City*. However the image of the rebel Dr. House (played by Hugh Laurie in an American TV series) is described as 'unorthodox' and 'radical' but most definitely a medical hero. Is this the type of leader that some might still long for? While the following comment was atypical of most people's definitions of what makes or fails to make a good leader it raises some interesting points about the contemporary regulatory discourses on leadership. Thus one participant said of another²³:

Now (Dr.) David is a really eccentric so he is not what you would naturally call a leader, erm ((1)) but people are really respectful... Because he really cares for patients ...And if he finds a junior doc, or nurse or anyone who is being unkind to an elderly patient then he is down on them like a ton of bricks but his, his patent commitment to medicine and clinical care just inspires admiration ...And great affection hopefully. But he is very odd. Yes. Erm, so he is like a one off so again there is no single person, you

²³ No identifying information is appropriate here.

know there are, there are, there are different leadership styles which are appropriate in different situations but David of course could never be a chief exec, he just wouldn't be able to do it, so he would be hopeless there.

On the surface this might be explained as a judgement based on 'evidence' and a job description. However, focusing-in on the discursive and regulatory practices with which this extract engages, a different view can be taken. The respondent here, being asked to describe the qualities of leadership, begins by suggesting that taking patient care very seriously is 'eccentric' and the person who does that is a 'one off' and 'odd'. Paradoxically (it is suggested) David inspires affection and admiration but despite the variety of leadership styles David would never make it to be CEO. Whether or not this is the case is irrelevant here because what is at stake are the ways in which discourses around 'leadership' and the qualities of the 'leader' *regulate conduct* setting normative behaviour through the discursive practices. There is little doubt that David would have been considered a leader (perhaps a leader in his field) during a different period when hospitals were smaller and perhaps when there was less specialisation in management.

A learning organisation?

The NHS has declared itself to be an organisation dedicated to learning for at least the last ten years and certain values underlie this declaration (see Davis and Nutley, 2000). It means that:

Although learning is something undertaken and developed by individuals, organisational arrangements can foster or inhibit the process. The organisational culture within which individuals work shapes their engagement with the learning process (p. 998).

In some cases the exercise of leadership clearly facilitated the (potential for) learning and learning facilitated leadership, while in others it did not. The facility for leading change in NHS Trusts is critical and developments in the role of nurses from a range of specialties to support leadership and learning have provided exemplars of how some organisational arrangements support leadership (Bellman, Bywood, & Dale, 2003; Doherty, 2009). However, some have argued that continued changes, the market as a driver and the complexity of the NHS might militate against whole system learning (Sheaff & Pilgrim, 2006). Questions have also been raised about the potential of the new generation of leaders who are expected to be inspirational, drive change and support learning (Phillips, 2005).

One capacity manager, for instance, was very clear that leadership was about enabling appropriate learning and the development of skills:

... probably more about empowerment and not necessarily of oneself but of others. So I think that indeed you need to feel empowered yourself, but I think that leadership, good leadership is about empowering and supporting those people who are not in power so that they are equipped with the skills that are required. some of it is actually around learning, it is about what stage they are at in terms of their learning curve.

This is not only a statement about distributed leadership but about a version of a transformational leadership that transcends individual leaders and requires an organisational culture that both supports individual learning and targeting individuals to ensure, that their learning is recognised and ongoing (Burke et al., 2006; Conger & Kanungo, 1988; Kuokkanen & Katajisto, 2003).

The respondent continues with this theme in a sophisticated, and it seems heartfelt, way:

But I think that sometimes that [learning] is not always consolidated, even those people that have been in that position for years. I think, it is more about the people actually understanding²⁴ what they have done, and almost sometimes talk it through, in basic detail about why they have got to the decision they got to. But just because you have been in a position for a long time doesn't necessarily mean that you have actually learnt erm and you may only then go up to a certain stage in my opinion in terms of your whole learning so then they may be stuck in, not novice, but in that middle stage rather than the expert. Which we would hope that most people would get to.

This suggests that organisations need to be vigilant and to constantly invigorate their members. For the respondent quoted above, an organisation that allows people to stop learning is one in which leaders and potential leaders stagnate (at their peril) (Mark & Scott, 1991).

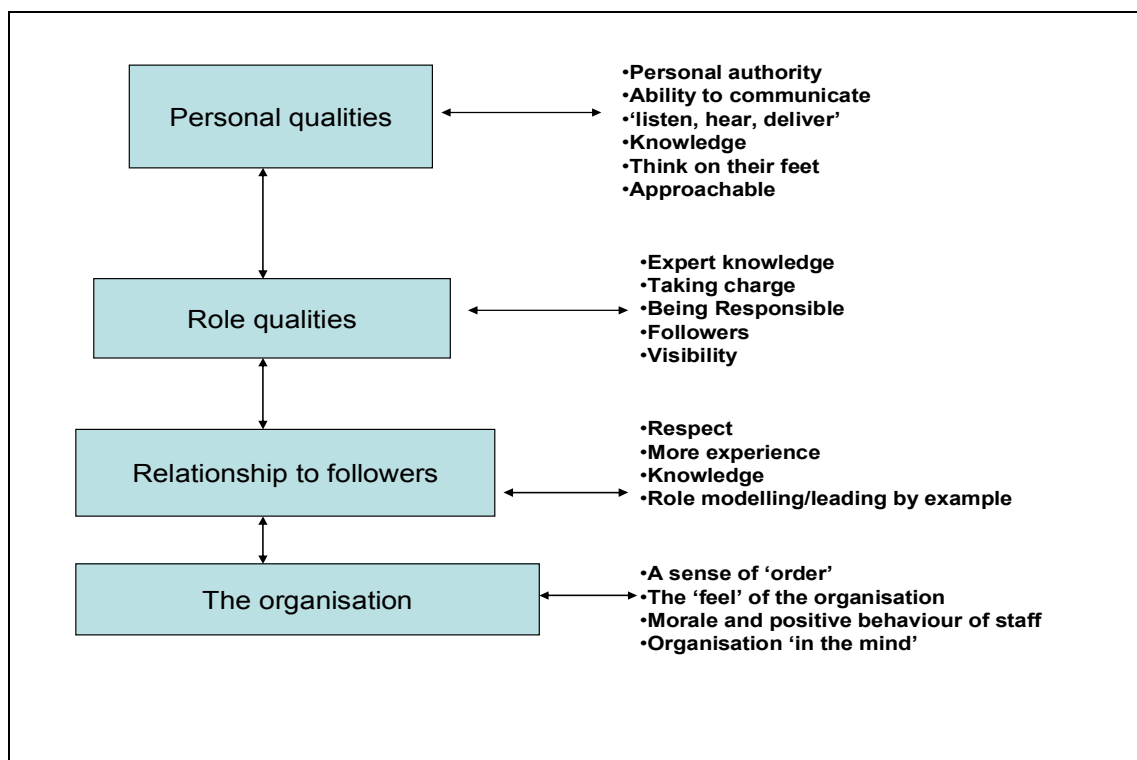
As we discuss again in Chapter Nine, the multi-disciplinary team presents an ideal opportunity for observing leadership (good and bad) and examining the ways in which these teams adhere to organisational norms which might support or inhibit learning (Burke et al., 2006; Day et al., 2004).

One senior non-medical clinical manager in a different Trust also took up the theme of learning and empowerment and specifically how it links to good patient care (Burke et al., 2006; Doherty, 2009; Kuokkanen & Katajisto, 2003).

²⁴ The transcriber who was also the interviewer made it clear that these words were emphasised by the respondent.

... [leadership] is about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is we worked with 'Training and Development' and we came up with a specific programme that was aimed at empowering them [all administrative staff] to improve their service area etc etc and also provided them with some skill sets that they probably didn't have prior to that.

Figure 11. What makes a leader?



4.6 Conclusion

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

Nonetheless, when asked to describe and define leadership, various stakeholders at all levels of the organisation have a view some of which coincides with contemporary NHS discourses and some which seems directly at odds with what the NHS is trying to achieve – that is, to support both

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distributed and transformational leadership that are seen as successful in ensuring effective patient care. However, it is clear that individual personalities and the impact of particular leaders cannot be taken out of the equation.

Leadership is experienced as distributed and transformational but there remains a belief that charismatic and transactional leadership also have their place in complex organisations. While vision is important, no vision can be achieved unless the leader takes 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. Supervision, peer support and informal advice are part of the emotionally intelligent distributed practice of leadership. 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.

In summary, the main ideas that emerged from the respondents' views of how leadership was exercised and experienced were it was about:

- Personal authority
- Ability to communicate
- 'listen', 'hear' 'deliver'
- Thinking on your feet
- Being approachable

Leadership can be exercised in a number of ways and qualities of leadership are seen to reside in different but interlinked 'places'. For example, it is clear that some people are perceived more than others to have the personal qualities that make them a leader, including being able to listen, deliver and be approachable (see Figure 11 above). The assigned/legitimated leadership role is also perceived to be an important quality for a leader, which is interesting, when thinking about the distributed leadership model and particularly the idea of concerted action where people have to work together to 'lead'. This links further to the qualities inherent in leader-follower relations identified as fundamental to the stakeholders interviewed here.

Finally, leadership means holding a sense of the organisation in mind. That is the mental model held by the leader through which they mediate and regulate their vision and actions as leaders, but it also refers to the leader's understanding of morale and the 'feel' of the organisation in which they are working, which itself regulates and constrains the possibilities for growth, development or atrophy.

In this chapter we identified some of the evidence of how organisational contexts evolve and the relationships between organisational culture/climates and the ways in which leadership is practiced. This will be developed across the next four chapters.

5 Leadership and Organisational Climate

5.1 Introduction

Despite its North American origins, where the health care system is fundamentally different from the NHS, Stringer's focus on both leadership and climate nudged us towards choosing an adaptation of his organisational climate survey for this study. We also identified an 'awareness', as he puts it himself, that "*People working in health care systems play drastically different roles that are more diverse than the roles typical in schools and businesses*" (Stringer, 2002, P. 188).

Through adapting the OCS we also captured demographic information from our participants as well as a data about satisfaction with the leadership one receives from his or her immediate supervisor²⁵. Thus, while on the whole Chapter Four dealt with general descriptions, definitions and values, in this Chapter we focus on specific relationships between individuals and the individual and the perception of their organisational climate.

The additional contribution the survey data makes to the overall aims of the study is to relate perceptions of leadership and management directly to organisational climate, thereby providing a triangulation with the story - telling and focus groups to explore the characteristics of organisations that facilitate or hinder leadership and service delivery.

5.2 Results

5.2.1 Normality of data

When normality was examined the KS-Lilifors test was found to be significant over all the scales, indicating that the data were not conforming to assumptions of normal distribution. However, inspection of the histograms and boxplots were found to present an acceptable level of

²⁵ Our version of the survey questionnaire is appended.

normality. Due to the nature of the data it was decided not to transform it, but rather to interpret the results which rely on the assumption of normality with caution.

5.2.2 Cronbach's Alpha

In order to check the reliability and internal consistency of the OCS in this setting we used Cronbach's Alphas (Cronbach, 1970) (See Table 2).

As can be seen from Table 2, the three dimensions of '*commitment*', '*support*' and '*recognition*' were considered to be high on reliability as their scores ranged from .69 to .74. These would be considered acceptable-good level of reliability (George & Mallery, 2003).

In contrast, the three dimensions '*structure*', '*standards*' and '*responsibility*' were low on reliability. This low reliability may be explained by confusing wording of the items, or it is possible that the individual items did not correspond well to one another in this sample. As such it was decided to remove the '*responsibility*' scale from the rest of the analysis. A further check to see whether '*structure*' and '*standards*' could be improved by removing single items, did not show any improvement to the alpha so these were retained in their original form.

Table 2: Cronbach's Alphas for the six dimensions

Scale	Cronbach's Alpha
Commitment	.74
Support	.72
Recognition	.69
Structure	.57
Standards	.43
Responsibility	.14

When managerial dimensions were examined for reliability' these were found to be very high ranging from .86 for '*recognition*' to .79 for '*commitment*' and '*responsibility*' (See Table 4).

Table 3: Cronbach's Alphas for the six Managerial dimensions

Scale	Cronbach's Alpha
Managerial Responsibility	.86
Managerial Recognition	.83
Managerial Standards	.83
Managerial Support	.81
Managerial Commitment	.79
Managerial Structure	.79

Overall scores for organisational dimensions

In order to derive the scores for individual dimensions, all the items on each dimension are summed [this is after all the negatively worded items were reversed].

The following were mean and standard deviations across all the six Organisational scales:

Table 4: Mean and Standard Deviation

Scale	Mean	Std
Commitment	14.82	2.86
Support	14.06	2.80
Responsibility	9.93	1.73
Structure	9.01	1.88
Recognition	8.42	2.55
Standards	8.36	1.69

Stringer, et al (2002) suggest an analysis of percentages of respondents who scored above the mean. In our analysis the following percentages were found:

Table 5: Scores above the mean

Scale	% above the mean
Commitment	60%
Support	47%
Recognition	49%
Standards	49%
Structure	39%
Responsibility	58%

Stringer offers a method of interpreting these percentages, according to benchmarked ratios collected through their extensive research to validate the tool.

High 'commitment' (60%) – In the current sample, there was a high degree of 'commitment' to the organisation and its goals. This would be typical of professional staff working for the NHS. However Stringer asserts that high 'commitment' needs to be accompanied by high 'support' and high 'recognition' – without these individuals will stop engaging with others in the organisation and their team (p.200). As indicated in Chapter Four engagement is crucial if leadership is to be effective.

High 'responsibility' (59%) – Stringer asserts that 'responsibility' is a difficult dimension to interpret within the health care setting. Effective performance in the NHS requires that procedures be double checked, which in many other contexts would put the role of 'responsibility' in an ambiguous position. However this is not the case in complex clinical settings (or for example in other precision performance occupations such as flying aeroplanes for instance). In the case of the current sample 'responsibility' was high, which is related to high sense of 'commitment', but is confused by the limited 'structure' – it is essential that people are clear about their roles, so that they may take charge and 'responsibility'.

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Moderate 'recognition' (49%) - According to Stringer scores lower than 50% may indicate that participants are feeling unappreciated. In this case there is just under the 50% mark, which translates into moderate agreement about the feeling of being rewarded for one's efforts. Having a high sense of 'recognition' in an environment such as this is of crucial importance for motivation, but 50% is within the normal range set out by Stringer. High 'recognition' is indicative of confidence in the organisations performance/reward ratio but in such a diverse setting as a hospital with a diverse staff group responding to the OCS then different groups with different management and professional/occupational structures would have different perceptions and experiences.

Moderate 'standards' (49%) – there is a moderate feeling of pressure - performance 'standards' and expectations are high but not to the point where they are stressful. This falls within an acceptable range. Considering that many of the 'standards' (targets) are set out by government policies rather than directly by Trust management/leaders it is important for these standards to be realistic and achievable.

Moderate 'support' (47%) – this falls within the low but acceptable range for this scale (45%-60%) according to Stringer's benchmarks. This indicates that there is sufficient unity between teams to approach and solve problems, without overly nurturing so as to discourage individual 'responsibility' and undertaking. Team work within the health care system is challenging because of the interdisciplinary nature of teams which inevitably calls upon different management and professional structures and networks for support.

Low - Moderate 'structure' (39%) – Under half of participants felt there was clarity in terms of their roles, responsibility and authority. On the one hand this means that there are less constraints and a less of a 'jobs-worth' approach, on the other hand though it means that there is (potentially) insufficient clarity in roles and responsibility. In an organisation such as the NHS, this may be a considerable shortcoming and Stringer (p.193) suggests that in a health care environment such as a hospital, one would ideally like to have 'structure' scores above the 70s. This is emphasised because of the complex nature of the hospital environment with so many individuals involved – accountability needs to be very clear. The NHS however has gone through so many changes over the previous ten years that it is inevitable that the 'structure' score would be influenced.

Associations between the six dimensions on the organisational level

Pearson's r was utilised to test the relationship between all the Organisational scales. It was found that the majority of scales showed modest, but significant relationships:

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Table 6: Correlations between the six organisational dimensions

	Standards	Structure	Recognition	Support	Commitment
Standards	1.00				
Structure	ns	1.00			
Recognition	.22*	.47**	1.00		
Support	.17*	.42**	.61**	1.00	
Commitment	.30**	.39**	.59**	.67**	1.00

* <.05

** >.001

As can be seen from Table 6, there are a number of high associations between these dimensions. The highest associations are for 'support' and 'commitment' (.67) 'support' and 'recognition' (.61) and 'commitment' and 'recognition' (.59). In other words, participants are reporting that when a feeling of co-operation within teams is present, this is often accompanied by acknowledgement and appreciation and is further related to a greater sense of dedication and 'commitment' to the goals and aims of the team. By definition, the converse also applies: feelings of isolation are more likely to be accompanied by lack of incentives and disenchantment with the objectives of one's team. This is 'supported by Stringer (p.200).

Satisfaction with leadership

When the *organisational dimensions* were examined in relation to satisfaction with the quality of leadership received from the immediate manager, which was asked as a single item, the scales which correlated most highly were 'support' (.61) and 'recognition' (.52). The weakest relationship was to 'standards' and 'structure'.

Table 7: Correlations between organisational dimensions and satisfaction with Leadership

	R (sig)
Standards	.14*
Structure	.30**
Recognition	.52**
Support	.61**
Commitment	.39**

In order to evaluate the individual contribution of each of the organisational dimensions to the overall 'satisfaction with leadership', a regression analysis was conducted, which included all items which were found to correlate significantly with satisfaction, namely 'standards', 'structure', 'support' and 'commitment'.

The total variance accounted for by the model was 40% (Adjusted $R^2 = .38$) therefore variability in 'satisfaction with leadership' is moderately accounted for by this model.

Specifically, of the five predictor variables the two which were found to predict the outcome variable of 'satisfaction with leadership' were 'support' and 'recognition', 'support' being the biggest contributor with a $B = .52$ ($p < .001$) and the other predictor was 'recognition' ($B = .27$, $p < .001$). The other variables were not significant. [Appendix 1 of this chapter].

In other words, feeling supported by one's team and believing that rewards are appropriate to effort, accounts for a significant proportion of an individual's satisfaction with leadership.

Correlations between dimensions on Managerial level

The second part of the questionnaire asked about individual experiences of management. All six dimensions on the managerial level were highly correlated with each other, with strong correlations ranging from $r = .71$ ($p < .001$) between 'structure' and 'responsibility' to a correlation of $.84$ ($p < .001$) between 'commitment' and 'standards'.

Table 8: Correlations between dimensions on Managerial level and Satisfaction with Leadership

	Manager Recognition	Manager Support	Manager standards	Manager structure	Manager Responsibility	Manager Commitment
Manager recognition	1.00					
Manager support	.83**	1.00				
Manager standards	.82**	.83**	1.00			
Manager structure	.73**	.78**	.79**	1.00		
Manager responsibility	.84**	.79**	.79**	.71**	1.00	
Manager commitment	.79**	.83**	.84**	.82**	.79**	1.00
Satisfaction with Leadership	.68**	.76**	.71**	.71**	.65**	.76**

** Significant at .001 level

A single item asked about satisfaction with the quality of leadership received from immediate manager. When this was examined in relation to the six dimensions appropriate to participants' own experience of management practices, it was found to correlate highly and positively with manager 'support' ($r=.76$); management 'structure' ($r=.71$, $p<.001$); manager 'commitment' ($r=.75$, $p<.001$) and 'standards' ($r=.71$, $p<.001$); manager 'recognition' ($r=.68$, $p<.001$); manager 'responsibility' ($r=.65$, $p<.001$);

A multiple regression was carried out to examine the perception of 'satisfaction with leadership', as a dependent variable of management practices. The overall association between management practices and satisfaction with leadership was strong ($R=.80$) with associated variance explained of 63%.

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Table 9: 'Manager' dimensions regressed onto 'satisfaction with leadership'

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	-.054	.226		-.240	.811
Manager Recognition	.001	.039	.002	.025	.980
Manager support	.175	.039	.410	4.501	.000
Manager structure	.060	.027	.177	2.260	.025
Manager responsibility	-.018	.032	-.047	-.559	.577
Manager commitment	.165	.056	.278	2.948	.004
Manager standards	.017	.056	.029	.310	.757

In this case, it was manager 'support' which best predicted satisfaction with leadership ($B=.41$, $p<.001$), next biggest contributor was management 'commitment' ($B=.28$, $p=.001$) and management 'structure' ($B=.177$, $p=.025$). In other words, a large proportion of feeling satisfied with one's leadership, pertained to feelings of being supported and the degree to which one's manager inspires and exudes 'commitment' to common goals. A further important element in the equation is that of 'structure' – where roles and responsibilities are clear, it is associated with greater satisfaction with leadership.

As the biggest predictor of 'satisfaction with leadership' was manager 'support', a further regression was done to look at what organisational dimensions related to having good managerial 'support'.

All the organisational scales were inputted into a regression, excluding organisational 'support', with managerial 'support' as the outcome variable. The following was found:

In total the model accounted for 35% variance in the outcome variable (Adjusted $R^2 = .35$). There were two contributors to the model: the strongest one was 'recognition' ($B = .44$, $p < .001$), i.e. the more employees feel that the organisation rewards and recognises their efforts, the more they feel supported. The other contributor to managerial 'support' was 'commitment' ($B = .20$, $p = .008$). [Appendix 3 of Chapter Five]

These findings indicate that organisational 'recognition' and 'commitment', are organisational climate dimensions which most affect the outcome of managerial 'support', and this in turn has the greatest effect on individual's sense of satisfaction with their leadership. This again corresponds with data discussed in Chapter Four highlighting the importance of the feel of an organisation that provides support at all levels.

Regression of all dimensions onto Satisfaction with leadership

When all the variables previously shown to be significant to Satisfaction with leadership, were entered into the model, from both the organisational and managerial dimensions, namely manager 'support', manager 'commitment' and manager 'structure' as well as organisational 'support' and organisational 'recognition', the following picture emerged:

There was a high degree of variance accounted for by the model - 65% (Adjusted R^2). The model was found to be significant ($F = .80.65$, $p < .001$).

The variables which remained significant, in order of their contribution are: manager 'support' ($B = .34$, $p < .001$), manager 'commitment' ($B = .33$, $p < .001$) and Organisational 'support' ($B = .13$, $p = .03$).

In other words, satisfaction with leadership, in this sample, was predicted by a greater perception of 'support' from management, a feeling that managers demonstrated their 'commitment' to achieving common goals and an atmosphere of 'support' and team-work within the organisation.

Organisational and Managerial dimensions

In order to investigate the relationships between organisational and managerial dimensions, a correlation was performed between all of these variables (Table 10). It was found that:

There were strong correlations between manager and organisational 'recognition', and manager and organisational 'support'. There were moderate correlations between manager and organisational 'commitment' and 'structure'. And there was a weak correlation between manager and

organisational 'standards'. In other words, where the dimensions were correlated weakly or moderately, we can identify that 'standards' of the organisation do not necessarily exist at the same level of managerial 'standards'. The same relationship goes for 'structure' – having organisational 'structure' does not predict clarity in roles, as espoused by one's manager. There is a greater degree of correspondence between organisational and manager 'commitment'. When we look at 'support' and 'recognition', we find that both these dimensions tend to be closely related – one is more likely to feel that both are high, or both are low.

Table 10: Relationship between managerial and organisational dimensions.

	Organisational Recognition	Organisational Support	Organisational standards	Organisational Structure	Organisational Responsibility	Organisational Commitment
Manager recognition	.60**					
Manager support		.65**				
Manager standards			.25**			
Manager structure				.34**		
Manager responsibility					-.02 ns	
Manager commitment						.48**

The significance of Role

The largest group of participants was nurses (31%), then clerical staff (14%), managers and porters (14% each). Doctors/consultants/physicians (11%), other allied professionals (10%) and 'support' staff (6%).

When looking at satisfaction with leadership the following findings were apparent: High satisfaction with leadership was reported in total by 54.3%

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(n=113) of staff. Although there were no significant differences by work role, it can be seen that consultants and doctors reported the highest satisfaction (74%), followed by managers (61%). It can be seen that clerical workers had the least high satisfaction (41%), followed by 'support' staff and other allied professionals (54%). This is significant in terms of the hierarchy within the organisation – the higher the position the more satisfied one is with their leadership.

Table 11: The significance of role and satisfaction with leadership

	n	% positive responses about satisfaction with leadership
Managers	28	60%
Doctors	23	74%
Allied professionals	22	54%
Nursing	65	49%
Support staff/Assistants	13	54%
Clerical	29	41%
Porters/maintenance	28	57%

A further examination of organisational dimensions according to role using a one way ANOVA, revealed the following:

In all there were large differences between respondents in terms of their role, however only two scales exhibited differences which reached significance. The first was 'commitment' – doctors/consultants were found to rate significantly higher than allied health professionals on this scale (mean difference = 2.86) ($p < .01$).

The second was 'recognition' – it was found that doctors were much more likely to rate higher than clerical staff on this scale (mean difference = 2.41) ($p < .01$). Both these findings were apparent even after using the Bonferroni correction.

Comparing doctors (all grades) in Trust 1 and Trust 3

An examination of the responses on the item looking at 'satisfaction with leadership' amongst doctors revealed that doctors at Trust 1 (n= 13) had lower satisfaction (Mean = 3.38, std = 1.38) in comparison to doctors at Trust 3 (n= 10) (Mean = 4.20, std = .42). This difference (.81), whilst small, was found to be approaching significance ($t = -2.003$, $p = .06$).

While it is not possible to make an objective comparison between doctors from Trusts 1 and 3 from the qualitative data, there is more evidence in Trust 3 of doctors being both emotionally engaged with both junior doctors and other members of multi-disciplinary teams than in Trust 1 and with distributed leadership. As will be evidenced in Chapter Six doctors and other staff considered 'management' as bureaucratic and distant rather than engaged.

Gender

There were no differences between men and women's scores on 'satisfaction with leadership' ($t = 1.71$, $p = .08$).

When examining differences between men and women on the organisational dimension it was found that only one dimension, 'recognition', was perceived significantly differently ($t = 3.42$, $p < .001$). Men perceived there to be greater 'recognition' (mean = 9.55) compared to women (mean = 8.13). All other dimensions were not significantly different (see Chapter Eight).

When examining the gender differences on managerial dimensions of the OCS there were trends approaching significance in terms of differences between the genders on managerial dimensions, but these did not reach significance when multiple comparisons were taken into account:

Manager 'recognition' ($t = 1.91$, $p = .06$)

Manager 'responsibility' ($t = 2.10$, $p = .03$)

Manager 'standards' ($t = 2.33$, $p = .02$).

5.3 Conclusions

The difficulty obtaining data across all three participating Trusts has not limited the value of using the OCS to triangulate the qualitative data, particularly because a) the OCS gathered information from staff groups who were not represented in the focus groups, shadowing or story-telling

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interviews and was able to identify generalisable predictors of satisfaction with leadership and management practices, and b) the OCS data captured information from specialty groups outside those involved in the participating Units from which qualitative data was collected.

What emerged here was that on the whole, the same climate variables are important in predicting satisfaction with leadership. Within the organisational domain these are 'support' and 'recognition' while predictors of 'satisfaction with leadership', within managerial practices, are manager 'support', 'commitment' and 'structure'.

Overall, therefore, 'satisfaction with leadership' was highly accounted for by manager 'support', manager 'commitment' and organisational 'support' – i.e. these were the 'ingredients' in this sample which were highly related and were able to predict satisfaction with leadership. This suggests once again that managers/leaders were effective if they engaged with followers and that organisations that supported distributed leadership and emotional engagement were more likely to support effective leadership (see Chapters Four and Six in particular).

In terms of role, the higher the position in the organisational hierarchy the more satisfied a person was likely to be with leadership. This was not necessarily the case though across all organisations in the study. The exploration of the case studies in Chapter Seven – where authority and leadership are discussed – reveals how some of the more senior leaders in organisations found themselves to be highly dissatisfied with leadership in other sectors of their Trust, if there was resistance or negligence of their authority.

Differences in gender were only apparent in terms the organisational dimension 'recognition' – it was only on this scale where women scored significantly lower than men. This may say something about equal opportunities and equal pay for equal work, but it might also relate to perception of 'recognition' between women and men discussed and exemplified in Chapter Eight below.

The overall importance of constructs such as 'support' and 'recognition' across the climate of an organisation, and management practices which demonstrate support and commitment, provide further evidence of the importance in engagement and (probably) emotion (including EI and SI) in an organisation.

6 'Organisation in the Mind': Transmission of Leadership and Organisational Context

6.1 Introduction

Leadership in any organisation is understood in a specific context by those involved as either leaders or followers, and as shown in Chapters Four and Five concepts such as satisfaction, support, responsibility, vision and communication among others are described and evaluated within a cognitive or mental framework within which the organisation itself is understood. It is through making sense of the organisational context that leadership and followership may be enacted and transmitted.

We saw how members of organisations *necessarily* hold in their mind fantasy/imagined understandings or images of the *system* (Morgan, 2006). This informs how they work in, relate to and talk about their organisation, based on their perceptions of their own and others' place and role within the system. For example, it is common to hear employees talk about how 'you can never get management attention in this company' or 'we are all dedicated to putting patients first here' (Armstrong, 2005; Morgan, 2006).

Similarly, the participants who completed the OCS held a view of the leadership and management in their organisations, in order to think about the various ways in which their work was recognised, supported and so on both generally and by their managers. While the focus in that case was upon on measuring the impact of organisational climate and thinking about a relationship with a specific manager, those who completed the survey would have had to hold a perception of what was happening in their department and the Trust overall.

This is apparent in what follows particularly in the ways 'management' is discussed and taking account of these perceptions provides some evidence about the ways in which leadership is transmitted in these particular organisational contexts and in general. The 'organisation in mind' then involves:

- An 'image' of the organisational structure and relationships within that structure
- A sense of your own role and place within it
- An emotional component
- An awareness at a conscious and/or unconscious level of important information below the surface

6.2 Organisation in the mind

The concept of the 'organisation in the mind' was a model developed originally in the early 1990s by organisational and group relations consultants working at the Grubb Institute, the Tavistock Centre and the Tavistock Institute of Human Relations, to refer to what an individual perceives mentally about how organisations, relations in the organisations and the structures are connected. *"It is a model internal to oneself ... which gives rise to images, emotions, values and responses in me, which may consequently be influencing my own management and leadership, positively or adversely"* (Hutton, Bazalgette and Reed, 1997, p. 114 quoted in Armstrong, 2005, p. 4).

In other words, when we talk about our colleagues, guess what the senior management are doing/going to do and have fantasies about how well we fit, or don't fit, into the structure or system we do so in the context of the organisation we 'hold' in our mind which may or may not relate to that which other members of the organisation hold (Pols, 2005).

Organisations are experienced cognitively and emotionally by their members when they think about how their organisations work and are structured (see Lewin, 1947; Armstrong, 2005; Morgan, 2006). As Stokes (1994) explains it, everyone carries a sense of the organisation in their mind but members from different parts of the same organisations may have *"different pictures and these may be in contradiction to one another. Although often partly unconscious, these pictures nevertheless inform and influence the behaviour and feelings of members"*. (p. 121)

Hutton (2000) talks about it as *"a conscious or pre-conscious construct focused around emotional experiences of tasks, roles, purposes, rituals, accountability, competence, failure, success"* (p. 2). Morgan suggests that an organisation may serve as a 'psychic prison' in that the:

...patterns and meanings that shape corporate culture and subculture may also have unconscious significance. The common values that bind an organisation often have their origin in shared concerns that lurk below the surface of conscious awareness. For example, in organisations that project a team image, various kinds of splitting mechanisms are often in operation, idealising the qualities of team members while projecting fears, anger, envy, and other bad impulses onto persons and objects that are not part of the team (Morgan, 2006, p. 226).

Some of this is apparent when talking to NHS staff about the leaders at various levels of their own Trusts and the NHS overall as was seen particularly in Chapter Four.

6.2.1 Organisation under the surface

So, when the respondent immediately below talks about the leader who has a 'really good understanding of the organisation or team' what exactly does that mean? How does that understanding come about? What do the team hold in mind about that particular leader?

Leadership is someone who has a really good understanding of the organisation or team, erm where it's going and where they imagine it to be going, so that sort of vision as well for their team, I think. (Lead Clinical Non-medical Health Professional, T3)

This respondent, referring to the (frequently used) concept 'vision', also identifies this with the *imagination* the leader holds about where the organisation is going. This is not simply a matter of guesswork. It is an intellectual/cognitive and *emotional* sense of an organisation. Indeed to take this slightly further, as Gabriel and Schwartz (2004) propose "... *what goes on at the surface of an organisation is not all that there is, and ... understanding organisations often means comprehending matters that lie beneath the surface*" (Gabriel and Schwartz, 2004, p. 1).

Although not necessarily (in fact mostly not) made explicit, even the most clear thinking senior members of organisations hold an image of the organisation in mind, expressing their fantasy/belief/perception of the organisation based on conscious and unconscious knowledge (Halton, 2007; James & Arroba, 2005). So for instance for this CEO leadership is understood emotionally as it is:

... about the feel of the organisation and what it feels like in terms of how it delivers patient care. Yeah, erm. I can best illustrate that, and interestingly we were thinking about this earlier this morning, so as a group, the executives, we were talking about it. When you walk onto a ward a hospital ward and there is real leadership on that ward, you walk in and there are a number of signals that are given off, which give you a feel. Erm the place looks organised, it has a welcoming feel, the nurses on the ward and the clinical staff greet you as they come into contact with you. They know you from the previous interactions that you have had and when you sit there and listen to what is being said on the ward they will know that the patients, the visitors on the ward, the families that are coming in the junior doctors who are in there in that environment and all of that has a feel²⁶ of a well led ward. (CEO)

²⁶ Respondent's emphasis.

The environment of the well led ward (unit or organisation) is implicitly and unconsciously identified by all who engage with that organisation. The staff communicate effectively (visually, verbally and emotionally) so that the information required is passed on through managers, clinicians to colleagues, patients and relatives. This account, which preceded the extract that focused on strategy, directed to the best patient care for the greatest number of patients, expresses his ideas at an *emotional* level. He also suggests his senior colleagues agree with this. Signals are 'given off', you can 'feel' the organisation and how it delivers patient care and there is a 'welcoming feel'. He also talks about 'empirical' evidence in that staff know the patients, the ward looks organised he remains convinced that there is a 'feel of a well led ward'.

From a slightly different position, a deputy CEO quoted below also holds in mind the fantasy that a manager might think that they run an institution but that such a fantasy might get the manager into trouble. He is suggesting a vision of an organisation in which a manager has very little control, and proposes the need to gain a sense of *reality* by recognising this and taking responsibility for this organisation (Hirschhorn, 1997; Porter-O'Grady, 1995). His perception, again which has an emotional component, is one of a stressful contradiction – responsibility without power or control (de Vries, 2000).

The minute, as a manager, you start to think that you do [run the service without accountability]... erm then you're in trouble. Unfortunately you have still got the accountability for the service but you have very, very little control so it's a whole different leadership and managerial skill that is required I think in terms of recognizing that you have no control over what happens you know across this organisation across the N,000 beds here at [Trust], the thousands of people that go through the organisation everyday, what happens to them is completely outside of my control but if anything goes wrong it is absolutely my responsibility. And that is quite difficult.
(Deputy CEO, T 1)

6.2.2 Structure in the mind

Most recently Laughlin and Sher (Laughlin & Sher, 2010) take up a version of this concept which they name the 'structure-in-the-mind' in their analysis of developing leadership in social care. They reassert, in their model, that not only the local stakeholders (staff and service users) have a sense of the organisation in the mind when considering, for instance, a particular Trust, but the range of stakeholders includes government bodies and service commissioners (in the round). They propose an inter-relationship between perceptions of communications from services (e.g. 'that you [management] don't listen and/or understand') and perceived communications from 'Head

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Office (or government or other bodies that control resources and practices) which include for example 'just do it' 'we know better' and 'be rational'. (p. 9)

What is significant here, in the context of NHS leadership, is that the organisation and/or structure *in the mind* is where the leader and followers 'meet' emotionally as, similarly, do the various levels of leadership and governance bodies. It is a kind of 'virtual' space.

An example of this structure in the mind might be seen through the increase in stress for NHS employees detailed in a recent report by NICE (the National Institute for Clinical Excellence²⁷) where it was revealed that staff absence caused by work related stress costs the UK over £28 billion. It was proposed that a poor working environment characterised by bullying and poor management was at the heart of this problem²⁸ (Edwards & O'Connell, 2007). In a context where there is distributed leadership and a highly trained professional, multi-disciplinary workforce, such mismatches in how to run organisations and departments that lead to staff stress in these ways (e.g. being bullied and bullying) evoke questions about what is happening in the space between those who plan, govern and resource NHS Trusts and those who carry out the work. The emotional elements of leadership and followership relations seem to be neglected to everyone's disadvantage.

The idea of the organisation in the mind raises important questions of how leadership (good and bad) is transmitted across the NHS and its Trusts (Harrison & Carroll, 1991; Walsh & Ungson, 1991). Organisational cultures and climates are reproduced over time despite the coming(s) and going(s) of CEOs. However, organisations also *adapt* and *evolve* as a response to changes in leadership and outside influences (Morgan, 2006).

In what follows we explore the characteristics of the organisations studied here that facilitate or hinder the transmission of leadership through the Trust as a *system* through which culture (e.g. principles and values about leadership) might be transmitted (Hatch, 1993; Schein, 2004).

²⁷ An organisation established to oversee and provide guidance on clinical practice and cost and clinical effectiveness.

²⁸ See news.bbc.co.uk/2/hi/health/8343074.stm and NICE web-site which has a power-point presentation.

6.2.3 Transmission of leadership and Organisational Contexts

What is held in mind about an organisation is often influenced by the formal and informal networks (Balkundi & Kilduff, 2005, 2006; Goodwin, 2000) which characterise complex adaptive systems. Network cognitions in the minds of leaders are embedded in the whole organisation and the inter-organisational linkages formed by leaders as representatives of organisations (Balkundi & Kilduff, 2005).

The context of the NHS seems to have become increasingly complex and chaotic (Currie et al., 2009) which, coupled with a sense of widespread unethical managerial practices, has raised questions about how leadership practices are transmitted through NHS organisations (Bowie & Werhane, 2005; Collier & Esteban, 2000; Huston & Brox, 2004). Bullying and poor management are in part at least a consequence of not taking the emotional context of organisational life seriously (Ashkanasy, Jordan, & James, 2003; Cocco, Gatti, Lima, & Camus, 2003; Johnson, Cooper, Cartwright et al. 2005; James, 1999; Hutchinson, Vickers, Jackson & Wilkes, 2006).

While there is no excuse for bullying or any other unethical management practices, it is necessary to understand what precipitated the relatively recent change in culture which has exacerbated (reports of) bullying. One factor has to be the extent to which top-down, politically driven changes have been forced through the NHS system and other public institutions and the impact that the drivers of these changes have upon the senior levels of management consciously and unconsciously (Christensen & Laegreid, 2003; Dent, 2005; Gabriel, 2004).

These recent developments have influenced the psychological and emotional aspects of working in teams, groups and organisations (Liden & Antonakis, 2009; West & Anderson, 1992) and by implication influenced possibilities for innovation in leadership and the authority of leaders and workers (Lewin, 1947; Miller, 1993; Carter, Garside, & Black, 2003; Hirschorn, 1997; Fineman, 1994, 2000; Payne and Cooper, 2001; Vince, 2002; Carter, Garside, & Black, 2003). Understanding the *context* of leadership, therefore, has become increasingly important as has the need to understand how that context is part of a *system*.

Post industrial (or postmodern) systems (Rose, 1991) have been reconsidered (or 're-described') relatively recently as 'complex adaptive systems' (Collier & Esteban, 2000; Dooley, 1997; Schuster, 2005). Systems that are complex because of multiple interconnecting relationships are liable to evolve through making new connections that increase their complexity (Collier & Esteban, 2000). In the NHS, even though change is structurally driven, the (perhaps unforeseen) consequences of changes have meant that instead of a command-and-control, top-down hierarchies where in particular

clinicians such as consultants and matrons had previously been seen as 'gods' (as with Sir Lancelot Spratt and Dr. Gregory House see Chapter Four) distributed leadership, networks and different statuses attributed to individual Trusts (e.g. Foundation Trusts with relative independence, Mental Health Trusts which have social care and NHS staff and diverse management practices) have evolved within different structures at all levels for coping with service delivery (see Chapter Nine).

6.3 Open systems theory and boundary management

An organisation that *evolves* like an organism and adapts to its environment necessarily has *porous boundaries* so that it can 'take in' and 'put out' beyond itself. This kind of organism is one that changes, develops and grows. A closed system may feel more secure in that it may not have to accede to unwanted influence or demands, but without taking in and providing for the world outside it will atrophy as with any other closed (minded) system (Morgan, 2006). In this way images and cultures of leadership from outside the boundaries might influence the development of leadership practices e.g. data and ideas from education (Currie et al., 2009; Gronn, 2000; Lumby, 2003)

Systemic thinking is a framework, or tool, for observing the way organisations behave (Schein, 1985; Lewin, 1947; Campbell et al, 1994) which evolved from General Systems Theory, (von Bertalanffy, 1956; Miller and Rice, 1967) and focuses upon concepts related to organisational structure particularly 'task', 'role', 'authority' and 'boundary'. There is also a psychodynamic part of the systemic thinking analysis which links with the conscious and unconscious emotional consequences of the systemic properties and the impact of social and personal factors on the functioning of the organisation (James and Huffington, 2004; Laughlin & Sher, 2010)²⁹.

Morgan (2006) identifies how knowledge and power are accessed and maintained through control of organisational boundaries. 'Boundary' is the term used in open-systems theory to describe the interface between different parts of the organisation and the organisation and the outside world. In the case of the NHS this is the physical boundary to the, for example, hospital building, the wards, the web-site, the reception desk, the

²⁹ This issue is further discussed and explained through object relations theory based on the works of Melanie Klein, Elliot Jaques and Isabel Menzies-Lyth which is outlined in detail in Chapter One and operationalised in the description of the role of obstetricians' anxiety in the delivery of patient care discussed in this chapter and below in Chapter Nine).

telephones, e-mail and so on and also between the different roles such as out-patient/ in-patient, staff /patient, clinician/manager and so on. Most leaders in organisations have the knowledge and abilities by definition to manage and negotiate those boundaries. For example, the senior managers relate to government/NHS/DoH in ways that junior nurses do not, but the senior staff are charged with having to manage the boundaries using knowledge and influence across the boundaries – inside with the staff and patients and outside with government and patient pressure groups. Moreover, as evidenced during the conduct of this project, hospitals merge into Trusts and the porosity or opacity of the boundaries between the different organisations that have come together are central to the functioning of leadership at most levels (see Chapter Seven where the limits of authority are discussed in this context).

Stating this in a slightly different way, this approach to the 'organisation in the mind' takes the *personal* (conscious, pre-conscious and unconscious) level of thinking and links it to the *system* in which that person works (systemic thinking). As any organisation comprises systems (with boundaries, in-puts and out-puts), groups and individuals, it follows that a person's experience of an organisation and *experience of themselves* in relation to others who are in the same organisation make up the culture, climate and everyday dynamics of any organisational context. Thus, our respondents' sense of the 'organisation in the mind' is a valuable concept for understanding how leadership relates to service delivery.

6.4 Images of the organisation

In what follows we explore some of the images 'held in mind' by staff across the three Trusts particularly examining the impact of the organisation in the mind on working collaboratively and the influence of this on service delivery and the quality of patient care that results from staff relations and effectiveness.

To begin, we focus on two specific examples that characterise much of what was said by staff across at least two Trusts:

- images (and fantasies) held about 'management' which highlight the construction of 'authority' in the system and its impact on patient care
- images (and fantasies) held about the 'others' (e.g. colleagues in the same Trust but on a different site or a different Unit) which brings boundary management into play
- how these images (and fantasies) facilitate and hinder the transmission of leadership and service delivery

We employ a critical discourse analysis (CDA) approach to the meaning and processes of leadership and organisation exploring how the organisation/system *looks* to the participants and how this in turn impacts upon the system of providing care for its patients.

6.4.1 'Management' in the mind

As in many organisations, rhetoric about 'management' abounds particularly played out as a 'them/us' dynamic as we demonstrated by separate means in Chapters Four and Five. Furthermore, among management, rhetoric about their own practices and role in relation to that of the workforce is equally active (Alvesson & Sveningsson, 2003a; Borins, 2000; Kuokkanen & Katajisto, 2003).

There is general cynicism across all the respondents who defined themselves as non-management *about* management. So for example: *"And you find that when there's a crisis that's when you find your management team will come down and put a policy in place regardless - like the swine flu thing" (Junior Midwife)*. So here managers are described as paying no heed to the routine tasks of the organisation (Cummings, Hayduk, & Estabrooks, 2005b). They are portrayed as simply responding to a crisis and (presumably following orders from the overall leaders of the service). Thus, managers are not seen as managing the boundaries between the Trust and those in overall charge of health care operating outside of the organisation (i.e. at the level of government) effectively for the facilitation of service delivery (Buchanan, Abbott, Bentley, Lanceley, & Meyer, 2005; Kane & Patapan, 2006). This resonates with Laughlin and Sher's (2010) analysis discussed above.

A focus group from one Trust proposed a particularly strident view of management and its relationship to wider bureaucratic imperatives which they saw as going against service delivery and effective patient care. The medical staff here were proposing that management was both absent, in person and from taking responsibility, while also being all controlling of medical care through instigating seemingly pointless rituals which seemed to maintain boundaries.

Consultant: There is a burning example [here] of bad leadership which is the absence of figure heads. Management can never be found which is frustrating.

Registrar: I've been in theatre now for two weeks and two cases were dropped. The doctor has to apologise to the patient but they are the ones [the doctors] who would like to continue. Management say 'NO it is lunch'. They should be the ones taking responsibility for telling the patient but the

doctor has to go back to the patient and look like a donkey saying 'I'm sorry I can't do your operation today'.

The members of this group, who clearly shared the same or similar images of management and its 'idiocy', went on to decry management incompetence across all staffing issues, and the registrar continued, imitating the management in a silly voice: "*he has to stop, that's the rule*" making it very clear that management was perceived by this man and others in this focus group as inflexible (and rather stupid). Here these participants are expressing total lack of faith in the authority of those who manage (rather than lead) them, although in fact it seems that despite this, they abide by the rules which suggests that there is a belief that at some level the managers in question here derive authority from somewhere higher up in the hospital system or from the NHS leadership beyond.

One factor to note, of course though, is that the power of the story in the focus group may belie the views of the whole group in that some would be silenced by the fear of disagreeing with their colleagues (Asch, 1956; Foucault, 1982). Furthermore, the articulation of the behaviour of management in these cases is *actually a form of leadership* and as such might influence the views of the focus group (and subsequently other staff) (Avolio et al., 2004; Pye, 2005).

From a different focus group, this time with junior midwives, it was apparently *giving up their authority* for a while that gained managers some important respect. For instance when a crisis occurred in the organisation (in this case a fire) then managers seemed to behave very differently and even impressively:

1³⁰. Yeah and then the managers - the bed managers - were carrying chairs and everything and you just had people on beanbags on the floor and everybody ...

2. I wasn't here that day I missed that.

1. Well it was a bit stressful but everybody just mucked in and people were just carrying people here and you know....

Q: Well that's really good if everybody even the managers mucked in.

1. Yeah you find in a crisis the managers do come out, the leadership the leaders come out and they have to come out.

3. And people were coming in from home to help that day.

³⁰ The number denotes the speaker.

2. *Why didn't they phone me? I don't know but never mind ...*

1. *No you find that in that kind of crisis everybody from execs downwards pulls rank and everybody comes in and helps out (T 2).*

So the image here is that a crisis brings out the best in everyone (and the boundaries between the groups of staff become temporarily porous). In times of crisis then the tasks (i.e. patient care and running an effective hospital) overcome other elements of potential discord and conflict such as the 'rank' order of 'execs' bed managers and others such as clinical staff.

There are also other times when it is possible for management to be seen as 'on side' as indicated by another nurse in a different site. For example:

Erm ... our manager, she is quite approachable. And she is willing to discuss things with you if you don't feel that something is right and you question it or question her. She is willing to sit down and explain it and sometimes she will say 'I'm not happy with things as well, but the people above me this is what they have decided, this is what we have to go along with. It is government guidelines or targets have to be met'. Although she might feel the same as us she explains why we have to do things in this way. And I think she is very approachable.

This manager above, demonstrates her willingness to communicate and be 'visible' but clearly she has adopted a them/us strategy similar to those who 'oppose' management by positioning herself as managing the boundary from the side of the clinician/nurse's while also at other times presenting herself as mediating between 'government' and clinicians and managing that boundary too (Laughlin & Sher, 2010).

In the example described here, this seems to 'work' as evidence of good leadership for the nurse telling the story, but it involves the manager in question in potentially difficult dynamics and conflicts in her role.

From another focus group discussion that included doctors and nurses the organisation in the mind experienced management as absent and failing in their responsibility (Hogan & Kaiser, 2005):

Absence would be correct. Management are often not there. They need to take command of the situation. Here is the reasoning – management don't take responsibility for their actions and there is a severe lack of managerial leadership.

This is significant in the concept of the organisation in the mind when juxtaposed with the account of the same organisation by the CEO who saw her/himself as seeing good leadership as manifested in:

Visibility in terms of being seen around the place, so go out wandering around the wards. The best part of the role, quite candidly is, the best part about being the chief executive is, you can go out and talk to patients, and that is what I really kind of enjoy. ... so there is something about my presence and my profile. There is also something about being very clear and repeating the message often enough so that it is clear in the organisation about what the organisation is there to do.

So, within the same organisation there is an image that management is invisible and absent, while senior managers see themselves as 'being seen around the place' constituting an important part of what they believe they do and that they see as being vital for effective leadership and patient care (Laughlin & Sher, 2010). Both sides agree on what would be good leadership but each 'side' has a different vision of what is happening in 'reality' (Alvesson & Sveningsson, 2003a; Buchanan et al., 2007).

In the absence of a shared vision of an organisation working together or a set of clear guidelines about how 'this organisation works', there seemed to be a wish from a deputy CEO of another Trust for a hero/charismatic leader to put things to rights and potentially cross the managers/others boundary (Ladkin, 2006; Laughlin & Sher, 2010).

Erm, this is a very complicated organisation, what we haven't got right is we haven't got a bible that says this is how this organisation works and I think that's a problem so, ((1)) so ((1)) it's very easy for ((1)) despite what I've said about how difficult it was to be a leader, erm and the personality of the individuals who are at the top of the tree, makes an enormous difference in how an organisation I think behaves and works. There is a great tendency if you are a very good individual for an organisation to be based around you and when you leave there is a problem, erm and so the best kind of leader, yes they have that aura of it's about them, of course that's what people look up to but they also put in place processes so that things can happen.

This is a view from the top of the organisation which is expressed at least in part as a vision of a (desirable) mechanistic model – an organisation with a 'bible' about how it works - although this participant also desires a charismatic transformation on the part of leaders.

The hero leader would be a 'very good individual for an organisation to be based around you' and also to have 'an aura'. The metaphors in this extract proliferate – the need for a 'messiah' to save the organisation but also a sense of *dependency* – that 'people look up to' this type of leader who (it would appear) single handedly will be able to put processes in place for things to happen. The vision here is though one in which the system is defunct, stagnant and closed.

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6.5 'Out of mind': leadership and the 'other'

Organisational change is frequently resisted, often because of the disruption to individual's *sense of the system* and their place within it (e.g. Hoyle, 2004). It is also related to the emotional involvement many people have in their work and the way they perceive they are valued within (and how they themselves value) a familiar structure and context (Bovey & Hede, 2001; Zoller & Fairhurst, 2007).

Emotional labour, as discussed in Chapter One, is a key feature of the work that many people do, and is an integral part of any job, but particularly so in an institution of the NHS (see for example Gabriel, 2004). Different occupations require different types of 'displays' and following Hochschild (1983) emotional labour requires adopting emotional displays and attitudes appropriate to the role.

Clearly in hospital work all staff have to expend emotional energy on 'caring' and 'kindness' but it is also the case that working in the NHS, with its many changes for (perhaps) better or (maybe) worse, also requires the ability to be able to 'move on' i.e. mourn the loss of the old structure, sets of relationships etc. and embrace the 'new' with some degree of enthusiasm. The failure to do this (or recognise the need to do this) results in emotional resistance to changes and hanging on to the old systems as long as possible which might defeat changes that improve service delivery and benefit patients (Hughes, 2005).

6.5.1 Leading change and transmitting leadership

In one particular case a senior clinical manager Gerald³¹, was charged with integrating clinical practice across two sites, each of which had their own different ways of working, and different relationships to the boundaries between each other and the clinical teams. While the one (where he was based primarily) had accepted quite radical changes to its organisation, the other (apparently) did not "*..because the sort of ethos and the sort of personalities of the two sites are in the background. They are completely different*".

Gerald's view is based on a reality in that the two sites are structured differently, look different from each other in that the buildings are from different eras and in different styles, and they are in physically different locations. They also serve different demographic populations and have different histories. However, Gerald sees the organisation of the different

³¹ Gerald's leadership is discussed in detail in Chapter Seven.

sites as really being about 'ethos' and 'personalities' which must be in the mind (mostly) as there is a system of authority and responsibility in place across the Trust (via the CEO and other senior people including Gerald) that takes up authority and leadership to ensure consistent practices and organisational change.

Thus, we need to ask why one Unit has (apparently) taken new ways of working on board with some enthusiasm while (apparently) there are barriers preventing the other one doing something similar.

For Gerald, management of the boundaries between in-patient care and primary care teams was the source of a key difficulty:

There are groups of people here who are completely behind the concept that we mind about – integration of primary care – joint working between the Trust and the Primary Care Trust. Some departments work extremely well and are keen to move forward and although we do have our minor difficulties - generally there's one or two departments who are completely against change and erm resistant to anything new. Just like any other organisation where you know you are going to get the type of people who actually make life extremely difficult for you and despite that we've proven how much better our system is.

In the extract above he moves from talking about the other *site* (as a whole system) as being the 'bad' resistant one, to identifying *individuals* on his own site within the 'good' system as making life difficult for him personally despite evidence (he and others have provided) to show how integration works better. This respondent's organisation in mind shifts depending on how well one part of the system fits with his particular vision of a good organisation. This *splitting* (see Chapter One) is a mechanism (unconscious) for preventing the overwhelming feeling that can come from persecutory anxieties (Jaques, 1953; Jaques, 1960; Menzies, 1970). In a management role where (for some reason) authority is being undermined, then the resurgence of persecutory anxiety might be dealt with by splitting of the 'bad' site and comforting oneself with the knowledge of a 'good' site where the organisation works as this leader/manager might wish it to do (Laughlin & Sher, 2010).

6.5.2 Resisting change

In the case of a medical secretary, with over twenty years experience of working in the same hospital, the thought of change in the structure of her working relationships was upsetting. She began engaging with the interviewer by talking about how busy she was and when asked if there was any particular reason why she was busy at that particular time she went into an explanation about organisational change. *"It's just generally busy, but we*

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are in teams now, erm couple of them [doctors] are away and one or two have come back, catching up with everything". It seems as if the teams were the problem for her because previously (and for many years) "...it was one secretary to one consultant and his team. Now for instance today I'm actually taking calls for four different consultants". She was asked about the new structure and made it clear:

erm ... I don't think it's going to work as well as the previous one. Because I think you'll be dipping in and out of so many different jobs that instead of concentrating on the ones that you do well and controlling your one doctor, it'll be confusing and I think there will be mistakes made because one person is trying to deal with too many parts of too many jobs.

Her perception that her role in the organisation might happily continue as one in which she controlled one consultant is characteristic of the 'comfort' of the closed system where authority, power and the processes of leadership are condensed and held 'constant' by an individual. As seen in Chapter Four also change is not usually welcomed without at least tacit resistance and in Chapter Seven two of the case studies will explore how leaders as potential change agents experience followers' avoidance or challenge to changes in practices and structure.

Changes in working relationships bring anxieties which need to be understood and anticipated by leaders if they are to support staff to position themselves differently in the system. Hoyle (2004, in Huffington et al) suggests that during any period of organisational change there is potential for heightened creativity which might lead to doing things differently and better. However, change also brings about risk, uncertainty and the chance of failure which can evoke anxiety both in those promoting the changes (the leaders) and those who might fear loss of their job and the loss of known ways of working (see Hoyle, 2004, p.87).

6.6 Conclusions

Understanding an organisation and what facilitates and/or hinders leaders to take up their authority involves considering the organisation systemically. That is taking account of the boundary management and how that relates to the tasks, roles and power/authority of those who work or are 'consumers' of its work.

Leading change depends upon ensuring those within the system have a sense of how the system works and an awareness of the culture that might be tested as a reality or not. This means, once again, that organisations which are learning environments and where emotional intelligence is applied, are more likely to respond to authority and less likely to subvert

leadership, thus distributed leadership/responsibilities may be taken up or shared more widely.

7 Leadership, Authority and Emotion

7.1 Introduction

As argued above, leadership and emotion are fundamentally intertwined in the workplace (Fineman, 2003). Leaders who appropriately manage both their own emotions (Goleman et al., 2001), and those of their followers, experience better leader-follower relationships, greater opportunity for innovation, motivation and productivity, a more positive organisational climate and improvement in employee and customer/patient satisfaction (Ashkanasy et al., 2003; Avolio et al., 2004; Hollander, 2009). Such outcomes can be associated with both *transformational leadership* (Bass et al., 2003; Corrigan & Garman, 1999; Currie & Lockett, 2007) and *distributed leadership* (Bass & Steidlmeier, 1999; Gronn, 2000, 2002; Mehra, Smith, L. Dixon, & Robertson, 2006b) patterns.

It has also been suggested that followers' 'dysfunctional' dependency is a consequence of failure of the leader to *engage* on an emotional level with those whom they lead (Alban-Metcalfe & Alimo-Metcalfe., 2009; Ashforth & Humphrey, 1995; Bion, 1961; George, 2000). There are different types of such engagement, e.g. acknowledging emotions, drawing them out, honouring them, confronting them, and deflecting them, but although this idea of engagement has been described as "*compelling on the surface, the meaning of the employee engagement concept is unclear*". (Macy & Schneider, 2008, p.3) Even so, there is a common view that such engagement is desirable for organisations in that it connotes involvement, commitment, passion, focused effort and energy from staff thus demonstrating both attitudinal and behavioural components for an effective workforce. (Macy & Schneider, 2008)

Studies of leadership and emotion have not typically been combined with attention to the 'authority' of the leader (Ford, 2006; Stein, 2007) or indeed to the concept of 'power', (sometimes seen and experienced interchangeably). (Morgan, 2006) A study combining exploration of the relationship of authority to concepts of both 'emotion' and 'engagement' (Hirschhorn, 1997) is particularly relevant to the agenda of the 'post-modern' organisation where leadership is distributed (Clegg, 1990; Tierney, 1996) and the organisation potentially fragmented, unmanageable and diverse.

The authority invested in a particular role, such as the CEO (Chief Executive Officer) or lead clinician may not explicitly engage emotion. However, in an organisation such as an NHS Trust, where leadership styles are, or at least

intended to be, characterised by distributed or transformational attributes, the concept of authority is more closely linked to *personal* authority whereby individuals “..bring more of themselves – their skills, ideas, feelings, and values – to their work. They are more psychologically present.” (Hirschorn, 1997, p.9). Thus for example clinical skills *and* personal investment are *both* required for someone to take up authority in practice as a clinical leaderⁱⁱ.

In this chapter we delve further into the concepts of leaders and leadership, particularly focusing upon leaders with a ‘mandate’ to lead change through their formal *role*. The group of participants we specifically focus upon here includes clinical and non-clinical senior managers and we examine the ways these individuals construct their role, their relationship to ‘followers’ and how their *authority* is taken up, experienced and constructed in their specific organisational context³². Authority has more than one meaning. It refers to the authority (sometimes seen as power) invested in a particular role.

Analysis of relationships between people who work in the NHS is underpinned by both the *interactional* and the (related) *emotional* contexts of an NHS Trust as a workplace (see for example Liden and Antonakis, 2009). This knowledge is particularly salient because on the surface, many of those occupying the leadership roles were inclined (at least superficially) to deny the role of emotion although analysis of their stories, shadowing and observations, following the pre-existing literature on organisational cultures, including those which study health care settings, indicated that emotion indeed plays a key role in service delivery and the ways leadership and authority are experienced and constructed in relation to patient care (Vince, 2002; Gabriel, 2004; Hirschorn, 1997; Huffington, 2007; Obholzer, 1994; Vega-Roberts, 1994).

7.2 Case studies

Three case studies were selected to examine the meanings given to the relationship between ‘leadership’, ‘emotion’ and ‘authority’ in relative depth. Each one was chosen (through discussion among the research team) to be (potentially) representative of a ‘typical’ approach to emotional management which reflected a personal style of authority (or lack of authority). These particular cases raised subtle but crucial questions about leadership, emotion and authority through exposing both the conscious and *unconscious* qualities which can either underpin or undermine a leadership *role* (Bovey & Hede, 2001).

³² In this chapter we focus specifically on the senior staff’s perspectives. Others’ perceptions of senior staff were discussed in Chapter Six.

1. The first leader, Gerald, had an 'authoritarian' manner (Adorno, 1950). That is, he appeared to believe that because he was in a senior position other staff ought to do what he told them to do. He was a senior clinician [for a group of particular services], relatively young, very enthusiastic and held an uncompromising vision of how a good hospital should be organised. He was interviewed once by a researcher, once by a group including the PI and 'shadowed' for two days by the same researcher.
2. Kerry in many ways held a similar outlook to Gerald, only she *believed* that she attended to the emotions of her staff if not her own. Kerry was Gerald's immediate boss and evidence from the interviews, shadowing and observations in both cases indicates they did not always work effectively together. Kerry was interviewed twice. Once for information as a key informant by two researchers and the second time by the PI and a researcher together. She was also observed by a researcher for an hour.
3. Quentin was a Clinical Director. He made overt efforts to weigh up the emotional 'risks' to his authority and thus seemed more able to engage with the 'followers' (and thus probably survive) in the *role*. At first he was reluctant to take part in the research directly (although he supported his colleagues' participation) but eventually agreed to be interviewed. Two researchers met him before the interview conducted by the PI, in his role as a key informant and observed him and the senior colleagues in their shared office space for about 30 minutes.

7.2.1 'Gerald'

Gerald held a clear vision of how a good hospital should be organised for the benefit of patients. What he appears to find problematic is managing staff who (for whatever reason) have a vested interest in different styles from those he advocates of patient care, working with colleagues and patients, and/or visions for service delivery.

The following extract is from the shadowing of Gerald.

From the two days spent with Gerald it was very clear that he believed that he was one of the main 'leaders' in the Trust and that he had a strong relationship with the middle and upper managers (including the CEO) which he uses to his advantage especially during long discussions regarding the 'new vision' (which appeared to be very much his vision) for the relationship between the two sites.

Gerald did indeed appear to be one of the main leaders. However, it was unclear whether the power and influence in this leadership role was all smoke and mirrors. Does Gerald play the role of the Wizard of Oz? Does he

think he has more power and influence than he actually has? Does he really have a good relationship with the Trust managers and Chief Executive?

The interview with Kerry (the CEO) made it apparent that she did not consider that he was one of the main leaders in the Trust and it was indicated that she didn't think much of him, and that their relationship might have been fraught.

Discussing the researcher's notes some weeks later, one thing that did emerge was that Gerald 'confused' those around him and was apparently unaware of how others saw him and how far his personal authority actually stretched. Hirschorn (1997) in a study of authority in contemporary organisations has suggested that leaders are no longer the old-style authority figures and because of changes in technology and economics "... bosses can no longer project the certainty, confidence and power that once facilitated employees' identification with them when they [employees] were young and dependent. This is why people are so disappointed in leaders today but also so unforgiving of them" (p. 9).

Gerald, although he had a clear management role and mandate to make the changes he focused on, did not get identified by his colleagues as fulfilling the vision of a leader as there is an implication in the observation extract that his authority may have been achieved via 'smoke and mirrors'. Furthermore his appointment (and that of several of his close senior colleagues) predated the appointment of the CEO. Several questions are raised here by the researcher about whether Gerald has been capable of taking up authority when the CEO takes a stance that at least tacitly opposes him. *This has to remain unanswered in the specific context of this Trust but is an important matter to consider in regard to distributed leadership.*

Gerald prefers to position himself as 'evidence-based' (and therefore up-to-date) dealing with practical matters and not positioning himself as an *emotional* leader. In the interview below, thus, he talks about making difficult decisions but paradoxically, almost from the beginning he focuses in upon dramatic inter-personal conflicts - talking about 'facing up to a fight' and declaring that the Trust 'absolutely' does not have the kind of leadership that enables 'direction' or 'vision'. Does this mean the CEO? Does this mean consultants? It may not even be intended so specifically perhaps it is an expression of general frustration that his vision is not shared.

While on the surface he claimed a good sense of what leadership is about he is also revealing in his talk, the opposite position. Taking a team or department in the direction of the vision and making difficult decisions is for him about a relationship with (not) being 'scared' or further down in this extract, (not) 'afraid'.

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Gerald: *Erm...good leadership, err having the ability to make difficult decisions, err, not being scared to face up to a fight...erm...being able to be clear about errr, the direction or vision of the trust, where we are going and be able to errr direct your team into the position that everyone errr everyone is meant to be going, erm I think*

Q: *Yeah...and do you see that kind of leadership in this hospital?*

Gerald: *No, absolutely not*

Q: *No? And why, why not? What's the problem to that kind of...*

Gerald: *I think that in the past, we .. we have been afraid to face up to a fight, and we have shied away from it.*

Q: *Yeah*

Gerald: *From making difficult decisions, and err, and we've let too many people get away with undermining the overall plan that we have...'cause we all know how to deliver excellent healthcare, we all have our views of how this is going ahead, but err, and the grand picture has been undermined by a few, and we've not been able to really face up to those people*

Gerald believes that while everyone knows how to deliver 'excellent healthcare' a few have undermined the/his 'grand picture'. He also identifies with a group who support his particular vision while not expressing empathy with those who do not. As the interview progresses, Gerald berates the power (rather than leadership qualities) that consultants have had in the past suggesting that they *undermine* changes that he clearly and sincerely holds about what constitutes good patient care.

Gerald however does reflect on what he is being asked as evidence by his suggestion later:

I don't know about what makes a good [leader]...you know, its difficult to say what makes a good leader...because I'm not sure I'm a good leader, because the qualities that I feel perhaps are necessary, I don't perhaps have ...one of those is patience perhaps...err, being able to tolerate people's err err, err stupidity in a nice way, is essential I think, but I don't have that, I don't think...being, having the ability to listen, err, err, err and not judge or criticise too quickly is very important, but then, taking everyone's opinion into account, but then at the end of all that being able to still go your own way, and persuade everyone else that it was their idea in the first place ... Well, I have certain qualities which help me get the goals that I like...erm...whether I have everybody behind me.

This is one (although not the only one) of the more (paradoxically) emotional interviews from among the senior managers in the study. Gerald

recognises, quite passionately, that a leader needs followers and has to be tolerant. Gerald, though, cannot help declaring that those who presumably hold differing opinions to him to be stupid. He also said later in the interview that he believed many people were *against him* when he was appointed to the senior post as the Trust itself changed shape. While he would not it seems position himself as emotional (rather he sees himself as evidence-based) he chooses to talk in emotive ways and reading and hearing what he says is quite exhausting as he uses all his energy in trying to take the organisation where he believes it should go, but through lack of emotional intelligence, many a time he draws a blank.

Gabriel and Hirschorn (2004) might describe Gerald, at least in part, as a 'narcissistic leader' in that he liked to be told he is important and influential but he is also potentially a bully and authoritarian in style (Adorno, 1950). He clearly found criticism intolerable and split off the 'bad' (i.e. the consultants who didn't go along with his changes from the 'good' i.e. the 'we'). Gerald has a dream which he is determined to make into a reality, however, there is a "*delicate balance between feelings of omnipotence and feelings of impotence which leaders must achieve, in order to enhance the chances of turning vision into reality*" (Gabriel and Hirschorn, 2004, p. 144). These authors argue that narcissistic leaders have a particular aptitude for getting this balance wrong and "*Even if they are talented in their field, their judgement increasingly fails them. This is compounded by the collusion of their followers*". This may be Gerald's 'we'. Gerald fails to connect emotionally with his (potential) followers from outside his close-knit 'we' group even though there may be some admiration for his clarity and link with the NHS mandate. This means, in effect, that important changes which may well be for the benefit of patients in the contemporary NHS are being (effectively) resisted because of Gerald's style of leadership. Gerald also appears to have little idea of how others might experience their worlds, including their emotions.

This theory might be borne out by the following participant, a young female career NHS manager just reaching a senior position. She proposed Gerald, unprompted, as an example of a good leader:

I think he's great, he gets a bit of bad press sometimes, I think people get agitated with him, but I think it's because he tries to manage things, and he tries to be very fair, and he tries to solve problems that have been with us for a long time, so again, I think he is a good leader, he is trying to do the right thing for the Trust in the long term. He is erm ... sometimes it's difficult for him to carry people with him, but I think that will pay off in the long run. And I think he's thinking of a long term plan, he's prepared to take a bit of short term flack...but I think it will work out in the end. I think he's going about doing stuff in the right way, he's being fair and he's trying

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to be consistent, he's making sure he's got an evidence base for doing things, it's not just a random decision, he's collecting information, and that kind of thing...I think there are a lot of people in this organisation at this point who would say they didn't think he was a good leader, but I think time will tell the story there.

This extract from the interview, while consistent with Gerald's descriptions of his own behaviour, proposes an evaluation of his style which indicates he is likely to be successful in the longer term because he is 'trying to do the right thing for the Trust'. However also she identifies quite clearly that his leadership is failing to take many of the people who matter along with him, she positions herself as sharing his vision for the longer term benefit of the Trust which may reflect her *a priori* engagement with NHS management rather than with a clinical profession as she does not have a clinical background herself. It also seems to reflect collusion with his narcissistic style because she seems to mirror his version of himself. This participant continues:

Sometimes they're [other senior staff particularly doctors] quite quick to criticise without really understanding what the problem is that needs to be solved, and what some of the rules are we can't ignore. Some of the national directives, that we just have to do, there's no point fighting against them, we've got to find a way of implementing them, and I think sometimes he gets a really raw deal...but he's said, he's consistent, he will communicate to people, write to people and speak to people very quickly the minute they raise a problem, and he definitely shows that he is not shying away from difficult problems...I think that's a very strong characteristic.

Her description of the other staff appears to chime with Bion's theory of a fight/flight basic assumption group based on unconscious emotional ties of the group involved which (mostly) represents an anti-task resistance to the leader (Bion, 1961). *This extract above reinforces the possibility that Gerald is emotionally disengaged from his followers* and perceives his Trust to be in line with and in favour of NHS 'national directives'. The participant here who in a way is 'damning' Gerald with *strong* praise may be looking to Gerald as a potential mentor by making it clear that she will support his particular efforts. However when the researcher asked her about her *own* leadership she said:

.... because one of my strengths is pulling people together, one of my strengths is building teams, so I think from that point of view then yes, but then sometimes I look at people like [Gerald and her immediate boss] and I think 'Oh my God'. I've got so much respect for the way they deal with

the very difficult issues. Sometimes I wonder if I really put my neck out enough to say 'Ok, Ok, this is what we all need to be passionately aiming for.' Even if not everybody is quite wanting to do the same thing. I think sometimes I sit back a bit more and wait to see what the general feedback is, rather than stick my neck out and say 'Ok, this is the direction we've got to go in.' And I think as a leader you have to...well, in fact you probably have to do a bit of both.

This participant, it seems, is somehow subjugating her own skills and strengths to those whose skills and strengths do not correspond with what she believes in makes her a good leader and seems to be putting herself down for the skills she has got and does seem to value. Alternatively, she might have realised that her strengths might complement Gerald's and through his own narcissistic valency he may position her as someone to promote.

Finally, in relation to Gerald, whose example she insists on returning to, having described other more emotional and successful clinical leaders in the Trust:

.... And they [other senior staff] make it very evident that they don't support him [Gerald] in his role, and not only do they make it very evident, but they do a lot of stirring behind the scenes, to get up a bit of a frenzy against him And I think there's some very clever leadership involved in that process, and there's a lot of learning, gathering people in, getting them on board and uniting them in a common purpose, and this and that and the other, but it's not constructive.

7.2.2 'Kerry'

Kerry is Gerald's immediate boss (the CEO) and evidence from the interviews, shadowing and observations in both cases indicates they do not always work effectively together³³. Kerry herself has met with similar difficulties which seem to be the outcome of her attempts to encourage distributed leadership in that:

Kerry: Erm, erm, well we set up a process to...we re-wrote the discharge policy here. I chaired the group. I wanted to know what the problem was about discharges, and I was told we needed to rewrite the discharge policy,

³³ Regardless of personal authority in the cases of both Kerry and Gerald, it is clear that the organisation has had its own very particular problems which are *endemic in the system* (see Chapter Six for a more systemic analysis of leadership).

and we'd just done it. People looked at me, and I just said, well I've spent...I've chaired five meetings myself, where we put all the information forward, and all these arrangements in place and nobody's done anything about it. I think that's poor leadership.

Q: So erm...poor leadership on whose part? Because presumably you had people who you delegated this to?

Kerry: So the consultants, the nurse managers, the matrons...all the people that were on the working group really. And they just didn't implement it. Beyond belief really.

This extract reveals several levels of emotion and authority and (as with Gerald's narrative) there is an 'I' who takes action and the 'they' who are against her. Kerry had identified a problem with discharges but had to ask 'them' what it was and was told that 'we' needed to rewrite the policy. She took up the role of chairing five meetings, the group/'we' put the information forward and the arrangements in place (presumably to take action) but 'no-one' did anything. It is not known how she handled this 'failure' of leadership on 'their' part. Kerry appears to be a micro-manager (in that she herself was involved in the meetings). Reflecting on this interview, and reading the text, one of us reported back to the research team that she had misunderstood Kerry, thinking that Kerry had been talking about her *own* case of poor leadership. Perhaps it was as unclear in the action as it was in the telling (thus perhaps on an unconscious level the lack of clarity was communicated in the meetings). Why did Kerry, as the leader, not pick up the group's dependence (or *resistance*) (Bovey & Hede, 2001; Hughes, 2005)? This suggests that she herself had resisted emotional attachment to her 'followers' and failed to engage them on an emotional level during the meetings. One approach that helps to understand the example above of *resistance*, specifically in the context of the five reported meetings, is the idea of '*fight/flight*' from the work of Wilfred Bion (1961/1983). He suggested that a 'group mentality' (or group culture) emerges from the development of a group over time as it continues to meet, because individual contributions conform to this mentality. In brief, the formed 'group culture' unconsciously constrains individual members (see also Sherwood, 1964).

So, in this case it may have been that despite the seniority of the staff involved in rewriting the discharge procedure, the culture that had developed over the course of the five meetings (and possibly prior to this as 'they' had suggested the need to re-write the discharge policy) had *prevented/resisted distributed leadership*. This could have led to the group not making sense of the leader's expectations and reverting to the comfortable pattern of being that had not been challenged possibly (again) because of the leader failing to manage her own emotions or engage with those of her team.

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Bion (1961/86) suggests, that the group mentality exists on both at a conscious and unconscious level so that the team were probably not deliberately, or consciously, going against the leader. It seemed from the leader's description that the team had been almost 'sleep walking' – not recognising that they had already done what they later ignored and suggested needed doing. Dependency, according to Bion, meant dependency on the leader or "... *when all individuals in the group look to myself as a person with whom each has an exclusive relationship*" (Bion, 1961/86: 119). Within this mode there is little connection between the members themselves and there is a '*mass inertia*' (op cit). This links to Klein's depressive position (Gould, 1997). It also raises questions of who is depressed here - Kerry, the group, or the group in Kerry's fantasy? The unconscious resistance and frustration experienced by the leader here demonstrates the fluidity of power and potentially the influence of gender (Fletcher, 2004; Nicolson, 1996; Vince, 2001)

Kerry, however, did claim success in turning around previously identified failings in patient care targets. How did she manage this?

Well I ... I... I mean it requires a great deal of focus, which hasn't been succeeded by other individuals, so...and it's required the organisation to understand its importance, and that it is possible to do. So it's been trying to talk to people about 'OK it's a target, but it's a quality... a patient quality target, so don't look at it in a sort of derogatory manner'.And ((3)) ...so it's a bit of culture about are you being bullied, as a member of staff to achieve the target and if you're not being bullied well then why is important and then well it's important because its patient quality ((1))...and then I suppose, something about... I mean one of the turning points for me is about our reputation as well, which is...well everyone else is achieving it, and we're not, 'why do you want to be in the bottom 20% of the country?'

Resisting her own emotional attachment here she talks in the third person. Rather than saying that as a new senior manager she had managed to engage the staff, which to a point she seems to have accomplished, she states that successfully addressing targets has 'required the organisation to understand its importance'. She clearly perceives senior staff as taking a negative position in relation to government targets and has attempted to persuade people that such targets are about good quality patient care. Another feature of the discourse slips in here – is her style of leadership perceived to be a bullying one? It may be that a group mentality, which takes resistance and dependency to be part of its culture, perceives a leader with a vision, or at least with determination (and 'focus' to quote Kerry) to be bullying them out of their emotional safety. This is a problem for any organisation that suggests to its staff that successful change and development is solely about strong leadership. We have to turn again and again to the clear message emerging from the data that without an

emotional attachment and the ability to manage their own emotions leaders and followers are not going to achieve goals related to patient care.

7.2.3 'Quentin'

Unlike Gerald, Quentin feels that he is succeeding in bringing about change and unlike Kerry he is mostly positive about the impact he is having upon the staff groups. He told two stories, one of which was when his leadership worked, and another where he continues to experience problems although he emphasised (to support his authority) that the latter was not a great a worry to him. In his interview he focused very much on the importance of personal authority: *"I'm still playing the trick of getting people to do things by example"*. He tries to back up his personal authority through making personal contact as much as he can:

You know my job could be answering my e-mails and I'm desperately trying not to. I've made a pact with myself that I will not explain myself in e-mail. If it needs to be explained I will go and explain it [personally].

He distinguished between the roles of the CEO and medical director, which in his opinion were *manager* roles, and that of clinical director which was a *leadership* role.

Quentin moves between the position where:

...people need constantly to be reminded of what they need to achieve ... [in relation to patient care] ...I use the word good care because [they] have the tendency to lapse into what is acceptable or even worse, what they can get away with.

To the position that:

And I think there is some requirement to continually challenge the organisation about what it is providing and sort of have a re-education process. And I guess we all need that – because I need that as well you know and it is one of my roles to keep reminding everybody why they are doing what they are doing.

Quentin sees himself as needing space to reflect upon the aims of the service provision and recognises that he is just as able to lose track of the organisation's main purpose as his colleagues/followers are, given the daily round of work. While Quentin gives an interesting example of how he and the team succeeded in meeting a target for patient waiting times in Accident & Emergency (which involved him engaging personally with the staff in an emergency meeting):

... which was all about persuading your senior contemporaries and peers. It's about the juniors, the people who are actually delivering the services. It's about making a reasoned argument. It's about being visible. It's about being honest and it's about delivering it.

The success, he believes, was about the personal contact and his own visible attachment in trying to change things alongside his colleagues and being very clear that " *...this needs to be achieved at all costs - which was quite liberating*". The rhetoric here is very different from that used by both Gerald and Kerry, who feel their colleagues are letting them down; possibly they are 'splitting' the 'bad' and projecting it into recalcitrant colleagues in order to feel reasonably good about their own positions (Klein 1987, 1983). Quentin is talking about success and success through *taking an emotional risk*. Saying that a change needed to be achieved at all costs (which he described as liberating) could be interpreted as Quentin making an emotional commitment to engage with his followers about something identified by the government, the NHS and his Trust as important. This stands in direct contrast to the experiences and rhetoric of both Gerald and Kerry who express the frustrations at what the 'others' are failing to do. However with what Quentin called a "*slightly different problem*". He has had great difficulty dealing with a doctor who is "*just a very difficult person to manage ... and I need to say to him 'this is crap and needs to be done in a completely different way'. I don't quite know why I haven't done that*". Once again Quentin was expressing an emotion – anger but without pushing/projecting blame on to the other, but being clear what the other person was doing and reflecting on his own sense of why, how and when he might take this issue up with the protagonist.

While Quentin operates with a quiet assurance and takes up his formal authority, and the power that accompanies it, from a classic Kleinian 'depressive position' (Klein, 1975; Segal, 1973), both Gerald and Kerry, despite their formal authority, fail to engage with their followers which leads to their powerlessness and a sense of rage and frustration.

7.3 Conclusion

The interconnections between power, authority and emotion play a complex part in understanding what leadership means to all those involved and in each organisational context. Leadership cannot be understood as something that can be observed and/or measured 'objectively', it is not an essential 'quality' which resides in an individual but is socially constructed, meaning different things to different people at different times. Following Ford (2010) a more contemporary, appropriate and critical approach to the study of leadership "*pays attention to situations, events, institutions, ideas, social practices and processes that may be seen as creating additional repression or discursive disclosure*" (Ford, 2010, p. 51)

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To be specific Rioch (Rioch, 1975), and others had made the point that *"'Leader' is a word which implies a relationship So the word 'leader' does not have any sense without a word like 'follower' implied in it".* (p. 159).

The relationship between leaders and followers might be more or less successful and in order to be a follower a person needs (even on a very temporary basis) to 'give over' something of themselves (i.e. make themselves emotionally open) to the leader for the relationship to have meaning. Being a follower may be both (or either) passive or active and there is the potential for the follower to engage and support, or subvert leadership (Bondi, 1997; Halton, 2007; O'Brien, 1994). Consequently, in order to analyse what it means to 'lead' in an organisation, understanding the practice(s) of emotional management alongside an analysis of power relations is fundamental (Grint, 2005; Schilling, 2009). For Foucault (Burrell, 1988; Foucault, 1982) power *"exists only when it is put into action, even if, of course, it is integrated into a disparate field of possibilities brought to bear upon permanent structures."* (1982, p. 788) Thus, while organisations give formal power to relatively few leaders (including in a distributed model of leadership) consent is still required for the power to be maintained. Furthermore, 'the other' that is the one over whom power is exercised, needs to be *"recognised and maintained to the very end as a person who acts"* (Foucault, 1982, p. 789).

The leaders we have described above all admit falling into traps where their authority has been challenged/resisted and they have been (potentially) made powerless. Quentin alone demonstrated awareness that he was working *with* people rather than treating them as resources. This meant that despite experiencing some frustrations, he managed to continue to *feel* and *think*, and with his colleagues/followers on board, *implement* changes. Kerry and Gerald, while attempting to take up their 'legitimate' power and lead change, both squander their authority through failing to manage and/or engage with their own and their followers' emotions. This is evidenced by their displays of frustration, impatience and anger with those who fail *to do what they are expected/commanded to do*.

Gerald held a classic authoritarian view of power, indicating that whether he takes people with him or not, he intends to get to the *'goals that I like'*. He also sees the resistant followers as stupid. He defines leadership accordingly, in that the leader should *'direct [the] team'* and not be afraid to *'face up to a fight'*.

Kerry sees herself somewhat differently even though she experiences anger and frustration when followers fail to do what she wants and expects. In attempting to empower her subordinates and set up the 'processes' to distribute empowerment (such as the meetings described above) she was left feeling disempowered following an (apparent) breakdown of

communication between herself and the senior team she tried to work with. That one of the interviewers also had to clarify: "*poor leadership on whose part?*" suggested that Kerry possibly re-experienced the rage and frustration she felt at the time of her encounter with the followers in her story when she told it. This rage obscured clear communication both then and in the telling. It might be that the overwhelming need to prevent the Trust from being '*in the bottom 20% of the country*' was a source of anxiety for her and the importance of achieving these specific sets of goals contributed to her impoverished emotional literacy.

Distributed leadership (Gronn, 2002; Mehra et al., 2006b), as a response to 'postmodern' organisations (Tierney, 1996) sets out the changing nature of authority/power. In combination with ideas from the emotional/social intelligence literature, distributed leadership suggests a more relational model of leader/follower relations whereby leadership decisions may represent both outcomes and inputs (Ashkanasy et al., 2003; Wolff, Pescosolido, & Druskat, 2002). A warning note, however, reminds us of the persistence of the patriarchal version of 'the' leader (Ford, 2010; Ford & Harding, 2008) which occupies the dominant discourse within which the notion of 'effectiveness' neglects (if not ignores) the importance of the management of emotions in the leader and followers.

Through the use of innovative research methods and data analysis, which take account of both conscious and unconscious processes through which leadership is socially constructed and exercised, the intrinsic complex connections between authority, power, emotion and leadership in the context of health care can begin to be disentangled.

Leadership that 'works' for an organisation such as the NHS is a multifaceted, emotional *process* in which leaders manoeuvre to manage their own and their followers' emotions and behaviours on both intellectual and emotional levels. To be effective in, what are now seen to be, postmodern organisational contexts, leaders also need to reflect upon themselves in their role and to understand the structural, cultural and emotional expressions of their authority and the authority and power of their followers. The legitimization of emotionally engaged leaders' authority supports effective service delivery across the different levels of the organisation through undermining conscious and unconscious resistance(s) as described in the examples above. Power as a coercive violence (see Foucault, 1982) has been exposed and undermined in such organisations and 'replaced' by concepts of 'distributed' leadership where the persistent claim to power is by definition and necessity more fluid.

8 Gender and Leadership

8.1 Introduction

Gender and leadership is an area that has attracted interest among policy makers and researchers, because the styles of leadership that are currently perceived to be the most effective, such as transformational and distributed, are believed to 'fit' more closely to 'feminine' styles of leadership. Fletcher (2004) notes that traditional 'heroic' leadership is usually associated with masculine traits (rather than men and women *per se*) such as individualism, control, assertiveness advocacy and domination, while 'post heroic leadership traits (such as empathy, community vulnerability, collaboration) are more associated with feminine traits. Ford (Ford, 2010) reconsiders the concept of *effective* leadership which is in fact a patriarchal model perpetuating an exclusionary and privileged view of the leader (metaphorically the 'father' figure).

Traditional research into gender, organisations power and leadership suggests that there are particular 'masculine' and 'feminine' leadership traits that are generally believed to characterise men and women's leadership styles (Rosener, 1990; Collinson and Hearn, 1994; Nicolson, 1996; Carless, 1998). Because women are widely believed to adopt a more democratic leadership style and men believed to adopt a more autocratic one, distributed leadership and concerted action in networked organisations may potentially be more conducive to those (women or men) who can adopt a more traditionally feminine relational style of leadership. Furthermore, feminine styles are more akin to displaying social and/or emotional intelligence (Guy & Newman, 2004; Leon, 2005).

In reality, both men and women display a variety of 'masculine' and 'feminine' leadership styles, depending upon their individual personality, age, position and the situation involved (Cross & Bagilhole, 2002; McDowell, 2001). However, gender *expectations* influence perceptions and beliefs and research suggests that subordinates are often more satisfied with leaders who behave in gender-typical ways than those who go against gender-type (Porter, 1992; Rosener, 1990; Williams, 1993).

Indeed, women in explicit leadership roles often tend to be viewed less positively than men, in the belief that 'masculine' traits (competition, authority, lack of emotion) conform more to expectations of how a 'leader' should behave but not how a woman should (cf. the work of Broverman et al. 1970). The 'paradox' it seems persists in contemporary organisations so that some women leaders feel they have to behave in a 'masculine' way which frequently makes them appear rather heavy-handed and/or as a 'bullying' because these behaviours do not fit with ideas about women (Eagly & Carli, 2003).

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Most of the women and (some) of the men we spoke to during the study, made a point of denying that gender was an issue in today's NHS, indicating that they believed that women and men were treated equally, with an equal chance of success. However, several participants also mentioned gender differences in the negotiation of power and identities describing how either women or men were likely to gain advantage through use of their gender-typed styles (Lewis, 2000; Schnurr, 2008; West, 1984).

Gender and leadership it seems remains a contradiction in people's minds but gender is a fundamental component of the discourses surrounding leadership in the NHS because of the demographic issues in clinical management and leadership (Evans, 1997; Gardiner & Tiggerman, 1999) and as we have shown in Chapters Four to Seven, role models and styles of leader/follower engagement have a major part to play in the transmission and exercise of leadership (Gill, Mills, Franzway, & Sharp, 2008; Greener, 2007).

We want to note here, partly in passing, although an example below (in the interview with 'Jeff')³⁴ demonstrates its importance - that the *researchers'* gender and physical appearance (age, ethnicity, attractiveness) also played an important role in the research process.

8.1.1 Senior women managers: 'we're all the same now'

Women in senior managerial and/or professional positions either deny that being a woman is an issue for them or for their organisation or that they know what they had to do to prevent being seen as a senior '*woman*', rather than a senior leader.

Denying the impact of your own gender on how you are seen and how you manage and lead is not an easy position to maintain and we observed some senior women working hard not to be seen as women even though at the same time they were arguing that *this behaviour was not necessary* because of the way 'things have changed'.

The researcher's observation of a senior female manager (Catherine) indicated that she thought that Catherine was trying to avoid being 'feminine' in her interactions. When the two interviewers were waiting to begin the interview, Catherine's PA came into the room with an important message but was shouted at in front of them. Thus in her notes one researcher judged that Catherine wanted:

....to indicate lack of interest and assume a position of superiority. Catherine was transgressing the boundaries of polite professional behaviour and attempting to define 'her' territory of the hospital. Answers to the

³⁴ Not his real name.

questions were also defensive, perhaps indicating a lack of self-assurance. Despite the tough exterior she obviously felt a need to stamp her authority on people in order to maintain control of the situation. This may partially be related to her gender and need to appear 'more masculine than the men' in a competitive environment.

The researcher following on from her observational notes with comments following the interview suggested that *"whilst she [Catherine] initially denied gender to be a relevant issue [for senior managers in the NHS], she then went on to make reference to 'testosterone' and 'the emotions of females' as problems in managing in her senior role".*

The relevant part of the interview transcript is below:

Q: Ok, so are men a problem? Are women a problem? Are there gender politics? Or am I just old fashioned there?

A: I don't think there are anymore, I think there were. I mean when I was appointed, I could have been one of [only] four [senior] women, so the whole senior management was very ... very 'suitish'. I don't think, no, I don't think it is a problem anymore. No, I think it is, if you talk to people in the north of England, they will say it's still a problem, and I think its a bit more of a problem to get females into acute trusts, big acute trusts, it's a bit of a climate difference. I think there's a lot less testosterone around now, there's a sort of slightly...erm I mean I've got quite a young male management team.

Q: Right

A: I find the testosterone and sort of challenges a bit much from time to time So I mean from that point of view, it is quite interesting, it does manifest itself. As do emotions of females really.

Catherine's somewhat aggressive, or at least uncompromising, behaviour witnessed by the researcher tended to soften after that and she added:

A; So I do think the answer to the question is that there are differences, but I don't think they're... they don't fundamentally affect how you do the job.

Vicki, a senior geriatrician, discussed the question of gender openly and at some length with the researcher who suggested that she had seen both Vicki and Mandy, another senior female consultant geriatrician, being very 'gentle' in their approach to patients and the researcher wanted to know how far this was linked to the fact they were women. Vicki thought though that their approach was not about gender but:

You know it could be a geriatrician thing, I don't know, ((1)) you know you'd automatically say 'it's oh because we're women', but I think it's only when you start following a few men around as well who are doing the specialty as we are, because the thing that attracts us to elderly care rather

than any other specialties in the first place, and that could simply be what you're observing.

It seemed important to Vicki that she was not stereotyped as a woman leader although she was keenly aware that as more women took up medicine and were arriving in senior positions that this demographic change would in some way impact on leadership.

So maybe that's where you've got to go as well as men in geriatrics you actually need to look at women in other specialties and follow them on a ward round and see what they do and that may be a good idea as well for the gender thing. But it's quite important for your study because at the end of the day we're training over 50% of women as doctors and in the future they think that almost all GPs will be women so that will affect the leadership and sort of, that you see in patient care.

So Vicki, while seeing feminine *characteristics* as more important in her clinical specialism than gender *per se*, still believes women doctors (e.g. GPs) will make different kinds of leaders from men.

During her shadowing of Mandy, the researcher noted what she identified as gender-typical behaviour:

Mandy also implements a mothering aspect to her leadership role (also noticed in Vicki) as she is always thoughtful and considerate to her followers, making sure they are comfortable and happy with decisions made and that they are up to speed with their medical knowledge. This mothering role also seeps into the delivery of patient care. Mandy is also a leader that appreciates the help of her followers and always thanks them for their input and help.

While keeping in mind that the researcher herself is making assumptions about what is a 'mothering' style and also recalling Vicki's assertion that it may be more to do with the kind of people who are attracted to geriatrics than gender itself, it is important to note that the researcher spent several days shadowing and observing female *and* male geriatricians. Further, she discussed reflexively what she saw and how she interpreted it with the research team to check out her observations.

8.1.2 Men: the 'natural' leaders?

The researcher who interviewed and observed Catherine also interviewed and observed Jeff (another non-clinical manager) and contrasted their styles of interaction with other people in the organisation, and with her, during the interview. At first Jeff seemed more approachable, relaxed and generally more amenable than Catherine had been:

Jeff was a newly appointed male senior manager. From the outset he displayed supreme confidence in his own authority and power as a 'leader'

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and obviously did not regard a young female researcher as a threat. He was very friendly and personable and happy to open up the space of the hospital for us, answering his own emails rather than through a secretary, coming to collect me personally from the main reception and chatting and joking all the way back to his office. Throughout the interview he showed confidence in his own opinions and was happy to talk in detail about both his own and others' leadership. This confidence may be a result of several factors such as position, age, class, gender or personality. He freely admitted that he did not mind appearing 'hard' or unpopular if it was necessary to get the job done, however he felt that his main asset was his own 'charm' and 'charisma'.

Thus Jeff firmly claimed his place within the (masculine) 'heroic' leadership tradition.

While Catherine was perceived as guarding her territory and demonstrating her power, Jeff appeared to be relaxed, being more approachable and particularly not hiding behind his PA. In fact, his account of himself in the interview was somewhat disarming.

Q And do you see yourself as a leader?

*A: Oh yes certainly. I can remember the time when I realised that I should be in management. I was working in a **** clinic in [a Trust] and it was so inefficiently run and I said as much to the manager. She said 'if you think you can do it better then why don't you manage?' So I said 'OK I will!' And I think I'm pretty damn good at it. I don't play by the rules, I don't have any formal qualifications, but I can get things done. I'm not perfect – I shout, I swear and mostly I'm just very, very cheeky, but I'm good with people and that's what you need in this job. You have to be tough too, take knock-backs and step on people to reach your targets. But mostly I care passionately about the patients. I would never ever chase a target if I didn't think it would improve patient care. So that's why I went into management, and I suppose the other thing is I discovered, I surprised myself actually about, I was going to say how easy it was, it wasn't easy, erm I had a natural aptitude to do it, you know it was something that I was successful in so you know yeah?*

Jeff wanted it made clear that the 'inefficient' manager was a woman and that he himself is 'good' with people (and on the surface the researcher acknowledged this). However, he also valued the tough, target-driven 'stepping on people' (masculine) qualities of his leadership which he believed were important in delivering patient care.

Jeff put his confidence and self-identified ability partly down to personality, but also to his gender and upbringing, adding that certain class backgrounds seem to 'breed' leaders:

I do think that great leaders are kind of born, but my background was that I was at all male public boarding school for 10 years. As my father said 'the biggest waste of money' given my academic erm qualifications at the end of it, erm and there was something there about you know that sort of environment. I mean does it grow leaders? You would think so, you look at the number of public schoolboys that end up as MPs, that's probably not a good analogy

Q:((Laughs))

A: But there is something about that kind of white middle class upper class upbringing that you have, and although I wasn't from that background before I went to the school, erm you learn survival among your peers, you learn I think to survive, you know if you think at the age of eight you are sent away you have to survive you haven't got your infrastructure.

It seems that Jeff is suggesting that leaders are either 'bred' or 'grown' but either way the influence that makes them a leader comes early in their lives. In the example he gives here, 'growing' takes place in a male-only context reinforced by social class, possibly wealth and a general sense of entitlement. This model does not echo the efforts and ambitions of the NHS in everyday practice nor would it appear to be in any way appropriate to the model proposed by the NHS (see Chapter One) which is focused on the type of leadership appropriate to managing and leading 'diversity' and 'difference'.

8.1.3 Gender wars?

Being motherly (like Vicki and Mandy) is not equivalent to being weak or compliant as perhaps some gender stereotypes might describe women (see for example Bem, 1993; Nicolson, 1996). During an observation of Mandy, the researcher identified what she considered to be a 'battle of the sexes':

Gender issues were brought into consideration during the interaction between Mandy, a female consultant and a male consultant. During this interaction a battle of the sexes and power occurred with the two consultants struggling for power in very different ways. The male consultant tried to assert his power through attempting to ignore Mandy's presence, never looking directly at her, but was raising his voice and being rude. On the other hand Mandy was always very polite, looked directly at him, spoke very softly and smiled a lot, although it was quite obvious that behind the soft smile was a vicious bite.

Perhaps this isn't so much a battle of the sexes but an example of how men and women might behave differently towards each other in the course of a power struggle. The detailed observation notes show the encounter move by move:

There are some territory issues with Patient 9 and Mandy is angry that there is a patient on her ward that is being treated by another doctor. She asks why the doctor has continued his care now that the patient has moved ward and suggests that if the doctor feels that he needs to continue with the patient's care then the patient should be kept on one of his wards rather than blocking a bed that could be used for one of her patients. She asks "why can't we look after this patient? We are not supposed to have any outliers on this ward!" Mandy's registrar Melvyn can not, or does not want to answer her questions and simply shakes his head and shrugs. Mandy says she needs to speak with the consultant and asks Melvyn who the patient is under. Melvyn gives the name and admits that he has seen him arrive on the ward a couple of minutes ago, so he should still be there.

Who is Melvyn afraid of here? Or is Melvyn simply not wanting to witness a battle over territory and patient care?

Mandy walks round the other side of the nurse's station to find the [male] consultant with three other doctors/medical students standing some distance away and his registrar to whom he is speaking. Mandy and 'our' group move over to his location and the junior doctors from both groups greet each other and share whispered conversations. Mandy stands patiently at the side of the registrar waiting to speak with the consultant. Although Mandy continues to smile pleasantly I think that she is angry or frustrated on two levels. First because the consultant is on her ward and hasn't come to speak to her and second, because he doesn't seem to have the manners to even acknowledge she is waiting. After the conversation between the consultant and registrar has finished the consultant turns his attention to his paper work and the registrar moves to be with the other doctors (some distance away) Mandy lifts her eyebrows up to Melvyn (clearly annoyed with the male consultant's behaviour) and then asks if she can speak to him about Patient 9. Mandy explains politely that they do not have outliers on this ward and therefore asks whether the patient could be moved to another ward or if this cannot be arranged she take over the care for the patient. While she speaks the consultant doesn't look at her and continues to write, his body language and behaviour are both arrogant and rude. The consultant says that the patient is his and he will not be passing the patient over as she has problems not solely aligned with geriatric care and that she needs a specialist. Although this was clearly a statement to undermine Mandy's capabilities she continues to smile and tell him that the patient will be moved before the weekend so that a patient needing specialist geriatric care can have a bed.

Moving through this detailed account the gender issue becomes obscured by the fact of Mandy's skill as a clinician, a leader, her concern to give appropriate care within a context of limited resources and her ability to handle herself in the face of rudeness and arrogance. These are skills that ensure she will shine through as a leader in any context but particularly one

which is still a man's world. In a socially or emotionally intelligent context where concerted action is seen as important, patience, politeness and clarity of purposes will eventually win out over arrogance and bluster. As we see in the next extract Mandy's 'opponent' does not possess these attributes.

The male consultant becomes angry and raises his voice to Mandy and says there is nowhere else for the patient to go. Mandy lowers her voice and says that the patient must have been on one of his wards before she was moved so she can move back. The other consultant looks swiftly at the group of doctors who are stood behind him (both his own and Mandy's) and then eyes me suspiciously before turning back to Mandy and speaking in a lowered voice. The conversation moves back and forth between Mandy and the other consultant and it is clear that despite his outbursts and undermining statements to Mandy that she has the upper hand and although she continues to smile, she is very forceful and strong in her argument and objectives. To conclude the whispered conversation Mandy raises her voice and tells the group that the patient will be transferred on Friday and that she will be getting a transfer set up straight away. She then thanks the other consultant for understanding and walks back round to the group with a smile on her face and asks Melvyn to set the transfer up.

This is a consummate example of patience, calm and the ability to lead doing what she considers to be the best for her patients, her team and her department. Her skills in continuing to be quiet, calm and smiling have 'seen off' the male consultant in the meantime but reading this it would be surprising if the humiliated man does not try to take revenge. Although there is very little evidence that this is anything other than a 'normal' power struggle it is the case that Mandy is in fact a woman and has played, what is mostly recognized to be, a feminine role.

Returning to male expressions of power it is important to be aware that blatant attacks, such as the one in the encounter above, are not necessarily the only ways of demonstrating confrontational masculinity.

It appeared from the interview with Jeff (discussed above) that he believed he did not need to defend himself in the face of gender stereotyping. He had strong opinions on women's leadership and also on women's 'availability' with no qualms about voicing these which contrasts strongly with women's accounts where they try to underplay gender, that is that many senior women take the view (overtly) that gender is irrelevant.

The researcher's notes about the meeting with Jeff continue describing a dramatic example:

Jeff's supreme confidence meant that whilst he came across well in an interview situation, he crossed boundaries of professionalism in other ways, telling unsuitable stories about staff and inviting me (researcher) out for a drink after the interview, invading my personal space. In the extract below

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he accuses a female colleague of not only being attracted to him, but trying to use her sexuality (unsuccessfully) to get ahead at work, whilst simultaneously flattering me that I am his 'type' by subsequently asking me to meet him for a drink.

And in the interview:

Q: And could you give me some examples of bad leadership that you've seen?

A: Well, Melanie Willson³⁵, have you met her?

Q: No I was meant to but she cancelled the interview three times...

A: Exactly, she probably thought she was too important to talk to you. Now I can tell you an interesting story about her. She's a good looking woman, stunning, very intelligent too. But there's something not quite right, I don't know what it is... really cold. She's got no soul. I appointed her as divisional manager and at first she was doing really well, but then she ran into some problems. She was failing in her job. And that's when she started to flirt outrageously with me. It was like she couldn't beat me intellectually so she was going to do it another way. But, well... she's not my type. And she was really jealous when I got this job, I had Lucy (PA) go and announce it at the morning meeting and you should have seen her face. Anyway I hear she's got a promotion now so she must be doing something right.

Melanie Willson clearly perplexed Jeff – 'stunning' but no 'soul'; 'flirting' to avoid being faced with 'failing' in her job; unable to beat Jeff 'intellectually' and resorting to using her sexual attractiveness. After stating that she was not his type (indicating that the flirting also failed) he then made another woman humiliate Melanie in a public context. The implication of her subsequent promotion being based on something other than ability was also a powerful 'aside'.

Discriminatory comments against women though are perhaps not that commonplace. Jeff's sense of 'entitlement' may be a dying one across most NHS organisations and it is certainly against all stated mores. Discrimination on the basis of gender is more opaque. The researcher interviewed Helen, a senior female consultant, and talked about gender and arrogance of male consultants. The researcher suggested:

... this was possibly seeing me as an ally as a young female professional. In addition to the immediately obvious behavioural differences between women and men she also mentioned unseen discrimination in the form of merit awards at senior levels and problems of combining work and family commitments which may mean female staff are less likely to achieve these.

³⁵ Not her real name.

In the interview Helen responded:

Q: Do you think there are any gender differences in leadership that you have noticed?

A: Yeah, yeah I think, I think so, erm you know the men are more well, can I, the men are less inclusive of a group and they have ((1)) already formed an opinion sometimes and before listening, erm, ((1)) err ((1)) yeah.

Q: Yeah ((laughs))

A: Need I say more ((laughs))? But I think there is a difference ...Competitive, that's what I was saying, there's that competition, yeah competitive, exactly ...Of course not but the insight is very, very small, and then those meetings go on and on and on and it's people trying to get one up on another so... I just want to leave. It's handy having a beep you know you can say 'oh, I've got to be off (laughs)'.

The suggestion here is that men are apt to waste time on each other and power struggles and that for them competition is central to their 'nature'.

8.2 Conclusions

Despite the increased numbers of women who have reached senior leadership positions in the NHS, both as senior managers (clinical and non-clinical) and as senior clinicians *per se*, there were nonetheless some interesting differences between women and men's self-descriptions and perceptions of others as leaders, sometimes made on the basis of gender alone (Gill et al., 2008). Descriptions given of leaders and leadership for members of the 'other' sex were also frequently gender-typed.

It may be that despite valiant and frequently effective attempts to change the culture of NHS Trusts that a 'traditional' view of leadership remains at least in the organisational 'memory'. This might go some way to explaining why women who are clearly powerful and influential are reluctant to identify themselves as taking up these more 'feminine' styles even though they may in fact use the skills associated with these qualities. Eagly and Carli (2003) make a case for women as having a leadership 'advantage' in contemporary organisations where the type of leadership required has changed. However, they argue that in many cases women have to battle against the inherent prejudices in male dominated organisations. Although there is still a reference to gender stereotypes when discussing gender in organisations and gender and leadership as we have seen from the extracts above in this chapter, as Rosener (1990) stated: "*Women managers who have broken the glass ceiling in medium-sized, non-traditional organisations have proven that effective leaders don't come from one mould*" (p. 119).

In Chapter Five the OCS revealed that women across all professions scored lower than men on 'recognition' in that they perceived their managers as

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not recognising their particular attributes as clinicians or managers and they also perceived that the organisational climate was one in which 'recognition' was more likely to be given to men than women. That men did not see this as a problem for them reinforces the view that regardless of trying to establish gender equality across NHS organisations it is still not embedded in the management culture.

As we have seen and has been well documented in the literature, it remains difficult for women to exercise leadership without their behaviours being construed as either 'weak' or 'aggressive'. The paradox is that leadership requiring more 'feminine' characteristics is at least explicitly more desirable in the contemporary NHS.

9 Patient Care, Leadership and Service Delivery

9.1 Introduction

The NHS has a history of reform/modernisation aimed at making patient choice and care more cost and clinically effective by improving the organisational structures through which care is delivered (Bate & Robert, 2002; Becher & Chassin, 2001; Darzi, 2008; Wilson, 2009) .

The NHS remains committed to its original aims of providing a cost and clinically effective patient care (Doherty, 2009; Phillips, 2005), at least partially through the NHS's organisational structures, including the gate keeping function of primary care, while providing a universal service free at the point of delivery. Since the 1990s patient choice has been added to the longer term commitment to efficiency (Bhandari & Naudeer, 2008; Bojke, Gravelle, Hassell, & Whittington, 2004; Bryan, Gill, Greenfield, Gutridge, & Marshall, 2006). And at the same time there has been an explosion in new diagnostic and therapeutic technologies accompanied by a public awareness of the availability, or lack of availability, of those technologies (Aberbach & Christensen, 2005; Greener & Powell, 2003; Mueller, Sillince, Harvey, & Howorth, 2004a).

In this chapter we particularly address:

- what respondents (staff and patients) say about patient care and service delivery based on the interviews and focus groups;

- what we *observed* about service delivery and patient care and particularly the *interactions* between clinical staff and patients *observed* and *described* during the shadowing.

As in Chapter Six the Trusts are conceptualised as open systems whereby high quality patient care (the input) corresponds with effective service delivery (the output) with the primary task defined as caring for sick patients (or those who are giving birth).

9.2 Defining patient care and service delivery

The thematic analysis highlights similarities across all grades, statuses and disciplines of the staff and the patients involved in the study. The themes that emerged consistently from the data that were about good patient care were:

1. Putting the patient first:

...of course patients do come first but actually really, on everything that you do, I mean everything you do you think of the patients (service manager in acute medicine).

2. Thinking about what is good for the patient (all the time):

I still believe and I believe to this day that if you absolutely concentrate on what the patients' needs are, all other things take care of themselves. it's about really showing that you care. I mean genuinely showing that you care about your patients, erm there's a lot of talk about also looking after your staff and caring for your staff. I think that's important but I think the health service has got itself stuck far too many times concentrating on the needs of the staff and not the patients (Chief Operating Officer).

I think that's what you have to make sure is that everyday you are thinking to yourself, 'am I doing this for the good for the patient?' 'is it the right way to do it?' so I think when you get eleven years down the line, one of the things is that you can loose sight of is that, very easily (Matron).

3. Awareness of the diversity in the patient's world (culture, family, age, home and work environments):

..it would be making sure older patients have high quality of care during their surgical admission (senior consultant Geriatrician).

you need to support your staff ... you know and you have to have an awareness of the different culture of the patients (administrator).

4. Making sure the patient received the care that staff would expect for themselves and their relatives:

I would define patient care that of - if it was one of my relatives who were ill (senior manager).

5. Talking to patients about what has happened, their medical history and their clinical condition:

....if they talk to you one-on-one and you know where you're at (patient).

6. Safety and empowerment of patients:

They [the multidisciplinary care of the elderly team] believe that good patient care sits around ideas of timely discharges, safety, making sure the patient understands their condition and their treatment, empowering patients by allowing them to make their own decisions about their care (to a point), providing the appropriate treatment and care, being responsible for the patient. Examples of bad patient care are viewed as delayed discharges, poor decision making and discontinuous care. (Notes from an observation of a team meeting).

From the descriptions it is clear (and perhaps no surprise) that senior managers, clinicians and patients all hold slightly different perceptions which inform their judgements to give 'patient care' a specific meaning. Some of the judgements are related to their particular clinical specialty or organisational responsibility although generally respondents reiterated that patients need to be at the centre of daily practices. Patients in all cases wanted more than anything to be kept informed about their care, and if possible this should be done by the clinician in charge.

At a more complex level the definitions above reveal a 'vision' of good patient care which links the 'practical', 'professional' and 'political' elements of NHS life. It also links to the 'human' elements associated with the tasks of caring. For example, the Matron (quoted above) shows a revealing insight that the routine *organisational* tasks might take over as a perceived priority from what a person initially knew to be their primary task (i.e. patient care). As she says, several years down the line you might lose sight of what you are really there to do.

9.3 How is good patient care achieved?

9.3.1 Managers

Managers each have different levels of responsibility for delivering good patient care which may differ from priorities expressed by patients and clinicians:

Erm, that's the bit about lifting your eyes up off of the horizon, and lifting the eyes up above the horizon is about looking at the totality because the

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medical, again, the medical management model is very much that you should do what you need to do when the patient is in front of you. The management model, the pure management model is about doing the right thing for the 450,000 patients who were looked after last year, so some of that will be about compromising, and offering the best care to the widest group that you can (CEO).

Immediately this respondent exposes the potential for conflict at senior level in that he/she³⁶ positions the 'medical management model' differently from the 'pure management model'. In the former the patient is a particular individual with a health care problem – the patient 'in front of you'. However for senior management there are many thousands of patients that require good patient care which means (maybe) compromising to provide the best possible care to the greatest number. Despite this, another senior manager had a different 'take' upon good patient care and in answering the question focuses on what they themselves would expect evoking a more individualised model:

I would want good consultant input into my care ((1)) as soon as it was appropriate in the pathway that I was on. I would want to be able to have a conversation about what was wrong with me and what treatments and options there were, ((1)) erm ((1)). I would want the assurances of the people that deliver the care know what they are doing. ((1)) I would want the care to be provided in an environment that was clean and in an ideal world I would want a single ensuite room, err and I would like to choose my own food and all that jazz. ((1)) erm and the erm, ((2)) so really you want the environment to be correct and you want to have the confidence in the clinicians giving care and you want to have had input into what your care should have been (Senior Manager.)

This manager has a very clear model of their 'ideal type' which positions the relationship between the patient and clinician, the skills/expertise of the clinician and the physical space and environment as central to good care. There is awareness here that planning and teamwork are also part of the process of care but particularly important is the knowledge of how to deliver the appropriate care and information in order to facilitate joint decision-making.

³⁶ We do not want to risk identification of any individual participant.

9.3.2 Clinicians

Good quality patient care for most doctors interviewed was:

... making sure that erm the patient achieves the outcome that you would wish them to as a result of either their outpatient visit or their inpatient stay erm and that outcome is kind of on a objective kind of medical measure, erm but it's also in terms of the quality of the care that they've received and whether they are satisfied with the care that they've received. (Senior consultant)

Another senior consultant who is also on the senior management team of the Trust took the concept of patient care further:

... it should be delivered well I think is the answer ((laughs)). I think on the whole we do deliver it well, we have the lowest mortality rate in the country, ((1)) or one of them. I think we do actually and we ((1)) I'm very proud of the care and I think there are two things to be proud of and one is the basic care and ... we do emergency work I am very proud of. Then the other bit of care we're proud of is that ... I think there is a real culture of innovation and I'm trying to do something new up here, and I think that's actually really important in terms of leadership. My job is being able to see a clinician with an idea and then work out of him or her how to turn that idea into a self service innovation. I think that we have created over the last few years a much stronger patient safety culture.

This respondent clearly links leadership and patient care stressing both the relationship between supporting other clinicians in innovations that improve care (particularly attending to safety) while also being proud of the culture across the Trust for low mortality, innovation, and supporting staff. Crucially there is a pride and energy about this account. The culture puts patients first but the staff gain satisfaction and a sense of professional pride from the performance of the Trust as a whole [T3].

The clinician manager below takes up the relationship between staff empowerment (and support which links clearly to the outcomes reported in Chapter Five) and returns us to the focus on staff training and skills, indicating here that if the managers train and empower staff – services to patients will improve.

... it's about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is, we worked with training and development and we came up with a specific programme that was aimed at empowering them to improve their service area etc. etc. and

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also provided them with some skill sets that they probably didn't have prior to that. (Senior Manager, Therapies)

While from a similar perspective the nurse quoted below stresses that team work and morale mark the path towards good patient care and you need to look after *staff* in order to deliver a good service to patients.

... And I think it is also, sort of, taking into account the people they work with, the team members and boost the morale, and that can make a lot of difference to, you know, to have people at work and sort of take the stress levels off and I think, you know, it would sort of, quality certainly would happen, sort of energise them, able to care for the patient. (Nurse, focus group)

9.3.3 Patients

For patients overall it was clear that most of all direct communication and consistency of staff was experienced to be good care:

A: ... I've been transferred here from [another Trust] and there it's a bit more, not one-to-one but you see a lot of different doctors here whilst there [the other Trust] you have only one doctor, your one midwife and your one consultant. Here you see a lot of different people.

Q: And which one do you prefer?

A: I'd say probably just to see the one 'cause lots people tell you different things.

Q: Okay, so it can be a bit confusing?

A: Yeah, sometimes it can be, yeah.

The patient quoted below reinforces the need for clear patient/clinician contact and communication.

For another woman:

Now whilst I'm here my care has been very good especially with the [specialist] who first saw erm, who first flagged up the problem. Erm yep it's been good it's been good since I've been in. It's just the initial communication as an outpatient to an inpatient I should have really - you know that should have been. I don't know where the fault lies but there should have been some communication there between the appropriate people (Maternity patient on postnatal ward).

9.4 Delivering patient care

9.4.1 Doctor-patient interactions

We look firstly at three consultants' (Cameron, Kenneth and Henry) styles across two different Trusts as they interact with patients to explore the importance (or otherwise) of good communication and engagement. What emerges, perhaps unsurprisingly, is that different consultants have different styles of engaging. The style adopted though feeds through to the 'ethos' of the clinical team, relates to, and impacts upon, the culture of the Unit thus affecting the doctor-patient interactions as part of an evolutionary cycle.

9.4.2 Empathy and Communication

9.4.2.1 'Cameron'

From the researcher's notes we gain an impression of Cameron who deals mostly with stroke patients for whom verbal and non-verbal communication may be very restricted:

Cameron offers a very personal and individualised style of patient care to his patients. He is often very tactile often rubbing the tops of their hands, arms and heads to encourage them or to show support when he is discussing difficult problems with them such as their inability to go home, the definition of a stroke and the future impacts of them having a stroke. He also speaks to the patients in a very friendly and informal way and sometimes draws on their mother tongue to say a few phrases to make them feel welcome and at ease.

In his interactions with his patients he is very positive and upbeat, often speaking loudly to encourage and motivate his patients. He also tries to share a few jokes with them and breaks down doctor/patient power relationships by crouching down in front of his patients or sitting on a chair or their bed so that he is always the same height or lower.

This description alone demonstrates how Cameron's *behaviour* relates to several of the descriptions above which identify good patient care in that he:

- communicates (verbally and physically)
- takes care to acknowledge their humanity through recognition of their cultural (linguistic) heritages the fact that they have a life outside the hospital
- attempts to empower them within the relationship (at least via discussion and physical presence and to an extent with knowledge of their condition).

Below is a detailed example of Cameron (and his team's) encounter with an elderly stroke patient (Mrs. D) which is part of the evidence the researcher has employed for her assessment of the processes engaged by Cameron in his provision of patient care:

"Hello Mrs. D? (Patient nods head and smiles) do you have a headache? (Patient nods head) Do you know why? (patient shakes her head staring wide eyed at B). "OK, I'll tell you..." Cameron sits on the edge of the patient's bed and explains that she has had a stroke and she has a headache because sometimes patients who have had strokes will have suffered from headaches due to pressures on the brain. The patient stares and nods her head occasionally as Cameron explains. "Mrs. D, do you understand what I have just told you?" (patient nods her head and then croaks "yes") on this speech Cameron sounds surprised and encourages her to speak again "Oh wow Mrs. D, that sounded good, can you say something else for me?...well done". The patient looks up at the doctor and smiles croaking again "I don't have anything to say doctor", "well never mind Mrs. D, I am sure I can get something out you a bit later!...excellent, your voice seems to be coming back...isn't that good?. We will have you singing in no time!" (Mrs. D. smiles and shakes her head "can't sing" Cameron smiles and laughs.

Despite the clear power differentials, doctor/patient and healthy/unhealthy, in this relationship Cameron is doing what he can to encourage and communicate effectively with the patient. Not only does he literally get down to her level by sitting on the bed but he explains the condition, how it happened and communicates the indicators for (potential) recovery. He is respectful and careful although the intellectual/cultural difference between the patient, Cameron and the care team is exposed by the encounters below.

"Now Mrs. D. can I examine you?" (Patient nods her head) Cameron takes the patients hand and she flinches "cold!" Cameron smiles and apologies saying it that "it is the alcohol" (alcohol gel he had just rubbed into his hand). The patient eyes Cameron suspiciously "have you been drinking?" the group laugh and Cameron explains that it is the hand-wash and she nods slowly and looks at each member of the team for what seems confirmation that this is the truth. Cameron then begins testing the patient's strength. He checks her arms and then her legs with simple strength tests calling out numbers between 1-5 for the SHO to write in the notes. As he instructs the patient with her tests he speaks very slowly and loudly and the instructions are very simple and clear and he often demonstrated his instructions, especially for those patients that have cognition problems. As the patient does the task Cameron is very encouraging shouting words such as "good", "excellent" or "well done after

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each task". After the strength tests Cameron checks the patient's reflexes with a small hammer. Again he shouts out numbers and makes comments about the reflexes that the SHO writes down in the notes. Following the reflexes Cameron checks the patient's facial muscles by asking the patient to smile, grit their teeth, stick out their tongues and move them about. He then checks her speech by asking her to repeat phrases or noises after him. The first phrases or groups of words were given as words that would be familiar to the patient such as the patient's name or names of simple objects such as pens. As the patient is able to say these words he moves on to more complex words such as "hippopotamus" which the patient struggles with. Cameron then checks the patient's ability to co-ordinate by getting the patient to touch her nose and then his finger with her index finger. The patient clearly struggles with this and is very slow and inaccurate.

For a brief moment after the tests Cameron has a quick discussion with L [another doctor] asking him what he thought about the tests and what they would expect to see on the CT scan. Cameron then turns to the patient and says "sorry Mrs. D, just discussing your test results with my colleague, we think that you are progressing very well...there has been much improvement hasn't there?" the patient stares blankly at Cameron for a brief moment before shaking her head "no, you don't think so? Now what about your speech, when you first arrived you couldn't say a word, now listen to you, don't you think you have improved?" patient shrugs her shoulders and looks down at the bed. "Well Mrs. D, we all think you are improving...so well done..." patient looks up and smiles sadly.

The style of meetings between clinical staff and patients was as much a feature of *Unit and team culture* as of a particular clinician's practices. Thus, while Cameron above was engaging with the patient in what appeared to be a *genuinely caring* manner, his colleagues were attentive, while in the background.

9.4.2.2 'Kenneth' and 'Henry'

In what follows two consultants worked together and while Kenneth was the more senior and experienced clinically, Henry held a senior managerial role (as well as being a senior consultant). Kenneth was described by the researcher as:

... a very warm and caring man ... he is very sweet, kind and caring to his patients and makes them feel comfortable and less vulnerable by empathising with them and drawing on his own personal experiences as a patient.

As with Cameron above, Kenneth was also described as 'tactile' and that he took the time to explain things to patients. Kenneth empathised with patients by sharing a joke (as did Cameron):

For example one lady was embarrassed because she had fallen down in her flat and sustained injuries and did not really want to explain how she had fallen over or what she had hurt [to the whole team]. Kenneth then told the patient that he had slipped over in the hospital and in the M&S food section. This meant that she no longer kept quiet through embarrassment and told Kenneth after that exactly what had happened.

However, during the two day shadowing of Kenneth the researcher was particularly:

...struck by how intimidating this group of doctors must be to the patient, especially an elderly or vulnerable patient as a large group of faces arrive at their bedside and close the curtains around them making the space feel incredibly claustrophobic and that the patient's space felt 'invaded'.

While shadowing Kenneth, the researcher was in a position to observe Henry (who was also shadowed for two days on a different occasion). The researcher's notes here, which describe a joint ward round with Kenneth and Henry, state:

I was struck by how impersonal Henry was towards the patients [in direct contrast to Kenneth]. He did not greet them or introduce himself. [In one case] Instead of asking the patient how she was getting on with the oxygen machine Henry asks the SHO how she thought the patient was getting on with the machine. When the patient tried to give reasons they seemed irrelevant to Henry who just told her she must use her oxygen machine every day or she will not get better.

The researcher goes on to describe how Kenneth (the senior clinical consultant although Henry has a senior leadership role) stands quietly behind the junior doctors on the round with Henry at the front of the group talking to the patient. Henry stands up. Kenneth stands at the back of the group with his hands folded behind his back and Henry every so often asks Kenneth if he agrees with Henry's thoughts on the patient's health status and treatment. While Henry is taking the lead in this way the researcher notes:

Not one of the doctors explains to the patients what will be happening to them that day or beyond nor do any of them say goodbye.

One patient on Henry's round is in the bathroom as the team arrive at her bed.

Henry knocks on the door of the bathroom and says "Mrs. X, it's Dr. Henry we are all here to see you". He then asks a nurse if she can hurry the patient along as he is very busy. It seemed strange [to the researcher] that Henry could not have just visited another patient until this patient had finished rather than rushing her. Before the nurse can enter the bathroom another nurse pokes her head out from behind the door and says that she is washing the patient. Henry asks whether this could be finished after he has seen her. The nurse, who looks frustrated, says she will be a minute. The nurse then helps the elderly lady to shuffle to her chair and helps her sit down. Without greeting the patient Henry begins talking over the patient's bed about her X-ray that was taken yesterday and then asks the nurse about the patient's progress.

In the examples above describing both Cameron and Kenneth's interactions with patients there is evidence that the patients were given a chance to explain to their consultant how they felt and either to tell the doctor what had happened to them or to hear the doctor's explanation of why they felt like they did.

The patients were treated in both these examples as human beings and in doing so the doctors themselves positioned themselves in their *clinical role* but also as *people occupying that role*. By acknowledging mutual humanity (albeit in different styles) these doctors were able to *take authority* from their position as medical experts (see Chapter Seven above).

By contrast Henry also took authority but did this by silencing junior colleagues, Kenneth his fellow consultant and most importantly, the patients. While Kenneth and Henry were in the same Unit, the scenario described above suggests that Henry held more power and therefore exercised greater influence on junior colleagues (and this fed into the culture of the Trust).

In what follows we trace how these contrasting styles might link to the culture of the Units and the teams themselves and consider how this fits in with the definitions of good patient care and service delivery.

9.5 Clinical team work and service delivery

9.5.1 Giving patients care

Miller and Gwynne (1972) suggested that a 'warehousing' model of care operates for those who may be institutionalised in the medium to long term which they contrast with the possibility of a 'horticultural' model of care, akin to what might be identified today as a learning environment. Working in the care of the elderly takes its toll on the emotions of all the clinical staff

particularly in the 'horticultural'/learning setting, where efforts are made to ensure two-way communication and mutual understanding and development takes place. This can leave clinical staff open to experiencing directly the pain and distress experienced by their patients (see Menzies-Lyth, 1960 and the 'stories' below).

The following example demonstrates how engagement between clinicians and patients impacts emotionally upon even (and possibly especially) senior experienced staff. The researcher here, shadowing Mandy, a female senior consultant describes the following case:

Whilst cleaning up a suppurating wound an elderly male patient cried. It was a really touching and sad moment and Mandy was clearly distressed that she had hurt the man. On first seeing him cry Mandy appeared to have a moment of shock/panic where she looked amongst her team to find out whether this was normal behaviour for this patient. On hearing the answer was 'no' Mandy tried to soothe the patient and seemed genuinely sorry for hurting him. The nurse who arrived at the scene also appears to be genuinely concerned about the patient and goes over to help Mandy and prevent the patient from crying. This scene was particularly sad because in today's society and especially in the patient's generation it is thought that men don't cry or show emotion. For the man to cry he must have been in severe pain and must have been struggling with himself to prevent the tears. Mandy's genuine empathy and somewhat guilt might have reflected that.

Mandy and the nurse in this context are using emotional intelligence (see Chapter One) in a relevant situation. Mandy also engages in conjoint action with the nurse rather than take action in an autocratic fashion without consultation. Mandy notes the patient's crying with a start (according to the description) and instead of continuing with the work on the wound (which many doctors might well do because it was necessary for a positive health outcome) she immediately appears to take in the context as a whole – thinking about her patient's behaviour and reactions. The nurse in this case mirrors the behaviour of the consultant. This is an important issue for discussions of leadership and patient care in that teams tend to reflect the beliefs and actions of their leaders.

9.5.2 Discussing patient care

In a shadowing the researcher at the start of the observation describes in detail the way two doctors discussed the patients before embarking on the ward round. This is another case of concerted action:

09:00 Breakfast meeting with Cameron [T3]

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Once they have consumed their breakfast Cameron and Mandy turn to business. Cameron begins by asking Mandy's opinion on one of the patients that they had seen on the ward round that morning. They chat for a couple of minutes about the patient before both getting a patient list out and going through the names systematically and discussing their care plan for each patient. Several patients will need to be discussed in a patient case meeting as they have complex discharge problems, others will need to be referred to the CCP so that a greater social package will be considered. Mandy says that she will go and see a few of the patients herself later and occasionally delegates tasks to do for Cameron, but mostly he is autonomous and says what he needs to do for a patient and what he will organise on behalf of the patient.

This is a quiet and supportive meeting between Mandy the senior consultant and Cameron the more junior member of the team. However, the researcher notes the systematic discussion of the patients and their care along with a plan about who Mandy will see and how Cameron's tasks are designated.

A similar atmosphere of calm and authority are evoked by the description of a case meeting with Cameron's team at the start of the first day of shadowing:

I approach the nurse's station and look around to see if I can see Cameron. I spot him at the far end of the ward sat at a computer with a mixed group of staff (doctors, nurses) surrounding him. I approach the group and stand amongst them. Cameron is facing the computer screen and discusses a CT scan with his registrar [L].I notice that as these two doctors discuss the scan a SHO writes notes in the patient's file occasionally craning his neck to look at the scan at certain parts of the discussion. A few nurses also crane their necks at various points but most just stand patiently in silence waiting to visit the patient. Once the discussion draws to a close Cameron turns his head from the computer and asks the team if they have anything to add. ...[later on in the same meeting the researcher listens to a telephone conversation] ...Cameron has rung the wife of a patient to update her on her husband's health. He is very honest with the wife saying that her husband has had a second stroke during the night at that he is now in worse health. Despite the bad news Cameron is very friendly and pleasant with the relative and is very sympathetic to her questions and on several occasions empathises with her. Coming off the phone Cameron returns to the team and gives a brief update to L regarding the conversation with the patient's wife. The SHO writes this summary in the notes. Cameron takes a short sharp breath before asking "shall we go and visit the patient?" Cameron turns quickly on his heels and enters the ward.

The observation here reveals the high workload and 'multi-tasking' undertaken by the team (looking at the computer, discussing scans, taking notes, calling relatives and so on). But there seems to be focused attention on patient care and individual patients. At the end of this extract it also seems that Cameron himself takes the ward rounds very seriously – gathering his mind together and possibly seeking the emotional strength to move from the clinical team and considering evidence from notes and colleagues to imparting and collecting information from the patients.

The same researcher who has shadowed both Kenneth and Henry at a different Trust from Cameron, gives examples of how some of Henry's patients are discussed. For example she describes a meeting to discuss patients chaired by Henry.

Henry criticises the way [Site B] is run and the management of beds and patients by that hospital. He praises the doctors for the current situation on [Site A] where they have spare beds stating that they have done so well in 'kicking them out'. Henry stated during [a previous meeting] that the patients needed to be removed or 'kicked out' of hospital as soon as possible. The rapid turnover of patients may on the surface appear that they are not receiving good care However getting patients home quickly reduces the risk of hospital acquired infections.

And is likely also to be what many patients would want.

As the researcher makes clear, it is important not to confuse the rhetoric with the quality of patient care, but rhetoric does determine and reflect a dominant ward or Unit culture.

9.6 Responsibility for patient care

Responsibility was a key element of the discussions of leadership particularly in Chapters Four and Five. Responsibility for individual patient care is in the hands of clinical teams led by the medical consultant but above that person is the clinical leadership/management (Clinical and Medical Directors) as well as the senior operational managers (CEO and COO and others).

Primary responsibilities for patient care however vary from *individual care* i.e. for both identifying care pathways and day-to-day care to responsibility overall for the care of all the patients. In Chapter Ten we review the findings from this study with some recent cases where responsibility has been mishandled to explore what lessons might be learnt.

In an interview with a consultant:

... we try to just have a really open forum where we can discuss that [specific patient care], just like open it up and letting people put their viewpoints first and then kind of trying to question where they're coming from with that in a positive kind of way but them also laying out where you feel that that might not be the right course of action. Erm and also at the end of that discussion making sure that everyone is happy with the outcome, and sometimes people aren't erm .. but it also realising that it is a consultant's responsibility at the end of the day and making sure that everyone knows that you're happy making that kind of decision and that you are happy to be made accountable for that decision.

9.6.1 Responsibility for emotion

It frequently falls on the clinical leader to cope with their own, the patient's and the relatives' emotional reactions and distress and also with those of the other members of the team. As the researcher noted:

One senior consultant, Tricia, made it clear that as the clinical lead she also took responsibility for talking to patients about DNR³⁷ forms and delivering 'bad news' to patients/ relatives. During the ward round Tricia removed the pressure from a junior member of the team who had been told by a relative that they didn't want their mother to be resuscitated. Being told this information had stressed out this junior member of the team as he was not yet ready for this type of responsibility. Tricia supports her junior colleague saying that he should have never been confronted with this situation.

One question here then is how do the clinical team handle such multi-layered emotional problems? How important is leadership in supporting (and developing) teams to cope?

9.6.2 Responsibility for teaching

Most clinicians in the study from all disciplines were interested in teaching the next generation, and their activities will influence patient care, provide role models for leadership and influence climate and culture of the organisation. The example below is chosen because Dr. Jenkins was very enthusiastic but also demonstrated compassion and courtesy when he was face to face with the patients. The researcher's notes describe this in detail:

Approaching the patient Dr. Jenkins shakes the patients hand and says "how are we doing today?...I see you were referred by your GP...you have a

³⁷ Do not resuscitate.

wonderful GP" (he comments on how wonderfully clear and precise the notes are). "That's not my GP, that's my missus's GP, mine's on holiday...I have Dr. U. U". "What a name! But looks like they have to wonderful GPs at your practice...the notes are seamless...you are lucky!" Jenkins then continues to ask the patient about his medical history. The patient is able to tell the doctor his entire medical in great detail including the drugs [more description from the researcher]. Dr. Jenkins stops the patient and asks the medical student to take a mental note of how a good GP leads to a well informed patient, which helps him (Jenkins) in his (patient's) treatment. He talks about 'aspects of professionalism' and the right ways of informing patients about their treatment and condition, he openly praises the patient for knowing so much about his patient history and tells the students that "medical history in patient care is so important". The patient begins talking about his treatment in the hospital and Dr. Jenkins states that "patient feedback is great, and they like to hear about it...we need to be more professional...primary care pathways are the key to patient care".

Dr. Jenkins behaves with humour towards the patients and the students and junior doctors but does so while continuing with his assessment of the patient, taking the relevant history and trying to impart good practice and professionalism. He manages to balance giving the students and junior a chance to gain hands-on experience while making sure he himself has all the information he needs for the care of the patient.

Dr. Jenkins then checks the patient's lungs and heart asking a SHO, Dr. Williams to check the cardiogram as he can hear an AF flutter. As Dr. Williams looks for the chart the patient tells him that his GP had thought the same and that is why he was thinking of changing his drugs. Dr. Jenkins looks at the students and says "wonderful isn't he?" he continues that the GP must have heard or felt it himself [the heart condition] and now they will need to see the chart to prove it then they can change the drugs as the GP had predicted. After looking at the chart Dr. Jenkins asks Dr. Williams to change the drugs and to get rid of one of the drugs he thinks are unnecessary. Dr Jenkins shakes the patients hand when he leaves and says that one of the juniors will be back later to sign off the new drugs.

Looking over the notes Dr Jenkins spends a lot of time teaching the [medical] students about various medical conditions and treatments that have arisen out of [a particular] patient and asks them to suggest other possible diagnosis and other treatments for his condition. Jenkins is a very enthusiastic teacher and the enthusiasm rubs off on the students who are all eager to share their knowledge and take stabs at questions they don't know. In the middle of the question and answer session he asks one of the students "what year are you in? I don't know how much you guys know already". The student base is a mixture from students from [different

schools] and he relishes the opportunity to teach the students some new medical knowledge. Whilst getting the students to look at the cardiogram he looks up and apologises to Irene [matron] for taking so long on his ward round "Sorry Irene, I will be here all day, this is such a pleasure to have students!" Concluding the teaching session he quotes someone for saying something about the health of gamblers and drinkers and then asks "now who said that?" the students look round each other and then he exclaims "me mother!" all the students laugh including the female registrar and Irene. He then ushers them onto the ward saying that he doesn't want to get in trouble with the matron.

9.6.3 Subverting responsibility

There are diverse ways that staff at both Trusts had for coping with emotional aspects of patient care and resisting authority (and thus taking responsibility for care into their own hands). One way that nurses (including senior nurses) operated was to *subvert* some of the doctors – particularly when the relevant doctors showed little interest. The shadowing of a senior nurse [Irene, the matron] during a ward round produced the case of Lola (described when shadowing Irene):

Irene tells me it is because many of the patients are elderly with complex cases and therefore they tend to stay for a long time. I note that one of the patients has been here for a long time and I ask whether due to the long length of stay on the wards whether she becomes attached to any of the patients, I point particularly to the patient who had been here for three months. Irene says, 'oh that's Lola, mmm has she been here 3 months?...let me check her notes'. Irene leaves the file that she is reading and picks up Lola's file and looks at the admissions page and then states (sounding surprised). That three months is correct. She then continues that she does find herself getting attached to her patients, especially if they have been here as long as Lola. She mentions that Lola should really have been moved to G Ward but she really doesn't want to move her 'she should be elsewhere, but she is ours' (highlighting emotional attachment and the sense of ownership over patients). She tells me that Lola is really sweet and all the nurses really like her and it would be quite strange if she was no longer on the ward as she is a returning patient and 'it is always nice to have her back'.

As we have suggested in Chapter One (and witnessed above), in order to protect one's self against anxiety clinical staff often 'split' patients into 'good' and 'bad'. Here the treatment of Lola indicates that the nurses may be using their care of her to defend themselves against some of the harsh treatment decisions made about other patients (by doctors and managers) particularly when there is pressure to discharge older patients due to bed

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shortages. This might lead them to consciously and unconsciously subvert these authorities when they can and there is a particular pleasure to be gained when they succeed in this 'subversion' with a 'good' patient such as Lola. What remains at stake is whether Lola's stay is actually benefitting her clinically (or even socially) and also whether it is preventing another patient receiving medical care.

9.6.4 Responsibility for end of life decisions

Responsibility for patient care resides not only with the clinical team but is sometimes shared between the team, the patient or the patient's closest relatives which is usually the case with end of life decisions. Sometimes the greatest emotional engagement is with the *relatives* of the patient rather than the patient themselves. This is particularly the case when the patient is likely to die which is particularly sensitive when it is a case of withdrawing life support. The following example of Cameron's Patient G and his daughter brings this into sharp focus.

The biggest emotional situation this day surrounded Patient G, a coma patient and his daughter. Cameron had to encourage the daughter to agree with his plan that her father's treatment should cease and palliative care take over. This is a very emotional situation especially due to the young girl's age but also because she was in 'denial' asserting that her father would get better and this caused her to present a whole range of emotions that Cameron had to deal with.

We enter the side room. The blinds are drawn causing the room to be quite dim. There is a young girl sat up right on a make-shift bed that she has made from four visitor chairs from the lounge. She has a blanket over her legs and is typing on her lap top her mobile phone ear phones in her ears and bags and other items are scattered around her chair. She looks up as we enter and pulls the ear phones from her ears. I am surprised at how young she is, I had expected a daughter of forty something not a teenager of 18 perhaps, but no more than twenty. She pulls the covers off her legs and places her lap top on the window sill. Cameron asks if she is ok and she nods and says she will leave him to it. Cameron says that he will bring her in once he has examined her father, she nods and opens the door pulling her jumper down over her leggings as she leaves. Cameron looks at me and comments (adding to what I was already thinking) "I think she is far too young to be dealing with this on her own....it is not fair".

He turns his attention to the patient and begins speaking loudly to him. He explains that he is a doctor in [Trust 3] hospital and that he wants to examine him. At each point of examination Cameron explains to the patient what he is going to do. Cameron is able to move the patient's limbs like he

is a doll. Each time the limbs are placed in a position they remain there. The patient doesn't respond to any pain stimulus as Cameron pinches the patient's skin and scratches the bottom of his feet with a stick. Cameron then checks the patient's eyes by pulling back the patients eye lids, the eye lids roll from side to side and Cameron explains that it is called a coma roll, which suggests that the patient is in a deep coma. Cameron teaches W by the patient's bedside and talks him through the patient's condition and talks about how the patient's recreational drug habits could probably have contributed to his stroke. Cameron and W engage in a small conversation about the problems of cannabis on the brain.

Cameron made the decision in consultation with his team to discuss with the daughter that they need to end the patient's treatment (and thus in all likelihood, his life). Cameron deals here not only with the daughter's distress but with the daughter's worry that she is involved in the decision to let her father die. Again a high degree of emotional intelligence and leadership as well as clinical knowledge operates in this communication.

While shadowing Owen [Trust 2] the researcher sees that while behaving perfectly correctly he puts emphasis on the clinical and health related aspects in an end of life situation above communication and empathy. He is not unkind but 'misses' the emotional level of communication. Here in the presence of a daughter and father the woman (mother/wife/patient) is clearly dying and being kept alive by the clinical team. Owen:

... talks directly to the daughter stating that her mother is coming to the natural end to her life and therefore she [the mother] is giving up - 'withdrawing from life' and tells the daughter that although they will feed her through a tube she [daughter] should prepare herself and her family for the inevitable. He also says that her mother will also start ripping the feeding tubes out to prevent herself from getting the right nourishment.

The image conjured by the 'withdrawing' from life and 'ripping' feeding tubes is dramatic and seems to give agency to the dying woman – almost indicating that somehow she is to blame as she will prevent herself getting the right nourishment. However, the researcher, as participant in this encounter, is bringing out a sense of the culture of this particular event. While Owen is probably protecting himself emotionally from the loss of life and the sense of clinical 'failure' he does not protect the daughter or the husband from the emotional onslaught of the woman's impending death.

The daughter says that she understands and turns to her father and says 'dad do you understand what the doctor is saying?' the husband paces up and down the side of his wife's bed looking lost and lonely. He looks up at Owen and says that his wife is giving up because someone at the nursing home said she was a burden. The daughter scolds the father for saying that

in front of her mother. She explains to Owen that although she [mother] doesn't say anything she listens to everything and the more her father says it the more she doesn't eat. Owen says he understands and asks how the family is coping.

The daughter here is also protecting Owen from the family's pain by scolding her father even though Owen asks how they are coping. However, although kind and polite, Owen does not seem to operate with emotional intelligence or engagement with others' pain.

The daughter says that her father is finding it very difficult because he is the main carer for her; she herself has taken time off work to care for her when she can to support her father. As she speaks about her father and how upset he is becoming she begins to become tearful. Owen listens to her as she speaks and occasionally asks further questions. The husband continues to potter around the room occasionally touching his wife's head and face. The daughter watches him.

Owen, while allowing the daughter to cry and not acting as if he is irritated or embarrassed, equally pays little heed as he continues to talk of the mother's deterioration.

Owen begins to talk about the deterioration of her mother and what they will be able to do for her. The daughter says that she knows what Owen wants to talk about 'you're talking about DNR aren't you?' Owen says yes he is and the daughter tells him that she knows about it because her friend's mother recently died and this was discussed with her. The daughter says that she knows what she would prefer but they will have to talk this through with her father. The daughter calls her father over and begins explaining DNR. He looks at his daughter, he looks lost and scared and she tells him that it is his decision but she thinks that the doctors should not resuscitate her mother because she will be resuscitated to the same state. Owen inputs that she will be 'worse' than how she is currently because she will be a lot weaker. The daughter says that she will have to talk through this with her father. Owen nods and leaves the room.

9.6.5 Stories of patient care

The following two stories show in detail the ways in which responsibility and power can shift between team members and highlight anxieties faced by doctors about caring for patients.

9.6.5.1 A story of system failure: Cancelled Clinic

The first story is told by a female registrar who describes a situation in which she felt disappointed with patient care due to cancelled clinics. In the

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following account, the narrative is broken down to four moments, and each is discussed to demonstrate how the doctor's anxiety is managed by being linked to a failure in 'the system' that climaxes in her interaction with patients.

Q: What about any time or incident that made you feel disappointed with patient care in this hospital?

A: Lots of times, particularly since we've not had a secretary. Every clinic, every single clinic I send somebody home because the notes aren't there at all. They are supposed to be coming to see the consultant [her immediate superior] and he's not there, and they've been put into my clinic and you look at the letter and it clearly says on the letter 'consultant only to see', and they turn up and he's in Italy, on holiday.

The registrar is expressing frustration. On the surface it is towards a recurring failure in patient care attributed to firstly not having a secretary and secondly because the consultant 'is not here'. The expression of the frustration however is confused; there is no secretary but the patients 'have been put' into her clinic. Furthermore, she sends someone home from each of her clinics because the notes are not there. The letter 'clearly says' the patient is to see the consultant who is not only not there but he's in Italy 'on holiday'. There is a feeling of being overwhelmed, and of rage and envy towards the consultant - and possibly the patients - emerging from this short paragraph (for discussions of workplace envy, see Vidaillet, 2007; Stein, 2000). There is also an expression of omnipotence in that she sends patients home. She has the 'legal' justification to do so because there are no notes and also because their letter says they have to see the consultant and the energy is directed towards this activity rather than getting patient appointments changed. The consultant is on holiday, presumably one to which he is entitled and one which has clear boundaries enabling them and the staff who make the appointments to re-arrange the patient dates.

There is clearly a high degree of frustration and anxiety present in this account; there are too many patients with 'needs' and not enough clinical or support staff backing the work in the way in which the doctor would feel comfortable with. As there is little opportunity either to express or assuage her anxiety so she becomes 'prey' to primitive phantasies and unconscious mechanisms to relieve the anxieties.

The story also sheds some light on doctors' anxieties about working in a multidisciplinary team. Medical education and postgraduate training provide a culture in which doctors believe they can rely on each other through which a sense of being an elite group and confirmation of professional omnipotence and responsibility - particularly of the consultant - arises. However the role of the consultant also brings about a sense of envy and

destructiveness in others which has its origins in the primitive defence mechanism of splitting off the painful parts of one self (e.g. the realisation that you are not omnipotent and that another has the ability to do what you cannot) and projecting them onto others in an envious attack (Klein, 1959).

...and you have to go out and say, 'I know you've waited three months for this appointment but I'm afraid the consultant is not here and he wants to see you personally, so thanks for coming but if you can just go away' and you can't even say to them 'you're getting an appointment for next week' because realistically they're getting an appointment in three months time, and I think that's really disappointing.

'Breaking bad news' is considered to be a difficult task for health professionals and one that is a constant cause of anxiety. In addition to having to find the appropriate means of communicating prospectively devastating prognosis and supporting patient through the immediate emotions, doctors must come to terms with possible changes in how the patients perceive them (Barnett, 2002). Even though the situation described here does not involve delivering bad news about an illness, it is a moment of disappointment for both the patient and the doctor. The patient's anticipation to receive treatment is rejected and the doctor has to acknowledge failure in service delivery. The patient's possible anger and anxiety is directed towards the messenger, who in this case, is unable to offer any practical solution. Instead of being the helpful, trustworthy saviour, the doctor transforms into an envoy of disappointment and will have to see to the patient's emotions as well as her own disappointment, to which there is no external consolation on offer. To alleviate the anxiety caused by the situation, the registrar clings on to a narrative regarding her workplace – she is disappointed in the system.

I feel very disappointed in the system, which, I know the system is a big, wide thing, but ... [it] lets people down from that point of view and, you know, we overbook theatre lists and they get cancelled and then again I feel disappointed.

By seeing the NHS as a faceless, bureaucratic, 'machine-like' (Elkind, 1998) entity, the registrar convinces herself that the situation is not her fault – it is not what she would want for the patients, or for herself. She feels anxiety for she cannot provide the care required, and as a consequence she projects this anxiety through blaming 'the system'; regardless of their individual efforts, doctors are powerless when the system fails. As this registrar said epigrammatically later on in the interview: 'I don't think the NHS works anymore' which at a conscious level represents the impact on her working life of a problematic bureaucracy while at an unconscious level it provides uncontainable stress. The doctor does not have the opportunity to delegate

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tasks to her superiors to reduce the 'heavy burden of responsibility' (Menzies, 1960, p. 118) thus feels that she is left to deal with the failure of 'the system', a system, which ironically is set to heal people, not cause them angst.

It's mostly because I'm thinking, how must that patient feel. You know, they've worked themselves up, they've told work they are gonna be off work for three weeks or four weeks or whatever and arranged cover and you go and tell them, sorry, you can't have your operation, you can go back to work tomorrow. That's really disappointing, to do that to people, very much so.

In the conclusion to her story, the doctor moves beyond expressing antagonism to the system to empathising with the patient. Thus, by failing, the system provides the doctor with a social defence mechanism but through empathizing with the victims of the failure, she fails to contain her anxiety.

9.6.5.2 A story of grace in adversity: Supporting the mother of a still-birth baby

The second story is told by a male registrar who describes how he provided good patient care by supporting a mother of a still-birth baby. Despite the plot, the story is not told as a tragic narrative but as a proud patient-care moment, a sequence of events that had thoroughly positive impact on the doctor's perception of himself. This narrative is also analysed in sections.

Q: Could you give an example where you felt that you have given good patient care?

A: I think that one of them was this lady who actually came to the labour ward and told me that she hasn't felt her baby move in the past one day and she had had some bleeding. Obviously there was some concerns on my behalf for the baby, because there could be a problem. This was a very wanted pregnancy because she was quite old and this was an IVF pregnancy. I examined her a little bit and on examining her I found that the baby did not have a heart beat, so she had lost the baby.

Describing the situation at first with the patient as an object helps the doctor to distance himself from the scenario and to do routine checks expected in this kind of situation. In a hospital setting instructions are given about the way each task should be performed and these rituals form a reassuring tool for staff (Menzies, 1960: 121).

I did explain everything to her, and obviously as a doctor responsible for her, I need to follow all the procedures that needed to be done and all the care that she needed to have, you know I explained it to her that, you know this by far something that words, you know cannot express, as you can imagine how

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difficult this situation would be, and if we could make it the slightest bit better, we would try everything in our power, you know, to make the situation a lot more comfortable. I ensured that she was given a quiet room, with a very good midwife looking after her at all times. Obviously I had my duties towards the rest of the labour ward as well. People visiting her room making sure she was ok, making sure the pain relief was ok, we had induced her because we did not want her to go home with a dead baby inside her. It was a very, very painful and stressful scenario, it really, really was, it was horrible, absolutely and it is very distressing, exceedingly, exceedingly distressing because, you know the woman is going through all that pain of labour.

Here, the doctor is empathising with the patient, feeling her emotional pain and in this case is mostly able to contain it through wanting to relieve the situation and then by offering extra care, by 'going an extra mile'. In this extract, there is a clear shift as the doctor uses strong emotional words to describe the crisis. In telling the story, he is projecting his own anxiety on the patient, living the distressing emotions with her and having to remind himself of his position as a medical professional - 'obviously I had my duties towards the rest of the labour ward as well'. By referring to 'all that pain of labour' the doctor enters a relationship with the pain. The phenomenon of pain and our relation to pain, whether someone else's or our own, is more immediate than that of reflective knowledge – we do not think about pain but react to it so the sensation is intersubjective. The person who is not experiencing the pain but affected by it is an 'interlocutor' in the situation (Crossley, 1996, p. 37).

...I tried to make it a point that I was present, present as much as I possibly, feasibly could during her emotional outbursts. I wanted her to have all the support that she needed... I did get attached to the patient, being around her, trying to get her care, even if I was out of hours, which means that when I was not meant to be in the hospital. Now I think that some people will argue that, that is a bit over the top, but I think that, I guess, I guess, that that is medicine for you, you know it is about lives, and sometimes you have to make that extra effort, to make that person feel that little bit more special.

In this excerpt the doctor starts to explain and justify his actions. Through self-reflection he has realised how he acted in a way not normally accepted in the hospital culture, that is, he went against the 'social defence system' to deliver patient care, but also to cope with his own anxiety. He dedicated extended time to his patient even though hospital doctor's time is considered to be 'fast and efficient'; 'doctors move quickly in the hospital wards. Their time is expensive. They cannot afford to linger too long in any one spot' (Mattingly, 1998, p. 21).

Menzies (1960) noted that while institutions have social defence systems, individuals may resort to their own defensive mechanisms, but a membership of an institution 'necessitates an adequate degree of matching

between individual and social defence system'. If the individual and the social defence systems are in disagreement, what follows is some degree of breakdown between them, for example, a doctor's work colleagues might reject them for behaving in an inconsistent or unprofessional way to the system. Consequently, the registrar providing patient care to the mother of the still-born baby is not only coping with anxieties created by that emotionally charged situation, but he also has to think about the culturally accepted limits of caring and possibly negotiate his way with other members of staff. On this occasion, the doctor keeps to his defences and spends extra hours with the patient, without being criticised by his peers.

Well you know that when things get worse, they get worse and they get worse and they get worse. Ultimately what happened with her was that we tried all the induction of labour, we tried everything possible to get that baby out, by induction. And in her case with the induction, it failed as well... and I can't tell you how dreadful that scenario was, that she needed a Caesarean section to have that baby out... I wanted to make sure that I was present at the Caesarean section, as well so that she would have a face that she knows. Once she delivered, you know obviously I was there with her, with the [dead] baby in her arms, and she was happy from the point of view.... and thanking me every now and then, which I said that she shouldn't because it was my job and one should do it. But she kept signalling the fact that not many people would do it the way that I had and I that was very special.

Much hospital work contains a 'constant sense of impending crisis' (Menzies, 1960, p. 26) which creates pressure and anxiety. The level of predictability in medical work is low and – as the registrar expresses it – 'when things get worse, they get worse'. The doctor explains that he attended the Caesarean section for the patient's sake, but this could also be interpreted as his coping mechanism – the need for a closure (Mattingly, 1996: 37). If you only see trauma and dramatic events without closure, the events will stay lingering and cause anxiety, stress and possibly depression. The doctor needed to be there and needed to have closure to be used as a coping mechanism against accumulating anxiety. So far the patient had been in a powerless position while the doctor had presumably been in control of the situation and emotions involved in it. Therefore, when the patient thanks the doctor, he gets confused. The patient had survived through the ordeal and suddenly has the power to relieve the doctor's anxiety, to nurse him (Menzies, 1960). The acute physical and emotional stress is released and the doctor can reflect back on his experiences.

And I think that is something very, very special and dear to my heart. And these are those situations when you sit back and you reflect on your life and

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say, "wow I have done something good, really, really something good and it is wonderful".... I saw her every single day on the post natal ward and obviously I made a point not to neglect her, or neglect her partner because people assume that the only person going through the trauma is the woman who has actually delivered, but they are a couple, and that needs to be understood so that was important as well. And he appreciated that quite a lot. They went home, two weeks later, I did receive a lovely letter, which kind of expressed a lot of gratitude, for what I had done for them.

The thanking letter provides closure for a difficult story, but maybe also goes beyond this. It hints at redemption – instead of a medical tragedy possibly compounded by failure in patient care, the story becomes one of a victory or at least grace under fire, a positive example of the doctor's powers even when he cannot actually perform miracles by restoring life. Anxiety is successfully overcome by the absolution from the patient and the doctor's 'priesthood' (Elkind, 1998) is restored. The letter from the patient acts as the final seal to exalt the extra efforts the doctor put in to solving the problem (Menzies, 1960, p. 31).

I know that I put in extra hours and I KNOW that I shouldn't have been there but no-one complained, because everyone knew that I was helping a situation. It is just an understanding that we have. It would be a terrible job if you were only allowed to work your set number of hours.

A narrative like this one permits people to attach themselves to 'desirable' ends, think well of themselves in moral terms', 'support their needs for autonomy and control', and 'promote feelings of self-worth' (see Baumeister, 1986 in Brown, Stacey & Nandhakumar, 2008, p. 1054). By telling this, not an easy or comfortable story, as a proud moment of good patient care, the registrar restores his professional and personal integrity. There is no 'system' in this story to blame on, no failure to confess, but despite the drama the story draws to a happily-ever-after ending. The story has entailed a narrative for the self (Brown et al., 2008) that has released the anxiety the event contained.

9.7 Conclusions

Patient care is a process and a social construction and as such means different things to different people. Norms and styles of patient care also change across time and differ site to site not only because of differences in beliefs, but also because there are different possibilities (technological advancement, different types and mixes of professional groupings) and different types of constraints on what might be offered. It is not always possible to put a clear value judgement on patient care and one example is to do with 'length of stay'.

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Managers, whose concern is to ensure that beds are not blocked, may or may not be holding in mind the image of an organisation that shares care with agencies and families in the community. They may simply be responding to government targets. They may have their mind fixed on those waiting for beds who have still not received treatment. Patients themselves may want to return home as soon as they can or become bewildered when they are discharged rapidly after treatment.

Working in multi-disciplinary teams with distributed leadership patterns may have improved practices for clinicians. Accountability for patient care still resides with the consultant and the hierarchy who manage the Trust. While senior managers are responsible for ensuring patient safety and preventing negligence to individual patients, they are also responsible for ensuring access to care for the community which involves managing scarce resources such as equipment, pharmaceuticals, beds and staffing.

Not all clinicians appreciated or respected these pressures as we saw particularly in Chapter Six. Nor do patients necessarily agree that good care is anything other than good and consistent communication with specific clinicians.

As demonstrated in Chapters Six and Seven managers are frequently frustrated by demands from staff who may try to subvert managerial targets (set by government and as such fundamental to resourcing of the Trust).

The quality of leadership is intimately linked to patient care. Good patient care relies on effective leadership of the kind that engages with staff and imparts to them the vision that (as far as humanly possible) the patient comes first. That in turn impacts upon the climate, culture and ethos of the Trust. When leadership fails, so does patient care.

10 Leadership and patient care: Assessing the past and thinking of the future

10.1 *Introduction*

Without effective leadership at all levels of the NHS and its various organisations patient care suffers. This knowledge has been evidenced in

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several key studies across recent years as reported above and elsewhere and consequently fed into the NHS Qualities Framework (see Chapter One).

In this report we have critically reviewed the relevant literature on leadership exploring as far as possible the relationship between leadership, followership and service delivery across five hospitals comprising three NHS Trusts (see Chapter Three). We employed different research methodologies (see Chapter Two) to capture data to investigate leadership qualities and their interaction with the climate and culture of the organisation and linked these to service delivery and patient care in different settings (ranging from obstetrics and gynaecology and cardiology to care of the elderly).

10.1.1 The organisational contexts

The organisational contexts of each Trust and each site or unit varied physically, structurally and in 'atmosphere' (the full details are provided in Chapter Three). We have been concerned in the report (and future papers) to steer a path between maintaining anonymity and confidentiality and thus not overtly identifying a Trust or site within a Trust, while also pointing to how the contexts impacted on the practices of leadership and service delivery.

Overall the Foundation Trust (3) in this study, which had not been experiencing mergers or threats of closures, where staff morale was high and where leadership practices were distributed across teams and clinical and management specialties, was clearly the one most conducive to effective communication and leader-follower engagement. There was an 'atmosphere' of connection and pride in belonging to the Trust as evidenced explicitly in Chapters Four and Nine in particular.

Trust 1 was applying for foundation status during the time of the investigation but also threatened by closure of some of its units, and with the senior managers possibly being transferred to the other site which was perceived by the participants as a threat to their status and possibly to resources for service delivery. This did not happen during the course of the investigation. The managers in Trust 1 were committed to their staff and to service delivery although there did appear to be some discontent with senior management from the medical staff. This may have been because most of the distributed leadership involved non-clinical managers and nurse managers with the medical teams appearing to take a more 'traditional' hierarchical stance. Most of the data from the OCS was derived from Trust 1 which demonstrated among other things the importance of management support for identifying good leadership and patient care practices.

In Trust 2 there appeared to be the greatest amount of conflict between groups of staff who sometimes seemed to be leading in different directions.

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Trust 2 was perhaps the 'victim' of a relatively recent merger between two large hospitals (and one or two other smaller units) which were some physical distance apart and had had a different history – one being a DGH and the other a teaching hospital. The DGH appeared at first to have a professionally diverse group of senior managers who distributed their leadership to effect, but one or two figures emerged during the course of the study who transgressed this approach with one person taking a back-seat while another was trying to drive through change in a somewhat cavalier manner. Furthermore in this particular Trust there were changes among the senior managers (some left, others moved to the other site during the course of this study). The CEO also indicated that it was difficult to recruit good middle-range managers and nurses in particular because both sites were away from the centre of the city where most people would look for a promoted post.

10.2 *Limitations of the study methods*

As with any large scale and complex study such as this one not all of our intentions were achievable although some were satisfied beyond our expectations.

We had difficulties capturing data from patients for two main reasons (fully detailed in Chapter Three).

Firstly, the 'gate-keeping' staff working on the Units on a day-to-day basis (as distinct from those who supported overall access to the Trust overall) obstructed data collection.

Secondly, it was also difficult gaining access to patients while they were in hospital because of ward procedures and in other cases the poor health of patients. So in the end we managed to conduct ten patient interviews but were unable to collect organisational climate survey data from patients at all³⁸. To overcome this we gained permission to observe clinicians' interactions with patients in their care and we believe we have managed to do more than compensate, making a contribution to knowledge with important new material to demonstrate patient care in different contexts and the processes involved in patient care and service delivery (see in particular Chapter Nine).

We also met with difficulties, with one Trust in particular, collecting *survey* data from staff although individual staff members proved more than willing

³⁸ These difficulties were reported to SDO in the interim reports and also separately when they arose.

to support the researchers by allowing them to interview, observe and shadow them during their working days. *This is all reported fully in Chapter Three.*

10.3 *Reviewing the findings*

In this final chapter then we draw together the findings from the study and make suggestions as to how they might contribute to policy and practice beyond the participating organisations.

This chapter is organised around the original study aims which were about leadership, organisational climate (culture and context) and how they impact on patient care. The overall plan was to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery.

This research further sought to explore the following broad-based questions.

- First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
- Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?
- Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The specific aims and objectives are listed again below and we conflate these in what follows directing the reader to the relevant chapters.

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines, to patients;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts service delivery;

- To learn how different stakeholders (specifically patients, nurses, members of professions allied to medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care;
- To identify how the need for change in service delivery is identified and what drives the need for change.

10.3.1 How far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?

Throughout the participating Trusts there is evidence of the importance of high quality patient care. Chapter Nine in particular brings this together with quoted respondents emphasising that above all patient care matters to the aims of the organisation and those who work in it. Thus on a basic level, working for patient care is inspiring in itself and staff across the Trusts see good patient care as their *modus operandi*.

Our use of innovative ethnographic methods and story telling were particularly effective in providing the evidence of how patient-clinician relationships were practiced and how staff made sense of their own actions reflexively in the context of caring for patients³⁹.

Chapter Nine provided evidence of the ways in which care is practiced.

We begin here by summarising some of the evidence from the Foundation Trust in this study, which consistently appeared to demonstrate high levels of distributed leadership, emotional engagement and multi-disciplinary working across all levels. The data included several key examples of positive statements about the role and effectiveness of management. We saw, for example a senior clinical manager summarise the issue with reference to his

³⁹ For example, interviews opened with questions about leadership and patient care, and participants were then encouraged to tell 'stories and critical incidents illustrating their experiences'. The early parts of the interviews provided themes and indications of what the clinicians regarded as crucial to delivering good patient care, e.g. 'cleanliness', 'efficient administration', 'communication', 'empathy', 'sympathy', 'knowing the recent developments in your field' and 'everything behind the scenes the patients don't see'. However, it was the stories they relate to that provided us with insights into their core experiences of patient care (see Chapter Nine).

pride in working for the organisation drawing attention to its low mortality rates, and that the high quality staff and its reputation for patient care act to attract others at the top (or with the potential to be at the top) of their specialty.

By contrast, the CEO of one of the other Trusts had made the point in their interview that one of the difficulties they had was attracting high caliber nursing staff, partly because of their location (in the suburbs). In Chapter Four we identified the ways in which an organisation might be seen as a learning organisation as significant in supporting staff to develop their clinical and managerial skills and develop capacity for patient care. Where support for learning was apparent so was the enthusiasm and pride for the organisation and its goals.

What was striking was the way that all respondents who addressed this point were looking to see how patient care could be improved with aspirations that patients were satisfied with more than just the health outcome (although that is the bottom line) but also with the facilities and the atmosphere. In addition, several respondents made the point that they themselves were mindful of delivering (or at least aspiring to deliver) the type of care they themselves would want to receive.

That so many of the staff (clinical and non-clinical) worked long hours in which they were engaged in intensive work with either their clinical or management teams, or their caring for patients with the aim of delivering the best possible care, is yet further evidence of the ways in which patient care is inspirational.

What is most noticeable, however, is how some styles of clinical and managerial leadership appear wanting, when compared with the best. While some respondents are clearly excellent communicators who engage fully with their professional knowledge and with the patients and staff, others - equally expert and equally inspired to provide the best for their patients - seem to fall short in comparison. In Chapter Nine for instance, Cameron and Kenneth engage with their patients in human ways and there are examples in the chapter in which each clinician manages to gain important information from and for their patients by their hard work *and* their humanity. However, in Cameron's case he is supported by a team which has clearly been nourished and inspired by the organisational context (see references to Cameron's work in this report).

Kenneth, while equally able and empathic, from the ethnographic evidence reported in Chapter Nine, appears to be less able to transmit this or influence others to take up his brand of leadership and patient care. He remains slightly in the background while the younger and (it appears) more influential Henry sets the tone. The clinical team give the impression of

being business-like and impersonal and somewhat intimidating when they conduct their ward round. The culture being transmitted to the other clinical staff tends towards Henry's approach rather than Kenneth's. This raises questions about why this Trust and site is different from the FT in which Cameron and Mandy work. These matters were addressed in Chapters Six, Seven and Nine in particular and will be subjected to further analysis in subsequent publications. However the FT is established and settled. The Trust where Kenneth and Henry work was the product of a relatively recent merger and norms and values were still being 'negotiated' (see Chapter Seven and above in this chapter).

Subsequently we see Mandy working directly on a patient's wound not only acting humanely when she hurts the patient but working with the nurse to assess how they might best improve the patient's condition while caring for his mental state and self-esteem.

High quality care and inspiration come together through the ways in which clinicians and managers take responsibility for their work – for managing emotions (their own, their colleagues' and their patients'), teaching, making decisions about end of life care, communication with relatives and coping with everyday situations that raise anxiety levels for patients and staff. The story of the doctor in Trust 1 who cared for a woman with a still-born baby itself demonstrates how he went the extra mile (in his words) inspired by the possibility of providing care in a case where some might have tried to make minimal contact because a still-born baby might be seen as a clinical failure.

Overall emotional engagement with patients and followers leads to people working together in a human, humane and inspired way and impacts on the organisation itself which can become one with which people are proud to be associated.

10.3.2 How do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

This question underpinned the entire study, but specifically we reviewed the relevant research literature on leadership and organisational climate (Chapter One) and discussed this in Chapters Four through to Eight. We began by reviewing the results from the story-telling interviews, focus groups and ethnographic methods (observations and shadowing). A range of potential practices and behaviours were reported to us which suggested where problems might lie in current leadership practices, as well as what many respondents held to be ideal types. What we summarise now represents a combination of what works and what does not although it needs to be noted (as identified in Chapter Nine in particular) that what

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patients see as good leadership (that they received clear and consistent information from one or two key staff) may not always intersect with what staff meant by good patient care or effective leadership and service delivery. The latter was usually seen as best delivered by a well-functioning multi-disciplinary team albeit frequently constrained by limited resources.

The following issues stand out as good practice that could feed into NHS (and local Trust) policy:

Leadership is a complex concept meaning different things to different people. Over recent years leadership in changing contexts such as the NHS has shifted from the 'heroic' model where leadership is hierarchical to a model that is more distributed across different levels and different parts of the organisations. The heroic and hierarchical (related) models frequently depended upon individual characteristics and where the senior managers were indeed heroic and charismatic, leadership might well have led to good patient care. However, this is unreliable and unpredictable and the NHS Qualities Framework which has identified leadership skills is more appropriate to the context (see Chapter One).

Our most important findings, however, make it clear that leadership which is emotionally engaging and distributed is the one which is most likely to lead and support service delivery successfully as well as drive necessary changes.

At the end of Chapter One we focused on contemporary studies of leadership which promoted the importance of *context* and of taking a more discursive stance in the analysis of leader-follower relations. We also drew attention to the revival (and reappraisal) of concepts from organisational studies from the 1960s to the 1990s which took psychodynamic ideas into account and related them to more 'popular' contemporary ideas about the significance of social and emotional intelligence in leader-follower relations. Thus, we explored the ways in which stakeholder accounts of the experiences and exercising of leadership demanded an attachment or engagement at an emotional level, which took account of the unconscious as well as conscious understanding of these experiences. There were several examples offered in the previous chapters of leadership practices that delivered the required services or changes through different types of concerted action and those that didn't. In some cases we were able to show that with the best will in the world if the leader, for whatever reason, was unable to *engage* and thus be supported by the followers, then their leadership failed to deliver.

Recent analyses of distributed leadership styles and organisational contexts show that if such leadership is to work then people need to act and work together and be prepared to both take up and relinquish authority for

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certain tasks and roles at the appropriate intervals. We saw in Chapters Six and Seven for instance that authority is hard to maintain if a leader loses touch with their staff and fails to hold their own organisation 'in mind'. We used the OCS survey results in combination with the data derived from the interviews, focus groups and ethnographies to demonstrate the importance to a positive organisational climate of good leadership. Satisfaction with a manager was predicted by the same variables that identified a positive organisational climate. For staff in the organisations surveyed it was important that managers were committed, responsible and supportive of their staff/followers.

But how were these characteristics demonstrated? Leaders who were experienced as effective, supportive and emotionally engaged with their followers were able to communicate their vision and dedication to improving the quality of care to patients, which in itself co-existed with good staff morale. Such leaders were also good listeners as well as being able to take staff with them when less palatable or unpopular changes were mooted by senior management or government. These effective leaders were closely connected to the way the organisation was structured (physically and emotionally). They were thus able to access the information they needed in order to lead. The evidence for this frequently came from the stories and accounts of staff and observations made by researchers – often of good leadership but perhaps more acutely when leadership was poor. Then there was a jarring effect or mismatch between (local) policy and the attempt to drive changes to meet improvement targets. There was also evidence on occasions of senior clinicians' behaviours being disengaged. Sometimes attempts were made to subvert the senior people when leadership went against the grain. There are examples in Chapters Seven and Nine in particular.

A final comment here is that despite the changes in gender demographics at the top of clinical specialties in medicine, nursing and related professions, as well as in senior management, gender has not 'gone away'. Indeed distributed forms of leadership have (perhaps stereotypically but with some evidence base) been associated with women's behaviours. The OCS (Chapter Five) suggested that women's perception of 'recognition' for their work and achievements was more negative than that of men. Men were either satisfied with the recognition they received or less in need of recognition from their managers within the organisation than were women. In the qualitative data (see Chapter Eight) it was also the case that while senior women were keen to deny the relevance of being female to their professional lives and their career progression per se, women used different strategies and perceived their roles slightly differently than did men, although the point was well made by some respondents that feminine and

masculine choices of specialty may have been more significant predictors of management styles than gender itself.

10.3.3 Do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The contemporary NHS with its (mostly) distributed leadership practices at all levels tends to militate against the possibility of one person's vision being paramount. However, as suggested above in this chapter, there are nuanced influences of leadership style that (may) flow from one or two people's vision and/or style of leadership and patient care that influence organisational approaches.

In Chapter Seven, for example, we explored three senior people's visions and consequent behaviours to consider their authority and influence with the possibility that as opinion leaders they influenced organisational approaches to patient care. Quentin, for example, reflected his role as a senior clinical leader, and although there is no irrefutable evidence that his style was mirrored in the organisation itself, he does provide some evidence that in certain cases in relation to certain actions his vision had an impact on the overall organisational approach.

While the OCS (Chapter Five) captures data from a wider population, the ethnographic methods made a greater contribution to exploring how far an individual's vision influenced the organisations approach to patient care. Again in Chapter Seven we see Kerry battling against a resistant (and probably disillusioned for some reason) senior management team to improve discharge policy and meet government targets. She tries again and again (by her own account) to show her staff that they need to focus on targets because they will lead to improved care quality. She appears to fail (again according to her own standards) and expresses this by almost literally demonstrating that she is banging her head against a brick wall.

Differently with the same effect Gerald is introduced as having a clear vision for patient care in his Trust. However, his inability to take staff (at all levels of the organisation) with him in his vision is attributed in our analysis to his lack of emotional engagement and autocratic (verging on the authoritarian) style of management. His narcissism further ensures his inability to understand how his behaviour is impacting upon staff and he sees himself as having failed to win a 'fight'.

Chapter Six explores the organisation as an open system, and ways in which all stakeholders⁴⁰ hold a vision of the organisation in the mind at a

⁴⁰ Including patients but we cannot really speak definitively here due to lack of data.

conscious and an unconscious/emotional level acting accordingly. Thus, they have an image of the organisation (how well it is managed, how effectively it cares for patients), a sense of their own role and place within the organisation and how well the leadership understands the experiences of staff and patients. Recognition of the primary task, the roles and responsibilities of those who manage it and the (changing or threatened) boundaries of the organisation itself are critical concepts.

No doubt some members of the organisation have more personal and role/task related power and influence than others in the NHS Trust. Furthermore, the NHS as a system is fluid and dynamic, so that there is overall a group influence over the evolution of organisational context (climate and culture) which responds to visions from within and without (government, health care consumers) the wider system.

10.4 *What have we learnt from this study?*

10.4.1 How leadership relates to patient care

It is clear, from our empirical work and evidence from previous studies, that leadership is a process and set of practices which generally do not equate with the qualities residing in a particular individual regardless of their authority and formal role and status in the organisation. Leadership that 'works', as seen particularly (but not only) in the case studies in Chapter Seven, involves the person in the leadership role exercising social and emotional intelligence and engaging with their 'followers' (see Chapters One and Four) and offering staff recognition and support (Chapter Five). Moreover the role of leader is particularly effective when it is distributed among those who are best placed to exercise leadership towards the task in hand. So that in the context of an NHS hospital Trust, leadership might be exercised in relation to organising the administration for a unit, running an audit, or developing an innovatory clinical practice. Leadership in such contexts is time/project limited.

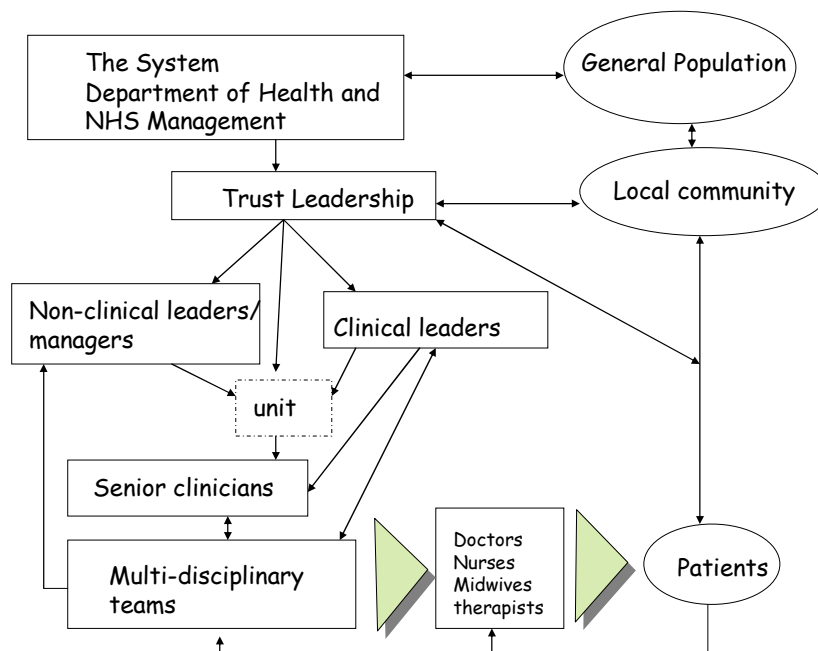
The primary task for NHS Trusts is to deliver a service to patients, as proposed in Chapter Six. All NHS Trusts operate as open systems with porous boundaries which enable change (planned and/or evolved). Leadership therefore can occur throughout the system at different levels including those of ward clerical and cleaning staff and the CEOs who 'manage upwards' and influence NHS/ Department of Health policy. Information of all kinds passes across the various boundaries not simply from the 'top' downwards.

Below in Figure 12 the relationship of the Trust leaders and patients within the NHS system is illustrated. It is also the case, as shown, that policy

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influences individual care, and the quality of that influence depends very much on the quality of leadership again across the system at all levels.

Figure 12. From the DoH to the Patient: An Open System



Patient care is represented here at three levels. The population who influence service delivery and patient care using their vote and/or lobbying through relevant patient groups, the local community who are served by a particular Trust and patients who are actively receiving medical treatment from individual clinical teams.

While on the whole it was the last group who were the main focus in this study some participants, particularly those in senior leadership/management roles, were concerned with service delivery at the local community and population levels. This sometimes meant that senior managers faced the dilemma of how to care for the community while attending to individuals and some individual clinicians were equally concerned about how their interactions with patients were influenced by some of the management dictates which derived from NHS policy that they

found difficult to understand (see Chapter Six and in 10.4.2. below for example).

10.4.2 Systemic dilemmas in patient care: Managing in the NHS

One participant had faced a 'dilemma' in wanting more face-to-face knowledge of patients in the community in order to be a more effective and informed leader, while also as his role required, attending to the demands of working within the wider system of the NHS:

As a chief exec in the NHS it was my privilege to make decisions. That was my privilege to go on and up the ladder. It was that I could go on and make faster and faster decisions. I get in the way I have always got in the way... the thing I would do is go out with the district nurse for the day, because I needed to be grounded in that. (Retired CEO)

Another manager who had previously had a military background advocated (along similar lines) that the best way to lead towards good patient care was to 'walk around' and support the leaders across the different parts of the organisation. In a seminar to clinical staff, which we attended and recorded, he drew participants' attention to the importance of *influencing* policy to achieving good patient care (at the population and community levels).

I hope some of you will find yourself in policy jobs at some point. Totally different, yes it still leads, but the actual process is so ... changing...both the chief executive and I spend a lot of time nurturing relationships which are partly to do with policy, but unless you get it right ... you communicate with them, it won't work.

In other words to be effective and to ensure the best for those in the Trust (staff and patients) a leader has to 'manage upwards' which gains influence. He continued by contrasting the experiences and perceptions of doctors with managers who lead at the macro level, drawing on the example of a recently qualified doctor. When the respondent quoted here asked this man about leadership in the NHS and how it impacts on patients he apparently answered:

'Oh I have got communication skills'. 'Blimey!' I said 'what do you know about the NHS?' And I asked him a couple of questions, nothing! But he hasn't been taught at an academic level about the context in which he is working. I think that is crucial and I know that is not how everyone does things. You know [doctors] keep people alive, but they really ought to have this basis of information about the context in which they are working.

While it is self-evident that the NHS is the context in which patient care is delivered, there is a tension between those who exercise leadership in that context and those who 'keep people alive'. In Chapter Seven, the frustration expressed by Kerry in trying to meet the demands of the government and community by improving the Trust's record of patient care, as well as motivate her senior staff to hold similar ideas, was palpable. From others' perspectives as shown in Chapter Six, there was evidence that 'management' was experienced negatively by several clinical staff when it tried to respond to Department of Health directives.

Managing the numbers

At another level of management good patient care was defined through achievement of returning satisfactory statistics, as this observational note of a meeting between capacity managers and clinicians suggests:

Patient care for the capacity managers appears to be a number crunching exercise. The need to get the patients in the right beds according to government targets meeting four hour waits and single sex bays. However because there is not a shortage of beds on this day, patient care moves from an exercise in numbers to thinking about patients in real human terms.

Sally (the capacity manager) talks about how better patient care can be delivered when there is less pressure on all the staff to meet their targets and get their job done. She talks about how [clinical] staff are then more able to talk to their patients and spend time with them. However, whilst reduced pressure means that for some, numbers translate into real people it is clear that in the capacity meeting that the role of the capacity manager is to think in terms of numbers and beds to deliver good patient care.

There is a potential conflict between the target driven service and the patient-clinician relationship which is about face-to-face contact. Perhaps this is well illustrated in Chapter Nine with the example of the 'grace in adversity' story, whereby the obstetrician spent extra time with a patient while his clinical colleagues turned a sympathetic blind-eye. The story of the patient 'Lola' also discussed in Chapter Nine who had been occupying a bed for three months with the tacit support of nursing staff would also have been anathema to staff responsible for managing targets about capacity.

10.4.3 Who judges what is good leadership and good patient care?

As shown above and throughout this report there is a tension throughout the system. The primary task of senior managers and leaders at and above the level of the Trust is to ensure the demands of the NHS and Department

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of Health leadership are met. These are policy driven with differing priorities at any particular time. The general population of (potential) patients has a keen influence on policy in different ways but particularly during local and general elections. For example the recent change from a Labour to the Coalition Government has raised questions about the role of 'targets' for future NHS priorities. Apart from other matters, finance makes a difference as to how priorities for service delivery are set.

Senior management at the Trust level is judged in a number of ways particularly related to how far the Trust meets the national priorities. However there is also pressure on CEOs and senior teams to get direct patient care and safety 'right'. This may be assessed through statistics as in the following example described by a senior midwifery manager:

Between 2002 and 2005 there were ten maternal deaths at [Trust], which exceeded the national figures. So the Healthcare Commission came in and reviewed a number of clinical organisational cultural governance issues, and then actually put the maternity services under special measures

There was a key number of issues then, and an action plan was developed, so actually I was newly appointed at that time, and there was a number of work streams that we had to work on, and it's never happened before, and I don't think its happened since in a maternity unit. So basically, even though that was a very sad event for all the families involved and very tragic for them, it was difficult for the staff, and obviously difficult for the Board in terms of reputation management. The whole action plan was implemented, the unit was turned around, and the special measures were lifted in 2006.

In this case there was a notable failure to deliver maternity care to the standards of safety prescribed by the NHS. Furthermore there was a failure of leadership perceived by this participant in terms of both 'culture' and 'governance' giving rise to the high proportion of maternal deaths and the consequent special measures. This participant also makes clear how much the staff themselves are influenced by events of this kind.

Another member of that staff team praised the changes at the top following these problems and combined the policy, context and face to face care in her assessment of the relationship of good leadership to good patient care:

.... the end goal for us, is ensuring the services we're providing.. the patients, are getting the best service from us on top of meeting all the Trust targets and the Trust strategy...for me really it's about ensuring that the patients are getting the best quality care, which, you know, I think they've got an improved quality of care here, with the team like mine who are here...and I think [leadership] is from the top down, so from Chief

Executive, right down to every level, to leaders in the ward, right down to our portering, to our domestics. Yeah, there certainly is, and we lead by example really don't we? and I think our chief exec, director of ops, deputy chief, they've all got good leadership skills.

Good leadership skills among senior managers can pay dividends in terms of reputation management. For example in August 2010 North Cumbria University Hospitals NHS Trust admitted a series of false positive diagnoses following breast cancer screening⁴¹. The CEO moved quickly to review the situation and apologise publicly. In other cases though, when there have been wrong diagnoses, neglect or medical errors over drug doses senior managers have been blamed for the failures - sometimes warranted and sometimes possibly not so (see below). Anecdotally it appears that leaders who are prepared to acknowledge problems as soon as they appear and deal with them in a transparent and effective way bring about improvements in service delivery and patient care in the ways perhaps that those who try to 'bury' problems might not achieve.

10.4.4 Leadership practices across the organisation

Leadership and patient care are intrinsically linked. Leadership is above all about taking responsibility but with changes in organisational structures, a growing emphasis on networks, open systems with porous boundaries, mergers and changes in the shape, structure and functions of Trusts, it is no longer tenable for leadership to be in the hands of a few. Leadership, then, is about a series of relationships and connections within and without specific organisational boundaries which have the potential for diffusing responsibility or sharing it, and therefore making leadership practices more co-operative.

It is important to focus, as we have done, on the many examples of good and excellent leadership we found within the three Trusts taking part in this study (each of which of course being hospital based and therefore not focused on the role of leadership in primary care). These sit in contrast to the examples of less effective and sometimes failures in leadership that we have cited. The differences crucially were about emotional attachment and engagement between leaders and followers. We did not meet any respondents who were disengaged with the aims of the NHS and none who were uncommitted to deliver the best patient care. But as evidenced above in the report and in this chapter, some leadership practices failed to take

⁴¹ <http://www.bbc.co.uk/news/uk-england-cumbria-10958423>

followers with them because of autocratic, insensitive behaviours and poor communication skills. Leaders need to be able to listen and engage – having a vision is not enough.

Leadership taking the importance of emotional engagement into account also needs to be transmitted across the organisation. This is best accomplished through making full use of individual skills. Clinical staff and managers can be effectively involved in specific change projects. These may be time-limited and/or specialism specific but collaborative concerted action is frequently the most significant way that a system might flourish with the staff taking responsibility and enhancing their sense of commitment.

10.4.5 When leadership fails patient care

The converse of good leadership is potentially catastrophic. The case of Beverly Allitt in the early 1990s, the nurse who murdered children in the Lincolnshire Hospital by injecting them with insulin, went relatively unchallenged because she was poorly supervised. Harold Shipman, a different case in that he was a GP in a sole practice, similarly was eventually thought to have committed over 200 murders of patients throughout his career. However, the report into his murders showed that doctors at Thameside hospital had failed to report suspicions about his prescribing⁴². The Alder Hey organs scandal involved the unauthorised removal, retention and disposal of human tissue, including children's organs during 1988 to 1995 and the Bristol Royal Infirmary inquiry about children's deaths during surgery resulted in doctors being struck off. All these cases represent a failure of leadership in which those who were responsible for patient care at all levels failed to identify and follow up on problems. More recently the independent inquiry into the Airedale NHS Trust, where the late Anne Grigg-Booth continued as night-nurse despite a high proportion of deaths of patients while under her care, identified 'a catalogue of systemic failures' whereby her dangerous behaviour was not spotted.

At the time of writing this report the Prime Minister David Cameron has ordered a full public inquiry into the events at Staffordshire hospital which have led to deaths of patients, it would appear in these cases, more due to negligence than intent. The Francis report which was published in 2009 found that patients were routinely neglected and there were systemic failings in patient care. Managers had been pre-occupied with cost cutting and meeting targets and unable to spot the build up of failures in patient care that were to cost several patients their lives. There were too few

⁴² These cases were subjected to inquiries which exposed a range of complexities which are not relevant here.

nurses, those who were employed were ill-trained, equipment was inadequate and experienced medical cover was not always available. It was a supreme failure of management and leadership. The Trust was poor at identifying when things went wrong and managing risk. Some serious errors happened more than once and there were higher levels of complaints compared with other trusts. Staffordshire was a foundation hospital that had managed to 'tick the boxes' although clearly there were a series of chasms between the clinical and managerial staff.

10.5 *Final thoughts*

By using innovative qualitative methodologies (described fully in Chapter Two) such as story telling, ethnographic observations and shadowing, to both supplement and augment data from interviews and focus groups, we have built up a picture of what happens in the daily lives of NHS staff working both with and as managers and in clinical teams. Using these methods provides opportunities to extend the scope of more traditional in-depth interviews and focus groups. The 'story', because it is chosen by the participant themselves, provides not only detail and depth but demonstrates the specific indices used by each interviewee to make sense of their own and others' behaviours within the organisational context.

The ethnographic observations, and the shadowing in particular, enabled the researchers to gain a sense of what 'a day in the life' of a member of the organisation *feels* like. They can 'experience' the interactions between staff, between staff and patients as well as the frustrations and pleasures of working in that Trust. No other method provides such acute insights. The subjective ingredients in this method enhance the process (i.e. as outlined in Chapter Two whereby the researcher themselves is the 'instrument' through which data is mediated). Moreover, and possibly conversely, the subjective elements are reconciled when the observation notes are discussed by other members of the research team, which again as discussed in Chapter Two is also a source of data (Czarniawska, 2008).

As a qualitative study, the success is proven by the richness of the data, showing the clear emotional connection participants had with the topics of both 'leadership' and 'patient care' (Lincoln & Denzin, 1994, p. 575). From this we were able to make sense of how leadership is experienced and exercised (see Chapters Four and then Six to Eight) and about the practices around patient care and service delivery that support patients to understand the relationship between their particular health-status, quality of life and the care and treatment they are receiving and/or expect (see Chapter Nine in particular).

The statistical analysis of the OCS⁴³ showed that, on the whole, the climate variables, 'support' and 'recognition' from managers and the system overall, predict 'satisfaction' with leadership and management. This reinforces the ideas expressed throughout the report that good practices by managers/leaders are about ongoing engagement with followers with concerted or conjoint leadership processes most likely to promote a sense of being supported and recognised (Roberts et al. 2005).

Thus we have not produced a list of 'good leader' qualities or a similar record of what constitutes 'good patient care', as these would fail to capture the crucial point that both leadership and patient care are experienced as a process. Thus this report aims to delegate *good practices* that were observed during the project, for the use and reflection of any staff member of the NHS – whether a leader, follower or patient.

10.6 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.

⁴³ As made clear above we were unable to capture corresponding data from patients.

- 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.

Appendix 1

Focus Group Questions

1. Leadership means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this hospital?

Prompts

1. Charismatic / Authoritative / Consultative / Directional / Varies – depends on situation/activity etc
2. Can you think of some incidents that sum up for you the way leadership is exercised in this hospital?

Follow-ups

1. Does this type of leadership operate throughout the hospital?
2. Could you give some examples of ways in which leadership is exercised in your team/the hospital
3. Patient care means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this organisation?
4. How important is patient care as a priority in the service that you and your colleagues provide?
5. What are your main priorities in ensuring a high level of patient care in this hospital?
6. Can you think of some incidents that sum up the way you and your colleagues try to deliver patient care?
7. To what extent is leadership reflected in the quality of patient care you and your colleagues provide?
8. Can you think of some incidents that sum up the way that leadership in this hospital approaches the issue of patient care?
9. Can you think of specific incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

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Follow-up

1. What would you suggest to improve this/these situations?
3. Stories and critical incidents
 - a) Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
 - b) Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
 - c) Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

Could you tell me about a time that made you feel disappointed with leadership in this hospital?

- In this unit?

Appendix 2 Interview Questions

Interview

*Introductions, background and experience in relation to patient care and leadership in the organisation

- The interviewees position/level
- Years at the hospital
- Role in the organisation

1. Leadership

'Leadership' means different things to different people.

- a. How would you define it?
 - Do you see that kind of leadership at this hospital? Why/not?
 - What about in this unit?
 - What makes someone a good leader/Qualities of a good leader? Can you give me an example?
 - Who here at work do you see as providing leadership to you personally? Why? Do you have a direct supervisor? Who? Do they have leadership qualities?
- b. Do you see yourself as someone who could be a leader?
 - Why/not?

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- Under what circumstances?
- c. Can you give me an example of leadership in this hospital?

2. Patient care

- a. Like leadership, 'patient care' means different things to different people.
 - How would you define it?
- b. Tell me about patient care in this hospital. How is it defined?
 - Are there differences between units? Tell me about them. Why do you think this is?
 - How would you improve patient care in the hospital?
 - How would you improve patient care in this unit?
- c. How do you [as a hospital worker, nurse, etc.] try to deliver good patient care?
- d. What do you think are some obstacles to delivering the sort of patient care you'd like to see? How could these obstacles be removed?
- e. Do you think leadership could improve patient care in this hospital?
 - Why/not?
 - Do you think that better leadership would improve patient care? Why/not?
 - How does good leadership influence patient care?
 - Has the leadership in this hospital improved patient care since you've been a member of staff? How so? Or why not?

3. Stories and critical incidents

- a. Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
- b. Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
- c. Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

- d. Could you tell me about a time that made you feel disappointed with leadership in this hospital?
- In this unit?

Appendix 3: Focus Group Questions: patients

1. Leadership means different things to different people. What does it mean to you as a patient of this hospital?
2. What is your opinion of the way leadership is exercised in this hospital?
3. Patient care means different things to different people. What does it mean to you as a patient of this hospital?
4. Can you think of some incidents that sum up the kind of patient care that staff in this hospital deliver?
5. Can you think of ways that leadership in this hospital could enhance the quality of patient care, as far as you are concerned?
6. Can you think of some incidents that sum up what else leadership could be doing?
7. Can you think of any other incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

Appendix 4: Staff Organisational Climate Survey

[attached separately]

Appendix 5: Participant Information Sheet

Leadership and Better patient Care: From Idea to Practice

Participant Information Sheet: Staff Interviews

You are being invited to take part in an interview study about leadership and patient care in three different hospital settings. Before you decide to participate in this study it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Contact me (see full contact information at the end of this sheet) if there is anything that is unclear or if you want to know more.

Take time to decide whether or not you wish to take part.

Thank you for reading this.

1. What is the purpose of the study?

The purpose of this study is to try to identify the circumstances under which leadership can be an effective engine for change in the organisation of health care, especially for patient care and service delivery. Although we suspect that leadership motivates workers and affects the climate or atmosphere of the places where people work, leadership can mean different things to different people. The same is true of patient care which can also mean different things to different people. In order to understand how leadership inspires health workers to provide better patient care, we want to learn how nurses, doctors, other medical professionals as well as managers and patients define and understand leadership and patient care. This includes exploring how their perceptions mesh or conflict with one another. It also includes listening to stories of important incidents that describe their experiences of leadership and patient care.

2. Why have I been chosen?

As part of the study we are interviewing staff (clinical, managerial and others) as well as patients to examine what leadership and

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patient care mean to them. You have been chosen as someone whose views represent the views of staff.

3. Do I have to take part?

No

4. What will happen to me if I do take part?

You will participate in a tape-recorded interview with a qualified researcher, which will last under an hour.

5. What do I have to do?

Arrange a mutually convenient time to have the interview.

6. What are the possible disadvantages and risks of taking part?

It is possible that the discussion may stir up distressing feelings you have regarding your organisation, its leadership and the patient care it provides. However, care will be taken to prevent this and you are free to leave the interview at any time. Apart from that, the only disadvantage is that you will be giving up some of your time.

7. What are the possible benefits of taking part?

This study may not directly help you but it is part of a serious initiative to improve the quality of leadership and patient care provided by the NHS.

8. Will my taking part in this study be kept confidential?

Yes. All data will be stored in locked filing cabinet in a locked office. It will be made anonymous and all names will be edited out of the transcripts. Only members of the research team will have access to the data.

9. What will happen to the results of the research study?

They will be published in a report to the funder and also presented in peer reviewed papers and conferences. A copy of the report will be provided for each participant who requests it.

10. Who is organising and funding the research?

The study is funded by the NHS Service Delivery and Organisation (SDO) Research and Development Programme of the National Institute for Health Research (NIHR) Programmes. The NIHR has been established as a part of the government's strategy Best Research for Best Health to provide the framework that will position, manage and maintain the research, research staff and infrastructure of the NHS in England. The study is conducted by a group of researchers from Royal Holloway University of London led by myself, which won the grant following a competitive bid.

11. What if I have any concerns?

If you have any concerns or other questions about this study or the way it has been carried out you should contact me (details below) or you may contact the hospital complaints department.

Contact for further information

Professor Paula Nicolson, Head of Department, Health and Social Care
Royal Holloway University of London, Egham, Surrey, TW20 0EX

Paula.Nicolson@rhul.ac.uk

Tel. 01784 414 470

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Appendix 5: Consent form (generic)

Title of Project: Leadership and Better Patient Care: From Idea to Practice

Name of Researchers: Emma Rowland Paula Lökman

Please initial each box

☐ I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

☐ I understand that some coded extracts from the interviews may be used for the purposes of the research report and academic articles.

☐ I give my consent for quotations to be used in the report and research papers on the understanding that I will not be able to be identified by the use of these in any way.

☐ I agree to take part in the above study.

Name of participant

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Date

Signature

Appendix 6: Patient Organisational Climate Survey

Thank you for agreeing to participate in this study which as you will know is part of a larger study on leadership and patient care in the NHS.

The following questions explore how NHS patients feel about the care they received and how things generally worked in the units where their care was managed.

The survey is anonymous, so please do not put your name on the survey.

If, however, you would like to receive the final results of the survey when the study is completed, please fill in the tear-out form on the questionnaire's last page and submit it to the researcher or the collection box.

It is important that you answer all the questions. This should take you approximately 10 minutes.

Your individual responses will be kept strictly confidential.

Researchers

Dr Paula Lökman

Department of Health and Social Care
Social Care
Royal Holloway University of London

Ms Emma Rowland

Department of Health and
Royal Holloway University of

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Please circle one number that best describes how you feel for each question in relation to the service provided by your NURSE.

1. I feel understood by my nurse.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

2. I am able to be open with my nurse at our meetings.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

3. My nurse has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

4. My nurse encourages me to ask questions.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

5. I trust my nurse.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

6. My nurse answers my questions fully and carefully.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

7. My nurse deals very well with my emotions.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

8. I feel that my nurse cares about me as a person.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

9. I don't feel very good about the way my nurse talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

10. My nurse tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

11. The way my nurse interacts with me influences my perception of quality care.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

12. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

Please circle one number that best describes how you feel for each question in relation to the service provided by your DOCTOR.

13. I feel understood by my doctor.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

14. I am able to be open with my doctor at our meetings.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

15. My doctor has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

16. My doctor encourages me to ask questions.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

17. I trust my doctor.

1 2 3 4
strongly
disagree

5 6 7
neutral

strongly
agree

18. My doctor answers my questions fully and carefully.

1 2 3 4
strongly
disagree

5 6 7
neutral

strongly
agree

19. My doctor deals very well with my emotions.

1 2 3 4
strongly
disagree

5 6 7
neutral

strongly
agree

20. I feel that my doctor cares about me as a person.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

21. I don't feel very good about the way my doctor talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

22. My doctor tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

23. The way my doctor interacts with me influences my perception of quality care.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

24. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

25. What would improve the quality of care you receive at this hospital?

26. What services are you using within this hospital?

Demographic Information

27. In which year were you born?

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28. What is your marital or civil partnership status?

- ☐ Single
- ☐ Co-habiting
- ☐ Married
- ☐ Divorced

29. How many children do you have?

30. How would you describe your ethnic background?

31. What is your current salary?

- 1. Less than or around £20,000 per annum
- 2. Between £21,000 and 39,000 per annum
- 3. Between £40,000 and £59,000 per annum
- 4. Between £60,000 and £99,000 per annum
- 5. Above £99,000 per annum

Thank you again for your time. If you have any questions please speak with the researcher or alternatively you can contact Professor Nicolson.

I would like to receive the final results of the survey when the study is completed

Name:

Address:

Contact Telephone:

Please return this form to either the researcher or the collection box.

Appendix 7: Appendices for Chapter Five

[attached separately]

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⁷ There is a parallel ongoing debate as to whether university leaders should be drawn from outside academia.

Addendum:

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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.

Leadership and Better Patient Care: Managing in the NHS

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Executive Summary

The NHS National Leadership Council Website¹ (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)

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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.

Leadership and Better Patient Care: Managing in the NHS

1 Leadership, organisation and the NHS

1.1 Leadership

What is currently known about leaders and leadership? The ongoing attempt to identify the characteristics necessary for effective leadership over recent years has been described as an 'obsession' studied more extensively than almost any other characteristic of human behaviour (Higgs, 2002; Tourish, 2008). Alimo-Metcalfe, Alban-Metcalfe et al. (2007) in their comprehensive review of the literature, show that formal studies of leadership date back (at least) to the beginning of the 20th century. They propose, that despite changes in the way leadership has been studied and the underlying epistemological stance taken by the researchers, *"in all cases, the emphasis has been on identifying those factors that make certain individuals particularly effective in influencing the behaviour of other individuals or groups and in making things happen that would not otherwise occur or preventing undesired outcomes"* (p. 2). As *"many have pointed out, that in spite of the plethora of studies, we still seem to know little about the defining characteristics of effective leadership"* (Higgs, 2002, p.3). Even so this has not appeared to quell the appetite for pursuing an ideal of leadership, impelled by the changing demands of organisations echoed across public sector institutions such as the NHS. These changes are in part the result of technological advancements which impact upon clinical practices, demographic changes both of which have altered the strategic, structural and financial profile of health (and social) care (Tierney, 1996).

The tantalising questions remain though about what those factors might actually be and the significance of the context to 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).

But in addition, or conversely, the context, culture, climate and/or structure of an organisation each have an impact on the performance of the people who lead in it (Carroll, Levy, & Richmond, 2008; Goodwin, 2000; Michie & West, 2004).

Focusing on the relationship(s) between 'leadership' and context has revitalised contemporary research particularly through the development of qualitative research, discursive and social constructionist epistemologies (Grint, 2005; Uhl-Bien, 2006) although it is unclear at this stage how far a connection might be developed between this research and its applications, for example in health care services (Fambrough & Hart, 2008).

In what follows in this chapter we explore the changing ways in which leadership has been conceptualised over the past fifty years, particularly focusing on how it has and *might* be operationalised in the NHS (particularly although not exclusively in a *hospital* context) .

1.2 Background and introduction to the study

The NHS Modernisation Agency Leadership Centre (NHSMALC) website³ had originally suggested that effective leadership is a key ingredient in modernising today's health care services. In its own words:

Effective leadership and management in the healthcare system are key drivers in patient experience. Governance and good environments matter to patients, their visitors and carers and staff.

But how might effective leadership be achieved and sustained? The NHS Leadership Centre commissioned a number of leadership initiatives (Larsen et al., 2005). The NHS Institute for Innovation and Improvement (2005) *NHS Leadership Qualities Framework*⁴ emphasised the *situational* nature of leadership and indicated the circumstances under which different leadership qualities will take precedence.

These comprise fifteen contextualised qualities covering a range of personal, cognitive, and social characteristics arranged in three clusters which are set out in Figure 1:

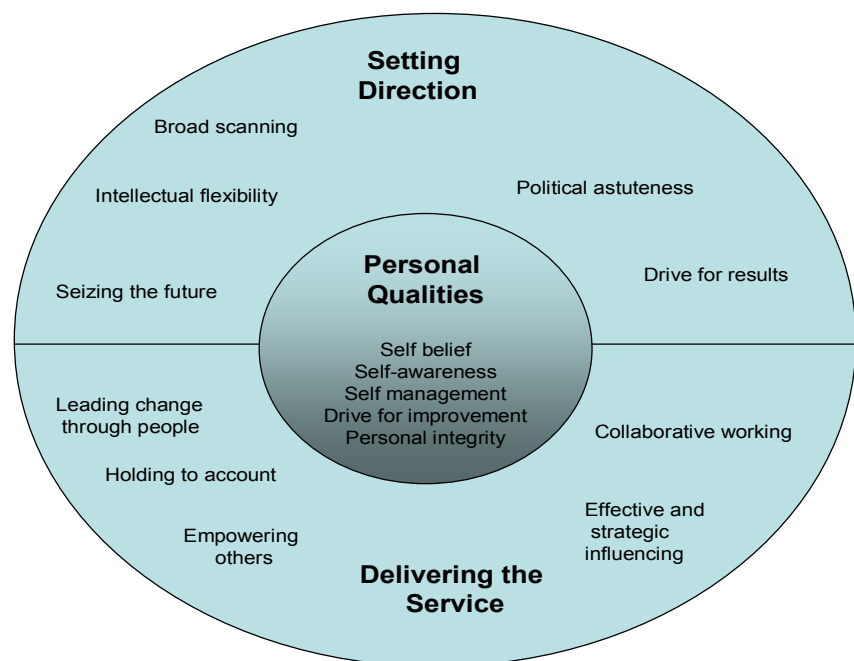
³ <http://www.dh.gov.uk/en/managingyourorganisation/leadershipandmanagement/index.htm>

⁴ <http://www.nhsleadershipqualities.nhs.uk/>

- *Personal Qualities*
- *Setting Direction*
- *Delivering the Service*

Thus, a competent leader enables development in an organisation that is goal directed, geared to developing processes and systems and enables staff at all levels to plan effectively and efficiently towards agreed goals (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Figure 1. The NHS Qualities Framework



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However, these same authors underscore the point that there is something beyond leadership competency that needs to be addressed, particularly in a changing and complex context such as an NHS Trust. *That is that a leader is someone who encourages and enables the development of an organisation in a culture based on integrity, transparency and valuing others. Leaders also need to question, think critically as well as strategically* (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Since the publication of the *NHS Leadership Qualities Framework* in 2005 all efforts have been directed to recognising and discussing leadership qualities and making strides towards their implementation. In 2008 Clare Chapman, Director General of the Department of Health's Workforce declared:

*Leadership is all about creating value for customers and citizens whilst also making work worthwhile for staff. This sounds incredibly straight forward - but it requires courage and resilience, and commitment throughout the entire piece*⁵

David Nicholson the CEO of the NHS in the report *Inspiring Leaders: Leadership for Quality* (January 2009) building on Darzi's *NHS Next Stage Review*⁶ stated:

It is imperative that we align what we are doing on leadership with what we want to achieve on quality. This is what I call leadership with a purpose.

Over the past year, the Department of Health has worked extensively with the NHS and other stakeholders to determine how best to foster talent and leadership development, and it is clear that there is a great deal of enthusiasm for a more systematic approach.

Spotting and developing confident leaders is a priority for us all if improving quality is our shared purpose. This guidance represents our best collective thinking to date. I invite you to use it and contribute to its improvement as we learn how to bring leadership centre stage over the coming months.

Nicholson and his team have charged the Strategic Health Authorities with finding gaps in leadership and systematically nurturing talent across the whole of the NHS. Clearly, the enthusiasm of successive senior officers in

⁵ DH_083353.

⁶ www.dh.gov.uk/en/Healthcare/Highqualitycareforall/index.htm

government and the NHS has been to link effective leadership with good service delivery and patient care as the primary outcome.

1.2.1 Leadership and Better Patient Care in this Study

This rhetoric and confidence about the type of leadership that best suits the NHS from those who lead it gave us pause for thought (Milewa, Valentine, & Calnan, 1998; Mueller, Sillince, Harvey, & Howorth, 2004b). 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 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 aims were overall to seek out the meanings and perceptions of relationships between (effective) 'leadership' and (better) 'patient care' and how leadership is transmitted across organisations to impact upon service delivery, taking account of the mixed methods and specific social science and systemic approaches that the investigatory team proposed. This inevitably has brought certain issues to the fore and (possibly) obscured others.

Our starting point therefore was to hold the NHS model of leadership in mind while calling on our own specific strengths as academics, from a range of social science and methodological backgrounds, to take a cross section of Trusts, clinical specialties, services, staff grades and patient needs, and to observe the *processes of leadership* in everyday working life. From this we proposed it should be possible to determine the ways in which leadership, NHS organisations and patient care were socially and discursively constructed so that links between leadership and patient care might be explored.

In Chapter One we outline some of the important contemporary social science and organisational thinking on leaders and leadership and explore the links between this and the NHS perspectives.

In Chapter Two we set out the innovative methodologies employed to investigate and analyse the research questions. This is followed in Chapter Three with the detailed procedures used for data collection.

The results are presented across four separate chapters. Chapter Four provides the analysis of what leadership means and how it is experienced by staff and patients (Christensen & Laegreid, 2003; Fairhurst, 2005).

Chapter Five presents the results of the Organisational Climate Survey (OCS) (Stringer, 2002). In Chapter Six, open systems theory and the concept of the 'organisation in the mind' are introduced particularly focusing upon the transmission of leadership across organisations. The relationship

between leadership, authority and emotion is discussed in Chapter Seven and in Chapter Eight the role of gender relations and their impact on leadership are reviewed (Begun, Hamilton, Tornabeni, & White, 2006; Ford, 2010; Telford, 2007).

Chapter Nine covers definitions, explanations and experiences of patient care and particularly how it relates to leadership by NHS staff and patients (Begun et al., 2006; Disch, Edwardson, & Adwan, 2004).

Finally in Chapter Ten we summarise our findings, make recommendations and draw conclusions.

Appendices provide copies of the research instruments, additional statistical results and the relevant NRES information.

1.3 Theoretical Approaches to leadership

Leadership research and theory is prolific with the consequence that numerous, frequently overlapping, models of leadership are available to agencies attempting to analyse or train leaders (and indeed managers, as until relatively recently little distinction was made between these two categories, see e.g. Kotter, 1996). Over the past fifty years leadership theories have shifted through different points of focus from the 'trait (or 'great man') approach in the 1940s, through the 'behavioural' perspectives in the 1950s whereby some styles of behaviour were seen as being more or less influential on potential followers. Then since the 1960s and 1970s the focus has been upon 'situational' leadership based mostly upon Fiedler's 'contingency' theory which proposed that different leadership styles were needed for different situations (see Alimo-Metcalfe, Alban-Metcalfe, et al. 2007; Western, 2008 for further details). During the 1970s and 1980s leadership research, albeit prolific, had reached an all time low in terms of its perceived contribution to theory and added value to knowledge for practice, so that as Cummings (1981 p. 366, quoted in a review by Bryman, 2004) asserted:

As we all know, the study and more particularly the results produced by the study, of leadership has been a major disappointment for many of us working within organisational behaviour.

Bryman unpicked the implications of the phrase Cummings used "as we all know" noting that it was "simultaneously sweeping and damning" (2004, p. 730). Bryman also picks out Miner's (1975) suggestion for temporarily abandoning the concept because of its limited utility in helping us understand organisational behaviour. *Why had leadership research reached this nadir during those decades? Why has there been a more recent upsurge of interest in leadership again almost to the point of saturation?*

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Bryman in his review suggests, that the renewed confidence and interest in the study of leadership has come from improved measurement and analytic techniques, greater use of meta-analysis so that more systematic reviews could be compiled, the emphasis on *transformational leadership* and *charismatic leadership* which have provided a fulcrum for the area of research, more and better cross-cultural studies and greater diversity in the types of leadership and organisational contexts that have been studied.

A factor that may also have contributed to the idea that leadership research continues to be fruitful is that a greater diversity of methodological approaches have been added and Bryman's review specifically focused on the value added by qualitative research.

Towards the end of the 1980s and beyond, thinking about the meaning(s) of leadership came to take greater precedence than in the previous two decades, possibly because of a perceived dearth of leadership *per se*.

These deliberations cast light onto the:

- *interactions between leaders and followers* and organisational cultures (Avolio, Gardner, Walumbwa, Luthans, & May, 2004; Lewis, 2000; Schilling, 2009)
- the *management of emotion* (George, 2000; Lewis, 2005; Pescosolido, 2002)
- the *processes* of leadership (Collinson, 2005; Dopson & Waddington, 1996; Vangen & Huxham, 2003)

Even so, or perhaps because of the use of qualitative approaches and related conceptualisation, Alvesson and Sveningsson (2003) were able to entitle a recent paper arising out of their study of leadership in a research and development company: "*The great disappearing act: Difficulties in doing 'leadership'*".

By this they meant that during their study they were able to identify how the existence of the label 'leadership' led to an assumption that the concept had an empirical reality. However the results of their work indicated that leadership might be better explained as a *process or series of processes of interaction*. This conclusion raises questions about mainstream thinking on leadership which presumes observable and possibly measurable characteristics (Alvesson and Sveningsson, 2003, p. 361; see also Ford, 2010).

Most recently there has been reconsideration and development of ideas about leadership in context taking account of the relevance of some earlier studies of organisations (e.g. Lewin, 1947) and open systems theories (see

Chapter Six; Laughlin and Sher, 2010) and new epistemological positions (e.g. Ford, 2010).

In our study, as a consequence of these recent critiques of leadership research and the result of methodological innovation, we approached the concept of 'leadership' as not necessarily a property of one individual (although it can be) or of one specific role, such as Clinical Director or a service manager, but rather we identified leadership as a *process* occurring within a group, organisation or collectivity that *imagines, wills and drives change* (Gabriel, 2004; Gronn, 2002).

1.3.1 Dimensions of Leadership and their Value for the NHS

Leadership, *as a practice*, has been on occasions constructed as 'a beautiful or rarefied ideal' an idea which has little use in the real world particularly as it has been suggested there are at least 350,000 definitions of leadership in the academic literature (Pye, 2005; Tourish, 2008; Western, 2008). *The question for this report is how to identify the literature on leadership and organisation with the most relevance for the contemporary NHS.*

Most discussed in theory and in practice over the past two decades has been the idea of *transformational leadership* (Bass, 1985) a model to explain ways in which a leader can be identified or trained to demonstrate the qualities that enable her/him to *perform beyond expectations*. The phrase 'transformational leadership' was coined originally in 1973 by Downtown but did not gain impetus until 1978 when Burns published his book, *Leadership*, which highlighted the *relationship* between leaders and followers (Burns, 1978).

Until then, as shown above (see Bryman, 2004) there had been little by way of a breakthrough in applicable knowledge. Burns (1978) demonstrated a *psychological* difference between an exchange relationship - where followers respond to leaders because of rewards they might receive - and one in which they respond to leaders who transform their attitudes and behaviours through inspiration and/or charisma (Bass, 1985; Yukl, 1999; Rafferty and Griffin, 2004). Transformational leadership then, is concerned with emotions, values and ethics, standards and long term goals which include assessing followers' moves and satisfying their needs (Currie & Lockett, 2007; Day, Gronn, & Salas, 2006; Eagley & Johannesen-Schmidt, 2003; Northouse, 2004).

Recognition that transformational leadership is not simply an individualistic model but one that *teams* can display (Day et al., 2006; Gronn, 2002; Sivasubramaniam, Murry, Avolio, & Jung, 2002) has shifted the

concentration from individual leaders per se to a more diffuse and distributed model of leadership and organisation context.

1.3.2 What constitutes transformational leadership?

Bass (1985) highlighted several characteristics of *transformational* (or *transformative*) *leadership* that allow followers and leaders to achieve far beyond their expectations. These are not discrete categories but given the significance placed upon the ideas behind transformational leadership in the scientific and training literature it is worth outlining the basic ideas behind these characteristics/types which have been identified as:

- Charismatic leadership
- Inspirational motivator
- Intellectually stimulating leadership
- Considerate leadership

Charismatic leadership

Bass (1985) proposed that "*charisma is a necessary component of transformational leadership*" (cited in Yukl 2002, p.261) and that charismatic leaders are endowed with exceptional personal qualities that attract followers. Charisma, a word derived from the Greek, means "*divinely inspired gift*" and is thought to give people the ability to perform miracles or predict the future (Yukl 2002, P. 241).

It is for this reason that charismatic leaders are often regarded as "*visionary, a futuristic, or a catalyst for change*" (Murphy 2005, p. 131; see also Bass 1985; Bennis & Nanus, 1985). Due to their rare personal qualities charismatic leaders are able to convey their visions to their followers in a clear and concise manner allowing them to visualise what they could achieve in the future if they worked together towards a common goal. As the leader's vision is normally realistic yet optimistic, it empowers the followers granting them greater self-esteem, encouraging and inspiring them to achieve the vision (Bennis & Nanus, 1985; Northouse, 2004; Yukl, 2002).

Inspirational motivator

Through their charisma, transformative leaders have the ability to inspire their followers through words of profound wisdom, or at least is what is *perceived* to be profound wisdom, such as with the case of Jim Jones⁷ in the USA or more positively President Obama who has reformed health care and banking legislation in the USA against the odds. Transformative leaders are

⁷ In 1978 Jim Jones persuaded more than 900 members of his People's Temple in Jonestown, Guyana to commit mass suicide.

excellent communicators which allow them to turn their visions into reality. Many use emotional and optimistic speeches to inspire their followers. They usually lead by example and often become role models to their followers who are in awe of their moral and ethical character. Many followers try and emulate their leaders' good qualities and are confident that their leaders will make just decisions on their behalf leading them to a prosperous future (Kellerman, 2004; Rafferty & Griffin, 2004).

Intellectually stimulating leadership

Transformational leaders have the ability to captivate their audience making the most mundane speeches and events interesting. They encourage their followers to be innovative, challenging the status quo and their own values and beliefs (Northouse, 2004). They also encourage their followers to solve problems and take an active role in the organisation, thus enhancing their self-worth and self-esteem, increasing their job satisfaction and productivity.

Considerate leadership

Transformational leaders are often also considerate leaders who are adept at performing mentoring or advisory roles to support their followers' emotional needs (Hiller, Day, & Vance, 2006; Rafferty & Griffin, 2004). Such leaders listen carefully to their followers' needs and desires, empathising with them during difficult periods. Being empathetic also builds a strong bond between leader and follower and thus a strong reciprocal relationship (Simpson & French, 2005).

It is important to note though, despite the wide take-up of transformational leadership as a conceptual model and a *practice*, that there remains uncertainty about the ambiguity of subdivisions and distinctions between elements in the model. Theoretical distinctions between 'charisma' and 'inspirational motivation' have become blurred over time and some theorists have suggested that elements of transformational leadership might also be identified as *transactions* (see Rafferty and Griffin, 2004 for a discussion of the implications).

Further concerns have been raised about how transformational leadership can take place in organisations, particularly public service ones, which are constrained by government initiative and targets and localised regulatory and normative pressures (Currie & Lockett, 2007; McNulty & Ferlie, 2004). However, it may also be that professional staff (rather than leaders/managers) in contexts such as health care, may in fact be more transformational than might be predicted because of their long-term commitment to the organisational goals (McGuire & Kennerly, 2006).

Most recently the notion that transformational leaders are very much 'engaging' leaders has been proposed (Alimo-Metcalfe, Alban-Metcalfe et al, 2007; Alban-Metcalfe & Alimo-Metcalfe, 2009; Macy & Schneider, 2008).

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One further comment here concerns the role of *gender* in styles of leadership and its consequent impact on organisational transformation (Fletcher, 2004; Mandell & Pherwani, 2003). There is evidence that (whether displayed by a woman or a man) feminine styles of leadership may be more related to engagement, emotional and social intelligence and distributed leadership, which may be important for complex organisations such as the NHS (see below).

1.4 Leadership, organisation and emotion at the turn to the 21st Century

Models of leadership and organisation theory have evolved over time and leadership and organisational structures and cultures are intrinsically linked in the literature. Leadership, if it is to motivate, innovate and move organisations to change, has to have an *emotional dimension* and, thus, effective leaders have a clear *emotional agenda* (as well as a strategic and structural one) which is particularly acute in services such as the NHS which is working to serve people's health care needs (Ashforth & Humphrey, 1995; Bolton, 2000; Pye, 2005).

Exploring organisations and leadership at the level of 'emotion' has become contested territory, as recognition, that organisations and their leaders need to take account of emotional engagement (Alban-Metcalf & Alimo-Metcalf, 2009; Vince & Broussine, 1996) at all levels of the work place, has emerged. Prior to the 1980's, organisational literature had been dominated by cognitive orientation (George, 2000) which favoured the rational, 'masculine' and scientific explanations of organisations and their leaders. This notion therefore ignored the (so called) irrational and 'feminine' characteristics of emotion, which were deemed detrimental to productivity and success. At that time emotions were regarded as the culprits that distort an individual's perceptual and cognitive faculties and therefore should be kept under control (Alvesson & Sveningsson, 2003b; Clarke, Hope-Hailey, & Kelliher, 2007; Dasborough, 2006; de Raeye, 2002; Ford, 2006).

As social and occupational psychologists began to study the effects of positive and negative moods on decision making, job satisfaction, choice of work-based activities and organisational climate, however, (Isen & Means, 1983; Rafaeli & Sutton, 1987, 1989) 'emotion' as part of organisational life gained impetus once again. This resurgence coincided with leadership theorists studying how moods and emotions could effect the quality of leadership (George, 2000).

It is possible to trace a rough trajectory from the 'hard nosed' scientific management, with the organisation perceived as a 'machine' in the early twentieth century, through towards a more humanistic, emotional and

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sometimes even spiritual way of thinking about contemporary leadership and organisational metaphors towards the twenty-first century, all of which are potentially transformational, not simply to the individuals concerned, but to the organisational dynamics.

Hochschild's (1983) *The Managed Heart* has been credited with being one of the earliest examples of research into emotions and organisational settings (Ashkanasy, Hartel, & Daus, 2002). She looked particularly at the airline industry and how airline cabin crew managed their emotions for dealing with difficult passengers and to promote a particular airline image. She termed this emotional management '*emotional labour*' (Hochschild, 1983).

Since this publication, the study of emotions in organisations has increased (Ashkanasy et al., 2002) with academics concentrating on key concepts such as emotional labour, emotional intelligence, mood analysis and Affective Events Theory (AET) and most recently a return to psychodynamic understanding of organisations and groups (see Ford, 2010; Schwarz, 1990). Since the 1990's a plethora of literature has emphasised the role of emotional concerns in private sector organisations such as the airline industry (Hochschild, 1983; Taylor & Tyler, 2000; Tyler & Abbott, 1998), service sector (Crang, 1994), merchant banking (McDowell & Court, 1994; Pugh, 2001), law (Harris, 2002) and image consultancy (Bryson & Wellington, 2003; Wellington & Bryson, 2001).

However, emotionality in the public sector was mostly neglected until 2000's when a surge of literature began to be published analysing the NHS (Allan & Smith, 2005; Bolton, 2000; Cummings, Hayduk, & Estabrooks, 2005a; Hunter, 2005; Lewis, 2005; McCreight, 2005; McQueen, 2004; Michie & Gooty, 2005; Michie & West, 2004; Smith, 1992) and the fire service (Archer, 1999; Scott & Myers, 2005; Ward & Winstanley, 2006; Yarnal, Dowler, & Hutchinson, 2004).

1.4.1 Emotional labour, leadership and patient care

Hochschild differentiates between emotional labour and emotional work or 'face-work' (Goffman, 1967). Emotional work has been described as the effort we put into presenting and representing our feelings as well as into feeling what we ought to feel (see Fineman, 2003). For example, a person ought to feel happy at a wedding and sad at a funeral and if their emotions do not match these expectations then a person must perform emotional work to display the appropriate emotion. This is sometimes difficult as people struggle to disguise their true emotions and perform the socially acceptable emotion.

When a person's emotions are appropriated and performed for commercial gain it is known as *emotional labour*. Hochschild states that emotional labour occurs in many occupations. However, she believes it to be more

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prevalent in service industries, such as the airline industry, where workers' emotions are sold as part of a commercial package⁸. Employees working in service industries must be skilled at managing their emotions and facial expressions in order to project the correct emotion to the customer (Crang, 1994; Lewis, 2005). This often means that employees have to suppress their own emotions in order to perform and display emotions that are suitable for commercial gain and in alignment with the organisations' image (McDowell and Court 1994).

Surface acting allows the employee to make up an outward gesture (Hochschild, 1983), to perform emotions that are not actually felt. In contrast, deep acting means that the employee can suppress or become estranged from their true feelings and *actually feel the emotions* that the employer wants them to display. *"One finds that the performer can be fully taken in by his own act, he can sincerely be convinced that the impression of reality which he stages is the real reality"* (Goffman 1990, p.28).

In the NHS, positively managed emotions *could* lead to better patient care, greater patient satisfaction and a relaxed and professional organisational climate (Amendoldair 2003; Bolton 2003). Lewis (2005) highlights how nurses in a special care baby unit appropriately managed their emotions to create a professional organisational climate, in which to offer quality patient care to special needs babies and emotional support to their parents. Lewis suggests that a nurse's job is sometimes very stressful and emotionally destabilising, especially when a baby dies. Nurses need to be conscious of their own emotions and regulate them to prevent causing further distress to the parents by displaying a professional demeanour (Bolton 2001).

However, managing emotions in this way, particularly if they are not felt, comes at a psychological and emotional cost and the whole process would be problematic without attending to emotional intelligence.

1.4.2 Emotional intelligence, leadership and patient care

The 'discovery' of emotional intelligence (EI), despite on-going valid critiques (see below) marked a turning point in contemporary organisational theories and approaches to leadership because of the tradition that emotions represent a threat to rationality – a view that has been widespread particularly in North America and North Western Europe (Fambrough & Hart, 2008; Western, 2008).

⁸ For a critical analysis of Hochschild's dichotomy of emotional labour and work see Bolton 2000 and Bolton and Boyd 2003.

Mayer and Salovey (1995), who conceived the idea of emotional intelligence, defined it as the ability to manage and understand one's own and other people's emotions in a consistent way so as to reflectively promote emotional and intellectual growth. Goleman (1996; 1998) who popularised the concept, identified emotional intelligence as a set of competencies, redefined and restated by George (2000) as follows:

- The expression and appraisal of emotion
- Enhancing cognitive process and decision making
- Emotional knowledge
- Managing emotions

These characteristics appear to have much in common with the rhetoric of transformational qualities of leadership although in many ways EI has become a management 'tool' rather than a critical model. To this end (apparently) Goleman (Goleman, 2000; Goleman, Boyatzis, & McKee, 2001) focused on 'styles' and 'performance' which seem far away from the 'heady' descriptions below of qualities of emotional intelligent leadership, which refer to feelings, empathy and creativity.

The expression and appraisal of emotion

An emotionally intelligent person will be able to understand their own and others' feelings and able to empathise, which may enable them to be manipulative for better or for worse.

Enhancing cognitive processes and decision making

Having emotional intelligence allows a person to use emotion to be creative, solve problems, make decisions and flexible plans for themselves and on the behalf of a group. An emotionally intelligent leader will be able to judge their mood and make decisions accordingly. If the person is in a negative mood this may mean choosing to wait until such negative episodes have past in order to make a comprehensive decision.

Emotional Knowledge

Emotionally intelligent people understand how other people may be affected by their negative moods and therefore may take care not to spread bad feeling around the group.

Managing Emotions

Many leaders are able to manage their followers' emotions as well as their own, but as indicated below, developing the qualities required to manage emotions effectively is highly complex and more about processes than style or performance (Fambrough & Hart, 2008; Hughes, 2005). As Fambrough and Hart argue 'emotional intelligence' has passed into common use among organisational leaders with little recognition of the way it has been identified

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as problematic. *What has been so attractive about EI to leaders in health care organisations?*

The idea of emotional intelligence captured the imagination of some training NHS staff as a means to improve staff relationships and enable clinicians to empathise with their patients (Allan & Smith, 2005; Cummings et al., 2005a; McQueen, 2004; Amendolair 2003, Luker et al 2002). McQueen (2004) reflecting on the 1960's when health care workers were encouraged to hide their emotions from their patients, for the sake of maintaining a professional role, suggests that in recent decades this view of nursing has changed and health care workers frequently display emotions to illustrate their commitment to patient care (Williams 2000). McQueen suggests that emotionally intelligent nurses are important for building strong patient-nurse relationships (Conger and Kanungo 1987 and (Lewis, 2005). Nurses with high Emotional Intelligence are able to build rapport quickly with their patients through communication and interactive skills (Schutte et al 2001).

McQueen (2004) also states that "*emotional labour calls upon and engages*" emotional intelligence (2004, p. 103). In order for patients to feel cared for nurses have to constantly *perform* positive emotions and behaviours such as warmth, friendliness and consideration. However, when confronted with a 'difficult' patient nurses may experience negative emotions such as frustration, irritation or anger. The nurses must be emotionally intelligent enough to identify their emotions and then perform emotional labour to submerge the negative emotions in favour of more positive emotions (Bolton 2003).

While EI *per se* needs to be understood more critically (Fambrough & Hart, 2008), the introduction of emotional management and engagement by leaders (and others) in health care organisations needs further scrutiny (see below); despite the best efforts of some management gurus emotion is a fact of personal, interpersonal and organisational life particularly when considering what it means to deliver patient care.

1.4.3 Beyond emotional intelligence

Interest in EI has continued to grow among management and organisational academics with a focus on how to measure it – the conclusions generally indicating the need for caution in measures to predict or to establish baselines for its development among managers (Conte, 2005). The conflation of managerial skills as listed by Mintzberg (Mintzberg, 1973) cited in Riggio and Reichard, (2008) which included the ability to 'deal' with subordinates, 'empathize' with top-level leaders and establish and maintain social networks, alongside managing emotions as a leader, have come to be known as 'people skills'. These are clearly represented in the NHS leadership qualities framework and vital for managing in any organisation (see Figure 1).

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1.4.3.1 Social intelligence (SI) and leadership

In 2006, taking account of advances in neurological psychology, Goleman (Goleman, 2006) proposed that because humans are *designed* for social connection, rapport and supportive emotional interactions enhance performance of managers and leaders. He listed these qualities under the umbrella of 'social intelligence' and identified four dimensions:

- *Synchronization* – whereby matching moods lead to a sense of rapport
- *Attunement* – listening fully
- *Social cognition* – understanding how people interact
- *Social facility* – finding it easy to interact with others

While some people have little difficulty meeting these criteria and mastering their social intelligence, others (such as Narcissists, Machiavellian and Psychopathic types), Goleman argues, do not have the capacity for social intelligence, and thus he proposes a means of *selecting* effective leaders by testing these qualities. This model albeit individualistic has something to offer through extending the theoretical underpinnings of 'people skills' and emphasising the importance of taking followers and colleagues seriously in decision-making.

Following EI and SI in bringing management/organisational theories together with developments in psychology, particularly cognitive neuroscience and evolutionary psychology, is the reconsideration of the role of intuition in understanding leadership and organisational behaviours (Sadler-Smith, 2008). Sadler-Smith brings the idea of the 'gut feeling' into the foreground to explore the influence of this sense upon decision-making particularly under pressure (e.g. many emergency clinical decisions rely on the clinician's instinct of whether the patient should be operated on, admitted to hospital, whether to call for support).

It seems that while there is a continuing trend towards an evidence-based understanding of leadership, success there is also an emergence of features of human life that are difficult to explain and measure, although all the proponents cited above stick to the view that these characteristics are scientifically explicable and measureable despite challenges from both positivist and critical social constructionist positions (Ashforth & Humphrey, 1995; Conte, 2005).

1.4.3.2 Affective Events Theory (AET)

AET predicts that specific features of work (e.g. autonomy) have an impact on the arousal of emotions and moods at work that, in turn, co-determine job satisfaction of employees. AET further proposes that job satisfaction is

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an evaluative judgement that mainly explains cognitive-based behaviour, whereas emotions and moods better predict affective-based behaviour. The results support these assumptions (Jürgen, van Rolf, Fisher et al., 2006). Ashkanasy et al (2002) suggested that AET has two important messages for leaders in an organisation.

- Followers' emotions are heavily influenced by their leaders' emotions and therefore leaders must minimise the 'hassles' that they place on their followers in order to increase job satisfaction and performance. Short-term negativity can be tolerated without much impact on the team or organisation.
- However, if negative events persist it will affect followers' moods leading to negative emotions, poor performance, reduced job satisfaction and in the case of the NHS, (possibly) to poor quality patient care. It is therefore suggested that leaders need to give followers positive feedback regularly to "*ameliorate the daily hassles experienced by employees*" procuring positive behaviours such as team spirit and self-worth (Dasborough 2006, p. 165 ; Weiss & Cropanzano, 1996). The connections between the moods of individuals and their performance may be understood better in terms of emotional engagement between leaders and followers on both conscious and unconscious levels (see below).

1.5 Distributed leadership

The academic study of distributed leadership, that is when at various levels leadership (or influence) behaviour, identity, role and responsibility are distributed to more than one individual or group of individuals, has been at the forefront of much social scientific leadership research over the past ten years (Buchanan, Addicott, Fitzgerald, Ferlie, & Baeza, 2007; Day, Gronn, & Salas, 2004; Gronn, 2002; Mehra, Smith, Dixon, & Robertson, 2006a). The implication of this interest in distributed leadership is, that organisations have changed and previous models - including the charismatic, 'hero' leader and the 'command and control' organisational structures - are dysfunctional in a context where organisational change is rapid and diversification of strategic leadership and management essential (Butterfield, Edwards, & Woodall, 2005; Dent, 2005; Goodwin, 2000). In a competitive, diverse and divergent environment leadership needs to be distributed, in order to enhance democratic governance, thus enhancing legitimacy and increasing survival chances (Currie et al., 2009).

Distributed leadership also implies that organisations where it is practiced have (relatively) flat hierarchies with diverse service needs and expertise across all sectors of the organisation (Huffington, James, & Armstrong, 2007). This model applies to hospitals and primary care settings, where

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distinct professional groups each have their own standards of excellence, while at the same time sharing goals of competence and quality related to the service they provide to patients and how they interrelate to other organisations.

With this shift in focus of many leadership practices and leadership studies the definition of such leadership has been proposed as:

".. a status ascribed to one individual, an aggregate of separate individuals, sets of small numbers of individuals acting in concert or larger plural-member organisational units" (Gronn, 2002, p. 428).

Gronn suggests also that when leadership is distributed it may be that the duration of that influence is limited, perhaps (structurally) to a single project and therefore (psychologically) distributed leadership might mean having to 'give up' leadership as well as take it up (Huffington et al., 2007). Furthermore, according to Gronn (2002) the most common understanding of distributed leadership, witnessed by the growing number of references to it in the research and policy literature, is that it applies to numerous people across an organisation taking some degree of a leadership role or responsibility.

More importantly, Gronn identified distributed leadership as *concerted action* meaning that there are many roles comprising a 'leadership complex' with at least three potential forms:

- *collaborative modes of engagement* which arise spontaneously in the workplace. This suggests that leadership practice is 'stretched over' the context of the organisation and not a function of those in managerial roles such as matron or clinical director. However, if the matron, clinical director and other colleagues who share ideas for change or particular activities they *may "pool their expertise and regularise their conduct to solve a problem after which they may disband"* (Gronn, 2002, p. 430).
- the *intuitive understanding* that develops as part of a close working relationship among colleagues. These relationships tend to happen over time when organisation members come to rely on each other and develop a close working relationship, to solve problems or bring about change and others might be involved in a 'framework of understanding'.
- The variety of *structural relations* and institutionalized arrangements which constitute attempts to regularize distributed action. Thus, for example, if there were dissatisfaction with existing arrangements for particular practices, a team of 'equals'

might emerge to find ways to improve or change the problematic practices.

All of these are apparent particularly, but not exclusively, in Trust Three (the FT) as exemplified in Chapters Four and Nine in particular.

Gronn argues the importance of examination of these different forms of concerted action to understand where influence (and thus leadership and power) might lie in any organisational context. Emotionally, however, these different models of distributed leadership suggest the impact of these structures and practices at a deeper level (Gabriel, 2004) particularly around authority (Halton, 2007; Hirschhorn, 1997) competition (Morgan, 2006) rivalry and envy (James & Arriba, 2005; Stein, 2005)

1.6 Organisational Culture, Climate and Contexts

As introduced above, post-industrial (or even 'post-modern') organisations (Burrell, 1988; Fineman, Sims, & Gabriel, 2005) and networked (Balkundi & Kilduff, 2006; Goodwin, 2000) organisations are changing rapidly and the NHS is clearly among these. Changes in the NHS take place at a number of levels, emerging from the direct policy dictates from central government to become local initiatives. Moreover, the NHS has become increasingly team (and indeed multi-disciplinary team) based over the past two or three decades so that knowledge, influence and leadership for transformation and change are not only moving from a top-down to bottom-up model, but as indicated, to a distributed model which involves lateral influence (Begun et al., 2006; Day et al., 2006; Ferlie & Shortell, 2001).

The type of leadership that is supported and promoted in any organisation and the related concept of the organisational structure depends on and impacts upon organisational climate and culture.

Although research undertaken on organisational *climate* and organisational *culture* comes from different epistemological traditions, since around 1990 the literature and concepts referring to both have been overlapping and/or complementary (Schneider, 1990; Schneider, 2000) and increasingly the terms are used interchangeably (Ashkanasy et al. 2000).

It is, however, generally accepted that 'climate' is a logical extension of what was originally conceptualised as 'psychological' climate, that is, shared psychological meanings in an organisation; so that *organisational* climate is an aggregation of those individual perceptions of a work-place context (James, Choi et al. 2008).

Organisational culture on the other hand has its origins in anthropology and human relations (see Davies, Nutley and Mannion, 2000; Scott, Mannion et

al. 2003). Organisational psychologist Edgar Schein's (1985/2004) ideas about organisational *culture* as a pattern of *shared basic assumptions that have worked well enough and adapt to the external environment and serve internal integration*⁹, is one of the most frequently quoted definitions. Schein takes a systems theory approach to understanding organisations and his work has been built upon by himself and others to develop a variety of typologies which underpin measures of both organisational culture and climate (see Albino-Metcalf, Alban-Metcalf et al. 2008 for a comprehensive overview of this literature).

Organisational climate, with its origins in traditional psychology is *typically* "... the only domain of organisational research that simultaneously examines perceptions of jobs, groups, leaders, and organisational attributes and thus has the unique capacity of being able to decipher common denominators and latent relationships that are not available to those who study only specific domains such as perceived equity" (James et al., 2008, p.27). We therefore made a decision to use a measure of *climate* as a backdrop to this mostly qualitative study, in order to 'triangulate' with our findings on leadership and patient care.

However, we found a competing strand of interest in the measurement of organisational *culture* (e.g. Davies, Nutley and Mannion, 2000; Scott, Mannion, Davies and Marshall, 2003) which more frequently seems to attend to health care settings than studies of climate albeit with some notable exceptions (Dawson, Gonzalez-Roma, Davis and West, 2008).

1.6.1 Emotion and the unconscious in organisations

Organisational climate and/or culture cannot be discussed without acknowledging that organisations are places where both the intellect and emotion are called into play in order to achieve organisational goals and as we have made clear, emotions are intrinsic to service delivery and leader-follower engagement in the NHS. Emotional engagement, while available to human consciousness, also takes place at an unconscious level (Gabriel, 2004; Hugh, 1986; Lyons-Ruth, 1999; Morgan, 2006; Willmott, 1986), and anxiety or stress is particularly salient when having to care for and make potentially life-saving decisions for patients (James & Huffington, 2004; Menzies¹⁰¹¹, 1970).

⁹ A paraphrase.

The ideas that characterise transformational leadership models, such as 'charisma', 'influence', 'inspiration' 'thoughtfulness' and 'consideration', have intellectual roots beyond contemporary management theory and training. They are more closely related to group and organisational theories with late 19th and early 20th century origins (De Board, 1978; Gabriel, 2004) from which much contemporary organisational theory has emerged.

The first significant attempt to analyse group behaviour made at the start of the 20th Century by Le Bon (1917/1920) whose book *The Crowd* illustrated his observation that individuals in a large group can demonstrate a 'collective mind' which emerges when people are bound together in some way. McDougall's book *The Group Mind* (1922/2009) and Sigmund Freud's *Group Psychology and the Analysis of the Ego* (1921/1922) also focused on what would subsequently come to be recognised as unconscious group processes. Freud developed Le Bon's and McDougall's ideas in the context of psychodynamic theory, arguing that the binding force of the group derives from the *emotional* ties of the members, which are expressions of their libido or drive.

Studies of (and human 'experiments' about) group psychology, taking some of this perspective on board, flourished after the Second World War conducted and further developed by psychiatrists in the newly formed NHS. In Britain the work of Wilfred Bion, Tom Main, Maxwell Jones and others led to innovations in both group psychotherapy and the study of organisations. Bion's work on group relations and dynamics which contributed to the development of the Group Relations Training Programme (GRTP) at the Tavistock Institute in 1957 evolved into the Leicester Conferences with other organisations using this model across the world (Miller, 1993). However contemporary knowledge and understanding continues to reflect back upon this early work.

What was learnt during this period about group dynamics and group relations represents an important dimension in the understanding of contemporary organisations and the relationship between leaders and followers. We develop this further in Chapter Seven in particular. It is important to note how the intellectual journey from work on emotional labour to social intelligence and intuition has so far largely neglected to explore the extent to which unconscious processes remain part of the emotional context of human social interaction (Allan and Smith, 2005, p. 21).

¹¹ Isabel Menzies is sometimes referred to as Menzies-Lyth. Her work has been reprinted several times with each name used.

In a hospital environment it is inevitable that negative events such as death occur (see Lewis for discussion on the impact of death on nurses in a special care baby unit taking an 'emotional labour' approach). When death does occur nurses may display emotions (consciously and unconsciously) such as anxiety and fear (Allan & Smith, 2005; Obholzer & Roberts, 1994; Allan 2001; Smith et al 2003). Obholzer asserts that "[he] believes that many of the organisations' difficulties that occur in hospital settings arise from a neglect of the unconscious psychological impact of death and near-death on patients and staff" (1994, p.171). He explains that hospitals are sites where anxieties about social taboos such as death are *contained*, that is that staff and the organisation overall takes away the anxiety and the responsibility for care from the relatives. Patients and staff are socialised to believe that hospitals are institutions where illness is treated and that medical knowledge and practice is infallible. This is illustrated by patients who contend that doctors possess God-like qualities and have the ability to heal all ailments. When death does occur, medical staff and the patient's relatives may feel *duped* by the institution they believed would save their loved one.

At the turn of the 19th to the 20th Centuries psychoanalytic ideas were seen to have something new and important to say, not only about the psychology of the individual and the role of the individual unconscious, but about *unconscious processes when people converge in groups and crowds* as shown above. From psychoanalytic theory we take up ideas again today specifically about the relationships which exist between followers and leaders, made explicit in the paradigm shift from transactional to transformational leadership. Working together and accepting or resisting influence comes not only with an observable set of behaviours and measurable emotions, but with unconscious and 'secret' ones including dependency, envy, power, anger, authority and emotional contagion, which may be either conscious or unconscious but have important consequences for behaviours (Burke et al., 2006; Simpson & French, 2005; Stein, 2005; Whitely, 1997). In Chapter Seven for example we see examples of where two senior managers find themselves unable to influence despite their senior roles, legitimacy and operational power. As Gabriel (2004) has argued "*emotions are no simple side-effects of mental life*" as "*emotion lies at the heart of human motivation*" (p.215).

One key feature of caring for sick patients, managing change and the social context of the NHS Trust then, is the ways in which clinicians and managers manage their anxiety which is fundamental to working in any health care setting. In the section that follows below, we demonstrate how psychoanalytic thinking explains how individual psychology and unconscious defence mechanisms link to the ways in which human beings work in groups and organisations.

In Chapter Nine we attend in more detail to the anxieties involved in obstetrics and more generally on the emotions involved in care of the elderly. In anticipation of these we present the theoretical material in some detail immediately below in this chapter.

1.6.2 Clinicians' anxiety and patient care

To conceptualize anxiety we draw on object relations theory, the branch of psychoanalysis associated with Melanie Klein (1959) and, in particular, the work of scholars who applied object relations to an understanding of groups (Bion, 1961) and organisations (Jaques, 1952; Menzies, 1970; Klein, 1987; 1983) hypothesising that an infant responds from the earliest time to the withdrawal of the maternal breast by experiencing a powerful anxiety of a 'persecutory nature'. Being unable to grasp the separation from the breast intellectually, the infant, unconsciously, feels as if every discomfort were inflicted by hostile forces. A fundamental *splitting* takes place, whereby an object is experienced as two separate objects, one entirely good and one totally bad. Thus there is a good breast (which is always present and nourishing) and a bad breast (withdrawing and denying), a good mother and a bad mother.

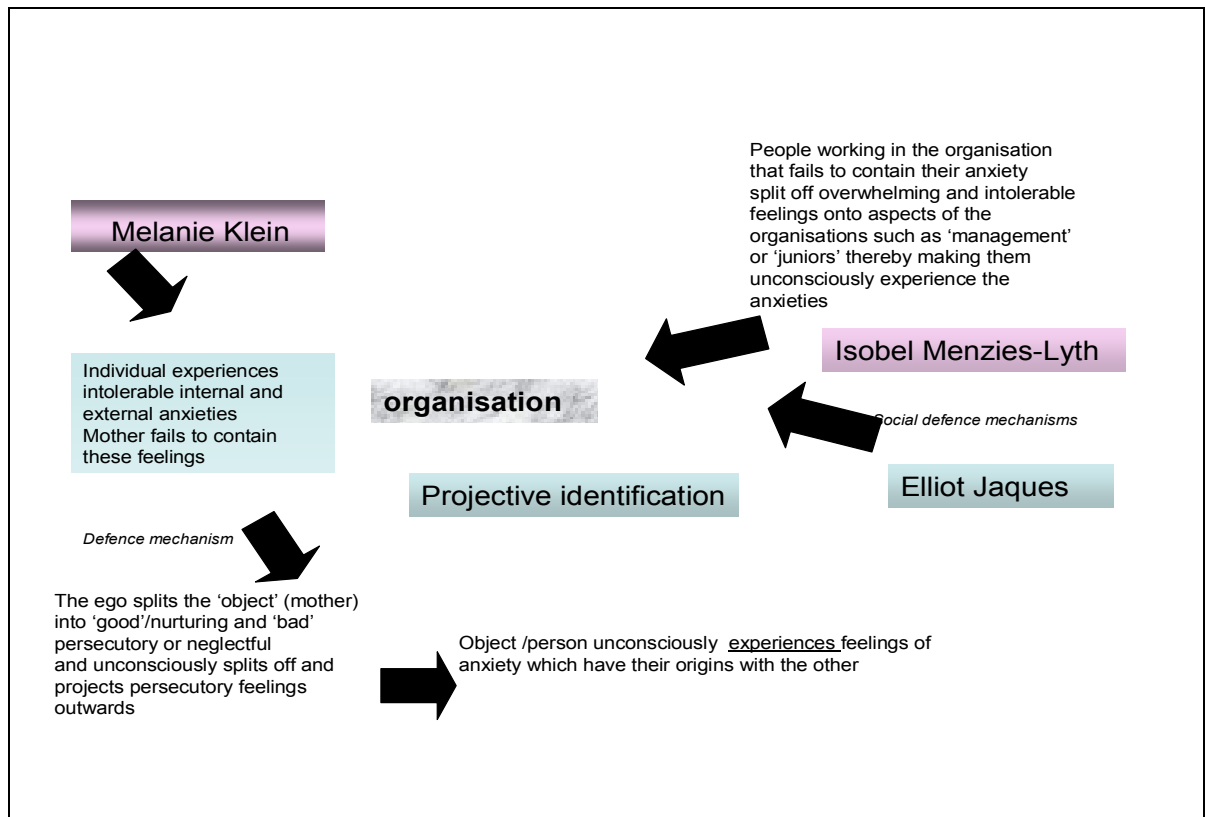
This is a pattern repeated in clinical settings, where patients routinely refer to a 'good nurse' and a 'bad nurse' and, almost identically, clinical staff referred to some patients as 'a good patient' and to others as 'a bad patient' (see Chapter Nine for an example of this). Splitting according to Klein extends in the child's own self – those aspects of him/herself that she cannot bear are projected outwards ("It is not I who is angry/fearful/envious; it is you"). Again this is a phenomenon observed many times in clinical settings. Frustration, discomfort and pain are experienced as persecution from hostile forces and their concomitants (e.g. hate) become destructive impulses which *are still operative in later life*, especially in times of stress and crisis.

Splitting and projection then are seen as fundamental *defences against primitive anxieties* by the object-relations school of psychoanalysis. Within this tradition, objects are not external entities but are shaped by phantasies¹² and feelings, they are *introjected* and projected, they split into good and bad and they constantly define and re-define the ego (or self). Object relations theory has found numerous important applications in the theory of organisations, primarily through the works of Jaques (1952) and Menzies Lyth (1960; 1970) in the UK, and more recently, Hirschhorn (1988), Gould (1993), Diamond (1993), Schwarz, (1990), Schwarz and Clore (2003) among others. Notable among these applications is the

¹² 'Phantasies' spelt in this way refers to those in unconscious experience.

treatment of *the whole organisation as an object which is liable to become incorporated in psychic reality* and towards which the individual may develop relations akin to early relations with significant objects from her environment and hold the 'organisation in the mind' (Armstrong, 2005) which we will discuss in more detail in the context of evidence from the study in Chapter Six.

Figure 2. Social Defences against Anxiety in Organisations



Menzies-Lyth, whose 1960 classic study of nursing staff occupies a privileged position in this literature, was driven by her initial observation that nursing work is highly anxiety-producing. She argued that nurses confront many different emotions from patients and their relatives - gratitude for the care they offer, admiration, envy for their skills and resentment stemming from forced dependence. Such projections create strong feelings in the nurses themselves:

The work situation arouses very strong and mixed feelings in the nurse: pity, compassion and love; guilt and anxiety; hatred and resentment of patients who arouse these strong feelings; envy of the care given to the patient. (Menzies-Lyth, 1988 , p. 46)

Faced with such an emotional cauldron, many nurses re-experience infantile persecutory anxieties, from which they seek to defend themselves, through

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the familiar mechanisms of projection, splitting and denial. Menzies-Lyth's important contribution was to establish how an organisation's own bureaucratic features, its rules and procedures, rotas, task-lists, paperwork, hierarchies and so on, in short '*the system*' acts as a support for the defensive techniques. By allowing for 'ritual task performance', by depersonalizing relations with the patients, by using organisational hierarchies, nurses contained their anxiety. Yet, in Menzies-Lyth's view, such organisational defences against anxiety were ultimately unsuccessful:

The system made little provision for confronting anxiety and working it through, the only way in which a real increase in the capacity to cope with it and personal maturation would take place. As a social defence system, it was ineffectual in containing anxiety. (Menzies-Lyth, 1991, p. 363)

The system's inadequacy in Menzies-Lyth's study is evidenced by its failure to train and retain nurses, the chronically low morale, high levels of stress and burn-out and absence of work satisfaction. By contrast, institutional health is testified not only by performance and output indicators, but also by morale indicators, and individual feelings of growth and maturation. Social defences against anxiety, then, are self-defeating. Instead of *containing* anxiety, they exacerbate it, just as neurotic symptoms far exacerbate the patient's malaise instead of containing it. Since Menzies-Lyth's pioneering work, some attention has been paid to how to support nurses and enable them to contain their emotions, without resorting to depersonalizing social defences. Yet, there is ample evidence that many nurses today continue to struggle with modest support against powerful anxieties (Theodosius, 2006; 2008). It is striking that no single study has sought to examine whether doctors face similar types of anxieties as nurses, whether they resort to similar psychological defences and the extent to which these defences function effectively across different individuals. In Chapter Nine we see evidence that doctors too appear to react similarly when faced with intolerable anxieties.

1.7 Developing our approach to leadership and the NHS

Studies of leadership and organisations such as the NHS clarify that diverse disciplinary perspectives have come together and separated more than once over the past century. The relationship between organisational and social context over that time has impacted on both practices of leadership and empirical and theoretical changes. In the 21st century the rules of scientific management or leader as therapist no-longer apply, and the rapid changes in organisations such as the NHS brought about by economic and technological imperatives, have left many who engage in leadership

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discourses, for practical and academic purposes, moving between the transformational and the post-heroic positions.

We now consider theoretical perspectives, ideas and practices that can potentially be brought together to good effect in this study for the benefit of patients and those who work for their good within the NHS, focusing on some of the recent debates which explore the context of leadership and the place of distributed leadership as they apply to NHS contexts.

1.7.1 The base-line:

- It is now widely acknowledged that organisations, their leaders and followers come together in a highly *emotional context*. How can those who lead and work in such organisations take account of the role of emotion while not being 'emotional' (i.e. making unfair and irrational decisions)? Understanding this is vital for enabling management and leadership particularly in a complex institution which has patient health, safety and care at its cutting edge (Morgan, 2006) .
- The NHS, individual Trusts and Units within these Trusts are constantly engaging staff in *change* (which may be evolutionary and/or politically driven) and which may be motivational and/or stressful or resisted (McNulty & Ferlie, 2002). This further demands emotional and social intelligence and engagement from leaders and followers (Bovey & Hede, 2001).
- The primary *tasks* and related *roles* might conflict at various points as these changes impact emotionally and intellectually on staff performance and service delivery (Zoller & Fairhurst, 2007).
- Organisations have to have leaders but leadership is not necessarily always the province of a small group of individuals but depends on the structure and demands placed on the organisations and the tasks required at any one time (Currie et al., 2009; Day et al., 2006; Harvey, 1989; Michie & West, 2004).
- An emotional context requires attention to both conscious and *unconscious* dimensions of human interaction and power relationships which may come into play in organisations which comprise multiple professional disciplines, different grades of role and people from diverse cultures, sexualities and gender (Ford, 2006; Gabriel, 2004). Acknowledgement of the importance of anxiety, envy, competition, anger and the emotional ties between people needs to be taken into account (see Figure 3 below).

Two models of leadership are therefore examined in this study (see Figure 3 below):

- First, *inspirational and transformative (or engaging) leadership* which has attracted much recent attention in that its absence was seen as a critical factor behind the failure of many organisational innovations. In this approach, leadership hinges on leaders' ability to communicate effectively, relate emotionally with their followers and develop a vision that is both attractive and achievable. The role of transformational leadership then is to lead an organisation towards change and thus some elements of transformational leadership are essential for understanding the practices and needs of the NHS (Alban-Metcalf & Alimo-Metcalf, 2009).
- The second relevant dimension is *distributed leadership* (sometimes called *dispersed, distributive, collective, or supportive 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). A *distributed leadership* approach is consistent with Bailey and Burr's (2005) research on successful NHS Trusts, which states:

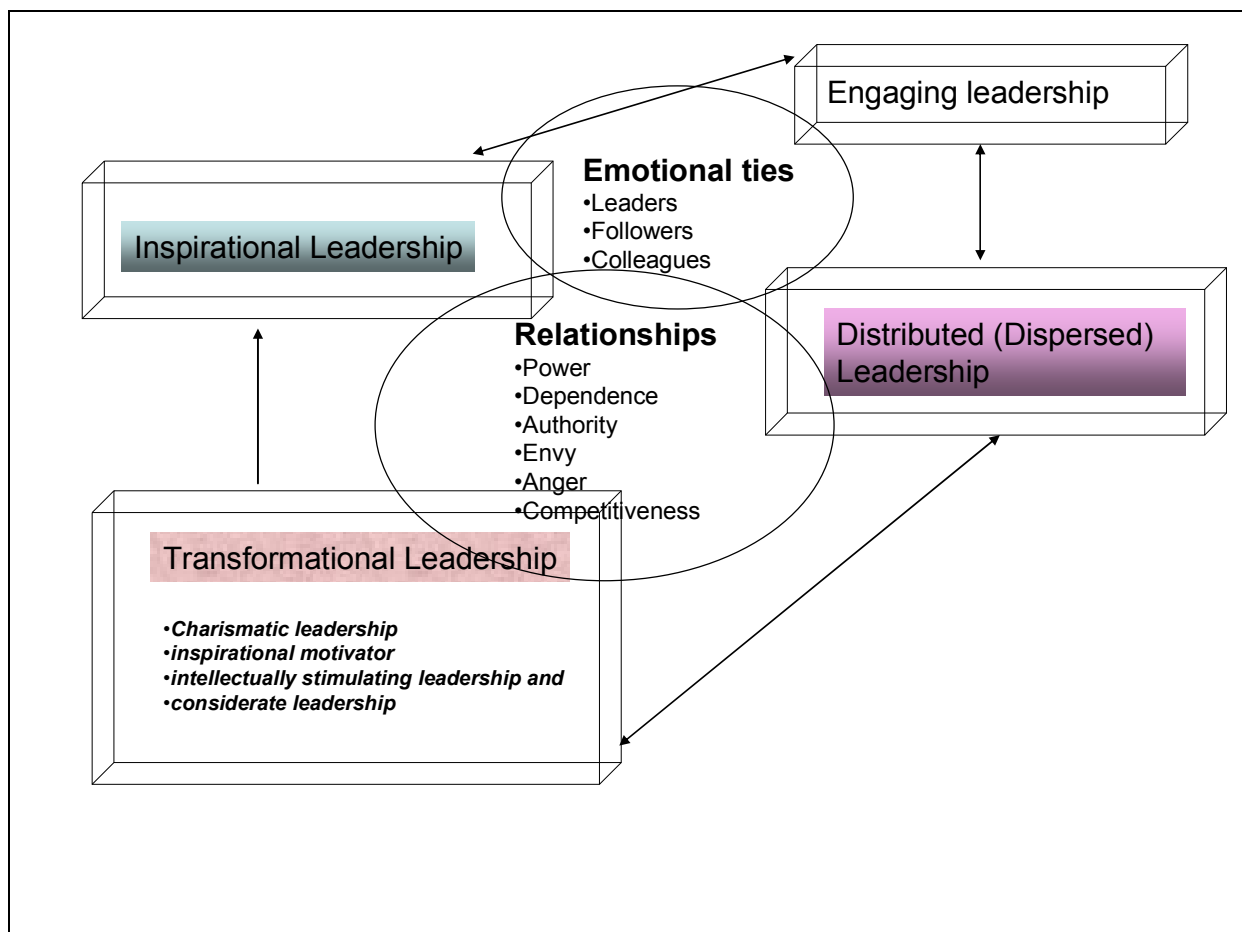
In contrast to the individual, heroic leader concept, leadership is seen in terms of the influence processes that contribute to the collective and individual capacity to work effectively. This idea of collective and distributed leadership is closely associated with the emergence and special requirements of 'new' organisational forms generally and the NHS in particular it is consistent with the agenda for devolved decision – making, empowerment of the frontline, de-centralisation, inclusion and such initiatives as 'Leadership at the Point of Care'.

Thus, distributed leadership is seen by Bailey and Burr (2005, p. 14) as directly linked to patient care.

A combination of these two models might now be seen as 'engaging' leadership as described by Alimo-Metcalf, Alban-Metcalf et al. (2007) and this combination will be explored further in our analysis of the (qualitative) data in particular.

Furthermore the model of the post-industrial/postmodern and or networked organisation will be 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).

Figure 3. Leadership Styles, Followership and Emotion



1.8 Conclusion

In an organisation like the NHS there are opportunities for leadership at all levels, as well as opportunities for success and unforeseen consequences leading to failure. Leaders in the NHS are involved *transformationally* in responding to policy initiatives and government demands, but the NHS is also an organisation that relies on the knowledge, skills and abilities of all its people – leaders and followers.

It would seem that *transformational/engaging and distributed leadership* are particularly useful conceptual resources to deploy in the context of the National Health Service, where a workforce of different ethnic, cultural and

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class backgrounds caters to the needs of a similarly diverse patient population.

Following Alimo-Metcalfe, Alban-Metcalfe et al (2007) "*an engaging 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'*" (2008, p. xi).

As part of the conceptual framework we develop, it is clear that the *emotional links* between individual staff, groups of staff and staff and patients need to be privileged as they play out at various organisational levels. Implicit therefore is that emotions above and below the surface (conscious and unconscious) are taken into account if the leader/follower and staff/patient relationships are to be understood and improved.

2 Aims and Methods

2.1 Introduction

The research questions in this study centre on identifying:

- (a) processes by which leadership is transmitted through health service organisations to effect the delivery of health services, and
- (b) how features of the organisation, the leader, and the service influence these processes.

The focus of this study was to explore the relationship(s) between (good) leadership in NHS organisations and (good) patient care. This demanded consideration not only of leadership characteristics, qualities and styles but the ways in which NHS organisational climate and culture interacted with individual practices and identities of those who worked in them and were patients. The overall plan was, thus, to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery. This research further sought to expand existing knowledge by exploring the following questions.

1. First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
2. Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

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3. Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

2.2 Aims and Objectives

We separated these overarching research questions into aims and objectives thus:

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients;
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts on service delivery;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted through health care organisations to affect service delivery, posits *organisational climate* as one feature of the organisation that could positively or negatively affect the quality and delivery of health services.
- To learn how different stakeholders (specifically, patients, nurses and professions allied with medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care.
- To identify how the need for change in service delivery is identified and what drives the need for change.

2.3 Methods

This multi-method study therefore uses a mixture of qualitative and quantitative methods to enable and support an innovatory approach to examining the psycho-

social and psychodynamic factors intrinsic to the meanings and processes of leadership, organisation and patient care.

Qualitative research methods now have a strong and long-standing profile in social science, particularly sociology and anthropology. But over recent years they have become increasingly relevant in social psychological research.

Furthermore nursing research (Finlay & Ballinger, 2006; Kerr, 2002) and most recently even health services research have begun to take evidence emerging from qualitative methods seriously. Perhaps this began with a series of papers in the British Medical Journal in 1995. Pope and Mays for example leading on this series aptly titled their paper *Reaching the Parts other Methods Cannot Reach* (Pope & Mays, 1995). Noteworthy from this point onwards is that there is no 'one' qualitative method of either data collection or analysis and we draw on several traditions and styles in this study which are outlined below.

Unlike health services research *per se*, but akin to critical social science, there is a powerful tradition in organisational research that has taken account of the diverse nature and intrinsic value of qualitative methodologies to understanding the life of organisations (see for example Cassell and Symon, 1994; Ybema et al., 2009)

What counts of course is choosing methods which meet the demands of the research hypothesis or overarching questions. We thus began from the premise that 'leadership', 'patient care' and 'organisational change' are not objective facts but social or discursive constructions. By this we mean that these concepts are constructed through discourse, i.e. a coherent system of statements which constructs an 'object' (Parker, 2002). In other words, talk about leadership is the process by which leadership is constructed (and thus recognised) as something that happens in organisations such as the NHS.

To capture these constructions we used a range of methods:

- focus groups;
- a survey-based questionnaire including a standardized measure of Organisational Climate;
- ethnographic 'shadowing';
- observations of social places, formal and informal and meetings;
- analysis of 'stories' of leadership collected through in-depth interviews.

2.4 Capturing the data

In what follows we present the outline plans for capturing, managing and analysing the data to meet our aims although as shown in Chapter Three not all of our goals were achieved.

We focused upon three NHS Trusts with at least one being a Foundation Trust specifically to explore whether any variations in the qualities of leadership, organisation and patient care could be distinguished. An

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investigation of three Trusts was considered to be manageable within the time frame and other resources available for the project.

Within each Trust we chose two distinct 'units' to study. We conjectured these would probably to be defined by clinical speciality or site (bearing in mind that many Trusts are organised across more than one hospital/physical space).

We conducted focus groups, an organisational climate survey, story-telling interviews and ethnographic work (observations and shadowing) across these six units with staff and patients.

We employed two researchers¹³ to carry out the majority of this work, but some members of the investigatory team also took an active part in the process.

The qualitative data would by necessity and designed be analysed using a variety of methods:

- a. Thematic analysis (TA)
- b. Critical Discourse Analysis (CDA)
- c. Narrative analysis

Each of these approaches to data analysis, again by necessity and design, was subject to nuances of interpretation, intrinsic to their nature.

¹³ In the event three researchers were involved because of maternity leave and cover.

locality, size and community) and that the sample had to include one Foundation Trust.

- they were in easy reach of London (for practical purposes as the study team were based in London and Surrey).
- we were able to gain access via personal contacts in R & D or senior management (the 'gatekeepers').

The Units

Sampling of the Units in each of the Trusts was achieved through negotiation with the gatekeepers and/ or key informants recommended by the gatekeepers with the intention that a balance might be struck between:

- the specific academic interests of the research team (for example the PI is particularly interested in Obstetrics and Gynaecology services).
- some degree of opportunity for comparison between Trusts, so that if possible some similar Units might be compared across the Trusts.
- and (possibly most influential) the concerns of the gatekeepers and other senior Trust staff.

The Sites

All three Trusts selected for an initial informal approach were on more than one site although the selection of study unit determined whether or not the data was collected on more than one site.

Individual Participants (staff)

Individual participants were to be selected on an 'informed' volunteer basis. That is that via a process of meetings with key informants and presentations to staff-groups individual staff would hear about the study and be offered the opportunity to participate. For those who were not involved in the meetings or presentations a staff e-mail list was used to communicate information about the study and request volunteers to participate in interviews and focus groups. The intention to meet the study aims was to ensure participation from a variety of staff groups and levels of seniority.

Individual Participants (patients)

Patients were to be recruited for interview either by the staff directly caring for them or by the researchers themselves once the staff of each unit had become familiar and accepted the presence of the researchers.

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Survey Respondents (staff)

The Organisational Climate Survey (OCS) was to be administered within the Units that were the focus of the study and, if possible, across other Units in the Trusts. The circulation was to be achieved either through e-mail or through internal mail depending on negotiation with the relevant gate-keepers.

Survey Respondents (patients)

Patients who might complete the patient version of the survey were to be recruited by staff and/or researchers if staff permitted the researchers 'on the ground' access.

Observations and 'Shadowing' (staff and patient-staff interactions)

These methods would require the participants to be familiar and comfortable with the presence of the researchers and familiar with the ongoing research process and also be prepared to co-operate. The rules for engagement in the activities would then be made on a strategic (i.e. the staff and / or situation that would yield the richest source of information) and a pragmatic basis (i.e. the possibility of the situation yielding important data regarding leadership, organisational culture and climate and patient care).

2.6 Ethical considerations

There are clearly considerations about confidentiality and anonymity in all data collection which involves human participants Easily identified in this study (and thus in the NRES application) is the matter of the safe keeping of the raw data including completed questionnaires, any identifying characteristics of these questionnaires, digital recordings, transcripts from focus groups and interviews and the researchers' field notes. It is important to note that this is not necessarily as simple to do as it is to describe particularly because a team of investigators, the researchers themselves and some 'casual' clerical staff ¹⁴all had different types of access to the data.

The solution was to have a shared drive set up by the computer centre at Royal Holloway, University of London (RHUL) on the main site at Egham which could only be accessed by specified investigators identified by the PI. Additionally there was an access pass-code to read the transcripts and the SPSS file.

¹⁴ The sheer volume of data made it necessary to use more than one person to input the data and transcribe the recordings. Two people other than the researchers were engaged to work on this although both were employees of RHUL who knew the importance of keeping the data safe.

Another ethical consideration specific to this project was that because the staff were discussing leadership and being asked to give examples of good and bad leadership, as well as examples of effective and poor patient care, it was inevitable that:

- they would be talking about *other* members of staff. These other staff could not be told that they had been talked about (by definition) leaving them unable to provide their version of the story or aware of the fact they had been discussed.
- the researchers would therefore be 'holding' some knowledge of others which would be 'data'. This fact drew attention to the ethical and empirical complexities of working in an organisation in which data is being collected on human interactions and relationships.

As patients' experiences and views and staff's views of patient care were also part of this investigation, similar issues applied.

Finally, frequently overlooked but nonetheless very important consideration was given to the fact that participants' time should not be wasted. We were confident in the design and our experience as investigators supporting and managing the researchers (who themselves were experienced in this kind of study) that the study was robust enough to adapt to the vagaries and quirks of 'real life' and that the outcome would be valid and add value to existing knowledge.

2.7 Methods of data collection and research instruments

As described above a mixture of qualitative and quantitative methods were used to ensure a full picture of leadership in the organisations to be studied. Collecting data in applied settings, where the participants are also engaged on a day-to-day basis is demanding work which is challenging for researchers involving persistence, social skills, the ability to develop rapport, clarity of purpose combined with flexibility, the skill of 'thinking on your feet' and making practical judgements about what is feasible at any one time. For example, if plans had been set for an interview with a staff member who was then called away for an important work matter, the researcher could arrange other potential participants or be prepared to engage in a period of systematic observation.

Immediately below we describe the methodologies we chose to employ to conduct our investigations which will be described in greater detail where appropriate in the context of specific case studies.

2.7.1 Focus groups

Focus groups, once the province of market researchers, in common with in-depth interviews, are now a popular method of collecting psycho-social data in the area of health research (Nicolson & Anderson, 2003; Nicolson et al., 2008) having gained recognition in social science overall as a robust way of eliciting “*shared and tacit beliefs, and the way these beliefs emerge in interaction with others in a local setting*” (Macnaghten and Myers, 2004, p. 65 in Seale et al) (p.8). In other words focus groups represent a means of gathering a sense of how those who work in an organisation share a sense of their ‘organisation in the mind’ (Armstrong, 2005) which may be mutually accepted, challenged or undermined by the perceptions of colleagues. Focus groups also enable the researchers to check out the quality and effectiveness of the communications themselves between members of the Unit or as Morgan (1998) suggests “*Focus groups are fundamentally a way of listening to people and learning from them* (1998, p. 9).

The process involves one or two researchers meeting with between four and eight participants who share a common situation and the guide lines for the discussion focus on key topics (see Appendices). One researcher takes notes although both are empowered to guide the discussion which is also digitally recorded. One benefit of this means of data collection is that through discussion among peers issues or perspective upon certain issues are brought into focus which might have escaped previous research authors and the researchers themselves (Morgan, 1998).

The *focus group guide* employed a similar structure to the *Interview Guide*.

2.7.2 Organisational climate

The Organisational Climate Questionnaire (OCQ) designed by Stringer (Litwin & Stringer, 1968; Stringer, 2002) also called ‘The Leadership Questionnaire’, was specifically designed to produce a scale to measure leadership in the context of climate albeit in a business rather than NHS setting. To complement the mostly qualitative methods of data gathering and analysis, we developed a questionnaire for staff and patients across the Trusts and used (a slightly adapted form of) Stringer’s measure of leadership and organisational climate, with the expectation that our results might also be linked to other studies undertaken with this measure, which had been used to examine management and leadership in organisations.

It identified six dimensions of organisational climate: *structure, standards, responsibility, recognition, support* and *commitment*, and uses eighteen leadership practices (three for each dimension) to capture how people feel about their jobs, how they are managed, and how things work in a particular organisation. Because this scale is designed to give practical

indicators on how to improve performance, many of the leadership measures are based on management practices, which are equally important to the overall success of an organisation. In general, however, each leadership practice measure is based on the premise that leaders care about arousing the motivation of members in the organisation (Stringer, 2002). The OCS was adapted from to fit a model relevant to NHS Staff working in a hospital setting and another version was adapted to be used with Patients (see Appendices).

2.7.2.1 Measurement tool: Stringer's OCS – Leadership and Organisational Climate

Stringer (2002) defines organisational climate as the "*collection and pattern of the environmental determinants of aroused motivation*" (p. 9) and he takes motivation to be central to the development of his climate questionnaire predominately based on the work of McClelland-Atkinson's framework with regards to intrinsic motivators of work related-behaviour: the need for achievement (nAch), the need for power (nPow), and the need for affiliation (nAff).

Stringer noted that specific dimensions of climate appear to have a predictable impact on motivated behaviour and can be measured and managed by those in senior positions accountable for organisational performance.

The six distinct dimensions identified and measured are:

- 'Structure'
- 'Standards'
- 'Responsibility'
- 'Recognition'
- 'Support'
- 'Commitment'

The statistical data was entered into an SPSS file to seek frequencies, correlations and to explore significance levels of differences and similarities between and within groups of respondents.

2.7.3 The survey structure and items

The survey is structured in two parts:

Part 1: measures *Organisational Climate* or how people perceive the work environment.

Part II: measures *Management Practices* or how people see their own managers behaving.

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Part 1:

This part consists of twenty-four items grouped into the six dimensions - 'structure', 'standards', 'responsibility', 'recognition', 'support' and 'commitment' - designed to measure how people feel about their work environment using a 4 point Likert scale. The directions ask the participants to describe the kind of working climate that has been created in their organisation (defining 'organisation' as the smallest work unit relevant to the participant).

Descriptions of the dimensions are as follows:

1. **'Structure'** pertains to the clarity of roles, responsibilities, accountability and expectations. According to Stringer this is more of a managerial than a leadership issue and one which is more practical than inspirational. It reflects the employees' sense of being well organised and of having a clear definition of his or her roles and responsibilities. *"structure is high when people feel that everyone's job is well defined and is low when there is confusion about who does which tasks and who has decision-making authority"* (Stringer, 2002, p.65).

The following items measure 'structure':

- The jobs in this organisation are clearly defined and logically structured.
- In this organisation, it is sometimes unclear who has the formal authority to make decisions.
- In some of the projects I've been on, I haven't been sure exactly who my boss was.
- Our productivity sometimes suffers from a lack of organisational planning.

2. **'Standards'** is about the need to achieve targets and reach goals. It is the drive to achieve and improve, it includes the 'commitment' and persistence to follow through on set targets. This dimension measures the feeling of pressure to improve performance as well as the degree of pride employees have in doing a good job. When interpreting this measure, high 'standards' indicate that people are always looking for ways to improve performance, whereas, a low score reflects lower expectations for performance.

The following items measure 'standards':

- In this organisation we set very high 'standards' for performance.
- In this organisation people don't seem to take much pride in their performance.
- Around here there is a feeling of pressure to continually improve our personal and group performance.
- Our management believes that no job is so well done that it couldn't be done better (Stringer, 2002, p.65).

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3. **'Responsibility'** is about taking ownership of the work and results which are obtained. Ideally people will be motivated to achieve results and take ownership over these. Where managers delegate and encourage responsibility, workers are more likely to feel a sense of 'responsibility'. It reflects employees' feelings of 'being their own boss' and not having to double-check decisions with others. A sense of high 'responsibility' signifies that employees feel encouraged to solve problems on their own. Low 'responsibility' indicates that risk taking and testing of new approaches tend to be discouraged (Stringer, 2002; p.66).

The following items measure 'responsibility':

- We don't rely too heavily on individual judgment in this organisation almost everything is double checked.
- Around here management resents your checking everything with them if you think you've got the right approach you just go ahead.
- You won't get ahead in the organisation unless you stick your neck out and try things on our own.
- Our philosophy emphasises that people should solve their own problems themselves.

4. **'Recognition'** relates to the relationships between one's performance and associated rewards, as well as broader sense of approval or disapproval of an individual's efforts. It indicates employees' feelings of being rewarded for a job well done. This is a measure of the emphasis placed on reward versus criticism and punishment. High 'recognition' climates are characterised by an appropriate balance of reward and criticism. Low 'recognition' means that good work is inconsistently rewarded (Stringer, 2002, p. 66).

The following items measure 'recognition':

- In this organisation the rewards and encouragements you get usually outweigh the threats and criticisms.
- There is not enough reward and 'recognition' given in this organisation for doing good work.
- We have a promotion system here that helps the best person rise to the top.
- In this organisation people are rewarded in proportion to the excellence of their job performance.

5. **'Support'** is the degree to which there is a sense of warmth and team work, within which the individual feels that they are 'backed up' by others. This will determine the amount of trust and respect amongst team members. It reflects the feelings of trust and mutual 'support' that prevails within a work group. 'Support' is high when employees feel that they are

part of a well-functioning team and when they sense that they can get help (especially from the boss) if they need it. When 'support' is low, employees feel isolated and alone. This dimension of climate has become increasingly important for today's e-business models in which resources are severely constrained and a premium is placed on teamwork (Stringer, 2002, p.66).

The following items measure 'support':

- You don't get much sympathy in this organisation if you make a mistake.
- When I am on a difficult assignment, I can usually count on getting assistance from my boss and co-workers.
- People in this organisation don't really trust each other enough.
- I feel that I am a member of a well-functioning team.

6. **'Commitment'** reflects employees' sense of pride in belonging to the organisation and their degree of 'commitment' to the organisation's goal. Strong feelings of 'commitment' are associated with high levels of personal loyalty. Lower levels of 'commitment' mean that employees feel apathetic toward the organisation and its goals (Stringer, 2002, p. 11).

The following items measure 'commitment':

- Generally, people are highly committed to the goals of this organisation.
- People here feel proud of belonging to this organisation.
- People don't really care what happens to this organisation.
- As far as I can see, there isn't much personal loyalty to the organisation.

Part II:

This part asks the participants to describe the practices of their managers. Using the same six dimensions as in Part I, participants are given eighteen statements which describe the way a manager might perform her or his duty and the respondents are asked to indicate how much he or she agrees with each of the statements. Here a 5 point Likert scale is used.

Once again the six dimensions are used to assess perceptions of managers' practices:

1. 'Structure'

- Establishing clear, specific performance goals for subordinates' job.
- Clarify who is responsible for what within the group.
- Making sure tasks and projects are clearly and thoroughly explained and understood when they are assigned.

2. 'Standards'

- Setting challenging performance goals and 'standards' for subordinates.
- Demonstrating personal 'commitment' to achieving goals.
- Giving subordinates feedback on how they are doing on their job.

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3. 'Responsibility'

- Encouraging subordinates to initiate tasks or projects they think are important.
- Expecting subordinates to find and correct their own errors rather than doing this for them.
- Encouraging innovation and calculated risk in others.

4. 'Recognition'

- Recognizing subordinates for good performance more often than criticizing them for poor performance.
- Using 'recognition', praise and similar methods to reward subordinates for excellent performance.
- Relating the total reward system to performance rather than to the other factors such as seniority or personal relationships.

5. 'Support'

- Being supportive and helpful to subordinates in their day to day activities.
- Going 'to bat' for subordinates with superiors when the manager believes their subordinates are right.
- Conducting team meetings in a way that builds trust and mutual respect.

6. 'Commitment'

- Communicating excitement and enthusiasm about the work.
- Involving people in setting goals.
- Encouraging subordinates to participate in making decisions.

Leadership question

We also asked a single question to capture directly how satisfied an employee is with the leadership they receive from their immediate supervisor. It was a simple statement: *I am satisfied with the quality of the leadership I receive from my immediate manager* which we measured using a 4 point Likert scale.

2.7.4 Ethnographic observations and 'shadowing'

Ethnographic observations and shadowing are especially useful to organisational research because they allow people to *physically* express their inner thoughts, and put ideas into *observable action*, all of which would be inaccessible through the survey or structured interview questions.

Ethnographic observation (often referred to as *participant observation*) has its roots in anthropology but has become increasingly deployed in sociology, cultural and social geographies. In the field (which in this case is a Unit in an NHS Trust) the researcher's aim is to "*understand how the cultures they are studying 'work'*" that is, to grasp "*what the world looks like*" to the

participants in the context being observed (Delamont, 2004, p. 206). In this study observation and shadowing opportunities were (mostly) formally set up and pre-arranged. However, the researchers, through taking their roles as interviewers, focus group leaders and having an every-day presence with key informants, gate-keepers and participants, were able to immerse themselves in the lives and atmosphere of each of the Trusts and Units providing evidence about the processes of leadership and patient care as well as 'climate' (Bloor, 2001; Goffman, 1961).

Shadowing involved the same conceptual framework as ethnographic observation in that the aim was to understand what the world looks like from the perspective of the staff member being shadowed as well as the worlds of the other staff and patients that they engaged with in the course of their work (Czarniawska, 2008; McDonald, 2005). It involved meeting the participant (usually) at 8 am and for one or two days accompany them including at break times until the participant went home. In Trusts where there was more than one site and/or when the nature of the day's work involved meetings outside the hospital (as in nearly every case) then the researcher spent time in a car with the participant and if agreed the conversation was digitally recorded as an *aide memoire* for the field notes. The participant was able to withdraw at any time, or for a period of time, across the shadowing period.

Thus the sense of 'what the Unit world looked like' was recorded in field notes which were then discussed with the other members of the team (who had some familiarity with the relevant part of the Unit/Trust) in a context where the researcher could be reflexive and explore the 'silent space' of the 'ethnographic self' (Coffey, 1999). The researcher's notes and expressed thoughts were then discussed with other members of the team, some of whom were familiar and others not so with the specific context (Barry, 2003). A similar approach was used to discuss the interview material because even though the interviews were digitally recorded and transcribed verbatim, this did not account for the reflexivity that took place following the interview itself and on transcribing and reading the transcript, and therefore featuring in the analysis (Nicolson, 2003).

In this context there was concern to capture the emotional content and atmosphere of the organisations. This meant that ethnographic methodologies were implemented to analyse the emotionality of the interactions (verbal and non-verbal) between patient and practitioner. It was through these observations that the use and importance of the researcher's *body as a 'research instrument'* became palpable, especially for understanding the emotions emerging out of the interactions between patient, relatives and practitioner(s). This process has been proposed as the antithesis of taking for granted that emotion should be removed from

ethnographic investigation and that in fact the research process is highly emotive and far from an emotionally barren terrain (Bondi, Davidson, & Smith, 2005).

As the researcher collects data they move through a continuum of emotions from the euphoric highs of excitement at starting a new research project, sense of achievement and pride as they begin to make contacts and collect initial data, perhaps trepidation, fear and nervousness as they meet new participants or research settings through to the depths of despair, isolation and frustration as the research process (inevitably at times) becomes chaotic and messy. However, these emotions are often neglected, regarded as unimportant to the overall research process and abandoned in the writing up phase. We use these frequently neglected emotions and feelings as part of, and beneficial to, the project as representing a rich source of data.

By being more attentive to their emotions and bodily senses ethnographers also become more sensitive to their environment and their participants thus gaining a greater awareness of what they are observing. In recalling a sound, smell or feeling the ethnographer is able to open up their mind's eye to re-visualise the interaction with greater clarity and accuracy making it more likely that an accurate representation of what was observed will be recorded.

2.7.5 In-depth semi-structured and 'story-telling' interviews

In-depth semi-structured Interviews: Over the past fifteen years this method of qualitative data collection has become increasingly common in health services and health research in general (Pope and Mays, 1995; Kvale, 1996; Grbich, 1999) consistently a method of choice for identifying perceptions, meanings and experiences of dynamic and complex concepts such as 'leadership' and 'patient care' (Rubin and Rubin, 1995; Denzin and Lincoln, 1998; Rapley, in Seale et al, 2004).

The use of such interviews has led to increased levels of sophistication in the interpretation of qualitative in-depth data in the context of historical, cultural and political frameworks demonstrating that in-depth semi-structured interviews (and more generally qualitative research) have capability beyond simply adding rich description to statistical evidence (see Denzin and Lincoln, 2002; Willig, 2008).

Story-Telling: One of the explicit aims of the interviews was to collect a number of stories to reflect critical experiences in the organisations' past and present life. In the field of organisational studies, there is now an extensive literature of how to use stories told by organisational participants

as windows into organisational culture, politics and numerous other phenomena (Gabriel, 2000; Hannabuss, 2000).

The inclusion of story-telling in the context of the in-depth interview increases the scope for making sense of data in ways that delve deeply into the respondents' perceptions and meaning of the *processes* of leadership and patient care. Story-telling also increases the validity of the interview through the use of reflexivity, and positioning the events and 'atmosphere' of the stories in the context of the organisational analysis.

Of particular relevance to this study, stories can instigate insights into the processes of positive or negative social and organisational change and leadership which involves the management of meaning and emotions, both of which rely heavily upon the use of stories, allegories, metaphors, labels and other narrative devices.

The study of *organisational stories* is particularly relevant in health care settings that are liable to unleash strong emotions and fantasies. Hence, hospitals are rich grounds for collecting stories, as numerous researchers have recognized (Kleinman, 1988; Frank, 1998; Greenhalgh, 2002; Hurwitz, 2006; Mattingly, 1998). Storytelling permeates everyday clinical practices and "*medical professionals find ways to 'routinize' their practice and thus, metaphorically at least, bring the unruly and frightening world of illness under control*" (Mattingly 1998, p. 277).

The *interview schedule* (see Appendices) therefore was designed to elicit information on the participant's view of 'leadership' and 'patient care' through 'stories' to provide examples in their opinion that constituted good and poor leadership and good and poor patient care through 'critical incidents'.

As the interviews were semi-structured and in-depth they relied to a great extent on the interviewing skills of the researchers and their ability to establish rapport and consequent willingness of the participants to engage in the process. The early pilot interviews therefore were unlikely to influence the details of the interview schedule itself although the early interviews were planned to enable the research team to identify the best *strategies* to engage participants in the task.

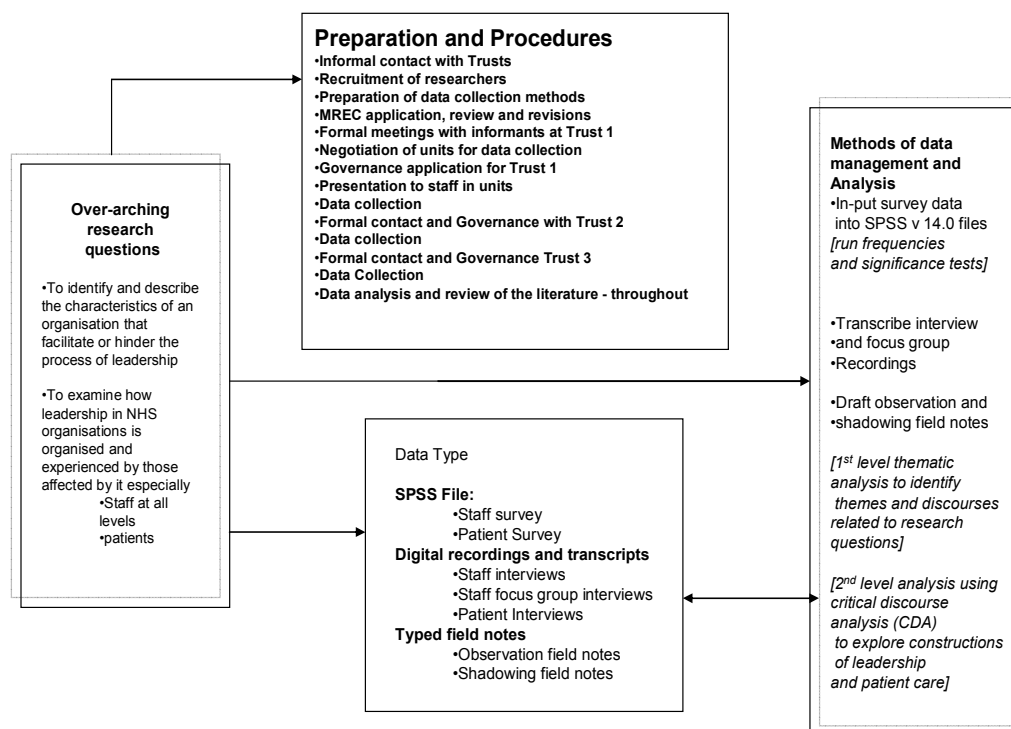
2.8 Data Management

The interviews and focus groups were digitally recorded and transcribed verbatim. The transcripts stored on a password protected Word file (initially on the researchers' PCs but subsequently on the secure shared drive described above) and sound recordings stored on audio files (password protected on the PC of the PI and not on the shared drive).

The OCS data was entered and stored on an SPSS file, password protected and placed on the secure shared drive.

Fieldwork notes from observations and shadowing were similarly password protected stored on the shared drive once they had been prepared by the individual researchers.

Figure 5. Outline of Study Procedures and Methods



2.8.1 Data Analysis

There are effectively therefore three categories of data.

1. Qualitative data representing verbatim 'talk' (digital recordings/transcripts) of interviews and focus groups.
2. Qualitative data from observations, shadowing and other field notes. These were subjective accounts of observations, perceptions, emotions and meanings given to the field work by one researcher. This may have been following discussion with the other researcher on occasions when that person had had access to the same raw

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material. Discussion with another member of the investigatory team (frequently but not always the PI) also took place following the first drafting of the field notes in order to clarify the meanings given to specific behaviours and relate theory and data.

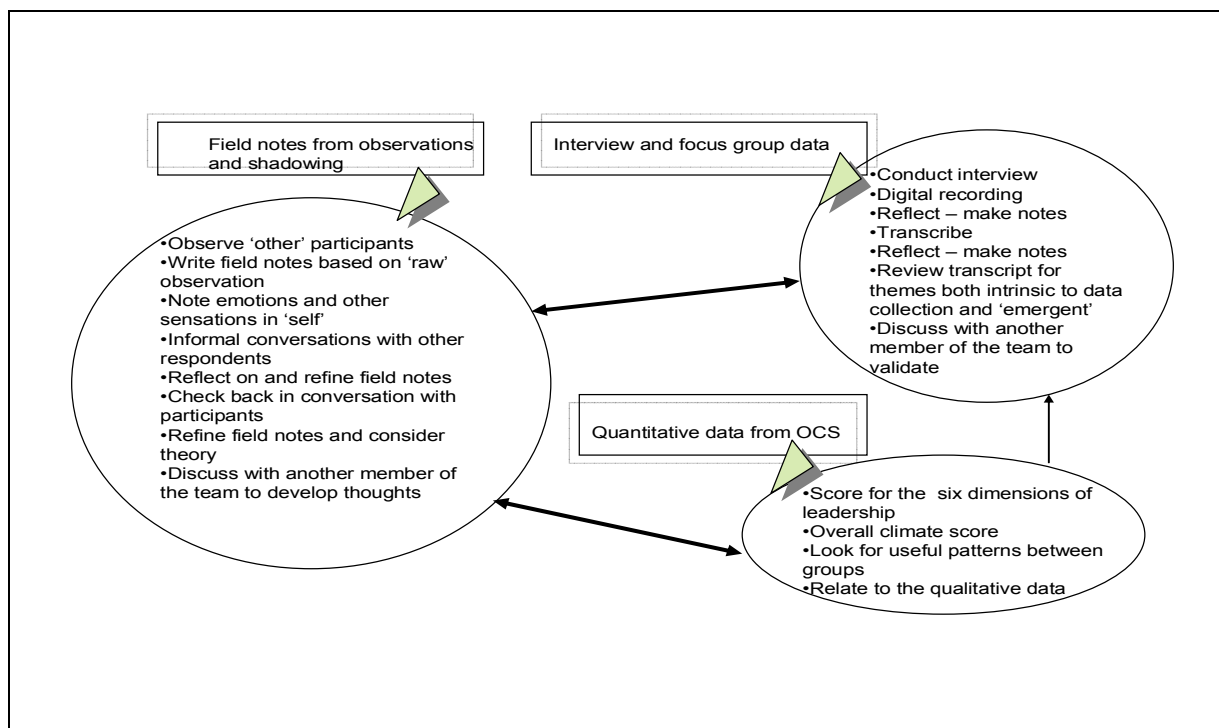
3. Statistical data from the OCS.

2.8.2 Thematic Analysis (TA)

The transcripts and field notes were examined initially for relevant extracts related to the main themes ('leadership', 'organisation' and 'patient care').

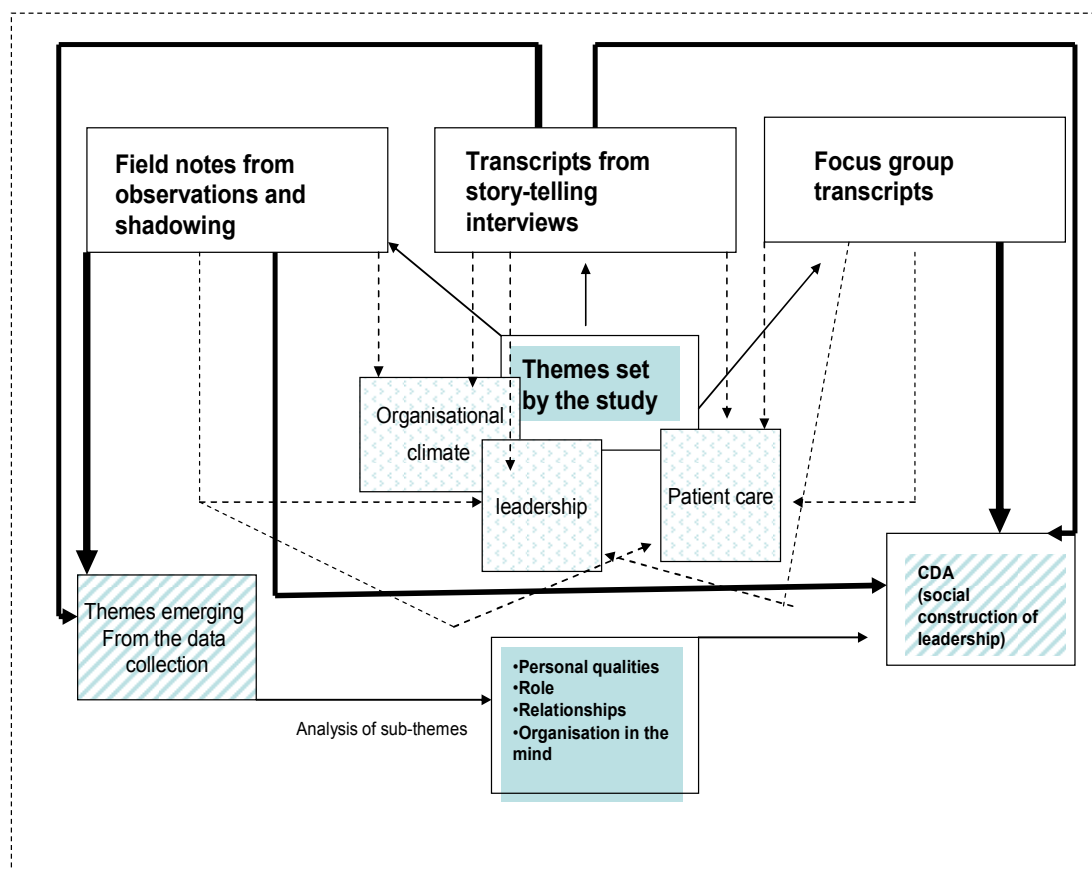
Sub-themes were then to be identified, some of which are likely to relate closely to the previous research literature on leadership and organisational climate, although it is likely that each organisation will demonstrate particular issues that were more difficult to anticipate at the outset.

Figure 6. From data collection to data analysis



Data relating to these themes and sub-themes was to be collated on Word files and where deemed relevant to the study aims, analysed further using the following methods – Discursive Psychology, Critical Discourse Analysis and Narrative Analysis. All these approaches focus on language and the way language is used to construct key concepts (e.g. the organisation) but there are different nuances to each perspective each of which adds an important dimension to the analysis of this data.

Figure 7. Thematic to CDA with Narrative analysis



2.8.3 Discursive Psychology, Discourse Analysis and Critical Discourse Analysis (CDA)

Hepburn and Potter (2004) argue convincingly and with justification that DA has evolved to have several iterations over recent years. One common feature though has been that 'discourse' (i.e. what is said) and 'context' are difficult to separate and it is the ways in which context is worked into the analysis of discourse that distinguishes the character of DA deployed in a particular piece of analysis.

The thematic analysis was a starting point from which to focus in upon the close readings of the texts, which related to the processes of leadership and patient care, as it represents a flexible and clear way of identifying what is emerging from the data and points a way forward with more detailed analysis (Braun and Clarke, 2006)

We argue that leadership is a social construction and there is a growing body of literature providing evidence to support this view. There has also been a recent focus in organisational research and theory to specify an Organisational Discourse Analysis (ODA) (Pritchard, Jones and Stablein, 2004) which involves four approaches i.e. *Narrative*, *Foucauldian*, *Linguistic* and *Deconstruction* which in turn are influenced by a *reflexive awareness* of the organisational culture in which the research is being conducted.

Pritchard et al, (2004) argue further that the exact methodology and approach to the data depends on the 'researcher position' in the organisation being studied. In other words this approach *benefits* from the subjectivity of the researcher's interpretation of what processes mean and specifically from researcher reflexivity about their 'take' on a situation and set of interactions.

To qualify this method of analysis further, a discursive approach means that language is represented not so much as an objective truth but as a means of *constructing* what might be understood (Parker, 1992; Coyle, 2007).

Particularly relevant in this study, in which participants are asked to tell stories and provide evidence to support what is good and bad about both leadership and patient care (and implicitly the organisation in which these actions take place), is discursive psychology (DP) that highlights how "*descriptions of events are bound up with doing actions, such as providing justification for actions and blaming others*" (Hepburn and Potter, 2004, p. 169).

Thus Critical Discourse Analysis (CDA) sees language as a *social practice* and thus considers carefully the context in which language is used (see

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Wodak, 2004). CDA is related to the notion that *power is negotiated through language*. This is particularly apposite in a study of leadership in organisations. Even more so CDA is 'abductive' so that a constant movement between theory and empirical data is needed which suits ethnographic methods such as shadowing and observations enabling the researcher to test out their ideas as they progress with the data collection, and the attempt to understand how cultures work and how the research participants make sense of and experience their worlds.

2.8.4 Narrative Analysis

Narrative approaches to data analysis have been able to cut through the great complexity of the NHS - the intense emotions, positive and negative, it evokes among most of its stakeholders (e.g. Rooksby, Gerry & Smith, 2007; Bryant, 2006; Iedema et al., 2009; Brown et al., 2008; Elkind, 1998; Brooks, 1997). These studies have, for example, addressed power issues in the doctor-patient relationship, exploring communication in a consultation situation. In these analyses, the patient's 'subordinate' narratives have often been neglected or taken over by the doctor's privileged 'medicalizing' discussion (Mattingly, 1998, p. 12; see also Radley, Mayberry & Pearce, 2008). However, there is also a recognition that many of these narratives are co-constructed by patient and physician (Mattingly, 1998, p. 43; Kirkpatrick, 2008); exploring solely the patient voice in isolation and presuming that doctors will at all times occupy a dominant position in this relationship may be missing half of the story - the doctor's experience. As Mattingly (1998) points out, *"[h]ealers too, may be able to give a different kind of voice to their practice when they describe their work in narrative terms rather than the flattened prose of biomedical discourse"* (p. 14).

As a genre, narrative psychology is thriving (Smith & Sparkes 2006). There has been talk of the 'narrative turn in psychotherapy and psychiatry' (Brown, Nolan, Crawford & Lewis, 1996), and Crossley (2003a & 2003b) for example argues strongly for a 'perspective that retains a sense of both psychological and sociological complexity and integrity' noting that narrative psychology is concerned with 'coming to grips with how a person thinks and feels about what is happening to her' (2000, p. 6). She employs a phenomenological framework to explore narratives of 'the voice' of 'the mentally ill' (Crossley & Crossley 2001) and the experience of temporal elements and self/identity of people living with serious illness (HIV, cancer; see also Söderberg, Lundman & Norberg, 1997). Narrative research in health care has also been used to study the lived experience of patients (see for example Hemsley, Balandin & Togher, 2007; Hök, Wachtler, Falkenberg & Tishelman, 2007) and an emerging genre of 'narrative based medicine' seeks to make use of stories in developing a fuller understanding of illness experiences (Launer, 2003; Taylor, 2003; Greenhalgh, 1999).

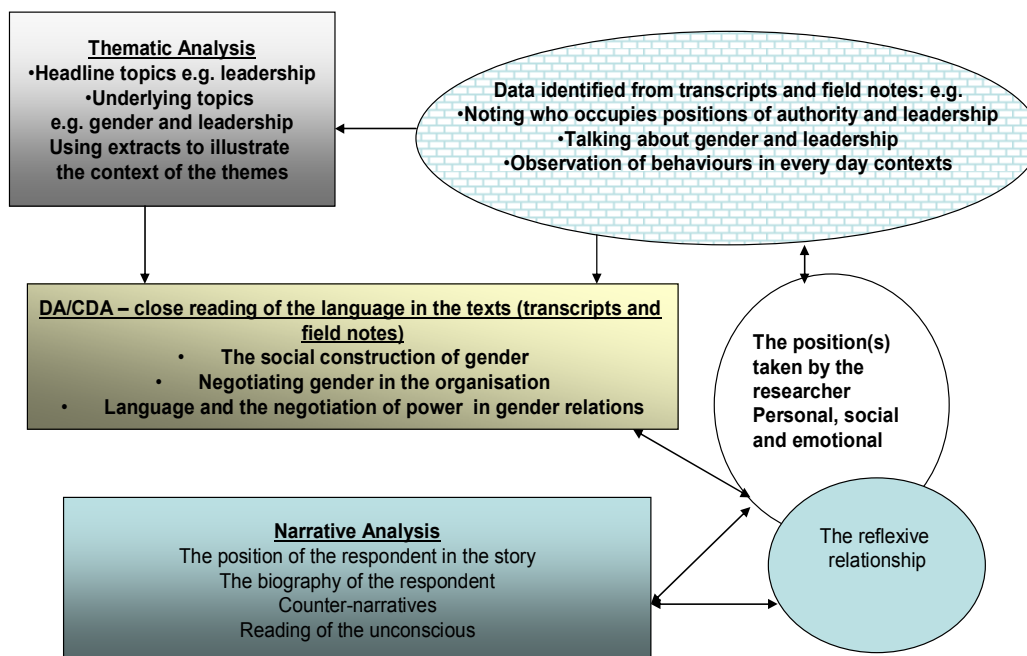
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Narrative based medicine is not merely an insightful way of doing research, but may have powerful policy implications. As Overcash (2003) argues, "*narrative methods are an effective research option that can lead to enhanced patient care*" (p. 179). While interpreting narratives can enhance the possibilities of integrating evidence-based research findings with individual illness experiences, and Winterbottom and colleagues (2008) suggest numerous courses of further research on why and how narratives may influence medical decision making.

Narrative analysis, as with DA, has been approached differently by academics from a range of disciplines so that the ideas surrounding the analysis of *narratives* (or stories told in a sequence) have a variety of emphases. The strength of taking the narrative approach over DA /CDA *per se* is that the 'subject' of the story (the narrator) retains a central role (Crossley, 2007). This can be seen in some detail in subsequent chapters particularly where the accounts of ethnographic observations and shadowing are highlighted where the 'story' becomes that of the researcher herself and with the stories unfolding through the interviews.

Furthermore the narrative analysis places the respondent's story as part of their own *identity construction* which lends an important dimension to the relationship of the story-telling to the teller. Particularly interesting here is Andrews' (Andrews, Sclater-Day et al., 2004) approach which focuses specifically on the elements of stories "*that lie in tension with the ones we are socialised to expect*" (2004, p. 97) or what she calls 'counter-narratives'. Researchers such as Hollway and Jefferson, 2002; Gough, 2003; Sclater, 2004; Allcorn, 2004 and Gabriel, 2004 and 2005, take on board the role of the interlocutor in positioning themselves in their story while considering some of the unconscious and emotional elements both of the story being told and the way that the relationship between the researcher and respondent plays out to construct and limit the story that is told. This dimension is particularly important in the context of this study where emotions are rife at least in part because of the high pressure (exacerbated to some extent by the changing political initiatives directed towards NHS institutions) and the particular nature of the work in caring for ill people (see for example Menzies-Lyth 1960).

Figure 8. Levels of qualitative data analysis e.g. 'gender'



2.8.5 Statistical Analysis

The data from the OCS was coded and in-putted into an SPSS v 14.0 file and significance tests were run (see Chapter Five for the full details).

3 Research Procedure

3.1 Introduction and Overview

The nature of this study, much of which involved the researchers immersing themselves in the 'world' of the participants, meant that it is not possible to provide an authentic *sequential* account of the procedure of data collection except possibly for the administering of the OCS (Organisational Climate Survey).

The bulk of the study, as identified in Chapter Two, comprised multiple methods of collecting different types of data across three Trusts, six Units and five sites.

3.1.1 Negotiating Access

The study took place across a three year period. Negotiation of access was complicated as indicated, although in itself a valuable procedure which occurred at several levels and helped to increase the richness of the team's understanding of leadership, patient care and the context of each organisation.

- Negotiating access began from the 'notional' level while writing the grant application whereby the investigatory team needed to identify whether a project with this design was in fact feasible. We thus made informal inquiries via personal contacts.
- More formal contacts were made once the project was confirmed with the intention to achieve verbal agreement about access for planning the NRES application.
- Following that we met to formalise the details with key informants (i.e. senior clinicians and managers) who had been identified in the previous stage.
- Once we had achieved a favourable NRES review, we pursued local governance applications with the help of the key informants.

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- These stages were managed by approaching one Trust at a time although during the latter part of the study some overlapping negotiations and governance were necessary.
- Part of the formal stage of negotiation concerned consideration of which *Units* could/would form the focus for the study. This was very much two-way but also serendipitous with suggestions from the team of investigators moderated by whichever senior clinical staff the key informants considered would be amenable to 'hosting' the study.
- The key informants then identified opportunities for the team to present the project to staff in the selected Units in 'educational half days' or 'staff meetings' depending upon the local structures.
- These formal presentations only took place in Trusts One and Three however. The procedure in Trust Two (because of the culture, location and structure) was on the basis of a 'tour' (which with permission was digitally recorded) organised by a senior nurse manager so the researchers, one of the co-investigators and the PI could meet various key nursing and medical staff across one of the Trust sites.

Once all that had been achieved it was the researchers on the whole who managed the day-to-day negotiations about who could and would agree to take part in the various elements of the study. This was complicated because of the day-to-day patterns of staff, changes in staff roles, particularly at senior levels, shift patterns and the sheer numbers of staff who may or may not have been aware and willing to allow access to, say, a particular meeting or team for observation or interviews.

Figure 9. Procedures and time-line

	2006/7	2008	2009
Winter	<ul style="list-style-type: none"> •Recruit and prepare researchers •Informal contact with 3 Trusts 1 and 2 •Informal visits to Trusts 1 and 2 •Develop research instruments •Prepare COREC/NRES application •MREC presentation and revisions •MREC approval •Start to review literature on leadership 	<ul style="list-style-type: none"> •Arranging formal contacts with Trust 2 (on 2 sites) •Visit to Site A •Further data collection in Trust 1 •Patient interviews 	<ul style="list-style-type: none"> •Researcher begins maternity leave and new researcher inducted into the team •Data collection in Trust 2 Site 2 •<u>[difficulties gaining access to staff list in Trust 2 for survey]</u> •Presentation to staff in Trust 3 (Unit 1) •Distribution of staff survey (individually handed out) in Trust 3
March - June	<ul style="list-style-type: none"> •Formal meeting with Trust 1 R & D director •Governance application •Formal meetings with senior staff to negotiate units for study •Unit based meetings and introductions •Presentation at educational half day on Unit 1 (obs & gyn) of Trust •Pilot interviews •Pilot staff survey 	<ul style="list-style-type: none"> •Formal meeting in Trust 2. Tour of Site A •Visit to Site 2 •Governance for Trust 2 •Informal meetings •Data collection begins in Trust 2 •<u>Trust 1 staff in Unit 1 return surveys to PI saying they won't give them out</u> 	<ul style="list-style-type: none"> •<u>[further difficulties gaining access to staff list in Trust 2 for survey – now due to key staff transfers]</u> •Preparation and presentation of invited paper to SDO conference in June •Paper preparation and further conference presentations
Summer	<ul style="list-style-type: none"> •Organise, send out and in-put data from staff survey in Trust 1 •Observations and interviews with key staff •Presentation to Unit 2 •Focus groups and interviews on Unit 2 	<ul style="list-style-type: none"> •Application for extension to project (successful) 	<ul style="list-style-type: none"> •Put staff survey on Trust 2's 'intranet' with information about how to complete and return •E-mail staff in Trust 3 who had not received a staff survey •<u>[a low response in both cases]</u>
Autumn	<ul style="list-style-type: none"> •Data collection •Data in-putting from staff survey •Patient survey given to staff on Unit 1 to distribute 	<ul style="list-style-type: none"> •Preparation of journal paper 1 •Further review of literature •Governance for Trust 3 •Identifying key contacts in Trust 3 •Negotiation about Unit 1 (Care of the Elderly) 	<ul style="list-style-type: none"> •Journal paper 1 (anxiety) being revised for publication •Journal paper 2 in preparation (gender) •Journal paper 3 (in preparation) leadership and 'territory') •Presentation prepared and delivered to NHS Surrey and Borders conference •Final draft report

3.1.2 Time frame and Participation of Investigators

We negotiated the formal details of access consecutively in order to make the process manageable. Most data was collected by the researchers (Dr. Fox, Dr. Lokman¹⁵ and Ms. Rowland) although the PI and other investigators made the initial contacts, met with key informants, contributed to the presentations and conducted some of the interviews and focus groups and (Profs. Gabriel and Nicolson, Dr. Heffernan and Mr. Howorth). The PI (Nicolson) and at least one of the researchers was present at all initial meetings with the gate-keepers and key informants.

3.1.3 NRES review

This was prepared and submitted at the end of 2006 and the PI, one of the researchers (Lokman) and another member of the investigation team (Gabriel) attended the appointment with London-Surrey Borders Research Ethics Committee in January 2007.

Annual reports were submitted to the NRES subsequently as required.

3.2 Sample characteristics

The three Trusts, selected as stated above in Chapter Two were each very different from each other, not only in formal terms (size, budget, location and organisational structures) but also informally and culturally and this influenced the 'access pathways'. Thus for example in Trust One our informal and then formal contact was with the R & D director (also a senior clinician) and assistant R & D director, who introduced us to the CEO, the clinical directors and senior nurses.

In Trust Two we had begun with meeting the CEO at the 'notional' phase who then retired in the meantime. This meant starting again with delayed local governance and to accomplish this, we were directed towards a senior clinical manager who then changed their role and location which meant dislocation of our planned procedures.

Trust Three involved a personal contact initially who was directly involved as a clinician in one of the Units who then arranged for us to have a

¹⁵ Dr. Lokman worked on the project for over two years and Dr. Fox took her place.

meeting with another senior clinician who in turn arranged for us to give a presentation to the Care of the Elderly/Geriatric Unit. From there we sought a second Unit for Study independently through contacts made during the course of working in the first Unit.

Trust 1 (One site only) a DGH (District General Hospital)

The Research and Development director here suggested the Units for study to be:

- Unit 1, Obstetrics and Gynaecology
- Unit 2, Cardiology

We were happy with his suggestions, and the staff was generally co-operative and supportive of the researchers.

The Trust itself covers two sites but the choice of these Units meant that all data was collected from one site. This was helpful because it meant the researchers and some of the investigators could spend time familiarising ourselves with the layout of the Units and the Trust site and become familiar 'faces' so that gaining consent from respondents was made easier than it would have been if the researchers and the study itself had to be presented as 'new' on each occasion.

While the study was taking place there were many fears expressed among the staff at all levels that the site we were investigating would become the less powerful with the other site taking over many of the executive functions. While the study team were collecting data on this site however this did not happen and the general 'morale' has improved so that the Trust is currently applying for Foundation Trust statusⁱ.

Self-Description of the hospital

The site we studied had 400 beds and a range of acute care services, including an Accident and Emergency department. It is situated in 52 acres of Green Belt parkland within 40 – 60 minutes of London. Originally it was built to serve casualties of the Second World War. Over the years, the hospital has been rebuilt, developed and extended to include maternity services, a departmental and clinic area, and a new theatre complex. In the early 1990s, the X¹⁶ Wing, which includes a Postgraduate Education Centre and modern well-equipped wards, was opened. A new building for the Accident & Emergency, ITU and Orthopedic Unit opened in the summer of 1998. In addition, comprehensive HIV and genitourinary medicine services are provided in a dedicated building.

¹⁶ We have used 'X' to ensure anonymity.

Obstetrics and Gynaecology

The study territory for this Unit¹⁷ comprised the labour ward, postnatal ward, a general outpatient clinic a dedicated ante-natal clinic and the Maternity Services Administration. The unit offered midwife care for home births, one to one care, water births and there was always a consultant obstetrician available and compared to other local hospitals it gained a score of 3/5 which was joint top score.

Cardiology

This Unit studied comprised one in-patient ward, the Medical Assessment Unit (MAU) and the Critical Care Unit.

In addition we spent time in the Management Suite where five interviews also took place of the CEO, Clinical Director, the Director and Deputy Director of R & D and a middle-ranking manager.

Observations also took place in public and eating spaces and shadowing involved walking around the hospital between different specialty wards and administrative departments.

Trust 2 (2 sites)

The Trust was one of the biggest DGHs in London with 4,200 staff. It had had a history of problems in its financial management and the quality of care but recent information on the web-site and confirmed by the CEO made it clear that:

The Care Quality Commission, the organisation that regulates health care nationally, has awarded the Trust a rating of excellent for the quality of services we provide to our local population. This is the highest possible performance rating in the 2008/09 Care Quality Commission annual national assessment report.

It seems that problems with the financial management remain although improvement had been noted.

The structure and organisation of Trust 2 differed significantly from Trusts 1 and 3. Trust 2 comprised two sites (recently combined into one Trust where one was a teaching hospital) which were at least eight miles apart and it

¹⁷ There were other parts of the Maternity Services at Trust 1 that were not observed directly.

was difficult to travel between one and the other on public transport other than using more than one bus or travelling in and out again from London. The journey by car varied from about thirty minutes upwards depending upon traffic.

Physically the two sites were very different. Site A was a relatively new building designed (as one researcher stated) to look like a motel or contemporary hotel. The other, B, was a traditional middle height rise built in the 1970s on a green site and appeared far more formal with long corridors and many signs to departments. Site A was more 'angular' and you could not walk very far without having to turn a corner which presented a very different 'feel'.

It was not possible, particularly in Site A to select a discrete specialist Unit (unlike Trust 1). Site A focused on acute medicine and care of the elderly and there were no formal divisions in where patients were treated as either in-patients or out-patients. So an older person with 'geriatric' health related problems could be in a bed next to a much younger person. We have identified a Unit as a Site in the case of this Trust. We found it equally difficult to 'pin down' a specialty in Site B as well.

At Site B we collected data from acute medical specialties, obstetrics and gynaecology and therapies (the latter being both physical and psychological).

This was in part because senior management at Site A (who were our key informants and 'gatekeepers') introduced us to staff they considered amenable. Thus for purposes of the study we had to identify Site B as our second Unit. Despite the introductions we managed, via snowballing, to find a range of participants who demonstrated many different view points.

To summarise then in Trust 2 the study was carried out in the following two Units which we have identified as follows:

- Site A / Unit 1 (Acute Medicine; Care of the Elderly)
- Site B / Unit 2 (Acute Medicine; Obstetrics and Gynaecology; Therapies)

We also interviewed a Clinical and Nursing Director both of whom worked across both sites and senior managers including the CEO and deputy CEO.

It became clear very early on that there was intense rivalry, even animosity between the two sites and some of this is explored in later chapters.

Trust 3 (2 sites)

Trust Three, in central London, is a long established hospital and a Foundation Trust with connections to a prestigious medical school. Travel

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between the sites took about twenty to thirty minutes by public transport. 9,000 staff are employed by the Trust with 1,100 beds available across the Trust at any one time.

- Unit 1 (Care of the Elderly, Acute Medicine)
- Unit 2 (Therapies)

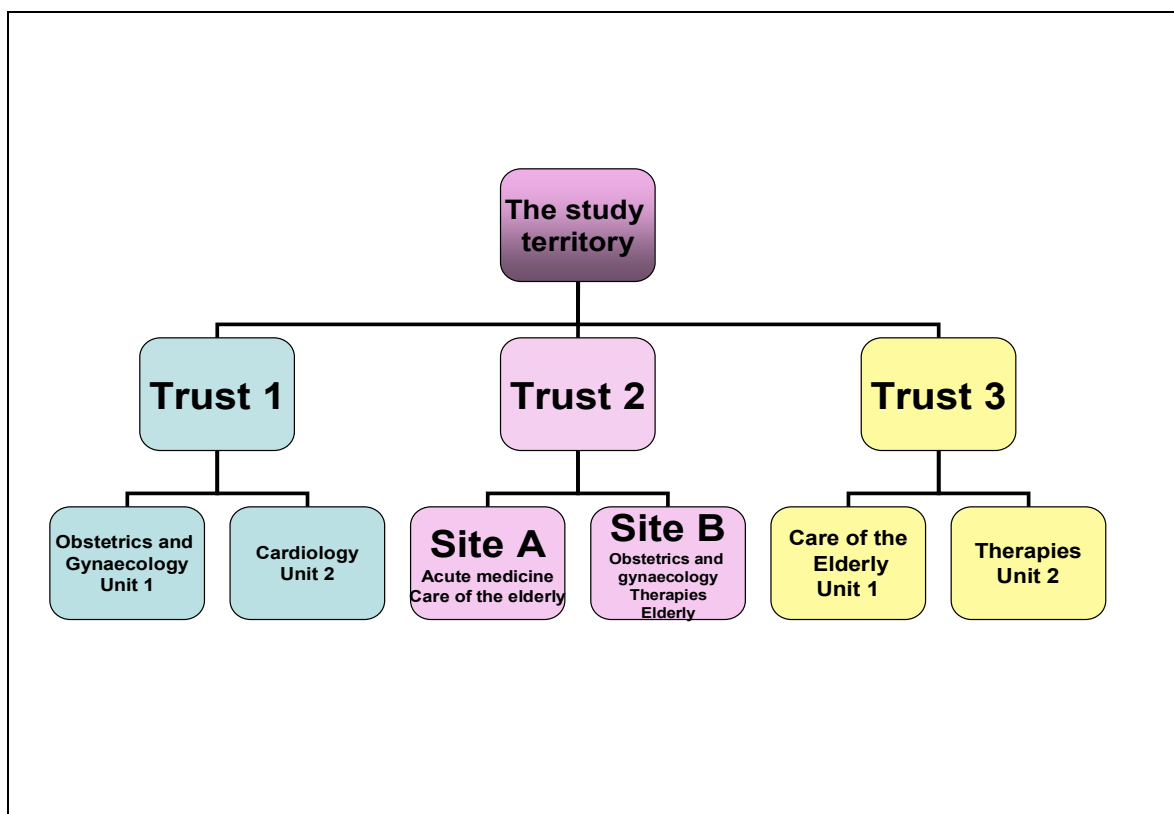
Unit 1 is described on the web-site thus:

Geriatric medicine specializes in the diagnosis and management of common symptoms and diseases in older people, particularly:

- *problems with mobility*
- *falls*
- *continence*
- *difficulties with looking after oneself*

Unit 2 (therapies) which included physiotherapy and psychological therapies spanned both the sites and covered many clinical departments and extended to primary care services especially local GP practices as well.

Figure 10. Participating Trusts and Units



3.2.1 Response rates (qualitative approaches)

It is difficult to identify an accurate response rate for the qualitative components (the majority) of the study because the sampling was conducted in an opportunist manner in many cases – i.e. whether someone agreed to take part in an interview or focus group if the researchers were on site and made a serendipitous approach.

As stated in Chapter Two, much of the qualitative data was collected by virtue of the researchers 'being there' in the right place at the right time and therefore gaining the trust of potential participants. In many cases the researchers were introduced to a member of staff who suggested ways in which other respondents might be accessed. Methods included personal introductions, using e-mail lists or sometimes a staff member knowing what was happening asked the researchers if they might participate in the study.

Overall the majority of staff approached to participate agreed to do so, although circumstances sometimes prevented it (e.g. one focus group was cancelled in Cardiology due to a patient emergency and one observation was cut short because the consultant refused to have the researcher in the ward round, although they had been observing on the ward before the consultant arrived having been given permission by the nursing staff).

Although the key staff across all three Trusts agreed to support the researchers in gaining access to patients for the OCS and interviews, the patient form of OCS was anonymously returned to the PI by someone at Trust 1 saying they did not want patients to participate in that exercise¹⁸.

It proved impossible to administer the patient OCS in the other two Trusts also, because the staff said in advance they were too busy to help and the researchers had difficulty in making contact with individual patients who were always either in busy wards or with a member of staff. Thus interviews and observations were conducted, with patients' consent, during shadowing.

The OCS for the staff is discussed fully in its own right in Chapter Five.

3.2.2 Individual participants

Respondents were either NHS staff or patients so by definition there were elements of uncertainty about whether they would be available at appointed

¹⁸ We sought advice but in line with the NRES review participants could withdraw their consent at any time so we did not feel free to pursue this further.

times and whether (as acknowledged in the NRES consent form) they choose to drop out at any time, even after having agreed to take part.

As shown below in Table 1, forty six respondents took part in in-depth story-telling interviews, thirty nine took part in focus groups. During twenty six days of shadowing of key staff, numerous other staff and patients were involved in data collection and similarly, during the eleven and a half days of observations on wards and in administration areas across the Trusts.

In addition, ten patients consented to be interviewed in depth and, again more staff were involved in the eight meetings that were observed and an introductory walking tour with a staff member in one Trust involved additional staff and patients in the study.

Each of these data collecting encounters represents a different unit of study and a different 'order' of data.

The nature of the study required a commitment of between 30 minutes (for completion of a survey or a short interview) up to two days, in the case of 'shadowing', of respondents time. Most respondents' contributions to the study, however, took about 90 minutes although this also represented an important commitment of their time (and energy).

Table 1. Qualitative Data Collection

Table 1. Qualitative Data by modes of collection							
	Interviews		Focus groups	Shadowing (staff and patients)	Ethnographic observation	Patient interviews	Other meetings and visits
Trust	N = men	N= women	N = Group (n = participants)	N = days	N = days		
1	13	19	5 (15)	5	9	10	4
2	5	9	3 (24)	8	3 x .5 + 1	0	2
3	4	8	0 (0)	13	0	0	2
Totals	22	26	8 (39)	26 days	11.5 days	10	8

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3.2.3 OCS (Organisational Climate Survey)

Trust 1

The staff survey

An administrator in Trust 1 provided a staff list (name and location) from which a random sample (35%) was identified using the SPSS software version 14 providing a list of 939 potential participants from staff across the Trust (including and beyond the Units participating in the main data gathering). The questionnaires were all individually addressed and sent through internal mail.

Of these 223 (24%) individuals returned a completed questionnaire, although ten blank surveys were returned with a note that the intended recipient had left the trust and one said they were unable to read English (1). Thus the final number of participants for Trust 1 was 210.

The patient survey

In Trust 1 we gained agreement from the senior staff on the two study Units (Obstetrics and Gynaecology and Cardiology) that they would arrange wherever possible for patients to complete the patient version of the OCS and would arrange for the researchers to collect the completed forms.

However the full batch of uncompleted patient questionnaires was sent back to the PI at the College several weeks later with an anonymous note stating that the staff did not wish to administer these to the patients. We were unsure how to proceed after this because ethically, although the survey was directed to the patients, the staff had completed consent forms and had copies of participant information sheets, and were aware that they (staff) could withdraw from the study at any time. We considered that this constitute an ethical dilemma for the team.

The researchers made other attempts to hand out the questionnaires directly to patients but found that while some patients were prepared to consent to being interviewed and almost all consented to having a researcher present during patient/doctor/nurse meeting it was not looking possible to obtain a valid sample of questionnaire returns.

Trust 2

Trust two was organised across two distinct sites and although the senior staff work across both sites, as will be made clear from Chapters Three and Four below, each site is very different in its organisation. We initially

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approached the senior staff on Site A first about how to distribute the questionnaires and they referred us to Human Resources on Site B who were the only people with access to a staff list. We did not get any acknowledgement from HR despite several attempts including one visit to the head of HR from one of the researchers. He said he would get back in touch once he had checked whether he could release this list but he did not and we considered there was little more we could do to pursue this particular approach.

The PI then contacted the senior nurse manager, who had been one of our original gatekeepers, for help but found that she had left for another post.

Following the abortive attempts to contact HR (or anyone else who might have been able to help) a PA in one of the many departments we contacted suggested that there was a staff intranet which went out once a week with an 'update' section with news for staff across the Trust. The PI made contact with the editor of this site who agreed to include an electronic version of the OCS.

Consequently, the questionnaire was included on this web-site, with a preamble (adapted from the NRES participant information sheet) on two occasions. However it only produced one reply. We made one final attempt via the PA of the CEO to contact HR for a staff list to no avail.

What was interesting and perplexing though was, that there was no difficulty obtaining a commitment from staff across the Trust to participate in an interview or focus group which was much more time consuming and personally revealing.

By the time we were ready to collect the patient survey data at Trust 2 we already recognised the problems with the responses from the staff. Also, by contrast, we had established the effectiveness of eliciting patient data from the shadowing and observations. We therefore made a decision to focus on this approach to data collection from patients rather than pursue more blind alleys.

Trust 3

In Trust 3 the early signs were that there was no overarching administrative structure from which we could obtain a staff list and nobody we asked could advise on the best way to gain that information. However we did have some 'local' e-mail addresses of the staff in the Units and therefore we e-mailed the OCS to staff on the two study Units and obtained 13 replies all together.

3.2.4 Participant characteristics

There were 224 respondents who completed and returned the questionnaire, of which 77% were women (n = 172) and there were 23% men (n = 49). These included from Trust 1 (n = 210, 93% of respondents), Trust 2 (n=1, 0.4%) and Trust 3 (n= 13, 5.8% of respondents).

The mean age was 46 years, standard deviation 11.1. The majority of respondents were married (62.7%), with a further 7% cohabiting. Twenty percent of respondents were single and almost 10% divorced. The majority of respondents were White (72%), the next biggest group were Asian (18%) and other ethnic minorities such as Black (6.5%) and Oriental (3%) consisted of much smaller groups.

Pay level: most of the respondents had a salary of less than £20k (44.3%) or between £20k- £40k (38.8%). A much smaller percentage (5%) earned between £60k and £90k and a further 2.3% of respondents had a salary exceeding £90k.

3.2.5 Professional demographics

The majority of respondents had been working in the NHS for over 5 years (68%), with a further 26% for between 1-5 years. Only 5.8% reported less than one year's service.

3.2.6 Stability within individual Trusts and Units:

Most respondents had been employed by the same hospital for over 5 years (56%) and another 34% had worked there between 1-5 years. The rest (10%) had been employed by the hospital for less than a year.

Most respondents reported working for the same Unit for over 5 years (45%), a further 43% reported working there for 1-5 years and only 12% reported service of less than 1 year. A similar pattern was seen in terms of length of time in same job. However the majority in this case had been working at the same job for between 1-5 years (45%) and slightly less (41%) had been working in the job for over 5 years. Another 12% had been employed in the same job for less than one year.

3.2.7 Role:

The majority of respondents were nurses, 31%. 13.5% of respondents were managers; 11% consultants/doctors/physicians. Other allied professionals, such as scientists and psychologists made up 10% and support staff made up a further 6%. Clerical staff and 'other' staff (such as porters, maintenance) made up a further 13% each.

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3.3 Data Analysis

This was conducted in the manner described in Chapter Two and the results are discussed separately in the following chapters each of which when relevant provides more context to the conceptual framework and analysis in the substantive area of focus.

3.4 Conclusion

The diverse nature of each of the organisations studied provided valuable information about the different kinds of challenges that different leaders at all levels might face in different institutions across the NHS.

Staff at senior level (particularly non-clinical managers) moved around within and between Trusts. During the course of conducting our study some key gate-keepers and participants left the Trust, others joined and yet others moved position and role even during the relatively short time we collected data there.

In some cases mergers had just taken place or were expected. This was experienced by some as opportunities and others as threats, but in all cases it meant structural reorganisation, staff being re-assigned or choosing to leave for another post.

This has to be taken to be part of the changing face of the NHS overall and central to the culture and climate of the participating Trusts, and can no doubt be generalised to every NHS Trust across the country. In what follows, we have used our different strategies for data capture to examine the relationships between leadership and service delivery in this fluid and (potentially) exciting context.

4 Leadership in the NHS

4.1 Introduction

In any organisation:

Leadership is needed to pull the whole organisation together in a common purpose, to articulate a shared vision, set direction, inspire and command

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commitment, loyalty, and ownership of change efforts (Huffington, 2007, p. 31).

and

Leadership would be easy to achieve and manage if it weren't for the uncomfortable reality that without followership there could be no leadership except, perhaps for the delusional sort. (Obholzer, 2007, p. 33).

In this chapter we examine the ways in which leadership is defined, exercised, experienced and transmitted taking account of how far leadership is perceived as pulling the organisation together to pursue the common purposes of patient care and the relationship between leaders and followers.

We specifically:

- Explore how leadership is defined by different stakeholders and what they see as determining its quality;
- Seek to begin to understand how leadership is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients through examining the data from focus groups and story-telling interviews;
- Using the same data sets, explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted.

4.2 How is leadership defined by different stakeholders and what do they see as determining its quality?

We start this particular exploration with a *thematic analysis* of the qualitative data to identify what themes emerge from the definitions, while also making interpretations using *CDA* and *narrative analysis*. In so doing we pay attention to what Gough has termed 'emotional ruptures' (Gough, 2004) in the text which serve to illuminate some of the subordinated or unconscious information in the stories of the respondents and the subjectivity of the narrator (Frosh, 2003; Frosh, Phoenix, & Pattman, 2003; Hollway & Jefferson, 2000).

In Chapter One we proposed that 'leadership' as a concept has been subjected to continuous scrutiny and moved through different theoretical and paradigmatic iterations. The NHS has identified the qualities it requires in a leader and the role that NHS leaders (at all levels) are expected to strive towards (see Figure 1). We therefore inferred that respondents, imbued in the culture, would focus on 'transformational' or 'distributed'

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explanations and definitions about leaders and leadership because these models are embraced by the style of the coaching and training on offer.

4.3 Definitions

Respondents distinguished between 'leader' and 'leadership'. A 'leader' was described and defined in diverse ways including as:

Obviously strong minded and opinionated (Administrator, T, 2¹⁹).

Particular personality traits - need to be - to have integrity, ((1²⁰)) to ((1)) be clear, err to be facilitative, to have energy to listen, erm, to negotiate, ((2)) to make decisions (Senior Non-clinical Manager, T, 2).

... making sure that you're the person who is erm keeping the team focused getting them to achieve those goals looking at different ways of working (Senior Clinician, Trust 3).

These definitions suggest diverse ways of thinking about the idea of 'leader', indicating that commonality of stakeholder views should not be taken for granted. The qualities a leader has to have are determined in these definitions through having opinions, being strong-minded while also having integrity. A leader also needs to be able to facilitate actions, negotiate and keep the team focused towards the achievement of its goals supporting team-work.

4.3.1 Defining leadership

Leadership in this first definition below was about a formal role and implicitly hierarchical rather than distributed:

I don't think there is anything magical about good leadership. It is about establishing what the organisation wants to do and allowing people to get on and do it (Recently retired CEO with clinical background, T2).

This respondent, who had occupied a senior position, saw the structure and strategic direction of the organisation as fundamental to what works as leadership which was not 'magic'.

¹⁹ In some cases we are able to identify the Trust but where there is any chance of a breach of confidentiality we adjust the 'credit' to ensure anonymity.

²⁰ Where the transcription has included double brackets it denotes pauses timed in seconds.

The following respondent expresses it differently suggesting that it means different things to different people on the one hand, while also being an imponderable (possibly even magical):

Leadership is like love, we all know it exists, but you can't actually prove it, you can't define it, and it comprises of lots of different things that people do, if you demand evidence for everything...you will get rid of leadership eventually (Senior Clinician, T2).

This clinician seems to take distributed leadership for granted in that it is about 'lots of different things that people do'. A warning is expressed it appears, though, that trying to *show* leadership exists across the organisation (perhaps rather than residing in designated roles) might ultimately destroy the possibility of leadership. Following Gronn (Gronn, 2002) this might be a way of suggesting that through concerted action leading to conjoint agency, leadership might not be so obvious (as in the first definition immediately above) but it might be more effective in a hospital where there are different qualities needed to lead in different activities.

Resonating with the view above that a leader has to have integrity, is the view from one leader's experience:

I learnt that it's very important thing for leadership... to not lie, not hide anything and just tell them the reality and be true to yourself, and that's really important (CEO, Non-clinical).

There is an immutable relationship between the leader and the follower. Being true to oneself and honest towards followers must be fundamental to the emotional engagement or attachment between leaders and followers. The significance of emotional engagement as well as emotional and social intelligence was high on many respondents' agendas for determining leadership quality:

... leadership is about having, or being able to demonstrate at any level a coherent vision for where you're trying to go and getting people getting there (Nursing Manager, T 2).

[Leadership in the NHS] is a people focused, leadership job (Senior Non-clinical Manager, T3).

.. it's not always leading from the front (Senior Clinical [therapies] Manager, T 3).

While the leader needs to have vision, these definitions imply that vision alone does not determine how leadership can be exercised or experienced. Leadership will not work unless the leader engages the followers with that vision.

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If leadership fulfils an organisational role ('establishing what the organisation wants') then can it also be 'people focused'? If good leadership is about transparency and honesty is there an assumption that it has not always been so or may not be so at some future time? What does this imply? Does leadership have an 'indefinable' quality' or set of characteristics that work within a specific context but may not be transferable as 'skills'?

Leadership presents dilemmas for the maintenance of personal integrity ('tell them the reality and be true to yourself'), it is a 'job', it requires 'vision' and flexibility and most importantly it seems it is about focusing on people.

4.4 How is leadership in NHS health care organisations exercised and experienced by those affected by it?

Respondents talked about the *role* of the leader as central to the practice of leadership in the organisation. Leadership was understood to be intrinsically linked to particular tasks/goals while necessarily engaging with the followers who had to implement much of these tasks and achieve the goals. There was a sense that many respondents held an idealised view about leadership in their own Trust. Sometimes though the reality for them fell short of expectations because the person occupying that role failed to live up to their hopes.

For example, as the following extended extract illustrates:

.. one of the things about the leadership and management of this Trust is first of all clinical leadership is strong in most places. The clinical directors here have general clout and they are not just figureheads .. and the other bit I think - relationships between general managers and clinicians on the whole are much more positive here than other Trusts (Senior Clinician).

This proposes that strong leadership among clinicians (distributed both horizontally and vertically via the clinical grouping) enables managers to deliver the service to patients. However, this does not in itself identify the characteristics of the links between strong leadership and service delivery.

For many respondents leadership is exercised at least in part through each leader's personal characteristics (good and bad). Almost without exception when asked about the qualities that make a leader, and to 'story' their own explanations, respondents placed a degree of emphasis on the characteristics of an 'ideal type'. The following exemplifies this:

Most important quality is the communication. Being able to listen - hear what is being said and to deliver that--what they want to say, so that it is heard by all. That it be quite quick thinking, being able to develop an idea

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and roll it out, umm being able to think on their feet as well, because sometimes you get things that turn up and you have to deal with it there and then, umm, reasonably personable so people will confide in that person, um also strong so that when things are tough they can um deal with them (Clinical Midwifery Manager, T1).

The comprehensive but daunting picture of how leadership is exercised described above, represents an ideal of distributed leadership as *concerted action* (Gronn, 2002). This type of leadership is exercised through being able to communicate – to listen and to express clearly (so as to be ‘heard’) how action will be taken. ‘Rolling out’ the idea again suggests taking peers and followers along with you and being ‘personable’, so people will confide in that person, further indicates the ability to take the views of others into account calling for both emotional and social intelligence (Amendolair, 2003; George, 2000; Goleman, 2006; Lopes, Grewal, Kadis, Gall, & Salovey, 2006; Riggio & Reichard, 2008). In this model, the multifaceted communications rely on the ability to use the information to think quickly and be strong under ‘tough’ circumstances.

However, in the next extract (from a non-clinical manager) the ideal type of leadership is represented by responding to short and medium term organisational goals (Buchanan, Fitzgerald et al., 2005; Riccucci, Meyers, Lurie, & Han, 2004).

Erm, I think leadership is about erm, encouragement. It is about showing people direction in which you as an organisation and them as individuals engage in. I think it's incredibly important especially in an organisation like the NHS where there are lots of different groups of people and lots of different objectives - sort of daily ones, monthly ones more long term, and you have quite a clear sort of vision of where you're going and I think that the good leaders in the NHS show that, and examples of bad leadership are where that is not so defined. (Middle Manager, T2).

This suggests a *transactional* model of leadership, whereby the good or effective leader offers ‘encouragement’ to the followers in return for people accepting the practices of the wider organisation (Bass, Avolio, Jung, & Berson, 2003; Eagly and Johannesen-Schmidt, 2003)

4.4.1 Exercising leadership through their organisational ‘role’

Leadership is experienced by some as being exercised through the legitimated role. Organisational role in the leadership discourse equates with the leader’s professional position as the respondent below shows clearly:

Who would be a leader to me? I think there's a number of different areas, there's your direct line manager, who's the clinical leader of your department. Who's who in this structure there's line managers above them, and above them and so on. There would be people you would look to within your own specialty clinically who are more experienced than you ((2))²¹ in certain areas, to ask for advice, erm ((1)) and similarly in an academic environment ((1)) there are other people there who have more experience that you would want to take advantage from or advice from. ((2)) And in the wider circle, national or international leaders in the field who are so expert at those things that you also turn to. (Medical Consultant, T3).

While the formal roles and organisational hierarchical structures are taken seriously by this respondent, there is also a clear vision of leadership being exercised through concerted action in collaborations that arise *spontaneously* where clinical and/or experience is valued and sought within this respondent's speciality and sometimes *intuitive* leadership (Day, Gronn, & Salas, 2006; Pearce, 2004). However, there is also a sense that this respondent experiences leadership through the institutionalisation not only of formal roles locally, in the organisation itself, but through the structural relationships with those who are seen as experts in a much wider networked context (Pearce, 2004). This version of leadership is particularly important in that it demonstrates that leadership can be both experienced and exercised beyond the boundary of the organisation and the NHS, based on knowledge and expertise originating outside these systems.

Respondents frequently combined personal qualities with their understanding of the leadership role, particularly related to taking responsibility as part of that role:

It's quite difficult, I mean I think taking responsibility (4) making sure that things happen that are supposed to happen, or don't happen that aren't supposed to happen (3) um.., (6) that's it. (Clinical Medical Consultant, T1).

Not everyone saw leadership in this way. This respondent is talking about their own experience of being in a role in which then 'buck' frequently stops and thus by definition they are in the role of leader.

The exercise of leadership through being a 'role model' (Trevino, Hartman, & Brown, 2000) where qualities of leadership were displayed was important for some:

The leaders that I've worked for and have wanted to follow ... push something in me that says 'I want to be like them' or I completely support

their vision of where they're going or you know so I want to follow that person and I want to do the best that I can do for them because I believe in them and their vision. (Head of Non-Medical Clinical Team, T3)

This explanation has a flavour of heroic or charismatic leadership, although not as a quality that resides in a specific person necessarily, but one that resides in a relationship that 'fires' up both leaders and followers (Klein & House, 1995). Even though the idea of the charismatic leader has been at least partly consigned to the history of the late 20th century organisation, it has not disappeared and needs further thought particularly in an organisation such as the NHS where changes are sometimes rapid and stressful (James, 1999) and internal culture needs to be taken into account (Dopson & Waddington, 1996; Tourish & Vatcha, 2005).

4.4.2 The relationship of the 'leader' to 'followers': how leadership is experienced

While leadership is the focus of the professional and political debates about the NHS and other organisations, until recently, relatively little attention has been paid to followers' experiences of leadership (Avolio et al., 2004; Howell & Hall-Merenda, 1999; Lewis, 2000; Schilling, 2009). From the perspective of a manager taking the position here as 'follower' looking 'upwards' in the organisation:

I think it's, it's providing, you know direction and to lead and that's a leader's main job in my mind. And (2) that's .. what they say for leadership, you must have followers. If nobody's following you, what you are saying then? you are not a good leader. So that's a good, you know, test for a leader to evaluate themselves. That's what they are saying and what they are trying to achieve. Are people behind them or not? If they are not behind the leader there's something wrong with that. (Middle Non-clinical Manager)

From the perspective of a junior doctor taking the 'followership' position:

I think in order for you ... well in my opinion a leader, I have to be able to kind of respect them. If I don't respect or kind of have faith in what they do, then it's, it's a personal authority, so in order, you know in order for me to do that I have to believe in what they say. I mean, I might not always agree with them in my opinion but at the end of the day I have to be able to respect them enough and for them to have certain authority, someone who's probably experienced and gained that knowledge, so yeah. (Junior doctor)

For leadership in the NHS to be exercised effectively then there has to be an engagement between the leader and the followers (Macy & Schneider, 2008) and to understand fully how the engagement takes place, a degree of

emotional engagement and/or attachment to the leader and the organisational vision is fundamental (Riggio & Reichard, 2008; Rubin, Munz, & Bommer, 2005; Vince & Broussine, 1996).

The failure to take followers with you is made explicit here from the perspective of one (designated) leader:

A: I was forced upon them...

Q: that's what I was going to ask. So presumably there was a lot of resentment I guess?

A: Yes.

Q: And how does it manifest itself?

A: Erm, non-cooperation, making life difficult for you sometimes, people talking about erm ((2)) sort of criticising you behind your back and erm playing silly games behind your back that makes management of other people more and more difficult. Erm you know, and yet we sort of have to fight another battle to win hearts and minds, when we, you know, don't really have the time to do that, we have got to have our focus on doing what we are meant to do, which is to manage patients and to manage our beds properly.

This extract from the interview with someone whose role it is to lead change is revealing. The respondent recognises that he is not taking people with him and in his view, the followers appear to eschew co-operation. He also believes they are mocking him and that that mockery is contagious. He may or may not be able to evidence this, but that it is in his mind is potentially detrimental to his experience of leading in his organisation (Stein, 2005). Furthermore, instead of looking at himself, this respondent wants to push the blame for the leadership failures onto the followers (in other words he engages in splitting described in Chapter One) (Klein, 1975; Segal, 1973). Such a process is diametrically opposite to leadership studies that identify authenticity and trust between leaders and followers as being one of the basic qualities for leadership (Avolio et al., 2004; de Raeye, 2002; Novicevic, Harvey, Ronald, & Brown-Radford, 2006).

There is also some evidence of concerted action here, distributed among those who were leaders of the *resistance*, which is not necessarily against the values of the organisation in any negative way, but may be seen as upholding important principles and challenging change (or a particular form of leadership) that might be perceived as counteracting these important values (Collinson, 2005; Zoller & Fairhurst, 2007).

Trust is one important quality in the way leadership is exercised and experienced by followers and developing trust is essential if changes in

practice are to be implemented (Bass & Steidlmeier, 1999; Hunter, 2005). So, for example, 'engaging' with others involves trust:

Yeah definitely there are some good examples of where it's obvious that people have been able to engage lots of different kinds of people in different groups and I think they've done that just by sort of making relationships with them in the first place and then when it comes to having to lead them and be influential then you can see that those relationships are already there and then they can call on that you know, that sort of that trust or that sort of relationship that they've got (Middle Non-clinical Manager, T2).

The same respondent continued with a specific example that aptly demonstrates the links between all the three sub-themes.

Yep, I think Florence who is our head of [a non-clinical department] .. I think she is a very good example of what I'm talking about in terms of her job. And her role relies a lot on other people. Erm so as a personality she is a very responsible person, she gets on with everybody and you can really see how that works for her because when she needs somebody to do something or she needs people to listen they are going to because they have got a good relationship with her and she has taken time to build relationships when it is perhaps not necessary.

To summarise so far - *good* leadership in the NHS is understood by staff at various levels as:

- Taking responsibility
- Being 'given' authority by the followers
- Getting on with the people in the organisation
- Taking time to build relationships
- Being trusted by followers
- Winning hearts and minds
- Having a vision for the organisation
- Taking colleagues with you

4.4.3 Patients' perspectives on how leadership is exercised

While there were several things held in common (particularly 'trust' and 'taking responsibility') with the staff, patients unsurprisingly, considered leadership from a different position, based upon how they themselves had experienced a specific episode of care. One woman, who had had a previous bad experience in the same Trust in which she was now a patient, said:

Well somebody taking responsibility really for erm you know your care, erm especially. I keep going back to the same example but you know someone being responsible for not reading through my notes and if someone had taken that leadership erm and actually said 'right I'm going to look through

these notes', you know they would have obviously seen what they had to see and so basically yeah I think there is a lack of leadership.

The emphasis was on wanting the leader to take responsibility for patient care in contrast to poor practice whereby notes were not read. It was taking responsibility, and reassuring the patient that they were taking responsibility, that could be experienced by patients as good leadership.

Another patient similarly suggested that in their exercising of leadership, the clinical staff need to make sure that they were seen to be acting in the patients' best interest. For example:

When they're explaining their-selves, they do explain their-selves and what they're thinking. And they do tell me like the 'ifs' and 'buts' blah blah blah about this certain thing, but then one says something and [another] one says something else but they do explain themselves and what they're on about.

Also, another patient indicated that there needed to be one person who held overall responsibility for service delivery:

I don't know how it works hierarchy wise, whether there's like a top doctor or whatever, whoever it is somebody really needs to, you know, take a really ((2)) be sort of, you know, held responsible.

It is perhaps worth noting that the patients overall focused on the role of clinical leadership but saw that as being practiced by an individual rather than in a distributed form. There was a general view that individuals needed to be accountable and accountability equated with leadership.

4.5 What are the characteristics of an organisation that facilitate, or hinder, the process of leadership?

Leadership happens in a context and that context can facilitate or hinder leadership processes (Currie et al., 2009) and the influences of the organisation are particularly acute when the environment is changing rapidly (Goodwin, 2000; Michie & West, 2004) as in the NHS.

One respondent felt they no longer knew 'who was who' in the leadership hierarchy but considered it didn't really matter:

..., here is this model that says here is the Board and here is the chief exec and here is whoever else is up there. And there's this, this and this ... and [a colleague suggested] shouldn't we be transparent all the way through and shouldn't everything link? and I thought, this came up somebody legitimately asked the question that people here need to know what is happening here. Why? Why? I don't care. (Clinical Physiotherapist, T3).

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One senior Occupational Therapist, in the same Trust, on the other hand felt that knowledge of the organisation was important to facilitate leadership at every level so that when:

... people feel they are working as part of an organisation that's working for something, as part of a team and are appreciated and valued as part of that and are working for someone as well who feels what they are doing is worthwhile, I think that patient care will be of better quality.

This respondent was also convinced that supervision was part of the process by which an organisation facilitated both leadership and good practice in patient care. *"I have once a month supervision, like set time for supervision so I think that is really good."*

Furthermore, supervision and informal contact with peers facilitated effective distributed leadership which impacted across the organisation: *".. you can go to people informally, your peers erm whenever it's quite flexible like that and even if you're a senior like me you think 'hang on I don't know if I'm on the right track here so am I missing something?' You can just go and speak to you team about it or one of our colleagues downstairs or whatever if you want to.*

More dramatically a senior clinical leader suggested that leadership is facilitated in 'moral' organisations:

A²²: So one thinks they are better than the other, so the seven deadly sins basically...pride, the other one is gluttony, which means excess...one can never have enough, for the sake of it, and then just goes beyond, you know, one million, two million, you know, which kind of greed isn't it...excess basically, and also rushing is in there, doing things too fast. A good system will reduce its workload, yeah? The NHS has a thing of needing to do more and more, erm anyway, I don't know whether you find this useful or not, so greed, gluttony, there's rushing, and then jealousy, which is really envy, which is really competition.

Q: Yeah

A: You need to get rid of competition, and I will tell you in a moment what could replace it, which is basically team work, team work and kindness; how you get on with each other...anger is on the list. Anger is, is blame, and the opposite is blame free culture.

Q: Yeah

²² Q = question, A = answer.

A: Or forgiveness if you want, so you need to forgive mistakes, and you know you will be forgiven...and, erm...erm...next one is laziness, that's obvious, that's hard...people either have it or not, but laziness is joylessness, you need to make sure people enjoy it, and diligence, yeah? So there needs to be something in place of ...and we have that now with trust away days and things like that, but you have to have somebody dedicated to making people understand it's about having fun

Q: Yeah, yeah

A: working is about having fun...yeah? And then its... which comes really from up here, it's just an, an, yeah, can't have enough...which is also, it's also, the opposite is erm...do not take more than you can, do not take more than you need...and that is quite a moral stand ground, more than you need...for everyone

Q: Yeah

A: and if you employ that rule, then the whole organisation becomes so successful that there's masses of money left over ... Everything works well...the problem is everyone doesn't understand that, and believe in that, and then there's a difficulty...so that's moral high ground, very moral high ground, but if you go along those, you actually have all the features of leadership.

For this respondent the organisation needs to focus on patient care, treating patients *and* staff with 'kindness'. This is counter in his view to the process of setting targets for service delivery and organisational growth (or survival) and thus competition between organisations and competition between individual staff or staff teams, which is a force that (it seems) promotes the wrong kind of leadership (Kuokkanen & Katajisto, 2003; Sambrook, 2007). Furthermore, supportive teamwork and 'forgiving' mistakes and preventing the 'blame game' enhances socially and emotionally intelligent leadership distributed responsibility across the organisation and enhancing the culture and climate (Riggio & Reichard, 2008) .

Another senior medical leader and manager (T3) reinforced this idea:

I think the ethos within the hospital, is one that encourages people to develop and grow, and deliver good quality care, you know, so, I mean I think wherever it comes from it is enabled within this organisation, and it works very effectively. One of the features that enables that to happen...it's firstly being an organisation that attracts good people to want to work here in the first place. So you get high quality people applying for the position, be it in medicine, or managing, or nursing or any of the other professions By and large, we're fortunate in that. And that's partly due to the reputation, and partly due to the [location] but I think the ethos that comes

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from the leadership makes it desirable to be here. Erm...so it attracts the right people in, it then enables, it doesn't put the brakes on, it doesn't try to control people too much.

Thus, organisational performance and culture/climate were 'enabled' through a cycle of encouragement, good practice, reputation and a supportive and 'hands-off' approach to leadership. This suggests concerted action, leader/follower engagement and emotionally supportive behaviours at all levels. That the physical location of the hospital is attractive is perhaps but one factor in this equation, although a central location makes it possible to draw on a wide range of staff as opposed to a location which is in a small town or distant suburb.

It is not just features of the organisation itself that impact on leadership. Organisations reflect changing discursive constructions of leadership and the values that underlie what it means to be effective as a leader in that place at that time (Ferlie & Shortell, 2001; Lansisalmi, 2006; Michie & West, 2004; Scott, Mannion, Davies, & Marshall, 2003). As demonstrated in Chapter One theories of leadership have developed and different approaches have become significant at different times as witnessed by the shift from promoting and studying transactional, charismatic and heroic leadership styles to the contemporary emphasis on forms of distributed, networked and transformational leadership (Bryman, 2004; Butterfield et al., 2005).

One dramatic change over the past twenty and more years has been the image of the medical consultant in the public psyche. Thus the 'heroic' leadership of Sir Lancelot Spratt has been firmly (it seems) replaced by the team work in the TV series *Casualty* or *Holby City*. However the image of the rebel Dr. House (played by Hugh Laurie in an American TV series) is described as 'unorthodox' and 'radical' but most definitely a medical hero. Is this the type of leader that some might still long for? While the following comment was atypical of most people's definitions of what makes or fails to make a good leader it raises some interesting points about the contemporary regulatory discourses on leadership. Thus one participant said of another²³:

Now (Dr.) David is a really eccentric so he is not what you would naturally call a leader, erm ((1)) but people are really respectful... Because he really cares for patients ...And if he finds a junior doc, or nurse or anyone who is being unkind to an elderly patient then he is down on them like a ton of bricks but his, his patent commitment to medicine and clinical care just inspires admiration ...And great affection hopefully. But he is very odd. Yes. Erm, so he is like a one off so again there is no single person, you

²³ No identifying information is appropriate here.

know there are, there are, there are different leadership styles which are appropriate in different situations but David of course could never be a chief exec, he just wouldn't be able to do it, so he would be hopeless there.

On the surface this might be explained as a judgement based on 'evidence' and a job description. However, focusing-in on the discursive and regulatory practices with which this extract engages, a different view can be taken. The respondent here, being asked to describe the qualities of leadership, begins by suggesting that taking patient care very seriously is 'eccentric' and the person who does that is a 'one off' and 'odd'. Paradoxically (it is suggested) David inspires affection and admiration but despite the variety of leadership styles David would never make it to be CEO. Whether or not this is the case is irrelevant here because what is at stake are the ways in which discourses around 'leadership' and the qualities of the 'leader' *regulate conduct* setting normative behaviour through the discursive practices. There is little doubt that David would have been considered a leader (perhaps a leader in his field) during a different period when hospitals were smaller and perhaps when there was less specialisation in management.

A learning organisation?

The NHS has declared itself to be an organisation dedicated to learning for at least the last ten years and certain values underlie this declaration (see Davis and Nutley, 2000). It means that:

Although learning is something undertaken and developed by individuals, organisational arrangements can foster or inhibit the process. The organisational culture within which individuals work shapes their engagement with the learning process (p. 998).

In some cases the exercise of leadership clearly facilitated the (potential for) learning and learning facilitated leadership, while in others it did not. The facility for leading change in NHS Trusts is critical and developments in the role of nurses from a range of specialties to support leadership and learning have provided exemplars of how some organisational arrangements support leadership (Bellman, Bywood, & Dale, 2003; Doherty, 2009). However, some have argued that continued changes, the market as a driver and the complexity of the NHS might militate against whole system learning (Sheaff & Pilgrim, 2006). Questions have also been raised about the potential of the new generation of leaders who are expected to be inspirational, drive change and support learning (Phillips, 2005).

One capacity manager, for instance, was very clear that leadership was about enabling appropriate learning and the development of skills:

... probably more about empowerment and not necessarily of oneself but of others. So I think that indeed you need to feel empowered yourself, but I think that leadership, good leadership is about empowering and supporting those people who are not in power so that they are equipped with the skills that are required. some of it is actually around learning, it is about what stage they are at in terms of their learning curve.

This is not only a statement about distributed leadership but about a version of a transformational leadership that transcends individual leaders and requires an organisational culture that both supports individual learning and targeting individuals to ensure, that their learning is recognised and ongoing (Burke et al., 2006; Conger & Kanungo, 1988; Kuokkanen & Katajisto, 2003).

The respondent continues with this theme in a sophisticated, and it seems heartfelt, way:

But I think that sometimes that [learning] is not always consolidated, even those people that have been in that position for years. I think, it is more about the people actually understanding²⁴ what they have done, and almost sometimes talk it through, in basic detail about why they have got to the decision they got to. But just because you have been in a position for a long time doesn't necessarily mean that you have actually learnt erm and you may only then go up to a certain stage in my opinion in terms of your whole learning so then they may be stuck in, not novice, but in that middle stage rather than the expert. Which we would hope that most people would get to.

This suggests that organisations need to be vigilant and to constantly invigorate their members. For the respondent quoted above, an organisation that allows people to stop learning is one in which leaders and potential leaders stagnate (at their peril) (Mark & Scott, 1991).

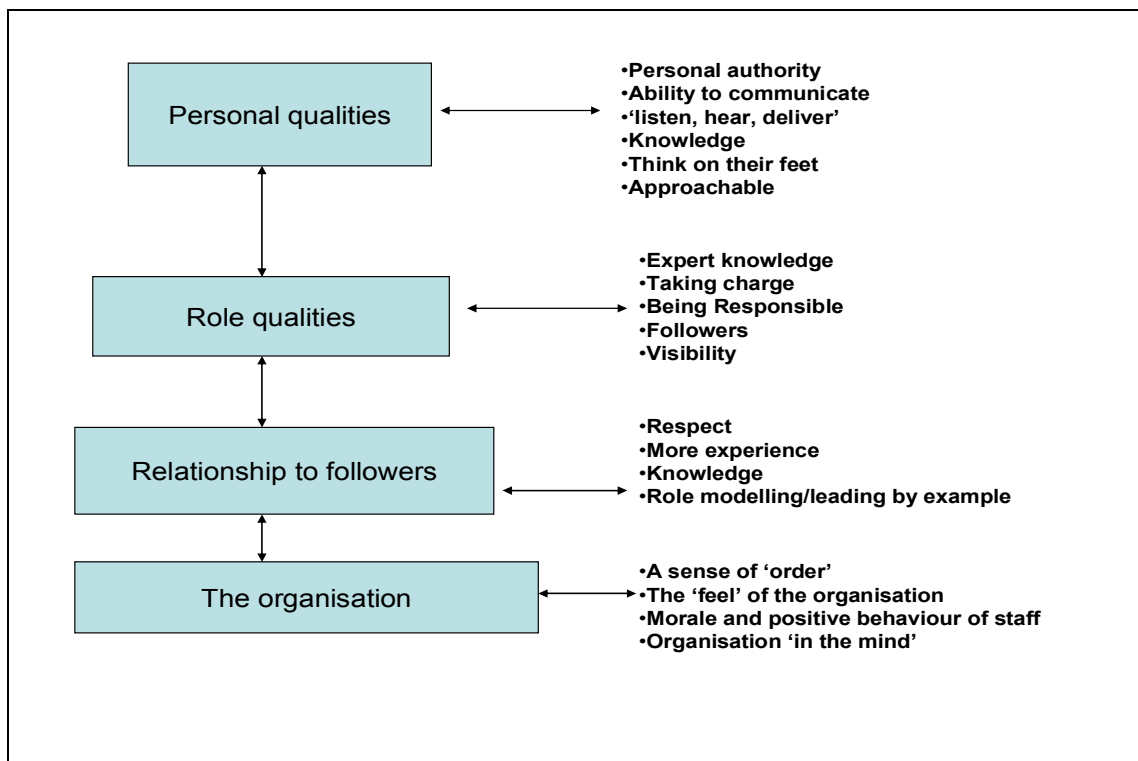
As we discuss again in Chapter Nine, the multi-disciplinary team presents an ideal opportunity for observing leadership (good and bad) and examining the ways in which these teams adhere to organisational norms which might support or inhibit learning (Burke et al., 2006; Day et al., 2004).

One senior non-medical clinical manager in a different Trust also took up the theme of learning and empowerment and specifically how it links to good patient care (Burke et al., 2006; Doherty, 2009; Kuokkanen & Katajisto, 2003).

²⁴ The transcriber who was also the interviewer made it clear that these words were emphasised by the respondent.

... [leadership] is about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is we worked with 'Training and Development' and we came up with a specific programme that was aimed at empowering them [all administrative staff] to improve their service area etc etc and also provided them with some skill sets that they probably didn't have prior to that.

Figure 11. What makes a leader?



4.6 Conclusion

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

Nonetheless, when asked to describe and define leadership, various stakeholders at all levels of the organisation have a view some of which coincides with contemporary NHS discourses and some which seems directly at odds with what the NHS is trying to achieve – that is, to support both

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distributed and transformational leadership that are seen as successful in ensuring effective patient care. However, it is clear that individual personalities and the impact of particular leaders cannot be taken out of the equation.

Leadership is experienced as distributed and transformational but there remains a belief that charismatic and transactional leadership also have their place in complex organisations. While vision is important, no vision can be achieved unless the leader takes 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. Supervision, peer support and informal advice are part of the emotionally intelligent distributed practice of leadership. 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.

In summary, the main ideas that emerged from the respondents' views of how leadership was exercised and experienced were it was about:

- Personal authority
- Ability to communicate
- 'listen', 'hear' 'deliver'
- Thinking on your feet
- Being approachable

Leadership can be exercised in a number of ways and qualities of leadership are seen to reside in different but interlinked 'places'. For example, it is clear that some people are perceived more than others to have the personal qualities that make them a leader, including being able to listen, deliver and be approachable (see Figure 11 above). The assigned/legitimated leadership role is also perceived to be an important quality for a leader, which is interesting, when thinking about the distributed leadership model and particularly the idea of concerted action where people have to work together to 'lead'. This links further to the qualities inherent in leader-follower relations identified as fundamental to the stakeholders interviewed here.

Finally, leadership means holding a sense of the organisation in mind. That is the mental model held by the leader through which they mediate and regulate their vision and actions as leaders, but it also refers to the leader's understanding of morale and the 'feel' of the organisation in which they are working, which itself regulates and constrains the possibilities for growth, development or atrophy.

In this chapter we identified some of the evidence of how organisational contexts evolve and the relationships between organisational culture/climates and the ways in which leadership is practiced. This will be developed across the next four chapters.

5 Leadership and Organisational Climate

5.1 Introduction

Despite its North American origins, where the health care system is fundamentally different from the NHS, Stringer's focus on both leadership and climate nudged us towards choosing an adaptation of his organisational climate survey for this study. We also identified an 'awareness', as he puts it himself, that "*People working in health care systems play drastically different roles that are more diverse than the roles typical in schools and businesses*" (Stringer, 2002, P. 188).

Through adapting the OCS we also captured demographic information from our participants as well as a data about satisfaction with the leadership one receives from his or her immediate supervisor²⁵. Thus, while on the whole Chapter Four dealt with general descriptions, definitions and values, in this Chapter we focus on specific relationships between individuals and the individual and the perception of their organisational climate.

The additional contribution the survey data makes to the overall aims of the study is to relate perceptions of leadership and management directly to organisational climate, thereby providing a triangulation with the story - telling and focus groups to explore the characteristics of organisations that facilitate or hinder leadership and service delivery.

5.2 Results

5.2.1 Normality of data

When normality was examined the KS-Lilifors test was found to be significant over all the scales, indicating that the data were not conforming to assumptions of normal distribution. However, inspection of the histograms and boxplots were found to present an acceptable level of

²⁵ Our version of the survey questionnaire is appended.

normality. Due to the nature of the data it was decided not to transform it, but rather to interpret the results which rely on the assumption of normality with caution.

5.2.2 Cronbach's Alpha

In order to check the reliability and internal consistency of the OCS in this setting we used Cronbach's Alphas (Cronbach, 1970) (See Table 2).

As can be seen from Table 2, the three dimensions of '*commitment*', '*support*' and '*recognition*' were considered to be high on reliability as their scores ranged from .69 to .74. These would be considered acceptable-good level of reliability (George & Mallery, 2003).

In contrast, the three dimensions '*structure*', '*standards*' and '*responsibility*' were low on reliability. This low reliability may be explained by confusing wording of the items, or it is possible that the individual items did not correspond well to one another in this sample. As such it was decided to remove the '*responsibility*' scale from the rest of the analysis. A further check to see whether '*structure*' and '*standards*' could be improved by removing single items, did not show any improvement to the alpha so these were retained in their original form.

Table 2: Cronbach's Alphas for the six dimensions

Scale	Cronbach's Alpha
Commitment	.74
Support	.72
Recognition	.69
Structure	.57
Standards	.43
Responsibility	.14

When managerial dimensions were examined for reliability' these were found to be very high ranging from .86 for '*recognition*' to .79 for '*commitment*' and '*responsibility*' (See Table 4).

Table 3: Cronbach's Alphas for the six Managerial dimensions

Scale	Cronbach's Alpha
Managerial Responsibility	.86
Managerial Recognition	.83
Managerial Standards	.83
Managerial Support	.81
Managerial Commitment	.79
Managerial Structure	.79

Overall scores for organisational dimensions

In order to derive the scores for individual dimensions, all the items on each dimension are summed [this is after all the negatively worded items were reversed].

The following were mean and standard deviations across all the six Organisational scales:

Table 4: Mean and Standard Deviation

Scale	Mean	Std
Commitment	14.82	2.86
Support	14.06	2.80
Responsibility	9.93	1.73
Structure	9.01	1.88
Recognition	8.42	2.55
Standards	8.36	1.69

Stringer, et al (2002) suggest an analysis of percentages of respondents who scored above the mean. In our analysis the following percentages were found:

Table 5: Scores above the mean

Scale	% above the mean
Commitment	60%
Support	47%
Recognition	49%
Standards	49%
Structure	39%
Responsibility	58%

Stringer offers a method of interpreting these percentages, according to benchmarked ratios collected through their extensive research to validate the tool.

High 'commitment' (60%) – In the current sample, there was a high degree of 'commitment' to the organisation and its goals. This would be typical of professional staff working for the NHS. However Stringer asserts that high 'commitment' needs to be accompanied by high 'support' and high 'recognition' – without these individuals will stop engaging with others in the organisation and their team (p.200). As indicated in Chapter Four engagement is crucial if leadership is to be effective.

High 'responsibility' (59%) – Stringer asserts that 'responsibility' is a difficult dimension to interpret within the health care setting. Effective performance in the NHS requires that procedures be double checked, which in many other contexts would put the role of 'responsibility' in an ambiguous position. However this is not the case in complex clinical settings (or for example in other precision performance occupations such as flying aeroplanes for instance). In the case of the current sample 'responsibility' was high, which is related to high sense of 'commitment', but is confused by the limited 'structure' – it is essential that people are clear about their roles, so that they may take charge and 'responsibility'.

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Moderate 'recognition' (49%) - According to Stringer scores lower than 50% may indicate that participants are feeling unappreciated. In this case there is just under the 50% mark, which translates into moderate agreement about the feeling of being rewarded for one's efforts. Having a high sense of 'recognition' in an environment such as this is of crucial importance for motivation, but 50% is within the normal range set out by Stringer. High 'recognition' is indicative of confidence in the organisations performance/reward ratio but in such a diverse setting as a hospital with a diverse staff group responding to the OCS then different groups with different management and professional/occupational structures would have different perceptions and experiences.

Moderate 'standards' (49%) – there is a moderate feeling of pressure - performance 'standards' and expectations are high but not to the point where they are stressful. This falls within an acceptable range. Considering that many of the 'standards' (targets) are set out by government policies rather than directly by Trust management/leaders it is important for these standards to be realistic and achievable.

Moderate 'support' (47%) – this falls within the low but acceptable range for this scale (45%-60%) according to Stringer's benchmarks. This indicates that there is sufficient unity between teams to approach and solve problems, without overly nurturing so as to discourage individual 'responsibility' and undertaking. Team work within the health care system is challenging because of the interdisciplinary nature of teams which inevitably calls upon different management and professional structures and networks for support.

Low - Moderate 'structure' (39%) – Under half of participants felt there was clarity in terms of their roles, responsibility and authority. On the one hand this means that there are less constraints and a less of a 'jobs-worth' approach, on the other hand though it means that there is (potentially) insufficient clarity in roles and responsibility. In an organisation such as the NHS, this may be a considerable shortcoming and Stringer (p.193) suggests that in a health care environment such as a hospital, one would ideally like to have 'structure' scores above the 70s. This is emphasised because of the complex nature of the hospital environment with so many individuals involved – accountability needs to be very clear. The NHS however has gone through so many changes over the previous ten years that it is inevitable that the 'structure' score would be influenced.

Associations between the six dimensions on the organisational level

Pearson's r was utilised to test the relationship between all the Organisational scales. It was found that the majority of scales showed modest, but significant relationships:

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Table 6: Correlations between the six organisational dimensions

	Standards	Structure	Recognition	Support	Commitment
Standards	1.00				
Structure	ns	1.00			
Recognition	.22*	.47**	1.00		
Support	.17*	.42**	.61**	1.00	
Commitment	.30**	.39**	.59**	.67**	1.00

* <.05

** >.001

As can be seen from Table 6, there are a number of high associations between these dimensions. The highest associations are for 'support' and 'commitment' (.67) 'support' and 'recognition' (.61) and 'commitment' and 'recognition' (.59). In other words, participants are reporting that when a feeling of co-operation within teams is present, this is often accompanied by acknowledgement and appreciation and is further related to a greater sense of dedication and 'commitment' to the goals and aims of the team. By definition, the converse also applies: feelings of isolation are more likely to be accompanied by lack of incentives and disenchantment with the objectives of one's team. This is 'supported by Stringer (p.200).

Satisfaction with leadership

When the *organisational dimensions* were examined in relation to satisfaction with the quality of leadership received from the immediate manager, which was asked as a single item, the scales which correlated most highly were 'support' (.61) and 'recognition' (.52). The weakest relationship was to 'standards' and 'structure'.

Table 7: Correlations between organisational dimensions and satisfaction with Leadership

	R (sig)
Standards	.14*
Structure	.30**
Recognition	.52**
Support	.61**
Commitment	.39**

In order to evaluate the individual contribution of each of the organisational dimensions to the overall 'satisfaction with leadership', a regression analysis was conducted, which included all items which were found to correlate significantly with satisfaction, namely 'standards', 'structure', 'support' and 'commitment'.

The total variance accounted for by the model was 40% (Adjusted $R^2 = .38$) therefore variability in 'satisfaction with leadership' is moderately accounted for by this model.

Specifically, of the five predictor variables the two which were found to predict the outcome variable of 'satisfaction with leadership' were 'support' and 'recognition', 'support' being the biggest contributor with a $B = .52$ ($p < .001$) and the other predictor was 'recognition' ($B = .27$, $p < .001$). The other variables were not significant. [Appendix 1 of this chapter].

In other words, feeling supported by one's team and believing that rewards are appropriate to effort, accounts for a significant proportion of an individual's satisfaction with leadership.

Correlations between dimensions on Managerial level

The second part of the questionnaire asked about individual experiences of management. All six dimensions on the managerial level were highly correlated with each other, with strong correlations ranging from $r = .71$ ($p < .001$) between 'structure' and 'responsibility' to a correlation of $.84$ ($p < .001$) between 'commitment' and 'standards'.

Table 8: Correlations between dimensions on Managerial level and Satisfaction with Leadership

	Manager Recognition	Manager Support	Manager standards	Manager structure	Manager Responsibility	Manager Commitment
Manager recognition	1.00					
Manager support	.83**	1.00				
Manager standards	.82**	.83**	1.00			
Manager structure	.73**	.78**	.79**	1.00		
Manager responsibility	.84**	.79**	.79**	.71**	1.00	
Manager commitment	.79**	.83**	.84**	.82**	.79**	1.00
Satisfaction with Leadership	.68**	.76**	.71**	.71**	.65**	.76**

** Significant at .001 level

A single item asked about satisfaction with the quality of leadership received from immediate manager. When this was examined in relation to the six dimensions appropriate to participants' own experience of management practices, it was found to correlate highly and positively with manager 'support' ($r=.76$); management 'structure' ($r=.71$, $p<.001$); manager 'commitment' ($r=.75$, $p<.001$) and 'standards' ($r=.71$, $p<.001$); manager 'recognition' ($r=.68$, $p<.001$); manager 'responsibility' ($r=.65$, $p<.001$);

A multiple regression was carried out to examine the perception of 'satisfaction with leadership', as a dependent variable of management practices. The overall association between management practices and satisfaction with leadership was strong ($R=.80$) with associated variance explained of 63%.

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Table 9: 'Manager' dimensions regressed onto 'satisfaction with leadership'

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	-.054	.226		-.240	.811
Manager Recognition	.001	.039	.002	.025	.980
Manager support	.175	.039	.410	4.501	.000
Manager structure	.060	.027	.177	2.260	.025
Manager responsibility	-.018	.032	-.047	-.559	.577
Manager commitment	.165	.056	.278	2.948	.004
Manager standards	.017	.056	.029	.310	.757

In this case, it was manager 'support' which best predicted satisfaction with leadership ($B=.41$, $p<.001$), next biggest contributor was management 'commitment' ($B=.28$, $p=.001$) and management 'structure' ($B=.177$, $p=.025$). In other words, a large proportion of feeling satisfied with one's leadership, pertained to feelings of being supported and the degree to which one's manager inspires and exudes 'commitment' to common goals. A further important element in the equation is that of 'structure' – where roles and responsibilities are clear, it is associated with greater satisfaction with leadership.

As the biggest predictor of 'satisfaction with leadership' was manager 'support', a further regression was done to look at what organisational dimensions related to having good managerial 'support'.

All the organisational scales were inputted into a regression, excluding organisational 'support', with managerial 'support' as the outcome variable. The following was found:

In total the model accounted for 35% variance in the outcome variable (Adjusted $R^2 = .35$). There were two contributors to the model: the strongest one was 'recognition' ($B = .44$, $p < .001$), i.e. the more employees feel that the organisation rewards and recognises their efforts, the more they feel supported. The other contributor to managerial 'support' was 'commitment' ($B = .20$, $p = .008$). [Appendix 3 of Chapter Five]

These findings indicate that organisational 'recognition' and 'commitment', are organisational climate dimensions which most affect the outcome of managerial 'support', and this in turn has the greatest effect on individual's sense of satisfaction with their leadership. This again corresponds with data discussed in Chapter Four highlighting the importance of the feel of an organisation that provides support at all levels.

Regression of all dimensions onto Satisfaction with leadership

When all the variables previously shown to be significant to Satisfaction with leadership, were entered into the model, from both the organisational and managerial dimensions, namely manager 'support', manager 'commitment' and manager 'structure' as well as organisational 'support' and organisational 'recognition', the following picture emerged:

There was a high degree of variance accounted for by the model - 65% (Adjusted R^2). The model was found to be significant ($F = .80.65$, $p < .001$).

The variables which remained significant, in order of their contribution are: manager 'support' ($B = .34$, $p < .001$), manager 'commitment' ($B = .33$, $p < .001$) and Organisational 'support' ($B = .13$, $p = .03$).

In other words, satisfaction with leadership, in this sample, was predicted by a greater perception of 'support' from management, a feeling that managers demonstrated their 'commitment' to achieving common goals and an atmosphere of 'support' and team-work within the organisation.

Organisational and Managerial dimensions

In order to investigate the relationships between organisational and managerial dimensions, a correlation was performed between all of these variables (Table 10). It was found that:

There were strong correlations between manager and organisational 'recognition', and manager and organisational 'support'. There were moderate correlations between manager and organisational 'commitment' and 'structure'. And there was a weak correlation between manager and

organisational 'standards'. In other words, where the dimensions were correlated weakly or moderately, we can identify that 'standards' of the organisation do not necessarily exist at the same level of managerial 'standards'. The same relationship goes for 'structure' – having organisational 'structure' does not predict clarity in roles, as espoused by one's manager. There is a greater degree of correspondence between organisational and manager 'commitment'. When we look at 'support' and 'recognition', we find that both these dimensions tend to be closely related – one is more likely to feel that both are high, or both are low.

Table 10: Relationship between managerial and organisational dimensions.

	Organisational Recognition	Organisational Support	Organisational standards	Organisational Structure	Organisational Responsibility	Organisational Commitment
Manager recognition	.60**					
Manager support		.65**				
Manager standards			.25**			
Manager structure				.34**		
Manager responsibility					-.02 ns	
Manager commitment						.48**

The significance of Role

The largest group of participants was nurses (31%), then clerical staff (14%), managers and porters (14% each). Doctors/consultants/physicians (11%), other allied professionals (10%) and 'support' staff (6%).

When looking at satisfaction with leadership the following findings were apparent: High satisfaction with leadership was reported in total by 54.3%

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(n=113) of staff. Although there were no significant differences by work role, it can be seen that consultants and doctors reported the highest satisfaction (74%), followed by managers (61%). It can be seen that clerical workers had the least high satisfaction (41%), followed by 'support' staff and other allied professionals (54%). This is significant in terms of the hierarchy within the organisation – the higher the position the more satisfied one is with their leadership.

Table 11: The significance of role and satisfaction with leadership

	n	% positive responses about satisfaction with leadership
Managers	28	60%
Doctors	23	74%
Allied professionals	22	54%
Nursing	65	49%
Support staff/Assistants	13	54%
Clerical	29	41%
Porters/maintenance	28	57%

A further examination of organisational dimensions according to role using a one way ANOVA, revealed the following:

In all there were large differences between respondents in terms of their role, however only two scales exhibited differences which reached significance. The first was 'commitment' – doctors/consultants were found to rate significantly higher than allied health professionals on this scale (mean difference = 2.86) ($p < .01$).

The second was 'recognition' – it was found that doctors were much more likely to rate higher than clerical staff on this scale (mean difference = 2.41) ($p < .01$). Both these findings were apparent even after using the Bonferroni correction.

Comparing doctors (all grades) in Trust 1 and Trust 3

An examination of the responses on the item looking at 'satisfaction with leadership' amongst doctors revealed that doctors at Trust 1 (n= 13) had lower satisfaction (Mean = 3.38, std = 1.38) in comparison to doctors at Trust 3 (n= 10) (Mean = 4.20, std = .42). This difference (.81), whilst small, was found to be approaching significance ($t = -2.003$, $p = .06$).

While it is not possible to make an objective comparison between doctors from Trusts 1 and 3 from the qualitative data, there is more evidence in Trust 3 of doctors being both emotionally engaged with both junior doctors and other members of multi-disciplinary teams than in Trust 1 and with distributed leadership. As will be evidenced in Chapter Six doctors and other staff considered 'management' as bureaucratic and distant rather than engaged.

Gender

There were no differences between men and women's scores on 'satisfaction with leadership' ($t = 1.71$, $p = .08$).

When examining differences between men and women on the organisational dimension it was found that only one dimension, 'recognition', was perceived significantly differently ($t = 3.42$, $p < .001$). Men perceived there to be greater 'recognition' (mean = 9.55) compared to women (mean = 8.13). All other dimensions were not significantly different (see Chapter Eight).

When examining the gender differences on managerial dimensions of the OCS there were trends approaching significance in terms of differences between the genders on managerial dimensions, but these did not reach significance when multiple comparisons were taken into account:

Manager 'recognition' ($t = 1.91$, $p = .06$)

Manager 'responsibility' ($t = 2.10$, $p = .03$)

Manager 'standards' ($t = 2.33$, $p = .02$).

5.3 Conclusions

The difficulty obtaining data across all three participating Trusts has not limited the value of using the OCS to triangulate the qualitative data, particularly because a) the OCS gathered information from staff groups who were not represented in the focus groups, shadowing or story-telling

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interviews and was able to identify generalisable predictors of satisfaction with leadership and management practices, and b) the OCS data captured information from specialty groups outside those involved in the participating Units from which qualitative data was collected.

What emerged here was that on the whole, the same climate variables are important in predicting satisfaction with leadership. Within the organisational domain these are 'support' and 'recognition' while predictors of 'satisfaction with leadership', within managerial practices, are manager 'support', 'commitment' and 'structure'.

Overall, therefore, 'satisfaction with leadership' was highly accounted for by manager 'support', manager 'commitment' and organisational 'support' – i.e. these were the 'ingredients' in this sample which were highly related and were able to predict satisfaction with leadership. This suggests once again that managers/leaders were effective if they engaged with followers and that organisations that supported distributed leadership and emotional engagement were more likely to support effective leadership (see Chapters Four and Six in particular).

In terms of role, the higher the position in the organisational hierarchy the more satisfied a person was likely to be with leadership. This was not necessarily the case though across all organisations in the study. The exploration of the case studies in Chapter Seven – where authority and leadership are discussed – reveals how some of the more senior leaders in organisations found themselves to be highly dissatisfied with leadership in other sectors of their Trust, if there was resistance or negligence of their authority.

Differences in gender were only apparent in terms the organisational dimension 'recognition' – it was only on this scale where women scored significantly lower than men. This may say something about equal opportunities and equal pay for equal work, but it might also relate to perception of 'recognition' between women and men discussed and exemplified in Chapter Eight below.

The overall importance of constructs such as 'support' and 'recognition' across the climate of an organisation, and management practices which demonstrate support and commitment, provide further evidence of the importance in engagement and (probably) emotion (including EI and SI) in an organisation.

6 'Organisation in the Mind': Transmission of Leadership and Organisational Context

6.1 Introduction

Leadership in any organisation is understood in a specific context by those involved as either leaders or followers, and as shown in Chapters Four and Five concepts such as satisfaction, support, responsibility, vision and communication among others are described and evaluated within a cognitive or mental framework within which the organisation itself is understood. It is through making sense of the organisational context that leadership and followership may be enacted and transmitted.

We saw how members of organisations *necessarily* hold in their mind fantasy/imagined understandings or images of the *system* (Morgan, 2006). This informs how they work in, relate to and talk about their organisation, based on their perceptions of their own and others' place and role within the system. For example, it is common to hear employees talk about how 'you can never get management attention in this company' or 'we are all dedicated to putting patients first here' (Armstrong, 2005; Morgan, 2006).

Similarly, the participants who completed the OCS held a view of the leadership and management in their organisations, in order to think about the various ways in which their work was recognised, supported and so on both generally and by their managers. While the focus in that case was upon measuring the impact of organisational climate and thinking about a relationship with a specific manager, those who completed the survey would have had to hold a perception of what was happening in their department and the Trust overall.

This is apparent in what follows particularly in the ways 'management' is discussed and taking account of these perceptions provides some evidence about the ways in which leadership is transmitted in these particular organisational contexts and in general. The 'organisation in mind' then involves:

- An 'image' of the organisational structure and relationships within that structure
- A sense of your own role and place within it
- An emotional component
- An awareness at a conscious and/or unconscious level of important information below the surface

6.2 Organisation in the mind

The concept of the 'organisation in the mind' was a model developed originally in the early 1990s by organisational and group relations consultants working at the Grubb Institute, the Tavistock Centre and the Tavistock Institute of Human Relations, to refer to what an individual perceives mentally about how organisations, relations in the organisations and the structures are connected. *"It is a model internal to oneself ... which gives rise to images, emotions, values and responses in me, which may consequently be influencing my own management and leadership, positively or adversely"* (Hutton, Bazalgette and Reed, 1997, p. 114 quoted in Armstrong, 2005, p. 4).

In other words, when we talk about our colleagues, guess what the senior management are doing/going to do and have fantasies about how well we fit, or don't fit, into the structure or system we do so in the context of the organisation we 'hold' in our mind which may or may not relate to that which other members of the organisation hold (Pols, 2005).

Organisations are experienced cognitively and emotionally by their members when they think about how their organisations work and are structured (see Lewin, 1947; Armstrong, 2005; Morgan, 2006). As Stokes (1994) explains it, everyone carries a sense of the organisation in their mind but members from different parts of the same organisations may have *"different pictures and these may be in contradiction to one another. Although often partly unconscious, these pictures nevertheless inform and influence the behaviour and feelings of members"*. (p. 121)

Hutton (2000) talks about it as *"a conscious or pre-conscious construct focused around emotional experiences of tasks, roles, purposes, rituals, accountability, competence, failure, success"* (p. 2). Morgan suggests that an organisation may serve as a 'psychic prison' in that the:

...patterns and meanings that shape corporate culture and subculture may also have unconscious significance. The common values that bind an organisation often have their origin in shared concerns that lurk below the surface of conscious awareness. For example, in organisations that project a team image, various kinds of splitting mechanisms are often in operation, idealising the qualities of team members while projecting fears, anger, envy, and other bad impulses onto persons and objects that are not part of the team (Morgan, 2006, p. 226).

Some of this is apparent when talking to NHS staff about the leaders at various levels of their own Trusts and the NHS overall as was seen particularly in Chapter Four.

6.2.1 Organisation under the surface

So, when the respondent immediately below talks about the leader who has a 'really good understanding of the organisation or team' what exactly does that mean? How does that understanding come about? What do the team hold in mind about that particular leader?

Leadership is someone who has a really good understanding of the organisation or team, erm where it's going and where they imagine it to be going, so that sort of vision as well for their team, I think. (Lead Clinical Non-medical Health Professional, T3)

This respondent, referring to the (frequently used) concept 'vision', also identifies this with the *imagination* the leader holds about where the organisation is going. This is not simply a matter of guesswork. It is an intellectual/cognitive and *emotional* sense of an organisation. Indeed to take this slightly further, as Gabriel and Schwartz (2004) propose "... *what goes on at the surface of an organisation is not all that there is, and ... understanding organisations often means comprehending matters that lie beneath the surface*" (Gabriel and Schwartz, 2004, p. 1).

Although not necessarily (in fact mostly not) made explicit, even the most clear thinking senior members of organisations hold an image of the organisation in mind, expressing their fantasy/belief/perception of the organisation based on conscious and unconscious knowledge (Halton, 2007; James & Arroba, 2005). So for instance for this CEO leadership is understood emotionally as it is:

... about the feel of the organisation and what it feels like in terms of how it delivers patient care. Yeah, erm. I can best illustrate that, and interestingly we were thinking about this earlier this morning, so as a group, the executives, we were talking about it. When you walk onto a ward a hospital ward and there is real leadership on that ward, you walk in and there are a number of signals that are given off, which give you a feel. Erm the place looks organised, it has a welcoming feel, the nurses on the ward and the clinical staff greet you as they come into contact with you. They know you from the previous interactions that you have had and when you sit there and listen to what is being said on the ward they will know that the patients, the visitors on the ward, the families that are coming in the junior doctors who are in there in that environment and all of that has a feel²⁶ of a well led ward. (CEO)

²⁶ Respondent's emphasis.

The environment of the well led ward (unit or organisation) is implicitly and unconsciously identified by all who engage with that organisation. The staff communicate effectively (visually, verbally and emotionally) so that the information required is passed on through managers, clinicians to colleagues, patients and relatives. This account, which preceded the extract that focused on strategy, directed to the best patient care for the greatest number of patients, expresses his ideas at an *emotional* level. He also suggests his senior colleagues agree with this. Signals are 'given off', you can 'feel' the organisation and how it delivers patient care and there is a 'welcoming feel'. He also talks about 'empirical' evidence in that staff know the patients, the ward looks organised he remains convinced that there is a 'feel of a well led ward'.

From a slightly different position, a deputy CEO quoted below also holds in mind the fantasy that a manager might think that they run an institution but that such a fantasy might get the manager into trouble. He is suggesting a vision of an organisation in which a manager has very little control, and proposes the need to gain a sense of *reality* by recognising this and taking responsibility for this organisation (Hirschhorn, 1997; Porter-O'Grady, 1995). His perception, again which has an emotional component, is one of a stressful contradiction – responsibility without power or control (de Vries, 2000).

The minute, as a manager, you start to think that you do [run the service without accountability]... erm then you're in trouble. Unfortunately you have still got the accountability for the service but you have very, very little control so it's a whole different leadership and managerial skill that is required I think in terms of recognizing that you have no control over what happens you know across this organisation across the N,000 beds here at [Trust], the thousands of people that go through the organisation everyday, what happens to them is completely outside of my control but if anything goes wrong it is absolutely my responsibility. And that is quite difficult.
(Deputy CEO, T 1)

6.2.2 Structure in the mind

Most recently Laughlin and Sher (Laughlin & Sher, 2010) take up a version of this concept which they name the 'structure-in-the-mind' in their analysis of developing leadership in social care. They reassert, in their model, that not only the local stakeholders (staff and service users) have a sense of the organisation in the mind when considering, for instance, a particular Trust, but the range of stakeholders includes government bodies and service commissioners (in the round). They propose an inter-relationship between perceptions of communications from services (e.g. 'that you [management] don't listen and/or understand') and perceived communications from 'Head

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Office (or government or other bodies that control resources and practices) which include for example 'just do it' 'we know better' and 'be rational'. (p. 9)

What is significant here, in the context of NHS leadership, is that the organisation and/or structure *in the mind* is where the leader and followers 'meet' emotionally as, similarly, do the various levels of leadership and governance bodies. It is a kind of 'virtual' space.

An example of this structure in the mind might be seen through the increase in stress for NHS employees detailed in a recent report by NICE (the National Institute for Clinical Excellence²⁷) where it was revealed that staff absence caused by work related stress costs the UK over £28 billion. It was proposed that a poor working environment characterised by bullying and poor management was at the heart of this problem²⁸ (Edwards & O'Connell, 2007). In a context where there is distributed leadership and a highly trained professional, multi-disciplinary workforce, such mismatches in how to run organisations and departments that lead to staff stress in these ways (e.g. being bullied and bullying) evoke questions about what is happening in the space between those who plan, govern and resource NHS Trusts and those who carry out the work. The emotional elements of leadership and followership relations seem to be neglected to everyone's disadvantage.

The idea of the organisation in the mind raises important questions of how leadership (good and bad) is transmitted across the NHS and its Trusts (Harrison & Carroll, 1991; Walsh & Ungson, 1991). Organisational cultures and climates are reproduced over time despite the coming(s) and going(s) of CEOs. However, organisations also *adapt* and *evolve* as a response to changes in leadership and outside influences (Morgan, 2006).

In what follows we explore the characteristics of the organisations studied here that facilitate or hinder the transmission of leadership through the Trust as a *system* through which culture (e.g. principles and values about leadership) might be transmitted (Hatch, 1993; Schein, 2004).

²⁷ An organisation established to oversee and provide guidance on clinical practice and cost and clinical effectiveness.

²⁸ See news.bbc.co.uk/2/hi/health/8343074.stm and NICE web-site which has a power-point presentation.

6.2.3 Transmission of leadership and Organisational Contexts

What is held in mind about an organisation is often influenced by the formal and informal networks (Balkundi & Kilduff, 2005, 2006; Goodwin, 2000) which characterise complex adaptive systems. Network cognitions in the minds of leaders are embedded in the whole organisation and the inter-organisational linkages formed by leaders as representatives of organisations (Balkundi & Kilduff, 2005).

The context of the NHS seems to have become increasingly complex and chaotic (Currie et al., 2009) which, coupled with a sense of widespread unethical managerial practices, has raised questions about how leadership practices are transmitted through NHS organisations (Bowie & Werhane, 2005; Collier & Esteban, 2000; Huston & Brox, 2004). Bullying and poor management are in part at least a consequence of not taking the emotional context of organisational life seriously (Ashkanasy, Jordan, & James, 2003; Cocco, Gatti, Lima, & Camus, 2003; Johnson, Cooper, Cartwright et al. 2005; James, 1999; Hutchinson, Vickers, Jackson & Wilkes, 2006).

While there is no excuse for bullying or any other unethical management practices, it is necessary to understand what precipitated the relatively recent change in culture which has exacerbated (reports of) bullying. One factor has to be the extent to which top-down, politically driven changes have been forced through the NHS system and other public institutions and the impact that the drivers of these changes have upon the senior levels of management consciously and unconsciously (Christensen & Laegreid, 2003; Dent, 2005; Gabriel, 2004).

These recent developments have influenced the psychological and emotional aspects of working in teams, groups and organisations (Liden & Antonakis, 2009; West & Anderson, 1992) and by implication influenced possibilities for innovation in leadership and the authority of leaders and workers (Lewin, 1947; Miller, 1993; Carter, Garside, & Black, 2003; Hirschorn, 1997; Fineman, 1994, 2000; Payne and Cooper, 2001; Vince, 2002; Carter, Garside, & Black, 2003). Understanding the *context* of leadership, therefore, has become increasingly important as has the need to understand how that context is part of a *system*.

Post industrial (or postmodern) systems (Rose, 1991) have been reconsidered (or 're-described') relatively recently as 'complex adaptive systems' (Collier & Esteban, 2000; Dooley, 1997; Schuster, 2005). Systems that are complex because of multiple interconnecting relationships are liable to evolve through making new connections that increase their complexity (Collier & Esteban, 2000). In the NHS, even though change is structurally driven, the (perhaps unforeseen) consequences of changes have meant that instead of a command-and-control, top-down hierarchies where in particular

clinicians such as consultants and matrons had previously been seen as 'gods' (as with Sir Lancelot Spratt and Dr. Gregory House see Chapter Four) distributed leadership, networks and different statuses attributed to individual Trusts (e.g. Foundation Trusts with relative independence, Mental Health Trusts which have social care and NHS staff and diverse management practices) have evolved within different structures at all levels for coping with service delivery (see Chapter Nine).

6.3 Open systems theory and boundary management

An organisation that *evolves* like an organism and adapts to its environment necessarily has *porous boundaries* so that it can 'take in' and 'put out' beyond itself. This kind of organism is one that changes, develops and grows. A closed system may feel more secure in that it may not have to accede to unwanted influence or demands, but without taking in and providing for the world outside it will atrophy as with any other closed (minded) system (Morgan, 2006). In this way images and cultures of leadership from outside the boundaries might influence the development of leadership practices e.g. data and ideas from education (Currie et al., 2009; Gronn, 2000; Lumby, 2003)

Systemic thinking is a framework, or tool, for observing the way organisations behave (Schein, 1985; Lewin, 1947; Campbell et al, 1994) which evolved from General Systems Theory, (von Bertalanffy, 1956; Miller and Rice, 1967) and focuses upon concepts related to organisational structure particularly 'task', 'role', 'authority' and 'boundary'. There is also a psychodynamic part of the systemic thinking analysis which links with the conscious and unconscious emotional consequences of the systemic properties and the impact of social and personal factors on the functioning of the organisation (James and Huffington, 2004; Laughlin & Sher, 2010)²⁹.

Morgan (2006) identifies how knowledge and power are accessed and maintained through control of organisational boundaries. 'Boundary' is the term used in open-systems theory to describe the interface between different parts of the organisation and the organisation and the outside world. In the case of the NHS this is the physical boundary to the, for example, hospital building, the wards, the web-site, the reception desk, the

²⁹ This issue is further discussed and explained through object relations theory based on the works of Melanie Klein, Elliot Jaques and Isabel Menzies-Lyth which is outlined in detail in Chapter One and operationalised in the description of the role of obstetricians' anxiety in the delivery of patient care discussed in this chapter and below in Chapter Nine).

telephones, e-mail and so on and also between the different roles such as out-patient/ in-patient, staff /patient, clinician/manager and so on. Most leaders in organisations have the knowledge and abilities by definition to manage and negotiate those boundaries. For example, the senior managers relate to government/NHS/DoH in ways that junior nurses do not, but the senior staff are charged with having to manage the boundaries using knowledge and influence across the boundaries – inside with the staff and patients and outside with government and patient pressure groups. Moreover, as evidenced during the conduct of this project, hospitals merge into Trusts and the porosity or opacity of the boundaries between the different organisations that have come together are central to the functioning of leadership at most levels (see Chapter Seven where the limits of authority are discussed in this context).

Stating this in a slightly different way, this approach to the 'organisation in the mind' takes the *personal* (conscious, pre-conscious and unconscious) level of thinking and links it to the *system* in which that person works (systemic thinking). As any organisation comprises systems (with boundaries, in-puts and out-puts), groups and individuals, it follows that a person's experience of an organisation and *experience of themselves* in relation to others who are in the same organisation make up the culture, climate and everyday dynamics of any organisational context. Thus, our respondents' sense of the 'organisation in the mind' is a valuable concept for understanding how leadership relates to service delivery.

6.4 Images of the organisation

In what follows we explore some of the images 'held in mind' by staff across the three Trusts particularly examining the impact of the organisation in the mind on working collaboratively and the influence of this on service delivery and the quality of patient care that results from staff relations and effectiveness.

To begin, we focus on two specific examples that characterise much of what was said by staff across at least two Trusts:

- images (and fantasies) held about 'management' which highlight the construction of 'authority' in the system and its impact on patient care
- images (and fantasies) held about the 'others' (e.g. colleagues in the same Trust but on a different site or a different Unit) which brings boundary management into play
- how these images (and fantasies) facilitate and hinder the transmission of leadership and service delivery

We employ a critical discourse analysis (CDA) approach to the meaning and processes of leadership and organisation exploring how the organisation/system *looks* to the participants and how this in turn impacts upon the system of providing care for its patients.

6.4.1 'Management' in the mind

As in many organisations, rhetoric about 'management' abounds particularly played out as a 'them/us' dynamic as we demonstrated by separate means in Chapters Four and Five. Furthermore, among management, rhetoric about their own practices and role in relation to that of the workforce is equally active (Alvesson & Sveningsson, 2003a; Borins, 2000; Kuokkanen & Katajisto, 2003).

There is general cynicism across all the respondents who defined themselves as non-management *about* management. So for example: *"And you find that when there's a crisis that's when you find your management team will come down and put a policy in place regardless - like the swine flu thing" (Junior Midwife)*. So here managers are described as paying no heed to the routine tasks of the organisation (Cummings, Hayduk, & Estabrooks, 2005b). They are portrayed as simply responding to a crisis and (presumably following orders from the overall leaders of the service). Thus, managers are not seen as managing the boundaries between the Trust and those in overall charge of health care operating outside of the organisation (i.e. at the level of government) effectively for the facilitation of service delivery (Buchanan, Abbott, Bentley, Lanceley, & Meyer, 2005; Kane & Patapan, 2006). This resonates with Laughlin and Sher's (2010) analysis discussed above.

A focus group from one Trust proposed a particularly strident view of management and its relationship to wider bureaucratic imperatives which they saw as going against service delivery and effective patient care. The medical staff here were proposing that management was both absent, in person and from taking responsibility, while also being all controlling of medical care through instigating seemingly pointless rituals which seemed to maintain boundaries.

Consultant: There is a burning example [here] of bad leadership which is the absence of figure heads. Management can never be found which is frustrating.

Registrar: I've been in theatre now for two weeks and two cases were dropped. The doctor has to apologise to the patient but they are the ones [the doctors] who would like to continue. Management say 'NO it is lunch'. They should be the ones taking responsibility for telling the patient but the

doctor has to go back to the patient and look like a donkey saying 'I'm sorry I can't do your operation today'.

The members of this group, who clearly shared the same or similar images of management and its 'idiocy', went on to decry management incompetence across all staffing issues, and the registrar continued, imitating the management in a silly voice: "*he has to stop, that's the rule*" making it very clear that management was perceived by this man and others in this focus group as inflexible (and rather stupid). Here these participants are expressing total lack of faith in the authority of those who manage (rather than lead) them, although in fact it seems that despite this, they abide by the rules which suggests that there is a belief that at some level the managers in question here derive authority from somewhere higher up in the hospital system or from the NHS leadership beyond.

One factor to note, of course though, is that the power of the story in the focus group may belie the views of the whole group in that some would be silenced by the fear of disagreeing with their colleagues (Asch, 1956; Foucault, 1982). Furthermore, the articulation of the behaviour of management in these cases is *actually a form of leadership* and as such might influence the views of the focus group (and subsequently other staff) (Avolio et al., 2004; Pye, 2005).

From a different focus group, this time with junior midwives, it was apparently *giving up their authority* for a while that gained managers some important respect. For instance when a crisis occurred in the organisation (in this case a fire) then managers seemed to behave very differently and even impressively:

1³⁰. Yeah and then the managers - the bed managers - were carrying chairs and everything and you just had people on beanbags on the floor and everybody ...

2. I wasn't here that day I missed that.

1. Well it was a bit stressful but everybody just mucked in and people were just carrying people here and you know....

Q: Well that's really good if everybody even the managers mucked in.

1. Yeah you find in a crisis the managers do come out, the leadership the leaders come out and they have to come out.

3. And people were coming in from home to help that day.

³⁰ The number denotes the speaker.

2. *Why didn't they phone me? I don't know but never mind ...*

1. *No you find that in that kind of crisis everybody from execs downwards pulls rank and everybody comes in and helps out (T 2).*

So the image here is that a crisis brings out the best in everyone (and the boundaries between the groups of staff become temporarily porous). In times of crisis then the tasks (i.e. patient care and running an effective hospital) overcome other elements of potential discord and conflict such as the 'rank' order of 'execs' bed managers and others such as clinical staff.

There are also other times when it is possible for management to be seen as 'on side' as indicated by another nurse in a different site. For example:

Erm ... our manager, she is quite approachable. And she is willing to discuss things with you if you don't feel that something is right and you question it or question her. She is willing to sit down and explain it and sometimes she will say 'I'm not happy with things as well, but the people above me this is what they have decided, this is what we have to go along with. It is government guidelines or targets have to be met'. Although she might feel the same as us she explains why we have to do things in this way. And I think she is very approachable.

This manager above, demonstrates her willingness to communicate and be 'visible' but clearly she has adopted a them/us strategy similar to those who 'oppose' management by positioning herself as managing the boundary from the side of the clinician/nurse's while also at other times presenting herself as mediating between 'government' and clinicians and managing that boundary too (Laughlin & Sher, 2010).

In the example described here, this seems to 'work' as evidence of good leadership for the nurse telling the story, but it involves the manager in question in potentially difficult dynamics and conflicts in her role.

From another focus group discussion that included doctors and nurses the organisation in the mind experienced management as absent and failing in their responsibility (Hogan & Kaiser, 2005):

Absence would be correct. Management are often not there. They need to take command of the situation. Here is the reasoning – management don't take responsibility for their actions and there is a severe lack of managerial leadership.

This is significant in the concept of the organisation in the mind when juxtaposed with the account of the same organisation by the CEO who saw her/himself as seeing good leadership as manifested in:

Visibility in terms of being seen around the place, so go out wandering around the wards. The best part of the role, quite candidly is, the best part about being the chief executive is, you can go out and talk to patients, and that is what I really kind of enjoy. ... so there is something about my presence and my profile. There is also something about being very clear and repeating the message often enough so that it is clear in the organisation about what the organisation is there to do.

So, within the same organisation there is an image that management is invisible and absent, while senior managers see themselves as 'being seen around the place' constituting an important part of what they believe they do and that they see as being vital for effective leadership and patient care (Laughlin & Sher, 2010). Both sides agree on what would be good leadership but each 'side' has a different vision of what is happening in 'reality' (Alvesson & Sveningsson, 2003a; Buchanan et al., 2007).

In the absence of a shared vision of an organisation working together or a set of clear guidelines about how 'this organisation works', there seemed to be a wish from a deputy CEO of another Trust for a hero/charismatic leader to put things to rights and potentially cross the managers/others boundary (Ladkin, 2006; Laughlin & Sher, 2010).

Erm, this is a very complicated organisation, what we haven't got right is we haven't got a bible that says this is how this organisation works and I think that's a problem so, ((1)) so ((1)) it's very easy for ((1)) despite what I've said about how difficult it was to be a leader, erm and the personality of the individuals who are at the top of the tree, makes an enormous difference in how an organisation I think behaves and works. There is a great tendency if you are a very good individual for an organisation to be based around you and when you leave there is a problem, erm and so the best kind of leader, yes they have that aura of it's about them, of course that's what people look up to but they also put in place processes so that things can happen.

This is a view from the top of the organisation which is expressed at least in part as a vision of a (desirable) mechanistic model – an organisation with a 'bible' about how it works - although this participant also desires a charismatic transformation on the part of leaders.

The hero leader would be a 'very good individual for an organisation to be based around you' and also to have 'an aura'. The metaphors in this extract proliferate – the need for a 'messiah' to save the organisation but also a sense of *dependency* – that 'people look up to' this type of leader who (it would appear) single handedly will be able to put processes in place for things to happen. The vision here is though one in which the system is defunct, stagnant and closed.

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6.5 'Out of mind': leadership and the 'other'

Organisational change is frequently resisted, often because of the disruption to individual's *sense of the system* and their place within it (e.g. Hoyle, 2004). It is also related to the emotional involvement many people have in their work and the way they perceive they are valued within (and how they themselves value) a familiar structure and context (Bovey & Hede, 2001; Zoller & Fairhurst, 2007).

Emotional labour, as discussed in Chapter One, is a key feature of the work that many people do, and is an integral part of any job, but particularly so in an institution of the NHS (see for example Gabriel, 2004). Different occupations require different types of 'displays' and following Hochschild (1983) emotional labour requires adopting emotional displays and attitudes appropriate to the role.

Clearly in hospital work all staff have to expend emotional energy on 'caring' and 'kindness' but it is also the case that working in the NHS, with its many changes for (perhaps) better or (maybe) worse, also requires the ability to be able to 'move on' i.e. mourn the loss of the old structure, sets of relationships etc. and embrace the 'new' with some degree of enthusiasm. The failure to do this (or recognise the need to do this) results in emotional resistance to changes and hanging on to the old systems as long as possible which might defeat changes that improve service delivery and benefit patients (Hughes, 2005).

6.5.1 Leading change and transmitting leadership

In one particular case a senior clinical manager Gerald³¹, was charged with integrating clinical practice across two sites, each of which had their own different ways of working, and different relationships to the boundaries between each other and the clinical teams. While the one (where he was based primarily) had accepted quite radical changes to its organisation, the other (apparently) did not "*..because the sort of ethos and the sort of personalities of the two sites are in the background. They are completely different*".

Gerald's view is based on a reality in that the two sites are structured differently, look different from each other in that the buildings are from different eras and in different styles, and they are in physically different locations. They also serve different demographic populations and have different histories. However, Gerald sees the organisation of the different

³¹ Gerald's leadership is discussed in detail in Chapter Seven.

sites as really being about 'ethos' and 'personalities' which must be in the mind (mostly) as there is a system of authority and responsibility in place across the Trust (via the CEO and other senior people including Gerald) that takes up authority and leadership to ensure consistent practices and organisational change.

Thus, we need to ask why one Unit has (apparently) taken new ways of working on board with some enthusiasm while (apparently) there are barriers preventing the other one doing something similar.

For Gerald, management of the boundaries between in-patient care and primary care teams was the source of a key difficulty:

There are groups of people here who are completely behind the concept that we mind about – integration of primary care – joint working between the Trust and the Primary Care Trust. Some departments work extremely well and are keen to move forward and although we do have our minor difficulties - generally there's one or two departments who are completely against change and erm resistant to anything new. Just like any other organisation where you know you are going to get the type of people who actually make life extremely difficult for you and despite that we've proven how much better our system is.

In the extract above he moves from talking about the other *site* (as a whole system) as being the 'bad' resistant one, to identifying *individuals* on his own site within the 'good' system as making life difficult for him personally despite evidence (he and others have provided) to show how integration works better. This respondent's organisation in mind shifts depending on how well one part of the system fits with his particular vision of a good organisation. This *splitting* (see Chapter One) is a mechanism (unconscious) for preventing the overwhelming feeling that can come from persecutory anxieties (Jaques, 1953; Jaques, 1960; Menzies, 1970). In a management role where (for some reason) authority is being undermined, then the resurgence of persecutory anxiety might be dealt with by splitting of the 'bad' site and comforting oneself with the knowledge of a 'good' site where the organisation works as this leader/manager might wish it to do (Laughlin & Sher, 2010).

6.5.2 Resisting change

In the case of a medical secretary, with over twenty years experience of working in the same hospital, the thought of change in the structure of her working relationships was upsetting. She began engaging with the interviewer by talking about how busy she was and when asked if there was any particular reason why she was busy at that particular time she went into an explanation about organisational change. *"It's just generally busy, but we*

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are in teams now, erm couple of them [doctors] are away and one or two have come back, catching up with everything". It seems as if the teams were the problem for her because previously (and for many years) "...it was one secretary to one consultant and his team. Now for instance today I'm actually taking calls for four different consultants". She was asked about the new structure and made it clear:

erm ... I don't think it's going to work as well as the previous one. Because I think you'll be dipping in and out of so many different jobs that instead of concentrating on the ones that you do well and controlling your one doctor, it'll be confusing and I think there will be mistakes made because one person is trying to deal with too many parts of too many jobs.

Her perception that her role in the organisation might happily continue as one in which she controlled one consultant is characteristic of the 'comfort' of the closed system where authority, power and the processes of leadership are condensed and held 'constant' by an individual. As seen in Chapter Four also change is not usually welcomed without at least tacit resistance and in Chapter Seven two of the case studies will explore how leaders as potential change agents experience followers' avoidance or challenge to changes in practices and structure.

Changes in working relationships bring anxieties which need to be understood and anticipated by leaders if they are to support staff to position themselves differently in the system. Hoyle (2004, in Huffington et al) suggests that during any period of organisational change there is potential for heightened creativity which might lead to doing things differently and better. However, change also brings about risk, uncertainty and the chance of failure which can evoke anxiety both in those promoting the changes (the leaders) and those who might fear loss of their job and the loss of known ways of working (see Hoyle, 2004, p.87).

6.6 Conclusions

Understanding an organisation and what facilitates and/or hinders leaders to take up their authority involves considering the organisation systemically. That is taking account of the boundary management and how that relates to the tasks, roles and power/authority of those who work or are 'consumers' of its work.

Leading change depends upon ensuring those within the system have a sense of how the system works and an awareness of the culture that might be tested as a reality or not. This means, once again, that organisations which are learning environments and where emotional intelligence is applied, are more likely to respond to authority and less likely to subvert

leadership, thus distributed leadership/responsibilities may be taken up or shared more widely.

7 Leadership, Authority and Emotion

7.1 Introduction

As argued above, leadership and emotion are fundamentally intertwined in the workplace (Fineman, 2003). Leaders who appropriately manage both their own emotions (Goleman et al., 2001), and those of their followers, experience better leader-follower relationships, greater opportunity for innovation, motivation and productivity, a more positive organisational climate and improvement in employee and customer/patient satisfaction (Ashkanasy et al., 2003; Avolio et al., 2004; Hollander, 2009). Such outcomes can be associated with both *transformational leadership* (Bass et al., 2003; Corrigan & Garman, 1999; Currie & Lockett, 2007) and *distributed leadership* (Bass & Steidlmeier, 1999; Gronn, 2000, 2002; Mehra, Smith, L. Dixon, & Robertson, 2006b) patterns.

It has also been suggested that followers' 'dysfunctional' dependency is a consequence of failure of the leader to *engage* on an emotional level with those whom they lead (Alban-Metcalfe & Alimo-Metcalfe., 2009; Ashforth & Humphrey, 1995; Bion, 1961; George, 2000). There are different types of such engagement, e.g. acknowledging emotions, drawing them out, honouring them, confronting them, and deflecting them, but although this idea of engagement has been described as "*compelling on the surface, the meaning of the employee engagement concept is unclear*". (Macy & Schneider, 2008, p.3) Even so, there is a common view that such engagement is desirable for organisations in that it connotes involvement, commitment, passion, focused effort and energy from staff thus demonstrating both attitudinal and behavioural components for an effective workforce. (Macy & Schneider, 2008)

Studies of leadership and emotion have not typically been combined with attention to the 'authority' of the leader (Ford, 2006; Stein, 2007) or indeed to the concept of 'power', (sometimes seen and experienced interchangeably). (Morgan, 2006) A study combining exploration of the relationship of authority to concepts of both 'emotion' and 'engagement' (Hirschhorn, 1997) is particularly relevant to the agenda of the 'post-modern' organisation where leadership is distributed (Clegg, 1990; Tierney, 1996) and the organisation potentially fragmented, unmanageable and diverse.

The authority invested in a particular role, such as the CEO (Chief Executive Officer) or lead clinician may not explicitly engage emotion. However, in an organisation such as an NHS Trust, where leadership styles are, or at least

intended to be, characterised by distributed or transformational attributes, the concept of authority is more closely linked to *personal* authority whereby individuals “..bring more of themselves – their skills, ideas, feelings, and values – to their work. They are more psychologically present.” (Hirschorn, 1997, p.9). Thus for example clinical skills *and* personal investment are *both* required for someone to take up authority in practice as a clinical leaderⁱⁱ.

In this chapter we delve further into the concepts of leaders and leadership, particularly focusing upon leaders with a ‘mandate’ to lead change through their formal *role*. The group of participants we specifically focus upon here includes clinical and non-clinical senior managers and we examine the ways these individuals construct their role, their relationship to ‘followers’ and how their *authority* is taken up, experienced and constructed in their specific organisational context³². Authority has more than one meaning. It refers to the authority (sometimes seen as power) invested in a particular role.

Analysis of relationships between people who work in the NHS is underpinned by both the *interactional* and the (related) *emotional* contexts of an NHS Trust as a workplace (see for example Liden and Antonakis, 2009). This knowledge is particularly salient because on the surface, many of those occupying the leadership roles were inclined (at least superficially) to deny the role of emotion although analysis of their stories, shadowing and observations, following the pre-existing literature on organisational cultures, including those which study health care settings, indicated that emotion indeed plays a key role in service delivery and the ways leadership and authority are experienced and constructed in relation to patient care (Vince, 2002; Gabriel, 2004; Hirschorn, 1997; Huffington, 2007; Obholzer, 1994; Vega-Roberts, 1994).

7.2 Case studies

Three case studies were selected to examine the meanings given to the relationship between ‘leadership’, ‘emotion’ and ‘authority’ in relative depth. Each one was chosen (through discussion among the research team) to be (potentially) representative of a ‘typical’ approach to emotional management which reflected a personal style of authority (or lack of authority). These particular cases raised subtle but crucial questions about leadership, emotion and authority through exposing both the conscious and *unconscious* qualities which can either underpin or undermine a leadership *role* (Bovey & Hede, 2001).

³² In this chapter we focus specifically on the senior staff’s perspectives. Others’ perceptions of senior staff were discussed in Chapter Six.

1. The first leader, Gerald, had an 'authoritarian' manner (Adorno, 1950). That is, he appeared to believe that because he was in a senior position other staff ought to do what he told them to do. He was a senior clinician [for a group of particular services], relatively young, very enthusiastic and held an uncompromising vision of how a good hospital should be organised. He was interviewed once by a researcher, once by a group including the PI and 'shadowed' for two days by the same researcher.
2. Kerry in many ways held a similar outlook to Gerald, only she *believed* that she attended to the emotions of her staff if not her own. Kerry was Gerald's immediate boss and evidence from the interviews, shadowing and observations in both cases indicates they did not always work effectively together. Kerry was interviewed twice. Once for information as a key informant by two researchers and the second time by the PI and a researcher together. She was also observed by a researcher for an hour.
3. Quentin was a Clinical Director. He made overt efforts to weigh up the emotional 'risks' to his authority and thus seemed more able to engage with the 'followers' (and thus probably survive) in the *role*. At first he was reluctant to take part in the research directly (although he supported his colleagues' participation) but eventually agreed to be interviewed. Two researchers met him before the interview conducted by the PI, in his role as a key informant and observed him and the senior colleagues in their shared office space for about 30 minutes.

7.2.1 'Gerald'

Gerald held a clear vision of how a good hospital should be organised for the benefit of patients. What he appears to find problematic is managing staff who (for whatever reason) have a vested interest in different styles from those he advocates of patient care, working with colleagues and patients, and/or visions for service delivery.

The following extract is from the shadowing of Gerald.

From the two days spent with Gerald it was very clear that he believed that he was one of the main 'leaders' in the Trust and that he had a strong relationship with the middle and upper managers (including the CEO) which he uses to his advantage especially during long discussions regarding the 'new vision' (which appeared to be very much his vision) for the relationship between the two sites.

Gerald did indeed appear to be one of the main leaders. However, it was unclear whether the power and influence in this leadership role was all smoke and mirrors. Does Gerald play the role of the Wizard of Oz? Does he

think he has more power and influence than he actually has? Does he really have a good relationship with the Trust managers and Chief Executive?

The interview with Kerry (the CEO) made it apparent that she did not consider that he was one of the main leaders in the Trust and it was indicated that she didn't think much of him, and that their relationship might have been fraught.

Discussing the researcher's notes some weeks later, one thing that did emerge was that Gerald 'confused' those around him and was apparently unaware of how others saw him and how far his personal authority actually stretched. Hirschorn (1997) in a study of authority in contemporary organisations has suggested that leaders are no longer the old-style authority figures and because of changes in technology and economics "... bosses can no longer project the certainty, confidence and power that once facilitated employees' identification with them when they [employees] were young and dependent. This is why people are so disappointed in leaders today but also so unforgiving of them" (p. 9).

Gerald, although he had a clear management role and mandate to make the changes he focused on, did not get identified by his colleagues as fulfilling the vision of a leader as there is an implication in the observation extract that his authority may have been achieved via 'smoke and mirrors'. Furthermore his appointment (and that of several of his close senior colleagues) predated the appointment of the CEO. Several questions are raised here by the researcher about whether Gerald has been capable of taking up authority when the CEO takes a stance that at least tacitly opposes him. *This has to remain unanswered in the specific context of this Trust but is an important matter to consider in regard to distributed leadership.*

Gerald prefers to position himself as 'evidence-based' (and therefore up-to-date) dealing with practical matters and not positioning himself as an *emotional* leader. In the interview below, thus, he talks about making difficult decisions but paradoxically, almost from the beginning he focuses in upon dramatic inter-personal conflicts - talking about 'facing up to a fight' and declaring that the Trust 'absolutely' does not have the kind of leadership that enables 'direction' or 'vision'. Does this mean the CEO? Does this mean consultants? It may not even be intended so specifically perhaps it is an expression of general frustration that his vision is not shared.

While on the surface he claimed a good sense of what leadership is about he is also revealing in his talk, the opposite position. Taking a team or department in the direction of the vision and making difficult decisions is for him about a relationship with (not) being 'scared' or further down in this extract, (not) 'afraid'.

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Gerald: Erm...good leadership, err having the ability to make difficult decisions, err, not being scared to face up to a fight...erm...being able to be clear about errr, the direction or vision of the trust, where we are going and be able to errr direct your team into the position that everyone errr everyone is meant to be going, erm I think

Q: Yeah...and do you see that kind of leadership in this hospital?

Gerald: No, absolutely not

Q: No? And why, why not? What's the problem to that kind of...

Gerald: I think that in the past, we .. we have been afraid to face up to a fight, and we have shied away from it.

Q: Yeah

Gerald: From making difficult decisions, and err, and we've let too many people get away with undermining the overall plan that we have...'cause we all know how to deliver excellent healthcare, we all have our views of how this is going ahead, but err, and the grand picture has been undermined by a few, and we've not been able to really face up to those people

Gerald believes that while everyone knows how to deliver 'excellent healthcare' a few have undermined the/his 'grand picture'. He also identifies with a group who support his particular vision while not expressing empathy with those who do not. As the interview progresses, Gerald berates the power (rather than leadership qualities) that consultants have had in the past suggesting that they *undermine* changes that he clearly and sincerely holds about what constitutes good patient care.

Gerald however does reflect on what he is being asked as evidence by his suggestion later:

I don't know about what makes a good [leader]...you know, its difficult to say what makes a good leader...because I'm not sure I'm a good leader, because the qualities that I feel perhaps are necessary, I don't perhaps have ...one of those is patience perhaps...err, being able to tolerate people's err err, err stupidity in a nice way, is essential I think, but I don't have that, I don't think...being, having the ability to listen, err, err, err and not judge or criticise too quickly is very important, but then, taking everyone's opinion into account, but then at the end of all that being able to still go your own way, and persuade everyone else that it was their idea in the first place ... Well, I have certain qualities which help me get the goals that I like...erm...whether I have everybody behind me.

This is one (although not the only one) of the more (paradoxically) emotional interviews from among the senior managers in the study. Gerald

recognises, quite passionately, that a leader needs followers and has to be tolerant. Gerald, though, cannot help declaring that those who presumably hold differing opinions to him to be stupid. He also said later in the interview that he believed many people were *against him* when he was appointed to the senior post as the Trust itself changed shape. While he would not it seems position himself as emotional (rather he sees himself as evidence-based) he chooses to talk in emotive ways and reading and hearing what he says is quite exhausting as he uses all his energy in trying to take the organisation where he believes it should go, but through lack of emotional intelligence, many a time he draws a blank.

Gabriel and Hirschorn (2004) might describe Gerald, at least in part, as a 'narcissistic leader' in that he liked to be told he is important and influential but he is also potentially a bully and authoritarian in style (Adorno, 1950). He clearly found criticism intolerable and split off the 'bad' (i.e. the consultants who didn't go along with his changes from the 'good' i.e. the 'we'). Gerald has a dream which he is determined to make into a reality, however, there is a "*delicate balance between feelings of omnipotence and feelings of impotence which leaders must achieve, in order to enhance the chances of turning vision into reality*" (Gabriel and Hirschorn, 2004, p. 144). These authors argue that narcissistic leaders have a particular aptitude for getting this balance wrong and "*Even if they are talented in their field, their judgement increasingly fails them. This is compounded by the collusion of their followers*". This may be Gerald's 'we'. Gerald fails to connect emotionally with his (potential) followers from outside his close-knit 'we' group even though there may be some admiration for his clarity and link with the NHS mandate. This means, in effect, that important changes which may well be for the benefit of patients in the contemporary NHS are being (effectively) resisted because of Gerald's style of leadership. Gerald also appears to have little idea of how others might experience their worlds, including their emotions.

This theory might be borne out by the following participant, a young female career NHS manager just reaching a senior position. She proposed Gerald, unprompted, as an example of a good leader:

I think he's great, he gets a bit of bad press sometimes, I think people get agitated with him, but I think it's because he tries to manage things, and he tries to be very fair, and he tries to solve problems that have been with us for a long time, so again, I think he is a good leader, he is trying to do the right thing for the Trust in the long term. He is erm ... sometimes it's difficult for him to carry people with him, but I think that will pay off in the long run. And I think he's thinking of a long term plan, he's prepared to take a bit of short term flack...but I think it will work out in the end. I think he's going about doing stuff in the right way, he's being fair and he's trying

to be consistent, he's making sure he's got an evidence base for doing things, it's not just a random decision, he's collecting information, and that kind of thing...I think there are a lot of people in this organisation at this point who would say they didn't think he was a good leader, but I think time will tell the story there.

This extract from the interview, while consistent with Gerald's descriptions of his own behaviour, proposes an evaluation of his style which indicates he is likely to be successful in the longer term because he is 'trying to do the right thing for the Trust'. However also she identifies quite clearly that his leadership is failing to take many of the people who matter along with him, she positions herself as sharing his vision for the longer term benefit of the Trust which may reflect her *a priori* engagement with NHS management rather than with a clinical profession as she does not have a clinical background herself. It also seems to reflect collusion with his narcissistic style because she seems to mirror his version of himself. This participant continues:

Sometimes they're [other senior staff particularly doctors] quite quick to criticise without really understanding what the problem is that needs to be solved, and what some of the rules are we can't ignore. Some of the national directives, that we just have to do, there's no point fighting against them, we've got to find a way of implementing them, and I think sometimes he gets a really raw deal...but he's said, he's consistent, he will communicate to people, write to people and speak to people very quickly the minute they raise a problem, and he definitely shows that he is not shying away from difficult problems...I think that's a very strong characteristic.

Her description of the other staff appears to chime with Bion's theory of a fight/flight basic assumption group based on unconscious emotional ties of the group involved which (mostly) represents an anti-task resistance to the leader (Bion, 1961). *This extract above reinforces the possibility that Gerald is emotionally disengaged from his followers* and perceives his Trust to be in line with and in favour of NHS 'national directives'. The participant here who in a way is 'damning' Gerald with *strong* praise may be looking to Gerald as a potential mentor by making it clear that she will support his particular efforts. However when the researcher asked her about her *own* leadership she said:

.... because one of my strengths is pulling people together, one of my strengths is building teams, so I think from that point of view then yes, but then sometimes I look at people like [Gerald and her immediate boss] and I think 'Oh my God'. I've got so much respect for the way they deal with

the very difficult issues. Sometimes I wonder if I really put my neck out enough to say 'Ok, Ok, this is what we all need to be passionately aiming for.' Even if not everybody is quite wanting to do the same thing. I think sometimes I sit back a bit more and wait to see what the general feedback is, rather than stick my neck out and say 'Ok, this is the direction we've got to go in.' And I think as a leader you have to...well, in fact you probably have to do a bit of both.

This participant, it seems, is somehow subjugating her own skills and strengths to those whose skills and strengths do not correspond with what she believes in makes her a good leader and seems to be putting herself down for the skills she has got and does seem to value. Alternatively, she might have realised that her strengths might complement Gerald's and through his own narcissistic valency he may position her as someone to promote.

Finally, in relation to Gerald, whose example she insists on returning to, having described other more emotional and successful clinical leaders in the Trust:

.... And they [other senior staff] make it very evident that they don't support him [Gerald] in his role, and not only do they make it very evident, but they do a lot of stirring behind the scenes, to get up a bit of a frenzy against him And I think there's some very clever leadership involved in that process, and there's a lot of learning, gathering people in, getting them on board and uniting them in a common purpose, and this and that and the other, but it's not constructive.

7.2.2 'Kerry'

Kerry is Gerald's immediate boss (the CEO) and evidence from the interviews, shadowing and observations in both cases indicates they do not always work effectively together³³. Kerry herself has met with similar difficulties which seem to be the outcome of her attempts to encourage distributed leadership in that:

Kerry: Erm, erm, well we set up a process to...we re-wrote the discharge policy here. I chaired the group. I wanted to know what the problem was about discharges, and I was told we needed to rewrite the discharge policy,

³³ Regardless of personal authority in the cases of both Kerry and Gerald, it is clear that the organisation has had its own very particular problems which are *endemic in the system* (see Chapter Six for a more systemic analysis of leadership).

and we'd just done it. People looked at me, and I just said, well I've spent...I've chaired five meetings myself, where we put all the information forward, and all these arrangements in place and nobody's done anything about it. I think that's poor leadership.

Q: So erm...poor leadership on whose part? Because presumably you had people who you delegated this to?

Kerry: So the consultants, the nurse managers, the matrons...all the people that were on the working group really. And they just didn't implement it. Beyond belief really.

This extract reveals several levels of emotion and authority and (as with Gerald's narrative) there is an 'I' who takes action and the 'they' who are against her. Kerry had identified a problem with discharges but had to ask 'them' what it was and was told that 'we' needed to rewrite the policy. She took up the role of chairing five meetings, the group/'we' put the information forward and the arrangements in place (presumably to take action) but 'no-one' did anything. It is not known how she handled this 'failure' of leadership on 'their' part. Kerry appears to be a micro-manager (in that she herself was involved in the meetings). Reflecting on this interview, and reading the text, one of us reported back to the research team that she had misunderstood Kerry, thinking that Kerry had been talking about her *own* case of poor leadership. Perhaps it was as unclear in the action as it was in the telling (thus perhaps on an unconscious level the lack of clarity was communicated in the meetings). Why did Kerry, as the leader, not pick up the group's dependence (or *resistance*) (Bovey & Hede, 2001; Hughes, 2005)? This suggests that she herself had resisted emotional attachment to her 'followers' and failed to engage them on an emotional level during the meetings. One approach that helps to understand the example above of *resistance*, specifically in the context of the five reported meetings, is the idea of '*fight/flight*' from the work of Wilfred Bion (1961/1983). He suggested that a 'group mentality' (or group culture) emerges from the development of a group over time as it continues to meet, because individual contributions conform to this mentality. In brief, the formed 'group culture' unconsciously constrains individual members (see also Sherwood, 1964).

So, in this case it may have been that despite the seniority of the staff involved in rewriting the discharge procedure, the culture that had developed over the course of the five meetings (and possibly prior to this as 'they' had suggested the need to re-write the discharge policy) had *prevented/resisted distributed leadership*. This could have led to the group not making sense of the leader's expectations and reverting to the comfortable pattern of being that had not been challenged possibly (again) because of the leader failing to manage her own emotions or engage with those of her team.

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Bion (1961/86) suggests, that the group mentality exists on both at a conscious and unconscious level so that the team were probably not deliberately, or consciously, going against the leader. It seemed from the leader's description that the team had been almost 'sleep walking' – not recognising that they had already done what they later ignored and suggested needed doing. Dependency, according to Bion, meant dependency on the leader or "... *when all individuals in the group look to myself as a person with whom each has an exclusive relationship*" (Bion, 1961/86: 119). Within this mode there is little connection between the members themselves and there is a '*mass inertia*' (op cit). This links to Klein's depressive position (Gould, 1997). It also raises questions of who is depressed here - Kerry, the group, or the group in Kerry's fantasy? The unconscious resistance and frustration experienced by the leader here demonstrates the fluidity of power and potentially the influence of gender (Fletcher, 2004; Nicolson, 1996; Vince, 2001)

Kerry, however, did claim success in turning around previously identified failings in patient care targets. How did she manage this?

Well I ... I... I mean it requires a great deal of focus, which hasn't been succeeded by other individuals, so...and it's required the organisation to understand its importance, and that it is possible to do. So it's been trying to talk to people about 'OK it's a target, but it's a quality... a patient quality target, so don't look at it in a sort of derogatory manner'.And ((3)) ...so it's a bit of culture about are you being bullied, as a member of staff to achieve the target and if you're not being bullied well then why is important and then well it's important because its patient quality ((1))...and then I suppose, something about... I mean one of the turning points for me is about our reputation as well, which is...well everyone else is achieving it, and we're not, 'why do you want to be in the bottom 20% of the country?'

Resisting her own emotional attachment here she talks in the third person. Rather than saying that as a new senior manager she had managed to engage the staff, which to a point she seems to have accomplished, she states that successfully addressing targets has 'required the organisation to understand its importance'. She clearly perceives senior staff as taking a negative position in relation to government targets and has attempted to persuade people that such targets are about good quality patient care. Another feature of the discourse slips in here – is her style of leadership perceived to be a bullying one? It may be that a group mentality, which takes resistance and dependency to be part of its culture, perceives a leader with a vision, or at least with determination (and 'focus' to quote Kerry) to be bullying them out of their emotional safety. This is a problem for any organisation that suggests to its staff that successful change and development is solely about strong leadership. We have to turn again and again to the clear message emerging from the data that without an

emotional attachment and the ability to manage their own emotions leaders and followers are not going to achieve goals related to patient care.

7.2.3 'Quentin'

Unlike Gerald, Quentin feels that he is succeeding in bringing about change and unlike Kerry he is mostly positive about the impact he is having upon the staff groups. He told two stories, one of which was when his leadership worked, and another where he continues to experience problems although he emphasised (to support his authority) that the latter was not a great a worry to him. In his interview he focused very much on the importance of personal authority: *"I'm still playing the trick of getting people to do things by example"*. He tries to back up his personal authority through making personal contact as much as he can:

You know my job could be answering my e-mails and I'm desperately trying not to. I've made a pact with myself that I will not explain myself in e-mail. If it needs to be explained I will go and explain it [personally].

He distinguished between the roles of the CEO and medical director, which in his opinion were *manager* roles, and that of clinical director which was a *leadership* role.

Quentin moves between the position where:

...people need constantly to be reminded of what they need to achieve ... [in relation to patient care] ...I use the word good care because [they] have the tendency to lapse into what is acceptable or even worse, what they can get away with.

To the position that:

And I think there is some requirement to continually challenge the organisation about what it is providing and sort of have a re-education process. And I guess we all need that – because I need that as well you know and it is one of my roles to keep reminding everybody why they are doing what they are doing.

Quentin sees himself as needing space to reflect upon the aims of the service provision and recognises that he is just as able to lose track of the organisation's main purpose as his colleagues/followers are, given the daily round of work. While Quentin gives an interesting example of how he and the team succeeded in meeting a target for patient waiting times in Accident & Emergency (which involved him engaging personally with the staff in an emergency meeting):

... which was all about persuading your senior contemporaries and peers. It's about the juniors, the people who are actually delivering the services. It's about making a reasoned argument. It's about being visible. It's about being honest and it's about delivering it.

The success, he believes, was about the personal contact and his own visible attachment in trying to change things alongside his colleagues and being very clear that " *...this needs to be achieved at all costs - which was quite liberating*". The rhetoric here is very different from that used by both Gerald and Kerry, who feel their colleagues are letting them down; possibly they are 'splitting' the 'bad' and projecting it into recalcitrant colleagues in order to feel reasonably good about their own positions (Klein 1987, 1983). Quentin is talking about success and success through *taking an emotional risk*. Saying that a change needed to be achieved at all costs (which he described as liberating) could be interpreted as Quentin making an emotional commitment to engage with his followers about something identified by the government, the NHS and his Trust as important. This stands in direct contrast to the experiences and rhetoric of both Gerald and Kerry who express the frustrations at what the 'others' are failing to do. However with what Quentin called a "*slightly different problem*". He has had great difficulty dealing with a doctor who is "*just a very difficult person to manage ... and I need to say to him 'this is crap and needs to be done in a completely different way'. I don't quite know why I haven't done that*". Once again Quentin was expressing an emotion – anger but without pushing/projecting blame on to the other, but being clear what the other person was doing and reflecting on his own sense of why, how and when he might take this issue up with the protagonist.

While Quentin operates with a quiet assurance and takes up his formal authority, and the power that accompanies it, from a classic Kleinian 'depressive position' (Klein, 1975; Segal, 1973), both Gerald and Kerry, despite their formal authority, fail to engage with their followers which leads to their powerlessness and a sense of rage and frustration.

7.3 Conclusion

The interconnections between power, authority and emotion play a complex part in understanding what leadership means to all those involved and in each organisational context. Leadership cannot be understood as something that can be observed and/or measured 'objectively', it is not an essential 'quality' which resides in an individual but is socially constructed, meaning different things to different people at different times. Following Ford (2010) a more contemporary, appropriate and critical approach to the study of leadership "*pays attention to situations, events, institutions, ideas, social practices and processes that may be seen as creating additional repression or discursive disclosure*" (Ford, 2010, p. 51)

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To be specific Rioch (Rioch, 1975), and others had made the point that *"'Leader' is a word which implies a relationship So the word 'leader' does not have any sense without a word like 'follower' implied in it".* (p. 159).

The relationship between leaders and followers might be more or less successful and in order to be a follower a person needs (even on a very temporary basis) to 'give over' something of themselves (i.e. make themselves emotionally open) to the leader for the relationship to have meaning. Being a follower may be both (or either) passive or active and there is the potential for the follower to engage and support, or subvert leadership (Bondi, 1997; Halton, 2007; O'Brien, 1994). Consequently, in order to analyse what it means to 'lead' in an organisation, understanding the practice(s) of emotional management alongside an analysis of power relations is fundamental (Grint, 2005; Schilling, 2009). For Foucault (Burrell, 1988; Foucault, 1982) power *"exists only when it is put into action, even if, of course, it is integrated into a disparate field of possibilities brought to bear upon permanent structures."* (1982, p. 788) Thus, while organisations give formal power to relatively few leaders (including in a distributed model of leadership) consent is still required for the power to be maintained. Furthermore, 'the other' that is the one over whom power is exercised, needs to be *"recognised and maintained to the very end as a person who acts"* (Foucault, 1982, p. 789).

The leaders we have described above all admit falling into traps where their authority has been challenged/resisted and they have been (potentially) made powerless. Quentin alone demonstrated awareness that he was working *with* people rather than treating them as resources. This meant that despite experiencing some frustrations, he managed to continue to *feel* and *think*, and with his colleagues/followers on board, *implement* changes. Kerry and Gerald, while attempting to take up their 'legitimate' power and lead change, both squander their authority through failing to manage and/or engage with their own and their followers' emotions. This is evidenced by their displays of frustration, impatience and anger with those who fail *to do what they are expected/commanded to do*.

Gerald held a classic authoritarian view of power, indicating that whether he takes people with him or not, he intends to get to the *'goals that I like'*. He also sees the resistant followers as stupid. He defines leadership accordingly, in that the leader should *'direct [the] team'* and not be afraid to *'face up to a fight'*.

Kerry sees herself somewhat differently even though she experiences anger and frustration when followers fail to do what she wants and expects. In attempting to empower her subordinates and set up the 'processes' to distribute empowerment (such as the meetings described above) she was left feeling disempowered following an (apparent) breakdown of

communication between herself and the senior team she tried to work with. That one of the interviewers also had to clarify: "*poor leadership on whose part?*" suggested that Kerry possibly re-experienced the rage and frustration she felt at the time of her encounter with the followers in her story when she told it. This rage obscured clear communication both then and in the telling. It might be that the overwhelming need to prevent the Trust from being '*in the bottom 20% of the country*' was a source of anxiety for her and the importance of achieving these specific sets of goals contributed to her impoverished emotional literacy.

Distributed leadership (Gronn, 2002; Mehra et al., 2006b), as a response to 'postmodern' organisations (Tierney, 1996) sets out the changing nature of authority/power. In combination with ideas from the emotional/social intelligence literature, distributed leadership suggests a more relational model of leader/follower relations whereby leadership decisions may represent both outcomes and inputs (Ashkanasy et al., 2003; Wolff, Pescosolido, & Druskat, 2002). A warning note, however, reminds us of the persistence of the patriarchal version of 'the' leader (Ford, 2010; Ford & Harding, 2008) which occupies the dominant discourse within which the notion of 'effectiveness' neglects (if not ignores) the importance of the management of emotions in the leader and followers.

Through the use of innovative research methods and data analysis, which take account of both conscious and unconscious processes through which leadership is socially constructed and exercised, the intrinsic complex connections between authority, power, emotion and leadership in the context of health care can begin to be disentangled.

Leadership that 'works' for an organisation such as the NHS is a multifaceted, emotional *process* in which leaders manoeuvre to manage their own and their followers' emotions and behaviours on both intellectual and emotional levels. To be effective in, what are now seen to be, postmodern organisational contexts, leaders also need to reflect upon themselves in their role and to understand the structural, cultural and emotional expressions of their authority and the authority and power of their followers. The legitimization of emotionally engaged leaders' authority supports effective service delivery across the different levels of the organisation through undermining conscious and unconscious resistance(s) as described in the examples above. Power as a coercive violence (see Foucault, 1982) has been exposed and undermined in such organisations and 'replaced' by concepts of 'distributed' leadership where the persistent claim to power is by definition and necessity more fluid.

8 Gender and Leadership

8.1 Introduction

Gender and leadership is an area that has attracted interest among policy makers and researchers, because the styles of leadership that are currently perceived to be the most effective, such as transformational and distributed, are believed to 'fit' more closely to 'feminine' styles of leadership. Fletcher (2004) notes that traditional 'heroic' leadership is usually associated with masculine traits (rather than men and women *per se*) such as individualism, control, assertiveness advocacy and domination, while 'post heroic leadership traits (such as empathy, community vulnerability, collaboration) are more associated with feminine traits. Ford (Ford, 2010) reconsiders the concept of *effective* leadership which is in fact a patriarchal model perpetuating an exclusionary and privileged view of the leader (metaphorically the 'father' figure).

Traditional research into gender, organisations power and leadership suggests that there are particular 'masculine' and 'feminine' leadership traits that are generally believed to characterise men and women's leadership styles (Rosener, 1990; Collinson and Hearn, 1994; Nicolson, 1996; Carless, 1998). Because women are widely believed to adopt a more democratic leadership style and men believed to adopt a more autocratic one, distributed leadership and concerted action in networked organisations may potentially be more conducive to those (women or men) who can adopt a more traditionally feminine relational style of leadership. Furthermore, feminine styles are more akin to displaying social and/or emotional intelligence (Guy & Newman, 2004; Leon, 2005).

In reality, both men and women display a variety of 'masculine' and 'feminine' leadership styles, depending upon their individual personality, age, position and the situation involved (Cross & Bagilhole, 2002; McDowell, 2001). However, gender *expectations* influence perceptions and beliefs and research suggests that subordinates are often more satisfied with leaders who behave in gender-typical ways than those who go against gender-type (Porter, 1992; Rosener, 1990; Williams, 1993).

Indeed, women in explicit leadership roles often tend to be viewed less positively than men, in the belief that 'masculine' traits (competition, authority, lack of emotion) conform more to expectations of how a 'leader' should behave but not how a woman should (cf. the work of Broverman et al. 1970). The 'paradox' it seems persists in contemporary organisations so that some women leaders feel they have to behave in a 'masculine' way which frequently makes them appear rather heavy-handed and/or as a 'bullying' because these behaviours do not fit with ideas about women (Eagly & Carli, 2003).

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Most of the women and (some) of the men we spoke to during the study, made a point of denying that gender was an issue in today's NHS, indicating that they believed that women and men were treated equally, with an equal chance of success. However, several participants also mentioned gender differences in the negotiation of power and identities describing how either women or men were likely to gain advantage through use of their gender-typed styles (Lewis, 2000; Schnurr, 2008; West, 1984).

Gender and leadership it seems remains a contradiction in people's minds but gender is a fundamental component of the discourses surrounding leadership in the NHS because of the demographic issues in clinical management and leadership (Evans, 1997; Gardiner & Tiggerman, 1999) and as we have shown in Chapters Four to Seven, role models and styles of leader/follower engagement have a major part to play in the transmission and exercise of leadership (Gill, Mills, Franzway, & Sharp, 2008; Greener, 2007).

We want to note here, partly in passing, although an example below (in the interview with 'Jeff')³⁴ demonstrates its importance - that the *researchers'* gender and physical appearance (age, ethnicity, attractiveness) also played an important role in the research process.

8.1.1 Senior women managers: 'we're all the same now'

Women in senior managerial and/or professional positions either deny that being a woman is an issue for them or for their organisation or that they know what they had to do to prevent being seen as a senior '*woman*', rather than a senior leader.

Denying the impact of your own gender on how you are seen and how you manage and lead is not an easy position to maintain and we observed some senior women working hard not to be seen as women even though at the same time they were arguing that *this behaviour was not necessary* because of the way 'things have changed'.

The researcher's observation of a senior female manager (Catherine) indicated that she thought that Catherine was trying to avoid being 'feminine' in her interactions. When the two interviewers were waiting to begin the interview, Catherine's PA came into the room with an important message but was shouted at in front of them. Thus in her notes one researcher judged that Catherine wanted:

....to indicate lack of interest and assume a position of superiority. Catherine was transgressing the boundaries of polite professional behaviour and attempting to define 'her' territory of the hospital. Answers to the

³⁴ Not his real name.

questions were also defensive, perhaps indicating a lack of self-assurance. Despite the tough exterior she obviously felt a need to stamp her authority on people in order to maintain control of the situation. This may partially be related to her gender and need to appear 'more masculine than the men' in a competitive environment.

The researcher following on from her observational notes with comments following the interview suggested that *"whilst she [Catherine] initially denied gender to be a relevant issue [for senior managers in the NHS], she then went on to make reference to 'testosterone' and 'the emotions of females' as problems in managing in her senior role".*

The relevant part of the interview transcript is below:

Q: Ok, so are men a problem? Are women a problem? Are there gender politics? Or am I just old fashioned there?

A: I don't think there are anymore, I think there were. I mean when I was appointed, I could have been one of [only] four [senior] women, so the whole senior management was very ... very 'suitish'. I don't think, no, I don't think it is a problem anymore. No, I think it is, if you talk to people in the north of England, they will say it's still a problem, and I think its a bit more of a problem to get females into acute trusts, big acute trusts, it's a bit of a climate difference. I think there's a lot less testosterone around now, there's a sort of slightly...erm I mean I've got quite a young male management team.

Q: Right

A: I find the testosterone and sort of challenges a bit much from time to time So I mean from that point of view, it is quite interesting, it does manifest itself. As do emotions of females really.

Catherine's somewhat aggressive, or at least uncompromising, behaviour witnessed by the researcher tended to soften after that and she added:

A; So I do think the answer to the question is that there are differences, but I don't think they're... they don't fundamentally affect how you do the job.

Vicki, a senior geriatrician, discussed the question of gender openly and at some length with the researcher who suggested that she had seen both Vicki and Mandy, another senior female consultant geriatrician, being very 'gentle' in their approach to patients and the researcher wanted to know how far this was linked to the fact they were women. Vicki thought though that their approach was not about gender but:

You know it could be a geriatrician thing, I don't know, ((1)) you know you'd automatically say 'it's oh because we're women', but I think it's only when you start following a few men around as well who are doing the specialty as we are, because the thing that attracts us to elderly care rather

than any other specialties in the first place, and that could simply be what you're observing.

It seemed important to Vicki that she was not stereotyped as a woman leader although she was keenly aware that as more women took up medicine and were arriving in senior positions that this demographic change would in some way impact on leadership.

So maybe that's where you've got to go as well as men in geriatrics you actually need to look at women in other specialties and follow them on a ward round and see what they do and that may be a good idea as well for the gender thing. But it's quite important for your study because at the end of the day we're training over 50% of women as doctors and in the future they think that almost all GPs will be women so that will affect the leadership and sort of, that you see in patient care.

So Vicki, while seeing feminine *characteristics* as more important in her clinical specialism than gender *per se*, still believes women doctors (e.g. GPs) will make different kinds of leaders from men.

During her shadowing of Mandy, the researcher noted what she identified as gender-typical behaviour:

Mandy also implements a mothering aspect to her leadership role (also noticed in Vicki) as she is always thoughtful and considerate to her followers, making sure they are comfortable and happy with decisions made and that they are up to speed with their medical knowledge. This mothering role also seeps into the delivery of patient care. Mandy is also a leader that appreciates the help of her followers and always thanks them for their input and help.

While keeping in mind that the researcher herself is making assumptions about what is a 'mothering' style and also recalling Vicki's assertion that it may be more to do with the kind of people who are attracted to geriatrics than gender itself, it is important to note that the researcher spent several days shadowing and observing female *and* male geriatricians. Further, she discussed reflexively what she saw and how she interpreted it with the research team to check out her observations.

8.1.2 Men: the 'natural' leaders?

The researcher who interviewed and observed Catherine also interviewed and observed Jeff (another non-clinical manager) and contrasted their styles of interaction with other people in the organisation, and with her, during the interview. At first Jeff seemed more approachable, relaxed and generally more amenable than Catherine had been:

Jeff was a newly appointed male senior manager. From the outset he displayed supreme confidence in his own authority and power as a 'leader'

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and obviously did not regard a young female researcher as a threat. He was very friendly and personable and happy to open up the space of the hospital for us, answering his own emails rather than through a secretary, coming to collect me personally from the main reception and chatting and joking all the way back to his office. Throughout the interview he showed confidence in his own opinions and was happy to talk in detail about both his own and others' leadership. This confidence may be a result of several factors such as position, age, class, gender or personality. He freely admitted that he did not mind appearing 'hard' or unpopular if it was necessary to get the job done, however he felt that his main asset was his own 'charm' and 'charisma'.

Thus Jeff firmly claimed his place within the (masculine) 'heroic' leadership tradition.

While Catherine was perceived as guarding her territory and demonstrating her power, Jeff appeared to be relaxed, being more approachable and particularly not hiding behind his PA. In fact, his account of himself in the interview was somewhat disarming.

Q And do you see yourself as a leader?

*A: Oh yes certainly. I can remember the time when I realised that I should be in management. I was working in a **** clinic in [a Trust] and it was so inefficiently run and I said as much to the manager. She said 'if you think you can do it better then why don't you manage?' So I said 'OK I will!' And I think I'm pretty damn good at it. I don't play by the rules, I don't have any formal qualifications, but I can get things done. I'm not perfect – I shout, I swear and mostly I'm just very, very cheeky, but I'm good with people and that's what you need in this job. You have to be tough too, take knock-backs and step on people to reach your targets. But mostly I care passionately about the patients. I would never ever chase a target if I didn't think it would improve patient care. So that's why I went into management, and I suppose the other thing is I discovered, I surprised myself actually about, I was going to say how easy it was, it wasn't easy, erm I had a natural aptitude to do it, you know it was something that I was successful in so you know yeah?*

Jeff wanted it made clear that the 'inefficient' manager was a woman and that he himself is 'good' with people (and on the surface the researcher acknowledged this). However, he also valued the tough, target-driven 'stepping on people' (masculine) qualities of his leadership which he believed were important in delivering patient care.

Jeff put his confidence and self-identified ability partly down to personality, but also to his gender and upbringing, adding that certain class backgrounds seem to 'breed' leaders:

I do think that great leaders are kind of born, but my background was that I was at all male public boarding school for 10 years. As my father said 'the biggest waste of money' given my academic erm qualifications at the end of it, erm and there was something there about you know that sort of environment. I mean does it grow leaders? You would think so, you look at the number of public schoolboys that end up as MPs, that's probably not a good analogy

Q:((Laughs))

A: But there is something about that kind of white middle class upper class upbringing that you have, and although I wasn't from that background before I went to the school, erm you learn survival among your peers, you learn I think to survive, you know if you think at the age of eight you are sent away you have to survive you haven't got your infrastructure.

It seems that Jeff is suggesting that leaders are either 'bred' or 'grown' but either way the influence that makes them a leader comes early in their lives. In the example he gives here, 'growing' takes place in a male-only context reinforced by social class, possibly wealth and a general sense of entitlement. This model does not echo the efforts and ambitions of the NHS in everyday practice nor would it appear to be in any way appropriate to the model proposed by the NHS (see Chapter One) which is focused on the type of leadership appropriate to managing and leading 'diversity' and 'difference'.

8.1.3 Gender wars?

Being motherly (like Vicki and Mandy) is not equivalent to being weak or compliant as perhaps some gender stereotypes might describe women (see for example Bem, 1993; Nicolson, 1996). During an observation of Mandy, the researcher identified what she considered to be a 'battle of the sexes':

Gender issues were brought into consideration during the interaction between Mandy, a female consultant and a male consultant. During this interaction a battle of the sexes and power occurred with the two consultants struggling for power in very different ways. The male consultant tried to assert his power through attempting to ignore Mandy's presence, never looking directly at her, but was raising his voice and being rude. On the other hand Mandy was always very polite, looked directly at him, spoke very softly and smiled a lot, although it was quite obvious that behind the soft smile was a vicious bite.

Perhaps this isn't so much a battle of the sexes but an example of how men and women might behave differently towards each other in the course of a power struggle. The detailed observation notes show the encounter move by move:

There are some territory issues with Patient 9 and Mandy is angry that there is a patient on her ward that is being treated by another doctor. She asks why the doctor has continued his care now that the patient has moved ward and suggests that if the doctor feels that he needs to continue with the patient's care then the patient should be kept on one of his wards rather than blocking a bed that could be used for one of her patients. She asks "why can't we look after this patient? We are not supposed to have any outliers on this ward!" Mandy's registrar Melvyn can not, or does not want to answer her questions and simply shakes his head and shrugs. Mandy says she needs to speak with the consultant and asks Melvyn who the patient is under. Melvyn gives the name and admits that he has seen him arrive on the ward a couple of minutes ago, so he should still be there.

Who is Melvyn afraid of here? Or is Melvyn simply not wanting to witness a battle over territory and patient care?

Mandy walks round the other side of the nurse's station to find the [male] consultant with three other doctors/medical students standing some distance away and his registrar to whom he is speaking. Mandy and 'our' group move over to his location and the junior doctors from both groups greet each other and share whispered conversations. Mandy stands patiently at the side of the registrar waiting to speak with the consultant. Although Mandy continues to smile pleasantly I think that she is angry or frustrated on two levels. First because the consultant is on her ward and hasn't come to speak to her and second, because he doesn't seem to have the manners to even acknowledge she is waiting. After the conversation between the consultant and registrar has finished the consultant turns his attention to his paper work and the registrar moves to be with the other doctors (some distance away) Mandy lifts her eyebrows up to Melvyn (clearly annoyed with the male consultant's behaviour) and then asks if she can speak to him about Patient 9. Mandy explains politely that they do not have outliers on this ward and therefore asks whether the patient could be moved to another ward or if this cannot be arranged she take over the care for the patient. While she speaks the consultant doesn't look at her and continues to write, his body language and behaviour are both arrogant and rude. The consultant says that the patient is his and he will not be passing the patient over as she has problems not solely aligned with geriatric care and that she needs a specialist. Although this was clearly a statement to undermine Mandy's capabilities she continues to smile and tell him that the patient will be moved before the weekend so that a patient needing specialist geriatric care can have a bed.

Moving through this detailed account the gender issue becomes obscured by the fact of Mandy's skill as a clinician, a leader, her concern to give appropriate care within a context of limited resources and her ability to handle herself in the face of rudeness and arrogance. These are skills that ensure she will shine through as a leader in any context but particularly one

which is still a man's world. In a socially or emotionally intelligent context where concerted action is seen as important, patience, politeness and clarity of purposes will eventually win out over arrogance and bluster. As we see in the next extract Mandy's 'opponent' does not possess these attributes.

The male consultant becomes angry and raises his voice to Mandy and says there is nowhere else for the patient to go. Mandy lowers her voice and says that the patient must have been on one of his wards before she was moved so she can move back. The other consultant looks swiftly at the group of doctors who are stood behind him (both his own and Mandy's) and then eyes me suspiciously before turning back to Mandy and speaking in a lowered voice. The conversation moves back and forth between Mandy and the other consultant and it is clear that despite his outbursts and undermining statements to Mandy that she has the upper hand and although she continues to smile, she is very forceful and strong in her argument and objectives. To conclude the whispered conversation Mandy raises her voice and tells the group that the patient will be transferred on Friday and that she will be getting a transfer set up straight away. She then thanks the other consultant for understanding and walks back round to the group with a smile on her face and asks Melvyn to set the transfer up.

This is a consummate example of patience, calm and the ability to lead doing what she considers to be the best for her patients, her team and her department. Her skills in continuing to be quiet, calm and smiling have 'seen off' the male consultant in the meantime but reading this it would be surprising if the humiliated man does not try to take revenge. Although there is very little evidence that this is anything other than a 'normal' power struggle it is the case that Mandy is in fact a woman and has played, what is mostly recognized to be, a feminine role.

Returning to male expressions of power it is important to be aware that blatant attacks, such as the one in the encounter above, are not necessarily the only ways of demonstrating confrontational masculinity.

It appeared from the interview with Jeff (discussed above) that he believed he did not need to defend himself in the face of gender stereotyping. He had strong opinions on women's leadership and also on women's 'availability' with no qualms about voicing these which contrasts strongly with women's accounts where they try to underplay gender, that is that many senior women take the view (overtly) that gender is irrelevant.

The researcher's notes about the meeting with Jeff continue describing a dramatic example:

Jeff's supreme confidence meant that whilst he came across well in an interview situation, he crossed boundaries of professionalism in other ways, telling unsuitable stories about staff and inviting me (researcher) out for a drink after the interview, invading my personal space. In the extract below

he accuses a female colleague of not only being attracted to him, but trying to use her sexuality (unsuccessfully) to get ahead at work, whilst simultaneously flattering me that I am his 'type' by subsequently asking me to meet him for a drink.

And in the interview:

Q: And could you give me some examples of bad leadership that you've seen?

A: Well, Melanie Willson³⁵, have you met her?

Q: No I was meant to but she cancelled the interview three times...

A: Exactly, she probably thought she was too important to talk to you. Now I can tell you an interesting story about her. She's a good looking woman, stunning, very intelligent too. But there's something not quite right, I don't know what it is... really cold. She's got no soul. I appointed her as divisional manager and at first she was doing really well, but then she ran into some problems. She was failing in her job. And that's when she started to flirt outrageously with me. It was like she couldn't beat me intellectually so she was going to do it another way. But, well... she's not my type. And she was really jealous when I got this job, I had Lucy (PA) go and announce it at the morning meeting and you should have seen her face. Anyway I hear she's got a promotion now so she must be doing something right.

Melanie Willson clearly perplexed Jeff – 'stunning' but no 'soul'; 'flirting' to avoid being faced with 'failing' in her job; unable to beat Jeff 'intellectually' and resorting to using her sexual attractiveness. After stating that she was not his type (indicating that the flirting also failed) he then made another woman humiliate Melanie in a public context. The implication of her subsequent promotion being based on something other than ability was also a powerful 'aside'.

Discriminatory comments against women though are perhaps not that commonplace. Jeff's sense of 'entitlement' may be a dying one across most NHS organisations and it is certainly against all stated mores. Discrimination on the basis of gender is more opaque. The researcher interviewed Helen, a senior female consultant, and talked about gender and arrogance of male consultants. The researcher suggested:

... this was possibly seeing me as an ally as a young female professional. In addition to the immediately obvious behavioural differences between women and men she also mentioned unseen discrimination in the form of merit awards at senior levels and problems of combining work and family commitments which may mean female staff are less likely to achieve these.

³⁵ Not her real name.

In the interview Helen responded:

Q: Do you think there are any gender differences in leadership that you have noticed?

A: Yeah, yeah I think, I think so, erm you know the men are more well, can I, the men are less inclusive of a group and they have ((1)) already formed an opinion sometimes and before listening, erm, ((1)) err ((1)) yeah.

Q: Yeah ((laughs))

A: Need I say more ((laughs))? But I think there is a difference ...Competitive, that's what I was saying, there's that competition, yeah competitive, exactly ...Of course not but the insight is very, very small, and then those meetings go on and on and on and it's people trying to get one up on another so... I just want to leave. It's handy having a beep you know you can say 'oh, I've got to be off (laughs)'.

The suggestion here is that men are apt to waste time on each other and power struggles and that for them competition is central to their 'nature'.

8.2 Conclusions

Despite the increased numbers of women who have reached senior leadership positions in the NHS, both as senior managers (clinical and non-clinical) and as senior clinicians *per se*, there were nonetheless some interesting differences between women and men's self-descriptions and perceptions of others as leaders, sometimes made on the basis of gender alone (Gill et al., 2008). Descriptions given of leaders and leadership for members of the 'other' sex were also frequently gender-typed.

It may be that despite valiant and frequently effective attempts to change the culture of NHS Trusts that a 'traditional' view of leadership remains at least in the organisational 'memory'. This might go some way to explaining why women who are clearly powerful and influential are reluctant to identify themselves as taking up these more 'feminine' styles even though they may in fact use the skills associated with these qualities. Eagly and Carli (2003) make a case for women as having a leadership 'advantage' in contemporary organisations where the type of leadership required has changed. However, they argue that in many cases women have to battle against the inherent prejudices in male dominated organisations. Although there is still a reference to gender stereotypes when discussing gender in organisations and gender and leadership as we have seen from the extracts above in this chapter, as Rosener (1990) stated: "*Women managers who have broken the glass ceiling in medium-sized, non-traditional organisations have proven that effective leaders don't come from one mould*" (p. 119).

In Chapter Five the OCS revealed that women across all professions scored lower than men on 'recognition' in that they perceived their managers as

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not recognising their particular attributes as clinicians or managers and they also perceived that the organisational climate was one in which 'recognition' was more likely to be given to men than women. That men did not see this as a problem for them reinforces the view that regardless of trying to establish gender equality across NHS organisations it is still not embedded in the management culture.

As we have seen and has been well documented in the literature, it remains difficult for women to exercise leadership without their behaviours being construed as either 'weak' or 'aggressive'. The paradox is that leadership requiring more 'feminine' characteristics is at least explicitly more desirable in the contemporary NHS.

9 Patient Care, Leadership and Service Delivery

9.1 Introduction

The NHS has a history of reform/modernisation aimed at making patient choice and care more cost and clinically effective by improving the organisational structures through which care is delivered (Bate & Robert, 2002; Becher & Chassin, 2001; Darzi, 2008; Wilson, 2009) .

The NHS remains committed to its original aims of providing a cost and clinically effective patient care (Doherty, 2009; Phillips, 2005), at least partially through the NHS's organisational structures, including the gate keeping function of primary care, while providing a universal service free at the point of delivery. Since the 1990s patient choice has been added to the longer term commitment to efficiency (Bhandari & Naudeer, 2008; Bojke, Gravelle, Hassell, & Whittington, 2004; Bryan, Gill, Greenfield, Gutridge, & Marshall, 2006). And at the same time there has been an explosion in new diagnostic and therapeutic technologies accompanied by a public awareness of the availability, or lack of availability, of those technologies (Aberbach & Christensen, 2005; Greener & Powell, 2003; Mueller, Sillince, Harvey, & Howorth, 2004a).

In this chapter we particularly address:

- what respondents (staff and patients) say about patient care and service delivery based on the interviews and focus groups;

- what we *observed* about service delivery and patient care and particularly the *interactions* between clinical staff and patients *observed* and *described* during the shadowing.

As in Chapter Six the Trusts are conceptualised as open systems whereby high quality patient care (the input) corresponds with effective service delivery (the output) with the primary task defined as caring for sick patients (or those who are giving birth).

9.2 Defining patient care and service delivery

The thematic analysis highlights similarities across all grades, statuses and disciplines of the staff and the patients involved in the study. The themes that emerged consistently from the data that were about good patient care were:

1. Putting the patient first:

...of course patients do come first but actually really, on everything that you do, I mean everything you do you think of the patients (service manager in acute medicine).

2. Thinking about what is good for the patient (all the time):

I still believe and I believe to this day that if you absolutely concentrate on what the patients' needs are, all other things take care of themselves. it's about really showing that you care. I mean genuinely showing that you care about your patients, erm there's a lot of talk about also looking after your staff and caring for your staff. I think that's important but I think the health service has got itself stuck far too many times concentrating on the needs of the staff and not the patients (Chief Operating Officer).

I think that's what you have to make sure is that everyday you are thinking to yourself, 'am I doing this for the good for the patient?' 'is it the right way to do it?' so I think when you get eleven years down the line, one of the things is that you can loose sight of is that, very easily (Matron).

3. Awareness of the diversity in the patient's world (culture, family, age, home and work environments):

..it would be making sure older patients have high quality of care during their surgical admission (senior consultant Geriatrician).

you need to support your staff ... you know and you have to have an awareness of the different culture of the patients (administrator).

4. Making sure the patient received the care that staff would expect for themselves and their relatives:

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I would define patient care that of - if it was one of my relatives who were ill (senior manager).

5. Talking to patients about what has happened, their medical history and their clinical condition:

....if they talk to you one-on-one and you know where you're at (patient).

6. Safety and empowerment of patients:

They [the multidisciplinary care of the elderly team] believe that good patient care sits around ideas of timely discharges, safety, making sure the patient understands their condition and their treatment, empowering patients by allowing them to make their own decisions about their care (to a point), providing the appropriate treatment and care, being responsible for the patient. Examples of bad patient care are viewed as delayed discharges, poor decision making and discontinuous care. (Notes from an observation of a team meeting).

From the descriptions it is clear (and perhaps no surprise) that senior managers, clinicians and patients all hold slightly different perceptions which inform their judgements to give 'patient care' a specific meaning. Some of the judgements are related to their particular clinical specialty or organisational responsibility although generally respondents reiterated that patients need to be at the centre of daily practices. Patients in all cases wanted more than anything to be kept informed about their care, and if possible this should be done by the clinician in charge.

At a more complex level the definitions above reveal a 'vision' of good patient care which links the 'practical', 'professional' and 'political' elements of NHS life. It also links to the 'human' elements associated with the tasks of caring. For example, the Matron (quoted above) shows a revealing insight that the routine *organisational* tasks might take over as a perceived priority from what a person initially knew to be their primary task (i.e. patient care). As she says, several years down the line you might lose sight of what you are really there to do.

9.3 How is good patient care achieved?

9.3.1 Managers

Managers each have different levels of responsibility for delivering good patient care which may differ from priorities expressed by patients and clinicians:

Erm, that's the bit about lifting your eyes up off of the horizon, and lifting the eyes up above the horizon is about looking at the totality because the

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medical, again, the medical management model is very much that you should do what you need to do when the patient is in front of you. The management model, the pure management model is about doing the right thing for the 450,000 patients who were looked after last year, so some of that will be about compromising, and offering the best care to the widest group that you can (CEO).

Immediately this respondent exposes the potential for conflict at senior level in that he/she³⁶ positions the 'medical management model' differently from the 'pure management model'. In the former the patient is a particular individual with a health care problem – the patient 'in front of you'. However for senior management there are many thousands of patients that require good patient care which means (maybe) compromising to provide the best possible care to the greatest number. Despite this, another senior manager had a different 'take' upon good patient care and in answering the question focuses on what they themselves would expect evoking a more individualised model:

I would want good consultant input into my care ((1)) as soon as it was appropriate in the pathway that I was on. I would want to be able to have a conversation about what was wrong with me and what treatments and options there were, ((1)) erm ((1)). I would want the assurances of the people that deliver the care know what they are doing. ((1)) I would want the care to be provided in an environment that was clean and in an ideal world I would want a single ensuite room, err and I would like to choose my own food and all that jazz. ((1)) erm and the erm, ((2)) so really you want the environment to be correct and you want to have the confidence in the clinicians giving care and you want to have had input into what your care should have been (Senior Manager.)

This manager has a very clear model of their 'ideal type' which positions the relationship between the patient and clinician, the skills/expertise of the clinician and the physical space and environment as central to good care. There is awareness here that planning and teamwork are also part of the process of care but particularly important is the knowledge of how to deliver the appropriate care and information in order to facilitate joint decision-making.

³⁶ We do not want to risk identification of any individual participant.

9.3.2 Clinicians

Good quality patient care for most doctors interviewed was:

... making sure that erm the patient achieves the outcome that you would wish them to as a result of either their outpatient visit or their inpatient stay erm and that outcome is kind of on a objective kind of medical measure, erm but it's also in terms of the quality of the care that they've received and whether they are satisfied with the care that they've received. (Senior consultant)

Another senior consultant who is also on the senior management team of the Trust took the concept of patient care further:

... it should be delivered well I think is the answer ((laughs)). I think on the whole we do deliver it well, we have the lowest mortality rate in the country, ((1)) or one of them. I think we do actually and we ((1)) I'm very proud of the care and I think there are two things to be proud of and one is the basic care and ... we do emergency work I am very proud of. Then the other bit of care we're proud of is that ... I think there is a real culture of innovation and I'm trying to do something new up here, and I think that's actually really important in terms of leadership. My job is being able to see a clinician with an idea and then work out of him or her how to turn that idea into a self service innovation. I think that we have created over the last few years a much stronger patient safety culture.

This respondent clearly links leadership and patient care stressing both the relationship between supporting other clinicians in innovations that improve care (particularly attending to safety) while also being proud of the culture across the Trust for low mortality, innovation, and supporting staff. Crucially there is a pride and energy about this account. The culture puts patients first but the staff gain satisfaction and a sense of professional pride from the performance of the Trust as a whole [T3].

The clinician manager below takes up the relationship between staff empowerment (and support which links clearly to the outcomes reported in Chapter Five) and returns us to the focus on staff training and skills, indicating here that if the managers train and empower staff – services to patients will improve.

... it's about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is, we worked with training and development and we came up with a specific programme that was aimed at empowering them to improve their service area etc. etc. and

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also provided them with some skill sets that they probably didn't have prior to that. (Senior Manager, Therapies)

While from a similar perspective the nurse quoted below stresses that team work and morale mark the path towards good patient care and you need to look after *staff* in order to deliver a good service to patients.

... And I think it is also, sort of, taking into account the people they work with, the team members and boost the morale, and that can make a lot of difference to, you know, to have people at work and sort of take the stress levels off and I think, you know, it would sort of, quality certainly would happen, sort of energise them, able to care for the patient. (Nurse, focus group)

9.3.3 Patients

For patients overall it was clear that most of all direct communication and consistency of staff was experienced to be good care:

A: ... I've been transferred here from [another Trust] and there it's a bit more, not one-to-one but you see a lot of different doctors here whilst there [the other Trust] you have only one doctor, your one midwife and your one consultant. Here you see a lot of different people.

Q: And which one do you prefer?

A: I'd say probably just to see the one 'cause lots people tell you different things.

Q: Okay, so it can be a bit confusing?

A: Yeah, sometimes it can be, yeah.

The patient quoted below reinforces the need for clear patient/clinician contact and communication.

For another woman:

Now whilst I'm here my care has been very good especially with the [specialist] who first saw erm, who first flagged up the problem. Erm yep it's been good it's been good since I've been in. It's just the initial communication as an outpatient to an inpatient I should have really - you know that should have been. I don't know where the fault lies but there should have been some communication there between the appropriate people (Maternity patient on postnatal ward).

9.4 Delivering patient care

9.4.1 Doctor-patient interactions

We look firstly at three consultants' (Cameron, Kenneth and Henry) styles across two different Trusts as they interact with patients to explore the importance (or otherwise) of good communication and engagement. What emerges, perhaps unsurprisingly, is that different consultants have different styles of engaging. The style adopted though feeds through to the 'ethos' of the clinical team, relates to, and impacts upon, the culture of the Unit thus affecting the doctor-patient interactions as part of an evolutionary cycle.

9.4.2 Empathy and Communication

9.4.2.1 'Cameron'

From the researcher's notes we gain an impression of Cameron who deals mostly with stroke patients for whom verbal and non-verbal communication may be very restricted:

Cameron offers a very personal and individualised style of patient care to his patients. He is often very tactile often rubbing the tops of their hands, arms and heads to encourage them or to show support when he is discussing difficult problems with them such as their inability to go home, the definition of a stroke and the future impacts of them having a stroke. He also speaks to the patients in a very friendly and informal way and sometimes draws on their mother tongue to say a few phrases to make them feel welcome and at ease.

In his interactions with his patients he is very positive and upbeat, often speaking loudly to encourage and motivate his patients. He also tries to share a few jokes with them and breaks down doctor/patient power relationships by crouching down in front of his patients or sitting on a chair or their bed so that he is always the same height or lower.

This description alone demonstrates how Cameron's *behaviour* relates to several of the descriptions above which identify good patient care in that he:

- communicates (verbally and physically)
- takes care to acknowledge their humanity through recognition of their cultural (linguistic) heritages the fact that they have a life outside the hospital
- attempts to empower them within the relationship (at least via discussion and physical presence and to an extent with knowledge of their condition).

Below is a detailed example of Cameron (and his team's) encounter with an elderly stroke patient (Mrs. D) which is part of the evidence the researcher has employed for her assessment of the processes engaged by Cameron in his provision of patient care:

"Hello Mrs. D? (Patient nods head and smiles) do you have a headache? (Patient nods head) Do you know why? (patient shakes her head staring wide eyed at B). "OK, I'll tell you..." Cameron sits on the edge of the patient's bed and explains that she has had a stroke and she has a headache because sometimes patients who have had strokes will have suffered from headaches due to pressures on the brain. The patient stares and nods her head occasionally as Cameron explains. "Mrs. D, do you understand what I have just told you?" (patient nods her head and then croaks "yes") on this speech Cameron sounds surprised and encourages her to speak again "Oh wow Mrs. D, that sounded good, can you say something else for me?...well done". The patient looks up at the doctor and smiles croaking again "I don't have anything to say doctor", "well never mind Mrs. D, I am sure I can get something out you a bit later!...excellent, your voice seems to be coming back...isn't that good?. We will have you singing in no time!" (Mrs. D. smiles and shakes her head "can't sing" Cameron smiles and laughs.

Despite the clear power differentials, doctor/patient and healthy/unhealthy, in this relationship Cameron is doing what he can to encourage and communicate effectively with the patient. Not only does he literally get down to her level by sitting on the bed but he explains the condition, how it happened and communicates the indicators for (potential) recovery. He is respectful and careful although the intellectual/cultural difference between the patient, Cameron and the care team is exposed by the encounters below.

"Now Mrs. D. can I examine you?" (Patient nods her head) Cameron takes the patients hand and she flinches "cold!" Cameron smiles and apologies saying it that "it is the alcohol" (alcohol gel he had just rubbed into his hand). The patient eyes Cameron suspiciously "have you been drinking?" the group laugh and Cameron explains that it is the hand-wash and she nods slowly and looks at each member of the team for what seems confirmation that this is the truth. Cameron then begins testing the patient's strength. He checks her arms and then her legs with simple strength tests calling out numbers between 1-5 for the SHO to write in the notes. As he instructs the patient with her tests he speaks very slowly and loudly and the instructions are very simple and clear and he often demonstrated his instructions, especially for those patients that have cognition problems. As the patient does the task Cameron is very encouraging shouting words such as "good", "excellent" or "well done after

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each task". After the strength tests Cameron checks the patient's reflexes with a small hammer. Again he shouts out numbers and makes comments about the reflexes that the SHO writes down in the notes. Following the reflexes Cameron checks the patient's facial muscles by asking the patient to smile, grit their teeth, stick out their tongues and move them about. He then checks her speech by asking her to repeat phrases or noises after him. The first phrases or groups of words were given as words that would be familiar to the patient such as the patient's name or names of simple objects such as pens. As the patient is able to say these words he moves on to more complex words such as "hippopotamus" which the patient struggles with. Cameron then checks the patient's ability to co-ordinate by getting the patient to touch her nose and then his finger with her index finger. The patient clearly struggles with this and is very slow and inaccurate.

For a brief moment after the tests Cameron has a quick discussion with L [another doctor] asking him what he thought about the tests and what they would expect to see on the CT scan. Cameron then turns to the patient and says "sorry Mrs. D, just discussing your test results with my colleague, we think that you are progressing very well...there has been much improvement hasn't there?" the patient stares blankly at Cameron for a brief moment before shaking her head "no, you don't think so? Now what about your speech, when you first arrived you couldn't say a word, now listen to you, don't you think you have improved?" patient shrugs her shoulders and looks down at the bed. "Well Mrs. D, we all think you are improving...so well done..." patient looks up and smiles sadly.

The style of meetings between clinical staff and patients was as much a feature of *Unit and team culture* as of a particular clinician's practices. Thus, while Cameron above was engaging with the patient in what appeared to be a *genuinely caring* manner, his colleagues were attentive, while in the background.

9.4.2.2 'Kenneth' and 'Henry'

In what follows two consultants worked together and while Kenneth was the more senior and experienced clinically, Henry held a senior managerial role (as well as being a senior consultant). Kenneth was described by the researcher as:

... a very warm and caring man ... he is very sweet, kind and caring to his patients and makes them feel comfortable and less vulnerable by empathising with them and drawing on his own personal experiences as a patient.

As with Cameron above, Kenneth was also described as 'tactile' and that he took the time to explain things to patients. Kenneth empathised with patients by sharing a joke (as did Cameron):

For example one lady was embarrassed because she had fallen down in her flat and sustained injuries and did not really want to explain how she had fallen over or what she had hurt [to the whole team]. Kenneth then told the patient that he had slipped over in the hospital and in the M&S food section. This meant that she no longer kept quiet through embarrassment and told Kenneth after that exactly what had happened.

However, during the two day shadowing of Kenneth the researcher was particularly:

...struck by how intimidating this group of doctors must be to the patient, especially an elderly or vulnerable patient as a large group of faces arrive at their bedside and close the curtains around them making the space feel incredibly claustrophobic and that the patient's space felt 'invaded'.

While shadowing Kenneth, the researcher was in a position to observe Henry (who was also shadowed for two days on a different occasion). The researcher's notes here, which describe a joint ward round with Kenneth and Henry, state:

I was struck by how impersonal Henry was towards the patients [in direct contrast to Kenneth]. He did not greet them or introduce himself. [In one case] Instead of asking the patient how she was getting on with the oxygen machine Henry asks the SHO how she thought the patient was getting on with the machine. When the patient tried to give reasons they seemed irrelevant to Henry who just told her she must use her oxygen machine every day or she will not get better.

The researcher goes on to describe how Kenneth (the senior clinical consultant although Henry has a senior leadership role) stands quietly behind the junior doctors on the round with Henry at the front of the group talking to the patient. Henry stands up. Kenneth stands at the back of the group with his hands folded behind his back and Henry every so often asks Kenneth if he agrees with Henry's thoughts on the patient's health status and treatment. While Henry is taking the lead in this way the researcher notes:

Not one of the doctors explains to the patients what will be happening to them that day or beyond nor do any of them say goodbye.

One patient on Henry's round is in the bathroom as the team arrive at her bed.

Henry knocks on the door of the bathroom and says "Mrs. X, it's Dr. Henry we are all here to see you". He then asks a nurse if she can hurry the patient along as he is very busy. It seemed strange [to the researcher] that Henry could not have just visited another patient until this patient had finished rather than rushing her. Before the nurse can enter the bathroom another nurse pokes her head out from behind the door and says that she is washing the patient. Henry asks whether this could be finished after he has seen her. The nurse, who looks frustrated, says she will be a minute. The nurse then helps the elderly lady to shuffle to her chair and helps her sit down. Without greeting the patient Henry begins talking over the patient's bed about her X-ray that was taken yesterday and then asks the nurse about the patient's progress.

In the examples above describing both Cameron and Kenneth's interactions with patients there is evidence that the patients were given a chance to explain to their consultant how they felt and either to tell the doctor what had happened to them or to hear the doctor's explanation of why they felt like they did.

The patients were treated in both these examples as human beings and in doing so the doctors themselves positioned themselves in their *clinical role* but also as *people occupying that role*. By acknowledging mutual humanity (albeit in different styles) these doctors were able to *take authority* from their position as medical experts (see Chapter Seven above).

By contrast Henry also took authority but did this by silencing junior colleagues, Kenneth his fellow consultant and most importantly, the patients. While Kenneth and Henry were in the same Unit, the scenario described above suggests that Henry held more power and therefore exercised greater influence on junior colleagues (and this fed into the culture of the Trust).

In what follows we trace how these contrasting styles might link to the culture of the Units and the teams themselves and consider how this fits in with the definitions of good patient care and service delivery.

9.5 Clinical team work and service delivery

9.5.1 Giving patients care

Miller and Gwynne (1972) suggested that a 'warehousing' model of care operates for those who may be institutionalised in the medium to long term which they contrast with the possibility of a 'horticultural' model of care, akin to what might be identified today as a learning environment. Working in the care of the elderly takes its toll on the emotions of all the clinical staff

particularly in the 'horticultural'/learning setting, where efforts are made to ensure two-way communication and mutual understanding and development takes place. This can leave clinical staff open to experiencing directly the pain and distress experienced by their patients (see Menzies-Lyth, 1960 and the 'stories' below).

The following example demonstrates how engagement between clinicians and patients impacts emotionally upon even (and possibly especially) senior experienced staff. The researcher here, shadowing Mandy, a female senior consultant describes the following case:

Whilst cleaning up a suppurating wound an elderly male patient cried. It was a really touching and sad moment and Mandy was clearly distressed that she had hurt the man. On first seeing him cry Mandy appeared to have a moment of shock/panic where she looked amongst her team to find out whether this was normal behaviour for this patient. On hearing the answer was 'no' Mandy tried to soothe the patient and seemed genuinely sorry for hurting him. The nurse who arrived at the scene also appears to be genuinely concerned about the patient and goes over to help Mandy and prevent the patient from crying. This scene was particularly sad because in today's society and especially in the patient's generation it is thought that men don't cry or show emotion. For the man to cry he must have been in severe pain and must have been struggling with himself to prevent the tears. Mandy's genuine empathy and somewhat guilt might have reflected that.

Mandy and the nurse in this context are using emotional intelligence (see Chapter One) in a relevant situation. Mandy also engages in conjoint action with the nurse rather than take action in an autocratic fashion without consultation. Mandy notes the patient's crying with a start (according to the description) and instead of continuing with the work on the wound (which many doctors might well do because it was necessary for a positive health outcome) she immediately appears to take in the context as a whole – thinking about her patient's behaviour and reactions. The nurse in this case mirrors the behaviour of the consultant. This is an important issue for discussions of leadership and patient care in that teams tend to reflect the beliefs and actions of their leaders.

9.5.2 Discussing patient care

In a shadowing the researcher at the start of the observation describes in detail the way two doctors discussed the patients before embarking on the ward round. This is another case of concerted action:

09:00 Breakfast meeting with Cameron [T3]

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Once they have consumed their breakfast Cameron and Mandy turn to business. Cameron begins by asking Mandy's opinion on one of the patients that they had seen on the ward round that morning. They chat for a couple of minutes about the patient before both getting a patient list out and going through the names systematically and discussing their care plan for each patient. Several patients will need to be discussed in a patient case meeting as they have complex discharge problems, others will need to be referred to the CCP so that a greater social package will be considered. Mandy says that she will go and see a few of the patients herself later and occasionally delegates tasks to do for Cameron, but mostly he is autonomous and says what he needs to do for a patient and what he will organise on behalf of the patient.

This is a quiet and supportive meeting between Mandy the senior consultant and Cameron the more junior member of the team. However, the researcher notes the systematic discussion of the patients and their care along with a plan about who Mandy will see and how Cameron's tasks are designated.

A similar atmosphere of calm and authority are evoked by the description of a case meeting with Cameron's team at the start of the first day of shadowing:

I approach the nurse's station and look around to see if I can see Cameron. I spot him at the far end of the ward sat at a computer with a mixed group of staff (doctors, nurses) surrounding him. I approach the group and stand amongst them. Cameron is facing the computer screen and discusses a CT scan with his registrar [L].I notice that as these two doctors discuss the scan a SHO writes notes in the patient's file occasionally craning his neck to look at the scan at certain parts of the discussion. A few nurses also crane their necks at various points but most just stand patiently in silence waiting to visit the patient. Once the discussion draws to a close Cameron turns his head from the computer and asks the team if they have anything to add. ...[later on in the same meeting the researcher listens to a telephone conversation] ...Cameron has rung the wife of a patient to update her on her husband's health. He is very honest with the wife saying that her husband has had a second stroke during the night at that he is now in worse health. Despite the bad news Cameron is very friendly and pleasant with the relative and is very sympathetic to her questions and on several occasions empathises with her. Coming off the phone Cameron returns to the team and gives a brief update to L regarding the conversation with the patient's wife. The SHO writes this summary in the notes. Cameron takes a short sharp breath before asking "shall we go and visit the patient?" Cameron turns quickly on his heels and enters the ward.

The observation here reveals the high workload and 'multi-tasking' undertaken by the team (looking at the computer, discussing scans, taking notes, calling relatives and so on). But there seems to be focused attention on patient care and individual patients. At the end of this extract it also seems that Cameron himself takes the ward rounds very seriously – gathering his mind together and possibly seeking the emotional strength to move from the clinical team and considering evidence from notes and colleagues to imparting and collecting information from the patients.

The same researcher who has shadowed both Kenneth and Henry at a different Trust from Cameron, gives examples of how some of Henry's patients are discussed. For example she describes a meeting to discuss patients chaired by Henry.

Henry criticises the way [Site B] is run and the management of beds and patients by that hospital. He praises the doctors for the current situation on [Site A] where they have spare beds stating that they have done so well in 'kicking them out'. Henry stated during [a previous meeting] that the patients needed to be removed or 'kicked out' of hospital as soon as possible. The rapid turnover of patients may on the surface appear that they are not receiving good care However getting patients home quickly reduces the risk of hospital acquired infections.

And is likely also to be what many patients would want.

As the researcher makes clear, it is important not to confuse the rhetoric with the quality of patient care, but rhetoric does determine and reflect a dominant ward or Unit culture.

9.6 Responsibility for patient care

Responsibility was a key element of the discussions of leadership particularly in Chapters Four and Five. Responsibility for individual patient care is in the hands of clinical teams led by the medical consultant but above that person is the clinical leadership/management (Clinical and Medical Directors) as well as the senior operational managers (CEO and COO and others).

Primary responsibilities for patient care however vary from *individual care* i.e. for both identifying care pathways and day-to-day care to responsibility overall for the care of all the patients. In Chapter Ten we review the findings from this study with some recent cases where responsibility has been mishandled to explore what lessons might be learnt.

In an interview with a consultant:

... we try to just have a really open forum where we can discuss that [specific patient care], just like open it up and letting people put their viewpoints first and then kind of trying to question where they're coming from with that in a positive kind of way but them also laying out where you feel that that might not be the right course of action. Erm and also at the end of that discussion making sure that everyone is happy with the outcome, and sometimes people aren't erm .. but it also realising that it is a consultant's responsibility at the end of the day and making sure that everyone knows that you're happy making that kind of decision and that you are happy to be made accountable for that decision.

9.6.1 Responsibility for emotion

It frequently falls on the clinical leader to cope with their own, the patient's and the relatives' emotional reactions and distress and also with those of the other members of the team. As the researcher noted:

One senior consultant, Tricia, made it clear that as the clinical lead she also took responsibility for talking to patients about DNR³⁷ forms and delivering 'bad news' to patients/ relatives. During the ward round Tricia removed the pressure from a junior member of the team who had been told by a relative that they didn't want their mother to be resuscitated. Being told this information had stressed out this junior member of the team as he was not yet ready for this type of responsibility. Tricia supports her junior colleague saying that he should have never been confronted with this situation.

One question here then is how do the clinical team handle such multi-layered emotional problems? How important is leadership in supporting (and developing) teams to cope?

9.6.2 Responsibility for teaching

Most clinicians in the study from all disciplines were interested in teaching the next generation, and their activities will influence patient care, provide role models for leadership and influence climate and culture of the organisation. The example below is chosen because Dr. Jenkins was very enthusiastic but also demonstrated compassion and courtesy when he was face to face with the patients. The researcher's notes describe this in detail:

Approaching the patient Dr. Jenkins shakes the patients hand and says "how are we doing today?...I see you were referred by your GP...you have a

³⁷ Do not resuscitate.

wonderful GP" (he comments on how wonderfully clear and precise the notes are). "That's not my GP, that's my missus's GP, mine's on holiday...I have Dr. U. U". "What a name! But looks like they have to wonderful GPs at your practice...the notes are seamless...you are lucky!" Jenkins then continues to ask the patient about his medical history. The patient is able to tell the doctor his entire medical in great detail including the drugs [more description from the researcher]. Dr. Jenkins stops the patient and asks the medical student to take a mental note of how a good GP leads to a well informed patient, which helps him (Jenkins) in his (patient's) treatment. He talks about 'aspects of professionalism' and the right ways of informing patients about their treatment and condition, he openly praises the patient for knowing so much about his patient history and tells the students that "medical history in patient care is so important". The patient begins talking about his treatment in the hospital and Dr. Jenkins states that "patient feedback is great, and they like to hear about it...we need to be more professional...primary care pathways are the key to patient care".

Dr. Jenkins behaves with humour towards the patients and the students and junior doctors but does so while continuing with his assessment of the patient, taking the relevant history and trying to impart good practice and professionalism. He manages to balance giving the students and junior a chance to gain hands-on experience while making sure he himself has all the information he needs for the care of the patient.

Dr. Jenkins then checks the patient's lungs and heart asking a SHO, Dr. Williams to check the cardiogram as he can hear an AF flutter. As Dr. Williams looks for the chart the patient tells him that his GP had thought the same and that is why he was thinking of changing his drugs. Dr. Jenkins looks at the students and says "wonderful isn't he?" he continues that the GP must have heard or felt it himself [the heart condition] and now they will need to see the chart to prove it then they can change the drugs as the GP had predicted. After looking at the chart Dr. Jenkins asks Dr. Williams to change the drugs and to get rid of one of the drugs he thinks are unnecessary. Dr Jenkins shakes the patients hand when he leaves and says that one of the juniors will be back later to sign off the new drugs.

Looking over the notes Dr Jenkins spends a lot of time teaching the [medical] students about various medical conditions and treatments that have arisen out of [a particular] patient and asks them to suggest other possible diagnosis and other treatments for his condition. Jenkins is a very enthusiastic teacher and the enthusiasm rubs off on the students who are all eager to share their knowledge and take stabs at questions they don't know. In the middle of the question and answer session he asks one of the students "what year are you in? I don't know how much you guys know already". The student base is a mixture from students from [different

schools] and he relishes the opportunity to teach the students some new medical knowledge. Whilst getting the students to look at the cardiogram he looks up and apologises to Irene [matron] for taking so long on his ward round "Sorry Irene, I will be here all day, this is such a pleasure to have students!" Concluding the teaching session he quotes someone for saying something about the health of gamblers and drinkers and then asks "now who said that?" the students look round each other and then he exclaims "me mother!" all the students laugh including the female registrar and Irene. He then ushers them onto the ward saying that he doesn't want to get in trouble with the matron.

9.6.3 Subverting responsibility

There are diverse ways that staff at both Trusts had for coping with emotional aspects of patient care and resisting authority (and thus taking responsibility for care into their own hands). One way that nurses (including senior nurses) operated was to *subvert* some of the doctors – particularly when the relevant doctors showed little interest. The shadowing of a senior nurse [Irene, the matron] during a ward round produced the case of Lola (described when shadowing Irene):

Irene tells me it is because many of the patients are elderly with complex cases and therefore they tend to stay for a long time. I note that one of the patients has been here for a long time and I ask whether due to the long length of stay on the wards whether she becomes attached to any of the patients, I point particularly to the patient who had been here for three months. Irene says, 'oh that's Lola, mmm has she been here 3 months?...let me check her notes'. Irene leaves the file that she is reading and picks up Lola's file and looks at the admissions page and then states (sounding surprised). That three months is correct. She then continues that she does find herself getting attached to her patients, especially if they have been here as long as Lola. She mentions that Lola should really have been moved to G Ward but she really doesn't want to move her 'she should be elsewhere, but she is ours' (highlighting emotional attachment and the sense of ownership over patients). She tells me that Lola is really sweet and all the nurses really like her and it would be quite strange if she was no longer on the ward as she is a returning patient and 'it is always nice to have her back'.

As we have suggested in Chapter One (and witnessed above), in order to protect one's self against anxiety clinical staff often 'split' patients into 'good' and 'bad'. Here the treatment of Lola indicates that the nurses may be using their care of her to defend themselves against some of the harsh treatment decisions made about other patients (by doctors and managers) particularly when there is pressure to discharge older patients due to bed

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shortages. This might lead them to consciously and unconsciously subvert these authorities when they can and there is a particular pleasure to be gained when they succeed in this 'subversion' with a 'good' patient such as Lola. What remains at stake is whether Lola's stay is actually benefitting her clinically (or even socially) and also whether it is preventing another patient receiving medical care.

9.6.4 Responsibility for end of life decisions

Responsibility for patient care resides not only with the clinical team but is sometimes shared between the team, the patient or the patient's closest relatives which is usually the case with end of life decisions. Sometimes the greatest emotional engagement is with the *relatives* of the patient rather than the patient themselves. This is particularly the case when the patient is likely to die which is particularly sensitive when it is a case of withdrawing life support. The following example of Cameron's Patient G and his daughter brings this into sharp focus.

The biggest emotional situation this day surrounded Patient G, a coma patient and his daughter. Cameron had to encourage the daughter to agree with his plan that her father's treatment should cease and palliative care take over. This is a very emotional situation especially due to the young girl's age but also because she was in 'denial' asserting that her father would get better and this caused her to present a whole range of emotions that Cameron had to deal with.

We enter the side room. The blinds are drawn causing the room to be quite dim. There is a young girl sat up right on a make-shift bed that she has made from four visitor chairs from the lounge. She has a blanket over her legs and is typing on her lap top her mobile phone ear phones in her ears and bags and other items are scattered around her chair. She looks up as we enter and pulls the ear phones from her ears. I am surprised at how young she is, I had expected a daughter of forty something not a teenager of 18 perhaps, but no more than twenty. She pulls the covers off her legs and places her lap top on the window sill. Cameron asks if she is ok and she nods and says she will leave him to it. Cameron says that he will bring her in once he has examined her father, she nods and opens the door pulling her jumper down over her leggings as she leaves. Cameron looks at me and comments (adding to what I was already thinking) "I think she is far too young to be dealing with this on her own....it is not fair".

He turns his attention to the patient and begins speaking loudly to him. He explains that he is a doctor in [Trust 3] hospital and that he wants to examine him. At each point of examination Cameron explains to the patient what he is going to do. Cameron is able to move the patient's limbs like he

is a doll. Each time the limbs are placed in a position they remain there. The patient doesn't respond to any pain stimulus as Cameron pinches the patient's skin and scratches the bottom of his feet with a stick. Cameron then checks the patient's eyes by pulling back the patients eye lids, the eye lids roll from side to side and Cameron explains that it is called a coma roll, which suggests that the patient is in a deep coma. Cameron teaches W by the patient's bedside and talks him through the patient's condition and talks about how the patient's recreational drug habits could probably have contributed to his stroke. Cameron and W engage in a small conversation about the problems of cannabis on the brain.

Cameron made the decision in consultation with his team to discuss with the daughter that they need to end the patient's treatment (and thus in all likelihood, his life). Cameron deals here not only with the daughter's distress but with the daughter's worry that she is involved in the decision to let her father die. Again a high degree of emotional intelligence and leadership as well as clinical knowledge operates in this communication.

While shadowing Owen [Trust 2] the researcher sees that while behaving perfectly correctly he puts emphasis on the clinical and health related aspects in an end of life situation above communication and empathy. He is not unkind but 'misses' the emotional level of communication. Here in the presence of a daughter and father the woman (mother/wife/patient) is clearly dying and being kept alive by the clinical team. Owen:

... talks directly to the daughter stating that her mother is coming to the natural end to her life and therefore she [the mother] is giving up - 'withdrawing from life' and tells the daughter that although they will feed her through a tube she [daughter] should prepare herself and her family for the inevitable. He also says that her mother will also start ripping the feeding tubes out to prevent herself from getting the right nourishment.

The image conjured by the 'withdrawing' from life and 'ripping' feeding tubes is dramatic and seems to give agency to the dying woman – almost indicating that somehow she is to blame as she will prevent herself getting the right nourishment. However, the researcher, as participant in this encounter, is bringing out a sense of the culture of this particular event. While Owen is probably protecting himself emotionally from the loss of life and the sense of clinical 'failure' he does not protect the daughter or the husband from the emotional onslaught of the woman's impending death.

The daughter says that she understands and turns to her father and says 'dad do you understand what the doctor is saying?' the husband paces up and down the side of his wife's bed looking lost and lonely. He looks up at Owen and says that his wife is giving up because someone at the nursing home said she was a burden. The daughter scolds the father for saying that

in front of her mother. She explains to Owen that although she [mother] doesn't say anything she listens to everything and the more her father says it the more she doesn't eat. Owen says he understands and asks how the family is coping.

The daughter here is also protecting Owen from the family's pain by scolding her father even though Owen asks how they are coping. However, although kind and polite, Owen does not seem to operate with emotional intelligence or engagement with others' pain.

The daughter says that her father is finding it very difficult because he is the main carer for her; she herself has taken time off work to care for her when she can to support her father. As she speaks about her father and how upset he is becoming she begins to become tearful. Owen listens to her as she speaks and occasionally asks further questions. The husband continues to potter around the room occasionally touching his wife's head and face. The daughter watches him.

Owen, while allowing the daughter to cry and not acting as if he is irritated or embarrassed, equally pays little heed as he continues to talk of the mother's deterioration.

Owen begins to talk about the deterioration of her mother and what they will be able to do for her. The daughter says that she knows what Owen wants to talk about 'you're talking about DNR aren't you?' Owen says yes he is and the daughter tells him that she knows about it because her friend's mother recently died and this was discussed with her. The daughter says that she knows what she would prefer but they will have to talk this through with her father. The daughter calls her father over and begins explaining DNR. He looks at his daughter, he looks lost and scared and she tells him that it is his decision but she thinks that the doctors should not resuscitate her mother because she will be resuscitated to the same state. Owen inputs that she will be 'worse' than how she is currently because she will be a lot weaker. The daughter says that she will have to talk through this with her father. Owen nods and leaves the room.

9.6.5 Stories of patient care

The following two stories show in detail the ways in which responsibility and power can shift between team members and highlight anxieties faced by doctors about caring for patients.

9.6.5.1 A story of system failure: Cancelled Clinic

The first story is told by a female registrar who describes a situation in which she felt disappointed with patient care due to cancelled clinics. In the

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following account, the narrative is broken down to four moments, and each is discussed to demonstrate how the doctor's anxiety is managed by being linked to a failure in 'the system' that climaxes in her interaction with patients.

Q: What about any time or incident that made you feel disappointed with patient care in this hospital?

A: Lots of times, particularly since we've not had a secretary. Every clinic, every single clinic I send somebody home because the notes aren't there at all. They are supposed to be coming to see the consultant [her immediate superior] and he's not there, and they've been put into my clinic and you look at the letter and it clearly says on the letter 'consultant only to see', and they turn up and he's in Italy, on holiday.

The registrar is expressing frustration. On the surface it is towards a recurring failure in patient care attributed to firstly not having a secretary and secondly because the consultant 'is not here'. The expression of the frustration however is confused; there is no secretary but the patients 'have been put' into her clinic. Furthermore, she sends someone home from each of her clinics because the notes are not there. The letter 'clearly says' the patient is to see the consultant who is not only not there but he's in Italy 'on holiday'. There is a feeling of being overwhelmed, and of rage and envy towards the consultant - and possibly the patients - emerging from this short paragraph (for discussions of workplace envy, see Vidaillet, 2007; Stein, 2000). There is also an expression of omnipotence in that she sends patients home. She has the 'legal' justification to do so because there are no notes and also because their letter says they have to see the consultant and the energy is directed towards this activity rather than getting patient appointments changed. The consultant is on holiday, presumably one to which he is entitled and one which has clear boundaries enabling them and the staff who make the appointments to re-arrange the patient dates.

There is clearly a high degree of frustration and anxiety present in this account; there are too many patients with 'needs' and not enough clinical or support staff backing the work in the way in which the doctor would feel comfortable with. As there is little opportunity either to express or assuage her anxiety so she becomes 'prey' to primitive phantasies and unconscious mechanisms to relieve the anxieties.

The story also sheds some light on doctors' anxieties about working in a multidisciplinary team. Medical education and postgraduate training provide a culture in which doctors believe they can rely on each other through which a sense of being an elite group and confirmation of professional omnipotence and responsibility - particularly of the consultant - arises. However the role of the consultant also brings about a sense of envy and

destructiveness in others which has its origins in the primitive defence mechanism of splitting off the painful parts of one self (e.g. the realisation that you are not omnipotent and that another has the ability to do what you cannot) and projecting them onto others in an envious attack (Klein, 1959).

...and you have to go out and say, 'I know you've waited three months for this appointment but I'm afraid the consultant is not here and he wants to see you personally, so thanks for coming but if you can just go away' and you can't even say to them 'you're getting an appointment for next week' because realistically they're getting an appointment in three months time, and I think that's really disappointing.

'Breaking bad news' is considered to be a difficult task for health professionals and one that is a constant cause of anxiety. In addition to having to find the appropriate means of communicating prospectively devastating prognosis and supporting patient through the immediate emotions, doctors must come to terms with possible changes in how the patients perceive them (Barnett, 2002). Even though the situation described here does not involve delivering bad news about an illness, it is a moment of disappointment for both the patient and the doctor. The patient's anticipation to receive treatment is rejected and the doctor has to acknowledge failure in service delivery. The patient's possible anger and anxiety is directed towards the messenger, who in this case, is unable to offer any practical solution. Instead of being the helpful, trustworthy saviour, the doctor transforms into an envoy of disappointment and will have to see to the patient's emotions as well as her own disappointment, to which there is no external consolation on offer. To alleviate the anxiety caused by the situation, the registrar clings on to a narrative regarding her workplace – she is disappointed in the system.

I feel very disappointed in the system, which, I know the system is a big, wide thing, but ... [it] lets people down from that point of view and, you know, we overbook theatre lists and they get cancelled and then again I feel disappointed.

By seeing the NHS as a faceless, bureaucratic, 'machine-like' (Elkind, 1998) entity, the registrar convinces herself that the situation is not her fault – it is not what she would want for the patients, or for herself. She feels anxiety for she cannot provide the care required, and as a consequence she projects this anxiety through blaming 'the system'; regardless of their individual efforts, doctors are powerless when the system fails. As this registrar said epigrammatically later on in the interview: 'I don't think the NHS works anymore' which at a conscious level represents the impact on her working life of a problematic bureaucracy while at an unconscious level it provides uncontainable stress. The doctor does not have the opportunity to delegate

tasks to her superiors to reduce the 'heavy burden of responsibility' (Menzies, 1960, p. 118) thus feels that she is left to deal with the failure of 'the system', a system, which ironically is set to heal people, not cause them angst.

It's mostly because I'm thinking, how must that patient feel. You know, they've worked themselves up, they've told work they are gonna be off work for three weeks or four weeks or whatever and arranged cover and you go and tell them, sorry, you can't have your operation, you can go back to work tomorrow. That's really disappointing, to do that to people, very much so.

In the conclusion to her story, the doctor moves beyond expressing antagonism to the system to empathising with the patient. Thus, by failing, the system provides the doctor with a social defence mechanism but through empathizing with the victims of the failure, she fails to contain her anxiety.

9.6.5.2 A story of grace in adversity: Supporting the mother of a still-birth baby

The second story is told by a male registrar who describes how he provided good patient care by supporting a mother of a still-birth baby. Despite the plot, the story is not told as a tragic narrative but as a proud patient-care moment, a sequence of events that had thoroughly positive impact on the doctor's perception of himself. This narrative is also analysed in sections.

Q: Could you give an example where you felt that you have given good patient care?

A: I think that one of them was this lady who actually came to the labour ward and told me that she hasn't felt her baby move in the past one day and she had had some bleeding. Obviously there was some concerns on my behalf for the baby, because there could be a problem. This was a very wanted pregnancy because she was quite old and this was an IVF pregnancy. I examined her a little bit and on examining her I found that the baby did not have a heart beat, so she had lost the baby.

Describing the situation at first with the patient as an object helps the doctor to distance himself from the scenario and to do routine checks expected in this kind of situation. In a hospital setting instructions are given about the way each task should be performed and these rituals form a reassuring tool for staff (Menzies, 1960: 121).

I did explain everything to her, and obviously as a doctor responsible for her, I need to follow all the procedures that needed to be done and all the care that she needed to have, you know I explained it to her that, you know this by far something that words, you know cannot express, as you can imagine how

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difficult this situation would be, and if we could make it the slightest bit better, we would try everything in our power, you know, to make the situation a lot more comfortable. I ensured that she was given a quiet room, with a very good midwife looking after her at all times. Obviously I had my duties towards the rest of the labour ward as well. People visiting her room making sure she was ok, making sure the pain relief was ok, we had induced her because we did not want her to go home with a dead baby inside her. It was a very, very painful and stressful scenario, it really, really was, it was horrible, absolutely and it is very distressing, exceedingly, exceedingly distressing because, you know the woman is going through all that pain of labour.

Here, the doctor is empathising with the patient, feeling her emotional pain and in this case is mostly able to contain it through wanting to relieve the situation and then by offering extra care, by 'going an extra mile'. In this extract, there is a clear shift as the doctor uses strong emotional words to describe the crisis. In telling the story, he is projecting his own anxiety on the patient, living the distressing emotions with her and having to remind himself of his position as a medical professional - 'obviously I had my duties towards the rest of the labour ward as well'. By referring to 'all that pain of labour' the doctor enters a relationship with the pain. The phenomenon of pain and our relation to pain, whether someone else's or our own, is more immediate than that of reflective knowledge – we do not think about pain but react to it so the sensation is intersubjective. The person who is not experiencing the pain but affected by it is an 'interlocutor' in the situation (Crossley, 1996, p. 37).

...I tried to make it a point that I was present, present as much as I possibly, feasibly could during her emotional outbursts. I wanted her to have all the support that she needed... I did get attached to the patient, being around her, trying to get her care, even if I was out of hours, which means that when I was not meant to be in the hospital. Now I think that some people will argue that, that is a bit over the top, but I think that, I guess, I guess, that that is medicine for you, you know it is about lives, and sometimes you have to make that extra effort, to make that person feel that little bit more special.

In this excerpt the doctor starts to explain and justify his actions. Through self-reflection he has realised how he acted in a way not normally accepted in the hospital culture, that is, he went against the 'social defence system' to deliver patient care, but also to cope with his own anxiety. He dedicated extended time to his patient even though hospital doctor's time is considered to be 'fast and efficient'; 'doctors move quickly in the hospital wards. Their time is expensive. They cannot afford to linger too long in any one spot' (Mattingly, 1998, p. 21).

Menzies (1960) noted that while institutions have social defence systems, individuals may resort to their own defensive mechanisms, but a membership of an institution 'necessitates an adequate degree of matching

between individual and social defence system'. If the individual and the social defence systems are in disagreement, what follows is some degree of breakdown between them, for example, a doctor's work colleagues might reject them for behaving in an inconsistent or unprofessional way to the system. Consequently, the registrar providing patient care to the mother of the still-born baby is not only coping with anxieties created by that emotionally charged situation, but he also has to think about the culturally accepted limits of caring and possibly negotiate his way with other members of staff. On this occasion, the doctor keeps to his defences and spends extra hours with the patient, without being criticised by his peers.

Well you know that when things get worse, they get worse and they get worse and they get worse. Ultimately what happened with her was that we tried all the induction of labour, we tried everything possible to get that baby out, by induction. And in her case with the induction, it failed as well... and I can't tell you how dreadful that scenario was, that she needed a Caesarean section to have that baby out... I wanted to make sure that I was present at the Caesarean section, as well so that she would have a face that she knows. Once she delivered, you know obviously I was there with her, with the [dead] baby in her arms, and she was happy from the point of view.... and thanking me every now and then, which I said that she shouldn't because it was my job and one should do it. But she kept signalling the fact that not many people would do it the way that I had and I that was very special.

Much hospital work contains a 'constant sense of impending crisis' (Menzies, 1960, p. 26) which creates pressure and anxiety. The level of predictability in medical work is low and – as the registrar expresses it – 'when things get worse, they get worse'. The doctor explains that he attended the Caesarean section for the patient's sake, but this could also be interpreted as his coping mechanism – the need for a closure (Mattingly, 1996: 37). If you only see trauma and dramatic events without closure, the events will stay lingering and cause anxiety, stress and possibly depression. The doctor needed to be there and needed to have closure to be used as a coping mechanism against accumulating anxiety. So far the patient had been in a powerless position while the doctor had presumably been in control of the situation and emotions involved in it. Therefore, when the patient thanks the doctor, he gets confused. The patient had survived through the ordeal and suddenly has the power to relieve the doctor's anxiety, to nurse him (Menzies, 1960). The acute physical and emotional stress is released and the doctor can reflect back on his experiences.

And I think that is something very, very special and dear to my heart. And these are those situations when you sit back and you reflect on your life and

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say, "wow I have done something good, really, really something good and it is wonderful".... I saw her every single day on the post natal ward and obviously I made a point not to neglect her, or neglect her partner because people assume that the only person going through the trauma is the woman who has actually delivered, but they are a couple, and that needs to be understood so that was important as well. And he appreciated that quite a lot. They went home, two weeks later, I did receive a lovely letter, which kind of expressed a lot of gratitude, for what I had done for them.

The thanking letter provides closure for a difficult story, but maybe also goes beyond this. It hints at redemption – instead of a medical tragedy possibly compounded by failure in patient care, the story becomes one of a victory or at least grace under fire, a positive example of the doctor's powers even when he cannot actually perform miracles by restoring life. Anxiety is successfully overcome by the absolution from the patient and the doctor's 'priesthood' (Elkind, 1998) is restored. The letter from the patient acts as the final seal to exalt the extra efforts the doctor put in to solving the problem (Menzies, 1960, p. 31).

I know that I put in extra hours and I KNOW that I shouldn't have been there but no-one complained, because everyone knew that I was helping a situation. It is just an understanding that we have. It would be a terrible job if you were only allowed to work your set number of hours.

A narrative like this one permits people to attach themselves to 'desirable' ends, think well of themselves in moral terms', 'support their needs for autonomy and control', and 'promote feelings of self-worth' (see Baumeister, 1986 in Brown, Stacey & Nandhakumar, 2008, p. 1054). By telling this, not an easy or comfortable story, as a proud moment of good patient care, the registrar restores his professional and personal integrity. There is no 'system' in this story to blame on, no failure to confess, but despite the drama the story draws to a happily-ever-after ending. The story has entailed a narrative for the self (Brown et al., 2008) that has released the anxiety the event contained.

9.7 Conclusions

Patient care is a process and a social construction and as such means different things to different people. Norms and styles of patient care also change across time and differ site to site not only because of differences in beliefs, but also because there are different possibilities (technological advancement, different types and mixes of professional groupings) and different types of constraints on what might be offered. It is not always possible to put a clear value judgement on patient care and one example is to do with 'length of stay'.

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Managers, whose concern is to ensure that beds are not blocked, may or may not be holding in mind the image of an organisation that shares care with agencies and families in the community. They may simply be responding to government targets. They may have their mind fixed on those waiting for beds who have still not received treatment. Patients themselves may want to return home as soon as they can or become bewildered when they are discharged rapidly after treatment.

Working in multi-disciplinary teams with distributed leadership patterns may have improved practices for clinicians. Accountability for patient care still resides with the consultant and the hierarchy who manage the Trust. While senior managers are responsible for ensuring patient safety and preventing negligence to individual patients, they are also responsible for ensuring access to care for the community which involves managing scarce resources such as equipment, pharmaceuticals, beds and staffing.

Not all clinicians appreciated or respected these pressures as we saw particularly in Chapter Six. Nor do patients necessarily agree that good care is anything other than good and consistent communication with specific clinicians.

As demonstrated in Chapters Six and Seven managers are frequently frustrated by demands from staff who may try to subvert managerial targets (set by government and as such fundamental to resourcing of the Trust).

The quality of leadership is intimately linked to patient care. Good patient care relies on effective leadership of the kind that engages with staff and imparts to them the vision that (as far as humanly possible) the patient comes first. That in turn impacts upon the climate, culture and ethos of the Trust. When leadership fails, so does patient care.

10 Leadership and patient care: Assessing the past and thinking of the future

10.1 *Introduction*

Without effective leadership at all levels of the NHS and its various organisations patient care suffers. This knowledge has been evidenced in

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several key studies across recent years as reported above and elsewhere and consequently fed into the NHS Qualities Framework (see Chapter One).

In this report we have critically reviewed the relevant literature on leadership exploring as far as possible the relationship between leadership, followership and service delivery across five hospitals comprising three NHS Trusts (see Chapter Three). We employed different research methodologies (see Chapter Two) to capture data to investigate leadership qualities and their interaction with the climate and culture of the organisation and linked these to service delivery and patient care in different settings (ranging from obstetrics and gynaecology and cardiology to care of the elderly).

10.1.1 The organisational contexts

The organisational contexts of each Trust and each site or unit varied physically, structurally and in 'atmosphere' (the full details are provided in Chapter Three). We have been concerned in the report (and future papers) to steer a path between maintaining anonymity and confidentiality and thus not overtly identifying a Trust or site within a Trust, while also pointing to how the contexts impacted on the practices of leadership and service delivery.

Overall the Foundation Trust (3) in this study, which had not been experiencing mergers or threats of closures, where staff morale was high and where leadership practices were distributed across teams and clinical and management specialties, was clearly the one most conducive to effective communication and leader-follower engagement. There was an 'atmosphere' of connection and pride in belonging to the Trust as evidenced explicitly in Chapters Four and Nine in particular.

Trust 1 was applying for foundation status during the time of the investigation but also threatened by closure of some of its units, and with the senior managers possibly being transferred to the other site which was perceived by the participants as a threat to their status and possibly to resources for service delivery. This did not happen during the course of the investigation. The managers in Trust 1 were committed to their staff and to service delivery although there did appear to be some discontent with senior management from the medical staff. This may have been because most of the distributed leadership involved non-clinical managers and nurse managers with the medical teams appearing to take a more 'traditional' hierarchical stance. Most of the data from the OCS was derived from Trust 1 which demonstrated among other things the importance of management support for identifying good leadership and patient care practices.

In Trust 2 there appeared to be the greatest amount of conflict between groups of staff who sometimes seemed to be leading in different directions.

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Trust 2 was perhaps the 'victim' of a relatively recent merger between two large hospitals (and one or two other smaller units) which were some physical distance apart and had had a different history – one being a DGH and the other a teaching hospital. The DGH appeared at first to have a professionally diverse group of senior managers who distributed their leadership to effect, but one or two figures emerged during the course of the study who transgressed this approach with one person taking a back-seat while another was trying to drive through change in a somewhat cavalier manner. Furthermore in this particular Trust there were changes among the senior managers (some left, others moved to the other site during the course of this study). The CEO also indicated that it was difficult to recruit good middle-range managers and nurses in particular because both sites were away from the centre of the city where most people would look for a promoted post.

10.2 *Limitations of the study methods*

As with any large scale and complex study such as this one not all of our intentions were achievable although some were satisfied beyond our expectations.

We had difficulties capturing data from patients for two main reasons (fully detailed in Chapter Three).

Firstly, the 'gate-keeping' staff working on the Units on a day-to-day basis (as distinct from those who supported overall access to the Trust overall) obstructed data collection.

Secondly, it was also difficult gaining access to patients while they were in hospital because of ward procedures and in other cases the poor health of patients. So in the end we managed to conduct ten patient interviews but were unable to collect organisational climate survey data from patients at all³⁸. To overcome this we gained permission to observe clinicians' interactions with patients in their care and we believe we have managed to do more than compensate, making a contribution to knowledge with important new material to demonstrate patient care in different contexts and the processes involved in patient care and service delivery (see in particular Chapter Nine).

We also met with difficulties, with one Trust in particular, collecting *survey* data from staff although individual staff members proved more than willing

³⁸ These difficulties were reported to SDO in the interim reports and also separately when they arose.

to support the researchers by allowing them to interview, observe and shadow them during their working days. *This is all reported fully in Chapter Three.*

10.3 *Reviewing the findings*

In this final chapter then we draw together the findings from the study and make suggestions as to how they might contribute to policy and practice beyond the participating organisations.

This chapter is organised around the original study aims which were about leadership, organisational climate (culture and context) and how they impact on patient care. The overall plan was to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery.

This research further sought to explore the following broad-based questions.

- First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
- Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?
- Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The specific aims and objectives are listed again below and we conflate these in what follows directing the reader to the relevant chapters.

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines, to patients;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts service delivery;

- To learn how different stakeholders (specifically patients, nurses, members of professions allied to medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care;
- To identify how the need for change in service delivery is identified and what drives the need for change.

10.3.1 How far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?

Throughout the participating Trusts there is evidence of the importance of high quality patient care. Chapter Nine in particular brings this together with quoted respondents emphasising that above all patient care matters to the aims of the organisation and those who work in it. Thus on a basic level, working for patient care is inspiring in itself and staff across the Trusts see good patient care as their *modus operandi*.

Our use of innovative ethnographic methods and story telling were particularly effective in providing the evidence of how patient-clinician relationships were practiced and how staff made sense of their own actions reflexively in the context of caring for patients³⁹.

Chapter Nine provided evidence of the ways in which care is practiced.

We begin here by summarising some of the evidence from the Foundation Trust in this study, which consistently appeared to demonstrate high levels of distributed leadership, emotional engagement and multi-disciplinary working across all levels. The data included several key examples of positive statements about the role and effectiveness of management. We saw, for example a senior clinical manager summarise the issue with reference to his

³⁹ For example, interviews opened with questions about leadership and patient care, and participants were then encouraged to tell 'stories and critical incidents illustrating their experiences'. The early parts of the interviews provided themes and indications of what the clinicians regarded as crucial to delivering good patient care, e.g. 'cleanliness', 'efficient administration', 'communication', 'empathy', 'sympathy', 'knowing the recent developments in your field' and 'everything behind the scenes the patients don't see'. However, it was the stories they relate to that provided us with insights into their core experiences of patient care (see Chapter Nine).

pride in working for the organisation drawing attention to its low mortality rates, and that the high quality staff and its reputation for patient care act to attract others at the top (or with the potential to be at the top) of their specialty.

By contrast, the CEO of one of the other Trusts had made the point in their interview that one of the difficulties they had was attracting high caliber nursing staff, partly because of their location (in the suburbs). In Chapter Four we identified the ways in which an organisation might be seen as a learning organisation as significant in supporting staff to develop their clinical and managerial skills and develop capacity for patient care. Where support for learning was apparent so was the enthusiasm and pride for the organisation and its goals.

What was striking was the way that all respondents who addressed this point were looking to see how patient care could be improved with aspirations that patients were satisfied with more than just the health outcome (although that is the bottom line) but also with the facilities and the atmosphere. In addition, several respondents made the point that they themselves were mindful of delivering (or at least aspiring to deliver) the type of care they themselves would want to receive.

That so many of the staff (clinical and non-clinical) worked long hours in which they were engaged in intensive work with either their clinical or management teams, or their caring for patients with the aim of delivering the best possible care, is yet further evidence of the ways in which patient care is inspirational.

What is most noticeable, however, is how some styles of clinical and managerial leadership appear wanting, when compared with the best. While some respondents are clearly excellent communicators who engage fully with their professional knowledge and with the patients and staff, others - equally expert and equally inspired to provide the best for their patients - seem to fall short in comparison. In Chapter Nine for instance, Cameron and Kenneth engage with their patients in human ways and there are examples in the chapter in which each clinician manages to gain important information from and for their patients by their hard work *and* their humanity. However, in Cameron's case he is supported by a team which has clearly been nourished and inspired by the organisational context (see references to Cameron's work in this report).

Kenneth, while equally able and empathic, from the ethnographic evidence reported in Chapter Nine, appears to be less able to transmit this or influence others to take up his brand of leadership and patient care. He remains slightly in the background while the younger and (it appears) more influential Henry sets the tone. The clinical team give the impression of

being business-like and impersonal and somewhat intimidating when they conduct their ward round. The culture being transmitted to the other clinical staff tends towards Henry's approach rather than Kenneth's. This raises questions about why this Trust and site is different from the FT in which Cameron and Mandy work. These matters were addressed in Chapters Six, Seven and Nine in particular and will be subjected to further analysis in subsequent publications. However the FT is established and settled. The Trust where Kenneth and Henry work was the product of a relatively recent merger and norms and values were still being 'negotiated' (see Chapter Seven and above in this chapter).

Subsequently we see Mandy working directly on a patient's wound not only acting humanely when she hurts the patient but working with the nurse to assess how they might best improve the patient's condition while caring for his mental state and self-esteem.

High quality care and inspiration come together through the ways in which clinicians and managers take responsibility for their work – for managing emotions (their own, their colleagues' and their patients'), teaching, making decisions about end of life care, communication with relatives and coping with everyday situations that raise anxiety levels for patients and staff. The story of the doctor in Trust 1 who cared for a woman with a still-born baby itself demonstrates how he went the extra mile (in his words) inspired by the possibility of providing care in a case where some might have tried to make minimal contact because a still-born baby might be seen as a clinical failure.

Overall emotional engagement with patients and followers leads to people working together in a human, humane and inspired way and impacts on the organisation itself which can become one with which people are proud to be associated.

10.3.2 How do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

This question underpinned the entire study, but specifically we reviewed the relevant research literature on leadership and organisational climate (Chapter One) and discussed this in Chapters Four through to Eight. We began by reviewing the results from the story-telling interviews, focus groups and ethnographic methods (observations and shadowing). A range of potential practices and behaviours were reported to us which suggested where problems might lie in current leadership practices, as well as what many respondents held to be ideal types. What we summarise now represents a combination of what works and what does not although it needs to be noted (as identified in Chapter Nine in particular) that what

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patients see as good leadership (that they received clear and consistent information from one or two key staff) may not always intersect with what staff meant by good patient care or effective leadership and service delivery. The latter was usually seen as best delivered by a well-functioning multi-disciplinary team albeit frequently constrained by limited resources.

The following issues stand out as good practice that could feed into NHS (and local Trust) policy:

Leadership is a complex concept meaning different things to different people. Over recent years leadership in changing contexts such as the NHS has shifted from the 'heroic' model where leadership is hierarchical to a model that is more distributed across different levels and different parts of the organisations. The heroic and hierarchical (related) models frequently depended upon individual characteristics and where the senior managers were indeed heroic and charismatic, leadership might well have led to good patient care. However, this is unreliable and unpredictable and the NHS Qualities Framework which has identified leadership skills is more appropriate to the context (see Chapter One).

Our most important findings, however, make it clear that leadership which is emotionally engaging and distributed is the one which is most likely to lead and support service delivery successfully as well as drive necessary changes.

At the end of Chapter One we focused on contemporary studies of leadership which promoted the importance of *context* and of taking a more discursive stance in the analysis of leader-follower relations. We also drew attention to the revival (and reappraisal) of concepts from organisational studies from the 1960s to the 1990s which took psychodynamic ideas into account and related them to more 'popular' contemporary ideas about the significance of social and emotional intelligence in leader-follower relations. Thus, we explored the ways in which stakeholder accounts of the experiences and exercising of leadership demanded an attachment or engagement at an emotional level, which took account of the unconscious as well as conscious understanding of these experiences. There were several examples offered in the previous chapters of leadership practices that delivered the required services or changes through different types of concerted action and those that didn't. In some cases we were able to show that with the best will in the world if the leader, for whatever reason, was unable to *engage* and thus be supported by the followers, then their leadership failed to deliver.

Recent analyses of distributed leadership styles and organisational contexts show that if such leadership is to work then people need to act and work together and be prepared to both take up and relinquish authority for

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certain tasks and roles at the appropriate intervals. We saw in Chapters Six and Seven for instance that authority is hard to maintain if a leader loses touch with their staff and fails to hold their own organisation 'in mind'. We used the OCS survey results in combination with the data derived from the interviews, focus groups and ethnographies to demonstrate the importance to a positive organisational climate of good leadership. Satisfaction with a manager was predicted by the same variables that identified a positive organisational climate. For staff in the organisations surveyed it was important that managers were committed, responsible and supportive of their staff/followers.

But how were these characteristics demonstrated? Leaders who were experienced as effective, supportive and emotionally engaged with their followers were able to communicate their vision and dedication to improving the quality of care to patients, which in itself co-existed with good staff morale. Such leaders were also good listeners as well as being able to take staff with them when less palatable or unpopular changes were mooted by senior management or government. These effective leaders were closely connected to the way the organisation was structured (physically and emotionally). They were thus able to access the information they needed in order to lead. The evidence for this frequently came from the stories and accounts of staff and observations made by researchers – often of good leadership but perhaps more acutely when leadership was poor. Then there was a jarring effect or mismatch between (local) policy and the attempt to drive changes to meet improvement targets. There was also evidence on occasions of senior clinicians' behaviours being disengaged. Sometimes attempts were made to subvert the senior people when leadership went against the grain. There are examples in Chapters Seven and Nine in particular.

A final comment here is that despite the changes in gender demographics at the top of clinical specialties in medicine, nursing and related professions, as well as in senior management, gender has not 'gone away'. Indeed distributed forms of leadership have (perhaps stereotypically but with some evidence base) been associated with women's behaviours. The OCS (Chapter Five) suggested that women's perception of 'recognition' for their work and achievements was more negative than that of men. Men were either satisfied with the recognition they received or less in need of recognition from their managers within the organisation than were women. In the qualitative data (see Chapter Eight) it was also the case that while senior women were keen to deny the relevance of being female to their professional lives and their career progression per se, women used different strategies and perceived their roles slightly differently than did men, although the point was well made by some respondents that feminine and

masculine choices of specialty may have been more significant predictors of management styles than gender itself.

10.3.3 Do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The contemporary NHS with its (mostly) distributed leadership practices at all levels tends to militate against the possibility of one person's vision being paramount. However, as suggested above in this chapter, there are nuanced influences of leadership style that (may) flow from one or two people's vision and/or style of leadership and patient care that influence organisational approaches.

In Chapter Seven, for example, we explored three senior people's visions and consequent behaviours to consider their authority and influence with the possibility that as opinion leaders they influenced organisational approaches to patient care. Quentin, for example, reflected his role as a senior clinical leader, and although there is no irrefutable evidence that his style was mirrored in the organisation itself, he does provide some evidence that in certain cases in relation to certain actions his vision had an impact on the overall organisational approach.

While the OCS (Chapter Five) captures data from a wider population, the ethnographic methods made a greater contribution to exploring how far an individual's vision influenced the organisations approach to patient care. Again in Chapter Seven we see Kerry battling against a resistant (and probably disillusioned for some reason) senior management team to improve discharge policy and meet government targets. She tries again and again (by her own account) to show her staff that they need to focus on targets because they will lead to improved care quality. She appears to fail (again according to her own standards) and expresses this by almost literally demonstrating that she is banging her head against a brick wall.

Differently with the same effect Gerald is introduced as having a clear vision for patient care in his Trust. However, his inability to take staff (at all levels of the organisation) with him in his vision is attributed in our analysis to his lack of emotional engagement and autocratic (verging on the authoritarian) style of management. His narcissism further ensures his inability to understand how his behaviour is impacting upon staff and he sees himself as having failed to win a 'fight'.

Chapter Six explores the organisation as an open system, and ways in which all stakeholders⁴⁰ hold a vision of the organisation in the mind at a

⁴⁰ Including patients but we cannot really speak definitively here due to lack of data.

conscious and an unconscious/emotional level acting accordingly. Thus, they have an image of the organisation (how well it is managed, how effectively it cares for patients), a sense of their own role and place within the organisation and how well the leadership understands the experiences of staff and patients. Recognition of the primary task, the roles and responsibilities of those who manage it and the (changing or threatened) boundaries of the organisation itself are critical concepts.

No doubt some members of the organisation have more personal and role/task related power and influence than others in the NHS Trust. Furthermore, the NHS as a system is fluid and dynamic, so that there is overall a group influence over the evolution of organisational context (climate and culture) which responds to visions from within and without (government, health care consumers) the wider system.

10.4 *What have we learnt from this study?*

10.4.1 How leadership relates to patient care

It is clear, from our empirical work and evidence from previous studies, that leadership is a process and set of practices which generally do not equate with the qualities residing in a particular individual regardless of their authority and formal role and status in the organisation. Leadership that 'works', as seen particularly (but not only) in the case studies in Chapter Seven, involves the person in the leadership role exercising social and emotional intelligence and engaging with their 'followers' (see Chapters One and Four) and offering staff recognition and support (Chapter Five). Moreover the role of leader is particularly effective when it is distributed among those who are best placed to exercise leadership towards the task in hand. So that in the context of an NHS hospital Trust, leadership might be exercised in relation to organising the administration for a unit, running an audit, or developing an innovatory clinical practice. Leadership in such contexts is time/project limited.

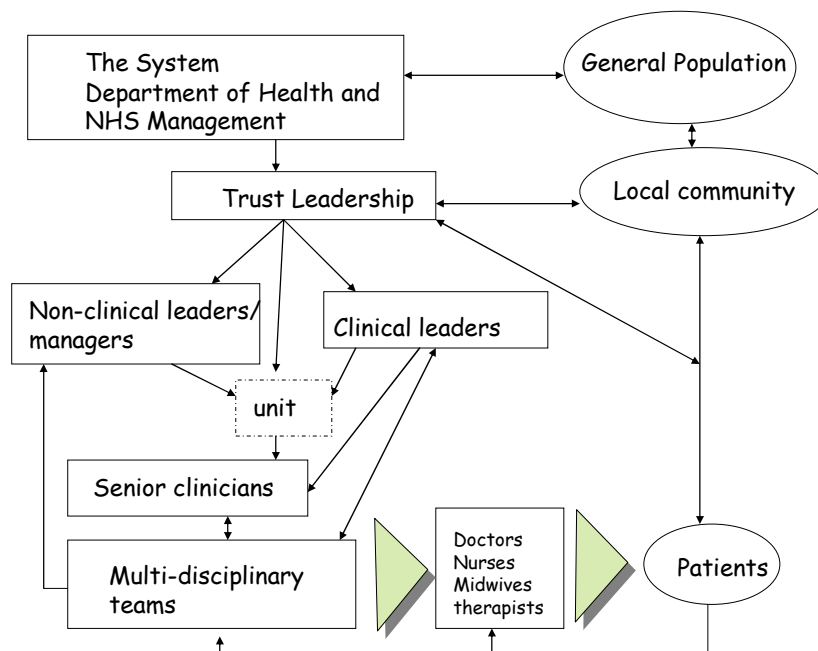
The primary task for NHS Trusts is to deliver a service to patients, as proposed in Chapter Six. All NHS Trusts operate as open systems with porous boundaries which enable change (planned and/or evolved). Leadership therefore can occur throughout the system at different levels including those of ward clerical and cleaning staff and the CEOs who 'manage upwards' and influence NHS/ Department of Health policy. Information of all kinds passes across the various boundaries not simply from the 'top' downwards.

Below in Figure 12 the relationship of the Trust leaders and patients within the NHS system is illustrated. It is also the case, as shown, that policy

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influences individual care, and the quality of that influence depends very much on the quality of leadership again across the system at all levels.

Figure 12. From the DoH to the Patient: An Open System



Patient care is represented here at three levels. The population who influence service delivery and patient care using their vote and/or lobbying through relevant patient groups, the local community who are served by a particular Trust and patients who are actively receiving medical treatment from individual clinical teams.

While on the whole it was the last group who were the main focus in this study some participants, particularly those in senior leadership/management roles, were concerned with service delivery at the local community and population levels. This sometimes meant that senior managers faced the dilemma of how to care for the community while attending to individuals and some individual clinicians were equally concerned about how their interactions with patients were influenced by some of the management dictates which derived from NHS policy that they

found difficult to understand (see Chapter Six and in 10.4.2. below for example).

10.4.2 Systemic dilemmas in patient care: Managing in the NHS

One participant had faced a 'dilemma' in wanting more face-to-face knowledge of patients in the community in order to be a more effective and informed leader, while also as his role required, attending to the demands of working within the wider system of the NHS:

As a chief exec in the NHS it was my privilege to make decisions. That was my privilege to go on and up the ladder. It was that I could go on and make faster and faster decisions. I get in the way I have always got in the way... the thing I would do is go out with the district nurse for the day, because I needed to be grounded in that. (Retired CEO)

Another manager who had previously had a military background advocated (along similar lines) that the best way to lead towards good patient care was to 'walk around' and support the leaders across the different parts of the organisation. In a seminar to clinical staff, which we attended and recorded, he drew participants' attention to the importance of *influencing* policy to achieving good patient care (at the population and community levels).

I hope some of you will find yourself in policy jobs at some point. Totally different, yes it still leads, but the actual process is so ... changing...both the chief executive and I spend a lot of time nurturing relationships which are partly to do with policy, but unless you get it right ... you communicate with them, it won't work.

In other words to be effective and to ensure the best for those in the Trust (staff and patients) a leader has to 'manage upwards' which gains influence. He continued by contrasting the experiences and perceptions of doctors with managers who lead at the macro level, drawing on the example of a recently qualified doctor. When the respondent quoted here asked this man about leadership in the NHS and how it impacts on patients he apparently answered:

'Oh I have got communication skills'. 'Blimey!' I said 'what do you know about the NHS?' And I asked him a couple of questions, nothing! But he hasn't been taught at an academic level about the context in which he is working. I think that is crucial and I know that is not how everyone does things. You know [doctors] keep people alive, but they really ought to have this basis of information about the context in which they are working.

While it is self-evident that the NHS is the context in which patient care is delivered, there is a tension between those who exercise leadership in that context and those who 'keep people alive'. In Chapter Seven, the frustration expressed by Kerry in trying to meet the demands of the government and community by improving the Trust's record of patient care, as well as motivate her senior staff to hold similar ideas, was palpable. From others' perspectives as shown in Chapter Six, there was evidence that 'management' was experienced negatively by several clinical staff when it tried to respond to Department of Health directives.

Managing the numbers

At another level of management good patient care was defined through achievement of returning satisfactory statistics, as this observational note of a meeting between capacity managers and clinicians suggests:

Patient care for the capacity managers appears to be a number crunching exercise. The need to get the patients in the right beds according to government targets meeting four hour waits and single sex bays. However because there is not a shortage of beds on this day, patient care moves from an exercise in numbers to thinking about patients in real human terms.

Sally (the capacity manager) talks about how better patient care can be delivered when there is less pressure on all the staff to meet their targets and get their job done. She talks about how [clinical] staff are then more able to talk to their patients and spend time with them. However, whilst reduced pressure means that for some, numbers translate into real people it is clear that in the capacity meeting that the role of the capacity manager is to think in terms of numbers and beds to deliver good patient care.

There is a potential conflict between the target driven service and the patient-clinician relationship which is about face-to-face contact. Perhaps this is well illustrated in Chapter Nine with the example of the 'grace in adversity' story, whereby the obstetrician spent extra time with a patient while his clinical colleagues turned a sympathetic blind-eye. The story of the patient 'Lola' also discussed in Chapter Nine who had been occupying a bed for three months with the tacit support of nursing staff would also have been anathema to staff responsible for managing targets about capacity.

10.4.3 Who judges what is good leadership and good patient care?

As shown above and throughout this report there is a tension throughout the system. The primary task of senior managers and leaders at and above the level of the Trust is to ensure the demands of the NHS and Department

of Health leadership are met. These are policy driven with differing priorities at any particular time. The general population of (potential) patients has a keen influence on policy in different ways but particularly during local and general elections. For example the recent change from a Labour to the Coalition Government has raised questions about the role of 'targets' for future NHS priorities. Apart from other matters, finance makes a difference as to how priorities for service delivery are set.

Senior management at the Trust level is judged in a number of ways particularly related to how far the Trust meets the national priorities. However there is also pressure on CEOs and senior teams to get direct patient care and safety 'right'. This may be assessed through statistics as in the following example described by a senior midwifery manager:

Between 2002 and 2005 there were ten maternal deaths at [Trust], which exceeded the national figures. So the Healthcare Commission came in and reviewed a number of clinical organisational cultural governance issues, and then actually put the maternity services under special measures

There was a key number of issues then, and an action plan was developed, so actually I was newly appointed at that time, and there was a number of work streams that we had to work on, and it's never happened before, and I don't think its happened since in a maternity unit. So basically, even though that was a very sad event for all the families involved and very tragic for them, it was difficult for the staff, and obviously difficult for the Board in terms of reputation management. The whole action plan was implemented, the unit was turned around, and the special measures were lifted in 2006.

In this case there was a notable failure to deliver maternity care to the standards of safety prescribed by the NHS. Furthermore there was a failure of leadership perceived by this participant in terms of both 'culture' and 'governance' giving rise to the high proportion of maternal deaths and the consequent special measures. This participant also makes clear how much the staff themselves are influenced by events of this kind.

Another member of that staff team praised the changes at the top following these problems and combined the policy, context and face to face care in her assessment of the relationship of good leadership to good patient care:

.... the end goal for us, is ensuring the services we're providing.. the patients, are getting the best service from us on top of meeting all the Trust targets and the Trust strategy...for me really it's about ensuring that the patients are getting the best quality care, which, you know, I think they've got an improved quality of care here, with the team like mine who are here...and I think [leadership] is from the top down, so from Chief

Executive, right down to every level, to leaders in the ward, right down to our portering, to our domestics. Yeah, there certainly is, and we lead by example really don't we? and I think our chief exec, director of ops, deputy chief, they've all got good leadership skills.

Good leadership skills among senior managers can pay dividends in terms of reputation management. For example in August 2010 North Cumbria University Hospitals NHS Trust admitted a series of false positive diagnoses following breast cancer screening⁴¹. The CEO moved quickly to review the situation and apologise publicly. In other cases though, when there have been wrong diagnoses, neglect or medical errors over drug doses senior managers have been blamed for the failures - sometimes warranted and sometimes possibly not so (see below). Anecdotally it appears that leaders who are prepared to acknowledge problems as soon as they appear and deal with them in a transparent and effective way bring about improvements in service delivery and patient care in the ways perhaps that those who try to 'bury' problems might not achieve.

10.4.4 Leadership practices across the organisation

Leadership and patient care are intrinsically linked. Leadership is above all about taking responsibility but with changes in organisational structures, a growing emphasis on networks, open systems with porous boundaries, mergers and changes in the shape, structure and functions of Trusts, it is no longer tenable for leadership to be in the hands of a few. Leadership, then, is about a series of relationships and connections within and without specific organisational boundaries which have the potential for diffusing responsibility or sharing it, and therefore making leadership practices more co-operative.

It is important to focus, as we have done, on the many examples of good and excellent leadership we found within the three Trusts taking part in this study (each of which of course being hospital based and therefore not focused on the role of leadership in primary care). These sit in contrast to the examples of less effective and sometimes failures in leadership that we have cited. The differences crucially were about emotional attachment and engagement between leaders and followers. We did not meet any respondents who were disengaged with the aims of the NHS and none who were uncommitted to deliver the best patient care. But as evidenced above in the report and in this chapter, some leadership practices failed to take

⁴¹ <http://www.bbc.co.uk/news/uk-england-cumbria-10958423>

followers with them because of autocratic, insensitive behaviours and poor communication skills. Leaders need to be able to listen and engage – having a vision is not enough.

Leadership taking the importance of emotional engagement into account also needs to be transmitted across the organisation. This is best accomplished through making full use of individual skills. Clinical staff and managers can be effectively involved in specific change projects. These may be time-limited and/or specialism specific but collaborative concerted action is frequently the most significant way that a system might flourish with the staff taking responsibility and enhancing their sense of commitment.

10.4.5 When leadership fails patient care

The converse of good leadership is potentially catastrophic. The case of Beverly Allitt in the early 1990s, the nurse who murdered children in the Lincolnshire Hospital by injecting them with insulin, went relatively unchallenged because she was poorly supervised. Harold Shipman, a different case in that he was a GP in a sole practice, similarly was eventually thought to have committed over 200 murders of patients throughout his career. However, the report into his murders showed that doctors at Thameside hospital had failed to report suspicions about his prescribing⁴². The Alder Hey organs scandal involved the unauthorised removal, retention and disposal of human tissue, including children's organs during 1988 to 1995 and the Bristol Royal Infirmary inquiry about children's deaths during surgery resulted in doctors being struck off. All these cases represent a failure of leadership in which those who were responsible for patient care at all levels failed to identify and follow up on problems. More recently the independent inquiry into the Airedale NHS Trust, where the late Anne Grigg-Booth continued as night-nurse despite a high proportion of deaths of patients while under her care, identified 'a catalogue of systemic failures' whereby her dangerous behaviour was not spotted.

At the time of writing this report the Prime Minister David Cameron has ordered a full public inquiry into the events at Staffordshire hospital which have led to deaths of patients, it would appear in these cases, more due to negligence than intent. The Francis report which was published in 2009 found that patients were routinely neglected and there were systemic failings in patient care. Managers had been pre-occupied with cost cutting and meeting targets and unable to spot the build up of failures in patient care that were to cost several patients their lives. There were too few

⁴² These cases were subjected to inquiries which exposed a range of complexities which are not relevant here.

nurses, those who were employed were ill-trained, equipment was inadequate and experienced medical cover was not always available. It was a supreme failure of management and leadership. The Trust was poor at identifying when things went wrong and managing risk. Some serious errors happened more than once and there were higher levels of complaints compared with other trusts. Staffordshire was a foundation hospital that had managed to 'tick the boxes' although clearly there were a series of chasms between the clinical and managerial staff.

10.5 *Final thoughts*

By using innovative qualitative methodologies (described fully in Chapter Two) such as story telling, ethnographic observations and shadowing, to both supplement and augment data from interviews and focus groups, we have built up a picture of what happens in the daily lives of NHS staff working both with and as managers and in clinical teams. Using these methods provides opportunities to extend the scope of more traditional in-depth interviews and focus groups. The 'story', because it is chosen by the participant themselves, provides not only detail and depth but demonstrates the specific indices used by each interviewee to make sense of their own and others' behaviours within the organisational context.

The ethnographic observations, and the shadowing in particular, enabled the researchers to gain a sense of what 'a day in the life' of a member of the organisation *feels* like. They can 'experience' the interactions between staff, between staff and patients as well as the frustrations and pleasures of working in that Trust. No other method provides such acute insights. The subjective ingredients in this method enhance the process (i.e. as outlined in Chapter Two whereby the researcher themselves is the 'instrument' through which data is mediated). Moreover, and possibly conversely, the subjective elements are reconciled when the observation notes are discussed by other members of the research team, which again as discussed in Chapter Two is also a source of data (Czarniawska, 2008).

As a qualitative study, the success is proven by the richness of the data, showing the clear emotional connection participants had with the topics of both 'leadership' and 'patient care' (Lincoln & Denzin, 1994, p. 575). From this we were able to make sense of how leadership is experienced and exercised (see Chapters Four and then Six to Eight) and about the practices around patient care and service delivery that support patients to understand the relationship between their particular health-status, quality of life and the care and treatment they are receiving and/or expect (see Chapter Nine in particular).

The statistical analysis of the OCS⁴³ showed that, on the whole, the climate variables, 'support' and 'recognition' from managers and the system overall, predict 'satisfaction' with leadership and management. This reinforces the ideas expressed throughout the report that good practices by managers/leaders are about ongoing engagement with followers with concerted or conjoint leadership processes most likely to promote a sense of being supported and recognised (Roberts et al. 2005).

Thus we have not produced a list of 'good leader' qualities or a similar record of what constitutes 'good patient care', as these would fail to capture the crucial point that both leadership and patient care are experienced as a process. Thus this report aims to delegate *good practices* that were observed during the project, for the use and reflection of any staff member of the NHS – whether a leader, follower or patient.

10.6 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.

⁴³ As made clear above we were unable to capture corresponding data from patients.

- 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.

Appendix 1

Focus Group Questions

1. Leadership means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this hospital?

Prompts

1. Charismatic / Authoritative / Consultative / Directional / Varies – depends on situation/activity etc

2. Can you think of some incidents that sum up for you the way leadership is exercised in this hospital?

Follow-ups

1. Does this type of leadership operate throughout the hospital?

2. Could you give some examples of ways in which leadership is exercised in your team/the hospital

3. Patient care means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this organisation?

4. How important is patient care as a priority in the service that you and your colleagues provide?

5. What are your main priorities in ensuring a high level of patient care in this hospital?

6. Can you think of some incidents that sum up the way you and your colleagues try to deliver patient care?

7. To what extent is leadership reflected in the quality of patient care you and your colleagues provide?

8. Can you think of some incidents that sum up the way that leadership in this hospital approaches the issue of patient care?

9. Can you think of specific incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

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Follow-up

1. What would you suggest to improve this/these situations?
3. Stories and critical incidents
 - a) Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
 - b) Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
 - c) Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

Could you tell me about a time that made you feel disappointed with leadership in this hospital?

- In this unit?

Appendix 2 Interview Questions

Interview

*Introductions, background and experience in relation to patient care and leadership in the organisation

- The interviewees position/level
- Years at the hospital
- Role in the organisation

1. Leadership

'Leadership' means different things to different people.

- a. How would you define it?
 - Do you see that kind of leadership at this hospital? Why/not?
 - What about in this unit?
 - What makes someone a good leader/Qualities of a good leader? Can you give me an example?
 - Who here at work do you see as providing leadership to you personally? Why? Do you have a direct supervisor? Who? Do they have leadership qualities?
- b. Do you see yourself as someone who could be a leader?
 - Why/not?

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- Under what circumstances?
- c. Can you give me an example of leadership in this hospital?

2. Patient care

- a. Like leadership, 'patient care' means different things to different people.
 - How would you define it?
- b. Tell me about patient care in this hospital. How is it defined?
 - Are there differences between units? Tell me about them. Why do you think this is?
 - How would you improve patient care in the hospital?
 - How would you improve patient care in this unit?
- c. How do you [as a hospital worker, nurse, etc.] try to deliver good patient care?
- d. What do you think are some obstacles to delivering the sort of patient care you'd like to see? How could these obstacles be removed?
- e. Do you think leadership could improve patient care in this hospital?
 - Why/not?
 - Do you think that better leadership would improve patient care? Why/not?
 - How does good leadership influence patient care?
 - Has the leadership in this hospital improved patient care since you've been a member of staff? How so? Or why not?

3. Stories and critical incidents

- a. Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
- b. Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
- c. Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

- d. Could you tell me about a time that made you feel disappointed with leadership in this hospital?
- In this unit?

Appendix 3: Focus Group Questions: patients

1. Leadership means different things to different people. What does it mean to you as a patient of this hospital?
2. What is your opinion of the way leadership is exercised in this hospital?
3. Patient care means different things to different people. What does it mean to you as a patient of this hospital?
4. Can you think of some incidents that sum up the kind of patient care that staff in this hospital deliver?
5. Can you think of ways that leadership in this hospital could enhance the quality of patient care, as far as you are concerned?
6. Can you think of some incidents that sum up what else leadership could be doing?
7. Can you think of any other incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

Appendix 4: Staff Organisational Climate Survey

[attached separately]

Appendix 5: Participant Information Sheet

Leadership and Better patient Care: From Idea to Practice

Participant Information Sheet: Staff Interviews

You are being invited to take part in an interview study about leadership and patient care in three different hospital settings. Before you decide to participate in this study it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Contact me (see full contact information at the end of this sheet) if there is anything that is unclear or if you want to know more.

Take time to decide whether or not you wish to take part.

Thank you for reading this.

1. What is the purpose of the study?

The purpose of this study is to try to identify the circumstances under which leadership can be an effective engine for change in the organisation of health care, especially for patient care and service delivery. Although we suspect that leadership motivates workers and affects the climate or atmosphere of the places where people work, leadership can mean different things to different people. The same is true of patient care which can also mean different things to different people. In order to understand how leadership inspires health workers to provide better patient care, we want to learn how nurses, doctors, other medical professionals as well as managers and patients define and understand leadership and patient care. This includes exploring how their perceptions mesh or conflict with one another. It also includes listening to stories of important incidents that describe their experiences of leadership and patient care.

2. Why have I been chosen?

As part of the study we are interviewing staff (clinical, managerial and others) as well as patients to examine what leadership and

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patient care mean to them. You have been chosen as someone whose views represent the views of staff.

3. Do I have to take part?

No

4. What will happen to me if I do take part?

You will participate in a tape-recorded interview with a qualified researcher, which will last under an hour.

5. What do I have to do?

Arrange a mutually convenient time to have the interview.

6. What are the possible disadvantages and risks of taking part?

It is possible that the discussion may stir up distressing feelings you have regarding your organisation, its leadership and the patient care it provides. However, care will be taken to prevent this and you are free to leave the interview at any time. Apart from that, the only disadvantage is that you will be giving up some of your time.

7. What are the possible benefits of taking part?

This study may not directly help you but it is part of a serious initiative to improve the quality of leadership and patient care provided by the NHS.

8. Will my taking part in this study be kept confidential?

Yes. All data will be stored in locked filing cabinet in a locked office. It will be made anonymous and all names will be edited out of the transcripts. Only members of the research team will have access to the data.

9. What will happen to the results of the research study?

They will be published in a report to the funder and also presented in peer reviewed papers and conferences. A copy of the report will be provided for each participant who requests it.

10. Who is organising and funding the research?

The study is funded by the NHS Service Delivery and Organisation (SDO) Research and Development Programme of the National Institute for Health Research (NIHR) Programmes. The NIHR has been established as a part of the government's strategy Best Research for Best Health to provide the framework that will position, manage and maintain the research, research staff and infrastructure of the NHS in England. The study is conducted by a group of researchers from Royal Holloway University of London led by myself, which won the grant following a competitive bid.

11. What if I have any concerns?

If you have any concerns or other questions about this study or the way it has been carried out you should contact me (details below) or you may contact the hospital complaints department.

Contact for further information

Professor Paula Nicolson, Head of Department, Health and Social Care
Royal Holloway University of London, Egham, Surrey, TW20 0EX

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Tel. 01784 414 470

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Appendix 5: Consent form (generic)

Title of Project: Leadership and Better Patient Care: From Idea to Practice

Name of Researchers: Emma Rowland Paula Lökman

Please initial each box

☐ I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

☐ I understand that some coded extracts from the interviews may be used for the purposes of the research report and academic articles.

☐ I give my consent for quotations to be used in the report and research papers on the understanding that I will not be able to be identified by the use of these in any way.

☐ I agree to take part in the above study.

Name of participant

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Date

Signature

Appendix 6: Patient Organisational Climate Survey

Thank you for agreeing to participate in this study which as you will know is part of a larger study on leadership and patient care in the NHS.

The following questions explore how NHS patients feel about the care they received and how things generally worked in the units where their care was managed.

The survey is anonymous, so please do not put your name on the survey.

If, however, you would like to receive the final results of the survey when the study is completed, please fill in the tear-out form on the questionnaire's last page and submit it to the researcher or the collection box.

It is important that you answer all the questions. This should take you approximately 10 minutes.

Your individual responses will be kept strictly confidential.

Researchers

Dr Paula Lökman

Department of Health and Social Care
Social Care
Royal Holloway University of London

Ms Emma Rowland

Department of Health and
Royal Holloway University of

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Please circle one number that best describes how you feel for each question in relation to the service provided by your NURSE.

1. I feel understood by my nurse.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

2. I am able to be open with my nurse at our meetings.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

3. My nurse has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

4. My nurse encourages me to ask questions.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

5. I trust my nurse.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

6. My nurse answers my questions fully and carefully.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

7. My nurse deals very well with my emotions.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

8. I feel that my nurse cares about me as a person.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

9. I don't feel very good about the way my nurse talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

10. My nurse tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

11. The way my nurse interacts with me influences my perception of quality care.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

12. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

Please circle one number that best describes how you feel for each question in relation to the service provided by your DOCTOR.

13. I feel understood by my doctor.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

14. I am able to be open with my doctor at our meetings.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

15. My doctor has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

16. My doctor encourages me to ask questions.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

17. I trust my doctor.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

18. My doctor answers my questions fully and carefully.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

19. My doctor deals very well with my emotions.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

20. I feel that my doctor cares about me as a person.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

21. I don't feel very good about the way my doctor talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

22. My doctor tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

23. The way my doctor interacts with me influences my perception of quality care.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

24. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1 2 3 4
strongly
disagree

5 6 7
neutral

strongly
agree

25. What would improve the quality of care you receive at this hospital?

26. What services are you using within this hospital?

Demographic Information

27. In which year were you born?

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28. What is your marital or civil partnership status?

- ☐ Single
- ☐ Co-habiting
- ☐ Married
- ☐ Divorced

29. How many children do you have?

30. How would you describe your ethnic background?

31. What is your current salary?

- 1. Less than or around £20,000 per annum
- 2. Between £21,000 and 39,000 per annum
- 3. Between £40,000 and £59,000 per annum
- 4. Between £60,000 and £99,000 per annum
- 5. Above £99,000 per annum

Thank you again for your time. If you have any questions please speak with the researcher or alternatively you can contact Professor Nicolson.

I would like to receive the final results of the survey when the study is completed

Name:

Address:

Contact Telephone:

Please return this form to either the researcher or the collection box.

Appendix 7: Appendices for Chapter Five

[attached separately]

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⁷ There is a parallel ongoing debate as to whether university leaders should be drawn from outside academia.

Addendum:

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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.

Leadership and Better Patient Care: Managing in the NHS

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Finally each one of us has a commitment to the future of the NHS and we are therefore optimistic that at least some of the content of this report will contribute to future planning and development to benefit staff and patients.

Executive Summary

The NHS National Leadership Council Website¹ (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)

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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.

Leadership and Better Patient Care: Managing in the NHS

1 Leadership, organisation and the NHS

1.1 Leadership

What is currently known about leaders and leadership? The ongoing attempt to identify the characteristics necessary for effective leadership over recent years has been described as an 'obsession' studied more extensively than almost any other characteristic of human behaviour (Higgs, 2002; Tourish, 2008). Alimo-Metcalfe, Alban-Metcalfe et al. (2007) in their comprehensive review of the literature, show that formal studies of leadership date back (at least) to the beginning of the 20th century. They propose, that despite changes in the way leadership has been studied and the underlying epistemological stance taken by the researchers, *"in all cases, the emphasis has been on identifying those factors that make certain individuals particularly effective in influencing the behaviour of other individuals or groups and in making things happen that would not otherwise occur or preventing undesired outcomes"* (p. 2). As *"many have pointed out, that in spite of the plethora of studies, we still seem to know little about the defining characteristics of effective leadership"* (Higgs, 2002, p.3). Even so this has not appeared to quell the appetite for pursuing an ideal of leadership, impelled by the changing demands of organisations echoed across public sector institutions such as the NHS. These changes are in part the result of technological advancements which impact upon clinical practices, demographic changes both of which have altered the strategic, structural and financial profile of health (and social) care (Tierney, 1996).

The tantalising questions remain though about what those factors might actually be and the significance of the context to 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).

But in addition, or conversely, the context, culture, climate and/or structure of an organisation each have an impact on the performance of the people who lead in it (Carroll, Levy, & Richmond, 2008; Goodwin, 2000; Michie & West, 2004).

Focusing on the relationship(s) between 'leadership' and context has revitalised contemporary research particularly through the development of qualitative research, discursive and social constructionist epistemologies (Grint, 2005; Uhl-Bien, 2006) although it is unclear at this stage how far a connection might be developed between this research and its applications, for example in health care services (Fambrough & Hart, 2008).

In what follows in this chapter we explore the changing ways in which leadership has been conceptualised over the past fifty years, particularly focusing on how it has and *might* be operationalised in the NHS (particularly although not exclusively in a *hospital* context) .

1.2 Background and introduction to the study

The NHS Modernisation Agency Leadership Centre (NHSMALC) website³ had originally suggested that effective leadership is a key ingredient in modernising today's health care services. In its own words:

Effective leadership and management in the healthcare system are key drivers in patient experience. Governance and good environments matter to patients, their visitors and carers and staff.

But how might effective leadership be achieved and sustained? The NHS Leadership Centre commissioned a number of leadership initiatives (Larsen et al., 2005). The NHS Institute for Innovation and Improvement (2005) *NHS Leadership Qualities Framework*⁴ emphasised the *situational* nature of leadership and indicated the circumstances under which different leadership qualities will take precedence.

These comprise fifteen contextualised qualities covering a range of personal, cognitive, and social characteristics arranged in three clusters which are set out in Figure 1:

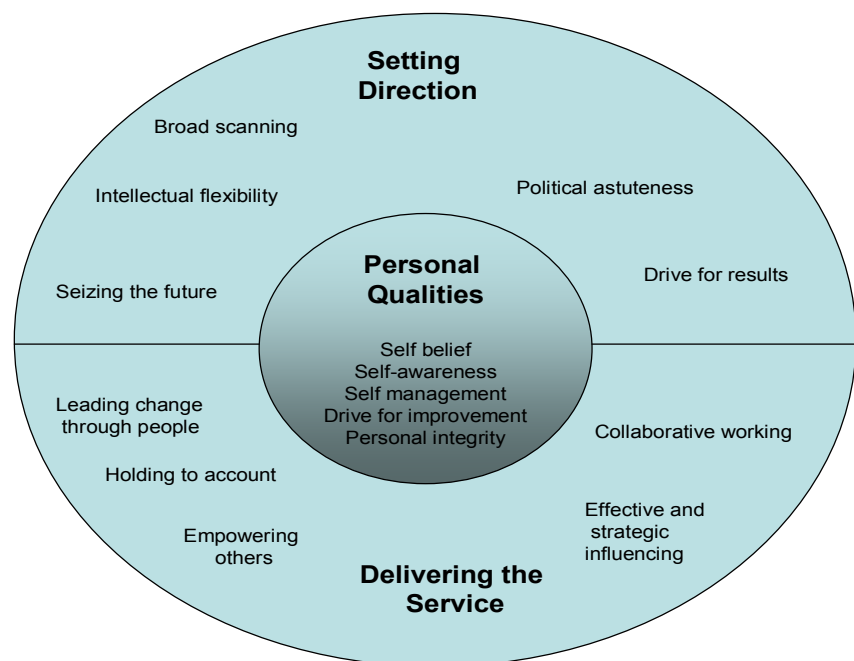
³ <http://www.dh.gov.uk/en/managingyourorganisation/leadershipandmanagement/index.htm>

⁴ <http://www.nhsleadershipqualities.nhs.uk/>

- *Personal Qualities*
- *Setting Direction*
- *Delivering the Service*

Thus, a competent leader enables development in an organisation that is goal directed, geared to developing processes and systems and enables staff at all levels to plan effectively and efficiently towards agreed goals (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Figure 1. The NHS Qualities Framework



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However, these same authors underscore the point that there is something beyond leadership competency that needs to be addressed, particularly in a changing and complex context such as an NHS Trust. *That is that a leader is someone who encourages and enables the development of an organisation in a culture based on integrity, transparency and valuing others. Leaders also need to question, think critically as well as strategically* (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Since the publication of the *NHS Leadership Qualities Framework* in 2005 all efforts have been directed to recognising and discussing leadership qualities and making strides towards their implementation. In 2008 Clare Chapman, Director General of the Department of Health's Workforce declared:

*Leadership is all about creating value for customers and citizens whilst also making work worthwhile for staff. This sounds incredibly straight forward - but it requires courage and resilience, and commitment throughout the entire piece*⁵

David Nicholson the CEO of the NHS in the report *Inspiring Leaders: Leadership for Quality* (January 2009) building on Darzi's *NHS Next Stage Review*⁶ stated:

It is imperative that we align what we are doing on leadership with what we want to achieve on quality. This is what I call leadership with a purpose.

Over the past year, the Department of Health has worked extensively with the NHS and other stakeholders to determine how best to foster talent and leadership development, and it is clear that there is a great deal of enthusiasm for a more systematic approach.

Spotting and developing confident leaders is a priority for us all if improving quality is our shared purpose. This guidance represents our best collective thinking to date. I invite you to use it and contribute to its improvement as we learn how to bring leadership centre stage over the coming months.

Nicholson and his team have charged the Strategic Health Authorities with finding gaps in leadership and systematically nurturing talent across the whole of the NHS. Clearly, the enthusiasm of successive senior officers in

⁵ DH_083353.

⁶ www.dh.gov.uk/en/Healthcare/Highqualitycareforall/index.htm

government and the NHS has been to link effective leadership with good service delivery and patient care as the primary outcome.

1.2.1 Leadership and Better Patient Care in this Study

This rhetoric and confidence about the type of leadership that best suits the NHS from those who lead it gave us pause for thought (Milewa, Valentine, & Calnan, 1998; Mueller, Sillince, Harvey, & Howorth, 2004b). 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 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 aims were overall to seek out the meanings and perceptions of relationships between (effective) 'leadership' and (better) 'patient care' and how leadership is transmitted across organisations to impact upon service delivery, taking account of the mixed methods and specific social science and systemic approaches that the investigatory team proposed. This inevitably has brought certain issues to the fore and (possibly) obscured others.

Our starting point therefore was to hold the NHS model of leadership in mind while calling on our own specific strengths as academics, from a range of social science and methodological backgrounds, to take a cross section of Trusts, clinical specialties, services, staff grades and patient needs, and to observe the *processes of leadership* in everyday working life. From this we proposed it should be possible to determine the ways in which leadership, NHS organisations and patient care were socially and discursively constructed so that links between leadership and patient care might be explored.

In Chapter One we outline some of the important contemporary social science and organisational thinking on leaders and leadership and explore the links between this and the NHS perspectives.

In Chapter Two we set out the innovative methodologies employed to investigate and analyse the research questions. This is followed in Chapter Three with the detailed procedures used for data collection.

The results are presented across four separate chapters. Chapter Four provides the analysis of what leadership means and how it is experienced by staff and patients (Christensen & Laegreid, 2003; Fairhurst, 2005).

Chapter Five presents the results of the Organisational Climate Survey (OCS) (Stringer, 2002). In Chapter Six, open systems theory and the concept of the 'organisation in the mind' are introduced particularly focusing upon the transmission of leadership across organisations. The relationship

between leadership, authority and emotion is discussed in Chapter Seven and in Chapter Eight the role of gender relations and their impact on leadership are reviewed (Begun, Hamilton, Tornabeni, & White, 2006; Ford, 2010; Telford, 2007).

Chapter Nine covers definitions, explanations and experiences of patient care and particularly how it relates to leadership by NHS staff and patients (Begun et al., 2006; Disch, Edwardson, & Adwan, 2004).

Finally in Chapter Ten we summarise our findings, make recommendations and draw conclusions.

Appendices provide copies of the research instruments, additional statistical results and the relevant NRES information.

1.3 Theoretical Approaches to leadership

Leadership research and theory is prolific with the consequence that numerous, frequently overlapping, models of leadership are available to agencies attempting to analyse or train leaders (and indeed managers, as until relatively recently little distinction was made between these two categories, see e.g. Kotter, 1996). Over the past fifty years leadership theories have shifted through different points of focus from the 'trait (or 'great man') approach in the 1940s, through the 'behavioural' perspectives in the 1950s whereby some styles of behaviour were seen as being more or less influential on potential followers. Then since the 1960s and 1970s the focus has been upon 'situational' leadership based mostly upon Fiedler's 'contingency' theory which proposed that different leadership styles were needed for different situations (see Alimo-Metcalfe, Alban-Metcalfe, et al. 2007; Western, 2008 for further details). During the 1970s and 1980s leadership research, albeit prolific, had reached an all time low in terms of its perceived contribution to theory and added value to knowledge for practice, so that as Cummings (1981 p. 366, quoted in a review by Bryman, 2004) asserted:

As we all know, the study and more particularly the results produced by the study, of leadership has been a major disappointment for many of us working within organisational behaviour.

Bryman unpicked the implications of the phrase Cummings used "as we all know" noting that it was "simultaneously sweeping and damning" (2004, p. 730). Bryman also picks out Miner's (1975) suggestion for temporarily abandoning the concept because of its limited utility in helping us understand organisational behaviour. *Why had leadership research reached this nadir during those decades? Why has there been a more recent upsurge of interest in leadership again almost to the point of saturation?*

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Bryman in his review suggests, that the renewed confidence and interest in the study of leadership has come from improved measurement and analytic techniques, greater use of meta-analysis so that more systematic reviews could be compiled, the emphasis on *transformational leadership* and *charismatic leadership* which have provided a fulcrum for the area of research, more and better cross-cultural studies and greater diversity in the types of leadership and organisational contexts that have been studied.

A factor that may also have contributed to the idea that leadership research continues to be fruitful is that a greater diversity of methodological approaches have been added and Bryman's review specifically focused on the value added by qualitative research.

Towards the end of the 1980s and beyond, thinking about the meaning(s) of leadership came to take greater precedence than in the previous two decades, possibly because of a perceived dearth of leadership *per se*.

These deliberations cast light onto the:

- *interactions between leaders and followers* and organisational cultures (Avolio, Gardner, Walumbwa, Luthans, & May, 2004; Lewis, 2000; Schilling, 2009)
- the *management of emotion* (George, 2000; Lewis, 2005; Pescosolido, 2002)
- the *processes* of leadership (Collinson, 2005; Dopson & Waddington, 1996; Vangen & Huxham, 2003)

Even so, or perhaps because of the use of qualitative approaches and related conceptualisation, Alvesson and Sveningsson (2003) were able to entitle a recent paper arising out of their study of leadership in a research and development company: "*The great disappearing act: Difficulties in doing 'leadership'*".

By this they meant that during their study they were able to identify how the existence of the label 'leadership' led to an assumption that the concept had an empirical reality. However the results of their work indicated that leadership might be better explained as a *process or series of processes of interaction*. This conclusion raises questions about mainstream thinking on leadership which presumes observable and possibly measurable characteristics (Alvesson and Sveningsson, 2003, p. 361; see also Ford, 2010).

Most recently there has been reconsideration and development of ideas about leadership in context taking account of the relevance of some earlier studies of organisations (e.g. Lewin, 1947) and open systems theories (see

Chapter Six; Laughlin and Sher, 2010) and new epistemological positions (e.g. Ford, 2010).

In our study, as a consequence of these recent critiques of leadership research and the result of methodological innovation, we approached the concept of 'leadership' as not necessarily a property of one individual (although it can be) or of one specific role, such as Clinical Director or a service manager, but rather we identified leadership as a *process* occurring within a group, organisation or collectivity that *imagines, wills and drives change* (Gabriel, 2004; Gronn, 2002).

1.3.1 Dimensions of Leadership and their Value for the NHS

Leadership, *as a practice*, has been on occasions constructed as 'a beautiful or rarefied ideal' an idea which has little use in the real world particularly as it has been suggested there are at least 350,000 definitions of leadership in the academic literature (Pye, 2005; Tourish, 2008; Western, 2008). *The question for this report is how to identify the literature on leadership and organisation with the most relevance for the contemporary NHS.*

Most discussed in theory and in practice over the past two decades has been the idea of *transformational leadership* (Bass, 1985) a model to explain ways in which a leader can be identified or trained to demonstrate the qualities that enable her/him to *perform beyond expectations*. The phrase 'transformational leadership' was coined originally in 1973 by Downtown but did not gain impetus until 1978 when Burns published his book, *Leadership*, which highlighted the *relationship* between leaders and followers (Burns, 1978).

Until then, as shown above (see Bryman, 2004) there had been little by way of a breakthrough in applicable knowledge. Burns (1978) demonstrated a *psychological* difference between an exchange relationship - where followers respond to leaders because of rewards they might receive - and one in which they respond to leaders who transform their attitudes and behaviours through inspiration and/or charisma (Bass, 1985; Yukl, 1999; Rafferty and Griffin, 2004). Transformational leadership then, is concerned with emotions, values and ethics, standards and long term goals which include assessing followers' moves and satisfying their needs (Currie & Lockett, 2007; Day, Gronn, & Salas, 2006; Eagley & Johannesen-Schmidt, 2003; Northouse, 2004).

Recognition that transformational leadership is not simply an individualistic model but one that *teams* can display (Day et al., 2006; Gronn, 2002; Sivasubramaniam, Murry, Avolio, & Jung, 2002) has shifted the

concentration from individual leaders per se to a more diffuse and distributed model of leadership and organisation context.

1.3.2 What constitutes transformational leadership?

Bass (1985) highlighted several characteristics of *transformational (or transformative) leadership* that allow followers and leaders to achieve far beyond their expectations. These are not discrete categories but given the significance placed upon the ideas behind transformational leadership in the scientific and training literature it is worth outlining the basic ideas behind these characteristics/types which have been identified as:

- Charismatic leadership
- Inspirational motivator
- Intellectually stimulating leadership
- Considerate leadership

Charismatic leadership

Bass (1985) proposed that "*charisma is a necessary component of transformational leadership*" (cited in Yukl 2002, p.261) and that charismatic leaders are endowed with exceptional personal qualities that attract followers. Charisma, a word derived from the Greek, means "*divinely inspired gift*" and is thought to give people the ability to perform miracles or predict the future (Yukl 2002, P. 241).

It is for this reason that charismatic leaders are often regarded as "*visionary, a futuristic, or a catalyst for change*" (Murphy 2005, p. 131; see also Bass 1985; Bennis & Nanus, 1985). Due to their rare personal qualities charismatic leaders are able to convey their visions to their followers in a clear and concise manner allowing them to visualise what they could achieve in the future if they worked together towards a common goal. As the leader's vision is normally realistic yet optimistic, it empowers the followers granting them greater self-esteem, encouraging and inspiring them to achieve the vision (Bennis & Nanus, 1985; Northouse, 2004; Yukl, 2002).

Inspirational motivator

Through their charisma, transformative leaders have the ability to inspire their followers through words of profound wisdom, or at least is what is *perceived* to be profound wisdom, such as with the case of Jim Jones⁷ in the USA or more positively President Obama who has reformed health care and banking legislation in the USA against the odds. Transformative leaders are

⁷ In 1978 Jim Jones persuaded more than 900 members of his People's Temple in Jonestown, Guyana to commit mass suicide.

excellent communicators which allow them to turn their visions into reality. Many use emotional and optimistic speeches to inspire their followers. They usually lead by example and often become role models to their followers who are in awe of their moral and ethical character. Many followers try and emulate their leaders' good qualities and are confident that their leaders will make just decisions on their behalf leading them to a prosperous future (Kellerman, 2004; Rafferty & Griffin, 2004).

Intellectually stimulating leadership

Transformational leaders have the ability to captivate their audience making the most mundane speeches and events interesting. They encourage their followers to be innovative, challenging the status quo and their own values and beliefs (Northouse, 2004). They also encourage their followers to solve problems and take an active role in the organisation, thus enhancing their self-worth and self-esteem, increasing their job satisfaction and productivity.

Considerate leadership

Transformational leaders are often also considerate leaders who are adept at performing mentoring or advisory roles to support their followers' emotional needs (Hiller, Day, & Vance, 2006; Rafferty & Griffin, 2004). Such leaders listen carefully to their followers' needs and desires, empathising with them during difficult periods. Being empathetic also builds a strong bond between leader and follower and thus a strong reciprocal relationship (Simpson & French, 2005).

It is important to note though, despite the wide take-up of transformational leadership as a conceptual model and a *practice*, that there remains uncertainty about the ambiguity of subdivisions and distinctions between elements in the model. Theoretical distinctions between 'charisma' and 'inspirational motivation' have become blurred over time and some theorists have suggested that elements of transformational leadership might also be identified as *transactions* (see Rafferty and Griffin, 2004 for a discussion of the implications).

Further concerns have been raised about how transformational leadership can take place in organisations, particularly public service ones, which are constrained by government initiative and targets and localised regulatory and normative pressures (Currie & Lockett, 2007; McNulty & Ferlie, 2004). However, it may also be that professional staff (rather than leaders/managers) in contexts such as health care, may in fact be more transformational than might be predicted because of their long-term commitment to the organisational goals (McGuire & Kennerly, 2006).

Most recently the notion that transformational leaders are very much 'engaging' leaders has been proposed (Alimo-Metcalfe, Alban-Metcalfe et al, 2007; Alban-Metcalfe & Alimo-Metcalfe, 2009; Macy & Schneider, 2008).

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One further comment here concerns the role of *gender* in styles of leadership and its consequent impact on organisational transformation (Fletcher, 2004; Mandell & Pherwani, 2003). There is evidence that (whether displayed by a woman or a man) feminine styles of leadership may be more related to engagement, emotional and social intelligence and distributed leadership, which may be important for complex organisations such as the NHS (see below).

1.4 Leadership, organisation and emotion at the turn to the 21st Century

Models of leadership and organisation theory have evolved over time and leadership and organisational structures and cultures are intrinsically linked in the literature. Leadership, if it is to motivate, innovate and move organisations to change, has to have an *emotional dimension* and, thus, effective leaders have a clear *emotional agenda* (as well as a strategic and structural one) which is particularly acute in services such as the NHS which is working to serve people's health care needs (Ashforth & Humphrey, 1995; Bolton, 2000; Pye, 2005).

Exploring organisations and leadership at the level of 'emotion' has become contested territory, as recognition, that organisations and their leaders need to take account of emotional engagement (Alban-Metcalf & Alimo-Metcalf, 2009; Vince & Broussine, 1996) at all levels of the work place, has emerged. Prior to the 1980's, organisational literature had been dominated by cognitive orientation (George, 2000) which favoured the rational, 'masculine' and scientific explanations of organisations and their leaders. This notion therefore ignored the (so called) irrational and 'feminine' characteristics of emotion, which were deemed detrimental to productivity and success. At that time emotions were regarded as the culprits that distort an individual's perceptual and cognitive faculties and therefore should be kept under control (Alvesson & Sveningsson, 2003b; Clarke, Hope-Hailey, & Kelliher, 2007; Dasborough, 2006; de Raeve, 2002; Ford, 2006).

As social and occupational psychologists began to study the effects of positive and negative moods on decision making, job satisfaction, choice of work-based activities and organisational climate, however, (Isen & Means, 1983; Rafaeli & Sutton, 1987, 1989) 'emotion' as part of organisational life gained impetus once again. This resurgence coincided with leadership theorists studying how moods and emotions could effect the quality of leadership (George, 2000).

It is possible to trace a rough trajectory from the 'hard nosed' scientific management, with the organisation perceived as a 'machine' in the early twentieth century, through towards a more humanistic, emotional and

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sometimes even spiritual way of thinking about contemporary leadership and organisational metaphors towards the twenty-first century, all of which are potentially transformational, not simply to the individuals concerned, but to the organisational dynamics.

Hochschild's (1983) *The Managed Heart* has been credited with being one of the earliest examples of research into emotions and organisational settings (Ashkanasy, Hartel, & Daus, 2002). She looked particularly at the airline industry and how airline cabin crew managed their emotions for dealing with difficult passengers and to promote a particular airline image. She termed this emotional management '*emotional labour*' (Hochschild, 1983).

Since this publication, the study of emotions in organisations has increased (Ashkanasy et al., 2002) with academics concentrating on key concepts such as emotional labour, emotional intelligence, mood analysis and Affective Events Theory (AET) and most recently a return to psychodynamic understanding of organisations and groups (see Ford, 2010; Schwarz, 1990). Since the 1990's a plethora of literature has emphasised the role of emotional concerns in private sector organisations such as the airline industry (Hochschild, 1983; Taylor & Tyler, 2000; Tyler & Abbott, 1998), service sector (Crang, 1994), merchant banking (McDowell & Court, 1994; Pugh, 2001), law (Harris, 2002) and image consultancy (Bryson & Wellington, 2003; Wellington & Bryson, 2001).

However, emotionality in the public sector was mostly neglected until 2000's when a surge of literature began to be published analysing the NHS (Allan & Smith, 2005; Bolton, 2000; Cummings, Hayduk, & Estabrooks, 2005a; Hunter, 2005; Lewis, 2005; McCreight, 2005; McQueen, 2004; Michie & Gooty, 2005; Michie & West, 2004; Smith, 1992) and the fire service (Archer, 1999; Scott & Myers, 2005; Ward & Winstanley, 2006; Yarnal, Dowler, & Hutchinson, 2004).

1.4.1 Emotional labour, leadership and patient care

Hochschild differentiates between emotional labour and emotional work or 'face-work' (Goffman, 1967). Emotional work has been described as the effort we put into presenting and representing our feelings as well as into feeling what we ought to feel (see Fineman, 2003). For example, a person ought to feel happy at a wedding and sad at a funeral and if their emotions do not match these expectations then a person must perform emotional work to display the appropriate emotion. This is sometimes difficult as people struggle to disguise their true emotions and perform the socially acceptable emotion.

When a person's emotions are appropriated and performed for commercial gain it is known as *emotional labour*. Hochschild states that emotional labour occurs in many occupations. However, she believes it to be more

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prevalent in service industries, such as the airline industry, where workers' emotions are sold as part of a commercial package⁸. Employees working in service industries must be skilled at managing their emotions and facial expressions in order to project the correct emotion to the customer (Crang, 1994; Lewis, 2005). This often means that employees have to suppress their own emotions in order to perform and display emotions that are suitable for commercial gain and in alignment with the organisations' image (McDowell and Court 1994).

Surface acting allows the employee to make up an outward gesture (Hochschild, 1983), to perform emotions that are not actually felt. In contrast, deep acting means that the employee can suppress or become estranged from their true feelings and *actually feel the emotions* that the employer wants them to display. *"One finds that the performer can be fully taken in by his own act, he can sincerely be convinced that the impression of reality which he stages is the real reality"* (Goffman 1990, p.28).

In the NHS, positively managed emotions *could* lead to better patient care, greater patient satisfaction and a relaxed and professional organisational climate (Amendoldair 2003; Bolton 2003). Lewis (2005) highlights how nurses in a special care baby unit appropriately managed their emotions to create a professional organisational climate, in which to offer quality patient care to special needs babies and emotional support to their parents. Lewis suggests that a nurse's job is sometimes very stressful and emotionally destabilising, especially when a baby dies. Nurses need to be conscious of their own emotions and regulate them to prevent causing further distress to the parents by displaying a professional demeanour (Bolton 2001).

However, managing emotions in this way, particularly if they are not felt, comes at a psychological and emotional cost and the whole process would be problematic without attending to emotional intelligence.

1.4.2 Emotional intelligence, leadership and patient care

The 'discovery' of emotional intelligence (EI), despite on-going valid critiques (see below) marked a turning point in contemporary organisational theories and approaches to leadership because of the tradition that emotions represent a threat to rationality – a view that has been widespread particularly in North America and North Western Europe (Fambrough & Hart, 2008; Western, 2008).

⁸ For a critical analysis of Hochschild's dichotomy of emotional labour and work see Bolton 2000 and Bolton and Boyd 2003.

Mayer and Salovey (1995), who conceived the idea of emotional intelligence, defined it as the ability to manage and understand one's own and other people's emotions in a consistent way so as to reflectively promote emotional and intellectual growth. Goleman (1996; 1998) who popularised the concept, identified emotional intelligence as a set of competencies, redefined and restated by George (2000) as follows:

- The expression and appraisal of emotion
- Enhancing cognitive process and decision making
- Emotional knowledge
- Managing emotions

These characteristics appear to have much in common with the rhetoric of transformational qualities of leadership although in many ways EI has become a management 'tool' rather than a critical model. To this end (apparently) Goleman (Goleman, 2000; Goleman, Boyatzis, & McKee, 2001) focused on 'styles' and 'performance' which seem far away from the 'heady' descriptions below of qualities of emotional intelligent leadership, which refer to feelings, empathy and creativity.

The expression and appraisal of emotion

An emotionally intelligent person will be able to understand their own and others' feelings and able to empathise, which may enable them to be manipulative for better or for worse.

Enhancing cognitive processes and decision making

Having emotional intelligence allows a person to use emotion to be creative, solve problems, make decisions and flexible plans for themselves and on the behalf of a group. An emotionally intelligent leader will be able to judge their mood and make decisions accordingly. If the person is in a negative mood this may mean choosing to wait until such negative episodes have past in order to make a comprehensive decision.

Emotional Knowledge

Emotionally intelligent people understand how other people may be affected by their negative moods and therefore may take care not to spread bad feeling around the group.

Managing Emotions

Many leaders are able to manage their followers' emotions as well as their own, but as indicated below, developing the qualities required to manage emotions effectively is highly complex and more about processes than style or performance (Fambrough & Hart, 2008; Hughes, 2005). As Fambrough and Hart argue 'emotional intelligence' has passed into common use among organisational leaders with little recognition of the way it has been identified

as problematic. *What has been so attractive about EI to leaders in health care organisations?*

The idea of emotional intelligence captured the imagination of some training NHS staff as a means to improve staff relationships and enable clinicians to empathise with their patients (Allan & Smith, 2005; Cummings et al., 2005a; McQueen, 2004; Amendolair 2003, Luker et al 2002). McQueen (2004) reflecting on the 1960's when health care workers were encouraged to hide their emotions from their patients, for the sake of maintaining a professional role, suggests that in recent decades this view of nursing has changed and health care workers frequently display emotions to illustrate their commitment to patient care (Williams 2000). McQueen suggests that emotionally intelligent nurses are important for building strong patient-nurse relationships (Conger and Kanungo 1987 and (Lewis, 2005). Nurses with high Emotional Intelligence are able to build rapport quickly with their patients through communication and interactive skills (Schutte et al 2001).

McQueen (2004) also states that "*emotional labour calls upon and engages*" emotional intelligence (2004, p. 103). In order for patients to feel cared for nurses have to constantly *perform* positive emotions and behaviours such as warmth, friendliness and consideration. However, when confronted with a 'difficult' patient nurses may experience negative emotions such as frustration, irritation or anger. The nurses must be emotionally intelligent enough to identify their emotions and then perform emotional labour to submerge the negative emotions in favour of more positive emotions (Bolton 2003).

While EI *per se* needs to be understood more critically (Fambrough & Hart, 2008), the introduction of emotional management and engagement by leaders (and others) in health care organisations needs further scrutiny (see below); despite the best efforts of some management gurus emotion is a fact of personal, interpersonal and organisational life particularly when considering what it means to deliver patient care.

1.4.3 Beyond emotional intelligence

Interest in EI has continued to grow among management and organisational academics with a focus on how to measure it – the conclusions generally indicating the need for caution in measures to predict or to establish baselines for its development among managers (Conte, 2005). The conflation of managerial skills as listed by Mintzberg (Mintzberg, 1973) cited in Riggio and Reichard, (2008) which included the ability to 'deal' with subordinates, 'empathize' with top-level leaders and establish and maintain social networks, alongside managing emotions as a leader, have come to be known as 'people skills'. These are clearly represented in the NHS leadership qualities framework and vital for managing in any organisation (see Figure 1).

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1.4.3.1 Social intelligence (SI) and leadership

In 2006, taking account of advances in neurological psychology, Goleman (Goleman, 2006) proposed that because humans are *designed* for social connection, rapport and supportive emotional interactions enhance performance of managers and leaders. He listed these qualities under the umbrella of 'social intelligence' and identified four dimensions:

- *Synchronization* – whereby matching moods lead to a sense of rapport
- *Attunement* – listening fully
- *Social cognition* – understanding how people interact
- *Social facility* – finding it easy to interact with others

While some people have little difficulty meeting these criteria and mastering their social intelligence, others (such as Narcissists, Machiavellian and Psychopathic types), Goleman argues, do not have the capacity for social intelligence, and thus he proposes a means of *selecting* effective leaders by testing these qualities. This model albeit individualistic has something to offer through extending the theoretical underpinnings of 'people skills' and emphasising the importance of taking followers and colleagues seriously in decision-making.

Following EI and SI in bringing management/organisational theories together with developments in psychology, particularly cognitive neuroscience and evolutionary psychology, is the reconsideration of the role of intuition in understanding leadership and organisational behaviours (Sadler-Smith, 2008). Sadler-Smith brings the idea of the 'gut feeling' into the foreground to explore the influence of this sense upon decision-making particularly under pressure (e.g. many emergency clinical decisions rely on the clinician's instinct of whether the patient should be operated on, admitted to hospital, whether to call for support).

It seems that while there is a continuing trend towards an evidence-based understanding of leadership, success there is also an emergence of features of human life that are difficult to explain and measure, although all the proponents cited above stick to the view that these characteristics are scientifically explicable and measureable despite challenges from both positivist and critical social constructionist positions (Ashforth & Humphrey, 1995; Conte, 2005).

1.4.3.2 Affective Events Theory (AET)

AET predicts that specific features of work (e.g. autonomy) have an impact on the arousal of emotions and moods at work that, in turn, co-determine job satisfaction of employees. AET further proposes that job satisfaction is

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an evaluative judgement that mainly explains cognitive-based behaviour, whereas emotions and moods better predict affective-based behaviour. The results support these assumptions (Jürgen, van Rolf, Fisher et al., 2006). Ashkanasy et al (2002) suggested that AET has two important messages for leaders in an organisation.

- Followers' emotions are heavily influenced by their leaders' emotions and therefore leaders must minimise the 'hassles' that they place on their followers in order to increase job satisfaction and performance. Short-term negativity can be tolerated without much impact on the team or organisation.
- However, if negative events persist it will affect followers' moods leading to negative emotions, poor performance, reduced job satisfaction and in the case of the NHS, (possibly) to poor quality patient care. It is therefore suggested that leaders need to give followers positive feedback regularly to "*ameliorate the daily hassles experienced by employees*" procuring positive behaviours such as team spirit and self-worth (Dasborough 2006, p. 165 ; Weiss & Cropanzano, 1996). The connections between the moods of individuals and their performance may be understood better in terms of emotional engagement between leaders and followers on both conscious and unconscious levels (see below).

1.5 Distributed leadership

The academic study of distributed leadership, that is when at various levels leadership (or influence) behaviour, identity, role and responsibility are distributed to more than one individual or group of individuals, has been at the forefront of much social scientific leadership research over the past ten years (Buchanan, Addicott, Fitzgerald, Ferlie, & Baeza, 2007; Day, Gronn, & Salas, 2004; Gronn, 2002; Mehra, Smith, Dixon, & Robertson, 2006a). The implication of this interest in distributed leadership is, that organisations have changed and previous models - including the charismatic, 'hero' leader and the 'command and control' organisational structures - are dysfunctional in a context where organisational change is rapid and diversification of strategic leadership and management essential (Butterfield, Edwards, & Woodall, 2005; Dent, 2005; Goodwin, 2000). In a competitive, diverse and divergent environment leadership needs to be distributed, in order to enhance democratic governance, thus enhancing legitimacy and increasing survival chances (Currie et al., 2009).

Distributed leadership also implies that organisations where it is practiced have (relatively) flat hierarchies with diverse service needs and expertise across all sectors of the organisation (Huffington, James, & Armstrong, 2007). This model applies to hospitals and primary care settings, where

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distinct professional groups each have their own standards of excellence, while at the same time sharing goals of competence and quality related to the service they provide to patients and how they interrelate to other organisations.

With this shift in focus of many leadership practices and leadership studies the definition of such leadership has been proposed as:

".. a status ascribed to one individual, an aggregate of separate individuals, sets of small numbers of individuals acting in concert or larger plural-member organisational units" (Gronn, 2002, p. 428).

Gronn suggests also that when leadership is distributed it may be that the duration of that influence is limited, perhaps (structurally) to a single project and therefore (psychologically) distributed leadership might mean having to 'give up' leadership as well as take it up (Huffington et al., 2007). Furthermore, according to Gronn (2002) the most common understanding of distributed leadership, witnessed by the growing number of references to it in the research and policy literature, is that it applies to numerous people across an organisation taking some degree of a leadership role or responsibility.

More importantly, Gronn identified distributed leadership as *concerted action* meaning that there are many roles comprising a 'leadership complex' with at least three potential forms:

- *collaborative modes of engagement* which arise spontaneously in the workplace. This suggests that leadership practice is 'stretched over' the context of the organisation and not a function of those in managerial roles such as matron or clinical director. However, if the matron, clinical director and other colleagues who share ideas for change or particular activities they *may "pool their expertise and regularise their conduct to solve a problem after which they may disband"* (Gronn, 2002, p. 430).
- the *intuitive understanding* that develops as part of a close working relationship among colleagues. These relationships tend to happen over time when organisation members come to rely on each other and develop a close working relationship, to solve problems or bring about change and others might be involved in a 'framework of understanding'.
- The variety of *structural relations* and institutionalized arrangements which constitute attempts to regularize distributed action. Thus, for example, if there were dissatisfaction with existing arrangements for particular practices, a team of 'equals'

might emerge to find ways to improve or change the problematic practices.

All of these are apparent particularly, but not exclusively, in Trust Three (the FT) as exemplified in Chapters Four and Nine in particular.

Gronn argues the importance of examination of these different forms of concerted action to understand where influence (and thus leadership and power) might lie in any organisational context. Emotionally, however, these different models of distributed leadership suggest the impact of these structures and practices at a deeper level (Gabriel, 2004) particularly around authority (Halton, 2007; Hirschhorn, 1997) competition (Morgan, 2006) rivalry and envy (James & Arriba, 2005; Stein, 2005)

1.6 Organisational Culture, Climate and Contexts

As introduced above, post-industrial (or even 'post-modern') organisations (Burrell, 1988; Fineman, Sims, & Gabriel, 2005) and networked (Balkundi & Kilduff, 2006; Goodwin, 2000) organisations are changing rapidly and the NHS is clearly among these. Changes in the NHS take place at a number of levels, emerging from the direct policy dictates from central government to become local initiatives. Moreover, the NHS has become increasingly team (and indeed multi-disciplinary team) based over the past two or three decades so that knowledge, influence and leadership for transformation and change are not only moving from a top-down to bottom-up model, but as indicated, to a distributed model which involves lateral influence (Begun et al., 2006; Day et al., 2006; Ferlie & Shortell, 2001).

The type of leadership that is supported and promoted in any organisation and the related concept of the organisational structure depends on and impacts upon organisational climate and culture.

Although research undertaken on organisational *climate* and organisational *culture* comes from different epistemological traditions, since around 1990 the literature and concepts referring to both have been overlapping and/or complementary (Schneider, 1990; Schneider, 2000) and increasingly the terms are used interchangeably (Ashkanasy et al. 2000).

It is, however, generally accepted that 'climate' is a logical extension of what was originally conceptualised as 'psychological' climate, that is, shared psychological meanings in an organisation; so that *organisational* climate is an aggregation of those individual perceptions of a work-place context (James, Choi et al. 2008).

Organisational culture on the other hand has its origins in anthropology and human relations (see Davies, Nutley and Mannion, 2000; Scott, Mannion et

al. 2003). Organisational psychologist Edgar Schein's (1985/2004) ideas about organisational *culture* as a pattern of *shared basic assumptions that have worked well enough and adapt to the external environment and serve internal integration*⁹, is one of the most frequently quoted definitions. Schein takes a systems theory approach to understanding organisations and his work has been built upon by himself and others to develop a variety of typologies which underpin measures of both organisational culture and climate (see Albino-Metcalf, Alban-Metcalf et al. 2008 for a comprehensive overview of this literature).

Organisational climate, with its origins in traditional psychology is *typically* "... the only domain of organisational research that simultaneously examines perceptions of jobs, groups, leaders, and organisational attributes and thus has the unique capacity of being able to decipher common denominators and latent relationships that are not available to those who study only specific domains such as perceived equity" (James et al., 2008, p.27). We therefore made a decision to use a measure of *climate* as a backdrop to this mostly qualitative study, in order to 'triangulate' with our findings on leadership and patient care.

However, we found a competing strand of interest in the measurement of organisational *culture* (e.g. Davies, Nutley and Mannion, 2000; Scott, Mannion, Davies and Marshall, 2003) which more frequently seems to attend to health care settings than studies of climate albeit with some notable exceptions (Dawson, Gonzalez-Roma, Davis and West, 2008).

1.6.1 Emotion and the unconscious in organisations

Organisational climate and/or culture cannot be discussed without acknowledging that organisations are places where both the intellect and emotion are called into play in order to achieve organisational goals and as we have made clear, emotions are intrinsic to service delivery and leader-follower engagement in the NHS. Emotional engagement, while available to human consciousness, also takes place at an unconscious level (Gabriel, 2004; Hugh, 1986; Lyons-Ruth, 1999; Morgan, 2006; Willmott, 1986), and anxiety or stress is particularly salient when having to care for and make potentially life-saving decisions for patients (James & Huffington, 2004; Menzies¹⁰¹¹, 1970).

⁹ A paraphrase.

The ideas that characterise transformational leadership models, such as 'charisma', 'influence', 'inspiration' 'thoughtfulness' and 'consideration', have intellectual roots beyond contemporary management theory and training. They are more closely related to group and organisational theories with late 19th and early 20th century origins (De Board, 1978; Gabriel, 2004) from which much contemporary organisational theory has emerged.

The first significant attempt to analyse group behaviour made at the start of the 20th Century by Le Bon (1917/1920) whose book *The Crowd* illustrated his observation that individuals in a large group can demonstrate a 'collective mind' which emerges when people are bound together in some way. McDougall's book *The Group Mind* (1922/2009) and Sigmund Freud's *Group Psychology and the Analysis of the Ego* (1921/1922) also focused on what would subsequently come to be recognised as unconscious group processes. Freud developed Le Bon's and McDougall's ideas in the context of psychodynamic theory, arguing that the binding force of the group derives from the *emotional* ties of the members, which are expressions of their libido or drive.

Studies of (and human 'experiments' about) group psychology, taking some of this perspective on board, flourished after the Second World War conducted and further developed by psychiatrists in the newly formed NHS. In Britain the work of Wilfred Bion, Tom Main, Maxwell Jones and others led to innovations in both group psychotherapy and the study of organisations. Bion's work on group relations and dynamics which contributed to the development of the Group Relations Training Programme (GRTP) at the Tavistock Institute in 1957 evolved into the Leicester Conferences with other organisations using this model across the world (Miller, 1993). However contemporary knowledge and understanding continues to reflect back upon this early work.

What was learnt during this period about group dynamics and group relations represents an important dimension in the understanding of contemporary organisations and the relationship between leaders and followers. We develop this further in Chapter Seven in particular. It is important to note how the intellectual journey from work on emotional labour to social intelligence and intuition has so far largely neglected to explore the extent to which unconscious processes remain part of the emotional context of human social interaction (Allan and Smith, 2005, p. 21).

¹¹ Isabel Menzies is sometimes referred to as Menzies-Lyth. Her work has been reprinted several times with each name used.

In a hospital environment it is inevitable that negative events such as death occur (see Lewis for discussion on the impact of death on nurses in a special care baby unit taking an 'emotional labour' approach). When death does occur nurses may display emotions (consciously and unconsciously) such as anxiety and fear (Allan & Smith, 2005; Obholzer & Roberts, 1994; Allan 2001; Smith et al 2003). Obholzer asserts that "[he] believes that many of the organisations' difficulties that occur in hospital settings arise from a neglect of the unconscious psychological impact of death and near-death on patients and staff" (1994, p.171). He explains that hospitals are sites where anxieties about social taboos such as death are *contained*, that is that staff and the organisation overall takes away the anxiety and the responsibility for care from the relatives. Patients and staff are socialised to believe that hospitals are institutions where illness is treated and that medical knowledge and practice is infallible. This is illustrated by patients who contend that doctors possess God-like qualities and have the ability to heal all ailments. When death does occur, medical staff and the patient's relatives may feel *duped* by the institution they believed would save their loved one.

At the turn of the 19th to the 20th Centuries psychoanalytic ideas were seen to have something new and important to say, not only about the psychology of the individual and the role of the individual unconscious, but about *unconscious processes when people converge in groups and crowds* as shown above. From psychoanalytic theory we take up ideas again today specifically about the relationships which exist between followers and leaders, made explicit in the paradigm shift from transactional to transformational leadership. Working together and accepting or resisting influence comes not only with an observable set of behaviours and measurable emotions, but with unconscious and 'secret' ones including dependency, envy, power, anger, authority and emotional contagion, which may be either conscious or unconscious but have important consequences for behaviours (Burke et al., 2006; Simpson & French, 2005; Stein, 2005; Whitely, 1997). In Chapter Seven for example we see examples of where two senior managers find themselves unable to influence despite their senior roles, legitimacy and operational power. As Gabriel (2004) has argued "*emotions are no simple side-effects of mental life*" as "*emotion lies at the heart of human motivation*" (p.215).

One key feature of caring for sick patients, managing change and the social context of the NHS Trust then, is the ways in which clinicians and managers manage their anxiety which is fundamental to working in any health care setting. In the section that follows below, we demonstrate how psychoanalytic thinking explains how individual psychology and unconscious defence mechanisms link to the ways in which human beings work in groups and organisations.

In Chapter Nine we attend in more detail to the anxieties involved in obstetrics and more generally on the emotions involved in care of the elderly. In anticipation of these we present the theoretical material in some detail immediately below in this chapter.

1.6.2 Clinicians' anxiety and patient care

To conceptualize anxiety we draw on object relations theory, the branch of psychoanalysis associated with Melanie Klein (1959) and, in particular, the work of scholars who applied object relations to an understanding of groups (Bion, 1961) and organisations (Jaques, 1952; Menzies, 1970; Klein, 1987; 1983) hypothesising that an infant responds from the earliest time to the withdrawal of the maternal breast by experiencing a powerful anxiety of a 'persecutory nature'. Being unable to grasp the separation from the breast intellectually, the infant, unconsciously, feels as if every discomfort were inflicted by hostile forces. A fundamental *splitting* takes place, whereby an object is experienced as two separate objects, one entirely good and one totally bad. Thus there is a good breast (which is always present and nourishing) and a bad breast (withdrawing and denying), a good mother and a bad mother.

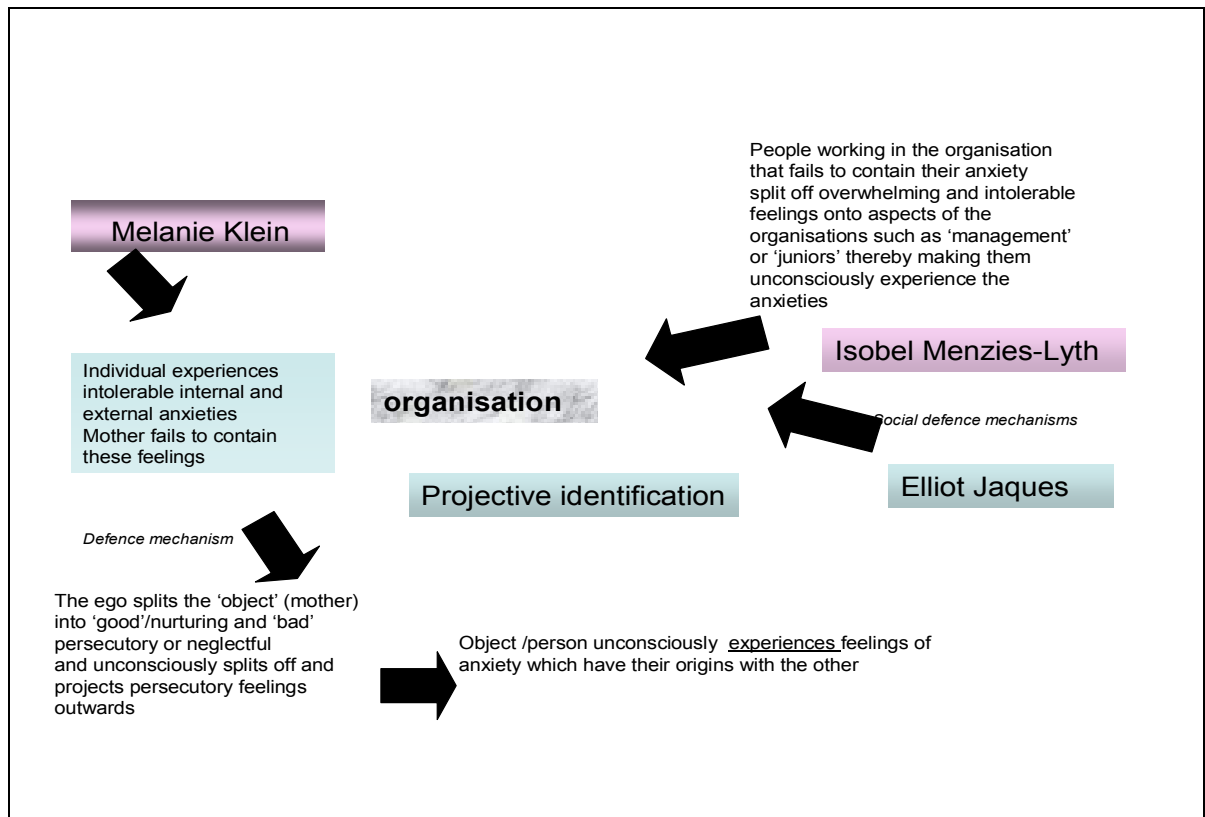
This is a pattern repeated in clinical settings, where patients routinely refer to a 'good nurse' and a 'bad nurse' and, almost identically, clinical staff referred to some patients as 'a good patient' and to others as 'a bad patient' (see Chapter Nine for an example of this). Splitting according to Klein extends in the child's own self – those aspects of him/herself that she cannot bear are projected outwards ("It is not I who is angry/fearful/envious; it is you"). Again this is a phenomenon observed many times in clinical settings. Frustration, discomfort and pain are experienced as persecution from hostile forces and their concomitants (e.g. hate) become destructive impulses which *are still operative in later life*, especially in times of stress and crisis.

Splitting and projection then are seen as fundamental *defences against primitive anxieties* by the object-relations school of psychoanalysis. Within this tradition, objects are not external entities but are shaped by phantasies¹² and feelings, they are *introjected* and projected, they split into good and bad and they constantly define and re-define the ego (or self). Object relations theory has found numerous important applications in the theory of organisations, primarily through the works of Jaques (1952) and Menzies Lyth (1960; 1970) in the UK, and more recently, Hirschhorn (1988), Gould (1993), Diamond (1993), Schwarz, (1990), Schwarz and Clore (2003) among others. Notable among these applications is the

¹² 'Phantasies' spelt in this way refers to those in unconscious experience.

treatment of *the whole organisation as an object which is liable to become incorporated in psychic reality* and towards which the individual may develop relations akin to early relations with significant objects from her environment and hold the 'organisation in the mind' (Armstrong, 2005) which we will discuss in more detail in the context of evidence from the study in Chapter Six.

Figure 2. Social Defences against Anxiety in Organisations



Menzies-Lyth, whose 1960 classic study of nursing staff occupies a privileged position in this literature, was driven by her initial observation that nursing work is highly anxiety-producing. She argued that nurses confront many different emotions from patients and their relatives - gratitude for the care they offer, admiration, envy for their skills and resentment stemming from forced dependence. Such projections create strong feelings in the nurses themselves:

The work situation arouses very strong and mixed feelings in the nurse: pity, compassion and love; guilt and anxiety; hatred and resentment of patients who arouse these strong feelings; envy of the care given to the patient. (Menzies-Lyth, 1988 , p. 46)

Faced with such an emotional cauldron, many nurses re-experience infantile persecutory anxieties, from which they seek to defend themselves, through

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the familiar mechanisms of projection, splitting and denial. Menzies-Lyth's important contribution was to establish how an organisation's own bureaucratic features, its rules and procedures, rotas, task-lists, paperwork, hierarchies and so on, in short '*the system*' acts as a support for the defensive techniques. By allowing for 'ritual task performance', by depersonalizing relations with the patients, by using organisational hierarchies, nurses contained their anxiety. Yet, in Menzies-Lyth's view, such organisational defences against anxiety were ultimately unsuccessful:

The system made little provision for confronting anxiety and working it through, the only way in which a real increase in the capacity to cope with it and personal maturation would take place. As a social defence system, it was ineffectual in containing anxiety. (Menzies-Lyth, 1991, p. 363)

The system's inadequacy in Menzies-Lyth's study is evidenced by its failure to train and retain nurses, the chronically low morale, high levels of stress and burn-out and absence of work satisfaction. By contrast, institutional health is testified not only by performance and output indicators, but also by morale indicators, and individual feelings of growth and maturation. Social defences against anxiety, then, are self-defeating. Instead of *containing* anxiety, they exacerbate it, just as neurotic symptoms far exacerbate the patient's malaise instead of containing it. Since Menzies-Lyth's pioneering work, some attention has been paid to how to support nurses and enable them to contain their emotions, without resorting to depersonalizing social defences. Yet, there is ample evidence that many nurses today continue to struggle with modest support against powerful anxieties (Theodosius, 2006; 2008). It is striking that no single study has sought to examine whether doctors face similar types of anxieties as nurses, whether they resort to similar psychological defences and the extent to which these defences function effectively across different individuals. In Chapter Nine we see evidence that doctors too appear to react similarly when faced with intolerable anxieties.

1.7 Developing our approach to leadership and the NHS

Studies of leadership and organisations such as the NHS clarify that diverse disciplinary perspectives have come together and separated more than once over the past century. The relationship between organisational and social context over that time has impacted on both practices of leadership and empirical and theoretical changes. In the 21st century the rules of scientific management or leader as therapist no-longer apply, and the rapid changes in organisations such as the NHS brought about by economic and technological imperatives, have left many who engage in leadership

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discourses, for practical and academic purposes, moving between the transformational and the post-heroic positions.

We now consider theoretical perspectives, ideas and practices that can potentially be brought together to good effect in this study for the benefit of patients and those who work for their good within the NHS, focusing on some of the recent debates which explore the context of leadership and the place of distributed leadership as they apply to NHS contexts.

1.7.1 The base-line:

- It is now widely acknowledged that organisations, their leaders and followers come together in a highly *emotional context*. How can those who lead and work in such organisations take account of the role of emotion while not being 'emotional' (i.e. making unfair and irrational decisions)? Understanding this is vital for enabling management and leadership particularly in a complex institution which has patient health, safety and care at its cutting edge (Morgan, 2006) .
- The NHS, individual Trusts and Units within these Trusts are constantly engaging staff in *change* (which may be evolutionary and/or politically driven) and which may be motivational and/or stressful or resisted (McNulty & Ferlie, 2002). This further demands emotional and social intelligence and engagement from leaders and followers (Bovey & Hede, 2001).
- The primary *tasks* and related *roles* might conflict at various points as these changes impact emotionally and intellectually on staff performance and service delivery (Zoller & Fairhurst, 2007).
- Organisations have to have leaders but leadership is not necessarily always the province of a small group of individuals but depends on the structure and demands placed on the organisations and the tasks required at any one time (Currie et al., 2009; Day et al., 2006; Harvey, 1989; Michie & West, 2004).
- An emotional context requires attention to both conscious and *unconscious* dimensions of human interaction and power relationships which may come into play in organisations which comprise multiple professional disciplines, different grades of role and people from diverse cultures, sexualities and gender (Ford, 2006; Gabriel, 2004). Acknowledgement of the importance of anxiety, envy, competition, anger and the emotional ties between people needs to be taken into account (see Figure 3 below).

Two models of leadership are therefore examined in this study (see Figure 3 below):

- First, *inspirational and transformative (or engaging) leadership* which has attracted much recent attention in that its absence was seen as a critical factor behind the failure of many organisational innovations. In this approach, leadership hinges on leaders' ability to communicate effectively, relate emotionally with their followers and develop a vision that is both attractive and achievable. The role of transformational leadership then is to lead an organisation towards change and thus some elements of transformational leadership are essential for understanding the practices and needs of the NHS (Alban-Metcalf & Alimo-Metcalf, 2009).
- The second relevant dimension is *distributed leadership* (sometimes called *dispersed, distributive, collective, or supportive 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). A *distributed leadership* approach is consistent with Bailey and Burr's (2005) research on successful NHS Trusts, which states:

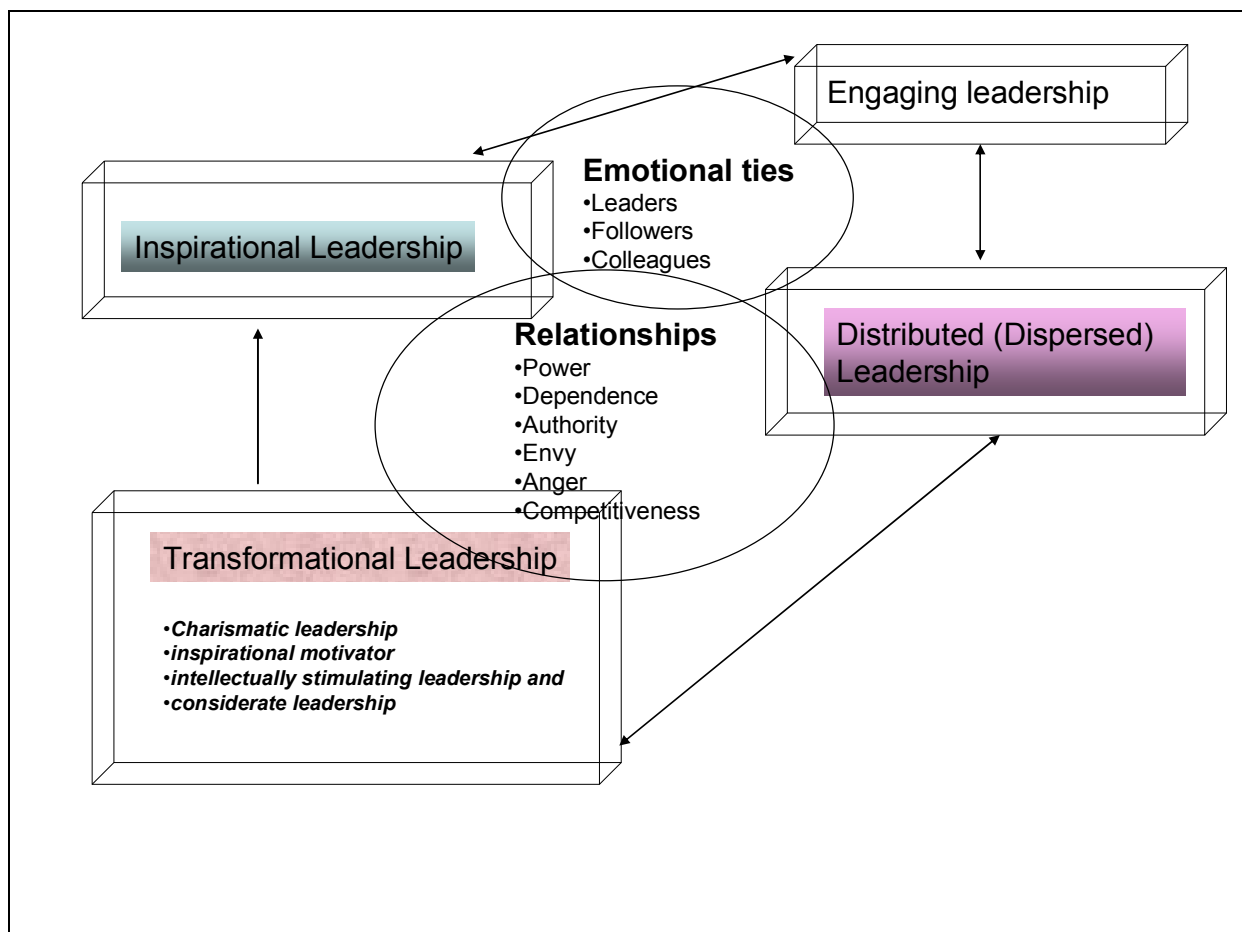
In contrast to the individual, heroic leader concept, leadership is seen in terms of the influence processes that contribute to the collective and individual capacity to work effectively. This idea of collective and distributed leadership is closely associated with the emergence and special requirements of 'new' organisational forms generally and the NHS in particular it is consistent with the agenda for devolved decision – making, empowerment of the frontline, de-centralisation, inclusion and such initiatives as 'Leadership at the Point of Care'.

Thus, distributed leadership is seen by Bailey and Burr (2005, p. 14) as directly linked to patient care.

A combination of these two models might now be seen as 'engaging' leadership as described by Alimo-Metcalf, Alban-Metcalf et al. (2007) and this combination will be explored further in our analysis of the (qualitative) data in particular.

Furthermore the model of the post-industrial/postmodern and or networked organisation will be 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).

Figure 3. Leadership Styles, Followership and Emotion



1.8 Conclusion

In an organisation like the NHS there are opportunities for leadership at all levels, as well as opportunities for success and unforeseen consequences leading to failure. Leaders in the NHS are involved *transformationally* in responding to policy initiatives and government demands, but the NHS is also an organisation that relies on the knowledge, skills and abilities of all its people – leaders and followers.

It would seem that *transformational/engaging and distributed leadership* are particularly useful conceptual resources to deploy in the context of the National Health Service, where a workforce of different ethnic, cultural and

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class backgrounds caters to the needs of a similarly diverse patient population.

Following Alimo-Metcalfe, Alban-Metcalfe et al (2007) "*an engaging 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'*" (2008, p. xi).

As part of the conceptual framework we develop, it is clear that the *emotional links* between individual staff, groups of staff and staff and patients need to be privileged as they play out at various organisational levels. Implicit therefore is that emotions above and below the surface (conscious and unconscious) are taken into account if the leader/follower and staff/patient relationships are to be understood and improved.

2 Aims and Methods

2.1 Introduction

The research questions in this study centre on identifying:

- (a) processes by which leadership is transmitted through health service organisations to effect the delivery of health services, and
- (b) how features of the organisation, the leader, and the service influence these processes.

The focus of this study was to explore the relationship(s) between (good) leadership in NHS organisations and (good) patient care. This demanded consideration not only of leadership characteristics, qualities and styles but the ways in which NHS organisational climate and culture interacted with individual practices and identities of those who worked in them and were patients. The overall plan was, thus, to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery. This research further sought to expand existing knowledge by exploring the following questions.

1. First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
2. Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

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3. Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

2.2 Aims and Objectives

We separated these overarching research questions into aims and objectives thus:

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients;
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts on service delivery;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted through health care organisations to affect service delivery, posits *organisational climate* as one feature of the organisation that could positively or negatively affect the quality and delivery of health services.
- To learn how different stakeholders (specifically, patients, nurses and professions allied with medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care.
- To identify how the need for change in service delivery is identified and what drives the need for change.

2.3 Methods

This multi-method study therefore uses a mixture of qualitative and quantitative methods to enable and support an innovatory approach to examining the psycho-

social and psychodynamic factors intrinsic to the meanings and processes of leadership, organisation and patient care.

Qualitative research methods now have a strong and long-standing profile in social science, particularly sociology and anthropology. But over recent years they have become increasingly relevant in social psychological research.

Furthermore nursing research (Finlay & Ballinger, 2006; Kerr, 2002) and most recently even health services research have begun to take evidence emerging from qualitative methods seriously. Perhaps this began with a series of papers in the British Medical Journal in 1995. Pope and Mays for example leading on this series aptly titled their paper *Reaching the Parts other Methods Cannot Reach* (Pope & Mays, 1995). Noteworthy from this point onwards is that there is no 'one' qualitative method of either data collection or analysis and we draw on several traditions and styles in this study which are outlined below.

Unlike health services research *per se*, but akin to critical social science, there is a powerful tradition in organisational research that has taken account of the diverse nature and intrinsic value of qualitative methodologies to understanding the life of organisations (see for example Cassell and Symon, 1994; Ybema et al., 2009)

What counts of course is choosing methods which meet the demands of the research hypothesis or overarching questions. We thus began from the premise that 'leadership', 'patient care' and 'organisational change' are not objective facts but social or discursive constructions. By this we mean that these concepts are constructed through discourse, i.e. a coherent system of statements which constructs an 'object' (Parker, 2002). In other words, talk about leadership is the process by which leadership is constructed (and thus recognised) as something that happens in organisations such as the NHS.

To capture these constructions we used a range of methods:

- focus groups;
- a survey-based questionnaire including a standardized measure of Organisational Climate;
- ethnographic 'shadowing';
- observations of social places, formal and informal and meetings;
- analysis of 'stories' of leadership collected through in-depth interviews.

2.4 Capturing the data

In what follows we present the outline plans for capturing, managing and analysing the data to meet our aims although as shown in Chapter Three not all of our goals were achieved.

We focused upon three NHS Trusts with at least one being a Foundation Trust specifically to explore whether any variations in the qualities of leadership, organisation and patient care could be distinguished. An

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investigation of three Trusts was considered to be manageable within the time frame and other resources available for the project.

Within each Trust we chose two distinct 'units' to study. We conjectured these would probably to be defined by clinical speciality or site (bearing in mind that many Trusts are organised across more than one hospital/physical space).

We conducted focus groups, an organisational climate survey, story-telling interviews and ethnographic work (observations and shadowing) across these six units with staff and patients.

We employed two researchers¹³ to carry out the majority of this work, but some members of the investigatory team also took an active part in the process.

The qualitative data would by necessity and designed be analysed using a variety of methods:

- a. Thematic analysis (TA)
- b. Critical Discourse Analysis (CDA)
- c. Narrative analysis

Each of these approaches to data analysis, again by necessity and design, was subject to nuances of interpretation, intrinsic to their nature.

¹³ In the event three researchers were involved because of maternity leave and cover.

The flowchart illustrates the research approach, starting with 'NRES application' and 'Informal and formal approaches to 'gate-keepers' by research team'. These lead to 'local governance' and 'The Trust'. 'The Trust' connects to 'Site A' and 'Site B'. 'Site A' leads to 'Unit 1', which connects to 'Unit 2 (As Unit 1)'. 'Unit 1' leads to 'Staff' and 'Patients'. 'Staff' and 'Patients' lead to 'Other parts of the Trust'. 'Other parts of the Trust' leads to 'Organisational Climate Survey'. 'Staff' and 'Patients' also lead to 'Interviews', 'Focus groups', 'Shadowing', and 'Observations'. 'Organisational Climate Survey' leads to 'Organisational Climate Survey'.

```

graph TD
    NRES[NRES application] --> Local[local governance]
    Informal[Informal and formal approaches to 'gate-keepers' by research team] --> Local
    Informal --> Trust[The Trust]
    Local --> Trust
    Trust --> SiteA[Site A]
    Trust --> SiteB[Site B]
    SiteA --> Unit1[Unit 1]
    Unit1 --> Unit2[Unit 2  
As Unit 1]
    Unit1 --> Staff[Staff]
    Unit1 --> Patients[Patients]
    Staff --> Other[Other parts of the Trust]
    Patients --> Other
    Other --> Survey[Organisational Climate Survey]
    Staff --> Methods[Interviews  
Focus groups  
Shadowing  
Observations]
    Patients --> Methods
    Methods -.-> Other
  
```

The Trusts

- they were each different from each other in the image they projected (on their web-sites, in terms of their physical style,

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locality, size and community) and that the sample had to include one Foundation Trust.

- they were in easy reach of London (for practical purposes as the study team were based in London and Surrey).
- we were able to gain access via personal contacts in R & D or senior management (the 'gatekeepers').

The Units

Sampling of the Units in each of the Trusts was achieved through negotiation with the gatekeepers and/ or key informants recommended by the gatekeepers with the intention that a balance might be struck between:

- the specific academic interests of the research team (for example the PI is particularly interested in Obstetrics and Gynaecology services).
- some degree of opportunity for comparison between Trusts, so that if possible some similar Units might be compared across the Trusts.
- and (possibly most influential) the concerns of the gatekeepers and other senior Trust staff.

The Sites

All three Trusts selected for an initial informal approach were on more than one site although the selection of study unit determined whether or not the data was collected on more than one site.

Individual Participants (staff)

Individual participants were to be selected on an 'informed' volunteer basis. That is that via a process of meetings with key informants and presentations to staff-groups individual staff would hear about the study and be offered the opportunity to participate. For those who were not involved in the meetings or presentations a staff e-mail list was used to communicate information about the study and request volunteers to participate in interviews and focus groups. The intention to meet the study aims was to ensure participation from a variety of staff groups and levels of seniority.

Individual Participants (patients)

Patients were to be recruited for interview either by the staff directly caring for them or by the researchers themselves once the staff of each unit had become familiar and accepted the presence of the researchers.

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Survey Respondents (staff)

The Organisational Climate Survey (OCS) was to be administered within the Units that were the focus of the study and, if possible, across other Units in the Trusts. The circulation was to be achieved either through e-mail or through internal mail depending on negotiation with the relevant gate-keepers.

Survey Respondents (patients)

Patients who might complete the patient version of the survey were to be recruited by staff and/or researchers if staff permitted the researchers 'on the ground' access.

Observations and 'Shadowing' (staff and patient-staff interactions)

These methods would require the participants to be familiar and comfortable with the presence of the researchers and familiar with the ongoing research process and also be prepared to co-operate. The rules for engagement in the activities would then be made on a strategic (i.e. the staff and / or situation that would yield the richest source of information) and a pragmatic basis (i.e. the possibility of the situation yielding important data regarding leadership, organisational culture and climate and patient care).

2.6 Ethical considerations

There are clearly considerations about confidentiality and anonymity in all data collection which involves human participants Easily identified in this study (and thus in the NRES application) is the matter of the safe keeping of the raw data including completed questionnaires, any identifying characteristics of these questionnaires, digital recordings, transcripts from focus groups and interviews and the researchers' field notes. It is important to note that this is not necessarily as simple to do as it is to describe particularly because a team of investigators, the researchers themselves and some 'casual' clerical staff ¹⁴all had different types of access to the data.

The solution was to have a shared drive set up by the computer centre at Royal Holloway, University of London (RHUL) on the main site at Egham which could only be accessed by specified investigators identified by the PI. Additionally there was an access pass-code to read the transcripts and the SPSS file.

¹⁴ The sheer volume of data made it necessary to use more than one person to input the data and transcribe the recordings. Two people other than the researchers were engaged to work on this although both were employees of RHUL who knew the importance of keeping the data safe.

Another ethical consideration specific to this project was that because the staff were discussing leadership and being asked to give examples of good and bad leadership, as well as examples of effective and poor patient care, it was inevitable that:

- they would be talking about *other* members of staff. These other staff could not be told that they had been talked about (by definition) leaving them unable to provide their version of the story or aware of the fact they had been discussed.
- the researchers would therefore be 'holding' some knowledge of others which would be 'data'. This fact drew attention to the ethical and empirical complexities of working in an organisation in which data is being collected on human interactions and relationships.

As patients' experiences and views and staff's views of patient care were also part of this investigation, similar issues applied.

Finally, frequently overlooked but nonetheless very important consideration was given to the fact that participants' time should not be wasted. We were confident in the design and our experience as investigators supporting and managing the researchers (who themselves were experienced in this kind of study) that the study was robust enough to adapt to the vagaries and quirks of 'real life' and that the outcome would be valid and add value to existing knowledge.

2.7 Methods of data collection and research instruments

As described above a mixture of qualitative and quantitative methods were used to ensure a full picture of leadership in the organisations to be studied. Collecting data in applied settings, where the participants are also engaged on a day-to-day basis is demanding work which is challenging for researchers involving persistence, social skills, the ability to develop rapport, clarity of purpose combined with flexibility, the skill of 'thinking on your feet' and making practical judgements about what is feasible at any one time. For example, if plans had been set for an interview with a staff member who was then called away for an important work matter, the researcher could arrange other potential participants or be prepared to engage in a period of systematic observation.

Immediately below we describe the methodologies we chose to employ to conduct our investigations which will be described in greater detail where appropriate in the context of specific case studies.

2.7.1 Focus groups

Focus groups, once the province of market researchers, in common with in-depth interviews, are now a popular method of collecting psycho-social data in the area of health research (Nicolson & Anderson, 2003; Nicolson et al., 2008) having gained recognition in social science overall as a robust way of eliciting “*shared and tacit beliefs, and the way these beliefs emerge in interaction with others in a local setting*” (Macnaghten and Myers, 2004, p. 65 in Seale et al) (p.8). In other words focus groups represent a means of gathering a sense of how those who work in an organisation share a sense of their ‘organisation in the mind’ (Armstrong, 2005) which may be mutually accepted, challenged or undermined by the perceptions of colleagues. Focus groups also enable the researchers to check out the quality and effectiveness of the communications themselves between members of the Unit or as Morgan (1998) suggests “*Focus groups are fundamentally a way of listening to people and learning from them* (1998, p. 9).

The process involves one or two researchers meeting with between four and eight participants who share a common situation and the guide lines for the discussion focus on key topics (see Appendices). One researcher takes notes although both are empowered to guide the discussion which is also digitally recorded. One benefit of this means of data collection is that through discussion among peers issues or perspective upon certain issues are brought into focus which might have escaped previous research authors and the researchers themselves (Morgan, 1998).

The *focus group guide* employed a similar structure to the *Interview Guide*.

2.7.2 Organisational climate

The Organisational Climate Questionnaire (OCQ) designed by Stringer (Litwin & Stringer, 1968; Stringer, 2002) also called ‘The Leadership Questionnaire’, was specifically designed to produce a scale to measure leadership in the context of climate albeit in a business rather than NHS setting. To complement the mostly qualitative methods of data gathering and analysis, we developed a questionnaire for staff and patients across the Trusts and used (a slightly adapted form of) Stringer’s measure of leadership and organisational climate, with the expectation that our results might also be linked to other studies undertaken with this measure, which had been used to examine management and leadership in organisations.

It identified six dimensions of organisational climate: *structure, standards, responsibility, recognition, support* and *commitment*, and uses eighteen leadership practices (three for each dimension) to capture how people feel about their jobs, how they are managed, and how things work in a particular organisation. Because this scale is designed to give practical

indicators on how to improve performance, many of the leadership measures are based on management practices, which are equally important to the overall success of an organisation. In general, however, each leadership practice measure is based on the premise that leaders care about arousing the motivation of members in the organisation (Stringer, 2002). The OCS was adapted from to fit a model relevant to NHS Staff working in a hospital setting and another version was adapted to be used with Patients (see Appendices).

2.7.2.1 Measurement tool: Stringer's OCS – Leadership and Organisational Climate

Stringer (2002) defines organisational climate as the "*collection and pattern of the environmental determinants of aroused motivation*" (p. 9) and he takes motivation to be central to the development of his climate questionnaire predominately based on the work of McClelland-Atkinson's framework with regards to intrinsic motivators of work related-behaviour: the need for achievement (nAch), the need for power (nPow), and the need for affiliation (nAff).

Stringer noted that specific dimensions of climate appear to have a predictable impact on motivated behaviour and can be measured and managed by those in senior positions accountable for organisational performance.

The six distinct dimensions identified and measured are:

- 'Structure'
- 'Standards'
- 'Responsibility'
- 'Recognition'
- 'Support'
- 'Commitment'

The statistical data was entered into an SPSS file to seek frequencies, correlations and to explore significance levels of differences and similarities between and within groups of respondents.

2.7.3 The survey structure and items

The survey is structured in two parts:

Part 1: measures *Organisational Climate* or how people perceive the work environment.

Part II: measures *Management Practices* or how people see their own managers behaving.

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Part 1:

This part consists of twenty-four items grouped into the six dimensions - 'structure', 'standards', 'responsibility', 'recognition', 'support' and 'commitment' - designed to measure how people feel about their work environment using a 4 point Likert scale. The directions ask the participants to describe the kind of working climate that has been created in their organisation (defining 'organisation' as the smallest work unit relevant to the participant).

Descriptions of the dimensions are as follows:

1. **'Structure'** pertains to the clarity of roles, responsibilities, accountability and expectations. According to Stringer this is more of a managerial than a leadership issue and one which is more practical than inspirational. It reflects the employees' sense of being well organised and of having a clear definition of his or her roles and responsibilities. *"structure is high when people feel that everyone's job is well defined and is low when there is confusion about who does which tasks and who has decision-making authority"* (Stringer, 2002, p.65).

The following items measure 'structure':

- The jobs in this organisation are clearly defined and logically structured.
- In this organisation, it is sometimes unclear who has the formal authority to make decisions.
- In some of the projects I've been on, I haven't been sure exactly who my boss was.
- Our productivity sometimes suffers from a lack of organisational planning.

2. **'Standards'** is about the need to achieve targets and reach goals. It is the drive to achieve and improve, it includes the 'commitment' and persistence to follow through on set targets. This dimension measures the feeling of pressure to improve performance as well as the degree of pride employees have in doing a good job. When interpreting this measure, high 'standards' indicate that people are always looking for ways to improve performance, whereas, a low score reflects lower expectations for performance.

The following items measure 'standards':

- In this organisation we set very high 'standards' for performance.
- In this organisation people don't seem to take much pride in their performance.
- Around here there is a feeling of pressure to continually improve our personal and group performance.
- Our management believes that no job is so well done that it couldn't be done better (Stringer, 2002, p.65).

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3. **'Responsibility'** is about taking ownership of the work and results which are obtained. Ideally people will be motivated to achieve results and take ownership over these. Where managers delegate and encourage responsibility, workers are more likely to feel a sense of 'responsibility'. It reflects employees' feelings of 'being their own boss' and not having to double-check decisions with others. A sense of high 'responsibility' signifies that employees feel encouraged to solve problems on their own. Low 'responsibility' indicates that risk taking and testing of new approaches tend to be discouraged (Stringer, 2002; p.66).

The following items measure 'responsibility':

- We don't rely too heavily on individual judgment in this organisation almost everything is double checked.
- Around here management resents your checking everything with them if you think you've got the right approach you just go ahead.
- You won't get ahead in the organisation unless you stick your neck out and try things on our own.
- Our philosophy emphasises that people should solve their own problems themselves.

4. **'Recognition'** relates to the relationships between one's performance and associated rewards, as well as broader sense of approval or disapproval of an individual's efforts. It indicates employees' feelings of being rewarded for a job well done. This is a measure of the emphasis placed on reward versus criticism and punishment. High 'recognition' climates are characterised by an appropriate balance of reward and criticism. Low 'recognition' means that good work is inconsistently rewarded (Stringer, 2002, p. 66).

The following items measure 'recognition':

- In this organisation the rewards and encouragements you get usually outweigh the threats and criticisms.
- There is not enough reward and 'recognition' given in this organisation for doing good work.
- We have a promotion system here that helps the best person rise to the top.
- In this organisation people are rewarded in proportion to the excellence of their job performance.

5. **'Support'** is the degree to which there is a sense of warmth and team work, within which the individual feels that they are 'backed up' by others. This will determine the amount of trust and respect amongst team members. It reflects the feelings of trust and mutual 'support' that prevails within a work group. 'Support' is high when employees feel that they are

part of a well-functioning team and when they sense that they can get help (especially from the boss) if they need it. When 'support' is low, employees feel isolated and alone. This dimension of climate has become increasingly important for today's e-business models in which resources are severely constrained and a premium is placed on teamwork (Stringer, 2002, p.66).

The following items measure 'support':

- You don't get much sympathy in this organisation if you make a mistake.
- When I am on a difficult assignment, I can usually count on getting assistance from my boss and co-workers.
- People in this organisation don't really trust each other enough.
- I feel that I am a member of a well-functioning team.

6. **'Commitment'** reflects employees' sense of pride in belonging to the organisation and their degree of 'commitment' to the organisation's goal. Strong feelings of 'commitment' are associated with high levels of personal loyalty. Lower levels of 'commitment' mean that employees feel apathetic toward the organisation and its goals (Stringer, 2002, p. 11).

The following items measure 'commitment':

- Generally, people are highly committed to the goals of this organisation.
- People here feel proud of belonging to this organisation.
- People don't really care what happens to this organisation.
- As far as I can see, there isn't much personal loyalty to the organisation.

Part II:

This part asks the participants to describe the practices of their managers. Using the same six dimensions as in Part I, participants are given eighteen statements which describe the way a manager might perform her or his duty and the respondents are asked to indicate how much he or she agrees with each of the statements. Here a 5 point Likert scale is used.

Once again the six dimensions are used to assess perceptions of managers' practices:

1. 'Structure'

- Establishing clear, specific performance goals for subordinates' job.
- Clarify who is responsible for what within the group.
- Making sure tasks and projects are clearly and thoroughly explained and understood when they are assigned.

2. 'Standards'

- Setting challenging performance goals and 'standards' for subordinates.
- Demonstrating personal 'commitment' to achieving goals.
- Giving subordinates feedback on how they are doing on their job.

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3. 'Responsibility'

- Encouraging subordinates to initiate tasks or projects they think are important.
- Expecting subordinates to find and correct their own errors rather than doing this for them.
- Encouraging innovation and calculated risk in others.

4. 'Recognition'

- Recognizing subordinates for good performance more often than criticizing them for poor performance.
- Using 'recognition', praise and similar methods to reward subordinates for excellent performance.
- Relating the total reward system to performance rather than to the other factors such as seniority or personal relationships.

5. 'Support'

- Being supportive and helpful to subordinates in their day to day activities.
- Going 'to bat' for subordinates with superiors when the manager believes their subordinates are right.
- Conducting team meetings in a way that builds trust and mutual respect.

6. 'Commitment'

- Communicating excitement and enthusiasm about the work.
- Involving people in setting goals.
- Encouraging subordinates to participate in making decisions.

Leadership question

We also asked a single question to capture directly how satisfied an employee is with the leadership they receive from their immediate supervisor. It was a simple statement: *I am satisfied with the quality of the leadership I receive from my immediate manager* which we measured using a 4 point Likert scale.

2.7.4 Ethnographic observations and 'shadowing'

Ethnographic observations and shadowing are especially useful to organisational research because they allow people to *physically* express their inner thoughts, and put ideas into *observable action*, all of which would be inaccessible through the survey or structured interview questions.

Ethnographic observation (often referred to as *participant observation*) has its roots in anthropology but has become increasingly deployed in sociology, cultural and social geographies. In the field (which in this case is a Unit in an NHS Trust) the researcher's aim is to "*understand how the cultures they are studying 'work'*" that is, to grasp "*what the world looks like*" to the

participants in the context being observed (Delamont, 2004, p. 206). In this study observation and shadowing opportunities were (mostly) formally set up and pre-arranged. However, the researchers, through taking their roles as interviewers, focus group leaders and having an every-day presence with key informants, gate-keepers and participants, were able to immerse themselves in the lives and atmosphere of each of the Trusts and Units providing evidence about the processes of leadership and patient care as well as 'climate' (Bloor, 2001; Goffman, 1961).

Shadowing involved the same conceptual framework as ethnographic observation in that the aim was to understand what the world looks like from the perspective of the staff member being shadowed as well as the worlds of the other staff and patients that they engaged with in the course of their work (Czarniawska, 2008; McDonald, 2005). It involved meeting the participant (usually) at 8 am and for one or two days accompany them including at break times until the participant went home. In Trusts where there was more than one site and/or when the nature of the day's work involved meetings outside the hospital (as in nearly every case) then the researcher spent time in a car with the participant and if agreed the conversation was digitally recorded as an *aide memoire* for the field notes. The participant was able to withdraw at any time, or for a period of time, across the shadowing period.

Thus the sense of 'what the Unit world looked like' was recorded in field notes which were then discussed with the other members of the team (who had some familiarity with the relevant part of the Unit/Trust) in a context where the researcher could be reflexive and explore the 'silent space' of the 'ethnographic self' (Coffey, 1999). The researcher's notes and expressed thoughts were then discussed with other members of the team, some of whom were familiar and others not so with the specific context (Barry, 2003). A similar approach was used to discuss the interview material because even though the interviews were digitally recorded and transcribed verbatim, this did not account for the reflexivity that took place following the interview itself and on transcribing and reading the transcript, and therefore featuring in the analysis (Nicolson, 2003).

In this context there was concern to capture the emotional content and atmosphere of the organisations. This meant that ethnographic methodologies were implemented to analyse the emotionality of the interactions (verbal and non-verbal) between patient and practitioner. It was through these observations that the use and importance of the researcher's *body as a 'research instrument'* became palpable, especially for understanding the emotions emerging out of the interactions between patient, relatives and practitioner(s). This process has been proposed as the antithesis of taking for granted that emotion should be removed from

ethnographic investigation and that in fact the research process is highly emotive and far from an emotionally barren terrain (Bondi, Davidson, & Smith, 2005).

As the researcher collects data they move through a continuum of emotions from the euphoric highs of excitement at starting a new research project, sense of achievement and pride as they begin to make contacts and collect initial data, perhaps trepidation, fear and nervousness as they meet new participants or research settings through to the depths of despair, isolation and frustration as the research process (inevitably at times) becomes chaotic and messy. However, these emotions are often neglected, regarded as unimportant to the overall research process and abandoned in the writing up phase. We use these frequently neglected emotions and feelings as part of, and beneficial to, the project as representing a rich source of data.

By being more attentive to their emotions and bodily senses ethnographers also become more sensitive to their environment and their participants thus gaining a greater awareness of what they are observing. In recalling a sound, smell or feeling the ethnographer is able to open up their mind's eye to re-visualise the interaction with greater clarity and accuracy making it more likely that an accurate representation of what was observed will be recorded.

2.7.5 In-depth semi-structured and 'story-telling' interviews

In-depth semi-structured Interviews: Over the past fifteen years this method of qualitative data collection has become increasingly common in health services and health research in general (Pope and Mays, 1995; Kvale, 1996; Grbich, 1999) consistently a method of choice for identifying perceptions, meanings and experiences of dynamic and complex concepts such as 'leadership' and 'patient care' (Rubin and Rubin, 1995; Denzin and Lincoln, 1998; Rapley, in Seale et al, 2004).

The use of such interviews has led to increased levels of sophistication in the interpretation of qualitative in-depth data in the context of historical, cultural and political frameworks demonstrating that in-depth semi-structured interviews (and more generally qualitative research) have capability beyond simply adding rich description to statistical evidence (see Denzin and Lincoln, 2002; Willig, 2008).

Story-Telling: One of the explicit aims of the interviews was to collect a number of stories to reflect critical experiences in the organisations' past and present life. In the field of organisational studies, there is now an extensive literature of how to use stories told by organisational participants

as windows into organisational culture, politics and numerous other phenomena (Gabriel, 2000; Hannabuss, 2000).

The inclusion of story-telling in the context of the in-depth interview increases the scope for making sense of data in ways that delve deeply into the respondents' perceptions and meaning of the *processes* of leadership and patient care. Story-telling also increases the validity of the interview through the use of reflexivity, and positioning the events and 'atmosphere' of the stories in the context of the organisational analysis.

Of particular relevance to this study, stories can instigate insights into the processes of positive or negative social and organisational change and leadership which involves the management of meaning and emotions, both of which rely heavily upon the use of stories, allegories, metaphors, labels and other narrative devices.

The study of *organisational stories* is particularly relevant in health care settings that are liable to unleash strong emotions and fantasies. Hence, hospitals are rich grounds for collecting stories, as numerous researchers have recognized (Kleinman, 1988; Frank, 1998; Greenhalgh, 2002; Hurwitz, 2006; Mattingly, 1998). Storytelling permeates everyday clinical practices and "*medical professionals find ways to 'routinize' their practice and thus, metaphorically at least, bring the unruly and frightening world of illness under control*" (Mattingly 1998, p. 277).

The *interview schedule* (see Appendices) therefore was designed to elicit information on the participant's view of 'leadership' and 'patient care' through 'stories' to provide examples in their opinion that constituted good and poor leadership and good and poor patient care through 'critical incidents'.

As the interviews were semi-structured and in-depth they relied to a great extent on the interviewing skills of the researchers and their ability to establish rapport and consequent willingness of the participants to engage in the process. The early pilot interviews therefore were unlikely to influence the details of the interview schedule itself although the early interviews were planned to enable the research team to identify the best *strategies* to engage participants in the task.

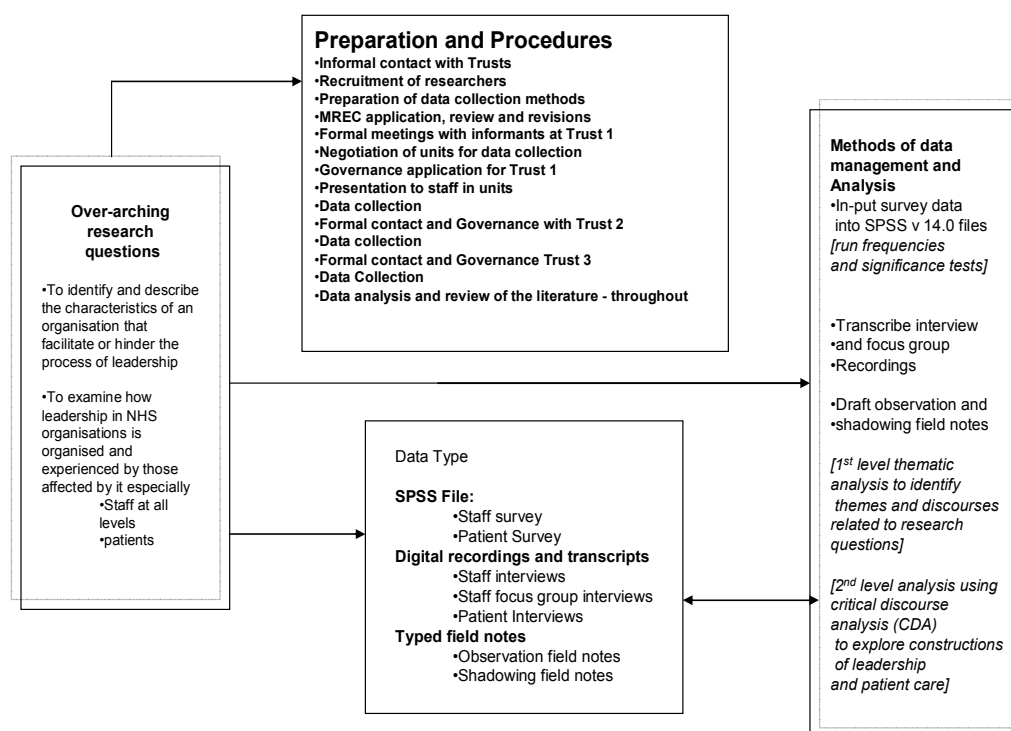
2.8 Data Management

The interviews and focus groups were digitally recorded and transcribed verbatim. The transcripts stored on a password protected Word file (initially on the researchers' PCs but subsequently on the secure shared drive described above) and sound recordings stored on audio files (password protected on the PC of the PI and not on the shared drive).

The OCS data was entered and stored on an SPSS file, password protected and placed on the secure shared drive.

Fieldwork notes from observations and shadowing were similarly password protected stored on the shared drive once they had been prepared by the individual researchers.

Figure 5. Outline of Study Procedures and Methods



2.8.1 Data Analysis

There are effectively therefore three categories of data.

1. Qualitative data representing verbatim 'talk' (digital recordings/transcripts) of interviews and focus groups.
2. Qualitative data from observations, shadowing and other field notes. These were subjective accounts of observations, perceptions, emotions and meanings given to the field work by one researcher. This may have been following discussion with the other researcher on occasions when that person had had access to the same raw

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material. Discussion with another member of the investigatory team (frequently but not always the PI) also took place following the first drafting of the field notes in order to clarify the meanings given to specific behaviours and relate theory and data.

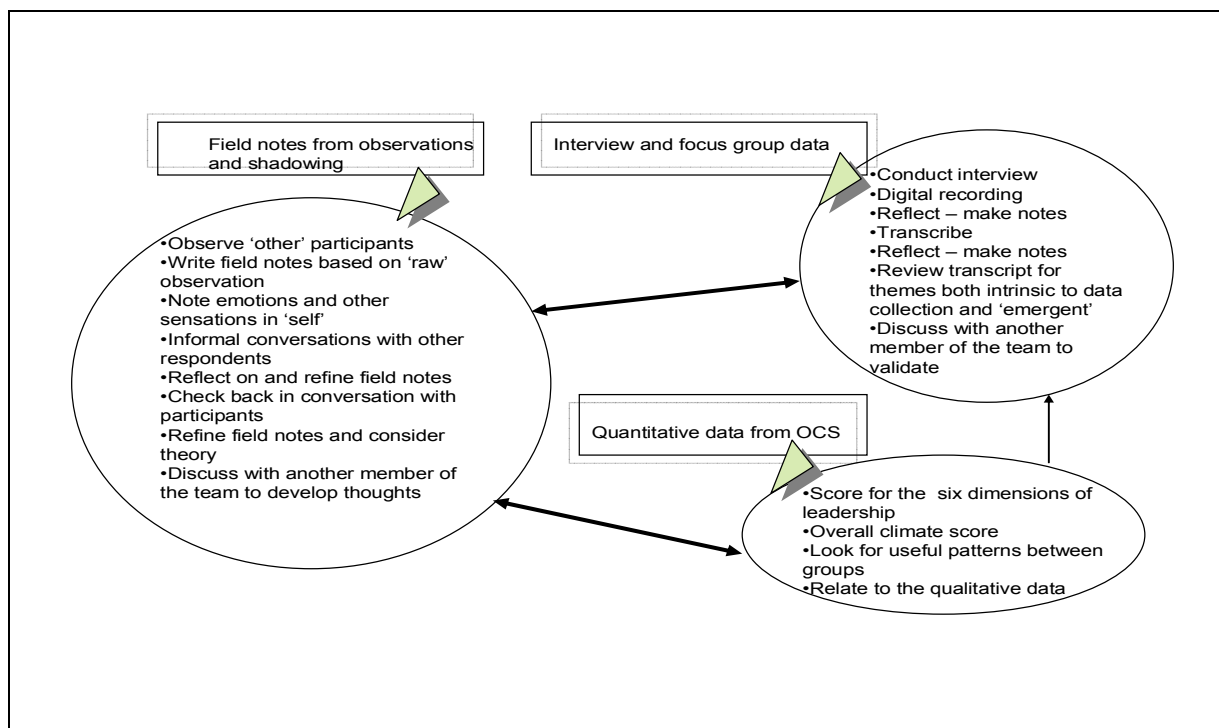
3. Statistical data from the OCS.

2.8.2 Thematic Analysis (TA)

The transcripts and field notes were examined initially for relevant extracts related to the main themes ('leadership', 'organisation' and 'patient care').

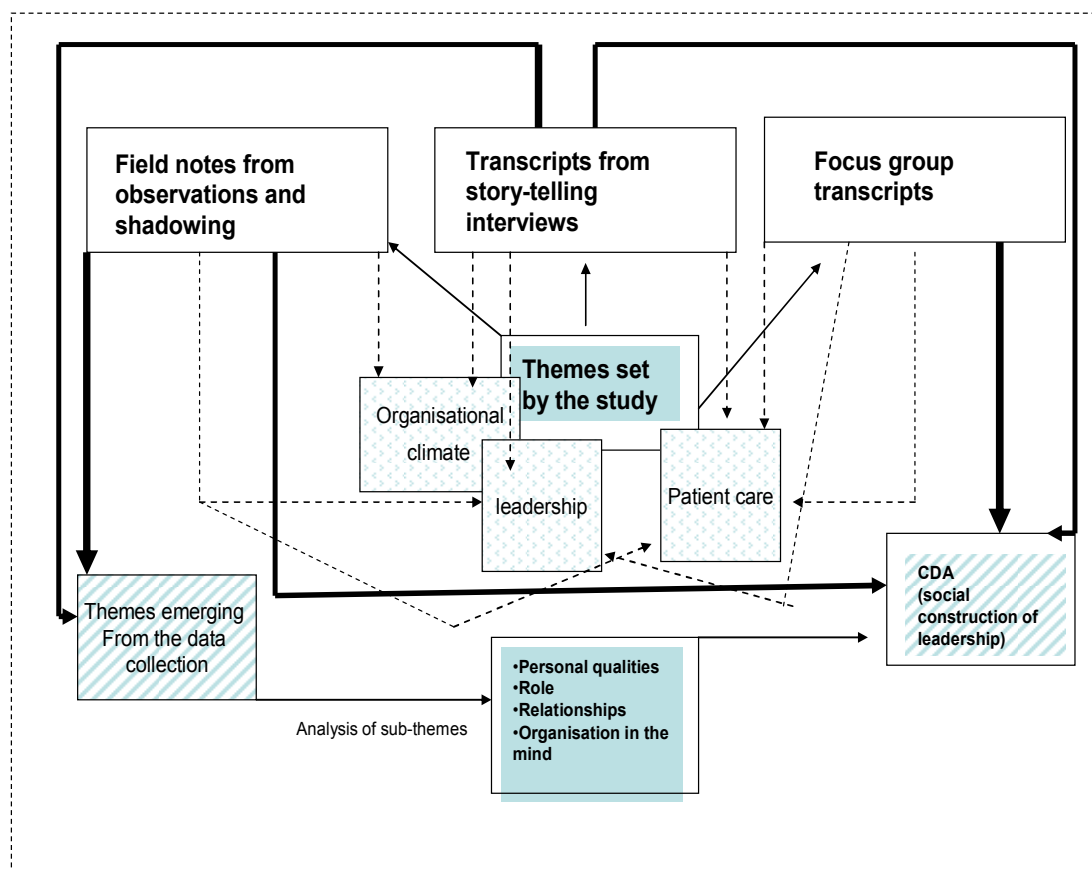
Sub-themes were then to be identified, some of which are likely to relate closely to the previous research literature on leadership and organisational climate, although it is likely that each organisation will demonstrate particular issues that were more difficult to anticipate at the outset.

Figure 6. From data collection to data analysis



Data relating to these themes and sub-themes was to be collated on Word files and where deemed relevant to the study aims, analysed further using the following methods – Discursive Psychology, Critical Discourse Analysis and Narrative Analysis. All these approaches focus on language and the way language is used to construct key concepts (e.g. the organisation) but there are different nuances to each perspective each of which adds an important dimension to the analysis of this data.

Figure 7. Thematic to CDA with Narrative analysis



2.8.3 Discursive Psychology, Discourse Analysis and Critical Discourse Analysis (CDA)

Hepburn and Potter (2004) argue convincingly and with justification that DA has evolved to have several iterations over recent years. One common feature though has been that 'discourse' (i.e. what is said) and 'context' are difficult to separate and it is the ways in which context is worked into the analysis of discourse that distinguishes the character of DA deployed in a particular piece of analysis.

The thematic analysis was a starting point from which to focus in upon the close readings of the texts, which related to the processes of leadership and patient care, as it represents a flexible and clear way of identifying what is emerging from the data and points a way forward with more detailed analysis (Braun and Clarke, 2006)

We argue that leadership is a social construction and there is a growing body of literature providing evidence to support this view. There has also been a recent focus in organisational research and theory to specify an Organisational Discourse Analysis (ODA) (Pritchard, Jones and Stablein, 2004) which involves four approaches i.e. *Narrative*, *Foucauldian*, *Linguistic* and *Deconstruction* which in turn are influenced by a *reflexive awareness* of the organisational culture in which the research is being conducted.

Pritchard et al, (2004) argue further that the exact methodology and approach to the data depends on the 'researcher position' in the organisation being studied. In other words this approach *benefits* from the subjectivity of the researcher's interpretation of what processes mean and specifically from researcher reflexivity about their 'take' on a situation and set of interactions.

To qualify this method of analysis further, a discursive approach means that language is represented not so much as an objective truth but as a means of *constructing* what might be understood (Parker, 1992; Coyle, 2007).

Particularly relevant in this study, in which participants are asked to tell stories and provide evidence to support what is good and bad about both leadership and patient care (and implicitly the organisation in which these actions take place), is discursive psychology (DP) that highlights how "*descriptions of events are bound up with doing actions, such as providing justification for actions and blaming others*" (Hepburn and Potter, 2004, p. 169).

Thus Critical Discourse Analysis (CDA) sees language as a *social practice* and thus considers carefully the context in which language is used (see

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Wodak, 2004). CDA is related to the notion that *power is negotiated through language*. This is particularly apposite in a study of leadership in organisations. Even more so CDA is 'abductive' so that a constant movement between theory and empirical data is needed which suits ethnographic methods such as shadowing and observations enabling the researcher to test out their ideas as they progress with the data collection, and the attempt to understand how cultures work and how the research participants make sense of and experience their worlds.

2.8.4 Narrative Analysis

Narrative approaches to data analysis have been able to cut through the great complexity of the NHS - the intense emotions, positive and negative, it evokes among most of its stakeholders (e.g. Rooksby, Gerry & Smith, 2007; Bryant, 2006; Iedema et al., 2009; Brown et al., 2008; Elkind, 1998; Brooks, 1997). These studies have, for example, addressed power issues in the doctor-patient relationship, exploring communication in a consultation situation. In these analyses, the patient's 'subordinate' narratives have often been neglected or taken over by the doctor's privileged 'medicalizing' discussion (Mattingly, 1998, p. 12; see also Radley, Mayberry & Pearce, 2008). However, there is also a recognition that many of these narratives are co-constructed by patient and physician (Mattingly, 1998, p. 43; Kirkpatrick, 2008); exploring solely the patient voice in isolation and presuming that doctors will at all times occupy a dominant position in this relationship may be missing half of the story - the doctor's experience. As Mattingly (1998) points out, *"[h]ealers too, may be able to give a different kind of voice to their practice when they describe their work in narrative terms rather than the flattened prose of biomedical discourse"* (p. 14).

As a genre, narrative psychology is thriving (Smith & Sparkes 2006). There has been talk of the 'narrative turn in psychotherapy and psychiatry' (Brown, Nolan, Crawford & Lewis, 1996), and Crossley (2003a & 2003b) for example argues strongly for a 'perspective that retains a sense of both psychological and sociological complexity and integrity' noting that narrative psychology is concerned with 'coming to grips with how a person thinks and feels about what is happening to her' (2000, p. 6). She employs a phenomenological framework to explore narratives of 'the voice' of 'the mentally ill' (Crossley & Crossley 2001) and the experience of temporal elements and self/identity of people living with serious illness (HIV, cancer; see also Söderberg, Lundman & Norberg, 1997). Narrative research in health care has also been used to study the lived experience of patients (see for example Hemsley, Balandin & Togher, 2007; Hök, Wachtler, Falkenberg & Tishelman, 2007) and an emerging genre of 'narrative based medicine' seeks to make use of stories in developing a fuller understanding of illness experiences (Launer, 2003; Taylor, 2003; Greenhalgh, 1999).

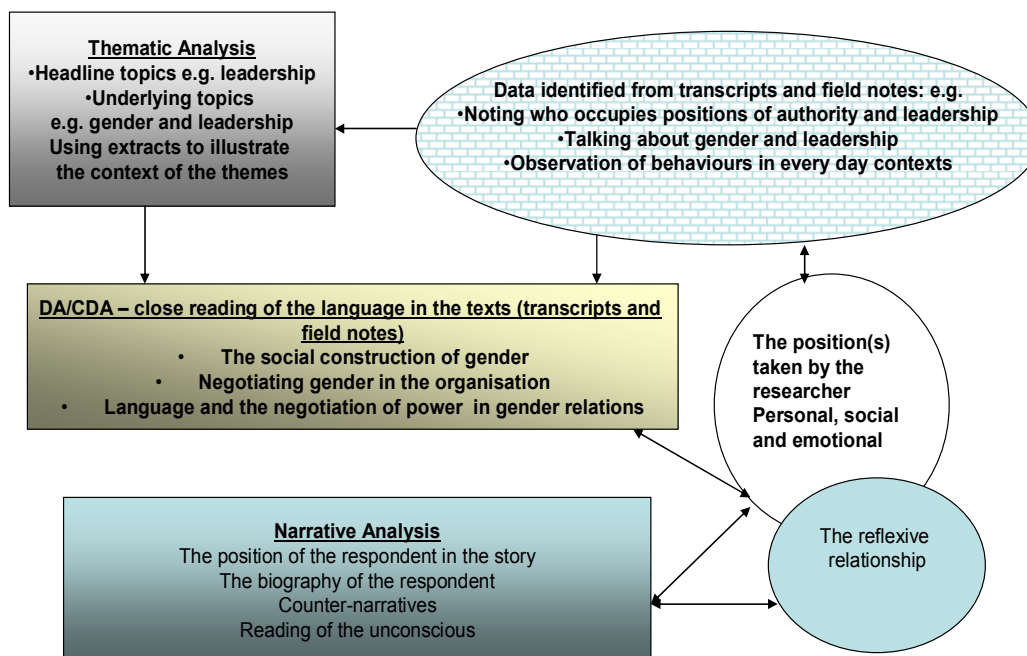
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Narrative based medicine is not merely an insightful way of doing research, but may have powerful policy implications. As Overcash (2003) argues, "*narrative methods are an effective research option that can lead to enhanced patient care*" (p. 179). While interpreting narratives can enhance the possibilities of integrating evidence-based research findings with individual illness experiences, and Winterbottom and colleagues (2008) suggest numerous courses of further research on why and how narratives may influence medical decision making.

Narrative analysis, as with DA, has been approached differently by academics from a range of disciplines so that the ideas surrounding the analysis of *narratives* (or stories told in a sequence) have a variety of emphases. The strength of taking the narrative approach over DA /CDA *per se* is that the 'subject' of the story (the narrator) retains a central role (Crossley, 2007). This can be seen in some detail in subsequent chapters particularly where the accounts of ethnographic observations and shadowing are highlighted where the 'story' becomes that of the researcher herself and with the stories unfolding through the interviews.

Furthermore the narrative analysis places the respondent's story as part of their own *identity construction* which lends an important dimension to the relationship of the story-telling to the teller. Particularly interesting here is Andrews' (Andrews, Sclater-Day et al., 2004) approach which focuses specifically on the elements of stories "*that lie in tension with the ones we are socialised to expect*" (2004, p. 97) or what she calls 'counter-narratives'. Researchers such as Hollway and Jefferson, 2002; Gough, 2003; Sclater, 2004; Allcorn, 2004 and Gabriel, 2004 and 2005, take on board the role of the interlocutor in positioning themselves in their story while considering some of the unconscious and emotional elements both of the story being told and the way that the relationship between the researcher and respondent plays out to construct and limit the story that is told. This dimension is particularly important in the context of this study where emotions are rife at least in part because of the high pressure (exacerbated to some extent by the changing political initiatives directed towards NHS institutions) and the particular nature of the work in caring for ill people (see for example Menzies-Lyth 1960).

Figure 8. Levels of qualitative data analysis e.g. 'gender'



2.8.5 Statistical Analysis

The data from the OCS was coded and in-putted into an SPSS v 14.0 file and significance tests were run (see Chapter Five for the full details).

3 Research Procedure

3.1 Introduction and Overview

The nature of this study, much of which involved the researchers immersing themselves in the 'world' of the participants, meant that it is not possible to provide an authentic *sequential* account of the procedure of data collection except possibly for the administering of the OCS (Organisational Climate Survey).

The bulk of the study, as identified in Chapter Two, comprised multiple methods of collecting different types of data across three Trusts, six Units and five sites.

3.1.1 Negotiating Access

The study took place across a three year period. Negotiation of access was complicated as indicated, although in itself a valuable procedure which occurred at several levels and helped to increase the richness of the team's understanding of leadership, patient care and the context of each organisation.

- Negotiating access began from the 'notional' level while writing the grant application whereby the investigatory team needed to identify whether a project with this design was in fact feasible. We thus made informal inquiries via personal contacts.
- More formal contacts were made once the project was confirmed with the intention to achieve verbal agreement about access for planning the NRES application.
- Following that we met to formalise the details with key informants (i.e. senior clinicians and managers) who had been identified in the previous stage.
- Once we had achieved a favourable NRES review, we pursued local governance applications with the help of the key informants.

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- These stages were managed by approaching one Trust at a time although during the latter part of the study some overlapping negotiations and governance were necessary.
- Part of the formal stage of negotiation concerned consideration of which *Units* could/would form the focus for the study. This was very much two-way but also serendipitous with suggestions from the team of investigators moderated by whichever senior clinical staff the key informants considered would be amenable to 'hosting' the study.
- The key informants then identified opportunities for the team to present the project to staff in the selected Units in 'educational half days' or 'staff meetings' depending upon the local structures.
- These formal presentations only took place in Trusts One and Three however. The procedure in Trust Two (because of the culture, location and structure) was on the basis of a 'tour' (which with permission was digitally recorded) organised by a senior nurse manager so the researchers, one of the co-investigators and the PI could meet various key nursing and medical staff across one of the Trust sites.

Once all that had been achieved it was the researchers on the whole who managed the day-to-day negotiations about who could and would agree to take part in the various elements of the study. This was complicated because of the day-to-day patterns of staff, changes in staff roles, particularly at senior levels, shift patterns and the sheer numbers of staff who may or may not have been aware and willing to allow access to, say, a particular meeting or team for observation or interviews.

Figure 9. Procedures and time-line

	2006/7	2008	2009
Winter	<ul style="list-style-type: none"> •Recruit and prepare researchers •Informal contact with 3 Trusts 1 and 2 •Informal visits to Trusts 1 and 2 •Develop research instruments •Prepare COREC/NRES application •MREC presentation and revisions •MREC approval •Start to review literature on leadership 	<ul style="list-style-type: none"> •Arranging formal contacts with Trust 2 (on 2 sites) •Visit to Site A •Further data collection in Trust 1 •Patient interviews 	<ul style="list-style-type: none"> •Researcher begins maternity leave and new researcher inducted into the team •Data collection in Trust 2 Site 2 •<u>[difficulties gaining access to staff list in Trust 2 for survey]</u> •Presentation to staff in Trust 3 (Unit 1) •Distribution of staff survey (individually handed out) in Trust 3
March - June	<ul style="list-style-type: none"> •Formal meeting with Trust 1 R & D director •Governance application •Formal meetings with senior staff to negotiate units for study •Unit based meetings and introductions •Presentation at educational half day on Unit 1 (obs & gyn) of Trust •Pilot interviews •Pilot staff survey 	<ul style="list-style-type: none"> •Formal meeting in Trust 2. Tour of Site A •Visit to Site 2 •Governance for Trust 2 •Informal meetings •Data collection begins in Trust 2 •<u>Trust 1 staff in Unit 1 return surveys to PI saying they won't give them out</u> 	<ul style="list-style-type: none"> •<u>[further difficulties gaining access to staff list in Trust 2 for survey – now due to key staff transfers]</u> •Preparation and presentation of invited paper to SDO conference in June •Paper preparation and further conference presentations
Summer	<ul style="list-style-type: none"> •Organise, send out and in-put data from staff survey in Trust 1 •Observations and interviews with key staff •Presentation to Unit 2 •Focus groups and interviews on Unit 2 	<ul style="list-style-type: none"> •Application for extension to project (successful) 	<ul style="list-style-type: none"> •Put staff survey on Trust 2's 'intranet' with information about how to complete and return •E-mail staff in Trust 3 who had not received a staff survey •<u>[a low response in both cases]</u>
Autumn	<ul style="list-style-type: none"> •Data collection •Data in-putting from staff survey •Patient survey given to staff on Unit 1 to distribute 	<ul style="list-style-type: none"> •Preparation of journal paper 1 •Further review of literature •Governance for Trust 3 •Identifying key contacts in Trust 3 •Negotiation about Unit 1 (Care of the Elderly) 	<ul style="list-style-type: none"> •Journal paper 1 (anxiety) being revised for publication •Journal paper 2 in preparation (gender) •Journal paper 3 (in preparation) leadership and 'territory') •Presentation prepared and delivered to NHS Surrey and Borders conference •Final draft report

3.1.2 Time frame and Participation of Investigators

We negotiated the formal details of access consecutively in order to make the process manageable. Most data was collected by the researchers (Dr. Fox, Dr. Lokman¹⁵ and Ms. Rowland) although the PI and other investigators made the initial contacts, met with key informants, contributed to the presentations and conducted some of the interviews and focus groups and (Profs. Gabriel and Nicolson, Dr. Heffernan and Mr. Howorth). The PI (Nicolson) and at least one of the researchers was present at all initial meetings with the gate-keepers and key informants.

3.1.3 NRES review

This was prepared and submitted at the end of 2006 and the PI, one of the researchers (Lokman) and another member of the investigation team (Gabriel) attended the appointment with London-Surrey Borders Research Ethics Committee in January 2007.

Annual reports were submitted to the NRES subsequently as required.

3.2 Sample characteristics

The three Trusts, selected as stated above in Chapter Two were each very different from each other, not only in formal terms (size, budget, location and organisational structures) but also informally and culturally and this influenced the 'access pathways'. Thus for example in Trust One our informal and then formal contact was with the R & D director (also a senior clinician) and assistant R & D director, who introduced us to the CEO, the clinical directors and senior nurses.

In Trust Two we had begun with meeting the CEO at the 'notional' phase who then retired in the meantime. This meant starting again with delayed local governance and to accomplish this, we were directed towards a senior clinical manager who then changed their role and location which meant dislocation of our planned procedures.

Trust Three involved a personal contact initially who was directly involved as a clinician in one of the Units who then arranged for us to have a

¹⁵ Dr. Lokman worked on the project for over two years and Dr. Fox took her place.

meeting with another senior clinician who in turn arranged for us to give a presentation to the Care of the Elderly/Geriatric Unit. From there we sought a second Unit for Study independently through contacts made during the course of working in the first Unit.

Trust 1 (One site only) a DGH (District General Hospital)

The Research and Development director here suggested the Units for study to be:

- Unit 1, Obstetrics and Gynaecology
- Unit 2, Cardiology

We were happy with his suggestions, and the staff was generally co-operative and supportive of the researchers.

The Trust itself covers two sites but the choice of these Units meant that all data was collected from one site. This was helpful because it meant the researchers and some of the investigators could spend time familiarising ourselves with the layout of the Units and the Trust site and become familiar 'faces' so that gaining consent from respondents was made easier than it would have been if the researchers and the study itself had to be presented as 'new' on each occasion.

While the study was taking place there were many fears expressed among the staff at all levels that the site we were investigating would become the less powerful with the other site taking over many of the executive functions. While the study team were collecting data on this site however this did not happen and the general 'morale' has improved so that the Trust is currently applying for Foundation Trust statusⁱ.

Self-Description of the hospital

The site we studied had 400 beds and a range of acute care services, including an Accident and Emergency department. It is situated in 52 acres of Green Belt parkland within 40 – 60 minutes of London. Originally it was built to serve casualties of the Second World War. Over the years, the hospital has been rebuilt, developed and extended to include maternity services, a departmental and clinic area, and a new theatre complex. In the early 1990s, the X¹⁶ Wing, which includes a Postgraduate Education Centre and modern well-equipped wards, was opened. A new building for the Accident & Emergency, ITU and Orthopedic Unit opened in the summer of 1998. In addition, comprehensive HIV and genitourinary medicine services are provided in a dedicated building.

¹⁶ We have used 'X' to ensure anonymity.

Obstetrics and Gynaecology

The study territory for this Unit¹⁷ comprised the labour ward, postnatal ward, a general outpatient clinic a dedicated ante-natal clinic and the Maternity Services Administration. The unit offered midwife care for home births, one to one care, water births and there was always a consultant obstetrician available and compared to other local hospitals it gained a score of 3/5 which was joint top score.

Cardiology

This Unit studied comprised one in-patient ward, the Medical Assessment Unit (MAU) and the Critical Care Unit.

In addition we spent time in the Management Suite where five interviews also took place of the CEO, Clinical Director, the Director and Deputy Director of R & D and a middle-ranking manager.

Observations also took place in public and eating spaces and shadowing involved walking around the hospital between different specialty wards and administrative departments.

Trust 2 (2 sites)

The Trust was one of the biggest DGHs in London with 4,200 staff. It had had a history of problems in its financial management and the quality of care but recent information on the web-site and confirmed by the CEO made it clear that:

The Care Quality Commission, the organisation that regulates health care nationally, has awarded the Trust a rating of excellent for the quality of services we provide to our local population. This is the highest possible performance rating in the 2008/09 Care Quality Commission annual national assessment report.

It seems that problems with the financial management remain although improvement had been noted.

The structure and organisation of Trust 2 differed significantly from Trusts 1 and 3. Trust 2 comprised two sites (recently combined into one Trust where one was a teaching hospital) which were at least eight miles apart and it

¹⁷ There were other parts of the Maternity Services at Trust 1 that were not observed directly.

was difficult to travel between one and the other on public transport other than using more than one bus or travelling in and out again from London. The journey by car varied from about thirty minutes upwards depending upon traffic.

Physically the two sites were very different. Site A was a relatively new building designed (as one researcher stated) to look like a motel or contemporary hotel. The other, B, was a traditional middle height rise built in the 1970s on a green site and appeared far more formal with long corridors and many signs to departments. Site A was more 'angular' and you could not walk very far without having to turn a corner which presented a very different 'feel'.

It was not possible, particularly in Site A to select a discrete specialist Unit (unlike Trust 1). Site A focused on acute medicine and care of the elderly and there were no formal divisions in where patients were treated as either in-patients or out-patients. So an older person with 'geriatric' health related problems could be in a bed next to a much younger person. We have identified a Unit as a Site in the case of this Trust. We found it equally difficult to 'pin down' a specialty in Site B as well.

At Site B we collected data from acute medical specialties, obstetrics and gynaecology and therapies (the latter being both physical and psychological).

This was in part because senior management at Site A (who were our key informants and 'gatekeepers') introduced us to staff they considered amenable. Thus for purposes of the study we had to identify Site B as our second Unit. Despite the introductions we managed, via snowballing, to find a range of participants who demonstrated many different view points.

To summarise then in Trust 2 the study was carried out in the following two Units which we have identified as follows:

- Site A / Unit 1 (Acute Medicine; Care of the Elderly)
- Site B / Unit 2 (Acute Medicine; Obstetrics and Gynaecology; Therapies)

We also interviewed a Clinical and Nursing Director both of whom worked across both sites and senior managers including the CEO and deputy CEO.

It became clear very early on that there was intense rivalry, even animosity between the two sites and some of this is explored in later chapters.

Trust 3 (2 sites)

Trust Three, in central London, is a long established hospital and a Foundation Trust with connections to a prestigious medical school. Travel

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between the sites took about twenty to thirty minutes by public transport. 9,000 staff are employed by the Trust with 1,100 beds available across the Trust at any one time.

- Unit 1 (Care of the Elderly, Acute Medicine)
- Unit 2 (Therapies)

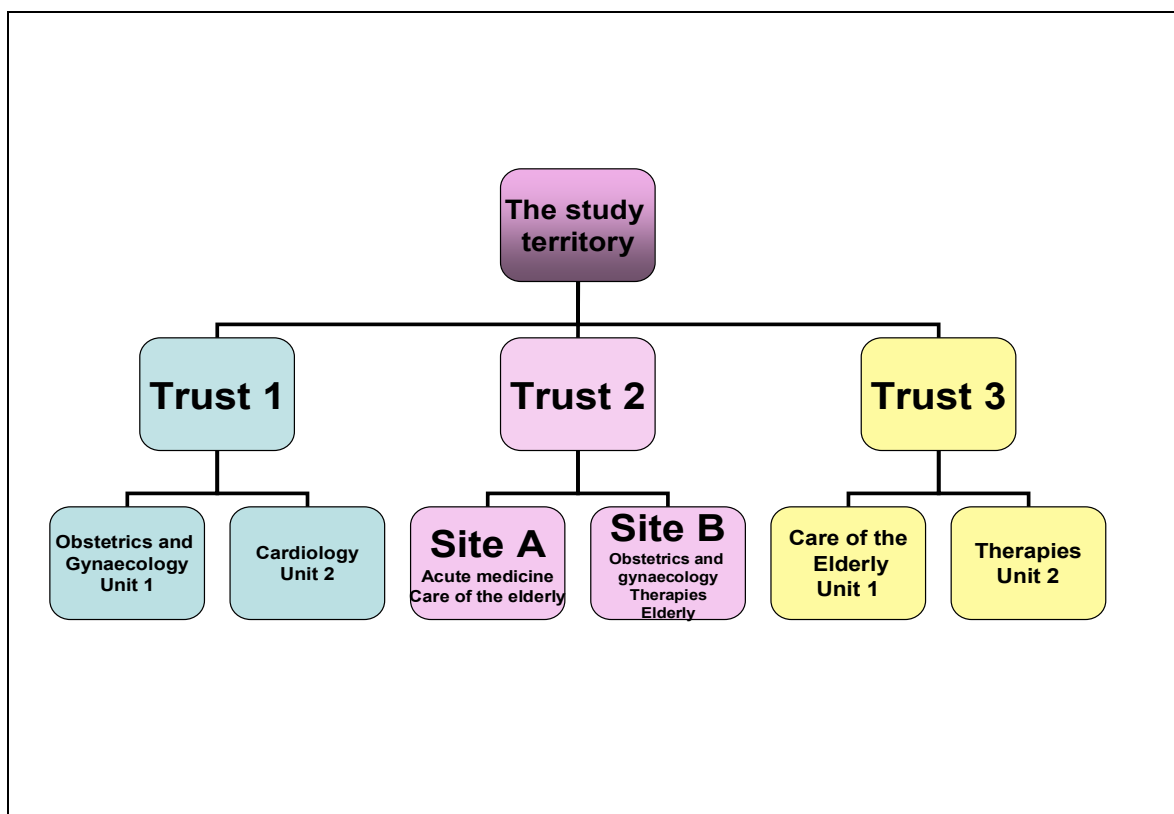
Unit 1 is described on the web-site thus:

Geriatric medicine specializes in the diagnosis and management of common symptoms and diseases in older people, particularly:

- *problems with mobility*
- *falls*
- *continence*
- *difficulties with looking after oneself*

Unit 2 (therapies) which included physiotherapy and psychological therapies spanned both the sites and covered many clinical departments and extended to primary care services especially local GP practices as well.

Figure 10. Participating Trusts and Units



3.2.1 Response rates (qualitative approaches)

It is difficult to identify an accurate response rate for the qualitative components (the majority) of the study because the sampling was conducted in an opportunist manner in many cases – i.e. whether someone agreed to take part in an interview or focus group if the researchers were on site and made a serendipitous approach.

As stated in Chapter Two, much of the qualitative data was collected by virtue of the researchers 'being there' in the right place at the right time and therefore gaining the trust of potential participants. In many cases the researchers were introduced to a member of staff who suggested ways in which other respondents might be accessed. Methods included personal introductions, using e-mail lists or sometimes a staff member knowing what was happening asked the researchers if they might participate in the study.

Overall the majority of staff approached to participate agreed to do so, although circumstances sometimes prevented it (e.g. one focus group was cancelled in Cardiology due to a patient emergency and one observation was cut short because the consultant refused to have the researcher in the ward round, although they had been observing on the ward before the consultant arrived having been given permission by the nursing staff).

Although the key staff across all three Trusts agreed to support the researchers in gaining access to patients for the OCS and interviews, the patient form of OCS was anonymously returned to the PI by someone at Trust 1 saying they did not want patients to participate in that exercise¹⁸.

It proved impossible to administer the patient OCS in the other two Trusts also, because the staff said in advance they were too busy to help and the researchers had difficulty in making contact with individual patients who were always either in busy wards or with a member of staff. Thus interviews and observations were conducted, with patients' consent, during shadowing.

The OCS for the staff is discussed fully in its own right in Chapter Five.

3.2.2 Individual participants

Respondents were either NHS staff or patients so by definition there were elements of uncertainty about whether they would be available at appointed

¹⁸ We sought advice but in line with the NRES review participants could withdraw their consent at any time so we did not feel free to pursue this further.

times and whether (as acknowledged in the NRES consent form) they choose to drop out at any time, even after having agreed to take part.

As shown below in Table 1, forty six respondents took part in in-depth story-telling interviews, thirty nine took part in focus groups. During twenty six days of shadowing of key staff, numerous other staff and patients were involved in data collection and similarly, during the eleven and a half days of observations on wards and in administration areas across the Trusts.

In addition, ten patients consented to be interviewed in depth and, again more staff were involved in the eight meetings that were observed and an introductory walking tour with a staff member in one Trust involved additional staff and patients in the study.

Each of these data collecting encounters represents a different unit of study and a different 'order' of data.

The nature of the study required a commitment of between 30 minutes (for completion of a survey or a short interview) up to two days, in the case of 'shadowing', of respondents time. Most respondents' contributions to the study, however, took about 90 minutes although this also represented an important commitment of their time (and energy).

Table 1. Qualitative Data Collection

Table 1. Qualitative Data by modes of collection							
	Interviews		Focus groups	Shadowing (staff and patients)	Ethnographic observation	Patient interviews	Other meetings and visits
Trust	N = men	N= women	N = Group (n = participants)	N = days	N = days		
1	13	19	5 (15)	5	9	10	4
2	5	9	3 (24)	8	3 x .5 + 1	0	2
3	4	8	0 (0)	13	0	0	2
Totals	22	26	8 (39)	26 days	11.5 days	10	8

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3.2.3 OCS (Organisational Climate Survey)

Trust 1

The staff survey

An administrator in Trust 1 provided a staff list (name and location) from which a random sample (35%) was identified using the SPSS software version 14 providing a list of 939 potential participants from staff across the Trust (including and beyond the Units participating in the main data gathering). The questionnaires were all individually addressed and sent through internal mail.

Of these 223 (24%) individuals returned a completed questionnaire, although ten blank surveys were returned with a note that the intended recipient had left the trust and one said they were unable to read English (1). Thus the final number of participants for Trust 1 was 210.

The patient survey

In Trust 1 we gained agreement from the senior staff on the two study Units (Obstetrics and Gynaecology and Cardiology) that they would arrange wherever possible for patients to complete the patient version of the OCS and would arrange for the researchers to collect the completed forms.

However the full batch of uncompleted patient questionnaires was sent back to the PI at the College several weeks later with an anonymous note stating that the staff did not wish to administer these to the patients. We were unsure how to proceed after this because ethically, although the survey was directed to the patients, the staff had completed consent forms and had copies of participant information sheets, and were aware that they (staff) could withdraw from the study at any time. We considered that this constitute an ethical dilemma for the team.

The researchers made other attempts to hand out the questionnaires directly to patients but found that while some patients were prepared to consent to being interviewed and almost all consented to having a researcher present during patient/doctor/nurse meeting it was not looking possible to obtain a valid sample of questionnaire returns.

Trust 2

Trust two was organised across two distinct sites and although the senior staff work across both sites, as will be made clear from Chapters Three and Four below, each site is very different in its organisation. We initially

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approached the senior staff on Site A first about how to distribute the questionnaires and they referred us to Human Resources on Site B who were the only people with access to a staff list. We did not get any acknowledgement from HR despite several attempts including one visit to the head of HR from one of the researchers. He said he would get back in touch once he had checked whether he could release this list but he did not and we considered there was little more we could do to pursue this particular approach.

The PI then contacted the senior nurse manager, who had been one of our original gatekeepers, for help but found that she had left for another post.

Following the abortive attempts to contact HR (or anyone else who might have been able to help) a PA in one of the many departments we contacted suggested that there was a staff intranet which went out once a week with an 'update' section with news for staff across the Trust. The PI made contact with the editor of this site who agreed to include an electronic version of the OCS.

Consequently, the questionnaire was included on this web-site, with a preamble (adapted from the NRES participant information sheet) on two occasions. However it only produced one reply. We made one final attempt via the PA of the CEO to contact HR for a staff list to no avail.

What was interesting and perplexing though was, that there was no difficulty obtaining a commitment from staff across the Trust to participate in an interview or focus group which was much more time consuming and personally revealing.

By the time we were ready to collect the patient survey data at Trust 2 we already recognised the problems with the responses from the staff. Also, by contrast, we had established the effectiveness of eliciting patient data from the shadowing and observations. We therefore made a decision to focus on this approach to data collection from patients rather than pursue more blind alleys.

Trust 3

In Trust 3 the early signs were that there was no overarching administrative structure from which we could obtain a staff list and nobody we asked could advise on the best way to gain that information. However we did have some 'local' e-mail addresses of the staff in the Units and therefore we e-mailed the OCS to staff on the two study Units and obtained 13 replies all together.

3.2.4 Participant characteristics

There were 224 respondents who completed and returned the questionnaire, of which 77% were women (n = 172) and there were 23% men (n = 49). These included from Trust 1 (n = 210, 93% of respondents), Trust 2 (n=1, 0.4%) and Trust 3 (n= 13, 5.8% of respondents).

The mean age was 46 years, standard deviation 11.1. The majority of respondents were married (62.7%), with a further 7% cohabiting. Twenty percent of respondents were single and almost 10% divorced. The majority of respondents were White (72%), the next biggest group were Asian (18%) and other ethnic minorities such as Black (6.5%) and Oriental (3%) consisted of much smaller groups.

Pay level: most of the respondents had a salary of less than £20k (44.3%) or between £20k- £40k (38.8%). A much smaller percentage (5%) earned between £60k and £90k and a further 2.3% of respondents had a salary exceeding £90k.

3.2.5 Professional demographics

The majority of respondents had been working in the NHS for over 5 years (68%), with a further 26% for between 1-5 years. Only 5.8% reported less than one year's service.

3.2.6 Stability within individual Trusts and Units:

Most respondents had been employed by the same hospital for over 5 years (56%) and another 34% had worked there between 1-5 years. The rest (10%) had been employed by the hospital for less than a year.

Most respondents reported working for the same Unit for over 5 years (45%), a further 43% reported working there for 1-5 years and only 12% reported service of less than 1 year. A similar pattern was seen in terms of length of time in same job. However the majority in this case had been working at the same job for between 1-5 years (45%) and slightly less (41%) had been working in the job for over 5 years. Another 12% had been employed in the same job for less than one year.

3.2.7 Role:

The majority of respondents were nurses, 31%. 13.5% of respondents were managers; 11% consultants/doctors/physicians. Other allied professionals, such as scientists and psychologists made up 10% and support staff made up a further 6%. Clerical staff and 'other' staff (such as porters, maintenance) made up a further 13% each.

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3.3 Data Analysis

This was conducted in the manner described in Chapter Two and the results are discussed separately in the following chapters each of which when relevant provides more context to the conceptual framework and analysis in the substantive area of focus.

3.4 Conclusion

The diverse nature of each of the organisations studied provided valuable information about the different kinds of challenges that different leaders at all levels might face in different institutions across the NHS.

Staff at senior level (particularly non-clinical managers) moved around within and between Trusts. During the course of conducting our study some key gate-keepers and participants left the Trust, others joined and yet others moved position and role even during the relatively short time we collected data there.

In some cases mergers had just taken place or were expected. This was experienced by some as opportunities and others as threats, but in all cases it meant structural reorganisation, staff being re-assigned or choosing to leave for another post.

This has to be taken to be part of the changing face of the NHS overall and central to the culture and climate of the participating Trusts, and can no doubt be generalised to every NHS Trust across the country. In what follows, we have used our different strategies for data capture to examine the relationships between leadership and service delivery in this fluid and (potentially) exciting context.

4 Leadership in the NHS

4.1 Introduction

In any organisation:

Leadership is needed to pull the whole organisation together in a common purpose, to articulate a shared vision, set direction, inspire and command

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commitment, loyalty, and ownership of change efforts (Huffington, 2007, p. 31).

and

Leadership would be easy to achieve and manage if it weren't for the uncomfortable reality that without followership there could be no leadership except, perhaps for the delusional sort. (Obholzer, 2007, p. 33).

In this chapter we examine the ways in which leadership is defined, exercised, experienced and transmitted taking account of how far leadership is perceived as pulling the organisation together to pursue the common purposes of patient care and the relationship between leaders and followers.

We specifically:

- Explore how leadership is defined by different stakeholders and what they see as determining its quality;
- Seek to begin to understand how leadership is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients through examining the data from focus groups and story-telling interviews;
- Using the same data sets, explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted.

4.2 How is leadership defined by different stakeholders and what do they see as determining its quality?

We start this particular exploration with a *thematic analysis* of the qualitative data to identify what themes emerge from the definitions, while also making interpretations using *CDA* and *narrative analysis*. In so doing we pay attention to what Gough has termed 'emotional ruptures' (Gough, 2004) in the text which serve to illuminate some of the subordinated or unconscious information in the stories of the respondents and the subjectivity of the narrator (Frosh, 2003; Frosh, Phoenix, & Pattman, 2003; Hollway & Jefferson, 2000).

In Chapter One we proposed that 'leadership' as a concept has been subjected to continuous scrutiny and moved through different theoretical and paradigmatic iterations. The NHS has identified the qualities it requires in a leader and the role that NHS leaders (at all levels) are expected to strive towards (see Figure 1). We therefore inferred that respondents, imbued in the culture, would focus on 'transformational' or 'distributed'

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explanations and definitions about leaders and leadership because these models are embraced by the style of the coaching and training on offer.

4.3 Definitions

Respondents distinguished between 'leader' and 'leadership'. A 'leader' was described and defined in diverse ways including as:

Obviously strong minded and opinionated (Administrator, T, 2¹⁹).

Particular personality traits - need to be - to have integrity, ((1²⁰)) to ((1)) be clear, err to be facilitative, to have energy to listen, erm, to negotiate, ((2)) to make decisions (Senior Non-clinical Manager, T, 2).

... making sure that you're the person who is erm keeping the team focused getting them to achieve those goals looking at different ways of working (Senior Clinician, Trust 3).

These definitions suggest diverse ways of thinking about the idea of 'leader', indicating that commonality of stakeholder views should not be taken for granted. The qualities a leader has to have are determined in these definitions through having opinions, being strong-minded while also having integrity. A leader also needs to be able to facilitate actions, negotiate and keep the team focused towards the achievement of its goals supporting team-work.

4.3.1 Defining leadership

Leadership in this first definition below was about a formal role and implicitly hierarchical rather than distributed:

I don't think there is anything magical about good leadership. It is about establishing what the organisation wants to do and allowing people to get on and do it (Recently retired CEO with clinical background, T2).

This respondent, who had occupied a senior position, saw the structure and strategic direction of the organisation as fundamental to what works as leadership which was not 'magic'.

¹⁹ In some cases we are able to identify the Trust but where there is any chance of a breach of confidentiality we adjust the 'credit' to ensure anonymity.

²⁰ Where the transcription has included double brackets it denotes pauses timed in seconds.

The following respondent expresses it differently suggesting that it means different things to different people on the one hand, while also being an imponderable (possibly even magical):

Leadership is like love, we all know it exists, but you can't actually prove it, you can't define it, and it comprises of lots of different things that people do, if you demand evidence for everything...you will get rid of leadership eventually (Senior Clinician, T2).

This clinician seems to take distributed leadership for granted in that it is about 'lots of different things that people do'. A warning is expressed it appears, though, that trying to *show* leadership exists across the organisation (perhaps rather than residing in designated roles) might ultimately destroy the possibility of leadership. Following Gronn (Gronn, 2002) this might be a way of suggesting that through concerted action leading to conjoint agency, leadership might not be so obvious (as in the first definition immediately above) but it might be more effective in a hospital where there are different qualities needed to lead in different activities.

Resonating with the view above that a leader has to have integrity, is the view from one leader's experience:

I learnt that it's very important thing for leadership... to not lie, not hide anything and just tell them the reality and be true to yourself, and that's really important (CEO, Non-clinical).

There is an immutable relationship between the leader and the follower. Being true to oneself and honest towards followers must be fundamental to the emotional engagement or attachment between leaders and followers. The significance of emotional engagement as well as emotional and social intelligence was high on many respondents' agendas for determining leadership quality:

... leadership is about having, or being able to demonstrate at any level a coherent vision for where you're trying to go and getting people getting there (Nursing Manager, T 2).

[Leadership in the NHS] is a people focused, leadership job (Senior Non-clinical Manager, T3).

.. it's not always leading from the front (Senior Clinical [therapies] Manager, T 3).

While the leader needs to have vision, these definitions imply that vision alone does not determine how leadership can be exercised or experienced. Leadership will not work unless the leader engages the followers with that vision.

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If leadership fulfils an organisational role ('establishing what the organisation wants') then can it also be 'people focused'? If good leadership is about transparency and honesty is there an assumption that it has not always been so or may not be so at some future time? What does this imply? Does leadership have an 'indefinable' quality' or set of characteristics that work within a specific context but may not be transferable as 'skills'?

Leadership presents dilemmas for the maintenance of personal integrity ('tell them the reality and be true to yourself'), it is a 'job', it requires 'vision' and flexibility and most importantly it seems it is about focusing on people.

4.4 How is leadership in NHS health care organisations exercised and experienced by those affected by it?

Respondents talked about the *role* of the leader as central to the practice of leadership in the organisation. Leadership was understood to be intrinsically linked to particular tasks/goals while necessarily engaging with the followers who had to implement much of these tasks and achieve the goals. There was a sense that many respondents held an idealised view about leadership in their own Trust. Sometimes though the reality for them fell short of expectations because the person occupying that role failed to live up to their hopes.

For example, as the following extended extract illustrates:

.. one of the things about the leadership and management of this Trust is first of all clinical leadership is strong in most places. The clinical directors here have general clout and they are not just figureheads .. and the other bit I think - relationships between general managers and clinicians on the whole are much more positive here than other Trusts (Senior Clinician).

This proposes that strong leadership among clinicians (distributed both horizontally and vertically via the clinical grouping) enables managers to deliver the service to patients. However, this does not in itself identify the characteristics of the links between strong leadership and service delivery.

For many respondents leadership is exercised at least in part through each leader's personal characteristics (good and bad). Almost without exception when asked about the qualities that make a leader, and to 'story' their own explanations, respondents placed a degree of emphasis on the characteristics of an 'ideal type'. The following exemplifies this:

Most important quality is the communication. Being able to listen - hear what is being said and to deliver that--what they want to say, so that it is heard by all. That it be quite quick thinking, being able to develop an idea

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and roll it out, umm being able to think on their feet as well, because sometimes you get things that turn up and you have to deal with it there and then, umm, reasonably personable so people will confide in that person, um also strong so that when things are tough they can um deal with them (Clinical Midwifery Manager, T1).

The comprehensive but daunting picture of how leadership is exercised described above, represents an ideal of distributed leadership as *concerted action* (Gronn, 2002). This type of leadership is exercised through being able to communicate – to listen and to express clearly (so as to be ‘heard’) how action will be taken. ‘Rolling out’ the idea again suggests taking peers and followers along with you and being ‘personable’, so people will confide in that person, further indicates the ability to take the views of others into account calling for both emotional and social intelligence (Amendolair, 2003; George, 2000; Goleman, 2006; Lopes, Grewal, Kadis, Gall, & Salovey, 2006; Riggio & Reichard, 2008). In this model, the multifaceted communications rely on the ability to use the information to think quickly and be strong under ‘tough’ circumstances.

However, in the next extract (from a non-clinical manager) the ideal type of leadership is represented by responding to short and medium term organisational goals (Buchanan, Fitzgerald et al., 2005; Riccucci, Meyers, Lurie, & Han, 2004).

Erm, I think leadership is about erm, encouragement. It is about showing people direction in which you as an organisation and them as individuals engage in. I think it's incredibly important especially in an organisation like the NHS where there are lots of different groups of people and lots of different objectives - sort of daily ones, monthly ones more long term, and you have quite a clear sort of vision of where you're going and I think that the good leaders in the NHS show that, and examples of bad leadership are where that is not so defined. (Middle Manager, T2).

This suggests a *transactional* model of leadership, whereby the good or effective leader offers ‘encouragement’ to the followers in return for people accepting the practices of the wider organisation (Bass, Avolio, Jung, & Berson, 2003; Eagly and Johannesen-Schmidt, 2003)

4.4.1 Exercising leadership through their organisational ‘role’

Leadership is experienced by some as being exercised through the legitimated role. Organisational role in the leadership discourse equates with the leader’s professional position as the respondent below shows clearly:

Who would be a leader to me? I think there's a number of different areas, there's your direct line manager, who's the clinical leader of your department. Who's who in this structure there's line managers above them, and above them and so on. There would be people you would look to within your own specialty clinically who are more experienced than you ((2))²¹ in certain areas, to ask for advice, erm ((1)) and similarly in an academic environment ((1)) there are other people there who have more experience that you would want to take advantage from or advice from. ((2)) And in the wider circle, national or international leaders in the field who are so expert at those things that you also turn to. (Medical Consultant, T3).

While the formal roles and organisational hierarchical structures are taken seriously by this respondent, there is also a clear vision of leadership being exercised through concerted action in collaborations that arise *spontaneously* where clinical and/or experience is valued and sought within this respondent's speciality and sometimes *intuitive* leadership (Day, Gronn, & Salas, 2006; Pearce, 2004). However, there is also a sense that this respondent experiences leadership through the institutionalisation not only of formal roles locally, in the organisation itself, but through the structural relationships with those who are seen as experts in a much wider networked context (Pearce, 2004). This version of leadership is particularly important in that it demonstrates that leadership can be both experienced and exercised beyond the boundary of the organisation and the NHS, based on knowledge and expertise originating outside these systems.

Respondents frequently combined personal qualities with their understanding of the leadership role, particularly related to taking responsibility as part of that role:

It's quite difficult, I mean I think taking responsibility (4) making sure that things happen that are supposed to happen, or don't happen that aren't supposed to happen (3) um.., (6) that's it. (Clinical Medical Consultant, T1).

Not everyone saw leadership in this way. This respondent is talking about their own experience of being in a role in which then 'buck' frequently stops and thus by definition they are in the role of leader.

The exercise of leadership through being a 'role model' (Trevino, Hartman, & Brown, 2000) where qualities of leadership were displayed was important for some:

The leaders that I've worked for and have wanted to follow ... push something in me that says 'I want to be like them' or I completely support

their vision of where they're going or you know so I want to follow that person and I want to do the best that I can do for them because I believe in them and their vision. (Head of Non-Medical Clinical Team, T3)

This explanation has a flavour of heroic or charismatic leadership, although not as a quality that resides in a specific person necessarily, but one that resides in a relationship that 'fires' up both leaders and followers (Klein & House, 1995). Even though the idea of the charismatic leader has been at least partly consigned to the history of the late 20th century organisation, it has not disappeared and needs further thought particularly in an organisation such as the NHS where changes are sometimes rapid and stressful (James, 1999) and internal culture needs to be taken into account (Dopson & Waddington, 1996; Tourish & Vatcha, 2005).

4.4.2 The relationship of the 'leader' to 'followers': how leadership is experienced

While leadership is the focus of the professional and political debates about the NHS and other organisations, until recently, relatively little attention has been paid to followers' experiences of leadership (Avolio et al., 2004; Howell & Hall-Merenda, 1999; Lewis, 2000; Schilling, 2009). From the perspective of a manager taking the position here as 'follower' looking 'upwards' in the organisation:

I think it's, it's providing, you know direction and to lead and that's a leader's main job in my mind. And (2) that's .. what they say for leadership, you must have followers. If nobody's following you, what you are saying then? you are not a good leader. So that's a good, you know, test for a leader to evaluate themselves. That's what they are saying and what they are trying to achieve. Are people behind them or not? If they are not behind the leader there's something wrong with that. (Middle Non-clinical Manager)

From the perspective of a junior doctor taking the 'followership' position:

I think in order for you ... well in my opinion a leader, I have to be able to kind of respect them. If I don't respect or kind of have faith in what they do, then it's, it's a personal authority, so in order, you know in order for me to do that I have to believe in what they say. I mean, I might not always agree with them in my opinion but at the end of the day I have to be able to respect them enough and for them to have certain authority, someone who's probably experienced and gained that knowledge, so yeah. (Junior doctor)

For leadership in the NHS to be exercised effectively then there has to be an engagement between the leader and the followers (Macy & Schneider, 2008) and to understand fully how the engagement takes place, a degree of

emotional engagement and/or attachment to the leader and the organisational vision is fundamental (Riggio & Reichard, 2008; Rubin, Munz, & Bommer, 2005; Vince & Broussine, 1996).

The failure to take followers with you is made explicit here from the perspective of one (designated) leader:

A: I was forced upon them...

Q: that's what I was going to ask. So presumably there was a lot of resentment I guess?

A: Yes.

Q: And how does it manifest itself?

A: Erm, non-cooperation, making life difficult for you sometimes, people talking about erm ((2)) sort of criticising you behind your back and erm playing silly games behind your back that makes management of other people more and more difficult. Erm you know, and yet we sort of have to fight another battle to win hearts and minds, when we, you know, don't really have the time to do that, we have got to have our focus on doing what we are meant to do, which is to manage patients and to manage our beds properly.

This extract from the interview with someone whose role it is to lead change is revealing. The respondent recognises that he is not taking people with him and in his view, the followers appear to eschew co-operation. He also believes they are mocking him and that that mockery is contagious. He may or may not be able to evidence this, but that it is in his mind is potentially detrimental to his experience of leading in his organisation (Stein, 2005). Furthermore, instead of looking at himself, this respondent wants to push the blame for the leadership failures onto the followers (in other words he engages in splitting described in Chapter One) (Klein, 1975; Segal, 1973). Such a process is diametrically opposite to leadership studies that identify authenticity and trust between leaders and followers as being one of the basic qualities for leadership (Avolio et al., 2004; de Raeye, 2002; Novicevic, Harvey, Ronald, & Brown-Radford, 2006).

There is also some evidence of concerted action here, distributed among those who were leaders of the *resistance*, which is not necessarily against the values of the organisation in any negative way, but may be seen as upholding important principles and challenging change (or a particular form of leadership) that might be perceived as counteracting these important values (Collinson, 2005; Zoller & Fairhurst, 2007).

Trust is one important quality in the way leadership is exercised and experienced by followers and developing trust is essential if changes in

practice are to be implemented (Bass & Steidlmeier, 1999; Hunter, 2005). So, for example, 'engaging' with others involves trust:

Yeah definitely there are some good examples of where it's obvious that people have been able to engage lots of different kinds of people in different groups and I think they've done that just by sort of making relationships with them in the first place and then when it comes to having to lead them and be influential then you can see that those relationships are already there and then they can call on that you know, that sort of that trust or that sort of relationship that they've got (Middle Non-clinical Manager, T2).

The same respondent continued with a specific example that aptly demonstrates the links between all the three sub-themes.

Yep, I think Florence who is our head of [a non-clinical department] .. I think she is a very good example of what I'm talking about in terms of her job. And her role relies a lot on other people. Erm so as a personality she is a very responsible person, she gets on with everybody and you can really see how that works for her because when she needs somebody to do something or she needs people to listen they are going to because they have got a good relationship with her and she has taken time to build relationships when it is perhaps not necessary.

To summarise so far - *good* leadership in the NHS is understood by staff at various levels as:

- Taking responsibility
- Being 'given' authority by the followers
- Getting on with the people in the organisation
- Taking time to build relationships
- Being trusted by followers
- Winning hearts and minds
- Having a vision for the organisation
- Taking colleagues with you

4.4.3 Patients' perspectives on how leadership is exercised

While there were several things held in common (particularly 'trust' and 'taking responsibility') with the staff, patients unsurprisingly, considered leadership from a different position, based upon how they themselves had experienced a specific episode of care. One woman, who had had a previous bad experience in the same Trust in which she was now a patient, said:

Well somebody taking responsibility really for erm you know your care, erm especially. I keep going back to the same example but you know someone being responsible for not reading through my notes and if someone had taken that leadership erm and actually said 'right I'm going to look through

these notes', you know they would have obviously seen what they had to see and so basically yeah I think there is a lack of leadership.

The emphasis was on wanting the leader to take responsibility for patient care in contrast to poor practice whereby notes were not read. It was taking responsibility, and reassuring the patient that they were taking responsibility, that could be experienced by patients as good leadership.

Another patient similarly suggested that in their exercising of leadership, the clinical staff need to make sure that they were seen to be acting in the patients' best interest. For example:

When they're explaining their-selves, they do explain their-selves and what they're thinking. And they do tell me like the 'ifs' and 'buts' blah blah blah about this certain thing, but then one says something and [another] one says something else but they do explain themselves and what they're on about.

Also, another patient indicated that there needed to be one person who held overall responsibility for service delivery:

I don't know how it works hierarchy wise, whether there's like a top doctor or whatever, whoever it is somebody really needs to, you know, take a really ((2)) be sort of, you know, held responsible.

It is perhaps worth noting that the patients overall focused on the role of clinical leadership but saw that as being practiced by an individual rather than in a distributed form. There was a general view that individuals needed to be accountable and accountability equated with leadership.

4.5 What are the characteristics of an organisation that facilitate, or hinder, the process of leadership?

Leadership happens in a context and that context can facilitate or hinder leadership processes (Currie et al., 2009) and the influences of the organisation are particularly acute when the environment is changing rapidly (Goodwin, 2000; Michie & West, 2004) as in the NHS.

One respondent felt they no longer knew 'who was who' in the leadership hierarchy but considered it didn't really matter:

..., here is this model that says here is the Board and here is the chief exec and here is whoever else is up there. And there's this, this and this ... and [a colleague suggested] shouldn't we be transparent all the way through and shouldn't everything link? and I thought, this came up somebody legitimately asked the question that people here need to know what is happening here. Why? Why? I don't care. (Clinical Physiotherapist, T3).

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One senior Occupational Therapist, in the same Trust, on the other hand felt that knowledge of the organisation was important to facilitate leadership at every level so that when:

... people feel they are working as part of an organisation that's working for something, as part of a team and are appreciated and valued as part of that and are working for someone as well who feels what they are doing is worthwhile, I think that patient care will be of better quality.

This respondent was also convinced that supervision was part of the process by which an organisation facilitated both leadership and good practice in patient care. *"I have once a month supervision, like set time for supervision so I think that is really good."*

Furthermore, supervision and informal contact with peers facilitated effective distributed leadership which impacted across the organisation: *".. you can go to people informally, your peers erm whenever it's quite flexible like that and even if you're a senior like me you think 'hang on I don't know if I'm on the right track here so am I missing something?' You can just go and speak to you team about it or one of our colleagues downstairs or whatever if you want to.*

More dramatically a senior clinical leader suggested that leadership is facilitated in 'moral' organisations:

A²²: So one thinks they are better than the other, so the seven deadly sins basically...pride, the other one is gluttony, which means excess...one can never have enough, for the sake of it, and then just goes beyond, you know, one million, two million, you know, which kind of greed isn't it...excess basically, and also rushing is in there, doing things too fast. A good system will reduce its workload, yeah? The NHS has a thing of needing to do more and more, erm anyway, I don't know whether you find this useful or not, so greed, gluttony, there's rushing, and then jealousy, which is really envy, which is really competition.

Q: Yeah

A: You need to get rid of competition, and I will tell you in a moment what could replace it, which is basically team work, team work and kindness; how you get on with each other...anger is on the list. Anger is, is blame, and the opposite is blame free culture.

Q: Yeah

²² Q = question, A = answer.

A: Or forgiveness if you want, so you need to forgive mistakes, and you know you will be forgiven...and, erm...erm...next one is laziness, that's obvious, that's hard...people either have it or not, but laziness is joylessness, you need to make sure people enjoy it, and diligence, yeah? So there needs to be something in place of ...and we have that now with trust away days and things like that, but you have to have somebody dedicated to making people understand it's about having fun

Q: Yeah, yeah

A: working is about having fun...yeah? And then its... which comes really from up here, it's just an, an, yeah, can't have enough...which is also, it's also, the opposite is erm...do not take more than you can, do not take more than you need...and that is quite a moral stand ground, more than you need...for everyone

Q: Yeah

A: and if you employ that rule, then the whole organisation becomes so successful that there's masses of money left over ... Everything works well...the problem is everyone doesn't understand that, and believe in that, and then there's a difficulty...so that's moral high ground, very moral high ground, but if you go along those, you actually have all the features of leadership.

For this respondent the organisation needs to focus on patient care, treating patients *and* staff with 'kindness'. This is counter in his view to the process of setting targets for service delivery and organisational growth (or survival) and thus competition between organisations and competition between individual staff or staff teams, which is a force that (it seems) promotes the wrong kind of leadership (Kuokkanen & Katajisto, 2003; Sambrook, 2007). Furthermore, supportive teamwork and 'forgiving' mistakes and preventing the 'blame game' enhances socially and emotionally intelligent leadership distributed responsibility across the organisation and enhancing the culture and climate (Riggio & Reichard, 2008) .

Another senior medical leader and manager (T3) reinforced this idea:

I think the ethos within the hospital, is one that encourages people to develop and grow, and deliver good quality care, you know, so, I mean I think wherever it comes from it is enabled within this organisation, and it works very effectively. One of the features that enables that to happen...it's firstly being an organisation that attracts good people to want to work here in the first place. So you get high quality people applying for the position, be it in medicine, or managing, or nursing or any of the other professions By and large, we're fortunate in that. And that's partly due to the reputation, and partly due to the [location] but I think the ethos that comes

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from the leadership makes it desirable to be here. Erm...so it attracts the right people in, it then enables, it doesn't put the brakes on, it doesn't try to control people too much.

Thus, organisational performance and culture/climate were 'enabled' through a cycle of encouragement, good practice, reputation and a supportive and 'hands-off' approach to leadership. This suggests concerted action, leader/follower engagement and emotionally supportive behaviours at all levels. That the physical location of the hospital is attractive is perhaps but one factor in this equation, although a central location makes it possible to draw on a wide range of staff as opposed to a location which is in a small town or distant suburb.

It is not just features of the organisation itself that impact on leadership. Organisations reflect changing discursive constructions of leadership and the values that underlie what it means to be effective as a leader in that place at that time (Ferlie & Shortell, 2001; Lansisalmi, 2006; Michie & West, 2004; Scott, Mannion, Davies, & Marshall, 2003). As demonstrated in Chapter One theories of leadership have developed and different approaches have become significant at different times as witnessed by the shift from promoting and studying transactional, charismatic and heroic leadership styles to the contemporary emphasis on forms of distributed, networked and transformational leadership (Bryman, 2004; Butterfield et al., 2005).

One dramatic change over the past twenty and more years has been the image of the medical consultant in the public psyche. Thus the 'heroic' leadership of Sir Lancelot Spratt has been firmly (it seems) replaced by the team work in the TV series *Casualty* or *Holby City*. However the image of the rebel Dr. House (played by Hugh Laurie in an American TV series) is described as 'unorthodox' and 'radical' but most definitely a medical hero. Is this the type of leader that some might still long for? While the following comment was atypical of most people's definitions of what makes or fails to make a good leader it raises some interesting points about the contemporary regulatory discourses on leadership. Thus one participant said of another²³:

Now (Dr.) David is a really eccentric so he is not what you would naturally call a leader, erm ((1)) but people are really respectful... Because he really cares for patients ...And if he finds a junior doc, or nurse or anyone who is being unkind to an elderly patient then he is down on them like a ton of bricks but his, his patent commitment to medicine and clinical care just inspires admiration ...And great affection hopefully. But he is very odd. Yes. Erm, so he is like a one off so again there is no single person, you

²³ No identifying information is appropriate here.

know there are, there are, there are different leadership styles which are appropriate in different situations but David of course could never be a chief exec, he just wouldn't be able to do it, so he would be hopeless there.

On the surface this might be explained as a judgement based on 'evidence' and a job description. However, focusing-in on the discursive and regulatory practices with which this extract engages, a different view can be taken. The respondent here, being asked to describe the qualities of leadership, begins by suggesting that taking patient care very seriously is 'eccentric' and the person who does that is a 'one off' and 'odd'. Paradoxically (it is suggested) David inspires affection and admiration but despite the variety of leadership styles David would never make it to be CEO. Whether or not this is the case is irrelevant here because what is at stake are the ways in which discourses around 'leadership' and the qualities of the 'leader' *regulate conduct* setting normative behaviour through the discursive practices. There is little doubt that David would have been considered a leader (perhaps a leader in his field) during a different period when hospitals were smaller and perhaps when there was less specialisation in management.

A learning organisation?

The NHS has declared itself to be an organisation dedicated to learning for at least the last ten years and certain values underlie this declaration (see Davis and Nutley, 2000). It means that:

Although learning is something undertaken and developed by individuals, organisational arrangements can foster or inhibit the process. The organisational culture within which individuals work shapes their engagement with the learning process (p. 998).

In some cases the exercise of leadership clearly facilitated the (potential for) learning and learning facilitated leadership, while in others it did not. The facility for leading change in NHS Trusts is critical and developments in the role of nurses from a range of specialties to support leadership and learning have provided exemplars of how some organisational arrangements support leadership (Bellman, Bywood, & Dale, 2003; Doherty, 2009). However, some have argued that continued changes, the market as a driver and the complexity of the NHS might militate against whole system learning (Sheaff & Pilgrim, 2006). Questions have also been raised about the potential of the new generation of leaders who are expected to be inspirational, drive change and support learning (Phillips, 2005).

One capacity manager, for instance, was very clear that leadership was about enabling appropriate learning and the development of skills:

... probably more about empowerment and not necessarily of oneself but of others. So I think that indeed you need to feel empowered yourself, but I think that leadership, good leadership is about empowering and supporting those people who are not in power so that they are equipped with the skills that are required. some of it is actually around learning, it is about what stage they are at in terms of their learning curve.

This is not only a statement about distributed leadership but about a version of a transformational leadership that transcends individual leaders and requires an organisational culture that both supports individual learning and targeting individuals to ensure, that their learning is recognised and ongoing (Burke et al., 2006; Conger & Kanungo, 1988; Kuokkanen & Katajisto, 2003).

The respondent continues with this theme in a sophisticated, and it seems heartfelt, way:

But I think that sometimes that [learning] is not always consolidated, even those people that have been in that position for years. I think, it is more about the people actually understanding²⁴ what they have done, and almost sometimes talk it through, in basic detail about why they have got to the decision they got to. But just because you have been in a position for a long time doesn't necessarily mean that you have actually learnt erm and you may only then go up to a certain stage in my opinion in terms of your whole learning so then they may be stuck in, not novice, but in that middle stage rather than the expert. Which we would hope that most people would get to.

This suggests that organisations need to be vigilant and to constantly invigorate their members. For the respondent quoted above, an organisation that allows people to stop learning is one in which leaders and potential leaders stagnate (at their peril) (Mark & Scott, 1991).

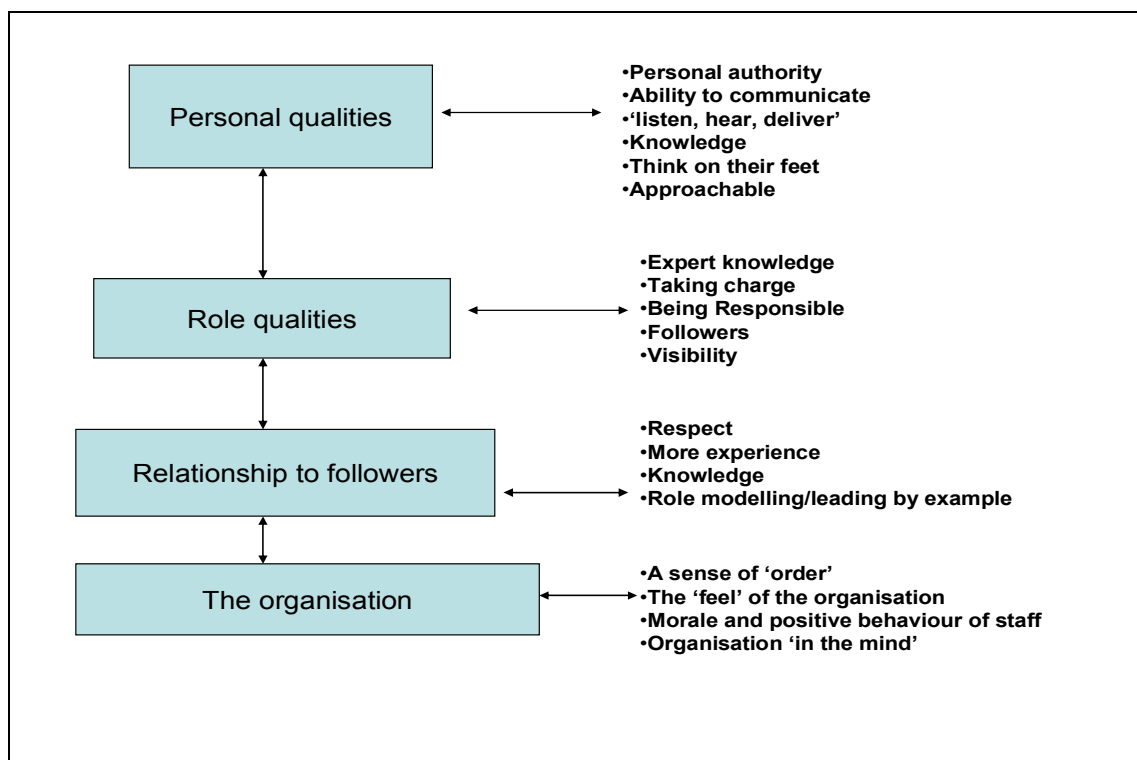
As we discuss again in Chapter Nine, the multi-disciplinary team presents an ideal opportunity for observing leadership (good and bad) and examining the ways in which these teams adhere to organisational norms which might support or inhibit learning (Burke et al., 2006; Day et al., 2004).

One senior non-medical clinical manager in a different Trust also took up the theme of learning and empowerment and specifically how it links to good patient care (Burke et al., 2006; Doherty, 2009; Kuokkanen & Katajisto, 2003).

²⁴ The transcriber who was also the interviewer made it clear that these words were emphasised by the respondent.

... [leadership] is about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is we worked with 'Training and Development' and we came up with a specific programme that was aimed at empowering them [all administrative staff] to improve their service area etc etc and also provided them with some skill sets that they probably didn't have prior to that.

Figure 11. What makes a leader?



4.6 Conclusion

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

Nonetheless, when asked to describe and define leadership, various stakeholders at all levels of the organisation have a view some of which coincides with contemporary NHS discourses and some which seems directly at odds with what the NHS is trying to achieve – that is, to support both

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distributed and transformational leadership that are seen as successful in ensuring effective patient care. However, it is clear that individual personalities and the impact of particular leaders cannot be taken out of the equation.

Leadership is experienced as distributed and transformational but there remains a belief that charismatic and transactional leadership also have their place in complex organisations. While vision is important, no vision can be achieved unless the leader takes 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. Supervision, peer support and informal advice are part of the emotionally intelligent distributed practice of leadership. 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.

In summary, the main ideas that emerged from the respondents' views of how leadership was exercised and experienced were it was about:

- Personal authority
- Ability to communicate
- 'listen', 'hear' 'deliver'
- Thinking on your feet
- Being approachable

Leadership can be exercised in a number of ways and qualities of leadership are seen to reside in different but interlinked 'places'. For example, it is clear that some people are perceived more than others to have the personal qualities that make them a leader, including being able to listen, deliver and be approachable (see Figure 11 above). The assigned/legitimated leadership role is also perceived to be an important quality for a leader, which is interesting, when thinking about the distributed leadership model and particularly the idea of concerted action where people have to work together to 'lead'. This links further to the qualities inherent in leader-follower relations identified as fundamental to the stakeholders interviewed here.

Finally, leadership means holding a sense of the organisation in mind. That is the mental model held by the leader through which they mediate and regulate their vision and actions as leaders, but it also refers to the leader's understanding of morale and the 'feel' of the organisation in which they are working, which itself regulates and constrains the possibilities for growth, development or atrophy.

In this chapter we identified some of the evidence of how organisational contexts evolve and the relationships between organisational culture/climates and the ways in which leadership is practiced. This will be developed across the next four chapters.

5 Leadership and Organisational Climate

5.1 Introduction

Despite its North American origins, where the health care system is fundamentally different from the NHS, Stringer's focus on both leadership and climate nudged us towards choosing an adaptation of his organisational climate survey for this study. We also identified an 'awareness', as he puts it himself, that "*People working in health care systems play drastically different roles that are more diverse than the roles typical in schools and businesses*" (Stringer, 2002, P. 188).

Through adapting the OCS we also captured demographic information from our participants as well as a data about satisfaction with the leadership one receives from his or her immediate supervisor²⁵. Thus, while on the whole Chapter Four dealt with general descriptions, definitions and values, in this Chapter we focus on specific relationships between individuals and the individual and the perception of their organisational climate.

The additional contribution the survey data makes to the overall aims of the study is to relate perceptions of leadership and management directly to organisational climate, thereby providing a triangulation with the story - telling and focus groups to explore the characteristics of organisations that facilitate or hinder leadership and service delivery.

5.2 Results

5.2.1 Normality of data

When normality was examined the KS-Lilifors test was found to be significant over all the scales, indicating that the data were not conforming to assumptions of normal distribution. However, inspection of the histograms and boxplots were found to present an acceptable level of

²⁵ Our version of the survey questionnaire is appended.

normality. Due to the nature of the data it was decided not to transform it, but rather to interpret the results which rely on the assumption of normality with caution.

5.2.2 Cronbach's Alpha

In order to check the reliability and internal consistency of the OCS in this setting we used Cronbach's Alphas (Cronbach, 1970) (See Table 2).

As can be seen from Table 2, the three dimensions of '*commitment*', '*support*' and '*recognition*' were considered to be high on reliability as their scores ranged from .69 to .74. These would be considered acceptable-good level of reliability (George & Mallery, 2003).

In contrast, the three dimensions '*structure*', '*standards*' and '*responsibility*' were low on reliability. This low reliability may be explained by confusing wording of the items, or it is possible that the individual items did not correspond well to one another in this sample. As such it was decided to remove the '*responsibility*' scale from the rest of the analysis. A further check to see whether '*structure*' and '*standards*' could be improved by removing single items, did not show any improvement to the alpha so these were retained in their original form.

Table 2: Cronbach's Alphas for the six dimensions

Scale	Cronbach's Alpha
Commitment	.74
Support	.72
Recognition	.69
Structure	.57
Standards	.43
Responsibility	.14

When managerial dimensions were examined for reliability' these were found to be very high ranging from .86 for '*recognition*' to .79 for '*commitment*' and '*responsibility*' (See Table 4).

Table 3: Cronbach's Alphas for the six Managerial dimensions

Scale	Cronbach's Alpha
Managerial Responsibility	.86
Managerial Recognition	.83
Managerial Standards	.83
Managerial Support	.81
Managerial Commitment	.79
Managerial Structure	.79

Overall scores for organisational dimensions

In order to derive the scores for individual dimensions, all the items on each dimension are summed [this is after all the negatively worded items were reversed].

The following were mean and standard deviations across all the six Organisational scales:

Table 4: Mean and Standard Deviation

Scale	Mean	Std
Commitment	14.82	2.86
Support	14.06	2.80
Responsibility	9.93	1.73
Structure	9.01	1.88
Recognition	8.42	2.55
Standards	8.36	1.69

Stringer, et al (2002) suggest an analysis of percentages of respondents who scored above the mean. In our analysis the following percentages were found:

Table 5: Scores above the mean

Scale	% above the mean
Commitment	60%
Support	47%
Recognition	49%
Standards	49%
Structure	39%
Responsibility	58%

Stringer offers a method of interpreting these percentages, according to benchmarked ratios collected through their extensive research to validate the tool.

High 'commitment' (60%) – In the current sample, there was a high degree of 'commitment' to the organisation and its goals. This would be typical of professional staff working for the NHS. However Stringer asserts that high 'commitment' needs to be accompanied by high 'support' and high 'recognition' – without these individuals will stop engaging with others in the organisation and their team (p.200). As indicated in Chapter Four engagement is crucial if leadership is to be effective.

High 'responsibility' (59%) – Stringer asserts that 'responsibility' is a difficult dimension to interpret within the health care setting. Effective performance in the NHS requires that procedures be double checked, which in many other contexts would put the role of 'responsibility' in an ambiguous position. However this is not the case in complex clinical settings (or for example in other precision performance occupations such as flying aeroplanes for instance). In the case of the current sample 'responsibility' was high, which is related to high sense of 'commitment', but is confused by the limited 'structure' – it is essential that people are clear about their roles, so that they may take charge and 'responsibility'.

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Moderate 'recognition' (49%) - According to Stringer scores lower than 50% may indicate that participants are feeling unappreciated. In this case there is just under the 50% mark, which translates into moderate agreement about the feeling of being rewarded for one's efforts. Having a high sense of 'recognition' in an environment such as this is of crucial importance for motivation, but 50% is within the normal range set out by Stringer. High 'recognition' is indicative of confidence in the organisations performance/reward ratio but in such a diverse setting as a hospital with a diverse staff group responding to the OCS then different groups with different management and professional/occupational structures would have different perceptions and experiences.

Moderate 'standards' (49%) – there is a moderate feeling of pressure - performance 'standards' and expectations are high but not to the point where they are stressful. This falls within an acceptable range. Considering that many of the 'standards' (targets) are set out by government policies rather than directly by Trust management/leaders it is important for these standards to be realistic and achievable.

Moderate 'support' (47%) – this falls within the low but acceptable range for this scale (45%-60%) according to Stringer's benchmarks. This indicates that there is sufficient unity between teams to approach and solve problems, without overly nurturing so as to discourage individual 'responsibility' and undertaking. Team work within the health care system is challenging because of the interdisciplinary nature of teams which inevitably calls upon different management and professional structures and networks for support.

Low - Moderate 'structure' (39%) – Under half of participants felt there was clarity in terms of their roles, responsibility and authority. On the one hand this means that there are less constraints and a less of a 'jobs-worth' approach, on the other hand though it means that there is (potentially) insufficient clarity in roles and responsibility. In an organisation such as the NHS, this may be a considerable shortcoming and Stringer (p.193) suggests that in a health care environment such as a hospital, one would ideally like to have 'structure' scores above the 70s. This is emphasised because of the complex nature of the hospital environment with so many individuals involved – accountability needs to be very clear. The NHS however has gone through so many changes over the previous ten years that it is inevitable that the 'structure' score would be influenced.

Associations between the six dimensions on the organisational level

Pearson's r was utilised to test the relationship between all the Organisational scales. It was found that the majority of scales showed modest, but significant relationships:

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Table 6: Correlations between the six organisational dimensions

	Standards	Structure	Recognition	Support	Commitment
Standards	1.00				
Structure	ns	1.00			
Recognition	.22*	.47**	1.00		
Support	.17*	.42**	.61**	1.00	
Commitment	.30**	.39**	.59**	.67**	1.00

* <.05

** >.001

As can be seen from Table 6, there are a number of high associations between these dimensions. The highest associations are for 'support' and 'commitment' (.67) 'support' and 'recognition' (.61) and 'commitment' and 'recognition' (.59). In other words, participants are reporting that when a feeling of co-operation within teams is present, this is often accompanied by acknowledgement and appreciation and is further related to a greater sense of dedication and 'commitment' to the goals and aims of the team. By definition, the converse also applies: feelings of isolation are more likely to be accompanied by lack of incentives and disenchantment with the objectives of one's team. This is 'supported by Stringer (p.200).

Satisfaction with leadership

When the *organisational dimensions* were examined in relation to satisfaction with the quality of leadership received from the immediate manager, which was asked as a single item, the scales which correlated most highly were 'support' (.61) and 'recognition' (.52). The weakest relationship was to 'standards' and 'structure'.

Table 7: Correlations between organisational dimensions and satisfaction with Leadership

	R (sig)
Standards	.14*
Structure	.30**
Recognition	.52**
Support	.61**
Commitment	.39**

In order to evaluate the individual contribution of each of the organisational dimensions to the overall 'satisfaction with leadership', a regression analysis was conducted, which included all items which were found to correlate significantly with satisfaction, namely 'standards', 'structure', 'support' and 'commitment'.

The total variance accounted for by the model was 40% (Adjusted $R^2 = .38$) therefore variability in 'satisfaction with leadership' is moderately accounted for by this model.

Specifically, of the five predictor variables the two which were found to predict the outcome variable of 'satisfaction with leadership' were 'support' and 'recognition', 'support' being the biggest contributor with a $B = .52$ ($p < .001$) and the other predictor was 'recognition' ($B = .27$, $p < .001$). The other variables were not significant. [Appendix 1 of this chapter].

In other words, feeling supported by one's team and believing that rewards are appropriate to effort, accounts for a significant proportion of an individual's satisfaction with leadership.

Correlations between dimensions on Managerial level

The second part of the questionnaire asked about individual experiences of management. All six dimensions on the managerial level were highly correlated with each other, with strong correlations ranging from $r = .71$ ($p < .001$) between 'structure' and 'responsibility' to a correlation of $.84$ ($p < .001$) between 'commitment' and 'standards'.

Table 8: Correlations between dimensions on Managerial level and Satisfaction with Leadership

	Manager Recognition	Manager Support	Manager standards	Manager structure	Manager Responsibility	Manager Commitment
Manager recognition	1.00					
Manager support	.83**	1.00				
Manager standards	.82**	.83**	1.00			
Manager structure	.73**	.78**	.79**	1.00		
Manager responsibility	.84**	.79**	.79**	.71**	1.00	
Manager commitment	.79**	.83**	.84**	.82**	.79**	1.00
Satisfaction with Leadership	.68**	.76**	.71**	.71**	.65**	.76**

** Significant at .001 level

A single item asked about satisfaction with the quality of leadership received from immediate manager. When this was examined in relation to the six dimensions appropriate to participants' own experience of management practices, it was found to correlate highly and positively with manager 'support' ($r=.76$); management 'structure' ($r=.71$, $p<.001$); manager 'commitment' ($r=.75$, $p<.001$) and 'standards' ($r=.71$, $p<.001$); manager 'recognition' ($r=.68$, $p<.001$); manager 'responsibility' ($r=.65$, $p<.001$);

A multiple regression was carried out to examine the perception of 'satisfaction with leadership', as a dependent variable of management practices. The overall association between management practices and satisfaction with leadership was strong ($R=.80$) with associated variance explained of 63%.

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Table 9: 'Manager' dimensions regressed onto 'satisfaction with leadership'

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	-.054	.226		-.240	.811
Manager Recognition	.001	.039	.002	.025	.980
Manager support	.175	.039	.410	4.501	.000
Manager structure	.060	.027	.177	2.260	.025
Manager responsibility	-.018	.032	-.047	-.559	.577
Manager commitment	.165	.056	.278	2.948	.004
Manager standards	.017	.056	.029	.310	.757

In this case, it was manager 'support' which best predicted satisfaction with leadership ($B=.41$, $p<.001$), next biggest contributor was management 'commitment' ($B=.28$, $p=.001$) and management 'structure' ($B=.177$, $p=.025$). In other words, a large proportion of feeling satisfied with one's leadership, pertained to feelings of being supported and the degree to which one's manager inspires and exudes 'commitment' to common goals. A further important element in the equation is that of 'structure' – where roles and responsibilities are clear, it is associated with greater satisfaction with leadership.

As the biggest predictor of 'satisfaction with leadership' was manager 'support', a further regression was done to look at what organisational dimensions related to having good managerial 'support'.

All the organisational scales were inputted into a regression, excluding organisational 'support', with managerial 'support' as the outcome variable. The following was found:

In total the model accounted for 35% variance in the outcome variable (Adjusted $R^2 = .35$). There were two contributors to the model: the strongest one was 'recognition' ($B = .44$, $p < .001$), i.e. the more employees feel that the organisation rewards and recognises their efforts, the more they feel supported. The other contributor to managerial 'support' was 'commitment' ($B = .20$, $p = .008$). [Appendix 3 of Chapter Five]

These findings indicate that organisational 'recognition' and 'commitment', are organisational climate dimensions which most affect the outcome of managerial 'support', and this in turn has the greatest effect on individual's sense of satisfaction with their leadership. This again corresponds with data discussed in Chapter Four highlighting the importance of the feel of an organisation that provides support at all levels.

Regression of all dimensions onto Satisfaction with leadership

When all the variables previously shown to be significant to Satisfaction with leadership, were entered into the model, from both the organisational and managerial dimensions, namely manager 'support', manager 'commitment' and manager 'structure' as well as organisational 'support' and organisational 'recognition', the following picture emerged:

There was a high degree of variance accounted for by the model - 65% (Adjusted R^2). The model was found to be significant ($F = .80.65$, $p < .001$).

The variables which remained significant, in order of their contribution are: manager 'support' ($B = .34$, $p < .001$), manager 'commitment' ($B = .33$, $p < .001$) and Organisational 'support' ($B = .13$, $p = .03$).

In other words, satisfaction with leadership, in this sample, was predicted by a greater perception of 'support' from management, a feeling that managers demonstrated their 'commitment' to achieving common goals and an atmosphere of 'support' and team-work within the organisation.

Organisational and Managerial dimensions

In order to investigate the relationships between organisational and managerial dimensions, a correlation was performed between all of these variables (Table 10). It was found that:

There were strong correlations between manager and organisational 'recognition', and manager and organisational 'support'. There were moderate correlations between manager and organisational 'commitment' and 'structure'. And there was a weak correlation between manager and

organisational 'standards'. In other words, where the dimensions were correlated weakly or moderately, we can identify that 'standards' of the organisation do not necessarily exist at the same level of managerial 'standards'. The same relationship goes for 'structure' – having organisational 'structure' does not predict clarity in roles, as espoused by one's manager. There is a greater degree of correspondence between organisational and manager 'commitment'. When we look at 'support' and 'recognition', we find that both these dimensions tend to be closely related – one is more likely to feel that both are high, or both are low.

Table 10: Relationship between managerial and organisational dimensions.

	Organisational Recognition	Organisational Support	Organisational standards	Organisational Structure	Organisational Responsibility	Organisational Commitment
Manager recognition	.60**					
Manager support		.65**				
Manager standards			.25**			
Manager structure				.34**		
Manager responsibility					-.02 ns	
Manager commitment						.48**

The significance of Role

The largest group of participants was nurses (31%), then clerical staff (14%), managers and porters (14% each). Doctors/consultants/physicians (11%), other allied professionals (10%) and 'support' staff (6%).

When looking at satisfaction with leadership the following findings were apparent: High satisfaction with leadership was reported in total by 54.3%

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(n=113) of staff. Although there were no significant differences by work role, it can be seen that consultants and doctors reported the highest satisfaction (74%), followed by managers (61%). It can be seen that clerical workers had the least high satisfaction (41%), followed by 'support' staff and other allied professionals (54%). This is significant in terms of the hierarchy within the organisation – the higher the position the more satisfied one is with their leadership.

Table 11: The significance of role and satisfaction with leadership

	n	% positive responses about satisfaction with leadership
Managers	28	60%
Doctors	23	74%
Allied professionals	22	54%
Nursing	65	49%
Support staff/Assistants	13	54%
Clerical	29	41%
Porters/maintenance	28	57%

A further examination of organisational dimensions according to role using a one way ANOVA, revealed the following:

In all there were large differences between respondents in terms of their role, however only two scales exhibited differences which reached significance. The first was 'commitment' – doctors/consultants were found to rate significantly higher than allied health professionals on this scale (mean difference = 2.86) ($p < .01$).

The second was 'recognition' – it was found that doctors were much more likely to rate higher than clerical staff on this scale (mean difference = 2.41) ($p < .01$). Both these findings were apparent even after using the Bonferroni correction.

Comparing doctors (all grades) in Trust 1 and Trust 3

An examination of the responses on the item looking at 'satisfaction with leadership' amongst doctors revealed that doctors at Trust 1 (n= 13) had lower satisfaction (Mean = 3.38, std = 1.38) in comparison to doctors at Trust 3 (n= 10) (Mean = 4.20, std = .42). This difference (.81), whilst small, was found to be approaching significance (t = -2.003, p = .06).

While it is not possible to make an objective comparison between doctors from Trusts 1 and 3 from the qualitative data, there is more evidence in Trust 3 of doctors being both emotionally engaged with both junior doctors and other members of multi-disciplinary teams than in Trust 1 and with distributed leadership. As will be evidenced in Chapter Six doctors and other staff considered 'management' as bureaucratic and distant rather than engaged.

Gender

There were no differences between men and women's scores on 'satisfaction with leadership' (t = 1.71, p = .08).

When examining differences between men and women on the organisational dimension it was found that only one dimension, 'recognition', was perceived significantly differently (t = 3.42, p<.001). Men perceived there to be greater 'recognition' (mean = 9.55) compared to women (mean = 8.13). All other dimensions were not significantly different (see Chapter Eight).

When examining the gender differences on managerial dimensions of the OCS there were trends approaching significance in terms of differences between the genders on managerial dimensions, but these did not reach significance when multiple comparisons were taken into account:

Manager 'recognition' (t = 1.91, p = .06)

Manager 'responsibility' (t = 2.10, p = .03)

Manager 'standards' (t = 2.33, p = .02).

5.3 Conclusions

The difficulty obtaining data across all three participating Trusts has not limited the value of using the OCS to triangulate the qualitative data, particularly because a) the OCS gathered information from staff groups who were not represented in the focus groups, shadowing or story-telling

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interviews and was able to identify generalisable predictors of satisfaction with leadership and management practices, and b) the OCS data captured information from specialty groups outside those involved in the participating Units from which qualitative data was collected.

What emerged here was that on the whole, the same climate variables are important in predicting satisfaction with leadership. Within the organisational domain these are 'support' and 'recognition' while predictors of 'satisfaction with leadership', within managerial practices, are manager 'support', 'commitment' and 'structure'.

Overall, therefore, 'satisfaction with leadership' was highly accounted for by manager 'support', manager 'commitment' and organisational 'support' – i.e. these were the 'ingredients' in this sample which were highly related and were able to predict satisfaction with leadership. This suggests once again that managers/leaders were effective if they engaged with followers and that organisations that supported distributed leadership and emotional engagement were more likely to support effective leadership (see Chapters Four and Six in particular).

In terms of role, the higher the position in the organisational hierarchy the more satisfied a person was likely to be with leadership. This was not necessarily the case though across all organisations in the study. The exploration of the case studies in Chapter Seven – where authority and leadership are discussed – reveals how some of the more senior leaders in organisations found themselves to be highly dissatisfied with leadership in other sectors of their Trust, if there was resistance or negligence of their authority.

Differences in gender were only apparent in terms the organisational dimension 'recognition' – it was only on this scale where women scored significantly lower than men. This may say something about equal opportunities and equal pay for equal work, but it might also relate to perception of 'recognition' between women and men discussed and exemplified in Chapter Eight below.

The overall importance of constructs such as 'support' and 'recognition' across the climate of an organisation, and management practices which demonstrate support and commitment, provide further evidence of the importance in engagement and (probably) emotion (including EI and SI) in an organisation.

6 'Organisation in the Mind': Transmission of Leadership and Organisational Context

6.1 Introduction

Leadership in any organisation is understood in a specific context by those involved as either leaders or followers, and as shown in Chapters Four and Five concepts such as satisfaction, support, responsibility, vision and communication among others are described and evaluated within a cognitive or mental framework within which the organisation itself is understood. It is through making sense of the organisational context that leadership and followership may be enacted and transmitted.

We saw how members of organisations *necessarily* hold in their mind fantasy/imagined understandings or images of the *system* (Morgan, 2006). This informs how they work in, relate to and talk about their organisation, based on their perceptions of their own and others' place and role within the system. For example, it is common to hear employees talk about how 'you can never get management attention in this company' or 'we are all dedicated to putting patients first here' (Armstrong, 2005; Morgan, 2006).

Similarly, the participants who completed the OCS held a view of the leadership and management in their organisations, in order to think about the various ways in which their work was recognised, supported and so on both generally and by their managers. While the focus in that case was upon on measuring the impact of organisational climate and thinking about a relationship with a specific manager, those who completed the survey would have had to hold a perception of what was happening in their department and the Trust overall.

This is apparent in what follows particularly in the ways 'management' is discussed and taking account of these perceptions provides some evidence about the ways in which leadership is transmitted in these particular organisational contexts and in general. The 'organisation in mind' then involves:

- An 'image' of the organisational structure and relationships within that structure
- A sense of your own role and place within it
- An emotional component
- An awareness at a conscious and/or unconscious level of important information below the surface

6.2 Organisation in the mind

The concept of the 'organisation in the mind' was a model developed originally in the early 1990s by organisational and group relations consultants working at the Grubb Institute, the Tavistock Centre and the Tavistock Institute of Human Relations, to refer to what an individual perceives mentally about how organisations, relations in the organisations and the structures are connected. *"It is a model internal to oneself ... which gives rise to images, emotions, values and responses in me, which may consequently be influencing my own management and leadership, positively or adversely"* (Hutton, Bazalgette and Reed, 1997, p. 114 quoted in Armstrong, 2005, p. 4).

In other words, when we talk about our colleagues, guess what the senior management are doing/going to do and have fantasies about how well we fit, or don't fit, into the structure or system we do so in the context of the organisation we 'hold' in our mind which may or may not relate to that which other members of the organisation hold (Pols, 2005).

Organisations are experienced cognitively and emotionally by their members when they think about how their organisations work and are structured (see Lewin, 1947; Armstrong, 2005; Morgan, 2006). As Stokes (1994) explains it, everyone carries a sense of the organisation in their mind but members from different parts of the same organisations may have *"different pictures and these may be in contradiction to one another. Although often partly unconscious, these pictures nevertheless inform and influence the behaviour and feelings of members"*. (p. 121)

Hutton (2000) talks about it as *"a conscious or pre-conscious construct focused around emotional experiences of tasks, roles, purposes, rituals, accountability, competence, failure, success"* (p. 2). Morgan suggests that an organisation may serve as a 'psychic prison' in that the:

...patterns and meanings that shape corporate culture and subculture may also have unconscious significance. The common values that bind an organisation often have their origin in shared concerns that lurk below the surface of conscious awareness. For example, in organisations that project a team image, various kinds of splitting mechanisms are often in operation, idealising the qualities of team members while projecting fears, anger, envy, and other bad impulses onto persons and objects that are not part of the team (Morgan, 2006, p. 226).

Some of this is apparent when talking to NHS staff about the leaders at various levels of their own Trusts and the NHS overall as was seen particularly in Chapter Four.

6.2.1 Organisation under the surface

So, when the respondent immediately below talks about the leader who has a 'really good understanding of the organisation or team' what exactly does that mean? How does that understanding come about? What do the team hold in mind about that particular leader?

Leadership is someone who has a really good understanding of the organisation or team, erm where it's going and where they imagine it to be going, so that sort of vision as well for their team, I think. (Lead Clinical Non-medical Health Professional, T3)

This respondent, referring to the (frequently used) concept 'vision', also identifies this with the *imagination* the leader holds about where the organisation is going. This is not simply a matter of guesswork. It is an intellectual/cognitive and *emotional* sense of an organisation. Indeed to take this slightly further, as Gabriel and Schwartz (2004) propose "... *what goes on at the surface of an organisation is not all that there is, and ... understanding organisations often means comprehending matters that lie beneath the surface*" (Gabriel and Schwartz, 2004, p. 1).

Although not necessarily (in fact mostly not) made explicit, even the most clear thinking senior members of organisations hold an image of the organisation in mind, expressing their fantasy/belief/perception of the organisation based on conscious and unconscious knowledge (Halton, 2007; James & Arroba, 2005). So for instance for this CEO leadership is understood emotionally as it is:

... about the feel of the organisation and what it feels like in terms of how it delivers patient care. Yeah, erm. I can best illustrate that, and interestingly we were thinking about this earlier this morning, so as a group, the executives, we were talking about it. When you walk onto a ward a hospital ward and there is real leadership on that ward, you walk in and there are a number of signals that are given off, which give you a feel. Erm the place looks organised, it has a welcoming feel, the nurses on the ward and the clinical staff greet you as they come into contact with you. They know you from the previous interactions that you have had and when you sit there and listen to what is being said on the ward they will know that the patients, the visitors on the ward, the families that are coming in the junior doctors who are in there in that environment and all of that has a feel²⁶ of a well led ward. (CEO)

²⁶ Respondent's emphasis.

The environment of the well led ward (unit or organisation) is implicitly and unconsciously identified by all who engage with that organisation. The staff communicate effectively (visually, verbally and emotionally) so that the information required is passed on through managers, clinicians to colleagues, patients and relatives. This account, which preceded the extract that focused on strategy, directed to the best patient care for the greatest number of patients, expresses his ideas at an *emotional* level. He also suggests his senior colleagues agree with this. Signals are 'given off', you can 'feel' the organisation and how it delivers patient care and there is a 'welcoming feel'. He also talks about 'empirical' evidence in that staff know the patients, the ward looks organised he remains convinced that there is a 'feel of a well led ward'.

From a slightly different position, a deputy CEO quoted below also holds in mind the fantasy that a manager might think that they run an institution but that such a fantasy might get the manager into trouble. He is suggesting a vision of an organisation in which a manager has very little control, and proposes the need to gain a sense of *reality* by recognising this and taking responsibility for this organisation (Hirschhorn, 1997; Porter-O'Grady, 1995). His perception, again which has an emotional component, is one of a stressful contradiction – responsibility without power or control (de Vries, 2000).

The minute, as a manager, you start to think that you do [run the service without accountability]... erm then you're in trouble. Unfortunately you have still got the accountability for the service but you have very, very little control so it's a whole different leadership and managerial skill that is required I think in terms of recognizing that you have no control over what happens you know across this organisation across the N,000 beds here at [Trust], the thousands of people that go through the organisation everyday, what happens to them is completely outside of my control but if anything goes wrong it is absolutely my responsibility. And that is quite difficult.
(Deputy CEO, T 1)

6.2.2 Structure in the mind

Most recently Laughlin and Sher (Laughlin & Sher, 2010) take up a version of this concept which they name the 'structure-in-the-mind' in their analysis of developing leadership in social care. They reassert, in their model, that not only the local stakeholders (staff and service users) have a sense of the organisation in the mind when considering, for instance, a particular Trust, but the range of stakeholders includes government bodies and service commissioners (in the round). They propose an inter-relationship between perceptions of communications from services (e.g. 'that you [management] don't listen and/or understand') and perceived communications from 'Head

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Office (or government or other bodies that control resources and practices) which include for example 'just do it' 'we know better' and 'be rational'. (p. 9)

What is significant here, in the context of NHS leadership, is that the organisation and/or structure *in the mind* is where the leader and followers 'meet' emotionally as, similarly, do the various levels of leadership and governance bodies. It is a kind of 'virtual' space.

An example of this structure in the mind might be seen through the increase in stress for NHS employees detailed in a recent report by NICE (the National Institute for Clinical Excellence²⁷) where it was revealed that staff absence caused by work related stress costs the UK over £28 billion. It was proposed that a poor working environment characterised by bullying and poor management was at the heart of this problem²⁸ (Edwards & O'Connell, 2007). In a context where there is distributed leadership and a highly trained professional, multi-disciplinary workforce, such mismatches in how to run organisations and departments that lead to staff stress in these ways (e.g. being bullied and bullying) evoke questions about what is happening in the space between those who plan, govern and resource NHS Trusts and those who carry out the work. The emotional elements of leadership and followership relations seem to be neglected to everyone's disadvantage.

The idea of the organisation in the mind raises important questions of how leadership (good and bad) is transmitted across the NHS and its Trusts (Harrison & Carroll, 1991; Walsh & Ungson, 1991). Organisational cultures and climates are reproduced over time despite the coming(s) and going(s) of CEOs. However, organisations also *adapt* and *evolve* as a response to changes in leadership and outside influences (Morgan, 2006).

In what follows we explore the characteristics of the organisations studied here that facilitate or hinder the transmission of leadership through the Trust as a *system* through which culture (e.g. principles and values about leadership) might be transmitted (Hatch, 1993; Schein, 2004).

²⁷ An organisation established to oversee and provide guidance on clinical practice and cost and clinical effectiveness.

²⁸ See news.bbc.co.uk/2/hi/health/8343074.stm and NICE web-site which has a power-point presentation.

6.2.3 Transmission of leadership and Organisational Contexts

What is held in mind about an organisation is often influenced by the formal and informal networks (Balkundi & Kilduff, 2005, 2006; Goodwin, 2000) which characterise complex adaptive systems. Network cognitions in the minds of leaders are embedded in the whole organisation and the inter-organisational linkages formed by leaders as representatives of organisations (Balkundi & Kilduff, 2005).

The context of the NHS seems to have become increasingly complex and chaotic (Currie et al., 2009) which, coupled with a sense of widespread unethical managerial practices, has raised questions about how leadership practices are transmitted through NHS organisations (Bowie & Werhane, 2005; Collier & Esteban, 2000; Huston & Brox, 2004). Bullying and poor management are in part at least a consequence of not taking the emotional context of organisational life seriously (Ashkanasy, Jordan, & James, 2003; Cocco, Gatti, Lima, & Camus, 2003; Johnson, Cooper, Cartwright et al. 2005; James, 1999; Hutchinson, Vickers, Jackson & Wilkes, 2006).

While there is no excuse for bullying or any other unethical management practices, it is necessary to understand what precipitated the relatively recent change in culture which has exacerbated (reports of) bullying. One factor has to be the extent to which top-down, politically driven changes have been forced through the NHS system and other public institutions and the impact that the drivers of these changes have upon the senior levels of management consciously and unconsciously (Christensen & Laegreid, 2003; Dent, 2005; Gabriel, 2004).

These recent developments have influenced the psychological and emotional aspects of working in teams, groups and organisations (Liden & Antonakis, 2009; West & Anderson, 1992) and by implication influenced possibilities for innovation in leadership and the authority of leaders and workers (Lewin, 1947; Miller, 1993; Carter, Garside, & Black, 2003; Hirschorn, 1997; Fineman, 1994, 2000; Payne and Cooper, 2001; Vince, 2002; Carter, Garside, & Black, 2003). Understanding the *context* of leadership, therefore, has become increasingly important as has the need to understand how that context is part of a *system*.

Post industrial (or postmodern) systems (Rose, 1991) have been reconsidered (or 're-described') relatively recently as 'complex adaptive systems' (Collier & Esteban, 2000; Dooley, 1997; Schuster, 2005). Systems that are complex because of multiple interconnecting relationships are liable to evolve through making new connections that increase their complexity (Collier & Esteban, 2000). In the NHS, even though change is structurally driven, the (perhaps unforeseen) consequences of changes have meant that instead of a command-and-control, top-down hierarchies where in particular

clinicians such as consultants and matrons had previously been seen as 'gods' (as with Sir Lancelot Spratt and Dr. Gregory House see Chapter Four) distributed leadership, networks and different statuses attributed to individual Trusts (e.g. Foundation Trusts with relative independence, Mental Health Trusts which have social care and NHS staff and diverse management practices) have evolved within different structures at all levels for coping with service delivery (see Chapter Nine).

6.3 Open systems theory and boundary management

An organisation that *evolves* like an organism and adapts to its environment necessarily has *porous boundaries* so that it can 'take in' and 'put out' beyond itself. This kind of organism is one that changes, develops and grows. A closed system may feel more secure in that it may not have to accede to unwanted influence or demands, but without taking in and providing for the world outside it will atrophy as with any other closed (minded) system (Morgan, 2006). In this way images and cultures of leadership from outside the boundaries might influence the development of leadership practices e.g. data and ideas from education (Currie et al., 2009; Gronn, 2000; Lumby, 2003)

Systemic thinking is a framework, or tool, for observing the way organisations behave (Schein, 1985; Lewin, 1947; Campbell et al, 1994) which evolved from General Systems Theory, (von Bertalanffy, 1956; Miller and Rice, 1967) and focuses upon concepts related to organisational structure particularly 'task', 'role', 'authority' and 'boundary'. There is also a psychodynamic part of the systemic thinking analysis which links with the conscious and unconscious emotional consequences of the systemic properties and the impact of social and personal factors on the functioning of the organisation (James and Huffington, 2004; Laughlin & Sher, 2010)²⁹.

Morgan (2006) identifies how knowledge and power are accessed and maintained through control of organisational boundaries. 'Boundary' is the term used in open-systems theory to describe the interface between different parts of the organisation and the organisation and the outside world. In the case of the NHS this is the physical boundary to the, for example, hospital building, the wards, the web-site, the reception desk, the

²⁹ This issue is further discussed and explained through object relations theory based on the works of Melanie Klein, Elliot Jaques and Isabel Menzies-Lyth which is outlined in detail in Chapter One and operationalised in the description of the role of obstetricians' anxiety in the delivery of patient care discussed in this chapter and below in Chapter Nine).

telephones, e-mail and so on and also between the different roles such as out-patient/ in-patient, staff /patient, clinician/manager and so on. Most leaders in organisations have the knowledge and abilities by definition to manage and negotiate those boundaries. For example, the senior managers relate to government/NHS/DoH in ways that junior nurses do not, but the senior staff are charged with having to manage the boundaries using knowledge and influence across the boundaries – inside with the staff and patients and outside with government and patient pressure groups. Moreover, as evidenced during the conduct of this project, hospitals merge into Trusts and the porosity or opacity of the boundaries between the different organisations that have come together are central to the functioning of leadership at most levels (see Chapter Seven where the limits of authority are discussed in this context).

Stating this in a slightly different way, this approach to the 'organisation in the mind' takes the *personal* (conscious, pre-conscious and unconscious) level of thinking and links it to the *system* in which that person works (systemic thinking). As any organisation comprises systems (with boundaries, in-puts and out-puts), groups and individuals, it follows that a person's experience of an organisation and *experience of themselves* in relation to others who are in the same organisation make up the culture, climate and everyday dynamics of any organisational context. Thus, our respondents' sense of the 'organisation in the mind' is a valuable concept for understanding how leadership relates to service delivery.

6.4 Images of the organisation

In what follows we explore some of the images 'held in mind' by staff across the three Trusts particularly examining the impact of the organisation in the mind on working collaboratively and the influence of this on service delivery and the quality of patient care that results from staff relations and effectiveness.

To begin, we focus on two specific examples that characterise much of what was said by staff across at least two Trusts:

- images (and fantasies) held about 'management' which highlight the construction of 'authority' in the system and its impact on patient care
- images (and fantasies) held about the 'others' (e.g. colleagues in the same Trust but on a different site or a different Unit) which brings boundary management into play
- how these images (and fantasies) facilitate and hinder the transmission of leadership and service delivery

We employ a critical discourse analysis (CDA) approach to the meaning and processes of leadership and organisation exploring how the organisation/system *looks* to the participants and how this in turn impacts upon the system of providing care for its patients.

6.4.1 'Management' in the mind

As in many organisations, rhetoric about 'management' abounds particularly played out as a 'them/us' dynamic as we demonstrated by separate means in Chapters Four and Five. Furthermore, among management, rhetoric about their own practices and role in relation to that of the workforce is equally active (Alvesson & Sveningsson, 2003a; Borins, 2000; Kuokkanen & Katajisto, 2003).

There is general cynicism across all the respondents who defined themselves as non-management *about* management. So for example: *"And you find that when there's a crisis that's when you find your management team will come down and put a policy in place regardless - like the swine flu thing" (Junior Midwife)*. So here managers are described as paying no heed to the routine tasks of the organisation (Cummings, Hayduk, & Estabrooks, 2005b). They are portrayed as simply responding to a crisis and (presumably following orders from the overall leaders of the service). Thus, managers are not seen as managing the boundaries between the Trust and those in overall charge of health care operating outside of the organisation (i.e. at the level of government) effectively for the facilitation of service delivery (Buchanan, Abbott, Bentley, Lanceley, & Meyer, 2005; Kane & Patapan, 2006). This resonates with Laughlin and Sher's (2010) analysis discussed above.

A focus group from one Trust proposed a particularly strident view of management and its relationship to wider bureaucratic imperatives which they saw as going against service delivery and effective patient care. The medical staff here were proposing that management was both absent, in person and from taking responsibility, while also being all controlling of medical care through instigating seemingly pointless rituals which seemed to maintain boundaries.

Consultant: There is a burning example [here] of bad leadership which is the absence of figure heads. Management can never be found which is frustrating.

Registrar: I've been in theatre now for two weeks and two cases were dropped. The doctor has to apologise to the patient but they are the ones [the doctors] who would like to continue. Management say 'NO it is lunch'. They should be the ones taking responsibility for telling the patient but the

doctor has to go back to the patient and look like a donkey saying 'I'm sorry I can't do your operation today'.

The members of this group, who clearly shared the same or similar images of management and its 'idiocy', went on to decry management incompetence across all staffing issues, and the registrar continued, imitating the management in a silly voice: "*he has to stop, that's the rule*" making it very clear that management was perceived by this man and others in this focus group as inflexible (and rather stupid). Here these participants are expressing total lack of faith in the authority of those who manage (rather than lead) them, although in fact it seems that despite this, they abide by the rules which suggests that there is a belief that at some level the managers in question here derive authority from somewhere higher up in the hospital system or from the NHS leadership beyond.

One factor to note, of course though, is that the power of the story in the focus group may belie the views of the whole group in that some would be silenced by the fear of disagreeing with their colleagues (Asch, 1956; Foucault, 1982). Furthermore, the articulation of the behaviour of management in these cases is *actually a form of leadership* and as such might influence the views of the focus group (and subsequently other staff) (Avolio et al., 2004; Pye, 2005).

From a different focus group, this time with junior midwives, it was apparently *giving up their authority* for a while that gained managers some important respect. For instance when a crisis occurred in the organisation (in this case a fire) then managers seemed to behave very differently and even impressively:

1³⁰. Yeah and then the managers - the bed managers - were carrying chairs and everything and you just had people on beanbags on the floor and everybody ...

2. I wasn't here that day I missed that.

1. Well it was a bit stressful but everybody just mucked in and people were just carrying people here and you know....

Q: Well that's really good if everybody even the managers mucked in.

1. Yeah you find in a crisis the managers do come out, the leadership the leaders come out and they have to come out.

3. And people were coming in from home to help that day.

³⁰ The number denotes the speaker.

2. *Why didn't they phone me? I don't know but never mind ...*

1. *No you find that in that kind of crisis everybody from execs downwards pulls rank and everybody comes in and helps out (T 2).*

So the image here is that a crisis brings out the best in everyone (and the boundaries between the groups of staff become temporarily porous). In times of crisis then the tasks (i.e. patient care and running an effective hospital) overcome other elements of potential discord and conflict such as the 'rank' order of 'execs' bed managers and others such as clinical staff.

There are also other times when it is possible for management to be seen as 'on side' as indicated by another nurse in a different site. For example:

Erm ... our manager, she is quite approachable. And she is willing to discuss things with you if you don't feel that something is right and you question it or question her. She is willing to sit down and explain it and sometimes she will say 'I'm not happy with things as well, but the people above me this is what they have decided, this is what we have to go along with. It is government guidelines or targets have to be met'. Although she might feel the same as us she explains why we have to do things in this way. And I think she is very approachable.

This manager above, demonstrates her willingness to communicate and be 'visible' but clearly she has adopted a them/us strategy similar to those who 'oppose' management by positioning herself as managing the boundary from the side of the clinician/nurse's while also at other times presenting herself as mediating between 'government' and clinicians and managing that boundary too (Laughlin & Sher, 2010).

In the example described here, this seems to 'work' as evidence of good leadership for the nurse telling the story, but it involves the manager in question in potentially difficult dynamics and conflicts in her role.

From another focus group discussion that included doctors and nurses the organisation in the mind experienced management as absent and failing in their responsibility (Hogan & Kaiser, 2005):

Absence would be correct. Management are often not there. They need to take command of the situation. Here is the reasoning – management don't take responsibility for their actions and there is a severe lack of managerial leadership.

This is significant in the concept of the organisation in the mind when juxtaposed with the account of the same organisation by the CEO who saw her/himself as seeing good leadership as manifested in:

Visibility in terms of being seen around the place, so go out wandering around the wards. The best part of the role, quite candidly is, the best part about being the chief executive is, you can go out and talk to patients, and that is what I really kind of enjoy. ... so there is something about my presence and my profile. There is also something about being very clear and repeating the message often enough so that it is clear in the organisation about what the organisation is there to do.

So, within the same organisation there is an image that management is invisible and absent, while senior managers see themselves as 'being seen around the place' constituting an important part of what they believe they do and that they see as being vital for effective leadership and patient care (Laughlin & Sher, 2010). Both sides agree on what would be good leadership but each 'side' has a different vision of what is happening in 'reality' (Alvesson & Sveningsson, 2003a; Buchanan et al., 2007).

In the absence of a shared vision of an organisation working together or a set of clear guidelines about how 'this organisation works', there seemed to be a wish from a deputy CEO of another Trust for a hero/charismatic leader to put things to rights and potentially cross the managers/others boundary (Ladkin, 2006; Laughlin & Sher, 2010).

Erm, this is a very complicated organisation, what we haven't got right is we haven't got a bible that says this is how this organisation works and I think that's a problem so, ((1)) so ((1)) it's very easy for ((1)) despite what I've said about how difficult it was to be a leader, erm and the personality of the individuals who are at the top of the tree, makes an enormous difference in how an organisation I think behaves and works. There is a great tendency if you are a very good individual for an organisation to be based around you and when you leave there is a problem, erm and so the best kind of leader, yes they have that aura of it's about them, of course that's what people look up to but they also put in place processes so that things can happen.

This is a view from the top of the organisation which is expressed at least in part as a vision of a (desirable) mechanistic model – an organisation with a 'bible' about how it works - although this participant also desires a charismatic transformation on the part of leaders.

The hero leader would be a 'very good individual for an organisation to be based around you' and also to have 'an aura'. The metaphors in this extract proliferate – the need for a 'messiah' to save the organisation but also a sense of *dependency* – that 'people look up to' this type of leader who (it would appear) single handedly will be able to put processes in place for things to happen. The vision here is though one in which the system is defunct, stagnant and closed.

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6.5 'Out of mind': leadership and the 'other'

Organisational change is frequently resisted, often because of the disruption to individual's *sense of the system* and their place within it (e.g. Hoyle, 2004). It is also related to the emotional involvement many people have in their work and the way they perceive they are valued within (and how they themselves value) a familiar structure and context (Bovey & Hede, 2001; Zoller & Fairhurst, 2007).

Emotional labour, as discussed in Chapter One, is a key feature of the work that many people do, and is an integral part of any job, but particularly so in an institution of the NHS (see for example Gabriel, 2004). Different occupations require different types of 'displays' and following Hochschild (1983) emotional labour requires adopting emotional displays and attitudes appropriate to the role.

Clearly in hospital work all staff have to expend emotional energy on 'caring' and 'kindness' but it is also the case that working in the NHS, with its many changes for (perhaps) better or (maybe) worse, also requires the ability to be able to 'move on' i.e. mourn the loss of the old structure, sets of relationships etc. and embrace the 'new' with some degree of enthusiasm. The failure to do this (or recognise the need to do this) results in emotional resistance to changes and hanging on to the old systems as long as possible which might defeat changes that improve service delivery and benefit patients (Hughes, 2005).

6.5.1 Leading change and transmitting leadership

In one particular case a senior clinical manager Gerald³¹, was charged with integrating clinical practice across two sites, each of which had their own different ways of working, and different relationships to the boundaries between each other and the clinical teams. While the one (where he was based primarily) had accepted quite radical changes to its organisation, the other (apparently) did not "*..because the sort of ethos and the sort of personalities of the two sites are in the background. They are completely different*".

Gerald's view is based on a reality in that the two sites are structured differently, look different from each other in that the buildings are from different eras and in different styles, and they are in physically different locations. They also serve different demographic populations and have different histories. However, Gerald sees the organisation of the different

³¹ Gerald's leadership is discussed in detail in Chapter Seven.

sites as really being about 'ethos' and 'personalities' which must be in the mind (mostly) as there is a system of authority and responsibility in place across the Trust (via the CEO and other senior people including Gerald) that takes up authority and leadership to ensure consistent practices and organisational change.

Thus, we need to ask why one Unit has (apparently) taken new ways of working on board with some enthusiasm while (apparently) there are barriers preventing the other one doing something similar.

For Gerald, management of the boundaries between in-patient care and primary care teams was the source of a key difficulty:

There are groups of people here who are completely behind the concept that we mind about – integration of primary care – joint working between the Trust and the Primary Care Trust. Some departments work extremely well and are keen to move forward and although we do have our minor difficulties - generally there's one or two departments who are completely against change and erm resistant to anything new. Just like any other organisation where you know you are going to get the type of people who actually make life extremely difficult for you and despite that we've proven how much better our system is.

In the extract above he moves from talking about the other *site* (as a whole system) as being the 'bad' resistant one, to identifying *individuals* on his own site within the 'good' system as making life difficult for him personally despite evidence (he and others have provided) to show how integration works better. This respondent's organisation in mind shifts depending on how well one part of the system fits with his particular vision of a good organisation. This *splitting* (see Chapter One) is a mechanism (unconscious) for preventing the overwhelming feeling that can come from persecutory anxieties (Jaques, 1953; Jaques, 1960; Menzies, 1970). In a management role where (for some reason) authority is being undermined, then the resurgence of persecutory anxiety might be dealt with by splitting of the 'bad' site and comforting oneself with the knowledge of a 'good' site where the organisation works as this leader/manager might wish it to do (Laughlin & Sher, 2010).

6.5.2 Resisting change

In the case of a medical secretary, with over twenty years experience of working in the same hospital, the thought of change in the structure of her working relationships was upsetting. She began engaging with the interviewer by talking about how busy she was and when asked if there was any particular reason why she was busy at that particular time she went into an explanation about organisational change. *"It's just generally busy, but we*

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are in teams now, erm couple of them [doctors] are away and one or two have come back, catching up with everything". It seems as if the teams were the problem for her because previously (and for many years) "...it was one secretary to one consultant and his team. Now for instance today I'm actually taking calls for four different consultants". She was asked about the new structure and made it clear:

erm ... I don't think it's going to work as well as the previous one. Because I think you'll be dipping in and out of so many different jobs that instead of concentrating on the ones that you do well and controlling your one doctor, it'll be confusing and I think there will be mistakes made because one person is trying to deal with too many parts of too many jobs.

Her perception that her role in the organisation might happily continue as one in which she controlled one consultant is characteristic of the 'comfort' of the closed system where authority, power and the processes of leadership are condensed and held 'constant' by an individual. As seen in Chapter Four also change is not usually welcomed without at least tacit resistance and in Chapter Seven two of the case studies will explore how leaders as potential change agents experience followers' avoidance or challenge to changes in practices and structure.

Changes in working relationships bring anxieties which need to be understood and anticipated by leaders if they are to support staff to position themselves differently in the system. Hoyle (2004, in Huffington et al) suggests that during any period of organisational change there is potential for heightened creativity which might lead to doing things differently and better. However, change also brings about risk, uncertainty and the chance of failure which can evoke anxiety both in those promoting the changes (the leaders) and those who might fear loss of their job and the loss of known ways of working (see Hoyle, 2004, p.87).

6.6 Conclusions

Understanding an organisation and what facilitates and/or hinders leaders to take up their authority involves considering the organisation systemically. That is taking account of the boundary management and how that relates to the tasks, roles and power/authority of those who work or are 'consumers' of its work.

Leading change depends upon ensuring those within the system have a sense of how the system works and an awareness of the culture that might be tested as a reality or not. This means, once again, that organisations which are learning environments and where emotional intelligence is applied, are more likely to respond to authority and less likely to subvert

leadership, thus distributed leadership/responsibilities may be taken up or shared more widely.

7 Leadership, Authority and Emotion

7.1 Introduction

As argued above, leadership and emotion are fundamentally intertwined in the workplace (Fineman, 2003). Leaders who appropriately manage both their own emotions (Goleman et al., 2001), and those of their followers, experience better leader-follower relationships, greater opportunity for innovation, motivation and productivity, a more positive organisational climate and improvement in employee and customer/patient satisfaction (Ashkanasy et al., 2003; Avolio et al., 2004; Hollander, 2009). Such outcomes can be associated with both *transformational leadership* (Bass et al., 2003; Corrigan & Garman, 1999; Currie & Lockett, 2007) and *distributed leadership* (Bass & Steidlmeier, 1999; Gronn, 2000, 2002; Mehra, Smith, L. Dixon, & Robertson, 2006b) patterns.

It has also been suggested that followers' 'dysfunctional' dependency is a consequence of failure of the leader to *engage* on an emotional level with those whom they lead (Alban-Metcalfe & Alimo-Metcalfe., 2009; Ashforth & Humphrey, 1995; Bion, 1961; George, 2000). There are different types of such engagement, e.g. acknowledging emotions, drawing them out, honouring them, confronting them, and deflecting them, but although this idea of engagement has been described as "*compelling on the surface, the meaning of the employee engagement concept is unclear*". (Macy & Schneider, 2008, p.3) Even so, there is a common view that such engagement is desirable for organisations in that it connotes involvement, commitment, passion, focused effort and energy from staff thus demonstrating both attitudinal and behavioural components for an effective workforce. (Macy & Schneider, 2008)

Studies of leadership and emotion have not typically been combined with attention to the 'authority' of the leader (Ford, 2006; Stein, 2007) or indeed to the concept of 'power', (sometimes seen and experienced interchangeably). (Morgan, 2006) A study combining exploration of the relationship of authority to concepts of both 'emotion' and 'engagement' (Hirschhorn, 1997) is particularly relevant to the agenda of the 'post-modern' organisation where leadership is distributed (Clegg, 1990; Tierney, 1996) and the organisation potentially fragmented, unmanageable and diverse.

The authority invested in a particular role, such as the CEO (Chief Executive Officer) or lead clinician may not explicitly engage emotion. However, in an organisation such as an NHS Trust, where leadership styles are, or at least

intended to be, characterised by distributed or transformational attributes, the concept of authority is more closely linked to *personal* authority whereby individuals “..bring more of themselves – their skills, ideas, feelings, and values – to their work. They are more psychologically present.” (Hirschorn, 1997, p.9). Thus for example clinical skills *and* personal investment are *both* required for someone to take up authority in practice as a clinical leaderⁱⁱ.

In this chapter we delve further into the concepts of leaders and leadership, particularly focusing upon leaders with a ‘mandate’ to lead change through their formal *role*. The group of participants we specifically focus upon here includes clinical and non-clinical senior managers and we examine the ways these individuals construct their role, their relationship to ‘followers’ and how their *authority* is taken up, experienced and constructed in their specific organisational context³². Authority has more than one meaning. It refers to the authority (sometimes seen as power) invested in a particular role.

Analysis of relationships between people who work in the NHS is underpinned by both the *interactional* and the (related) *emotional* contexts of an NHS Trust as a workplace (see for example Liden and Antonakis, 2009). This knowledge is particularly salient because on the surface, many of those occupying the leadership roles were inclined (at least superficially) to deny the role of emotion although analysis of their stories, shadowing and observations, following the pre-existing literature on organisational cultures, including those which study health care settings, indicated that emotion indeed plays a key role in service delivery and the ways leadership and authority are experienced and constructed in relation to patient care (Vince, 2002; Gabriel, 2004; Hirschorn, 1997; Huffington, 2007; Obholzer, 1994; Vega-Roberts, 1994).

7.2 Case studies

Three case studies were selected to examine the meanings given to the relationship between ‘leadership’, ‘emotion’ and ‘authority’ in relative depth. Each one was chosen (through discussion among the research team) to be (potentially) representative of a ‘typical’ approach to emotional management which reflected a personal style of authority (or lack of authority). These particular cases raised subtle but crucial questions about leadership, emotion and authority through exposing both the conscious and *unconscious* qualities which can either underpin or undermine a leadership *role* (Bovey & Hede, 2001).

³² In this chapter we focus specifically on the senior staff’s perspectives. Others’ perceptions of senior staff were discussed in Chapter Six.

1. The first leader, Gerald, had an 'authoritarian' manner (Adorno, 1950). That is, he appeared to believe that because he was in a senior position other staff ought to do what he told them to do. He was a senior clinician [for a group of particular services], relatively young, very enthusiastic and held an uncompromising vision of how a good hospital should be organised. He was interviewed once by a researcher, once by a group including the PI and 'shadowed' for two days by the same researcher.
2. Kerry in many ways held a similar outlook to Gerald, only she *believed* that she attended to the emotions of her staff if not her own. Kerry was Gerald's immediate boss and evidence from the interviews, shadowing and observations in both cases indicates they did not always work effectively together. Kerry was interviewed twice. Once for information as a key informant by two researchers and the second time by the PI and a researcher together. She was also observed by a researcher for an hour.
3. Quentin was a Clinical Director. He made overt efforts to weigh up the emotional 'risks' to his authority and thus seemed more able to engage with the 'followers' (and thus probably survive) in the *role*. At first he was reluctant to take part in the research directly (although he supported his colleagues' participation) but eventually agreed to be interviewed. Two researchers met him before the interview conducted by the PI, in his role as a key informant and observed him and the senior colleagues in their shared office space for about 30 minutes.

7.2.1 'Gerald'

Gerald held a clear vision of how a good hospital should be organised for the benefit of patients. What he appears to find problematic is managing staff who (for whatever reason) have a vested interest in different styles from those he advocates of patient care, working with colleagues and patients, and/or visions for service delivery.

The following extract is from the shadowing of Gerald.

From the two days spent with Gerald it was very clear that he believed that he was one of the main 'leaders' in the Trust and that he had a strong relationship with the middle and upper managers (including the CEO) which he uses to his advantage especially during long discussions regarding the 'new vision' (which appeared to be very much his vision) for the relationship between the two sites.

Gerald did indeed appear to be one of the main leaders. However, it was unclear whether the power and influence in this leadership role was all smoke and mirrors. Does Gerald play the role of the Wizard of Oz? Does he

think he has more power and influence than he actually has? Does he really have a good relationship with the Trust managers and Chief Executive?

The interview with Kerry (the CEO) made it apparent that she did not consider that he was one of the main leaders in the Trust and it was indicated that she didn't think much of him, and that their relationship might have been fraught.

Discussing the researcher's notes some weeks later, one thing that did emerge was that Gerald 'confused' those around him and was apparently unaware of how others saw him and how far his personal authority actually stretched. Hirschorn (1997) in a study of authority in contemporary organisations has suggested that leaders are no longer the old-style authority figures and because of changes in technology and economics "... bosses can no longer project the certainty, confidence and power that once facilitated employees' identification with them when they [employees] were young and dependent. This is why people are so disappointed in leaders today but also so unforgiving of them" (p. 9).

Gerald, although he had a clear management role and mandate to make the changes he focused on, did not get identified by his colleagues as fulfilling the vision of a leader as there is an implication in the observation extract that his authority may have been achieved via 'smoke and mirrors'. Furthermore his appointment (and that of several of his close senior colleagues) predated the appointment of the CEO. Several questions are raised here by the researcher about whether Gerald has been capable of taking up authority when the CEO takes a stance that at least tacitly opposes him. *This has to remain unanswered in the specific context of this Trust but is an important matter to consider in regard to distributed leadership.*

Gerald prefers to position himself as 'evidence-based' (and therefore up-to-date) dealing with practical matters and not positioning himself as an *emotional* leader. In the interview below, thus, he talks about making difficult decisions but paradoxically, almost from the beginning he focuses in upon dramatic inter-personal conflicts - talking about 'facing up to a fight' and declaring that the Trust 'absolutely' does not have the kind of leadership that enables 'direction' or 'vision'. Does this mean the CEO? Does this mean consultants? It may not even be intended so specifically perhaps it is an expression of general frustration that his vision is not shared.

While on the surface he claimed a good sense of what leadership is about he is also revealing in his talk, the opposite position. Taking a team or department in the direction of the vision and making difficult decisions is for him about a relationship with (not) being 'scared' or further down in this extract, (not) 'afraid'.

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Gerald: Erm...good leadership, err having the ability to make difficult decisions, err, not being scared to face up to a fight...erm...being able to be clear about errr, the direction or vision of the trust, where we are going and be able to errr direct your team into the position that everyone errr everyone is meant to be going, erm I think

Q: Yeah...and do you see that kind of leadership in this hospital?

Gerald: No, absolutely not

Q: No? And why, why not? What's the problem to that kind of...

Gerald: I think that in the past, we .. we have been afraid to face up to a fight, and we have shied away from it.

Q: Yeah

Gerald: From making difficult decisions, and err, and we've let too many people get away with undermining the overall plan that we have...'cause we all know how to deliver excellent healthcare, we all have our views of how this is going ahead, but err, and the grand picture has been undermined by a few, and we've not been able to really face up to those people

Gerald believes that while everyone knows how to deliver 'excellent healthcare' a few have undermined the/his 'grand picture'. He also identifies with a group who support his particular vision while not expressing empathy with those who do not. As the interview progresses, Gerald berates the power (rather than leadership qualities) that consultants have had in the past suggesting that they *undermine* changes that he clearly and sincerely holds about what constitutes good patient care.

Gerald however does reflect on what he is being asked as evidence by his suggestion later:

I don't know about what makes a good [leader]...you know, its difficult to say what makes a good leader...because I'm not sure I'm a good leader, because the qualities that I feel perhaps are necessary, I don't perhaps have ...one of those is patience perhaps...err, being able to tolerate people's err err, err stupidity in a nice way, is essential I think, but I don't have that, I don't think...being, having the ability to listen, err, err, err and not judge or criticise too quickly is very important, but then, taking everyone's opinion into account, but then at the end of all that being able to still go your own way, and persuade everyone else that it was their idea in the first place ... Well, I have certain qualities which help me get the goals that I like...erm...whether I have everybody behind me.

This is one (although not the only one) of the more (paradoxically) emotional interviews from among the senior managers in the study. Gerald

recognises, quite passionately, that a leader needs followers and has to be tolerant. Gerald, though, cannot help declaring that those who presumably hold differing opinions to him to be stupid. He also said later in the interview that he believed many people were *against him* when he was appointed to the senior post as the Trust itself changed shape. While he would not it seems position himself as emotional (rather he sees himself as evidence-based) he chooses to talk in emotive ways and reading and hearing what he says is quite exhausting as he uses all his energy in trying to take the organisation where he believes it should go, but through lack of emotional intelligence, many a time he draws a blank.

Gabriel and Hirschorn (2004) might describe Gerald, at least in part, as a 'narcissistic leader' in that he liked to be told he is important and influential but he is also potentially a bully and authoritarian in style (Adorno, 1950). He clearly found criticism intolerable and split off the 'bad' (i.e. the consultants who didn't go along with his changes from the 'good' i.e. the 'we'). Gerald has a dream which he is determined to make into a reality, however, there is a "*delicate balance between feelings of omnipotence and feelings of impotence which leaders must achieve, in order to enhance the chances of turning vision into reality*" (Gabriel and Hirschorn, 2004, p. 144). These authors argue that narcissistic leaders have a particular aptitude for getting this balance wrong and "*Even if they are talented in their field, their judgement increasingly fails them. This is compounded by the collusion of their followers*". This may be Gerald's 'we'. Gerald fails to connect emotionally with his (potential) followers from outside his close-knit 'we' group even though there may be some admiration for his clarity and link with the NHS mandate. This means, in effect, that important changes which may well be for the benefit of patients in the contemporary NHS are being (effectively) resisted because of Gerald's style of leadership. Gerald also appears to have little idea of how others might experience their worlds, including their emotions.

This theory might be borne out by the following participant, a young female career NHS manager just reaching a senior position. She proposed Gerald, unprompted, as an example of a good leader:

I think he's great, he gets a bit of bad press sometimes, I think people get agitated with him, but I think it's because he tries to manage things, and he tries to be very fair, and he tries to solve problems that have been with us for a long time, so again, I think he is a good leader, he is trying to do the right thing for the Trust in the long term. He is erm ... sometimes it's difficult for him to carry people with him, but I think that will pay off in the long run. And I think he's thinking of a long term plan, he's prepared to take a bit of short term flack...but I think it will work out in the end. I think he's going about doing stuff in the right way, he's being fair and he's trying

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to be consistent, he's making sure he's got an evidence base for doing things, it's not just a random decision, he's collecting information, and that kind of thing...I think there are a lot of people in this organisation at this point who would say they didn't think he was a good leader, but I think time will tell the story there.

This extract from the interview, while consistent with Gerald's descriptions of his own behaviour, proposes an evaluation of his style which indicates he is likely to be successful in the longer term because he is 'trying to do the right thing for the Trust'. However also she identifies quite clearly that his leadership is failing to take many of the people who matter along with him, she positions herself as sharing his vision for the longer term benefit of the Trust which may reflect her *a priori* engagement with NHS management rather than with a clinical profession as she does not have a clinical background herself. It also seems to reflect collusion with his narcissistic style because she seems to mirror his version of himself. This participant continues:

Sometimes they're [other senior staff particularly doctors] quite quick to criticise without really understanding what the problem is that needs to be solved, and what some of the rules are we can't ignore. Some of the national directives, that we just have to do, there's no point fighting against them, we've got to find a way of implementing them, and I think sometimes he gets a really raw deal...but he's said, he's consistent, he will communicate to people, write to people and speak to people very quickly the minute they raise a problem, and he definitely shows that he is not shying away from difficult problems...I think that's a very strong characteristic.

Her description of the other staff appears to chime with Bion's theory of a fight/flight basic assumption group based on unconscious emotional ties of the group involved which (mostly) represents an anti-task resistance to the leader (Bion, 1961). *This extract above reinforces the possibility that Gerald is emotionally disengaged from his followers* and perceives his Trust to be in line with and in favour of NHS 'national directives'. The participant here who in a way is 'damning' Gerald with *strong* praise may be looking to Gerald as a potential mentor by making it clear that she will support his particular efforts. However when the researcher asked her about her *own* leadership she said:

.... because one of my strengths is pulling people together, one of my strengths is building teams, so I think from that point of view then yes, but then sometimes I look at people like [Gerald and her immediate boss] and I think 'Oh my God'. I've got so much respect for the way they deal with

the very difficult issues. Sometimes I wonder if I really put my neck out enough to say 'Ok, Ok, this is what we all need to be passionately aiming for.' Even if not everybody is quite wanting to do the same thing. I think sometimes I sit back a bit more and wait to see what the general feedback is, rather than stick my neck out and say 'Ok, this is the direction we've got to go in.' And I think as a leader you have to...well, in fact you probably have to do a bit of both.

This participant, it seems, is somehow subjugating her own skills and strengths to those whose skills and strengths do not correspond with what she believes in makes her a good leader and seems to be putting herself down for the skills she has got and does seem to value. Alternatively, she might have realised that her strengths might complement Gerald's and through his own narcissistic valency he may position her as someone to promote.

Finally, in relation to Gerald, whose example she insists on returning to, having described other more emotional and successful clinical leaders in the Trust:

.... And they [other senior staff] make it very evident that they don't support him [Gerald] in his role, and not only do they make it very evident, but they do a lot of stirring behind the scenes, to get up a bit of a frenzy against him And I think there's some very clever leadership involved in that process, and there's a lot of learning, gathering people in, getting them on board and uniting them in a common purpose, and this and that and the other, but it's not constructive.

7.2.2 'Kerry'

Kerry is Gerald's immediate boss (the CEO) and evidence from the interviews, shadowing and observations in both cases indicates they do not always work effectively together³³. Kerry herself has met with similar difficulties which seem to be the outcome of her attempts to encourage distributed leadership in that:

Kerry: Erm, erm, well we set up a process to...we re-wrote the discharge policy here. I chaired the group. I wanted to know what the problem was about discharges, and I was told we needed to rewrite the discharge policy,

³³ Regardless of personal authority in the cases of both Kerry and Gerald, it is clear that the organisation has had its own very particular problems which are *endemic in the system* (see Chapter Six for a more systemic analysis of leadership).

and we'd just done it. People looked at me, and I just said, well I've spent...I've chaired five meetings myself, where we put all the information forward, and all these arrangements in place and nobody's done anything about it. I think that's poor leadership.

Q: So erm...poor leadership on whose part? Because presumably you had people who you delegated this to?

Kerry: So the consultants, the nurse managers, the matrons...all the people that were on the working group really. And they just didn't implement it. Beyond belief really.

This extract reveals several levels of emotion and authority and (as with Gerald's narrative) there is an 'I' who takes action and the 'they' who are against her. Kerry had identified a problem with discharges but had to ask 'them' what it was and was told that 'we' needed to rewrite the policy. She took up the role of chairing five meetings, the group/'we' put the information forward and the arrangements in place (presumably to take action) but 'no-one' did anything. It is not known how she handled this 'failure' of leadership on 'their' part. Kerry appears to be a micro-manager (in that she herself was involved in the meetings). Reflecting on this interview, and reading the text, one of us reported back to the research team that she had misunderstood Kerry, thinking that Kerry had been talking about her *own* case of poor leadership. Perhaps it was as unclear in the action as it was in the telling (thus perhaps on an unconscious level the lack of clarity was communicated in the meetings). Why did Kerry, as the leader, not pick up the group's dependence (or *resistance*) (Bovey & Hede, 2001; Hughes, 2005)? This suggests that she herself had resisted emotional attachment to her 'followers' and failed to engage them on an emotional level during the meetings. One approach that helps to understand the example above of *resistance*, specifically in the context of the five reported meetings, is the idea of 'fight/flight' from the work of Wilfred Bion (1961/1983). He suggested that a 'group mentality' (or group culture) emerges from the development of a group over time as it continues to meet, because individual contributions conform to this mentality. In brief, the formed 'group culture' unconsciously constrains individual members (see also Sherwood, 1964).

So, in this case it may have been that despite the seniority of the staff involved in rewriting the discharge procedure, the culture that had developed over the course of the five meetings (and possibly prior to this as 'they' had suggested the need to re-write the discharge policy) had *prevented/resisted distributed leadership*. This could have led to the group not making sense of the leader's expectations and reverting to the comfortable pattern of being that had not been challenged possibly (again) because of the leader failing to manage her own emotions or engage with those of her team.

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Bion (1961/86) suggests, that the group mentality exists on both at a conscious and unconscious level so that the team were probably not deliberately, or consciously, going against the leader. It seemed from the leader's description that the team had been almost 'sleep walking' – not recognising that they had already done what they later ignored and suggested needed doing. Dependency, according to Bion, meant dependency on the leader or "... *when all individuals in the group look to myself as a person with whom each has an exclusive relationship*" (Bion, 1961/86: 119). Within this mode there is little connection between the members themselves and there is a '*mass inertia*' (op cit). This links to Klein's depressive position (Gould, 1997). It also raises questions of who is depressed here - Kerry, the group, or the group in Kerry's fantasy? The unconscious resistance and frustration experienced by the leader here demonstrates the fluidity of power and potentially the influence of gender (Fletcher, 2004; Nicolson, 1996; Vince, 2001)

Kerry, however, did claim success in turning around previously identified failings in patient care targets. How did she manage this?

Well I ... I... I mean it requires a great deal of focus, which hasn't been succeeded by other individuals, so...and it's required the organisation to understand its importance, and that it is possible to do. So it's been trying to talk to people about 'OK it's a target, but it's a quality... a patient quality target, so don't look at it in a sort of derogatory manner'.And ((3)) ...so it's a bit of culture about are you being bullied, as a member of staff to achieve the target and if you're not being bullied well then why is important and then well it's important because its patient quality ((1))...and then I suppose, something about... I mean one of the turning points for me is about our reputation as well, which is...well everyone else is achieving it, and we're not, 'why do you want to be in the bottom 20% of the country?'

Resisting her own emotional attachment here she talks in the third person. Rather than saying that as a new senior manager she had managed to engage the staff, which to a point she seems to have accomplished, she states that successfully addressing targets has 'required the organisation to understand its importance'. She clearly perceives senior staff as taking a negative position in relation to government targets and has attempted to persuade people that such targets are about good quality patient care. Another feature of the discourse slips in here – is her style of leadership perceived to be a bullying one? It may be that a group mentality, which takes resistance and dependency to be part of its culture, perceives a leader with a vision, or at least with determination (and 'focus' to quote Kerry) to be bullying them out of their emotional safety. This is a problem for any organisation that suggests to its staff that successful change and development is solely about strong leadership. We have to turn again and again to the clear message emerging from the data that without an

emotional attachment and the ability to manage their own emotions leaders and followers are not going to achieve goals related to patient care.

7.2.3 'Quentin'

Unlike Gerald, Quentin feels that he is succeeding in bringing about change and unlike Kerry he is mostly positive about the impact he is having upon the staff groups. He told two stories, one of which was when his leadership worked, and another where he continues to experience problems although he emphasised (to support his authority) that the latter was not a great a worry to him. In his interview he focused very much on the importance of personal authority: *"I'm still playing the trick of getting people to do things by example"*. He tries to back up his personal authority through making personal contact as much as he can:

You know my job could be answering my e-mails and I'm desperately trying not to. I've made a pact with myself that I will not explain myself in e-mail. If it needs to be explained I will go and explain it [personally].

He distinguished between the roles of the CEO and medical director, which in his opinion were *manager* roles, and that of clinical director which was a *leadership* role.

Quentin moves between the position where:

...people need constantly to be reminded of what they need to achieve ... [in relation to patient care] ...I use the word good care because [they] have the tendency to lapse into what is acceptable or even worse, what they can get away with.

To the position that:

And I think there is some requirement to continually challenge the organisation about what it is providing and sort of have a re-education process. And I guess we all need that – because I need that as well you know and it is one of my roles to keep reminding everybody why they are doing what they are doing.

Quentin sees himself as needing space to reflect upon the aims of the service provision and recognises that he is just as able to lose track of the organisation's main purpose as his colleagues/followers are, given the daily round of work. While Quentin gives an interesting example of how he and the team succeeded in meeting a target for patient waiting times in Accident & Emergency (which involved him engaging personally with the staff in an emergency meeting):

... which was all about persuading your senior contemporaries and peers. It's about the juniors, the people who are actually delivering the services. It's about making a reasoned argument. It's about being visible. It's about being honest and it's about delivering it.

The success, he believes, was about the personal contact and his own visible attachment in trying to change things alongside his colleagues and being very clear that " *...this needs to be achieved at all costs - which was quite liberating*". The rhetoric here is very different from that used by both Gerald and Kerry, who feel their colleagues are letting them down; possibly they are 'splitting' the 'bad' and projecting it into recalcitrant colleagues in order to feel reasonably good about their own positions (Klein 1987, 1983). Quentin is talking about success and success through *taking an emotional risk*. Saying that a change needed to be achieved at all costs (which he described as liberating) could be interpreted as Quentin making an emotional commitment to engage with his followers about something identified by the government, the NHS and his Trust as important. This stands in direct contrast to the experiences and rhetoric of both Gerald and Kerry who express the frustrations at what the 'others' are failing to do. However with what Quentin called a "*slightly different problem*". He has had great difficulty dealing with a doctor who is "*just a very difficult person to manage ... and I need to say to him 'this is crap and needs to be done in a completely different way'. I don't quite know why I haven't done that*". Once again Quentin was expressing an emotion – anger but without pushing/projecting blame on to the other, but being clear what the other person was doing and reflecting on his own sense of why, how and when he might take this issue up with the protagonist.

While Quentin operates with a quiet assurance and takes up his formal authority, and the power that accompanies it, from a classic Kleinian 'depressive position' (Klein, 1975; Segal, 1973), both Gerald and Kerry, despite their formal authority, fail to engage with their followers which leads to their powerlessness and a sense of rage and frustration.

7.3 Conclusion

The interconnections between power, authority and emotion play a complex part in understanding what leadership means to all those involved and in each organisational context. Leadership cannot be understood as something that can be observed and/or measured 'objectively', it is not an essential 'quality' which resides in an individual but is socially constructed, meaning different things to different people at different times. Following Ford (2010) a more contemporary, appropriate and critical approach to the study of leadership "*pays attention to situations, events, institutions, ideas, social practices and processes that may be seen as creating additional repression or discursive disclosure*" (Ford, 2010, p. 51)

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To be specific Rioch (Rioch, 1975), and others had made the point that *"'Leader' is a word which implies a relationship So the word 'leader' does not have any sense without a word like 'follower' implied in it".* (p. 159).

The relationship between leaders and followers might be more or less successful and in order to be a follower a person needs (even on a very temporary basis) to 'give over' something of themselves (i.e. make themselves emotionally open) to the leader for the relationship to have meaning. Being a follower may be both (or either) passive or active and there is the potential for the follower to engage and support, or subvert leadership (Bondi, 1997; Halton, 2007; O'Brien, 1994). Consequently, in order to analyse what it means to 'lead' in an organisation, understanding the practice(s) of emotional management alongside an analysis of power relations is fundamental (Grint, 2005; Schilling, 2009). For Foucault (Burrell, 1988; Foucault, 1982) power *"exists only when it is put into action, even if, of course, it is integrated into a disparate field of possibilities brought to bear upon permanent structures."* (1982, p. 788) Thus, while organisations give formal power to relatively few leaders (including in a distributed model of leadership) consent is still required for the power to be maintained. Furthermore, 'the other' that is the one over whom power is exercised, needs to be *"recognised and maintained to the very end as a person who acts"* (Foucault, 1982, p. 789).

The leaders we have described above all admit falling into traps where their authority has been challenged/resisted and they have been (potentially) made powerless. Quentin alone demonstrated awareness that he was working *with* people rather than treating them as resources. This meant that despite experiencing some frustrations, he managed to continue to *feel* and *think*, and with his colleagues/followers on board, *implement* changes. Kerry and Gerald, while attempting to take up their 'legitimate' power and lead change, both squander their authority through failing to manage and/or engage with their own and their followers' emotions. This is evidenced by their displays of frustration, impatience and anger with those who fail *to do what they are expected/commanded to do*.

Gerald held a classic authoritarian view of power, indicating that whether he takes people with him or not, he intends to get to the *'goals that I like'*. He also sees the resistant followers as stupid. He defines leadership accordingly, in that the leader should *'direct [the] team'* and not be afraid to *'face up to a fight'*.

Kerry sees herself somewhat differently even though she experiences anger and frustration when followers fail to do what she wants and expects. In attempting to empower her subordinates and set up the 'processes' to distribute empowerment (such as the meetings described above) she was left feeling disempowered following an (apparent) breakdown of

communication between herself and the senior team she tried to work with. That one of the interviewers also had to clarify: "*poor leadership on whose part?*" suggested that Kerry possibly re-experienced the rage and frustration she felt at the time of her encounter with the followers in her story when she told it. This rage obscured clear communication both then and in the telling. It might be that the overwhelming need to prevent the Trust from being '*in the bottom 20% of the country*' was a source of anxiety for her and the importance of achieving these specific sets of goals contributed to her impoverished emotional literacy.

Distributed leadership (Gronn, 2002; Mehra et al., 2006b), as a response to 'postmodern' organisations (Tierney, 1996) sets out the changing nature of authority/power. In combination with ideas from the emotional/social intelligence literature, distributed leadership suggests a more relational model of leader/follower relations whereby leadership decisions may represent both outcomes and inputs (Ashkanasy et al., 2003; Wolff, Pescosolido, & Druskat, 2002). A warning note, however, reminds us of the persistence of the patriarchal version of 'the' leader (Ford, 2010; Ford & Harding, 2008) which occupies the dominant discourse within which the notion of 'effectiveness' neglects (if not ignores) the importance of the management of emotions in the leader and followers.

Through the use of innovative research methods and data analysis, which take account of both conscious and unconscious processes through which leadership is socially constructed and exercised, the intrinsic complex connections between authority, power, emotion and leadership in the context of health care can begin to be disentangled.

Leadership that 'works' for an organisation such as the NHS is a multifaceted, emotional *process* in which leaders manoeuvre to manage their own and their followers' emotions and behaviours on both intellectual and emotional levels. To be effective in, what are now seen to be, postmodern organisational contexts, leaders also need to reflect upon themselves in their role and to understand the structural, cultural and emotional expressions of their authority and the authority and power of their followers. The legitimization of emotionally engaged leaders' authority supports effective service delivery across the different levels of the organisation through undermining conscious and unconscious resistance(s) as described in the examples above. Power as a coercive violence (see Foucault, 1982) has been exposed and undermined in such organisations and 'replaced' by concepts of 'distributed' leadership where the persistent claim to power is by definition and necessity more fluid.

8 Gender and Leadership

8.1 Introduction

Gender and leadership is an area that has attracted interest among policy makers and researchers, because the styles of leadership that are currently perceived to be the most effective, such as transformational and distributed, are believed to 'fit' more closely to 'feminine' styles of leadership. Fletcher (2004) notes that traditional 'heroic' leadership is usually associated with masculine traits (rather than men and women *per se*) such as individualism, control, assertiveness advocacy and domination, while 'post heroic leadership traits (such as empathy, community vulnerability, collaboration) are more associated with feminine traits. Ford (Ford, 2010) reconsiders the concept of *effective* leadership which is in fact a patriarchal model perpetuating an exclusionary and privileged view of the leader (metaphorically the 'father' figure).

Traditional research into gender, organisations power and leadership suggests that there are particular 'masculine' and 'feminine' leadership traits that are generally believed to characterise men and women's leadership styles (Rosener, 1990; Collinson and Hearn, 1994; Nicolson, 1996; Carless, 1998). Because women are widely believed to adopt a more democratic leadership style and men believed to adopt a more autocratic one, distributed leadership and concerted action in networked organisations may potentially be more conducive to those (women or men) who can adopt a more traditionally feminine relational style of leadership. Furthermore, feminine styles are more akin to displaying social and/or emotional intelligence (Guy & Newman, 2004; Leon, 2005).

In reality, both men and women display a variety of 'masculine' and 'feminine' leadership styles, depending upon their individual personality, age, position and the situation involved (Cross & Bagilhole, 2002; McDowell, 2001). However, gender *expectations* influence perceptions and beliefs and research suggests that subordinates are often more satisfied with leaders who behave in gender-typical ways than those who go against gender-type (Porter, 1992; Rosener, 1990; Williams, 1993).

Indeed, women in explicit leadership roles often tend to be viewed less positively than men, in the belief that 'masculine' traits (competition, authority, lack of emotion) conform more to expectations of how a 'leader' should behave but not how a woman should (cf. the work of Broverman et al. 1970). The 'paradox' it seems persists in contemporary organisations so that some women leaders feel they have to behave in a 'masculine' way which frequently makes them appear rather heavy-handed and/or as a 'bullying' because these behaviours do not fit with ideas about women (Eagly & Carli, 2003).

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Most of the women and (some) of the men we spoke to during the study, made a point of denying that gender was an issue in today's NHS, indicating that they believed that women and men were treated equally, with an equal chance of success. However, several participants also mentioned gender differences in the negotiation of power and identities describing how either women or men were likely to gain advantage through use of their gender-typed styles (Lewis, 2000; Schnurr, 2008; West, 1984).

Gender and leadership it seems remains a contradiction in people's minds but gender is a fundamental component of the discourses surrounding leadership in the NHS because of the demographic issues in clinical management and leadership (Evans, 1997; Gardiner & Tiggerman, 1999) and as we have shown in Chapters Four to Seven, role models and styles of leader/follower engagement have a major part to play in the transmission and exercise of leadership (Gill, Mills, Franzway, & Sharp, 2008; Greener, 2007).

We want to note here, partly in passing, although an example below (in the interview with 'Jeff')³⁴ demonstrates its importance - that the *researchers'* gender and physical appearance (age, ethnicity, attractiveness) also played an important role in the research process.

8.1.1 Senior women managers: 'we're all the same now'

Women in senior managerial and/or professional positions either deny that being a woman is an issue for them or for their organisation or that they know what they had to do to prevent being seen as a senior '*woman*', rather than a senior leader.

Denying the impact of your own gender on how you are seen and how you manage and lead is not an easy position to maintain and we observed some senior women working hard not to be seen as women even though at the same time they were arguing that *this behaviour was not necessary* because of the way 'things have changed'.

The researcher's observation of a senior female manager (Catherine) indicated that she thought that Catherine was trying to avoid being 'feminine' in her interactions. When the two interviewers were waiting to begin the interview, Catherine's PA came into the room with an important message but was shouted at in front of them. Thus in her notes one researcher judged that Catherine wanted:

....to indicate lack of interest and assume a position of superiority. Catherine was transgressing the boundaries of polite professional behaviour and attempting to define 'her' territory of the hospital. Answers to the

³⁴ Not his real name.

questions were also defensive, perhaps indicating a lack of self-assurance. Despite the tough exterior she obviously felt a need to stamp her authority on people in order to maintain control of the situation. This may partially be related to her gender and need to appear 'more masculine than the men' in a competitive environment.

The researcher following on from her observational notes with comments following the interview suggested that *"whilst she [Catherine] initially denied gender to be a relevant issue [for senior managers in the NHS], she then went on to make reference to 'testosterone' and 'the emotions of females' as problems in managing in her senior role".*

The relevant part of the interview transcript is below:

Q: Ok, so are men a problem? Are women a problem? Are there gender politics? Or am I just old fashioned there?

A: I don't think there are anymore, I think there were. I mean when I was appointed, I could have been one of [only] four [senior] women, so the whole senior management was very ... very 'suitish'. I don't think, no, I don't think it is a problem anymore. No, I think it is, if you talk to people in the north of England, they will say it's still a problem, and I think its a bit more of a problem to get females into acute trusts, big acute trusts, it's a bit of a climate difference. I think there's a lot less testosterone around now, there's a sort of slightly...erm I mean I've got quite a young male management team.

Q: Right

A: I find the testosterone and sort of challenges a bit much from time to time So I mean from that point of view, it is quite interesting, it does manifest itself. As do emotions of females really.

Catherine's somewhat aggressive, or at least uncompromising, behaviour witnessed by the researcher tended to soften after that and she added:

A; So I do think the answer to the question is that there are differences, but I don't think they're... they don't fundamentally affect how you do the job.

Vicki, a senior geriatrician, discussed the question of gender openly and at some length with the researcher who suggested that she had seen both Vicki and Mandy, another senior female consultant geriatrician, being very 'gentle' in their approach to patients and the researcher wanted to know how far this was linked to the fact they were women. Vicki thought though that their approach was not about gender but:

You know it could be a geriatrician thing, I don't know, ((1)) you know you'd automatically say 'it's oh because we're women', but I think it's only when you start following a few men around as well who are doing the specialty as we are, because the thing that attracts us to elderly care rather

than any other specialties in the first place, and that could simply be what you're observing.

It seemed important to Vicki that she was not stereotyped as a woman leader although she was keenly aware that as more women took up medicine and were arriving in senior positions that this demographic change would in some way impact on leadership.

So maybe that's where you've got to go as well as men in geriatrics you actually need to look at women in other specialties and follow them on a ward round and see what they do and that may be a good idea as well for the gender thing. But it's quite important for your study because at the end of the day we're training over 50% of women as doctors and in the future they think that almost all GPs will be women so that will affect the leadership and sort of, that you see in patient care.

So Vicki, while seeing feminine *characteristics* as more important in her clinical specialism than gender *per se*, still believes women doctors (e.g. GPs) will make different kinds of leaders from men.

During her shadowing of Mandy, the researcher noted what she identified as gender-typical behaviour:

Mandy also implements a mothering aspect to her leadership role (also noticed in Vicki) as she is always thoughtful and considerate to her followers, making sure they are comfortable and happy with decisions made and that they are up to speed with their medical knowledge. This mothering role also seeps into the delivery of patient care. Mandy is also a leader that appreciates the help of her followers and always thanks them for their input and help.

While keeping in mind that the researcher herself is making assumptions about what is a 'mothering' style and also recalling Vicki's assertion that it may be more to do with the kind of people who are attracted to geriatrics than gender itself, it is important to note that the researcher spent several days shadowing and observing female *and* male geriatricians. Further, she discussed reflexively what she saw and how she interpreted it with the research team to check out her observations.

8.1.2 Men: the 'natural' leaders?

The researcher who interviewed and observed Catherine also interviewed and observed Jeff (another non-clinical manager) and contrasted their styles of interaction with other people in the organisation, and with her, during the interview. At first Jeff seemed more approachable, relaxed and generally more amenable than Catherine had been:

Jeff was a newly appointed male senior manager. From the outset he displayed supreme confidence in his own authority and power as a 'leader'

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and obviously did not regard a young female researcher as a threat. He was very friendly and personable and happy to open up the space of the hospital for us, answering his own emails rather than through a secretary, coming to collect me personally from the main reception and chatting and joking all the way back to his office. Throughout the interview he showed confidence in his own opinions and was happy to talk in detail about both his own and others' leadership. This confidence may be a result of several factors such as position, age, class, gender or personality. He freely admitted that he did not mind appearing 'hard' or unpopular if it was necessary to get the job done, however he felt that his main asset was his own 'charm' and 'charisma'.

Thus Jeff firmly claimed his place within the (masculine) 'heroic' leadership tradition.

While Catherine was perceived as guarding her territory and demonstrating her power, Jeff appeared to be relaxed, being more approachable and particularly not hiding behind his PA. In fact, his account of himself in the interview was somewhat disarming.

Q And do you see yourself as a leader?

*A: Oh yes certainly. I can remember the time when I realised that I should be in management. I was working in a **** clinic in [a Trust] and it was so inefficiently run and I said as much to the manager. She said 'if you think you can do it better then why don't you manage?' So I said 'OK I will!' And I think I'm pretty damn good at it. I don't play by the rules, I don't have any formal qualifications, but I can get things done. I'm not perfect – I shout, I swear and mostly I'm just very, very cheeky, but I'm good with people and that's what you need in this job. You have to be tough too, take knock-backs and step on people to reach your targets. But mostly I care passionately about the patients. I would never ever chase a target if I didn't think it would improve patient care. So that's why I went into management, and I suppose the other thing is I discovered, I surprised myself actually about, I was going to say how easy it was, it wasn't easy, erm I had a natural aptitude to do it, you know it was something that I was successful in so you know yeah?*

Jeff wanted it made clear that the 'inefficient' manager was a woman and that he himself is 'good' with people (and on the surface the researcher acknowledged this). However, he also valued the tough, target-driven 'stepping on people' (masculine) qualities of his leadership which he believed were important in delivering patient care.

Jeff put his confidence and self-identified ability partly down to personality, but also to his gender and upbringing, adding that certain class backgrounds seem to 'breed' leaders:

I do think that great leaders are kind of born, but my background was that I was at all male public boarding school for 10 years. As my father said 'the biggest waste of money' given my academic erm qualifications at the end of it, erm and there was something there about you know that sort of environment. I mean does it grow leaders? You would think so, you look at the number of public schoolboys that end up as MPs, that's probably not a good analogy

Q:((Laughs))

A: But there is something about that kind of white middle class upper class upbringing that you have, and although I wasn't from that background before I went to the school, erm you learn survival among your peers, you learn I think to survive, you know if you think at the age of eight you are sent away you have to survive you haven't got your infrastructure.

It seems that Jeff is suggesting that leaders are either 'bred' or 'grown' but either way the influence that makes them a leader comes early in their lives. In the example he gives here, 'growing' takes place in a male-only context reinforced by social class, possibly wealth and a general sense of entitlement. This model does not echo the efforts and ambitions of the NHS in everyday practice nor would it appear to be in any way appropriate to the model proposed by the NHS (see Chapter One) which is focused on the type of leadership appropriate to managing and leading 'diversity' and 'difference'.

8.1.3 Gender wars?

Being motherly (like Vicki and Mandy) is not equivalent to being weak or compliant as perhaps some gender stereotypes might describe women (see for example Bem, 1993; Nicolson, 1996). During an observation of Mandy, the researcher identified what she considered to be a 'battle of the sexes':

Gender issues were brought into consideration during the interaction between Mandy, a female consultant and a male consultant. During this interaction a battle of the sexes and power occurred with the two consultants struggling for power in very different ways. The male consultant tried to assert his power through attempting to ignore Mandy's presence, never looking directly at her, but was raising his voice and being rude. On the other hand Mandy was always very polite, looked directly at him, spoke very softly and smiled a lot, although it was quite obvious that behind the soft smile was a vicious bite.

Perhaps this isn't so much a battle of the sexes but an example of how men and women might behave differently towards each other in the course of a power struggle. The detailed observation notes show the encounter move by move:

There are some territory issues with Patient 9 and Mandy is angry that there is a patient on her ward that is being treated by another doctor. She asks why the doctor has continued his care now that the patient has moved ward and suggests that if the doctor feels that he needs to continue with the patient's care then the patient should be kept on one of his wards rather than blocking a bed that could be used for one of her patients. She asks "why can't we look after this patient? We are not supposed to have any outliers on this ward!" Mandy's registrar Melvyn can not, or does not want to answer her questions and simply shakes his head and shrugs. Mandy says she needs to speak with the consultant and asks Melvyn who the patient is under. Melvyn gives the name and admits that he has seen him arrive on the ward a couple of minutes ago, so he should still be there.

Who is Melvyn afraid of here? Or is Melvyn simply not wanting to witness a battle over territory and patient care?

Mandy walks round the other side of the nurse's station to find the [male] consultant with three other doctors/medical students standing some distance away and his registrar to whom he is speaking. Mandy and 'our' group move over to his location and the junior doctors from both groups greet each other and share whispered conversations. Mandy stands patiently at the side of the registrar waiting to speak with the consultant. Although Mandy continues to smile pleasantly I think that she is angry or frustrated on two levels. First because the consultant is on her ward and hasn't come to speak to her and second, because he doesn't seem to have the manners to even acknowledge she is waiting. After the conversation between the consultant and registrar has finished the consultant turns his attention to his paper work and the registrar moves to be with the other doctors (some distance away) Mandy lifts her eyebrows up to Melvyn (clearly annoyed with the male consultant's behaviour) and then asks if she can speak to him about Patient 9. Mandy explains politely that they do not have outliers on this ward and therefore asks whether the patient could be moved to another ward or if this cannot be arranged she take over the care for the patient. While she speaks the consultant doesn't look at her and continues to write, his body language and behaviour are both arrogant and rude. The consultant says that the patient is his and he will not be passing the patient over as she has problems not solely aligned with geriatric care and that she needs a specialist. Although this was clearly a statement to undermine Mandy's capabilities she continues to smile and tell him that the patient will be moved before the weekend so that a patient needing specialist geriatric care can have a bed.

Moving through this detailed account the gender issue becomes obscured by the fact of Mandy's skill as a clinician, a leader, her concern to give appropriate care within a context of limited resources and her ability to handle herself in the face of rudeness and arrogance. These are skills that ensure she will shine through as a leader in any context but particularly one

which is still a man's world. In a socially or emotionally intelligent context where concerted action is seen as important, patience, politeness and clarity of purposes will eventually win out over arrogance and bluster. As we see in the next extract Mandy's 'opponent' does not possess these attributes.

The male consultant becomes angry and raises his voice to Mandy and says there is nowhere else for the patient to go. Mandy lowers her voice and says that the patient must have been on one of his wards before she was moved so she can move back. The other consultant looks swiftly at the group of doctors who are stood behind him (both his own and Mandy's) and then eyes me suspiciously before turning back to Mandy and speaking in a lowered voice. The conversation moves back and forth between Mandy and the other consultant and it is clear that despite his outbursts and undermining statements to Mandy that she has the upper hand and although she continues to smile, she is very forceful and strong in her argument and objectives. To conclude the whispered conversation Mandy raises her voice and tells the group that the patient will be transferred on Friday and that she will be getting a transfer set up straight away. She then thanks the other consultant for understanding and walks back round to the group with a smile on her face and asks Melvyn to set the transfer up.

This is a consummate example of patience, calm and the ability to lead doing what she considers to be the best for her patients, her team and her department. Her skills in continuing to be quiet, calm and smiling have 'seen off' the male consultant in the meantime but reading this it would be surprising if the humiliated man does not try to take revenge. Although there is very little evidence that this is anything other than a 'normal' power struggle it is the case that Mandy is in fact a woman and has played, what is mostly recognized to be, a feminine role.

Returning to male expressions of power it is important to be aware that blatant attacks, such as the one in the encounter above, are not necessarily the only ways of demonstrating confrontational masculinity.

It appeared from the interview with Jeff (discussed above) that he believed he did not need to defend himself in the face of gender stereotyping. He had strong opinions on women's leadership and also on women's 'availability' with no qualms about voicing these which contrasts strongly with women's accounts where they try to underplay gender, that is that many senior women take the view (overtly) that gender is irrelevant.

The researcher's notes about the meeting with Jeff continue describing a dramatic example:

Jeff's supreme confidence meant that whilst he came across well in an interview situation, he crossed boundaries of professionalism in other ways, telling unsuitable stories about staff and inviting me (researcher) out for a drink after the interview, invading my personal space. In the extract below

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he accuses a female colleague of not only being attracted to him, but trying to use her sexuality (unsuccessfully) to get ahead at work, whilst simultaneously flattering me that I am his 'type' by subsequently asking me to meet him for a drink.

And in the interview:

Q: And could you give me some examples of bad leadership that you've seen?

A: Well, Melanie Willson³⁵, have you met her?

Q: No I was meant to but she cancelled the interview three times...

A: Exactly, she probably thought she was too important to talk to you. Now I can tell you an interesting story about her. She's a good looking woman, stunning, very intelligent too. But there's something not quite right, I don't know what it is... really cold. She's got no soul. I appointed her as divisional manager and at first she was doing really well, but then she ran into some problems. She was failing in her job. And that's when she started to flirt outrageously with me. It was like she couldn't beat me intellectually so she was going to do it another way. But, well... she's not my type. And she was really jealous when I got this job, I had Lucy (PA) go and announce it at the morning meeting and you should have seen her face. Anyway I hear she's got a promotion now so she must be doing something right.

Melanie Willson clearly perplexed Jeff – 'stunning' but no 'soul'; 'flirting' to avoid being faced with 'failing' in her job; unable to beat Jeff 'intellectually' and resorting to using her sexual attractiveness. After stating that she was not his type (indicating that the flirting also failed) he then made another woman humiliate Melanie in a public context. The implication of her subsequent promotion being based on something other than ability was also a powerful 'aside'.

Discriminatory comments against women though are perhaps not that commonplace. Jeff's sense of 'entitlement' may be a dying one across most NHS organisations and it is certainly against all stated mores. Discrimination on the basis of gender is more opaque. The researcher interviewed Helen, a senior female consultant, and talked about gender and arrogance of male consultants. The researcher suggested:

... this was possibly seeing me as an ally as a young female professional. In addition to the immediately obvious behavioural differences between women and men she also mentioned unseen discrimination in the form of merit awards at senior levels and problems of combining work and family commitments which may mean female staff are less likely to achieve these.

³⁵ Not her real name.

In the interview Helen responded:

Q: Do you think there are any gender differences in leadership that you have noticed?

A: Yeah, yeah I think, I think so, erm you know the men are more well, can I, the men are less inclusive of a group and they have ((1)) already formed an opinion sometimes and before listening, erm, ((1)) err ((1)) yeah.

Q: Yeah ((laughs))

A: Need I say more ((laughs))? But I think there is a difference ...Competitive, that's what I was saying, there's that competition, yeah competitive, exactly ...Of course not but the insight is very, very small, and then those meetings go on and on and on and it's people trying to get one up on another so... I just want to leave. It's handy having a beep you know you can say 'oh, I've got to be off (laughs)'.

The suggestion here is that men are apt to waste time on each other and power struggles and that for them competition is central to their 'nature'.

8.2 Conclusions

Despite the increased numbers of women who have reached senior leadership positions in the NHS, both as senior managers (clinical and non-clinical) and as senior clinicians *per se*, there were nonetheless some interesting differences between women and men's self-descriptions and perceptions of others as leaders, sometimes made on the basis of gender alone (Gill et al., 2008). Descriptions given of leaders and leadership for members of the 'other' sex were also frequently gender-typed.

It may be that despite valiant and frequently effective attempts to change the culture of NHS Trusts that a 'traditional' view of leadership remains at least in the organisational 'memory'. This might go some way to explaining why women who are clearly powerful and influential are reluctant to identify themselves as taking up these more 'feminine' styles even though they may in fact use the skills associated with these qualities. Eagly and Carli (2003) make a case for women as having a leadership 'advantage' in contemporary organisations where the type of leadership required has changed. However, they argue that in many cases women have to battle against the inherent prejudices in male dominated organisations. Although there is still a reference to gender stereotypes when discussing gender in organisations and gender and leadership as we have seen from the extracts above in this chapter, as Rosener (1990) stated: "*Women managers who have broken the glass ceiling in medium-sized, non-traditional organisations have proven that effective leaders don't come from one mould*" (p. 119).

In Chapter Five the OCS revealed that women across all professions scored lower than men on 'recognition' in that they perceived their managers as

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not recognising their particular attributes as clinicians or managers and they also perceived that the organisational climate was one in which 'recognition' was more likely to be given to men than women. That men did not see this as a problem for them reinforces the view that regardless of trying to establish gender equality across NHS organisations it is still not embedded in the management culture.

As we have seen and has been well documented in the literature, it remains difficult for women to exercise leadership without their behaviours being construed as either 'weak' or 'aggressive'. The paradox is that leadership requiring more 'feminine' characteristics is at least explicitly more desirable in the contemporary NHS.

9 Patient Care, Leadership and Service Delivery

9.1 Introduction

The NHS has a history of reform/modernisation aimed at making patient choice and care more cost and clinically effective by improving the organisational structures through which care is delivered (Bate & Robert, 2002; Becher & Chassin, 2001; Darzi, 2008; Wilson, 2009) .

The NHS remains committed to its original aims of providing a cost and clinically effective patient care (Doherty, 2009; Phillips, 2005), at least partially through the NHS's organisational structures, including the gate keeping function of primary care, while providing a universal service free at the point of delivery. Since the 1990s patient choice has been added to the longer term commitment to efficiency (Bhandari & Naudeer, 2008; Bojke, Gravelle, Hassell, & Whittington, 2004; Bryan, Gill, Greenfield, Gutridge, & Marshall, 2006). And at the same time there has been an explosion in new diagnostic and therapeutic technologies accompanied by a public awareness of the availability, or lack of availability, of those technologies (Aberbach & Christensen, 2005; Greener & Powell, 2003; Mueller, Sillince, Harvey, & Howorth, 2004a).

In this chapter we particularly address:

- what respondents (staff and patients) say about patient care and service delivery based on the interviews and focus groups;

- what we *observed* about service delivery and patient care and particularly the *interactions* between clinical staff and patients *observed* and *described* during the shadowing.

As in Chapter Six the Trusts are conceptualised as open systems whereby high quality patient care (the input) corresponds with effective service delivery (the output) with the primary task defined as caring for sick patients (or those who are giving birth).

9.2 Defining patient care and service delivery

The thematic analysis highlights similarities across all grades, statuses and disciplines of the staff and the patients involved in the study. The themes that emerged consistently from the data that were about good patient care were:

1. Putting the patient first:

...of course patients do come first but actually really, on everything that you do, I mean everything you do you think of the patients (service manager in acute medicine).

2. Thinking about what is good for the patient (all the time):

I still believe and I believe to this day that if you absolutely concentrate on what the patients' needs are, all other things take care of themselves. it's about really showing that you care. I mean genuinely showing that you care about your patients, erm there's a lot of talk about also looking after your staff and caring for your staff. I think that's important but I think the health service has got itself stuck far too many times concentrating on the needs of the staff and not the patients (Chief Operating Officer).

I think that's what you have to make sure is that everyday you are thinking to yourself, 'am I doing this for the good for the patient?' 'is it the right way to do it?' so I think when you get eleven years down the line, one of the things is that you can loose sight of is that, very easily (Matron).

3. Awareness of the diversity in the patient's world (culture, family, age, home and work environments):

..it would be making sure older patients have high quality of care during their surgical admission (senior consultant Geriatrician).

you need to support your staff ... you know and you have to have an awareness of the different culture of the patients (administrator).

4. Making sure the patient received the care that staff would expect for themselves and their relatives:

I would define patient care that of - if it was one of my relatives who were ill (senior manager).

5. Talking to patients about what has happened, their medical history and their clinical condition:

....if they talk to you one-on-one and you know where you're at (patient).

6. Safety and empowerment of patients:

They [the multidisciplinary care of the elderly team] believe that good patient care sits around ideas of timely discharges, safety, making sure the patient understands their condition and their treatment, empowering patients by allowing them to make their own decisions about their care (to a point), providing the appropriate treatment and care, being responsible for the patient. Examples of bad patient care are viewed as delayed discharges, poor decision making and discontinuous care. (Notes from an observation of a team meeting).

From the descriptions it is clear (and perhaps no surprise) that senior managers, clinicians and patients all hold slightly different perceptions which inform their judgements to give 'patient care' a specific meaning. Some of the judgements are related to their particular clinical specialty or organisational responsibility although generally respondents reiterated that patients need to be at the centre of daily practices. Patients in all cases wanted more than anything to be kept informed about their care, and if possible this should be done by the clinician in charge.

At a more complex level the definitions above reveal a 'vision' of good patient care which links the 'practical', 'professional' and 'political' elements of NHS life. It also links to the 'human' elements associated with the tasks of caring. For example, the Matron (quoted above) shows a revealing insight that the routine *organisational* tasks might take over as a perceived priority from what a person initially knew to be their primary task (i.e. patient care). As she says, several years down the line you might lose sight of what you are really there to do.

9.3 How is good patient care achieved?

9.3.1 Managers

Managers each have different levels of responsibility for delivering good patient care which may differ from priorities expressed by patients and clinicians:

Erm, that's the bit about lifting your eyes up off of the horizon, and lifting the eyes up above the horizon is about looking at the totality because the

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medical, again, the medical management model is very much that you should do what you need to do when the patient is in front of you. The management model, the pure management model is about doing the right thing for the 450,000 patients who were looked after last year, so some of that will be about compromising, and offering the best care to the widest group that you can (CEO).

Immediately this respondent exposes the potential for conflict at senior level in that he/she³⁶ positions the 'medical management model' differently from the 'pure management model'. In the former the patient is a particular individual with a health care problem – the patient 'in front of you'. However for senior management there are many thousands of patients that require good patient care which means (maybe) compromising to provide the best possible care to the greatest number. Despite this, another senior manager had a different 'take' upon good patient care and in answering the question focuses on what they themselves would expect evoking a more individualised model:

I would want good consultant input into my care ((1)) as soon as it was appropriate in the pathway that I was on. I would want to be able to have a conversation about what was wrong with me and what treatments and options there were, ((1)) erm ((1)). I would want the assurances of the people that deliver the care know what they are doing. ((1)) I would want the care to be provided in an environment that was clean and in an ideal world I would want a single ensuite room, err and I would like to choose my own food and all that jazz. ((1)) erm and the erm, ((2)) so really you want the environment to be correct and you want to have the confidence in the clinicians giving care and you want to have had input into what your care should have been (Senior Manager.)

This manager has a very clear model of their 'ideal type' which positions the relationship between the patient and clinician, the skills/expertise of the clinician and the physical space and environment as central to good care. There is awareness here that planning and teamwork are also part of the process of care but particularly important is the knowledge of how to deliver the appropriate care and information in order to facilitate joint decision-making.

³⁶ We do not want to risk identification of any individual participant.

9.3.2 Clinicians

Good quality patient care for most doctors interviewed was:

... making sure that erm the patient achieves the outcome that you would wish them to as a result of either their outpatient visit or their inpatient stay erm and that outcome is kind of on a objective kind of medical measure, erm but it's also in terms of the quality of the care that they've received and whether they are satisfied with the care that they've received. (Senior consultant)

Another senior consultant who is also on the senior management team of the Trust took the concept of patient care further:

... it should be delivered well I think is the answer ((laughs)). I think on the whole we do deliver it well, we have the lowest mortality rate in the country, ((1)) or one of them. I think we do actually and we ((1)) I'm very proud of the care and I think there are two things to be proud of and one is the basic care and ... we do emergency work I am very proud of. Then the other bit of care we're proud of is that ... I think there is a real culture of innovation and I'm trying to do something new up here, and I think that's actually really important in terms of leadership. My job is being able to see a clinician with an idea and then work out of him or her how to turn that idea into a self service innovation. I think that we have created over the last few years a much stronger patient safety culture.

This respondent clearly links leadership and patient care stressing both the relationship between supporting other clinicians in innovations that improve care (particularly attending to safety) while also being proud of the culture across the Trust for low mortality, innovation, and supporting staff. Crucially there is a pride and energy about this account. The culture puts patients first but the staff gain satisfaction and a sense of professional pride from the performance of the Trust as a whole [T3].

The clinician manager below takes up the relationship between staff empowerment (and support which links clearly to the outcomes reported in Chapter Five) and returns us to the focus on staff training and skills, indicating here that if the managers train and empower staff – services to patients will improve.

... it's about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is, we worked with training and development and we came up with a specific programme that was aimed at empowering them to improve their service area etc. etc. and

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also provided them with some skill sets that they probably didn't have prior to that. (Senior Manager, Therapies)

While from a similar perspective the nurse quoted below stresses that team work and morale mark the path towards good patient care and you need to look after *staff* in order to deliver a good service to patients.

... And I think it is also, sort of, taking into account the people they work with, the team members and boost the morale, and that can make a lot of difference to, you know, to have people at work and sort of take the stress levels off and I think, you know, it would sort of, quality certainly would happen, sort of energise them, able to care for the patient. (Nurse, focus group)

9.3.3 Patients

For patients overall it was clear that most of all direct communication and consistency of staff was experienced to be good care:

A: ... I've been transferred here from [another Trust] and there it's a bit more, not one-to-one but you see a lot of different doctors here whilst there [the other Trust] you have only one doctor, your one midwife and your one consultant. Here you see a lot of different people.

Q: And which one do you prefer?

A: I'd say probably just to see the one 'cause lots people tell you different things.

Q: Okay, so it can be a bit confusing?

A: Yeah, sometimes it can be, yeah.

The patient quoted below reinforces the need for clear patient/clinician contact and communication.

For another woman:

Now whilst I'm here my care has been very good especially with the [specialist] who first saw erm, who first flagged up the problem. Erm yep it's been good it's been good since I've been in. It's just the initial communication as an outpatient to an inpatient I should have really - you know that should have been. I don't know where the fault lies but there should have been some communication there between the appropriate people (Maternity patient on postnatal ward).

9.4 Delivering patient care

9.4.1 Doctor-patient interactions

We look firstly at three consultants' (Cameron, Kenneth and Henry) styles across two different Trusts as they interact with patients to explore the importance (or otherwise) of good communication and engagement. What emerges, perhaps unsurprisingly, is that different consultants have different styles of engaging. The style adopted though feeds through to the 'ethos' of the clinical team, relates to, and impacts upon, the culture of the Unit thus affecting the doctor-patient interactions as part of an evolutionary cycle.

9.4.2 Empathy and Communication

9.4.2.1 'Cameron'

From the researcher's notes we gain an impression of Cameron who deals mostly with stroke patients for whom verbal and non-verbal communication may be very restricted:

Cameron offers a very personal and individualised style of patient care to his patients. He is often very tactile often rubbing the tops of their hands, arms and heads to encourage them or to show support when he is discussing difficult problems with them such as their inability to go home, the definition of a stroke and the future impacts of them having a stroke. He also speaks to the patients in a very friendly and informal way and sometimes draws on their mother tongue to say a few phrases to make them feel welcome and at ease.

In his interactions with his patients he is very positive and upbeat, often speaking loudly to encourage and motivate his patients. He also tries to share a few jokes with them and breaks down doctor/patient power relationships by crouching down in front of his patients or sitting on a chair or their bed so that he is always the same height or lower.

This description alone demonstrates how Cameron's *behaviour* relates to several of the descriptions above which identify good patient care in that he:

- communicates (verbally and physically)
- takes care to acknowledge their humanity through recognition of their cultural (linguistic) heritages the fact that they have a life outside the hospital
- attempts to empower them within the relationship (at least via discussion and physical presence and to an extent with knowledge of their condition).

Below is a detailed example of Cameron (and his team's) encounter with an elderly stroke patient (Mrs. D) which is part of the evidence the researcher has employed for her assessment of the processes engaged by Cameron in his provision of patient care:

"Hello Mrs. D? (Patient nods head and smiles) do you have a headache? (Patient nods head) Do you know why? (patient shakes her head staring wide eyed at B). "OK, I'll tell you..." Cameron sits on the edge of the patient's bed and explains that she has had a stroke and she has a headache because sometimes patients who have had strokes will have suffered from headaches due to pressures on the brain. The patient stares and nods her head occasionally as Cameron explains. "Mrs. D, do you understand what I have just told you?" (patient nods her head and then croaks "yes") on this speech Cameron sounds surprised and encourages her to speak again "Oh wow Mrs. D, that sounded good, can you say something else for me?...well done". The patient looks up at the doctor and smiles croaking again "I don't have anything to say doctor", "well never mind Mrs. D, I am sure I can get something out you a bit later!...excellent, your voice seems to be coming back...isn't that good?. We will have you singing in no time!" (Mrs. D. smiles and shakes her head "can't sing" Cameron smiles and laughs.

Despite the clear power differentials, doctor/patient and healthy/unhealthy, in this relationship Cameron is doing what he can to encourage and communicate effectively with the patient. Not only does he literally get down to her level by sitting on the bed but he explains the condition, how it happened and communicates the indicators for (potential) recovery. He is respectful and careful although the intellectual/cultural difference between the patient, Cameron and the care team is exposed by the encounters below.

"Now Mrs. D. can I examine you?" (Patient nods her head) Cameron takes the patients hand and she flinches "cold!" Cameron smiles and apologies saying it that "it is the alcohol" (alcohol gel he had just rubbed into his hand). The patient eyes Cameron suspiciously "have you been drinking?" the group laugh and Cameron explains that it is the hand-wash and she nods slowly and looks at each member of the team for what seems confirmation that this is the truth. Cameron then begins testing the patient's strength. He checks her arms and then her legs with simple strength tests calling out numbers between 1-5 for the SHO to write in the notes. As he instructs the patient with her tests he speaks very slowly and loudly and the instructions are very simple and clear and he often demonstrated his instructions, especially for those patients that have cognition problems. As the patient does the task Cameron is very encouraging shouting words such as "good", "excellent" or "well done after

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each task". After the strength tests Cameron checks the patient's reflexes with a small hammer. Again he shouts out numbers and makes comments about the reflexes that the SHO writes down in the notes. Following the reflexes Cameron checks the patient's facial muscles by asking the patient to smile, grit their teeth, stick out their tongues and move them about. He then checks her speech by asking her to repeat phrases or noises after him. The first phrases or groups of words were given as words that would be familiar to the patient such as the patient's name or names of simple objects such as pens. As the patient is able to say these words he moves on to more complex words such as "hippopotamus" which the patient struggles with. Cameron then checks the patient's ability to co-ordinate by getting the patient to touch her nose and then his finger with her index finger. The patient clearly struggles with this and is very slow and inaccurate.

For a brief moment after the tests Cameron has a quick discussion with L [another doctor] asking him what he thought about the tests and what they would expect to see on the CT scan. Cameron then turns to the patient and says "sorry Mrs. D, just discussing your test results with my colleague, we think that you are progressing very well...there has been much improvement hasn't there?" the patient stares blankly at Cameron for a brief moment before shaking her head "no, you don't think so? Now what about your speech, when you first arrived you couldn't say a word, now listen to you, don't you think you have improved?" patient shrugs her shoulders and looks down at the bed. "Well Mrs. D, we all think you are improving...so well done..." patient looks up and smiles sadly.

The style of meetings between clinical staff and patients was as much a feature of *Unit and team culture* as of a particular clinician's practices. Thus, while Cameron above was engaging with the patient in what appeared to be a *genuinely caring* manner, his colleagues were attentive, while in the background.

9.4.2.2 'Kenneth' and 'Henry'

In what follows two consultants worked together and while Kenneth was the more senior and experienced clinically, Henry held a senior managerial role (as well as being a senior consultant). Kenneth was described by the researcher as:

... a very warm and caring man ... he is very sweet, kind and caring to his patients and makes them feel comfortable and less vulnerable by empathising with them and drawing on his own personal experiences as a patient.

As with Cameron above, Kenneth was also described as 'tactile' and that he took the time to explain things to patients. Kenneth empathised with patients by sharing a joke (as did Cameron):

For example one lady was embarrassed because she had fallen down in her flat and sustained injuries and did not really want to explain how she had fallen over or what she had hurt [to the whole team]. Kenneth then told the patient that he had slipped over in the hospital and in the M&S food section. This meant that she no longer kept quiet through embarrassment and told Kenneth after that exactly what had happened.

However, during the two day shadowing of Kenneth the researcher was particularly:

...struck by how intimidating this group of doctors must be to the patient, especially an elderly or vulnerable patient as a large group of faces arrive at their bedside and close the curtains around them making the space feel incredibly claustrophobic and that the patient's space felt 'invaded'.

While shadowing Kenneth, the researcher was in a position to observe Henry (who was also shadowed for two days on a different occasion). The researcher's notes here, which describe a joint ward round with Kenneth and Henry, state:

I was struck by how impersonal Henry was towards the patients [in direct contrast to Kenneth]. He did not greet them or introduce himself. [In one case] Instead of asking the patient how she was getting on with the oxygen machine Henry asks the SHO how she thought the patient was getting on with the machine. When the patient tried to give reasons they seemed irrelevant to Henry who just told her she must use her oxygen machine every day or she will not get better.

The researcher goes on to describe how Kenneth (the senior clinical consultant although Henry has a senior leadership role) stands quietly behind the junior doctors on the round with Henry at the front of the group talking to the patient. Henry stands up. Kenneth stands at the back of the group with his hands folded behind his back and Henry every so often asks Kenneth if he agrees with Henry's thoughts on the patient's health status and treatment. While Henry is taking the lead in this way the researcher notes:

Not one of the doctors explains to the patients what will be happening to them that day or beyond nor do any of them say goodbye.

One patient on Henry's round is in the bathroom as the team arrive at her bed.

Henry knocks on the door of the bathroom and says "Mrs. X, it's Dr. Henry we are all here to see you". He then asks a nurse if she can hurry the patient along as he is very busy. It seemed strange [to the researcher] that Henry could not have just visited another patient until this patient had finished rather than rushing her. Before the nurse can enter the bathroom another nurse pokes her head out from behind the door and says that she is washing the patient. Henry asks whether this could be finished after he has seen her. The nurse, who looks frustrated, says she will be a minute. The nurse then helps the elderly lady to shuffle to her chair and helps her sit down. Without greeting the patient Henry begins talking over the patient's bed about her X-ray that was taken yesterday and then asks the nurse about the patient's progress.

In the examples above describing both Cameron and Kenneth's interactions with patients there is evidence that the patients were given a chance to explain to their consultant how they felt and either to tell the doctor what had happened to them or to hear the doctor's explanation of why they felt like they did.

The patients were treated in both these examples as human beings and in doing so the doctors themselves positioned themselves in their *clinical role* but also as *people occupying that role*. By acknowledging mutual humanity (albeit in different styles) these doctors were able to *take authority* from their position as medical experts (see Chapter Seven above).

By contrast Henry also took authority but did this by silencing junior colleagues, Kenneth his fellow consultant and most importantly, the patients. While Kenneth and Henry were in the same Unit, the scenario described above suggests that Henry held more power and therefore exercised greater influence on junior colleagues (and this fed into the culture of the Trust).

In what follows we trace how these contrasting styles might link to the culture of the Units and the teams themselves and consider how this fits in with the definitions of good patient care and service delivery.

9.5 Clinical team work and service delivery

9.5.1 Giving patients care

Miller and Gwynne (1972) suggested that a 'warehousing' model of care operates for those who may be institutionalised in the medium to long term which they contrast with the possibility of a 'horticultural' model of care, akin to what might be identified today as a learning environment. Working in the care of the elderly takes its toll on the emotions of all the clinical staff

particularly in the 'horticultural'/learning setting, where efforts are made to ensure two-way communication and mutual understanding and development takes place. This can leave clinical staff open to experiencing directly the pain and distress experienced by their patients (see Menzies-Lyth, 1960 and the 'stories' below).

The following example demonstrates how engagement between clinicians and patients impacts emotionally upon even (and possibly especially) senior experienced staff. The researcher here, shadowing Mandy, a female senior consultant describes the following case:

Whilst cleaning up a suppurating wound an elderly male patient cried. It was a really touching and sad moment and Mandy was clearly distressed that she had hurt the man. On first seeing him cry Mandy appeared to have a moment of shock/panic where she looked amongst her team to find out whether this was normal behaviour for this patient. On hearing the answer was 'no' Mandy tried to soothe the patient and seemed genuinely sorry for hurting him. The nurse who arrived at the scene also appears to be genuinely concerned about the patient and goes over to help Mandy and prevent the patient from crying. This scene was particularly sad because in today's society and especially in the patient's generation it is thought that men don't cry or show emotion. For the man to cry he must have been in severe pain and must have been struggling with himself to prevent the tears. Mandy's genuine empathy and somewhat guilt might have reflected that.

Mandy and the nurse in this context are using emotional intelligence (see Chapter One) in a relevant situation. Mandy also engages in conjoint action with the nurse rather than take action in an autocratic fashion without consultation. Mandy notes the patient's crying with a start (according to the description) and instead of continuing with the work on the wound (which many doctors might well do because it was necessary for a positive health outcome) she immediately appears to take in the context as a whole – thinking about her patient's behaviour and reactions. The nurse in this case mirrors the behaviour of the consultant. This is an important issue for discussions of leadership and patient care in that teams tend to reflect the beliefs and actions of their leaders.

9.5.2 Discussing patient care

In a shadowing the researcher at the start of the observation describes in detail the way two doctors discussed the patients before embarking on the ward round. This is another case of concerted action:

09:00 Breakfast meeting with Cameron [T3]

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Once they have consumed their breakfast Cameron and Mandy turn to business. Cameron begins by asking Mandy's opinion on one of the patients that they had seen on the ward round that morning. They chat for a couple of minutes about the patient before both getting a patient list out and going through the names systematically and discussing their care plan for each patient. Several patients will need to be discussed in a patient case meeting as they have complex discharge problems, others will need to be referred to the CCP so that a greater social package will be considered. Mandy says that she will go and see a few of the patients herself later and occasionally delegates tasks to do for Cameron, but mostly he is autonomous and says what he needs to do for a patient and what he will organise on behalf of the patient.

This is a quiet and supportive meeting between Mandy the senior consultant and Cameron the more junior member of the team. However, the researcher notes the systematic discussion of the patients and their care along with a plan about who Mandy will see and how Cameron's tasks are designated.

A similar atmosphere of calm and authority are evoked by the description of a case meeting with Cameron's team at the start of the first day of shadowing:

I approach the nurse's station and look around to see if I can see Cameron. I spot him at the far end of the ward sat at a computer with a mixed group of staff (doctors, nurses) surrounding him. I approach the group and stand amongst them. Cameron is facing the computer screen and discusses a CT scan with his registrar [L].I notice that as these two doctors discuss the scan a SHO writes notes in the patient's file occasionally craning his neck to look at the scan at certain parts of the discussion. A few nurses also crane their necks at various points but most just stand patiently in silence waiting to visit the patient. Once the discussion draws to a close Cameron turns his head from the computer and asks the team if they have anything to add. ...[later on in the same meeting the researcher listens to a telephone conversation] ...Cameron has rung the wife of a patient to update her on her husband's health. He is very honest with the wife saying that her husband has had a second stroke during the night at that he is now in worse health. Despite the bad news Cameron is very friendly and pleasant with the relative and is very sympathetic to her questions and on several occasions empathises with her. Coming off the phone Cameron returns to the team and gives a brief update to L regarding the conversation with the patient's wife. The SHO writes this summary in the notes. Cameron takes a short sharp breath before asking "shall we go and visit the patient?" Cameron turns quickly on his heels and enters the ward.

The observation here reveals the high workload and 'multi-tasking' undertaken by the team (looking at the computer, discussing scans, taking notes, calling relatives and so on). But there seems to be focused attention on patient care and individual patients. At the end of this extract it also seems that Cameron himself takes the ward rounds very seriously – gathering his mind together and possibly seeking the emotional strength to move from the clinical team and considering evidence from notes and colleagues to imparting and collecting information from the patients.

The same researcher who has shadowed both Kenneth and Henry at a different Trust from Cameron, gives examples of how some of Henry's patients are discussed. For example she describes a meeting to discuss patients chaired by Henry.

Henry criticises the way [Site B] is run and the management of beds and patients by that hospital. He praises the doctors for the current situation on [Site A] where they have spare beds stating that they have done so well in 'kicking them out'. Henry stated during [a previous meeting] that the patients needed to be removed or 'kicked out' of hospital as soon as possible. The rapid turnover of patients may on the surface appear that they are not receiving good care However getting patients home quickly reduces the risk of hospital acquired infections.

And is likely also to be what many patients would want.

As the researcher makes clear, it is important not to confuse the rhetoric with the quality of patient care, but rhetoric does determine and reflect a dominant ward or Unit culture.

9.6 Responsibility for patient care

Responsibility was a key element of the discussions of leadership particularly in Chapters Four and Five. Responsibility for individual patient care is in the hands of clinical teams led by the medical consultant but above that person is the clinical leadership/management (Clinical and Medical Directors) as well as the senior operational managers (CEO and COO and others).

Primary responsibilities for patient care however vary from *individual care* i.e. for both identifying care pathways and day-to-day care to responsibility overall for the care of all the patients. In Chapter Ten we review the findings from this study with some recent cases where responsibility has been mishandled to explore what lessons might be learnt.

In an interview with a consultant:

... we try to just have a really open forum where we can discuss that [specific patient care], just like open it up and letting people put their viewpoints first and then kind of trying to question where they're coming from with that in a positive kind of way but them also laying out where you feel that that might not be the right course of action. Erm and also at the end of that discussion making sure that everyone is happy with the outcome, and sometimes people aren't erm .. but it also realising that it is a consultant's responsibility at the end of the day and making sure that everyone knows that you're happy making that kind of decision and that you are happy to be made accountable for that decision.

9.6.1 Responsibility for emotion

It frequently falls on the clinical leader to cope with their own, the patient's and the relatives' emotional reactions and distress and also with those of the other members of the team. As the researcher noted:

One senior consultant, Tricia, made it clear that as the clinical lead she also took responsibility for talking to patients about DNR³⁷ forms and delivering 'bad news' to patients/ relatives. During the ward round Tricia removed the pressure from a junior member of the team who had been told by a relative that they didn't want their mother to be resuscitated. Being told this information had stressed out this junior member of the team as he was not yet ready for this type of responsibility. Tricia supports her junior colleague saying that he should have never been confronted with this situation.

One question here then is how do the clinical team handle such multi-layered emotional problems? How important is leadership in supporting (and developing) teams to cope?

9.6.2 Responsibility for teaching

Most clinicians in the study from all disciplines were interested in teaching the next generation, and their activities will influence patient care, provide role models for leadership and influence climate and culture of the organisation. The example below is chosen because Dr. Jenkins was very enthusiastic but also demonstrated compassion and courtesy when he was face to face with the patients. The researcher's notes describe this in detail:

Approaching the patient Dr. Jenkins shakes the patients hand and says "how are we doing today?...I see you were referred by your GP...you have a

³⁷ Do not resuscitate.

wonderful GP" (he comments on how wonderfully clear and precise the notes are). "That's not my GP, that's my missus's GP, mine's on holiday...I have Dr. U. U". "What a name! But looks like they have to wonderful GPs at your practice...the notes are seamless...you are lucky!" Jenkins then continues to ask the patient about his medical history. The patient is able to tell the doctor his entire medical in great detail including the drugs [more description from the researcher]. Dr. Jenkins stops the patient and asks the medical student to take a mental note of how a good GP leads to a well informed patient, which helps him (Jenkins) in his (patient's) treatment. He talks about 'aspects of professionalism' and the right ways of informing patients about their treatment and condition, he openly praises the patient for knowing so much about his patient history and tells the students that "medical history in patient care is so important". The patient begins talking about his treatment in the hospital and Dr. Jenkins states that "patient feedback is great, and they like to hear about it...we need to be more professional...primary care pathways are the key to patient care".

Dr. Jenkins behaves with humour towards the patients and the students and junior doctors but does so while continuing with his assessment of the patient, taking the relevant history and trying to impart good practice and professionalism. He manages to balance giving the students and junior a chance to gain hands-on experience while making sure he himself has all the information he needs for the care of the patient.

Dr. Jenkins then checks the patient's lungs and heart asking a SHO, Dr. Williams to check the cardiogram as he can hear an AF flutter. As Dr. Williams looks for the chart the patient tells him that his GP had thought the same and that is why he was thinking of changing his drugs. Dr. Jenkins looks at the students and says "wonderful isn't he?" he continues that the GP must have heard or felt it himself [the heart condition] and now they will need to see the chart to prove it then they can change the drugs as the GP had predicted. After looking at the chart Dr. Jenkins asks Dr. Williams to change the drugs and to get rid of one of the drugs he thinks are unnecessary. Dr Jenkins shakes the patients hand when he leaves and says that one of the juniors will be back later to sign off the new drugs.

Looking over the notes Dr Jenkins spends a lot of time teaching the [medical] students about various medical conditions and treatments that have arisen out of [a particular] patient and asks them to suggest other possible diagnosis and other treatments for his condition. Jenkins is a very enthusiastic teacher and the enthusiasm rubs off on the students who are all eager to share their knowledge and take stabs at questions they don't know. In the middle of the question and answer session he asks one of the students "what year are you in? I don't know how much you guys know already". The student base is a mixture from students from [different

schools] and he relishes the opportunity to teach the students some new medical knowledge. Whilst getting the students to look at the cardiogram he looks up and apologises to Irene [matron] for taking so long on his ward round "Sorry Irene, I will be here all day, this is such a pleasure to have students!" Concluding the teaching session he quotes someone for saying something about the health of gamblers and drinkers and then asks "now who said that?" the students look round each other and then he exclaims "me mother!" all the students laugh including the female registrar and Irene. He then ushers them onto the ward saying that he doesn't want to get in trouble with the matron.

9.6.3 Subverting responsibility

There are diverse ways that staff at both Trusts had for coping with emotional aspects of patient care and resisting authority (and thus taking responsibility for care into their own hands). One way that nurses (including senior nurses) operated was to *subvert* some of the doctors – particularly when the relevant doctors showed little interest. The shadowing of a senior nurse [Irene, the matron] during a ward round produced the case of Lola (described when shadowing Irene):

Irene tells me it is because many of the patients are elderly with complex cases and therefore they tend to stay for a long time. I note that one of the patients has been here for a long time and I ask whether due to the long length of stay on the wards whether she becomes attached to any of the patients, I point particularly to the patient who had been here for three months. Irene says, 'oh that's Lola, mmm has she been here 3 months?...let me check her notes'. Irene leaves the file that she is reading and picks up Lola's file and looks at the admissions page and then states (sounding surprised). That three months is correct. She then continues that she does find herself getting attached to her patients, especially if they have been here as long as Lola. She mentions that Lola should really have been moved to G Ward but she really doesn't want to move her 'she should be elsewhere, but she is ours' (highlighting emotional attachment and the sense of ownership over patients). She tells me that Lola is really sweet and all the nurses really like her and it would be quite strange if she was no longer on the ward as she is a returning patient and 'it is always nice to have her back'.

As we have suggested in Chapter One (and witnessed above), in order to protect one's self against anxiety clinical staff often 'split' patients into 'good' and 'bad'. Here the treatment of Lola indicates that the nurses may be using their care of her to defend themselves against some of the harsh treatment decisions made about other patients (by doctors and managers) particularly when there is pressure to discharge older patients due to bed

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shortages. This might lead them to consciously and unconsciously subvert these authorities when they can and there is a particular pleasure to be gained when they succeed in this 'subversion' with a 'good' patient such as Lola. What remains at stake is whether Lola's stay is actually benefitting her clinically (or even socially) and also whether it is preventing another patient receiving medical care.

9.6.4 Responsibility for end of life decisions

Responsibility for patient care resides not only with the clinical team but is sometimes shared between the team, the patient or the patient's closest relatives which is usually the case with end of life decisions. Sometimes the greatest emotional engagement is with the *relatives* of the patient rather than the patient themselves. This is particularly the case when the patient is likely to die which is particularly sensitive when it is a case of withdrawing life support. The following example of Cameron's Patient G and his daughter brings this into sharp focus.

The biggest emotional situation this day surrounded Patient G, a coma patient and his daughter. Cameron had to encourage the daughter to agree with his plan that her father's treatment should cease and palliative care take over. This is a very emotional situation especially due to the young girl's age but also because she was in 'denial' asserting that her father would get better and this caused her to present a whole range of emotions that Cameron had to deal with.

We enter the side room. The blinds are drawn causing the room to be quite dim. There is a young girl sat up right on a make-shift bed that she has made from four visitor chairs from the lounge. She has a blanket over her legs and is typing on her lap top her mobile phone ear phones in her ears and bags and other items are scattered around her chair. She looks up as we enter and pulls the ear phones from her ears. I am surprised at how young she is, I had expected a daughter of forty something not a teenager of 18 perhaps, but no more than twenty. She pulls the covers off her legs and places her lap top on the window sill. Cameron asks if she is ok and she nods and says she will leave him to it. Cameron says that he will bring her in once he has examined her father, she nods and opens the door pulling her jumper down over her leggings as she leaves. Cameron looks at me and comments (adding to what I was already thinking) "I think she is far too young to be dealing with this on her own....it is not fair".

He turns his attention to the patient and begins speaking loudly to him. He explains that he is a doctor in [Trust 3] hospital and that he wants to examine him. At each point of examination Cameron explains to the patient what he is going to do. Cameron is able to move the patient's limbs like he

is a doll. Each time the limbs are placed in a position they remain there. The patient doesn't respond to any pain stimulus as Cameron pinches the patient's skin and scratches the bottom of his feet with a stick. Cameron then checks the patient's eyes by pulling back the patients eye lids, the eye lids roll from side to side and Cameron explains that it is called a coma roll, which suggests that the patient is in a deep coma. Cameron teaches W by the patient's bedside and talks him through the patient's condition and talks about how the patient's recreational drug habits could probably have contributed to his stroke. Cameron and W engage in a small conversation about the problems of cannabis on the brain.

Cameron made the decision in consultation with his team to discuss with the daughter that they need to end the patient's treatment (and thus in all likelihood, his life). Cameron deals here not only with the daughter's distress but with the daughter's worry that she is involved in the decision to let her father die. Again a high degree of emotional intelligence and leadership as well as clinical knowledge operates in this communication.

While shadowing Owen [Trust 2] the researcher sees that while behaving perfectly correctly he puts emphasis on the clinical and health related aspects in an end of life situation above communication and empathy. He is not unkind but 'misses' the emotional level of communication. Here in the presence of a daughter and father the woman (mother/wife/patient) is clearly dying and being kept alive by the clinical team. Owen:

... talks directly to the daughter stating that her mother is coming to the natural end to her life and therefore she [the mother] is giving up - 'withdrawing from life' and tells the daughter that although they will feed her through a tube she [daughter] should prepare herself and her family for the inevitable. He also says that her mother will also start ripping the feeding tubes out to prevent herself from getting the right nourishment.

The image conjured by the 'withdrawing' from life and 'ripping' feeding tubes is dramatic and seems to give agency to the dying woman – almost indicating that somehow she is to blame as she will prevent herself getting the right nourishment. However, the researcher, as participant in this encounter, is bringing out a sense of the culture of this particular event. While Owen is probably protecting himself emotionally from the loss of life and the sense of clinical 'failure' he does not protect the daughter or the husband from the emotional onslaught of the woman's impending death.

The daughter says that she understands and turns to her father and says 'dad do you understand what the doctor is saying?' the husband paces up and down the side of his wife's bed looking lost and lonely. He looks up at Owen and says that his wife is giving up because someone at the nursing home said she was a burden. The daughter scolds the father for saying that

in front of her mother. She explains to Owen that although she [mother] doesn't say anything she listens to everything and the more her father says it the more she doesn't eat. Owen says he understands and asks how the family is coping.

The daughter here is also protecting Owen from the family's pain by scolding her father even though Owen asks how they are coping. However, although kind and polite, Owen does not seem to operate with emotional intelligence or engagement with others' pain.

The daughter says that her father is finding it very difficult because he is the main carer for her; she herself has taken time off work to care for her when she can to support her father. As she speaks about her father and how upset he is becoming she begins to become tearful. Owen listens to her as she speaks and occasionally asks further questions. The husband continues to potter around the room occasionally touching his wife's head and face. The daughter watches him.

Owen, while allowing the daughter to cry and not acting as if he is irritated or embarrassed, equally pays little heed as he continues to talk of the mother's deterioration.

Owen begins to talk about the deterioration of her mother and what they will be able to do for her. The daughter says that she knows what Owen wants to talk about 'you're talking about DNR aren't you?' Owen says yes he is and the daughter tells him that she knows about it because her friend's mother recently died and this was discussed with her. The daughter says that she knows what she would prefer but they will have to talk this through with her father. The daughter calls her father over and begins explaining DNR. He looks at his daughter, he looks lost and scared and she tells him that it is his decision but she thinks that the doctors should not resuscitate her mother because she will be resuscitated to the same state. Owen inputs that she will be 'worse' than how she is currently because she will be a lot weaker. The daughter says that she will have to talk through this with her father. Owen nods and leaves the room.

9.6.5 Stories of patient care

The following two stories show in detail the ways in which responsibility and power can shift between team members and highlight anxieties faced by doctors about caring for patients.

9.6.5.1 A story of system failure: Cancelled Clinic

The first story is told by a female registrar who describes a situation in which she felt disappointed with patient care due to cancelled clinics. In the

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following account, the narrative is broken down to four moments, and each is discussed to demonstrate how the doctor's anxiety is managed by being linked to a failure in 'the system' that climaxes in her interaction with patients.

Q: What about any time or incident that made you feel disappointed with patient care in this hospital?

A: Lots of times, particularly since we've not had a secretary. Every clinic, every single clinic I send somebody home because the notes aren't there at all. They are supposed to be coming to see the consultant [her immediate superior] and he's not there, and they've been put into my clinic and you look at the letter and it clearly says on the letter 'consultant only to see', and they turn up and he's in Italy, on holiday.

The registrar is expressing frustration. On the surface it is towards a recurring failure in patient care attributed to firstly not having a secretary and secondly because the consultant 'is not here'. The expression of the frustration however is confused; there is no secretary but the patients 'have been put' into her clinic. Furthermore, she sends someone home from each of her clinics because the notes are not there. The letter 'clearly says' the patient is to see the consultant who is not only not there but he's in Italy 'on holiday'. There is a feeling of being overwhelmed, and of rage and envy towards the consultant - and possibly the patients - emerging from this short paragraph (for discussions of workplace envy, see Vidaillet, 2007; Stein, 2000). There is also an expression of omnipotence in that she sends patients home. She has the 'legal' justification to do so because there are no notes and also because their letter says they have to see the consultant and the energy is directed towards this activity rather than getting patient appointments changed. The consultant is on holiday, presumably one to which he is entitled and one which has clear boundaries enabling them and the staff who make the appointments to re-arrange the patient dates.

There is clearly a high degree of frustration and anxiety present in this account; there are too many patients with 'needs' and not enough clinical or support staff backing the work in the way in which the doctor would feel comfortable with. As there is little opportunity either to express or assuage her anxiety so she becomes 'prey' to primitive phantasies and unconscious mechanisms to relieve the anxieties.

The story also sheds some light on doctors' anxieties about working in a multidisciplinary team. Medical education and postgraduate training provide a culture in which doctors believe they can rely on each other through which a sense of being an elite group and confirmation of professional omnipotence and responsibility - particularly of the consultant - arises. However the role of the consultant also brings about a sense of envy and

destructiveness in others which has its origins in the primitive defence mechanism of splitting off the painful parts of one self (e.g. the realisation that you are not omnipotent and that another has the ability to do what you cannot) and projecting them onto others in an envious attack (Klein, 1959).

...and you have to go out and say, 'I know you've waited three months for this appointment but I'm afraid the consultant is not here and he wants to see you personally, so thanks for coming but if you can just go away' and you can't even say to them 'you're getting an appointment for next week' because realistically they're getting an appointment in three months time, and I think that's really disappointing.

'Breaking bad news' is considered to be a difficult task for health professionals and one that is a constant cause of anxiety. In addition to having to find the appropriate means of communicating prospectively devastating prognosis and supporting patient through the immediate emotions, doctors must come to terms with possible changes in how the patients perceive them (Barnett, 2002). Even though the situation described here does not involve delivering bad news about an illness, it is a moment of disappointment for both the patient and the doctor. The patient's anticipation to receive treatment is rejected and the doctor has to acknowledge failure in service delivery. The patient's possible anger and anxiety is directed towards the messenger, who in this case, is unable to offer any practical solution. Instead of being the helpful, trustworthy saviour, the doctor transforms into an envoy of disappointment and will have to see to the patient's emotions as well as her own disappointment, to which there is no external consolation on offer. To alleviate the anxiety caused by the situation, the registrar clings on to a narrative regarding her workplace – she is disappointed in the system.

I feel very disappointed in the system, which, I know the system is a big, wide thing, but ... [it] lets people down from that point of view and, you know, we overbook theatre lists and they get cancelled and then again I feel disappointed.

By seeing the NHS as a faceless, bureaucratic, 'machine-like' (Elkind, 1998) entity, the registrar convinces herself that the situation is not her fault – it is not what she would want for the patients, or for herself. She feels anxiety for she cannot provide the care required, and as a consequence she projects this anxiety through blaming 'the system'; regardless of their individual efforts, doctors are powerless when the system fails. As this registrar said epigrammatically later on in the interview: 'I don't think the NHS works anymore' which at a conscious level represents the impact on her working life of a problematic bureaucracy while at an unconscious level it provides uncontainable stress. The doctor does not have the opportunity to delegate

tasks to her superiors to reduce the 'heavy burden of responsibility' (Menzies, 1960, p. 118) thus feels that she is left to deal with the failure of 'the system', a system, which ironically is set to heal people, not cause them angst.

It's mostly because I'm thinking, how must that patient feel. You know, they've worked themselves up, they've told work they are gonna be off work for three weeks or four weeks or whatever and arranged cover and you go and tell them, sorry, you can't have your operation, you can go back to work tomorrow. That's really disappointing, to do that to people, very much so.

In the conclusion to her story, the doctor moves beyond expressing antagonism to the system to empathising with the patient. Thus, by failing, the system provides the doctor with a social defence mechanism but through empathizing with the victims of the failure, she fails to contain her anxiety.

9.6.5.2 A story of grace in adversity: Supporting the mother of a still-birth baby

The second story is told by a male registrar who describes how he provided good patient care by supporting a mother of a still-birth baby. Despite the plot, the story is not told as a tragic narrative but as a proud patient-care moment, a sequence of events that had thoroughly positive impact on the doctor's perception of himself. This narrative is also analysed in sections.

Q: Could you give an example where you felt that you have given good patient care?

A: I think that one of them was this lady who actually came to the labour ward and told me that she hasn't felt her baby move in the past one day and she had had some bleeding. Obviously there was some concerns on my behalf for the baby, because there could be a problem. This was a very wanted pregnancy because she was quite old and this was an IVF pregnancy. I examined her a little bit and on examining her I found that the baby did not have a heart beat, so she had lost the baby.

Describing the situation at first with the patient as an object helps the doctor to distance himself from the scenario and to do routine checks expected in this kind of situation. In a hospital setting instructions are given about the way each task should be performed and these rituals form a reassuring tool for staff (Menzies, 1960: 121).

I did explain everything to her, and obviously as a doctor responsible for her, I need to follow all the procedures that needed to be done and all the care that she needed to have, you know I explained it to her that, you know this by far something that words, you know cannot express, as you can imagine how

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difficult this situation would be, and if we could make it the slightest bit better, we would try everything in our power, you know, to make the situation a lot more comfortable. I ensured that she was given a quiet room, with a very good midwife looking after her at all times. Obviously I had my duties towards the rest of the labour ward as well. People visiting her room making sure she was ok, making sure the pain relief was ok, we had induced her because we did not want her to go home with a dead baby inside her. It was a very, very painful and stressful scenario, it really, really was, it was horrible, absolutely and it is very distressing, exceedingly, exceedingly distressing because, you know the woman is going through all that pain of labour.

Here, the doctor is empathising with the patient, feeling her emotional pain and in this case is mostly able to contain it through wanting to relieve the situation and then by offering extra care, by 'going an extra mile'. In this extract, there is a clear shift as the doctor uses strong emotional words to describe the crisis. In telling the story, he is projecting his own anxiety on the patient, living the distressing emotions with her and having to remind himself of his position as a medical professional - 'obviously I had my duties towards the rest of the labour ward as well'. By referring to 'all that pain of labour' the doctor enters a relationship with the pain. The phenomenon of pain and our relation to pain, whether someone else's or our own, is more immediate than that of reflective knowledge – we do not think about pain but react to it so the sensation is intersubjective. The person who is not experiencing the pain but affected by it is an 'interlocutor' in the situation (Crossley, 1996, p. 37).

...I tried to make it a point that I was present, present as much as I possibly, feasibly could during her emotional outbursts. I wanted her to have all the support that she needed... I did get attached to the patient, being around her, trying to get her care, even if I was out of hours, which means that when I was not meant to be in the hospital. Now I think that some people will argue that, that is a bit over the top, but I think that, I guess, I guess, that that is medicine for you, you know it is about lives, and sometimes you have to make that extra effort, to make that person feel that little bit more special.

In this excerpt the doctor starts to explain and justify his actions. Through self-reflection he has realised how he acted in a way not normally accepted in the hospital culture, that is, he went against the 'social defence system' to deliver patient care, but also to cope with his own anxiety. He dedicated extended time to his patient even though hospital doctor's time is considered to be 'fast and efficient'; 'doctors move quickly in the hospital wards. Their time is expensive. They cannot afford to linger too long in any one spot' (Mattingly, 1998, p. 21).

Menzies (1960) noted that while institutions have social defence systems, individuals may resort to their own defensive mechanisms, but a membership of an institution 'necessitates an adequate degree of matching

between individual and social defence system'. If the individual and the social defence systems are in disagreement, what follows is some degree of breakdown between them, for example, a doctor's work colleagues might reject them for behaving in an inconsistent or unprofessional way to the system. Consequently, the registrar providing patient care to the mother of the still-born baby is not only coping with anxieties created by that emotionally charged situation, but he also has to think about the culturally accepted limits of caring and possibly negotiate his way with other members of staff. On this occasion, the doctor keeps to his defences and spends extra hours with the patient, without being criticised by his peers.

Well you know that when things get worse, they get worse and they get worse and they get worse. Ultimately what happened with her was that we tried all the induction of labour, we tried everything possible to get that baby out, by induction. And in her case with the induction, it failed as well... and I can't tell you how dreadful that scenario was, that she needed a Caesarean section to have that baby out... I wanted to make sure that I was present at the Caesarean section, as well so that she would have a face that she knows. Once she delivered, you know obviously I was there with her, with the [dead] baby in her arms, and she was happy from the point of view.... and thanking me every now and then, which I said that she shouldn't because it was my job and one should do it. But she kept signalling the fact that not many people would do it the way that I had and I that was very special.

Much hospital work contains a 'constant sense of impending crisis' (Menzies, 1960, p. 26) which creates pressure and anxiety. The level of predictability in medical work is low and – as the registrar expresses it – 'when things get worse, they get worse'. The doctor explains that he attended the Caesarean section for the patient's sake, but this could also be interpreted as his coping mechanism – the need for a closure (Mattingly, 1996: 37). If you only see trauma and dramatic events without closure, the events will stay lingering and cause anxiety, stress and possibly depression. The doctor needed to be there and needed to have closure to be used as a coping mechanism against accumulating anxiety. So far the patient had been in a powerless position while the doctor had presumably been in control of the situation and emotions involved in it. Therefore, when the patient thanks the doctor, he gets confused. The patient had survived through the ordeal and suddenly has the power to relieve the doctor's anxiety, to nurse him (Menzies, 1960). The acute physical and emotional stress is released and the doctor can reflect back on his experiences.

And I think that is something very, very special and dear to my heart. And these are those situations when you sit back and you reflect on your life and

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say, "wow I have done something good, really, really something good and it is wonderful".... I saw her every single day on the post natal ward and obviously I made a point not to neglect her, or neglect her partner because people assume that the only person going through the trauma is the woman who has actually delivered, but they are a couple, and that needs to be understood so that was important as well. And he appreciated that quite a lot. They went home, two weeks later, I did receive a lovely letter, which kind of expressed a lot of gratitude, for what I had done for them.

The thanking letter provides closure for a difficult story, but maybe also goes beyond this. It hints at redemption – instead of a medical tragedy possibly compounded by failure in patient care, the story becomes one of a victory or at least grace under fire, a positive example of the doctor's powers even when he cannot actually perform miracles by restoring life. Anxiety is successfully overcome by the absolution from the patient and the doctor's 'priesthood' (Elkind, 1998) is restored. The letter from the patient acts as the final seal to exalt the extra efforts the doctor put in to solving the problem (Menzies, 1960, p. 31).

I know that I put in extra hours and I KNOW that I shouldn't have been there but no-one complained, because everyone knew that I was helping a situation. It is just an understanding that we have. It would be a terrible job if you were only allowed to work your set number of hours.

A narrative like this one permits people to attach themselves to 'desirable' ends, think well of themselves in moral terms', 'support their needs for autonomy and control', and 'promote feelings of self-worth' (see Baumeister, 1986 in Brown, Stacey & Nandhakumar, 2008, p. 1054). By telling this, not an easy or comfortable story, as a proud moment of good patient care, the registrar restores his professional and personal integrity. There is no 'system' in this story to blame on, no failure to confess, but despite the drama the story draws to a happily-ever-after ending. The story has entailed a narrative for the self (Brown et al., 2008) that has released the anxiety the event contained.

9.7 Conclusions

Patient care is a process and a social construction and as such means different things to different people. Norms and styles of patient care also change across time and differ site to site not only because of differences in beliefs, but also because there are different possibilities (technological advancement, different types and mixes of professional groupings) and different types of constraints on what might be offered. It is not always possible to put a clear value judgement on patient care and one example is to do with 'length of stay'.

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Managers, whose concern is to ensure that beds are not blocked, may or may not be holding in mind the image of an organisation that shares care with agencies and families in the community. They may simply be responding to government targets. They may have their mind fixed on those waiting for beds who have still not received treatment. Patients themselves may want to return home as soon as they can or become bewildered when they are discharged rapidly after treatment.

Working in multi-disciplinary teams with distributed leadership patterns may have improved practices for clinicians. Accountability for patient care still resides with the consultant and the hierarchy who manage the Trust. While senior managers are responsible for ensuring patient safety and preventing negligence to individual patients, they are also responsible for ensuring access to care for the community which involves managing scarce resources such as equipment, pharmaceuticals, beds and staffing.

Not all clinicians appreciated or respected these pressures as we saw particularly in Chapter Six. Nor do patients necessarily agree that good care is anything other than good and consistent communication with specific clinicians.

As demonstrated in Chapters Six and Seven managers are frequently frustrated by demands from staff who may try to subvert managerial targets (set by government and as such fundamental to resourcing of the Trust).

The quality of leadership is intimately linked to patient care. Good patient care relies on effective leadership of the kind that engages with staff and imparts to them the vision that (as far as humanly possible) the patient comes first. That in turn impacts upon the climate, culture and ethos of the Trust. When leadership fails, so does patient care.

10 Leadership and patient care: Assessing the past and thinking of the future

10.1 *Introduction*

Without effective leadership at all levels of the NHS and its various organisations patient care suffers. This knowledge has been evidenced in

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several key studies across recent years as reported above and elsewhere and consequently fed into the NHS Qualities Framework (see Chapter One).

In this report we have critically reviewed the relevant literature on leadership exploring as far as possible the relationship between leadership, followership and service delivery across five hospitals comprising three NHS Trusts (see Chapter Three). We employed different research methodologies (see Chapter Two) to capture data to investigate leadership qualities and their interaction with the climate and culture of the organisation and linked these to service delivery and patient care in different settings (ranging from obstetrics and gynaecology and cardiology to care of the elderly).

10.1.1 The organisational contexts

The organisational contexts of each Trust and each site or unit varied physically, structurally and in 'atmosphere' (the full details are provided in Chapter Three). We have been concerned in the report (and future papers) to steer a path between maintaining anonymity and confidentiality and thus not overtly identifying a Trust or site within a Trust, while also pointing to how the contexts impacted on the practices of leadership and service delivery.

Overall the Foundation Trust (3) in this study, which had not been experiencing mergers or threats of closures, where staff morale was high and where leadership practices were distributed across teams and clinical and management specialties, was clearly the one most conducive to effective communication and leader-follower engagement. There was an 'atmosphere' of connection and pride in belonging to the Trust as evidenced explicitly in Chapters Four and Nine in particular.

Trust 1 was applying for foundation status during the time of the investigation but also threatened by closure of some of its units, and with the senior managers possibly being transferred to the other site which was perceived by the participants as a threat to their status and possibly to resources for service delivery. This did not happen during the course of the investigation. The managers in Trust 1 were committed to their staff and to service delivery although there did appear to be some discontent with senior management from the medical staff. This may have been because most of the distributed leadership involved non-clinical managers and nurse managers with the medical teams appearing to take a more 'traditional' hierarchical stance. Most of the data from the OCS was derived from Trust 1 which demonstrated among other things the importance of management support for identifying good leadership and patient care practices.

In Trust 2 there appeared to be the greatest amount of conflict between groups of staff who sometimes seemed to be leading in different directions.

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Trust 2 was perhaps the 'victim' of a relatively recent merger between two large hospitals (and one or two other smaller units) which were some physical distance apart and had had a different history – one being a DGH and the other a teaching hospital. The DGH appeared at first to have a professionally diverse group of senior managers who distributed their leadership to effect, but one or two figures emerged during the course of the study who transgressed this approach with one person taking a back-seat while another was trying to drive through change in a somewhat cavalier manner. Furthermore in this particular Trust there were changes among the senior managers (some left, others moved to the other site during the course of this study). The CEO also indicated that it was difficult to recruit good middle-range managers and nurses in particular because both sites were away from the centre of the city where most people would look for a promoted post.

10.2 *Limitations of the study methods*

As with any large scale and complex study such as this one not all of our intentions were achievable although some were satisfied beyond our expectations.

We had difficulties capturing data from patients for two main reasons (fully detailed in Chapter Three).

Firstly, the 'gate-keeping' staff working on the Units on a day-to-day basis (as distinct from those who supported overall access to the Trust overall) obstructed data collection.

Secondly, it was also difficult gaining access to patients while they were in hospital because of ward procedures and in other cases the poor health of patients. So in the end we managed to conduct ten patient interviews but were unable to collect organisational climate survey data from patients at all³⁸. To overcome this we gained permission to observe clinicians' interactions with patients in their care and we believe we have managed to do more than compensate, making a contribution to knowledge with important new material to demonstrate patient care in different contexts and the processes involved in patient care and service delivery (see in particular Chapter Nine).

We also met with difficulties, with one Trust in particular, collecting *survey* data from staff although individual staff members proved more than willing

³⁸ These difficulties were reported to SDO in the interim reports and also separately when they arose.

to support the researchers by allowing them to interview, observe and shadow them during their working days. *This is all reported fully in Chapter Three.*

10.3 *Reviewing the findings*

In this final chapter then we draw together the findings from the study and make suggestions as to how they might contribute to policy and practice beyond the participating organisations.

This chapter is organised around the original study aims which were about leadership, organisational climate (culture and context) and how they impact on patient care. The overall plan was to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery.

This research further sought to explore the following broad-based questions.

- First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
- Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?
- Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The specific aims and objectives are listed again below and we conflate these in what follows directing the reader to the relevant chapters.

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines, to patients;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts service delivery;

- To learn how different stakeholders (specifically patients, nurses, members of professions allied to medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care;
- To identify how the need for change in service delivery is identified and what drives the need for change.

10.3.1 How far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?

Throughout the participating Trusts there is evidence of the importance of high quality patient care. Chapter Nine in particular brings this together with quoted respondents emphasising that above all patient care matters to the aims of the organisation and those who work in it. Thus on a basic level, working for patient care is inspiring in itself and staff across the Trusts see good patient care as their *modus operandi*.

Our use of innovative ethnographic methods and story telling were particularly effective in providing the evidence of how patient-clinician relationships were practiced and how staff made sense of their own actions reflexively in the context of caring for patients³⁹.

Chapter Nine provided evidence of the ways in which care is practiced.

We begin here by summarising some of the evidence from the Foundation Trust in this study, which consistently appeared to demonstrate high levels of distributed leadership, emotional engagement and multi-disciplinary working across all levels. The data included several key examples of positive statements about the role and effectiveness of management. We saw, for example a senior clinical manager summarise the issue with reference to his

³⁹ For example, interviews opened with questions about leadership and patient care, and participants were then encouraged to tell 'stories and critical incidents illustrating their experiences'. The early parts of the interviews provided themes and indications of what the clinicians regarded as crucial to delivering good patient care, e.g. 'cleanliness', 'efficient administration', 'communication', 'empathy', 'sympathy', 'knowing the recent developments in your field' and 'everything behind the scenes the patients don't see'. However, it was the stories they relate to that provided us with insights into their core experiences of patient care (see Chapter Nine).

pride in working for the organisation drawing attention to its low mortality rates, and that the high quality staff and its reputation for patient care act to attract others at the top (or with the potential to be at the top) of their specialty.

By contrast, the CEO of one of the other Trusts had made the point in their interview that one of the difficulties they had was attracting high caliber nursing staff, partly because of their location (in the suburbs). In Chapter Four we identified the ways in which an organisation might be seen as a learning organisation as significant in supporting staff to develop their clinical and managerial skills and develop capacity for patient care. Where support for learning was apparent so was the enthusiasm and pride for the organisation and its goals.

What was striking was the way that all respondents who addressed this point were looking to see how patient care could be improved with aspirations that patients were satisfied with more than just the health outcome (although that is the bottom line) but also with the facilities and the atmosphere. In addition, several respondents made the point that they themselves were mindful of delivering (or at least aspiring to deliver) the type of care they themselves would want to receive.

That so many of the staff (clinical and non-clinical) worked long hours in which they were engaged in intensive work with either their clinical or management teams, or their caring for patients with the aim of delivering the best possible care, is yet further evidence of the ways in which patient care is inspirational.

What is most noticeable, however, is how some styles of clinical and managerial leadership appear wanting, when compared with the best. While some respondents are clearly excellent communicators who engage fully with their professional knowledge and with the patients and staff, others - equally expert and equally inspired to provide the best for their patients - seem to fall short in comparison. In Chapter Nine for instance, Cameron and Kenneth engage with their patients in human ways and there are examples in the chapter in which each clinician manages to gain important information from and for their patients by their hard work *and* their humanity. However, in Cameron's case he is supported by a team which has clearly been nourished and inspired by the organisational context (see references to Cameron's work in this report).

Kenneth, while equally able and empathic, from the ethnographic evidence reported in Chapter Nine, appears to be less able to transmit this or influence others to take up his brand of leadership and patient care. He remains slightly in the background while the younger and (it appears) more influential Henry sets the tone. The clinical team give the impression of

being business-like and impersonal and somewhat intimidating when they conduct their ward round. The culture being transmitted to the other clinical staff tends towards Henry's approach rather than Kenneth's. This raises questions about why this Trust and site is different from the FT in which Cameron and Mandy work. These matters were addressed in Chapters Six, Seven and Nine in particular and will be subjected to further analysis in subsequent publications. However the FT is established and settled. The Trust where Kenneth and Henry work was the product of a relatively recent merger and norms and values were still being 'negotiated' (see Chapter Seven and above in this chapter).

Subsequently we see Mandy working directly on a patient's wound not only acting humanely when she hurts the patient but working with the nurse to assess how they might best improve the patient's condition while caring for his mental state and self-esteem.

High quality care and inspiration come together through the ways in which clinicians and managers take responsibility for their work – for managing emotions (their own, their colleagues' and their patients'), teaching, making decisions about end of life care, communication with relatives and coping with everyday situations that raise anxiety levels for patients and staff. The story of the doctor in Trust 1 who cared for a woman with a still-born baby itself demonstrates how he went the extra mile (in his words) inspired by the possibility of providing care in a case where some might have tried to make minimal contact because a still-born baby might be seen as a clinical failure.

Overall emotional engagement with patients and followers leads to people working together in a human, humane and inspired way and impacts on the organisation itself which can become one with which people are proud to be associated.

10.3.2 How do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

This question underpinned the entire study, but specifically we reviewed the relevant research literature on leadership and organisational climate (Chapter One) and discussed this in Chapters Four through to Eight. We began by reviewing the results from the story-telling interviews, focus groups and ethnographic methods (observations and shadowing). A range of potential practices and behaviours were reported to us which suggested where problems might lie in current leadership practices, as well as what many respondents held to be ideal types. What we summarise now represents a combination of what works and what does not although it needs to be noted (as identified in Chapter Nine in particular) that what

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patients see as good leadership (that they received clear and consistent information from one or two key staff) may not always intersect with what staff meant by good patient care or effective leadership and service delivery. The latter was usually seen as best delivered by a well-functioning multi-disciplinary team albeit frequently constrained by limited resources.

The following issues stand out as good practice that could feed into NHS (and local Trust) policy:

Leadership is a complex concept meaning different things to different people. Over recent years leadership in changing contexts such as the NHS has shifted from the 'heroic' model where leadership is hierarchical to a model that is more distributed across different levels and different parts of the organisations. The heroic and hierarchical (related) models frequently depended upon individual characteristics and where the senior managers were indeed heroic and charismatic, leadership might well have led to good patient care. However, this is unreliable and unpredictable and the NHS Qualities Framework which has identified leadership skills is more appropriate to the context (see Chapter One).

Our most important findings, however, make it clear that leadership which is emotionally engaging and distributed is the one which is most likely to lead and support service delivery successfully as well as drive necessary changes.

At the end of Chapter One we focused on contemporary studies of leadership which promoted the importance of *context* and of taking a more discursive stance in the analysis of leader-follower relations. We also drew attention to the revival (and reappraisal) of concepts from organisational studies from the 1960s to the 1990s which took psychodynamic ideas into account and related them to more 'popular' contemporary ideas about the significance of social and emotional intelligence in leader-follower relations. Thus, we explored the ways in which stakeholder accounts of the experiences and exercising of leadership demanded an attachment or engagement at an emotional level, which took account of the unconscious as well as conscious understanding of these experiences. There were several examples offered in the previous chapters of leadership practices that delivered the required services or changes through different types of concerted action and those that didn't. In some cases we were able to show that with the best will in the world if the leader, for whatever reason, was unable to *engage* and thus be supported by the followers, then their leadership failed to deliver.

Recent analyses of distributed leadership styles and organisational contexts show that if such leadership is to work then people need to act and work together and be prepared to both take up and relinquish authority for

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certain tasks and roles at the appropriate intervals. We saw in Chapters Six and Seven for instance that authority is hard to maintain if a leader loses touch with their staff and fails to hold their own organisation 'in mind'. We used the OCS survey results in combination with the data derived from the interviews, focus groups and ethnographies to demonstrate the importance to a positive organisational climate of good leadership. Satisfaction with a manager was predicted by the same variables that identified a positive organisational climate. For staff in the organisations surveyed it was important that managers were committed, responsible and supportive of their staff/followers.

But how were these characteristics demonstrated? Leaders who were experienced as effective, supportive and emotionally engaged with their followers were able to communicate their vision and dedication to improving the quality of care to patients, which in itself co-existed with good staff morale. Such leaders were also good listeners as well as being able to take staff with them when less palatable or unpopular changes were mooted by senior management or government. These effective leaders were closely connected to the way the organisation was structured (physically and emotionally). They were thus able to access the information they needed in order to lead. The evidence for this frequently came from the stories and accounts of staff and observations made by researchers – often of good leadership but perhaps more acutely when leadership was poor. Then there was a jarring effect or mismatch between (local) policy and the attempt to drive changes to meet improvement targets. There was also evidence on occasions of senior clinicians' behaviours being disengaged. Sometimes attempts were made to subvert the senior people when leadership went against the grain. There are examples in Chapters Seven and Nine in particular.

A final comment here is that despite the changes in gender demographics at the top of clinical specialties in medicine, nursing and related professions, as well as in senior management, gender has not 'gone away'. Indeed distributed forms of leadership have (perhaps stereotypically but with some evidence base) been associated with women's behaviours. The OCS (Chapter Five) suggested that women's perception of 'recognition' for their work and achievements was more negative than that of men. Men were either satisfied with the recognition they received or less in need of recognition from their managers within the organisation than were women. In the qualitative data (see Chapter Eight) it was also the case that while senior women were keen to deny the relevance of being female to their professional lives and their career progression per se, women used different strategies and perceived their roles slightly differently than did men, although the point was well made by some respondents that feminine and

masculine choices of specialty may have been more significant predictors of management styles than gender itself.

10.3.3 Do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The contemporary NHS with its (mostly) distributed leadership practices at all levels tends to militate against the possibility of one person's vision being paramount. However, as suggested above in this chapter, there are nuanced influences of leadership style that (may) flow from one or two people's vision and/or style of leadership and patient care that influence organisational approaches.

In Chapter Seven, for example, we explored three senior people's visions and consequent behaviours to consider their authority and influence with the possibility that as opinion leaders they influenced organisational approaches to patient care. Quentin, for example, reflected his role as a senior clinical leader, and although there is no irrefutable evidence that his style was mirrored in the organisation itself, he does provide some evidence that in certain cases in relation to certain actions his vision had an impact on the overall organisational approach.

While the OCS (Chapter Five) captures data from a wider population, the ethnographic methods made a greater contribution to exploring how far an individual's vision influenced the organisations approach to patient care. Again in Chapter Seven we see Kerry battling against a resistant (and probably disillusioned for some reason) senior management team to improve discharge policy and meet government targets. She tries again and again (by her own account) to show her staff that they need to focus on targets because they will lead to improved care quality. She appears to fail (again according to her own standards) and expresses this by almost literally demonstrating that she is banging her head against a brick wall.

Differently with the same effect Gerald is introduced as having a clear vision for patient care in his Trust. However, his inability to take staff (at all levels of the organisation) with him in his vision is attributed in our analysis to his lack of emotional engagement and autocratic (verging on the authoritarian) style of management. His narcissism further ensures his inability to understand how his behaviour is impacting upon staff and he sees himself as having failed to win a 'fight'.

Chapter Six explores the organisation as an open system, and ways in which all stakeholders⁴⁰ hold a vision of the organisation in the mind at a

⁴⁰ Including patients but we cannot really speak definitively here due to lack of data.

conscious and an unconscious/emotional level acting accordingly. Thus, they have an image of the organisation (how well it is managed, how effectively it cares for patients), a sense of their own role and place within the organisation and how well the leadership understands the experiences of staff and patients. Recognition of the primary task, the roles and responsibilities of those who manage it and the (changing or threatened) boundaries of the organisation itself are critical concepts.

No doubt some members of the organisation have more personal and role/task related power and influence than others in the NHS Trust. Furthermore, the NHS as a system is fluid and dynamic, so that there is overall a group influence over the evolution of organisational context (climate and culture) which responds to visions from within and without (government, health care consumers) the wider system.

10.4 *What have we learnt from this study?*

10.4.1 How leadership relates to patient care

It is clear, from our empirical work and evidence from previous studies, that leadership is a process and set of practices which generally do not equate with the qualities residing in a particular individual regardless of their authority and formal role and status in the organisation. Leadership that 'works', as seen particularly (but not only) in the case studies in Chapter Seven, involves the person in the leadership role exercising social and emotional intelligence and engaging with their 'followers' (see Chapters One and Four) and offering staff recognition and support (Chapter Five). Moreover the role of leader is particularly effective when it is distributed among those who are best placed to exercise leadership towards the task in hand. So that in the context of an NHS hospital Trust, leadership might be exercised in relation to organising the administration for a unit, running an audit, or developing an innovatory clinical practice. Leadership in such contexts is time/project limited.

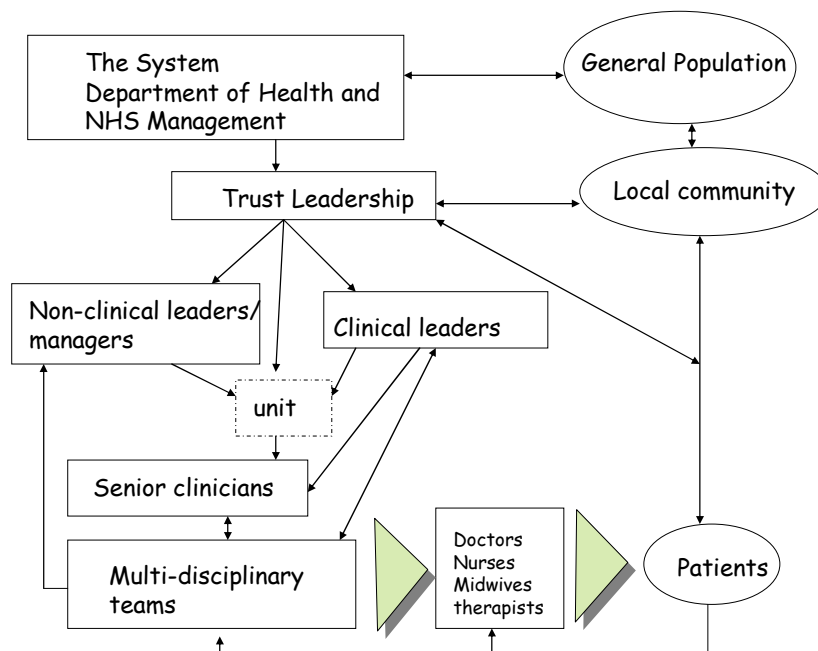
The primary task for NHS Trusts is to deliver a service to patients, as proposed in Chapter Six. All NHS Trusts operate as open systems with porous boundaries which enable change (planned and/or evolved). Leadership therefore can occur throughout the system at different levels including those of ward clerical and cleaning staff and the CEOs who 'manage upwards' and influence NHS/ Department of Health policy. Information of all kinds passes across the various boundaries not simply from the 'top' downwards.

Below in Figure 12 the relationship of the Trust leaders and patients within the NHS system is illustrated. It is also the case, as shown, that policy

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influences individual care, and the quality of that influence depends very much on the quality of leadership again across the system at all levels.

Figure 12. From the DoH to the Patient: An Open System



Patient care is represented here at three levels. The population who influence service delivery and patient care using their vote and/or lobbying through relevant patient groups, the local community who are served by a particular Trust and patients who are actively receiving medical treatment from individual clinical teams.

While on the whole it was the last group who were the main focus in this study some participants, particularly those in senior leadership/management roles, were concerned with service delivery at the local community and population levels. This sometimes meant that senior managers faced the dilemma of how to care for the community while attending to individuals and some individual clinicians were equally concerned about how their interactions with patients were influenced by some of the management dictates which derived from NHS policy that they

found difficult to understand (see Chapter Six and in 10.4.2. below for example).

10.4.2 Systemic dilemmas in patient care: Managing in the NHS

One participant had faced a 'dilemma' in wanting more face-to-face knowledge of patients in the community in order to be a more effective and informed leader, while also as his role required, attending to the demands of working within the wider system of the NHS:

As a chief exec in the NHS it was my privilege to make decisions. That was my privilege to go on and up the ladder. It was that I could go on and make faster and faster decisions. I get in the way I have always got in the way... the thing I would do is go out with the district nurse for the day, because I needed to be grounded in that. (Retired CEO)

Another manager who had previously had a military background advocated (along similar lines) that the best way to lead towards good patient care was to 'walk around' and support the leaders across the different parts of the organisation. In a seminar to clinical staff, which we attended and recorded, he drew participants' attention to the importance of *influencing* policy to achieving good patient care (at the population and community levels).

I hope some of you will find yourself in policy jobs at some point. Totally different, yes it still leads, but the actual process is so ... changing...both the chief executive and I spend a lot of time nurturing relationships which are partly to do with policy, but unless you get it right ... you communicate with them, it won't work.

In other words to be effective and to ensure the best for those in the Trust (staff and patients) a leader has to 'manage upwards' which gains influence. He continued by contrasting the experiences and perceptions of doctors with managers who lead at the macro level, drawing on the example of a recently qualified doctor. When the respondent quoted here asked this man about leadership in the NHS and how it impacts on patients he apparently answered:

'Oh I have got communication skills'. 'Blimey!' I said 'what do you know about the NHS?' And I asked him a couple of questions, nothing! But he hasn't been taught at an academic level about the context in which he is working. I think that is crucial and I know that is not how everyone does things. You know [doctors] keep people alive, but they really ought to have this basis of information about the context in which they are working.

While it is self-evident that the NHS is the context in which patient care is delivered, there is a tension between those who exercise leadership in that context and those who 'keep people alive'. In Chapter Seven, the frustration expressed by Kerry in trying to meet the demands of the government and community by improving the Trust's record of patient care, as well as motivate her senior staff to hold similar ideas, was palpable. From others' perspectives as shown in Chapter Six, there was evidence that 'management' was experienced negatively by several clinical staff when it tried to respond to Department of Health directives.

Managing the numbers

At another level of management good patient care was defined through achievement of returning satisfactory statistics, as this observational note of a meeting between capacity managers and clinicians suggests:

Patient care for the capacity managers appears to be a number crunching exercise. The need to get the patients in the right beds according to government targets meeting four hour waits and single sex bays. However because there is not a shortage of beds on this day, patient care moves from an exercise in numbers to thinking about patients in real human terms.

Sally (the capacity manager) talks about how better patient care can be delivered when there is less pressure on all the staff to meet their targets and get their job done. She talks about how [clinical] staff are then more able to talk to their patients and spend time with them. However, whilst reduced pressure means that for some, numbers translate into real people it is clear that in the capacity meeting that the role of the capacity manager is to think in terms of numbers and beds to deliver good patient care.

There is a potential conflict between the target driven service and the patient-clinician relationship which is about face-to-face contact. Perhaps this is well illustrated in Chapter Nine with the example of the 'grace in adversity' story, whereby the obstetrician spent extra time with a patient while his clinical colleagues turned a sympathetic blind-eye. The story of the patient 'Lola' also discussed in Chapter Nine who had been occupying a bed for three months with the tacit support of nursing staff would also have been anathema to staff responsible for managing targets about capacity.

10.4.3 Who judges what is good leadership and good patient care?

As shown above and throughout this report there is a tension throughout the system. The primary task of senior managers and leaders at and above the level of the Trust is to ensure the demands of the NHS and Department

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of Health leadership are met. These are policy driven with differing priorities at any particular time. The general population of (potential) patients has a keen influence on policy in different ways but particularly during local and general elections. For example the recent change from a Labour to the Coalition Government has raised questions about the role of 'targets' for future NHS priorities. Apart from other matters, finance makes a difference as to how priorities for service delivery are set.

Senior management at the Trust level is judged in a number of ways particularly related to how far the Trust meets the national priorities. However there is also pressure on CEOs and senior teams to get direct patient care and safety 'right'. This may be assessed through statistics as in the following example described by a senior midwifery manager:

Between 2002 and 2005 there were ten maternal deaths at [Trust], which exceeded the national figures. So the Healthcare Commission came in and reviewed a number of clinical organisational cultural governance issues, and then actually put the maternity services under special measures

There was a key number of issues then, and an action plan was developed, so actually I was newly appointed at that time, and there was a number of work streams that we had to work on, and it's never happened before, and I don't think its happened since in a maternity unit. So basically, even though that was a very sad event for all the families involved and very tragic for them, it was difficult for the staff, and obviously difficult for the Board in terms of reputation management. The whole action plan was implemented, the unit was turned around, and the special measures were lifted in 2006.

In this case there was a notable failure to deliver maternity care to the standards of safety prescribed by the NHS. Furthermore there was a failure of leadership perceived by this participant in terms of both 'culture' and 'governance' giving rise to the high proportion of maternal deaths and the consequent special measures. This participant also makes clear how much the staff themselves are influenced by events of this kind.

Another member of that staff team praised the changes at the top following these problems and combined the policy, context and face to face care in her assessment of the relationship of good leadership to good patient care:

.... the end goal for us, is ensuring the services we're providing.. the patients, are getting the best service from us on top of meeting all the Trust targets and the Trust strategy...for me really it's about ensuring that the patients are getting the best quality care, which, you know, I think they've got an improved quality of care here, with the team like mine who are here...and I think [leadership] is from the top down, so from Chief

Executive, right down to every level, to leaders in the ward, right down to our portering, to our domestics. Yeah, there certainly is, and we lead by example really don't we? and I think our chief exec, director of ops, deputy chief, they've all got good leadership skills.

Good leadership skills among senior managers can pay dividends in terms of reputation management. For example in August 2010 North Cumbria University Hospitals NHS Trust admitted a series of false positive diagnoses following breast cancer screening⁴¹. The CEO moved quickly to review the situation and apologise publicly. In other cases though, when there have been wrong diagnoses, neglect or medical errors over drug doses senior managers have been blamed for the failures - sometimes warranted and sometimes possibly not so (see below). Anecdotally it appears that leaders who are prepared to acknowledge problems as soon as they appear and deal with them in a transparent and effective way bring about improvements in service delivery and patient care in the ways perhaps that those who try to 'bury' problems might not achieve.

10.4.4 Leadership practices across the organisation

Leadership and patient care are intrinsically linked. Leadership is above all about taking responsibility but with changes in organisational structures, a growing emphasis on networks, open systems with porous boundaries, mergers and changes in the shape, structure and functions of Trusts, it is no longer tenable for leadership to be in the hands of a few. Leadership, then, is about a series of relationships and connections within and without specific organisational boundaries which have the potential for diffusing responsibility or sharing it, and therefore making leadership practices more co-operative.

It is important to focus, as we have done, on the many examples of good and excellent leadership we found within the three Trusts taking part in this study (each of which of course being hospital based and therefore not focused on the role of leadership in primary care). These sit in contrast to the examples of less effective and sometimes failures in leadership that we have cited. The differences crucially were about emotional attachment and engagement between leaders and followers. We did not meet any respondents who were disengaged with the aims of the NHS and none who were uncommitted to deliver the best patient care. But as evidenced above in the report and in this chapter, some leadership practices failed to take

⁴¹ <http://www.bbc.co.uk/news/uk-england-cumbria-10958423>

followers with them because of autocratic, insensitive behaviours and poor communication skills. Leaders need to be able to listen and engage – having a vision is not enough.

Leadership taking the importance of emotional engagement into account also needs to be transmitted across the organisation. This is best accomplished through making full use of individual skills. Clinical staff and managers can be effectively involved in specific change projects. These may be time-limited and/or specialism specific but collaborative concerted action is frequently the most significant way that a system might flourish with the staff taking responsibility and enhancing their sense of commitment.

10.4.5 When leadership fails patient care

The converse of good leadership is potentially catastrophic. The case of Beverly Allitt in the early 1990s, the nurse who murdered children in the Lincolnshire Hospital by injecting them with insulin, went relatively unchallenged because she was poorly supervised. Harold Shipman, a different case in that he was a GP in a sole practice, similarly was eventually thought to have committed over 200 murders of patients throughout his career. However, the report into his murders showed that doctors at Thameside hospital had failed to report suspicions about his prescribing⁴². The Alder Hey organs scandal involved the unauthorised removal, retention and disposal of human tissue, including children's organs during 1988 to 1995 and the Bristol Royal Infirmary inquiry about children's deaths during surgery resulted in doctors being struck off. All these cases represent a failure of leadership in which those who were responsible for patient care at all levels failed to identify and follow up on problems. More recently the independent inquiry into the Airedale NHS Trust, where the late Anne Grigg-Booth continued as night-nurse despite a high proportion of deaths of patients while under her care, identified 'a catalogue of systemic failures' whereby her dangerous behaviour was not spotted.

At the time of writing this report the Prime Minister David Cameron has ordered a full public inquiry into the events at Staffordshire hospital which have led to deaths of patients, it would appear in these cases, more due to negligence than intent. The Francis report which was published in 2009 found that patients were routinely neglected and there were systemic failings in patient care. Managers had been pre-occupied with cost cutting and meeting targets and unable to spot the build up of failures in patient care that were to cost several patients their lives. There were too few

⁴² These cases were subjected to inquiries which exposed a range of complexities which are not relevant here.

nurses, those who were employed were ill-trained, equipment was inadequate and experienced medical cover was not always available. It was a supreme failure of management and leadership. The Trust was poor at identifying when things went wrong and managing risk. Some serious errors happened more than once and there were higher levels of complaints compared with other trusts. Staffordshire was a foundation hospital that had managed to 'tick the boxes' although clearly there were a series of chasms between the clinical and managerial staff.

10.5 *Final thoughts*

By using innovative qualitative methodologies (described fully in Chapter Two) such as story telling, ethnographic observations and shadowing, to both supplement and augment data from interviews and focus groups, we have built up a picture of what happens in the daily lives of NHS staff working both with and as managers and in clinical teams. Using these methods provides opportunities to extend the scope of more traditional in-depth interviews and focus groups. The 'story', because it is chosen by the participant themselves, provides not only detail and depth but demonstrates the specific indices used by each interviewee to make sense of their own and others' behaviours within the organisational context.

The ethnographic observations, and the shadowing in particular, enabled the researchers to gain a sense of what 'a day in the life' of a member of the organisation *feels* like. They can 'experience' the interactions between staff, between staff and patients as well as the frustrations and pleasures of working in that Trust. No other method provides such acute insights. The subjective ingredients in this method enhance the process (i.e. as outlined in Chapter Two whereby the researcher themselves is the 'instrument' through which data is mediated). Moreover, and possibly conversely, the subjective elements are reconciled when the observation notes are discussed by other members of the research team, which again as discussed in Chapter Two is also a source of data (Czarniawska, 2008).

As a qualitative study, the success is proven by the richness of the data, showing the clear emotional connection participants had with the topics of both 'leadership' and 'patient care' (Lincoln & Denzin, 1994, p. 575). From this we were able to make sense of how leadership is experienced and exercised (see Chapters Four and then Six to Eight) and about the practices around patient care and service delivery that support patients to understand the relationship between their particular health-status, quality of life and the care and treatment they are receiving and/or expect (see Chapter Nine in particular).

The statistical analysis of the OCS⁴³ showed that, on the whole, the climate variables, 'support' and 'recognition' from managers and the system overall, predict 'satisfaction' with leadership and management. This reinforces the ideas expressed throughout the report that good practices by managers/leaders are about ongoing engagement with followers with concerted or conjoint leadership processes most likely to promote a sense of being supported and recognised (Roberts et al. 2005).

Thus we have not produced a list of 'good leader' qualities or a similar record of what constitutes 'good patient care', as these would fail to capture the crucial point that both leadership and patient care are experienced as a process. Thus this report aims to delegate *good practices* that were observed during the project, for the use and reflection of any staff member of the NHS – whether a leader, follower or patient.

10.6 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.

⁴³ As made clear above we were unable to capture corresponding data from patients.

- 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.

Appendix 1

Focus Group Questions

1. Leadership means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this hospital?

Prompts

1. Charismatic / Authoritative / Consultative / Directional / Varies – depends on situation/activity etc

2. Can you think of some incidents that sum up for you the way leadership is exercised in this hospital?

Follow-ups

1. Does this type of leadership operate throughout the hospital?

2. Could you give some examples of ways in which leadership is exercised in your team/the hospital

3. Patient care means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this organisation?

4. How important is patient care as a priority in the service that you and your colleagues provide?

5. What are your main priorities in ensuring a high level of patient care in this hospital?

6. Can you think of some incidents that sum up the way you and your colleagues try to deliver patient care?

7. To what extent is leadership reflected in the quality of patient care you and your colleagues provide?

8. Can you think of some incidents that sum up the way that leadership in this hospital approaches the issue of patient care?

9. Can you think of specific incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

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Follow-up

1. What would you suggest to improve this/these situations?
3. Stories and critical incidents
 - a) Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
 - b) Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
 - c) Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

Could you tell me about a time that made you feel disappointed with leadership in this hospital?

- In this unit?

Appendix 2 Interview Questions

Interview

*Introductions, background and experience in relation to patient care and leadership in the organisation

- The interviewees position/level
- Years at the hospital
- Role in the organisation

1. Leadership

'Leadership' means different things to different people.

- a. How would you define it?
 - Do you see that kind of leadership at this hospital? Why/not?
 - What about in this unit?
 - What makes someone a good leader/Qualities of a good leader? Can you give me an example?
 - Who here at work do you see as providing leadership to you personally? Why? Do you have a direct supervisor? Who? Do they have leadership qualities?
- b. Do you see yourself as someone who could be a leader?
 - Why/not?

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- Under what circumstances?
- c. Can you give me an example of leadership in this hospital?

2. Patient care

- a. Like leadership, 'patient care' means different things to different people.
 - How would you define it?
- b. Tell me about patient care in this hospital. How is it defined?
 - Are there differences between units? Tell me about them. Why do you think this is?
 - How would you improve patient care in the hospital?
 - How would you improve patient care in this unit?
- c. How do you [as a hospital worker, nurse, etc.] try to deliver good patient care?
- d. What do you think are some obstacles to delivering the sort of patient care you'd like to see? How could these obstacles be removed?
- e. Do you think leadership could improve patient care in this hospital?
 - Why/not?
 - Do you think that better leadership would improve patient care? Why/not?
 - How does good leadership influence patient care?
 - Has the leadership in this hospital improved patient care since you've been a member of staff? How so? Or why not?

3. Stories and critical incidents

- a. Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
- b. Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
- c. Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

- d. Could you tell me about a time that made you feel disappointed with leadership in this hospital?
- In this unit?

Appendix 3: Focus Group Questions: patients

1. Leadership means different things to different people. What does it mean to you as a patient of this hospital?
2. What is your opinion of the way leadership is exercised in this hospital?
3. Patient care means different things to different people. What does it mean to you as a patient of this hospital?
4. Can you think of some incidents that sum up the kind of patient care that staff in this hospital deliver?
5. Can you think of ways that leadership in this hospital could enhance the quality of patient care, as far as you are concerned?
6. Can you think of some incidents that sum up what else leadership could be doing?
7. Can you think of any other incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

Appendix 4: Staff Organisational Climate Survey

[attached separately]

Appendix 5: Participant Information Sheet

Leadership and Better patient Care: From Idea to Practice

Participant Information Sheet: Staff Interviews

You are being invited to take part in an interview study about leadership and patient care in three different hospital settings. Before you decide to participate in this study it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Contact me (see full contact information at the end of this sheet) if there is anything that is unclear or if you want to know more.

Take time to decide whether or not you wish to take part.

Thank you for reading this.

1. What is the purpose of the study?

The purpose of this study is to try to identify the circumstances under which leadership can be an effective engine for change in the organisation of health care, especially for patient care and service delivery. Although we suspect that leadership motivates workers and affects the climate or atmosphere of the places where people work, leadership can mean different things to different people. The same is true of patient care which can also mean different things to different people. In order to understand how leadership inspires health workers to provide better patient care, we want to learn how nurses, doctors, other medical professionals as well as managers and patients define and understand leadership and patient care. This includes exploring how their perceptions mesh or conflict with one another. It also includes listening to stories of important incidents that describe their experiences of leadership and patient care.

2. Why have I been chosen?

As part of the study we are interviewing staff (clinical, managerial and others) as well as patients to examine what leadership and

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patient care mean to them. You have been chosen as someone whose views represent the views of staff.

3. Do I have to take part?

No

4. What will happen to me if I do take part?

You will participate in a tape-recorded interview with a qualified researcher, which will last under an hour.

5. What do I have to do?

Arrange a mutually convenient time to have the interview.

6. What are the possible disadvantages and risks of taking part?

It is possible that the discussion may stir up distressing feelings you have regarding your organisation, its leadership and the patient care it provides. However, care will be taken to prevent this and you are free to leave the interview at any time. Apart from that, the only disadvantage is that you will be giving up some of your time.

7. What are the possible benefits of taking part?

This study may not directly help you but it is part of a serious initiative to improve the quality of leadership and patient care provided by the NHS.

8. Will my taking part in this study be kept confidential?

Yes. All data will be stored in locked filing cabinet in a locked office. It will be made anonymous and all names will be edited out of the transcripts. Only members of the research team will have access to the data.

9. What will happen to the results of the research study?

They will be published in a report to the funder and also presented in peer reviewed papers and conferences. A copy of the report will be provided for each participant who requests it.

10. Who is organising and funding the research?

The study is funded by the NHS Service Delivery and Organisation (SDO) Research and Development Programme of the National Institute for Health Research (NIHR) Programmes. The NIHR has been established as a part of the government's strategy Best Research for Best Health to provide the framework that will position, manage and maintain the research, research staff and infrastructure of the NHS in England. The study is conducted by a group of researchers from Royal Holloway University of London led by myself, which won the grant following a competitive bid.

11. What if I have any concerns?

If you have any concerns or other questions about this study or the way it has been carried out you should contact me (details below) or you may contact the hospital complaints department.

Contact for further information

Professor Paula Nicolson, Head of Department, Health and Social Care
Royal Holloway University of London, Egham, Surrey, TW20 0EX

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Appendix 5: Consent form (generic)

Title of Project: Leadership and Better Patient Care: From Idea to Practice

Name of Researchers: Emma Rowland Paula Lökman

Please initial each box

☐ I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

☐ I understand that some coded extracts from the interviews may be used for the purposes of the research report and academic articles.

☐ I give my consent for quotations to be used in the report and research papers on the understanding that I will not be able to be identified by the use of these in any way.

☐ I agree to take part in the above study.

Name of participant

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Date

Signature

Appendix 6: Patient Organisational Climate Survey

Thank you for agreeing to participate in this study which as you will know is part of a larger study on leadership and patient care in the NHS.

The following questions explore how NHS patients feel about the care they received and how things generally worked in the units where their care was managed.

The survey is anonymous, so please do not put your name on the survey.

If, however, you would like to receive the final results of the survey when the study is completed, please fill in the tear-out form on the questionnaire's last page and submit it to the researcher or the collection box.

It is important that you answer all the questions. This should take you approximately 10 minutes.

Your individual responses will be kept strictly confidential.

Researchers

Dr Paula Lökman

Department of Health and Social Care
Social Care
Royal Holloway University of London

Ms Emma Rowland

Department of Health and
Royal Holloway University of

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Please circle one number that best describes how you feel for each question in relation to the service provided by your NURSE.

1. I feel understood by my nurse.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

2. I am able to be open with my nurse at our meetings.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

3. My nurse has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

4. My nurse encourages me to ask questions.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

5. I trust my nurse.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

6. My nurse answers my questions fully and carefully.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

7. My nurse deals very well with my emotions.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

8. I feel that my nurse cares about me as a person.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

9. I don't feel very good about the way my nurse talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

10. My nurse tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

11. The way my nurse interacts with me influences my perception of quality care.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

12. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

Please circle one number that best describes how you feel for each question in relation to the service provided by your DOCTOR.

13. I feel understood by my doctor.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

14. I am able to be open with my doctor at our meetings.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

15. My doctor has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

16. My doctor encourages me to ask questions.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

17. I trust my doctor.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

18. My doctor answers my questions fully and carefully.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

19. My doctor deals very well with my emotions.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

20. I feel that my doctor cares about me as a person.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

21. I don't feel very good about the way my doctor talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

22. My doctor tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

23. The way my doctor interacts with me influences my perception of quality care.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

24. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

25. What would improve the quality of care you receive at this hospital?

26. What services are you using within this hospital?

Demographic Information

27. In which year were you born?

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28. What is your marital or civil partnership status?

- ☐ Single
- ☐ Co-habiting
- ☐ Married
- ☐ Divorced

29. How many children do you have?

30. How would you describe your ethnic background?

31. What is your current salary?

- 1. Less than or around £20,000 per annum
- 2. Between £21,000 and 39,000 per annum
- 3. Between £40,000 and £59,000 per annum
- 4. Between £60,000 and £99,000 per annum
- 5. Above £99,000 per annum

Thank you again for your time. If you have any questions please speak with the researcher or alternatively you can contact Professor Nicolson.

I would like to receive the final results of the survey when the study is completed

Name:

Address:

Contact Telephone:

Please return this form to either the researcher or the collection box.

Appendix 7: Appendices for Chapter Five

[attached separately]

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⁷ There is a parallel ongoing debate as to whether university leaders should be drawn from outside academia.

Addendum:

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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.

Leadership and Better Patient Care: Managing in the NHS

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Executive Summary

The NHS National Leadership Council Website¹ (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)

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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.

Leadership and Better Patient Care: Managing in the NHS

1 Leadership, organisation and the NHS

1.1 Leadership

What is currently known about leaders and leadership? The ongoing attempt to identify the characteristics necessary for effective leadership over recent years has been described as an 'obsession' studied more extensively than almost any other characteristic of human behaviour (Higgs, 2002; Tourish, 2008). Alimo-Metcalfe, Alban-Metcalfe et al. (2007) in their comprehensive review of the literature, show that formal studies of leadership date back (at least) to the beginning of the 20th century. They propose, that despite changes in the way leadership has been studied and the underlying epistemological stance taken by the researchers, *"in all cases, the emphasis has been on identifying those factors that make certain individuals particularly effective in influencing the behaviour of other individuals or groups and in making things happen that would not otherwise occur or preventing undesired outcomes"* (p. 2). As *"many have pointed out, that in spite of the plethora of studies, we still seem to know little about the defining characteristics of effective leadership"* (Higgs, 2002, p.3). Even so this has not appeared to quell the appetite for pursuing an ideal of leadership, impelled by the changing demands of organisations echoed across public sector institutions such as the NHS. These changes are in part the result of technological advancements which impact upon clinical practices, demographic changes both of which have altered the strategic, structural and financial profile of health (and social) care (Tierney, 1996).

The tantalising questions remain though about what those factors might actually be and the significance of the context to 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).

But in addition, or conversely, the context, culture, climate and/or structure of an organisation each have an impact on the performance of the people who lead in it (Carroll, Levy, & Richmond, 2008; Goodwin, 2000; Michie & West, 2004).

Focusing on the relationship(s) between 'leadership' and context has revitalised contemporary research particularly through the development of qualitative research, discursive and social constructionist epistemologies (Grint, 2005; Uhl-Bien, 2006) although it is unclear at this stage how far a connection might be developed between this research and its applications, for example in health care services (Fambrough & Hart, 2008).

In what follows in this chapter we explore the changing ways in which leadership has been conceptualised over the past fifty years, particularly focusing on how it has and *might* be operationalised in the NHS (particularly although not exclusively in a *hospital* context) .

1.2 Background and introduction to the study

The NHS Modernisation Agency Leadership Centre (NHSMALC) website³ had originally suggested that effective leadership is a key ingredient in modernising today's health care services. In its own words:

Effective leadership and management in the healthcare system are key drivers in patient experience. Governance and good environments matter to patients, their visitors and carers and staff.

But how might effective leadership be achieved and sustained? The NHS Leadership Centre commissioned a number of leadership initiatives (Larsen et al., 2005). The NHS Institute for Innovation and Improvement (2005) *NHS Leadership Qualities Framework*⁴ emphasised the *situational* nature of leadership and indicated the circumstances under which different leadership qualities will take precedence.

These comprise fifteen contextualised qualities covering a range of personal, cognitive, and social characteristics arranged in three clusters which are set out in Figure 1:

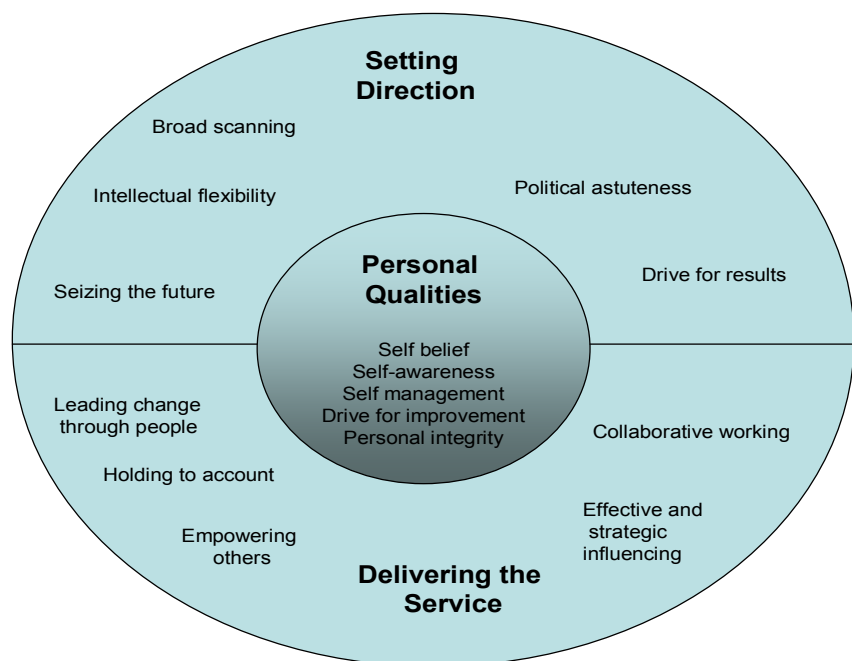
³ <http://www.dh.gov.uk/en/managingyourorganisation/leadershipandmanagement/index.htm>

⁴ <http://www.nhsleadershipqualities.nhs.uk/>

- *Personal Qualities*
- *Setting Direction*
- *Delivering the Service*

Thus, a competent leader enables development in an organisation that is goal directed, geared to developing processes and systems and enables staff at all levels to plan effectively and efficiently towards agreed goals (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Figure 1. The NHS Qualities Framework



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However, these same authors underscore the point that there is something beyond leadership competency that needs to be addressed, particularly in a changing and complex context such as an NHS Trust. *That is that a leader is someone who encourages and enables the development of an organisation in a culture based on integrity, transparency and valuing others. Leaders also need to question, think critically as well as strategically* (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Since the publication of the *NHS Leadership Qualities Framework* in 2005 all efforts have been directed to recognising and discussing leadership qualities and making strides towards their implementation. In 2008 Clare Chapman, Director General of the Department of Health's Workforce declared:

*Leadership is all about creating value for customers and citizens whilst also making work worthwhile for staff. This sounds incredibly straight forward - but it requires courage and resilience, and commitment throughout the entire piece*⁵

David Nicholson the CEO of the NHS in the report *Inspiring Leaders: Leadership for Quality* (January 2009) building on Darzi's *NHS Next Stage Review*⁶ stated:

It is imperative that we align what we are doing on leadership with what we want to achieve on quality. This is what I call leadership with a purpose.

Over the past year, the Department of Health has worked extensively with the NHS and other stakeholders to determine how best to foster talent and leadership development, and it is clear that there is a great deal of enthusiasm for a more systematic approach.

Spotting and developing confident leaders is a priority for us all if improving quality is our shared purpose. This guidance represents our best collective thinking to date. I invite you to use it and contribute to its improvement as we learn how to bring leadership centre stage over the coming months.

Nicholson and his team have charged the Strategic Health Authorities with finding gaps in leadership and systematically nurturing talent across the whole of the NHS. Clearly, the enthusiasm of successive senior officers in

⁵ DH_083353.

⁶ www.dh.gov.uk/en/Healthcare/Highqualitycareforall/index.htm

government and the NHS has been to link effective leadership with good service delivery and patient care as the primary outcome.

1.2.1 Leadership and Better Patient Care in this Study

This rhetoric and confidence about the type of leadership that best suits the NHS from those who lead it gave us pause for thought (Milewa, Valentine, & Calnan, 1998; Mueller, Sillince, Harvey, & Howorth, 2004b). 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 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 aims were overall to seek out the meanings and perceptions of relationships between (effective) 'leadership' and (better) 'patient care' and how leadership is transmitted across organisations to impact upon service delivery, taking account of the mixed methods and specific social science and systemic approaches that the investigatory team proposed. This inevitably has brought certain issues to the fore and (possibly) obscured others.

Our starting point therefore was to hold the NHS model of leadership in mind while calling on our own specific strengths as academics, from a range of social science and methodological backgrounds, to take a cross section of Trusts, clinical specialties, services, staff grades and patient needs, and to observe the *processes of leadership* in everyday working life. From this we proposed it should be possible to determine the ways in which leadership, NHS organisations and patient care were socially and discursively constructed so that links between leadership and patient care might be explored.

In Chapter One we outline some of the important contemporary social science and organisational thinking on leaders and leadership and explore the links between this and the NHS perspectives.

In Chapter Two we set out the innovative methodologies employed to investigate and analyse the research questions. This is followed in Chapter Three with the detailed procedures used for data collection.

The results are presented across four separate chapters. Chapter Four provides the analysis of what leadership means and how it is experienced by staff and patients (Christensen & Laegreid, 2003; Fairhurst, 2005).

Chapter Five presents the results of the Organisational Climate Survey (OCS) (Stringer, 2002). In Chapter Six, open systems theory and the concept of the 'organisation in the mind' are introduced particularly focusing upon the transmission of leadership across organisations. The relationship

between leadership, authority and emotion is discussed in Chapter Seven and in Chapter Eight the role of gender relations and their impact on leadership are reviewed (Begun, Hamilton, Tornabeni, & White, 2006; Ford, 2010; Telford, 2007).

Chapter Nine covers definitions, explanations and experiences of patient care and particularly how it relates to leadership by NHS staff and patients (Begun et al., 2006; Disch, Edwardson, & Adwan, 2004).

Finally in Chapter Ten we summarise our findings, make recommendations and draw conclusions.

Appendices provide copies of the research instruments, additional statistical results and the relevant NRES information.

1.3 Theoretical Approaches to leadership

Leadership research and theory is prolific with the consequence that numerous, frequently overlapping, models of leadership are available to agencies attempting to analyse or train leaders (and indeed managers, as until relatively recently little distinction was made between these two categories, see e.g. Kotter, 1996). Over the past fifty years leadership theories have shifted through different points of focus from the 'trait (or 'great man') approach in the 1940s, through the 'behavioural' perspectives in the 1950s whereby some styles of behaviour were seen as being more or less influential on potential followers. Then since the 1960s and 1970s the focus has been upon 'situational' leadership based mostly upon Fiedler's 'contingency' theory which proposed that different leadership styles were needed for different situations (see Alimo-Metcalfe, Alban-Metcalfe, et al. 2007; Western, 2008 for further details). During the 1970s and 1980s leadership research, albeit prolific, had reached an all time low in terms of its perceived contribution to theory and added value to knowledge for practice, so that as Cummings (1981 p. 366, quoted in a review by Bryman, 2004) asserted:

As we all know, the study and more particularly the results produced by the study, of leadership has been a major disappointment for many of us working within organisational behaviour.

Bryman unpicked the implications of the phrase Cummings used "as we all know" noting that it was "simultaneously sweeping and damning" (2004, p. 730). Bryman also picks out Miner's (1975) suggestion for temporarily abandoning the concept because of its limited utility in helping us understand organisational behaviour. *Why had leadership research reached this nadir during those decades? Why has there been a more recent upsurge of interest in leadership again almost to the point of saturation?*

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Bryman in his review suggests, that the renewed confidence and interest in the study of leadership has come from improved measurement and analytic techniques, greater use of meta-analysis so that more systematic reviews could be compiled, the emphasis on *transformational leadership* and *charismatic leadership* which have provided a fulcrum for the area of research, more and better cross-cultural studies and greater diversity in the types of leadership and organisational contexts that have been studied.

A factor that may also have contributed to the idea that leadership research continues to be fruitful is that a greater diversity of methodological approaches have been added and Bryman's review specifically focused on the value added by qualitative research.

Towards the end of the 1980s and beyond, thinking about the meaning(s) of leadership came to take greater precedence than in the previous two decades, possibly because of a perceived dearth of leadership *per se*.

These deliberations cast light onto the:

- *interactions between leaders and followers* and organisational cultures (Avolio, Gardner, Walumbwa, Luthans, & May, 2004; Lewis, 2000; Schilling, 2009)
- the *management of emotion* (George, 2000; Lewis, 2005; Pescosolido, 2002)
- the *processes* of leadership (Collinson, 2005; Dopson & Waddington, 1996; Vangen & Huxham, 2003)

Even so, or perhaps because of the use of qualitative approaches and related conceptualisation, Alvesson and Sveningsson (2003) were able to entitle a recent paper arising out of their study of leadership in a research and development company: "*The great disappearing act: Difficulties in doing 'leadership'*".

By this they meant that during their study they were able to identify how the existence of the label 'leadership' led to an assumption that the concept had an empirical reality. However the results of their work indicated that leadership might be better explained as a *process or series of processes of interaction*. This conclusion raises questions about mainstream thinking on leadership which presumes observable and possibly measurable characteristics (Alvesson and Sveningsson, 2003, p. 361; see also Ford, 2010).

Most recently there has been reconsideration and development of ideas about leadership in context taking account of the relevance of some earlier studies of organisations (e.g. Lewin, 1947) and open systems theories (see

Chapter Six; Laughlin and Sher, 2010) and new epistemological positions (e.g. Ford, 2010).

In our study, as a consequence of these recent critiques of leadership research and the result of methodological innovation, we approached the concept of 'leadership' as not necessarily a property of one individual (although it can be) or of one specific role, such as Clinical Director or a service manager, but rather we identified leadership as a *process* occurring within a group, organisation or collectivity that *imagines, wills and drives change* (Gabriel, 2004; Gronn, 2002).

1.3.1 Dimensions of Leadership and their Value for the NHS

Leadership, *as a practice*, has been on occasions constructed as 'a beautiful or rarefied ideal' an idea which has little use in the real world particularly as it has been suggested there are at least 350,000 definitions of leadership in the academic literature (Pye, 2005; Tourish, 2008; Western, 2008). *The question for this report is how to identify the literature on leadership and organisation with the most relevance for the contemporary NHS.*

Most discussed in theory and in practice over the past two decades has been the idea of *transformational leadership* (Bass, 1985) a model to explain ways in which a leader can be identified or trained to demonstrate the qualities that enable her/him to *perform beyond expectations*. The phrase 'transformational leadership' was coined originally in 1973 by Downtown but did not gain impetus until 1978 when Burns published his book, *Leadership*, which highlighted the *relationship* between leaders and followers (Burns, 1978).

Until then, as shown above (see Bryman, 2004) there had been little by way of a breakthrough in applicable knowledge. Burns (1978) demonstrated a *psychological* difference between an exchange relationship - where followers respond to leaders because of rewards they might receive - and one in which they respond to leaders who transform their attitudes and behaviours through inspiration and/or charisma (Bass, 1985; Yukl, 1999; Rafferty and Griffin, 2004). Transformational leadership then, is concerned with emotions, values and ethics, standards and long term goals which include assessing followers' moves and satisfying their needs (Currie & Lockett, 2007; Day, Gronn, & Salas, 2006; Eagley & Johannesen-Schmidt, 2003; Northouse, 2004).

Recognition that transformational leadership is not simply an individualistic model but one that *teams* can display (Day et al., 2006; Gronn, 2002; Sivasubramaniam, Murry, Avolio, & Jung, 2002) has shifted the

concentration from individual leaders per se to a more diffuse and distributed model of leadership and organisation context.

1.3.2 What constitutes transformational leadership?

Bass (1985) highlighted several characteristics of *transformational* (or *transformative*) *leadership* that allow followers and leaders to achieve far beyond their expectations. These are not discrete categories but given the significance placed upon the ideas behind transformational leadership in the scientific and training literature it is worth outlining the basic ideas behind these characteristics/types which have been identified as:

- Charismatic leadership
- Inspirational motivator
- Intellectually stimulating leadership
- Considerate leadership

Charismatic leadership

Bass (1985) proposed that "*charisma is a necessary component of transformational leadership*" (cited in Yukl 2002, p.261) and that charismatic leaders are endowed with exceptional personal qualities that attract followers. Charisma, a word derived from the Greek, means "*divinely inspired gift*" and is thought to give people the ability to perform miracles or predict the future (Yukl 2002, P. 241).

It is for this reason that charismatic leaders are often regarded as "*visionary, a futuristic, or a catalyst for change*" (Murphy 2005, p. 131; see also Bass 1985; Bennis & Nanus, 1985). Due to their rare personal qualities charismatic leaders are able to convey their visions to their followers in a clear and concise manner allowing them to visualise what they could achieve in the future if they worked together towards a common goal. As the leader's vision is normally realistic yet optimistic, it empowers the followers granting them greater self-esteem, encouraging and inspiring them to achieve the vision (Bennis & Nanus, 1985; Northouse, 2004; Yukl, 2002).

Inspirational motivator

Through their charisma, transformative leaders have the ability to inspire their followers through words of profound wisdom, or at least is what is *perceived* to be profound wisdom, such as with the case of Jim Jones⁷ in the USA or more positively President Obama who has reformed health care and banking legislation in the USA against the odds. Transformative leaders are

⁷ In 1978 Jim Jones persuaded more than 900 members of his People's Temple in Jonestown, Guyana to commit mass suicide.

excellent communicators which allow them to turn their visions into reality. Many use emotional and optimistic speeches to inspire their followers. They usually lead by example and often become role models to their followers who are in awe of their moral and ethical character. Many followers try and emulate their leaders' good qualities and are confident that their leaders will make just decisions on their behalf leading them to a prosperous future (Kellerman, 2004; Rafferty & Griffin, 2004).

Intellectually stimulating leadership

Transformational leaders have the ability to captivate their audience making the most mundane speeches and events interesting. They encourage their followers to be innovative, challenging the status quo and their own values and beliefs (Northouse, 2004). They also encourage their followers to solve problems and take an active role in the organisation, thus enhancing their self-worth and self-esteem, increasing their job satisfaction and productivity.

Considerate leadership

Transformational leaders are often also considerate leaders who are adept at performing mentoring or advisory roles to support their followers' emotional needs (Hiller, Day, & Vance, 2006; Rafferty & Griffin, 2004). Such leaders listen carefully to their followers' needs and desires, empathising with them during difficult periods. Being empathetic also builds a strong bond between leader and follower and thus a strong reciprocal relationship (Simpson & French, 2005).

It is important to note though, despite the wide take-up of transformational leadership as a conceptual model and a *practice*, that there remains uncertainty about the ambiguity of subdivisions and distinctions between elements in the model. Theoretical distinctions between 'charisma' and 'inspirational motivation' have become blurred over time and some theorists have suggested that elements of transformational leadership might also be identified as *transactions* (see Rafferty and Griffin, 2004 for a discussion of the implications).

Further concerns have been raised about how transformational leadership can take place in organisations, particularly public service ones, which are constrained by government initiative and targets and localised regulatory and normative pressures (Currie & Lockett, 2007; McNulty & Ferlie, 2004). However, it may also be that professional staff (rather than leaders/managers) in contexts such as health care, may in fact be more transformational than might be predicted because of their long-term commitment to the organisational goals (McGuire & Kennerly, 2006).

Most recently the notion that transformational leaders are very much 'engaging' leaders has been proposed (Alimo-Metcalfe, Alban-Metcalfe et al, 2007; Alban-Metcalfe & Alimo-Metcalfe, 2009; Macy & Schneider, 2008).

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One further comment here concerns the role of *gender* in styles of leadership and its consequent impact on organisational transformation (Fletcher, 2004; Mandell & Pherwani, 2003). There is evidence that (whether displayed by a woman or a man) feminine styles of leadership may be more related to engagement, emotional and social intelligence and distributed leadership, which may be important for complex organisations such as the NHS (see below).

1.4 Leadership, organisation and emotion at the turn to the 21st Century

Models of leadership and organisation theory have evolved over time and leadership and organisational structures and cultures are intrinsically linked in the literature. Leadership, if it is to motivate, innovate and move organisations to change, has to have an *emotional dimension* and, thus, effective leaders have a clear *emotional agenda* (as well as a strategic and structural one) which is particularly acute in services such as the NHS which is working to serve people's health care needs (Ashforth & Humphrey, 1995; Bolton, 2000; Pye, 2005).

Exploring organisations and leadership at the level of 'emotion' has become contested territory, as recognition, that organisations and their leaders need to take account of emotional engagement (Alban-Metcalf & Alimo-Metcalf, 2009; Vince & Broussine, 1996) at all levels of the work place, has emerged. Prior to the 1980's, organisational literature had been dominated by cognitive orientation (George, 2000) which favoured the rational, 'masculine' and scientific explanations of organisations and their leaders. This notion therefore ignored the (so called) irrational and 'feminine' characteristics of emotion, which were deemed detrimental to productivity and success. At that time emotions were regarded as the culprits that distort an individual's perceptual and cognitive faculties and therefore should be kept under control (Alvesson & Sveningsson, 2003b; Clarke, Hope-Hailey, & Kelliher, 2007; Dasborough, 2006; de Raeye, 2002; Ford, 2006).

As social and occupational psychologists began to study the effects of positive and negative moods on decision making, job satisfaction, choice of work-based activities and organisational climate, however, (Isen & Means, 1983; Rafaeli & Sutton, 1987, 1989) 'emotion' as part of organisational life gained impetus once again. This resurgence coincided with leadership theorists studying how moods and emotions could effect the quality of leadership (George, 2000).

It is possible to trace a rough trajectory from the 'hard nosed' scientific management, with the organisation perceived as a 'machine' in the early twentieth century, through towards a more humanistic, emotional and

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sometimes even spiritual way of thinking about contemporary leadership and organisational metaphors towards the twenty-first century, all of which are potentially transformational, not simply to the individuals concerned, but to the organisational dynamics.

Hochschild's (1983) *The Managed Heart* has been credited with being one of the earliest examples of research into emotions and organisational settings (Ashkanasy, Hartel, & Daus, 2002). She looked particularly at the airline industry and how airline cabin crew managed their emotions for dealing with difficult passengers and to promote a particular airline image. She termed this emotional management '*emotional labour*' (Hochschild, 1983).

Since this publication, the study of emotions in organisations has increased (Ashkanasy et al., 2002) with academics concentrating on key concepts such as emotional labour, emotional intelligence, mood analysis and Affective Events Theory (AET) and most recently a return to psychodynamic understanding of organisations and groups (see Ford, 2010; Schwarz, 1990). Since the 1990's a plethora of literature has emphasised the role of emotional concerns in private sector organisations such as the airline industry (Hochschild, 1983; Taylor & Tyler, 2000; Tyler & Abbott, 1998), service sector (Crang, 1994), merchant banking (McDowell & Court, 1994; Pugh, 2001), law (Harris, 2002) and image consultancy (Bryson & Wellington, 2003; Wellington & Bryson, 2001).

However, emotionality in the public sector was mostly neglected until 2000's when a surge of literature began to be published analysing the NHS (Allan & Smith, 2005; Bolton, 2000; Cummings, Hayduk, & Estabrooks, 2005a; Hunter, 2005; Lewis, 2005; McCreight, 2005; McQueen, 2004; Michie & Gooty, 2005; Michie & West, 2004; Smith, 1992) and the fire service (Archer, 1999; Scott & Myers, 2005; Ward & Winstanley, 2006; Yarnal, Dowler, & Hutchinson, 2004).

1.4.1 Emotional labour, leadership and patient care

Hochschild differentiates between emotional labour and emotional work or 'face-work' (Goffman, 1967). Emotional work has been described as the effort we put into presenting and representing our feelings as well as into feeling what we ought to feel (see Fineman, 2003). For example, a person ought to feel happy at a wedding and sad at a funeral and if their emotions do not match these expectations then a person must perform emotional work to display the appropriate emotion. This is sometimes difficult as people struggle to disguise their true emotions and perform the socially acceptable emotion.

When a person's emotions are appropriated and performed for commercial gain it is known as *emotional labour*. Hochschild states that emotional labour occurs in many occupations. However, she believes it to be more

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prevalent in service industries, such as the airline industry, where workers' emotions are sold as part of a commercial package⁸. Employees working in service industries must be skilled at managing their emotions and facial expressions in order to project the correct emotion to the customer (Crang, 1994; Lewis, 2005). This often means that employees have to suppress their own emotions in order to perform and display emotions that are suitable for commercial gain and in alignment with the organisations' image (McDowell and Court 1994).

Surface acting allows the employee to make up an outward gesture (Hochschild, 1983), to perform emotions that are not actually felt. In contrast, deep acting means that the employee can suppress or become estranged from their true feelings and *actually feel the emotions* that the employer wants them to display. *"One finds that the performer can be fully taken in by his own act, he can sincerely be convinced that the impression of reality which he stages is the real reality"* (Goffman 1990, p.28).

In the NHS, positively managed emotions *could* lead to better patient care, greater patient satisfaction and a relaxed and professional organisational climate (Amendoldair 2003; Bolton 2003). Lewis (2005) highlights how nurses in a special care baby unit appropriately managed their emotions to create a professional organisational climate, in which to offer quality patient care to special needs babies and emotional support to their parents. Lewis suggests that a nurse's job is sometimes very stressful and emotionally destabilising, especially when a baby dies. Nurses need to be conscious of their own emotions and regulate them to prevent causing further distress to the parents by displaying a professional demeanour (Bolton 2001).

However, managing emotions in this way, particularly if they are not felt, comes at a psychological and emotional cost and the whole process would be problematic without attending to emotional intelligence.

1.4.2 Emotional intelligence, leadership and patient care

The 'discovery' of emotional intelligence (EI), despite on-going valid critiques (see below) marked a turning point in contemporary organisational theories and approaches to leadership because of the tradition that emotions represent a threat to rationality – a view that has been widespread particularly in North America and North Western Europe (Fambrough & Hart, 2008; Western, 2008).

⁸ For a critical analysis of Hochschild's dichotomy of emotional labour and work see Bolton 2000 and Bolton and Boyd 2003.

Mayer and Salovey (1995), who conceived the idea of emotional intelligence, defined it as the ability to manage and understand one's own and other people's emotions in a consistent way so as to reflectively promote emotional and intellectual growth. Goleman (1996; 1998) who popularised the concept, identified emotional intelligence as a set of competencies, redefined and restated by George (2000) as follows:

- The expression and appraisal of emotion
- Enhancing cognitive process and decision making
- Emotional knowledge
- Managing emotions

These characteristics appear to have much in common with the rhetoric of transformational qualities of leadership although in many ways EI has become a management 'tool' rather than a critical model. To this end (apparently) Goleman (Goleman, 2000; Goleman, Boyatzis, & McKee, 2001) focused on 'styles' and 'performance' which seem far away from the 'heady' descriptions below of qualities of emotional intelligent leadership, which refer to feelings, empathy and creativity.

The expression and appraisal of emotion

An emotionally intelligent person will be able to understand their own and others' feelings and able to empathise, which may enable them to be manipulative for better or for worse.

Enhancing cognitive processes and decision making

Having emotional intelligence allows a person to use emotion to be creative, solve problems, make decisions and flexible plans for themselves and on the behalf of a group. An emotionally intelligent leader will be able to judge their mood and make decisions accordingly. If the person is in a negative mood this may mean choosing to wait until such negative episodes have past in order to make a comprehensive decision.

Emotional Knowledge

Emotionally intelligent people understand how other people may be affected by their negative moods and therefore may take care not to spread bad feeling around the group.

Managing Emotions

Many leaders are able to manage their followers' emotions as well as their own, but as indicated below, developing the qualities required to manage emotions effectively is highly complex and more about processes than style or performance (Fambrough & Hart, 2008; Hughes, 2005). As Fambrough and Hart argue 'emotional intelligence' has passed into common use among organisational leaders with little recognition of the way it has been identified

as problematic. *What has been so attractive about EI to leaders in health care organisations?*

The idea of emotional intelligence captured the imagination of some training NHS staff as a means to improve staff relationships and enable clinicians to empathise with their patients (Allan & Smith, 2005; Cummings et al., 2005a; McQueen, 2004; Amendolair 2003, Luker et al 2002). McQueen (2004) reflecting on the 1960's when health care workers were encouraged to hide their emotions from their patients, for the sake of maintaining a professional role, suggests that in recent decades this view of nursing has changed and health care workers frequently display emotions to illustrate their commitment to patient care (Williams 2000). McQueen suggests that emotionally intelligent nurses are important for building strong patient-nurse relationships (Conger and Kanungo 1987 and (Lewis, 2005). Nurses with high Emotional Intelligence are able to build rapport quickly with their patients through communication and interactive skills (Schutte et al 2001).

McQueen (2004) also states that "*emotional labour calls upon and engages*" emotional intelligence (2004, p. 103). In order for patients to feel cared for nurses have to constantly *perform* positive emotions and behaviours such as warmth, friendliness and consideration. However, when confronted with a 'difficult' patient nurses may experience negative emotions such as frustration, irritation or anger. The nurses must be emotionally intelligent enough to identify their emotions and then perform emotional labour to submerge the negative emotions in favour of more positive emotions (Bolton 2003).

While EI *per se* needs to be understood more critically (Fambrough & Hart, 2008), the introduction of emotional management and engagement by leaders (and others) in health care organisations needs further scrutiny (see below); despite the best efforts of some management gurus emotion is a fact of personal, interpersonal and organisational life particularly when considering what it means to deliver patient care.

1.4.3 Beyond emotional intelligence

Interest in EI has continued to grow among management and organisational academics with a focus on how to measure it – the conclusions generally indicating the need for caution in measures to predict or to establish baselines for its development among managers (Conte, 2005). The conflation of managerial skills as listed by Mintzberg (Mintzberg, 1973) cited in Riggio and Reichard, (2008) which included the ability to 'deal' with subordinates, 'empathize' with top-level leaders and establish and maintain social networks, alongside managing emotions as a leader, have come to be known as 'people skills'. These are clearly represented in the NHS leadership qualities framework and vital for managing in any organisation (see Figure 1).

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1.4.3.1 Social intelligence (SI) and leadership

In 2006, taking account of advances in neurological psychology, Goleman (Goleman, 2006) proposed that because humans are *designed* for social connection, rapport and supportive emotional interactions enhance performance of managers and leaders. He listed these qualities under the umbrella of 'social intelligence' and identified four dimensions:

- *Synchronization* – whereby matching moods lead to a sense of rapport
- *Attunement* – listening fully
- *Social cognition* – understanding how people interact
- *Social facility* – finding it easy to interact with others

While some people have little difficulty meeting these criteria and mastering their social intelligence, others (such as Narcissists, Machiavellian and Psychopathic types), Goleman argues, do not have the capacity for social intelligence, and thus he proposes a means of *selecting* effective leaders by testing these qualities. This model albeit individualistic has something to offer through extending the theoretical underpinnings of 'people skills' and emphasising the importance of taking followers and colleagues seriously in decision-making.

Following EI and SI in bringing management/organisational theories together with developments in psychology, particularly cognitive neuroscience and evolutionary psychology, is the reconsideration of the role of intuition in understanding leadership and organisational behaviours (Sadler-Smith, 2008). Sadler-Smith brings the idea of the 'gut feeling' into the foreground to explore the influence of this sense upon decision-making particularly under pressure (e.g. many emergency clinical decisions rely on the clinician's instinct of whether the patient should be operated on, admitted to hospital, whether to call for support).

It seems that while there is a continuing trend towards an evidence-based understanding of leadership, success there is also an emergence of features of human life that are difficult to explain and measure, although all the proponents cited above stick to the view that these characteristics are scientifically explicable and measureable despite challenges from both positivist and critical social constructionist positions (Ashforth & Humphrey, 1995; Conte, 2005).

1.4.3.2 Affective Events Theory (AET)

AET predicts that specific features of work (e.g. autonomy) have an impact on the arousal of emotions and moods at work that, in turn, co-determine job satisfaction of employees. AET further proposes that job satisfaction is

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an evaluative judgement that mainly explains cognitive-based behaviour, whereas emotions and moods better predict affective-based behaviour. The results support these assumptions (Jürgen, van Rolf, Fisher et al., 2006). Ashkanasy et al (2002) suggested that AET has two important messages for leaders in an organisation.

- Followers' emotions are heavily influenced by their leaders' emotions and therefore leaders must minimise the 'hassles' that they place on their followers in order to increase job satisfaction and performance. Short-term negativity can be tolerated without much impact on the team or organisation.
- However, if negative events persist it will affect followers' moods leading to negative emotions, poor performance, reduced job satisfaction and in the case of the NHS, (possibly) to poor quality patient care. It is therefore suggested that leaders need to give followers positive feedback regularly to "*ameliorate the daily hassles experienced by employees*" procuring positive behaviours such as team spirit and self-worth (Dasborough 2006, p. 165 ; Weiss & Cropanzano, 1996). The connections between the moods of individuals and their performance may be understood better in terms of emotional engagement between leaders and followers on both conscious and unconscious levels (see below).

1.5 Distributed leadership

The academic study of distributed leadership, that is when at various levels leadership (or influence) behaviour, identity, role and responsibility are distributed to more than one individual or group of individuals, has been at the forefront of much social scientific leadership research over the past ten years (Buchanan, Addicott, Fitzgerald, Ferlie, & Baeza, 2007; Day, Gronn, & Salas, 2004; Gronn, 2002; Mehra, Smith, Dixon, & Robertson, 2006a). The implication of this interest in distributed leadership is, that organisations have changed and previous models - including the charismatic, 'hero' leader and the 'command and control' organisational structures - are dysfunctional in a context where organisational change is rapid and diversification of strategic leadership and management essential (Butterfield, Edwards, & Woodall, 2005; Dent, 2005; Goodwin, 2000). In a competitive, diverse and divergent environment leadership needs to be distributed, in order to enhance democratic governance, thus enhancing legitimacy and increasing survival chances (Currie et al., 2009).

Distributed leadership also implies that organisations where it is practiced have (relatively) flat hierarchies with diverse service needs and expertise across all sectors of the organisation (Huffington, James, & Armstrong, 2007). This model applies to hospitals and primary care settings, where

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distinct professional groups each have their own standards of excellence, while at the same time sharing goals of competence and quality related to the service they provide to patients and how they interrelate to other organisations.

With this shift in focus of many leadership practices and leadership studies the definition of such leadership has been proposed as:

".. a status ascribed to one individual, an aggregate of separate individuals, sets of small numbers of individuals acting in concert or larger plural-member organisational units" (Gronn, 2002, p. 428).

Gronn suggests also that when leadership is distributed it may be that the duration of that influence is limited, perhaps (structurally) to a single project and therefore (psychologically) distributed leadership might mean having to 'give up' leadership as well as take it up (Huffington et al., 2007). Furthermore, according to Gronn (2002) the most common understanding of distributed leadership, witnessed by the growing number of references to it in the research and policy literature, is that it applies to numerous people across an organisation taking some degree of a leadership role or responsibility.

More importantly, Gronn identified distributed leadership as *concerted action* meaning that there are many roles comprising a 'leadership complex' with at least three potential forms:

- *collaborative modes of engagement* which arise spontaneously in the workplace. This suggests that leadership practice is 'stretched over' the context of the organisation and not a function of those in managerial roles such as matron or clinical director. However, if the matron, clinical director and other colleagues who share ideas for change or particular activities they *may "pool their expertise and regularise their conduct to solve a problem after which they may disband"* (Gronn, 2002, p. 430).
- the *intuitive understanding* that develops as part of a close working relationship among colleagues. These relationships tend to happen over time when organisation members come to rely on each other and develop a close working relationship, to solve problems or bring about change and others might be involved in a 'framework of understanding'.
- The variety of *structural relations* and institutionalized arrangements which constitute attempts to regularize distributed action. Thus, for example, if there were dissatisfaction with existing arrangements for particular practices, a team of 'equals'

might emerge to find ways to improve or change the problematic practices.

All of these are apparent particularly, but not exclusively, in Trust Three (the FT) as exemplified in Chapters Four and Nine in particular.

Gronn argues the importance of examination of these different forms of concerted action to understand where influence (and thus leadership and power) might lie in any organisational context. Emotionally, however, these different models of distributed leadership suggest the impact of these structures and practices at a deeper level (Gabriel, 2004) particularly around authority (Halton, 2007; Hirschhorn, 1997) competition (Morgan, 2006) rivalry and envy (James & Arriba, 2005; Stein, 2005)

1.6 Organisational Culture, Climate and Contexts

As introduced above, post-industrial (or even 'post-modern') organisations (Burrell, 1988; Fineman, Sims, & Gabriel, 2005) and networked (Balkundi & Kilduff, 2006; Goodwin, 2000) organisations are changing rapidly and the NHS is clearly among these. Changes in the NHS take place at a number of levels, emerging from the direct policy dictates from central government to become local initiatives. Moreover, the NHS has become increasingly team (and indeed multi-disciplinary team) based over the past two or three decades so that knowledge, influence and leadership for transformation and change are not only moving from a top-down to bottom-up model, but as indicated, to a distributed model which involves lateral influence (Begun et al., 2006; Day et al., 2006; Ferlie & Shortell, 2001).

The type of leadership that is supported and promoted in any organisation and the related concept of the organisational structure depends on and impacts upon organisational climate and culture.

Although research undertaken on organisational *climate* and organisational *culture* comes from different epistemological traditions, since around 1990 the literature and concepts referring to both have been overlapping and/or complementary (Schneider, 1990; Schneider, 2000) and increasingly the terms are used interchangeably (Ashkanasy et al. 2000).

It is, however, generally accepted that 'climate' is a logical extension of what was originally conceptualised as 'psychological' climate, that is, shared psychological meanings in an organisation; so that *organisational* climate is an aggregation of those individual perceptions of a work-place context (James, Choi et al. 2008).

Organisational culture on the other hand has its origins in anthropology and human relations (see Davies, Nutley and Mannion, 2000; Scott, Mannion et

al. 2003). Organisational psychologist Edgar Schein's (1985/2004) ideas about organisational *culture* as a pattern of *shared basic assumptions that have worked well enough and adapt to the external environment and serve internal integration*⁹, is one of the most frequently quoted definitions. Schein takes a systems theory approach to understanding organisations and his work has been built upon by himself and others to develop a variety of typologies which underpin measures of both organisational culture and climate (see Albino-Metcalf, Alban-Metcalf et al. 2008 for a comprehensive overview of this literature).

Organisational climate, with its origins in traditional psychology is *typically* "... the only domain of organisational research that simultaneously examines perceptions of jobs, groups, leaders, and organisational attributes and thus has the unique capacity of being able to decipher common denominators and latent relationships that are not available to those who study only specific domains such as perceived equity" (James et al., 2008, p.27). We therefore made a decision to use a measure of *climate* as a backdrop to this mostly qualitative study, in order to 'triangulate' with our findings on leadership and patient care.

However, we found a competing strand of interest in the measurement of organisational *culture* (e.g. Davies, Nutley and Mannion, 2000; Scott, Mannion, Davies and Marshall, 2003) which more frequently seems to attend to health care settings than studies of climate albeit with some notable exceptions (Dawson, Gonzalez-Roma, Davis and West, 2008).

1.6.1 Emotion and the unconscious in organisations

Organisational climate and/or culture cannot be discussed without acknowledging that organisations are places where both the intellect and emotion are called into play in order to achieve organisational goals and as we have made clear, emotions are intrinsic to service delivery and leader-follower engagement in the NHS. Emotional engagement, while available to human consciousness, also takes place at an unconscious level (Gabriel, 2004; Hugh, 1986; Lyons-Ruth, 1999; Morgan, 2006; Willmott, 1986), and anxiety or stress is particularly salient when having to care for and make potentially life-saving decisions for patients (James & Huffington, 2004; Menzies¹⁰¹¹, 1970).

⁹ A paraphrase.

The ideas that characterise transformational leadership models, such as 'charisma', 'influence', 'inspiration' 'thoughtfulness' and 'consideration', have intellectual roots beyond contemporary management theory and training. They are more closely related to group and organisational theories with late 19th and early 20th century origins (De Board, 1978; Gabriel, 2004) from which much contemporary organisational theory has emerged.

The first significant attempt to analyse group behaviour made at the start of the 20th Century by Le Bon (1917/1920) whose book *The Crowd* illustrated his observation that individuals in a large group can demonstrate a 'collective mind' which emerges when people are bound together in some way. McDougall's book *The Group Mind* (1922/2009) and Sigmund Freud's *Group Psychology and the Analysis of the Ego* (1921/1922) also focused on what would subsequently come to be recognised as unconscious group processes. Freud developed Le Bon's and McDougall's ideas in the context of psychodynamic theory, arguing that the binding force of the group derives from the *emotional* ties of the members, which are expressions of their libido or drive.

Studies of (and human 'experiments' about) group psychology, taking some of this perspective on board, flourished after the Second World War conducted and further developed by psychiatrists in the newly formed NHS. In Britain the work of Wilfred Bion, Tom Main, Maxwell Jones and others led to innovations in both group psychotherapy and the study of organisations. Bion's work on group relations and dynamics which contributed to the development of the Group Relations Training Programme (GRTP) at the Tavistock Institute in 1957 evolved into the Leicester Conferences with other organisations using this model across the world (Miller, 1993). However contemporary knowledge and understanding continues to reflect back upon this early work.

What was learnt during this period about group dynamics and group relations represents an important dimension in the understanding of contemporary organisations and the relationship between leaders and followers. We develop this further in Chapter Seven in particular. It is important to note how the intellectual journey from work on emotional labour to social intelligence and intuition has so far largely neglected to explore the extent to which unconscious processes remain part of the emotional context of human social interaction (Allan and Smith, 2005, p. 21).

¹¹ Isabel Menzies is sometimes referred to as Menzies-Lyth. Her work has been reprinted several times with each name used.

In a hospital environment it is inevitable that negative events such as death occur (see Lewis for discussion on the impact of death on nurses in a special care baby unit taking an 'emotional labour' approach). When death does occur nurses may display emotions (consciously and unconsciously) such as anxiety and fear (Allan & Smith, 2005; Obholzer & Roberts, 1994; Allan 2001; Smith et al 2003). Obholzer asserts that "[he] believes that many of the organisations' difficulties that occur in hospital settings arise from a neglect of the unconscious psychological impact of death and near-death on patients and staff" (1994, p.171). He explains that hospitals are sites where anxieties about social taboos such as death are *contained*, that is that staff and the organisation overall takes away the anxiety and the responsibility for care from the relatives. Patients and staff are socialised to believe that hospitals are institutions where illness is treated and that medical knowledge and practice is infallible. This is illustrated by patients who contend that doctors possess God-like qualities and have the ability to heal all ailments. When death does occur, medical staff and the patient's relatives may feel *duped* by the institution they believed would save their loved one.

At the turn of the 19th to the 20th Centuries psychoanalytic ideas were seen to have something new and important to say, not only about the psychology of the individual and the role of the individual unconscious, but about *unconscious processes when people converge in groups and crowds* as shown above. From psychoanalytic theory we take up ideas again today specifically about the relationships which exist between followers and leaders, made explicit in the paradigm shift from transactional to transformational leadership. Working together and accepting or resisting influence comes not only with an observable set of behaviours and measurable emotions, but with unconscious and 'secret' ones including dependency, envy, power, anger, authority and emotional contagion, which may be either conscious or unconscious but have important consequences for behaviours (Burke et al., 2006; Simpson & French, 2005; Stein, 2005; Whitely, 1997). In Chapter Seven for example we see examples of where two senior managers find themselves unable to influence despite their senior roles, legitimacy and operational power. As Gabriel (2004) has argued "*emotions are no simple side-effects of mental life*" as "*emotion lies at the heart of human motivation*" (p.215).

One key feature of caring for sick patients, managing change and the social context of the NHS Trust then, is the ways in which clinicians and managers manage their anxiety which is fundamental to working in any health care setting. In the section that follows below, we demonstrate how psychoanalytic thinking explains how individual psychology and unconscious defence mechanisms link to the ways in which human beings work in groups and organisations.

In Chapter Nine we attend in more detail to the anxieties involved in obstetrics and more generally on the emotions involved in care of the elderly. In anticipation of these we present the theoretical material in some detail immediately below in this chapter.

1.6.2 Clinicians' anxiety and patient care

To conceptualize anxiety we draw on object relations theory, the branch of psychoanalysis associated with Melanie Klein (1959) and, in particular, the work of scholars who applied object relations to an understanding of groups (Bion, 1961) and organisations (Jaques, 1952; Menzies, 1970; Klein, 1987; 1983) hypothesising that an infant responds from the earliest time to the withdrawal of the maternal breast by experiencing a powerful anxiety of a 'persecutory nature'. Being unable to grasp the separation from the breast intellectually, the infant, unconsciously, feels as if every discomfort were inflicted by hostile forces. A fundamental *splitting* takes place, whereby an object is experienced as two separate objects, one entirely good and one totally bad. Thus there is a good breast (which is always present and nourishing) and a bad breast (withdrawing and denying), a good mother and a bad mother.

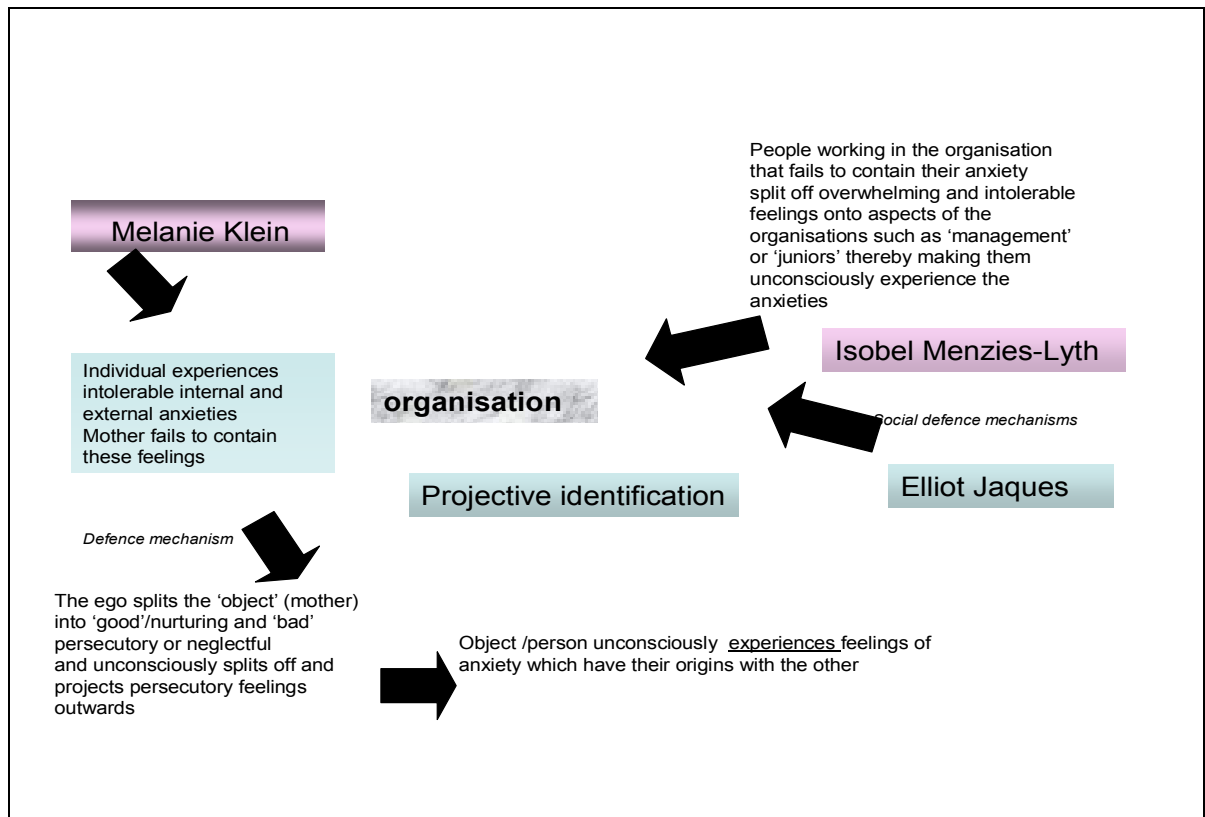
This is a pattern repeated in clinical settings, where patients routinely refer to a 'good nurse' and a 'bad nurse' and, almost identically, clinical staff referred to some patients as 'a good patient' and to others as 'a bad patient' (see Chapter Nine for an example of this). Splitting according to Klein extends in the child's own self – those aspects of him/herself that she cannot bear are projected outwards ("It is not I who is angry/fearful/envious; it is you"). Again this is a phenomenon observed many times in clinical settings. Frustration, discomfort and pain are experienced as persecution from hostile forces and their concomitants (e.g. hate) become destructive impulses which *are still operative in later life*, especially in times of stress and crisis.

Splitting and projection then are seen as fundamental *defences against primitive anxieties* by the object-relations school of psychoanalysis. Within this tradition, objects are not external entities but are shaped by phantasies¹² and feelings, they are *introjected* and projected, they split into good and bad and they constantly define and re-define the ego (or self). Object relations theory has found numerous important applications in the theory of organisations, primarily through the works of Jaques (1952) and Menzies Lyth (1960; 1970) in the UK, and more recently, Hirschhorn (1988), Gould (1993), Diamond (1993), Schwarz, (1990), Schwarz and Clore (2003) among others. Notable among these applications is the

¹² 'Phantasies' spelt in this way refers to those in unconscious experience.

treatment of *the whole organisation as an object which is liable to become incorporated in psychic reality* and towards which the individual may develop relations akin to early relations with significant objects from her environment and hold the 'organisation in the mind' (Armstrong, 2005) which we will discuss in more detail in the context of evidence from the study in Chapter Six.

Figure 2. Social Defences against Anxiety in Organisations



Menzies-Lyth, whose 1960 classic study of nursing staff occupies a privileged position in this literature, was driven by her initial observation that nursing work is highly anxiety-producing. She argued that nurses confront many different emotions from patients and their relatives - gratitude for the care they offer, admiration, envy for their skills and resentment stemming from forced dependence. Such projections create strong feelings in the nurses themselves:

The work situation arouses very strong and mixed feelings in the nurse: pity, compassion and love; guilt and anxiety; hatred and resentment of patients who arouse these strong feelings; envy of the care given to the patient. (Menzies-Lyth, 1988 , p. 46)

Faced with such an emotional cauldron, many nurses re-experience infantile persecutory anxieties, from which they seek to defend themselves, through

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the familiar mechanisms of projection, splitting and denial. Menzies-Lyth's important contribution was to establish how an organisation's own bureaucratic features, its rules and procedures, rotas, task-lists, paperwork, hierarchies and so on, in short '*the system*' acts as a support for the defensive techniques. By allowing for 'ritual task performance', by depersonalizing relations with the patients, by using organisational hierarchies, nurses contained their anxiety. Yet, in Menzies-Lyth's view, such organisational defences against anxiety were ultimately unsuccessful:

The system made little provision for confronting anxiety and working it through, the only way in which a real increase in the capacity to cope with it and personal maturation would take place. As a social defence system, it was ineffectual in containing anxiety. (Menzies-Lyth, 1991, p. 363)

The system's inadequacy in Menzies-Lyth's study is evidenced by its failure to train and retain nurses, the chronically low morale, high levels of stress and burn-out and absence of work satisfaction. By contrast, institutional health is testified not only by performance and output indicators, but also by morale indicators, and individual feelings of growth and maturation. Social defences against anxiety, then, are self-defeating. Instead of *containing* anxiety, they exacerbate it, just as neurotic symptoms far exacerbate the patient's malaise instead of containing it. Since Menzies-Lyth's pioneering work, some attention has been paid to how to support nurses and enable them to contain their emotions, without resorting to depersonalizing social defences. Yet, there is ample evidence that many nurses today continue to struggle with modest support against powerful anxieties (Theodosius, 2006; 2008). It is striking that no single study has sought to examine whether doctors face similar types of anxieties as nurses, whether they resort to similar psychological defences and the extent to which these defences function effectively across different individuals. In Chapter Nine we see evidence that doctors too appear to react similarly when faced with intolerable anxieties.

1.7 Developing our approach to leadership and the NHS

Studies of leadership and organisations such as the NHS clarify that diverse disciplinary perspectives have come together and separated more than once over the past century. The relationship between organisational and social context over that time has impacted on both practices of leadership and empirical and theoretical changes. In the 21st century the rules of scientific management or leader as therapist no-longer apply, and the rapid changes in organisations such as the NHS brought about by economic and technological imperatives, have left many who engage in leadership

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discourses, for practical and academic purposes, moving between the transformational and the post-heroic positions.

We now consider theoretical perspectives, ideas and practices that can potentially be brought together to good effect in this study for the benefit of patients and those who work for their good within the NHS, focusing on some of the recent debates which explore the context of leadership and the place of distributed leadership as they apply to NHS contexts.

1.7.1 The base-line:

- It is now widely acknowledged that organisations, their leaders and followers come together in a highly *emotional context*. How can those who lead and work in such organisations take account of the role of emotion while not being 'emotional' (i.e. making unfair and irrational decisions)? Understanding this is vital for enabling management and leadership particularly in a complex institution which has patient health, safety and care at its cutting edge (Morgan, 2006) .
- The NHS, individual Trusts and Units within these Trusts are constantly engaging staff in *change* (which may be evolutionary and/or politically driven) and which may be motivational and/or stressful or resisted (McNulty & Ferlie, 2002). This further demands emotional and social intelligence and engagement from leaders and followers (Bovey & Hede, 2001).
- The primary *tasks* and related *roles* might conflict at various points as these changes impact emotionally and intellectually on staff performance and service delivery (Zoller & Fairhurst, 2007).
- Organisations have to have leaders but leadership is not necessarily always the province of a small group of individuals but depends on the structure and demands placed on the organisations and the tasks required at any one time (Currie et al., 2009; Day et al., 2006; Harvey, 1989; Michie & West, 2004).
- An emotional context requires attention to both conscious and *unconscious* dimensions of human interaction and power relationships which may come into play in organisations which comprise multiple professional disciplines, different grades of role and people from diverse cultures, sexualities and gender (Ford, 2006; Gabriel, 2004). Acknowledgement of the importance of anxiety, envy, competition, anger and the emotional ties between people needs to be taken into account (see Figure 3 below).

Two models of leadership are therefore examined in this study (see Figure 3 below):

- First, *inspirational and transformative (or engaging) leadership* which has attracted much recent attention in that its absence was seen as a critical factor behind the failure of many organisational innovations. In this approach, leadership hinges on leaders' ability to communicate effectively, relate emotionally with their followers and develop a vision that is both attractive and achievable. The role of transformational leadership then is to lead an organisation towards change and thus some elements of transformational leadership are essential for understanding the practices and needs of the NHS (Alban-Metcalf & Alimo-Metcalf, 2009).
- The second relevant dimension is *distributed leadership* (sometimes called *dispersed, distributive, collective, or supportive 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). A *distributed leadership* approach is consistent with Bailey and Burr's (2005) research on successful NHS Trusts, which states:

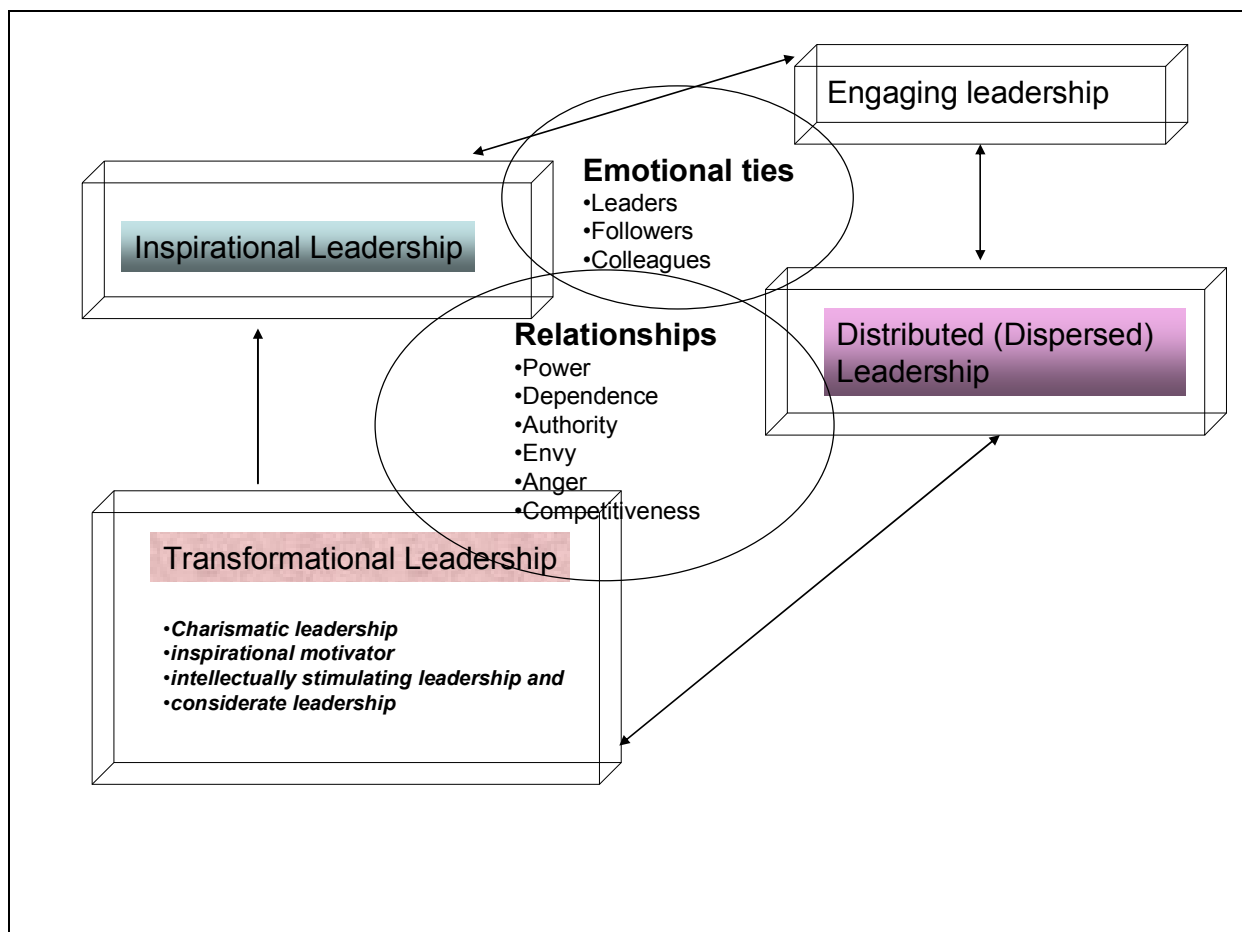
In contrast to the individual, heroic leader concept, leadership is seen in terms of the influence processes that contribute to the collective and individual capacity to work effectively. This idea of collective and distributed leadership is closely associated with the emergence and special requirements of 'new' organisational forms generally and the NHS in particular it is consistent with the agenda for devolved decision – making, empowerment of the frontline, de-centralisation, inclusion and such initiatives as 'Leadership at the Point of Care'.

Thus, distributed leadership is seen by Bailey and Burr (2005, p. 14) as directly linked to patient care.

A combination of these two models might now be seen as 'engaging' leadership as described by Alimo-Metcalf, Alban-Metcalf et al. (2007) and this combination will be explored further in our analysis of the (qualitative) data in particular.

Furthermore the model of the post-industrial/postmodern and or networked organisation will be 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).

Figure 3. Leadership Styles, Followership and Emotion



1.8 Conclusion

In an organisation like the NHS there are opportunities for leadership at all levels, as well as opportunities for success and unforeseen consequences leading to failure. Leaders in the NHS are involved *transformationally* in responding to policy initiatives and government demands, but the NHS is also an organisation that relies on the knowledge, skills and abilities of all its people – leaders and followers.

It would seem that *transformational/engaging and distributed leadership* are particularly useful conceptual resources to deploy in the context of the National Health Service, where a workforce of different ethnic, cultural and

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class backgrounds caters to the needs of a similarly diverse patient population.

Following Alimo-Metcalfe, Alban-Metcalfe et al (2007) "*an engaging 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'*" (2008, p. xi).

As part of the conceptual framework we develop, it is clear that the *emotional links* between individual staff, groups of staff and staff and patients need to be privileged as they play out at various organisational levels. Implicit therefore is that emotions above and below the surface (conscious and unconscious) are taken into account if the leader/follower and staff/patient relationships are to be understood and improved.

2 Aims and Methods

2.1 Introduction

The research questions in this study centre on identifying:

- (a) processes by which leadership is transmitted through health service organisations to effect the delivery of health services, and
- (b) how features of the organisation, the leader, and the service influence these processes.

The focus of this study was to explore the relationship(s) between (good) leadership in NHS organisations and (good) patient care. This demanded consideration not only of leadership characteristics, qualities and styles but the ways in which NHS organisational climate and culture interacted with individual practices and identities of those who worked in them and were patients. The overall plan was, thus, to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery. This research further sought to expand existing knowledge by exploring the following questions.

1. First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
2. Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

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3. Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

2.2 Aims and Objectives

We separated these overarching research questions into aims and objectives thus:

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients;
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts on service delivery;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted through health care organisations to affect service delivery, posits *organisational climate* as one feature of the organisation that could positively or negatively affect the quality and delivery of health services.
- To learn how different stakeholders (specifically, patients, nurses and professions allied with medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care.
- To identify how the need for change in service delivery is identified and what drives the need for change.

2.3 Methods

This multi-method study therefore uses a mixture of qualitative and quantitative methods to enable and support an innovatory approach to examining the psycho-

social and psychodynamic factors intrinsic to the meanings and processes of leadership, organisation and patient care.

Qualitative research methods now have a strong and long-standing profile in social science, particularly sociology and anthropology. But over recent years they have become increasingly relevant in social psychological research.

Furthermore nursing research (Finlay & Ballinger, 2006; Kerr, 2002) and most recently even health services research have begun to take evidence emerging from qualitative methods seriously. Perhaps this began with a series of papers in the British Medical Journal in 1995. Pope and Mays for example leading on this series aptly titled their paper *Reaching the Parts other Methods Cannot Reach* (Pope & Mays, 1995). Noteworthy from this point onwards is that there is no 'one' qualitative method of either data collection or analysis and we draw on several traditions and styles in this study which are outlined below.

Unlike health services research *per se*, but akin to critical social science, there is a powerful tradition in organisational research that has taken account of the diverse nature and intrinsic value of qualitative methodologies to understanding the life of organisations (see for example Cassell and Symon, 1994; Ybema et al., 2009)

What counts of course is choosing methods which meet the demands of the research hypothesis or overarching questions. We thus began from the premise that 'leadership', 'patient care' and 'organisational change' are not objective facts but social or discursive constructions. By this we mean that these concepts are constructed through discourse, i.e. a coherent system of statements which constructs an 'object' (Parker, 2002). In other words, talk about leadership is the process by which leadership is constructed (and thus recognised) as something that happens in organisations such as the NHS.

To capture these constructions we used a range of methods:

- focus groups;
- a survey-based questionnaire including a standardized measure of Organisational Climate;
- ethnographic 'shadowing';
- observations of social places, formal and informal and meetings;
- analysis of 'stories' of leadership collected through in-depth interviews.

2.4 Capturing the data

In what follows we present the outline plans for capturing, managing and analysing the data to meet our aims although as shown in Chapter Three not all of our goals were achieved.

We focused upon three NHS Trusts with at least one being a Foundation Trust specifically to explore whether any variations in the qualities of leadership, organisation and patient care could be distinguished. An

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investigation of three Trusts was considered to be manageable within the time frame and other resources available for the project.

Within each Trust we chose two distinct 'units' to study. We conjectured these would probably to be defined by clinical speciality or site (bearing in mind that many Trusts are organised across more than one hospital/physical space).

We conducted focus groups, an organisational climate survey, story-telling interviews and ethnographic work (observations and shadowing) across these six units with staff and patients.

We employed two researchers¹³ to carry out the majority of this work, but some members of the investigatory team also took an active part in the process.

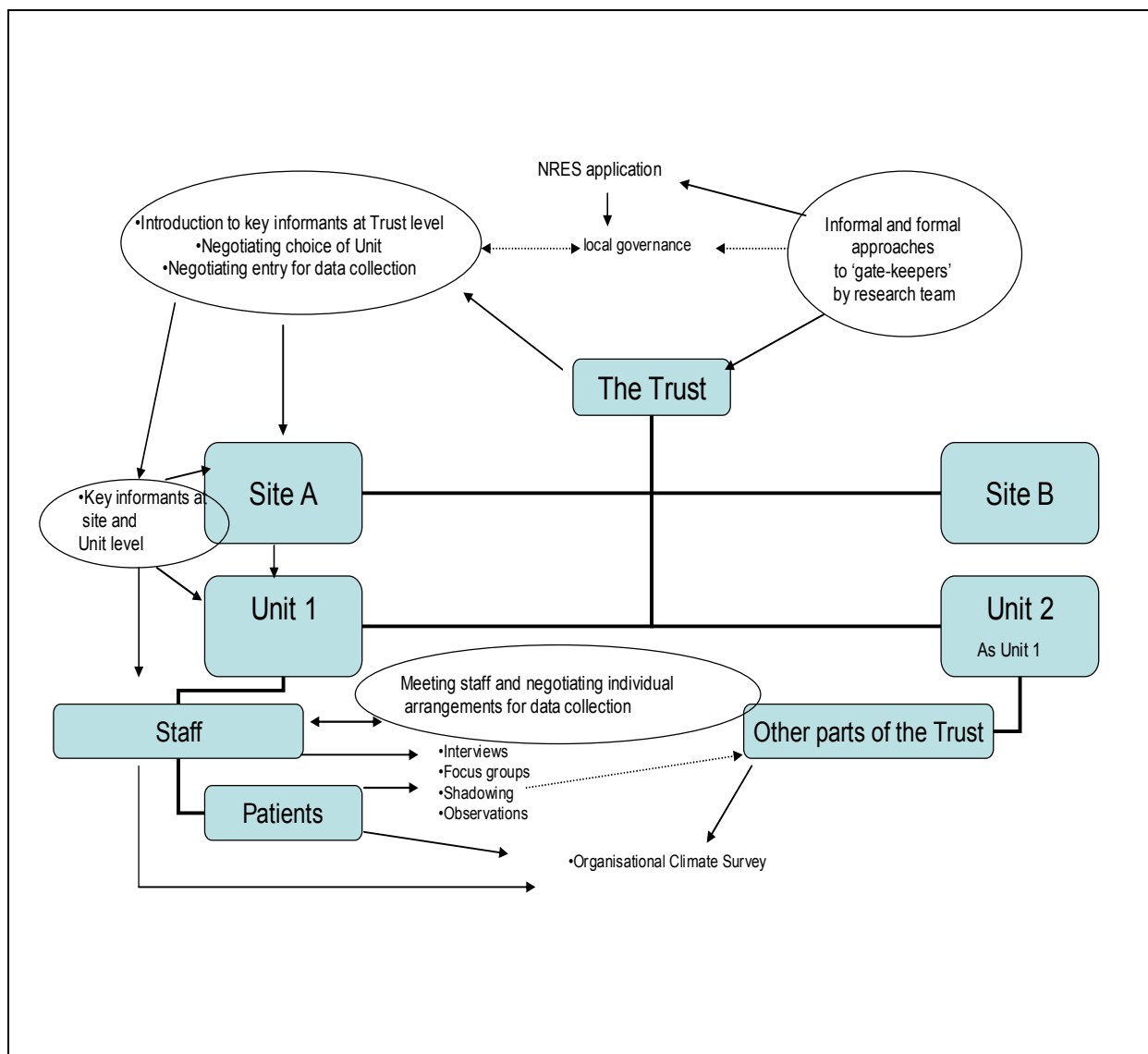
The qualitative data would by necessity and designed be analysed using a variety of methods:

- a. Thematic analysis (TA)
- b. Critical Discourse Analysis (CDA)
- c. Narrative analysis

Each of these approaches to data analysis, again by necessity and design, was subject to nuances of interpretation, intrinsic to their nature.

¹³ In the event three researchers were involved because of maternity leave and cover.

Figure 4. Access Pathways, Sampling Procedure and Data Collection Process



2.5 Sampling

The Trusts

Sampling the Trusts was decided according to three criteria that:

- they were each different from each other in the image they projected (on their web-sites, in terms of their physical style,

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locality, size and community) and that the sample had to include one Foundation Trust.

- they were in easy reach of London (for practical purposes as the study team were based in London and Surrey).
- we were able to gain access via personal contacts in R & D or senior management (the 'gatekeepers').

The Units

Sampling of the Units in each of the Trusts was achieved through negotiation with the gatekeepers and/ or key informants recommended by the gatekeepers with the intention that a balance might be struck between:

- the specific academic interests of the research team (for example the PI is particularly interested in Obstetrics and Gynaecology services).
- some degree of opportunity for comparison between Trusts, so that if possible some similar Units might be compared across the Trusts.
- and (possibly most influential) the concerns of the gatekeepers and other senior Trust staff.

The Sites

All three Trusts selected for an initial informal approach were on more than one site although the selection of study unit determined whether or not the data was collected on more than one site.

Individual Participants (staff)

Individual participants were to be selected on an 'informed' volunteer basis. That is that via a process of meetings with key informants and presentations to staff-groups individual staff would hear about the study and be offered the opportunity to participate. For those who were not involved in the meetings or presentations a staff e-mail list was used to communicate information about the study and request volunteers to participate in interviews and focus groups. The intention to meet the study aims was to ensure participation from a variety of staff groups and levels of seniority.

Individual Participants (patients)

Patients were to be recruited for interview either by the staff directly caring for them or by the researchers themselves once the staff of each unit had become familiar and accepted the presence of the researchers.

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Survey Respondents (staff)

The Organisational Climate Survey (OCS) was to be administered within the Units that were the focus of the study and, if possible, across other Units in the Trusts. The circulation was to be achieved either through e-mail or through internal mail depending on negotiation with the relevant gate-keepers.

Survey Respondents (patients)

Patients who might complete the patient version of the survey were to be recruited by staff and/or researchers if staff permitted the researchers 'on the ground' access.

Observations and 'Shadowing' (staff and patient-staff interactions)

These methods would require the participants to be familiar and comfortable with the presence of the researchers and familiar with the ongoing research process and also be prepared to co-operate. The rules for engagement in the activities would then be made on a strategic (i.e. the staff and / or situation that would yield the richest source of information) and a pragmatic basis (i.e. the possibility of the situation yielding important data regarding leadership, organisational culture and climate and patient care).

2.6 Ethical considerations

There are clearly considerations about confidentiality and anonymity in all data collection which involves human participants Easily identified in this study (and thus in the NRES application) is the matter of the safe keeping of the raw data including completed questionnaires, any identifying characteristics of these questionnaires, digital recordings, transcripts from focus groups and interviews and the researchers' field notes. It is important to note that this is not necessarily as simple to do as it is to describe particularly because a team of investigators, the researchers themselves and some 'casual' clerical staff ¹⁴all had different types of access to the data.

The solution was to have a shared drive set up by the computer centre at Royal Holloway, University of London (RHUL) on the main site at Egham which could only be accessed by specified investigators identified by the PI. Additionally there was an access pass-code to read the transcripts and the SPSS file.

¹⁴ The sheer volume of data made it necessary to use more than one person to input the data and transcribe the recordings. Two people other than the researchers were engaged to work on this although both were employees of RHUL who knew the importance of keeping the data safe.

Another ethical consideration specific to this project was that because the staff were discussing leadership and being asked to give examples of good and bad leadership, as well as examples of effective and poor patient care, it was inevitable that:

- they would be talking about *other* members of staff. These other staff could not be told that they had been talked about (by definition) leaving them unable to provide their version of the story or aware of the fact they had been discussed.
- the researchers would therefore be 'holding' some knowledge of others which would be 'data'. This fact drew attention to the ethical and empirical complexities of working in an organisation in which data is being collected on human interactions and relationships.

As patients' experiences and views and staff's views of patient care were also part of this investigation, similar issues applied.

Finally, frequently overlooked but nonetheless very important consideration was given to the fact that participants' time should not be wasted. We were confident in the design and our experience as investigators supporting and managing the researchers (who themselves were experienced in this kind of study) that the study was robust enough to adapt to the vagaries and quirks of 'real life' and that the outcome would be valid and add value to existing knowledge.

2.7 Methods of data collection and research instruments

As described above a mixture of qualitative and quantitative methods were used to ensure a full picture of leadership in the organisations to be studied. Collecting data in applied settings, where the participants are also engaged on a day-to-day basis is demanding work which is challenging for researchers involving persistence, social skills, the ability to develop rapport, clarity of purpose combined with flexibility, the skill of 'thinking on your feet' and making practical judgements about what is feasible at any one time. For example, if plans had been set for an interview with a staff member who was then called away for an important work matter, the researcher could arrange other potential participants or be prepared to engage in a period of systematic observation.

Immediately below we describe the methodologies we chose to employ to conduct our investigations which will be described in greater detail where appropriate in the context of specific case studies.

2.7.1 Focus groups

Focus groups, once the province of market researchers, in common with in-depth interviews, are now a popular method of collecting psycho-social data in the area of health research (Nicolson & Anderson, 2003; Nicolson et al., 2008) having gained recognition in social science overall as a robust way of eliciting “*shared and tacit beliefs, and the way these beliefs emerge in interaction with others in a local setting*” (Macnaghten and Myers, 2004, p. 65 in Seale et al) (p.8). In other words focus groups represent a means of gathering a sense of how those who work in an organisation share a sense of their ‘organisation in the mind’ (Armstrong, 2005) which may be mutually accepted, challenged or undermined by the perceptions of colleagues. Focus groups also enable the researchers to check out the quality and effectiveness of the communications themselves between members of the Unit or as Morgan (1998) suggests “*Focus groups are fundamentally a way of listening to people and learning from them* (1998, p. 9).

The process involves one or two researchers meeting with between four and eight participants who share a common situation and the guide lines for the discussion focus on key topics (see Appendices). One researcher takes notes although both are empowered to guide the discussion which is also digitally recorded. One benefit of this means of data collection is that through discussion among peers issues or perspective upon certain issues are brought into focus which might have escaped previous research authors and the researchers themselves (Morgan, 1998).

The *focus group guide* employed a similar structure to the *Interview Guide*.

2.7.2 Organisational climate

The Organisational Climate Questionnaire (OCQ) designed by Stringer (Litwin & Stringer, 1968; Stringer, 2002) also called ‘The Leadership Questionnaire’, was specifically designed to produce a scale to measure leadership in the context of climate albeit in a business rather than NHS setting. To complement the mostly qualitative methods of data gathering and analysis, we developed a questionnaire for staff and patients across the Trusts and used (a slightly adapted form of) Stringer’s measure of leadership and organisational climate, with the expectation that our results might also be linked to other studies undertaken with this measure, which had been used to examine management and leadership in organisations.

It identified six dimensions of organisational climate: *structure, standards, responsibility, recognition, support* and *commitment*, and uses eighteen leadership practices (three for each dimension) to capture how people feel about their jobs, how they are managed, and how things work in a particular organisation. Because this scale is designed to give practical

indicators on how to improve performance, many of the leadership measures are based on management practices, which are equally important to the overall success of an organisation. In general, however, each leadership practice measure is based on the premise that leaders care about arousing the motivation of members in the organisation (Stringer, 2002). The OCS was adapted from to fit a model relevant to NHS Staff working in a hospital setting and another version was adapted to be used with Patients (see Appendices).

2.7.2.1 Measurement tool: Stringer's OCS – Leadership and Organisational Climate

Stringer (2002) defines organisational climate as the "*collection and pattern of the environmental determinants of aroused motivation*" (p. 9) and he takes motivation to be central to the development of his climate questionnaire predominately based on the work of McClelland-Atkinson's framework with regards to intrinsic motivators of work related-behaviour: the need for achievement (nAch), the need for power (nPow), and the need for affiliation (nAff).

Stringer noted that specific dimensions of climate appear to have a predictable impact on motivated behaviour and can be measured and managed by those in senior positions accountable for organisational performance.

The six distinct dimensions identified and measured are:

- 'Structure'
- 'Standards'
- 'Responsibility'
- 'Recognition'
- 'Support'
- 'Commitment'

The statistical data was entered into an SPSS file to seek frequencies, correlations and to explore significance levels of differences and similarities between and within groups of respondents.

2.7.3 The survey structure and items

The survey is structured in two parts:

Part 1: measures *Organisational Climate* or how people perceive the work environment.

Part II: measures *Management Practices* or how people see their own managers behaving.

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Part 1:

This part consists of twenty-four items grouped into the six dimensions - 'structure', 'standards', 'responsibility', 'recognition', 'support' and 'commitment' - designed to measure how people feel about their work environment using a 4 point Likert scale. The directions ask the participants to describe the kind of working climate that has been created in their organisation (defining 'organisation' as the smallest work unit relevant to the participant).

Descriptions of the dimensions are as follows:

1. **'Structure'** pertains to the clarity of roles, responsibilities, accountability and expectations. According to Stringer this is more of a managerial than a leadership issue and one which is more practical than inspirational. It reflects the employees' sense of being well organised and of having a clear definition of his or her roles and responsibilities. *"structure is high when people feel that everyone's job is well defined and is low when there is confusion about who does which tasks and who has decision-making authority"* (Stringer, 2002, p.65).

The following items measure 'structure':

- The jobs in this organisation are clearly defined and logically structured.
- In this organisation, it is sometimes unclear who has the formal authority to make decisions.
- In some of the projects I've been on, I haven't been sure exactly who my boss was.
- Our productivity sometimes suffers from a lack of organisational planning.

2. **'Standards'** is about the need to achieve targets and reach goals. It is the drive to achieve and improve, it includes the 'commitment' and persistence to follow through on set targets. This dimension measures the feeling of pressure to improve performance as well as the degree of pride employees have in doing a good job. When interpreting this measure, high 'standards' indicate that people are always looking for ways to improve performance, whereas, a low score reflects lower expectations for performance.

The following items measure 'standards':

- In this organisation we set very high 'standards' for performance.
- In this organisation people don't seem to take much pride in their performance.
- Around here there is a feeling of pressure to continually improve our personal and group performance.
- Our management believes that no job is so well done that it couldn't be done better (Stringer, 2002, p.65).

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3. **'Responsibility'** is about taking ownership of the work and results which are obtained. Ideally people will be motivated to achieve results and take ownership over these. Where managers delegate and encourage responsibility, workers are more likely to feel a sense of 'responsibility'. It reflects employees' feelings of 'being their own boss' and not having to double-check decisions with others. A sense of high 'responsibility' signifies that employees feel encouraged to solve problems on their own. Low 'responsibility' indicates that risk taking and testing of new approaches tend to be discouraged (Stringer, 2002; p.66).

The following items measure 'responsibility':

- We don't rely too heavily on individual judgment in this organisation almost everything is double checked.
- Around here management resents your checking everything with them if you think you've got the right approach you just go ahead.
- You won't get ahead in the organisation unless you stick your neck out and try things on our own.
- Our philosophy emphasises that people should solve their own problems themselves.

4. **'Recognition'** relates to the relationships between one's performance and associated rewards, as well as broader sense of approval or disapproval of an individual's efforts. It indicates employees' feelings of being rewarded for a job well done. This is a measure of the emphasis placed on reward versus criticism and punishment. High 'recognition' climates are characterised by an appropriate balance of reward and criticism. Low 'recognition' means that good work is inconsistently rewarded (Stringer, 2002, p. 66).

The following items measure 'recognition':

- In this organisation the rewards and encouragements you get usually outweigh the threats and criticisms.
- There is not enough reward and 'recognition' given in this organisation for doing good work.
- We have a promotion system here that helps the best person rise to the top.
- In this organisation people are rewarded in proportion to the excellence of their job performance.

5. **'Support'** is the degree to which there is a sense of warmth and team work, within which the individual feels that they are 'backed up' by others. This will determine the amount of trust and respect amongst team members. It reflects the feelings of trust and mutual 'support' that prevails within a work group. 'Support' is high when employees feel that they are

part of a well-functioning team and when they sense that they can get help (especially from the boss) if they need it. When 'support' is low, employees feel isolated and alone. This dimension of climate has become increasingly important for today's e-business models in which resources are severely constrained and a premium is placed on teamwork (Stringer, 2002, p.66).

The following items measure 'support':

- You don't get much sympathy in this organisation if you make a mistake.
- When I am on a difficult assignment, I can usually count on getting assistance from my boss and co-workers.
- People in this organisation don't really trust each other enough.
- I feel that I am a member of a well-functioning team.

6. **'Commitment'** reflects employees' sense of pride in belonging to the organisation and their degree of 'commitment' to the organisation's goal. Strong feelings of 'commitment' are associated with high levels of personal loyalty. Lower levels of 'commitment' mean that employees feel apathetic toward the organisation and its goals (Stringer, 2002, p. 11).

The following items measure 'commitment':

- Generally, people are highly committed to the goals of this organisation.
- People here feel proud of belonging to this organisation.
- People don't really care what happens to this organisation.
- As far as I can see, there isn't much personal loyalty to the organisation.

Part II:

This part asks the participants to describe the practices of their managers. Using the same six dimensions as in Part I, participants are given eighteen statements which describe the way a manager might perform her or his duty and the respondents are asked to indicate how much he or she agrees with each of the statements. Here a 5 point Likert scale is used.

Once again the six dimensions are used to assess perceptions of managers' practices:

1. 'Structure'

- Establishing clear, specific performance goals for subordinates' job.
- Clarify who is responsible for what within the group.
- Making sure tasks and projects are clearly and thoroughly explained and understood when they are assigned.

2. 'Standards'

- Setting challenging performance goals and 'standards' for subordinates.
- Demonstrating personal 'commitment' to achieving goals.
- Giving subordinates feedback on how they are doing on their job.

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3. 'Responsibility'

- Encouraging subordinates to initiate tasks or projects they think are important.
- Expecting subordinates to find and correct their own errors rather than doing this for them.
- Encouraging innovation and calculated risk in others.

4. 'Recognition'

- Recognizing subordinates for good performance more often than criticizing them for poor performance.
- Using 'recognition', praise and similar methods to reward subordinates for excellent performance.
- Relating the total reward system to performance rather than to the other factors such as seniority or personal relationships.

5. 'Support'

- Being supportive and helpful to subordinates in their day to day activities.
- Going 'to bat' for subordinates with superiors when the manager believes their subordinates are right.
- Conducting team meetings in a way that builds trust and mutual respect.

6. 'Commitment'

- Communicating excitement and enthusiasm about the work.
- Involving people in setting goals.
- Encouraging subordinates to participate in making decisions.

Leadership question

We also asked a single question to capture directly how satisfied an employee is with the leadership they receive from their immediate supervisor. It was a simple statement: *I am satisfied with the quality of the leadership I receive from my immediate manager* which we measured using a 4 point Likert scale.

2.7.4 Ethnographic observations and 'shadowing'

Ethnographic observations and shadowing are especially useful to organisational research because they allow people to *physically* express their inner thoughts, and put ideas into *observable action*, all of which would be inaccessible through the survey or structured interview questions.

Ethnographic observation (often referred to as *participant observation*) has its roots in anthropology but has become increasingly deployed in sociology, cultural and social geographies. In the field (which in this case is a Unit in an NHS Trust) the researcher's aim is to "*understand how the cultures they are studying 'work'*" that is, to grasp "*what the world looks like*" to the

participants in the context being observed (Delamont, 2004, p. 206). In this study observation and shadowing opportunities were (mostly) formally set up and pre-arranged. However, the researchers, through taking their roles as interviewers, focus group leaders and having an every-day presence with key informants, gate-keepers and participants, were able to immerse themselves in the lives and atmosphere of each of the Trusts and Units providing evidence about the processes of leadership and patient care as well as 'climate' (Bloor, 2001; Goffman, 1961).

Shadowing involved the same conceptual framework as ethnographic observation in that the aim was to understand what the world looks like from the perspective of the staff member being shadowed as well as the worlds of the other staff and patients that they engaged with in the course of their work (Czarniawska, 2008; McDonald, 2005). It involved meeting the participant (usually) at 8 am and for one or two days accompany them including at break times until the participant went home. In Trusts where there was more than one site and/or when the nature of the day's work involved meetings outside the hospital (as in nearly every case) then the researcher spent time in a car with the participant and if agreed the conversation was digitally recorded as an *aide memoire* for the field notes. The participant was able to withdraw at any time, or for a period of time, across the shadowing period.

Thus the sense of 'what the Unit world looked like' was recorded in field notes which were then discussed with the other members of the team (who had some familiarity with the relevant part of the Unit/Trust) in a context where the researcher could be reflexive and explore the 'silent space' of the 'ethnographic self' (Coffey, 1999). The researcher's notes and expressed thoughts were then discussed with other members of the team, some of whom were familiar and others not so with the specific context (Barry, 2003). A similar approach was used to discuss the interview material because even though the interviews were digitally recorded and transcribed verbatim, this did not account for the reflexivity that took place following the interview itself and on transcribing and reading the transcript, and therefore featuring in the analysis (Nicolson, 2003).

In this context there was concern to capture the emotional content and atmosphere of the organisations. This meant that ethnographic methodologies were implemented to analyse the emotionality of the interactions (verbal and non-verbal) between patient and practitioner. It was through these observations that the use and importance of the researcher's *body as a 'research instrument'* became palpable, especially for understanding the emotions emerging out of the interactions between patient, relatives and practitioner(s). This process has been proposed as the antithesis of taking for granted that emotion should be removed from

ethnographic investigation and that in fact the research process is highly emotive and far from an emotionally barren terrain (Bondi, Davidson, & Smith, 2005).

As the researcher collects data they move through a continuum of emotions from the euphoric highs of excitement at starting a new research project, sense of achievement and pride as they begin to make contacts and collect initial data, perhaps trepidation, fear and nervousness as they meet new participants or research settings through to the depths of despair, isolation and frustration as the research process (inevitably at times) becomes chaotic and messy. However, these emotions are often neglected, regarded as unimportant to the overall research process and abandoned in the writing up phase. We use these frequently neglected emotions and feelings as part of, and beneficial to, the project as representing a rich source of data.

By being more attentive to their emotions and bodily senses ethnographers also become more sensitive to their environment and their participants thus gaining a greater awareness of what they are observing. In recalling a sound, smell or feeling the ethnographer is able to open up their mind's eye to re-visualise the interaction with greater clarity and accuracy making it more likely that an accurate representation of what was observed will be recorded.

2.7.5 In-depth semi-structured and 'story-telling' interviews

In-depth semi-structured Interviews: Over the past fifteen years this method of qualitative data collection has become increasingly common in health services and health research in general (Pope and Mays, 1995; Kvale, 1996; Grbich, 1999) consistently a method of choice for identifying perceptions, meanings and experiences of dynamic and complex concepts such as 'leadership' and 'patient care' (Rubin and Rubin, 1995; Denzin and Lincoln, 1998; Rapley, in Seale et al, 2004).

The use of such interviews has led to increased levels of sophistication in the interpretation of qualitative in-depth data in the context of historical, cultural and political frameworks demonstrating that in-depth semi-structured interviews (and more generally qualitative research) have capability beyond simply adding rich description to statistical evidence (see Denzin and Lincoln, 2002; Willig, 2008).

Story-Telling: One of the explicit aims of the interviews was to collect a number of stories to reflect critical experiences in the organisations' past and present life. In the field of organisational studies, there is now an extensive literature of how to use stories told by organisational participants

as windows into organisational culture, politics and numerous other phenomena (Gabriel, 2000; Hannabuss, 2000).

The inclusion of story-telling in the context of the in-depth interview increases the scope for making sense of data in ways that delve deeply into the respondents' perceptions and meaning of the *processes* of leadership and patient care. Story-telling also increases the validity of the interview through the use of reflexivity, and positioning the events and 'atmosphere' of the stories in the context of the organisational analysis.

Of particular relevance to this study, stories can instigate insights into the processes of positive or negative social and organisational change and leadership which involves the management of meaning and emotions, both of which rely heavily upon the use of stories, allegories, metaphors, labels and other narrative devices.

The study of *organisational stories* is particularly relevant in health care settings that are liable to unleash strong emotions and fantasies. Hence, hospitals are rich grounds for collecting stories, as numerous researchers have recognized (Kleinman, 1988; Frank, 1998; Greenhalgh, 2002; Hurwitz, 2006; Mattingly, 1998). Storytelling permeates everyday clinical practices and "*medical professionals find ways to 'routinize' their practice and thus, metaphorically at least, bring the unruly and frightening world of illness under control*" (Mattingly 1998, p. 277).

The *interview schedule* (see Appendices) therefore was designed to elicit information on the participant's view of 'leadership' and 'patient care' through 'stories' to provide examples in their opinion that constituted good and poor leadership and good and poor patient care through 'critical incidents'.

As the interviews were semi-structured and in-depth they relied to a great extent on the interviewing skills of the researchers and their ability to establish rapport and consequent willingness of the participants to engage in the process. The early pilot interviews therefore were unlikely to influence the details of the interview schedule itself although the early interviews were planned to enable the research team to identify the best *strategies* to engage participants in the task.

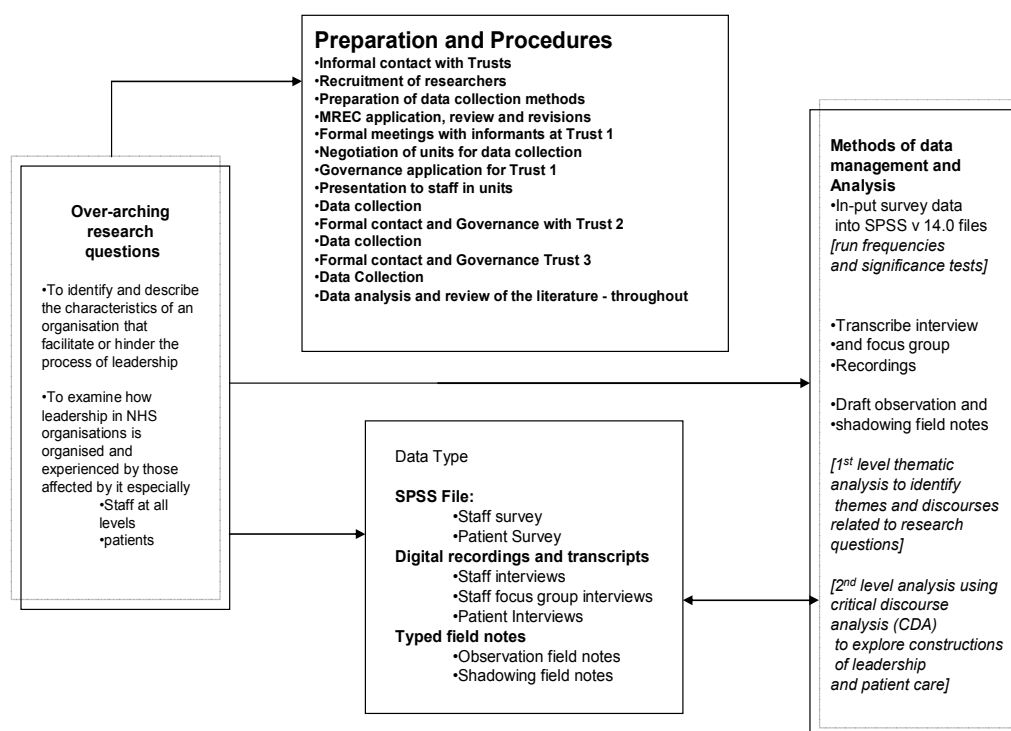
2.8 Data Management

The interviews and focus groups were digitally recorded and transcribed verbatim. The transcripts stored on a password protected Word file (initially on the researchers' PCs but subsequently on the secure shared drive described above) and sound recordings stored on audio files (password protected on the PC of the PI and not on the shared drive).

The OCS data was entered and stored on an SPSS file, password protected and placed on the secure shared drive.

Fieldwork notes from observations and shadowing were similarly password protected stored on the shared drive once they had been prepared by the individual researchers.

Figure 5. Outline of Study Procedures and Methods



2.8.1 Data Analysis

There are effectively therefore three categories of data.

1. Qualitative data representing verbatim 'talk' (digital recordings/transcripts) of interviews and focus groups.
2. Qualitative data from observations, shadowing and other field notes. These were subjective accounts of observations, perceptions, emotions and meanings given to the field work by one researcher. This may have been following discussion with the other researcher on occasions when that person had had access to the same raw

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material. Discussion with another member of the investigatory team (frequently but not always the PI) also took place following the first drafting of the field notes in order to clarify the meanings given to specific behaviours and relate theory and data.

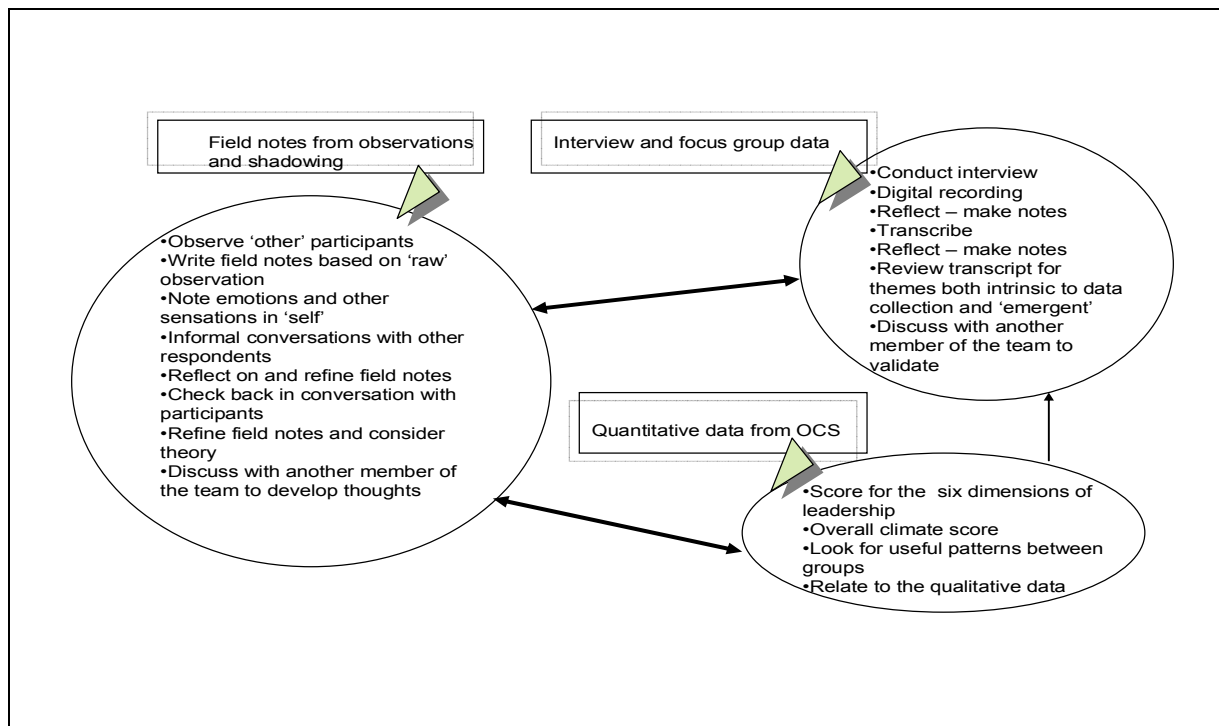
3. Statistical data from the OCS.

2.8.2 Thematic Analysis (TA)

The transcripts and field notes were examined initially for relevant extracts related to the main themes ('leadership', 'organisation' and 'patient care').

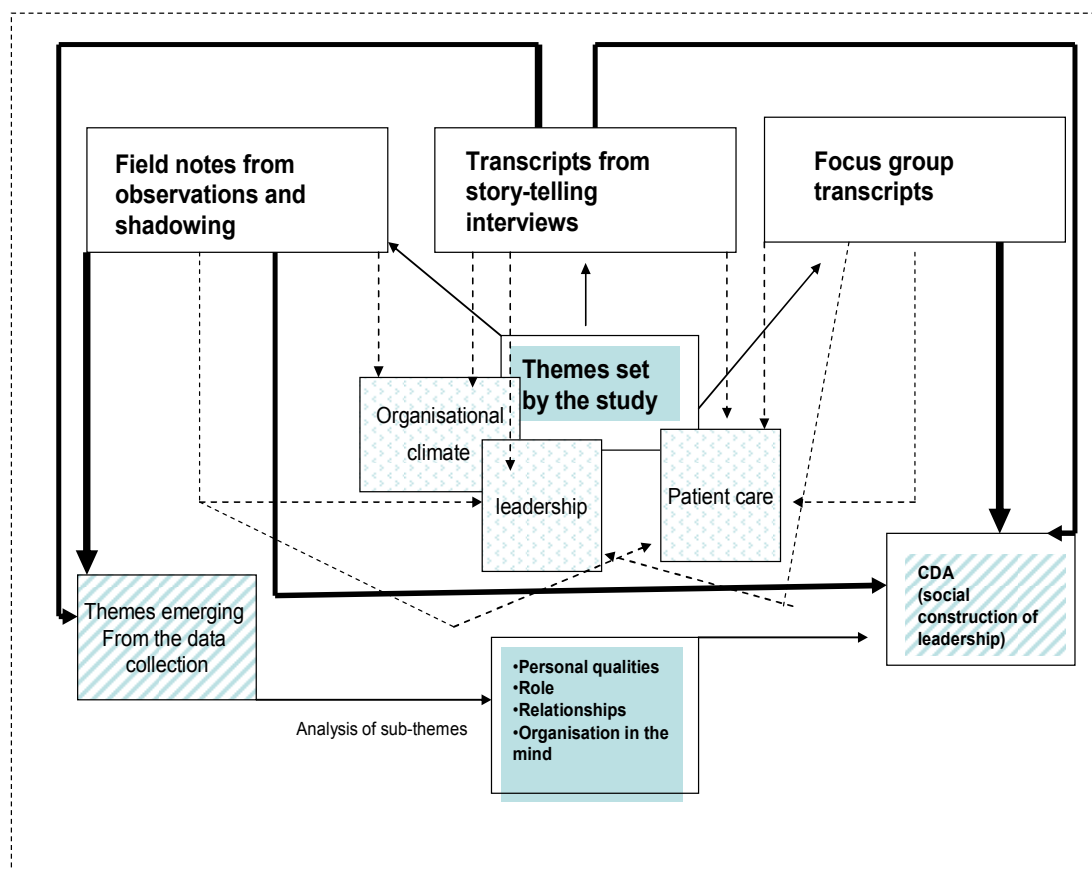
Sub-themes were then to be identified, some of which are likely to relate closely to the previous research literature on leadership and organisational climate, although it is likely that each organisation will demonstrate particular issues that were more difficult to anticipate at the outset.

Figure 6. From data collection to data analysis



Data relating to these themes and sub-themes was to be collated on Word files and where deemed relevant to the study aims, analysed further using the following methods – Discursive Psychology, Critical Discourse Analysis and Narrative Analysis. All these approaches focus on language and the way language is used to construct key concepts (e.g. the organisation) but there are different nuances to each perspective each of which adds an important dimension to the analysis of this data.

Figure 7. Thematic to CDA with Narrative analysis



2.8.3 Discursive Psychology, Discourse Analysis and Critical Discourse Analysis (CDA)

Hepburn and Potter (2004) argue convincingly and with justification that DA has evolved to have several iterations over recent years. One common feature though has been that 'discourse' (i.e. what is said) and 'context' are difficult to separate and it is the ways in which context is worked into the analysis of discourse that distinguishes the character of DA deployed in a particular piece of analysis.

The thematic analysis was a starting point from which to focus in upon the close readings of the texts, which related to the processes of leadership and patient care, as it represents a flexible and clear way of identifying what is emerging from the data and points a way forward with more detailed analysis (Braun and Clarke, 2006)

We argue that leadership is a social construction and there is a growing body of literature providing evidence to support this view. There has also been a recent focus in organisational research and theory to specify an Organisational Discourse Analysis (ODA) (Pritchard, Jones and Stablein, 2004) which involves four approaches i.e. *Narrative*, *Foucauldian*, *Linguistic* and *Deconstruction* which in turn are influenced by a *reflexive awareness* of the organisational culture in which the research is being conducted.

Pritchard et al, (2004) argue further that the exact methodology and approach to the data depends on the 'researcher position' in the organisation being studied. In other words this approach *benefits* from the subjectivity of the researcher's interpretation of what processes mean and specifically from researcher reflexivity about their 'take' on a situation and set of interactions.

To qualify this method of analysis further, a discursive approach means that language is represented not so much as an objective truth but as a means of *constructing* what might be understood (Parker, 1992; Coyle, 2007).

Particularly relevant in this study, in which participants are asked to tell stories and provide evidence to support what is good and bad about both leadership and patient care (and implicitly the organisation in which these actions take place), is discursive psychology (DP) that highlights how "*descriptions of events are bound up with doing actions, such as providing justification for actions and blaming others*" (Hepburn and Potter, 2004, p. 169).

Thus Critical Discourse Analysis (CDA) sees language as a *social practice* and thus considers carefully the context in which language is used (see

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Wodak, 2004). CDA is related to the notion that *power is negotiated through language*. This is particularly apposite in a study of leadership in organisations. Even more so CDA is 'abductive' so that a constant movement between theory and empirical data is needed which suits ethnographic methods such as shadowing and observations enabling the researcher to test out their ideas as they progress with the data collection, and the attempt to understand how cultures work and how the research participants make sense of and experience their worlds.

2.8.4 Narrative Analysis

Narrative approaches to data analysis have been able to cut through the great complexity of the NHS - the intense emotions, positive and negative, it evokes among most of its stakeholders (e.g. Rooksby, Gerry & Smith, 2007; Bryant, 2006; Iedema et al., 2009; Brown et al., 2008; Elkind, 1998; Brooks, 1997). These studies have, for example, addressed power issues in the doctor-patient relationship, exploring communication in a consultation situation. In these analyses, the patient's 'subordinate' narratives have often been neglected or taken over by the doctor's privileged 'medicalizing' discussion (Mattingly, 1998, p. 12; see also Radley, Mayberry & Pearce, 2008). However, there is also a recognition that many of these narratives are co-constructed by patient and physician (Mattingly, 1998, p. 43; Kirkpatrick, 2008); exploring solely the patient voice in isolation and presuming that doctors will at all times occupy a dominant position in this relationship may be missing half of the story - the doctor's experience. As Mattingly (1998) points out, *"[h]ealers too, may be able to give a different kind of voice to their practice when they describe their work in narrative terms rather than the flattened prose of biomedical discourse"* (p. 14).

As a genre, narrative psychology is thriving (Smith & Sparkes 2006). There has been talk of the 'narrative turn in psychotherapy and psychiatry' (Brown, Nolan, Crawford & Lewis, 1996), and Crossley (2003a & 2003b) for example argues strongly for a 'perspective that retains a sense of both psychological and sociological complexity and integrity' noting that narrative psychology is concerned with 'coming to grips with how a person thinks and feels about what is happening to her' (2000, p. 6). She employs a phenomenological framework to explore narratives of 'the voice' of 'the mentally ill' (Crossley & Crossley 2001) and the experience of temporal elements and self/identity of people living with serious illness (HIV, cancer; see also Söderberg, Lundman & Norberg, 1997). Narrative research in health care has also been used to study the lived experience of patients (see for example Hemsley, Balandin & Togher, 2007; Hök, Wachtler, Falkenberg & Tishelman, 2007) and an emerging genre of 'narrative based medicine' seeks to make use of stories in developing a fuller understanding of illness experiences (Launer, 2003; Taylor, 2003; Greenhalgh, 1999).

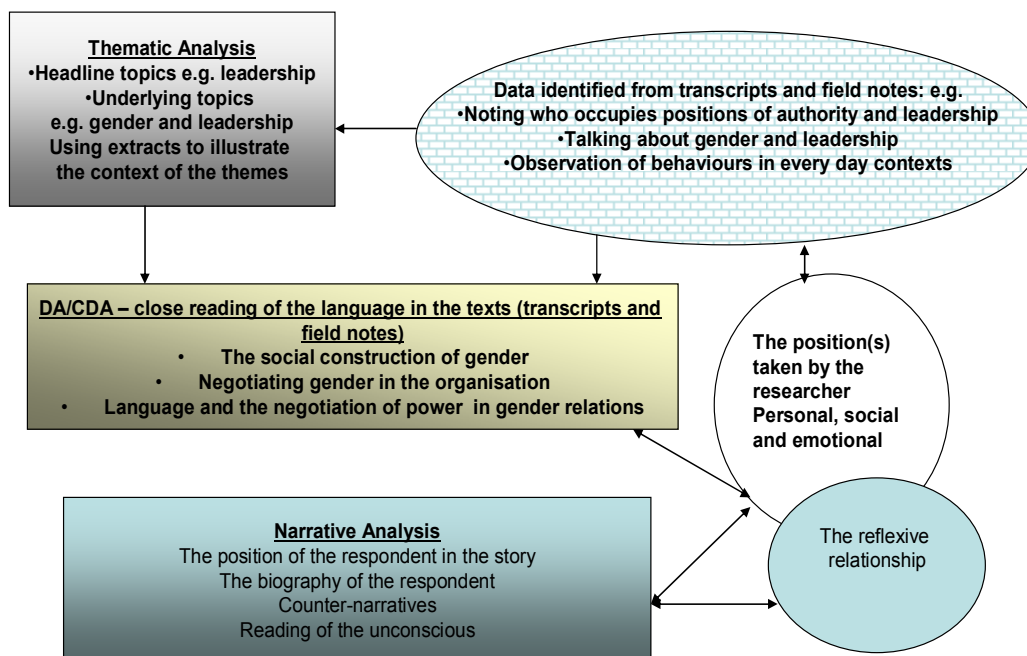
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Narrative based medicine is not merely an insightful way of doing research, but may have powerful policy implications. As Overcash (2003) argues, "*narrative methods are an effective research option that can lead to enhanced patient care*" (p. 179). While interpreting narratives can enhance the possibilities of integrating evidence-based research findings with individual illness experiences, and Winterbottom and colleagues (2008) suggest numerous courses of further research on why and how narratives may influence medical decision making.

Narrative analysis, as with DA, has been approached differently by academics from a range of disciplines so that the ideas surrounding the analysis of *narratives* (or stories told in a sequence) have a variety of emphases. The strength of taking the narrative approach over DA /CDA *per se* is that the 'subject' of the story (the narrator) retains a central role (Crossley, 2007). This can be seen in some detail in subsequent chapters particularly where the accounts of ethnographic observations and shadowing are highlighted where the 'story' becomes that of the researcher herself and with the stories unfolding through the interviews.

Furthermore the narrative analysis places the respondent's story as part of their own *identity construction* which lends an important dimension to the relationship of the story-telling to the teller. Particularly interesting here is Andrews' (Andrews, Sclater-Day et al., 2004) approach which focuses specifically on the elements of stories "*that lie in tension with the ones we are socialised to expect*" (2004, p. 97) or what she calls 'counter-narratives'. Researchers such as Hollway and Jefferson, 2002; Gough, 2003; Sclater, 2004; Allcorn, 2004 and Gabriel, 2004 and 2005, take on board the role of the interlocutor in positioning themselves in their story while considering some of the unconscious and emotional elements both of the story being told and the way that the relationship between the researcher and respondent plays out to construct and limit the story that is told. This dimension is particularly important in the context of this study where emotions are rife at least in part because of the high pressure (exacerbated to some extent by the changing political initiatives directed towards NHS institutions) and the particular nature of the work in caring for ill people (see for example Menzies-Lyth 1960).

Figure 8. Levels of qualitative data analysis e.g. 'gender'



2.8.5 Statistical Analysis

The data from the OCS was coded and in-putted into an SPSS v 14.0 file and significance tests were run (see Chapter Five for the full details).

3 Research Procedure

3.1 Introduction and Overview

The nature of this study, much of which involved the researchers immersing themselves in the 'world' of the participants, meant that it is not possible to provide an authentic *sequential* account of the procedure of data collection except possibly for the administering of the OCS (Organisational Climate Survey).

The bulk of the study, as identified in Chapter Two, comprised multiple methods of collecting different types of data across three Trusts, six Units and five sites.

3.1.1 Negotiating Access

The study took place across a three year period. Negotiation of access was complicated as indicated, although in itself a valuable procedure which occurred at several levels and helped to increase the richness of the team's understanding of leadership, patient care and the context of each organisation.

- Negotiating access began from the 'notional' level while writing the grant application whereby the investigatory team needed to identify whether a project with this design was in fact feasible. We thus made informal inquiries via personal contacts.
- More formal contacts were made once the project was confirmed with the intention to achieve verbal agreement about access for planning the NRES application.
- Following that we met to formalise the details with key informants (i.e. senior clinicians and managers) who had been identified in the previous stage.
- Once we had achieved a favourable NRES review, we pursued local governance applications with the help of the key informants.

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- These stages were managed by approaching one Trust at a time although during the latter part of the study some overlapping negotiations and governance were necessary.
- Part of the formal stage of negotiation concerned consideration of which *Units* could/would form the focus for the study. This was very much two-way but also serendipitous with suggestions from the team of investigators moderated by whichever senior clinical staff the key informants considered would be amenable to 'hosting' the study.
- The key informants then identified opportunities for the team to present the project to staff in the selected Units in 'educational half days' or 'staff meetings' depending upon the local structures.
- These formal presentations only took place in Trusts One and Three however. The procedure in Trust Two (because of the culture, location and structure) was on the basis of a 'tour' (which with permission was digitally recorded) organised by a senior nurse manager so the researchers, one of the co-investigators and the PI could meet various key nursing and medical staff across one of the Trust sites.

Once all that had been achieved it was the researchers on the whole who managed the day-to-day negotiations about who could and would agree to take part in the various elements of the study. This was complicated because of the day-to-day patterns of staff, changes in staff roles, particularly at senior levels, shift patterns and the sheer numbers of staff who may or may not have been aware and willing to allow access to, say, a particular meeting or team for observation or interviews.

Figure 9. Procedures and time-line

	2006/7	2008	2009
Winter	<ul style="list-style-type: none"> •Recruit and prepare researchers •Informal contact with 3 Trusts 1 and 2 •Informal visits to Trusts 1 and 2 •Develop research instruments •Prepare COREC/NRES application •MREC presentation and revisions •MREC approval •Start to review literature on leadership 	<ul style="list-style-type: none"> •Arranging formal contacts with Trust 2 (on 2 sites) •Visit to Site A •Further data collection in Trust 1 •Patient interviews 	<ul style="list-style-type: none"> •Researcher begins maternity leave and new researcher inducted into the team •Data collection in Trust 2 Site 2 •<u>[difficulties gaining access to staff list in Trust 2 for survey]</u> •Presentation to staff in Trust 3 (Unit 1) •Distribution of staff survey (individually handed out) in Trust 3
March - June	<ul style="list-style-type: none"> •Formal meeting with Trust 1 R & D director •Governance application •Formal meetings with senior staff to negotiate units for study •Unit based meetings and introductions •Presentation at educational half day on Unit 1 (obs & gyn) of Trust •Pilot interviews •Pilot staff survey 	<ul style="list-style-type: none"> •Formal meeting in Trust 2. Tour of Site A •Visit to Site 2 •Governance for Trust 2 •Informal meetings •Data collection begins in Trust 2 •<u>Trust 1 staff in Unit 1 return surveys to PI saying they won't give them out</u> 	<ul style="list-style-type: none"> •<u>[further difficulties gaining access to staff list in Trust 2 for survey – now due to key staff transfers]</u> •Preparation and presentation of invited paper to SDO conference in June •Paper preparation and further conference presentations
Summer	<ul style="list-style-type: none"> •Organise, send out and in-put data from staff survey in Trust 1 •Observations and interviews with key staff •Presentation to Unit 2 •Focus groups and interviews on Unit 2 	<ul style="list-style-type: none"> •Application for extension to project (successful) 	<ul style="list-style-type: none"> •Put staff survey on Trust 2's 'intranet' with information about how to complete and return •E-mail staff in Trust 3 who had not received a staff survey •<u>[a low response in both cases]</u>
Autumn	<ul style="list-style-type: none"> •Data collection •Data in-putting from staff survey •Patient survey given to staff on Unit 1 to distribute 	<ul style="list-style-type: none"> •Preparation of journal paper 1 •Further review of literature •Governance for Trust 3 •Identifying key contacts in Trust 3 •Negotiation about Unit 1 (Care of the Elderly) 	<ul style="list-style-type: none"> •Journal paper 1 (anxiety) being revised for publication •Journal paper 2 in preparation (gender) •Journal paper 3 (in preparation) leadership and 'territory') •Presentation prepared and delivered to NHS Surrey and Borders conference •Final draft report

3.1.2 Time frame and Participation of Investigators

We negotiated the formal details of access consecutively in order to make the process manageable. Most data was collected by the researchers (Dr. Fox, Dr. Lokman¹⁵ and Ms. Rowland) although the PI and other investigators made the initial contacts, met with key informants, contributed to the presentations and conducted some of the interviews and focus groups and (Profs. Gabriel and Nicolson, Dr. Heffernan and Mr. Howorth). The PI (Nicolson) and at least one of the researchers was present at all initial meetings with the gate-keepers and key informants.

3.1.3 NRES review

This was prepared and submitted at the end of 2006 and the PI, one of the researchers (Lokman) and another member of the investigation team (Gabriel) attended the appointment with London-Surrey Borders Research Ethics Committee in January 2007.

Annual reports were submitted to the NRES subsequently as required.

3.2 Sample characteristics

The three Trusts, selected as stated above in Chapter Two were each very different from each other, not only in formal terms (size, budget, location and organisational structures) but also informally and culturally and this influenced the 'access pathways'. Thus for example in Trust One our informal and then formal contact was with the R & D director (also a senior clinician) and assistant R & D director, who introduced us to the CEO, the clinical directors and senior nurses.

In Trust Two we had begun with meeting the CEO at the 'notional' phase who then retired in the meantime. This meant starting again with delayed local governance and to accomplish this, we were directed towards a senior clinical manager who then changed their role and location which meant dislocation of our planned procedures.

Trust Three involved a personal contact initially who was directly involved as a clinician in one of the Units who then arranged for us to have a

¹⁵ Dr. Lokman worked on the project for over two years and Dr. Fox took her place.

meeting with another senior clinician who in turn arranged for us to give a presentation to the Care of the Elderly/Geriatric Unit. From there we sought a second Unit for Study independently through contacts made during the course of working in the first Unit.

Trust 1 (One site only) a DGH (District General Hospital)

The Research and Development director here suggested the Units for study to be:

- Unit 1, Obstetrics and Gynaecology
- Unit 2, Cardiology

We were happy with his suggestions, and the staff was generally co-operative and supportive of the researchers.

The Trust itself covers two sites but the choice of these Units meant that all data was collected from one site. This was helpful because it meant the researchers and some of the investigators could spend time familiarising ourselves with the layout of the Units and the Trust site and become familiar 'faces' so that gaining consent from respondents was made easier than it would have been if the researchers and the study itself had to be presented as 'new' on each occasion.

While the study was taking place there were many fears expressed among the staff at all levels that the site we were investigating would become the less powerful with the other site taking over many of the executive functions. While the study team were collecting data on this site however this did not happen and the general 'morale' has improved so that the Trust is currently applying for Foundation Trust statusⁱ.

Self-Description of the hospital

The site we studied had 400 beds and a range of acute care services, including an Accident and Emergency department. It is situated in 52 acres of Green Belt parkland within 40 – 60 minutes of London. Originally it was built to serve casualties of the Second World War. Over the years, the hospital has been rebuilt, developed and extended to include maternity services, a departmental and clinic area, and a new theatre complex. In the early 1990s, the X¹⁶ Wing, which includes a Postgraduate Education Centre and modern well-equipped wards, was opened. A new building for the Accident & Emergency, ITU and Orthopedic Unit opened in the summer of 1998. In addition, comprehensive HIV and genitourinary medicine services are provided in a dedicated building.

¹⁶ We have used 'X' to ensure anonymity.

Obstetrics and Gynaecology

The study territory for this Unit¹⁷ comprised the labour ward, postnatal ward, a general outpatient clinic a dedicated ante-natal clinic and the Maternity Services Administration. The unit offered midwife care for home births, one to one care, water births and there was always a consultant obstetrician available and compared to other local hospitals it gained a score of 3/5 which was joint top score.

Cardiology

This Unit studied comprised one in-patient ward, the Medical Assessment Unit (MAU) and the Critical Care Unit.

In addition we spent time in the Management Suite where five interviews also took place of the CEO, Clinical Director, the Director and Deputy Director of R & D and a middle-ranking manager.

Observations also took place in public and eating spaces and shadowing involved walking around the hospital between different specialty wards and administrative departments.

Trust 2 (2 sites)

The Trust was one of the biggest DGHs in London with 4,200 staff. It had had a history of problems in its financial management and the quality of care but recent information on the web-site and confirmed by the CEO made it clear that:

The Care Quality Commission, the organisation that regulates health care nationally, has awarded the Trust a rating of excellent for the quality of services we provide to our local population. This is the highest possible performance rating in the 2008/09 Care Quality Commission annual national assessment report.

It seems that problems with the financial management remain although improvement had been noted.

The structure and organisation of Trust 2 differed significantly from Trusts 1 and 3. Trust 2 comprised two sites (recently combined into one Trust where one was a teaching hospital) which were at least eight miles apart and it

¹⁷ There were other parts of the Maternity Services at Trust 1 that were not observed directly.

was difficult to travel between one and the other on public transport other than using more than one bus or travelling in and out again from London. The journey by car varied from about thirty minutes upwards depending upon traffic.

Physically the two sites were very different. Site A was a relatively new building designed (as one researcher stated) to look like a motel or contemporary hotel. The other, B, was a traditional middle height rise built in the 1970s on a green site and appeared far more formal with long corridors and many signs to departments. Site A was more 'angular' and you could not walk very far without having to turn a corner which presented a very different 'feel'.

It was not possible, particularly in Site A to select a discrete specialist Unit (unlike Trust 1). Site A focused on acute medicine and care of the elderly and there were no formal divisions in where patients were treated as either in-patients or out-patients. So an older person with 'geriatric' health related problems could be in a bed next to a much younger person. We have identified a Unit as a Site in the case of this Trust. We found it equally difficult to 'pin down' a specialty in Site B as well.

At Site B we collected data from acute medical specialties, obstetrics and gynaecology and therapies (the latter being both physical and psychological).

This was in part because senior management at Site A (who were our key informants and 'gatekeepers') introduced us to staff they considered amenable. Thus for purposes of the study we had to identify Site B as our second Unit. Despite the introductions we managed, via snowballing, to find a range of participants who demonstrated many different view points.

To summarise then in Trust 2 the study was carried out in the following two Units which we have identified as follows:

- Site A / Unit 1 (Acute Medicine; Care of the Elderly)
- Site B / Unit 2 (Acute Medicine; Obstetrics and Gynaecology; Therapies)

We also interviewed a Clinical and Nursing Director both of whom worked across both sites and senior managers including the CEO and deputy CEO.

It became clear very early on that there was intense rivalry, even animosity between the two sites and some of this is explored in later chapters.

Trust 3 (2 sites)

Trust Three, in central London, is a long established hospital and a Foundation Trust with connections to a prestigious medical school. Travel

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between the sites took about twenty to thirty minutes by public transport. 9,000 staff are employed by the Trust with 1,100 beds available across the Trust at any one time.

- Unit 1 (Care of the Elderly, Acute Medicine)
- Unit 2 (Therapies)

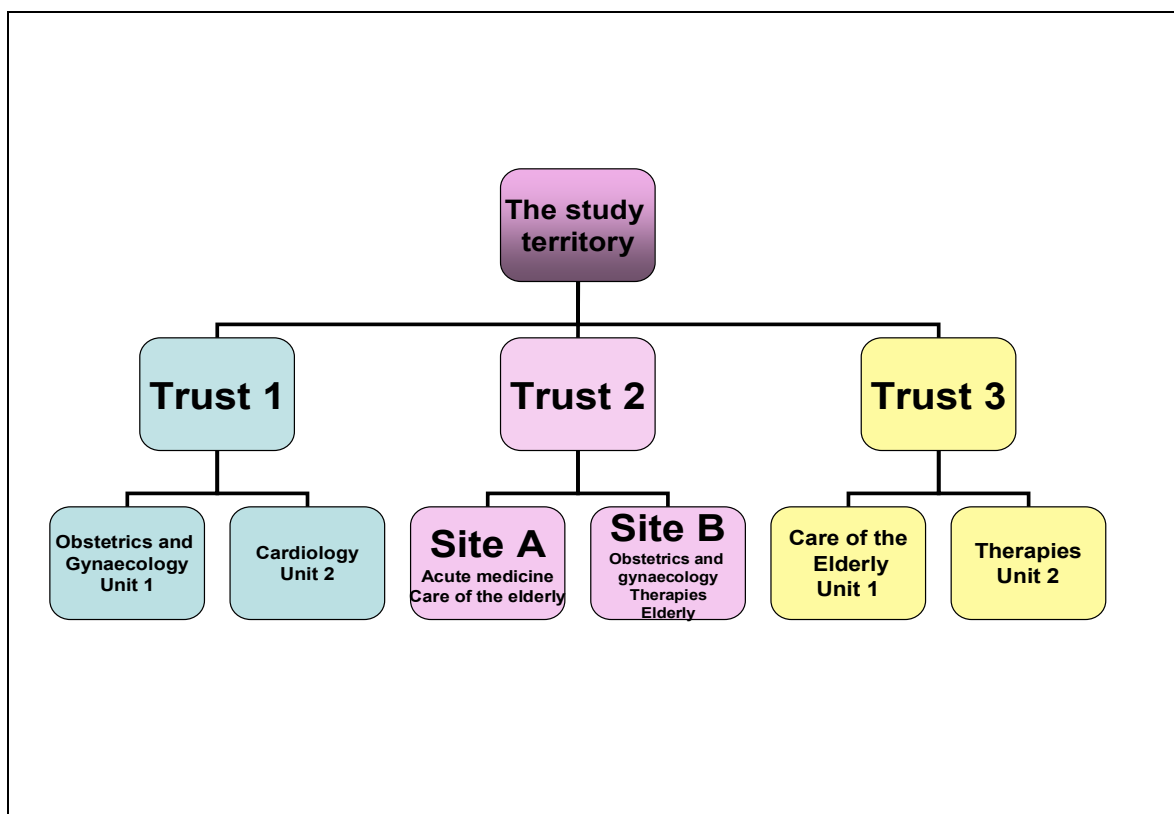
Unit 1 is described on the web-site thus:

Geriatric medicine specializes in the diagnosis and management of common symptoms and diseases in older people, particularly:

- *problems with mobility*
- *falls*
- *continence*
- *difficulties with looking after oneself*

Unit 2 (therapies) which included physiotherapy and psychological therapies spanned both the sites and covered many clinical departments and extended to primary care services especially local GP practices as well.

Figure 10. Participating Trusts and Units



3.2.1 Response rates (qualitative approaches)

It is difficult to identify an accurate response rate for the qualitative components (the majority) of the study because the sampling was conducted in an opportunist manner in many cases – i.e. whether someone agreed to take part in an interview or focus group if the researchers were on site and made a serendipitous approach.

As stated in Chapter Two, much of the qualitative data was collected by virtue of the researchers 'being there' in the right place at the right time and therefore gaining the trust of potential participants. In many cases the researchers were introduced to a member of staff who suggested ways in which other respondents might be accessed. Methods included personal introductions, using e-mail lists or sometimes a staff member knowing what was happening asked the researchers if they might participate in the study.

Overall the majority of staff approached to participate agreed to do so, although circumstances sometimes prevented it (e.g. one focus group was cancelled in Cardiology due to a patient emergency and one observation was cut short because the consultant refused to have the researcher in the ward round, although they had been observing on the ward before the consultant arrived having been given permission by the nursing staff).

Although the key staff across all three Trusts agreed to support the researchers in gaining access to patients for the OCS and interviews, the patient form of OCS was anonymously returned to the PI by someone at Trust 1 saying they did not want patients to participate in that exercise¹⁸.

It proved impossible to administer the patient OCS in the other two Trusts also, because the staff said in advance they were too busy to help and the researchers had difficulty in making contact with individual patients who were always either in busy wards or with a member of staff. Thus interviews and observations were conducted, with patients' consent, during shadowing.

The OCS for the staff is discussed fully in its own right in Chapter Five.

3.2.2 Individual participants

Respondents were either NHS staff or patients so by definition there were elements of uncertainty about whether they would be available at appointed

¹⁸ We sought advice but in line with the NRES review participants could withdraw their consent at any time so we did not feel free to pursue this further.

times and whether (as acknowledged in the NRES consent form) they choose to drop out at any time, even after having agreed to take part.

As shown below in Table 1, forty six respondents took part in in-depth story-telling interviews, thirty nine took part in focus groups. During twenty six days of shadowing of key staff, numerous other staff and patients were involved in data collection and similarly, during the eleven and a half days of observations on wards and in administration areas across the Trusts.

In addition, ten patients consented to be interviewed in depth and, again more staff were involved in the eight meetings that were observed and an introductory walking tour with a staff member in one Trust involved additional staff and patients in the study.

Each of these data collecting encounters represents a different unit of study and a different 'order' of data.

The nature of the study required a commitment of between 30 minutes (for completion of a survey or a short interview) up to two days, in the case of 'shadowing', of respondents time. Most respondents' contributions to the study, however, took about 90 minutes although this also represented an important commitment of their time (and energy).

Table 1. Qualitative Data Collection

Table 1. Qualitative Data by modes of collection							
	Interviews		Focus groups	Shadowing (staff and patients)	Ethnographic observation	Patient interviews	Other meetings and visits
Trust	N = men	N= women	N = Group (n = participants)	N = days	N = days		
1	13	19	5 (15)	5	9	10	4
2	5	9	3 (24)	8	3 x .5 + 1	0	2
3	4	8	0 (0)	13	0	0	2
Totals	22	26	8 (39)	26 days	11.5 days	10	8

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3.2.3 OCS (Organisational Climate Survey)

Trust 1

The staff survey

An administrator in Trust 1 provided a staff list (name and location) from which a random sample (35%) was identified using the SPSS software version 14 providing a list of 939 potential participants from staff across the Trust (including and beyond the Units participating in the main data gathering). The questionnaires were all individually addressed and sent through internal mail.

Of these 223 (24%) individuals returned a completed questionnaire, although ten blank surveys were returned with a note that the intended recipient had left the trust and one said they were unable to read English (1). Thus the final number of participants for Trust 1 was 210.

The patient survey

In Trust 1 we gained agreement from the senior staff on the two study Units (Obstetrics and Gynaecology and Cardiology) that they would arrange wherever possible for patients to complete the patient version of the OCS and would arrange for the researchers to collect the completed forms.

However the full batch of uncompleted patient questionnaires was sent back to the PI at the College several weeks later with an anonymous note stating that the staff did not wish to administer these to the patients. We were unsure how to proceed after this because ethically, although the survey was directed to the patients, the staff had completed consent forms and had copies of participant information sheets, and were aware that they (staff) could withdraw from the study at any time. We considered that this constitute an ethical dilemma for the team.

The researchers made other attempts to hand out the questionnaires directly to patients but found that while some patients were prepared to consent to being interviewed and almost all consented to having a researcher present during patient/doctor/nurse meeting it was not looking possible to obtain a valid sample of questionnaire returns.

Trust 2

Trust two was organised across two distinct sites and although the senior staff work across both sites, as will be made clear from Chapters Three and Four below, each site is very different in its organisation. We initially

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approached the senior staff on Site A first about how to distribute the questionnaires and they referred us to Human Resources on Site B who were the only people with access to a staff list. We did not get any acknowledgement from HR despite several attempts including one visit to the head of HR from one of the researchers. He said he would get back in touch once he had checked whether he could release this list but he did not and we considered there was little more we could do to pursue this particular approach.

The PI then contacted the senior nurse manager, who had been one of our original gatekeepers, for help but found that she had left for another post.

Following the abortive attempts to contact HR (or anyone else who might have been able to help) a PA in one of the many departments we contacted suggested that there was a staff intranet which went out once a week with an 'update' section with news for staff across the Trust. The PI made contact with the editor of this site who agreed to include an electronic version of the OCS.

Consequently, the questionnaire was included on this web-site, with a preamble (adapted from the NRES participant information sheet) on two occasions. However it only produced one reply. We made one final attempt via the PA of the CEO to contact HR for a staff list to no avail.

What was interesting and perplexing though was, that there was no difficulty obtaining a commitment from staff across the Trust to participate in an interview or focus group which was much more time consuming and personally revealing.

By the time we were ready to collect the patient survey data at Trust 2 we already recognised the problems with the responses from the staff. Also, by contrast, we had established the effectiveness of eliciting patient data from the shadowing and observations. We therefore made a decision to focus on this approach to data collection from patients rather than pursue more blind alleys.

Trust 3

In Trust 3 the early signs were that there was no overarching administrative structure from which we could obtain a staff list and nobody we asked could advise on the best way to gain that information. However we did have some 'local' e-mail addresses of the staff in the Units and therefore we e-mailed the OCS to staff on the two study Units and obtained 13 replies all together.

3.2.4 Participant characteristics

There were 224 respondents who completed and returned the questionnaire, of which 77% were women (n = 172) and there were 23% men (n = 49). These included from Trust 1 (n = 210, 93% of respondents), Trust 2 (n=1, 0.4%) and Trust 3 (n= 13, 5.8% of respondents).

The mean age was 46 years, standard deviation 11.1. The majority of respondents were married (62.7%), with a further 7% cohabiting. Twenty percent of respondents were single and almost 10% divorced. The majority of respondents were White (72%), the next biggest group were Asian (18%) and other ethnic minorities such as Black (6.5%) and Oriental (3%) consisted of much smaller groups.

Pay level: most of the respondents had a salary of less than £20k (44.3%) or between £20k- £40k (38.8%). A much smaller percentage (5%) earned between £60k and £90k and a further 2.3% of respondents had a salary exceeding £90k.

3.2.5 Professional demographics

The majority of respondents had been working in the NHS for over 5 years (68%), with a further 26% for between 1-5 years. Only 5.8% reported less than one year's service.

3.2.6 Stability within individual Trusts and Units:

Most respondents had been employed by the same hospital for over 5 years (56%) and another 34% had worked there between 1-5 years. The rest (10%) had been employed by the hospital for less than a year.

Most respondents reported working for the same Unit for over 5 years (45%), a further 43% reported working there for 1-5 years and only 12% reported service of less than 1 year. A similar pattern was seen in terms of length of time in same job. However the majority in this case had been working at the same job for between 1-5 years (45%) and slightly less (41%) had been working in the job for over 5 years. Another 12% had been employed in the same job for less than one year.

3.2.7 Role:

The majority of respondents were nurses, 31%. 13.5% of respondents were managers; 11% consultants/doctors/physicians. Other allied professionals, such as scientists and psychologists made up 10% and support staff made up a further 6%. Clerical staff and 'other' staff (such as porters, maintenance) made up a further 13% each.

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3.3 Data Analysis

This was conducted in the manner described in Chapter Two and the results are discussed separately in the following chapters each of which when relevant provides more context to the conceptual framework and analysis in the substantive area of focus.

3.4 Conclusion

The diverse nature of each of the organisations studied provided valuable information about the different kinds of challenges that different leaders at all levels might face in different institutions across the NHS.

Staff at senior level (particularly non-clinical managers) moved around within and between Trusts. During the course of conducting our study some key gate-keepers and participants left the Trust, others joined and yet others moved position and role even during the relatively short time we collected data there.

In some cases mergers had just taken place or were expected. This was experienced by some as opportunities and others as threats, but in all cases it meant structural reorganisation, staff being re-assigned or choosing to leave for another post.

This has to be taken to be part of the changing face of the NHS overall and central to the culture and climate of the participating Trusts, and can no doubt be generalised to every NHS Trust across the country. In what follows, we have used our different strategies for data capture to examine the relationships between leadership and service delivery in this fluid and (potentially) exciting context.

4 Leadership in the NHS

4.1 Introduction

In any organisation:

Leadership is needed to pull the whole organisation together in a common purpose, to articulate a shared vision, set direction, inspire and command

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commitment, loyalty, and ownership of change efforts (Huffington, 2007, p. 31).

and

Leadership would be easy to achieve and manage if it weren't for the uncomfortable reality that without followership there could be no leadership except, perhaps for the delusional sort. (Obholzer, 2007, p. 33).

In this chapter we examine the ways in which leadership is defined, exercised, experienced and transmitted taking account of how far leadership is perceived as pulling the organisation together to pursue the common purposes of patient care and the relationship between leaders and followers.

We specifically:

- Explore how leadership is defined by different stakeholders and what they see as determining its quality;
- Seek to begin to understand how leadership is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients through examining the data from focus groups and story-telling interviews;
- Using the same data sets, explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted.

4.2 How is leadership defined by different stakeholders and what do they see as determining its quality?

We start this particular exploration with a *thematic analysis* of the qualitative data to identify what themes emerge from the definitions, while also making interpretations using *CDA* and *narrative analysis*. In so doing we pay attention to what Gough has termed 'emotional ruptures' (Gough, 2004) in the text which serve to illuminate some of the subordinated or unconscious information in the stories of the respondents and the subjectivity of the narrator (Frosh, 2003; Frosh, Phoenix, & Pattman, 2003; Hollway & Jefferson, 2000).

In Chapter One we proposed that 'leadership' as a concept has been subjected to continuous scrutiny and moved through different theoretical and paradigmatic iterations. The NHS has identified the qualities it requires in a leader and the role that NHS leaders (at all levels) are expected to strive towards (see Figure 1). We therefore inferred that respondents, imbued in the culture, would focus on 'transformational' or 'distributed'

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explanations and definitions about leaders and leadership because these models are embraced by the style of the coaching and training on offer.

4.3 Definitions

Respondents distinguished between 'leader' and 'leadership'. A 'leader' was described and defined in diverse ways including as:

Obviously strong minded and opinionated (Administrator, T, 2¹⁹).

Particular personality traits - need to be - to have integrity, ((1²⁰)) to ((1)) be clear, err to be facilitative, to have energy to listen, erm, to negotiate, ((2)) to make decisions (Senior Non-clinical Manager, T, 2).

... making sure that you're the person who is erm keeping the team focused getting them to achieve those goals looking at different ways of working (Senior Clinician, Trust 3).

These definitions suggest diverse ways of thinking about the idea of 'leader', indicating that commonality of stakeholder views should not be taken for granted. The qualities a leader has to have are determined in these definitions through having opinions, being strong-minded while also having integrity. A leader also needs to be able to facilitate actions, negotiate and keep the team focused towards the achievement of its goals supporting team-work.

4.3.1 Defining leadership

Leadership in this first definition below was about a formal role and implicitly hierarchical rather than distributed:

I don't think there is anything magical about good leadership. It is about establishing what the organisation wants to do and allowing people to get on and do it (Recently retired CEO with clinical background, T2).

This respondent, who had occupied a senior position, saw the structure and strategic direction of the organisation as fundamental to what works as leadership which was not 'magic'.

¹⁹ In some cases we are able to identify the Trust but where there is any chance of a breach of confidentiality we adjust the 'credit' to ensure anonymity.

²⁰ Where the transcription has included double brackets it denotes pauses timed in seconds.

The following respondent expresses it differently suggesting that it means different things to different people on the one hand, while also being an imponderable (possibly even magical):

Leadership is like love, we all know it exists, but you can't actually prove it, you can't define it, and it comprises of lots of different things that people do, if you demand evidence for everything...you will get rid of leadership eventually (Senior Clinician, T2).

This clinician seems to take distributed leadership for granted in that it is about 'lots of different things that people do'. A warning is expressed it appears, though, that trying to *show* leadership exists across the organisation (perhaps rather than residing in designated roles) might ultimately destroy the possibility of leadership. Following Gronn (Gronn, 2002) this might be a way of suggesting that through concerted action leading to conjoint agency, leadership might not be so obvious (as in the first definition immediately above) but it might be more effective in a hospital where there are different qualities needed to lead in different activities.

Resonating with the view above that a leader has to have integrity, is the view from one leader's experience:

I learnt that it's very important thing for leadership... to not lie, not hide anything and just tell them the reality and be true to yourself, and that's really important (CEO, Non-clinical).

There is an immutable relationship between the leader and the follower. Being true to oneself and honest towards followers must be fundamental to the emotional engagement or attachment between leaders and followers. The significance of emotional engagement as well as emotional and social intelligence was high on many respondents' agendas for determining leadership quality:

... leadership is about having, or being able to demonstrate at any level a coherent vision for where you're trying to go and getting people getting there (Nursing Manager, T 2).

[Leadership in the NHS] is a people focused, leadership job (Senior Non-clinical Manager, T3).

.. it's not always leading from the front (Senior Clinical [therapies] Manager, T 3).

While the leader needs to have vision, these definitions imply that vision alone does not determine how leadership can be exercised or experienced. Leadership will not work unless the leader engages the followers with that vision.

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If leadership fulfils an organisational role ('establishing what the organisation wants') then can it also be 'people focused'? If good leadership is about transparency and honesty is there an assumption that it has not always been so or may not be so at some future time? What does this imply? Does leadership have an 'indefinable' quality' or set of characteristics that work within a specific context but may not be transferable as 'skills'?

Leadership presents dilemmas for the maintenance of personal integrity ('tell them the reality and be true to yourself'), it is a 'job', it requires 'vision' and flexibility and most importantly it seems it is about focusing on people.

4.4 How is leadership in NHS health care organisations exercised and experienced by those affected by it?

Respondents talked about the *role* of the leader as central to the practice of leadership in the organisation. Leadership was understood to be intrinsically linked to particular tasks/goals while necessarily engaging with the followers who had to implement much of these tasks and achieve the goals. There was a sense that many respondents held an idealised view about leadership in their own Trust. Sometimes though the reality for them fell short of expectations because the person occupying that role failed to live up to their hopes.

For example, as the following extended extract illustrates:

.. one of the things about the leadership and management of this Trust is first of all clinical leadership is strong in most places. The clinical directors here have general clout and they are not just figureheads .. and the other bit I think - relationships between general managers and clinicians on the whole are much more positive here than other Trusts (Senior Clinician).

This proposes that strong leadership among clinicians (distributed both horizontally and vertically via the clinical grouping) enables managers to deliver the service to patients. However, this does not in itself identify the characteristics of the links between strong leadership and service delivery.

For many respondents leadership is exercised at least in part through each leader's personal characteristics (good and bad). Almost without exception when asked about the qualities that make a leader, and to 'story' their own explanations, respondents placed a degree of emphasis on the characteristics of an 'ideal type'. The following exemplifies this:

Most important quality is the communication. Being able to listen - hear what is being said and to deliver that--what they want to say, so that it is heard by all. That it be quite quick thinking, being able to develop an idea

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and roll it out, umm being able to think on their feet as well, because sometimes you get things that turn up and you have to deal with it there and then, umm, reasonably personable so people will confide in that person, um also strong so that when things are tough they can um deal with them (Clinical Midwifery Manager, T1).

The comprehensive but daunting picture of how leadership is exercised described above, represents an ideal of distributed leadership as *concerted action* (Gronn, 2002). This type of leadership is exercised through being able to communicate – to listen and to express clearly (so as to be ‘heard’) how action will be taken. ‘Rolling out’ the idea again suggests taking peers and followers along with you and being ‘personable’, so people will confide in that person, further indicates the ability to take the views of others into account calling for both emotional and social intelligence (Amendolair, 2003; George, 2000; Goleman, 2006; Lopes, Grewal, Kadis, Gall, & Salovey, 2006; Riggio & Reichard, 2008). In this model, the multifaceted communications rely on the ability to use the information to think quickly and be strong under ‘tough’ circumstances.

However, in the next extract (from a non-clinical manager) the ideal type of leadership is represented by responding to short and medium term organisational goals (Buchanan, Fitzgerald et al., 2005; Riccucci, Meyers, Lurie, & Han, 2004).

Erm, I think leadership is about erm, encouragement. It is about showing people direction in which you as an organisation and them as individuals engage in. I think it's incredibly important especially in an organisation like the NHS where there are lots of different groups of people and lots of different objectives - sort of daily ones, monthly ones more long term, and you have quite a clear sort of vision of where you're going and I think that the good leaders in the NHS show that, and examples of bad leadership are where that is not so defined. (Middle Manager, T2).

This suggests a *transactional* model of leadership, whereby the good or effective leader offers ‘encouragement’ to the followers in return for people accepting the practices of the wider organisation (Bass, Avolio, Jung, & Berson, 2003; Eagly and Johannesen-Schmidt, 2003)

4.4.1 Exercising leadership through their organisational ‘role’

Leadership is experienced by some as being exercised through the legitimated role. Organisational role in the leadership discourse equates with the leader’s professional position as the respondent below shows clearly:

Who would be a leader to me? I think there's a number of different areas, there's your direct line manager, who's the clinical leader of your department. Who's who in this structure there's line managers above them, and above them and so on. There would be people you would look to within your own specialty clinically who are more experienced than you ((2))²¹ in certain areas, to ask for advice, erm ((1)) and similarly in an academic environment ((1)) there are other people there who have more experience that you would want to take advantage from or advice from. ((2)) And in the wider circle, national or international leaders in the field who are so expert at those things that you also turn to. (Medical Consultant, T3).

While the formal roles and organisational hierarchical structures are taken seriously by this respondent, there is also a clear vision of leadership being exercised through concerted action in collaborations that arise *spontaneously* where clinical and/or experience is valued and sought within this respondent's speciality and sometimes *intuitive* leadership (Day, Gronn, & Salas, 2006; Pearce, 2004). However, there is also a sense that this respondent experiences leadership through the institutionalisation not only of formal roles locally, in the organisation itself, but through the structural relationships with those who are seen as experts in a much wider networked context (Pearce, 2004). This version of leadership is particularly important in that it demonstrates that leadership can be both experienced and exercised beyond the boundary of the organisation and the NHS, based on knowledge and expertise originating outside these systems.

Respondents frequently combined personal qualities with their understanding of the leadership role, particularly related to taking responsibility as part of that role:

It's quite difficult, I mean I think taking responsibility (4) making sure that things happen that are supposed to happen, or don't happen that aren't supposed to happen (3) um.., (6) that's it. (Clinical Medical Consultant, T1).

Not everyone saw leadership in this way. This respondent is talking about their own experience of being in a role in which then 'buck' frequently stops and thus by definition they are in the role of leader.

The exercise of leadership through being a 'role model' (Trevino, Hartman, & Brown, 2000) where qualities of leadership were displayed was important for some:

The leaders that I've worked for and have wanted to follow ... push something in me that says 'I want to be like them' or I completely support

their vision of where they're going or you know so I want to follow that person and I want to do the best that I can do for them because I believe in them and their vision. (Head of Non-Medical Clinical Team, T3)

This explanation has a flavour of heroic or charismatic leadership, although not as a quality that resides in a specific person necessarily, but one that resides in a relationship that 'fires' up both leaders and followers (Klein & House, 1995). Even though the idea of the charismatic leader has been at least partly consigned to the history of the late 20th century organisation, it has not disappeared and needs further thought particularly in an organisation such as the NHS where changes are sometimes rapid and stressful (James, 1999) and internal culture needs to be taken into account (Dopson & Waddington, 1996; Tourish & Vatcha, 2005).

4.4.2 The relationship of the 'leader' to 'followers': how leadership is experienced

While leadership is the focus of the professional and political debates about the NHS and other organisations, until recently, relatively little attention has been paid to followers' experiences of leadership (Avolio et al., 2004; Howell & Hall-Merenda, 1999; Lewis, 2000; Schilling, 2009). From the perspective of a manager taking the position here as 'follower' looking 'upwards' in the organisation:

I think it's, it's providing, you know direction and to lead and that's a leader's main job in my mind. And (2) that's .. what they say for leadership, you must have followers. If nobody's following you, what you are saying then? you are not a good leader. So that's a good, you know, test for a leader to evaluate themselves. That's what they are saying and what they are trying to achieve. Are people behind them or not? If they are not behind the leader there's something wrong with that. (Middle Non-clinical Manager)

From the perspective of a junior doctor taking the 'followership' position:

I think in order for you ... well in my opinion a leader, I have to be able to kind of respect them. If I don't respect or kind of have faith in what they do, then it's, it's a personal authority, so in order, you know in order for me to do that I have to believe in what they say. I mean, I might not always agree with them in my opinion but at the end of the day I have to be able to respect them enough and for them to have certain authority, someone who's probably experienced and gained that knowledge, so yeah. (Junior doctor)

For leadership in the NHS to be exercised effectively then there has to be an engagement between the leader and the followers (Macy & Schneider, 2008) and to understand fully how the engagement takes place, a degree of

emotional engagement and/or attachment to the leader and the organisational vision is fundamental (Riggio & Reichard, 2008; Rubin, Munz, & Bommer, 2005; Vince & Broussine, 1996).

The failure to take followers with you is made explicit here from the perspective of one (designated) leader:

A: I was forced upon them...

Q: that's what I was going to ask. So presumably there was a lot of resentment I guess?

A: Yes.

Q: And how does it manifest itself?

A: Erm, non-cooperation, making life difficult for you sometimes, people talking about erm ((2)) sort of criticising you behind your back and erm playing silly games behind your back that makes management of other people more and more difficult. Erm you know, and yet we sort of have to fight another battle to win hearts and minds, when we, you know, don't really have the time to do that, we have got to have our focus on doing what we are meant to do, which is to manage patients and to manage our beds properly.

This extract from the interview with someone whose role it is to lead change is revealing. The respondent recognises that he is not taking people with him and in his view, the followers appear to eschew co-operation. He also believes they are mocking him and that that mockery is contagious. He may or may not be able to evidence this, but that it is in his mind is potentially detrimental to his experience of leading in his organisation (Stein, 2005). Furthermore, instead of looking at himself, this respondent wants to push the blame for the leadership failures onto the followers (in other words he engages in splitting described in Chapter One) (Klein, 1975; Segal, 1973). Such a process is diametrically opposite to leadership studies that identify authenticity and trust between leaders and followers as being one of the basic qualities for leadership (Avolio et al., 2004; de Raeye, 2002; Novicevic, Harvey, Ronald, & Brown-Radford, 2006).

There is also some evidence of concerted action here, distributed among those who were leaders of the *resistance*, which is not necessarily against the values of the organisation in any negative way, but may be seen as upholding important principles and challenging change (or a particular form of leadership) that might be perceived as counteracting these important values (Collinson, 2005; Zoller & Fairhurst, 2007).

Trust is one important quality in the way leadership is exercised and experienced by followers and developing trust is essential if changes in

practice are to be implemented (Bass & Steidlmeier, 1999; Hunter, 2005). So, for example, 'engaging' with others involves trust:

Yeah definitely there are some good examples of where it's obvious that people have been able to engage lots of different kinds of people in different groups and I think they've done that just by sort of making relationships with them in the first place and then when it comes to having to lead them and be influential then you can see that those relationships are already there and then they can call on that you know, that sort of that trust or that sort of relationship that they've got (Middle Non-clinical Manager, T2).

The same respondent continued with a specific example that aptly demonstrates the links between all the three sub-themes.

Yep, I think Florence who is our head of [a non-clinical department] .. I think she is a very good example of what I'm talking about in terms of her job. And her role relies a lot on other people. Erm so as a personality she is a very responsible person, she gets on with everybody and you can really see how that works for her because when she needs somebody to do something or she needs people to listen they are going to because they have got a good relationship with her and she has taken time to build relationships when it is perhaps not necessary.

To summarise so far - *good* leadership in the NHS is understood by staff at various levels as:

- Taking responsibility
- Being 'given' authority by the followers
- Getting on with the people in the organisation
- Taking time to build relationships
- Being trusted by followers
- Winning hearts and minds
- Having a vision for the organisation
- Taking colleagues with you

4.4.3 Patients' perspectives on how leadership is exercised

While there were several things held in common (particularly 'trust' and 'taking responsibility') with the staff, patients unsurprisingly, considered leadership from a different position, based upon how they themselves had experienced a specific episode of care. One woman, who had had a previous bad experience in the same Trust in which she was now a patient, said:

Well somebody taking responsibility really for erm you know your care, erm especially. I keep going back to the same example but you know someone being responsible for not reading through my notes and if someone had taken that leadership erm and actually said 'right I'm going to look through

these notes', you know they would have obviously seen what they had to see and so basically yeah I think there is a lack of leadership.

The emphasis was on wanting the leader to take responsibility for patient care in contrast to poor practice whereby notes were not read. It was taking responsibility, and reassuring the patient that they were taking responsibility, that could be experienced by patients as good leadership.

Another patient similarly suggested that in their exercising of leadership, the clinical staff need to make sure that they were seen to be acting in the patients' best interest. For example:

When they're explaining their-selves, they do explain their-selves and what they're thinking. And they do tell me like the 'ifs' and 'buts' blah blah blah about this certain thing, but then one says something and [another] one says something else but they do explain themselves and what they're on about.

Also, another patient indicated that there needed to be one person who held overall responsibility for service delivery:

I don't know how it works hierarchy wise, whether there's like a top doctor or whatever, whoever it is somebody really needs to, you know, take a really ((2)) be sort of, you know, held responsible.

It is perhaps worth noting that the patients overall focused on the role of clinical leadership but saw that as being practiced by an individual rather than in a distributed form. There was a general view that individuals needed to be accountable and accountability equated with leadership.

4.5 What are the characteristics of an organisation that facilitate, or hinder, the process of leadership?

Leadership happens in a context and that context can facilitate or hinder leadership processes (Currie et al., 2009) and the influences of the organisation are particularly acute when the environment is changing rapidly (Goodwin, 2000; Michie & West, 2004) as in the NHS.

One respondent felt they no longer knew 'who was who' in the leadership hierarchy but considered it didn't really matter:

..., here is this model that says here is the Board and here is the chief exec and here is whoever else is up there. And there's this, this and this ... and [a colleague suggested] shouldn't we be transparent all the way through and shouldn't everything link? and I thought, this came up somebody legitimately asked the question that people here need to know what is happening here. Why? Why? I don't care. (Clinical Physiotherapist, T3).

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One senior Occupational Therapist, in the same Trust, on the other hand felt that knowledge of the organisation was important to facilitate leadership at every level so that when:

... people feel they are working as part of an organisation that's working for something, as part of a team and are appreciated and valued as part of that and are working for someone as well who feels what they are doing is worthwhile, I think that patient care will be of better quality.

This respondent was also convinced that supervision was part of the process by which an organisation facilitated both leadership and good practice in patient care. *"I have once a month supervision, like set time for supervision so I think that is really good."*

Furthermore, supervision and informal contact with peers facilitated effective distributed leadership which impacted across the organisation: *".. you can go to people informally, your peers erm whenever it's quite flexible like that and even if you're a senior like me you think 'hang on I don't know if I'm on the right track here so am I missing something?' You can just go and speak to you team about it or one of our colleagues downstairs or whatever if you want to.*

More dramatically a senior clinical leader suggested that leadership is facilitated in 'moral' organisations:

A²²: So one thinks they are better than the other, so the seven deadly sins basically...pride, the other one is gluttony, which means excess...one can never have enough, for the sake of it, and then just goes beyond, you know, one million, two million, you know, which kind of greed isn't it...excess basically, and also rushing is in there, doing things too fast. A good system will reduce its workload, yeah? The NHS has a thing of needing to do more and more, erm anyway, I don't know whether you find this useful or not, so greed, gluttony, there's rushing, and then jealousy, which is really envy, which is really competition.

Q: Yeah

A: You need to get rid of competition, and I will tell you in a moment what could replace it, which is basically team work, team work and kindness; how you get on with each other...anger is on the list. Anger is, is blame, and the opposite is blame free culture.

Q: Yeah

²² Q = question, A = answer.

A: Or forgiveness if you want, so you need to forgive mistakes, and you know you will be forgiven...and, erm...erm...next one is laziness, that's obvious, that's hard...people either have it or not, but laziness is joylessness, you need to make sure people enjoy it, and diligence, yeah? So there needs to be something in place of ...and we have that now with trust away days and things like that, but you have to have somebody dedicated to making people understand it's about having fun

Q: Yeah, yeah

A: working is about having fun...yeah? And then its... which comes really from up here, it's just an, an, yeah, can't have enough...which is also, it's also, the opposite is erm...do not take more than you can, do not take more than you need...and that is quite a moral stand ground, more than you need...for everyone

Q: Yeah

A: and if you employ that rule, then the whole organisation becomes so successful that there's masses of money left over ... Everything works well...the problem is everyone doesn't understand that, and believe in that, and then there's a difficulty...so that's moral high ground, very moral high ground, but if you go along those, you actually have all the features of leadership.

For this respondent the organisation needs to focus on patient care, treating patients *and* staff with 'kindness'. This is counter in his view to the process of setting targets for service delivery and organisational growth (or survival) and thus competition between organisations and competition between individual staff or staff teams, which is a force that (it seems) promotes the wrong kind of leadership (Kuokkanen & Katajisto, 2003; Sambrook, 2007). Furthermore, supportive teamwork and 'forgiving' mistakes and preventing the 'blame game' enhances socially and emotionally intelligent leadership distributed responsibility across the organisation and enhancing the culture and climate (Riggio & Reichard, 2008) .

Another senior medical leader and manager (T3) reinforced this idea:

I think the ethos within the hospital, is one that encourages people to develop and grow, and deliver good quality care, you know, so, I mean I think wherever it comes from it is enabled within this organisation, and it works very effectively. One of the features that enables that to happen...it's firstly being an organisation that attracts good people to want to work here in the first place. So you get high quality people applying for the position, be it in medicine, or managing, or nursing or any of the other professions By and large, we're fortunate in that. And that's partly due to the reputation, and partly due to the [location] but I think the ethos that comes

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from the leadership makes it desirable to be here. Erm...so it attracts the right people in, it then enables, it doesn't put the brakes on, it doesn't try to control people too much.

Thus, organisational performance and culture/climate were 'enabled' through a cycle of encouragement, good practice, reputation and a supportive and 'hands-off' approach to leadership. This suggests concerted action, leader/follower engagement and emotionally supportive behaviours at all levels. That the physical location of the hospital is attractive is perhaps but one factor in this equation, although a central location makes it possible to draw on a wide range of staff as opposed to a location which is in a small town or distant suburb.

It is not just features of the organisation itself that impact on leadership. Organisations reflect changing discursive constructions of leadership and the values that underlie what it means to be effective as a leader in that place at that time (Ferlie & Shortell, 2001; Lansisalmi, 2006; Michie & West, 2004; Scott, Mannion, Davies, & Marshall, 2003). As demonstrated in Chapter One theories of leadership have developed and different approaches have become significant at different times as witnessed by the shift from promoting and studying transactional, charismatic and heroic leadership styles to the contemporary emphasis on forms of distributed, networked and transformational leadership (Bryman, 2004; Butterfield et al., 2005).

One dramatic change over the past twenty and more years has been the image of the medical consultant in the public psyche. Thus the 'heroic' leadership of Sir Lancelot Spratt has been firmly (it seems) replaced by the team work in the TV series *Casualty* or *Holby City*. However the image of the rebel Dr. House (played by Hugh Laurie in an American TV series) is described as 'unorthodox' and 'radical' but most definitely a medical hero. Is this the type of leader that some might still long for? While the following comment was atypical of most people's definitions of what makes or fails to make a good leader it raises some interesting points about the contemporary regulatory discourses on leadership. Thus one participant said of another²³:

Now (Dr.) David is a really eccentric so he is not what you would naturally call a leader, erm ((1)) but people are really respectful... Because he really cares for patients ...And if he finds a junior doc, or nurse or anyone who is being unkind to an elderly patient then he is down on them like a ton of bricks but his, his patent commitment to medicine and clinical care just inspires admiration ...And great affection hopefully. But he is very odd. Yes. Erm, so he is like a one off so again there is no single person, you

²³ No identifying information is appropriate here.

know there are, there are, there are different leadership styles which are appropriate in different situations but David of course could never be a chief exec, he just wouldn't be able to do it, so he would be hopeless there.

On the surface this might be explained as a judgement based on 'evidence' and a job description. However, focusing-in on the discursive and regulatory practices with which this extract engages, a different view can be taken. The respondent here, being asked to describe the qualities of leadership, begins by suggesting that taking patient care very seriously is 'eccentric' and the person who does that is a 'one off' and 'odd'. Paradoxically (it is suggested) David inspires affection and admiration but despite the variety of leadership styles David would never make it to be CEO. Whether or not this is the case is irrelevant here because what is at stake are the ways in which discourses around 'leadership' and the qualities of the 'leader' *regulate conduct* setting normative behaviour through the discursive practices. There is little doubt that David would have been considered a leader (perhaps a leader in his field) during a different period when hospitals were smaller and perhaps when there was less specialisation in management.

A learning organisation?

The NHS has declared itself to be an organisation dedicated to learning for at least the last ten years and certain values underlie this declaration (see Davis and Nutley, 2000). It means that:

Although learning is something undertaken and developed by individuals, organisational arrangements can foster or inhibit the process. The organisational culture within which individuals work shapes their engagement with the learning process (p. 998).

In some cases the exercise of leadership clearly facilitated the (potential for) learning and learning facilitated leadership, while in others it did not. The facility for leading change in NHS Trusts is critical and developments in the role of nurses from a range of specialties to support leadership and learning have provided exemplars of how some organisational arrangements support leadership (Bellman, Bywood, & Dale, 2003; Doherty, 2009). However, some have argued that continued changes, the market as a driver and the complexity of the NHS might militate against whole system learning (Sheaff & Pilgrim, 2006). Questions have also been raised about the potential of the new generation of leaders who are expected to be inspirational, drive change and support learning (Phillips, 2005).

One capacity manager, for instance, was very clear that leadership was about enabling appropriate learning and the development of skills:

... probably more about empowerment and not necessarily of oneself but of others. So I think that indeed you need to feel empowered yourself, but I think that leadership, good leadership is about empowering and supporting those people who are not in power so that they are equipped with the skills that are required. some of it is actually around learning, it is about what stage they are at in terms of their learning curve.

This is not only a statement about distributed leadership but about a version of a transformational leadership that transcends individual leaders and requires an organisational culture that both supports individual learning and targeting individuals to ensure, that their learning is recognised and ongoing (Burke et al., 2006; Conger & Kanungo, 1988; Kuokkanen & Katajisto, 2003).

The respondent continues with this theme in a sophisticated, and it seems heartfelt, way:

But I think that sometimes that [learning] is not always consolidated, even those people that have been in that position for years. I think, it is more about the people actually understanding²⁴ what they have done, and almost sometimes talk it through, in basic detail about why they have got to the decision they got to. But just because you have been in a position for a long time doesn't necessarily mean that you have actually learnt erm and you may only then go up to a certain stage in my opinion in terms of your whole learning so then they may be stuck in, not novice, but in that middle stage rather than the expert. Which we would hope that most people would get to.

This suggests that organisations need to be vigilant and to constantly invigorate their members. For the respondent quoted above, an organisation that allows people to stop learning is one in which leaders and potential leaders stagnate (at their peril) (Mark & Scott, 1991).

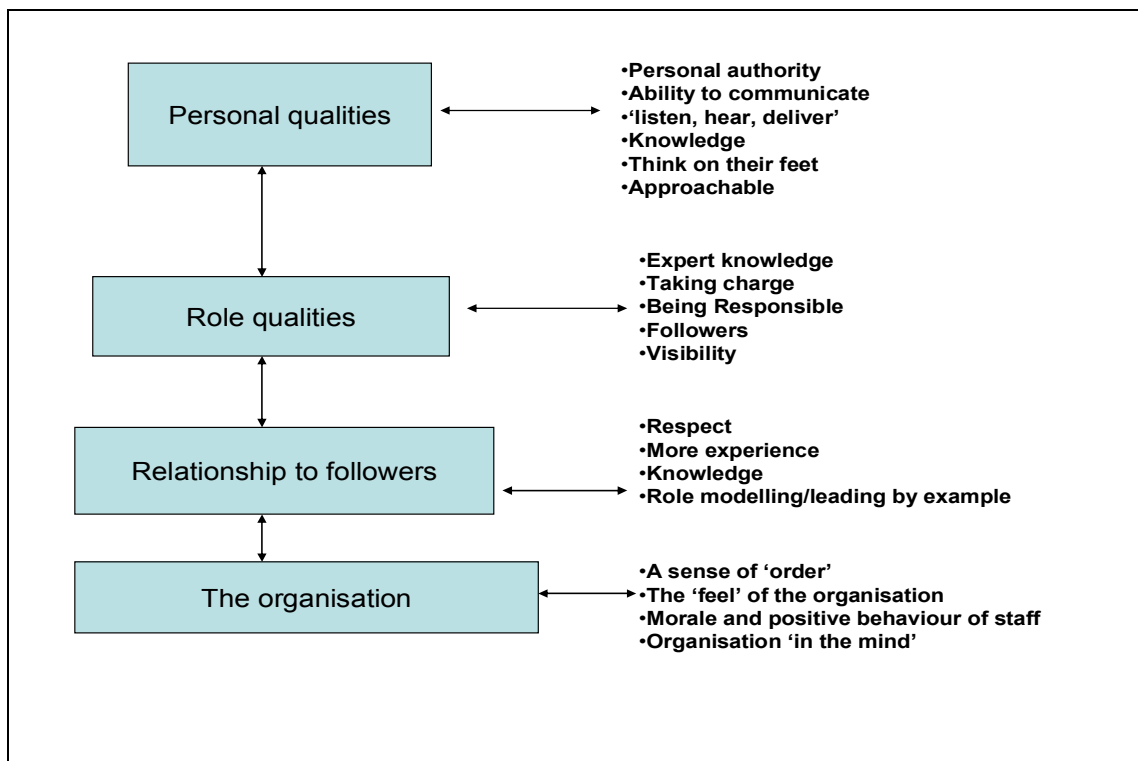
As we discuss again in Chapter Nine, the multi-disciplinary team presents an ideal opportunity for observing leadership (good and bad) and examining the ways in which these teams adhere to organisational norms which might support or inhibit learning (Burke et al., 2006; Day et al., 2004).

One senior non-medical clinical manager in a different Trust also took up the theme of learning and empowerment and specifically how it links to good patient care (Burke et al., 2006; Doherty, 2009; Kuokkanen & Katajisto, 2003).

²⁴ The transcriber who was also the interviewer made it clear that these words were emphasised by the respondent.

... [leadership] is about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is we worked with 'Training and Development' and we came up with a specific programme that was aimed at empowering them [all administrative staff] to improve their service area etc etc and also provided them with some skill sets that they probably didn't have prior to that.

Figure 11. What makes a leader?



4.6 Conclusion

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

Nonetheless, when asked to describe and define leadership, various stakeholders at all levels of the organisation have a view some of which coincides with contemporary NHS discourses and some which seems directly at odds with what the NHS is trying to achieve – that is, to support both

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distributed and transformational leadership that are seen as successful in ensuring effective patient care. However, it is clear that individual personalities and the impact of particular leaders cannot be taken out of the equation.

Leadership is experienced as distributed and transformational but there remains a belief that charismatic and transactional leadership also have their place in complex organisations. While vision is important, no vision can be achieved unless the leader takes 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. Supervision, peer support and informal advice are part of the emotionally intelligent distributed practice of leadership. 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.

In summary, the main ideas that emerged from the respondents' views of how leadership was exercised and experienced were it was about:

- Personal authority
- Ability to communicate
- 'listen', 'hear' 'deliver'
- Thinking on your feet
- Being approachable

Leadership can be exercised in a number of ways and qualities of leadership are seen to reside in different but interlinked 'places'. For example, it is clear that some people are perceived more than others to have the personal qualities that make them a leader, including being able to listen, deliver and be approachable (see Figure 11 above). The assigned/legitimated leadership role is also perceived to be an important quality for a leader, which is interesting, when thinking about the distributed leadership model and particularly the idea of concerted action where people have to work together to 'lead'. This links further to the qualities inherent in leader-follower relations identified as fundamental to the stakeholders interviewed here.

Finally, leadership means holding a sense of the organisation in mind. That is the mental model held by the leader through which they mediate and regulate their vision and actions as leaders, but it also refers to the leader's understanding of morale and the 'feel' of the organisation in which they are working, which itself regulates and constrains the possibilities for growth, development or atrophy.

In this chapter we identified some of the evidence of how organisational contexts evolve and the relationships between organisational culture/climates and the ways in which leadership is practiced. This will be developed across the next four chapters.

5 Leadership and Organisational Climate

5.1 Introduction

Despite its North American origins, where the health care system is fundamentally different from the NHS, Stringer's focus on both leadership and climate nudged us towards choosing an adaptation of his organisational climate survey for this study. We also identified an 'awareness', as he puts it himself, that "*People working in health care systems play drastically different roles that are more diverse than the roles typical in schools and businesses*" (Stringer, 2002, P. 188).

Through adapting the OCS we also captured demographic information from our participants as well as a data about satisfaction with the leadership one receives from his or her immediate supervisor²⁵. Thus, while on the whole Chapter Four dealt with general descriptions, definitions and values, in this Chapter we focus on specific relationships between individuals and the individual and the perception of their organisational climate.

The additional contribution the survey data makes to the overall aims of the study is to relate perceptions of leadership and management directly to organisational climate, thereby providing a triangulation with the story - telling and focus groups to explore the characteristics of organisations that facilitate or hinder leadership and service delivery.

5.2 Results

5.2.1 Normality of data

When normality was examined the KS-Lilifors test was found to be significant over all the scales, indicating that the data were not conforming to assumptions of normal distribution. However, inspection of the histograms and boxplots were found to present an acceptable level of

²⁵ Our version of the survey questionnaire is appended.

normality. Due to the nature of the data it was decided not to transform it, but rather to interpret the results which rely on the assumption of normality with caution.

5.2.2 Cronbach's Alpha

In order to check the reliability and internal consistency of the OCS in this setting we used Cronbach's Alphas (Cronbach, 1970) (See Table 2).

As can be seen from Table 2, the three dimensions of '*commitment*', '*support*' and '*recognition*' were considered to be high on reliability as their scores ranged from .69 to .74. These would be considered acceptable-good level of reliability (George & Mallery, 2003).

In contrast, the three dimensions '*structure*', '*standards*' and '*responsibility*' were low on reliability. This low reliability may be explained by confusing wording of the items, or it is possible that the individual items did not correspond well to one another in this sample. As such it was decided to remove the '*responsibility*' scale from the rest of the analysis. A further check to see whether '*structure*' and '*standards*' could be improved by removing single items, did not show any improvement to the alpha so these were retained in their original form.

Table 2: Cronbach's Alphas for the six dimensions

Scale	Cronbach's Alpha
Commitment	.74
Support	.72
Recognition	.69
Structure	.57
Standards	.43
Responsibility	.14

When managerial dimensions were examined for reliability' these were found to be very high ranging from .86 for '*recognition*' to .79 for '*commitment*' and '*responsibility*' (See Table 4).

Table 3: Cronbach's Alphas for the six Managerial dimensions

Scale	Cronbach's Alpha
Managerial Responsibility	.86
Managerial Recognition	.83
Managerial Standards	.83
Managerial Support	.81
Managerial Commitment	.79
Managerial Structure	.79

Overall scores for organisational dimensions

In order to derive the scores for individual dimensions, all the items on each dimension are summed [this is after all the negatively worded items were reversed].

The following were mean and standard deviations across all the six Organisational scales:

Table 4: Mean and Standard Deviation

Scale	Mean	Std
Commitment	14.82	2.86
Support	14.06	2.80
Responsibility	9.93	1.73
Structure	9.01	1.88
Recognition	8.42	2.55
Standards	8.36	1.69

Stringer, et al (2002) suggest an analysis of percentages of respondents who scored above the mean. In our analysis the following percentages were found:

Table 5: Scores above the mean

Scale	% above the mean
Commitment	60%
Support	47%
Recognition	49%
Standards	49%
Structure	39%
Responsibility	58%

Stringer offers a method of interpreting these percentages, according to benchmarked ratios collected through their extensive research to validate the tool.

High 'commitment' (60%) – In the current sample, there was a high degree of 'commitment' to the organisation and its goals. This would be typical of professional staff working for the NHS. However Stringer asserts that high 'commitment' needs to be accompanied by high 'support' and high 'recognition' – without these individuals will stop engaging with others in the organisation and their team (p.200). As indicated in Chapter Four engagement is crucial if leadership is to be effective.

High 'responsibility' (59%) – Stringer asserts that 'responsibility' is a difficult dimension to interpret within the health care setting. Effective performance in the NHS requires that procedures be double checked, which in many other contexts would put the role of 'responsibility' in an ambiguous position. However this is not the case in complex clinical settings (or for example in other precision performance occupations such as flying aeroplanes for instance). In the case of the current sample 'responsibility' was high, which is related to high sense of 'commitment', but is confused by the limited 'structure' – it is essential that people are clear about their roles, so that they may take charge and 'responsibility'.

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Moderate 'recognition' (49%) - According to Stringer scores lower than 50% may indicate that participants are feeling unappreciated. In this case there is just under the 50% mark, which translates into moderate agreement about the feeling of being rewarded for one's efforts. Having a high sense of 'recognition' in an environment such as this is of crucial importance for motivation, but 50% is within the normal range set out by Stringer. High 'recognition' is indicative of confidence in the organisations performance/reward ratio but in such a diverse setting as a hospital with a diverse staff group responding to the OCS then different groups with different management and professional/occupational structures would have different perceptions and experiences.

Moderate 'standards' (49%) – there is a moderate feeling of pressure - performance 'standards' and expectations are high but not to the point where they are stressful. This falls within an acceptable range. Considering that many of the 'standards' (targets) are set out by government policies rather than directly by Trust management/leaders it is important for these standards to be realistic and achievable.

Moderate 'support' (47%) – this falls within the low but acceptable range for this scale (45%-60%) according to Stringer's benchmarks. This indicates that there is sufficient unity between teams to approach and solve problems, without overly nurturing so as to discourage individual 'responsibility' and undertaking. Team work within the health care system is challenging because of the interdisciplinary nature of teams which inevitably calls upon different management and professional structures and networks for support.

Low - Moderate 'structure' (39%) – Under half of participants felt there was clarity in terms of their roles, responsibility and authority. On the one hand this means that there are less constraints and a less of a 'jobs-worth' approach, on the other hand though it means that there is (potentially) insufficient clarity in roles and responsibility. In an organisation such as the NHS, this may be a considerable shortcoming and Stringer (p.193) suggests that in a health care environment such as a hospital, one would ideally like to have 'structure' scores above the 70s. This is emphasised because of the complex nature of the hospital environment with so many individuals involved – accountability needs to be very clear. The NHS however has gone through so many changes over the previous ten years that it is inevitable that the 'structure' score would be influenced.

Associations between the six dimensions on the organisational level

Pearson's r was utilised to test the relationship between all the Organisational scales. It was found that the majority of scales showed modest, but significant relationships:

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Table 6: Correlations between the six organisational dimensions

	Standards	Structure	Recognition	Support	Commitment
Standards	1.00				
Structure	ns	1.00			
Recognition	.22*	.47**	1.00		
Support	.17*	.42**	.61**	1.00	
Commitment	.30**	.39**	.59**	.67**	1.00

* <.05

** >.001

As can be seen from Table 6, there are a number of high associations between these dimensions. The highest associations are for 'support' and 'commitment' (.67) 'support' and 'recognition' (.61) and 'commitment' and 'recognition' (.59). In other words, participants are reporting that when a feeling of co-operation within teams is present, this is often accompanied by acknowledgement and appreciation and is further related to a greater sense of dedication and 'commitment' to the goals and aims of the team. By definition, the converse also applies: feelings of isolation are more likely to be accompanied by lack of incentives and disenchantment with the objectives of one's team. This is 'supported by Stringer (p.200).

Satisfaction with leadership

When the *organisational dimensions* were examined in relation to satisfaction with the quality of leadership received from the immediate manager, which was asked as a single item, the scales which correlated most highly were 'support' (.61) and 'recognition' (.52). The weakest relationship was to 'standards' and 'structure'.

Table 7: Correlations between organisational dimensions and satisfaction with Leadership

	R (sig)
Standards	.14*
Structure	.30**
Recognition	.52**
Support	.61**
Commitment	.39**

In order to evaluate the individual contribution of each of the organisational dimensions to the overall 'satisfaction with leadership', a regression analysis was conducted, which included all items which were found to correlate significantly with satisfaction, namely 'standards', 'structure', 'support' and 'commitment'.

The total variance accounted for by the model was 40% (Adjusted $R^2 = .38$) therefore variability in 'satisfaction with leadership' is moderately accounted for by this model.

Specifically, of the five predictor variables the two which were found to predict the outcome variable of 'satisfaction with leadership' were 'support' and 'recognition', 'support' being the biggest contributor with a $B = .52$ ($p < .001$) and the other predictor was 'recognition' ($B = .27$, $p < .001$). The other variables were not significant. [Appendix 1 of this chapter].

In other words, feeling supported by one's team and believing that rewards are appropriate to effort, accounts for a significant proportion of an individual's satisfaction with leadership.

Correlations between dimensions on Managerial level

The second part of the questionnaire asked about individual experiences of management. All six dimensions on the managerial level were highly correlated with each other, with strong correlations ranging from $r = .71$ ($p < .001$) between 'structure' and 'responsibility' to a correlation of $.84$ ($p < .001$) between 'commitment' and 'standards'.

Table 8: Correlations between dimensions on Managerial level and Satisfaction with Leadership

	Manager Recognition	Manager Support	Manager standards	Manager structure	Manager Responsibility	Manager Commitment
Manager recognition	1.00					
Manager support	.83**	1.00				
Manager standards	.82**	.83**	1.00			
Manager structure	.73**	.78**	.79**	1.00		
Manager responsibility	.84**	.79**	.79**	.71**	1.00	
Manager commitment	.79**	.83**	.84**	.82**	.79**	1.00
Satisfaction with Leadership	.68**	.76**	.71**	.71**	.65**	.76**

** Significant at .001 level

A single item asked about satisfaction with the quality of leadership received from immediate manager. When this was examined in relation to the six dimensions appropriate to participants' own experience of management practices, it was found to correlate highly and positively with manager 'support' ($r=.76$); management 'structure' ($r=.71$, $p<.001$); manager 'commitment' ($r=.75$, $p<.001$) and 'standards' ($r=.71$, $p<.001$); manager 'recognition' ($r=.68$, $p<.001$); manager 'responsibility' ($r=.65$, $p<.001$);

A multiple regression was carried out to examine the perception of 'satisfaction with leadership', as a dependent variable of management practices. The overall association between management practices and satisfaction with leadership was strong ($R=.80$) with associated variance explained of 63%.

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Table 9: 'Manager' dimensions regressed onto 'satisfaction with leadership'

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	-.054	.226		-.240	.811
Manager Recognition	.001	.039	.002	.025	.980
Manager support	.175	.039	.410	4.501	.000
Manager structure	.060	.027	.177	2.260	.025
Manager responsibility	-.018	.032	-.047	-.559	.577
Manager commitment	.165	.056	.278	2.948	.004
Manager standards	.017	.056	.029	.310	.757

In this case, it was manager 'support' which best predicted satisfaction with leadership ($B=.41$, $p<.001$), next biggest contributor was management 'commitment' ($B=.28$, $p=.001$) and management 'structure' ($B=.177$, $p=.025$). In other words, a large proportion of feeling satisfied with one's leadership, pertained to feelings of being supported and the degree to which one's manager inspires and exudes 'commitment' to common goals. A further important element in the equation is that of 'structure' – where roles and responsibilities are clear, it is associated with greater satisfaction with leadership.

As the biggest predictor of 'satisfaction with leadership' was manager 'support', a further regression was done to look at what organisational dimensions related to having good managerial 'support'.

All the organisational scales were inputted into a regression, excluding organisational 'support', with managerial 'support' as the outcome variable. The following was found:

In total the model accounted for 35% variance in the outcome variable (Adjusted $R^2 = .35$). There were two contributors to the model: the strongest one was 'recognition' ($B = .44$, $p < .001$), i.e. the more employees feel that the organisation rewards and recognises their efforts, the more they feel supported. The other contributor to managerial 'support' was 'commitment' ($B = .20$, $p = .008$). [Appendix 3 of Chapter Five]

These findings indicate that organisational 'recognition' and 'commitment', are organisational climate dimensions which most affect the outcome of managerial 'support', and this in turn has the greatest effect on individual's sense of satisfaction with their leadership. This again corresponds with data discussed in Chapter Four highlighting the importance of the feel of an organisation that provides support at all levels.

Regression of all dimensions onto Satisfaction with leadership

When all the variables previously shown to be significant to Satisfaction with leadership, were entered into the model, from both the organisational and managerial dimensions, namely manager 'support', manager 'commitment' and manager 'structure' as well as organisational 'support' and organisational 'recognition', the following picture emerged:

There was a high degree of variance accounted for by the model - 65% (Adjusted R^2). The model was found to be significant ($F = .80.65$, $p < .001$).

The variables which remained significant, in order of their contribution are: manager 'support' ($B = .34$, $p < .001$), manager 'commitment' ($B = .33$, $p < .001$) and Organisational 'support' ($B = .13$, $p = .03$).

In other words, satisfaction with leadership, in this sample, was predicted by a greater perception of 'support' from management, a feeling that managers demonstrated their 'commitment' to achieving common goals and an atmosphere of 'support' and team-work within the organisation.

Organisational and Managerial dimensions

In order to investigate the relationships between organisational and managerial dimensions, a correlation was performed between all of these variables (Table 10). It was found that:

There were strong correlations between manager and organisational 'recognition', and manager and organisational 'support'. There were moderate correlations between manager and organisational 'commitment' and 'structure'. And there was a weak correlation between manager and

organisational 'standards'. In other words, where the dimensions were correlated weakly or moderately, we can identify that 'standards' of the organisation do not necessarily exist at the same level of managerial 'standards'. The same relationship goes for 'structure' – having organisational 'structure' does not predict clarity in roles, as espoused by one's manager. There is a greater degree of correspondence between organisational and manager 'commitment'. When we look at 'support' and 'recognition', we find that both these dimensions tend to be closely related – one is more likely to feel that both are high, or both are low.

Table 10: Relationship between managerial and organisational dimensions.

	Organisational Recognition	Organisational Support	Organisational standards	Organisational Structure	Organisational Responsibility	Organisational Commitment
Manager recognition	.60**					
Manager support		.65**				
Manager standards			.25**			
Manager structure				.34**		
Manager responsibility					-.02 ns	
Manager commitment						.48**

The significance of Role

The largest group of participants was nurses (31%), then clerical staff (14%), managers and porters (14% each). Doctors/consultants/physicians (11%), other allied professionals (10%) and 'support' staff (6%).

When looking at satisfaction with leadership the following findings were apparent: High satisfaction with leadership was reported in total by 54.3%

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(n=113) of staff. Although there were no significant differences by work role, it can be seen that consultants and doctors reported the highest satisfaction (74%), followed by managers (61%). It can be seen that clerical workers had the least high satisfaction (41%), followed by 'support' staff and other allied professionals (54%). This is significant in terms of the hierarchy within the organisation – the higher the position the more satisfied one is with their leadership.

Table 11: The significance of role and satisfaction with leadership

	n	% positive responses about satisfaction with leadership
Managers	28	60%
Doctors	23	74%
Allied professionals	22	54%
Nursing	65	49%
Support staff/Assistants	13	54%
Clerical	29	41%
Porters/maintenance	28	57%

A further examination of organisational dimensions according to role using a one way ANOVA, revealed the following:

In all there were large differences between respondents in terms of their role, however only two scales exhibited differences which reached significance. The first was 'commitment' – doctors/consultants were found to rate significantly higher than allied health professionals on this scale (mean difference = 2.86) ($p < .01$).

The second was 'recognition' – it was found that doctors were much more likely to rate higher than clerical staff on this scale (mean difference = 2.41) ($p < .01$). Both these findings were apparent even after using the Bonferroni correction.

Comparing doctors (all grades) in Trust 1 and Trust 3

An examination of the responses on the item looking at 'satisfaction with leadership' amongst doctors revealed that doctors at Trust 1 (n= 13) had lower satisfaction (Mean = 3.38, std = 1.38) in comparison to doctors at Trust 3 (n= 10) (Mean = 4.20, std = .42). This difference (.81), whilst small, was found to be approaching significance ($t = -2.003$, $p = .06$).

While it is not possible to make an objective comparison between doctors from Trusts 1 and 3 from the qualitative data, there is more evidence in Trust 3 of doctors being both emotionally engaged with both junior doctors and other members of multi-disciplinary teams than in Trust 1 and with distributed leadership. As will be evidenced in Chapter Six doctors and other staff considered 'management' as bureaucratic and distant rather than engaged.

Gender

There were no differences between men and women's scores on 'satisfaction with leadership' ($t = 1.71$, $p = .08$).

When examining differences between men and women on the organisational dimension it was found that only one dimension, 'recognition', was perceived significantly differently ($t = 3.42$, $p < .001$). Men perceived there to be greater 'recognition' (mean = 9.55) compared to women (mean = 8.13). All other dimensions were not significantly different (see Chapter Eight).

When examining the gender differences on managerial dimensions of the OCS there were trends approaching significance in terms of differences between the genders on managerial dimensions, but these did not reach significance when multiple comparisons were taken into account:

Manager 'recognition' ($t = 1.91$, $p = .06$)

Manager 'responsibility' ($t = 2.10$, $p = .03$)

Manager 'standards' ($t = 2.33$, $p = .02$).

5.3 Conclusions

The difficulty obtaining data across all three participating Trusts has not limited the value of using the OCS to triangulate the qualitative data, particularly because a) the OCS gathered information from staff groups who were not represented in the focus groups, shadowing or story-telling

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interviews and was able to identify generalisable predictors of satisfaction with leadership and management practices, and b) the OCS data captured information from specialty groups outside those involved in the participating Units from which qualitative data was collected.

What emerged here was that on the whole, the same climate variables are important in predicting satisfaction with leadership. Within the organisational domain these are 'support' and 'recognition' while predictors of 'satisfaction with leadership', within managerial practices, are manager 'support', 'commitment' and 'structure'.

Overall, therefore, 'satisfaction with leadership' was highly accounted for by manager 'support', manager 'commitment' and organisational 'support' – i.e. these were the 'ingredients' in this sample which were highly related and were able to predict satisfaction with leadership. This suggests once again that managers/leaders were effective if they engaged with followers and that organisations that supported distributed leadership and emotional engagement were more likely to support effective leadership (see Chapters Four and Six in particular).

In terms of role, the higher the position in the organisational hierarchy the more satisfied a person was likely to be with leadership. This was not necessarily the case though across all organisations in the study. The exploration of the case studies in Chapter Seven – where authority and leadership are discussed – reveals how some of the more senior leaders in organisations found themselves to be highly dissatisfied with leadership in other sectors of their Trust, if there was resistance or negligence of their authority.

Differences in gender were only apparent in terms the organisational dimension 'recognition' – it was only on this scale where women scored significantly lower than men. This may say something about equal opportunities and equal pay for equal work, but it might also relate to perception of 'recognition' between women and men discussed and exemplified in Chapter Eight below.

The overall importance of constructs such as 'support' and 'recognition' across the climate of an organisation, and management practices which demonstrate support and commitment, provide further evidence of the importance in engagement and (probably) emotion (including EI and SI) in an organisation.

6 'Organisation in the Mind': Transmission of Leadership and Organisational Context

6.1 Introduction

Leadership in any organisation is understood in a specific context by those involved as either leaders or followers, and as shown in Chapters Four and Five concepts such as satisfaction, support, responsibility, vision and communication among others are described and evaluated within a cognitive or mental framework within which the organisation itself is understood. It is through making sense of the organisational context that leadership and followership may be enacted and transmitted.

We saw how members of organisations *necessarily* hold in their mind fantasy/imagined understandings or images of the *system* (Morgan, 2006). This informs how they work in, relate to and talk about their organisation, based on their perceptions of their own and others' place and role within the system. For example, it is common to hear employees talk about how 'you can never get management attention in this company' or 'we are all dedicated to putting patients first here' (Armstrong, 2005; Morgan, 2006).

Similarly, the participants who completed the OCS held a view of the leadership and management in their organisations, in order to think about the various ways in which their work was recognised, supported and so on both generally and by their managers. While the focus in that case was upon on measuring the impact of organisational climate and thinking about a relationship with a specific manager, those who completed the survey would have had to hold a perception of what was happening in their department and the Trust overall.

This is apparent in what follows particularly in the ways 'management' is discussed and taking account of these perceptions provides some evidence about the ways in which leadership is transmitted in these particular organisational contexts and in general. The 'organisation in mind' then involves:

- An 'image' of the organisational structure and relationships within that structure
- A sense of your own role and place within it
- An emotional component
- An awareness at a conscious and/or unconscious level of important information below the surface

6.2 Organisation in the mind

The concept of the 'organisation in the mind' was a model developed originally in the early 1990s by organisational and group relations consultants working at the Grubb Institute, the Tavistock Centre and the Tavistock Institute of Human Relations, to refer to what an individual perceives mentally about how organisations, relations in the organisations and the structures are connected. *"It is a model internal to oneself ... which gives rise to images, emotions, values and responses in me, which may consequently be influencing my own management and leadership, positively or adversely"* (Hutton, Bazalgette and Reed, 1997, p. 114 quoted in Armstrong, 2005, p. 4).

In other words, when we talk about our colleagues, guess what the senior management are doing/going to do and have fantasies about how well we fit, or don't fit, into the structure or system we do so in the context of the organisation we 'hold' in our mind which may or may not relate to that which other members of the organisation hold (Pols, 2005).

Organisations are experienced cognitively and emotionally by their members when they think about how their organisations work and are structured (see Lewin, 1947; Armstrong, 2005; Morgan, 2006). As Stokes (1994) explains it, everyone carries a sense of the organisation in their mind but members from different parts of the same organisations may have *"different pictures and these may be in contradiction to one another. Although often partly unconscious, these pictures nevertheless inform and influence the behaviour and feelings of members"*. (p. 121)

Hutton (2000) talks about it as *"a conscious or pre-conscious construct focused around emotional experiences of tasks, roles, purposes, rituals, accountability, competence, failure, success"* (p. 2). Morgan suggests that an organisation may serve as a 'psychic prison' in that the:

...patterns and meanings that shape corporate culture and subculture may also have unconscious significance. The common values that bind an organisation often have their origin in shared concerns that lurk below the surface of conscious awareness. For example, in organisations that project a team image, various kinds of splitting mechanisms are often in operation, idealising the qualities of team members while projecting fears, anger, envy, and other bad impulses onto persons and objects that are not part of the team (Morgan, 2006, p. 226).

Some of this is apparent when talking to NHS staff about the leaders at various levels of their own Trusts and the NHS overall as was seen particularly in Chapter Four.

6.2.1 Organisation under the surface

So, when the respondent immediately below talks about the leader who has a 'really good understanding of the organisation or team' what exactly does that mean? How does that understanding come about? What do the team hold in mind about that particular leader?

Leadership is someone who has a really good understanding of the organisation or team, erm where it's going and where they imagine it to be going, so that sort of vision as well for their team, I think. (Lead Clinical Non-medical Health Professional, T3)

This respondent, referring to the (frequently used) concept 'vision', also identifies this with the *imagination* the leader holds about where the organisation is going. This is not simply a matter of guesswork. It is an intellectual/cognitive and *emotional* sense of an organisation. Indeed to take this slightly further, as Gabriel and Schwartz (2004) propose "... *what goes on at the surface of an organisation is not all that there is, and ... understanding organisations often means comprehending matters that lie beneath the surface*" (Gabriel and Schwartz, 2004, p. 1).

Although not necessarily (in fact mostly not) made explicit, even the most clear thinking senior members of organisations hold an image of the organisation in mind, expressing their fantasy/belief/perception of the organisation based on conscious and unconscious knowledge (Halton, 2007; James & Arroba, 2005). So for instance for this CEO leadership is understood emotionally as it is:

... about the feel of the organisation and what it feels like in terms of how it delivers patient care. Yeah, erm. I can best illustrate that, and interestingly we were thinking about this earlier this morning, so as a group, the executives, we were talking about it. When you walk onto a ward a hospital ward and there is real leadership on that ward, you walk in and there are a number of signals that are given off, which give you a feel. Erm the place looks organised, it has a welcoming feel, the nurses on the ward and the clinical staff greet you as they come into contact with you. They know you from the previous interactions that you have had and when you sit there and listen to what is being said on the ward they will know that the patients, the visitors on the ward, the families that are coming in the junior doctors who are in there in that environment and all of that has a feel²⁶ of a well led ward. (CEO)

²⁶ Respondent's emphasis.

The environment of the well led ward (unit or organisation) is implicitly and unconsciously identified by all who engage with that organisation. The staff communicate effectively (visually, verbally and emotionally) so that the information required is passed on through managers, clinicians to colleagues, patients and relatives. This account, which preceded the extract that focused on strategy, directed to the best patient care for the greatest number of patients, expresses his ideas at an *emotional* level. He also suggests his senior colleagues agree with this. Signals are 'given off', you can 'feel' the organisation and how it delivers patient care and there is a 'welcoming feel'. He also talks about 'empirical' evidence in that staff know the patients, the ward looks organised he remains convinced that there is a 'feel of a well led ward'.

From a slightly different position, a deputy CEO quoted below also holds in mind the fantasy that a manager might think that they run an institution but that such a fantasy might get the manager into trouble. He is suggesting a vision of an organisation in which a manager has very little control, and proposes the need to gain a sense of *reality* by recognising this and taking responsibility for this organisation (Hirschhorn, 1997; Porter-O'Grady, 1995). His perception, again which has an emotional component, is one of a stressful contradiction – responsibility without power or control (de Vries, 2000).

The minute, as a manager, you start to think that you do [run the service without accountability]... erm then you're in trouble. Unfortunately you have still got the accountability for the service but you have very, very little control so it's a whole different leadership and managerial skill that is required I think in terms of recognizing that you have no control over what happens you know across this organisation across the N,000 beds here at [Trust], the thousands of people that go through the organisation everyday, what happens to them is completely outside of my control but if anything goes wrong it is absolutely my responsibility. And that is quite difficult.
(Deputy CEO, T 1)

6.2.2 Structure in the mind

Most recently Laughlin and Sher (Laughlin & Sher, 2010) take up a version of this concept which they name the 'structure-in-the-mind' in their analysis of developing leadership in social care. They reassert, in their model, that not only the local stakeholders (staff and service users) have a sense of the organisation in the mind when considering, for instance, a particular Trust, but the range of stakeholders includes government bodies and service commissioners (in the round). They propose an inter-relationship between perceptions of communications from services (e.g. 'that you [management] don't listen and/or understand') and perceived communications from 'Head

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Office (or government or other bodies that control resources and practices) which include for example 'just do it' 'we know better' and 'be rational'. (p. 9)

What is significant here, in the context of NHS leadership, is that the organisation and/or structure *in the mind* is where the leader and followers 'meet' emotionally as, similarly, do the various levels of leadership and governance bodies. It is a kind of 'virtual' space.

An example of this structure in the mind might be seen through the increase in stress for NHS employees detailed in a recent report by NICE (the National Institute for Clinical Excellence²⁷) where it was revealed that staff absence caused by work related stress costs the UK over £28 billion. It was proposed that a poor working environment characterised by bullying and poor management was at the heart of this problem²⁸ (Edwards & O'Connell, 2007). In a context where there is distributed leadership and a highly trained professional, multi-disciplinary workforce, such mismatches in how to run organisations and departments that lead to staff stress in these ways (e.g. being bullied and bullying) evoke questions about what is happening in the space between those who plan, govern and resource NHS Trusts and those who carry out the work. The emotional elements of leadership and followership relations seem to be neglected to everyone's disadvantage.

The idea of the organisation in the mind raises important questions of how leadership (good and bad) is transmitted across the NHS and its Trusts (Harrison & Carroll, 1991; Walsh & Ungson, 1991). Organisational cultures and climates are reproduced over time despite the coming(s) and going(s) of CEOs. However, organisations also *adapt* and *evolve* as a response to changes in leadership and outside influences (Morgan, 2006).

In what follows we explore the characteristics of the organisations studied here that facilitate or hinder the transmission of leadership through the Trust as a *system* through which culture (e.g. principles and values about leadership) might be transmitted (Hatch, 1993; Schein, 2004).

²⁷ An organisation established to oversee and provide guidance on clinical practice and cost and clinical effectiveness.

²⁸ See news.bbc.co.uk/2/hi/health/8343074.stm and NICE web-site which has a power-point presentation.

6.2.3 Transmission of leadership and Organisational Contexts

What is held in mind about an organisation is often influenced by the formal and informal networks (Balkundi & Kilduff, 2005, 2006; Goodwin, 2000) which characterise complex adaptive systems. Network cognitions in the minds of leaders are embedded in the whole organisation and the inter-organisational linkages formed by leaders as representatives of organisations (Balkundi & Kilduff, 2005).

The context of the NHS seems to have become increasingly complex and chaotic (Currie et al., 2009) which, coupled with a sense of widespread unethical managerial practices, has raised questions about how leadership practices are transmitted through NHS organisations (Bowie & Werhane, 2005; Collier & Esteban, 2000; Huston & Brox, 2004). Bullying and poor management are in part at least a consequence of not taking the emotional context of organisational life seriously (Ashkanasy, Jordan, & James, 2003; Cocco, Gatti, Lima, & Camus, 2003; Johnson, Cooper, Cartwright et al. 2005; James, 1999; Hutchinson, Vickers, Jackson & Wilkes, 2006).

While there is no excuse for bullying or any other unethical management practices, it is necessary to understand what precipitated the relatively recent change in culture which has exacerbated (reports of) bullying. One factor has to be the extent to which top-down, politically driven changes have been forced through the NHS system and other public institutions and the impact that the drivers of these changes have upon the senior levels of management consciously and unconsciously (Christensen & Laegreid, 2003; Dent, 2005; Gabriel, 2004).

These recent developments have influenced the psychological and emotional aspects of working in teams, groups and organisations (Liden & Antonakis, 2009; West & Anderson, 1992) and by implication influenced possibilities for innovation in leadership and the authority of leaders and workers (Lewin, 1947; Miller, 1993; Carter, Garside, & Black, 2003; Hirschorn, 1997; Fineman, 1994, 2000; Payne and Cooper, 2001; Vince, 2002; Carter, Garside, & Black, 2003). Understanding the *context* of leadership, therefore, has become increasingly important as has the need to understand how that context is part of a *system*.

Post industrial (or postmodern) systems (Rose, 1991) have been reconsidered (or 're-described') relatively recently as 'complex adaptive systems' (Collier & Esteban, 2000; Dooley, 1997; Schuster, 2005). Systems that are complex because of multiple interconnecting relationships are liable to evolve through making new connections that increase their complexity (Collier & Esteban, 2000). In the NHS, even though change is structurally driven, the (perhaps unforeseen) consequences of changes have meant that instead of a command-and-control, top-down hierarchies where in particular

clinicians such as consultants and matrons had previously been seen as 'gods' (as with Sir Lancelot Spratt and Dr. Gregory House see Chapter Four) distributed leadership, networks and different statuses attributed to individual Trusts (e.g. Foundation Trusts with relative independence, Mental Health Trusts which have social care and NHS staff and diverse management practices) have evolved within different structures at all levels for coping with service delivery (see Chapter Nine).

6.3 Open systems theory and boundary management

An organisation that *evolves* like an organism and adapts to its environment necessarily has *porous boundaries* so that it can 'take in' and 'put out' beyond itself. This kind of organism is one that changes, develops and grows. A closed system may feel more secure in that it may not have to accede to unwanted influence or demands, but without taking in and providing for the world outside it will atrophy as with any other closed (minded) system (Morgan, 2006). In this way images and cultures of leadership from outside the boundaries might influence the development of leadership practices e.g. data and ideas from education (Currie et al., 2009; Gronn, 2000; Lumby, 2003)

Systemic thinking is a framework, or tool, for observing the way organisations behave (Schein, 1985; Lewin, 1947; Campbell et al, 1994) which evolved from General Systems Theory, (von Bertalanffy, 1956; Miller and Rice, 1967) and focuses upon concepts related to organisational structure particularly 'task', 'role', 'authority' and 'boundary'. There is also a psychodynamic part of the systemic thinking analysis which links with the conscious and unconscious emotional consequences of the systemic properties and the impact of social and personal factors on the functioning of the organisation (James and Huffington, 2004; Laughlin & Sher, 2010)²⁹.

Morgan (2006) identifies how knowledge and power are accessed and maintained through control of organisational boundaries. 'Boundary' is the term used in open-systems theory to describe the interface between different parts of the organisation and the organisation and the outside world. In the case of the NHS this is the physical boundary to the, for example, hospital building, the wards, the web-site, the reception desk, the

²⁹ This issue is further discussed and explained through object relations theory based on the works of Melanie Klein, Elliot Jaques and Isabel Menzies-Lyth which is outlined in detail in Chapter One and operationalised in the description of the role of obstetricians' anxiety in the delivery of patient care discussed in this chapter and below in Chapter Nine).

telephones, e-mail and so on and also between the different roles such as out-patient/ in-patient, staff /patient, clinician/manager and so on. Most leaders in organisations have the knowledge and abilities by definition to manage and negotiate those boundaries. For example, the senior managers relate to government/NHS/DoH in ways that junior nurses do not, but the senior staff are charged with having to manage the boundaries using knowledge and influence across the boundaries – inside with the staff and patients and outside with government and patient pressure groups. Moreover, as evidenced during the conduct of this project, hospitals merge into Trusts and the porosity or opacity of the boundaries between the different organisations that have come together are central to the functioning of leadership at most levels (see Chapter Seven where the limits of authority are discussed in this context).

Stating this in a slightly different way, this approach to the 'organisation in the mind' takes the *personal* (conscious, pre-conscious and unconscious) level of thinking and links it to the *system* in which that person works (systemic thinking). As any organisation comprises systems (with boundaries, in-puts and out-puts), groups and individuals, it follows that a person's experience of an organisation and *experience of themselves* in relation to others who are in the same organisation make up the culture, climate and everyday dynamics of any organisational context. Thus, our respondents' sense of the 'organisation in the mind' is a valuable concept for understanding how leadership relates to service delivery.

6.4 Images of the organisation

In what follows we explore some of the images 'held in mind' by staff across the three Trusts particularly examining the impact of the organisation in the mind on working collaboratively and the influence of this on service delivery and the quality of patient care that results from staff relations and effectiveness.

To begin, we focus on two specific examples that characterise much of what was said by staff across at least two Trusts:

- images (and fantasies) held about 'management' which highlight the construction of 'authority' in the system and its impact on patient care
- images (and fantasies) held about the 'others' (e.g. colleagues in the same Trust but on a different site or a different Unit) which brings boundary management into play
- how these images (and fantasies) facilitate and hinder the transmission of leadership and service delivery

We employ a critical discourse analysis (CDA) approach to the meaning and processes of leadership and organisation exploring how the organisation/system *looks* to the participants and how this in turn impacts upon the system of providing care for its patients.

6.4.1 'Management' in the mind

As in many organisations, rhetoric about 'management' abounds particularly played out as a 'them/us' dynamic as we demonstrated by separate means in Chapters Four and Five. Furthermore, among management, rhetoric about their own practices and role in relation to that of the workforce is equally active (Alvesson & Sveningsson, 2003a; Borins, 2000; Kuokkanen & Katajisto, 2003).

There is general cynicism across all the respondents who defined themselves as non-management *about* management. So for example: *"And you find that when there's a crisis that's when you find your management team will come down and put a policy in place regardless - like the swine flu thing" (Junior Midwife)*. So here managers are described as paying no heed to the routine tasks of the organisation (Cummings, Hayduk, & Estabrooks, 2005b). They are portrayed as simply responding to a crisis and (presumably following orders from the overall leaders of the service). Thus, managers are not seen as managing the boundaries between the Trust and those in overall charge of health care operating outside of the organisation (i.e. at the level of government) effectively for the facilitation of service delivery (Buchanan, Abbott, Bentley, Lanceley, & Meyer, 2005; Kane & Patapan, 2006). This resonates with Laughlin and Sher's (2010) analysis discussed above.

A focus group from one Trust proposed a particularly strident view of management and its relationship to wider bureaucratic imperatives which they saw as going against service delivery and effective patient care. The medical staff here were proposing that management was both absent, in person and from taking responsibility, while also being all controlling of medical care through instigating seemingly pointless rituals which seemed to maintain boundaries.

Consultant: There is a burning example [here] of bad leadership which is the absence of figure heads. Management can never be found which is frustrating.

Registrar: I've been in theatre now for two weeks and two cases were dropped. The doctor has to apologise to the patient but they are the ones [the doctors] who would like to continue. Management say 'NO it is lunch'. They should be the ones taking responsibility for telling the patient but the

doctor has to go back to the patient and look like a donkey saying 'I'm sorry I can't do your operation today'.

The members of this group, who clearly shared the same or similar images of management and its 'idiocy', went on to decry management incompetence across all staffing issues, and the registrar continued, imitating the management in a silly voice: "*he has to stop, that's the rule*" making it very clear that management was perceived by this man and others in this focus group as inflexible (and rather stupid). Here these participants are expressing total lack of faith in the authority of those who manage (rather than lead) them, although in fact it seems that despite this, they abide by the rules which suggests that there is a belief that at some level the managers in question here derive authority from somewhere higher up in the hospital system or from the NHS leadership beyond.

One factor to note, of course though, is that the power of the story in the focus group may belie the views of the whole group in that some would be silenced by the fear of disagreeing with their colleagues (Asch, 1956; Foucault, 1982). Furthermore, the articulation of the behaviour of management in these cases is *actually a form of leadership* and as such might influence the views of the focus group (and subsequently other staff) (Avolio et al., 2004; Pye, 2005).

From a different focus group, this time with junior midwives, it was apparently *giving up their authority* for a while that gained managers some important respect. For instance when a crisis occurred in the organisation (in this case a fire) then managers seemed to behave very differently and even impressively:

1³⁰. Yeah and then the managers - the bed managers - were carrying chairs and everything and you just had people on beanbags on the floor and everybody ...

2. I wasn't here that day I missed that.

1. Well it was a bit stressful but everybody just mucked in and people were just carrying people here and you know....

Q: Well that's really good if everybody even the managers mucked in.

1. Yeah you find in a crisis the managers do come out, the leadership the leaders come out and they have to come out.

3. And people were coming in from home to help that day.

³⁰ The number denotes the speaker.

2. *Why didn't they phone me? I don't know but never mind ...*

1. *No you find that in that kind of crisis everybody from execs downwards pulls rank and everybody comes in and helps out (T 2).*

So the image here is that a crisis brings out the best in everyone (and the boundaries between the groups of staff become temporarily porous). In times of crisis then the tasks (i.e. patient care and running an effective hospital) overcome other elements of potential discord and conflict such as the 'rank' order of 'execs' bed managers and others such as clinical staff.

There are also other times when it is possible for management to be seen as 'on side' as indicated by another nurse in a different site. For example:

Erm ... our manager, she is quite approachable. And she is willing to discuss things with you if you don't feel that something is right and you question it or question her. She is willing to sit down and explain it and sometimes she will say 'I'm not happy with things as well, but the people above me this is what they have decided, this is what we have to go along with. It is government guidelines or targets have to be met'. Although she might feel the same as us she explains why we have to do things in this way. And I think she is very approachable.

This manager above, demonstrates her willingness to communicate and be 'visible' but clearly she has adopted a them/us strategy similar to those who 'oppose' management by positioning herself as managing the boundary from the side of the clinician/nurse's while also at other times presenting herself as mediating between 'government' and clinicians and managing that boundary too (Laughlin & Sher, 2010).

In the example described here, this seems to 'work' as evidence of good leadership for the nurse telling the story, but it involves the manager in question in potentially difficult dynamics and conflicts in her role.

From another focus group discussion that included doctors and nurses the organisation in the mind experienced management as absent and failing in their responsibility (Hogan & Kaiser, 2005):

Absence would be correct. Management are often not there. They need to take command of the situation. Here is the reasoning – management don't take responsibility for their actions and there is a severe lack of managerial leadership.

This is significant in the concept of the organisation in the mind when juxtaposed with the account of the same organisation by the CEO who saw her/himself as seeing good leadership as manifested in:

Visibility in terms of being seen around the place, so go out wandering around the wards. The best part of the role, quite candidly is, the best part about being the chief executive is, you can go out and talk to patients, and that is what I really kind of enjoy. ... so there is something about my presence and my profile. There is also something about being very clear and repeating the message often enough so that it is clear in the organisation about what the organisation is there to do.

So, within the same organisation there is an image that management is invisible and absent, while senior managers see themselves as 'being seen around the place' constituting an important part of what they believe they do and that they see as being vital for effective leadership and patient care (Laughlin & Sher, 2010). Both sides agree on what would be good leadership but each 'side' has a different vision of what is happening in 'reality' (Alvesson & Sveningsson, 2003a; Buchanan et al., 2007).

In the absence of a shared vision of an organisation working together or a set of clear guidelines about how 'this organisation works', there seemed to be a wish from a deputy CEO of another Trust for a hero/charismatic leader to put things to rights and potentially cross the managers/others boundary (Ladkin, 2006; Laughlin & Sher, 2010).

Erm, this is a very complicated organisation, what we haven't got right is we haven't got a bible that says this is how this organisation works and I think that's a problem so, ((1)) so ((1)) it's very easy for ((1)) despite what I've said about how difficult it was to be a leader, erm and the personality of the individuals who are at the top of the tree, makes an enormous difference in how an organisation I think behaves and works. There is a great tendency if you are a very good individual for an organisation to be based around you and when you leave there is a problem, erm and so the best kind of leader, yes they have that aura of it's about them, of course that's what people look up to but they also put in place processes so that things can happen.

This is a view from the top of the organisation which is expressed at least in part as a vision of a (desirable) mechanistic model – an organisation with a 'bible' about how it works - although this participant also desires a charismatic transformation on the part of leaders.

The hero leader would be a 'very good individual for an organisation to be based around you' and also to have 'an aura'. The metaphors in this extract proliferate – the need for a 'messiah' to save the organisation but also a sense of *dependency* – that 'people look up to' this type of leader who (it would appear) single handedly will be able to put processes in place for things to happen. The vision here is though one in which the system is defunct, stagnant and closed.

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6.5 'Out of mind': leadership and the 'other'

Organisational change is frequently resisted, often because of the disruption to individual's *sense of the system* and their place within it (e.g. Hoyle, 2004). It is also related to the emotional involvement many people have in their work and the way they perceive they are valued within (and how they themselves value) a familiar structure and context (Bovey & Hede, 2001; Zoller & Fairhurst, 2007).

Emotional labour, as discussed in Chapter One, is a key feature of the work that many people do, and is an integral part of any job, but particularly so in an institution of the NHS (see for example Gabriel, 2004). Different occupations require different types of 'displays' and following Hochschild (1983) emotional labour requires adopting emotional displays and attitudes appropriate to the role.

Clearly in hospital work all staff have to expend emotional energy on 'caring' and 'kindness' but it is also the case that working in the NHS, with its many changes for (perhaps) better or (maybe) worse, also requires the ability to be able to 'move on' i.e. mourn the loss of the old structure, sets of relationships etc. and embrace the 'new' with some degree of enthusiasm. The failure to do this (or recognise the need to do this) results in emotional resistance to changes and hanging on to the old systems as long as possible which might defeat changes that improve service delivery and benefit patients (Hughes, 2005).

6.5.1 Leading change and transmitting leadership

In one particular case a senior clinical manager Gerald³¹, was charged with integrating clinical practice across two sites, each of which had their own different ways of working, and different relationships to the boundaries between each other and the clinical teams. While the one (where he was based primarily) had accepted quite radical changes to its organisation, the other (apparently) did not "*..because the sort of ethos and the sort of personalities of the two sites are in the background. They are completely different*".

Gerald's view is based on a reality in that the two sites are structured differently, look different from each other in that the buildings are from different eras and in different styles, and they are in physically different locations. They also serve different demographic populations and have different histories. However, Gerald sees the organisation of the different

³¹ Gerald's leadership is discussed in detail in Chapter Seven.

sites as really being about 'ethos' and 'personalities' which must be in the mind (mostly) as there is a system of authority and responsibility in place across the Trust (via the CEO and other senior people including Gerald) that takes up authority and leadership to ensure consistent practices and organisational change.

Thus, we need to ask why one Unit has (apparently) taken new ways of working on board with some enthusiasm while (apparently) there are barriers preventing the other one doing something similar.

For Gerald, management of the boundaries between in-patient care and primary care teams was the source of a key difficulty:

There are groups of people here who are completely behind the concept that we mind about – integration of primary care – joint working between the Trust and the Primary Care Trust. Some departments work extremely well and are keen to move forward and although we do have our minor difficulties - generally there's one or two departments who are completely against change and erm resistant to anything new. Just like any other organisation where you know you are going to get the type of people who actually make life extremely difficult for you and despite that we've proven how much better our system is.

In the extract above he moves from talking about the other *site* (as a whole system) as being the 'bad' resistant one, to identifying *individuals* on his own site within the 'good' system as making life difficult for him personally despite evidence (he and others have provided) to show how integration works better. This respondent's organisation in mind shifts depending on how well one part of the system fits with his particular vision of a good organisation. This *splitting* (see Chapter One) is a mechanism (unconscious) for preventing the overwhelming feeling that can come from persecutory anxieties (Jaques, 1953; Jaques, 1960; Menzies, 1970). In a management role where (for some reason) authority is being undermined, then the resurgence of persecutory anxiety might be dealt with by splitting of the 'bad' site and comforting oneself with the knowledge of a 'good' site where the organisation works as this leader/manager might wish it to do (Laughlin & Sher, 2010).

6.5.2 Resisting change

In the case of a medical secretary, with over twenty years experience of working in the same hospital, the thought of change in the structure of her working relationships was upsetting. She began engaging with the interviewer by talking about how busy she was and when asked if there was any particular reason why she was busy at that particular time she went into an explanation about organisational change. *"It's just generally busy, but we*

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are in teams now, erm couple of them [doctors] are away and one or two have come back, catching up with everything". It seems as if the teams were the problem for her because previously (and for many years) "...it was one secretary to one consultant and his team. Now for instance today I'm actually taking calls for four different consultants". She was asked about the new structure and made it clear:

erm ... I don't think it's going to work as well as the previous one. Because I think you'll be dipping in and out of so many different jobs that instead of concentrating on the ones that you do well and controlling your one doctor, it'll be confusing and I think there will be mistakes made because one person is trying to deal with too many parts of too many jobs.

Her perception that her role in the organisation might happily continue as one in which she controlled one consultant is characteristic of the 'comfort' of the closed system where authority, power and the processes of leadership are condensed and held 'constant' by an individual. As seen in Chapter Four also change is not usually welcomed without at least tacit resistance and in Chapter Seven two of the case studies will explore how leaders as potential change agents experience followers' avoidance or challenge to changes in practices and structure.

Changes in working relationships bring anxieties which need to be understood and anticipated by leaders if they are to support staff to position themselves differently in the system. Hoyle (2004, in Huffington et al) suggests that during any period of organisational change there is potential for heightened creativity which might lead to doing things differently and better. However, change also brings about risk, uncertainty and the chance of failure which can evoke anxiety both in those promoting the changes (the leaders) and those who might fear loss of their job and the loss of known ways of working (see Hoyle, 2004, p.87).

6.6 Conclusions

Understanding an organisation and what facilitates and/or hinders leaders to take up their authority involves considering the organisation systemically. That is taking account of the boundary management and how that relates to the tasks, roles and power/authority of those who work or are 'consumers' of its work.

Leading change depends upon ensuring those within the system have a sense of how the system works and an awareness of the culture that might be tested as a reality or not. This means, once again, that organisations which are learning environments and where emotional intelligence is applied, are more likely to respond to authority and less likely to subvert

leadership, thus distributed leadership/responsibilities may be taken up or shared more widely.

7 Leadership, Authority and Emotion

7.1 Introduction

As argued above, leadership and emotion are fundamentally intertwined in the workplace (Fineman, 2003). Leaders who appropriately manage both their own emotions (Goleman et al., 2001), and those of their followers, experience better leader-follower relationships, greater opportunity for innovation, motivation and productivity, a more positive organisational climate and improvement in employee and customer/patient satisfaction (Ashkanasy et al., 2003; Avolio et al., 2004; Hollander, 2009). Such outcomes can be associated with both *transformational leadership* (Bass et al., 2003; Corrigan & Garman, 1999; Currie & Lockett, 2007) and *distributed leadership* (Bass & Steidlmeier, 1999; Gronn, 2000, 2002; Mehra, Smith, L. Dixon, & Robertson, 2006b) patterns.

It has also been suggested that followers' 'dysfunctional' dependency is a consequence of failure of the leader to *engage* on an emotional level with those whom they lead (Alban-Metcalfe & Alimo-Metcalfe., 2009; Ashforth & Humphrey, 1995; Bion, 1961; George, 2000). There are different types of such engagement, e.g. acknowledging emotions, drawing them out, honouring them, confronting them, and deflecting them, but although this idea of engagement has been described as "*compelling on the surface, the meaning of the employee engagement concept is unclear*". (Macy & Schneider, 2008, p.3) Even so, there is a common view that such engagement is desirable for organisations in that it connotes involvement, commitment, passion, focused effort and energy from staff thus demonstrating both attitudinal and behavioural components for an effective workforce. (Macy & Schneider, 2008)

Studies of leadership and emotion have not typically been combined with attention to the 'authority' of the leader (Ford, 2006; Stein, 2007) or indeed to the concept of 'power', (sometimes seen and experienced interchangeably). (Morgan, 2006) A study combining exploration of the relationship of authority to concepts of both 'emotion' and 'engagement' (Hirschhorn, 1997) is particularly relevant to the agenda of the 'post-modern' organisation where leadership is distributed (Clegg, 1990; Tierney, 1996) and the organisation potentially fragmented, unmanageable and diverse.

The authority invested in a particular role, such as the CEO (Chief Executive Officer) or lead clinician may not explicitly engage emotion. However, in an organisation such as an NHS Trust, where leadership styles are, or at least

intended to be, characterised by distributed or transformational attributes, the concept of authority is more closely linked to *personal* authority whereby individuals “..bring more of themselves – their skills, ideas, feelings, and values – to their work. They are more psychologically present.” (Hirschorn, 1997, p.9). Thus for example clinical skills *and* personal investment are *both* required for someone to take up authority in practice as a clinical leaderⁱⁱ.

In this chapter we delve further into the concepts of leaders and leadership, particularly focusing upon leaders with a ‘mandate’ to lead change through their formal *role*. The group of participants we specifically focus upon here includes clinical and non-clinical senior managers and we examine the ways these individuals construct their role, their relationship to ‘followers’ and how their *authority* is taken up, experienced and constructed in their specific organisational context³². Authority has more than one meaning. It refers to the authority (sometimes seen as power) invested in a particular role.

Analysis of relationships between people who work in the NHS is underpinned by both the *interactional* and the (related) *emotional* contexts of an NHS Trust as a workplace (see for example Liden and Antonakis, 2009). This knowledge is particularly salient because on the surface, many of those occupying the leadership roles were inclined (at least superficially) to deny the role of emotion although analysis of their stories, shadowing and observations, following the pre-existing literature on organisational cultures, including those which study health care settings, indicated that emotion indeed plays a key role in service delivery and the ways leadership and authority are experienced and constructed in relation to patient care (Vince, 2002; Gabriel, 2004; Hirschorn, 1997; Huffington, 2007; Obholzer, 1994; Vega-Roberts, 1994).

7.2 Case studies

Three case studies were selected to examine the meanings given to the relationship between ‘leadership’, ‘emotion’ and ‘authority’ in relative depth. Each one was chosen (through discussion among the research team) to be (potentially) representative of a ‘typical’ approach to emotional management which reflected a personal style of authority (or lack of authority). These particular cases raised subtle but crucial questions about leadership, emotion and authority through exposing both the conscious and *unconscious* qualities which can either underpin or undermine a leadership *role* (Bovey & Hede, 2001).

³² In this chapter we focus specifically on the senior staff’s perspectives. Others’ perceptions of senior staff were discussed in Chapter Six.

1. The first leader, Gerald, had an 'authoritarian' manner (Adorno, 1950). That is, he appeared to believe that because he was in a senior position other staff ought to do what he told them to do. He was a senior clinician [for a group of particular services], relatively young, very enthusiastic and held an uncompromising vision of how a good hospital should be organised. He was interviewed once by a researcher, once by a group including the PI and 'shadowed' for two days by the same researcher.
2. Kerry in many ways held a similar outlook to Gerald, only she *believed* that she attended to the emotions of her staff if not her own. Kerry was Gerald's immediate boss and evidence from the interviews, shadowing and observations in both cases indicates they did not always work effectively together. Kerry was interviewed twice. Once for information as a key informant by two researchers and the second time by the PI and a researcher together. She was also observed by a researcher for an hour.
3. Quentin was a Clinical Director. He made overt efforts to weigh up the emotional 'risks' to his authority and thus seemed more able to engage with the 'followers' (and thus probably survive) in the *role*. At first he was reluctant to take part in the research directly (although he supported his colleagues' participation) but eventually agreed to be interviewed. Two researchers met him before the interview conducted by the PI, in his role as a key informant and observed him and the senior colleagues in their shared office space for about 30 minutes.

7.2.1 'Gerald'

Gerald held a clear vision of how a good hospital should be organised for the benefit of patients. What he appears to find problematic is managing staff who (for whatever reason) have a vested interest in different styles from those he advocates of patient care, working with colleagues and patients, and/or visions for service delivery.

The following extract is from the shadowing of Gerald.

From the two days spent with Gerald it was very clear that he believed that he was one of the main 'leaders' in the Trust and that he had a strong relationship with the middle and upper managers (including the CEO) which he uses to his advantage especially during long discussions regarding the 'new vision' (which appeared to be very much his vision) for the relationship between the two sites.

Gerald did indeed appear to be one of the main leaders. However, it was unclear whether the power and influence in this leadership role was all smoke and mirrors. Does Gerald play the role of the Wizard of Oz? Does he

think he has more power and influence than he actually has? Does he really have a good relationship with the Trust managers and Chief Executive?

The interview with Kerry (the CEO) made it apparent that she did not consider that he was one of the main leaders in the Trust and it was indicated that she didn't think much of him, and that their relationship might have been fraught.

Discussing the researcher's notes some weeks later, one thing that did emerge was that Gerald 'confused' those around him and was apparently unaware of how others saw him and how far his personal authority actually stretched. Hirschorn (1997) in a study of authority in contemporary organisations has suggested that leaders are no longer the old-style authority figures and because of changes in technology and economics "... bosses can no longer project the certainty, confidence and power that once facilitated employees' identification with them when they [employees] were young and dependent. This is why people are so disappointed in leaders today but also so unforgiving of them" (p. 9).

Gerald, although he had a clear management role and mandate to make the changes he focused on, did not get identified by his colleagues as fulfilling the vision of a leader as there is an implication in the observation extract that his authority may have been achieved via 'smoke and mirrors'. Furthermore his appointment (and that of several of his close senior colleagues) predated the appointment of the CEO. Several questions are raised here by the researcher about whether Gerald has been capable of taking up authority when the CEO takes a stance that at least tacitly opposes him. *This has to remain unanswered in the specific context of this Trust but is an important matter to consider in regard to distributed leadership.*

Gerald prefers to position himself as 'evidence-based' (and therefore up-to-date) dealing with practical matters and not positioning himself as an *emotional* leader. In the interview below, thus, he talks about making difficult decisions but paradoxically, almost from the beginning he focuses in upon dramatic inter-personal conflicts - talking about 'facing up to a fight' and declaring that the Trust 'absolutely' does not have the kind of leadership that enables 'direction' or 'vision'. Does this mean the CEO? Does this mean consultants? It may not even be intended so specifically perhaps it is an expression of general frustration that his vision is not shared.

While on the surface he claimed a good sense of what leadership is about he is also revealing in his talk, the opposite position. Taking a team or department in the direction of the vision and making difficult decisions is for him about a relationship with (not) being 'scared' or further down in this extract, (not) 'afraid'.

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Gerald: Erm...good leadership, err having the ability to make difficult decisions, err, not being scared to face up to a fight...erm...being able to be clear about errr, the direction or vision of the trust, where we are going and be able to errr direct your team into the position that everyone errr everyone is meant to be going, erm I think

Q: Yeah...and do you see that kind of leadership in this hospital?

Gerald: No, absolutely not

Q: No? And why, why not? What's the problem to that kind of...

Gerald: I think that in the past, we .. we have been afraid to face up to a fight, and we have shied away from it.

Q: Yeah

Gerald: From making difficult decisions, and err, and we've let too many people get away with undermining the overall plan that we have...'cause we all know how to deliver excellent healthcare, we all have our views of how this is going ahead, but err, and the grand picture has been undermined by a few, and we've not been able to really face up to those people

Gerald believes that while everyone knows how to deliver 'excellent healthcare' a few have undermined the/his 'grand picture'. He also identifies with a group who support his particular vision while not expressing empathy with those who do not. As the interview progresses, Gerald berates the power (rather than leadership qualities) that consultants have had in the past suggesting that they *undermine* changes that he clearly and sincerely holds about what constitutes good patient care.

Gerald however does reflect on what he is being asked as evidence by his suggestion later:

I don't know about what makes a good [leader]...you know, its difficult to say what makes a good leader...because I'm not sure I'm a good leader, because the qualities that I feel perhaps are necessary, I don't perhaps have ...one of those is patience perhaps...err, being able to tolerate people's err err, err stupidity in a nice way, is essential I think, but I don't have that, I don't think...being, having the ability to listen, err, err, err and not judge or criticise too quickly is very important, but then, taking everyone's opinion into account, but then at the end of all that being able to still go your own way, and persuade everyone else that it was their idea in the first place ... Well, I have certain qualities which help me get the goals that I like...erm...whether I have everybody behind me.

This is one (although not the only one) of the more (paradoxically) emotional interviews from among the senior managers in the study. Gerald

recognises, quite passionately, that a leader needs followers and has to be tolerant. Gerald, though, cannot help declaring that those who presumably hold differing opinions to him to be stupid. He also said later in the interview that he believed many people were *against him* when he was appointed to the senior post as the Trust itself changed shape. While he would not it seems position himself as emotional (rather he sees himself as evidence-based) he chooses to talk in emotive ways and reading and hearing what he says is quite exhausting as he uses all his energy in trying to take the organisation where he believes it should go, but through lack of emotional intelligence, many a time he draws a blank.

Gabriel and Hirschorn (2004) might describe Gerald, at least in part, as a 'narcissistic leader' in that he liked to be told he is important and influential but he is also potentially a bully and authoritarian in style (Adorno, 1950). He clearly found criticism intolerable and split off the 'bad' (i.e. the consultants who didn't go along with his changes from the 'good' i.e. the 'we'). Gerald has a dream which he is determined to make into a reality, however, there is a "*delicate balance between feelings of omnipotence and feelings of impotence which leaders must achieve, in order to enhance the chances of turning vision into reality*" (Gabriel and Hirschorn, 2004, p. 144). These authors argue that narcissistic leaders have a particular aptitude for getting this balance wrong and "*Even if they are talented in their field, their judgement increasingly fails them. This is compounded by the collusion of their followers*". This may be Gerald's 'we'. Gerald fails to connect emotionally with his (potential) followers from outside his close-knit 'we' group even though there may be some admiration for his clarity and link with the NHS mandate. This means, in effect, that important changes which may well be for the benefit of patients in the contemporary NHS are being (effectively) resisted because of Gerald's style of leadership. Gerald also appears to have little idea of how others might experience their worlds, including their emotions.

This theory might be borne out by the following participant, a young female career NHS manager just reaching a senior position. She proposed Gerald, unprompted, as an example of a good leader:

I think he's great, he gets a bit of bad press sometimes, I think people get agitated with him, but I think it's because he tries to manage things, and he tries to be very fair, and he tries to solve problems that have been with us for a long time, so again, I think he is a good leader, he is trying to do the right thing for the Trust in the long term. He is erm ... sometimes it's difficult for him to carry people with him, but I think that will pay off in the long run. And I think he's thinking of a long term plan, he's prepared to take a bit of short term flack...but I think it will work out in the end. I think he's going about doing stuff in the right way, he's being fair and he's trying

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to be consistent, he's making sure he's got an evidence base for doing things, it's not just a random decision, he's collecting information, and that kind of thing...I think there are a lot of people in this organisation at this point who would say they didn't think he was a good leader, but I think time will tell the story there.

This extract from the interview, while consistent with Gerald's descriptions of his own behaviour, proposes an evaluation of his style which indicates he is likely to be successful in the longer term because he is 'trying to do the right thing for the Trust'. However also she identifies quite clearly that his leadership is failing to take many of the people who matter along with him, she positions herself as sharing his vision for the longer term benefit of the Trust which may reflect her *a priori* engagement with NHS management rather than with a clinical profession as she does not have a clinical background herself. It also seems to reflect collusion with his narcissistic style because she seems to mirror his version of himself. This participant continues:

Sometimes they're [other senior staff particularly doctors] quite quick to criticise without really understanding what the problem is that needs to be solved, and what some of the rules are we can't ignore. Some of the national directives, that we just have to do, there's no point fighting against them, we've got to find a way of implementing them, and I think sometimes he gets a really raw deal...but he's said, he's consistent, he will communicate to people, write to people and speak to people very quickly the minute they raise a problem, and he definitely shows that he is not shying away from difficult problems...I think that's a very strong characteristic.

Her description of the other staff appears to chime with Bion's theory of a fight/flight basic assumption group based on unconscious emotional ties of the group involved which (mostly) represents an anti-task resistance to the leader (Bion, 1961). *This extract above reinforces the possibility that Gerald is emotionally disengaged from his followers* and perceives his Trust to be in line with and in favour of NHS 'national directives'. The participant here who in a way is 'damning' Gerald with *strong* praise may be looking to Gerald as a potential mentor by making it clear that she will support his particular efforts. However when the researcher asked her about her *own* leadership she said:

.... because one of my strengths is pulling people together, one of my strengths is building teams, so I think from that point of view then yes, but then sometimes I look at people like [Gerald and her immediate boss] and I think 'Oh my God'. I've got so much respect for the way they deal with

the very difficult issues. Sometimes I wonder if I really put my neck out enough to say 'Ok, Ok, this is what we all need to be passionately aiming for.' Even if not everybody is quite wanting to do the same thing. I think sometimes I sit back a bit more and wait to see what the general feedback is, rather than stick my neck out and say 'Ok, this is the direction we've got to go in.' And I think as a leader you have to...well, in fact you probably have to do a bit of both.

This participant, it seems, is somehow subjugating her own skills and strengths to those whose skills and strengths do not correspond with what she believes in makes her a good leader and seems to be putting herself down for the skills she has got and does seem to value. Alternatively, she might have realised that her strengths might complement Gerald's and through his own narcissistic valency he may position her as someone to promote.

Finally, in relation to Gerald, whose example she insists on returning to, having described other more emotional and successful clinical leaders in the Trust:

.... And they [other senior staff] make it very evident that they don't support him [Gerald] in his role, and not only do they make it very evident, but they do a lot of stirring behind the scenes, to get up a bit of a frenzy against him And I think there's some very clever leadership involved in that process, and there's a lot of learning, gathering people in, getting them on board and uniting them in a common purpose, and this and that and the other, but it's not constructive.

7.2.2 'Kerry'

Kerry is Gerald's immediate boss (the CEO) and evidence from the interviews, shadowing and observations in both cases indicates they do not always work effectively together³³. Kerry herself has met with similar difficulties which seem to be the outcome of her attempts to encourage distributed leadership in that:

Kerry: Erm, erm, well we set up a process to...we re-wrote the discharge policy here. I chaired the group. I wanted to know what the problem was about discharges, and I was told we needed to rewrite the discharge policy,

³³ Regardless of personal authority in the cases of both Kerry and Gerald, it is clear that the organisation has had its own very particular problems which are *endemic in the system* (see Chapter Six for a more systemic analysis of leadership).

and we'd just done it. People looked at me, and I just said, well I've spent...I've chaired five meetings myself, where we put all the information forward, and all these arrangements in place and nobody's done anything about it. I think that's poor leadership.

Q: So erm...poor leadership on whose part? Because presumably you had people who you delegated this to?

Kerry: So the consultants, the nurse managers, the matrons...all the people that were on the working group really. And they just didn't implement it. Beyond belief really.

This extract reveals several levels of emotion and authority and (as with Gerald's narrative) there is an 'I' who takes action and the 'they' who are against her. Kerry had identified a problem with discharges but had to ask 'them' what it was and was told that 'we' needed to rewrite the policy. She took up the role of chairing five meetings, the group/'we' put the information forward and the arrangements in place (presumably to take action) but 'no-one' did anything. It is not known how she handled this 'failure' of leadership on 'their' part. Kerry appears to be a micro-manager (in that she herself was involved in the meetings). Reflecting on this interview, and reading the text, one of us reported back to the research team that she had misunderstood Kerry, thinking that Kerry had been talking about her *own* case of poor leadership. Perhaps it was as unclear in the action as it was in the telling (thus perhaps on an unconscious level the lack of clarity was communicated in the meetings). Why did Kerry, as the leader, not pick up the group's dependence (or *resistance*) (Bovey & Hede, 2001; Hughes, 2005)? This suggests that she herself had resisted emotional attachment to her 'followers' and failed to engage them on an emotional level during the meetings. One approach that helps to understand the example above of *resistance*, specifically in the context of the five reported meetings, is the idea of '*fight/flight*' from the work of Wilfred Bion (1961/1983). He suggested that a 'group mentality' (or group culture) emerges from the development of a group over time as it continues to meet, because individual contributions conform to this mentality. In brief, the formed 'group culture' unconsciously constrains individual members (see also Sherwood, 1964).

So, in this case it may have been that despite the seniority of the staff involved in rewriting the discharge procedure, the culture that had developed over the course of the five meetings (and possibly prior to this as 'they' had suggested the need to re-write the discharge policy) had *prevented/resisted distributed leadership*. This could have led to the group not making sense of the leader's expectations and reverting to the comfortable pattern of being that had not been challenged possibly (again) because of the leader failing to manage her own emotions or engage with those of her team.

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Bion (1961/86) suggests, that the group mentality exists on both at a conscious and unconscious level so that the team were probably not deliberately, or consciously, going against the leader. It seemed from the leader's description that the team had been almost 'sleep walking' – not recognising that they had already done what they later ignored and suggested needed doing. Dependency, according to Bion, meant dependency on the leader or "... *when all individuals in the group look to myself as a person with whom each has an exclusive relationship*" (Bion, 1961/86: 119). Within this mode there is little connection between the members themselves and there is a '*mass inertia*' (op cit). This links to Klein's depressive position (Gould, 1997). It also raises questions of who is depressed here - Kerry, the group, or the group in Kerry's fantasy? The unconscious resistance and frustration experienced by the leader here demonstrates the fluidity of power and potentially the influence of gender (Fletcher, 2004; Nicolson, 1996; Vince, 2001)

Kerry, however, did claim success in turning around previously identified failings in patient care targets. How did she manage this?

Well I ... I... I mean it requires a great deal of focus, which hasn't been succeeded by other individuals, so...and it's required the organisation to understand its importance, and that it is possible to do. So it's been trying to talk to people about 'OK it's a target, but it's a quality... a patient quality target, so don't look at it in a sort of derogatory manner'.And ((3)) ...so it's a bit of culture about are you being bullied, as a member of staff to achieve the target and if you're not being bullied well then why is important and then well it's important because its patient quality ((1))...and then I suppose, something about... I mean one of the turning points for me is about our reputation as well, which is...well everyone else is achieving it, and we're not, 'why do you want to be in the bottom 20% of the country?'

Resisting her own emotional attachment here she talks in the third person. Rather than saying that as a new senior manager she had managed to engage the staff, which to a point she seems to have accomplished, she states that successfully addressing targets has 'required the organisation to understand its importance'. She clearly perceives senior staff as taking a negative position in relation to government targets and has attempted to persuade people that such targets are about good quality patient care. Another feature of the discourse slips in here – is her style of leadership perceived to be a bullying one? It may be that a group mentality, which takes resistance and dependency to be part of its culture, perceives a leader with a vision, or at least with determination (and 'focus' to quote Kerry) to be bullying them out of their emotional safety. This is a problem for any organisation that suggests to its staff that successful change and development is solely about strong leadership. We have to turn again and again to the clear message emerging from the data that without an

emotional attachment and the ability to manage their own emotions leaders and followers are not going to achieve goals related to patient care.

7.2.3 'Quentin'

Unlike Gerald, Quentin feels that he is succeeding in bringing about change and unlike Kerry he is mostly positive about the impact he is having upon the staff groups. He told two stories, one of which was when his leadership worked, and another where he continues to experience problems although he emphasised (to support his authority) that the latter was not a great a worry to him. In his interview he focused very much on the importance of personal authority: *"I'm still playing the trick of getting people to do things by example"*. He tries to back up his personal authority through making personal contact as much as he can:

You know my job could be answering my e-mails and I'm desperately trying not to. I've made a pact with myself that I will not explain myself in e-mail. If it needs to be explained I will go and explain it [personally].

He distinguished between the roles of the CEO and medical director, which in his opinion were *manager* roles, and that of clinical director which was a *leadership* role.

Quentin moves between the position where:

...people need constantly to be reminded of what they need to achieve ... [in relation to patient care] ...I use the word good care because [they] have the tendency to lapse into what is acceptable or even worse, what they can get away with.

To the position that:

And I think there is some requirement to continually challenge the organisation about what it is providing and sort of have a re-education process. And I guess we all need that – because I need that as well you know and it is one of my roles to keep reminding everybody why they are doing what they are doing.

Quentin sees himself as needing space to reflect upon the aims of the service provision and recognises that he is just as able to lose track of the organisation's main purpose as his colleagues/followers are, given the daily round of work. While Quentin gives an interesting example of how he and the team succeeded in meeting a target for patient waiting times in Accident & Emergency (which involved him engaging personally with the staff in an emergency meeting):

... which was all about persuading your senior contemporaries and peers. It's about the juniors, the people who are actually delivering the services. It's about making a reasoned argument. It's about being visible. It's about being honest and it's about delivering it.

The success, he believes, was about the personal contact and his own visible attachment in trying to change things alongside his colleagues and being very clear that " *...this needs to be achieved at all costs - which was quite liberating*". The rhetoric here is very different from that used by both Gerald and Kerry, who feel their colleagues are letting them down; possibly they are 'splitting' the 'bad' and projecting it into recalcitrant colleagues in order to feel reasonably good about their own positions (Klein 1987, 1983). Quentin is talking about success and success through *taking an emotional risk*. Saying that a change needed to be achieved at all costs (which he described as liberating) could be interpreted as Quentin making an emotional commitment to engage with his followers about something identified by the government, the NHS and his Trust as important. This stands in direct contrast to the experiences and rhetoric of both Gerald and Kerry who express the frustrations at what the 'others' are failing to do. However with what Quentin called a "*slightly different problem*". He has had great difficulty dealing with a doctor who is "*just a very difficult person to manage ... and I need to say to him 'this is crap and needs to be done in a completely different way'. I don't quite know why I haven't done that*". Once again Quentin was expressing an emotion – anger but without pushing/projecting blame on to the other, but being clear what the other person was doing and reflecting on his own sense of why, how and when he might take this issue up with the protagonist.

While Quentin operates with a quiet assurance and takes up his formal authority, and the power that accompanies it, from a classic Kleinian 'depressive position' (Klein, 1975; Segal, 1973), both Gerald and Kerry, despite their formal authority, fail to engage with their followers which leads to their powerlessness and a sense of rage and frustration.

7.3 Conclusion

The interconnections between power, authority and emotion play a complex part in understanding what leadership means to all those involved and in each organisational context. Leadership cannot be understood as something that can be observed and/or measured 'objectively', it is not an essential 'quality' which resides in an individual but is socially constructed, meaning different things to different people at different times. Following Ford (2010) a more contemporary, appropriate and critical approach to the study of leadership "*pays attention to situations, events, institutions, ideas, social practices and processes that may be seen as creating additional repression or discursive disclosure*" (Ford, 2010, p. 51)

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To be specific Rioch (Rioch, 1975), and others had made the point that *"'Leader' is a word which implies a relationship So the word 'leader' does not have any sense without a word like 'follower' implied in it".* (p. 159).

The relationship between leaders and followers might be more or less successful and in order to be a follower a person needs (even on a very temporary basis) to 'give over' something of themselves (i.e. make themselves emotionally open) to the leader for the relationship to have meaning. Being a follower may be both (or either) passive or active and there is the potential for the follower to engage and support, or subvert leadership (Bondi, 1997; Halton, 2007; O'Brien, 1994). Consequently, in order to analyse what it means to 'lead' in an organisation, understanding the practice(s) of emotional management alongside an analysis of power relations is fundamental (Grint, 2005; Schilling, 2009). For Foucault (Burrell, 1988; Foucault, 1982) power *"exists only when it is put into action, even if, of course, it is integrated into a disparate field of possibilities brought to bear upon permanent structures."* (1982, p. 788) Thus, while organisations give formal power to relatively few leaders (including in a distributed model of leadership) consent is still required for the power to be maintained. Furthermore, 'the other' that is the one over whom power is exercised, needs to be *"recognised and maintained to the very end as a person who acts"* (Foucault, 1982, p. 789).

The leaders we have described above all admit falling into traps where their authority has been challenged/resisted and they have been (potentially) made powerless. Quentin alone demonstrated awareness that he was working *with* people rather than treating them as resources. This meant that despite experiencing some frustrations, he managed to continue to *feel* and *think*, and with his colleagues/followers on board, *implement* changes. Kerry and Gerald, while attempting to take up their 'legitimate' power and lead change, both squander their authority through failing to manage and/or engage with their own and their followers' emotions. This is evidenced by their displays of frustration, impatience and anger with those who fail *to do what they are expected/commanded to do*.

Gerald held a classic authoritarian view of power, indicating that whether he takes people with him or not, he intends to get to the *'goals that I like'*. He also sees the resistant followers as stupid. He defines leadership accordingly, in that the leader should *'direct [the] team'* and not be afraid to *'face up to a fight'*.

Kerry sees herself somewhat differently even though she experiences anger and frustration when followers fail to do what she wants and expects. In attempting to empower her subordinates and set up the 'processes' to distribute empowerment (such as the meetings described above) she was left feeling disempowered following an (apparent) breakdown of

communication between herself and the senior team she tried to work with. That one of the interviewers also had to clarify: "*poor leadership on whose part?*" suggested that Kerry possibly re-experienced the rage and frustration she felt at the time of her encounter with the followers in her story when she told it. This rage obscured clear communication both then and in the telling. It might be that the overwhelming need to prevent the Trust from being '*in the bottom 20% of the country*' was a source of anxiety for her and the importance of achieving these specific sets of goals contributed to her impoverished emotional literacy.

Distributed leadership (Gronn, 2002; Mehra et al., 2006b), as a response to 'postmodern' organisations (Tierney, 1996) sets out the changing nature of authority/power. In combination with ideas from the emotional/social intelligence literature, distributed leadership suggests a more relational model of leader/follower relations whereby leadership decisions may represent both outcomes and inputs (Ashkanasy et al., 2003; Wolff, Pescosolido, & Druskat, 2002). A warning note, however, reminds us of the persistence of the patriarchal version of 'the' leader (Ford, 2010; Ford & Harding, 2008) which occupies the dominant discourse within which the notion of 'effectiveness' neglects (if not ignores) the importance of the management of emotions in the leader and followers.

Through the use of innovative research methods and data analysis, which take account of both conscious and unconscious processes through which leadership is socially constructed and exercised, the intrinsic complex connections between authority, power, emotion and leadership in the context of health care can begin to be disentangled.

Leadership that 'works' for an organisation such as the NHS is a multifaceted, emotional *process* in which leaders manoeuvre to manage their own and their followers' emotions and behaviours on both intellectual and emotional levels. To be effective in, what are now seen to be, postmodern organisational contexts, leaders also need to reflect upon themselves in their role and to understand the structural, cultural and emotional expressions of their authority and the authority and power of their followers. The legitimization of emotionally engaged leaders' authority supports effective service delivery across the different levels of the organisation through undermining conscious and unconscious resistance(s) as described in the examples above. Power as a coercive violence (see Foucault, 1982) has been exposed and undermined in such organisations and 'replaced' by concepts of 'distributed' leadership where the persistent claim to power is by definition and necessity more fluid.

8 Gender and Leadership

8.1 Introduction

Gender and leadership is an area that has attracted interest among policy makers and researchers, because the styles of leadership that are currently perceived to be the most effective, such as transformational and distributed, are believed to 'fit' more closely to 'feminine' styles of leadership. Fletcher (2004) notes that traditional 'heroic' leadership is usually associated with masculine traits (rather than men and women *per se*) such as individualism, control, assertiveness advocacy and domination, while 'post heroic leadership traits (such as empathy, community vulnerability, collaboration) are more associated with feminine traits. Ford (Ford, 2010) reconsiders the concept of *effective* leadership which is in fact a patriarchal model perpetuating an exclusionary and privileged view of the leader (metaphorically the 'father' figure).

Traditional research into gender, organisations power and leadership suggests that there are particular 'masculine' and 'feminine' leadership traits that are generally believed to characterise men and women's leadership styles (Rosener, 1990; Collinson and Hearn, 1994; Nicolson, 1996; Carless, 1998). Because women are widely believed to adopt a more democratic leadership style and men believed to adopt a more autocratic one, distributed leadership and concerted action in networked organisations may potentially be more conducive to those (women or men) who can adopt a more traditionally feminine relational style of leadership. Furthermore, feminine styles are more akin to displaying social and/or emotional intelligence (Guy & Newman, 2004; Leon, 2005).

In reality, both men and women display a variety of 'masculine' and 'feminine' leadership styles, depending upon their individual personality, age, position and the situation involved (Cross & Bagilhole, 2002; McDowell, 2001). However, gender *expectations* influence perceptions and beliefs and research suggests that subordinates are often more satisfied with leaders who behave in gender-typical ways than those who go against gender-type (Porter, 1992; Rosener, 1990; Williams, 1993).

Indeed, women in explicit leadership roles often tend to be viewed less positively than men, in the belief that 'masculine' traits (competition, authority, lack of emotion) conform more to expectations of how a 'leader' should behave but not how a woman should (cf. the work of Broverman et al. 1970). The 'paradox' it seems persists in contemporary organisations so that some women leaders feel they have to behave in a 'masculine' way which frequently makes them appear rather heavy-handed and/or as a 'bullying' because these behaviours do not fit with ideas about women (Eagly & Carli, 2003).

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Most of the women and (some) of the men we spoke to during the study, made a point of denying that gender was an issue in today's NHS, indicating that they believed that women and men were treated equally, with an equal chance of success. However, several participants also mentioned gender differences in the negotiation of power and identities describing how either women or men were likely to gain advantage through use of their gender-typed styles (Lewis, 2000; Schnurr, 2008; West, 1984).

Gender and leadership it seems remains a contradiction in people's minds but gender is a fundamental component of the discourses surrounding leadership in the NHS because of the demographic issues in clinical management and leadership (Evans, 1997; Gardiner & Tiggerman, 1999) and as we have shown in Chapters Four to Seven, role models and styles of leader/follower engagement have a major part to play in the transmission and exercise of leadership (Gill, Mills, Franzway, & Sharp, 2008; Greener, 2007).

We want to note here, partly in passing, although an example below (in the interview with 'Jeff')³⁴ demonstrates its importance - that the *researchers'* gender and physical appearance (age, ethnicity, attractiveness) also played an important role in the research process.

8.1.1 Senior women managers: 'we're all the same now'

Women in senior managerial and/or professional positions either deny that being a woman is an issue for them or for their organisation or that they know what they had to do to prevent being seen as a senior '*woman*', rather than a senior leader.

Denying the impact of your own gender on how you are seen and how you manage and lead is not an easy position to maintain and we observed some senior women working hard not to be seen as women even though at the same time they were arguing that *this behaviour was not necessary* because of the way 'things have changed'.

The researcher's observation of a senior female manager (Catherine) indicated that she thought that Catherine was trying to avoid being 'feminine' in her interactions. When the two interviewers were waiting to begin the interview, Catherine's PA came into the room with an important message but was shouted at in front of them. Thus in her notes one researcher judged that Catherine wanted:

....to indicate lack of interest and assume a position of superiority. Catherine was transgressing the boundaries of polite professional behaviour and attempting to define 'her' territory of the hospital. Answers to the

³⁴ Not his real name.

questions were also defensive, perhaps indicating a lack of self-assurance. Despite the tough exterior she obviously felt a need to stamp her authority on people in order to maintain control of the situation. This may partially be related to her gender and need to appear 'more masculine than the men' in a competitive environment.

The researcher following on from her observational notes with comments following the interview suggested that *"whilst she [Catherine] initially denied gender to be a relevant issue [for senior managers in the NHS], she then went on to make reference to 'testosterone' and 'the emotions of females' as problems in managing in her senior role".*

The relevant part of the interview transcript is below:

Q: Ok, so are men a problem? Are women a problem? Are there gender politics? Or am I just old fashioned there?

A: I don't think there are anymore, I think there were. I mean when I was appointed, I could have been one of [only] four [senior] women, so the whole senior management was very ... very 'suitish'. I don't think, no, I don't think it is a problem anymore. No, I think it is, if you talk to people in the north of England, they will say it's still a problem, and I think its a bit more of a problem to get females into acute trusts, big acute trusts, it's a bit of a climate difference. I think there's a lot less testosterone around now, there's a sort of slightly...erm I mean I've got quite a young male management team.

Q: Right

A: I find the testosterone and sort of challenges a bit much from time to time So I mean from that point of view, it is quite interesting, it does manifest itself. As do emotions of females really.

Catherine's somewhat aggressive, or at least uncompromising, behaviour witnessed by the researcher tended to soften after that and she added:

A; So I do think the answer to the question is that there are differences, but I don't think they're... they don't fundamentally affect how you do the job.

Vicki, a senior geriatrician, discussed the question of gender openly and at some length with the researcher who suggested that she had seen both Vicki and Mandy, another senior female consultant geriatrician, being very 'gentle' in their approach to patients and the researcher wanted to know how far this was linked to the fact they were women. Vicki thought though that their approach was not about gender but:

You know it could be a geriatrician thing, I don't know, ((1)) you know you'd automatically say 'it's oh because we're women', but I think it's only when you start following a few men around as well who are doing the specialty as we are, because the thing that attracts us to elderly care rather

than any other specialties in the first place, and that could simply be what you're observing.

It seemed important to Vicki that she was not stereotyped as a woman leader although she was keenly aware that as more women took up medicine and were arriving in senior positions that this demographic change would in some way impact on leadership.

So maybe that's where you've got to go as well as men in geriatrics you actually need to look at women in other specialties and follow them on a ward round and see what they do and that may be a good idea as well for the gender thing. But it's quite important for your study because at the end of the day we're training over 50% of women as doctors and in the future they think that almost all GPs will be women so that will affect the leadership and sort of, that you see in patient care.

So Vicki, while seeing feminine *characteristics* as more important in her clinical specialism than gender *per se*, still believes women doctors (e.g. GPs) will make different kinds of leaders from men.

During her shadowing of Mandy, the researcher noted what she identified as gender-typical behaviour:

Mandy also implements a mothering aspect to her leadership role (also noticed in Vicki) as she is always thoughtful and considerate to her followers, making sure they are comfortable and happy with decisions made and that they are up to speed with their medical knowledge. This mothering role also seeps into the delivery of patient care. Mandy is also a leader that appreciates the help of her followers and always thanks them for their input and help.

While keeping in mind that the researcher herself is making assumptions about what is a 'mothering' style and also recalling Vicki's assertion that it may be more to do with the kind of people who are attracted to geriatrics than gender itself, it is important to note that the researcher spent several days shadowing and observing female *and* male geriatricians. Further, she discussed reflexively what she saw and how she interpreted it with the research team to check out her observations.

8.1.2 Men: the 'natural' leaders?

The researcher who interviewed and observed Catherine also interviewed and observed Jeff (another non-clinical manager) and contrasted their styles of interaction with other people in the organisation, and with her, during the interview. At first Jeff seemed more approachable, relaxed and generally more amenable than Catherine had been:

Jeff was a newly appointed male senior manager. From the outset he displayed supreme confidence in his own authority and power as a 'leader'

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and obviously did not regard a young female researcher as a threat. He was very friendly and personable and happy to open up the space of the hospital for us, answering his own emails rather than through a secretary, coming to collect me personally from the main reception and chatting and joking all the way back to his office. Throughout the interview he showed confidence in his own opinions and was happy to talk in detail about both his own and others' leadership. This confidence may be a result of several factors such as position, age, class, gender or personality. He freely admitted that he did not mind appearing 'hard' or unpopular if it was necessary to get the job done, however he felt that his main asset was his own 'charm' and 'charisma'.

Thus Jeff firmly claimed his place within the (masculine) 'heroic' leadership tradition.

While Catherine was perceived as guarding her territory and demonstrating her power, Jeff appeared to be relaxed, being more approachable and particularly not hiding behind his PA. In fact, his account of himself in the interview was somewhat disarming.

Q And do you see yourself as a leader?

*A: Oh yes certainly. I can remember the time when I realised that I should be in management. I was working in a **** clinic in [a Trust] and it was so inefficiently run and I said as much to the manager. She said 'if you think you can do it better then why don't you manage?' So I said 'OK I will!' And I think I'm pretty damn good at it. I don't play by the rules, I don't have any formal qualifications, but I can get things done. I'm not perfect – I shout, I swear and mostly I'm just very, very cheeky, but I'm good with people and that's what you need in this job. You have to be tough too, take knock-backs and step on people to reach your targets. But mostly I care passionately about the patients. I would never ever chase a target if I didn't think it would improve patient care. So that's why I went into management, and I suppose the other thing is I discovered, I surprised myself actually about, I was going to say how easy it was, it wasn't easy, erm I had a natural aptitude to do it, you know it was something that I was successful in so you know yeah?*

Jeff wanted it made clear that the 'inefficient' manager was a woman and that he himself is 'good' with people (and on the surface the researcher acknowledged this). However, he also valued the tough, target-driven 'stepping on people' (masculine) qualities of his leadership which he believed were important in delivering patient care.

Jeff put his confidence and self-identified ability partly down to personality, but also to his gender and upbringing, adding that certain class backgrounds seem to 'breed' leaders:

I do think that great leaders are kind of born, but my background was that I was at all male public boarding school for 10 years. As my father said 'the biggest waste of money' given my academic erm qualifications at the end of it, erm and there was something there about you know that sort of environment. I mean does it grow leaders? You would think so, you look at the number of public schoolboys that end up as MPs, that's probably not a good analogy

Q:((Laughs))

A: But there is something about that kind of white middle class upper class upbringing that you have, and although I wasn't from that background before I went to the school, erm you learn survival among your peers, you learn I think to survive, you know if you think at the age of eight you are sent away you have to survive you haven't got your infrastructure.

It seems that Jeff is suggesting that leaders are either 'bred' or 'grown' but either way the influence that makes them a leader comes early in their lives. In the example he gives here, 'growing' takes place in a male-only context reinforced by social class, possibly wealth and a general sense of entitlement. This model does not echo the efforts and ambitions of the NHS in everyday practice nor would it appear to be in any way appropriate to the model proposed by the NHS (see Chapter One) which is focused on the type of leadership appropriate to managing and leading 'diversity' and 'difference'.

8.1.3 Gender wars?

Being motherly (like Vicki and Mandy) is not equivalent to being weak or compliant as perhaps some gender stereotypes might describe women (see for example Bem, 1993; Nicolson, 1996). During an observation of Mandy, the researcher identified what she considered to be a 'battle of the sexes':

Gender issues were brought into consideration during the interaction between Mandy, a female consultant and a male consultant. During this interaction a battle of the sexes and power occurred with the two consultants struggling for power in very different ways. The male consultant tried to assert his power through attempting to ignore Mandy's presence, never looking directly at her, but was raising his voice and being rude. On the other hand Mandy was always very polite, looked directly at him, spoke very softly and smiled a lot, although it was quite obvious that behind the soft smile was a vicious bite.

Perhaps this isn't so much a battle of the sexes but an example of how men and women might behave differently towards each other in the course of a power struggle. The detailed observation notes show the encounter move by move:

There are some territory issues with Patient 9 and Mandy is angry that there is a patient on her ward that is being treated by another doctor. She asks why the doctor has continued his care now that the patient has moved ward and suggests that if the doctor feels that he needs to continue with the patient's care then the patient should be kept on one of his wards rather than blocking a bed that could be used for one of her patients. She asks "why can't we look after this patient? We are not supposed to have any outliers on this ward!" Mandy's registrar Melvyn can not, or does not want to answer her questions and simply shakes his head and shrugs. Mandy says she needs to speak with the consultant and asks Melvyn who the patient is under. Melvyn gives the name and admits that he has seen him arrive on the ward a couple of minutes ago, so he should still be there.

Who is Melvyn afraid of here? Or is Melvyn simply not wanting to witness a battle over territory and patient care?

Mandy walks round the other side of the nurse's station to find the [male] consultant with three other doctors/medical students standing some distance away and his registrar to whom he is speaking. Mandy and 'our' group move over to his location and the junior doctors from both groups greet each other and share whispered conversations. Mandy stands patiently at the side of the registrar waiting to speak with the consultant. Although Mandy continues to smile pleasantly I think that she is angry or frustrated on two levels. First because the consultant is on her ward and hasn't come to speak to her and second, because he doesn't seem to have the manners to even acknowledge she is waiting. After the conversation between the consultant and registrar has finished the consultant turns his attention to his paper work and the registrar moves to be with the other doctors (some distance away) Mandy lifts her eyebrows up to Melvyn (clearly annoyed with the male consultant's behaviour) and then asks if she can speak to him about Patient 9. Mandy explains politely that they do not have outliers on this ward and therefore asks whether the patient could be moved to another ward or if this cannot be arranged she take over the care for the patient. While she speaks the consultant doesn't look at her and continues to write, his body language and behaviour are both arrogant and rude. The consultant says that the patient is his and he will not be passing the patient over as she has problems not solely aligned with geriatric care and that she needs a specialist. Although this was clearly a statement to undermine Mandy's capabilities she continues to smile and tell him that the patient will be moved before the weekend so that a patient needing specialist geriatric care can have a bed.

Moving through this detailed account the gender issue becomes obscured by the fact of Mandy's skill as a clinician, a leader, her concern to give appropriate care within a context of limited resources and her ability to handle herself in the face of rudeness and arrogance. These are skills that ensure she will shine through as a leader in any context but particularly one

which is still a man's world. In a socially or emotionally intelligent context where concerted action is seen as important, patience, politeness and clarity of purposes will eventually win out over arrogance and bluster. As we see in the next extract Mandy's 'opponent' does not possess these attributes.

The male consultant becomes angry and raises his voice to Mandy and says there is nowhere else for the patient to go. Mandy lowers her voice and says that the patient must have been on one of his wards before she was moved so she can move back. The other consultant looks swiftly at the group of doctors who are stood behind him (both his own and Mandy's) and then eyes me suspiciously before turning back to Mandy and speaking in a lowered voice. The conversation moves back and forth between Mandy and the other consultant and it is clear that despite his outbursts and undermining statements to Mandy that she has the upper hand and although she continues to smile, she is very forceful and strong in her argument and objectives. To conclude the whispered conversation Mandy raises her voice and tells the group that the patient will be transferred on Friday and that she will be getting a transfer set up straight away. She then thanks the other consultant for understanding and walks back round to the group with a smile on her face and asks Melvyn to set the transfer up.

This is a consummate example of patience, calm and the ability to lead doing what she considers to be the best for her patients, her team and her department. Her skills in continuing to be quiet, calm and smiling have 'seen off' the male consultant in the meantime but reading this it would be surprising if the humiliated man does not try to take revenge. Although there is very little evidence that this is anything other than a 'normal' power struggle it is the case that Mandy is in fact a woman and has played, what is mostly recognized to be, a feminine role.

Returning to male expressions of power it is important to be aware that blatant attacks, such as the one in the encounter above, are not necessarily the only ways of demonstrating confrontational masculinity.

It appeared from the interview with Jeff (discussed above) that he believed he did not need to defend himself in the face of gender stereotyping. He had strong opinions on women's leadership and also on women's 'availability' with no qualms about voicing these which contrasts strongly with women's accounts where they try to underplay gender, that is that many senior women take the view (overtly) that gender is irrelevant.

The researcher's notes about the meeting with Jeff continue describing a dramatic example:

Jeff's supreme confidence meant that whilst he came across well in an interview situation, he crossed boundaries of professionalism in other ways, telling unsuitable stories about staff and inviting me (researcher) out for a drink after the interview, invading my personal space. In the extract below

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he accuses a female colleague of not only being attracted to him, but trying to use her sexuality (unsuccessfully) to get ahead at work, whilst simultaneously flattering me that I am his 'type' by subsequently asking me to meet him for a drink.

And in the interview:

Q: And could you give me some examples of bad leadership that you've seen?

A: Well, Melanie Willson³⁵, have you met her?

Q: No I was meant to but she cancelled the interview three times...

A: Exactly, she probably thought she was too important to talk to you. Now I can tell you an interesting story about her. She's a good looking woman, stunning, very intelligent too. But there's something not quite right, I don't know what it is... really cold. She's got no soul. I appointed her as divisional manager and at first she was doing really well, but then she ran into some problems. She was failing in her job. And that's when she started to flirt outrageously with me. It was like she couldn't beat me intellectually so she was going to do it another way. But, well... she's not my type. And she was really jealous when I got this job, I had Lucy (PA) go and announce it at the morning meeting and you should have seen her face. Anyway I hear she's got a promotion now so she must be doing something right.

Melanie Willson clearly perplexed Jeff – 'stunning' but no 'soul'; 'flirting' to avoid being faced with 'failing' in her job; unable to beat Jeff 'intellectually' and resorting to using her sexual attractiveness. After stating that she was not his type (indicating that the flirting also failed) he then made another woman humiliate Melanie in a public context. The implication of her subsequent promotion being based on something other than ability was also a powerful 'aside'.

Discriminatory comments against women though are perhaps not that commonplace. Jeff's sense of 'entitlement' may be a dying one across most NHS organisations and it is certainly against all stated mores. Discrimination on the basis of gender is more opaque. The researcher interviewed Helen, a senior female consultant, and talked about gender and arrogance of male consultants. The researcher suggested:

... this was possibly seeing me as an ally as a young female professional. In addition to the immediately obvious behavioural differences between women and men she also mentioned unseen discrimination in the form of merit awards at senior levels and problems of combining work and family commitments which may mean female staff are less likely to achieve these.

³⁵ Not her real name.

In the interview Helen responded:

Q: Do you think there are any gender differences in leadership that you have noticed?

A: Yeah, yeah I think, I think so, erm you know the men are more well, can I, the men are less inclusive of a group and they have ((1)) already formed an opinion sometimes and before listening, erm, ((1)) err ((1)) yeah.

Q: Yeah ((laughs))

A: Need I say more ((laughs))? But I think there is a difference ...Competitive, that's what I was saying, there's that competition, yeah competitive, exactly ...Of course not but the insight is very, very small, and then those meetings go on and on and on and it's people trying to get one up on another so... I just want to leave. It's handy having a beep you know you can say 'oh, I've got to be off (laughs)'.

The suggestion here is that men are apt to waste time on each other and power struggles and that for them competition is central to their 'nature'.

8.2 Conclusions

Despite the increased numbers of women who have reached senior leadership positions in the NHS, both as senior managers (clinical and non-clinical) and as senior clinicians *per se*, there were nonetheless some interesting differences between women and men's self-descriptions and perceptions of others as leaders, sometimes made on the basis of gender alone (Gill et al., 2008). Descriptions given of leaders and leadership for members of the 'other' sex were also frequently gender-typed.

It may be that despite valiant and frequently effective attempts to change the culture of NHS Trusts that a 'traditional' view of leadership remains at least in the organisational 'memory'. This might go some way to explaining why women who are clearly powerful and influential are reluctant to identify themselves as taking up these more 'feminine' styles even though they may in fact use the skills associated with these qualities. Eagly and Carli (2003) make a case for women as having a leadership 'advantage' in contemporary organisations where the type of leadership required has changed. However, they argue that in many cases women have to battle against the inherent prejudices in male dominated organisations. Although there is still a reference to gender stereotypes when discussing gender in organisations and gender and leadership as we have seen from the extracts above in this chapter, as Rosener (1990) stated: "*Women managers who have broken the glass ceiling in medium-sized, non-traditional organisations have proven that effective leaders don't come from one mould*" (p. 119).

In Chapter Five the OCS revealed that women across all professions scored lower than men on 'recognition' in that they perceived their managers as

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not recognising their particular attributes as clinicians or managers and they also perceived that the organisational climate was one in which 'recognition' was more likely to be given to men than women. That men did not see this as a problem for them reinforces the view that regardless of trying to establish gender equality across NHS organisations it is still not embedded in the management culture.

As we have seen and has been well documented in the literature, it remains difficult for women to exercise leadership without their behaviours being construed as either 'weak' or 'aggressive'. The paradox is that leadership requiring more 'feminine' characteristics is at least explicitly more desirable in the contemporary NHS.

9 Patient Care, Leadership and Service Delivery

9.1 Introduction

The NHS has a history of reform/modernisation aimed at making patient choice and care more cost and clinically effective by improving the organisational structures through which care is delivered (Bate & Robert, 2002; Becher & Chassin, 2001; Darzi, 2008; Wilson, 2009) .

The NHS remains committed to its original aims of providing a cost and clinically effective patient care (Doherty, 2009; Phillips, 2005), at least partially through the NHS's organisational structures, including the gate keeping function of primary care, while providing a universal service free at the point of delivery. Since the 1990s patient choice has been added to the longer term commitment to efficiency (Bhandari & Naudeer, 2008; Bojke, Gravelle, Hassell, & Whittington, 2004; Bryan, Gill, Greenfield, Gutridge, & Marshall, 2006). And at the same time there has been an explosion in new diagnostic and therapeutic technologies accompanied by a public awareness of the availability, or lack of availability, of those technologies (Aberbach & Christensen, 2005; Greener & Powell, 2003; Mueller, Sillince, Harvey, & Howorth, 2004a).

In this chapter we particularly address:

- what respondents (staff and patients) say about patient care and service delivery based on the interviews and focus groups;

- what we *observed* about service delivery and patient care and particularly the *interactions* between clinical staff and patients *observed* and *described* during the shadowing.

As in Chapter Six the Trusts are conceptualised as open systems whereby high quality patient care (the input) corresponds with effective service delivery (the output) with the primary task defined as caring for sick patients (or those who are giving birth).

9.2 Defining patient care and service delivery

The thematic analysis highlights similarities across all grades, statuses and disciplines of the staff and the patients involved in the study. The themes that emerged consistently from the data that were about good patient care were:

1. Putting the patient first:

...of course patients do come first but actually really, on everything that you do, I mean everything you do you think of the patients (service manager in acute medicine).

2. Thinking about what is good for the patient (all the time):

I still believe and I believe to this day that if you absolutely concentrate on what the patients' needs are, all other things take care of themselves. it's about really showing that you care. I mean genuinely showing that you care about your patients, erm there's a lot of talk about also looking after your staff and caring for your staff. I think that's important but I think the health service has got itself stuck far too many times concentrating on the needs of the staff and not the patients (Chief Operating Officer).

I think that's what you have to make sure is that everyday you are thinking to yourself, 'am I doing this for the good for the patient?' 'is it the right way to do it?' so I think when you get eleven years down the line, one of the things is that you can loose sight of is that, very easily (Matron).

3. Awareness of the diversity in the patient's world (culture, family, age, home and work environments):

..it would be making sure older patients have high quality of care during their surgical admission (senior consultant Geriatrician).

you need to support your staff ... you know and you have to have an awareness of the different culture of the patients (administrator).

4. Making sure the patient received the care that staff would expect for themselves and their relatives:

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I would define patient care that of - if it was one of my relatives who were ill (senior manager).

5. Talking to patients about what has happened, their medical history and their clinical condition:

....if they talk to you one-on-one and you know where you're at (patient).

6. Safety and empowerment of patients:

They [the multidisciplinary care of the elderly team] believe that good patient care sits around ideas of timely discharges, safety, making sure the patient understands their condition and their treatment, empowering patients by allowing them to make their own decisions about their care (to a point), providing the appropriate treatment and care, being responsible for the patient. Examples of bad patient care are viewed as delayed discharges, poor decision making and discontinuous care. (Notes from an observation of a team meeting).

From the descriptions it is clear (and perhaps no surprise) that senior managers, clinicians and patients all hold slightly different perceptions which inform their judgements to give 'patient care' a specific meaning. Some of the judgements are related to their particular clinical specialty or organisational responsibility although generally respondents reiterated that patients need to be at the centre of daily practices. Patients in all cases wanted more than anything to be kept informed about their care, and if possible this should be done by the clinician in charge.

At a more complex level the definitions above reveal a 'vision' of good patient care which links the 'practical', 'professional' and 'political' elements of NHS life. It also links to the 'human' elements associated with the tasks of caring. For example, the Matron (quoted above) shows a revealing insight that the routine *organisational* tasks might take over as a perceived priority from what a person initially knew to be their primary task (i.e. patient care). As she says, several years down the line you might lose sight of what you are really there to do.

9.3 How is good patient care achieved?

9.3.1 Managers

Managers each have different levels of responsibility for delivering good patient care which may differ from priorities expressed by patients and clinicians:

Erm, that's the bit about lifting your eyes up off of the horizon, and lifting the eyes up above the horizon is about looking at the totality because the

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medical, again, the medical management model is very much that you should do what you need to do when the patient is in front of you. The management model, the pure management model is about doing the right thing for the 450,000 patients who were looked after last year, so some of that will be about compromising, and offering the best care to the widest group that you can (CEO).

Immediately this respondent exposes the potential for conflict at senior level in that he/she³⁶ positions the 'medical management model' differently from the 'pure management model'. In the former the patient is a particular individual with a health care problem – the patient 'in front of you'. However for senior management there are many thousands of patients that require good patient care which means (maybe) compromising to provide the best possible care to the greatest number. Despite this, another senior manager had a different 'take' upon good patient care and in answering the question focuses on what they themselves would expect evoking a more individualised model:

I would want good consultant input into my care ((1)) as soon as it was appropriate in the pathway that I was on. I would want to be able to have a conversation about what was wrong with me and what treatments and options there were, ((1)) erm ((1)). I would want the assurances of the people that deliver the care know what they are doing. ((1)) I would want the care to be provided in an environment that was clean and in an ideal world I would want a single ensuite room, err and I would like to choose my own food and all that jazz. ((1)) erm and the erm, ((2)) so really you want the environment to be correct and you want to have the confidence in the clinicians giving care and you want to have had input into what your care should have been (Senior Manager.)

This manager has a very clear model of their 'ideal type' which positions the relationship between the patient and clinician, the skills/expertise of the clinician and the physical space and environment as central to good care. There is awareness here that planning and teamwork are also part of the process of care but particularly important is the knowledge of how to deliver the appropriate care and information in order to facilitate joint decision-making.

³⁶ We do not want to risk identification of any individual participant.

9.3.2 Clinicians

Good quality patient care for most doctors interviewed was:

... making sure that erm the patient achieves the outcome that you would wish them to as a result of either their outpatient visit or their inpatient stay erm and that outcome is kind of on a objective kind of medical measure, erm but it's also in terms of the quality of the care that they've received and whether they are satisfied with the care that they've received. (Senior consultant)

Another senior consultant who is also on the senior management team of the Trust took the concept of patient care further:

... it should be delivered well I think is the answer ((laughs)). I think on the whole we do deliver it well, we have the lowest mortality rate in the country, ((1)) or one of them. I think we do actually and we ((1)) I'm very proud of the care and I think there are two things to be proud of and one is the basic care and ... we do emergency work I am very proud of. Then the other bit of care we're proud of is that ... I think there is a real culture of innovation and I'm trying to do something new up here, and I think that's actually really important in terms of leadership. My job is being able to see a clinician with an idea and then work out of him or her how to turn that idea into a self service innovation. I think that we have created over the last few years a much stronger patient safety culture.

This respondent clearly links leadership and patient care stressing both the relationship between supporting other clinicians in innovations that improve care (particularly attending to safety) while also being proud of the culture across the Trust for low mortality, innovation, and supporting staff. Crucially there is a pride and energy about this account. The culture puts patients first but the staff gain satisfaction and a sense of professional pride from the performance of the Trust as a whole [T3].

The clinician manager below takes up the relationship between staff empowerment (and support which links clearly to the outcomes reported in Chapter Five) and returns us to the focus on staff training and skills, indicating here that if the managers train and empower staff – services to patients will improve.

... it's about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is, we worked with training and development and we came up with a specific programme that was aimed at empowering them to improve their service area etc. etc. and

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also provided them with some skill sets that they probably didn't have prior to that. (Senior Manager, Therapies)

While from a similar perspective the nurse quoted below stresses that team work and morale mark the path towards good patient care and you need to look after *staff* in order to deliver a good service to patients.

... And I think it is also, sort of, taking into account the people they work with, the team members and boost the morale, and that can make a lot of difference to, you know, to have people at work and sort of take the stress levels off and I think, you know, it would sort of, quality certainly would happen, sort of energise them, able to care for the patient. (Nurse, focus group)

9.3.3 Patients

For patients overall it was clear that most of all direct communication and consistency of staff was experienced to be good care:

A: ... I've been transferred here from [another Trust] and there it's a bit more, not one-to-one but you see a lot of different doctors here whilst there [the other Trust] you have only one doctor, your one midwife and your one consultant. Here you see a lot of different people.

Q: And which one do you prefer?

A: I'd say probably just to see the one 'cause lots people tell you different things.

Q: Okay, so it can be a bit confusing?

A: Yeah, sometimes it can be, yeah.

The patient quoted below reinforces the need for clear patient/clinician contact and communication.

For another woman:

Now whilst I'm here my care has been very good especially with the [specialist] who first saw erm, who first flagged up the problem. Erm yep it's been good it's been good since I've been in. It's just the initial communication as an outpatient to an inpatient I should have really - you know that should have been. I don't know where the fault lies but there should have been some communication there between the appropriate people (Maternity patient on postnatal ward).

9.4 Delivering patient care

9.4.1 Doctor-patient interactions

We look firstly at three consultants' (Cameron, Kenneth and Henry) styles across two different Trusts as they interact with patients to explore the importance (or otherwise) of good communication and engagement. What emerges, perhaps unsurprisingly, is that different consultants have different styles of engaging. The style adopted though feeds through to the 'ethos' of the clinical team, relates to, and impacts upon, the culture of the Unit thus affecting the doctor-patient interactions as part of an evolutionary cycle.

9.4.2 Empathy and Communication

9.4.2.1 'Cameron'

From the researcher's notes we gain an impression of Cameron who deals mostly with stroke patients for whom verbal and non-verbal communication may be very restricted:

Cameron offers a very personal and individualised style of patient care to his patients. He is often very tactile often rubbing the tops of their hands, arms and heads to encourage them or to show support when he is discussing difficult problems with them such as their inability to go home, the definition of a stroke and the future impacts of them having a stroke. He also speaks to the patients in a very friendly and informal way and sometimes draws on their mother tongue to say a few phrases to make them feel welcome and at ease.

In his interactions with his patients he is very positive and upbeat, often speaking loudly to encourage and motivate his patients. He also tries to share a few jokes with them and breaks down doctor/patient power relationships by crouching down in front of his patients or sitting on a chair or their bed so that he is always the same height or lower.

This description alone demonstrates how Cameron's *behaviour* relates to several of the descriptions above which identify good patient care in that he:

- communicates (verbally and physically)
- takes care to acknowledge their humanity through recognition of their cultural (linguistic) heritages the fact that they have a life outside the hospital
- attempts to empower them within the relationship (at least via discussion and physical presence and to an extent with knowledge of their condition).

Below is a detailed example of Cameron (and his team's) encounter with an elderly stroke patient (Mrs. D) which is part of the evidence the researcher has employed for her assessment of the processes engaged by Cameron in his provision of patient care:

"Hello Mrs. D? (Patient nods head and smiles) do you have a headache? (Patient nods head) Do you know why? (patient shakes her head staring wide eyed at B). "OK, I'll tell you..." Cameron sits on the edge of the patient's bed and explains that she has had a stroke and she has a headache because sometimes patients who have had strokes will have suffered from headaches due to pressures on the brain. The patient stares and nods her head occasionally as Cameron explains. "Mrs. D, do you understand what I have just told you?" (patient nods her head and then croaks "yes") on this speech Cameron sounds surprised and encourages her to speak again "Oh wow Mrs. D, that sounded good, can you say something else for me?...well done". The patient looks up at the doctor and smiles croaking again "I don't have anything to say doctor", "well never mind Mrs. D, I am sure I can get something out you a bit later!...excellent, your voice seems to be coming back...isn't that good?. We will have you singing in no time!" (Mrs. D. smiles and shakes her head "can't sing" Cameron smiles and laughs.

Despite the clear power differentials, doctor/patient and healthy/unhealthy, in this relationship Cameron is doing what he can to encourage and communicate effectively with the patient. Not only does he literally get down to her level by sitting on the bed but he explains the condition, how it happened and communicates the indicators for (potential) recovery. He is respectful and careful although the intellectual/cultural difference between the patient, Cameron and the care team is exposed by the encounters below.

"Now Mrs. D. can I examine you?" (Patient nods her head) Cameron takes the patients hand and she flinches "cold!" Cameron smiles and apologies saying it that "it is the alcohol" (alcohol gel he had just rubbed into his hand). The patient eyes Cameron suspiciously "have you been drinking?" the group laugh and Cameron explains that it is the hand-wash and she nods slowly and looks at each member of the team for what seems confirmation that this is the truth. Cameron then begins testing the patient's strength. He checks her arms and then her legs with simple strength tests calling out numbers between 1-5 for the SHO to write in the notes. As he instructs the patient with her tests he speaks very slowly and loudly and the instructions are very simple and clear and he often demonstrated his instructions, especially for those patients that have cognition problems. As the patient does the task Cameron is very encouraging shouting words such as "good", "excellent" or "well done after

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each task". After the strength tests Cameron checks the patient's reflexes with a small hammer. Again he shouts out numbers and makes comments about the reflexes that the SHO writes down in the notes. Following the reflexes Cameron checks the patient's facial muscles by asking the patient to smile, grit their teeth, stick out their tongues and move them about. He then checks her speech by asking her to repeat phrases or noises after him. The first phrases or groups of words were given as words that would be familiar to the patient such as the patient's name or names of simple objects such as pens. As the patient is able to say these words he moves on to more complex words such as "hippopotamus" which the patient struggles with. Cameron then checks the patient's ability to co-ordinate by getting the patient to touch her nose and then his finger with her index finger. The patient clearly struggles with this and is very slow and inaccurate.

For a brief moment after the tests Cameron has a quick discussion with L [another doctor] asking him what he thought about the tests and what they would expect to see on the CT scan. Cameron then turns to the patient and says "sorry Mrs. D, just discussing your test results with my colleague, we think that you are progressing very well...there has been much improvement hasn't there?" the patient stares blankly at Cameron for a brief moment before shaking her head "no, you don't think so? Now what about your speech, when you first arrived you couldn't say a word, now listen to you, don't you think you have improved?" patient shrugs her shoulders and looks down at the bed. "Well Mrs. D, we all think you are improving...so well done..." patient looks up and smiles sadly.

The style of meetings between clinical staff and patients was as much a feature of *Unit and team culture* as of a particular clinician's practices. Thus, while Cameron above was engaging with the patient in what appeared to be a *genuinely caring* manner, his colleagues were attentive, while in the background.

9.4.2.2 'Kenneth' and 'Henry'

In what follows two consultants worked together and while Kenneth was the more senior and experienced clinically, Henry held a senior managerial role (as well as being a senior consultant). Kenneth was described by the researcher as:

... a very warm and caring man ... he is very sweet, kind and caring to his patients and makes them feel comfortable and less vulnerable by empathising with them and drawing on his own personal experiences as a patient.

As with Cameron above, Kenneth was also described as 'tactile' and that he took the time to explain things to patients. Kenneth empathised with patients by sharing a joke (as did Cameron):

For example one lady was embarrassed because she had fallen down in her flat and sustained injuries and did not really want to explain how she had fallen over or what she had hurt [to the whole team]. Kenneth then told the patient that he had slipped over in the hospital and in the M&S food section. This meant that she no longer kept quiet through embarrassment and told Kenneth after that exactly what had happened.

However, during the two day shadowing of Kenneth the researcher was particularly:

...struck by how intimidating this group of doctors must be to the patient, especially an elderly or vulnerable patient as a large group of faces arrive at their bedside and close the curtains around them making the space feel incredibly claustrophobic and that the patient's space felt 'invaded'.

While shadowing Kenneth, the researcher was in a position to observe Henry (who was also shadowed for two days on a different occasion). The researcher's notes here, which describe a joint ward round with Kenneth and Henry, state:

I was struck by how impersonal Henry was towards the patients [in direct contrast to Kenneth]. He did not greet them or introduce himself. [In one case] Instead of asking the patient how she was getting on with the oxygen machine Henry asks the SHO how she thought the patient was getting on with the machine. When the patient tried to give reasons they seemed irrelevant to Henry who just told her she must use her oxygen machine every day or she will not get better.

The researcher goes on to describe how Kenneth (the senior clinical consultant although Henry has a senior leadership role) stands quietly behind the junior doctors on the round with Henry at the front of the group talking to the patient. Henry stands up. Kenneth stands at the back of the group with his hands folded behind his back and Henry every so often asks Kenneth if he agrees with Henry's thoughts on the patient's health status and treatment. While Henry is taking the lead in this way the researcher notes:

Not one of the doctors explains to the patients what will be happening to them that day or beyond nor do any of them say goodbye.

One patient on Henry's round is in the bathroom as the team arrive at her bed.

Henry knocks on the door of the bathroom and says "Mrs. X, it's Dr. Henry we are all here to see you". He then asks a nurse if she can hurry the patient along as he is very busy. It seemed strange [to the researcher] that Henry could not have just visited another patient until this patient had finished rather than rushing her. Before the nurse can enter the bathroom another nurse pokes her head out from behind the door and says that she is washing the patient. Henry asks whether this could be finished after he has seen her. The nurse, who looks frustrated, says she will be a minute. The nurse then helps the elderly lady to shuffle to her chair and helps her sit down. Without greeting the patient Henry begins talking over the patient's bed about her X-ray that was taken yesterday and then asks the nurse about the patient's progress.

In the examples above describing both Cameron and Kenneth's interactions with patients there is evidence that the patients were given a chance to explain to their consultant how they felt and either to tell the doctor what had happened to them or to hear the doctor's explanation of why they felt like they did.

The patients were treated in both these examples as human beings and in doing so the doctors themselves positioned themselves in their *clinical role* but also as *people occupying that role*. By acknowledging mutual humanity (albeit in different styles) these doctors were able to *take authority* from their position as medical experts (see Chapter Seven above).

By contrast Henry also took authority but did this by silencing junior colleagues, Kenneth his fellow consultant and most importantly, the patients. While Kenneth and Henry were in the same Unit, the scenario described above suggests that Henry held more power and therefore exercised greater influence on junior colleagues (and this fed into the culture of the Trust).

In what follows we trace how these contrasting styles might link to the culture of the Units and the teams themselves and consider how this fits in with the definitions of good patient care and service delivery.

9.5 Clinical team work and service delivery

9.5.1 Giving patients care

Miller and Gwynne (1972) suggested that a 'warehousing' model of care operates for those who may be institutionalised in the medium to long term which they contrast with the possibility of a 'horticultural' model of care, akin to what might be identified today as a learning environment. Working in the care of the elderly takes its toll on the emotions of all the clinical staff

particularly in the 'horticultural'/learning setting, where efforts are made to ensure two-way communication and mutual understanding and development takes place. This can leave clinical staff open to experiencing directly the pain and distress experienced by their patients (see Menzies-Lyth, 1960 and the 'stories' below).

The following example demonstrates how engagement between clinicians and patients impacts emotionally upon even (and possibly especially) senior experienced staff. The researcher here, shadowing Mandy, a female senior consultant describes the following case:

Whilst cleaning up a suppurating wound an elderly male patient cried. It was a really touching and sad moment and Mandy was clearly distressed that she had hurt the man. On first seeing him cry Mandy appeared to have a moment of shock/panic where she looked amongst her team to find out whether this was normal behaviour for this patient. On hearing the answer was 'no' Mandy tried to soothe the patient and seemed genuinely sorry for hurting him. The nurse who arrived at the scene also appears to be genuinely concerned about the patient and goes over to help Mandy and prevent the patient from crying. This scene was particularly sad because in today's society and especially in the patient's generation it is thought that men don't cry or show emotion. For the man to cry he must have been in severe pain and must have been struggling with himself to prevent the tears. Mandy's genuine empathy and somewhat guilt might have reflected that.

Mandy and the nurse in this context are using emotional intelligence (see Chapter One) in a relevant situation. Mandy also engages in conjoint action with the nurse rather than take action in an autocratic fashion without consultation. Mandy notes the patient's crying with a start (according to the description) and instead of continuing with the work on the wound (which many doctors might well do because it was necessary for a positive health outcome) she immediately appears to take in the context as a whole – thinking about her patient's behaviour and reactions. The nurse in this case mirrors the behaviour of the consultant. This is an important issue for discussions of leadership and patient care in that teams tend to reflect the beliefs and actions of their leaders.

9.5.2 Discussing patient care

In a shadowing the researcher at the start of the observation describes in detail the way two doctors discussed the patients before embarking on the ward round. This is another case of concerted action:

09:00 Breakfast meeting with Cameron [T3]

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Once they have consumed their breakfast Cameron and Mandy turn to business. Cameron begins by asking Mandy's opinion on one of the patients that they had seen on the ward round that morning. They chat for a couple of minutes about the patient before both getting a patient list out and going through the names systematically and discussing their care plan for each patient. Several patients will need to be discussed in a patient case meeting as they have complex discharge problems, others will need to be referred to the CCP so that a greater social package will be considered. Mandy says that she will go and see a few of the patients herself later and occasionally delegates tasks to do for Cameron, but mostly he is autonomous and says what he needs to do for a patient and what he will organise on behalf of the patient.

This is a quiet and supportive meeting between Mandy the senior consultant and Cameron the more junior member of the team. However, the researcher notes the systematic discussion of the patients and their care along with a plan about who Mandy will see and how Cameron's tasks are designated.

A similar atmosphere of calm and authority are evoked by the description of a case meeting with Cameron's team at the start of the first day of shadowing:

I approach the nurse's station and look around to see if I can see Cameron. I spot him at the far end of the ward sat at a computer with a mixed group of staff (doctors, nurses) surrounding him. I approach the group and stand amongst them. Cameron is facing the computer screen and discusses a CT scan with his registrar [L].I notice that as these two doctors discuss the scan a SHO writes notes in the patient's file occasionally craning his neck to look at the scan at certain parts of the discussion. A few nurses also crane their necks at various points but most just stand patiently in silence waiting to visit the patient. Once the discussion draws to a close Cameron turns his head from the computer and asks the team if they have anything to add. ...[later on in the same meeting the researcher listens to a telephone conversation] ...Cameron has rung the wife of a patient to update her on her husband's health. He is very honest with the wife saying that her husband has had a second stroke during the night at that he is now in worse health. Despite the bad news Cameron is very friendly and pleasant with the relative and is very sympathetic to her questions and on several occasions empathises with her. Coming off the phone Cameron returns to the team and gives a brief update to L regarding the conversation with the patient's wife. The SHO writes this summary in the notes. Cameron takes a short sharp breath before asking "shall we go and visit the patient?" Cameron turns quickly on his heels and enters the ward.

The observation here reveals the high workload and 'multi-tasking' undertaken by the team (looking at the computer, discussing scans, taking notes, calling relatives and so on). But there seems to be focused attention on patient care and individual patients. At the end of this extract it also seems that Cameron himself takes the ward rounds very seriously – gathering his mind together and possibly seeking the emotional strength to move from the clinical team and considering evidence from notes and colleagues to imparting and collecting information from the patients.

The same researcher who has shadowed both Kenneth and Henry at a different Trust from Cameron, gives examples of how some of Henry's patients are discussed. For example she describes a meeting to discuss patients chaired by Henry.

Henry criticises the way [Site B] is run and the management of beds and patients by that hospital. He praises the doctors for the current situation on [Site A] where they have spare beds stating that they have done so well in 'kicking them out'. Henry stated during [a previous meeting] that the patients needed to be removed or 'kicked out' of hospital as soon as possible. The rapid turnover of patients may on the surface appear that they are not receiving good care However getting patients home quickly reduces the risk of hospital acquired infections.

And is likely also to be what many patients would want.

As the researcher makes clear, it is important not to confuse the rhetoric with the quality of patient care, but rhetoric does determine and reflect a dominant ward or Unit culture.

9.6 Responsibility for patient care

Responsibility was a key element of the discussions of leadership particularly in Chapters Four and Five. Responsibility for individual patient care is in the hands of clinical teams led by the medical consultant but above that person is the clinical leadership/management (Clinical and Medical Directors) as well as the senior operational managers (CEO and COO and others).

Primary responsibilities for patient care however vary from *individual care* i.e. for both identifying care pathways and day-to-day care to responsibility overall for the care of all the patients. In Chapter Ten we review the findings from this study with some recent cases where responsibility has been mishandled to explore what lessons might be learnt.

In an interview with a consultant:

... we try to just have a really open forum where we can discuss that [specific patient care], just like open it up and letting people put their viewpoints first and then kind of trying to question where they're coming from with that in a positive kind of way but them also laying out where you feel that that might not be the right course of action. Erm and also at the end of that discussion making sure that everyone is happy with the outcome, and sometimes people aren't erm .. but it also realising that it is a consultant's responsibility at the end of the day and making sure that everyone knows that you're happy making that kind of decision and that you are happy to be made accountable for that decision.

9.6.1 Responsibility for emotion

It frequently falls on the clinical leader to cope with their own, the patient's and the relatives' emotional reactions and distress and also with those of the other members of the team. As the researcher noted:

One senior consultant, Tricia, made it clear that as the clinical lead she also took responsibility for talking to patients about DNR³⁷ forms and delivering 'bad news' to patients/ relatives. During the ward round Tricia removed the pressure from a junior member of the team who had been told by a relative that they didn't want their mother to be resuscitated. Being told this information had stressed out this junior member of the team as he was not yet ready for this type of responsibility. Tricia supports her junior colleague saying that he should have never been confronted with this situation.

One question here then is how do the clinical team handle such multi-layered emotional problems? How important is leadership in supporting (and developing) teams to cope?

9.6.2 Responsibility for teaching

Most clinicians in the study from all disciplines were interested in teaching the next generation, and their activities will influence patient care, provide role models for leadership and influence climate and culture of the organisation. The example below is chosen because Dr. Jenkins was very enthusiastic but also demonstrated compassion and courtesy when he was face to face with the patients. The researcher's notes describe this in detail:

Approaching the patient Dr. Jenkins shakes the patients hand and says "how are we doing today?...I see you were referred by your GP...you have a

³⁷ Do not resuscitate.

wonderful GP" (he comments on how wonderfully clear and precise the notes are). "That's not my GP, that's my missus's GP, mine's on holiday...I have Dr. U. U". "What a name! But looks like they have to wonderful GPs at your practice...the notes are seamless...you are lucky!" Jenkins then continues to ask the patient about his medical history. The patient is able to tell the doctor his entire medical in great detail including the drugs [more description from the researcher]. Dr. Jenkins stops the patient and asks the medical student to take a mental note of how a good GP leads to a well informed patient, which helps him (Jenkins) in his (patient's) treatment. He talks about 'aspects of professionalism' and the right ways of informing patients about their treatment and condition, he openly praises the patient for knowing so much about his patient history and tells the students that "medical history in patient care is so important". The patient begins talking about his treatment in the hospital and Dr. Jenkins states that "patient feedback is great, and they like to hear about it...we need to be more professional...primary care pathways are the key to patient care".

Dr. Jenkins behaves with humour towards the patients and the students and junior doctors but does so while continuing with his assessment of the patient, taking the relevant history and trying to impart good practice and professionalism. He manages to balance giving the students and junior a chance to gain hands-on experience while making sure he himself has all the information he needs for the care of the patient.

Dr. Jenkins then checks the patient's lungs and heart asking a SHO, Dr. Williams to check the cardiogram as he can hear an AF flutter. As Dr. Williams looks for the chart the patient tells him that his GP had thought the same and that is why he was thinking of changing his drugs. Dr. Jenkins looks at the students and says "wonderful isn't he?" he continues that the GP must have heard or felt it himself [the heart condition] and now they will need to see the chart to prove it then they can change the drugs as the GP had predicted. After looking at the chart Dr. Jenkins asks Dr. Williams to change the drugs and to get rid of one of the drugs he thinks are unnecessary. Dr Jenkins shakes the patients hand when he leaves and says that one of the juniors will be back later to sign off the new drugs.

Looking over the notes Dr Jenkins spends a lot of time teaching the [medical] students about various medical conditions and treatments that have arisen out of [a particular] patient and asks them to suggest other possible diagnosis and other treatments for his condition. Jenkins is a very enthusiastic teacher and the enthusiasm rubs off on the students who are all eager to share their knowledge and take stabs at questions they don't know. In the middle of the question and answer session he asks one of the students "what year are you in? I don't know how much you guys know already". The student base is a mixture from students from [different

schools] and he relishes the opportunity to teach the students some new medical knowledge. Whilst getting the students to look at the cardiogram he looks up and apologises to Irene [matron] for taking so long on his ward round "Sorry Irene, I will be here all day, this is such a pleasure to have students!" Concluding the teaching session he quotes someone for saying something about the health of gamblers and drinkers and then asks "now who said that?" the students look round each other and then he exclaims "me mother!" all the students laugh including the female registrar and Irene. He then ushers them onto the ward saying that he doesn't want to get in trouble with the matron.

9.6.3 Subverting responsibility

There are diverse ways that staff at both Trusts had for coping with emotional aspects of patient care and resisting authority (and thus taking responsibility for care into their own hands). One way that nurses (including senior nurses) operated was to *subvert* some of the doctors – particularly when the relevant doctors showed little interest. The shadowing of a senior nurse [Irene, the matron] during a ward round produced the case of Lola (described when shadowing Irene):

Irene tells me it is because many of the patients are elderly with complex cases and therefore they tend to stay for a long time. I note that one of the patients has been here for a long time and I ask whether due to the long length of stay on the wards whether she becomes attached to any of the patients, I point particularly to the patient who had been here for three months. Irene says, 'oh that's Lola, mmm has she been here 3 months?...let me check her notes'. Irene leaves the file that she is reading and picks up Lola's file and looks at the admissions page and then states (sounding surprised). That three months is correct. She then continues that she does find herself getting attached to her patients, especially if they have been here as long as Lola. She mentions that Lola should really have been moved to G Ward but she really doesn't want to move her 'she should be elsewhere, but she is ours' (highlighting emotional attachment and the sense of ownership over patients). She tells me that Lola is really sweet and all the nurses really like her and it would be quite strange if she was no longer on the ward as she is a returning patient and 'it is always nice to have her back'.

As we have suggested in Chapter One (and witnessed above), in order to protect one's self against anxiety clinical staff often 'split' patients into 'good' and 'bad'. Here the treatment of Lola indicates that the nurses may be using their care of her to defend themselves against some of the harsh treatment decisions made about other patients (by doctors and managers) particularly when there is pressure to discharge older patients due to bed

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shortages. This might lead them to consciously and unconsciously subvert these authorities when they can and there is a particular pleasure to be gained when they succeed in this 'subversion' with a 'good' patient such as Lola. What remains at stake is whether Lola's stay is actually benefitting her clinically (or even socially) and also whether it is preventing another patient receiving medical care.

9.6.4 Responsibility for end of life decisions

Responsibility for patient care resides not only with the clinical team but is sometimes shared between the team, the patient or the patient's closest relatives which is usually the case with end of life decisions. Sometimes the greatest emotional engagement is with the *relatives* of the patient rather than the patient themselves. This is particularly the case when the patient is likely to die which is particularly sensitive when it is a case of withdrawing life support. The following example of Cameron's Patient G and his daughter brings this into sharp focus.

The biggest emotional situation this day surrounded Patient G, a coma patient and his daughter. Cameron had to encourage the daughter to agree with his plan that her father's treatment should cease and palliative care take over. This is a very emotional situation especially due to the young girl's age but also because she was in 'denial' asserting that her father would get better and this caused her to present a whole range of emotions that Cameron had to deal with.

We enter the side room. The blinds are drawn causing the room to be quite dim. There is a young girl sat up right on a make-shift bed that she has made from four visitor chairs from the lounge. She has a blanket over her legs and is typing on her lap top her mobile phone ear phones in her ears and bags and other items are scattered around her chair. She looks up as we enter and pulls the ear phones from her ears. I am surprised at how young she is, I had expected a daughter of forty something not a teenager of 18 perhaps, but no more than twenty. She pulls the covers off her legs and places her lap top on the window sill. Cameron asks if she is ok and she nods and says she will leave him to it. Cameron says that he will bring her in once he has examined her father, she nods and opens the door pulling her jumper down over her leggings as she leaves. Cameron looks at me and comments (adding to what I was already thinking) "I think she is far too young to be dealing with this on her own....it is not fair".

He turns his attention to the patient and begins speaking loudly to him. He explains that he is a doctor in [Trust 3] hospital and that he wants to examine him. At each point of examination Cameron explains to the patient what he is going to do. Cameron is able to move the patient's limbs like he

is a doll. Each time the limbs are placed in a position they remain there. The patient doesn't respond to any pain stimulus as Cameron pinches the patient's skin and scratches the bottom of his feet with a stick. Cameron then checks the patient's eyes by pulling back the patients eye lids, the eye lids roll from side to side and Cameron explains that it is called a coma roll, which suggests that the patient is in a deep coma. Cameron teaches W by the patient's bedside and talks him through the patient's condition and talks about how the patient's recreational drug habits could probably have contributed to his stroke. Cameron and W engage in a small conversation about the problems of cannabis on the brain.

Cameron made the decision in consultation with his team to discuss with the daughter that they need to end the patient's treatment (and thus in all likelihood, his life). Cameron deals here not only with the daughter's distress but with the daughter's worry that she is involved in the decision to let her father die. Again a high degree of emotional intelligence and leadership as well as clinical knowledge operates in this communication.

While shadowing Owen [Trust 2] the researcher sees that while behaving perfectly correctly he puts emphasis on the clinical and health related aspects in an end of life situation above communication and empathy. He is not unkind but 'misses' the emotional level of communication. Here in the presence of a daughter and father the woman (mother/wife/patient) is clearly dying and being kept alive by the clinical team. Owen:

... talks directly to the daughter stating that her mother is coming to the natural end to her life and therefore she [the mother] is giving up - 'withdrawing from life' and tells the daughter that although they will feed her through a tube she [daughter] should prepare herself and her family for the inevitable. He also says that her mother will also start ripping the feeding tubes out to prevent herself from getting the right nourishment.

The image conjured by the 'withdrawing' from life and 'ripping' feeding tubes is dramatic and seems to give agency to the dying woman – almost indicating that somehow she is to blame as she will prevent herself getting the right nourishment. However, the researcher, as participant in this encounter, is bringing out a sense of the culture of this particular event. While Owen is probably protecting himself emotionally from the loss of life and the sense of clinical 'failure' he does not protect the daughter or the husband from the emotional onslaught of the woman's impending death.

The daughter says that she understands and turns to her father and says 'dad do you understand what the doctor is saying?' the husband paces up and down the side of his wife's bed looking lost and lonely. He looks up at Owen and says that his wife is giving up because someone at the nursing home said she was a burden. The daughter scolds the father for saying that

in front of her mother. She explains to Owen that although she [mother] doesn't say anything she listens to everything and the more her father says it the more she doesn't eat. Owen says he understands and asks how the family is coping.

The daughter here is also protecting Owen from the family's pain by scolding her father even though Owen asks how they are coping. However, although kind and polite, Owen does not seem to operate with emotional intelligence or engagement with others' pain.

The daughter says that her father is finding it very difficult because he is the main carer for her; she herself has taken time off work to care for her when she can to support her father. As she speaks about her father and how upset he is becoming she begins to become tearful. Owen listens to her as she speaks and occasionally asks further questions. The husband continues to potter around the room occasionally touching his wife's head and face. The daughter watches him.

Owen, while allowing the daughter to cry and not acting as if he is irritated or embarrassed, equally pays little heed as he continues to talk of the mother's deterioration.

Owen begins to talk about the deterioration of her mother and what they will be able to do for her. The daughter says that she knows what Owen wants to talk about 'you're talking about DNR aren't you?' Owen says yes he is and the daughter tells him that she knows about it because her friend's mother recently died and this was discussed with her. The daughter says that she knows what she would prefer but they will have to talk this through with her father. The daughter calls her father over and begins explaining DNR. He looks at his daughter, he looks lost and scared and she tells him that it is his decision but she thinks that the doctors should not resuscitate her mother because she will be resuscitated to the same state. Owen inputs that she will be 'worse' than how she is currently because she will be a lot weaker. The daughter says that she will have to talk through this with her father. Owen nods and leaves the room.

9.6.5 Stories of patient care

The following two stories show in detail the ways in which responsibility and power can shift between team members and highlight anxieties faced by doctors about caring for patients.

9.6.5.1 A story of system failure: Cancelled Clinic

The first story is told by a female registrar who describes a situation in which she felt disappointed with patient care due to cancelled clinics. In the

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following account, the narrative is broken down to four moments, and each is discussed to demonstrate how the doctor's anxiety is managed by being linked to a failure in 'the system' that climaxes in her interaction with patients.

Q: What about any time or incident that made you feel disappointed with patient care in this hospital?

A: Lots of times, particularly since we've not had a secretary. Every clinic, every single clinic I send somebody home because the notes aren't there at all. They are supposed to be coming to see the consultant [her immediate superior] and he's not there, and they've been put into my clinic and you look at the letter and it clearly says on the letter 'consultant only to see', and they turn up and he's in Italy, on holiday.

The registrar is expressing frustration. On the surface it is towards a recurring failure in patient care attributed to firstly not having a secretary and secondly because the consultant 'is not here'. The expression of the frustration however is confused; there is no secretary but the patients 'have been put' into her clinic. Furthermore, she sends someone home from each of her clinics because the notes are not there. The letter 'clearly says' the patient is to see the consultant who is not only not there but he's in Italy 'on holiday'. There is a feeling of being overwhelmed, and of rage and envy towards the consultant - and possibly the patients - emerging from this short paragraph (for discussions of workplace envy, see Vidaillet, 2007; Stein, 2000). There is also an expression of omnipotence in that she sends patients home. She has the 'legal' justification to do so because there are no notes and also because their letter says they have to see the consultant and the energy is directed towards this activity rather than getting patient appointments changed. The consultant is on holiday, presumably one to which he is entitled and one which has clear boundaries enabling them and the staff who make the appointments to re-arrange the patient dates.

There is clearly a high degree of frustration and anxiety present in this account; there are too many patients with 'needs' and not enough clinical or support staff backing the work in the way in which the doctor would feel comfortable with. As there is little opportunity either to express or assuage her anxiety so she becomes 'prey' to primitive phantasies and unconscious mechanisms to relieve the anxieties.

The story also sheds some light on doctors' anxieties about working in a multidisciplinary team. Medical education and postgraduate training provide a culture in which doctors believe they can rely on each other through which a sense of being an elite group and confirmation of professional omnipotence and responsibility - particularly of the consultant - arises. However the role of the consultant also brings about a sense of envy and

destructiveness in others which has its origins in the primitive defence mechanism of splitting off the painful parts of one self (e.g. the realisation that you are not omnipotent and that another has the ability to do what you cannot) and projecting them onto others in an envious attack (Klein, 1959).

...and you have to go out and say, 'I know you've waited three months for this appointment but I'm afraid the consultant is not here and he wants to see you personally, so thanks for coming but if you can just go away' and you can't even say to them 'you're getting an appointment for next week' because realistically they're getting an appointment in three months time, and I think that's really disappointing.

'Breaking bad news' is considered to be a difficult task for health professionals and one that is a constant cause of anxiety. In addition to having to find the appropriate means of communicating prospectively devastating prognosis and supporting patient through the immediate emotions, doctors must come to terms with possible changes in how the patients perceive them (Barnett, 2002). Even though the situation described here does not involve delivering bad news about an illness, it is a moment of disappointment for both the patient and the doctor. The patient's anticipation to receive treatment is rejected and the doctor has to acknowledge failure in service delivery. The patient's possible anger and anxiety is directed towards the messenger, who in this case, is unable to offer any practical solution. Instead of being the helpful, trustworthy saviour, the doctor transforms into an envoy of disappointment and will have to see to the patient's emotions as well as her own disappointment, to which there is no external consolation on offer. To alleviate the anxiety caused by the situation, the registrar clings on to a narrative regarding her workplace – she is disappointed in the system.

I feel very disappointed in the system, which, I know the system is a big, wide thing, but ... [it] lets people down from that point of view and, you know, we overbook theatre lists and they get cancelled and then again I feel disappointed.

By seeing the NHS as a faceless, bureaucratic, 'machine-like' (Elkind, 1998) entity, the registrar convinces herself that the situation is not her fault – it is not what she would want for the patients, or for herself. She feels anxiety for she cannot provide the care required, and as a consequence she projects this anxiety through blaming 'the system'; regardless of their individual efforts, doctors are powerless when the system fails. As this registrar said epigrammatically later on in the interview: 'I don't think the NHS works anymore' which at a conscious level represents the impact on her working life of a problematic bureaucracy while at an unconscious level it provides uncontainable stress. The doctor does not have the opportunity to delegate

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tasks to her superiors to reduce the 'heavy burden of responsibility' (Menzies, 1960, p. 118) thus feels that she is left to deal with the failure of 'the system', a system, which ironically is set to heal people, not cause them angst.

It's mostly because I'm thinking, how must that patient feel. You know, they've worked themselves up, they've told work they are gonna be off work for three weeks or four weeks or whatever and arranged cover and you go and tell them, sorry, you can't have your operation, you can go back to work tomorrow. That's really disappointing, to do that to people, very much so.

In the conclusion to her story, the doctor moves beyond expressing antagonism to the system to empathising with the patient. Thus, by failing, the system provides the doctor with a social defence mechanism but through empathizing with the victims of the failure, she fails to contain her anxiety.

9.6.5.2 A story of grace in adversity: Supporting the mother of a still-birth baby

The second story is told by a male registrar who describes how he provided good patient care by supporting a mother of a still-birth baby. Despite the plot, the story is not told as a tragic narrative but as a proud patient-care moment, a sequence of events that had thoroughly positive impact on the doctor's perception of himself. This narrative is also analysed in sections.

Q: Could you give an example where you felt that you have given good patient care?

A: I think that one of them was this lady who actually came to the labour ward and told me that she hasn't felt her baby move in the past one day and she had had some bleeding. Obviously there was some concerns on my behalf for the baby, because there could be a problem. This was a very wanted pregnancy because she was quite old and this was an IVF pregnancy. I examined her a little bit and on examining her I found that the baby did not have a heart beat, so she had lost the baby.

Describing the situation at first with the patient as an object helps the doctor to distance himself from the scenario and to do routine checks expected in this kind of situation. In a hospital setting instructions are given about the way each task should be performed and these rituals form a reassuring tool for staff (Menzies, 1960: 121).

I did explain everything to her, and obviously as a doctor responsible for her, I need to follow all the procedures that needed to be done and all the care that she needed to have, you know I explained it to her that, you know this by far something that words, you know cannot express, as you can imagine how

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difficult this situation would be, and if we could make it the slightest bit better, we would try everything in our power, you know, to make the situation a lot more comfortable. I ensured that she was given a quiet room, with a very good midwife looking after her at all times. Obviously I had my duties towards the rest of the labour ward as well. People visiting her room making sure she was ok, making sure the pain relief was ok, we had induced her because we did not want her to go home with a dead baby inside her. It was a very, very painful and stressful scenario, it really, really was, it was horrible, absolutely and it is very distressing, exceedingly, exceedingly distressing because, you know the woman is going through all that pain of labour.

Here, the doctor is empathising with the patient, feeling her emotional pain and in this case is mostly able to contain it through wanting to relieve the situation and then by offering extra care, by 'going an extra mile'. In this extract, there is a clear shift as the doctor uses strong emotional words to describe the crisis. In telling the story, he is projecting his own anxiety on the patient, living the distressing emotions with her and having to remind himself of his position as a medical professional - 'obviously I had my duties towards the rest of the labour ward as well'. By referring to 'all that pain of labour' the doctor enters a relationship with the pain. The phenomenon of pain and our relation to pain, whether someone else's or our own, is more immediate than that of reflective knowledge – we do not think about pain but react to it so the sensation is intersubjective. The person who is not experiencing the pain but affected by it is an 'interlocutor' in the situation (Crossley, 1996, p. 37).

...I tried to make it a point that I was present, present as much as I possibly, feasibly could during her emotional outbursts. I wanted her to have all the support that she needed... I did get attached to the patient, being around her, trying to get her care, even if I was out of hours, which means that when I was not meant to be in the hospital. Now I think that some people will argue that, that is a bit over the top, but I think that, I guess, I guess, that that is medicine for you, you know it is about lives, and sometimes you have to make that extra effort, to make that person feel that little bit more special.

In this excerpt the doctor starts to explain and justify his actions. Through self-reflection he has realised how he acted in a way not normally accepted in the hospital culture, that is, he went against the 'social defence system' to deliver patient care, but also to cope with his own anxiety. He dedicated extended time to his patient even though hospital doctor's time is considered to be 'fast and efficient'; 'doctors move quickly in the hospital wards. Their time is expensive. They cannot afford to linger too long in any one spot' (Mattingly, 1998, p. 21).

Menzies (1960) noted that while institutions have social defence systems, individuals may resort to their own defensive mechanisms, but a membership of an institution 'necessitates an adequate degree of matching

between individual and social defence system'. If the individual and the social defence systems are in disagreement, what follows is some degree of breakdown between them, for example, a doctor's work colleagues might reject them for behaving in an inconsistent or unprofessional way to the system. Consequently, the registrar providing patient care to the mother of the still-born baby is not only coping with anxieties created by that emotionally charged situation, but he also has to think about the culturally accepted limits of caring and possibly negotiate his way with other members of staff. On this occasion, the doctor keeps to his defences and spends extra hours with the patient, without being criticised by his peers.

Well you know that when things get worse, they get worse and they get worse and they get worse. Ultimately what happened with her was that we tried all the induction of labour, we tried everything possible to get that baby out, by induction. And in her case with the induction, it failed as well... and I can't tell you how dreadful that scenario was, that she needed a Caesarean section to have that baby out... I wanted to make sure that I was present at the Caesarean section, as well so that she would have a face that she knows. Once she delivered, you know obviously I was there with her, with the [dead] baby in her arms, and she was happy from the point of view.... and thanking me every now and then, which I said that she shouldn't because it was my job and one should do it. But she kept signalling the fact that not many people would do it the way that I had and I that was very special.

Much hospital work contains a 'constant sense of impending crisis' (Menzies, 1960, p. 26) which creates pressure and anxiety. The level of predictability in medical work is low and – as the registrar expresses it – 'when things get worse, they get worse'. The doctor explains that he attended the Caesarean section for the patient's sake, but this could also be interpreted as his coping mechanism – the need for a closure (Mattingly, 1996: 37). If you only see trauma and dramatic events without closure, the events will stay lingering and cause anxiety, stress and possibly depression. The doctor needed to be there and needed to have closure to be used as a coping mechanism against accumulating anxiety. So far the patient had been in a powerless position while the doctor had presumably been in control of the situation and emotions involved in it. Therefore, when the patient thanks the doctor, he gets confused. The patient had survived through the ordeal and suddenly has the power to relieve the doctor's anxiety, to nurse him (Menzies, 1960). The acute physical and emotional stress is released and the doctor can reflect back on his experiences.

And I think that is something very, very special and dear to my heart. And these are those situations when you sit back and you reflect on your life and

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say, "wow I have done something good, really, really something good and it is wonderful".... I saw her every single day on the post natal ward and obviously I made a point not to neglect her, or neglect her partner because people assume that the only person going through the trauma is the woman who has actually delivered, but they are a couple, and that needs to be understood so that was important as well. And he appreciated that quite a lot. They went home, two weeks later, I did receive a lovely letter, which kind of expressed a lot of gratitude, for what I had done for them.

The thanking letter provides closure for a difficult story, but maybe also goes beyond this. It hints at redemption – instead of a medical tragedy possibly compounded by failure in patient care, the story becomes one of a victory or at least grace under fire, a positive example of the doctor's powers even when he cannot actually perform miracles by restoring life. Anxiety is successfully overcome by the absolution from the patient and the doctor's 'priesthood' (Elkind, 1998) is restored. The letter from the patient acts as the final seal to exalt the extra efforts the doctor put in to solving the problem (Menzies, 1960, p. 31).

I know that I put in extra hours and I KNOW that I shouldn't have been there but no-one complained, because everyone knew that I was helping a situation. It is just an understanding that we have. It would be a terrible job if you were only allowed to work your set number of hours.

A narrative like this one permits people to attach themselves to 'desirable' ends, think well of themselves in moral terms', 'support their needs for autonomy and control', and 'promote feelings of self-worth' (see Baumeister, 1986 in Brown, Stacey & Nandhakumar, 2008, p. 1054). By telling this, not an easy or comfortable story, as a proud moment of good patient care, the registrar restores his professional and personal integrity. There is no 'system' in this story to blame on, no failure to confess, but despite the drama the story draws to a happily-ever-after ending. The story has entailed a narrative for the self (Brown et al., 2008) that has released the anxiety the event contained.

9.7 Conclusions

Patient care is a process and a social construction and as such means different things to different people. Norms and styles of patient care also change across time and differ site to site not only because of differences in beliefs, but also because there are different possibilities (technological advancement, different types and mixes of professional groupings) and different types of constraints on what might be offered. It is not always possible to put a clear value judgement on patient care and one example is to do with 'length of stay'.

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Managers, whose concern is to ensure that beds are not blocked, may or may not be holding in mind the image of an organisation that shares care with agencies and families in the community. They may simply be responding to government targets. They may have their mind fixed on those waiting for beds who have still not received treatment. Patients themselves may want to return home as soon as they can or become bewildered when they are discharged rapidly after treatment.

Working in multi-disciplinary teams with distributed leadership patterns may have improved practices for clinicians. Accountability for patient care still resides with the consultant and the hierarchy who manage the Trust. While senior managers are responsible for ensuring patient safety and preventing negligence to individual patients, they are also responsible for ensuring access to care for the community which involves managing scarce resources such as equipment, pharmaceuticals, beds and staffing.

Not all clinicians appreciated or respected these pressures as we saw particularly in Chapter Six. Nor do patients necessarily agree that good care is anything other than good and consistent communication with specific clinicians.

As demonstrated in Chapters Six and Seven managers are frequently frustrated by demands from staff who may try to subvert managerial targets (set by government and as such fundamental to resourcing of the Trust).

The quality of leadership is intimately linked to patient care. Good patient care relies on effective leadership of the kind that engages with staff and imparts to them the vision that (as far as humanly possible) the patient comes first. That in turn impacts upon the climate, culture and ethos of the Trust. When leadership fails, so does patient care.

10 Leadership and patient care: Assessing the past and thinking of the future

10.1 *Introduction*

Without effective leadership at all levels of the NHS and its various organisations patient care suffers. This knowledge has been evidenced in

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several key studies across recent years as reported above and elsewhere and consequently fed into the NHS Qualities Framework (see Chapter One).

In this report we have critically reviewed the relevant literature on leadership exploring as far as possible the relationship between leadership, followership and service delivery across five hospitals comprising three NHS Trusts (see Chapter Three). We employed different research methodologies (see Chapter Two) to capture data to investigate leadership qualities and their interaction with the climate and culture of the organisation and linked these to service delivery and patient care in different settings (ranging from obstetrics and gynaecology and cardiology to care of the elderly).

10.1.1 The organisational contexts

The organisational contexts of each Trust and each site or unit varied physically, structurally and in 'atmosphere' (the full details are provided in Chapter Three). We have been concerned in the report (and future papers) to steer a path between maintaining anonymity and confidentiality and thus not overtly identifying a Trust or site within a Trust, while also pointing to how the contexts impacted on the practices of leadership and service delivery.

Overall the Foundation Trust (3) in this study, which had not been experiencing mergers or threats of closures, where staff morale was high and where leadership practices were distributed across teams and clinical and management specialties, was clearly the one most conducive to effective communication and leader-follower engagement. There was an 'atmosphere' of connection and pride in belonging to the Trust as evidenced explicitly in Chapters Four and Nine in particular.

Trust 1 was applying for foundation status during the time of the investigation but also threatened by closure of some of its units, and with the senior managers possibly being transferred to the other site which was perceived by the participants as a threat to their status and possibly to resources for service delivery. This did not happen during the course of the investigation. The managers in Trust 1 were committed to their staff and to service delivery although there did appear to be some discontent with senior management from the medical staff. This may have been because most of the distributed leadership involved non-clinical managers and nurse managers with the medical teams appearing to take a more 'traditional' hierarchical stance. Most of the data from the OCS was derived from Trust 1 which demonstrated among other things the importance of management support for identifying good leadership and patient care practices.

In Trust 2 there appeared to be the greatest amount of conflict between groups of staff who sometimes seemed to be leading in different directions.

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Trust 2 was perhaps the 'victim' of a relatively recent merger between two large hospitals (and one or two other smaller units) which were some physical distance apart and had had a different history – one being a DGH and the other a teaching hospital. The DGH appeared at first to have a professionally diverse group of senior managers who distributed their leadership to effect, but one or two figures emerged during the course of the study who transgressed this approach with one person taking a back-seat while another was trying to drive through change in a somewhat cavalier manner. Furthermore in this particular Trust there were changes among the senior managers (some left, others moved to the other site during the course of this study). The CEO also indicated that it was difficult to recruit good middle-range managers and nurses in particular because both sites were away from the centre of the city where most people would look for a promoted post.

10.2 *Limitations of the study methods*

As with any large scale and complex study such as this one not all of our intentions were achievable although some were satisfied beyond our expectations.

We had difficulties capturing data from patients for two main reasons (fully detailed in Chapter Three).

Firstly, the 'gate-keeping' staff working on the Units on a day-to-day basis (as distinct from those who supported overall access to the Trust overall) obstructed data collection.

Secondly, it was also difficult gaining access to patients while they were in hospital because of ward procedures and in other cases the poor health of patients. So in the end we managed to conduct ten patient interviews but were unable to collect organisational climate survey data from patients at all³⁸. To overcome this we gained permission to observe clinicians' interactions with patients in their care and we believe we have managed to do more than compensate, making a contribution to knowledge with important new material to demonstrate patient care in different contexts and the processes involved in patient care and service delivery (see in particular Chapter Nine).

We also met with difficulties, with one Trust in particular, collecting *survey* data from staff although individual staff members proved more than willing

³⁸ These difficulties were reported to SDO in the interim reports and also separately when they arose.

to support the researchers by allowing them to interview, observe and shadow them during their working days. *This is all reported fully in Chapter Three.*

10.3 *Reviewing the findings*

In this final chapter then we draw together the findings from the study and make suggestions as to how they might contribute to policy and practice beyond the participating organisations.

This chapter is organised around the original study aims which were about leadership, organisational climate (culture and context) and how they impact on patient care. The overall plan was to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery.

This research further sought to explore the following broad-based questions.

- First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
- Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?
- Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The specific aims and objectives are listed again below and we conflate these in what follows directing the reader to the relevant chapters.

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines, to patients;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts service delivery;

- To learn how different stakeholders (specifically patients, nurses, members of professions allied to medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care;
- To identify how the need for change in service delivery is identified and what drives the need for change.

10.3.1 How far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?

Throughout the participating Trusts there is evidence of the importance of high quality patient care. Chapter Nine in particular brings this together with quoted respondents emphasising that above all patient care matters to the aims of the organisation and those who work in it. Thus on a basic level, working for patient care is inspiring in itself and staff across the Trusts see good patient care as their *modus operandi*.

Our use of innovative ethnographic methods and story telling were particularly effective in providing the evidence of how patient-clinician relationships were practiced and how staff made sense of their own actions reflexively in the context of caring for patients³⁹.

Chapter Nine provided evidence of the ways in which care is practiced.

We begin here by summarising some of the evidence from the Foundation Trust in this study, which consistently appeared to demonstrate high levels of distributed leadership, emotional engagement and multi-disciplinary working across all levels. The data included several key examples of positive statements about the role and effectiveness of management. We saw, for example a senior clinical manager summarise the issue with reference to his

³⁹ For example, interviews opened with questions about leadership and patient care, and participants were then encouraged to tell 'stories and critical incidents illustrating their experiences'. The early parts of the interviews provided themes and indications of what the clinicians regarded as crucial to delivering good patient care, e.g. 'cleanliness', 'efficient administration', 'communication', 'empathy', 'sympathy', 'knowing the recent developments in your field' and 'everything behind the scenes the patients don't see'. However, it was the stories they relate to that provided us with insights into their core experiences of patient care (see Chapter Nine).

pride in working for the organisation drawing attention to its low mortality rates, and that the high quality staff and its reputation for patient care act to attract others at the top (or with the potential to be at the top) of their specialty.

By contrast, the CEO of one of the other Trusts had made the point in their interview that one of the difficulties they had was attracting high caliber nursing staff, partly because of their location (in the suburbs). In Chapter Four we identified the ways in which an organisation might be seen as a learning organisation as significant in supporting staff to develop their clinical and managerial skills and develop capacity for patient care. Where support for learning was apparent so was the enthusiasm and pride for the organisation and its goals.

What was striking was the way that all respondents who addressed this point were looking to see how patient care could be improved with aspirations that patients were satisfied with more than just the health outcome (although that is the bottom line) but also with the facilities and the atmosphere. In addition, several respondents made the point that they themselves were mindful of delivering (or at least aspiring to deliver) the type of care they themselves would want to receive.

That so many of the staff (clinical and non-clinical) worked long hours in which they were engaged in intensive work with either their clinical or management teams, or their caring for patients with the aim of delivering the best possible care, is yet further evidence of the ways in which patient care is inspirational.

What is most noticeable, however, is how some styles of clinical and managerial leadership appear wanting, when compared with the best. While some respondents are clearly excellent communicators who engage fully with their professional knowledge and with the patients and staff, others - equally expert and equally inspired to provide the best for their patients - seem to fall short in comparison. In Chapter Nine for instance, Cameron and Kenneth engage with their patients in human ways and there are examples in the chapter in which each clinician manages to gain important information from and for their patients by their hard work *and* their humanity. However, in Cameron's case he is supported by a team which has clearly been nourished and inspired by the organisational context (see references to Cameron's work in this report).

Kenneth, while equally able and empathic, from the ethnographic evidence reported in Chapter Nine, appears to be less able to transmit this or influence others to take up his brand of leadership and patient care. He remains slightly in the background while the younger and (it appears) more influential Henry sets the tone. The clinical team give the impression of

being business-like and impersonal and somewhat intimidating when they conduct their ward round. The culture being transmitted to the other clinical staff tends towards Henry's approach rather than Kenneth's. This raises questions about why this Trust and site is different from the FT in which Cameron and Mandy work. These matters were addressed in Chapters Six, Seven and Nine in particular and will be subjected to further analysis in subsequent publications. However the FT is established and settled. The Trust where Kenneth and Henry work was the product of a relatively recent merger and norms and values were still being 'negotiated' (see Chapter Seven and above in this chapter).

Subsequently we see Mandy working directly on a patient's wound not only acting humanely when she hurts the patient but working with the nurse to assess how they might best improve the patient's condition while caring for his mental state and self-esteem.

High quality care and inspiration come together through the ways in which clinicians and managers take responsibility for their work – for managing emotions (their own, their colleagues' and their patients'), teaching, making decisions about end of life care, communication with relatives and coping with everyday situations that raise anxiety levels for patients and staff. The story of the doctor in Trust 1 who cared for a woman with a still-born baby itself demonstrates how he went the extra mile (in his words) inspired by the possibility of providing care in a case where some might have tried to make minimal contact because a still-born baby might be seen as a clinical failure.

Overall emotional engagement with patients and followers leads to people working together in a human, humane and inspired way and impacts on the organisation itself which can become one with which people are proud to be associated.

10.3.2 How do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

This question underpinned the entire study, but specifically we reviewed the relevant research literature on leadership and organisational climate (Chapter One) and discussed this in Chapters Four through to Eight. We began by reviewing the results from the story-telling interviews, focus groups and ethnographic methods (observations and shadowing). A range of potential practices and behaviours were reported to us which suggested where problems might lie in current leadership practices, as well as what many respondents held to be ideal types. What we summarise now represents a combination of what works and what does not although it needs to be noted (as identified in Chapter Nine in particular) that what

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patients see as good leadership (that they received clear and consistent information from one or two key staff) may not always intersect with what staff meant by good patient care or effective leadership and service delivery. The latter was usually seen as best delivered by a well-functioning multi-disciplinary team albeit frequently constrained by limited resources.

The following issues stand out as good practice that could feed into NHS (and local Trust) policy:

Leadership is a complex concept meaning different things to different people. Over recent years leadership in changing contexts such as the NHS has shifted from the 'heroic' model where leadership is hierarchical to a model that is more distributed across different levels and different parts of the organisations. The heroic and hierarchical (related) models frequently depended upon individual characteristics and where the senior managers were indeed heroic and charismatic, leadership might well have led to good patient care. However, this is unreliable and unpredictable and the NHS Qualities Framework which has identified leadership skills is more appropriate to the context (see Chapter One).

Our most important findings, however, make it clear that leadership which is emotionally engaging and distributed is the one which is most likely to lead and support service delivery successfully as well as drive necessary changes.

At the end of Chapter One we focused on contemporary studies of leadership which promoted the importance of *context* and of taking a more discursive stance in the analysis of leader-follower relations. We also drew attention to the revival (and reappraisal) of concepts from organisational studies from the 1960s to the 1990s which took psychodynamic ideas into account and related them to more 'popular' contemporary ideas about the significance of social and emotional intelligence in leader-follower relations. Thus, we explored the ways in which stakeholder accounts of the experiences and exercising of leadership demanded an attachment or engagement at an emotional level, which took account of the unconscious as well as conscious understanding of these experiences. There were several examples offered in the previous chapters of leadership practices that delivered the required services or changes through different types of concerted action and those that didn't. In some cases we were able to show that with the best will in the world if the leader, for whatever reason, was unable to *engage* and thus be supported by the followers, then their leadership failed to deliver.

Recent analyses of distributed leadership styles and organisational contexts show that if such leadership is to work then people need to act and work together and be prepared to both take up and relinquish authority for

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certain tasks and roles at the appropriate intervals. We saw in Chapters Six and Seven for instance that authority is hard to maintain if a leader loses touch with their staff and fails to hold their own organisation 'in mind'. We used the OCS survey results in combination with the data derived from the interviews, focus groups and ethnographies to demonstrate the importance to a positive organisational climate of good leadership. Satisfaction with a manager was predicted by the same variables that identified a positive organisational climate. For staff in the organisations surveyed it was important that managers were committed, responsible and supportive of their staff/followers.

But how were these characteristics demonstrated? Leaders who were experienced as effective, supportive and emotionally engaged with their followers were able to communicate their vision and dedication to improving the quality of care to patients, which in itself co-existed with good staff morale. Such leaders were also good listeners as well as being able to take staff with them when less palatable or unpopular changes were mooted by senior management or government. These effective leaders were closely connected to the way the organisation was structured (physically and emotionally). They were thus able to access the information they needed in order to lead. The evidence for this frequently came from the stories and accounts of staff and observations made by researchers – often of good leadership but perhaps more acutely when leadership was poor. Then there was a jarring effect or mismatch between (local) policy and the attempt to drive changes to meet improvement targets. There was also evidence on occasions of senior clinicians' behaviours being disengaged. Sometimes attempts were made to subvert the senior people when leadership went against the grain. There are examples in Chapters Seven and Nine in particular.

A final comment here is that despite the changes in gender demographics at the top of clinical specialties in medicine, nursing and related professions, as well as in senior management, gender has not 'gone away'. Indeed distributed forms of leadership have (perhaps stereotypically but with some evidence base) been associated with women's behaviours. The OCS (Chapter Five) suggested that women's perception of 'recognition' for their work and achievements was more negative than that of men. Men were either satisfied with the recognition they received or less in need of recognition from their managers within the organisation than were women. In the qualitative data (see Chapter Eight) it was also the case that while senior women were keen to deny the relevance of being female to their professional lives and their career progression per se, women used different strategies and perceived their roles slightly differently than did men, although the point was well made by some respondents that feminine and

masculine choices of specialty may have been more significant predictors of management styles than gender itself.

10.3.3 Do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The contemporary NHS with its (mostly) distributed leadership practices at all levels tends to militate against the possibility of one person's vision being paramount. However, as suggested above in this chapter, there are nuanced influences of leadership style that (may) flow from one or two people's vision and/or style of leadership and patient care that influence organisational approaches.

In Chapter Seven, for example, we explored three senior people's visions and consequent behaviours to consider their authority and influence with the possibility that as opinion leaders they influenced organisational approaches to patient care. Quentin, for example, reflected his role as a senior clinical leader, and although there is no irrefutable evidence that his style was mirrored in the organisation itself, he does provide some evidence that in certain cases in relation to certain actions his vision had an impact on the overall organisational approach.

While the OCS (Chapter Five) captures data from a wider population, the ethnographic methods made a greater contribution to exploring how far an individual's vision influenced the organisations approach to patient care. Again in Chapter Seven we see Kerry battling against a resistant (and probably disillusioned for some reason) senior management team to improve discharge policy and meet government targets. She tries again and again (by her own account) to show her staff that they need to focus on targets because they will lead to improved care quality. She appears to fail (again according to her own standards) and expresses this by almost literally demonstrating that she is banging her head against a brick wall.

Differently with the same effect Gerald is introduced as having a clear vision for patient care in his Trust. However, his inability to take staff (at all levels of the organisation) with him in his vision is attributed in our analysis to his lack of emotional engagement and autocratic (verging on the authoritarian) style of management. His narcissism further ensures his inability to understand how his behaviour is impacting upon staff and he sees himself as having failed to win a 'fight'.

Chapter Six explores the organisation as an open system, and ways in which all stakeholders⁴⁰ hold a vision of the organisation in the mind at a

⁴⁰ Including patients but we cannot really speak definitively here due to lack of data.

conscious and an unconscious/emotional level acting accordingly. Thus, they have an image of the organisation (how well it is managed, how effectively it cares for patients), a sense of their own role and place within the organisation and how well the leadership understands the experiences of staff and patients. Recognition of the primary task, the roles and responsibilities of those who manage it and the (changing or threatened) boundaries of the organisation itself are critical concepts.

No doubt some members of the organisation have more personal and role/task related power and influence than others in the NHS Trust. Furthermore, the NHS as a system is fluid and dynamic, so that there is overall a group influence over the evolution of organisational context (climate and culture) which responds to visions from within and without (government, health care consumers) the wider system.

10.4 *What have we learnt from this study?*

10.4.1 How leadership relates to patient care

It is clear, from our empirical work and evidence from previous studies, that leadership is a process and set of practices which generally do not equate with the qualities residing in a particular individual regardless of their authority and formal role and status in the organisation. Leadership that 'works', as seen particularly (but not only) in the case studies in Chapter Seven, involves the person in the leadership role exercising social and emotional intelligence and engaging with their 'followers' (see Chapters One and Four) and offering staff recognition and support (Chapter Five). Moreover the role of leader is particularly effective when it is distributed among those who are best placed to exercise leadership towards the task in hand. So that in the context of an NHS hospital Trust, leadership might be exercised in relation to organising the administration for a unit, running an audit, or developing an innovatory clinical practice. Leadership in such contexts is time/project limited.

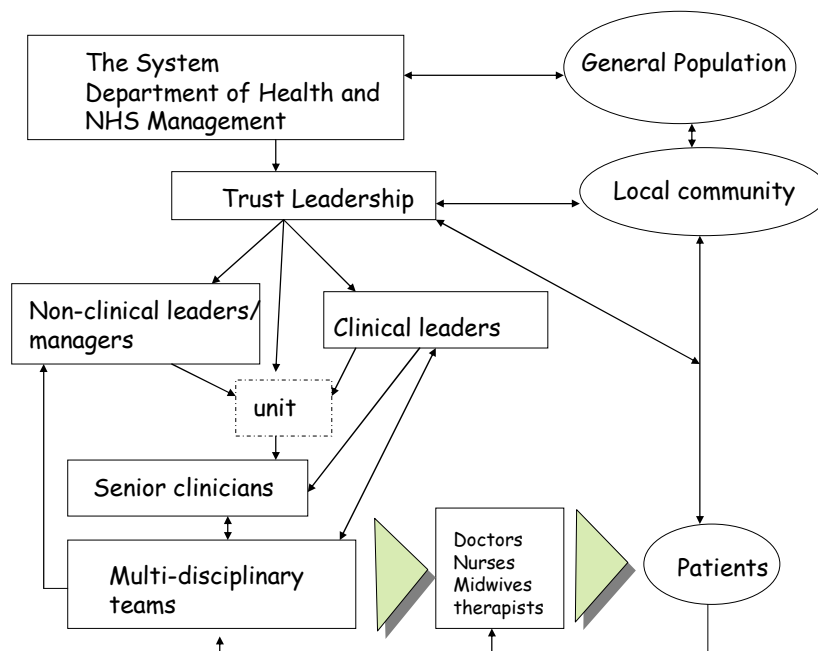
The primary task for NHS Trusts is to deliver a service to patients, as proposed in Chapter Six. All NHS Trusts operate as open systems with porous boundaries which enable change (planned and/or evolved). Leadership therefore can occur throughout the system at different levels including those of ward clerical and cleaning staff and the CEOs who 'manage upwards' and influence NHS/ Department of Health policy. Information of all kinds passes across the various boundaries not simply from the 'top' downwards.

Below in Figure 12 the relationship of the Trust leaders and patients within the NHS system is illustrated. It is also the case, as shown, that policy

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influences individual care, and the quality of that influence depends very much on the quality of leadership again across the system at all levels.

Figure 12. From the DoH to the Patient: An Open System



Patient care is represented here at three levels. The population who influence service delivery and patient care using their vote and/or lobbying through relevant patient groups, the local community who are served by a particular Trust and patients who are actively receiving medical treatment from individual clinical teams.

While on the whole it was the last group who were the main focus in this study some participants, particularly those in senior leadership/management roles, were concerned with service delivery at the local community and population levels. This sometimes meant that senior managers faced the dilemma of how to care for the community while attending to individuals and some individual clinicians were equally concerned about how their interactions with patients were influenced by some of the management dictates which derived from NHS policy that they

found difficult to understand (see Chapter Six and in 10.4.2. below for example).

10.4.2 Systemic dilemmas in patient care: Managing in the NHS

One participant had faced a 'dilemma' in wanting more face-to-face knowledge of patients in the community in order to be a more effective and informed leader, while also as his role required, attending to the demands of working within the wider system of the NHS:

As a chief exec in the NHS it was my privilege to make decisions. That was my privilege to go on and up the ladder. It was that I could go on and make faster and faster decisions. I get in the way I have always got in the way... the thing I would do is go out with the district nurse for the day, because I needed to be grounded in that. (Retired CEO)

Another manager who had previously had a military background advocated (along similar lines) that the best way to lead towards good patient care was to 'walk around' and support the leaders across the different parts of the organisation. In a seminar to clinical staff, which we attended and recorded, he drew participants' attention to the importance of *influencing* policy to achieving good patient care (at the population and community levels).

I hope some of you will find yourself in policy jobs at some point. Totally different, yes it still leads, but the actual process is so ... changing...both the chief executive and I spend a lot of time nurturing relationships which are partly to do with policy, but unless you get it right ... you communicate with them, it won't work.

In other words to be effective and to ensure the best for those in the Trust (staff and patients) a leader has to 'manage upwards' which gains influence. He continued by contrasting the experiences and perceptions of doctors with managers who lead at the macro level, drawing on the example of a recently qualified doctor. When the respondent quoted here asked this man about leadership in the NHS and how it impacts on patients he apparently answered:

'Oh I have got communication skills'. 'Blimey!' I said 'what do you know about the NHS?' And I asked him a couple of questions, nothing! But he hasn't been taught at an academic level about the context in which he is working. I think that is crucial and I know that is not how everyone does things. You know [doctors] keep people alive, but they really ought to have this basis of information about the context in which they are working.

While it is self-evident that the NHS is the context in which patient care is delivered, there is a tension between those who exercise leadership in that context and those who 'keep people alive'. In Chapter Seven, the frustration expressed by Kerry in trying to meet the demands of the government and community by improving the Trust's record of patient care, as well as motivate her senior staff to hold similar ideas, was palpable. From others' perspectives as shown in Chapter Six, there was evidence that 'management' was experienced negatively by several clinical staff when it tried to respond to Department of Health directives.

Managing the numbers

At another level of management good patient care was defined through achievement of returning satisfactory statistics, as this observational note of a meeting between capacity managers and clinicians suggests:

Patient care for the capacity managers appears to be a number crunching exercise. The need to get the patients in the right beds according to government targets meeting four hour waits and single sex bays. However because there is not a shortage of beds on this day, patient care moves from an exercise in numbers to thinking about patients in real human terms.

Sally (the capacity manager) talks about how better patient care can be delivered when there is less pressure on all the staff to meet their targets and get their job done. She talks about how [clinical] staff are then more able to talk to their patients and spend time with them. However, whilst reduced pressure means that for some, numbers translate into real people it is clear that in the capacity meeting that the role of the capacity manager is to think in terms of numbers and beds to deliver good patient care.

There is a potential conflict between the target driven service and the patient-clinician relationship which is about face-to-face contact. Perhaps this is well illustrated in Chapter Nine with the example of the 'grace in adversity' story, whereby the obstetrician spent extra time with a patient while his clinical colleagues turned a sympathetic blind-eye. The story of the patient 'Lola' also discussed in Chapter Nine who had been occupying a bed for three months with the tacit support of nursing staff would also have been anathema to staff responsible for managing targets about capacity.

10.4.3 Who judges what is good leadership and good patient care?

As shown above and throughout this report there is a tension throughout the system. The primary task of senior managers and leaders at and above the level of the Trust is to ensure the demands of the NHS and Department

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of Health leadership are met. These are policy driven with differing priorities at any particular time. The general population of (potential) patients has a keen influence on policy in different ways but particularly during local and general elections. For example the recent change from a Labour to the Coalition Government has raised questions about the role of 'targets' for future NHS priorities. Apart from other matters, finance makes a difference as to how priorities for service delivery are set.

Senior management at the Trust level is judged in a number of ways particularly related to how far the Trust meets the national priorities. However there is also pressure on CEOs and senior teams to get direct patient care and safety 'right'. This may be assessed through statistics as in the following example described by a senior midwifery manager:

Between 2002 and 2005 there were ten maternal deaths at [Trust], which exceeded the national figures. So the Healthcare Commission came in and reviewed a number of clinical organisational cultural governance issues, and then actually put the maternity services under special measures

There was a key number of issues then, and an action plan was developed, so actually I was newly appointed at that time, and there was a number of work streams that we had to work on, and it's never happened before, and I don't think its happened since in a maternity unit. So basically, even though that was a very sad event for all the families involved and very tragic for them, it was difficult for the staff, and obviously difficult for the Board in terms of reputation management. The whole action plan was implemented, the unit was turned around, and the special measures were lifted in 2006.

In this case there was a notable failure to deliver maternity care to the standards of safety prescribed by the NHS. Furthermore there was a failure of leadership perceived by this participant in terms of both 'culture' and 'governance' giving rise to the high proportion of maternal deaths and the consequent special measures. This participant also makes clear how much the staff themselves are influenced by events of this kind.

Another member of that staff team praised the changes at the top following these problems and combined the policy, context and face to face care in her assessment of the relationship of good leadership to good patient care:

.... the end goal for us, is ensuring the services we're providing.. the patients, are getting the best service from us on top of meeting all the Trust targets and the Trust strategy...for me really it's about ensuring that the patients are getting the best quality care, which, you know, I think they've got an improved quality of care here, with the team like mine who are here...and I think [leadership] is from the top down, so from Chief

Executive, right down to every level, to leaders in the ward, right down to our portering, to our domestics. Yeah, there certainly is, and we lead by example really don't we? and I think our chief exec, director of ops, deputy chief, they've all got good leadership skills.

Good leadership skills among senior managers can pay dividends in terms of reputation management. For example in August 2010 North Cumbria University Hospitals NHS Trust admitted a series of false positive diagnoses following breast cancer screening⁴¹. The CEO moved quickly to review the situation and apologise publicly. In other cases though, when there have been wrong diagnoses, neglect or medical errors over drug doses senior managers have been blamed for the failures - sometimes warranted and sometimes possibly not so (see below). Anecdotally it appears that leaders who are prepared to acknowledge problems as soon as they appear and deal with them in a transparent and effective way bring about improvements in service delivery and patient care in the ways perhaps that those who try to 'bury' problems might not achieve.

10.4.4 Leadership practices across the organisation

Leadership and patient care are intrinsically linked. Leadership is above all about taking responsibility but with changes in organisational structures, a growing emphasis on networks, open systems with porous boundaries, mergers and changes in the shape, structure and functions of Trusts, it is no longer tenable for leadership to be in the hands of a few. Leadership, then, is about a series of relationships and connections within and without specific organisational boundaries which have the potential for diffusing responsibility or sharing it, and therefore making leadership practices more co-operative.

It is important to focus, as we have done, on the many examples of good and excellent leadership we found within the three Trusts taking part in this study (each of which of course being hospital based and therefore not focused on the role of leadership in primary care). These sit in contrast to the examples of less effective and sometimes failures in leadership that we have cited. The differences crucially were about emotional attachment and engagement between leaders and followers. We did not meet any respondents who were disengaged with the aims of the NHS and none who were uncommitted to deliver the best patient care. But as evidenced above in the report and in this chapter, some leadership practices failed to take

⁴¹ <http://www.bbc.co.uk/news/uk-england-cumbria-10958423>

followers with them because of autocratic, insensitive behaviours and poor communication skills. Leaders need to be able to listen and engage – having a vision is not enough.

Leadership taking the importance of emotional engagement into account also needs to be transmitted across the organisation. This is best accomplished through making full use of individual skills. Clinical staff and managers can be effectively involved in specific change projects. These may be time-limited and/or specialism specific but collaborative concerted action is frequently the most significant way that a system might flourish with the staff taking responsibility and enhancing their sense of commitment.

10.4.5 When leadership fails patient care

The converse of good leadership is potentially catastrophic. The case of Beverly Allitt in the early 1990s, the nurse who murdered children in the Lincolnshire Hospital by injecting them with insulin, went relatively unchallenged because she was poorly supervised. Harold Shipman, a different case in that he was a GP in a sole practice, similarly was eventually thought to have committed over 200 murders of patients throughout his career. However, the report into his murders showed that doctors at Thameside hospital had failed to report suspicions about his prescribing⁴². The Alder Hey organs scandal involved the unauthorised removal, retention and disposal of human tissue, including children's organs during 1988 to 1995 and the Bristol Royal Infirmary inquiry about children's deaths during surgery resulted in doctors being struck off. All these cases represent a failure of leadership in which those who were responsible for patient care at all levels failed to identify and follow up on problems. More recently the independent inquiry into the Airedale NHS Trust, where the late Anne Grigg-Booth continued as night-nurse despite a high proportion of deaths of patients while under her care, identified 'a catalogue of systemic failures' whereby her dangerous behaviour was not spotted.

At the time of writing this report the Prime Minister David Cameron has ordered a full public inquiry into the events at Staffordshire hospital which have led to deaths of patients, it would appear in these cases, more due to negligence than intent. The Francis report which was published in 2009 found that patients were routinely neglected and there were systemic failings in patient care. Managers had been pre-occupied with cost cutting and meeting targets and unable to spot the build up of failures in patient care that were to cost several patients their lives. There were too few

⁴² These cases were subjected to inquiries which exposed a range of complexities which are not relevant here.

nurses, those who were employed were ill-trained, equipment was inadequate and experienced medical cover was not always available. It was a supreme failure of management and leadership. The Trust was poor at identifying when things went wrong and managing risk. Some serious errors happened more than once and there were higher levels of complaints compared with other trusts. Staffordshire was a foundation hospital that had managed to 'tick the boxes' although clearly there were a series of chasms between the clinical and managerial staff.

10.5 *Final thoughts*

By using innovative qualitative methodologies (described fully in Chapter Two) such as story telling, ethnographic observations and shadowing, to both supplement and augment data from interviews and focus groups, we have built up a picture of what happens in the daily lives of NHS staff working both with and as managers and in clinical teams. Using these methods provides opportunities to extend the scope of more traditional in-depth interviews and focus groups. The 'story', because it is chosen by the participant themselves, provides not only detail and depth but demonstrates the specific indices used by each interviewee to make sense of their own and others' behaviours within the organisational context.

The ethnographic observations, and the shadowing in particular, enabled the researchers to gain a sense of what 'a day in the life' of a member of the organisation *feels* like. They can 'experience' the interactions between staff, between staff and patients as well as the frustrations and pleasures of working in that Trust. No other method provides such acute insights. The subjective ingredients in this method enhance the process (i.e. as outlined in Chapter Two whereby the researcher themselves is the 'instrument' through which data is mediated). Moreover, and possibly conversely, the subjective elements are reconciled when the observation notes are discussed by other members of the research team, which again as discussed in Chapter Two is also a source of data (Czarniawska, 2008).

As a qualitative study, the success is proven by the richness of the data, showing the clear emotional connection participants had with the topics of both 'leadership' and 'patient care' (Lincoln & Denzin, 1994, p. 575). From this we were able to make sense of how leadership is experienced and exercised (see Chapters Four and then Six to Eight) and about the practices around patient care and service delivery that support patients to understand the relationship between their particular health-status, quality of life and the care and treatment they are receiving and/or expect (see Chapter Nine in particular).

The statistical analysis of the OCS⁴³ showed that, on the whole, the climate variables, 'support' and 'recognition' from managers and the system overall, predict 'satisfaction' with leadership and management. This reinforces the ideas expressed throughout the report that good practices by managers/leaders are about ongoing engagement with followers with concerted or conjoint leadership processes most likely to promote a sense of being supported and recognised (Roberts et al. 2005).

Thus we have not produced a list of 'good leader' qualities or a similar record of what constitutes 'good patient care', as these would fail to capture the crucial point that both leadership and patient care are experienced as a process. Thus this report aims to delegate *good practices* that were observed during the project, for the use and reflection of any staff member of the NHS – whether a leader, follower or patient.

10.6 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.

⁴³ As made clear above we were unable to capture corresponding data from patients.

- 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.

Appendix 1

Focus Group Questions

1. Leadership means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this hospital?

Prompts

1. Charismatic / Authoritative / Consultative / Directional / Varies – depends on situation/activity etc
2. Can you think of some incidents that sum up for you the way leadership is exercised in this hospital?

Follow-ups

1. Does this type of leadership operate throughout the hospital?
2. Could you give some examples of ways in which leadership is exercised in your team/the hospital
3. Patient care means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this organisation?
4. How important is patient care as a priority in the service that you and your colleagues provide?
5. What are your main priorities in ensuring a high level of patient care in this hospital?
6. Can you think of some incidents that sum up the way you and your colleagues try to deliver patient care?
7. To what extent is leadership reflected in the quality of patient care you and your colleagues provide?
8. Can you think of some incidents that sum up the way that leadership in this hospital approaches the issue of patient care?
9. Can you think of specific incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

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Follow-up

1. What would you suggest to improve this/these situations?
3. Stories and critical incidents
 - a) Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
 - b) Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
 - c) Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

Could you tell me about a time that made you feel disappointed with leadership in this hospital?

- In this unit?

Appendix 2 Interview Questions

Interview

*Introductions, background and experience in relation to patient care and leadership in the organisation

- The interviewees position/level
- Years at the hospital
- Role in the organisation

1. Leadership

'Leadership' means different things to different people.

- a. How would you define it?
 - Do you see that kind of leadership at this hospital? Why/not?
 - What about in this unit?
 - What makes someone a good leader/Qualities of a good leader? Can you give me an example?
 - Who here at work do you see as providing leadership to you personally? Why? Do you have a direct supervisor? Who? Do they have leadership qualities?
- b. Do you see yourself as someone who could be a leader?
 - Why/not?

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- Under what circumstances?
- c. Can you give me an example of leadership in this hospital?

2. Patient care

- a. Like leadership, 'patient care' means different things to different people.
 - How would you define it?
- b. Tell me about patient care in this hospital. How is it defined?
 - Are there differences between units? Tell me about them. Why do you think this is?
 - How would you improve patient care in the hospital?
 - How would you improve patient care in this unit?
- c. How do you [as a hospital worker, nurse, etc.] try to deliver good patient care?
- d. What do you think are some obstacles to delivering the sort of patient care you'd like to see? How could these obstacles be removed?
- e. Do you think leadership could improve patient care in this hospital?
 - Why/not?
 - Do you think that better leadership would improve patient care? Why/not?
 - How does good leadership influence patient care?
 - Has the leadership in this hospital improved patient care since you've been a member of staff? How so? Or why not?

3. Stories and critical incidents

- a. Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
- b. Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
- c. Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

- d. Could you tell me about a time that made you feel disappointed with leadership in this hospital?
- In this unit?

Appendix 3: Focus Group Questions: patients

1. Leadership means different things to different people. What does it mean to you as a patient of this hospital?
2. What is your opinion of the way leadership is exercised in this hospital?
3. Patient care means different things to different people. What does it mean to you as a patient of this hospital?
4. Can you think of some incidents that sum up the kind of patient care that staff in this hospital deliver?
5. Can you think of ways that leadership in this hospital could enhance the quality of patient care, as far as you are concerned?
6. Can you think of some incidents that sum up what else leadership could be doing?
7. Can you think of any other incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

Appendix 4: Staff Organisational Climate Survey

[attached separately]

Appendix 5: Participant Information Sheet

Leadership and Better patient Care: From Idea to Practice

Participant Information Sheet: Staff Interviews

You are being invited to take part in an interview study about leadership and patient care in three different hospital settings. Before you decide to participate in this study it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Contact me (see full contact information at the end of this sheet) if there is anything that is unclear or if you want to know more.

Take time to decide whether or not you wish to take part.

Thank you for reading this.

1. What is the purpose of the study?

The purpose of this study is to try to identify the circumstances under which leadership can be an effective engine for change in the organisation of health care, especially for patient care and service delivery. Although we suspect that leadership motivates workers and affects the climate or atmosphere of the places where people work, leadership can mean different things to different people. The same is true of patient care which can also mean different things to different people. In order to understand how leadership inspires health workers to provide better patient care, we want to learn how nurses, doctors, other medical professionals as well as managers and patients define and understand leadership and patient care. This includes exploring how their perceptions mesh or conflict with one another. It also includes listening to stories of important incidents that describe their experiences of leadership and patient care.

2. Why have I been chosen?

As part of the study we are interviewing staff (clinical, managerial and others) as well as patients to examine what leadership and

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patient care mean to them. You have been chosen as someone whose views represent the views of staff.

3. Do I have to take part?

No

4. What will happen to me if I do take part?

You will participate in a tape-recorded interview with a qualified researcher, which will last under an hour.

5. What do I have to do?

Arrange a mutually convenient time to have the interview.

6. What are the possible disadvantages and risks of taking part?

It is possible that the discussion may stir up distressing feelings you have regarding your organisation, its leadership and the patient care it provides. However, care will be taken to prevent this and you are free to leave the interview at any time. Apart from that, the only disadvantage is that you will be giving up some of your time.

7. What are the possible benefits of taking part?

This study may not directly help you but it is part of a serious initiative to improve the quality of leadership and patient care provided by the NHS.

8. Will my taking part in this study be kept confidential?

Yes. All data will be stored in locked filing cabinet in a locked office. It will be made anonymous and all names will be edited out of the transcripts. Only members of the research team will have access to the data.

9. What will happen to the results of the research study?

They will be published in a report to the funder and also presented in peer reviewed papers and conferences. A copy of the report will be provided for each participant who requests it.

10. Who is organising and funding the research?

The study is funded by the NHS Service Delivery and Organisation (SDO) Research and Development Programme of the National Institute for Health Research (NIHR) Programmes. The NIHR has been established as a part of the government's strategy Best Research for Best Health to provide the framework that will position, manage and maintain the research, research staff and infrastructure of the NHS in England. The study is conducted by a group of researchers from Royal Holloway University of London led by myself, which won the grant following a competitive bid.

11. What if I have any concerns?

If you have any concerns or other questions about this study or the way it has been carried out you should contact me (details below) or you may contact the hospital complaints department.

Contact for further information

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Appendix 5: Consent form (generic)

Title of Project: Leadership and Better Patient Care: From Idea to Practice

Name of Researchers: Emma Rowland Paula Lökman

Please initial each box

☐ I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

☐ I understand that some coded extracts from the interviews may be used for the purposes of the research report and academic articles.

☐ I give my consent for quotations to be used in the report and research papers on the understanding that I will not be able to be identified by the use of these in any way.

☐ I agree to take part in the above study.

Name of participant

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Date

Signature

Appendix 6: Patient Organisational Climate Survey

Thank you for agreeing to participate in this study which as you will know is part of a larger study on leadership and patient care in the NHS.

The following questions explore how NHS patients feel about the care they received and how things generally worked in the units where their care was managed.

The survey is anonymous, so please do not put your name on the survey.

If, however, you would like to receive the final results of the survey when the study is completed, please fill in the tear-out form on the questionnaire's last page and submit it to the researcher or the collection box.

It is important that you answer all the questions. This should take you approximately 10 minutes.

Your individual responses will be kept strictly confidential.

Researchers

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Department of Health and Social Care
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Ms Emma Rowland

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Please circle one number that best describes how you feel for each question in relation to the service provided by your NURSE.

1. I feel understood by my nurse.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

2. I am able to be open with my nurse at our meetings.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

3. My nurse has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

4. My nurse encourages me to ask questions.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

5. I trust my nurse.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

6. My nurse answers my questions fully and carefully.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

7. My nurse deals very well with my emotions.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

8. I feel that my nurse cares about me as a person.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

9. I don't feel very good about the way my nurse talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

10. My nurse tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

11. The way my nurse interacts with me influences my perception of quality care.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

12. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

Please circle one number that best describes how you feel for each question in relation to the service provided by your DOCTOR.

13. I feel understood by my doctor.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

14. I am able to be open with my doctor at our meetings.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

15. My doctor has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

16. My doctor encourages me to ask questions.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

17. I trust my doctor.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

18. My doctor answers my questions fully and carefully.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

19. My doctor deals very well with my emotions.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

20. I feel that my doctor cares about me as a person.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

21. I don't feel very good about the way my doctor talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

22. My doctor tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

23. The way my doctor interacts with me influences my perception of quality care.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

24. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

25. What would improve the quality of care you receive at this hospital?

26. What services are you using within this hospital?

Demographic Information

27. In which year were you born?

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28. What is your marital or civil partnership status?

- ☐ Single
- ☐ Co-habiting
- ☐ Married
- ☐ Divorced

29. How many children do you have?

30. How would you describe your ethnic background?

31. What is your current salary?

- 1. Less than or around £20,000 per annum
- 2. Between £21,000 and 39,000 per annum
- 3. Between £40,000 and £59,000 per annum
- 4. Between £60,000 and £99,000 per annum
- 5. Above £99,000 per annum

Thank you again for your time. If you have any questions please speak with the researcher or alternatively you can contact Professor Nicolson.

I would like to receive the final results of the survey when the study is completed

Name:

Address:

Contact Telephone:

Please return this form to either the researcher or the collection box.

Appendix 7: Appendices for Chapter Five

[attached separately]

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⁷ There is a parallel ongoing debate as to whether university leaders should be drawn from outside academia.

Addendum:

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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.

Leadership and Better Patient Care: Managing in the NHS

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Executive Summary

The NHS National Leadership Council Website¹ (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)

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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.

Leadership and Better Patient Care: Managing in the NHS

1 Leadership, organisation and the NHS

1.1 Leadership

What is currently known about leaders and leadership? The ongoing attempt to identify the characteristics necessary for effective leadership over recent years has been described as an 'obsession' studied more extensively than almost any other characteristic of human behaviour (Higgs, 2002; Tourish, 2008). Alimo-Metcalfe, Alban-Metcalfe et al. (2007) in their comprehensive review of the literature, show that formal studies of leadership date back (at least) to the beginning of the 20th century. They propose, that despite changes in the way leadership has been studied and the underlying epistemological stance taken by the researchers, *"in all cases, the emphasis has been on identifying those factors that make certain individuals particularly effective in influencing the behaviour of other individuals or groups and in making things happen that would not otherwise occur or preventing undesired outcomes"* (p. 2). As *"many have pointed out, that in spite of the plethora of studies, we still seem to know little about the defining characteristics of effective leadership"* (Higgs, 2002, p.3). Even so this has not appeared to quell the appetite for pursuing an ideal of leadership, impelled by the changing demands of organisations echoed across public sector institutions such as the NHS. These changes are in part the result of technological advancements which impact upon clinical practices, demographic changes both of which have altered the strategic, structural and financial profile of health (and social) care (Tierney, 1996).

The tantalising questions remain though about what those factors might actually be and the significance of the context to 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).

But in addition, or conversely, the context, culture, climate and/or structure of an organisation each have an impact on the performance of the people who lead in it (Carroll, Levy, & Richmond, 2008; Goodwin, 2000; Michie & West, 2004).

Focusing on the relationship(s) between 'leadership' and context has revitalised contemporary research particularly through the development of qualitative research, discursive and social constructionist epistemologies (Grint, 2005; Uhl-Bien, 2006) although it is unclear at this stage how far a connection might be developed between this research and its applications, for example in health care services (Fambrough & Hart, 2008).

In what follows in this chapter we explore the changing ways in which leadership has been conceptualised over the past fifty years, particularly focusing on how it has and *might* be operationalised in the NHS (particularly although not exclusively in a *hospital* context) .

1.2 Background and introduction to the study

The NHS Modernisation Agency Leadership Centre (NHSMALC) website³ had originally suggested that effective leadership is a key ingredient in modernising today's health care services. In its own words:

Effective leadership and management in the healthcare system are key drivers in patient experience. Governance and good environments matter to patients, their visitors and carers and staff.

But how might effective leadership be achieved and sustained? The NHS Leadership Centre commissioned a number of leadership initiatives (Larsen et al., 2005). The NHS Institute for Innovation and Improvement (2005) *NHS Leadership Qualities Framework*⁴ emphasised the *situational* nature of leadership and indicated the circumstances under which different leadership qualities will take precedence.

These comprise fifteen contextualised qualities covering a range of personal, cognitive, and social characteristics arranged in three clusters which are set out in Figure 1:

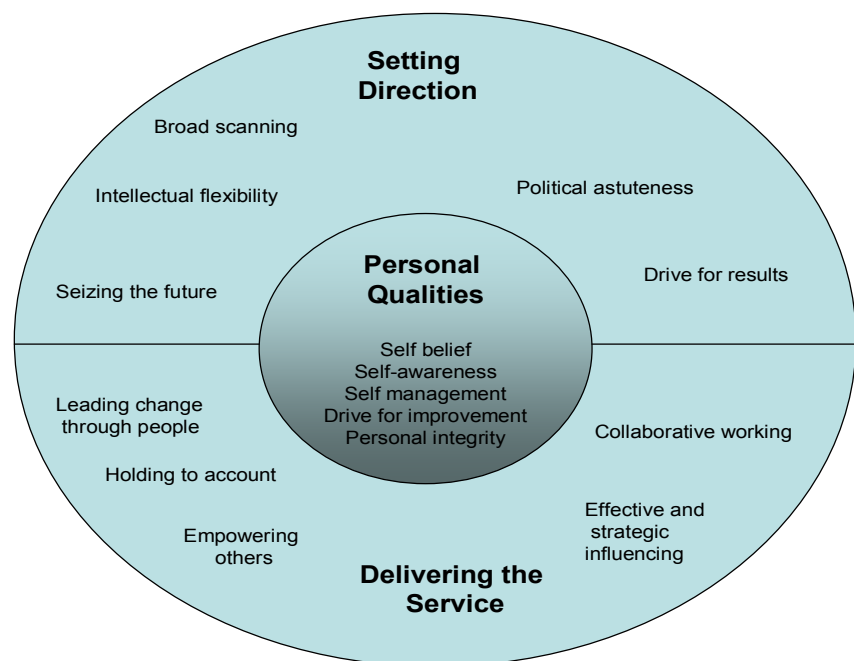
³ <http://www.dh.gov.uk/en/managingyourorganisation/leadershipandmanagement/index.htm>

⁴ <http://www.nhsleadershipqualities.nhs.uk/>

- *Personal Qualities*
- *Setting Direction*
- *Delivering the Service*

Thus, a competent leader enables development in an organisation that is goal directed, geared to developing processes and systems and enables staff at all levels to plan effectively and efficiently towards agreed goals (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Figure 1. The NHS Qualities Framework



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However, these same authors underscore the point that there is something beyond leadership competency that needs to be addressed, particularly in a changing and complex context such as an NHS Trust. *That is that a leader is someone who encourages and enables the development of an organisation in a culture based on integrity, transparency and valuing others. Leaders also need to question, think critically as well as strategically* (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Since the publication of the *NHS Leadership Qualities Framework* in 2005 all efforts have been directed to recognising and discussing leadership qualities and making strides towards their implementation. In 2008 Clare Chapman, Director General of the Department of Health's Workforce declared:

*Leadership is all about creating value for customers and citizens whilst also making work worthwhile for staff. This sounds incredibly straight forward - but it requires courage and resilience, and commitment throughout the entire piece*⁵

David Nicholson the CEO of the NHS in the report *Inspiring Leaders: Leadership for Quality* (January 2009) building on Darzi's *NHS Next Stage Review*⁶ stated:

It is imperative that we align what we are doing on leadership with what we want to achieve on quality. This is what I call leadership with a purpose.

Over the past year, the Department of Health has worked extensively with the NHS and other stakeholders to determine how best to foster talent and leadership development, and it is clear that there is a great deal of enthusiasm for a more systematic approach.

Spotting and developing confident leaders is a priority for us all if improving quality is our shared purpose. This guidance represents our best collective thinking to date. I invite you to use it and contribute to its improvement as we learn how to bring leadership centre stage over the coming months.

Nicholson and his team have charged the Strategic Health Authorities with finding gaps in leadership and systematically nurturing talent across the whole of the NHS. Clearly, the enthusiasm of successive senior officers in

⁵ DH_083353.

⁶ www.dh.gov.uk/en/Healthcare/Highqualitycareforall/index.htm

government and the NHS has been to link effective leadership with good service delivery and patient care as the primary outcome.

1.2.1 Leadership and Better Patient Care in this Study

This rhetoric and confidence about the type of leadership that best suits the NHS from those who lead it gave us pause for thought (Milewa, Valentine, & Calnan, 1998; Mueller, Sillince, Harvey, & Howorth, 2004b). 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 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 aims were overall to seek out the meanings and perceptions of relationships between (effective) 'leadership' and (better) 'patient care' and how leadership is transmitted across organisations to impact upon service delivery, taking account of the mixed methods and specific social science and systemic approaches that the investigatory team proposed. This inevitably has brought certain issues to the fore and (possibly) obscured others.

Our starting point therefore was to hold the NHS model of leadership in mind while calling on our own specific strengths as academics, from a range of social science and methodological backgrounds, to take a cross section of Trusts, clinical specialties, services, staff grades and patient needs, and to observe the *processes of leadership* in everyday working life. From this we proposed it should be possible to determine the ways in which leadership, NHS organisations and patient care were socially and discursively constructed so that links between leadership and patient care might be explored.

In Chapter One we outline some of the important contemporary social science and organisational thinking on leaders and leadership and explore the links between this and the NHS perspectives.

In Chapter Two we set out the innovative methodologies employed to investigate and analyse the research questions. This is followed in Chapter Three with the detailed procedures used for data collection.

The results are presented across four separate chapters. Chapter Four provides the analysis of what leadership means and how it is experienced by staff and patients (Christensen & Laegreid, 2003; Fairhurst, 2005).

Chapter Five presents the results of the Organisational Climate Survey (OCS) (Stringer, 2002). In Chapter Six, open systems theory and the concept of the 'organisation in the mind' are introduced particularly focusing upon the transmission of leadership across organisations. The relationship

between leadership, authority and emotion is discussed in Chapter Seven and in Chapter Eight the role of gender relations and their impact on leadership are reviewed (Begun, Hamilton, Tornabeni, & White, 2006; Ford, 2010; Telford, 2007).

Chapter Nine covers definitions, explanations and experiences of patient care and particularly how it relates to leadership by NHS staff and patients (Begun et al., 2006; Disch, Edwardson, & Adwan, 2004).

Finally in Chapter Ten we summarise our findings, make recommendations and draw conclusions.

Appendices provide copies of the research instruments, additional statistical results and the relevant NRES information.

1.3 Theoretical Approaches to leadership

Leadership research and theory is prolific with the consequence that numerous, frequently overlapping, models of leadership are available to agencies attempting to analyse or train leaders (and indeed managers, as until relatively recently little distinction was made between these two categories, see e.g. Kotter, 1996). Over the past fifty years leadership theories have shifted through different points of focus from the 'trait (or 'great man') approach in the 1940s, through the 'behavioural' perspectives in the 1950s whereby some styles of behaviour were seen as being more or less influential on potential followers. Then since the 1960s and 1970s the focus has been upon 'situational' leadership based mostly upon Fiedler's 'contingency' theory which proposed that different leadership styles were needed for different situations (see Alimo-Metcalfe, Alban-Metcalfe, et al. 2007; Western, 2008 for further details). During the 1970s and 1980s leadership research, albeit prolific, had reached an all time low in terms of its perceived contribution to theory and added value to knowledge for practice, so that as Cummings (1981 p. 366, quoted in a review by Bryman, 2004) asserted:

As we all know, the study and more particularly the results produced by the study, of leadership has been a major disappointment for many of us working within organisational behaviour.

Bryman unpicked the implications of the phrase Cummings used "as we all know" noting that it was "simultaneously sweeping and damning" (2004, p. 730). Bryman also picks out Miner's (1975) suggestion for temporarily abandoning the concept because of its limited utility in helping us understand organisational behaviour. *Why had leadership research reached this nadir during those decades? Why has there been a more recent upsurge of interest in leadership again almost to the point of saturation?*

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Bryman in his review suggests, that the renewed confidence and interest in the study of leadership has come from improved measurement and analytic techniques, greater use of meta-analysis so that more systematic reviews could be compiled, the emphasis on *transformational leadership* and *charismatic leadership* which have provided a fulcrum for the area of research, more and better cross-cultural studies and greater diversity in the types of leadership and organisational contexts that have been studied.

A factor that may also have contributed to the idea that leadership research continues to be fruitful is that a greater diversity of methodological approaches have been added and Bryman's review specifically focused on the value added by qualitative research.

Towards the end of the 1980s and beyond, thinking about the meaning(s) of leadership came to take greater precedence than in the previous two decades, possibly because of a perceived dearth of leadership *per se*.

These deliberations cast light onto the:

- *interactions between leaders and followers* and organisational cultures (Avolio, Gardner, Walumbwa, Luthans, & May, 2004; Lewis, 2000; Schilling, 2009)
- the *management of emotion* (George, 2000; Lewis, 2005; Pescosolido, 2002)
- the *processes* of leadership (Collinson, 2005; Dopson & Waddington, 1996; Vangen & Huxham, 2003)

Even so, or perhaps because of the use of qualitative approaches and related conceptualisation, Alvesson and Sveningsson (2003) were able to entitle a recent paper arising out of their study of leadership in a research and development company: "*The great disappearing act: Difficulties in doing 'leadership'*".

By this they meant that during their study they were able to identify how the existence of the label 'leadership' led to an assumption that the concept had an empirical reality. However the results of their work indicated that leadership might be better explained as a *process or series of processes of interaction*. This conclusion raises questions about mainstream thinking on leadership which presumes observable and possibly measurable characteristics (Alvesson and Sveningsson, 2003, p. 361; see also Ford, 2010).

Most recently there has been reconsideration and development of ideas about leadership in context taking account of the relevance of some earlier studies of organisations (e.g. Lewin, 1947) and open systems theories (see

Chapter Six; Laughlin and Sher, 2010) and new epistemological positions (e.g. Ford, 2010).

In our study, as a consequence of these recent critiques of leadership research and the result of methodological innovation, we approached the concept of 'leadership' as not necessarily a property of one individual (although it can be) or of one specific role, such as Clinical Director or a service manager, but rather we identified leadership as a *process* occurring within a group, organisation or collectivity that *imagines, wills and drives change* (Gabriel, 2004; Gronn, 2002).

1.3.1 Dimensions of Leadership and their Value for the NHS

Leadership, *as a practice*, has been on occasions constructed as 'a beautiful or rarefied ideal' an idea which has little use in the real world particularly as it has been suggested there are at least 350,000 definitions of leadership in the academic literature (Pye, 2005; Tourish, 2008; Western, 2008). *The question for this report is how to identify the literature on leadership and organisation with the most relevance for the contemporary NHS.*

Most discussed in theory and in practice over the past two decades has been the idea of *transformational leadership* (Bass, 1985) a model to explain ways in which a leader can be identified or trained to demonstrate the qualities that enable her/him to *perform beyond expectations*. The phrase 'transformational leadership' was coined originally in 1973 by Downtown but did not gain impetus until 1978 when Burns published his book, *Leadership*, which highlighted the *relationship* between leaders and followers (Burns, 1978).

Until then, as shown above (see Bryman, 2004) there had been little by way of a breakthrough in applicable knowledge. Burns (1978) demonstrated a *psychological* difference between an exchange relationship - where followers respond to leaders because of rewards they might receive - and one in which they respond to leaders who transform their attitudes and behaviours through inspiration and/or charisma (Bass, 1985; Yukl, 1999; Rafferty and Griffin, 2004). Transformational leadership then, is concerned with emotions, values and ethics, standards and long term goals which include assessing followers' moves and satisfying their needs (Currie & Lockett, 2007; Day, Gronn, & Salas, 2006; Eagley & Johannesen-Schmidt, 2003; Northouse, 2004).

Recognition that transformational leadership is not simply an individualistic model but one that *teams* can display (Day et al., 2006; Gronn, 2002; Sivasubramaniam, Murry, Avolio, & Jung, 2002) has shifted the

concentration from individual leaders per se to a more diffuse and distributed model of leadership and organisation context.

1.3.2 What constitutes transformational leadership?

Bass (1985) highlighted several characteristics of *transformational (or transformative) leadership* that allow followers and leaders to achieve far beyond their expectations. These are not discrete categories but given the significance placed upon the ideas behind transformational leadership in the scientific and training literature it is worth outlining the basic ideas behind these characteristics/types which have been identified as:

- Charismatic leadership
- Inspirational motivator
- Intellectually stimulating leadership
- Considerate leadership

Charismatic leadership

Bass (1985) proposed that "*charisma is a necessary component of transformational leadership*" (cited in Yukl 2002, p.261) and that charismatic leaders are endowed with exceptional personal qualities that attract followers. Charisma, a word derived from the Greek, means "*divinely inspired gift*" and is thought to give people the ability to perform miracles or predict the future (Yukl 2002, P. 241).

It is for this reason that charismatic leaders are often regarded as "*visionary, a futuristic, or a catalyst for change*" (Murphy 2005, p. 131; see also Bass 1985; Bennis & Nanus, 1985). Due to their rare personal qualities charismatic leaders are able to convey their visions to their followers in a clear and concise manner allowing them to visualise what they could achieve in the future if they worked together towards a common goal. As the leader's vision is normally realistic yet optimistic, it empowers the followers granting them greater self-esteem, encouraging and inspiring them to achieve the vision (Bennis & Nanus, 1985; Northouse, 2004; Yukl, 2002).

Inspirational motivator

Through their charisma, transformative leaders have the ability to inspire their followers through words of profound wisdom, or at least is what is *perceived* to be profound wisdom, such as with the case of Jim Jones⁷ in the USA or more positively President Obama who has reformed health care and banking legislation in the USA against the odds. Transformative leaders are

⁷ In 1978 Jim Jones persuaded more than 900 members of his People's Temple in Jonestown, Guyana to commit mass suicide.

excellent communicators which allow them to turn their visions into reality. Many use emotional and optimistic speeches to inspire their followers. They usually lead by example and often become role models to their followers who are in awe of their moral and ethical character. Many followers try and emulate their leaders' good qualities and are confident that their leaders will make just decisions on their behalf leading them to a prosperous future (Kellerman, 2004; Rafferty & Griffin, 2004).

Intellectually stimulating leadership

Transformational leaders have the ability to captivate their audience making the most mundane speeches and events interesting. They encourage their followers to be innovative, challenging the status quo and their own values and beliefs (Northouse, 2004). They also encourage their followers to solve problems and take an active role in the organisation, thus enhancing their self-worth and self-esteem, increasing their job satisfaction and productivity.

Considerate leadership

Transformational leaders are often also considerate leaders who are adept at performing mentoring or advisory roles to support their followers' emotional needs (Hiller, Day, & Vance, 2006; Rafferty & Griffin, 2004). Such leaders listen carefully to their followers' needs and desires, empathising with them during difficult periods. Being empathetic also builds a strong bond between leader and follower and thus a strong reciprocal relationship (Simpson & French, 2005).

It is important to note though, despite the wide take-up of transformational leadership as a conceptual model and a *practice*, that there remains uncertainty about the ambiguity of subdivisions and distinctions between elements in the model. Theoretical distinctions between 'charisma' and 'inspirational motivation' have become blurred over time and some theorists have suggested that elements of transformational leadership might also be identified as *transactions* (see Rafferty and Griffin, 2004 for a discussion of the implications).

Further concerns have been raised about how transformational leadership can take place in organisations, particularly public service ones, which are constrained by government initiative and targets and localised regulatory and normative pressures (Currie & Lockett, 2007; McNulty & Ferlie, 2004). However, it may also be that professional staff (rather than leaders/managers) in contexts such as health care, may in fact be more transformational than might be predicted because of their long-term commitment to the organisational goals (McGuire & Kennerly, 2006).

Most recently the notion that transformational leaders are very much 'engaging' leaders has been proposed (Alimo-Metcalfe, Alban-Metcalfe et al, 2007; Alban-Metcalfe & Alimo-Metcalfe, 2009; Macy & Schneider, 2008).

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One further comment here concerns the role of *gender* in styles of leadership and its consequent impact on organisational transformation (Fletcher, 2004; Mandell & Pherwani, 2003). There is evidence that (whether displayed by a woman or a man) feminine styles of leadership may be more related to engagement, emotional and social intelligence and distributed leadership, which may be important for complex organisations such as the NHS (see below).

1.4 Leadership, organisation and emotion at the turn to the 21st Century

Models of leadership and organisation theory have evolved over time and leadership and organisational structures and cultures are intrinsically linked in the literature. Leadership, if it is to motivate, innovate and move organisations to change, has to have an *emotional dimension* and, thus, effective leaders have a clear *emotional agenda* (as well as a strategic and structural one) which is particularly acute in services such as the NHS which is working to serve people's health care needs (Ashforth & Humphrey, 1995; Bolton, 2000; Pye, 2005).

Exploring organisations and leadership at the level of 'emotion' has become contested territory, as recognition, that organisations and their leaders need to take account of emotional engagement (Alban-Metcalf & Alimo-Metcalf, 2009; Vince & Broussine, 1996) at all levels of the work place, has emerged. Prior to the 1980's, organisational literature had been dominated by cognitive orientation (George, 2000) which favoured the rational, 'masculine' and scientific explanations of organisations and their leaders. This notion therefore ignored the (so called) irrational and 'feminine' characteristics of emotion, which were deemed detrimental to productivity and success. At that time emotions were regarded as the culprits that distort an individual's perceptual and cognitive faculties and therefore should be kept under control (Alvesson & Sveningsson, 2003b; Clarke, Hope-Hailey, & Kelliher, 2007; Dasborough, 2006; de Raeye, 2002; Ford, 2006).

As social and occupational psychologists began to study the effects of positive and negative moods on decision making, job satisfaction, choice of work-based activities and organisational climate, however, (Isen & Means, 1983; Rafaeli & Sutton, 1987, 1989) 'emotion' as part of organisational life gained impetus once again. This resurgence coincided with leadership theorists studying how moods and emotions could effect the quality of leadership (George, 2000).

It is possible to trace a rough trajectory from the 'hard nosed' scientific management, with the organisation perceived as a 'machine' in the early twentieth century, through towards a more humanistic, emotional and

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sometimes even spiritual way of thinking about contemporary leadership and organisational metaphors towards the twenty-first century, all of which are potentially transformational, not simply to the individuals concerned, but to the organisational dynamics.

Hochschild's (1983) *The Managed Heart* has been credited with being one of the earliest examples of research into emotions and organisational settings (Ashkanasy, Hartel, & Daus, 2002). She looked particularly at the airline industry and how airline cabin crew managed their emotions for dealing with difficult passengers and to promote a particular airline image. She termed this emotional management '*emotional labour*' (Hochschild, 1983).

Since this publication, the study of emotions in organisations has increased (Ashkanasy et al., 2002) with academics concentrating on key concepts such as emotional labour, emotional intelligence, mood analysis and Affective Events Theory (AET) and most recently a return to psychodynamic understanding of organisations and groups (see Ford, 2010; Schwarz, 1990). Since the 1990's a plethora of literature has emphasised the role of emotional concerns in private sector organisations such as the airline industry (Hochschild, 1983; Taylor & Tyler, 2000; Tyler & Abbott, 1998), service sector (Crang, 1994), merchant banking (McDowell & Court, 1994; Pugh, 2001), law (Harris, 2002) and image consultancy (Bryson & Wellington, 2003; Wellington & Bryson, 2001).

However, emotionality in the public sector was mostly neglected until 2000's when a surge of literature began to be published analysing the NHS (Allan & Smith, 2005; Bolton, 2000; Cummings, Hayduk, & Estabrooks, 2005a; Hunter, 2005; Lewis, 2005; McCreight, 2005; McQueen, 2004; Michie & Gooty, 2005; Michie & West, 2004; Smith, 1992) and the fire service (Archer, 1999; Scott & Myers, 2005; Ward & Winstanley, 2006; Yarnal, Dowler, & Hutchinson, 2004).

1.4.1 Emotional labour, leadership and patient care

Hochschild differentiates between emotional labour and emotional work or 'face-work' (Goffman, 1967). Emotional work has been described as the effort we put into presenting and representing our feelings as well as into feeling what we ought to feel (see Fineman, 2003). For example, a person ought to feel happy at a wedding and sad at a funeral and if their emotions do not match these expectations then a person must perform emotional work to display the appropriate emotion. This is sometimes difficult as people struggle to disguise their true emotions and perform the socially acceptable emotion.

When a person's emotions are appropriated and performed for commercial gain it is known as *emotional labour*. Hochschild states that emotional labour occurs in many occupations. However, she believes it to be more

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prevalent in service industries, such as the airline industry, where workers' emotions are sold as part of a commercial package⁸. Employees working in service industries must be skilled at managing their emotions and facial expressions in order to project the correct emotion to the customer (Crang, 1994; Lewis, 2005). This often means that employees have to suppress their own emotions in order to perform and display emotions that are suitable for commercial gain and in alignment with the organisations' image (McDowell and Court 1994).

Surface acting allows the employee to make up an outward gesture (Hochschild, 1983), to perform emotions that are not actually felt. In contrast, deep acting means that the employee can suppress or become estranged from their true feelings and *actually feel the emotions* that the employer wants them to display. *"One finds that the performer can be fully taken in by his own act, he can sincerely be convinced that the impression of reality which he stages is the real reality"* (Goffman 1990, p.28).

In the NHS, positively managed emotions *could* lead to better patient care, greater patient satisfaction and a relaxed and professional organisational climate (Amendoldair 2003; Bolton 2003). Lewis (2005) highlights how nurses in a special care baby unit appropriately managed their emotions to create a professional organisational climate, in which to offer quality patient care to special needs babies and emotional support to their parents. Lewis suggests that a nurse's job is sometimes very stressful and emotionally destabilising, especially when a baby dies. Nurses need to be conscious of their own emotions and regulate them to prevent causing further distress to the parents by displaying a professional demeanour (Bolton 2001).

However, managing emotions in this way, particularly if they are not felt, comes at a psychological and emotional cost and the whole process would be problematic without attending to emotional intelligence.

1.4.2 Emotional intelligence, leadership and patient care

The 'discovery' of emotional intelligence (EI), despite on-going valid critiques (see below) marked a turning point in contemporary organisational theories and approaches to leadership because of the tradition that emotions represent a threat to rationality – a view that has been widespread particularly in North America and North Western Europe (Fambrough & Hart, 2008; Western, 2008).

⁸ For a critical analysis of Hochschild's dichotomy of emotional labour and work see Bolton 2000 and Bolton and Boyd 2003.

Mayer and Salovey (1995), who conceived the idea of emotional intelligence, defined it as the ability to manage and understand one's own and other people's emotions in a consistent way so as to reflectively promote emotional and intellectual growth. Goleman (1996; 1998) who popularised the concept, identified emotional intelligence as a set of competencies, redefined and restated by George (2000) as follows:

- The expression and appraisal of emotion
- Enhancing cognitive process and decision making
- Emotional knowledge
- Managing emotions

These characteristics appear to have much in common with the rhetoric of transformational qualities of leadership although in many ways EI has become a management 'tool' rather than a critical model. To this end (apparently) Goleman (Goleman, 2000; Goleman, Boyatzis, & McKee, 2001) focused on 'styles' and 'performance' which seem far away from the 'heady' descriptions below of qualities of emotional intelligent leadership, which refer to feelings, empathy and creativity.

The expression and appraisal of emotion

An emotionally intelligent person will be able to understand their own and others' feelings and able to empathise, which may enable them to be manipulative for better or for worse.

Enhancing cognitive processes and decision making

Having emotional intelligence allows a person to use emotion to be creative, solve problems, make decisions and flexible plans for themselves and on the behalf of a group. An emotionally intelligent leader will be able to judge their mood and make decisions accordingly. If the person is in a negative mood this may mean choosing to wait until such negative episodes have past in order to make a comprehensive decision.

Emotional Knowledge

Emotionally intelligent people understand how other people may be affected by their negative moods and therefore may take care not to spread bad feeling around the group.

Managing Emotions

Many leaders are able to manage their followers' emotions as well as their own, but as indicated below, developing the qualities required to manage emotions effectively is highly complex and more about processes than style or performance (Fambrough & Hart, 2008; Hughes, 2005). As Fambrough and Hart argue 'emotional intelligence' has passed into common use among organisational leaders with little recognition of the way it has been identified

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as problematic. *What has been so attractive about EI to leaders in health care organisations?*

The idea of emotional intelligence captured the imagination of some training NHS staff as a means to improve staff relationships and enable clinicians to empathise with their patients (Allan & Smith, 2005; Cummings et al., 2005a; McQueen, 2004; Amendolair 2003, Luker et al 2002). McQueen (2004) reflecting on the 1960's when health care workers were encouraged to hide their emotions from their patients, for the sake of maintaining a professional role, suggests that in recent decades this view of nursing has changed and health care workers frequently display emotions to illustrate their commitment to patient care (Williams 2000). McQueen suggests that emotionally intelligent nurses are important for building strong patient-nurse relationships (Conger and Kanungo 1987 and (Lewis, 2005). Nurses with high Emotional Intelligence are able to build rapport quickly with their patients through communication and interactive skills (Schutte et al 2001).

McQueen (2004) also states that "*emotional labour calls upon and engages*" emotional intelligence (2004, p. 103). In order for patients to feel cared for nurses have to constantly *perform* positive emotions and behaviours such as warmth, friendliness and consideration. However, when confronted with a 'difficult' patient nurses may experience negative emotions such as frustration, irritation or anger. The nurses must be emotionally intelligent enough to identify their emotions and then perform emotional labour to submerge the negative emotions in favour of more positive emotions (Bolton 2003).

While EI *per se* needs to be understood more critically (Fambrough & Hart, 2008), the introduction of emotional management and engagement by leaders (and others) in health care organisations needs further scrutiny (see below); despite the best efforts of some management gurus emotion is a fact of personal, interpersonal and organisational life particularly when considering what it means to deliver patient care.

1.4.3 Beyond emotional intelligence

Interest in EI has continued to grow among management and organisational academics with a focus on how to measure it – the conclusions generally indicating the need for caution in measures to predict or to establish baselines for its development among managers (Conte, 2005). The conflation of managerial skills as listed by Mintzberg (Mintzberg, 1973) cited in Riggio and Reichard, (2008) which included the ability to 'deal' with subordinates, 'empathize' with top-level leaders and establish and maintain social networks, alongside managing emotions as a leader, have come to be known as 'people skills'. These are clearly represented in the NHS leadership qualities framework and vital for managing in any organisation (see Figure 1).

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1.4.3.1 Social intelligence (SI) and leadership

In 2006, taking account of advances in neurological psychology, Goleman (Goleman, 2006) proposed that because humans are *designed* for social connection, rapport and supportive emotional interactions enhance performance of managers and leaders. He listed these qualities under the umbrella of 'social intelligence' and identified four dimensions:

- *Synchronization* – whereby matching moods lead to a sense of rapport
- *Attunement* – listening fully
- *Social cognition* – understanding how people interact
- *Social facility* – finding it easy to interact with others

While some people have little difficulty meeting these criteria and mastering their social intelligence, others (such as Narcissists, Machiavellian and Psychopathic types), Goleman argues, do not have the capacity for social intelligence, and thus he proposes a means of *selecting* effective leaders by testing these qualities. This model albeit individualistic has something to offer through extending the theoretical underpinnings of 'people skills' and emphasising the importance of taking followers and colleagues seriously in decision-making.

Following EI and SI in bringing management/organisational theories together with developments in psychology, particularly cognitive neuroscience and evolutionary psychology, is the reconsideration of the role of intuition in understanding leadership and organisational behaviours (Sadler-Smith, 2008). Sadler-Smith brings the idea of the 'gut feeling' into the foreground to explore the influence of this sense upon decision-making particularly under pressure (e.g. many emergency clinical decisions rely on the clinician's instinct of whether the patient should be operated on, admitted to hospital, whether to call for support).

It seems that while there is a continuing trend towards an evidence-based understanding of leadership, success there is also an emergence of features of human life that are difficult to explain and measure, although all the proponents cited above stick to the view that these characteristics are scientifically explicable and measureable despite challenges from both positivist and critical social constructionist positions (Ashforth & Humphrey, 1995; Conte, 2005).

1.4.3.2 Affective Events Theory (AET)

AET predicts that specific features of work (e.g. autonomy) have an impact on the arousal of emotions and moods at work that, in turn, co-determine job satisfaction of employees. AET further proposes that job satisfaction is

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an evaluative judgement that mainly explains cognitive-based behaviour, whereas emotions and moods better predict affective-based behaviour. The results support these assumptions (Jürgen, van Rolf, Fisher et al., 2006). Ashkanasy et al (2002) suggested that AET has two important messages for leaders in an organisation.

- Followers' emotions are heavily influenced by their leaders' emotions and therefore leaders must minimise the 'hassles' that they place on their followers in order to increase job satisfaction and performance. Short-term negativity can be tolerated without much impact on the team or organisation.
- However, if negative events persist it will affect followers' moods leading to negative emotions, poor performance, reduced job satisfaction and in the case of the NHS, (possibly) to poor quality patient care. It is therefore suggested that leaders need to give followers positive feedback regularly to "*ameliorate the daily hassles experienced by employees*" procuring positive behaviours such as team spirit and self-worth (Dasborough 2006, p. 165 ; Weiss & Cropanzano, 1996). The connections between the moods of individuals and their performance may be understood better in terms of emotional engagement between leaders and followers on both conscious and unconscious levels (see below).

1.5 Distributed leadership

The academic study of distributed leadership, that is when at various levels leadership (or influence) behaviour, identity, role and responsibility are distributed to more than one individual or group of individuals, has been at the forefront of much social scientific leadership research over the past ten years (Buchanan, Addicott, Fitzgerald, Ferlie, & Baeza, 2007; Day, Gronn, & Salas, 2004; Gronn, 2002; Mehra, Smith, Dixon, & Robertson, 2006a). The implication of this interest in distributed leadership is, that organisations have changed and previous models - including the charismatic, 'hero' leader and the 'command and control' organisational structures - are dysfunctional in a context where organisational change is rapid and diversification of strategic leadership and management essential (Butterfield, Edwards, & Woodall, 2005; Dent, 2005; Goodwin, 2000). In a competitive, diverse and divergent environment leadership needs to be distributed, in order to enhance democratic governance, thus enhancing legitimacy and increasing survival chances (Currie et al., 2009).

Distributed leadership also implies that organisations where it is practiced have (relatively) flat hierarchies with diverse service needs and expertise across all sectors of the organisation (Huffington, James, & Armstrong, 2007). This model applies to hospitals and primary care settings, where

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distinct professional groups each have their own standards of excellence, while at the same time sharing goals of competence and quality related to the service they provide to patients and how they interrelate to other organisations.

With this shift in focus of many leadership practices and leadership studies the definition of such leadership has been proposed as:

".. a status ascribed to one individual, an aggregate of separate individuals, sets of small numbers of individuals acting in concert or larger plural-member organisational units" (Gronn, 2002, p. 428).

Gronn suggests also that when leadership is distributed it may be that the duration of that influence is limited, perhaps (structurally) to a single project and therefore (psychologically) distributed leadership might mean having to 'give up' leadership as well as take it up (Huffington et al., 2007). Furthermore, according to Gronn (2002) the most common understanding of distributed leadership, witnessed by the growing number of references to it in the research and policy literature, is that it applies to numerous people across an organisation taking some degree of a leadership role or responsibility.

More importantly, Gronn identified distributed leadership as *concerted action* meaning that there are many roles comprising a 'leadership complex' with at least three potential forms:

- *collaborative modes of engagement* which arise spontaneously in the workplace. This suggests that leadership practice is 'stretched over' the context of the organisation and not a function of those in managerial roles such as matron or clinical director. However, if the matron, clinical director and other colleagues who share ideas for change or particular activities they *may "pool their expertise and regularise their conduct to solve a problem after which they may disband"* (Gronn, 2002, p. 430).
- the *intuitive understanding* that develops as part of a close working relationship among colleagues. These relationships tend to happen over time when organisation members come to rely on each other and develop a close working relationship, to solve problems or bring about change and others might be involved in a 'framework of understanding'.
- The variety of *structural relations* and institutionalized arrangements which constitute attempts to regularize distributed action. Thus, for example, if there were dissatisfaction with existing arrangements for particular practices, a team of 'equals'

might emerge to find ways to improve or change the problematic practices.

All of these are apparent particularly, but not exclusively, in Trust Three (the FT) as exemplified in Chapters Four and Nine in particular.

Gronn argues the importance of examination of these different forms of concerted action to understand where influence (and thus leadership and power) might lie in any organisational context. Emotionally, however, these different models of distributed leadership suggest the impact of these structures and practices at a deeper level (Gabriel, 2004) particularly around authority (Halton, 2007; Hirschhorn, 1997) competition (Morgan, 2006) rivalry and envy (James & Arriba, 2005; Stein, 2005)

1.6 Organisational Culture, Climate and Contexts

As introduced above, post-industrial (or even 'post-modern') organisations (Burrell, 1988; Fineman, Sims, & Gabriel, 2005) and networked (Balkundi & Kilduff, 2006; Goodwin, 2000) organisations are changing rapidly and the NHS is clearly among these. Changes in the NHS take place at a number of levels, emerging from the direct policy dictates from central government to become local initiatives. Moreover, the NHS has become increasingly team (and indeed multi-disciplinary team) based over the past two or three decades so that knowledge, influence and leadership for transformation and change are not only moving from a top-down to bottom-up model, but as indicated, to a distributed model which involves lateral influence (Begun et al., 2006; Day et al., 2006; Ferlie & Shortell, 2001).

The type of leadership that is supported and promoted in any organisation and the related concept of the organisational structure depends on and impacts upon organisational climate and culture.

Although research undertaken on organisational *climate* and organisational *culture* comes from different epistemological traditions, since around 1990 the literature and concepts referring to both have been overlapping and/or complementary (Schneider, 1990; Schneider, 2000) and increasingly the terms are used interchangeably (Ashkanasy et al. 2000).

It is, however, generally accepted that 'climate' is a logical extension of what was originally conceptualised as 'psychological' climate, that is, shared psychological meanings in an organisation; so that *organisational* climate is an aggregation of those individual perceptions of a work-place context (James, Choi et al. 2008).

Organisational culture on the other hand has its origins in anthropology and human relations (see Davies, Nutley and Mannion, 2000; Scott, Mannion et

al. 2003). Organisational psychologist Edgar Schein's (1985/2004) ideas about organisational *culture* as a pattern of *shared basic assumptions that have worked well enough and adapt to the external environment and serve internal integration*⁹, is one of the most frequently quoted definitions. Schein takes a systems theory approach to understanding organisations and his work has been built upon by himself and others to develop a variety of typologies which underpin measures of both organisational culture and climate (see Albino-Metcalf, Alban-Metcalf et al. 2008 for a comprehensive overview of this literature).

Organisational climate, with its origins in traditional psychology is *typically* "... the only domain of organisational research that simultaneously examines perceptions of jobs, groups, leaders, and organisational attributes and thus has the unique capacity of being able to decipher common denominators and latent relationships that are not available to those who study only specific domains such as perceived equity" (James et al., 2008, p.27). We therefore made a decision to use a measure of *climate* as a backdrop to this mostly qualitative study, in order to 'triangulate' with our findings on leadership and patient care.

However, we found a competing strand of interest in the measurement of organisational *culture* (e.g. Davies, Nutley and Mannion, 2000; Scott, Mannion, Davies and Marshall, 2003) which more frequently seems to attend to health care settings than studies of climate albeit with some notable exceptions (Dawson, Gonzalez-Roma, Davis and West, 2008).

1.6.1 Emotion and the unconscious in organisations

Organisational climate and/or culture cannot be discussed without acknowledging that organisations are places where both the intellect and emotion are called into play in order to achieve organisational goals and as we have made clear, emotions are intrinsic to service delivery and leader-follower engagement in the NHS. Emotional engagement, while available to human consciousness, also takes place at an unconscious level (Gabriel, 2004; Hugh, 1986; Lyons-Ruth, 1999; Morgan, 2006; Willmott, 1986), and anxiety or stress is particularly salient when having to care for and make potentially life-saving decisions for patients (James & Huffington, 2004; Menzies¹⁰¹¹, 1970).

⁹ A paraphrase.

The ideas that characterise transformational leadership models, such as 'charisma', 'influence', 'inspiration' 'thoughtfulness' and 'consideration', have intellectual roots beyond contemporary management theory and training. They are more closely related to group and organisational theories with late 19th and early 20th century origins (De Board, 1978; Gabriel, 2004) from which much contemporary organisational theory has emerged.

The first significant attempt to analyse group behaviour made at the start of the 20th Century by Le Bon (1917/1920) whose book *The Crowd* illustrated his observation that individuals in a large group can demonstrate a 'collective mind' which emerges when people are bound together in some way. McDougall's book *The Group Mind* (1922/2009) and Sigmund Freud's *Group Psychology and the Analysis of the Ego* (1921/1922) also focused on what would subsequently come to be recognised as unconscious group processes. Freud developed Le Bon's and McDougall's ideas in the context of psychodynamic theory, arguing that the binding force of the group derives from the *emotional* ties of the members, which are expressions of their libido or drive.

Studies of (and human 'experiments' about) group psychology, taking some of this perspective on board, flourished after the Second World War conducted and further developed by psychiatrists in the newly formed NHS. In Britain the work of Wilfred Bion, Tom Main, Maxwell Jones and others led to innovations in both group psychotherapy and the study of organisations. Bion's work on group relations and dynamics which contributed to the development of the Group Relations Training Programme (GRTP) at the Tavistock Institute in 1957 evolved into the Leicester Conferences with other organisations using this model across the world (Miller, 1993). However contemporary knowledge and understanding continues to reflect back upon this early work.

What was learnt during this period about group dynamics and group relations represents an important dimension in the understanding of contemporary organisations and the relationship between leaders and followers. We develop this further in Chapter Seven in particular. It is important to note how the intellectual journey from work on emotional labour to social intelligence and intuition has so far largely neglected to explore the extent to which unconscious processes remain part of the emotional context of human social interaction (Allan and Smith, 2005, p. 21).

¹¹ Isabel Menzies is sometimes referred to as Menzies-Lyth. Her work has been reprinted several times with each name used.

In a hospital environment it is inevitable that negative events such as death occur (see Lewis for discussion on the impact of death on nurses in a special care baby unit taking an 'emotional labour' approach). When death does occur nurses may display emotions (consciously and unconsciously) such as anxiety and fear (Allan & Smith, 2005; Obholzer & Roberts, 1994; Allan 2001; Smith et al 2003). Obholzer asserts that "[he] believes that many of the organisations' difficulties that occur in hospital settings arise from a neglect of the unconscious psychological impact of death and near-death on patients and staff" (1994, p.171). He explains that hospitals are sites where anxieties about social taboos such as death are *contained*, that is that staff and the organisation overall takes away the anxiety and the responsibility for care from the relatives. Patients and staff are socialised to believe that hospitals are institutions where illness is treated and that medical knowledge and practice is infallible. This is illustrated by patients who contend that doctors possess God-like qualities and have the ability to heal all ailments. When death does occur, medical staff and the patient's relatives may feel *duped* by the institution they believed would save their loved one.

At the turn of the 19th to the 20th Centuries psychoanalytic ideas were seen to have something new and important to say, not only about the psychology of the individual and the role of the individual unconscious, but about *unconscious processes when people converge in groups and crowds* as shown above. From psychoanalytic theory we take up ideas again today specifically about the relationships which exist between followers and leaders, made explicit in the paradigm shift from transactional to transformational leadership. Working together and accepting or resisting influence comes not only with an observable set of behaviours and measurable emotions, but with unconscious and 'secret' ones including dependency, envy, power, anger, authority and emotional contagion, which may be either conscious or unconscious but have important consequences for behaviours (Burke et al., 2006; Simpson & French, 2005; Stein, 2005; Whitely, 1997). In Chapter Seven for example we see examples of where two senior managers find themselves unable to influence despite their senior roles, legitimacy and operational power. As Gabriel (2004) has argued "*emotions are no simple side-effects of mental life*" as "*emotion lies at the heart of human motivation*" (p.215).

One key feature of caring for sick patients, managing change and the social context of the NHS Trust then, is the ways in which clinicians and managers manage their anxiety which is fundamental to working in any health care setting. In the section that follows below, we demonstrate how psychoanalytic thinking explains how individual psychology and unconscious defence mechanisms link to the ways in which human beings work in groups and organisations.

In Chapter Nine we attend in more detail to the anxieties involved in obstetrics and more generally on the emotions involved in care of the elderly. In anticipation of these we present the theoretical material in some detail immediately below in this chapter.

1.6.2 Clinicians' anxiety and patient care

To conceptualize anxiety we draw on object relations theory, the branch of psychoanalysis associated with Melanie Klein (1959) and, in particular, the work of scholars who applied object relations to an understanding of groups (Bion, 1961) and organisations (Jaques, 1952; Menzies, 1970; Klein, 1987; 1983) hypothesising that an infant responds from the earliest time to the withdrawal of the maternal breast by experiencing a powerful anxiety of a 'persecutory nature'. Being unable to grasp the separation from the breast intellectually, the infant, unconsciously, feels as if every discomfort were inflicted by hostile forces. A fundamental *splitting* takes place, whereby an object is experienced as two separate objects, one entirely good and one totally bad. Thus there is a good breast (which is always present and nourishing) and a bad breast (withdrawing and denying), a good mother and a bad mother.

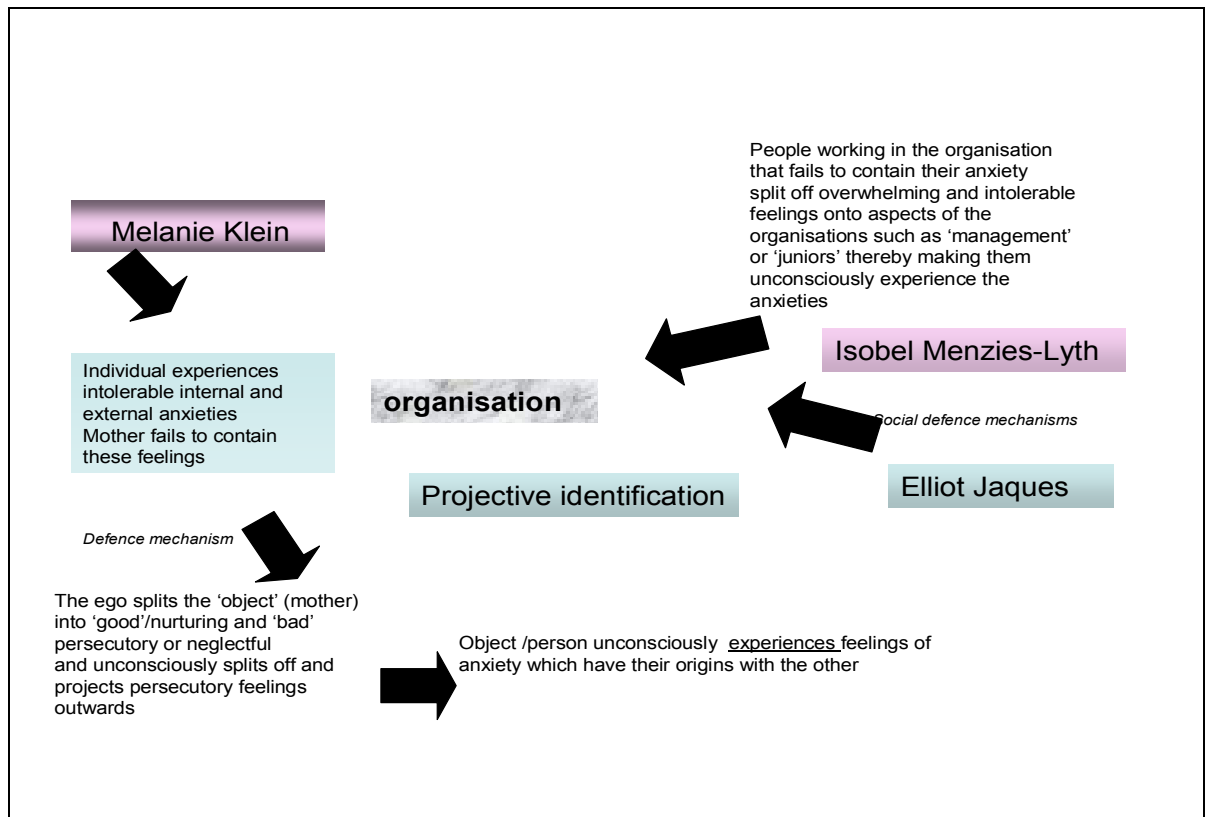
This is a pattern repeated in clinical settings, where patients routinely refer to a 'good nurse' and a 'bad nurse' and, almost identically, clinical staff referred to some patients as 'a good patient' and to others as 'a bad patient' (see Chapter Nine for an example of this). Splitting according to Klein extends in the child's own self – those aspects of him/herself that she cannot bear are projected outwards ("It is not I who is angry/fearful/envious; it is you"). Again this is a phenomenon observed many times in clinical settings. Frustration, discomfort and pain are experienced as persecution from hostile forces and their concomitants (e.g. hate) become destructive impulses which *are still operative in later life*, especially in times of stress and crisis.

Splitting and projection then are seen as fundamental *defences against primitive anxieties* by the object-relations school of psychoanalysis. Within this tradition, objects are not external entities but are shaped by phantasies¹² and feelings, they are *introjected* and projected, they split into good and bad and they constantly define and re-define the ego (or self). Object relations theory has found numerous important applications in the theory of organisations, primarily through the works of Jaques (1952) and Menzies Lyth (1960; 1970) in the UK, and more recently, Hirschhorn (1988), Gould (1993), Diamond (1993), Schwarz, (1990), Schwarz and Clore (2003) among others. Notable among these applications is the

¹² 'Phantasies' spelt in this way refers to those in unconscious experience.

treatment of *the whole organisation as an object which is liable to become incorporated in psychic reality* and towards which the individual may develop relations akin to early relations with significant objects from her environment and hold the 'organisation in the mind' (Armstrong, 2005) which we will discuss in more detail in the context of evidence from the study in Chapter Six.

Figure 2. Social Defences against Anxiety in Organisations



Menzies-Lyth, whose 1960 classic study of nursing staff occupies a privileged position in this literature, was driven by her initial observation that nursing work is highly anxiety-producing. She argued that nurses confront many different emotions from patients and their relatives - gratitude for the care they offer, admiration, envy for their skills and resentment stemming from forced dependence. Such projections create strong feelings in the nurses themselves:

The work situation arouses very strong and mixed feelings in the nurse: pity, compassion and love; guilt and anxiety; hatred and resentment of patients who arouse these strong feelings; envy of the care given to the patient. (Menzies-Lyth, 1988 , p. 46)

Faced with such an emotional cauldron, many nurses re-experience infantile persecutory anxieties, from which they seek to defend themselves, through

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the familiar mechanisms of projection, splitting and denial. Menzies-Lyth's important contribution was to establish how an organisation's own bureaucratic features, its rules and procedures, rotas, task-lists, paperwork, hierarchies and so on, in short '*the system*' acts as a support for the defensive techniques. By allowing for 'ritual task performance', by depersonalizing relations with the patients, by using organisational hierarchies, nurses contained their anxiety. Yet, in Menzies-Lyth's view, such organisational defences against anxiety were ultimately unsuccessful:

The system made little provision for confronting anxiety and working it through, the only way in which a real increase in the capacity to cope with it and personal maturation would take place. As a social defence system, it was ineffectual in containing anxiety. (Menzies-Lyth, 1991, p. 363)

The system's inadequacy in Menzies-Lyth's study is evidenced by its failure to train and retain nurses, the chronically low morale, high levels of stress and burn-out and absence of work satisfaction. By contrast, institutional health is testified not only by performance and output indicators, but also by morale indicators, and individual feelings of growth and maturation. Social defences against anxiety, then, are self-defeating. Instead of *containing* anxiety, they exacerbate it, just as neurotic symptoms far exacerbate the patient's malaise instead of containing it. Since Menzies-Lyth's pioneering work, some attention has been paid to how to support nurses and enable them to contain their emotions, without resorting to depersonalizing social defences. Yet, there is ample evidence that many nurses today continue to struggle with modest support against powerful anxieties (Theodosius, 2006; 2008). It is striking that no single study has sought to examine whether doctors face similar types of anxieties as nurses, whether they resort to similar psychological defences and the extent to which these defences function effectively across different individuals. In Chapter Nine we see evidence that doctors too appear to react similarly when faced with intolerable anxieties.

1.7 Developing our approach to leadership and the NHS

Studies of leadership and organisations such as the NHS clarify that diverse disciplinary perspectives have come together and separated more than once over the past century. The relationship between organisational and social context over that time has impacted on both practices of leadership and empirical and theoretical changes. In the 21st century the rules of scientific management or leader as therapist no-longer apply, and the rapid changes in organisations such as the NHS brought about by economic and technological imperatives, have left many who engage in leadership

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discourses, for practical and academic purposes, moving between the transformational and the post-heroic positions.

We now consider theoretical perspectives, ideas and practices that can potentially be brought together to good effect in this study for the benefit of patients and those who work for their good within the NHS, focusing on some of the recent debates which explore the context of leadership and the place of distributed leadership as they apply to NHS contexts.

1.7.1 The base-line:

- It is now widely acknowledged that organisations, their leaders and followers come together in a highly *emotional context*. How can those who lead and work in such organisations take account of the role of emotion while not being 'emotional' (i.e. making unfair and irrational decisions)? Understanding this is vital for enabling management and leadership particularly in a complex institution which has patient health, safety and care at its cutting edge (Morgan, 2006) .
- The NHS, individual Trusts and Units within these Trusts are constantly engaging staff in *change* (which may be evolutionary and/or politically driven) and which may be motivational and/or stressful or resisted (McNulty & Ferlie, 2002). This further demands emotional and social intelligence and engagement from leaders and followers (Bovey & Hede, 2001).
- The primary *tasks* and related *roles* might conflict at various points as these changes impact emotionally and intellectually on staff performance and service delivery (Zoller & Fairhurst, 2007).
- Organisations have to have leaders but leadership is not necessarily always the province of a small group of individuals but depends on the structure and demands placed on the organisations and the tasks required at any one time (Currie et al., 2009; Day et al., 2006; Harvey, 1989; Michie & West, 2004).
- An emotional context requires attention to both conscious and *unconscious* dimensions of human interaction and power relationships which may come into play in organisations which comprise multiple professional disciplines, different grades of role and people from diverse cultures, sexualities and gender (Ford, 2006; Gabriel, 2004). Acknowledgement of the importance of anxiety, envy, competition, anger and the emotional ties between people needs to be taken into account (see Figure 3 below).

Two models of leadership are therefore examined in this study (see Figure 3 below):

- First, *inspirational and transformative (or engaging) leadership* which has attracted much recent attention in that its absence was seen as a critical factor behind the failure of many organisational innovations. In this approach, leadership hinges on leaders' ability to communicate effectively, relate emotionally with their followers and develop a vision that is both attractive and achievable. The role of transformational leadership then is to lead an organisation towards change and thus some elements of transformational leadership are essential for understanding the practices and needs of the NHS (Alban-Metcalf & Alimo-Metcalf, 2009).
- The second relevant dimension is *distributed leadership* (sometimes called *dispersed, distributive, collective, or supportive 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). A *distributed leadership* approach is consistent with Bailey and Burr's (2005) research on successful NHS Trusts, which states:

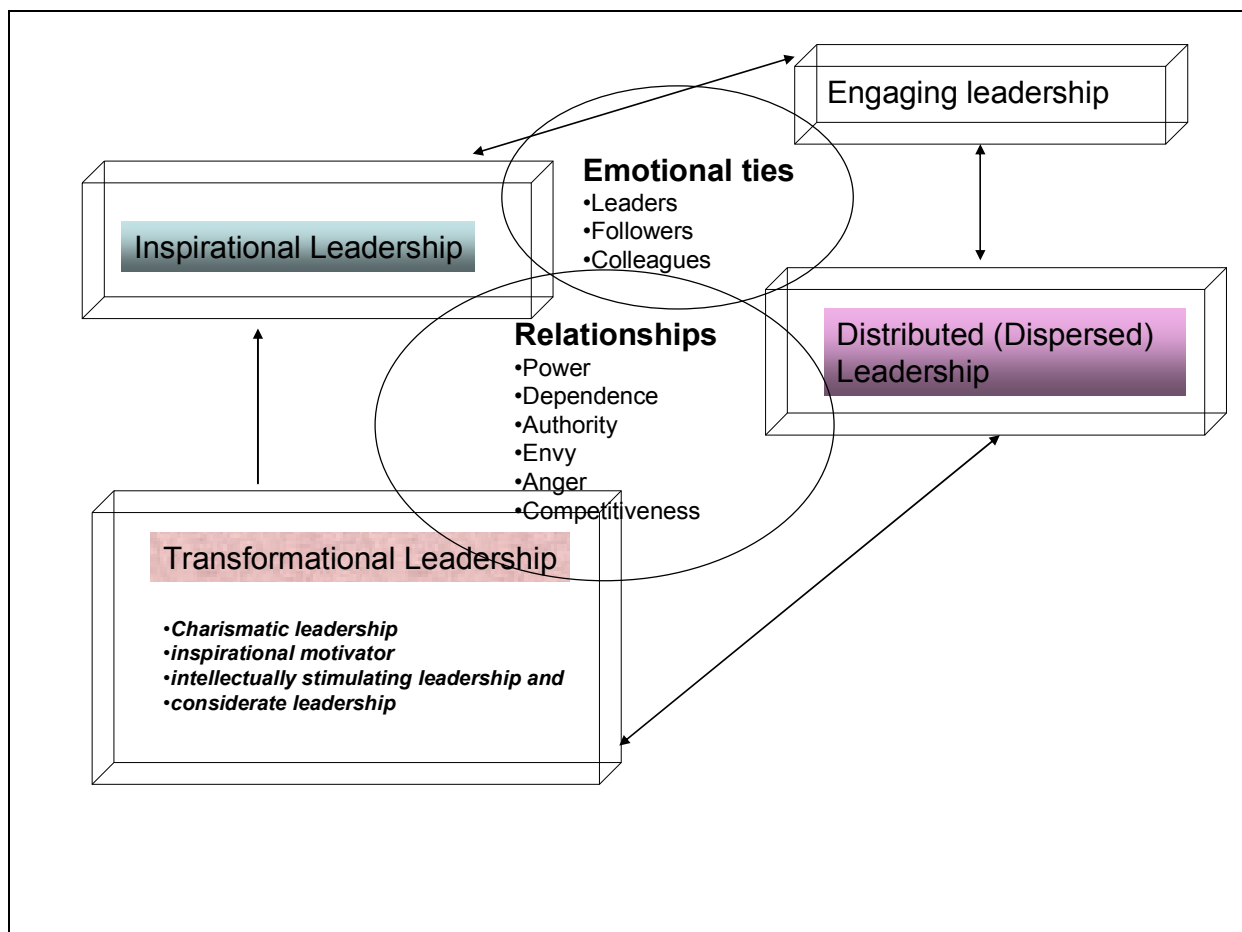
In contrast to the individual, heroic leader concept, leadership is seen in terms of the influence processes that contribute to the collective and individual capacity to work effectively. This idea of collective and distributed leadership is closely associated with the emergence and special requirements of 'new' organisational forms generally and the NHS in particular it is consistent with the agenda for devolved decision – making, empowerment of the frontline, de-centralisation, inclusion and such initiatives as 'Leadership at the Point of Care'.

Thus, distributed leadership is seen by Bailey and Burr (2005, p. 14) as directly linked to patient care.

A combination of these two models might now be seen as 'engaging' leadership as described by Alimo-Metcalf, Alban-Metcalf et al. (2007) and this combination will be explored further in our analysis of the (qualitative) data in particular.

Furthermore the model of the post-industrial/postmodern and or networked organisation will be 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).

Figure 3. Leadership Styles, Followership and Emotion



1.8 Conclusion

In an organisation like the NHS there are opportunities for leadership at all levels, as well as opportunities for success and unforeseen consequences leading to failure. Leaders in the NHS are involved *transformationally* in responding to policy initiatives and government demands, but the NHS is also an organisation that relies on the knowledge, skills and abilities of all its people – leaders and followers.

It would seem that *transformational/engaging and distributed leadership* are particularly useful conceptual resources to deploy in the context of the National Health Service, where a workforce of different ethnic, cultural and

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class backgrounds caters to the needs of a similarly diverse patient population.

Following Alimo-Metcalfe, Alban-Metcalfe et al (2007) "*an engaging 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'*" (2008, p. xi).

As part of the conceptual framework we develop, it is clear that the *emotional links* between individual staff, groups of staff and staff and patients need to be privileged as they play out at various organisational levels. Implicit therefore is that emotions above and below the surface (conscious and unconscious) are taken into account if the leader/follower and staff/patient relationships are to be understood and improved.

2 Aims and Methods

2.1 Introduction

The research questions in this study centre on identifying:

- (a) processes by which leadership is transmitted through health service organisations to effect the delivery of health services, and
- (b) how features of the organisation, the leader, and the service influence these processes.

The focus of this study was to explore the relationship(s) between (good) leadership in NHS organisations and (good) patient care. This demanded consideration not only of leadership characteristics, qualities and styles but the ways in which NHS organisational climate and culture interacted with individual practices and identities of those who worked in them and were patients. The overall plan was, thus, to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery. This research further sought to expand existing knowledge by exploring the following questions.

1. First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
2. Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

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3. Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

2.2 Aims and Objectives

We separated these overarching research questions into aims and objectives thus:

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients;
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts on service delivery;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted through health care organisations to affect service delivery, posits *organisational climate* as one feature of the organisation that could positively or negatively affect the quality and delivery of health services.
- To learn how different stakeholders (specifically, patients, nurses and professions allied with medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care.
- To identify how the need for change in service delivery is identified and what drives the need for change.

2.3 Methods

This multi-method study therefore uses a mixture of qualitative and quantitative methods to enable and support an innovatory approach to examining the psycho-

social and psychodynamic factors intrinsic to the meanings and processes of leadership, organisation and patient care.

Qualitative research methods now have a strong and long-standing profile in social science, particularly sociology and anthropology. But over recent years they have become increasingly relevant in social psychological research.

Furthermore nursing research (Finlay & Ballinger, 2006; Kerr, 2002) and most recently even health services research have begun to take evidence emerging from qualitative methods seriously. Perhaps this began with a series of papers in the British Medical Journal in 1995. Pope and Mays for example leading on this series aptly titled their paper *Reaching the Parts other Methods Cannot Reach* (Pope & Mays, 1995). Noteworthy from this point onwards is that there is no 'one' qualitative method of either data collection or analysis and we draw on several traditions and styles in this study which are outlined below.

Unlike health services research *per se*, but akin to critical social science, there is a powerful tradition in organisational research that has taken account of the diverse nature and intrinsic value of qualitative methodologies to understanding the life of organisations (see for example Cassell and Symon, 1994; Ybema et al., 2009)

What counts of course is choosing methods which meet the demands of the research hypothesis or overarching questions. We thus began from the premise that 'leadership', 'patient care' and 'organisational change' are not objective facts but social or discursive constructions. By this we mean that these concepts are constructed through discourse, i.e. a coherent system of statements which constructs an 'object' (Parker, 2002). In other words, talk about leadership is the process by which leadership is constructed (and thus recognised) as something that happens in organisations such as the NHS.

To capture these constructions we used a range of methods:

- focus groups;
- a survey-based questionnaire including a standardized measure of Organisational Climate;
- ethnographic 'shadowing';
- observations of social places, formal and informal and meetings;
- analysis of 'stories' of leadership collected through in-depth interviews.

2.4 Capturing the data

In what follows we present the outline plans for capturing, managing and analysing the data to meet our aims although as shown in Chapter Three not all of our goals were achieved.

We focused upon three NHS Trusts with at least one being a Foundation Trust specifically to explore whether any variations in the qualities of leadership, organisation and patient care could be distinguished. An

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investigation of three Trusts was considered to be manageable within the time frame and other resources available for the project.

Within each Trust we chose two distinct 'units' to study. We conjectured these would probably to be defined by clinical speciality or site (bearing in mind that many Trusts are organised across more than one hospital/physical space).

We conducted focus groups, an organisational climate survey, story-telling interviews and ethnographic work (observations and shadowing) across these six units with staff and patients.

We employed two researchers¹³ to carry out the majority of this work, but some members of the investigatory team also took an active part in the process.

The qualitative data would by necessity and designed be analysed using a variety of methods:

- a. Thematic analysis (TA)
- b. Critical Discourse Analysis (CDA)
- c. Narrative analysis

Each of these approaches to data analysis, again by necessity and design, was subject to nuances of interpretation, intrinsic to their nature.

¹³ In the event three researchers were involved because of maternity leave and cover.

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graph TD
    NRES[NRES application] --> Local[local governance]
    Informal[Informal and formal approaches to 'gate-keepers' by research team] --> Local
    Informal --> Trust[The Trust]
    Local --> Trust
    Local --> SiteA[Site A]
    Trust --> SiteA
    Trust --> SiteB[Site B]
    Trust --> Unit1[Unit 1]
    Trust --> Unit2[Unit 2  
As Unit 1]
    Trust --> Other[Other parts of the Trust]
    SiteA --> Unit1
    SiteA --> KeyInformants[Key informants at site and Unit level]
    KeyInformants --> Unit1
    KeyInformants --> Staff[Staff]
    KeyInformants --> Patients[Patients]
    Unit1 --> Staff
    Unit1 --> Patients
    Staff --> Patients
    Staff --> Other
    Patients --> Other
    Other --> Survey[Organisational Climate Survey]
    Other --> DataCollection[Meeting staff and negotiating individual arrangements for data collection]
    DataCollection --> Staff
    DataCollection --> Patients
    DataCollection --> Other
    DataCollection --> Interviews[Interviews]
    DataCollection --> FocusGroups[Focus groups]
    DataCollection --> Shadowing[Shadowing]
    DataCollection --> Observations[Observations]
  
```

The flowchart illustrates the research approach, starting with the NRES application and local governance. The research team uses informal and formal approaches to 'gate-keepers' to gain access to The Trust. The Trust then facilitates access to Site A, Site B, Unit 1, Unit 2 (As Unit 1), and Other parts of the Trust. Site A leads to Unit 1, which then leads to Staff and Patients. Staff and Patients are involved in the data collection process, which includes Interviews, Focus groups, Shadowing, and Observations. The data collection process also involves Meeting staff and negotiating individual arrangements for data collection. The final outcome is the Organisational Climate Survey.

The Trusts

- they were each different from each other in the image they projected (on their web-sites, in terms of their physical style,

50

locality, size and community) and that the sample had to include one Foundation Trust.

- they were in easy reach of London (for practical purposes as the study team were based in London and Surrey).
- we were able to gain access via personal contacts in R & D or senior management (the 'gatekeepers').

The Units

Sampling of the Units in each of the Trusts was achieved through negotiation with the gatekeepers and/ or key informants recommended by the gatekeepers with the intention that a balance might be struck between:

- the specific academic interests of the research team (for example the PI is particularly interested in Obstetrics and Gynaecology services).
- some degree of opportunity for comparison between Trusts, so that if possible some similar Units might be compared across the Trusts.
- and (possibly most influential) the concerns of the gatekeepers and other senior Trust staff.

The Sites

All three Trusts selected for an initial informal approach were on more than one site although the selection of study unit determined whether or not the data was collected on more than one site.

Individual Participants (staff)

Individual participants were to be selected on an 'informed' volunteer basis. That is that via a process of meetings with key informants and presentations to staff-groups individual staff would hear about the study and be offered the opportunity to participate. For those who were not involved in the meetings or presentations a staff e-mail list was used to communicate information about the study and request volunteers to participate in interviews and focus groups. The intention to meet the study aims was to ensure participation from a variety of staff groups and levels of seniority.

Individual Participants (patients)

Patients were to be recruited for interview either by the staff directly caring for them or by the researchers themselves once the staff of each unit had become familiar and accepted the presence of the researchers.

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Survey Respondents (staff)

The Organisational Climate Survey (OCS) was to be administered within the Units that were the focus of the study and, if possible, across other Units in the Trusts. The circulation was to be achieved either through e-mail or through internal mail depending on negotiation with the relevant gate-keepers.

Survey Respondents (patients)

Patients who might complete the patient version of the survey were to be recruited by staff and/or researchers if staff permitted the researchers 'on the ground' access.

Observations and 'Shadowing' (staff and patient-staff interactions)

These methods would require the participants to be familiar and comfortable with the presence of the researchers and familiar with the ongoing research process and also be prepared to co-operate. The rules for engagement in the activities would then be made on a strategic (i.e. the staff and / or situation that would yield the richest source of information) and a pragmatic basis (i.e. the possibility of the situation yielding important data regarding leadership, organisational culture and climate and patient care).

2.6 Ethical considerations

There are clearly considerations about confidentiality and anonymity in all data collection which involves human participants Easily identified in this study (and thus in the NRES application) is the matter of the safe keeping of the raw data including completed questionnaires, any identifying characteristics of these questionnaires, digital recordings, transcripts from focus groups and interviews and the researchers' field notes. It is important to note that this is not necessarily as simple to do as it is to describe particularly because a team of investigators, the researchers themselves and some 'casual' clerical staff ¹⁴all had different types of access to the data.

The solution was to have a shared drive set up by the computer centre at Royal Holloway, University of London (RHUL) on the main site at Egham which could only be accessed by specified investigators identified by the PI. Additionally there was an access pass-code to read the transcripts and the SPSS file.

¹⁴ The sheer volume of data made it necessary to use more than one person to input the data and transcribe the recordings. Two people other than the researchers were engaged to work on this although both were employees of RHUL who knew the importance of keeping the data safe.

Another ethical consideration specific to this project was that because the staff were discussing leadership and being asked to give examples of good and bad leadership, as well as examples of effective and poor patient care, it was inevitable that:

- they would be talking about *other* members of staff. These other staff could not be told that they had been talked about (by definition) leaving them unable to provide their version of the story or aware of the fact they had been discussed.
- the researchers would therefore be 'holding' some knowledge of others which would be 'data'. This fact drew attention to the ethical and empirical complexities of working in an organisation in which data is being collected on human interactions and relationships.

As patients' experiences and views and staff's views of patient care were also part of this investigation, similar issues applied.

Finally, frequently overlooked but nonetheless very important consideration was given to the fact that participants' time should not be wasted. We were confident in the design and our experience as investigators supporting and managing the researchers (who themselves were experienced in this kind of study) that the study was robust enough to adapt to the vagaries and quirks of 'real life' and that the outcome would be valid and add value to existing knowledge.

2.7 Methods of data collection and research instruments

As described above a mixture of qualitative and quantitative methods were used to ensure a full picture of leadership in the organisations to be studied. Collecting data in applied settings, where the participants are also engaged on a day-to-day basis is demanding work which is challenging for researchers involving persistence, social skills, the ability to develop rapport, clarity of purpose combined with flexibility, the skill of 'thinking on your feet' and making practical judgements about what is feasible at any one time. For example, if plans had been set for an interview with a staff member who was then called away for an important work matter, the researcher could arrange other potential participants or be prepared to engage in a period of systematic observation.

Immediately below we describe the methodologies we chose to employ to conduct our investigations which will be described in greater detail where appropriate in the context of specific case studies.

2.7.1 Focus groups

Focus groups, once the province of market researchers, in common with in-depth interviews, are now a popular method of collecting psycho-social data in the area of health research (Nicolson & Anderson, 2003; Nicolson et al., 2008) having gained recognition in social science overall as a robust way of eliciting “*shared and tacit beliefs, and the way these beliefs emerge in interaction with others in a local setting*” (Macnaghten and Myers, 2004, p. 65 in Seale et al) (p.8). In other words focus groups represent a means of gathering a sense of how those who work in an organisation share a sense of their ‘organisation in the mind’ (Armstrong, 2005) which may be mutually accepted, challenged or undermined by the perceptions of colleagues. Focus groups also enable the researchers to check out the quality and effectiveness of the communications themselves between members of the Unit or as Morgan (1998) suggests “*Focus groups are fundamentally a way of listening to people and learning from them* (1998, p. 9).

The process involves one or two researchers meeting with between four and eight participants who share a common situation and the guide lines for the discussion focus on key topics (see Appendices). One researcher takes notes although both are empowered to guide the discussion which is also digitally recorded. One benefit of this means of data collection is that through discussion among peers issues or perspective upon certain issues are brought into focus which might have escaped previous research authors and the researchers themselves (Morgan, 1998).

The *focus group guide* employed a similar structure to the *Interview Guide*.

2.7.2 Organisational climate

The Organisational Climate Questionnaire (OCQ) designed by Stringer (Litwin & Stringer, 1968; Stringer, 2002) also called ‘The Leadership Questionnaire’, was specifically designed to produce a scale to measure leadership in the context of climate albeit in a business rather than NHS setting. To complement the mostly qualitative methods of data gathering and analysis, we developed a questionnaire for staff and patients across the Trusts and used (a slightly adapted form of) Stringer’s measure of leadership and organisational climate, with the expectation that our results might also be linked to other studies undertaken with this measure, which had been used to examine management and leadership in organisations.

It identified six dimensions of organisational climate: *structure, standards, responsibility, recognition, support* and *commitment*, and uses eighteen leadership practices (three for each dimension) to capture how people feel about their jobs, how they are managed, and how things work in a particular organisation. Because this scale is designed to give practical

indicators on how to improve performance, many of the leadership measures are based on management practices, which are equally important to the overall success of an organisation. In general, however, each leadership practice measure is based on the premise that leaders care about arousing the motivation of members in the organisation (Stringer, 2002). The OCS was adapted from to fit a model relevant to NHS Staff working in a hospital setting and another version was adapted to be used with Patients (see Appendices).

2.7.2.1 Measurement tool: Stringer's OCS – Leadership and Organisational Climate

Stringer (2002) defines organisational climate as the "*collection and pattern of the environmental determinants of aroused motivation*" (p. 9) and he takes motivation to be central to the development of his climate questionnaire predominately based on the work of McClelland-Atkinson's framework with regards to intrinsic motivators of work related-behaviour: the need for achievement (nAch), the need for power (nPow), and the need for affiliation (nAff).

Stringer noted that specific dimensions of climate appear to have a predictable impact on motivated behaviour and can be measured and managed by those in senior positions accountable for organisational performance.

The six distinct dimensions identified and measured are:

- 'Structure'
- 'Standards'
- 'Responsibility'
- 'Recognition'
- 'Support'
- 'Commitment'

The statistical data was entered into an SPSS file to seek frequencies, correlations and to explore significance levels of differences and similarities between and within groups of respondents.

2.7.3 The survey structure and items

The survey is structured in two parts:

Part 1: measures *Organisational Climate* or how people perceive the work environment.

Part II: measures *Management Practices* or how people see their own managers behaving.

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Part 1:

This part consists of twenty-four items grouped into the six dimensions - 'structure', 'standards', 'responsibility', 'recognition', 'support' and 'commitment' - designed to measure how people feel about their work environment using a 4 point Likert scale. The directions ask the participants to describe the kind of working climate that has been created in their organisation (defining 'organisation' as the smallest work unit relevant to the participant).

Descriptions of the dimensions are as follows:

1. **'Structure'** pertains to the clarity of roles, responsibilities, accountability and expectations. According to Stringer this is more of a managerial than a leadership issue and one which is more practical than inspirational. It reflects the employees' sense of being well organised and of having a clear definition of his or her roles and responsibilities. *"structure is high when people feel that everyone's job is well defined and is low when there is confusion about who does which tasks and who has decision-making authority"* (Stringer, 2002, p.65).

The following items measure 'structure':

- The jobs in this organisation are clearly defined and logically structured.
- In this organisation, it is sometimes unclear who has the formal authority to make decisions.
- In some of the projects I've been on, I haven't been sure exactly who my boss was.
- Our productivity sometimes suffers from a lack of organisational planning.

2. **'Standards'** is about the need to achieve targets and reach goals. It is the drive to achieve and improve, it includes the 'commitment' and persistence to follow through on set targets. This dimension measures the feeling of pressure to improve performance as well as the degree of pride employees have in doing a good job. When interpreting this measure, high 'standards' indicate that people are always looking for ways to improve performance, whereas, a low score reflects lower expectations for performance.

The following items measure 'standards':

- In this organisation we set very high 'standards' for performance.
- In this organisation people don't seem to take much pride in their performance.
- Around here there is a feeling of pressure to continually improve our personal and group performance.
- Our management believes that no job is so well done that it couldn't be done better (Stringer, 2002, p.65).

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3. **'Responsibility'** is about taking ownership of the work and results which are obtained. Ideally people will be motivated to achieve results and take ownership over these. Where managers delegate and encourage responsibility, workers are more likely to feel a sense of 'responsibility'. It reflects employees' feelings of 'being their own boss' and not having to double-check decisions with others. A sense of high 'responsibility' signifies that employees feel encouraged to solve problems on their own. Low 'responsibility' indicates that risk taking and testing of new approaches tend to be discouraged (Stringer, 2002; p.66).

The following items measure 'responsibility':

- We don't rely too heavily on individual judgment in this organisation almost everything is double checked.
- Around here management resents your checking everything with them if you think you've got the right approach you just go ahead.
- You won't get ahead in the organisation unless you stick your neck out and try things on our own.
- Our philosophy emphasises that people should solve their own problems themselves.

4. **'Recognition'** relates to the relationships between one's performance and associated rewards, as well as broader sense of approval or disapproval of an individual's efforts. It indicates employees' feelings of being rewarded for a job well done. This is a measure of the emphasis placed on reward versus criticism and punishment. High 'recognition' climates are characterised by an appropriate balance of reward and criticism. Low 'recognition' means that good work is inconsistently rewarded (Stringer, 2002, p. 66).

The following items measure 'recognition':

- In this organisation the rewards and encouragements you get usually outweigh the threats and criticisms.
- There is not enough reward and 'recognition' given in this organisation for doing good work.
- We have a promotion system here that helps the best person rise to the top.
- In this organisation people are rewarded in proportion to the excellence of their job performance.

5. **'Support'** is the degree to which there is a sense of warmth and team work, within which the individual feels that they are 'backed up' by others. This will determine the amount of trust and respect amongst team members. It reflects the feelings of trust and mutual 'support' that prevails within a work group. 'Support' is high when employees feel that they are

part of a well-functioning team and when they sense that they can get help (especially from the boss) if they need it. When 'support' is low, employees feel isolated and alone. This dimension of climate has become increasingly important for today's e-business models in which resources are severely constrained and a premium is placed on teamwork (Stringer, 2002, p.66).

The following items measure 'support':

- You don't get much sympathy in this organisation if you make a mistake.
- When I am on a difficult assignment, I can usually count on getting assistance from my boss and co-workers.
- People in this organisation don't really trust each other enough.
- I feel that I am a member of a well-functioning team.

6. **'Commitment'** reflects employees' sense of pride in belonging to the organisation and their degree of 'commitment' to the organisation's goal. Strong feelings of 'commitment' are associated with high levels of personal loyalty. Lower levels of 'commitment' mean that employees feel apathetic toward the organisation and its goals (Stringer, 2002, p. 11).

The following items measure 'commitment':

- Generally, people are highly committed to the goals of this organisation.
- People here feel proud of belonging to this organisation.
- People don't really care what happens to this organisation.
- As far as I can see, there isn't much personal loyalty to the organisation.

Part II:

This part asks the participants to describe the practices of their managers. Using the same six dimensions as in Part I, participants are given eighteen statements which describe the way a manager might perform her or his duty and the respondents are asked to indicate how much he or she agrees with each of the statements. Here a 5 point Likert scale is used.

Once again the six dimensions are used to assess perceptions of managers' practices:

1. 'Structure'

- Establishing clear, specific performance goals for subordinates' job.
- Clarify who is responsible for what within the group.
- Making sure tasks and projects are clearly and thoroughly explained and understood when they are assigned.

2. 'Standards'

- Setting challenging performance goals and 'standards' for subordinates.
- Demonstrating personal 'commitment' to achieving goals.
- Giving subordinates feedback on how they are doing on their job.

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3. 'Responsibility'

- Encouraging subordinates to initiate tasks or projects they think are important.
- Expecting subordinates to find and correct their own errors rather than doing this for them.
- Encouraging innovation and calculated risk in others.

4. 'Recognition'

- Recognizing subordinates for good performance more often than criticizing them for poor performance.
- Using 'recognition', praise and similar methods to reward subordinates for excellent performance.
- Relating the total reward system to performance rather than to the other factors such as seniority or personal relationships.

5. 'Support'

- Being supportive and helpful to subordinates in their day to day activities.
- Going 'to bat' for subordinates with superiors when the manager believes their subordinates are right.
- Conducting team meetings in a way that builds trust and mutual respect.

6. 'Commitment'

- Communicating excitement and enthusiasm about the work.
- Involving people in setting goals.
- Encouraging subordinates to participate in making decisions.

Leadership question

We also asked a single question to capture directly how satisfied an employee is with the leadership they receive from their immediate supervisor. It was a simple statement: *I am satisfied with the quality of the leadership I receive from my immediate manager* which we measured using a 4 point Likert scale.

2.7.4 Ethnographic observations and 'shadowing'

Ethnographic observations and shadowing are especially useful to organisational research because they allow people to *physically* express their inner thoughts, and put ideas into *observable action*, all of which would be inaccessible through the survey or structured interview questions.

Ethnographic observation (often referred to as *participant observation*) has its roots in anthropology but has become increasingly deployed in sociology, cultural and social geographies. In the field (which in this case is a Unit in an NHS Trust) the researcher's aim is to "*understand how the cultures they are studying 'work'*" that is, to grasp "*what the world looks like*" to the

participants in the context being observed (Delamont, 2004, p. 206). In this study observation and shadowing opportunities were (mostly) formally set up and pre-arranged. However, the researchers, through taking their roles as interviewers, focus group leaders and having an every-day presence with key informants, gate-keepers and participants, were able to immerse themselves in the lives and atmosphere of each of the Trusts and Units providing evidence about the processes of leadership and patient care as well as 'climate' (Bloor, 2001; Goffman, 1961).

Shadowing involved the same conceptual framework as ethnographic observation in that the aim was to understand what the world looks like from the perspective of the staff member being shadowed as well as the worlds of the other staff and patients that they engaged with in the course of their work (Czarniawska, 2008; McDonald, 2005). It involved meeting the participant (usually) at 8 am and for one or two days accompany them including at break times until the participant went home. In Trusts where there was more than one site and/or when the nature of the day's work involved meetings outside the hospital (as in nearly every case) then the researcher spent time in a car with the participant and if agreed the conversation was digitally recorded as an *aide memoire* for the field notes. The participant was able to withdraw at any time, or for a period of time, across the shadowing period.

Thus the sense of 'what the Unit world looked like' was recorded in field notes which were then discussed with the other members of the team (who had some familiarity with the relevant part of the Unit/Trust) in a context where the researcher could be reflexive and explore the 'silent space' of the 'ethnographic self' (Coffey, 1999). The researcher's notes and expressed thoughts were then discussed with other members of the team, some of whom were familiar and others not so with the specific context (Barry, 2003). A similar approach was used to discuss the interview material because even though the interviews were digitally recorded and transcribed verbatim, this did not account for the reflexivity that took place following the interview itself and on transcribing and reading the transcript, and therefore featuring in the analysis (Nicolson, 2003).

In this context there was concern to capture the emotional content and atmosphere of the organisations. This meant that ethnographic methodologies were implemented to analyse the emotionality of the interactions (verbal and non-verbal) between patient and practitioner. It was through these observations that the use and importance of the researcher's *body as a 'research instrument'* became palpable, especially for understanding the emotions emerging out of the interactions between patient, relatives and practitioner(s). This process has been proposed as the antithesis of taking for granted that emotion should be removed from

ethnographic investigation and that in fact the research process is highly emotive and far from an emotionally barren terrain (Bondi, Davidson, & Smith, 2005).

As the researcher collects data they move through a continuum of emotions from the euphoric highs of excitement at starting a new research project, sense of achievement and pride as they begin to make contacts and collect initial data, perhaps trepidation, fear and nervousness as they meet new participants or research settings through to the depths of despair, isolation and frustration as the research process (inevitably at times) becomes chaotic and messy. However, these emotions are often neglected, regarded as unimportant to the overall research process and abandoned in the writing up phase. We use these frequently neglected emotions and feelings as part of, and beneficial to, the project as representing a rich source of data.

By being more attentive to their emotions and bodily senses ethnographers also become more sensitive to their environment and their participants thus gaining a greater awareness of what they are observing. In recalling a sound, smell or feeling the ethnographer is able to open up their mind's eye to re-visualise the interaction with greater clarity and accuracy making it more likely that an accurate representation of what was observed will be recorded.

2.7.5 In-depth semi-structured and 'story-telling' interviews

In-depth semi-structured Interviews: Over the past fifteen years this method of qualitative data collection has become increasingly common in health services and health research in general (Pope and Mays, 1995; Kvale, 1996; Grbich, 1999) consistently a method of choice for identifying perceptions, meanings and experiences of dynamic and complex concepts such as 'leadership' and 'patient care' (Rubin and Rubin, 1995; Denzin and Lincoln, 1998; Rapley, in Seale et al, 2004).

The use of such interviews has led to increased levels of sophistication in the interpretation of qualitative in-depth data in the context of historical, cultural and political frameworks demonstrating that in-depth semi-structured interviews (and more generally qualitative research) have capability beyond simply adding rich description to statistical evidence (see Denzin and Lincoln, 2002; Willig, 2008).

Story-Telling: One of the explicit aims of the interviews was to collect a number of stories to reflect critical experiences in the organisations' past and present life. In the field of organisational studies, there is now an extensive literature of how to use stories told by organisational participants

as windows into organisational culture, politics and numerous other phenomena (Gabriel, 2000; Hannabuss, 2000).

The inclusion of story-telling in the context of the in-depth interview increases the scope for making sense of data in ways that delve deeply into the respondents' perceptions and meaning of the *processes* of leadership and patient care. Story-telling also increases the validity of the interview through the use of reflexivity, and positioning the events and 'atmosphere' of the stories in the context of the organisational analysis.

Of particular relevance to this study, stories can instigate insights into the processes of positive or negative social and organisational change and leadership which involves the management of meaning and emotions, both of which rely heavily upon the use of stories, allegories, metaphors, labels and other narrative devices.

The study of *organisational stories* is particularly relevant in health care settings that are liable to unleash strong emotions and fantasies. Hence, hospitals are rich grounds for collecting stories, as numerous researchers have recognized (Kleinman, 1988; Frank, 1998; Greenhalgh, 2002; Hurwitz, 2006; Mattingly, 1998). Storytelling permeates everyday clinical practices and "*medical professionals find ways to 'routinize' their practice and thus, metaphorically at least, bring the unruly and frightening world of illness under control*" (Mattingly 1998, p. 277).

The *interview schedule* (see Appendices) therefore was designed to elicit information on the participant's view of 'leadership' and 'patient care' through 'stories' to provide examples in their opinion that constituted good and poor leadership and good and poor patient care through 'critical incidents'.

As the interviews were semi-structured and in-depth they relied to a great extent on the interviewing skills of the researchers and their ability to establish rapport and consequent willingness of the participants to engage in the process. The early pilot interviews therefore were unlikely to influence the details of the interview schedule itself although the early interviews were planned to enable the research team to identify the best *strategies* to engage participants in the task.

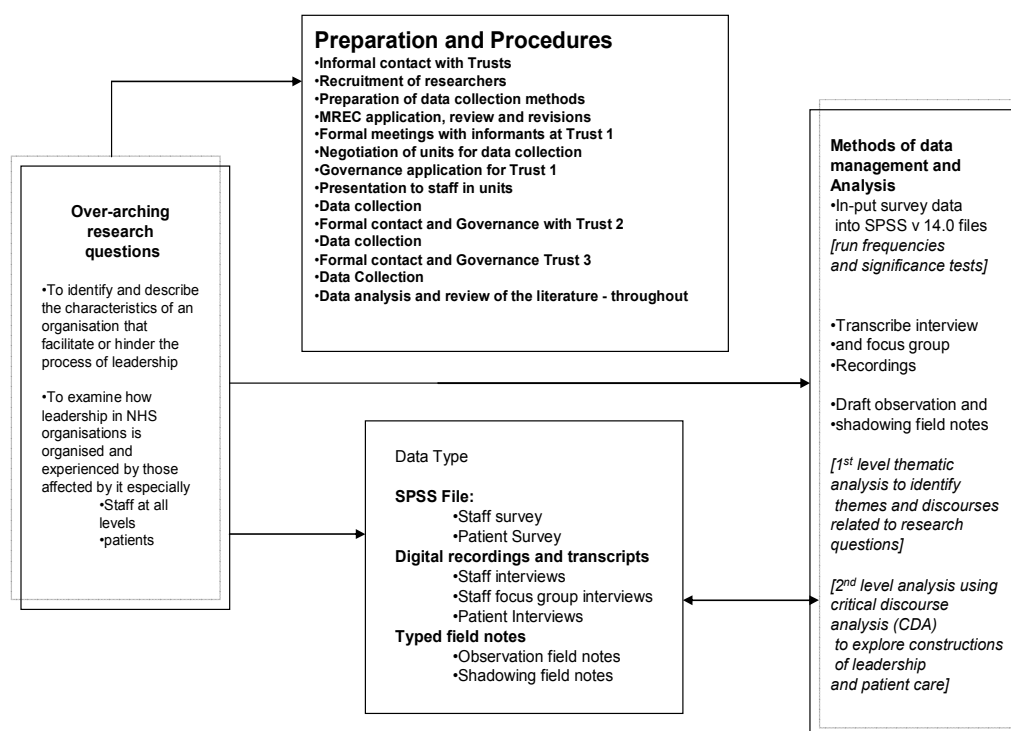
2.8 Data Management

The interviews and focus groups were digitally recorded and transcribed verbatim. The transcripts stored on a password protected Word file (initially on the researchers' PCs but subsequently on the secure shared drive described above) and sound recordings stored on audio files (password protected on the PC of the PI and not on the shared drive).

The OCS data was entered and stored on an SPSS file, password protected and placed on the secure shared drive.

Fieldwork notes from observations and shadowing were similarly password protected stored on the shared drive once they had been prepared by the individual researchers.

Figure 5. Outline of Study Procedures and Methods



2.8.1 Data Analysis

There are effectively therefore three categories of data.

1. Qualitative data representing verbatim 'talk' (digital recordings/transcripts) of interviews and focus groups.
2. Qualitative data from observations, shadowing and other field notes. These were subjective accounts of observations, perceptions, emotions and meanings given to the field work by one researcher. This may have been following discussion with the other researcher on occasions when that person had had access to the same raw

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material. Discussion with another member of the investigatory team (frequently but not always the PI) also took place following the first drafting of the field notes in order to clarify the meanings given to specific behaviours and relate theory and data.

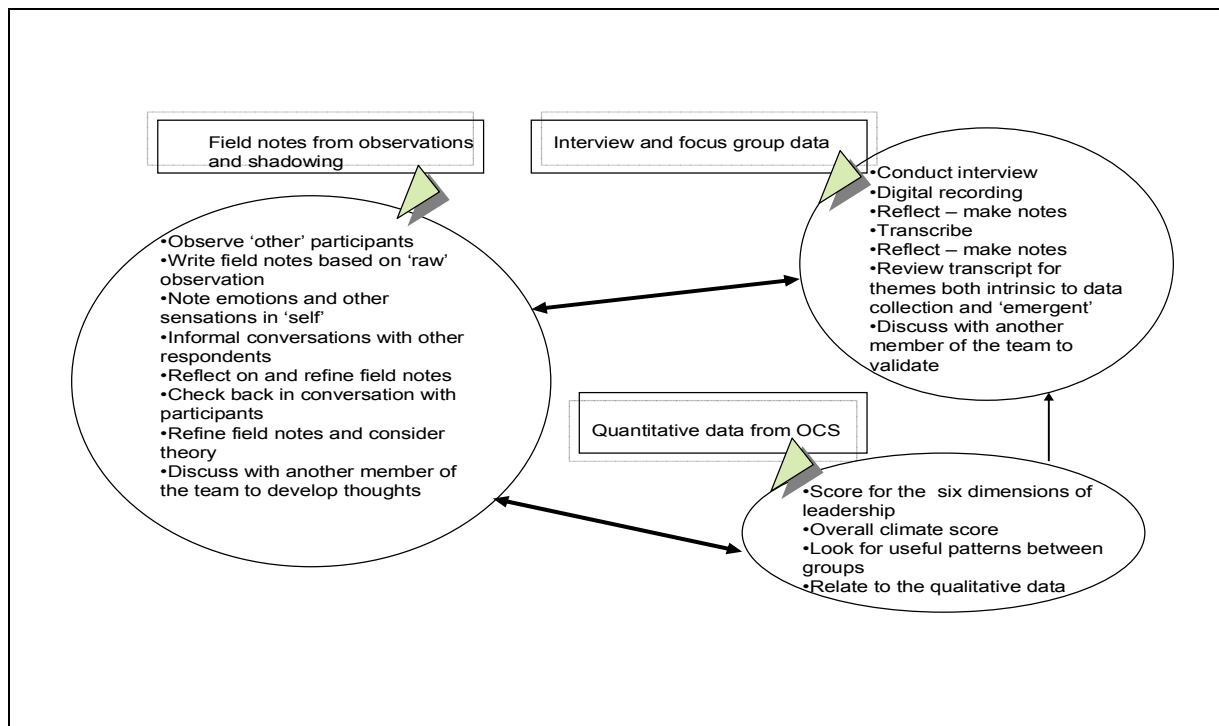
3. Statistical data from the OCS.

2.8.2 Thematic Analysis (TA)

The transcripts and field notes were examined initially for relevant extracts related to the main themes ('leadership', 'organisation' and 'patient care').

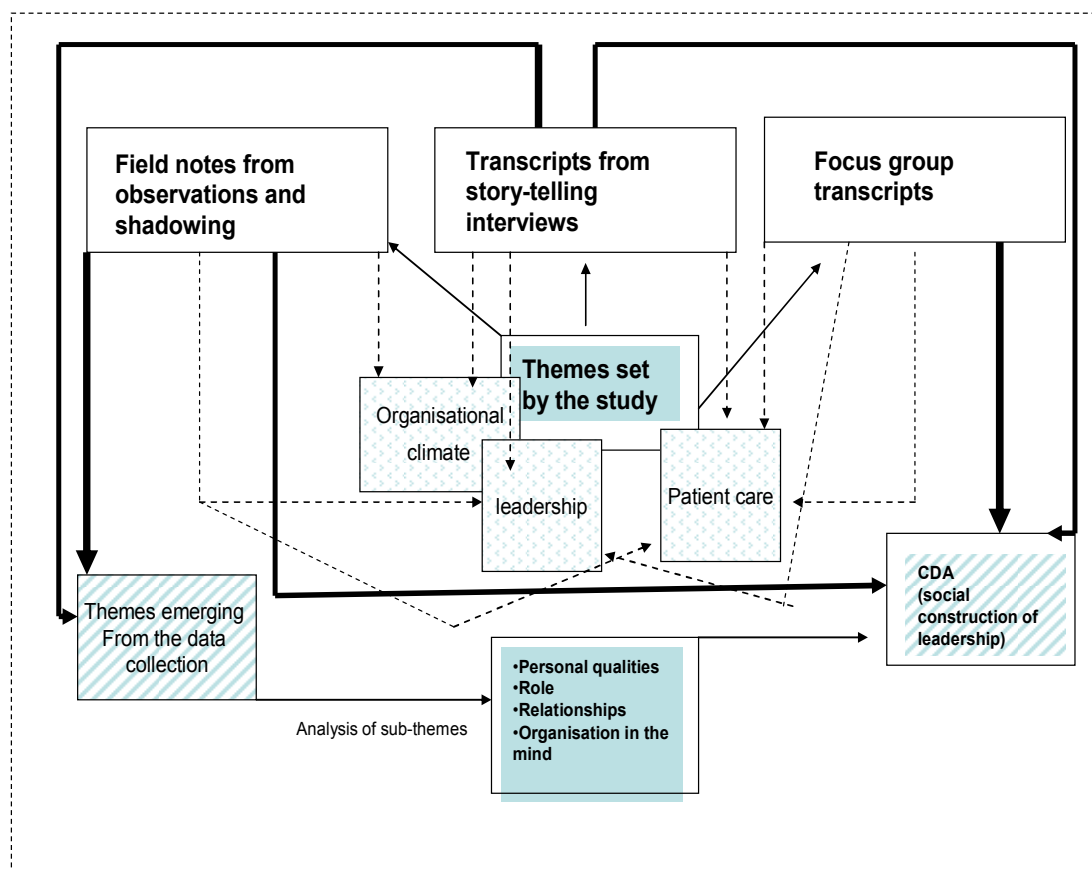
Sub-themes were then to be identified, some of which are likely to relate closely to the previous research literature on leadership and organisational climate, although it is likely that each organisation will demonstrate particular issues that were more difficult to anticipate at the outset.

Figure 6. From data collection to data analysis



Data relating to these themes and sub-themes was to be collated on Word files and where deemed relevant to the study aims, analysed further using the following methods – Discursive Psychology, Critical Discourse Analysis and Narrative Analysis. All these approaches focus on language and the way language is used to construct key concepts (e.g. the organisation) but there are different nuances to each perspective each of which adds an important dimension to the analysis of this data.

Figure 7. Thematic to CDA with Narrative analysis



2.8.3 Discursive Psychology, Discourse Analysis and Critical Discourse Analysis (CDA)

Hepburn and Potter (2004) argue convincingly and with justification that DA has evolved to have several iterations over recent years. One common feature though has been that 'discourse' (i.e. what is said) and 'context' are difficult to separate and it is the ways in which context is worked into the analysis of discourse that distinguishes the character of DA deployed in a particular piece of analysis.

The thematic analysis was a starting point from which to focus in upon the close readings of the texts, which related to the processes of leadership and patient care, as it represents a flexible and clear way of identifying what is emerging from the data and points a way forward with more detailed analysis (Braun and Clarke, 2006)

We argue that leadership is a social construction and there is a growing body of literature providing evidence to support this view. There has also been a recent focus in organisational research and theory to specify an Organisational Discourse Analysis (ODA) (Pritchard, Jones and Stablein, 2004) which involves four approaches i.e. *Narrative*, *Foucauldian*, *Linguistic* and *Deconstruction* which in turn are influenced by a *reflexive awareness* of the organisational culture in which the research is being conducted.

Pritchard et al, (2004) argue further that the exact methodology and approach to the data depends on the 'researcher position' in the organisation being studied. In other words this approach *benefits* from the subjectivity of the researcher's interpretation of what processes mean and specifically from researcher reflexivity about their 'take' on a situation and set of interactions.

To qualify this method of analysis further, a discursive approach means that language is represented not so much as an objective truth but as a means of *constructing* what might be understood (Parker, 1992; Coyle, 2007).

Particularly relevant in this study, in which participants are asked to tell stories and provide evidence to support what is good and bad about both leadership and patient care (and implicitly the organisation in which these actions take place), is discursive psychology (DP) that highlights how "*descriptions of events are bound up with doing actions, such as providing justification for actions and blaming others*" (Hepburn and Potter, 2004, p. 169).

Thus Critical Discourse Analysis (CDA) sees language as a *social practice* and thus considers carefully the context in which language is used (see

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Wodak, 2004). CDA is related to the notion that *power is negotiated through language*. This is particularly apposite in a study of leadership in organisations. Even more so CDA is 'abductive' so that a constant movement between theory and empirical data is needed which suits ethnographic methods such as shadowing and observations enabling the researcher to test out their ideas as they progress with the data collection, and the attempt to understand how cultures work and how the research participants make sense of and experience their worlds.

2.8.4 Narrative Analysis

Narrative approaches to data analysis have been able to cut through the great complexity of the NHS - the intense emotions, positive and negative, it evokes among most of its stakeholders (e.g. Rooksby, Gerry & Smith, 2007; Bryant, 2006; Iedema et al., 2009; Brown et al., 2008; Elkind, 1998; Brooks, 1997). These studies have, for example, addressed power issues in the doctor-patient relationship, exploring communication in a consultation situation. In these analyses, the patient's 'subordinate' narratives have often been neglected or taken over by the doctor's privileged 'medicalizing' discussion (Mattingly, 1998, p. 12; see also Radley, Mayberry & Pearce, 2008). However, there is also a recognition that many of these narratives are co-constructed by patient and physician (Mattingly, 1998, p. 43; Kirkpatrick, 2008); exploring solely the patient voice in isolation and presuming that doctors will at all times occupy a dominant position in this relationship may be missing half of the story - the doctor's experience. As Mattingly (1998) points out, *"[h]ealers too, may be able to give a different kind of voice to their practice when they describe their work in narrative terms rather than the flattened prose of biomedical discourse"* (p. 14).

As a genre, narrative psychology is thriving (Smith & Sparkes 2006). There has been talk of the 'narrative turn in psychotherapy and psychiatry' (Brown, Nolan, Crawford & Lewis, 1996), and Crossley (2003a & 2003b) for example argues strongly for a 'perspective that retains a sense of both psychological and sociological complexity and integrity' noting that narrative psychology is concerned with 'coming to grips with how a person thinks and feels about what is happening to her' (2000, p. 6). She employs a phenomenological framework to explore narratives of 'the voice' of 'the mentally ill' (Crossley & Crossley 2001) and the experience of temporal elements and self/identity of people living with serious illness (HIV, cancer; see also Söderberg, Lundman & Norberg, 1997). Narrative research in health care has also been used to study the lived experience of patients (see for example Hemsley, Balandin & Togher, 2007; Hök, Wachtler, Falkenberg & Tishelman, 2007) and an emerging genre of 'narrative based medicine' seeks to make use of stories in developing a fuller understanding of illness experiences (Launer, 2003; Taylor, 2003; Greenhalgh, 1999).

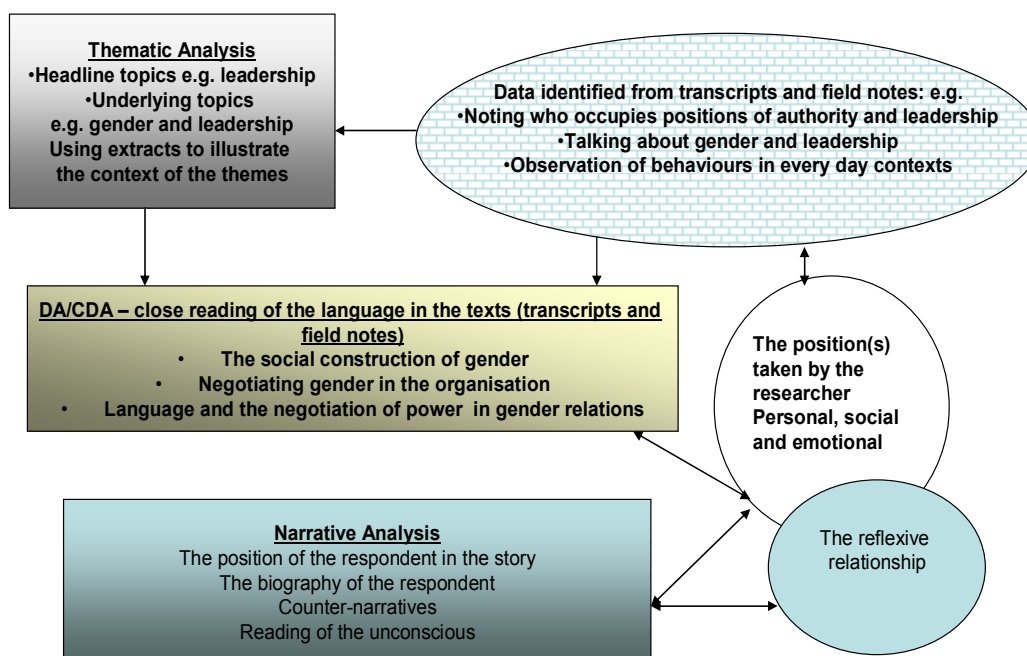
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Narrative based medicine is not merely an insightful way of doing research, but may have powerful policy implications. As Overcash (2003) argues, "*narrative methods are an effective research option that can lead to enhanced patient care*" (p. 179). While interpreting narratives can enhance the possibilities of integrating evidence-based research findings with individual illness experiences, and Winterbottom and colleagues (2008) suggest numerous courses of further research on why and how narratives may influence medical decision making.

Narrative analysis, as with DA, has been approached differently by academics from a range of disciplines so that the ideas surrounding the analysis of *narratives* (or stories told in a sequence) have a variety of emphases. The strength of taking the narrative approach over DA /CDA *per se* is that the 'subject' of the story (the narrator) retains a central role (Crossley, 2007). This can be seen in some detail in subsequent chapters particularly where the accounts of ethnographic observations and shadowing are highlighted where the 'story' becomes that of the researcher herself and with the stories unfolding through the interviews.

Furthermore the narrative analysis places the respondent's story as part of their own *identity construction* which lends an important dimension to the relationship of the story-telling to the teller. Particularly interesting here is Andrews' (Andrews, Sclater-Day et al., 2004) approach which focuses specifically on the elements of stories "*that lie in tension with the ones we are socialised to expect*" (2004, p. 97) or what she calls 'counter-narratives'. Researchers such as Hollway and Jefferson, 2002; Gough, 2003; Sclater, 2004; Allcorn, 2004 and Gabriel, 2004 and 2005, take on board the role of the interlocutor in positioning themselves in their story while considering some of the unconscious and emotional elements both of the story being told and the way that the relationship between the researcher and respondent plays out to construct and limit the story that is told. This dimension is particularly important in the context of this study where emotions are rife at least in part because of the high pressure (exacerbated to some extent by the changing political initiatives directed towards NHS institutions) and the particular nature of the work in caring for ill people (see for example Menzies-Lyth 1960).

Figure 8. Levels of qualitative data analysis e.g. 'gender'



2.8.5 Statistical Analysis

The data from the OCS was coded and in-putted into an SPSS v 14.0 file and significance tests were run (see Chapter Five for the full details).

3 Research Procedure

3.1 Introduction and Overview

The nature of this study, much of which involved the researchers immersing themselves in the 'world' of the participants, meant that it is not possible to provide an authentic *sequential* account of the procedure of data collection except possibly for the administering of the OCS (Organisational Climate Survey).

The bulk of the study, as identified in Chapter Two, comprised multiple methods of collecting different types of data across three Trusts, six Units and five sites.

3.1.1 Negotiating Access

The study took place across a three year period. Negotiation of access was complicated as indicated, although in itself a valuable procedure which occurred at several levels and helped to increase the richness of the team's understanding of leadership, patient care and the context of each organisation.

- Negotiating access began from the 'notional' level while writing the grant application whereby the investigatory team needed to identify whether a project with this design was in fact feasible. We thus made informal inquiries via personal contacts.
- More formal contacts were made once the project was confirmed with the intention to achieve verbal agreement about access for planning the NRES application.
- Following that we met to formalise the details with key informants (i.e. senior clinicians and managers) who had been identified in the previous stage.
- Once we had achieved a favourable NRES review, we pursued local governance applications with the help of the key informants.

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- These stages were managed by approaching one Trust at a time although during the latter part of the study some overlapping negotiations and governance were necessary.
- Part of the formal stage of negotiation concerned consideration of which *Units* could/would form the focus for the study. This was very much two-way but also serendipitous with suggestions from the team of investigators moderated by whichever senior clinical staff the key informants considered would be amenable to 'hosting' the study.
- The key informants then identified opportunities for the team to present the project to staff in the selected Units in 'educational half days' or 'staff meetings' depending upon the local structures.
- These formal presentations only took place in Trusts One and Three however. The procedure in Trust Two (because of the culture, location and structure) was on the basis of a 'tour' (which with permission was digitally recorded) organised by a senior nurse manager so the researchers, one of the co-investigators and the PI could meet various key nursing and medical staff across one of the Trust sites.

Once all that had been achieved it was the researchers on the whole who managed the day-to-day negotiations about who could and would agree to take part in the various elements of the study. This was complicated because of the day-to-day patterns of staff, changes in staff roles, particularly at senior levels, shift patterns and the sheer numbers of staff who may or may not have been aware and willing to allow access to, say, a particular meeting or team for observation or interviews.

Figure 9. Procedures and time-line

	2006/7	2008	2009
Winter	<ul style="list-style-type: none"> •Recruit and prepare researchers •Informal contact with 3 Trusts 1 and 2 •Informal visits to Trusts 1 and 2 •Develop research instruments •Prepare COREC/NRES application •MREC presentation and revisions •MREC approval •Start to review literature on leadership 	<ul style="list-style-type: none"> •Arranging formal contacts with Trust 2 (on 2 sites) •Visit to Site A •Further data collection in Trust 1 •Patient interviews 	<ul style="list-style-type: none"> •Researcher begins maternity leave and new researcher inducted into the team •Data collection in Trust 2 Site 2 •<u>[difficulties gaining access to staff list in Trust 2 for survey]</u> •Presentation to staff in Trust 3 (Unit 1) •Distribution of staff survey (individually handed out) in Trust 3
March - June	<ul style="list-style-type: none"> •Formal meeting with Trust 1 R & D director •Governance application •Formal meetings with senior staff to negotiate units for study •Unit based meetings and introductions •Presentation at educational half day on Unit 1 (obs & gyn) of Trust •Pilot interviews •Pilot staff survey 	<ul style="list-style-type: none"> •Formal meeting in Trust 2. Tour of Site A •Visit to Site 2 •Governance for Trust 2 •Informal meetings •Data collection begins in Trust 2 •<u>Trust 1 staff in Unit 1 return surveys to PI saying they won't give them out</u> 	<ul style="list-style-type: none"> •<u>[further difficulties gaining access to staff list in Trust 2 for survey – now due to key staff transfers]</u> •Preparation and presentation of invited paper to SDO conference in June •Paper preparation and further conference presentations
Summer	<ul style="list-style-type: none"> •Organise, send out and in-put data from staff survey in Trust 1 •Observations and interviews with key staff •Presentation to Unit 2 •Focus groups and interviews on Unit 2 	<ul style="list-style-type: none"> •Application for extension to project (successful) 	<ul style="list-style-type: none"> •Put staff survey on Trust 2's 'intranet' with information about how to complete and return •E-mail staff in Trust 3 who had not received a staff survey •<u>[a low response in both cases]</u>
Autumn	<ul style="list-style-type: none"> •Data collection •Data in-putting from staff survey •Patient survey given to staff on Unit 1 to distribute 	<ul style="list-style-type: none"> •Preparation of journal paper 1 •Further review of literature •Governance for Trust 3 •Identifying key contacts in Trust 3 •Negotiation about Unit 1 (Care of the Elderly) 	<ul style="list-style-type: none"> •Journal paper 1 (anxiety) being revised for publication •Journal paper 2 in preparation (gender) •Journal paper 3 (in preparation) leadership and 'territory') •Presentation prepared and delivered to NHS Surrey and Borders conference •Final draft report

3.1.2 Time frame and Participation of Investigators

We negotiated the formal details of access consecutively in order to make the process manageable. Most data was collected by the researchers (Dr. Fox, Dr. Lokman¹⁵ and Ms. Rowland) although the PI and other investigators made the initial contacts, met with key informants, contributed to the presentations and conducted some of the interviews and focus groups and (Profs. Gabriel and Nicolson, Dr. Heffernan and Mr. Howorth). The PI (Nicolson) and at least one of the researchers was present at all initial meetings with the gate-keepers and key informants.

3.1.3 NRES review

This was prepared and submitted at the end of 2006 and the PI, one of the researchers (Lokman) and another member of the investigation team (Gabriel) attended the appointment with London-Surrey Borders Research Ethics Committee in January 2007.

Annual reports were submitted to the NRES subsequently as required.

3.2 Sample characteristics

The three Trusts, selected as stated above in Chapter Two were each very different from each other, not only in formal terms (size, budget, location and organisational structures) but also informally and culturally and this influenced the 'access pathways'. Thus for example in Trust One our informal and then formal contact was with the R & D director (also a senior clinician) and assistant R & D director, who introduced us to the CEO, the clinical directors and senior nurses.

In Trust Two we had begun with meeting the CEO at the 'notional' phase who then retired in the meantime. This meant starting again with delayed local governance and to accomplish this, we were directed towards a senior clinical manager who then changed their role and location which meant dislocation of our planned procedures.

Trust Three involved a personal contact initially who was directly involved as a clinician in one of the Units who then arranged for us to have a

¹⁵ Dr. Lokman worked on the project for over two years and Dr. Fox took her place.

meeting with another senior clinician who in turn arranged for us to give a presentation to the Care of the Elderly/Geriatric Unit. From there we sought a second Unit for Study independently through contacts made during the course of working in the first Unit.

Trust 1 (One site only) a DGH (District General Hospital)

The Research and Development director here suggested the Units for study to be:

- Unit 1, Obstetrics and Gynaecology
- Unit 2, Cardiology

We were happy with his suggestions, and the staff was generally co-operative and supportive of the researchers.

The Trust itself covers two sites but the choice of these Units meant that all data was collected from one site. This was helpful because it meant the researchers and some of the investigators could spend time familiarising ourselves with the layout of the Units and the Trust site and become familiar 'faces' so that gaining consent from respondents was made easier than it would have been if the researchers and the study itself had to be presented as 'new' on each occasion.

While the study was taking place there were many fears expressed among the staff at all levels that the site we were investigating would become the less powerful with the other site taking over many of the executive functions. While the study team were collecting data on this site however this did not happen and the general 'morale' has improved so that the Trust is currently applying for Foundation Trust statusⁱ.

Self-Description of the hospital

The site we studied had 400 beds and a range of acute care services, including an Accident and Emergency department. It is situated in 52 acres of Green Belt parkland within 40 – 60 minutes of London. Originally it was built to serve casualties of the Second World War. Over the years, the hospital has been rebuilt, developed and extended to include maternity services, a departmental and clinic area, and a new theatre complex. In the early 1990s, the X¹⁶ Wing, which includes a Postgraduate Education Centre and modern well-equipped wards, was opened. A new building for the Accident & Emergency, ITU and Orthopedic Unit opened in the summer of 1998. In addition, comprehensive HIV and genitourinary medicine services are provided in a dedicated building.

¹⁶ We have used 'X' to ensure anonymity.

Obstetrics and Gynaecology

The study territory for this Unit¹⁷ comprised the labour ward, postnatal ward, a general outpatient clinic a dedicated ante-natal clinic and the Maternity Services Administration. The unit offered midwife care for home births, one to one care, water births and there was always a consultant obstetrician available and compared to other local hospitals it gained a score of 3/5 which was joint top score.

Cardiology

This Unit studied comprised one in-patient ward, the Medical Assessment Unit (MAU) and the Critical Care Unit.

In addition we spent time in the Management Suite where five interviews also took place of the CEO, Clinical Director, the Director and Deputy Director of R & D and a middle-ranking manager.

Observations also took place in public and eating spaces and shadowing involved walking around the hospital between different specialty wards and administrative departments.

Trust 2 (2 sites)

The Trust was one of the biggest DGHs in London with 4,200 staff. It had had a history of problems in its financial management and the quality of care but recent information on the web-site and confirmed by the CEO made it clear that:

The Care Quality Commission, the organisation that regulates health care nationally, has awarded the Trust a rating of excellent for the quality of services we provide to our local population. This is the highest possible performance rating in the 2008/09 Care Quality Commission annual national assessment report.

It seems that problems with the financial management remain although improvement had been noted.

The structure and organisation of Trust 2 differed significantly from Trusts 1 and 3. Trust 2 comprised two sites (recently combined into one Trust where one was a teaching hospital) which were at least eight miles apart and it

¹⁷ There were other parts of the Maternity Services at Trust 1 that were not observed directly.

was difficult to travel between one and the other on public transport other than using more than one bus or travelling in and out again from London. The journey by car varied from about thirty minutes upwards depending upon traffic.

Physically the two sites were very different. Site A was a relatively new building designed (as one researcher stated) to look like a motel or contemporary hotel. The other, B, was a traditional middle height rise built in the 1970s on a green site and appeared far more formal with long corridors and many signs to departments. Site A was more 'angular' and you could not walk very far without having to turn a corner which presented a very different 'feel'.

It was not possible, particularly in Site A to select a discrete specialist Unit (unlike Trust 1). Site A focused on acute medicine and care of the elderly and there were no formal divisions in where patients were treated as either in-patients or out-patients. So an older person with 'geriatric' health related problems could be in a bed next to a much younger person. We have identified a Unit as a Site in the case of this Trust. We found it equally difficult to 'pin down' a specialty in Site B as well.

At Site B we collected data from acute medical specialties, obstetrics and gynaecology and therapies (the latter being both physical and psychological).

This was in part because senior management at Site A (who were our key informants and 'gatekeepers') introduced us to staff they considered amenable. Thus for purposes of the study we had to identify Site B as our second Unit. Despite the introductions we managed, via snowballing, to find a range of participants who demonstrated many different view points.

To summarise then in Trust 2 the study was carried out in the following two Units which we have identified as follows:

- Site A / Unit 1 (Acute Medicine; Care of the Elderly)
- Site B / Unit 2 (Acute Medicine; Obstetrics and Gynaecology; Therapies)

We also interviewed a Clinical and Nursing Director both of whom worked across both sites and senior managers including the CEO and deputy CEO.

It became clear very early on that there was intense rivalry, even animosity between the two sites and some of this is explored in later chapters.

Trust 3 (2 sites)

Trust Three, in central London, is a long established hospital and a Foundation Trust with connections to a prestigious medical school. Travel

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between the sites took about twenty to thirty minutes by public transport. 9,000 staff are employed by the Trust with 1,100 beds available across the Trust at any one time.

- Unit 1 (Care of the Elderly, Acute Medicine)
- Unit 2 (Therapies)

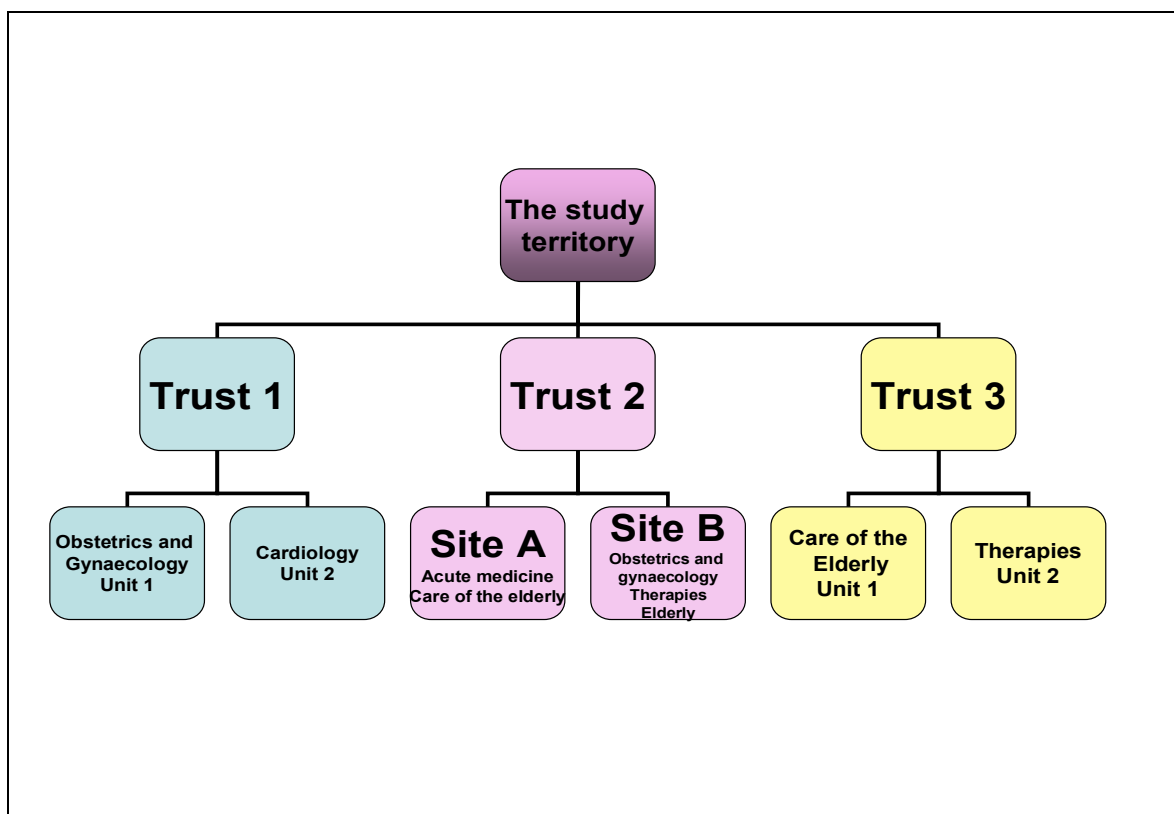
Unit 1 is described on the web-site thus:

Geriatric medicine specializes in the diagnosis and management of common symptoms and diseases in older people, particularly:

- *problems with mobility*
- *falls*
- *continence*
- *difficulties with looking after oneself*

Unit 2 (therapies) which included physiotherapy and psychological therapies spanned both the sites and covered many clinical departments and extended to primary care services especially local GP practices as well.

Figure 10. Participating Trusts and Units



3.2.1 Response rates (qualitative approaches)

It is difficult to identify an accurate response rate for the qualitative components (the majority) of the study because the sampling was conducted in an opportunist manner in many cases – i.e. whether someone agreed to take part in an interview or focus group if the researchers were on site and made a serendipitous approach.

As stated in Chapter Two, much of the qualitative data was collected by virtue of the researchers 'being there' in the right place at the right time and therefore gaining the trust of potential participants. In many cases the researchers were introduced to a member of staff who suggested ways in which other respondents might be accessed. Methods included personal introductions, using e-mail lists or sometimes a staff member knowing what was happening asked the researchers if they might participate in the study.

Overall the majority of staff approached to participate agreed to do so, although circumstances sometimes prevented it (e.g. one focus group was cancelled in Cardiology due to a patient emergency and one observation was cut short because the consultant refused to have the researcher in the ward round, although they had been observing on the ward before the consultant arrived having been given permission by the nursing staff).

Although the key staff across all three Trusts agreed to support the researchers in gaining access to patients for the OCS and interviews, the patient form of OCS was anonymously returned to the PI by someone at Trust 1 saying they did not want patients to participate in that exercise¹⁸.

It proved impossible to administer the patient OCS in the other two Trusts also, because the staff said in advance they were too busy to help and the researchers had difficulty in making contact with individual patients who were always either in busy wards or with a member of staff. Thus interviews and observations were conducted, with patients' consent, during shadowing.

The OCS for the staff is discussed fully in its own right in Chapter Five.

3.2.2 Individual participants

Respondents were either NHS staff or patients so by definition there were elements of uncertainty about whether they would be available at appointed

¹⁸ We sought advice but in line with the NRES review participants could withdraw their consent at any time so we did not feel free to pursue this further.

times and whether (as acknowledged in the NRES consent form) they choose to drop out at any time, even after having agreed to take part.

As shown below in Table 1, forty six respondents took part in in-depth story-telling interviews, thirty nine took part in focus groups. During twenty six days of shadowing of key staff, numerous other staff and patients were involved in data collection and similarly, during the eleven and a half days of observations on wards and in administration areas across the Trusts.

In addition, ten patients consented to be interviewed in depth and, again more staff were involved in the eight meetings that were observed and an introductory walking tour with a staff member in one Trust involved additional staff and patients in the study.

Each of these data collecting encounters represents a different unit of study and a different 'order' of data.

The nature of the study required a commitment of between 30 minutes (for completion of a survey or a short interview) up to two days, in the case of 'shadowing', of respondents time. Most respondents' contributions to the study, however, took about 90 minutes although this also represented an important commitment of their time (and energy).

Table 1. Qualitative Data Collection

Table 1. Qualitative Data by modes of collection							
	Interviews		Focus groups	Shadowing (staff and patients)	Ethnographic observation	Patient interviews	Other meetings and visits
Trust	N = men	N= women	N = Group (n = participants)	N = days	N = days		
1	13	19	5 (15)	5	9	10	4
2	5	9	3 (24)	8	3 x .5 + 1	0	2
3	4	8	0 (0)	13	0	0	2
Totals	22	26	8 (39)	26 days	11.5 days	10	8

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3.2.3 OCS (Organisational Climate Survey)

Trust 1

The staff survey

An administrator in Trust 1 provided a staff list (name and location) from which a random sample (35%) was identified using the SPSS software version 14 providing a list of 939 potential participants from staff across the Trust (including and beyond the Units participating in the main data gathering). The questionnaires were all individually addressed and sent through internal mail.

Of these 223 (24%) individuals returned a completed questionnaire, although ten blank surveys were returned with a note that the intended recipient had left the trust and one said they were unable to read English (1). Thus the final number of participants for Trust 1 was 210.

The patient survey

In Trust 1 we gained agreement from the senior staff on the two study Units (Obstetrics and Gynaecology and Cardiology) that they would arrange wherever possible for patients to complete the patient version of the OCS and would arrange for the researchers to collect the completed forms.

However the full batch of uncompleted patient questionnaires was sent back to the PI at the College several weeks later with an anonymous note stating that the staff did not wish to administer these to the patients. We were unsure how to proceed after this because ethically, although the survey was directed to the patients, the staff had completed consent forms and had copies of participant information sheets, and were aware that they (staff) could withdraw from the study at any time. We considered that this constitute an ethical dilemma for the team.

The researchers made other attempts to hand out the questionnaires directly to patients but found that while some patients were prepared to consent to being interviewed and almost all consented to having a researcher present during patient/doctor/nurse meeting it was not looking possible to obtain a valid sample of questionnaire returns.

Trust 2

Trust two was organised across two distinct sites and although the senior staff work across both sites, as will be made clear from Chapters Three and Four below, each site is very different in its organisation. We initially

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approached the senior staff on Site A first about how to distribute the questionnaires and they referred us to Human Resources on Site B who were the only people with access to a staff list. We did not get any acknowledgement from HR despite several attempts including one visit to the head of HR from one of the researchers. He said he would get back in touch once he had checked whether he could release this list but he did not and we considered there was little more we could do to pursue this particular approach.

The PI then contacted the senior nurse manager, who had been one of our original gatekeepers, for help but found that she had left for another post.

Following the abortive attempts to contact HR (or anyone else who might have been able to help) a PA in one of the many departments we contacted suggested that there was a staff intranet which went out once a week with an 'update' section with news for staff across the Trust. The PI made contact with the editor of this site who agreed to include an electronic version of the OCS.

Consequently, the questionnaire was included on this web-site, with a preamble (adapted from the NRES participant information sheet) on two occasions. However it only produced one reply. We made one final attempt via the PA of the CEO to contact HR for a staff list to no avail.

What was interesting and perplexing though was, that there was no difficulty obtaining a commitment from staff across the Trust to participate in an interview or focus group which was much more time consuming and personally revealing.

By the time we were ready to collect the patient survey data at Trust 2 we already recognised the problems with the responses from the staff. Also, by contrast, we had established the effectiveness of eliciting patient data from the shadowing and observations. We therefore made a decision to focus on this approach to data collection from patients rather than pursue more blind alleys.

Trust 3

In Trust 3 the early signs were that there was no overarching administrative structure from which we could obtain a staff list and nobody we asked could advise on the best way to gain that information. However we did have some 'local' e-mail addresses of the staff in the Units and therefore we e-mailed the OCS to staff on the two study Units and obtained 13 replies all together.

3.2.4 Participant characteristics

There were 224 respondents who completed and returned the questionnaire, of which 77% were women (n = 172) and there were 23% men (n = 49). These included from Trust 1 (n = 210, 93% of respondents), Trust 2 (n=1, 0.4%) and Trust 3 (n= 13, 5.8% of respondents).

The mean age was 46 years, standard deviation 11.1. The majority of respondents were married (62.7%), with a further 7% cohabiting. Twenty percent of respondents were single and almost 10% divorced. The majority of respondents were White (72%), the next biggest group were Asian (18%) and other ethnic minorities such as Black (6.5%) and Oriental (3%) consisted of much smaller groups.

Pay level: most of the respondents had a salary of less than £20k (44.3%) or between £20k- £40k (38.8%). A much smaller percentage (5%) earned between £60k and £90k and a further 2.3% of respondents had a salary exceeding £90k.

3.2.5 Professional demographics

The majority of respondents had been working in the NHS for over 5 years (68%), with a further 26% for between 1-5 years. Only 5.8% reported less than one year's service.

3.2.6 Stability within individual Trusts and Units:

Most respondents had been employed by the same hospital for over 5 years (56%) and another 34% had worked there between 1-5 years. The rest (10%) had been employed by the hospital for less than a year.

Most respondents reported working for the same Unit for over 5 years (45%), a further 43% reported working there for 1-5 years and only 12% reported service of less than 1 year. A similar pattern was seen in terms of length of time in same job. However the majority in this case had been working at the same job for between 1-5 years (45%) and slightly less (41%) had been working in the job for over 5 years. Another 12% had been employed in the same job for less than one year.

3.2.7 Role:

The majority of respondents were nurses, 31%. 13.5% of respondents were managers; 11% consultants/doctors/physicians. Other allied professionals, such as scientists and psychologists made up 10% and support staff made up a further 6%. Clerical staff and 'other' staff (such as porters, maintenance) made up a further 13% each.

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3.3 Data Analysis

This was conducted in the manner described in Chapter Two and the results are discussed separately in the following chapters each of which when relevant provides more context to the conceptual framework and analysis in the substantive area of focus.

3.4 Conclusion

The diverse nature of each of the organisations studied provided valuable information about the different kinds of challenges that different leaders at all levels might face in different institutions across the NHS.

Staff at senior level (particularly non-clinical managers) moved around within and between Trusts. During the course of conducting our study some key gate-keepers and participants left the Trust, others joined and yet others moved position and role even during the relatively short time we collected data there.

In some cases mergers had just taken place or were expected. This was experienced by some as opportunities and others as threats, but in all cases it meant structural reorganisation, staff being re-assigned or choosing to leave for another post.

This has to be taken to be part of the changing face of the NHS overall and central to the culture and climate of the participating Trusts, and can no doubt be generalised to every NHS Trust across the country. In what follows, we have used our different strategies for data capture to examine the relationships between leadership and service delivery in this fluid and (potentially) exciting context.

4 Leadership in the NHS

4.1 Introduction

In any organisation:

Leadership is needed to pull the whole organisation together in a common purpose, to articulate a shared vision, set direction, inspire and command

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commitment, loyalty, and ownership of change efforts (Huffington, 2007, p. 31).

and

Leadership would be easy to achieve and manage if it weren't for the uncomfortable reality that without followership there could be no leadership except, perhaps for the delusional sort. (Obholzer, 2007, p. 33).

In this chapter we examine the ways in which leadership is defined, exercised, experienced and transmitted taking account of how far leadership is perceived as pulling the organisation together to pursue the common purposes of patient care and the relationship between leaders and followers.

We specifically:

- Explore how leadership is defined by different stakeholders and what they see as determining its quality;
- Seek to begin to understand how leadership is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients through examining the data from focus groups and story-telling interviews;
- Using the same data sets, explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted.

4.2 How is leadership defined by different stakeholders and what do they see as determining its quality?

We start this particular exploration with a *thematic analysis* of the qualitative data to identify what themes emerge from the definitions, while also making interpretations using *CDA* and *narrative analysis*. In so doing we pay attention to what Gough has termed 'emotional ruptures' (Gough, 2004) in the text which serve to illuminate some of the subordinated or unconscious information in the stories of the respondents and the subjectivity of the narrator (Frosh, 2003; Frosh, Phoenix, & Pattman, 2003; Hollway & Jefferson, 2000).

In Chapter One we proposed that 'leadership' as a concept has been subjected to continuous scrutiny and moved through different theoretical and paradigmatic iterations. The NHS has identified the qualities it requires in a leader and the role that NHS leaders (at all levels) are expected to strive towards (see Figure 1). We therefore inferred that respondents, imbued in the culture, would focus on 'transformational' or 'distributed'

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explanations and definitions about leaders and leadership because these models are embraced by the style of the coaching and training on offer.

4.3 Definitions

Respondents distinguished between 'leader' and 'leadership'. A 'leader' was described and defined in diverse ways including as:

Obviously strong minded and opinionated (Administrator, T, 2¹⁹).

Particular personality traits - need to be - to have integrity, ((1²⁰)) to ((1)) be clear, err to be facilitative, to have energy to listen, erm, to negotiate, ((2)) to make decisions (Senior Non-clinical Manager, T, 2).

... making sure that you're the person who is erm keeping the team focused getting them to achieve those goals looking at different ways of working (Senior Clinician, Trust 3).

These definitions suggest diverse ways of thinking about the idea of 'leader', indicating that commonality of stakeholder views should not be taken for granted. The qualities a leader has to have are determined in these definitions through having opinions, being strong-minded while also having integrity. A leader also needs to be able to facilitate actions, negotiate and keep the team focused towards the achievement of its goals supporting team-work.

4.3.1 Defining leadership

Leadership in this first definition below was about a formal role and implicitly hierarchical rather than distributed:

I don't think there is anything magical about good leadership. It is about establishing what the organisation wants to do and allowing people to get on and do it (Recently retired CEO with clinical background, T2).

This respondent, who had occupied a senior position, saw the structure and strategic direction of the organisation as fundamental to what works as leadership which was not 'magic'.

¹⁹ In some cases we are able to identify the Trust but where there is any chance of a breach of confidentiality we adjust the 'credit' to ensure anonymity.

²⁰ Where the transcription has included double brackets it denotes pauses timed in seconds.

The following respondent expresses it differently suggesting that it means different things to different people on the one hand, while also being an imponderable (possibly even magical):

Leadership is like love, we all know it exists, but you can't actually prove it, you can't define it, and it comprises of lots of different things that people do, if you demand evidence for everything...you will get rid of leadership eventually (Senior Clinician, T2).

This clinician seems to take distributed leadership for granted in that it is about 'lots of different things that people do'. A warning is expressed it appears, though, that trying to *show* leadership exists across the organisation (perhaps rather than residing in designated roles) might ultimately destroy the possibility of leadership. Following Gronn (Gronn, 2002) this might be a way of suggesting that through concerted action leading to conjoint agency, leadership might not be so obvious (as in the first definition immediately above) but it might be more effective in a hospital where there are different qualities needed to lead in different activities.

Resonating with the view above that a leader has to have integrity, is the view from one leader's experience:

I learnt that it's very important thing for leadership... to not lie, not hide anything and just tell them the reality and be true to yourself, and that's really important (CEO, Non-clinical).

There is an immutable relationship between the leader and the follower. Being true to oneself and honest towards followers must be fundamental to the emotional engagement or attachment between leaders and followers. The significance of emotional engagement as well as emotional and social intelligence was high on many respondents' agendas for determining leadership quality:

... leadership is about having, or being able to demonstrate at any level a coherent vision for where you're trying to go and getting people getting there (Nursing Manager, T 2).

[Leadership in the NHS] is a people focused, leadership job (Senior Non-clinical Manager, T3).

.. it's not always leading from the front (Senior Clinical [therapies] Manager, T 3).

While the leader needs to have vision, these definitions imply that vision alone does not determine how leadership can be exercised or experienced. Leadership will not work unless the leader engages the followers with that vision.

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If leadership fulfils an organisational role ('establishing what the organisation wants') then can it also be 'people focused'? If good leadership is about transparency and honesty is there an assumption that it has not always been so or may not be so at some future time? What does this imply? Does leadership have an 'indefinable' quality' or set of characteristics that work within a specific context but may not be transferable as 'skills'?

Leadership presents dilemmas for the maintenance of personal integrity ('tell them the reality and be true to yourself'), it is a 'job', it requires 'vision' and flexibility and most importantly it seems it is about focusing on people.

4.4 How is leadership in NHS health care organisations exercised and experienced by those affected by it?

Respondents talked about the *role* of the leader as central to the practice of leadership in the organisation. Leadership was understood to be intrinsically linked to particular tasks/goals while necessarily engaging with the followers who had to implement much of these tasks and achieve the goals. There was a sense that many respondents held an idealised view about leadership in their own Trust. Sometimes though the reality for them fell short of expectations because the person occupying that role failed to live up to their hopes.

For example, as the following extended extract illustrates:

.. one of the things about the leadership and management of this Trust is first of all clinical leadership is strong in most places. The clinical directors here have general clout and they are not just figureheads .. and the other bit I think - relationships between general managers and clinicians on the whole are much more positive here than other Trusts (Senior Clinician).

This proposes that strong leadership among clinicians (distributed both horizontally and vertically via the clinical grouping) enables managers to deliver the service to patients. However, this does not in itself identify the characteristics of the links between strong leadership and service delivery.

For many respondents leadership is exercised at least in part through each leader's personal characteristics (good and bad). Almost without exception when asked about the qualities that make a leader, and to 'story' their own explanations, respondents placed a degree of emphasis on the characteristics of an 'ideal type'. The following exemplifies this:

Most important quality is the communication. Being able to listen - hear what is being said and to deliver that--what they want to say, so that it is heard by all. That it be quite quick thinking, being able to develop an idea

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and roll it out, umm being able to think on their feet as well, because sometimes you get things that turn up and you have to deal with it there and then, umm, reasonably personable so people will confide in that person, um also strong so that when things are tough they can um deal with them (Clinical Midwifery Manager, T1).

The comprehensive but daunting picture of how leadership is exercised described above, represents an ideal of distributed leadership as *concerted action* (Gronn, 2002). This type of leadership is exercised through being able to communicate – to listen and to express clearly (so as to be ‘heard’) how action will be taken. ‘Rolling out’ the idea again suggests taking peers and followers along with you and being ‘personable’, so people will confide in that person, further indicates the ability to take the views of others into account calling for both emotional and social intelligence (Amendolair, 2003; George, 2000; Goleman, 2006; Lopes, Grewal, Kadis, Gall, & Salovey, 2006; Riggio & Reichard, 2008). In this model, the multifaceted communications rely on the ability to use the information to think quickly and be strong under ‘tough’ circumstances.

However, in the next extract (from a non-clinical manager) the ideal type of leadership is represented by responding to short and medium term organisational goals (Buchanan, Fitzgerald et al., 2005; Riccucci, Meyers, Lurie, & Han, 2004).

Erm, I think leadership is about erm, encouragement. It is about showing people direction in which you as an organisation and them as individuals engage in. I think it's incredibly important especially in an organisation like the NHS where there are lots of different groups of people and lots of different objectives - sort of daily ones, monthly ones more long term, and you have quite a clear sort of vision of where you're going and I think that the good leaders in the NHS show that, and examples of bad leadership are where that is not so defined. (Middle Manager, T2).

This suggests a *transactional* model of leadership, whereby the good or effective leader offers ‘encouragement’ to the followers in return for people accepting the practices of the wider organisation (Bass, Avolio, Jung, & Berson, 2003; Eagly and Johannesen-Schmidt, 2003)

4.4.1 Exercising leadership through their organisational ‘role’

Leadership is experienced by some as being exercised through the legitimated role. Organisational role in the leadership discourse equates with the leader’s professional position as the respondent below shows clearly:

Who would be a leader to me? I think there's a number of different areas, there's your direct line manager, who's the clinical leader of your department. Who's who in this structure there's line managers above them, and above them and so on. There would be people you would look to within your own specialty clinically who are more experienced than you ((2))²¹ in certain areas, to ask for advice, erm ((1)) and similarly in an academic environment ((1)) there are other people there who have more experience that you would want to take advantage from or advice from. ((2)) And in the wider circle, national or international leaders in the field who are so expert at those things that you also turn to. (Medical Consultant, T3).

While the formal roles and organisational hierarchical structures are taken seriously by this respondent, there is also a clear vision of leadership being exercised through concerted action in collaborations that arise *spontaneously* where clinical and/or experience is valued and sought within this respondent's speciality and sometimes *intuitive* leadership (Day, Gronn, & Salas, 2006; Pearce, 2004). However, there is also a sense that this respondent experiences leadership through the institutionalisation not only of formal roles locally, in the organisation itself, but through the structural relationships with those who are seen as experts in a much wider networked context (Pearce, 2004). This version of leadership is particularly important in that it demonstrates that leadership can be both experienced and exercised beyond the boundary of the organisation and the NHS, based on knowledge and expertise originating outside these systems.

Respondents frequently combined personal qualities with their understanding of the leadership role, particularly related to taking responsibility as part of that role:

It's quite difficult, I mean I think taking responsibility (4) making sure that things happen that are supposed to happen, or don't happen that aren't supposed to happen (3) um.., (6) that's it. (Clinical Medical Consultant, T1).

Not everyone saw leadership in this way. This respondent is talking about their own experience of being in a role in which then 'buck' frequently stops and thus by definition they are in the role of leader.

The exercise of leadership through being a 'role model' (Trevino, Hartman, & Brown, 2000) where qualities of leadership were displayed was important for some:

The leaders that I've worked for and have wanted to follow ... push something in me that says 'I want to be like them' or I completely support

their vision of where they're going or you know so I want to follow that person and I want to do the best that I can do for them because I believe in them and their vision. (Head of Non-Medical Clinical Team, T3)

This explanation has a flavour of heroic or charismatic leadership, although not as a quality that resides in a specific person necessarily, but one that resides in a relationship that 'fires' up both leaders and followers (Klein & House, 1995). Even though the idea of the charismatic leader has been at least partly consigned to the history of the late 20th century organisation, it has not disappeared and needs further thought particularly in an organisation such as the NHS where changes are sometimes rapid and stressful (James, 1999) and internal culture needs to be taken into account (Dopson & Waddington, 1996; Tourish & Vatcha, 2005).

4.4.2 The relationship of the 'leader' to 'followers': how leadership is experienced

While leadership is the focus of the professional and political debates about the NHS and other organisations, until recently, relatively little attention has been paid to followers' experiences of leadership (Avolio et al., 2004; Howell & Hall-Merenda, 1999; Lewis, 2000; Schilling, 2009). From the perspective of a manager taking the position here as 'follower' looking 'upwards' in the organisation:

I think it's, it's providing, you know direction and to lead and that's a leader's main job in my mind. And (2) that's .. what they say for leadership, you must have followers. If nobody's following you, what you are saying then? you are not a good leader. So that's a good, you know, test for a leader to evaluate themselves. That's what they are saying and what they are trying to achieve. Are people behind them or not? If they are not behind the leader there's something wrong with that. (Middle Non-clinical Manager)

From the perspective of a junior doctor taking the 'followership' position:

I think in order for you ... well in my opinion a leader, I have to be able to kind of respect them. If I don't respect or kind of have faith in what they do, then it's, it's a personal authority, so in order, you know in order for me to do that I have to believe in what they say. I mean, I might not always agree with them in my opinion but at the end of the day I have to be able to respect them enough and for them to have certain authority, someone who's probably experienced and gained that knowledge, so yeah. (Junior doctor)

For leadership in the NHS to be exercised effectively then there has to be an engagement between the leader and the followers (Macy & Schneider, 2008) and to understand fully how the engagement takes place, a degree of

emotional engagement and/or attachment to the leader and the organisational vision is fundamental (Riggio & Reichard, 2008; Rubin, Munz, & Bommer, 2005; Vince & Broussine, 1996).

The failure to take followers with you is made explicit here from the perspective of one (designated) leader:

A: I was forced upon them...

Q: that's what I was going to ask. So presumably there was a lot of resentment I guess?

A: Yes.

Q: And how does it manifest itself?

A: Erm, non-cooperation, making life difficult for you sometimes, people talking about erm ((2)) sort of criticising you behind your back and erm playing silly games behind your back that makes management of other people more and more difficult. Erm you know, and yet we sort of have to fight another battle to win hearts and minds, when we, you know, don't really have the time to do that, we have got to have our focus on doing what we are meant to do, which is to manage patients and to manage our beds properly.

This extract from the interview with someone whose role it is to lead change is revealing. The respondent recognises that he is not taking people with him and in his view, the followers appear to eschew co-operation. He also believes they are mocking him and that that mockery is contagious. He may or may not be able to evidence this, but that it is in his mind is potentially detrimental to his experience of leading in his organisation (Stein, 2005). Furthermore, instead of looking at himself, this respondent wants to push the blame for the leadership failures onto the followers (in other words he engages in splitting described in Chapter One) (Klein, 1975; Segal, 1973). Such a process is diametrically opposite to leadership studies that identify authenticity and trust between leaders and followers as being one of the basic qualities for leadership (Avolio et al., 2004; de Raeye, 2002; Novicevic, Harvey, Ronald, & Brown-Radford, 2006).

There is also some evidence of concerted action here, distributed among those who were leaders of the *resistance*, which is not necessarily against the values of the organisation in any negative way, but may be seen as upholding important principles and challenging change (or a particular form of leadership) that might be perceived as counteracting these important values (Collinson, 2005; Zoller & Fairhurst, 2007).

Trust is one important quality in the way leadership is exercised and experienced by followers and developing trust is essential if changes in

practice are to be implemented (Bass & Steidlmeier, 1999; Hunter, 2005). So, for example, 'engaging' with others involves trust:

Yeah definitely there are some good examples of where it's obvious that people have been able to engage lots of different kinds of people in different groups and I think they've done that just by sort of making relationships with them in the first place and then when it comes to having to lead them and be influential then you can see that those relationships are already there and then they can call on that you know, that sort of that trust or that sort of relationship that they've got (Middle Non-clinical Manager, T2).

The same respondent continued with a specific example that aptly demonstrates the links between all the three sub-themes.

Yep, I think Florence who is our head of [a non-clinical department] .. I think she is a very good example of what I'm talking about in terms of her job. And her role relies a lot on other people. Erm so as a personality she is a very responsible person, she gets on with everybody and you can really see how that works for her because when she needs somebody to do something or she needs people to listen they are going to because they have got a good relationship with her and she has taken time to build relationships when it is perhaps not necessary.

To summarise so far - *good* leadership in the NHS is understood by staff at various levels as:

- Taking responsibility
- Being 'given' authority by the followers
- Getting on with the people in the organisation
- Taking time to build relationships
- Being trusted by followers
- Winning hearts and minds
- Having a vision for the organisation
- Taking colleagues with you

4.4.3 Patients' perspectives on how leadership is exercised

While there were several things held in common (particularly 'trust' and 'taking responsibility') with the staff, patients unsurprisingly, considered leadership from a different position, based upon how they themselves had experienced a specific episode of care. One woman, who had had a previous bad experience in the same Trust in which she was now a patient, said:

Well somebody taking responsibility really for erm you know your care, erm especially. I keep going back to the same example but you know someone being responsible for not reading through my notes and if someone had taken that leadership erm and actually said 'right I'm going to look through

these notes', you know they would have obviously seen what they had to see and so basically yeah I think there is a lack of leadership.

The emphasis was on wanting the leader to take responsibility for patient care in contrast to poor practice whereby notes were not read. It was taking responsibility, and reassuring the patient that they were taking responsibility, that could be experienced by patients as good leadership.

Another patient similarly suggested that in their exercising of leadership, the clinical staff need to make sure that they were seen to be acting in the patients' best interest. For example:

When they're explaining their-selves, they do explain their-selves and what they're thinking. And they do tell me like the 'ifs' and 'buts' blah blah blah about this certain thing, but then one says something and [another] one says something else but they do explain themselves and what they're on about.

Also, another patient indicated that there needed to be one person who held overall responsibility for service delivery:

I don't know how it works hierarchy wise, whether there's like a top doctor or whatever, whoever it is somebody really needs to, you know, take a really ((2)) be sort of, you know, held responsible.

It is perhaps worth noting that the patients overall focused on the role of clinical leadership but saw that as being practiced by an individual rather than in a distributed form. There was a general view that individuals needed to be accountable and accountability equated with leadership.

4.5 What are the characteristics of an organisation that facilitate, or hinder, the process of leadership?

Leadership happens in a context and that context can facilitate or hinder leadership processes (Currie et al., 2009) and the influences of the organisation are particularly acute when the environment is changing rapidly (Goodwin, 2000; Michie & West, 2004) as in the NHS.

One respondent felt they no longer knew 'who was who' in the leadership hierarchy but considered it didn't really matter:

..., here is this model that says here is the Board and here is the chief exec and here is whoever else is up there. And there's this, this and this ... and [a colleague suggested] shouldn't we be transparent all the way through and shouldn't everything link? and I thought, this came up somebody legitimately asked the question that people here need to know what is happening here. Why? Why? I don't care. (Clinical Physiotherapist, T3).

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One senior Occupational Therapist, in the same Trust, on the other hand felt that knowledge of the organisation was important to facilitate leadership at every level so that when:

... people feel they are working as part of an organisation that's working for something, as part of a team and are appreciated and valued as part of that and are working for someone as well who feels what they are doing is worthwhile, I think that patient care will be of better quality.

This respondent was also convinced that supervision was part of the process by which an organisation facilitated both leadership and good practice in patient care. *"I have once a month supervision, like set time for supervision so I think that is really good."*

Furthermore, supervision and informal contact with peers facilitated effective distributed leadership which impacted across the organisation: *".. you can go to people informally, your peers erm whenever it's quite flexible like that and even if you're a senior like me you think 'hang on I don't know if I'm on the right track here so am I missing something?' You can just go and speak to you team about it or one of our colleagues downstairs or whatever if you want to.*

More dramatically a senior clinical leader suggested that leadership is facilitated in 'moral' organisations:

A²²: So one thinks they are better than the other, so the seven deadly sins basically...pride, the other one is gluttony, which means excess...one can never have enough, for the sake of it, and then just goes beyond, you know, one million, two million, you know, which kind of greed isn't it...excess basically, and also rushing is in there, doing things too fast. A good system will reduce its workload, yeah? The NHS has a thing of needing to do more and more, erm anyway, I don't know whether you find this useful or not, so greed, gluttony, there's rushing, and then jealousy, which is really envy, which is really competition.

Q: Yeah

A: You need to get rid of competition, and I will tell you in a moment what could replace it, which is basically team work, team work and kindness; how you get on with each other...anger is on the list. Anger is, is blame, and the opposite is blame free culture.

Q: Yeah

²² Q = question, A = answer.

A: Or forgiveness if you want, so you need to forgive mistakes, and you know you will be forgiven...and, erm...erm...next one is laziness, that's obvious, that's hard...people either have it or not, but laziness is joylessness, you need to make sure people enjoy it, and diligence, yeah? So there needs to be something in place of ...and we have that now with trust away days and things like that, but you have to have somebody dedicated to making people understand it's about having fun

Q: Yeah, yeah

A: working is about having fun...yeah? And then its... which comes really from up here, it's just an, an, yeah, can't have enough...which is also, it's also, the opposite is erm...do not take more than you can, do not take more than you need...and that is quite a moral stand ground, more than you need...for everyone

Q: Yeah

A: and if you employ that rule, then the whole organisation becomes so successful that there's masses of money left over ... Everything works well...the problem is everyone doesn't understand that, and believe in that, and then there's a difficulty...so that's moral high ground, very moral high ground, but if you go along those, you actually have all the features of leadership.

For this respondent the organisation needs to focus on patient care, treating patients *and* staff with 'kindness'. This is counter in his view to the process of setting targets for service delivery and organisational growth (or survival) and thus competition between organisations and competition between individual staff or staff teams, which is a force that (it seems) promotes the wrong kind of leadership (Kuokkanen & Katajisto, 2003; Sambrook, 2007). Furthermore, supportive teamwork and 'forgiving' mistakes and preventing the 'blame game' enhances socially and emotionally intelligent leadership distributed responsibility across the organisation and enhancing the culture and climate (Riggio & Reichard, 2008) .

Another senior medical leader and manager (T3) reinforced this idea:

I think the ethos within the hospital, is one that encourages people to develop and grow, and deliver good quality care, you know, so, I mean I think wherever it comes from it is enabled within this organisation, and it works very effectively. One of the features that enables that to happen...it's firstly being an organisation that attracts good people to want to work here in the first place. So you get high quality people applying for the position, be it in medicine, or managing, or nursing or any of the other professions By and large, we're fortunate in that. And that's partly due to the reputation, and partly due to the [location] but I think the ethos that comes

from the leadership makes it desirable to be here. Erm...so it attracts the right people in, it then enables, it doesn't put the brakes on, it doesn't try to control people too much.

Thus, organisational performance and culture/climate were 'enabled' through a cycle of encouragement, good practice, reputation and a supportive and 'hands-off' approach to leadership. This suggests concerted action, leader/follower engagement and emotionally supportive behaviours at all levels. That the physical location of the hospital is attractive is perhaps but one factor in this equation, although a central location makes it possible to draw on a wide range of staff as opposed to a location which is in a small town or distant suburb.

It is not just features of the organisation itself that impact on leadership. Organisations reflect changing discursive constructions of leadership and the values that underlie what it means to be effective as a leader in that place at that time (Ferlie & Shortell, 2001; Lansisalmi, 2006; Michie & West, 2004; Scott, Mannion, Davies, & Marshall, 2003). As demonstrated in Chapter One theories of leadership have developed and different approaches have become significant at different times as witnessed by the shift from promoting and studying transactional, charismatic and heroic leadership styles to the contemporary emphasis on forms of distributed, networked and transformational leadership (Bryman, 2004; Butterfield et al., 2005).

One dramatic change over the past twenty and more years has been the image of the medical consultant in the public psyche. Thus the 'heroic' leadership of Sir Lancelot Spratt has been firmly (it seems) replaced by the team work in the TV series *Casualty* or *Holby City*. However the image of the rebel Dr. House (played by Hugh Laurie in an American TV series) is described as 'unorthodox' and 'radical' but most definitely a medical hero. Is this the type of leader that some might still long for? While the following comment was atypical of most people's definitions of what makes or fails to make a good leader it raises some interesting points about the contemporary regulatory discourses on leadership. Thus one participant said of another²³:

Now (Dr.) David is a really eccentric so he is not what you would naturally call a leader, erm ((1)) but people are really respectful... Because he really cares for patients ...And if he finds a junior doc, or nurse or anyone who is being unkind to an elderly patient then he is down on them like a ton of bricks but his, his patent commitment to medicine and clinical care just inspires admiration ...And great affection hopefully. But he is very odd. Yes. Erm, so he is like a one off so again there is no single person, you

²³ No identifying information is appropriate here.

know there are, there are, there are different leadership styles which are appropriate in different situations but David of course could never be a chief exec, he just wouldn't be able to do it, so he would be hopeless there.

On the surface this might be explained as a judgement based on 'evidence' and a job description. However, focusing-in on the discursive and regulatory practices with which this extract engages, a different view can be taken. The respondent here, being asked to describe the qualities of leadership, begins by suggesting that taking patient care very seriously is 'eccentric' and the person who does that is a 'one off' and 'odd'. Paradoxically (it is suggested) David inspires affection and admiration but despite the variety of leadership styles David would never make it to be CEO. Whether or not this is the case is irrelevant here because what is at stake are the ways in which discourses around 'leadership' and the qualities of the 'leader' *regulate conduct* setting normative behaviour through the discursive practices. There is little doubt that David would have been considered a leader (perhaps a leader in his field) during a different period when hospitals were smaller and perhaps when there was less specialisation in management.

A learning organisation?

The NHS has declared itself to be an organisation dedicated to learning for at least the last ten years and certain values underlie this declaration (see Davis and Nutley, 2000). It means that:

Although learning is something undertaken and developed by individuals, organisational arrangements can foster or inhibit the process. The organisational culture within which individuals work shapes their engagement with the learning process (p. 998).

In some cases the exercise of leadership clearly facilitated the (potential for) learning and learning facilitated leadership, while in others it did not. The facility for leading change in NHS Trusts is critical and developments in the role of nurses from a range of specialties to support leadership and learning have provided exemplars of how some organisational arrangements support leadership (Bellman, Bywood, & Dale, 2003; Doherty, 2009). However, some have argued that continued changes, the market as a driver and the complexity of the NHS might militate against whole system learning (Sheaff & Pilgrim, 2006). Questions have also been raised about the potential of the new generation of leaders who are expected to be inspirational, drive change and support learning (Phillips, 2005).

One capacity manager, for instance, was very clear that leadership was about enabling appropriate learning and the development of skills:

... probably more about empowerment and not necessarily of oneself but of others. So I think that indeed you need to feel empowered yourself, but I think that leadership, good leadership is about empowering and supporting those people who are not in power so that they are equipped with the skills that are required. some of it is actually around learning, it is about what stage they are at in terms of their learning curve.

This is not only a statement about distributed leadership but about a version of a transformational leadership that transcends individual leaders and requires an organisational culture that both supports individual learning and targeting individuals to ensure, that their learning is recognised and ongoing (Burke et al., 2006; Conger & Kanungo, 1988; Kuokkanen & Katajisto, 2003).

The respondent continues with this theme in a sophisticated, and it seems heartfelt, way:

But I think that sometimes that [learning] is not always consolidated, even those people that have been in that position for years. I think, it is more about the people actually understanding²⁴ what they have done, and almost sometimes talk it through, in basic detail about why they have got to the decision they got to. But just because you have been in a position for a long time doesn't necessarily mean that you have actually learnt erm and you may only then go up to a certain stage in my opinion in terms of your whole learning so then they may be stuck in, not novice, but in that middle stage rather than the expert. Which we would hope that most people would get to.

This suggests that organisations need to be vigilant and to constantly invigorate their members. For the respondent quoted above, an organisation that allows people to stop learning is one in which leaders and potential leaders stagnate (at their peril) (Mark & Scott, 1991).

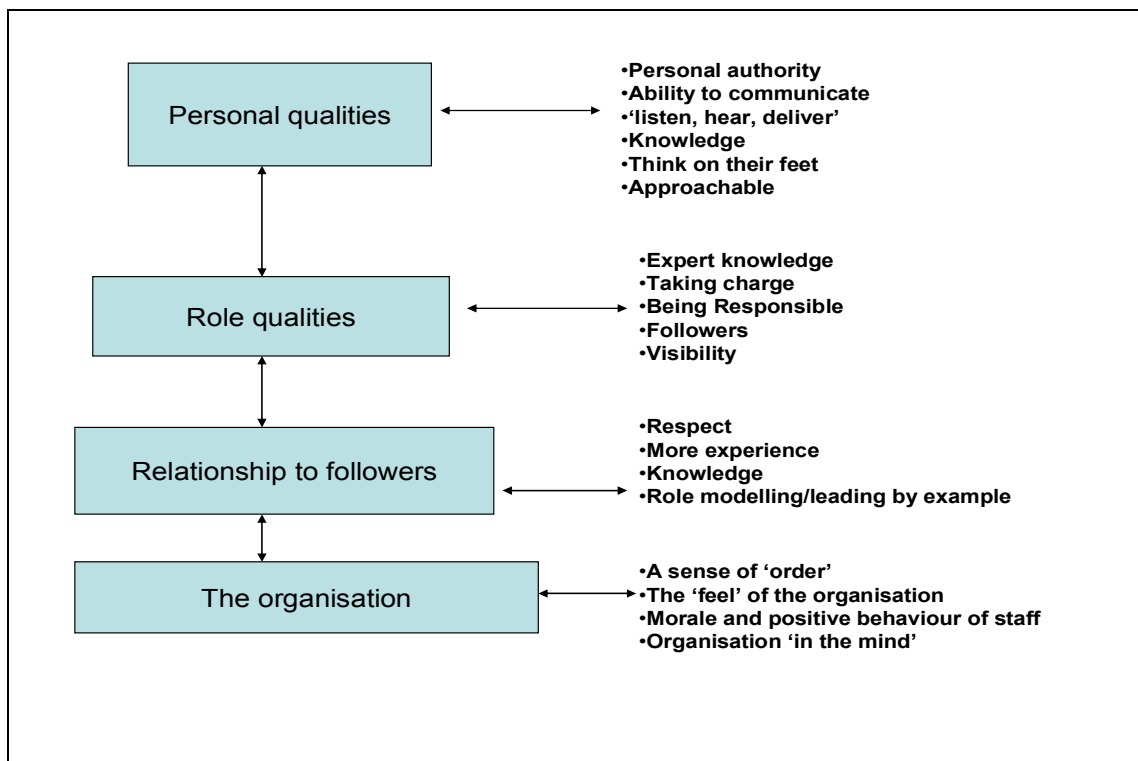
As we discuss again in Chapter Nine, the multi-disciplinary team presents an ideal opportunity for observing leadership (good and bad) and examining the ways in which these teams adhere to organisational norms which might support or inhibit learning (Burke et al., 2006; Day et al., 2004).

One senior non-medical clinical manager in a different Trust also took up the theme of learning and empowerment and specifically how it links to good patient care (Burke et al., 2006; Doherty, 2009; Kuokkanen & Katajisto, 2003).

²⁴ The transcriber who was also the interviewer made it clear that these words were emphasised by the respondent.

... [leadership] is about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is we worked with 'Training and Development' and we came up with a specific programme that was aimed at empowering them [all administrative staff] to improve their service area etc etc and also provided them with some skill sets that they probably didn't have prior to that.

Figure 11. What makes a leader?



4.6 Conclusion

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

Nonetheless, when asked to describe and define leadership, various stakeholders at all levels of the organisation have a view some of which coincides with contemporary NHS discourses and some which seems directly at odds with what the NHS is trying to achieve – that is, to support both

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distributed and transformational leadership that are seen as successful in ensuring effective patient care. However, it is clear that individual personalities and the impact of particular leaders cannot be taken out of the equation.

Leadership is experienced as distributed and transformational but there remains a belief that charismatic and transactional leadership also have their place in complex organisations. While vision is important, no vision can be achieved unless the leader takes 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. Supervision, peer support and informal advice are part of the emotionally intelligent distributed practice of leadership. 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.

In summary, the main ideas that emerged from the respondents' views of how leadership was exercised and experienced were it was about:

- Personal authority
- Ability to communicate
- 'listen', 'hear' 'deliver'
- Thinking on your feet
- Being approachable

Leadership can be exercised in a number of ways and qualities of leadership are seen to reside in different but interlinked 'places'. For example, it is clear that some people are perceived more than others to have the personal qualities that make them a leader, including being able to listen, deliver and be approachable (see Figure 11 above). The assigned/legitimated leadership role is also perceived to be an important quality for a leader, which is interesting, when thinking about the distributed leadership model and particularly the idea of concerted action where people have to work together to 'lead'. This links further to the qualities inherent in leader-follower relations identified as fundamental to the stakeholders interviewed here.

Finally, leadership means holding a sense of the organisation in mind. That is the mental model held by the leader through which they mediate and regulate their vision and actions as leaders, but it also refers to the leader's understanding of morale and the 'feel' of the organisation in which they are working, which itself regulates and constrains the possibilities for growth, development or atrophy.

In this chapter we identified some of the evidence of how organisational contexts evolve and the relationships between organisational culture/climates and the ways in which leadership is practiced. This will be developed across the next four chapters.

5 Leadership and Organisational Climate

5.1 Introduction

Despite its North American origins, where the health care system is fundamentally different from the NHS, Stringer's focus on both leadership and climate nudged us towards choosing an adaptation of his organisational climate survey for this study. We also identified an 'awareness', as he puts it himself, that "*People working in health care systems play drastically different roles that are more diverse than the roles typical in schools and businesses*" (Stringer, 2002, P. 188).

Through adapting the OCS we also captured demographic information from our participants as well as a data about satisfaction with the leadership one receives from his or her immediate supervisor²⁵. Thus, while on the whole Chapter Four dealt with general descriptions, definitions and values, in this Chapter we focus on specific relationships between individuals and the individual and the perception of their organisational climate.

The additional contribution the survey data makes to the overall aims of the study is to relate perceptions of leadership and management directly to organisational climate, thereby providing a triangulation with the story - telling and focus groups to explore the characteristics of organisations that facilitate or hinder leadership and service delivery.

5.2 Results

5.2.1 Normality of data

When normality was examined the KS-Lilifors test was found to be significant over all the scales, indicating that the data were not conforming to assumptions of normal distribution. However, inspection of the histograms and boxplots were found to present an acceptable level of

²⁵ Our version of the survey questionnaire is appended.

normality. Due to the nature of the data it was decided not to transform it, but rather to interpret the results which rely on the assumption of normality with caution.

5.2.2 Cronbach's Alpha

In order to check the reliability and internal consistency of the OCS in this setting we used Cronbach's Alphas (Cronbach, 1970) (See Table 2).

As can be seen from Table 2, the three dimensions of '*commitment*', '*support*' and '*recognition*' were considered to be high on reliability as their scores ranged from .69 to .74. These would be considered acceptable-good level of reliability (George & Mallery, 2003).

In contrast, the three dimensions '*structure*', '*standards*' and '*responsibility*' were low on reliability. This low reliability may be explained by confusing wording of the items, or it is possible that the individual items did not correspond well to one another in this sample. As such it was decided to remove the '*responsibility*' scale from the rest of the analysis. A further check to see whether '*structure*' and '*standards*' could be improved by removing single items, did not show any improvement to the alpha so these were retained in their original form.

Table 2: Cronbach's Alphas for the six dimensions

Scale	Cronbach's Alpha
Commitment	.74
Support	.72
Recognition	.69
Structure	.57
Standards	.43
Responsibility	.14

When managerial dimensions were examined for reliability' these were found to be very high ranging from .86 for '*recognition*' to .79 for '*commitment*' and '*responsibility*' (See Table 4).

Table 3: Cronbach's Alphas for the six Managerial dimensions

Scale	Cronbach's Alpha
Managerial Responsibility	.86
Managerial Recognition	.83
Managerial Standards	.83
Managerial Support	.81
Managerial Commitment	.79
Managerial Structure	.79

Overall scores for organisational dimensions

In order to derive the scores for individual dimensions, all the items on each dimension are summed [this is after all the negatively worded items were reversed].

The following were mean and standard deviations across all the six Organisational scales:

Table 4: Mean and Standard Deviation

Scale	Mean	Std
Commitment	14.82	2.86
Support	14.06	2.80
Responsibility	9.93	1.73
Structure	9.01	1.88
Recognition	8.42	2.55
Standards	8.36	1.69

Stringer, et al (2002) suggest an analysis of percentages of respondents who scored above the mean. In our analysis the following percentages were found:

Table 5: Scores above the mean

Scale	% above the mean
Commitment	60%
Support	47%
Recognition	49%
Standards	49%
Structure	39%
Responsibility	58%

Stringer offers a method of interpreting these percentages, according to benchmarked ratios collected through their extensive research to validate the tool.

High 'commitment' (60%) – In the current sample, there was a high degree of 'commitment' to the organisation and its goals. This would be typical of professional staff working for the NHS. However Stringer asserts that high 'commitment' needs to be accompanied by high 'support' and high 'recognition' – without these individuals will stop engaging with others in the organisation and their team (p.200). As indicated in Chapter Four engagement is crucial if leadership is to be effective.

High 'responsibility' (59%) – Stringer asserts that 'responsibility' is a difficult dimension to interpret within the health care setting. Effective performance in the NHS requires that procedures be double checked, which in many other contexts would put the role of 'responsibility' in an ambiguous position. However this is not the case in complex clinical settings (or for example in other precision performance occupations such as flying aeroplanes for instance). In the case of the current sample 'responsibility' was high, which is related to high sense of 'commitment', but is confused by the limited 'structure' – it is essential that people are clear about their roles, so that they may take charge and 'responsibility'.

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Moderate 'recognition' (49%) - According to Stringer scores lower than 50% may indicate that participants are feeling unappreciated. In this case there is just under the 50% mark, which translates into moderate agreement about the feeling of being rewarded for one's efforts. Having a high sense of 'recognition' in an environment such as this is of crucial importance for motivation, but 50% is within the normal range set out by Stringer. High 'recognition' is indicative of confidence in the organisations performance/reward ratio but in such a diverse setting as a hospital with a diverse staff group responding to the OCS then different groups with different management and professional/occupational structures would have different perceptions and experiences.

Moderate 'standards' (49%) – there is a moderate feeling of pressure - performance 'standards' and expectations are high but not to the point where they are stressful. This falls within an acceptable range. Considering that many of the 'standards' (targets) are set out by government policies rather than directly by Trust management/leaders it is important for these standards to be realistic and achievable.

Moderate 'support' (47%) – this falls within the low but acceptable range for this scale (45%-60%) according to Stringer's benchmarks. This indicates that there is sufficient unity between teams to approach and solve problems, without overly nurturing so as to discourage individual 'responsibility' and undertaking. Team work within the health care system is challenging because of the interdisciplinary nature of teams which inevitably calls upon different management and professional structures and networks for support.

Low - Moderate 'structure' (39%) – Under half of participants felt there was clarity in terms of their roles, responsibility and authority. On the one hand this means that there are less constraints and a less of a 'jobs-worth' approach, on the other hand though it means that there is (potentially) insufficient clarity in roles and responsibility. In an organisation such as the NHS, this may be a considerable shortcoming and Stringer (p.193) suggests that in a health care environment such as a hospital, one would ideally like to have 'structure' scores above the 70s. This is emphasised because of the complex nature of the hospital environment with so many individuals involved – accountability needs to be very clear. The NHS however has gone through so many changes over the previous ten years that it is inevitable that the 'structure' score would be influenced.

Associations between the six dimensions on the organisational level

Pearson's r was utilised to test the relationship between all the Organisational scales. It was found that the majority of scales showed modest, but significant relationships:

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Table 6: Correlations between the six organisational dimensions

	Standards	Structure	Recognition	Support	Commitment
Standards	1.00				
Structure	ns	1.00			
Recognition	.22*	.47**	1.00		
Support	.17*	.42**	.61**	1.00	
Commitment	.30**	.39**	.59**	.67**	1.00

* <.05

** >.001

As can be seen from Table 6, there are a number of high associations between these dimensions. The highest associations are for 'support' and 'commitment' (.67) 'support' and 'recognition' (.61) and 'commitment' and 'recognition' (.59). In other words, participants are reporting that when a feeling of co-operation within teams is present, this is often accompanied by acknowledgement and appreciation and is further related to a greater sense of dedication and 'commitment' to the goals and aims of the team. By definition, the converse also applies: feelings of isolation are more likely to be accompanied by lack of incentives and disenchantment with the objectives of one's team. This is 'supported by Stringer (p.200).

Satisfaction with leadership

When the *organisational dimensions* were examined in relation to satisfaction with the quality of leadership received from the immediate manager, which was asked as a single item, the scales which correlated most highly were 'support' (.61) and 'recognition' (.52). The weakest relationship was to 'standards' and 'structure'.

Table 7: Correlations between organisational dimensions and satisfaction with Leadership

	R (sig)
Standards	.14*
Structure	.30**
Recognition	.52**
Support	.61**
Commitment	.39**

In order to evaluate the individual contribution of each of the organisational dimensions to the overall 'satisfaction with leadership', a regression analysis was conducted, which included all items which were found to correlate significantly with satisfaction, namely 'standards', 'structure', 'support' and 'commitment'.

The total variance accounted for by the model was 40% (Adjusted $R^2 = .38$) therefore variability in 'satisfaction with leadership' is moderately accounted for by this model.

Specifically, of the five predictor variables the two which were found to predict the outcome variable of 'satisfaction with leadership' were 'support' and 'recognition', 'support' being the biggest contributor with a $B = .52$ ($p < .001$) and the other predictor was 'recognition' ($B = .27$, $p < .001$). The other variables were not significant. [Appendix 1 of this chapter].

In other words, feeling supported by one's team and believing that rewards are appropriate to effort, accounts for a significant proportion of an individual's satisfaction with leadership.

Correlations between dimensions on Managerial level

The second part of the questionnaire asked about individual experiences of management. All six dimensions on the managerial level were highly correlated with each other, with strong correlations ranging from $r = .71$ ($p < .001$) between 'structure' and 'responsibility' to a correlation of $.84$ ($p < .001$) between 'commitment' and 'standards'.

Table 8: Correlations between dimensions on Managerial level and Satisfaction with Leadership

	Manager Recognition	Manager Support	Manager standards	Manager structure	Manager Responsibility	Manager Commitment
Manager recognition	1.00					
Manager support	.83**	1.00				
Manager standards	.82**	.83**	1.00			
Manager structure	.73**	.78**	.79**	1.00		
Manager responsibility	.84**	.79**	.79**	.71**	1.00	
Manager commitment	.79**	.83**	.84**	.82**	.79**	1.00
Satisfaction with Leadership	.68**	.76**	.71**	.71**	.65**	.76**

** Significant at .001 level

A single item asked about satisfaction with the quality of leadership received from immediate manager. When this was examined in relation to the six dimensions appropriate to participants' own experience of management practices, it was found to correlate highly and positively with manager 'support' ($r=.76$); management 'structure' ($r=.71$, $p<.001$); manager 'commitment' ($r=.75$, $p<.001$) and 'standards' ($r=.71$, $p<.001$); manager 'recognition' ($r=.68$, $p<.001$); manager 'responsibility' ($r=.65$, $p<.001$);

A multiple regression was carried out to examine the perception of 'satisfaction with leadership', as a dependent variable of management practices. The overall association between management practices and satisfaction with leadership was strong ($R=.80$) with associated variance explained of 63%.

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Table 9: 'Manager' dimensions regressed onto 'satisfaction with leadership'

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	-.054	.226		-.240	.811
Manager Recognition	.001	.039	.002	.025	.980
Manager support	.175	.039	.410	4.501	.000
Manager structure	.060	.027	.177	2.260	.025
Manager responsibility	-.018	.032	-.047	-.559	.577
Manager commitment	.165	.056	.278	2.948	.004
Manager standards	.017	.056	.029	.310	.757

In this case, it was manager 'support' which best predicted satisfaction with leadership ($B=.41$, $p<.001$), next biggest contributor was management 'commitment' ($B=.28$, $p=.001$) and management 'structure' ($B=.177$, $p=.025$). In other words, a large proportion of feeling satisfied with one's leadership, pertained to feelings of being supported and the degree to which one's manager inspires and exudes 'commitment' to common goals. A further important element in the equation is that of 'structure' – where roles and responsibilities are clear, it is associated with greater satisfaction with leadership.

As the biggest predictor of 'satisfaction with leadership' was manager 'support', a further regression was done to look at what organisational dimensions related to having good managerial 'support'.

All the organisational scales were inputted into a regression, excluding organisational 'support', with managerial 'support' as the outcome variable. The following was found:

In total the model accounted for 35% variance in the outcome variable (Adjusted $R^2 = .35$). There were two contributors to the model: the strongest one was 'recognition' ($B = .44$, $p < .001$), i.e. the more employees feel that the organisation rewards and recognises their efforts, the more they feel supported. The other contributor to managerial 'support' was 'commitment' ($B = .20$, $p = .008$). [Appendix 3 of Chapter Five]

These findings indicate that organisational 'recognition' and 'commitment', are organisational climate dimensions which most affect the outcome of managerial 'support', and this in turn has the greatest effect on individual's sense of satisfaction with their leadership. This again corresponds with data discussed in Chapter Four highlighting the importance of the feel of an organisation that provides support at all levels.

Regression of all dimensions onto Satisfaction with leadership

When all the variables previously shown to be significant to Satisfaction with leadership, were entered into the model, from both the organisational and managerial dimensions, namely manager 'support', manager 'commitment' and manager 'structure' as well as organisational 'support' and organisational 'recognition', the following picture emerged:

There was a high degree of variance accounted for by the model - 65% (Adjusted R^2). The model was found to be significant ($F = .80.65$, $p < .001$).

The variables which remained significant, in order of their contribution are: manager 'support' ($B = .34$, $p < .001$), manager 'commitment' ($B = .33$, $p < .001$) and Organisational 'support' ($B = .13$, $p = .03$).

In other words, satisfaction with leadership, in this sample, was predicted by a greater perception of 'support' from management, a feeling that managers demonstrated their 'commitment' to achieving common goals and an atmosphere of 'support' and team-work within the organisation.

Organisational and Managerial dimensions

In order to investigate the relationships between organisational and managerial dimensions, a correlation was performed between all of these variables (Table 10). It was found that:

There were strong correlations between manager and organisational 'recognition', and manager and organisational 'support'. There were moderate correlations between manager and organisational 'commitment' and 'structure'. And there was a weak correlation between manager and

organisational 'standards'. In other words, where the dimensions were correlated weakly or moderately, we can identify that 'standards' of the organisation do not necessarily exist at the same level of managerial 'standards'. The same relationship goes for 'structure' – having organisational 'structure' does not predict clarity in roles, as espoused by one's manager. There is a greater degree of correspondence between organisational and manager 'commitment'. When we look at 'support' and 'recognition', we find that both these dimensions tend to be closely related – one is more likely to feel that both are high, or both are low.

Table 10: Relationship between managerial and organisational dimensions.

	Organisational Recognition	Organisational Support	Organisational standards	Organisational Structure	Organisational Responsibility	Organisational Commitment
Manager recognition	.60**					
Manager support		.65**				
Manager standards			.25**			
Manager structure				.34**		
Manager responsibility					-.02 ns	
Manager commitment						.48**

The significance of Role

The largest group of participants was nurses (31%), then clerical staff (14%), managers and porters (14% each). Doctors/consultants/physicians (11%), other allied professionals (10%) and 'support' staff (6%).

When looking at satisfaction with leadership the following findings were apparent: High satisfaction with leadership was reported in total by 54.3%

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(n=113) of staff. Although there were no significant differences by work role, it can be seen that consultants and doctors reported the highest satisfaction (74%), followed by managers (61%). It can be seen that clerical workers had the least high satisfaction (41%), followed by 'support' staff and other allied professionals (54%). This is significant in terms of the hierarchy within the organisation – the higher the position the more satisfied one is with their leadership.

Table 11: The significance of role and satisfaction with leadership

	n	% positive responses about satisfaction with leadership
Managers	28	60%
Doctors	23	74%
Allied professionals	22	54%
Nursing	65	49%
Support staff/Assistants	13	54%
Clerical	29	41%
Porters/maintenance	28	57%

A further examination of organisational dimensions according to role using a one way ANOVA, revealed the following:

In all there were large differences between respondents in terms of their role, however only two scales exhibited differences which reached significance. The first was 'commitment' – doctors/consultants were found to rate significantly higher than allied health professionals on this scale (mean difference = 2.86) ($p < .01$).

The second was 'recognition' – it was found that doctors were much more likely to rate higher than clerical staff on this scale (mean difference = 2.41) ($p < .01$). Both these findings were apparent even after using the Bonferroni correction.

Comparing doctors (all grades) in Trust 1 and Trust 3

An examination of the responses on the item looking at 'satisfaction with leadership' amongst doctors revealed that doctors at Trust 1 (n= 13) had lower satisfaction (Mean = 3.38, std = 1.38) in comparison to doctors at Trust 3 (n= 10) (Mean = 4.20, std = .42). This difference (.81), whilst small, was found to be approaching significance ($t = -2.003$, $p = .06$).

While it is not possible to make an objective comparison between doctors from Trusts 1 and 3 from the qualitative data, there is more evidence in Trust 3 of doctors being both emotionally engaged with both junior doctors and other members of multi-disciplinary teams than in Trust 1 and with distributed leadership. As will be evidenced in Chapter Six doctors and other staff considered 'management' as bureaucratic and distant rather than engaged.

Gender

There were no differences between men and women's scores on 'satisfaction with leadership' ($t = 1.71$, $p = .08$).

When examining differences between men and women on the organisational dimension it was found that only one dimension, 'recognition', was perceived significantly differently ($t = 3.42$, $p < .001$). Men perceived there to be greater 'recognition' (mean = 9.55) compared to women (mean = 8.13). All other dimensions were not significantly different (see Chapter Eight).

When examining the gender differences on managerial dimensions of the OCS there were trends approaching significance in terms of differences between the genders on managerial dimensions, but these did not reach significance when multiple comparisons were taken into account:

Manager 'recognition' ($t = 1.91$, $p = .06$)

Manager 'responsibility' ($t = 2.10$, $p = .03$)

Manager 'standards' ($t = 2.33$, $p = .02$).

5.3 Conclusions

The difficulty obtaining data across all three participating Trusts has not limited the value of using the OCS to triangulate the qualitative data, particularly because a) the OCS gathered information from staff groups who were not represented in the focus groups, shadowing or story-telling

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interviews and was able to identify generalisable predictors of satisfaction with leadership and management practices, and b) the OCS data captured information from specialty groups outside those involved in the participating Units from which qualitative data was collected.

What emerged here was that on the whole, the same climate variables are important in predicting satisfaction with leadership. Within the organisational domain these are 'support' and 'recognition' while predictors of 'satisfaction with leadership', within managerial practices, are manager 'support', 'commitment' and 'structure'.

Overall, therefore, 'satisfaction with leadership' was highly accounted for by manager 'support', manager 'commitment' and organisational 'support' – i.e. these were the 'ingredients' in this sample which were highly related and were able to predict satisfaction with leadership. This suggests once again that managers/leaders were effective if they engaged with followers and that organisations that supported distributed leadership and emotional engagement were more likely to support effective leadership (see Chapters Four and Six in particular).

In terms of role, the higher the position in the organisational hierarchy the more satisfied a person was likely to be with leadership. This was not necessarily the case though across all organisations in the study. The exploration of the case studies in Chapter Seven – where authority and leadership are discussed – reveals how some of the more senior leaders in organisations found themselves to be highly dissatisfied with leadership in other sectors of their Trust, if there was resistance or negligence of their authority.

Differences in gender were only apparent in terms the organisational dimension 'recognition' – it was only on this scale where women scored significantly lower than men. This may say something about equal opportunities and equal pay for equal work, but it might also relate to perception of 'recognition' between women and men discussed and exemplified in Chapter Eight below.

The overall importance of constructs such as 'support' and 'recognition' across the climate of an organisation, and management practices which demonstrate support and commitment, provide further evidence of the importance in engagement and (probably) emotion (including EI and SI) in an organisation.

6 'Organisation in the Mind': Transmission of Leadership and Organisational Context

6.1 Introduction

Leadership in any organisation is understood in a specific context by those involved as either leaders or followers, and as shown in Chapters Four and Five concepts such as satisfaction, support, responsibility, vision and communication among others are described and evaluated within a cognitive or mental framework within which the organisation itself is understood. It is through making sense of the organisational context that leadership and followership may be enacted and transmitted.

We saw how members of organisations *necessarily* hold in their mind fantasy/imagined understandings or images of the *system* (Morgan, 2006). This informs how they work in, relate to and talk about their organisation, based on their perceptions of their own and others' place and role within the system. For example, it is common to hear employees talk about how 'you can never get management attention in this company' or 'we are all dedicated to putting patients first here' (Armstrong, 2005; Morgan, 2006).

Similarly, the participants who completed the OCS held a view of the leadership and management in their organisations, in order to think about the various ways in which their work was recognised, supported and so on both generally and by their managers. While the focus in that case was upon on measuring the impact of organisational climate and thinking about a relationship with a specific manager, those who completed the survey would have had to hold a perception of what was happening in their department and the Trust overall.

This is apparent in what follows particularly in the ways 'management' is discussed and taking account of these perceptions provides some evidence about the ways in which leadership is transmitted in these particular organisational contexts and in general. The 'organisation in mind' then involves:

- An 'image' of the organisational structure and relationships within that structure
- A sense of your own role and place within it
- An emotional component
- An awareness at a conscious and/or unconscious level of important information below the surface

6.2 Organisation in the mind

The concept of the 'organisation in the mind' was a model developed originally in the early 1990s by organisational and group relations consultants working at the Grubb Institute, the Tavistock Centre and the Tavistock Institute of Human Relations, to refer to what an individual perceives mentally about how organisations, relations in the organisations and the structures are connected. *"It is a model internal to oneself ... which gives rise to images, emotions, values and responses in me, which may consequently be influencing my own management and leadership, positively or adversely"* (Hutton, Bazalgette and Reed, 1997, p. 114 quoted in Armstrong, 2005, p. 4).

In other words, when we talk about our colleagues, guess what the senior management are doing/going to do and have fantasies about how well we fit, or don't fit, into the structure or system we do so in the context of the organisation we 'hold' in our mind which may or may not relate to that which other members of the organisation hold (Pols, 2005).

Organisations are experienced cognitively and emotionally by their members when they think about how their organisations work and are structured (see Lewin, 1947; Armstrong, 2005; Morgan, 2006). As Stokes (1994) explains it, everyone carries a sense of the organisation in their mind but members from different parts of the same organisations may have *"different pictures and these may be in contradiction to one another. Although often partly unconscious, these pictures nevertheless inform and influence the behaviour and feelings of members"*. (p. 121)

Hutton (2000) talks about it as *"a conscious or pre-conscious construct focused around emotional experiences of tasks, roles, purposes, rituals, accountability, competence, failure, success"* (p. 2). Morgan suggests that an organisation may serve as a 'psychic prison' in that the:

...patterns and meanings that shape corporate culture and subculture may also have unconscious significance. The common values that bind an organisation often have their origin in shared concerns that lurk below the surface of conscious awareness. For example, in organisations that project a team image, various kinds of splitting mechanisms are often in operation, idealising the qualities of team members while projecting fears, anger, envy, and other bad impulses onto persons and objects that are not part of the team (Morgan, 2006, p. 226).

Some of this is apparent when talking to NHS staff about the leaders at various levels of their own Trusts and the NHS overall as was seen particularly in Chapter Four.

6.2.1 Organisation under the surface

So, when the respondent immediately below talks about the leader who has a 'really good understanding of the organisation or team' what exactly does that mean? How does that understanding come about? What do the team hold in mind about that particular leader?

Leadership is someone who has a really good understanding of the organisation or team, erm where it's going and where they imagine it to be going, so that sort of vision as well for their team, I think. (Lead Clinical Non-medical Health Professional, T3)

This respondent, referring to the (frequently used) concept 'vision', also identifies this with the *imagination* the leader holds about where the organisation is going. This is not simply a matter of guesswork. It is an intellectual/cognitive and *emotional* sense of an organisation. Indeed to take this slightly further, as Gabriel and Schwartz (2004) propose "... *what goes on at the surface of an organisation is not all that there is, and ... understanding organisations often means comprehending matters that lie beneath the surface*" (Gabriel and Schwartz, 2004, p. 1).

Although not necessarily (in fact mostly not) made explicit, even the most clear thinking senior members of organisations hold an image of the organisation in mind, expressing their fantasy/belief/perception of the organisation based on conscious and unconscious knowledge (Halton, 2007; James & Arroba, 2005). So for instance for this CEO leadership is understood emotionally as it is:

... about the feel of the organisation and what it feels like in terms of how it delivers patient care. Yeah, erm. I can best illustrate that, and interestingly we were thinking about this earlier this morning, so as a group, the executives, we were talking about it. When you walk onto a ward a hospital ward and there is real leadership on that ward, you walk in and there are a number of signals that are given off, which give you a feel. Erm the place looks organised, it has a welcoming feel, the nurses on the ward and the clinical staff greet you as they come into contact with you. They know you from the previous interactions that you have had and when you sit there and listen to what is being said on the ward they will know that the patients, the visitors on the ward, the families that are coming in the junior doctors who are in there in that environment and all of that has a feel²⁶ of a well led ward. (CEO)

²⁶ Respondent's emphasis.

The environment of the well led ward (unit or organisation) is implicitly and unconsciously identified by all who engage with that organisation. The staff communicate effectively (visually, verbally and emotionally) so that the information required is passed on through managers, clinicians to colleagues, patients and relatives. This account, which preceded the extract that focused on strategy, directed to the best patient care for the greatest number of patients, expresses his ideas at an *emotional* level. He also suggests his senior colleagues agree with this. Signals are 'given off', you can 'feel' the organisation and how it delivers patient care and there is a 'welcoming feel'. He also talks about 'empirical' evidence in that staff know the patients, the ward looks organised he remains convinced that there is a 'feel of a well led ward'.

From a slightly different position, a deputy CEO quoted below also holds in mind the fantasy that a manager might think that they run an institution but that such a fantasy might get the manager into trouble. He is suggesting a vision of an organisation in which a manager has very little control, and proposes the need to gain a sense of *reality* by recognising this and taking responsibility for this organisation (Hirschhorn, 1997; Porter-O'Grady, 1995). His perception, again which has an emotional component, is one of a stressful contradiction – responsibility without power or control (de Vries, 2000).

The minute, as a manager, you start to think that you do [run the service without accountability]... erm then you're in trouble. Unfortunately you have still got the accountability for the service but you have very, very little control so it's a whole different leadership and managerial skill that is required I think in terms of recognizing that you have no control over what happens you know across this organisation across the N,000 beds here at [Trust], the thousands of people that go through the organisation everyday, what happens to them is completely outside of my control but if anything goes wrong it is absolutely my responsibility. And that is quite difficult.
(Deputy CEO, T 1)

6.2.2 Structure in the mind

Most recently Laughlin and Sher (Laughlin & Sher, 2010) take up a version of this concept which they name the 'structure-in-the-mind' in their analysis of developing leadership in social care. They reassert, in their model, that not only the local stakeholders (staff and service users) have a sense of the organisation in the mind when considering, for instance, a particular Trust, but the range of stakeholders includes government bodies and service commissioners (in the round). They propose an inter-relationship between perceptions of communications from services (e.g. 'that you [management] don't listen and/or understand') and perceived communications from 'Head

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Office (or government or other bodies that control resources and practices) which include for example 'just do it' 'we know better' and 'be rational'. (p. 9)

What is significant here, in the context of NHS leadership, is that the organisation and/or structure *in the mind* is where the leader and followers 'meet' emotionally as, similarly, do the various levels of leadership and governance bodies. It is a kind of 'virtual' space.

An example of this structure in the mind might be seen through the increase in stress for NHS employees detailed in a recent report by NICE (the National Institute for Clinical Excellence²⁷) where it was revealed that staff absence caused by work related stress costs the UK over £28 billion. It was proposed that a poor working environment characterised by bullying and poor management was at the heart of this problem²⁸ (Edwards & O'Connell, 2007). In a context where there is distributed leadership and a highly trained professional, multi-disciplinary workforce, such mismatches in how to run organisations and departments that lead to staff stress in these ways (e.g. being bullied and bullying) evoke questions about what is happening in the space between those who plan, govern and resource NHS Trusts and those who carry out the work. The emotional elements of leadership and followership relations seem to be neglected to everyone's disadvantage.

The idea of the organisation in the mind raises important questions of how leadership (good and bad) is transmitted across the NHS and its Trusts (Harrison & Carroll, 1991; Walsh & Ungson, 1991). Organisational cultures and climates are reproduced over time despite the coming(s) and going(s) of CEOs. However, organisations also *adapt* and *evolve* as a response to changes in leadership and outside influences (Morgan, 2006).

In what follows we explore the characteristics of the organisations studied here that facilitate or hinder the transmission of leadership through the Trust as a *system* through which culture (e.g. principles and values about leadership) might be transmitted (Hatch, 1993; Schein, 2004).

²⁷ An organisation established to oversee and provide guidance on clinical practice and cost and clinical effectiveness.

²⁸ See news.bbc.co.uk/2/hi/health/8343074.stm and NICE web-site which has a power-point presentation.

6.2.3 Transmission of leadership and Organisational Contexts

What is held in mind about an organisation is often influenced by the formal and informal networks (Balkundi & Kilduff, 2005, 2006; Goodwin, 2000) which characterise complex adaptive systems. Network cognitions in the minds of leaders are embedded in the whole organisation and the inter-organisational linkages formed by leaders as representatives of organisations (Balkundi & Kilduff, 2005).

The context of the NHS seems to have become increasingly complex and chaotic (Currie et al., 2009) which, coupled with a sense of widespread unethical managerial practices, has raised questions about how leadership practices are transmitted through NHS organisations (Bowie & Werhane, 2005; Collier & Esteban, 2000; Huston & Brox, 2004). Bullying and poor management are in part at least a consequence of not taking the emotional context of organisational life seriously (Ashkanasy, Jordan, & James, 2003; Cocco, Gatti, Lima, & Camus, 2003; Johnson, Cooper, Cartwright et al. 2005; James, 1999; Hutchinson, Vickers, Jackson & Wilkes, 2006).

While there is no excuse for bullying or any other unethical management practices, it is necessary to understand what precipitated the relatively recent change in culture which has exacerbated (reports of) bullying. One factor has to be the extent to which top-down, politically driven changes have been forced through the NHS system and other public institutions and the impact that the drivers of these changes have upon the senior levels of management consciously and unconsciously (Christensen & Laegreid, 2003; Dent, 2005; Gabriel, 2004).

These recent developments have influenced the psychological and emotional aspects of working in teams, groups and organisations (Liden & Antonakis, 2009; West & Anderson, 1992) and by implication influenced possibilities for innovation in leadership and the authority of leaders and workers (Lewin, 1947; Miller, 1993; Carter, Garside, & Black, 2003; Hirschorn, 1997; Fineman, 1994, 2000; Payne and Cooper, 2001; Vince, 2002; Carter, Garside, & Black, 2003). Understanding the *context* of leadership, therefore, has become increasingly important as has the need to understand how that context is part of a *system*.

Post industrial (or postmodern) systems (Rose, 1991) have been reconsidered (or 're-described') relatively recently as 'complex adaptive systems' (Collier & Esteban, 2000; Dooley, 1997; Schuster, 2005). Systems that are complex because of multiple interconnecting relationships are liable to evolve through making new connections that increase their complexity (Collier & Esteban, 2000). In the NHS, even though change is structurally driven, the (perhaps unforeseen) consequences of changes have meant that instead of a command-and-control, top-down hierarchies where in particular

clinicians such as consultants and matrons had previously been seen as 'gods' (as with Sir Lancelot Spratt and Dr. Gregory House see Chapter Four) distributed leadership, networks and different statuses attributed to individual Trusts (e.g. Foundation Trusts with relative independence, Mental Health Trusts which have social care and NHS staff and diverse management practices) have evolved within different structures at all levels for coping with service delivery (see Chapter Nine).

6.3 Open systems theory and boundary management

An organisation that *evolves* like an organism and adapts to its environment necessarily has *porous boundaries* so that it can 'take in' and 'put out' beyond itself. This kind of organism is one that changes, develops and grows. A closed system may feel more secure in that it may not have to accede to unwanted influence or demands, but without taking in and providing for the world outside it will atrophy as with any other closed (minded) system (Morgan, 2006). In this way images and cultures of leadership from outside the boundaries might influence the development of leadership practices e.g. data and ideas from education (Currie et al., 2009; Gronn, 2000; Lumby, 2003)

Systemic thinking is a framework, or tool, for observing the way organisations behave (Schein, 1985; Lewin, 1947; Campbell et al, 1994) which evolved from General Systems Theory, (von Bertalanffy, 1956; Miller and Rice, 1967) and focuses upon concepts related to organisational structure particularly 'task', 'role', 'authority' and 'boundary'. There is also a psychodynamic part of the systemic thinking analysis which links with the conscious and unconscious emotional consequences of the systemic properties and the impact of social and personal factors on the functioning of the organisation (James and Huffington, 2004; Laughlin & Sher, 2010)²⁹.

Morgan (2006) identifies how knowledge and power are accessed and maintained through control of organisational boundaries. 'Boundary' is the term used in open-systems theory to describe the interface between different parts of the organisation and the organisation and the outside world. In the case of the NHS this is the physical boundary to the, for example, hospital building, the wards, the web-site, the reception desk, the

²⁹ This issue is further discussed and explained through object relations theory based on the works of Melanie Klein, Elliot Jaques and Isabel Menzies-Lyth which is outlined in detail in Chapter One and operationalised in the description of the role of obstetricians' anxiety in the delivery of patient care discussed in this chapter and below in Chapter Nine).

telephones, e-mail and so on and also between the different roles such as out-patient/ in-patient, staff /patient, clinician/manager and so on. Most leaders in organisations have the knowledge and abilities by definition to manage and negotiate those boundaries. For example, the senior managers relate to government/NHS/DoH in ways that junior nurses do not, but the senior staff are charged with having to manage the boundaries using knowledge and influence across the boundaries – inside with the staff and patients and outside with government and patient pressure groups. Moreover, as evidenced during the conduct of this project, hospitals merge into Trusts and the porosity or opacity of the boundaries between the different organisations that have come together are central to the functioning of leadership at most levels (see Chapter Seven where the limits of authority are discussed in this context).

Stating this in a slightly different way, this approach to the 'organisation in the mind' takes the *personal* (conscious, pre-conscious and unconscious) level of thinking and links it to the *system* in which that person works (systemic thinking). As any organisation comprises systems (with boundaries, in-puts and out-puts), groups and individuals, it follows that a person's experience of an organisation and *experience of themselves* in relation to others who are in the same organisation make up the culture, climate and everyday dynamics of any organisational context. Thus, our respondents' sense of the 'organisation in the mind' is a valuable concept for understanding how leadership relates to service delivery.

6.4 Images of the organisation

In what follows we explore some of the images 'held in mind' by staff across the three Trusts particularly examining the impact of the organisation in the mind on working collaboratively and the influence of this on service delivery and the quality of patient care that results from staff relations and effectiveness.

To begin, we focus on two specific examples that characterise much of what was said by staff across at least two Trusts:

- images (and fantasies) held about 'management' which highlight the construction of 'authority' in the system and its impact on patient care
- images (and fantasies) held about the 'others' (e.g. colleagues in the same Trust but on a different site or a different Unit) which brings boundary management into play
- how these images (and fantasies) facilitate and hinder the transmission of leadership and service delivery

We employ a critical discourse analysis (CDA) approach to the meaning and processes of leadership and organisation exploring how the organisation/system *looks* to the participants and how this in turn impacts upon the system of providing care for its patients.

6.4.1 'Management' in the mind

As in many organisations, rhetoric about 'management' abounds particularly played out as a 'them/us' dynamic as we demonstrated by separate means in Chapters Four and Five. Furthermore, among management, rhetoric about their own practices and role in relation to that of the workforce is equally active (Alvesson & Sveningsson, 2003a; Borins, 2000; Kuokkanen & Katajisto, 2003).

There is general cynicism across all the respondents who defined themselves as non-management *about* management. So for example: *"And you find that when there's a crisis that's when you find your management team will come down and put a policy in place regardless - like the swine flu thing" (Junior Midwife)*. So here managers are described as paying no heed to the routine tasks of the organisation (Cummings, Hayduk, & Estabrooks, 2005b). They are portrayed as simply responding to a crisis and (presumably following orders from the overall leaders of the service). Thus, managers are not seen as managing the boundaries between the Trust and those in overall charge of health care operating outside of the organisation (i.e. at the level of government) effectively for the facilitation of service delivery (Buchanan, Abbott, Bentley, Lanceley, & Meyer, 2005; Kane & Patapan, 2006). This resonates with Laughlin and Sher's (2010) analysis discussed above.

A focus group from one Trust proposed a particularly strident view of management and its relationship to wider bureaucratic imperatives which they saw as going against service delivery and effective patient care. The medical staff here were proposing that management was both absent, in person and from taking responsibility, while also being all controlling of medical care through instigating seemingly pointless rituals which seemed to maintain boundaries.

Consultant: There is a burning example [here] of bad leadership which is the absence of figure heads. Management can never be found which is frustrating.

Registrar: I've been in theatre now for two weeks and two cases were dropped. The doctor has to apologise to the patient but they are the ones [the doctors] who would like to continue. Management say 'NO it is lunch'. They should be the ones taking responsibility for telling the patient but the

doctor has to go back to the patient and look like a donkey saying 'I'm sorry I can't do your operation today'.

The members of this group, who clearly shared the same or similar images of management and its 'idiocy', went on to decry management incompetence across all staffing issues, and the registrar continued, imitating the management in a silly voice: "*he has to stop, that's the rule*" making it very clear that management was perceived by this man and others in this focus group as inflexible (and rather stupid). Here these participants are expressing total lack of faith in the authority of those who manage (rather than lead) them, although in fact it seems that despite this, they abide by the rules which suggests that there is a belief that at some level the managers in question here derive authority from somewhere higher up in the hospital system or from the NHS leadership beyond.

One factor to note, of course though, is that the power of the story in the focus group may belie the views of the whole group in that some would be silenced by the fear of disagreeing with their colleagues (Asch, 1956; Foucault, 1982). Furthermore, the articulation of the behaviour of management in these cases is *actually a form of leadership* and as such might influence the views of the focus group (and subsequently other staff) (Avolio et al., 2004; Pye, 2005).

From a different focus group, this time with junior midwives, it was apparently *giving up their authority* for a while that gained managers some important respect. For instance when a crisis occurred in the organisation (in this case a fire) then managers seemed to behave very differently and even impressively:

1³⁰. Yeah and then the managers - the bed managers - were carrying chairs and everything and you just had people on beanbags on the floor and everybody ...

2. I wasn't here that day I missed that.

1. Well it was a bit stressful but everybody just mucked in and people were just carrying people here and you know....

Q: Well that's really good if everybody even the managers mucked in.

1. Yeah you find in a crisis the managers do come out, the leadership the leaders come out and they have to come out.

3. And people were coming in from home to help that day.

³⁰ The number denotes the speaker.

2. *Why didn't they phone me? I don't know but never mind ...*

1. *No you find that in that kind of crisis everybody from execs downwards pulls rank and everybody comes in and helps out (T 2).*

So the image here is that a crisis brings out the best in everyone (and the boundaries between the groups of staff become temporarily porous). In times of crisis then the tasks (i.e. patient care and running an effective hospital) overcome other elements of potential discord and conflict such as the 'rank' order of 'execs' bed managers and others such as clinical staff.

There are also other times when it is possible for management to be seen as 'on side' as indicated by another nurse in a different site. For example:

Erm ... our manager, she is quite approachable. And she is willing to discuss things with you if you don't feel that something is right and you question it or question her. She is willing to sit down and explain it and sometimes she will say 'I'm not happy with things as well, but the people above me this is what they have decided, this is what we have to go along with. It is government guidelines or targets have to be met'. Although she might feel the same as us she explains why we have to do things in this way. And I think she is very approachable.

This manager above, demonstrates her willingness to communicate and be 'visible' but clearly she has adopted a them/us strategy similar to those who 'oppose' management by positioning herself as managing the boundary from the side of the clinician/nurse's while also at other times presenting herself as mediating between 'government' and clinicians and managing that boundary too (Laughlin & Sher, 2010).

In the example described here, this seems to 'work' as evidence of good leadership for the nurse telling the story, but it involves the manager in question in potentially difficult dynamics and conflicts in her role.

From another focus group discussion that included doctors and nurses the organisation in the mind experienced management as absent and failing in their responsibility (Hogan & Kaiser, 2005):

Absence would be correct. Management are often not there. They need to take command of the situation. Here is the reasoning – management don't take responsibility for their actions and there is a severe lack of managerial leadership.

This is significant in the concept of the organisation in the mind when juxtaposed with the account of the same organisation by the CEO who saw her/himself as seeing good leadership as manifested in:

Visibility in terms of being seen around the place, so go out wandering around the wards. The best part of the role, quite candidly is, the best part about being the chief executive is, you can go out and talk to patients, and that is what I really kind of enjoy. ... so there is something about my presence and my profile. There is also something about being very clear and repeating the message often enough so that it is clear in the organisation about what the organisation is there to do.

So, within the same organisation there is an image that management is invisible and absent, while senior managers see themselves as 'being seen around the place' constituting an important part of what they believe they do and that they see as being vital for effective leadership and patient care (Laughlin & Sher, 2010). Both sides agree on what would be good leadership but each 'side' has a different vision of what is happening in 'reality' (Alvesson & Sveningsson, 2003a; Buchanan et al., 2007).

In the absence of a shared vision of an organisation working together or a set of clear guidelines about how 'this organisation works', there seemed to be a wish from a deputy CEO of another Trust for a hero/charismatic leader to put things to rights and potentially cross the managers/others boundary (Ladkin, 2006; Laughlin & Sher, 2010).

Erm, this is a very complicated organisation, what we haven't got right is we haven't got a bible that says this is how this organisation works and I think that's a problem so, ((1)) so ((1)) it's very easy for ((1)) despite what I've said about how difficult it was to be a leader, erm and the personality of the individuals who are at the top of the tree, makes an enormous difference in how an organisation I think behaves and works. There is a great tendency if you are a very good individual for an organisation to be based around you and when you leave there is a problem, erm and so the best kind of leader, yes they have that aura of it's about them, of course that's what people look up to but they also put in place processes so that things can happen.

This is a view from the top of the organisation which is expressed at least in part as a vision of a (desirable) mechanistic model – an organisation with a 'bible' about how it works - although this participant also desires a charismatic transformation on the part of leaders.

The hero leader would be a 'very good individual for an organisation to be based around you' and also to have 'an aura'. The metaphors in this extract proliferate – the need for a 'messiah' to save the organisation but also a sense of *dependency* – that 'people look up to' this type of leader who (it would appear) single handedly will be able to put processes in place for things to happen. The vision here is though one in which the system is defunct, stagnant and closed.

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6.5 'Out of mind': leadership and the 'other'

Organisational change is frequently resisted, often because of the disruption to individual's *sense of the system* and their place within it (e.g. Hoyle, 2004). It is also related to the emotional involvement many people have in their work and the way they perceive they are valued within (and how they themselves value) a familiar structure and context (Bovey & Hede, 2001; Zoller & Fairhurst, 2007).

Emotional labour, as discussed in Chapter One, is a key feature of the work that many people do, and is an integral part of any job, but particularly so in an institution of the NHS (see for example Gabriel, 2004). Different occupations require different types of 'displays' and following Hochschild (1983) emotional labour requires adopting emotional displays and attitudes appropriate to the role.

Clearly in hospital work all staff have to expend emotional energy on 'caring' and 'kindness' but it is also the case that working in the NHS, with its many changes for (perhaps) better or (maybe) worse, also requires the ability to be able to 'move on' i.e. mourn the loss of the old structure, sets of relationships etc. and embrace the 'new' with some degree of enthusiasm. The failure to do this (or recognise the need to do this) results in emotional resistance to changes and hanging on to the old systems as long as possible which might defeat changes that improve service delivery and benefit patients (Hughes, 2005).

6.5.1 Leading change and transmitting leadership

In one particular case a senior clinical manager Gerald³¹, was charged with integrating clinical practice across two sites, each of which had their own different ways of working, and different relationships to the boundaries between each other and the clinical teams. While the one (where he was based primarily) had accepted quite radical changes to its organisation, the other (apparently) did not "*..because the sort of ethos and the sort of personalities of the two sites are in the background. They are completely different*".

Gerald's view is based on a reality in that the two sites are structured differently, look different from each other in that the buildings are from different eras and in different styles, and they are in physically different locations. They also serve different demographic populations and have different histories. However, Gerald sees the organisation of the different

³¹ Gerald's leadership is discussed in detail in Chapter Seven.

sites as really being about 'ethos' and 'personalities' which must be in the mind (mostly) as there is a system of authority and responsibility in place across the Trust (via the CEO and other senior people including Gerald) that takes up authority and leadership to ensure consistent practices and organisational change.

Thus, we need to ask why one Unit has (apparently) taken new ways of working on board with some enthusiasm while (apparently) there are barriers preventing the other one doing something similar.

For Gerald, management of the boundaries between in-patient care and primary care teams was the source of a key difficulty:

There are groups of people here who are completely behind the concept that we mind about – integration of primary care – joint working between the Trust and the Primary Care Trust. Some departments work extremely well and are keen to move forward and although we do have our minor difficulties - generally there's one or two departments who are completely against change and erm resistant to anything new. Just like any other organisation where you know you are going to get the type of people who actually make life extremely difficult for you and despite that we've proven how much better our system is.

In the extract above he moves from talking about the other *site* (as a whole system) as being the 'bad' resistant one, to identifying *individuals* on his own site within the 'good' system as making life difficult for him personally despite evidence (he and others have provided) to show how integration works better. This respondent's organisation in mind shifts depending on how well one part of the system fits with his particular vision of a good organisation. This *splitting* (see Chapter One) is a mechanism (unconscious) for preventing the overwhelming feeling that can come from persecutory anxieties (Jaques, 1953; Jaques, 1960; Menzies, 1970). In a management role where (for some reason) authority is being undermined, then the resurgence of persecutory anxiety might be dealt with by splitting of the 'bad' site and comforting oneself with the knowledge of a 'good' site where the organisation works as this leader/manager might wish it to do (Laughlin & Sher, 2010).

6.5.2 Resisting change

In the case of a medical secretary, with over twenty years experience of working in the same hospital, the thought of change in the structure of her working relationships was upsetting. She began engaging with the interviewer by talking about how busy she was and when asked if there was any particular reason why she was busy at that particular time she went into an explanation about organisational change. *"It's just generally busy, but we*

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are in teams now, erm couple of them [doctors] are away and one or two have come back, catching up with everything". It seems as if the teams were the problem for her because previously (and for many years) "...it was one secretary to one consultant and his team. Now for instance today I'm actually taking calls for four different consultants". She was asked about the new structure and made it clear:

erm ... I don't think it's going to work as well as the previous one. Because I think you'll be dipping in and out of so many different jobs that instead of concentrating on the ones that you do well and controlling your one doctor, it'll be confusing and I think there will be mistakes made because one person is trying to deal with too many parts of too many jobs.

Her perception that her role in the organisation might happily continue as one in which she controlled one consultant is characteristic of the 'comfort' of the closed system where authority, power and the processes of leadership are condensed and held 'constant' by an individual. As seen in Chapter Four also change is not usually welcomed without at least tacit resistance and in Chapter Seven two of the case studies will explore how leaders as potential change agents experience followers' avoidance or challenge to changes in practices and structure.

Changes in working relationships bring anxieties which need to be understood and anticipated by leaders if they are to support staff to position themselves differently in the system. Hoyle (2004, in Huffington et al) suggests that during any period of organisational change there is potential for heightened creativity which might lead to doing things differently and better. However, change also brings about risk, uncertainty and the chance of failure which can evoke anxiety both in those promoting the changes (the leaders) and those who might fear loss of their job and the loss of known ways of working (see Hoyle, 2004, p.87).

6.6 Conclusions

Understanding an organisation and what facilitates and/or hinders leaders to take up their authority involves considering the organisation systemically. That is taking account of the boundary management and how that relates to the tasks, roles and power/authority of those who work or are 'consumers' of its work.

Leading change depends upon ensuring those within the system have a sense of how the system works and an awareness of the culture that might be tested as a reality or not. This means, once again, that organisations which are learning environments and where emotional intelligence is applied, are more likely to respond to authority and less likely to subvert

leadership, thus distributed leadership/responsibilities may be taken up or shared more widely.

7 Leadership, Authority and Emotion

7.1 Introduction

As argued above, leadership and emotion are fundamentally intertwined in the workplace (Fineman, 2003). Leaders who appropriately manage both their own emotions (Goleman et al., 2001), and those of their followers, experience better leader-follower relationships, greater opportunity for innovation, motivation and productivity, a more positive organisational climate and improvement in employee and customer/patient satisfaction (Ashkanasy et al., 2003; Avolio et al., 2004; Hollander, 2009). Such outcomes can be associated with both *transformational leadership* (Bass et al., 2003; Corrigan & Garman, 1999; Currie & Lockett, 2007) and *distributed leadership* (Bass & Steidlmeier, 1999; Gronn, 2000, 2002; Mehra, Smith, L. Dixon, & Robertson, 2006b) patterns.

It has also been suggested that followers' 'dysfunctional' dependency is a consequence of failure of the leader to *engage* on an emotional level with those whom they lead (Alban-Metcalfe & Alimo-Metcalfe., 2009; Ashforth & Humphrey, 1995; Bion, 1961; George, 2000). There are different types of such engagement, e.g. acknowledging emotions, drawing them out, honouring them, confronting them, and deflecting them, but although this idea of engagement has been described as "*compelling on the surface, the meaning of the employee engagement concept is unclear*". (Macy & Schneider, 2008, p.3) Even so, there is a common view that such engagement is desirable for organisations in that it connotes involvement, commitment, passion, focused effort and energy from staff thus demonstrating both attitudinal and behavioural components for an effective workforce. (Macy & Schneider, 2008)

Studies of leadership and emotion have not typically been combined with attention to the 'authority' of the leader (Ford, 2006; Stein, 2007) or indeed to the concept of 'power', (sometimes seen and experienced interchangeably). (Morgan, 2006) A study combining exploration of the relationship of authority to concepts of both 'emotion' and 'engagement' (Hirschhorn, 1997) is particularly relevant to the agenda of the 'post-modern' organisation where leadership is distributed (Clegg, 1990; Tierney, 1996) and the organisation potentially fragmented, unmanageable and diverse.

The authority invested in a particular role, such as the CEO (Chief Executive Officer) or lead clinician may not explicitly engage emotion. However, in an organisation such as an NHS Trust, where leadership styles are, or at least

intended to be, characterised by distributed or transformational attributes, the concept of authority is more closely linked to *personal* authority whereby individuals “..bring more of themselves – their skills, ideas, feelings, and values – to their work. They are more psychologically present.” (Hirschorn, 1997, p.9). Thus for example clinical skills *and* personal investment are *both* required for someone to take up authority in practice as a clinical leaderⁱⁱ.

In this chapter we delve further into the concepts of leaders and leadership, particularly focusing upon leaders with a ‘mandate’ to lead change through their formal *role*. The group of participants we specifically focus upon here includes clinical and non-clinical senior managers and we examine the ways these individuals construct their role, their relationship to ‘followers’ and how their *authority* is taken up, experienced and constructed in their specific organisational context³². Authority has more than one meaning. It refers to the authority (sometimes seen as power) invested in a particular role.

Analysis of relationships between people who work in the NHS is underpinned by both the *interactional* and the (related) *emotional* contexts of an NHS Trust as a workplace (see for example Liden and Antonakis, 2009). This knowledge is particularly salient because on the surface, many of those occupying the leadership roles were inclined (at least superficially) to deny the role of emotion although analysis of their stories, shadowing and observations, following the pre-existing literature on organisational cultures, including those which study health care settings, indicated that emotion indeed plays a key role in service delivery and the ways leadership and authority are experienced and constructed in relation to patient care (Vince, 2002; Gabriel, 2004; Hirschorn, 1997; Huffington, 2007; Obholzer, 1994; Vega-Roberts, 1994).

7.2 Case studies

Three case studies were selected to examine the meanings given to the relationship between ‘leadership’, ‘emotion’ and ‘authority’ in relative depth. Each one was chosen (through discussion among the research team) to be (potentially) representative of a ‘typical’ approach to emotional management which reflected a personal style of authority (or lack of authority). These particular cases raised subtle but crucial questions about leadership, emotion and authority through exposing both the conscious and *unconscious* qualities which can either underpin or undermine a leadership *role* (Bovey & Hede, 2001).

³² In this chapter we focus specifically on the senior staff’s perspectives. Others’ perceptions of senior staff were discussed in Chapter Six.

1. The first leader, Gerald, had an 'authoritarian' manner (Adorno, 1950). That is, he appeared to believe that because he was in a senior position other staff ought to do what he told them to do. He was a senior clinician [for a group of particular services], relatively young, very enthusiastic and held an uncompromising vision of how a good hospital should be organised. He was interviewed once by a researcher, once by a group including the PI and 'shadowed' for two days by the same researcher.
2. Kerry in many ways held a similar outlook to Gerald, only she *believed* that she attended to the emotions of her staff if not her own. Kerry was Gerald's immediate boss and evidence from the interviews, shadowing and observations in both cases indicates they did not always work effectively together. Kerry was interviewed twice. Once for information as a key informant by two researchers and the second time by the PI and a researcher together. She was also observed by a researcher for an hour.
3. Quentin was a Clinical Director. He made overt efforts to weigh up the emotional 'risks' to his authority and thus seemed more able to engage with the 'followers' (and thus probably survive) in the *role*. At first he was reluctant to take part in the research directly (although he supported his colleagues' participation) but eventually agreed to be interviewed. Two researchers met him before the interview conducted by the PI, in his role as a key informant and observed him and the senior colleagues in their shared office space for about 30 minutes.

7.2.1 'Gerald'

Gerald held a clear vision of how a good hospital should be organised for the benefit of patients. What he appears to find problematic is managing staff who (for whatever reason) have a vested interest in different styles from those he advocates of patient care, working with colleagues and patients, and/or visions for service delivery.

The following extract is from the shadowing of Gerald.

From the two days spent with Gerald it was very clear that he believed that he was one of the main 'leaders' in the Trust and that he had a strong relationship with the middle and upper managers (including the CEO) which he uses to his advantage especially during long discussions regarding the 'new vision' (which appeared to be very much his vision) for the relationship between the two sites.

Gerald did indeed appear to be one of the main leaders. However, it was unclear whether the power and influence in this leadership role was all smoke and mirrors. Does Gerald play the role of the Wizard of Oz? Does he

think he has more power and influence than he actually has? Does he really have a good relationship with the Trust managers and Chief Executive?

The interview with Kerry (the CEO) made it apparent that she did not consider that he was one of the main leaders in the Trust and it was indicated that she didn't think much of him, and that their relationship might have been fraught.

Discussing the researcher's notes some weeks later, one thing that did emerge was that Gerald 'confused' those around him and was apparently unaware of how others saw him and how far his personal authority actually stretched. Hirschorn (1997) in a study of authority in contemporary organisations has suggested that leaders are no longer the old-style authority figures and because of changes in technology and economics "... bosses can no longer project the certainty, confidence and power that once facilitated employees' identification with them when they [employees] were young and dependent. This is why people are so disappointed in leaders today but also so unforgiving of them" (p. 9).

Gerald, although he had a clear management role and mandate to make the changes he focused on, did not get identified by his colleagues as fulfilling the vision of a leader as there is an implication in the observation extract that his authority may have been achieved via 'smoke and mirrors'. Furthermore his appointment (and that of several of his close senior colleagues) predated the appointment of the CEO. Several questions are raised here by the researcher about whether Gerald has been capable of taking up authority when the CEO takes a stance that at least tacitly opposes him. *This has to remain unanswered in the specific context of this Trust but is an important matter to consider in regard to distributed leadership.*

Gerald prefers to position himself as 'evidence-based' (and therefore up-to-date) dealing with practical matters and not positioning himself as an *emotional* leader. In the interview below, thus, he talks about making difficult decisions but paradoxically, almost from the beginning he focuses in upon dramatic inter-personal conflicts - talking about 'facing up to a fight' and declaring that the Trust 'absolutely' does not have the kind of leadership that enables 'direction' or 'vision'. Does this mean the CEO? Does this mean consultants? It may not even be intended so specifically perhaps it is an expression of general frustration that his vision is not shared.

While on the surface he claimed a good sense of what leadership is about he is also revealing in his talk, the opposite position. Taking a team or department in the direction of the vision and making difficult decisions is for him about a relationship with (not) being 'scared' or further down in this extract, (not) 'afraid'.

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Gerald: Erm...good leadership, err having the ability to make difficult decisions, err, not being scared to face up to a fight...erm...being able to be clear about errr, the direction or vision of the trust, where we are going and be able to errr direct your team into the position that everyone errr everyone is meant to be going, erm I think

Q: Yeah...and do you see that kind of leadership in this hospital?

Gerald: No, absolutely not

Q: No? And why, why not? What's the problem to that kind of...

Gerald: I think that in the past, we .. we have been afraid to face up to a fight, and we have shied away from it.

Q: Yeah

Gerald: From making difficult decisions, and err, and we've let too many people get away with undermining the overall plan that we have...'cause we all know how to deliver excellent healthcare, we all have our views of how this is going ahead, but err, and the grand picture has been undermined by a few, and we've not been able to really face up to those people

Gerald believes that while everyone knows how to deliver 'excellent healthcare' a few have undermined the/his 'grand picture'. He also identifies with a group who support his particular vision while not expressing empathy with those who do not. As the interview progresses, Gerald berates the power (rather than leadership qualities) that consultants have had in the past suggesting that they *undermine* changes that he clearly and sincerely holds about what constitutes good patient care.

Gerald however does reflect on what he is being asked as evidence by his suggestion later:

I don't know about what makes a good [leader]...you know, its difficult to say what makes a good leader...because I'm not sure I'm a good leader, because the qualities that I feel perhaps are necessary, I don't perhaps have ...one of those is patience perhaps...err, being able to tolerate people's err err, err stupidity in a nice way, is essential I think, but I don't have that, I don't think...being, having the ability to listen, err, err, err and not judge or criticise too quickly is very important, but then, taking everyone's opinion into account, but then at the end of all that being able to still go your own way, and persuade everyone else that it was their idea in the first place ... Well, I have certain qualities which help me get the goals that I like...erm...whether I have everybody behind me.

This is one (although not the only one) of the more (paradoxically) emotional interviews from among the senior managers in the study. Gerald

recognises, quite passionately, that a leader needs followers and has to be tolerant. Gerald, though, cannot help declaring that those who presumably hold differing opinions to him to be stupid. He also said later in the interview that he believed many people were *against him* when he was appointed to the senior post as the Trust itself changed shape. While he would not it seems position himself as emotional (rather he sees himself as evidence-based) he chooses to talk in emotive ways and reading and hearing what he says is quite exhausting as he uses all his energy in trying to take the organisation where he believes it should go, but through lack of emotional intelligence, many a time he draws a blank.

Gabriel and Hirschorn (2004) might describe Gerald, at least in part, as a 'narcissistic leader' in that he liked to be told he is important and influential but he is also potentially a bully and authoritarian in style (Adorno, 1950). He clearly found criticism intolerable and split off the 'bad' (i.e. the consultants who didn't go along with his changes from the 'good' i.e. the 'we'). Gerald has a dream which he is determined to make into a reality, however, there is a "*delicate balance between feelings of omnipotence and feelings of impotence which leaders must achieve, in order to enhance the chances of turning vision into reality*" (Gabriel and Hirschorn, 2004, p. 144). These authors argue that narcissistic leaders have a particular aptitude for getting this balance wrong and "*Even if they are talented in their field, their judgement increasingly fails them. This is compounded by the collusion of their followers*". This may be Gerald's 'we'. Gerald fails to connect emotionally with his (potential) followers from outside his close-knit 'we' group even though there may be some admiration for his clarity and link with the NHS mandate. This means, in effect, that important changes which may well be for the benefit of patients in the contemporary NHS are being (effectively) resisted because of Gerald's style of leadership. Gerald also appears to have little idea of how others might experience their worlds, including their emotions.

This theory might be borne out by the following participant, a young female career NHS manager just reaching a senior position. She proposed Gerald, unprompted, as an example of a good leader:

I think he's great, he gets a bit of bad press sometimes, I think people get agitated with him, but I think it's because he tries to manage things, and he tries to be very fair, and he tries to solve problems that have been with us for a long time, so again, I think he is a good leader, he is trying to do the right thing for the Trust in the long term. He is erm ... sometimes it's difficult for him to carry people with him, but I think that will pay off in the long run. And I think he's thinking of a long term plan, he's prepared to take a bit of short term flack...but I think it will work out in the end. I think he's going about doing stuff in the right way, he's being fair and he's trying

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to be consistent, he's making sure he's got an evidence base for doing things, it's not just a random decision, he's collecting information, and that kind of thing...I think there are a lot of people in this organisation at this point who would say they didn't think he was a good leader, but I think time will tell the story there.

This extract from the interview, while consistent with Gerald's descriptions of his own behaviour, proposes an evaluation of his style which indicates he is likely to be successful in the longer term because he is 'trying to do the right thing for the Trust'. However also she identifies quite clearly that his leadership is failing to take many of the people who matter along with him, she positions herself as sharing his vision for the longer term benefit of the Trust which may reflect her *a priori* engagement with NHS management rather than with a clinical profession as she does not have a clinical background herself. It also seems to reflect collusion with his narcissistic style because she seems to mirror his version of himself. This participant continues:

Sometimes they're [other senior staff particularly doctors] quite quick to criticise without really understanding what the problem is that needs to be solved, and what some of the rules are we can't ignore. Some of the national directives, that we just have to do, there's no point fighting against them, we've got to find a way of implementing them, and I think sometimes he gets a really raw deal...but he's said, he's consistent, he will communicate to people, write to people and speak to people very quickly the minute they raise a problem, and he definitely shows that he is not shying away from difficult problems...I think that's a very strong characteristic.

Her description of the other staff appears to chime with Bion's theory of a fight/flight basic assumption group based on unconscious emotional ties of the group involved which (mostly) represents an anti-task resistance to the leader (Bion, 1961). *This extract above reinforces the possibility that Gerald is emotionally disengaged from his followers* and perceives his Trust to be in line with and in favour of NHS 'national directives'. The participant here who in a way is 'damning' Gerald with *strong* praise may be looking to Gerald as a potential mentor by making it clear that she will support his particular efforts. However when the researcher asked her about her *own* leadership she said:

.... because one of my strengths is pulling people together, one of my strengths is building teams, so I think from that point of view then yes, but then sometimes I look at people like [Gerald and her immediate boss] and I think 'Oh my God'. I've got so much respect for the way they deal with

the very difficult issues. Sometimes I wonder if I really put my neck out enough to say 'Ok, Ok, this is what we all need to be passionately aiming for.' Even if not everybody is quite wanting to do the same thing. I think sometimes I sit back a bit more and wait to see what the general feedback is, rather than stick my neck out and say 'Ok, this is the direction we've got to go in.' And I think as a leader you have to...well, in fact you probably have to do a bit of both.

This participant, it seems, is somehow subjugating her own skills and strengths to those whose skills and strengths do not correspond with what she believes in makes her a good leader and seems to be putting herself down for the skills she has got and does seem to value. Alternatively, she might have realised that her strengths might complement Gerald's and through his own narcissistic valency he may position her as someone to promote.

Finally, in relation to Gerald, whose example she insists on returning to, having described other more emotional and successful clinical leaders in the Trust:

.... And they [other senior staff] make it very evident that they don't support him [Gerald] in his role, and not only do they make it very evident, but they do a lot of stirring behind the scenes, to get up a bit of a frenzy against him And I think there's some very clever leadership involved in that process, and there's a lot of learning, gathering people in, getting them on board and uniting them in a common purpose, and this and that and the other, but it's not constructive.

7.2.2 'Kerry'

Kerry is Gerald's immediate boss (the CEO) and evidence from the interviews, shadowing and observations in both cases indicates they do not always work effectively together³³. Kerry herself has met with similar difficulties which seem to be the outcome of her attempts to encourage distributed leadership in that:

Kerry: Erm, erm, well we set up a process to...we re-wrote the discharge policy here. I chaired the group. I wanted to know what the problem was about discharges, and I was told we needed to rewrite the discharge policy,

³³ Regardless of personal authority in the cases of both Kerry and Gerald, it is clear that the organisation has had its own very particular problems which are *endemic in the system* (see Chapter Six for a more systemic analysis of leadership).

and we'd just done it. People looked at me, and I just said, well I've spent...I've chaired five meetings myself, where we put all the information forward, and all these arrangements in place and nobody's done anything about it. I think that's poor leadership.

Q: So erm...poor leadership on whose part? Because presumably you had people who you delegated this to?

Kerry: So the consultants, the nurse managers, the matrons...all the people that were on the working group really. And they just didn't implement it. Beyond belief really.

This extract reveals several levels of emotion and authority and (as with Gerald's narrative) there is an 'I' who takes action and the 'they' who are against her. Kerry had identified a problem with discharges but had to ask 'them' what it was and was told that 'we' needed to rewrite the policy. She took up the role of chairing five meetings, the group/'we' put the information forward and the arrangements in place (presumably to take action) but 'no-one' did anything. It is not known how she handled this 'failure' of leadership on 'their' part. Kerry appears to be a micro-manager (in that she herself was involved in the meetings). Reflecting on this interview, and reading the text, one of us reported back to the research team that she had misunderstood Kerry, thinking that Kerry had been talking about her *own* case of poor leadership. Perhaps it was as unclear in the action as it was in the telling (thus perhaps on an unconscious level the lack of clarity was communicated in the meetings). Why did Kerry, as the leader, not pick up the group's dependence (or *resistance*) (Bovey & Hede, 2001; Hughes, 2005)? This suggests that she herself had resisted emotional attachment to her 'followers' and failed to engage them on an emotional level during the meetings. One approach that helps to understand the example above of *resistance*, specifically in the context of the five reported meetings, is the idea of '*fight/flight*' from the work of Wilfred Bion (1961/1983). He suggested that a 'group mentality' (or group culture) emerges from the development of a group over time as it continues to meet, because individual contributions conform to this mentality. In brief, the formed 'group culture' unconsciously constrains individual members (see also Sherwood, 1964).

So, in this case it may have been that despite the seniority of the staff involved in rewriting the discharge procedure, the culture that had developed over the course of the five meetings (and possibly prior to this as 'they' had suggested the need to re-write the discharge policy) had *prevented/resisted distributed leadership*. This could have led to the group not making sense of the leader's expectations and reverting to the comfortable pattern of being that had not been challenged possibly (again) because of the leader failing to manage her own emotions or engage with those of her team.

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Bion (1961/86) suggests, that the group mentality exists on both at a conscious and unconscious level so that the team were probably not deliberately, or consciously, going against the leader. It seemed from the leader's description that the team had been almost 'sleep walking' – not recognising that they had already done what they later ignored and suggested needed doing. Dependency, according to Bion, meant dependency on the leader or "... *when all individuals in the group look to myself as a person with whom each has an exclusive relationship*" (Bion, 1961/86: 119). Within this mode there is little connection between the members themselves and there is a '*mass inertia*' (op cit). This links to Klein's depressive position (Gould, 1997). It also raises questions of who is depressed here - Kerry, the group, or the group in Kerry's fantasy? The unconscious resistance and frustration experienced by the leader here demonstrates the fluidity of power and potentially the influence of gender (Fletcher, 2004; Nicolson, 1996; Vince, 2001)

Kerry, however, did claim success in turning around previously identified failings in patient care targets. How did she manage this?

Well I ... I... I mean it requires a great deal of focus, which hasn't been succeeded by other individuals, so...and it's required the organisation to understand its importance, and that it is possible to do. So it's been trying to talk to people about 'OK it's a target, but it's a quality... a patient quality target, so don't look at it in a sort of derogatory manner'.And ((3)) ...so it's a bit of culture about are you being bullied, as a member of staff to achieve the target and if you're not being bullied well then why is important and then well it's important because its patient quality ((1))...and then I suppose, something about... I mean one of the turning points for me is about our reputation as well, which is...well everyone else is achieving it, and we're not, 'why do you want to be in the bottom 20% of the country?'

Resisting her own emotional attachment here she talks in the third person. Rather than saying that as a new senior manager she had managed to engage the staff, which to a point she seems to have accomplished, she states that successfully addressing targets has 'required the organisation to understand its importance'. She clearly perceives senior staff as taking a negative position in relation to government targets and has attempted to persuade people that such targets are about good quality patient care. Another feature of the discourse slips in here – is her style of leadership perceived to be a bullying one? It may be that a group mentality, which takes resistance and dependency to be part of its culture, perceives a leader with a vision, or at least with determination (and 'focus' to quote Kerry) to be bullying them out of their emotional safety. This is a problem for any organisation that suggests to its staff that successful change and development is solely about strong leadership. We have to turn again and again to the clear message emerging from the data that without an

emotional attachment and the ability to manage their own emotions leaders and followers are not going to achieve goals related to patient care.

7.2.3 'Quentin'

Unlike Gerald, Quentin feels that he is succeeding in bringing about change and unlike Kerry he is mostly positive about the impact he is having upon the staff groups. He told two stories, one of which was when his leadership worked, and another where he continues to experience problems although he emphasised (to support his authority) that the latter was not a great a worry to him. In his interview he focused very much on the importance of personal authority: *"I'm still playing the trick of getting people to do things by example"*. He tries to back up his personal authority through making personal contact as much as he can:

You know my job could be answering my e-mails and I'm desperately trying not to. I've made a pact with myself that I will not explain myself in e-mail. If it needs to be explained I will go and explain it [personally].

He distinguished between the roles of the CEO and medical director, which in his opinion were *manager* roles, and that of clinical director which was a *leadership* role.

Quentin moves between the position where:

...people need constantly to be reminded of what they need to achieve ... [in relation to patient care] ...I use the word good care because [they] have the tendency to lapse into what is acceptable or even worse, what they can get away with.

To the position that:

And I think there is some requirement to continually challenge the organisation about what it is providing and sort of have a re-education process. And I guess we all need that – because I need that as well you know and it is one of my roles to keep reminding everybody why they are doing what they are doing.

Quentin sees himself as needing space to reflect upon the aims of the service provision and recognises that he is just as able to lose track of the organisation's main purpose as his colleagues/followers are, given the daily round of work. While Quentin gives an interesting example of how he and the team succeeded in meeting a target for patient waiting times in Accident & Emergency (which involved him engaging personally with the staff in an emergency meeting):

... which was all about persuading your senior contemporaries and peers. It's about the juniors, the people who are actually delivering the services. It's about making a reasoned argument. It's about being visible. It's about being honest and it's about delivering it.

The success, he believes, was about the personal contact and his own visible attachment in trying to change things alongside his colleagues and being very clear that " *...this needs to be achieved at all costs - which was quite liberating*". The rhetoric here is very different from that used by both Gerald and Kerry, who feel their colleagues are letting them down; possibly they are 'splitting' the 'bad' and projecting it into recalcitrant colleagues in order to feel reasonably good about their own positions (Klein 1987, 1983). Quentin is talking about success and success through *taking an emotional risk*. Saying that a change needed to be achieved at all costs (which he described as liberating) could be interpreted as Quentin making an emotional commitment to engage with his followers about something identified by the government, the NHS and his Trust as important. This stands in direct contrast to the experiences and rhetoric of both Gerald and Kerry who express the frustrations at what the 'others' are failing to do. However with what Quentin called a "*slightly different problem*". He has had great difficulty dealing with a doctor who is "*just a very difficult person to manage ... and I need to say to him 'this is crap and needs to be done in a completely different way'. I don't quite know why I haven't done that*". Once again Quentin was expressing an emotion – anger but without pushing/projecting blame on to the other, but being clear what the other person was doing and reflecting on his own sense of why, how and when he might take this issue up with the protagonist.

While Quentin operates with a quiet assurance and takes up his formal authority, and the power that accompanies it, from a classic Kleinian 'depressive position' (Klein, 1975; Segal, 1973), both Gerald and Kerry, despite their formal authority, fail to engage with their followers which leads to their powerlessness and a sense of rage and frustration.

7.3 Conclusion

The interconnections between power, authority and emotion play a complex part in understanding what leadership means to all those involved and in each organisational context. Leadership cannot be understood as something that can be observed and/or measured 'objectively', it is not an essential 'quality' which resides in an individual but is socially constructed, meaning different things to different people at different times. Following Ford (2010) a more contemporary, appropriate and critical approach to the study of leadership "*pays attention to situations, events, institutions, ideas, social practices and processes that may be seen as creating additional repression or discursive disclosure*" (Ford, 2010, p. 51)

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To be specific Rioch (Rioch, 1975), and others had made the point that *"'Leader' is a word which implies a relationship So the word 'leader' does not have any sense without a word like 'follower' implied in it".* (p. 159).

The relationship between leaders and followers might be more or less successful and in order to be a follower a person needs (even on a very temporary basis) to 'give over' something of themselves (i.e. make themselves emotionally open) to the leader for the relationship to have meaning. Being a follower may be both (or either) passive or active and there is the potential for the follower to engage and support, or subvert leadership (Bondi, 1997; Halton, 2007; O'Brien, 1994). Consequently, in order to analyse what it means to 'lead' in an organisation, understanding the practice(s) of emotional management alongside an analysis of power relations is fundamental (Grint, 2005; Schilling, 2009). For Foucault (Burrell, 1988; Foucault, 1982) power *"exists only when it is put into action, even if, of course, it is integrated into a disparate field of possibilities brought to bear upon permanent structures."* (1982, p. 788) Thus, while organisations give formal power to relatively few leaders (including in a distributed model of leadership) consent is still required for the power to be maintained. Furthermore, 'the other' that is the one over whom power is exercised, needs to be *"recognised and maintained to the very end as a person who acts"* (Foucault, 1982, p. 789).

The leaders we have described above all admit falling into traps where their authority has been challenged/resisted and they have been (potentially) made powerless. Quentin alone demonstrated awareness that he was working *with* people rather than treating them as resources. This meant that despite experiencing some frustrations, he managed to continue to *feel* and *think*, and with his colleagues/followers on board, *implement* changes. Kerry and Gerald, while attempting to take up their 'legitimate' power and lead change, both squander their authority through failing to manage and/or engage with their own and their followers' emotions. This is evidenced by their displays of frustration, impatience and anger with those who fail *to do what they are expected/commanded to do*.

Gerald held a classic authoritarian view of power, indicating that whether he takes people with him or not, he intends to get to the *'goals that I like'*. He also sees the resistant followers as stupid. He defines leadership accordingly, in that the leader should *'direct [the] team'* and not be afraid to *'face up to a fight'*.

Kerry sees herself somewhat differently even though she experiences anger and frustration when followers fail to do what she wants and expects. In attempting to empower her subordinates and set up the 'processes' to distribute empowerment (such as the meetings described above) she was left feeling disempowered following an (apparent) breakdown of

communication between herself and the senior team she tried to work with. That one of the interviewers also had to clarify: "*poor leadership on whose part?*" suggested that Kerry possibly re-experienced the rage and frustration she felt at the time of her encounter with the followers in her story when she told it. This rage obscured clear communication both then and in the telling. It might be that the overwhelming need to prevent the Trust from being '*in the bottom 20% of the country*' was a source of anxiety for her and the importance of achieving these specific sets of goals contributed to her impoverished emotional literacy.

Distributed leadership (Gronn, 2002; Mehra et al., 2006b), as a response to 'postmodern' organisations (Tierney, 1996) sets out the changing nature of authority/power. In combination with ideas from the emotional/social intelligence literature, distributed leadership suggests a more relational model of leader/follower relations whereby leadership decisions may represent both outcomes and inputs (Ashkanasy et al., 2003; Wolff, Pescosolido, & Druskat, 2002). A warning note, however, reminds us of the persistence of the patriarchal version of 'the' leader (Ford, 2010; Ford & Harding, 2008) which occupies the dominant discourse within which the notion of 'effectiveness' neglects (if not ignores) the importance of the management of emotions in the leader and followers.

Through the use of innovative research methods and data analysis, which take account of both conscious and unconscious processes through which leadership is socially constructed and exercised, the intrinsic complex connections between authority, power, emotion and leadership in the context of health care can begin to be disentangled.

Leadership that 'works' for an organisation such as the NHS is a multifaceted, emotional *process* in which leaders manoeuvre to manage their own and their followers' emotions and behaviours on both intellectual and emotional levels. To be effective in, what are now seen to be, postmodern organisational contexts, leaders also need to reflect upon themselves in their role and to understand the structural, cultural and emotional expressions of their authority and the authority and power of their followers. The legitimization of emotionally engaged leaders' authority supports effective service delivery across the different levels of the organisation through undermining conscious and unconscious resistance(s) as described in the examples above. Power as a coercive violence (see Foucault, 1982) has been exposed and undermined in such organisations and 'replaced' by concepts of 'distributed' leadership where the persistent claim to power is by definition and necessity more fluid.

8 Gender and Leadership

8.1 Introduction

Gender and leadership is an area that has attracted interest among policy makers and researchers, because the styles of leadership that are currently perceived to be the most effective, such as transformational and distributed, are believed to 'fit' more closely to 'feminine' styles of leadership. Fletcher (2004) notes that traditional 'heroic' leadership is usually associated with masculine traits (rather than men and women *per se*) such as individualism, control, assertiveness advocacy and domination, while 'post heroic leadership traits (such as empathy, community vulnerability, collaboration) are more associated with feminine traits. Ford (Ford, 2010) reconsiders the concept of *effective* leadership which is in fact a patriarchal model perpetuating an exclusionary and privileged view of the leader (metaphorically the 'father' figure).

Traditional research into gender, organisations power and leadership suggests that there are particular 'masculine' and 'feminine' leadership traits that are generally believed to characterise men and women's leadership styles (Rosener, 1990; Collinson and Hearn, 1994; Nicolson, 1996; Carless, 1998). Because women are widely believed to adopt a more democratic leadership style and men believed to adopt a more autocratic one, distributed leadership and concerted action in networked organisations may potentially be more conducive to those (women or men) who can adopt a more traditionally feminine relational style of leadership. Furthermore, feminine styles are more akin to displaying social and/or emotional intelligence (Guy & Newman, 2004; Leon, 2005).

In reality, both men and women display a variety of 'masculine' and 'feminine' leadership styles, depending upon their individual personality, age, position and the situation involved (Cross & Bagilhole, 2002; McDowell, 2001). However, gender *expectations* influence perceptions and beliefs and research suggests that subordinates are often more satisfied with leaders who behave in gender-typical ways than those who go against gender-type (Porter, 1992; Rosener, 1990; Williams, 1993).

Indeed, women in explicit leadership roles often tend to be viewed less positively than men, in the belief that 'masculine' traits (competition, authority, lack of emotion) conform more to expectations of how a 'leader' should behave but not how a woman should (cf. the work of Broverman et al. 1970). The 'paradox' it seems persists in contemporary organisations so that some women leaders feel they have to behave in a 'masculine' way which frequently makes them appear rather heavy-handed and/or as a 'bullying' because these behaviours do not fit with ideas about women (Eagly & Carli, 2003).

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Most of the women and (some) of the men we spoke to during the study, made a point of denying that gender was an issue in today's NHS, indicating that they believed that women and men were treated equally, with an equal chance of success. However, several participants also mentioned gender differences in the negotiation of power and identities describing how either women or men were likely to gain advantage through use of their gender-typed styles (Lewis, 2000; Schnurr, 2008; West, 1984).

Gender and leadership it seems remains a contradiction in people's minds but gender is a fundamental component of the discourses surrounding leadership in the NHS because of the demographic issues in clinical management and leadership (Evans, 1997; Gardiner & Tiggerman, 1999) and as we have shown in Chapters Four to Seven, role models and styles of leader/follower engagement have a major part to play in the transmission and exercise of leadership (Gill, Mills, Franzway, & Sharp, 2008; Greener, 2007).

We want to note here, partly in passing, although an example below (in the interview with 'Jeff')³⁴ demonstrates its importance - that the *researchers'* gender and physical appearance (age, ethnicity, attractiveness) also played an important role in the research process.

8.1.1 Senior women managers: 'we're all the same now'

Women in senior managerial and/or professional positions either deny that being a woman is an issue for them or for their organisation or that they know what they had to do to prevent being seen as a senior '*woman*', rather than a senior leader.

Denying the impact of your own gender on how you are seen and how you manage and lead is not an easy position to maintain and we observed some senior women working hard not to be seen as women even though at the same time they were arguing that *this behaviour was not necessary* because of the way 'things have changed'.

The researcher's observation of a senior female manager (Catherine) indicated that she thought that Catherine was trying to avoid being 'feminine' in her interactions. When the two interviewers were waiting to begin the interview, Catherine's PA came into the room with an important message but was shouted at in front of them. Thus in her notes one researcher judged that Catherine wanted:

....to indicate lack of interest and assume a position of superiority. Catherine was transgressing the boundaries of polite professional behaviour and attempting to define 'her' territory of the hospital. Answers to the

³⁴ Not his real name.

questions were also defensive, perhaps indicating a lack of self-assurance. Despite the tough exterior she obviously felt a need to stamp her authority on people in order to maintain control of the situation. This may partially be related to her gender and need to appear 'more masculine than the men' in a competitive environment.

The researcher following on from her observational notes with comments following the interview suggested that *"whilst she [Catherine] initially denied gender to be a relevant issue [for senior managers in the NHS], she then went on to make reference to 'testosterone' and 'the emotions of females' as problems in managing in her senior role".*

The relevant part of the interview transcript is below:

Q: Ok, so are men a problem? Are women a problem? Are there gender politics? Or am I just old fashioned there?

A: I don't think there are anymore, I think there were. I mean when I was appointed, I could have been one of [only] four [senior] women, so the whole senior management was very ... very 'suitish'. I don't think, no, I don't think it is a problem anymore. No, I think it is, if you talk to people in the north of England, they will say it's still a problem, and I think its a bit more of a problem to get females into acute trusts, big acute trusts, it's a bit of a climate difference. I think there's a lot less testosterone around now, there's a sort of slightly...erm I mean I've got quite a young male management team.

Q: Right

A: I find the testosterone and sort of challenges a bit much from time to time So I mean from that point of view, it is quite interesting, it does manifest itself. As do emotions of females really.

Catherine's somewhat aggressive, or at least uncompromising, behaviour witnessed by the researcher tended to soften after that and she added:

A; So I do think the answer to the question is that there are differences, but I don't think they're... they don't fundamentally affect how you do the job.

Vicki, a senior geriatrician, discussed the question of gender openly and at some length with the researcher who suggested that she had seen both Vicki and Mandy, another senior female consultant geriatrician, being very 'gentle' in their approach to patients and the researcher wanted to know how far this was linked to the fact they were women. Vicki thought though that their approach was not about gender but:

You know it could be a geriatrician thing, I don't know, ((1)) you know you'd automatically say 'it's oh because we're women', but I think it's only when you start following a few men around as well who are doing the specialty as we are, because the thing that attracts us to elderly care rather

than any other specialties in the first place, and that could simply be what you're observing.

It seemed important to Vicki that she was not stereotyped as a woman leader although she was keenly aware that as more women took up medicine and were arriving in senior positions that this demographic change would in some way impact on leadership.

So maybe that's where you've got to go as well as men in geriatrics you actually need to look at women in other specialties and follow them on a ward round and see what they do and that may be a good idea as well for the gender thing. But it's quite important for your study because at the end of the day we're training over 50% of women as doctors and in the future they think that almost all GPs will be women so that will affect the leadership and sort of, that you see in patient care.

So Vicki, while seeing feminine *characteristics* as more important in her clinical specialism than gender *per se*, still believes women doctors (e.g. GPs) will make different kinds of leaders from men.

During her shadowing of Mandy, the researcher noted what she identified as gender-typical behaviour:

Mandy also implements a mothering aspect to her leadership role (also noticed in Vicki) as she is always thoughtful and considerate to her followers, making sure they are comfortable and happy with decisions made and that they are up to speed with their medical knowledge. This mothering role also seeps into the delivery of patient care. Mandy is also a leader that appreciates the help of her followers and always thanks them for their input and help.

While keeping in mind that the researcher herself is making assumptions about what is a 'mothering' style and also recalling Vicki's assertion that it may be more to do with the kind of people who are attracted to geriatrics than gender itself, it is important to note that the researcher spent several days shadowing and observing female *and* male geriatricians. Further, she discussed reflexively what she saw and how she interpreted it with the research team to check out her observations.

8.1.2 Men: the 'natural' leaders?

The researcher who interviewed and observed Catherine also interviewed and observed Jeff (another non-clinical manager) and contrasted their styles of interaction with other people in the organisation, and with her, during the interview. At first Jeff seemed more approachable, relaxed and generally more amenable than Catherine had been:

Jeff was a newly appointed male senior manager. From the outset he displayed supreme confidence in his own authority and power as a 'leader'

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and obviously did not regard a young female researcher as a threat. He was very friendly and personable and happy to open up the space of the hospital for us, answering his own emails rather than through a secretary, coming to collect me personally from the main reception and chatting and joking all the way back to his office. Throughout the interview he showed confidence in his own opinions and was happy to talk in detail about both his own and others' leadership. This confidence may be a result of several factors such as position, age, class, gender or personality. He freely admitted that he did not mind appearing 'hard' or unpopular if it was necessary to get the job done, however he felt that his main asset was his own 'charm' and 'charisma'.

Thus Jeff firmly claimed his place within the (masculine) 'heroic' leadership tradition.

While Catherine was perceived as guarding her territory and demonstrating her power, Jeff appeared to be relaxed, being more approachable and particularly not hiding behind his PA. In fact, his account of himself in the interview was somewhat disarming.

Q And do you see yourself as a leader?

*A: Oh yes certainly. I can remember the time when I realised that I should be in management. I was working in a **** clinic in [a Trust] and it was so inefficiently run and I said as much to the manager. She said 'if you think you can do it better then why don't you manage?' So I said 'OK I will!' And I think I'm pretty damn good at it. I don't play by the rules, I don't have any formal qualifications, but I can get things done. I'm not perfect – I shout, I swear and mostly I'm just very, very cheeky, but I'm good with people and that's what you need in this job. You have to be tough too, take knock-backs and step on people to reach your targets. But mostly I care passionately about the patients. I would never ever chase a target if I didn't think it would improve patient care. So that's why I went into management, and I suppose the other thing is I discovered, I surprised myself actually about, I was going to say how easy it was, it wasn't easy, erm I had a natural aptitude to do it, you know it was something that I was successful in so you know yeah?*

Jeff wanted it made clear that the 'inefficient' manager was a woman and that he himself is 'good' with people (and on the surface the researcher acknowledged this). However, he also valued the tough, target-driven 'stepping on people' (masculine) qualities of his leadership which he believed were important in delivering patient care.

Jeff put his confidence and self-identified ability partly down to personality, but also to his gender and upbringing, adding that certain class backgrounds seem to 'breed' leaders:

I do think that great leaders are kind of born, but my background was that I was at all male public boarding school for 10 years. As my father said 'the biggest waste of money' given my academic erm qualifications at the end of it, erm and there was something there about you know that sort of environment. I mean does it grow leaders? You would think so, you look at the number of public schoolboys that end up as MPs, that's probably not a good analogy

Q:((Laughs))

A: But there is something about that kind of white middle class upper class upbringing that you have, and although I wasn't from that background before I went to the school, erm you learn survival among your peers, you learn I think to survive, you know if you think at the age of eight you are sent away you have to survive you haven't got your infrastructure.

It seems that Jeff is suggesting that leaders are either 'bred' or 'grown' but either way the influence that makes them a leader comes early in their lives. In the example he gives here, 'growing' takes place in a male-only context reinforced by social class, possibly wealth and a general sense of entitlement. This model does not echo the efforts and ambitions of the NHS in everyday practice nor would it appear to be in any way appropriate to the model proposed by the NHS (see Chapter One) which is focused on the type of leadership appropriate to managing and leading 'diversity' and 'difference'.

8.1.3 Gender wars?

Being motherly (like Vicki and Mandy) is not equivalent to being weak or compliant as perhaps some gender stereotypes might describe women (see for example Bem, 1993; Nicolson, 1996). During an observation of Mandy, the researcher identified what she considered to be a 'battle of the sexes':

Gender issues were brought into consideration during the interaction between Mandy, a female consultant and a male consultant. During this interaction a battle of the sexes and power occurred with the two consultants struggling for power in very different ways. The male consultant tried to assert his power through attempting to ignore Mandy's presence, never looking directly at her, but was raising his voice and being rude. On the other hand Mandy was always very polite, looked directly at him, spoke very softly and smiled a lot, although it was quite obvious that behind the soft smile was a vicious bite.

Perhaps this isn't so much a battle of the sexes but an example of how men and women might behave differently towards each other in the course of a power struggle. The detailed observation notes show the encounter move by move:

There are some territory issues with Patient 9 and Mandy is angry that there is a patient on her ward that is being treated by another doctor. She asks why the doctor has continued his care now that the patient has moved ward and suggests that if the doctor feels that he needs to continue with the patient's care then the patient should be kept on one of his wards rather than blocking a bed that could be used for one of her patients. She asks "why can't we look after this patient? We are not supposed to have any outliers on this ward!" Mandy's registrar Melvyn can not, or does not want to answer her questions and simply shakes his head and shrugs. Mandy says she needs to speak with the consultant and asks Melvyn who the patient is under. Melvyn gives the name and admits that he has seen him arrive on the ward a couple of minutes ago, so he should still be there.

Who is Melvyn afraid of here? Or is Melvyn simply not wanting to witness a battle over territory and patient care?

Mandy walks round the other side of the nurse's station to find the [male] consultant with three other doctors/medical students standing some distance away and his registrar to whom he is speaking. Mandy and 'our' group move over to his location and the junior doctors from both groups greet each other and share whispered conversations. Mandy stands patiently at the side of the registrar waiting to speak with the consultant. Although Mandy continues to smile pleasantly I think that she is angry or frustrated on two levels. First because the consultant is on her ward and hasn't come to speak to her and second, because he doesn't seem to have the manners to even acknowledge she is waiting. After the conversation between the consultant and registrar has finished the consultant turns his attention to his paper work and the registrar moves to be with the other doctors (some distance away) Mandy lifts her eyebrows up to Melvyn (clearly annoyed with the male consultant's behaviour) and then asks if she can speak to him about Patient 9. Mandy explains politely that they do not have outliers on this ward and therefore asks whether the patient could be moved to another ward or if this cannot be arranged she take over the care for the patient. While she speaks the consultant doesn't look at her and continues to write, his body language and behaviour are both arrogant and rude. The consultant says that the patient is his and he will not be passing the patient over as she has problems not solely aligned with geriatric care and that she needs a specialist. Although this was clearly a statement to undermine Mandy's capabilities she continues to smile and tell him that the patient will be moved before the weekend so that a patient needing specialist geriatric care can have a bed.

Moving through this detailed account the gender issue becomes obscured by the fact of Mandy's skill as a clinician, a leader, her concern to give appropriate care within a context of limited resources and her ability to handle herself in the face of rudeness and arrogance. These are skills that ensure she will shine through as a leader in any context but particularly one

which is still a man's world. In a socially or emotionally intelligent context where concerted action is seen as important, patience, politeness and clarity of purposes will eventually win out over arrogance and bluster. As we see in the next extract Mandy's 'opponent' does not possess these attributes.

The male consultant becomes angry and raises his voice to Mandy and says there is nowhere else for the patient to go. Mandy lowers her voice and says that the patient must have been on one of his wards before she was moved so she can move back. The other consultant looks swiftly at the group of doctors who are stood behind him (both his own and Mandy's) and then eyes me suspiciously before turning back to Mandy and speaking in a lowered voice. The conversation moves back and forth between Mandy and the other consultant and it is clear that despite his outbursts and undermining statements to Mandy that she has the upper hand and although she continues to smile, she is very forceful and strong in her argument and objectives. To conclude the whispered conversation Mandy raises her voice and tells the group that the patient will be transferred on Friday and that she will be getting a transfer set up straight away. She then thanks the other consultant for understanding and walks back round to the group with a smile on her face and asks Melvyn to set the transfer up.

This is a consummate example of patience, calm and the ability to lead doing what she considers to be the best for her patients, her team and her department. Her skills in continuing to be quiet, calm and smiling have 'seen off' the male consultant in the meantime but reading this it would be surprising if the humiliated man does not try to take revenge. Although there is very little evidence that this is anything other than a 'normal' power struggle it is the case that Mandy is in fact a woman and has played, what is mostly recognized to be, a feminine role.

Returning to male expressions of power it is important to be aware that blatant attacks, such as the one in the encounter above, are not necessarily the only ways of demonstrating confrontational masculinity.

It appeared from the interview with Jeff (discussed above) that he believed he did not need to defend himself in the face of gender stereotyping. He had strong opinions on women's leadership and also on women's 'availability' with no qualms about voicing these which contrasts strongly with women's accounts where they try to underplay gender, that is that many senior women take the view (overtly) that gender is irrelevant.

The researcher's notes about the meeting with Jeff continue describing a dramatic example:

Jeff's supreme confidence meant that whilst he came across well in an interview situation, he crossed boundaries of professionalism in other ways, telling unsuitable stories about staff and inviting me (researcher) out for a drink after the interview, invading my personal space. In the extract below

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he accuses a female colleague of not only being attracted to him, but trying to use her sexuality (unsuccessfully) to get ahead at work, whilst simultaneously flattering me that I am his 'type' by subsequently asking me to meet him for a drink.

And in the interview:

Q: And could you give me some examples of bad leadership that you've seen?

A: Well, Melanie Willson³⁵, have you met her?

Q: No I was meant to but she cancelled the interview three times...

A: Exactly, she probably thought she was too important to talk to you. Now I can tell you an interesting story about her. She's a good looking woman, stunning, very intelligent too. But there's something not quite right, I don't know what it is... really cold. She's got no soul. I appointed her as divisional manager and at first she was doing really well, but then she ran into some problems. She was failing in her job. And that's when she started to flirt outrageously with me. It was like she couldn't beat me intellectually so she was going to do it another way. But, well... she's not my type. And she was really jealous when I got this job, I had Lucy (PA) go and announce it at the morning meeting and you should have seen her face. Anyway I hear she's got a promotion now so she must be doing something right.

Melanie Willson clearly perplexed Jeff – 'stunning' but no 'soul'; 'flirting' to avoid being faced with 'failing' in her job; unable to beat Jeff 'intellectually' and resorting to using her sexual attractiveness. After stating that she was not his type (indicating that the flirting also failed) he then made another woman humiliate Melanie in a public context. The implication of her subsequent promotion being based on something other than ability was also a powerful 'aside'.

Discriminatory comments against women though are perhaps not that commonplace. Jeff's sense of 'entitlement' may be a dying one across most NHS organisations and it is certainly against all stated mores. Discrimination on the basis of gender is more opaque. The researcher interviewed Helen, a senior female consultant, and talked about gender and arrogance of male consultants. The researcher suggested:

... this was possibly seeing me as an ally as a young female professional. In addition to the immediately obvious behavioural differences between women and men she also mentioned unseen discrimination in the form of merit awards at senior levels and problems of combining work and family commitments which may mean female staff are less likely to achieve these.

³⁵ Not her real name.

In the interview Helen responded:

Q: Do you think there are any gender differences in leadership that you have noticed?

A: Yeah, yeah I think, I think so, erm you know the men are more well, can I, the men are less inclusive of a group and they have ((1)) already formed an opinion sometimes and before listening, erm, ((1)) err ((1)) yeah.

Q: Yeah ((laughs))

A: Need I say more ((laughs))? But I think there is a difference ...Competitive, that's what I was saying, there's that competition, yeah competitive, exactly ...Of course not but the insight is very, very small, and then those meetings go on and on and on and it's people trying to get one up on another so... I just want to leave. It's handy having a beep you know you can say 'oh, I've got to be off (laughs)'.

The suggestion here is that men are apt to waste time on each other and power struggles and that for them competition is central to their 'nature'.

8.2 Conclusions

Despite the increased numbers of women who have reached senior leadership positions in the NHS, both as senior managers (clinical and non-clinical) and as senior clinicians *per se*, there were nonetheless some interesting differences between women and men's self-descriptions and perceptions of others as leaders, sometimes made on the basis of gender alone (Gill et al., 2008). Descriptions given of leaders and leadership for members of the 'other' sex were also frequently gender-typed.

It may be that despite valiant and frequently effective attempts to change the culture of NHS Trusts that a 'traditional' view of leadership remains at least in the organisational 'memory'. This might go some way to explaining why women who are clearly powerful and influential are reluctant to identify themselves as taking up these more 'feminine' styles even though they may in fact use the skills associated with these qualities. Eagly and Carli (2003) make a case for women as having a leadership 'advantage' in contemporary organisations where the type of leadership required has changed. However, they argue that in many cases women have to battle against the inherent prejudices in male dominated organisations. Although there is still a reference to gender stereotypes when discussing gender in organisations and gender and leadership as we have seen from the extracts above in this chapter, as Rosener (1990) stated: "*Women managers who have broken the glass ceiling in medium-sized, non-traditional organisations have proven that effective leaders don't come from one mould*" (p. 119).

In Chapter Five the OCS revealed that women across all professions scored lower than men on 'recognition' in that they perceived their managers as

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not recognising their particular attributes as clinicians or managers and they also perceived that the organisational climate was one in which 'recognition' was more likely to be given to men than women. That men did not see this as a problem for them reinforces the view that regardless of trying to establish gender equality across NHS organisations it is still not embedded in the management culture.

As we have seen and has been well documented in the literature, it remains difficult for women to exercise leadership without their behaviours being construed as either 'weak' or 'aggressive'. The paradox is that leadership requiring more 'feminine' characteristics is at least explicitly more desirable in the contemporary NHS.

9 Patient Care, Leadership and Service Delivery

9.1 Introduction

The NHS has a history of reform/modernisation aimed at making patient choice and care more cost and clinically effective by improving the organisational structures through which care is delivered (Bate & Robert, 2002; Becher & Chassin, 2001; Darzi, 2008; Wilson, 2009) .

The NHS remains committed to its original aims of providing a cost and clinically effective patient care (Doherty, 2009; Phillips, 2005), at least partially through the NHS's organisational structures, including the gate keeping function of primary care, while providing a universal service free at the point of delivery. Since the 1990s patient choice has been added to the longer term commitment to efficiency (Bhandari & Naudeer, 2008; Bojke, Gravelle, Hassell, & Whittington, 2004; Bryan, Gill, Greenfield, Gutridge, & Marshall, 2006). And at the same time there has been an explosion in new diagnostic and therapeutic technologies accompanied by a public awareness of the availability, or lack of availability, of those technologies (Aberbach & Christensen, 2005; Greener & Powell, 2003; Mueller, Sillince, Harvey, & Howorth, 2004a).

In this chapter we particularly address:

- what respondents (staff and patients) say about patient care and service delivery based on the interviews and focus groups;

- what we *observed* about service delivery and patient care and particularly the *interactions* between clinical staff and patients *observed* and *described* during the shadowing.

As in Chapter Six the Trusts are conceptualised as open systems whereby high quality patient care (the input) corresponds with effective service delivery (the output) with the primary task defined as caring for sick patients (or those who are giving birth).

9.2 Defining patient care and service delivery

The thematic analysis highlights similarities across all grades, statuses and disciplines of the staff and the patients involved in the study. The themes that emerged consistently from the data that were about good patient care were:

1. Putting the patient first:

...of course patients do come first but actually really, on everything that you do, I mean everything you do you think of the patients (service manager in acute medicine).

2. Thinking about what is good for the patient (all the time):

I still believe and I believe to this day that if you absolutely concentrate on what the patients' needs are, all other things take care of themselves. it's about really showing that you care. I mean genuinely showing that you care about your patients, erm there's a lot of talk about also looking after your staff and caring for your staff. I think that's important but I think the health service has got itself stuck far too many times concentrating on the needs of the staff and not the patients (Chief Operating Officer).

I think that's what you have to make sure is that everyday you are thinking to yourself, 'am I doing this for the good for the patient?' 'is it the right way to do it?' so I think when you get eleven years down the line, one of the things is that you can loose sight of is that, very easily (Matron).

3. Awareness of the diversity in the patient's world (culture, family, age, home and work environments):

..it would be making sure older patients have high quality of care during their surgical admission (senior consultant Geriatrician).

you need to support your staff ... you know and you have to have an awareness of the different culture of the patients (administrator).

4. Making sure the patient received the care that staff would expect for themselves and their relatives:

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I would define patient care that of - if it was one of my relatives who were ill (senior manager).

5. Talking to patients about what has happened, their medical history and their clinical condition:

....if they talk to you one-on-one and you know where you're at (patient).

6. Safety and empowerment of patients:

They [the multidisciplinary care of the elderly team] believe that good patient care sits around ideas of timely discharges, safety, making sure the patient understands their condition and their treatment, empowering patients by allowing them to make their own decisions about their care (to a point), providing the appropriate treatment and care, being responsible for the patient. Examples of bad patient care are viewed as delayed discharges, poor decision making and discontinuous care. (Notes from an observation of a team meeting).

From the descriptions it is clear (and perhaps no surprise) that senior managers, clinicians and patients all hold slightly different perceptions which inform their judgements to give 'patient care' a specific meaning. Some of the judgements are related to their particular clinical specialty or organisational responsibility although generally respondents reiterated that patients need to be at the centre of daily practices. Patients in all cases wanted more than anything to be kept informed about their care, and if possible this should be done by the clinician in charge.

At a more complex level the definitions above reveal a 'vision' of good patient care which links the 'practical', 'professional' and 'political' elements of NHS life. It also links to the 'human' elements associated with the tasks of caring. For example, the Matron (quoted above) shows a revealing insight that the routine *organisational* tasks might take over as a perceived priority from what a person initially knew to be their primary task (i.e. patient care). As she says, several years down the line you might lose sight of what you are really there to do.

9.3 How is good patient care achieved?

9.3.1 Managers

Managers each have different levels of responsibility for delivering good patient care which may differ from priorities expressed by patients and clinicians:

Erm, that's the bit about lifting your eyes up off of the horizon, and lifting the eyes up above the horizon is about looking at the totality because the

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medical, again, the medical management model is very much that you should do what you need to do when the patient is in front of you. The management model, the pure management model is about doing the right thing for the 450,000 patients who were looked after last year, so some of that will be about compromising, and offering the best care to the widest group that you can (CEO).

Immediately this respondent exposes the potential for conflict at senior level in that he/she³⁶ positions the 'medical management model' differently from the 'pure management model'. In the former the patient is a particular individual with a health care problem – the patient 'in front of you'. However for senior management there are many thousands of patients that require good patient care which means (maybe) compromising to provide the best possible care to the greatest number. Despite this, another senior manager had a different 'take' upon good patient care and in answering the question focuses on what they themselves would expect evoking a more individualised model:

I would want good consultant input into my care ((1)) as soon as it was appropriate in the pathway that I was on. I would want to be able to have a conversation about what was wrong with me and what treatments and options there were, ((1)) erm ((1)). I would want the assurances of the people that deliver the care know what they are doing. ((1)) I would want the care to be provided in an environment that was clean and in an ideal world I would want a single ensuite room, err and I would like to choose my own food and all that jazz. ((1)) erm and the erm, ((2)) so really you want the environment to be correct and you want to have the confidence in the clinicians giving care and you want to have had input into what your care should have been (Senior Manager.)

This manager has a very clear model of their 'ideal type' which positions the relationship between the patient and clinician, the skills/expertise of the clinician and the physical space and environment as central to good care. There is awareness here that planning and teamwork are also part of the process of care but particularly important is the knowledge of how to deliver the appropriate care and information in order to facilitate joint decision-making.

³⁶ We do not want to risk identification of any individual participant.

9.3.2 Clinicians

Good quality patient care for most doctors interviewed was:

... making sure that erm the patient achieves the outcome that you would wish them to as a result of either their outpatient visit or their inpatient stay erm and that outcome is kind of on a objective kind of medical measure, erm but it's also in terms of the quality of the care that they've received and whether they are satisfied with the care that they've received. (Senior consultant)

Another senior consultant who is also on the senior management team of the Trust took the concept of patient care further:

... it should be delivered well I think is the answer ((laughs)). I think on the whole we do deliver it well, we have the lowest mortality rate in the country, ((1)) or one of them. I think we do actually and we ((1)) I'm very proud of the care and I think there are two things to be proud of and one is the basic care and ... we do emergency work I am very proud of. Then the other bit of care we're proud of is that ... I think there is a real culture of innovation and I'm trying to do something new up here, and I think that's actually really important in terms of leadership. My job is being able to see a clinician with an idea and then work out of him or her how to turn that idea into a self service innovation. I think that we have created over the last few years a much stronger patient safety culture.

This respondent clearly links leadership and patient care stressing both the relationship between supporting other clinicians in innovations that improve care (particularly attending to safety) while also being proud of the culture across the Trust for low mortality, innovation, and supporting staff. Crucially there is a pride and energy about this account. The culture puts patients first but the staff gain satisfaction and a sense of professional pride from the performance of the Trust as a whole [T3].

The clinician manager below takes up the relationship between staff empowerment (and support which links clearly to the outcomes reported in Chapter Five) and returns us to the focus on staff training and skills, indicating here that if the managers train and empower staff – services to patients will improve.

... it's about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is, we worked with training and development and we came up with a specific programme that was aimed at empowering them to improve their service area etc. etc. and

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also provided them with some skill sets that they probably didn't have prior to that. (Senior Manager, Therapies)

While from a similar perspective the nurse quoted below stresses that team work and morale mark the path towards good patient care and you need to look after *staff* in order to deliver a good service to patients.

... And I think it is also, sort of, taking into account the people they work with, the team members and boost the morale, and that can make a lot of difference to, you know, to have people at work and sort of take the stress levels off and I think, you know, it would sort of, quality certainly would happen, sort of energise them, able to care for the patient. (Nurse, focus group)

9.3.3 Patients

For patients overall it was clear that most of all direct communication and consistency of staff was experienced to be good care:

A: ... I've been transferred here from [another Trust] and there it's a bit more, not one-to-one but you see a lot of different doctors here whilst there [the other Trust] you have only one doctor, your one midwife and your one consultant. Here you see a lot of different people.

Q: And which one do you prefer?

A: I'd say probably just to see the one 'cause lots people tell you different things.

Q: Okay, so it can be a bit confusing?

A: Yeah, sometimes it can be, yeah.

The patient quoted below reinforces the need for clear patient/clinician contact and communication.

For another woman:

Now whilst I'm here my care has been very good especially with the [specialist] who first saw erm, who first flagged up the problem. Erm yep it's been good it's been good since I've been in. It's just the initial communication as an outpatient to an inpatient I should have really - you know that should have been. I don't know where the fault lies but there should have been some communication there between the appropriate people (Maternity patient on postnatal ward).

9.4 Delivering patient care

9.4.1 Doctor-patient interactions

We look firstly at three consultants' (Cameron, Kenneth and Henry) styles across two different Trusts as they interact with patients to explore the importance (or otherwise) of good communication and engagement. What emerges, perhaps unsurprisingly, is that different consultants have different styles of engaging. The style adopted though feeds through to the 'ethos' of the clinical team, relates to, and impacts upon, the culture of the Unit thus affecting the doctor-patient interactions as part of an evolutionary cycle.

9.4.2 Empathy and Communication

9.4.2.1 'Cameron'

From the researcher's notes we gain an impression of Cameron who deals mostly with stroke patients for whom verbal and non-verbal communication may be very restricted:

Cameron offers a very personal and individualised style of patient care to his patients. He is often very tactile often rubbing the tops of their hands, arms and heads to encourage them or to show support when he is discussing difficult problems with them such as their inability to go home, the definition of a stroke and the future impacts of them having a stroke. He also speaks to the patients in a very friendly and informal way and sometimes draws on their mother tongue to say a few phrases to make them feel welcome and at ease.

In his interactions with his patients he is very positive and upbeat, often speaking loudly to encourage and motivate his patients. He also tries to share a few jokes with them and breaks down doctor/patient power relationships by crouching down in front of his patients or sitting on a chair or their bed so that he is always the same height or lower.

This description alone demonstrates how Cameron's *behaviour* relates to several of the descriptions above which identify good patient care in that he:

- communicates (verbally and physically)
- takes care to acknowledge their humanity through recognition of their cultural (linguistic) heritages the fact that they have a life outside the hospital
- attempts to empower them within the relationship (at least via discussion and physical presence and to an extent with knowledge of their condition).

Below is a detailed example of Cameron (and his team's) encounter with an elderly stroke patient (Mrs. D) which is part of the evidence the researcher has employed for her assessment of the processes engaged by Cameron in his provision of patient care:

"Hello Mrs. D? (Patient nods head and smiles) do you have a headache? (Patient nods head) Do you know why? (patient shakes her head staring wide eyed at B). "OK, I'll tell you..." Cameron sits on the edge of the patient's bed and explains that she has had a stroke and she has a headache because sometimes patients who have had strokes will have suffered from headaches due to pressures on the brain. The patient stares and nods her head occasionally as Cameron explains. "Mrs. D, do you understand what I have just told you?" (patient nods her head and then croaks "yes") on this speech Cameron sounds surprised and encourages her to speak again "Oh wow Mrs. D, that sounded good, can you say something else for me?...well done". The patient looks up at the doctor and smiles croaking again "I don't have anything to say doctor", "well never mind Mrs. D, I am sure I can get something out you a bit later!...excellent, your voice seems to be coming back...isn't that good?. We will have you singing in no time!" (Mrs. D. smiles and shakes her head "can't sing" Cameron smiles and laughs.

Despite the clear power differentials, doctor/patient and healthy/unhealthy, in this relationship Cameron is doing what he can to encourage and communicate effectively with the patient. Not only does he literally get down to her level by sitting on the bed but he explains the condition, how it happened and communicates the indicators for (potential) recovery. He is respectful and careful although the intellectual/cultural difference between the patient, Cameron and the care team is exposed by the encounters below.

"Now Mrs. D. can I examine you?" (Patient nods her head) Cameron takes the patients hand and she flinches "cold!" Cameron smiles and apologies saying it that "it is the alcohol" (alcohol gel he had just rubbed into his hand). The patient eyes Cameron suspiciously "have you been drinking?" the group laugh and Cameron explains that it is the hand-wash and she nods slowly and looks at each member of the team for what seems confirmation that this is the truth. Cameron then begins testing the patient's strength. He checks her arms and then her legs with simple strength tests calling out numbers between 1-5 for the SHO to write in the notes. As he instructs the patient with her tests he speaks very slowly and loudly and the instructions are very simple and clear and he often demonstrated his instructions, especially for those patients that have cognition problems. As the patient does the task Cameron is very encouraging shouting words such as "good", "excellent" or "well done after

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each task". After the strength tests Cameron checks the patient's reflexes with a small hammer. Again he shouts out numbers and makes comments about the reflexes that the SHO writes down in the notes. Following the reflexes Cameron checks the patient's facial muscles by asking the patient to smile, grit their teeth, stick out their tongues and move them about. He then checks her speech by asking her to repeat phrases or noises after him. The first phrases or groups of words were given as words that would be familiar to the patient such as the patient's name or names of simple objects such as pens. As the patient is able to say these words he moves on to more complex words such as "hippopotamus" which the patient struggles with. Cameron then checks the patient's ability to co-ordinate by getting the patient to touch her nose and then his finger with her index finger. The patient clearly struggles with this and is very slow and inaccurate.

For a brief moment after the tests Cameron has a quick discussion with L [another doctor] asking him what he thought about the tests and what they would expect to see on the CT scan. Cameron then turns to the patient and says "sorry Mrs. D, just discussing your test results with my colleague, we think that you are progressing very well...there has been much improvement hasn't there?" the patient stares blankly at Cameron for a brief moment before shaking her head "no, you don't think so? Now what about your speech, when you first arrived you couldn't say a word, now listen to you, don't you think you have improved?" patient shrugs her shoulders and looks down at the bed. "Well Mrs. D, we all think you are improving...so well done..." patient looks up and smiles sadly.

The style of meetings between clinical staff and patients was as much a feature of *Unit and team culture* as of a particular clinician's practices. Thus, while Cameron above was engaging with the patient in what appeared to be a *genuinely caring* manner, his colleagues were attentive, while in the background.

9.4.2.2 'Kenneth' and 'Henry'

In what follows two consultants worked together and while Kenneth was the more senior and experienced clinically, Henry held a senior managerial role (as well as being a senior consultant). Kenneth was described by the researcher as:

... a very warm and caring man ... he is very sweet, kind and caring to his patients and makes them feel comfortable and less vulnerable by empathising with them and drawing on his own personal experiences as a patient.

As with Cameron above, Kenneth was also described as 'tactile' and that he took the time to explain things to patients. Kenneth empathised with patients by sharing a joke (as did Cameron):

For example one lady was embarrassed because she had fallen down in her flat and sustained injuries and did not really want to explain how she had fallen over or what she had hurt [to the whole team]. Kenneth then told the patient that he had slipped over in the hospital and in the M&S food section. This meant that she no longer kept quiet through embarrassment and told Kenneth after that exactly what had happened.

However, during the two day shadowing of Kenneth the researcher was particularly:

...struck by how intimidating this group of doctors must be to the patient, especially an elderly or vulnerable patient as a large group of faces arrive at their bedside and close the curtains around them making the space feel incredibly claustrophobic and that the patient's space felt 'invaded'.

While shadowing Kenneth, the researcher was in a position to observe Henry (who was also shadowed for two days on a different occasion). The researcher's notes here, which describe a joint ward round with Kenneth and Henry, state:

I was struck by how impersonal Henry was towards the patients [in direct contrast to Kenneth]. He did not greet them or introduce himself. [In one case] Instead of asking the patient how she was getting on with the oxygen machine Henry asks the SHO how she thought the patient was getting on with the machine. When the patient tried to give reasons they seemed irrelevant to Henry who just told her she must use her oxygen machine every day or she will not get better.

The researcher goes on to describe how Kenneth (the senior clinical consultant although Henry has a senior leadership role) stands quietly behind the junior doctors on the round with Henry at the front of the group talking to the patient. Henry stands up. Kenneth stands at the back of the group with his hands folded behind his back and Henry every so often asks Kenneth if he agrees with Henry's thoughts on the patient's health status and treatment. While Henry is taking the lead in this way the researcher notes:

Not one of the doctors explains to the patients what will be happening to them that day or beyond nor do any of them say goodbye.

One patient on Henry's round is in the bathroom as the team arrive at her bed.

Henry knocks on the door of the bathroom and says "Mrs. X, it's Dr. Henry we are all here to see you". He then asks a nurse if she can hurry the patient along as he is very busy. It seemed strange [to the researcher] that Henry could not have just visited another patient until this patient had finished rather than rushing her. Before the nurse can enter the bathroom another nurse pokes her head out from behind the door and says that she is washing the patient. Henry asks whether this could be finished after he has seen her. The nurse, who looks frustrated, says she will be a minute. The nurse then helps the elderly lady to shuffle to her chair and helps her sit down. Without greeting the patient Henry begins talking over the patient's bed about her X-ray that was taken yesterday and then asks the nurse about the patient's progress.

In the examples above describing both Cameron and Kenneth's interactions with patients there is evidence that the patients were given a chance to explain to their consultant how they felt and either to tell the doctor what had happened to them or to hear the doctor's explanation of why they felt like they did.

The patients were treated in both these examples as human beings and in doing so the doctors themselves positioned themselves in their *clinical role* but also as *people occupying that role*. By acknowledging mutual humanity (albeit in different styles) these doctors were able to *take authority* from their position as medical experts (see Chapter Seven above).

By contrast Henry also took authority but did this by silencing junior colleagues, Kenneth his fellow consultant and most importantly, the patients. While Kenneth and Henry were in the same Unit, the scenario described above suggests that Henry held more power and therefore exercised greater influence on junior colleagues (and this fed into the culture of the Trust).

In what follows we trace how these contrasting styles might link to the culture of the Units and the teams themselves and consider how this fits in with the definitions of good patient care and service delivery.

9.5 Clinical team work and service delivery

9.5.1 Giving patients care

Miller and Gwynne (1972) suggested that a 'warehousing' model of care operates for those who may be institutionalised in the medium to long term which they contrast with the possibility of a 'horticultural' model of care, akin to what might be identified today as a learning environment. Working in the care of the elderly takes its toll on the emotions of all the clinical staff

particularly in the 'horticultural'/learning setting, where efforts are made to ensure two-way communication and mutual understanding and development takes place. This can leave clinical staff open to experiencing directly the pain and distress experienced by their patients (see Menzies-Lyth, 1960 and the 'stories' below).

The following example demonstrates how engagement between clinicians and patients impacts emotionally upon even (and possibly especially) senior experienced staff. The researcher here, shadowing Mandy, a female senior consultant describes the following case:

Whilst cleaning up a suppurating wound an elderly male patient cried. It was a really touching and sad moment and Mandy was clearly distressed that she had hurt the man. On first seeing him cry Mandy appeared to have a moment of shock/panic where she looked amongst her team to find out whether this was normal behaviour for this patient. On hearing the answer was 'no' Mandy tried to soothe the patient and seemed genuinely sorry for hurting him. The nurse who arrived at the scene also appears to be genuinely concerned about the patient and goes over to help Mandy and prevent the patient from crying. This scene was particularly sad because in today's society and especially in the patient's generation it is thought that men don't cry or show emotion. For the man to cry he must have been in severe pain and must have been struggling with himself to prevent the tears. Mandy's genuine empathy and somewhat guilt might have reflected that.

Mandy and the nurse in this context are using emotional intelligence (see Chapter One) in a relevant situation. Mandy also engages in conjoint action with the nurse rather than take action in an autocratic fashion without consultation. Mandy notes the patient's crying with a start (according to the description) and instead of continuing with the work on the wound (which many doctors might well do because it was necessary for a positive health outcome) she immediately appears to take in the context as a whole – thinking about her patient's behaviour and reactions. The nurse in this case mirrors the behaviour of the consultant. This is an important issue for discussions of leadership and patient care in that teams tend to reflect the beliefs and actions of their leaders.

9.5.2 Discussing patient care

In a shadowing the researcher at the start of the observation describes in detail the way two doctors discussed the patients before embarking on the ward round. This is another case of concerted action:

09:00 Breakfast meeting with Cameron [T3]

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Once they have consumed their breakfast Cameron and Mandy turn to business. Cameron begins by asking Mandy's opinion on one of the patients that they had seen on the ward round that morning. They chat for a couple of minutes about the patient before both getting a patient list out and going through the names systematically and discussing their care plan for each patient. Several patients will need to be discussed in a patient case meeting as they have complex discharge problems, others will need to be referred to the CCP so that a greater social package will be considered. Mandy says that she will go and see a few of the patients herself later and occasionally delegates tasks to do for Cameron, but mostly he is autonomous and says what he needs to do for a patient and what he will organise on behalf of the patient.

This is a quiet and supportive meeting between Mandy the senior consultant and Cameron the more junior member of the team. However, the researcher notes the systematic discussion of the patients and their care along with a plan about who Mandy will see and how Cameron's tasks are designated.

A similar atmosphere of calm and authority are evoked by the description of a case meeting with Cameron's team at the start of the first day of shadowing:

I approach the nurse's station and look around to see if I can see Cameron. I spot him at the far end of the ward sat at a computer with a mixed group of staff (doctors, nurses) surrounding him. I approach the group and stand amongst them. Cameron is facing the computer screen and discusses a CT scan with his registrar [L].I notice that as these two doctors discuss the scan a SHO writes notes in the patient's file occasionally craning his neck to look at the scan at certain parts of the discussion. A few nurses also crane their necks at various points but most just stand patiently in silence waiting to visit the patient. Once the discussion draws to a close Cameron turns his head from the computer and asks the team if they have anything to add. ...[later on in the same meeting the researcher listens to a telephone conversation] ...Cameron has rung the wife of a patient to update her on her husband's health. He is very honest with the wife saying that her husband has had a second stroke during the night at that he is now in worse health. Despite the bad news Cameron is very friendly and pleasant with the relative and is very sympathetic to her questions and on several occasions empathises with her. Coming off the phone Cameron returns to the team and gives a brief update to L regarding the conversation with the patient's wife. The SHO writes this summary in the notes. Cameron takes a short sharp breath before asking "shall we go and visit the patient?" Cameron turns quickly on his heels and enters the ward.

The observation here reveals the high workload and 'multi-tasking' undertaken by the team (looking at the computer, discussing scans, taking notes, calling relatives and so on). But there seems to be focused attention on patient care and individual patients. At the end of this extract it also seems that Cameron himself takes the ward rounds very seriously – gathering his mind together and possibly seeking the emotional strength to move from the clinical team and considering evidence from notes and colleagues to imparting and collecting information from the patients.

The same researcher who has shadowed both Kenneth and Henry at a different Trust from Cameron, gives examples of how some of Henry's patients are discussed. For example she describes a meeting to discuss patients chaired by Henry.

Henry criticises the way [Site B] is run and the management of beds and patients by that hospital. He praises the doctors for the current situation on [Site A] where they have spare beds stating that they have done so well in 'kicking them out'. Henry stated during [a previous meeting] that the patients needed to be removed or 'kicked out' of hospital as soon as possible. The rapid turnover of patients may on the surface appear that they are not receiving good care However getting patients home quickly reduces the risk of hospital acquired infections.

And is likely also to be what many patients would want.

As the researcher makes clear, it is important not to confuse the rhetoric with the quality of patient care, but rhetoric does determine and reflect a dominant ward or Unit culture.

9.6 Responsibility for patient care

Responsibility was a key element of the discussions of leadership particularly in Chapters Four and Five. Responsibility for individual patient care is in the hands of clinical teams led by the medical consultant but above that person is the clinical leadership/management (Clinical and Medical Directors) as well as the senior operational managers (CEO and COO and others).

Primary responsibilities for patient care however vary from *individual care* i.e. for both identifying care pathways and day-to-day care to responsibility overall for the care of all the patients. In Chapter Ten we review the findings from this study with some recent cases where responsibility has been mishandled to explore what lessons might be learnt.

In an interview with a consultant:

... we try to just have a really open forum where we can discuss that [specific patient care], just like open it up and letting people put their viewpoints first and then kind of trying to question where they're coming from with that in a positive kind of way but them also laying out where you feel that that might not be the right course of action. Erm and also at the end of that discussion making sure that everyone is happy with the outcome, and sometimes people aren't erm .. but it also realising that it is a consultant's responsibility at the end of the day and making sure that everyone knows that you're happy making that kind of decision and that you are happy to be made accountable for that decision.

9.6.1 Responsibility for emotion

It frequently falls on the clinical leader to cope with their own, the patient's and the relatives' emotional reactions and distress and also with those of the other members of the team. As the researcher noted:

One senior consultant, Tricia, made it clear that as the clinical lead she also took responsibility for talking to patients about DNR³⁷ forms and delivering 'bad news' to patients/ relatives. During the ward round Tricia removed the pressure from a junior member of the team who had been told by a relative that they didn't want their mother to be resuscitated. Being told this information had stressed out this junior member of the team as he was not yet ready for this type of responsibility. Tricia supports her junior colleague saying that he should have never been confronted with this situation.

One question here then is how do the clinical team handle such multi-layered emotional problems? How important is leadership in supporting (and developing) teams to cope?

9.6.2 Responsibility for teaching

Most clinicians in the study from all disciplines were interested in teaching the next generation, and their activities will influence patient care, provide role models for leadership and influence climate and culture of the organisation. The example below is chosen because Dr. Jenkins was very enthusiastic but also demonstrated compassion and courtesy when he was face to face with the patients. The researcher's notes describe this in detail:

Approaching the patient Dr. Jenkins shakes the patients hand and says "how are we doing today?...I see you were referred by your GP...you have a

³⁷ Do not resuscitate.

wonderful GP" (he comments on how wonderfully clear and precise the notes are). "That's not my GP, that's my missus's GP, mine's on holiday...I have Dr. U. U". "What a name! But looks like they have to wonderful GPs at your practice...the notes are seamless...you are lucky!" Jenkins then continues to ask the patient about his medical history. The patient is able to tell the doctor his entire medical in great detail including the drugs [more description from the researcher]. Dr. Jenkins stops the patient and asks the medical student to take a mental note of how a good GP leads to a well informed patient, which helps him (Jenkins) in his (patient's) treatment. He talks about 'aspects of professionalism' and the right ways of informing patients about their treatment and condition, he openly praises the patient for knowing so much about his patient history and tells the students that "medical history in patient care is so important". The patient begins talking about his treatment in the hospital and Dr. Jenkins states that "patient feedback is great, and they like to hear about it...we need to be more professional...primary care pathways are the key to patient care".

Dr. Jenkins behaves with humour towards the patients and the students and junior doctors but does so while continuing with his assessment of the patient, taking the relevant history and trying to impart good practice and professionalism. He manages to balance giving the students and junior a chance to gain hands-on experience while making sure he himself has all the information he needs for the care of the patient.

Dr. Jenkins then checks the patient's lungs and heart asking a SHO, Dr. Williams to check the cardiogram as he can hear an AF flutter. As Dr. Williams looks for the chart the patient tells him that his GP had thought the same and that is why he was thinking of changing his drugs. Dr. Jenkins looks at the students and says "wonderful isn't he?" he continues that the GP must have heard or felt it himself [the heart condition] and now they will need to see the chart to prove it then they can change the drugs as the GP had predicted. After looking at the chart Dr. Jenkins asks Dr. Williams to change the drugs and to get rid of one of the drugs he thinks are unnecessary. Dr Jenkins shakes the patients hand when he leaves and says that one of the juniors will be back later to sign off the new drugs.

Looking over the notes Dr Jenkins spends a lot of time teaching the [medical] students about various medical conditions and treatments that have arisen out of [a particular] patient and asks them to suggest other possible diagnosis and other treatments for his condition. Jenkins is a very enthusiastic teacher and the enthusiasm rubs off on the students who are all eager to share their knowledge and take stabs at questions they don't know. In the middle of the question and answer session he asks one of the students "what year are you in? I don't know how much you guys know already". The student base is a mixture from students from [different

schools] and he relishes the opportunity to teach the students some new medical knowledge. Whilst getting the students to look at the cardiogram he looks up and apologises to Irene [matron] for taking so long on his ward round "Sorry Irene, I will be here all day, this is such a pleasure to have students!" Concluding the teaching session he quotes someone for saying something about the health of gamblers and drinkers and then asks "now who said that?" the students look round each other and then he exclaims "me mother!" all the students laugh including the female registrar and Irene. He then ushers them onto the ward saying that he doesn't want to get in trouble with the matron.

9.6.3 Subverting responsibility

There are diverse ways that staff at both Trusts had for coping with emotional aspects of patient care and resisting authority (and thus taking responsibility for care into their own hands). One way that nurses (including senior nurses) operated was to *subvert* some of the doctors – particularly when the relevant doctors showed little interest. The shadowing of a senior nurse [Irene, the matron] during a ward round produced the case of Lola (described when shadowing Irene):

Irene tells me it is because many of the patients are elderly with complex cases and therefore they tend to stay for a long time. I note that one of the patients has been here for a long time and I ask whether due to the long length of stay on the wards whether she becomes attached to any of the patients, I point particularly to the patient who had been here for three months. Irene says, 'oh that's Lola, mmm has she been here 3 months?...let me check her notes'. Irene leaves the file that she is reading and picks up Lola's file and looks at the admissions page and then states (sounding surprised). That three months is correct. She then continues that she does find herself getting attached to her patients, especially if they have been here as long as Lola. She mentions that Lola should really have been moved to G Ward but she really doesn't want to move her 'she should be elsewhere, but she is ours' (highlighting emotional attachment and the sense of ownership over patients). She tells me that Lola is really sweet and all the nurses really like her and it would be quite strange if she was no longer on the ward as she is a returning patient and 'it is always nice to have her back'.

As we have suggested in Chapter One (and witnessed above), in order to protect one's self against anxiety clinical staff often 'split' patients into 'good' and 'bad'. Here the treatment of Lola indicates that the nurses may be using their care of her to defend themselves against some of the harsh treatment decisions made about other patients (by doctors and managers) particularly when there is pressure to discharge older patients due to bed

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shortages. This might lead them to consciously and unconsciously subvert these authorities when they can and there is a particular pleasure to be gained when they succeed in this 'subversion' with a 'good' patient such as Lola. What remains at stake is whether Lola's stay is actually benefitting her clinically (or even socially) and also whether it is preventing another patient receiving medical care.

9.6.4 Responsibility for end of life decisions

Responsibility for patient care resides not only with the clinical team but is sometimes shared between the team, the patient or the patient's closest relatives which is usually the case with end of life decisions. Sometimes the greatest emotional engagement is with the *relatives* of the patient rather than the patient themselves. This is particularly the case when the patient is likely to die which is particularly sensitive when it is a case of withdrawing life support. The following example of Cameron's Patient G and his daughter brings this into sharp focus.

The biggest emotional situation this day surrounded Patient G, a coma patient and his daughter. Cameron had to encourage the daughter to agree with his plan that her father's treatment should cease and palliative care take over. This is a very emotional situation especially due to the young girl's age but also because she was in 'denial' asserting that her father would get better and this caused her to present a whole range of emotions that Cameron had to deal with.

We enter the side room. The blinds are drawn causing the room to be quite dim. There is a young girl sat up right on a make-shift bed that she has made from four visitor chairs from the lounge. She has a blanket over her legs and is typing on her lap top her mobile phone ear phones in her ears and bags and other items are scattered around her chair. She looks up as we enter and pulls the ear phones from her ears. I am surprised at how young she is, I had expected a daughter of forty something not a teenager of 18 perhaps, but no more than twenty. She pulls the covers off her legs and places her lap top on the window sill. Cameron asks if she is ok and she nods and says she will leave him to it. Cameron says that he will bring her in once he has examined her father, she nods and opens the door pulling her jumper down over her leggings as she leaves. Cameron looks at me and comments (adding to what I was already thinking) "I think she is far too young to be dealing with this on her own....it is not fair".

He turns his attention to the patient and begins speaking loudly to him. He explains that he is a doctor in [Trust 3] hospital and that he wants to examine him. At each point of examination Cameron explains to the patient what he is going to do. Cameron is able to move the patient's limbs like he

is a doll. Each time the limbs are placed in a position they remain there. The patient doesn't respond to any pain stimulus as Cameron pinches the patient's skin and scratches the bottom of his feet with a stick. Cameron then checks the patient's eyes by pulling back the patients eye lids, the eye lids roll from side to side and Cameron explains that it is called a coma roll, which suggests that the patient is in a deep coma. Cameron teaches W by the patient's bedside and talks him through the patient's condition and talks about how the patient's recreational drug habits could probably have contributed to his stroke. Cameron and W engage in a small conversation about the problems of cannabis on the brain.

Cameron made the decision in consultation with his team to discuss with the daughter that they need to end the patient's treatment (and thus in all likelihood, his life). Cameron deals here not only with the daughter's distress but with the daughter's worry that she is involved in the decision to let her father die. Again a high degree of emotional intelligence and leadership as well as clinical knowledge operates in this communication.

While shadowing Owen [Trust 2] the researcher sees that while behaving perfectly correctly he puts emphasis on the clinical and health related aspects in an end of life situation above communication and empathy. He is not unkind but 'misses' the emotional level of communication. Here in the presence of a daughter and father the woman (mother/wife/patient) is clearly dying and being kept alive by the clinical team. Owen:

... talks directly to the daughter stating that her mother is coming to the natural end to her life and therefore she [the mother] is giving up - 'withdrawing from life' and tells the daughter that although they will feed her through a tube she [daughter] should prepare herself and her family for the inevitable. He also says that her mother will also start ripping the feeding tubes out to prevent herself from getting the right nourishment.

The image conjured by the 'withdrawing' from life and 'ripping' feeding tubes is dramatic and seems to give agency to the dying woman – almost indicating that somehow she is to blame as she will prevent herself getting the right nourishment. However, the researcher, as participant in this encounter, is bringing out a sense of the culture of this particular event. While Owen is probably protecting himself emotionally from the loss of life and the sense of clinical 'failure' he does not protect the daughter or the husband from the emotional onslaught of the woman's impending death.

The daughter says that she understands and turns to her father and says 'dad do you understand what the doctor is saying?' the husband paces up and down the side of his wife's bed looking lost and lonely. He looks up at Owen and says that his wife is giving up because someone at the nursing home said she was a burden. The daughter scolds the father for saying that

in front of her mother. She explains to Owen that although she [mother] doesn't say anything she listens to everything and the more her father says it the more she doesn't eat. Owen says he understands and asks how the family is coping.

The daughter here is also protecting Owen from the family's pain by scolding her father even though Owen asks how they are coping. However, although kind and polite, Owen does not seem to operate with emotional intelligence or engagement with others' pain.

The daughter says that her father is finding it very difficult because he is the main carer for her; she herself has taken time off work to care for her when she can to support her father. As she speaks about her father and how upset he is becoming she begins to become tearful. Owen listens to her as she speaks and occasionally asks further questions. The husband continues to potter around the room occasionally touching his wife's head and face. The daughter watches him.

Owen, while allowing the daughter to cry and not acting as if he is irritated or embarrassed, equally pays little heed as he continues to talk of the mother's deterioration.

Owen begins to talk about the deterioration of her mother and what they will be able to do for her. The daughter says that she knows what Owen wants to talk about 'you're talking about DNR aren't you?' Owen says yes he is and the daughter tells him that she knows about it because her friend's mother recently died and this was discussed with her. The daughter says that she knows what she would prefer but they will have to talk this through with her father. The daughter calls her father over and begins explaining DNR. He looks at his daughter, he looks lost and scared and she tells him that it is his decision but she thinks that the doctors should not resuscitate her mother because she will be resuscitated to the same state. Owen inputs that she will be 'worse' than how she is currently because she will be a lot weaker. The daughter says that she will have to talk through this with her father. Owen nods and leaves the room.

9.6.5 Stories of patient care

The following two stories show in detail the ways in which responsibility and power can shift between team members and highlight anxieties faced by doctors about caring for patients.

9.6.5.1 A story of system failure: Cancelled Clinic

The first story is told by a female registrar who describes a situation in which she felt disappointed with patient care due to cancelled clinics. In the

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following account, the narrative is broken down to four moments, and each is discussed to demonstrate how the doctor's anxiety is managed by being linked to a failure in 'the system' that climaxes in her interaction with patients.

Q: What about any time or incident that made you feel disappointed with patient care in this hospital?

A: Lots of times, particularly since we've not had a secretary. Every clinic, every single clinic I send somebody home because the notes aren't there at all. They are supposed to be coming to see the consultant [her immediate superior] and he's not there, and they've been put into my clinic and you look at the letter and it clearly says on the letter 'consultant only to see', and they turn up and he's in Italy, on holiday.

The registrar is expressing frustration. On the surface it is towards a recurring failure in patient care attributed to firstly not having a secretary and secondly because the consultant 'is not here'. The expression of the frustration however is confused; there is no secretary but the patients 'have been put' into her clinic. Furthermore, she sends someone home from each of her clinics because the notes are not there. The letter 'clearly says' the patient is to see the consultant who is not only not there but he's in Italy 'on holiday'. There is a feeling of being overwhelmed, and of rage and envy towards the consultant - and possibly the patients - emerging from this short paragraph (for discussions of workplace envy, see Vidaillet, 2007; Stein, 2000). There is also an expression of omnipotence in that she sends patients home. She has the 'legal' justification to do so because there are no notes and also because their letter says they have to see the consultant and the energy is directed towards this activity rather than getting patient appointments changed. The consultant is on holiday, presumably one to which he is entitled and one which has clear boundaries enabling them and the staff who make the appointments to re-arrange the patient dates.

There is clearly a high degree of frustration and anxiety present in this account; there are too many patients with 'needs' and not enough clinical or support staff backing the work in the way in which the doctor would feel comfortable with. As there is little opportunity either to express or assuage her anxiety so she becomes 'prey' to primitive phantasies and unconscious mechanisms to relieve the anxieties.

The story also sheds some light on doctors' anxieties about working in a multidisciplinary team. Medical education and postgraduate training provide a culture in which doctors believe they can rely on each other through which a sense of being an elite group and confirmation of professional omnipotence and responsibility - particularly of the consultant - arises. However the role of the consultant also brings about a sense of envy and

destructiveness in others which has its origins in the primitive defence mechanism of splitting off the painful parts of one self (e.g. the realisation that you are not omnipotent and that another has the ability to do what you cannot) and projecting them onto others in an envious attack (Klein, 1959).

...and you have to go out and say, 'I know you've waited three months for this appointment but I'm afraid the consultant is not here and he wants to see you personally, so thanks for coming but if you can just go away' and you can't even say to them 'you're getting an appointment for next week' because realistically they're getting an appointment in three months time, and I think that's really disappointing.

'Breaking bad news' is considered to be a difficult task for health professionals and one that is a constant cause of anxiety. In addition to having to find the appropriate means of communicating prospectively devastating prognosis and supporting patient through the immediate emotions, doctors must come to terms with possible changes in how the patients perceive them (Barnett, 2002). Even though the situation described here does not involve delivering bad news about an illness, it is a moment of disappointment for both the patient and the doctor. The patient's anticipation to receive treatment is rejected and the doctor has to acknowledge failure in service delivery. The patient's possible anger and anxiety is directed towards the messenger, who in this case, is unable to offer any practical solution. Instead of being the helpful, trustworthy saviour, the doctor transforms into an envoy of disappointment and will have to see to the patient's emotions as well as her own disappointment, to which there is no external consolation on offer. To alleviate the anxiety caused by the situation, the registrar clings on to a narrative regarding her workplace – she is disappointed in the system.

I feel very disappointed in the system, which, I know the system is a big, wide thing, but ... [it] lets people down from that point of view and, you know, we overbook theatre lists and they get cancelled and then again I feel disappointed.

By seeing the NHS as a faceless, bureaucratic, 'machine-like' (Elkind, 1998) entity, the registrar convinces herself that the situation is not her fault – it is not what she would want for the patients, or for herself. She feels anxiety for she cannot provide the care required, and as a consequence she projects this anxiety through blaming 'the system'; regardless of their individual efforts, doctors are powerless when the system fails. As this registrar said epigrammatically later on in the interview: 'I don't think the NHS works anymore' which at a conscious level represents the impact on her working life of a problematic bureaucracy while at an unconscious level it provides uncontainable stress. The doctor does not have the opportunity to delegate

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tasks to her superiors to reduce the 'heavy burden of responsibility' (Menzies, 1960, p. 118) thus feels that she is left to deal with the failure of 'the system', a system, which ironically is set to heal people, not cause them angst.

It's mostly because I'm thinking, how must that patient feel. You know, they've worked themselves up, they've told work they are gonna be off work for three weeks or four weeks or whatever and arranged cover and you go and tell them, sorry, you can't have your operation, you can go back to work tomorrow. That's really disappointing, to do that to people, very much so.

In the conclusion to her story, the doctor moves beyond expressing antagonism to the system to empathising with the patient. Thus, by failing, the system provides the doctor with a social defence mechanism but through empathizing with the victims of the failure, she fails to contain her anxiety.

9.6.5.2 A story of grace in adversity: Supporting the mother of a still-birth baby

The second story is told by a male registrar who describes how he provided good patient care by supporting a mother of a still-birth baby. Despite the plot, the story is not told as a tragic narrative but as a proud patient-care moment, a sequence of events that had thoroughly positive impact on the doctor's perception of himself. This narrative is also analysed in sections.

Q: Could you give an example where you felt that you have given good patient care?

A: I think that one of them was this lady who actually came to the labour ward and told me that she hasn't felt her baby move in the past one day and she had had some bleeding. Obviously there was some concerns on my behalf for the baby, because there could be a problem. This was a very wanted pregnancy because she was quite old and this was an IVF pregnancy. I examined her a little bit and on examining her I found that the baby did not have a heart beat, so she had lost the baby.

Describing the situation at first with the patient as an object helps the doctor to distance himself from the scenario and to do routine checks expected in this kind of situation. In a hospital setting instructions are given about the way each task should be performed and these rituals form a reassuring tool for staff (Menzies, 1960: 121).

I did explain everything to her, and obviously as a doctor responsible for her, I need to follow all the procedures that needed to be done and all the care that she needed to have, you know I explained it to her that, you know this by far something that words, you know cannot express, as you can imagine how

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difficult this situation would be, and if we could make it the slightest bit better, we would try everything in our power, you know, to make the situation a lot more comfortable. I ensured that she was given a quiet room, with a very good midwife looking after her at all times. Obviously I had my duties towards the rest of the labour ward as well. People visiting her room making sure she was ok, making sure the pain relief was ok, we had induced her because we did not want her to go home with a dead baby inside her. It was a very, very painful and stressful scenario, it really, really was, it was horrible, absolutely and it is very distressing, exceedingly, exceedingly distressing because, you know the woman is going through all that pain of labour.

Here, the doctor is empathising with the patient, feeling her emotional pain and in this case is mostly able to contain it through wanting to relieve the situation and then by offering extra care, by 'going an extra mile'. In this extract, there is a clear shift as the doctor uses strong emotional words to describe the crisis. In telling the story, he is projecting his own anxiety on the patient, living the distressing emotions with her and having to remind himself of his position as a medical professional - 'obviously I had my duties towards the rest of the labour ward as well'. By referring to 'all that pain of labour' the doctor enters a relationship with the pain. The phenomenon of pain and our relation to pain, whether someone else's or our own, is more immediate than that of reflective knowledge – we do not think about pain but react to it so the sensation is intersubjective. The person who is not experiencing the pain but affected by it is an 'interlocutor' in the situation (Crossley, 1996, p. 37).

...I tried to make it a point that I was present, present as much as I possibly, feasibly could during her emotional outbursts. I wanted her to have all the support that she needed... I did get attached to the patient, being around her, trying to get her care, even if I was out of hours, which means that when I was not meant to be in the hospital. Now I think that some people will argue that, that is a bit over the top, but I think that, I guess, I guess, that that is medicine for you, you know it is about lives, and sometimes you have to make that extra effort, to make that person feel that little bit more special.

In this excerpt the doctor starts to explain and justify his actions. Through self-reflection he has realised how he acted in a way not normally accepted in the hospital culture, that is, he went against the 'social defence system' to deliver patient care, but also to cope with his own anxiety. He dedicated extended time to his patient even though hospital doctor's time is considered to be 'fast and efficient'; 'doctors move quickly in the hospital wards. Their time is expensive. They cannot afford to linger too long in any one spot' (Mattingly, 1998, p. 21).

Menzies (1960) noted that while institutions have social defence systems, individuals may resort to their own defensive mechanisms, but a membership of an institution 'necessitates an adequate degree of matching

between individual and social defence system'. If the individual and the social defence systems are in disagreement, what follows is some degree of breakdown between them, for example, a doctor's work colleagues might reject them for behaving in an inconsistent or unprofessional way to the system. Consequently, the registrar providing patient care to the mother of the still-born baby is not only coping with anxieties created by that emotionally charged situation, but he also has to think about the culturally accepted limits of caring and possibly negotiate his way with other members of staff. On this occasion, the doctor keeps to his defences and spends extra hours with the patient, without being criticised by his peers.

Well you know that when things get worse, they get worse and they get worse and they get worse. Ultimately what happened with her was that we tried all the induction of labour, we tried everything possible to get that baby out, by induction. And in her case with the induction, it failed as well... and I can't tell you how dreadful that scenario was, that she needed a Caesarean section to have that baby out... I wanted to make sure that I was present at the Caesarean section, as well so that she would have a face that she knows. Once she delivered, you know obviously I was there with her, with the [dead] baby in her arms, and she was happy from the point of view.... and thanking me every now and then, which I said that she shouldn't because it was my job and one should do it. But she kept signalling the fact that not many people would do it the way that I had and I that was very special.

Much hospital work contains a 'constant sense of impending crisis' (Menzies, 1960, p. 26) which creates pressure and anxiety. The level of predictability in medical work is low and – as the registrar expresses it – 'when things get worse, they get worse'. The doctor explains that he attended the Caesarean section for the patient's sake, but this could also be interpreted as his coping mechanism – the need for a closure (Mattingly, 1996: 37). If you only see trauma and dramatic events without closure, the events will stay lingering and cause anxiety, stress and possibly depression. The doctor needed to be there and needed to have closure to be used as a coping mechanism against accumulating anxiety. So far the patient had been in a powerless position while the doctor had presumably been in control of the situation and emotions involved in it. Therefore, when the patient thanks the doctor, he gets confused. The patient had survived through the ordeal and suddenly has the power to relieve the doctor's anxiety, to nurse him (Menzies, 1960). The acute physical and emotional stress is released and the doctor can reflect back on his experiences.

And I think that is something very, very special and dear to my heart. And these are those situations when you sit back and you reflect on your life and

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say, "wow I have done something good, really, really something good and it is wonderful".... I saw her every single day on the post natal ward and obviously I made a point not to neglect her, or neglect her partner because people assume that the only person going through the trauma is the woman who has actually delivered, but they are a couple, and that needs to be understood so that was important as well. And he appreciated that quite a lot. They went home, two weeks later, I did receive a lovely letter, which kind of expressed a lot of gratitude, for what I had done for them.

The thanking letter provides closure for a difficult story, but maybe also goes beyond this. It hints at redemption – instead of a medical tragedy possibly compounded by failure in patient care, the story becomes one of a victory or at least grace under fire, a positive example of the doctor's powers even when he cannot actually perform miracles by restoring life. Anxiety is successfully overcome by the absolution from the patient and the doctor's 'priesthood' (Elkind, 1998) is restored. The letter from the patient acts as the final seal to exalt the extra efforts the doctor put in to solving the problem (Menzies, 1960, p. 31).

I know that I put in extra hours and I KNOW that I shouldn't have been there but no-one complained, because everyone knew that I was helping a situation. It is just an understanding that we have. It would be a terrible job if you were only allowed to work your set number of hours.

A narrative like this one permits people to attach themselves to 'desirable' ends, think well of themselves in moral terms', 'support their needs for autonomy and control', and 'promote feelings of self-worth' (see Baumeister, 1986 in Brown, Stacey & Nandhakumar, 2008, p. 1054). By telling this, not an easy or comfortable story, as a proud moment of good patient care, the registrar restores his professional and personal integrity. There is no 'system' in this story to blame on, no failure to confess, but despite the drama the story draws to a happily-ever-after ending. The story has entailed a narrative for the self (Brown et al., 2008) that has released the anxiety the event contained.

9.7 Conclusions

Patient care is a process and a social construction and as such means different things to different people. Norms and styles of patient care also change across time and differ site to site not only because of differences in beliefs, but also because there are different possibilities (technological advancement, different types and mixes of professional groupings) and different types of constraints on what might be offered. It is not always possible to put a clear value judgement on patient care and one example is to do with 'length of stay'.

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Managers, whose concern is to ensure that beds are not blocked, may or may not be holding in mind the image of an organisation that shares care with agencies and families in the community. They may simply be responding to government targets. They may have their mind fixed on those waiting for beds who have still not received treatment. Patients themselves may want to return home as soon as they can or become bewildered when they are discharged rapidly after treatment.

Working in multi-disciplinary teams with distributed leadership patterns may have improved practices for clinicians. Accountability for patient care still resides with the consultant and the hierarchy who manage the Trust. While senior managers are responsible for ensuring patient safety and preventing negligence to individual patients, they are also responsible for ensuring access to care for the community which involves managing scarce resources such as equipment, pharmaceuticals, beds and staffing.

Not all clinicians appreciated or respected these pressures as we saw particularly in Chapter Six. Nor do patients necessarily agree that good care is anything other than good and consistent communication with specific clinicians.

As demonstrated in Chapters Six and Seven managers are frequently frustrated by demands from staff who may try to subvert managerial targets (set by government and as such fundamental to resourcing of the Trust).

The quality of leadership is intimately linked to patient care. Good patient care relies on effective leadership of the kind that engages with staff and imparts to them the vision that (as far as humanly possible) the patient comes first. That in turn impacts upon the climate, culture and ethos of the Trust. When leadership fails, so does patient care.

10 Leadership and patient care: Assessing the past and thinking of the future

10.1 *Introduction*

Without effective leadership at all levels of the NHS and its various organisations patient care suffers. This knowledge has been evidenced in

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several key studies across recent years as reported above and elsewhere and consequently fed into the NHS Qualities Framework (see Chapter One).

In this report we have critically reviewed the relevant literature on leadership exploring as far as possible the relationship between leadership, followership and service delivery across five hospitals comprising three NHS Trusts (see Chapter Three). We employed different research methodologies (see Chapter Two) to capture data to investigate leadership qualities and their interaction with the climate and culture of the organisation and linked these to service delivery and patient care in different settings (ranging from obstetrics and gynaecology and cardiology to care of the elderly).

10.1.1 The organisational contexts

The organisational contexts of each Trust and each site or unit varied physically, structurally and in 'atmosphere' (the full details are provided in Chapter Three). We have been concerned in the report (and future papers) to steer a path between maintaining anonymity and confidentiality and thus not overtly identifying a Trust or site within a Trust, while also pointing to how the contexts impacted on the practices of leadership and service delivery.

Overall the Foundation Trust (3) in this study, which had not been experiencing mergers or threats of closures, where staff morale was high and where leadership practices were distributed across teams and clinical and management specialties, was clearly the one most conducive to effective communication and leader-follower engagement. There was an 'atmosphere' of connection and pride in belonging to the Trust as evidenced explicitly in Chapters Four and Nine in particular.

Trust 1 was applying for foundation status during the time of the investigation but also threatened by closure of some of its units, and with the senior managers possibly being transferred to the other site which was perceived by the participants as a threat to their status and possibly to resources for service delivery. This did not happen during the course of the investigation. The managers in Trust 1 were committed to their staff and to service delivery although there did appear to be some discontent with senior management from the medical staff. This may have been because most of the distributed leadership involved non-clinical managers and nurse managers with the medical teams appearing to take a more 'traditional' hierarchical stance. Most of the data from the OCS was derived from Trust 1 which demonstrated among other things the importance of management support for identifying good leadership and patient care practices.

In Trust 2 there appeared to be the greatest amount of conflict between groups of staff who sometimes seemed to be leading in different directions.

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Trust 2 was perhaps the 'victim' of a relatively recent merger between two large hospitals (and one or two other smaller units) which were some physical distance apart and had had a different history – one being a DGH and the other a teaching hospital. The DGH appeared at first to have a professionally diverse group of senior managers who distributed their leadership to effect, but one or two figures emerged during the course of the study who transgressed this approach with one person taking a back-seat while another was trying to drive through change in a somewhat cavalier manner. Furthermore in this particular Trust there were changes among the senior managers (some left, others moved to the other site during the course of this study). The CEO also indicated that it was difficult to recruit good middle-range managers and nurses in particular because both sites were away from the centre of the city where most people would look for a promoted post.

10.2 *Limitations of the study methods*

As with any large scale and complex study such as this one not all of our intentions were achievable although some were satisfied beyond our expectations.

We had difficulties capturing data from patients for two main reasons (fully detailed in Chapter Three).

Firstly, the 'gate-keeping' staff working on the Units on a day-to-day basis (as distinct from those who supported overall access to the Trust overall) obstructed data collection.

Secondly, it was also difficult gaining access to patients while they were in hospital because of ward procedures and in other cases the poor health of patients. So in the end we managed to conduct ten patient interviews but were unable to collect organisational climate survey data from patients at all³⁸. To overcome this we gained permission to observe clinicians' interactions with patients in their care and we believe we have managed to do more than compensate, making a contribution to knowledge with important new material to demonstrate patient care in different contexts and the processes involved in patient care and service delivery (see in particular Chapter Nine).

We also met with difficulties, with one Trust in particular, collecting *survey* data from staff although individual staff members proved more than willing

³⁸ These difficulties were reported to SDO in the interim reports and also separately when they arose.

to support the researchers by allowing them to interview, observe and shadow them during their working days. *This is all reported fully in Chapter Three.*

10.3 *Reviewing the findings*

In this final chapter then we draw together the findings from the study and make suggestions as to how they might contribute to policy and practice beyond the participating organisations.

This chapter is organised around the original study aims which were about leadership, organisational climate (culture and context) and how they impact on patient care. The overall plan was to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery.

This research further sought to explore the following broad-based questions.

- First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
- Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?
- Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The specific aims and objectives are listed again below and we conflate these in what follows directing the reader to the relevant chapters.

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines, to patients;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts service delivery;

- To learn how different stakeholders (specifically patients, nurses, members of professions allied to medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care;
- To identify how the need for change in service delivery is identified and what drives the need for change.

10.3.1 How far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?

Throughout the participating Trusts there is evidence of the importance of high quality patient care. Chapter Nine in particular brings this together with quoted respondents emphasising that above all patient care matters to the aims of the organisation and those who work in it. Thus on a basic level, working for patient care is inspiring in itself and staff across the Trusts see good patient care as their *modus operandi*.

Our use of innovative ethnographic methods and story telling were particularly effective in providing the evidence of how patient-clinician relationships were practiced and how staff made sense of their own actions reflexively in the context of caring for patients³⁹.

Chapter Nine provided evidence of the ways in which care is practiced.

We begin here by summarising some of the evidence from the Foundation Trust in this study, which consistently appeared to demonstrate high levels of distributed leadership, emotional engagement and multi-disciplinary working across all levels. The data included several key examples of positive statements about the role and effectiveness of management. We saw, for example a senior clinical manager summarise the issue with reference to his

³⁹ For example, interviews opened with questions about leadership and patient care, and participants were then encouraged to tell 'stories and critical incidents illustrating their experiences'. The early parts of the interviews provided themes and indications of what the clinicians regarded as crucial to delivering good patient care, e.g. 'cleanliness', 'efficient administration', 'communication', 'empathy', 'sympathy', 'knowing the recent developments in your field' and 'everything behind the scenes the patients don't see'. However, it was the stories they relate to that provided us with insights into their core experiences of patient care (see Chapter Nine).

pride in working for the organisation drawing attention to its low mortality rates, and that the high quality staff and its reputation for patient care act to attract others at the top (or with the potential to be at the top) of their specialty.

By contrast, the CEO of one of the other Trusts had made the point in their interview that one of the difficulties they had was attracting high caliber nursing staff, partly because of their location (in the suburbs). In Chapter Four we identified the ways in which an organisation might be seen as a learning organisation as significant in supporting staff to develop their clinical and managerial skills and develop capacity for patient care. Where support for learning was apparent so was the enthusiasm and pride for the organisation and its goals.

What was striking was the way that all respondents who addressed this point were looking to see how patient care could be improved with aspirations that patients were satisfied with more than just the health outcome (although that is the bottom line) but also with the facilities and the atmosphere. In addition, several respondents made the point that they themselves were mindful of delivering (or at least aspiring to deliver) the type of care they themselves would want to receive.

That so many of the staff (clinical and non-clinical) worked long hours in which they were engaged in intensive work with either their clinical or management teams, or their caring for patients with the aim of delivering the best possible care, is yet further evidence of the ways in which patient care is inspirational.

What is most noticeable, however, is how some styles of clinical and managerial leadership appear wanting, when compared with the best. While some respondents are clearly excellent communicators who engage fully with their professional knowledge and with the patients and staff, others - equally expert and equally inspired to provide the best for their patients - seem to fall short in comparison. In Chapter Nine for instance, Cameron and Kenneth engage with their patients in human ways and there are examples in the chapter in which each clinician manages to gain important information from and for their patients by their hard work *and* their humanity. However, in Cameron's case he is supported by a team which has clearly been nourished and inspired by the organisational context (see references to Cameron's work in this report).

Kenneth, while equally able and empathic, from the ethnographic evidence reported in Chapter Nine, appears to be less able to transmit this or influence others to take up his brand of leadership and patient care. He remains slightly in the background while the younger and (it appears) more influential Henry sets the tone. The clinical team give the impression of

being business-like and impersonal and somewhat intimidating when they conduct their ward round. The culture being transmitted to the other clinical staff tends towards Henry's approach rather than Kenneth's. This raises questions about why this Trust and site is different from the FT in which Cameron and Mandy work. These matters were addressed in Chapters Six, Seven and Nine in particular and will be subjected to further analysis in subsequent publications. However the FT is established and settled. The Trust where Kenneth and Henry work was the product of a relatively recent merger and norms and values were still being 'negotiated' (see Chapter Seven and above in this chapter).

Subsequently we see Mandy working directly on a patient's wound not only acting humanely when she hurts the patient but working with the nurse to assess how they might best improve the patient's condition while caring for his mental state and self-esteem.

High quality care and inspiration come together through the ways in which clinicians and managers take responsibility for their work – for managing emotions (their own, their colleagues' and their patients'), teaching, making decisions about end of life care, communication with relatives and coping with everyday situations that raise anxiety levels for patients and staff. The story of the doctor in Trust 1 who cared for a woman with a still-born baby itself demonstrates how he went the extra mile (in his words) inspired by the possibility of providing care in a case where some might have tried to make minimal contact because a still-born baby might be seen as a clinical failure.

Overall emotional engagement with patients and followers leads to people working together in a human, humane and inspired way and impacts on the organisation itself which can become one with which people are proud to be associated.

10.3.2 How do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

This question underpinned the entire study, but specifically we reviewed the relevant research literature on leadership and organisational climate (Chapter One) and discussed this in Chapters Four through to Eight. We began by reviewing the results from the story-telling interviews, focus groups and ethnographic methods (observations and shadowing). A range of potential practices and behaviours were reported to us which suggested where problems might lie in current leadership practices, as well as what many respondents held to be ideal types. What we summarise now represents a combination of what works and what does not although it needs to be noted (as identified in Chapter Nine in particular) that what

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patients see as good leadership (that they received clear and consistent information from one or two key staff) may not always intersect with what staff meant by good patient care or effective leadership and service delivery. The latter was usually seen as best delivered by a well-functioning multi-disciplinary team albeit frequently constrained by limited resources.

The following issues stand out as good practice that could feed into NHS (and local Trust) policy:

Leadership is a complex concept meaning different things to different people. Over recent years leadership in changing contexts such as the NHS has shifted from the 'heroic' model where leadership is hierarchical to a model that is more distributed across different levels and different parts of the organisations. The heroic and hierarchical (related) models frequently depended upon individual characteristics and where the senior managers were indeed heroic and charismatic, leadership might well have led to good patient care. However, this is unreliable and unpredictable and the NHS Qualities Framework which has identified leadership skills is more appropriate to the context (see Chapter One).

Our most important findings, however, make it clear that leadership which is emotionally engaging and distributed is the one which is most likely to lead and support service delivery successfully as well as drive necessary changes.

At the end of Chapter One we focused on contemporary studies of leadership which promoted the importance of *context* and of taking a more discursive stance in the analysis of leader-follower relations. We also drew attention to the revival (and reappraisal) of concepts from organisational studies from the 1960s to the 1990s which took psychodynamic ideas into account and related them to more 'popular' contemporary ideas about the significance of social and emotional intelligence in leader-follower relations. Thus, we explored the ways in which stakeholder accounts of the experiences and exercising of leadership demanded an attachment or engagement at an emotional level, which took account of the unconscious as well as conscious understanding of these experiences. There were several examples offered in the previous chapters of leadership practices that delivered the required services or changes through different types of concerted action and those that didn't. In some cases we were able to show that with the best will in the world if the leader, for whatever reason, was unable to *engage* and thus be supported by the followers, then their leadership failed to deliver.

Recent analyses of distributed leadership styles and organisational contexts show that if such leadership is to work then people need to act and work together and be prepared to both take up and relinquish authority for

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certain tasks and roles at the appropriate intervals. We saw in Chapters Six and Seven for instance that authority is hard to maintain if a leader loses touch with their staff and fails to hold their own organisation 'in mind'. We used the OCS survey results in combination with the data derived from the interviews, focus groups and ethnographies to demonstrate the importance to a positive organisational climate of good leadership. Satisfaction with a manager was predicted by the same variables that identified a positive organisational climate. For staff in the organisations surveyed it was important that managers were committed, responsible and supportive of their staff/followers.

But how were these characteristics demonstrated? Leaders who were experienced as effective, supportive and emotionally engaged with their followers were able to communicate their vision and dedication to improving the quality of care to patients, which in itself co-existed with good staff morale. Such leaders were also good listeners as well as being able to take staff with them when less palatable or unpopular changes were mooted by senior management or government. These effective leaders were closely connected to the way the organisation was structured (physically and emotionally). They were thus able to access the information they needed in order to lead. The evidence for this frequently came from the stories and accounts of staff and observations made by researchers – often of good leadership but perhaps more acutely when leadership was poor. Then there was a jarring effect or mismatch between (local) policy and the attempt to drive changes to meet improvement targets. There was also evidence on occasions of senior clinicians' behaviours being disengaged. Sometimes attempts were made to subvert the senior people when leadership went against the grain. There are examples in Chapters Seven and Nine in particular.

A final comment here is that despite the changes in gender demographics at the top of clinical specialties in medicine, nursing and related professions, as well as in senior management, gender has not 'gone away'. Indeed distributed forms of leadership have (perhaps stereotypically but with some evidence base) been associated with women's behaviours. The OCS (Chapter Five) suggested that women's perception of 'recognition' for their work and achievements was more negative than that of men. Men were either satisfied with the recognition they received or less in need of recognition from their managers within the organisation than were women. In the qualitative data (see Chapter Eight) it was also the case that while senior women were keen to deny the relevance of being female to their professional lives and their career progression per se, women used different strategies and perceived their roles slightly differently than did men, although the point was well made by some respondents that feminine and

masculine choices of specialty may have been more significant predictors of management styles than gender itself.

10.3.3 Do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The contemporary NHS with its (mostly) distributed leadership practices at all levels tends to militate against the possibility of one person's vision being paramount. However, as suggested above in this chapter, there are nuanced influences of leadership style that (may) flow from one or two people's vision and/or style of leadership and patient care that influence organisational approaches.

In Chapter Seven, for example, we explored three senior people's visions and consequent behaviours to consider their authority and influence with the possibility that as opinion leaders they influenced organisational approaches to patient care. Quentin, for example, reflected his role as a senior clinical leader, and although there is no irrefutable evidence that his style was mirrored in the organisation itself, he does provide some evidence that in certain cases in relation to certain actions his vision had an impact on the overall organisational approach.

While the OCS (Chapter Five) captures data from a wider population, the ethnographic methods made a greater contribution to exploring how far an individual's vision influenced the organisations approach to patient care. Again in Chapter Seven we see Kerry battling against a resistant (and probably disillusioned for some reason) senior management team to improve discharge policy and meet government targets. She tries again and again (by her own account) to show her staff that they need to focus on targets because they will lead to improved care quality. She appears to fail (again according to her own standards) and expresses this by almost literally demonstrating that she is banging her head against a brick wall.

Differently with the same effect Gerald is introduced as having a clear vision for patient care in his Trust. However, his inability to take staff (at all levels of the organisation) with him in his vision is attributed in our analysis to his lack of emotional engagement and autocratic (verging on the authoritarian) style of management. His narcissism further ensures his inability to understand how his behaviour is impacting upon staff and he sees himself as having failed to win a 'fight'.

Chapter Six explores the organisation as an open system, and ways in which all stakeholders⁴⁰ hold a vision of the organisation in the mind at a

⁴⁰ Including patients but we cannot really speak definitively here due to lack of data.

conscious and an unconscious/emotional level acting accordingly. Thus, they have an image of the organisation (how well it is managed, how effectively it cares for patients), a sense of their own role and place within the organisation and how well the leadership understands the experiences of staff and patients. Recognition of the primary task, the roles and responsibilities of those who manage it and the (changing or threatened) boundaries of the organisation itself are critical concepts.

No doubt some members of the organisation have more personal and role/task related power and influence than others in the NHS Trust. Furthermore, the NHS as a system is fluid and dynamic, so that there is overall a group influence over the evolution of organisational context (climate and culture) which responds to visions from within and without (government, health care consumers) the wider system.

10.4 *What have we learnt from this study?*

10.4.1 How leadership relates to patient care

It is clear, from our empirical work and evidence from previous studies, that leadership is a process and set of practices which generally do not equate with the qualities residing in a particular individual regardless of their authority and formal role and status in the organisation. Leadership that 'works', as seen particularly (but not only) in the case studies in Chapter Seven, involves the person in the leadership role exercising social and emotional intelligence and engaging with their 'followers' (see Chapters One and Four) and offering staff recognition and support (Chapter Five). Moreover the role of leader is particularly effective when it is distributed among those who are best placed to exercise leadership towards the task in hand. So that in the context of an NHS hospital Trust, leadership might be exercised in relation to organising the administration for a unit, running an audit, or developing an innovatory clinical practice. Leadership in such contexts is time/project limited.

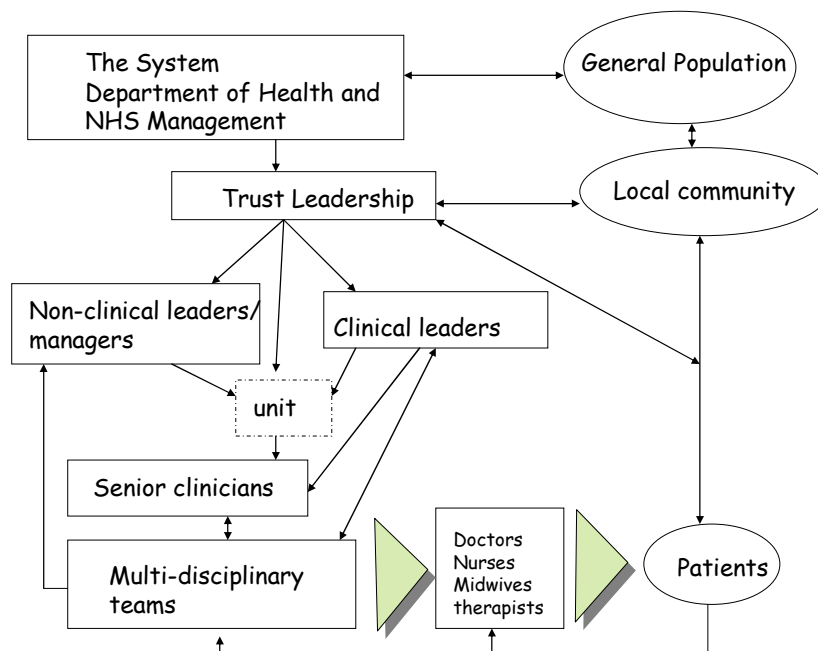
The primary task for NHS Trusts is to deliver a service to patients, as proposed in Chapter Six. All NHS Trusts operate as open systems with porous boundaries which enable change (planned and/or evolved). Leadership therefore can occur throughout the system at different levels including those of ward clerical and cleaning staff and the CEOs who 'manage upwards' and influence NHS/ Department of Health policy. Information of all kinds passes across the various boundaries not simply from the 'top' downwards.

Below in Figure 12 the relationship of the Trust leaders and patients within the NHS system is illustrated. It is also the case, as shown, that policy

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influences individual care, and the quality of that influence depends very much on the quality of leadership again across the system at all levels.

Figure 12. From the DoH to the Patient: An Open System



Patient care is represented here at three levels. The population who influence service delivery and patient care using their vote and/or lobbying through relevant patient groups, the local community who are served by a particular Trust and patients who are actively receiving medical treatment from individual clinical teams.

While on the whole it was the last group who were the main focus in this study some participants, particularly those in senior leadership/management roles, were concerned with service delivery at the local community and population levels. This sometimes meant that senior managers faced the dilemma of how to care for the community while attending to individuals and some individual clinicians were equally concerned about how their interactions with patients were influenced by some of the management dictates which derived from NHS policy that they

found difficult to understand (see Chapter Six and in 10.4.2. below for example).

10.4.2 Systemic dilemmas in patient care: Managing in the NHS

One participant had faced a 'dilemma' in wanting more face-to-face knowledge of patients in the community in order to be a more effective and informed leader, while also as his role required, attending to the demands of working within the wider system of the NHS:

As a chief exec in the NHS it was my privilege to make decisions. That was my privilege to go on and up the ladder. It was that I could go on and make faster and faster decisions. I get in the way I have always got in the way... the thing I would do is go out with the district nurse for the day, because I needed to be grounded in that. (Retired CEO)

Another manager who had previously had a military background advocated (along similar lines) that the best way to lead towards good patient care was to 'walk around' and support the leaders across the different parts of the organisation. In a seminar to clinical staff, which we attended and recorded, he drew participants' attention to the importance of *influencing* policy to achieving good patient care (at the population and community levels).

I hope some of you will find yourself in policy jobs at some point. Totally different, yes it still leads, but the actual process is so ... changing...both the chief executive and I spend a lot of time nurturing relationships which are partly to do with policy, but unless you get it right ... you communicate with them, it won't work.

In other words to be effective and to ensure the best for those in the Trust (staff and patients) a leader has to 'manage upwards' which gains influence. He continued by contrasting the experiences and perceptions of doctors with managers who lead at the macro level, drawing on the example of a recently qualified doctor. When the respondent quoted here asked this man about leadership in the NHS and how it impacts on patients he apparently answered:

'Oh I have got communication skills'. 'Blimey!' I said 'what do you know about the NHS?' And I asked him a couple of questions, nothing! But he hasn't been taught at an academic level about the context in which he is working. I think that is crucial and I know that is not how everyone does things. You know [doctors] keep people alive, but they really ought to have this basis of information about the context in which they are working.

While it is self-evident that the NHS is the context in which patient care is delivered, there is a tension between those who exercise leadership in that context and those who 'keep people alive'. In Chapter Seven, the frustration expressed by Kerry in trying to meet the demands of the government and community by improving the Trust's record of patient care, as well as motivate her senior staff to hold similar ideas, was palpable. From others' perspectives as shown in Chapter Six, there was evidence that 'management' was experienced negatively by several clinical staff when it tried to respond to Department of Health directives.

Managing the numbers

At another level of management good patient care was defined through achievement of returning satisfactory statistics, as this observational note of a meeting between capacity managers and clinicians suggests:

Patient care for the capacity managers appears to be a number crunching exercise. The need to get the patients in the right beds according to government targets meeting four hour waits and single sex bays. However because there is not a shortage of beds on this day, patient care moves from an exercise in numbers to thinking about patients in real human terms.

Sally (the capacity manager) talks about how better patient care can be delivered when there is less pressure on all the staff to meet their targets and get their job done. She talks about how [clinical] staff are then more able to talk to their patients and spend time with them. However, whilst reduced pressure means that for some, numbers translate into real people it is clear that in the capacity meeting that the role of the capacity manager is to think in terms of numbers and beds to deliver good patient care.

There is a potential conflict between the target driven service and the patient-clinician relationship which is about face-to-face contact. Perhaps this is well illustrated in Chapter Nine with the example of the 'grace in adversity' story, whereby the obstetrician spent extra time with a patient while his clinical colleagues turned a sympathetic blind-eye. The story of the patient 'Lola' also discussed in Chapter Nine who had been occupying a bed for three months with the tacit support of nursing staff would also have been anathema to staff responsible for managing targets about capacity.

10.4.3 Who judges what is good leadership and good patient care?

As shown above and throughout this report there is a tension throughout the system. The primary task of senior managers and leaders at and above the level of the Trust is to ensure the demands of the NHS and Department

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of Health leadership are met. These are policy driven with differing priorities at any particular time. The general population of (potential) patients has a keen influence on policy in different ways but particularly during local and general elections. For example the recent change from a Labour to the Coalition Government has raised questions about the role of 'targets' for future NHS priorities. Apart from other matters, finance makes a difference as to how priorities for service delivery are set.

Senior management at the Trust level is judged in a number of ways particularly related to how far the Trust meets the national priorities. However there is also pressure on CEOs and senior teams to get direct patient care and safety 'right'. This may be assessed through statistics as in the following example described by a senior midwifery manager:

Between 2002 and 2005 there were ten maternal deaths at [Trust], which exceeded the national figures. So the Healthcare Commission came in and reviewed a number of clinical organisational cultural governance issues, and then actually put the maternity services under special measures

There was a key number of issues then, and an action plan was developed, so actually I was newly appointed at that time, and there was a number of work streams that we had to work on, and it's never happened before, and I don't think its happened since in a maternity unit. So basically, even though that was a very sad event for all the families involved and very tragic for them, it was difficult for the staff, and obviously difficult for the Board in terms of reputation management. The whole action plan was implemented, the unit was turned around, and the special measures were lifted in 2006.

In this case there was a notable failure to deliver maternity care to the standards of safety prescribed by the NHS. Furthermore there was a failure of leadership perceived by this participant in terms of both 'culture' and 'governance' giving rise to the high proportion of maternal deaths and the consequent special measures. This participant also makes clear how much the staff themselves are influenced by events of this kind.

Another member of that staff team praised the changes at the top following these problems and combined the policy, context and face to face care in her assessment of the relationship of good leadership to good patient care:

.... the end goal for us, is ensuring the services we're providing.. the patients, are getting the best service from us on top of meeting all the Trust targets and the Trust strategy...for me really it's about ensuring that the patients are getting the best quality care, which, you know, I think they've got an improved quality of care here, with the team like mine who are here...and I think [leadership] is from the top down, so from Chief

Executive, right down to every level, to leaders in the ward, right down to our portering, to our domestics. Yeah, there certainly is, and we lead by example really don't we? and I think our chief exec, director of ops, deputy chief, they've all got good leadership skills.

Good leadership skills among senior managers can pay dividends in terms of reputation management. For example in August 2010 North Cumbria University Hospitals NHS Trust admitted a series of false positive diagnoses following breast cancer screening⁴¹. The CEO moved quickly to review the situation and apologise publicly. In other cases though, when there have been wrong diagnoses, neglect or medical errors over drug doses senior managers have been blamed for the failures - sometimes warranted and sometimes possibly not so (see below). Anecdotally it appears that leaders who are prepared to acknowledge problems as soon as they appear and deal with them in a transparent and effective way bring about improvements in service delivery and patient care in the ways perhaps that those who try to 'bury' problems might not achieve.

10.4.4 Leadership practices across the organisation

Leadership and patient care are intrinsically linked. Leadership is above all about taking responsibility but with changes in organisational structures, a growing emphasis on networks, open systems with porous boundaries, mergers and changes in the shape, structure and functions of Trusts, it is no longer tenable for leadership to be in the hands of a few. Leadership, then, is about a series of relationships and connections within and without specific organisational boundaries which have the potential for diffusing responsibility or sharing it, and therefore making leadership practices more co-operative.

It is important to focus, as we have done, on the many examples of good and excellent leadership we found within the three Trusts taking part in this study (each of which of course being hospital based and therefore not focused on the role of leadership in primary care). These sit in contrast to the examples of less effective and sometimes failures in leadership that we have cited. The differences crucially were about emotional attachment and engagement between leaders and followers. We did not meet any respondents who were disengaged with the aims of the NHS and none who were uncommitted to deliver the best patient care. But as evidenced above in the report and in this chapter, some leadership practices failed to take

⁴¹ <http://www.bbc.co.uk/news/uk-england-cumbria-10958423>

followers with them because of autocratic, insensitive behaviours and poor communication skills. Leaders need to be able to listen and engage – having a vision is not enough.

Leadership taking the importance of emotional engagement into account also needs to be transmitted across the organisation. This is best accomplished through making full use of individual skills. Clinical staff and managers can be effectively involved in specific change projects. These may be time-limited and/or specialism specific but collaborative concerted action is frequently the most significant way that a system might flourish with the staff taking responsibility and enhancing their sense of commitment.

10.4.5 When leadership fails patient care

The converse of good leadership is potentially catastrophic. The case of Beverly Allitt in the early 1990s, the nurse who murdered children in the Lincolnshire Hospital by injecting them with insulin, went relatively unchallenged because she was poorly supervised. Harold Shipman, a different case in that he was a GP in a sole practice, similarly was eventually thought to have committed over 200 murders of patients throughout his career. However, the report into his murders showed that doctors at Thameside hospital had failed to report suspicions about his prescribing⁴². The Alder Hey organs scandal involved the unauthorised removal, retention and disposal of human tissue, including children's organs during 1988 to 1995 and the Bristol Royal Infirmary inquiry about children's deaths during surgery resulted in doctors being struck off. All these cases represent a failure of leadership in which those who were responsible for patient care at all levels failed to identify and follow up on problems. More recently the independent inquiry into the Airedale NHS Trust, where the late Anne Grigg-Booth continued as night-nurse despite a high proportion of deaths of patients while under her care, identified 'a catalogue of systemic failures' whereby her dangerous behaviour was not spotted.

At the time of writing this report the Prime Minister David Cameron has ordered a full public inquiry into the events at Staffordshire hospital which have led to deaths of patients, it would appear in these cases, more due to negligence than intent. The Francis report which was published in 2009 found that patients were routinely neglected and there were systemic failings in patient care. Managers had been pre-occupied with cost cutting and meeting targets and unable to spot the build up of failures in patient care that were to cost several patients their lives. There were too few

⁴² These cases were subjected to inquiries which exposed a range of complexities which are not relevant here.

nurses, those who were employed were ill-trained, equipment was inadequate and experienced medical cover was not always available. It was a supreme failure of management and leadership. The Trust was poor at identifying when things went wrong and managing risk. Some serious errors happened more than once and there were higher levels of complaints compared with other trusts. Staffordshire was a foundation hospital that had managed to 'tick the boxes' although clearly there were a series of chasms between the clinical and managerial staff.

10.5 *Final thoughts*

By using innovative qualitative methodologies (described fully in Chapter Two) such as story telling, ethnographic observations and shadowing, to both supplement and augment data from interviews and focus groups, we have built up a picture of what happens in the daily lives of NHS staff working both with and as managers and in clinical teams. Using these methods provides opportunities to extend the scope of more traditional in-depth interviews and focus groups. The 'story', because it is chosen by the participant themselves, provides not only detail and depth but demonstrates the specific indices used by each interviewee to make sense of their own and others' behaviours within the organisational context.

The ethnographic observations, and the shadowing in particular, enabled the researchers to gain a sense of what 'a day in the life' of a member of the organisation *feels* like. They can 'experience' the interactions between staff, between staff and patients as well as the frustrations and pleasures of working in that Trust. No other method provides such acute insights. The subjective ingredients in this method enhance the process (i.e. as outlined in Chapter Two whereby the researcher themselves is the 'instrument' through which data is mediated). Moreover, and possibly conversely, the subjective elements are reconciled when the observation notes are discussed by other members of the research team, which again as discussed in Chapter Two is also a source of data (Czarniawska, 2008).

As a qualitative study, the success is proven by the richness of the data, showing the clear emotional connection participants had with the topics of both 'leadership' and 'patient care' (Lincoln & Denzin, 1994, p. 575). From this we were able to make sense of how leadership is experienced and exercised (see Chapters Four and then Six to Eight) and about the practices around patient care and service delivery that support patients to understand the relationship between their particular health-status, quality of life and the care and treatment they are receiving and/or expect (see Chapter Nine in particular).

The statistical analysis of the OCS⁴³ showed that, on the whole, the climate variables, 'support' and 'recognition' from managers and the system overall, predict 'satisfaction' with leadership and management. This reinforces the ideas expressed throughout the report that good practices by managers/leaders are about ongoing engagement with followers with concerted or conjoint leadership processes most likely to promote a sense of being supported and recognised (Roberts et al. 2005).

Thus we have not produced a list of 'good leader' qualities or a similar record of what constitutes 'good patient care', as these would fail to capture the crucial point that both leadership and patient care are experienced as a process. Thus this report aims to delegate *good practices* that were observed during the project, for the use and reflection of any staff member of the NHS – whether a leader, follower or patient.

10.6 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.

⁴³ As made clear above we were unable to capture corresponding data from patients.

- 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.

Appendix 1

Focus Group Questions

1. Leadership means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this hospital?

Prompts

1. Charismatic / Authoritative / Consultative / Directional / Varies – depends on situation/activity etc
2. Can you think of some incidents that sum up for you the way leadership is exercised in this hospital?

Follow-ups

1. Does this type of leadership operate throughout the hospital?
2. Could you give some examples of ways in which leadership is exercised in your team/the hospital
3. Patient care means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this organisation?
4. How important is patient care as a priority in the service that you and your colleagues provide?
5. What are your main priorities in ensuring a high level of patient care in this hospital?
6. Can you think of some incidents that sum up the way you and your colleagues try to deliver patient care?
7. To what extent is leadership reflected in the quality of patient care you and your colleagues provide?
8. Can you think of some incidents that sum up the way that leadership in this hospital approaches the issue of patient care?
9. Can you think of specific incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

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Follow-up

1. What would you suggest to improve this/these situations?
3. Stories and critical incidents
 - a) Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
 - b) Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
 - c) Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

Could you tell me about a time that made you feel disappointed with leadership in this hospital?

- In this unit?

Appendix 2 Interview Questions

Interview

*Introductions, background and experience in relation to patient care and leadership in the organisation

- The interviewees position/level
- Years at the hospital
- Role in the organisation

1. Leadership

'Leadership' means different things to different people.

- a. How would you define it?
 - Do you see that kind of leadership at this hospital? Why/not?
 - What about in this unit?
 - What makes someone a good leader/Qualities of a good leader? Can you give me an example?
 - Who here at work do you see as providing leadership to you personally? Why? Do you have a direct supervisor? Who? Do they have leadership qualities?
- b. Do you see yourself as someone who could be a leader?
 - Why/not?

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- Under what circumstances?
- c. Can you give me an example of leadership in this hospital?

2. Patient care

- a. Like leadership, 'patient care' means different things to different people.
 - How would you define it?
- b. Tell me about patient care in this hospital. How is it defined?
 - Are there differences between units? Tell me about them. Why do you think this is?
 - How would you improve patient care in the hospital?
 - How would you improve patient care in this unit?
- c. How do you [as a hospital worker, nurse, etc.] try to deliver good patient care?
- d. What do you think are some obstacles to delivering the sort of patient care you'd like to see? How could these obstacles be removed?
- e. Do you think leadership could improve patient care in this hospital?
 - Why/not?
 - Do you think that better leadership would improve patient care? Why/not?
 - How does good leadership influence patient care?
 - Has the leadership in this hospital improved patient care since you've been a member of staff? How so? Or why not?

3. Stories and critical incidents

- a. Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
- b. Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
- c. Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

- d. Could you tell me about a time that made you feel disappointed with leadership in this hospital?
- In this unit?

Appendix 3: Focus Group Questions: patients

1. Leadership means different things to different people. What does it mean to you as a patient of this hospital?
2. What is your opinion of the way leadership is exercised in this hospital?
3. Patient care means different things to different people. What does it mean to you as a patient of this hospital?
4. Can you think of some incidents that sum up the kind of patient care that staff in this hospital deliver?
5. Can you think of ways that leadership in this hospital could enhance the quality of patient care, as far as you are concerned?
6. Can you think of some incidents that sum up what else leadership could be doing?
7. Can you think of any other incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

Appendix 4: Staff Organisational Climate Survey

[attached separately]

Appendix 5: Participant Information Sheet

Leadership and Better patient Care: From Idea to Practice

Participant Information Sheet: Staff Interviews

You are being invited to take part in an interview study about leadership and patient care in three different hospital settings. Before you decide to participate in this study it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Contact me (see full contact information at the end of this sheet) if there is anything that is unclear or if you want to know more.

Take time to decide whether or not you wish to take part.

Thank you for reading this.

1. What is the purpose of the study?

The purpose of this study is to try to identify the circumstances under which leadership can be an effective engine for change in the organisation of health care, especially for patient care and service delivery. Although we suspect that leadership motivates workers and affects the climate or atmosphere of the places where people work, leadership can mean different things to different people. The same is true of patient care which can also mean different things to different people. In order to understand how leadership inspires health workers to provide better patient care, we want to learn how nurses, doctors, other medical professionals as well as managers and patients define and understand leadership and patient care. This includes exploring how their perceptions mesh or conflict with one another. It also includes listening to stories of important incidents that describe their experiences of leadership and patient care.

2. Why have I been chosen?

As part of the study we are interviewing staff (clinical, managerial and others) as well as patients to examine what leadership and

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patient care mean to them. You have been chosen as someone whose views represent the views of staff.

3. Do I have to take part?

No

4. What will happen to me if I do take part?

You will participate in a tape-recorded interview with a qualified researcher, which will last under an hour.

5. What do I have to do?

Arrange a mutually convenient time to have the interview.

6. What are the possible disadvantages and risks of taking part?

It is possible that the discussion may stir up distressing feelings you have regarding your organisation, its leadership and the patient care it provides. However, care will be taken to prevent this and you are free to leave the interview at any time. Apart from that, the only disadvantage is that you will be giving up some of your time.

7. What are the possible benefits of taking part?

This study may not directly help you but it is part of a serious initiative to improve the quality of leadership and patient care provided by the NHS.

8. Will my taking part in this study be kept confidential?

Yes. All data will be stored in locked filing cabinet in a locked office. It will be made anonymous and all names will be edited out of the transcripts. Only members of the research team will have access to the data.

9. What will happen to the results of the research study?

They will be published in a report to the funder and also presented in peer reviewed papers and conferences. A copy of the report will be provided for each participant who requests it.

10. Who is organising and funding the research?

The study is funded by the NHS Service Delivery and Organisation (SDO) Research and Development Programme of the National Institute for Health Research (NIHR) Programmes. The NIHR has been established as a part of the government's strategy Best Research for Best Health to provide the framework that will position, manage and maintain the research, research staff and infrastructure of the NHS in England. The study is conducted by a group of researchers from Royal Holloway University of London led by myself, which won the grant following a competitive bid.

11. What if I have any concerns?

If you have any concerns or other questions about this study or the way it has been carried out you should contact me (details below) or you may contact the hospital complaints department.

Contact for further information

Professor Paula Nicolson, Head of Department, Health and Social Care
Royal Holloway University of London, Egham, Surrey, TW20 0EX

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Appendix 5: Consent form (generic)

Title of Project: Leadership and Better Patient Care: From Idea to Practice

Name of Researchers: Emma Rowland Paula Lökman

Please initial each box

☐ I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

☐ I understand that some coded extracts from the interviews may be used for the purposes of the research report and academic articles.

☐ I give my consent for quotations to be used in the report and research papers on the understanding that I will not be able to be identified by the use of these in any way.

☐ I agree to take part in the above study.

Name of participant

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Date

Signature

Appendix 6: Patient Organisational Climate Survey

Thank you for agreeing to participate in this study which as you will know is part of a larger study on leadership and patient care in the NHS.

The following questions explore how NHS patients feel about the care they received and how things generally worked in the units where their care was managed.

The survey is anonymous, so please do not put your name on the survey.

If, however, you would like to receive the final results of the survey when the study is completed, please fill in the tear-out form on the questionnaire's last page and submit it to the researcher or the collection box.

It is important that you answer all the questions. This should take you approximately 10 minutes.

Your individual responses will be kept strictly confidential.

Researchers

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Department of Health and Social Care
Social Care
Royal Holloway University of London

Ms Emma Rowland

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Please circle one number that best describes how you feel for each question in relation to the service provided by your NURSE.

1. I feel understood by my nurse.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

2. I am able to be open with my nurse at our meetings.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

3. My nurse has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

4. My nurse encourages me to ask questions.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

5. I trust my nurse.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

6. My nurse answers my questions fully and carefully.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

7. My nurse deals very well with my emotions.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

8. I feel that my nurse cares about me as a person.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

9. I don't feel very good about the way my nurse talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

10. My nurse tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

11. The way my nurse interacts with me influences my perception of quality care.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

12. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

Please circle one number that best describes how you feel for each question in relation to the service provided by your DOCTOR.

13. I feel understood by my doctor.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

14. I am able to be open with my doctor at our meetings.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

15. My doctor has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

16. My doctor encourages me to ask questions.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

17. I trust my doctor.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

18. My doctor answers my questions fully and carefully.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

19. My doctor deals very well with my emotions.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

20. I feel that my doctor cares about me as a person.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

21. I don't feel very good about the way my doctor talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

22. My doctor tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

23. The way my doctor interacts with me influences my perception of quality care.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

24. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1 2 3 4
strongly
disagree

5 6 7
neutral

strongly
agree

25. What would improve the quality of care you receive at this hospital?

26. What services are you using within this hospital?

Demographic Information

27. In which year were you born?

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28. What is your marital or civil partnership status?

- ☐ Single
- ☐ Co-habiting
- ☐ Married
- ☐ Divorced

29. How many children do you have?

30. How would you describe your ethnic background?

31. What is your current salary?

- 1. Less than or around £20,000 per annum
- 2. Between £21,000 and 39,000 per annum
- 3. Between £40,000 and £59,000 per annum
- 4. Between £60,000 and £99,000 per annum
- 5. Above £99,000 per annum

Thank you again for your time. If you have any questions please speak with the researcher or alternatively you can contact Professor Nicolson.

I would like to receive the final results of the survey when the study is completed

Name:

Address:

Contact Telephone:

Please return this form to either the researcher or the collection box.

Appendix 7: Appendices for Chapter Five

[attached separately]

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⁷ There is a parallel ongoing debate as to whether university leaders should be drawn from outside academia.

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.

Leadership and Better Patient Care: Managing in the NHS

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Executive Summary

The NHS National Leadership Council Website¹ (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)

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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.

Leadership and Better Patient Care: Managing in the NHS

1 Leadership, organisation and the NHS

1.1 Leadership

What is currently known about leaders and leadership? The ongoing attempt to identify the characteristics necessary for effective leadership over recent years has been described as an 'obsession' studied more extensively than almost any other characteristic of human behaviour (Higgs, 2002; Tourish, 2008). Alimo-Metcalfe, Alban-Metcalfe et al. (2007) in their comprehensive review of the literature, show that formal studies of leadership date back (at least) to the beginning of the 20th century. They propose, that despite changes in the way leadership has been studied and the underlying epistemological stance taken by the researchers, *"in all cases, the emphasis has been on identifying those factors that make certain individuals particularly effective in influencing the behaviour of other individuals or groups and in making things happen that would not otherwise occur or preventing undesired outcomes"* (p. 2). As *"many have pointed out, that in spite of the plethora of studies, we still seem to know little about the defining characteristics of effective leadership"* (Higgs, 2002, p.3). Even so this has not appeared to quell the appetite for pursuing an ideal of leadership, impelled by the changing demands of organisations echoed across public sector institutions such as the NHS. These changes are in part the result of technological advancements which impact upon clinical practices, demographic changes both of which have altered the strategic, structural and financial profile of health (and social) care (Tierney, 1996).

The tantalising questions remain though about what those factors might actually be and the significance of the context to 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).

But in addition, or conversely, the context, culture, climate and/or structure of an organisation each have an impact on the performance of the people who lead in it (Carroll, Levy, & Richmond, 2008; Goodwin, 2000; Michie & West, 2004).

Focusing on the relationship(s) between 'leadership' and context has revitalised contemporary research particularly through the development of qualitative research, discursive and social constructionist epistemologies (Grint, 2005; Uhl-Bien, 2006) although it is unclear at this stage how far a connection might be developed between this research and its applications, for example in health care services (Fambrough & Hart, 2008).

In what follows in this chapter we explore the changing ways in which leadership has been conceptualised over the past fifty years, particularly focusing on how it has and *might* be operationalised in the NHS (particularly although not exclusively in a *hospital* context) .

1.2 Background and introduction to the study

The NHS Modernisation Agency Leadership Centre (NHSMALC) website³ had originally suggested that effective leadership is a key ingredient in modernising today's health care services. In its own words:

Effective leadership and management in the healthcare system are key drivers in patient experience. Governance and good environments matter to patients, their visitors and carers and staff.

But how might effective leadership be achieved and sustained? The NHS Leadership Centre commissioned a number of leadership initiatives (Larsen et al., 2005). The NHS Institute for Innovation and Improvement (2005) *NHS Leadership Qualities Framework*⁴ emphasised the *situational* nature of leadership and indicated the circumstances under which different leadership qualities will take precedence.

These comprise fifteen contextualised qualities covering a range of personal, cognitive, and social characteristics arranged in three clusters which are set out in Figure 1:

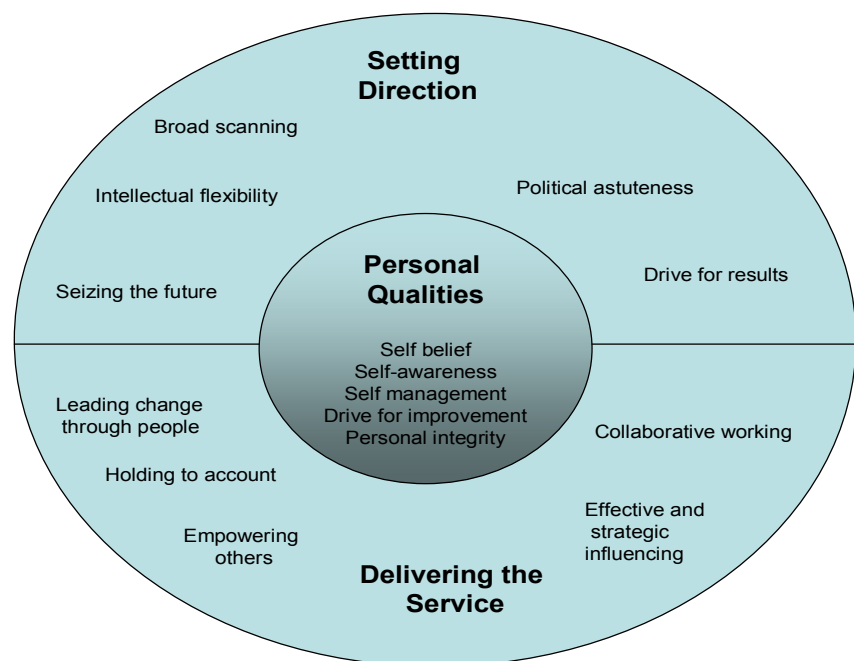
³ <http://www.dh.gov.uk/en/managingyourorganisation/leadershipandmanagement/index.htm>

⁴ <http://www.nhsleadershipqualities.nhs.uk/>

- *Personal Qualities*
- *Setting Direction*
- *Delivering the Service*

Thus, a competent leader enables development in an organisation that is goal directed, geared to developing processes and systems and enables staff at all levels to plan effectively and efficiently towards agreed goals (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Figure 1. The NHS Qualities Framework



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However, these same authors underscore the point that there is something beyond leadership competency that needs to be addressed, particularly in a changing and complex context such as an NHS Trust. *That is that a leader is someone who encourages and enables the development of an organisation in a culture based on integrity, transparency and valuing others. Leaders also need to question, think critically as well as strategically* (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Since the publication of the *NHS Leadership Qualities Framework* in 2005 all efforts have been directed to recognising and discussing leadership qualities and making strides towards their implementation. In 2008 Clare Chapman, Director General of the Department of Health's Workforce declared:

*Leadership is all about creating value for customers and citizens whilst also making work worthwhile for staff. This sounds incredibly straight forward - but it requires courage and resilience, and commitment throughout the entire piece*⁵

David Nicholson the CEO of the NHS in the report *Inspiring Leaders: Leadership for Quality* (January 2009) building on Darzi's *NHS Next Stage Review*⁶ stated:

It is imperative that we align what we are doing on leadership with what we want to achieve on quality. This is what I call leadership with a purpose.

Over the past year, the Department of Health has worked extensively with the NHS and other stakeholders to determine how best to foster talent and leadership development, and it is clear that there is a great deal of enthusiasm for a more systematic approach.

Spotting and developing confident leaders is a priority for us all if improving quality is our shared purpose. This guidance represents our best collective thinking to date. I invite you to use it and contribute to its improvement as we learn how to bring leadership centre stage over the coming months.

Nicholson and his team have charged the Strategic Health Authorities with finding gaps in leadership and systematically nurturing talent across the whole of the NHS. Clearly, the enthusiasm of successive senior officers in

⁵ DH_083353.

⁶ www.dh.gov.uk/en/Healthcare/Highqualitycareforall/index.htm

government and the NHS has been to link effective leadership with good service delivery and patient care as the primary outcome.

1.2.1 Leadership and Better Patient Care in this Study

This rhetoric and confidence about the type of leadership that best suits the NHS from those who lead it gave us pause for thought (Milewa, Valentine, & Calnan, 1998; Mueller, Sillince, Harvey, & Howorth, 2004b). 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 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 aims were overall to seek out the meanings and perceptions of relationships between (effective) 'leadership' and (better) 'patient care' and how leadership is transmitted across organisations to impact upon service delivery, taking account of the mixed methods and specific social science and systemic approaches that the investigatory team proposed. This inevitably has brought certain issues to the fore and (possibly) obscured others.

Our starting point therefore was to hold the NHS model of leadership in mind while calling on our own specific strengths as academics, from a range of social science and methodological backgrounds, to take a cross section of Trusts, clinical specialties, services, staff grades and patient needs, and to observe the *processes of leadership* in everyday working life. From this we proposed it should be possible to determine the ways in which leadership, NHS organisations and patient care were socially and discursively constructed so that links between leadership and patient care might be explored.

In Chapter One we outline some of the important contemporary social science and organisational thinking on leaders and leadership and explore the links between this and the NHS perspectives.

In Chapter Two we set out the innovative methodologies employed to investigate and analyse the research questions. This is followed in Chapter Three with the detailed procedures used for data collection.

The results are presented across four separate chapters. Chapter Four provides the analysis of what leadership means and how it is experienced by staff and patients (Christensen & Laegreid, 2003; Fairhurst, 2005).

Chapter Five presents the results of the Organisational Climate Survey (OCS) (Stringer, 2002). In Chapter Six, open systems theory and the concept of the 'organisation in the mind' are introduced particularly focusing upon the transmission of leadership across organisations. The relationship

between leadership, authority and emotion is discussed in Chapter Seven and in Chapter Eight the role of gender relations and their impact on leadership are reviewed (Begun, Hamilton, Tornabeni, & White, 2006; Ford, 2010; Telford, 2007).

Chapter Nine covers definitions, explanations and experiences of patient care and particularly how it relates to leadership by NHS staff and patients (Begun et al., 2006; Disch, Edwardson, & Adwan, 2004).

Finally in Chapter Ten we summarise our findings, make recommendations and draw conclusions.

Appendices provide copies of the research instruments, additional statistical results and the relevant NRES information.

1.3 Theoretical Approaches to leadership

Leadership research and theory is prolific with the consequence that numerous, frequently overlapping, models of leadership are available to agencies attempting to analyse or train leaders (and indeed managers, as until relatively recently little distinction was made between these two categories, see e.g. Kotter, 1996). Over the past fifty years leadership theories have shifted through different points of focus from the 'trait (or 'great man') approach in the 1940s, through the 'behavioural' perspectives in the 1950s whereby some styles of behaviour were seen as being more or less influential on potential followers. Then since the 1960s and 1970s the focus has been upon 'situational' leadership based mostly upon Fiedler's 'contingency' theory which proposed that different leadership styles were needed for different situations (see Alimo-Metcalfe, Alban-Metcalfe, et al. 2007; Western, 2008 for further details). During the 1970s and 1980s leadership research, albeit prolific, had reached an all time low in terms of its perceived contribution to theory and added value to knowledge for practice, so that as Cummings (1981 p. 366, quoted in a review by Bryman, 2004) asserted:

As we all know, the study and more particularly the results produced by the study, of leadership has been a major disappointment for many of us working within organisational behaviour.

Bryman unpicked the implications of the phrase Cummings used "as we all know" noting that it was "simultaneously sweeping and damning" (2004, p. 730). Bryman also picks out Miner's (1975) suggestion for temporarily abandoning the concept because of its limited utility in helping us understand organisational behaviour. *Why had leadership research reached this nadir during those decades? Why has there been a more recent upsurge of interest in leadership again almost to the point of saturation?*

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Bryman in his review suggests, that the renewed confidence and interest in the study of leadership has come from improved measurement and analytic techniques, greater use of meta-analysis so that more systematic reviews could be compiled, the emphasis on *transformational leadership* and *charismatic leadership* which have provided a fulcrum for the area of research, more and better cross-cultural studies and greater diversity in the types of leadership and organisational contexts that have been studied.

A factor that may also have contributed to the idea that leadership research continues to be fruitful is that a greater diversity of methodological approaches have been added and Bryman's review specifically focused on the value added by qualitative research.

Towards the end of the 1980s and beyond, thinking about the meaning(s) of leadership came to take greater precedence than in the previous two decades, possibly because of a perceived dearth of leadership *per se*.

These deliberations cast light onto the:

- *interactions between leaders and followers* and organisational cultures (Avolio, Gardner, Walumbwa, Luthans, & May, 2004; Lewis, 2000; Schilling, 2009)
- the *management of emotion* (George, 2000; Lewis, 2005; Pescosolido, 2002)
- the *processes* of leadership (Collinson, 2005; Dopson & Waddington, 1996; Vangen & Huxham, 2003)

Even so, or perhaps because of the use of qualitative approaches and related conceptualisation, Alvesson and Sveningsson (2003) were able to entitle a recent paper arising out of their study of leadership in a research and development company: "*The great disappearing act: Difficulties in doing 'leadership'*".

By this they meant that during their study they were able to identify how the existence of the label 'leadership' led to an assumption that the concept had an empirical reality. However the results of their work indicated that leadership might be better explained as a *process or series of processes of interaction*. This conclusion raises questions about mainstream thinking on leadership which presumes observable and possibly measurable characteristics (Alvesson and Sveningsson, 2003, p. 361; see also Ford, 2010).

Most recently there has been reconsideration and development of ideas about leadership in context taking account of the relevance of some earlier studies of organisations (e.g. Lewin, 1947) and open systems theories (see

Chapter Six; Laughlin and Sher, 2010) and new epistemological positions (e.g. Ford, 2010).

In our study, as a consequence of these recent critiques of leadership research and the result of methodological innovation, we approached the concept of 'leadership' as not necessarily a property of one individual (although it can be) or of one specific role, such as Clinical Director or a service manager, but rather we identified leadership as a *process* occurring within a group, organisation or collectivity that *imagines, wills and drives change* (Gabriel, 2004; Gronn, 2002).

1.3.1 Dimensions of Leadership and their Value for the NHS

Leadership, *as a practice*, has been on occasions constructed as 'a beautiful or rarefied ideal' an idea which has little use in the real world particularly as it has been suggested there are at least 350,000 definitions of leadership in the academic literature (Pye, 2005; Tourish, 2008; Western, 2008). *The question for this report is how to identify the literature on leadership and organisation with the most relevance for the contemporary NHS.*

Most discussed in theory and in practice over the past two decades has been the idea of *transformational leadership* (Bass, 1985) a model to explain ways in which a leader can be identified or trained to demonstrate the qualities that enable her/him to *perform beyond expectations*. The phrase 'transformational leadership' was coined originally in 1973 by Downtown but did not gain impetus until 1978 when Burns published his book, *Leadership*, which highlighted the *relationship* between leaders and followers (Burns, 1978).

Until then, as shown above (see Bryman, 2004) there had been little by way of a breakthrough in applicable knowledge. Burns (1978) demonstrated a *psychological* difference between an exchange relationship - where followers respond to leaders because of rewards they might receive - and one in which they respond to leaders who transform their attitudes and behaviours through inspiration and/or charisma (Bass, 1985; Yukl, 1999; Rafferty and Griffin, 2004). Transformational leadership then, is concerned with emotions, values and ethics, standards and long term goals which include assessing followers' moves and satisfying their needs (Currie & Lockett, 2007; Day, Gronn, & Salas, 2006; Eagley & Johannesen-Schmidt, 2003; Northouse, 2004).

Recognition that transformational leadership is not simply an individualistic model but one that *teams* can display (Day et al., 2006; Gronn, 2002; Sivasubramaniam, Murry, Avolio, & Jung, 2002) has shifted the

concentration from individual leaders per se to a more diffuse and distributed model of leadership and organisation context.

1.3.2 What constitutes transformational leadership?

Bass (1985) highlighted several characteristics of *transformational* (or *transformative*) leadership that allow followers and leaders to achieve far beyond their expectations. These are not discrete categories but given the significance placed upon the ideas behind transformational leadership in the scientific and training literature it is worth outlining the basic ideas behind these characteristics/types which have been identified as:

- Charismatic leadership
- Inspirational motivator
- Intellectually stimulating leadership
- Considerate leadership

Charismatic leadership

Bass (1985) proposed that "*charisma is a necessary component of transformational leadership*" (cited in Yukl 2002, p.261) and that charismatic leaders are endowed with exceptional personal qualities that attract followers. Charisma, a word derived from the Greek, means "*divinely inspired gift*" and is thought to give people the ability to perform miracles or predict the future (Yukl 2002, P. 241).

It is for this reason that charismatic leaders are often regarded as "*visionary, a futuristic, or a catalyst for change*" (Murphy 2005, p. 131; see also Bass 1985; Bennis & Nanus, 1985). Due to their rare personal qualities charismatic leaders are able to convey their visions to their followers in a clear and concise manner allowing them to visualise what they could achieve in the future if they worked together towards a common goal. As the leader's vision is normally realistic yet optimistic, it empowers the followers granting them greater self-esteem, encouraging and inspiring them to achieve the vision (Bennis & Nanus, 1985; Northouse, 2004; Yukl, 2002).

Inspirational motivator

Through their charisma, transformative leaders have the ability to inspire their followers through words of profound wisdom, or at least is what is *perceived* to be profound wisdom, such as with the case of Jim Jones⁷ in the USA or more positively President Obama who has reformed health care and banking legislation in the USA against the odds. Transformative leaders are

⁷ In 1978 Jim Jones persuaded more than 900 members of his People's Temple in Jonestown, Guyana to commit mass suicide.

excellent communicators which allow them to turn their visions into reality. Many use emotional and optimistic speeches to inspire their followers. They usually lead by example and often become role models to their followers who are in awe of their moral and ethical character. Many followers try and emulate their leaders' good qualities and are confident that their leaders will make just decisions on their behalf leading them to a prosperous future (Kellerman, 2004; Rafferty & Griffin, 2004).

Intellectually stimulating leadership

Transformational leaders have the ability to captivate their audience making the most mundane speeches and events interesting. They encourage their followers to be innovative, challenging the status quo and their own values and beliefs (Northouse, 2004). They also encourage their followers to solve problems and take an active role in the organisation, thus enhancing their self-worth and self-esteem, increasing their job satisfaction and productivity.

Considerate leadership

Transformational leaders are often also considerate leaders who are adept at performing mentoring or advisory roles to support their followers' emotional needs (Hiller, Day, & Vance, 2006; Rafferty & Griffin, 2004). Such leaders listen carefully to their followers' needs and desires, empathising with them during difficult periods. Being empathetic also builds a strong bond between leader and follower and thus a strong reciprocal relationship (Simpson & French, 2005).

It is important to note though, despite the wide take-up of transformational leadership as a conceptual model and a *practice*, that there remains uncertainty about the ambiguity of subdivisions and distinctions between elements in the model. Theoretical distinctions between 'charisma' and 'inspirational motivation' have become blurred over time and some theorists have suggested that elements of transformational leadership might also be identified as *transactions* (see Rafferty and Griffin, 2004 for a discussion of the implications).

Further concerns have been raised about how transformational leadership can take place in organisations, particularly public service ones, which are constrained by government initiative and targets and localised regulatory and normative pressures (Currie & Lockett, 2007; McNulty & Ferlie, 2004). However, it may also be that professional staff (rather than leaders/managers) in contexts such as health care, may in fact be more transformational than might be predicted because of their long-term commitment to the organisational goals (McGuire & Kennerly, 2006).

Most recently the notion that transformational leaders are very much 'engaging' leaders has been proposed (Alimo-Metcalfe, Alban-Metcalfe et al, 2007; Alban-Metcalfe & Alimo-Metcalfe, 2009; Macy & Schneider, 2008).

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One further comment here concerns the role of *gender* in styles of leadership and its consequent impact on organisational transformation (Fletcher, 2004; Mandell & Pherwani, 2003). There is evidence that (whether displayed by a woman or a man) feminine styles of leadership may be more related to engagement, emotional and social intelligence and distributed leadership, which may be important for complex organisations such as the NHS (see below).

1.4 Leadership, organisation and emotion at the turn to the 21st Century

Models of leadership and organisation theory have evolved over time and leadership and organisational structures and cultures are intrinsically linked in the literature. Leadership, if it is to motivate, innovate and move organisations to change, has to have an *emotional dimension* and, thus, effective leaders have a clear *emotional agenda* (as well as a strategic and structural one) which is particularly acute in services such as the NHS which is working to serve people's health care needs (Ashforth & Humphrey, 1995; Bolton, 2000; Pye, 2005).

Exploring organisations and leadership at the level of 'emotion' has become contested territory, as recognition, that organisations and their leaders need to take account of emotional engagement (Alban-Metcalf & Alimo-Metcalf, 2009; Vince & Broussine, 1996) at all levels of the work place, has emerged. Prior to the 1980's, organisational literature had been dominated by cognitive orientation (George, 2000) which favoured the rational, 'masculine' and scientific explanations of organisations and their leaders. This notion therefore ignored the (so called) irrational and 'feminine' characteristics of emotion, which were deemed detrimental to productivity and success. At that time emotions were regarded as the culprits that distort an individual's perceptual and cognitive faculties and therefore should be kept under control (Alvesson & Sveningsson, 2003b; Clarke, Hope-Hailey, & Kelliher, 2007; Dasborough, 2006; de Raeve, 2002; Ford, 2006).

As social and occupational psychologists began to study the effects of positive and negative moods on decision making, job satisfaction, choice of work-based activities and organisational climate, however, (Isen & Means, 1983; Rafaeli & Sutton, 1987, 1989) 'emotion' as part of organisational life gained impetus once again. This resurgence coincided with leadership theorists studying how moods and emotions could effect the quality of leadership (George, 2000).

It is possible to trace a rough trajectory from the 'hard nosed' scientific management, with the organisation perceived as a 'machine' in the early twentieth century, through towards a more humanistic, emotional and

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sometimes even spiritual way of thinking about contemporary leadership and organisational metaphors towards the twenty-first century, all of which are potentially transformational, not simply to the individuals concerned, but to the organisational dynamics.

Hochschild's (1983) *The Managed Heart* has been credited with being one of the earliest examples of research into emotions and organisational settings (Ashkanasy, Hartel, & Daus, 2002). She looked particularly at the airline industry and how airline cabin crew managed their emotions for dealing with difficult passengers and to promote a particular airline image. She termed this emotional management '*emotional labour*' (Hochschild, 1983).

Since this publication, the study of emotions in organisations has increased (Ashkanasy et al., 2002) with academics concentrating on key concepts such as emotional labour, emotional intelligence, mood analysis and Affective Events Theory (AET) and most recently a return to psychodynamic understanding of organisations and groups (see Ford, 2010; Schwarz, 1990). Since the 1990's a plethora of literature has emphasised the role of emotional concerns in private sector organisations such as the airline industry (Hochschild, 1983; Taylor & Tyler, 2000; Tyler & Abbott, 1998), service sector (Crang, 1994), merchant banking (McDowell & Court, 1994; Pugh, 2001), law (Harris, 2002) and image consultancy (Bryson & Wellington, 2003; Wellington & Bryson, 2001).

However, emotionality in the public sector was mostly neglected until 2000's when a surge of literature began to be published analysing the NHS (Allan & Smith, 2005; Bolton, 2000; Cummings, Hayduk, & Estabrooks, 2005a; Hunter, 2005; Lewis, 2005; McCreight, 2005; McQueen, 2004; Michie & Gooty, 2005; Michie & West, 2004; Smith, 1992) and the fire service (Archer, 1999; Scott & Myers, 2005; Ward & Winstanley, 2006; Yarnal, Dowler, & Hutchinson, 2004).

1.4.1 Emotional labour, leadership and patient care

Hochschild differentiates between emotional labour and emotional work or 'face-work' (Goffman, 1967). Emotional work has been described as the effort we put into presenting and representing our feelings as well as into feeling what we ought to feel (see Fineman, 2003). For example, a person ought to feel happy at a wedding and sad at a funeral and if their emotions do not match these expectations then a person must perform emotional work to display the appropriate emotion. This is sometimes difficult as people struggle to disguise their true emotions and perform the socially acceptable emotion.

When a person's emotions are appropriated and performed for commercial gain it is known as *emotional labour*. Hochschild states that emotional labour occurs in many occupations. However, she believes it to be more

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prevalent in service industries, such as the airline industry, where workers' emotions are sold as part of a commercial package⁸. Employees working in service industries must be skilled at managing their emotions and facial expressions in order to project the correct emotion to the customer (Crang, 1994; Lewis, 2005). This often means that employees have to suppress their own emotions in order to perform and display emotions that are suitable for commercial gain and in alignment with the organisations' image (McDowell and Court 1994).

Surface acting allows the employee to make up an outward gesture (Hochschild, 1983), to perform emotions that are not actually felt. In contrast, deep acting means that the employee can suppress or become estranged from their true feelings and *actually feel the emotions* that the employer wants them to display. *"One finds that the performer can be fully taken in by his own act, he can sincerely be convinced that the impression of reality which he stages is the real reality"* (Goffman 1990, p.28).

In the NHS, positively managed emotions *could* lead to better patient care, greater patient satisfaction and a relaxed and professional organisational climate (Amendoldair 2003; Bolton 2003). Lewis (2005) highlights how nurses in a special care baby unit appropriately managed their emotions to create a professional organisational climate, in which to offer quality patient care to special needs babies and emotional support to their parents. Lewis suggests that a nurse's job is sometimes very stressful and emotionally destabilising, especially when a baby dies. Nurses need to be conscious of their own emotions and regulate them to prevent causing further distress to the parents by displaying a professional demeanour (Bolton 2001).

However, managing emotions in this way, particularly if they are not felt, comes at a psychological and emotional cost and the whole process would be problematic without attending to emotional intelligence.

1.4.2 Emotional intelligence, leadership and patient care

The 'discovery' of emotional intelligence (EI), despite on-going valid critiques (see below) marked a turning point in contemporary organisational theories and approaches to leadership because of the tradition that emotions represent a threat to rationality – a view that has been widespread particularly in North America and North Western Europe (Fambrough & Hart, 2008; Western, 2008).

⁸ For a critical analysis of Hochschild's dichotomy of emotional labour and work see Bolton 2000 and Bolton and Boyd 2003.

Mayer and Salovey (1995), who conceived the idea of emotional intelligence, defined it as the ability to manage and understand one's own and other people's emotions in a consistent way so as to reflectively promote emotional and intellectual growth. Goleman (1996; 1998) who popularised the concept, identified emotional intelligence as a set of competencies, redefined and restated by George (2000) as follows:

- The expression and appraisal of emotion
- Enhancing cognitive process and decision making
- Emotional knowledge
- Managing emotions

These characteristics appear to have much in common with the rhetoric of transformational qualities of leadership although in many ways EI has become a management 'tool' rather than a critical model. To this end (apparently) Goleman (Goleman, 2000; Goleman, Boyatzis, & McKee, 2001) focused on 'styles' and 'performance' which seem far away from the 'heady' descriptions below of qualities of emotional intelligent leadership, which refer to feelings, empathy and creativity.

The expression and appraisal of emotion

An emotionally intelligent person will be able to understand their own and others' feelings and able to empathise, which may enable them to be manipulative for better or for worse.

Enhancing cognitive processes and decision making

Having emotional intelligence allows a person to use emotion to be creative, solve problems, make decisions and flexible plans for themselves and on the behalf of a group. An emotionally intelligent leader will be able to judge their mood and make decisions accordingly. If the person is in a negative mood this may mean choosing to wait until such negative episodes have past in order to make a comprehensive decision.

Emotional Knowledge

Emotionally intelligent people understand how other people may be affected by their negative moods and therefore may take care not to spread bad feeling around the group.

Managing Emotions

Many leaders are able to manage their followers' emotions as well as their own, but as indicated below, developing the qualities required to manage emotions effectively is highly complex and more about processes than style or performance (Fambrough & Hart, 2008; Hughes, 2005). As Fambrough and Hart argue 'emotional intelligence' has passed into common use among organisational leaders with little recognition of the way it has been identified

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as problematic. *What has been so attractive about EI to leaders in health care organisations?*

The idea of emotional intelligence captured the imagination of some training NHS staff as a means to improve staff relationships and enable clinicians to empathise with their patients (Allan & Smith, 2005; Cummings et al., 2005a; McQueen, 2004; Amendolair 2003, Luker et al 2002). McQueen (2004) reflecting on the 1960's when health care workers were encouraged to hide their emotions from their patients, for the sake of maintaining a professional role, suggests that in recent decades this view of nursing has changed and health care workers frequently display emotions to illustrate their commitment to patient care (Williams 2000). McQueen suggests that emotionally intelligent nurses are important for building strong patient-nurse relationships (Conger and Kanungo 1987 and (Lewis, 2005). Nurses with high Emotional Intelligence are able to build rapport quickly with their patients through communication and interactive skills (Schutte et al 2001).

McQueen (2004) also states that "*emotional labour calls upon and engages*" emotional intelligence (2004, p. 103). In order for patients to feel cared for nurses have to constantly *perform* positive emotions and behaviours such as warmth, friendliness and consideration. However, when confronted with a 'difficult' patient nurses may experience negative emotions such as frustration, irritation or anger. The nurses must be emotionally intelligent enough to identify their emotions and then perform emotional labour to submerge the negative emotions in favour of more positive emotions (Bolton 2003).

While EI *per se* needs to be understood more critically (Fambrough & Hart, 2008), the introduction of emotional management and engagement by leaders (and others) in health care organisations needs further scrutiny (see below); despite the best efforts of some management gurus emotion is a fact of personal, interpersonal and organisational life particularly when considering what it means to deliver patient care.

1.4.3 Beyond emotional intelligence

Interest in EI has continued to grow among management and organisational academics with a focus on how to measure it – the conclusions generally indicating the need for caution in measures to predict or to establish baselines for its development among managers (Conte, 2005). The conflation of managerial skills as listed by Mintzberg (Mintzberg, 1973) cited in Riggio and Reichard, (2008) which included the ability to 'deal' with subordinates, 'empathize' with top-level leaders and establish and maintain social networks, alongside managing emotions as a leader, have come to be known as 'people skills'. These are clearly represented in the NHS leadership qualities framework and vital for managing in any organisation (see Figure 1).

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1.4.3.1 Social intelligence (SI) and leadership

In 2006, taking account of advances in neurological psychology, Goleman (Goleman, 2006) proposed that because humans are *designed* for social connection, rapport and supportive emotional interactions enhance performance of managers and leaders. He listed these qualities under the umbrella of 'social intelligence' and identified four dimensions:

- *Synchronization* – whereby matching moods lead to a sense of rapport
- *Attunement* – listening fully
- *Social cognition* – understanding how people interact
- *Social facility* – finding it easy to interact with others

While some people have little difficulty meeting these criteria and mastering their social intelligence, others (such as Narcissists, Machiavellian and Psychopathic types), Goleman argues, do not have the capacity for social intelligence, and thus he proposes a means of *selecting* effective leaders by testing these qualities. This model albeit individualistic has something to offer through extending the theoretical underpinnings of 'people skills' and emphasising the importance of taking followers and colleagues seriously in decision-making.

Following EI and SI in bringing management/organisational theories together with developments in psychology, particularly cognitive neuroscience and evolutionary psychology, is the reconsideration of the role of intuition in understanding leadership and organisational behaviours (Sadler-Smith, 2008). Sadler-Smith brings the idea of the 'gut feeling' into the foreground to explore the influence of this sense upon decision-making particularly under pressure (e.g. many emergency clinical decisions rely on the clinician's instinct of whether the patient should be operated on, admitted to hospital, whether to call for support).

It seems that while there is a continuing trend towards an evidence-based understanding of leadership, success there is also an emergence of features of human life that are difficult to explain and measure, although all the proponents cited above stick to the view that these characteristics are scientifically explicable and measureable despite challenges from both positivist and critical social constructionist positions (Ashforth & Humphrey, 1995; Conte, 2005).

1.4.3.2 Affective Events Theory (AET)

AET predicts that specific features of work (e.g. autonomy) have an impact on the arousal of emotions and moods at work that, in turn, co-determine job satisfaction of employees. AET further proposes that job satisfaction is

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an evaluative judgement that mainly explains cognitive-based behaviour, whereas emotions and moods better predict affective-based behaviour. The results support these assumptions (Jürgen, van Rolf, Fisher et al., 2006). Ashkanasy et al (2002) suggested that AET has two important messages for leaders in an organisation.

- Followers' emotions are heavily influenced by their leaders' emotions and therefore leaders must minimise the 'hassles' that they place on their followers in order to increase job satisfaction and performance. Short-term negativity can be tolerated without much impact on the team or organisation.
- However, if negative events persist it will affect followers' moods leading to negative emotions, poor performance, reduced job satisfaction and in the case of the NHS, (possibly) to poor quality patient care. It is therefore suggested that leaders need to give followers positive feedback regularly to "*ameliorate the daily hassles experienced by employees*" procuring positive behaviours such as team spirit and self-worth (Dasborough 2006, p. 165 ; Weiss & Cropanzano, 1996). The connections between the moods of individuals and their performance may be understood better in terms of emotional engagement between leaders and followers on both conscious and unconscious levels (see below).

1.5 Distributed leadership

The academic study of distributed leadership, that is when at various levels leadership (or influence) behaviour, identity, role and responsibility are distributed to more than one individual or group of individuals, has been at the forefront of much social scientific leadership research over the past ten years (Buchanan, Addicott, Fitzgerald, Ferlie, & Baeza, 2007; Day, Gronn, & Salas, 2004; Gronn, 2002; Mehra, Smith, Dixon, & Robertson, 2006a). The implication of this interest in distributed leadership is, that organisations have changed and previous models - including the charismatic, 'hero' leader and the 'command and control' organisational structures - are dysfunctional in a context where organisational change is rapid and diversification of strategic leadership and management essential (Butterfield, Edwards, & Woodall, 2005; Dent, 2005; Goodwin, 2000). In a competitive, diverse and divergent environment leadership needs to be distributed, in order to enhance democratic governance, thus enhancing legitimacy and increasing survival chances (Currie et al., 2009).

Distributed leadership also implies that organisations where it is practiced have (relatively) flat hierarchies with diverse service needs and expertise across all sectors of the organisation (Huffington, James, & Armstrong, 2007). This model applies to hospitals and primary care settings, where

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distinct professional groups each have their own standards of excellence, while at the same time sharing goals of competence and quality related to the service they provide to patients and how they interrelate to other organisations.

With this shift in focus of many leadership practices and leadership studies the definition of such leadership has been proposed as:

".. a status ascribed to one individual, an aggregate of separate individuals, sets of small numbers of individuals acting in concert or larger plural-member organisational units" (Gronn, 2002, p. 428).

Gronn suggests also that when leadership is distributed it may be that the duration of that influence is limited, perhaps (structurally) to a single project and therefore (psychologically) distributed leadership might mean having to 'give up' leadership as well as take it up (Huffington et al., 2007). Furthermore, according to Gronn (2002) the most common understanding of distributed leadership, witnessed by the growing number of references to it in the research and policy literature, is that it applies to numerous people across an organisation taking some degree of a leadership role or responsibility.

More importantly, Gronn identified distributed leadership as *concerted action* meaning that there are many roles comprising a 'leadership complex' with at least three potential forms:

- *collaborative modes of engagement* which arise spontaneously in the workplace. This suggests that leadership practice is 'stretched over' the context of the organisation and not a function of those in managerial roles such as matron or clinical director. However, if the matron, clinical director and other colleagues who share ideas for change or particular activities they *may "pool their expertise and regularise their conduct to solve a problem after which they may disband"* (Gronn, 2002, p. 430).
- the *intuitive understanding* that develops as part of a close working relationship among colleagues. These relationships tend to happen over time when organisation members come to rely on each other and develop a close working relationship, to solve problems or bring about change and others might be involved in a 'framework of understanding'.
- The variety of *structural relations* and institutionalized arrangements which constitute attempts to regularize distributed action. Thus, for example, if there were dissatisfaction with existing arrangements for particular practices, a team of 'equals'

might emerge to find ways to improve or change the problematic practices.

All of these are apparent particularly, but not exclusively, in Trust Three (the FT) as exemplified in Chapters Four and Nine in particular.

Gronn argues the importance of examination of these different forms of concerted action to understand where influence (and thus leadership and power) might lie in any organisational context. Emotionally, however, these different models of distributed leadership suggest the impact of these structures and practices at a deeper level (Gabriel, 2004) particularly around authority (Halton, 2007; Hirschhorn, 1997) competition (Morgan, 2006) rivalry and envy (James & Arriba, 2005; Stein, 2005)

1.6 Organisational Culture, Climate and Contexts

As introduced above, post-industrial (or even 'post-modern') organisations (Burrell, 1988; Fineman, Sims, & Gabriel, 2005) and networked (Balkundi & Kilduff, 2006; Goodwin, 2000) organisations are changing rapidly and the NHS is clearly among these. Changes in the NHS take place at a number of levels, emerging from the direct policy dictates from central government to become local initiatives. Moreover, the NHS has become increasingly team (and indeed multi-disciplinary team) based over the past two or three decades so that knowledge, influence and leadership for transformation and change are not only moving from a top-down to bottom-up model, but as indicated, to a distributed model which involves lateral influence (Begun et al., 2006; Day et al., 2006; Ferlie & Shortell, 2001).

The type of leadership that is supported and promoted in any organisation and the related concept of the organisational structure depends on and impacts upon organisational climate and culture.

Although research undertaken on organisational *climate* and organisational *culture* comes from different epistemological traditions, since around 1990 the literature and concepts referring to both have been overlapping and/or complementary (Schneider, 1990; Schneider, 2000) and increasingly the terms are used interchangeably (Ashkanasy et al. 2000).

It is, however, generally accepted that 'climate' is a logical extension of what was originally conceptualised as 'psychological' climate, that is, shared psychological meanings in an organisation; so that *organisational* climate is an aggregation of those individual perceptions of a work-place context (James, Choi et al. 2008).

Organisational culture on the other hand has its origins in anthropology and human relations (see Davies, Nutley and Mannion, 2000; Scott, Mannion et

al. 2003). Organisational psychologist Edgar Schein's (1985/2004) ideas about organisational *culture* as a pattern of *shared basic assumptions that have worked well enough and adapt to the external environment and serve internal integration*⁹, is one of the most frequently quoted definitions. Schein takes a systems theory approach to understanding organisations and his work has been built upon by himself and others to develop a variety of typologies which underpin measures of both organisational culture and climate (see Albino-Metcalf, Alban-Metcalf et al. 2008 for a comprehensive overview of this literature).

Organisational climate, with its origins in traditional psychology is *typically* "... the only domain of organisational research that simultaneously examines perceptions of jobs, groups, leaders, and organisational attributes and thus has the unique capacity of being able to decipher common denominators and latent relationships that are not available to those who study only specific domains such as perceived equity" (James et al., 2008, p.27). We therefore made a decision to use a measure of *climate* as a backdrop to this mostly qualitative study, in order to 'triangulate' with our findings on leadership and patient care.

However, we found a competing strand of interest in the measurement of organisational *culture* (e.g. Davies, Nutley and Mannion, 2000; Scott, Mannion, Davies and Marshall, 2003) which more frequently seems to attend to health care settings than studies of climate albeit with some notable exceptions (Dawson, Gonzalez-Roma, Davis and West, 2008).

1.6.1 Emotion and the unconscious in organisations

Organisational climate and/or culture cannot be discussed without acknowledging that organisations are places where both the intellect and emotion are called into play in order to achieve organisational goals and as we have made clear, emotions are intrinsic to service delivery and leader-follower engagement in the NHS. Emotional engagement, while available to human consciousness, also takes place at an unconscious level (Gabriel, 2004; Hugh, 1986; Lyons-Ruth, 1999; Morgan, 2006; Willmott, 1986), and anxiety or stress is particularly salient when having to care for and make potentially life-saving decisions for patients (James & Huffington, 2004; Menzies¹⁰¹¹, 1970).

⁹ A paraphrase.

The ideas that characterise transformational leadership models, such as 'charisma', 'influence', 'inspiration' 'thoughtfulness' and 'consideration', have intellectual roots beyond contemporary management theory and training. They are more closely related to group and organisational theories with late 19th and early 20th century origins (De Board, 1978; Gabriel, 2004) from which much contemporary organisational theory has emerged.

The first significant attempt to analyse group behaviour made at the start of the 20th Century by Le Bon (1917/1920) whose book *The Crowd* illustrated his observation that individuals in a large group can demonstrate a 'collective mind' which emerges when people are bound together in some way. McDougall's book *The Group Mind* (1922/2009) and Sigmund Freud's *Group Psychology and the Analysis of the Ego* (1921/1922) also focused on what would subsequently come to be recognised as unconscious group processes. Freud developed Le Bon's and McDougall's ideas in the context of psychodynamic theory, arguing that the binding force of the group derives from the *emotional* ties of the members, which are expressions of their libido or drive.

Studies of (and human 'experiments' about) group psychology, taking some of this perspective on board, flourished after the Second World War conducted and further developed by psychiatrists in the newly formed NHS. In Britain the work of Wilfred Bion, Tom Main, Maxwell Jones and others led to innovations in both group psychotherapy and the study of organisations. Bion's work on group relations and dynamics which contributed to the development of the Group Relations Training Programme (GRTP) at the Tavistock Institute in 1957 evolved into the Leicester Conferences with other organisations using this model across the world (Miller, 1993). However contemporary knowledge and understanding continues to reflect back upon this early work.

What was learnt during this period about group dynamics and group relations represents an important dimension in the understanding of contemporary organisations and the relationship between leaders and followers. We develop this further in Chapter Seven in particular. It is important to note how the intellectual journey from work on emotional labour to social intelligence and intuition has so far largely neglected to explore the extent to which unconscious processes remain part of the emotional context of human social interaction (Allan and Smith, 2005, p. 21).

¹¹ Isabel Menzies is sometimes referred to as Menzies-Lyth. Her work has been reprinted several times with each name used.

In a hospital environment it is inevitable that negative events such as death occur (see Lewis for discussion on the impact of death on nurses in a special care baby unit taking an 'emotional labour' approach). When death does occur nurses may display emotions (consciously and unconsciously) such as anxiety and fear (Allan & Smith, 2005; Obholzer & Roberts, 1994; Allan 2001; Smith et al 2003). Obholzer asserts that "[he] believes that many of the organisations' difficulties that occur in hospital settings arise from a neglect of the unconscious psychological impact of death and near-death on patients and staff" (1994, p.171). He explains that hospitals are sites where anxieties about social taboos such as death are *contained*, that is that staff and the organisation overall takes away the anxiety and the responsibility for care from the relatives. Patients and staff are socialised to believe that hospitals are institutions where illness is treated and that medical knowledge and practice is infallible. This is illustrated by patients who contend that doctors possess God-like qualities and have the ability to heal all ailments. When death does occur, medical staff and the patient's relatives may feel *duped* by the institution they believed would save their loved one.

At the turn of the 19th to the 20th Centuries psychoanalytic ideas were seen to have something new and important to say, not only about the psychology of the individual and the role of the individual unconscious, but about *unconscious processes when people converge in groups and crowds* as shown above. From psychoanalytic theory we take up ideas again today specifically about the relationships which exist between followers and leaders, made explicit in the paradigm shift from transactional to transformational leadership. Working together and accepting or resisting influence comes not only with an observable set of behaviours and measurable emotions, but with unconscious and 'secret' ones including dependency, envy, power, anger, authority and emotional contagion, which may be either conscious or unconscious but have important consequences for behaviours (Burke et al., 2006; Simpson & French, 2005; Stein, 2005; Whitely, 1997). In Chapter Seven for example we see examples of where two senior managers find themselves unable to influence despite their senior roles, legitimacy and operational power. As Gabriel (2004) has argued "*emotions are no simple side-effects of mental life*" as "*emotion lies at the heart of human motivation*" (p.215).

One key feature of caring for sick patients, managing change and the social context of the NHS Trust then, is the ways in which clinicians and managers manage their anxiety which is fundamental to working in any health care setting. In the section that follows below, we demonstrate how psychoanalytic thinking explains how individual psychology and unconscious defence mechanisms link to the ways in which human beings work in groups and organisations.

In Chapter Nine we attend in more detail to the anxieties involved in obstetrics and more generally on the emotions involved in care of the elderly. In anticipation of these we present the theoretical material in some detail immediately below in this chapter.

1.6.2 Clinicians' anxiety and patient care

To conceptualize anxiety we draw on object relations theory, the branch of psychoanalysis associated with Melanie Klein (1959) and, in particular, the work of scholars who applied object relations to an understanding of groups (Bion, 1961) and organisations (Jaques, 1952; Menzies, 1970; Klein, 1987; 1983) hypothesising that an infant responds from the earliest time to the withdrawal of the maternal breast by experiencing a powerful anxiety of a 'persecutory nature'. Being unable to grasp the separation from the breast intellectually, the infant, unconsciously, feels as if every discomfort were inflicted by hostile forces. A fundamental *splitting* takes place, whereby an object is experienced as two separate objects, one entirely good and one totally bad. Thus there is a good breast (which is always present and nourishing) and a bad breast (withdrawing and denying), a good mother and a bad mother.

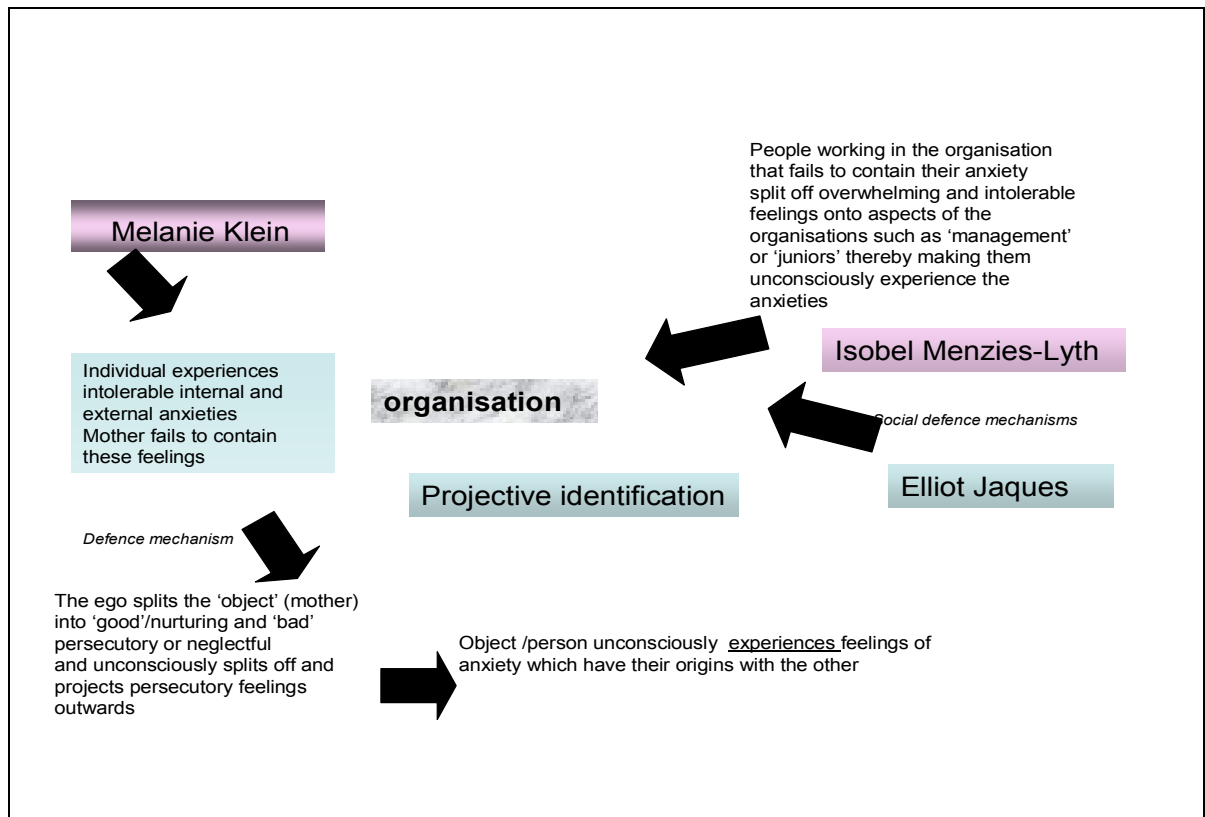
This is a pattern repeated in clinical settings, where patients routinely refer to a 'good nurse' and a 'bad nurse' and, almost identically, clinical staff referred to some patients as 'a good patient' and to others as 'a bad patient' (see Chapter Nine for an example of this). Splitting according to Klein extends in the child's own self – those aspects of him/herself that she cannot bear are projected outwards ("It is not I who is angry/fearful/envious; it is you"). Again this is a phenomenon observed many times in clinical settings. Frustration, discomfort and pain are experienced as persecution from hostile forces and their concomitants (e.g. hate) become destructive impulses which *are still operative in later life*, especially in times of stress and crisis.

Splitting and projection then are seen as fundamental *defences against primitive anxieties* by the object-relations school of psychoanalysis. Within this tradition, objects are not external entities but are shaped by phantasies¹² and feelings, they are *introjected* and projected, they split into good and bad and they constantly define and re-define the ego (or self). Object relations theory has found numerous important applications in the theory of organisations, primarily through the works of Jaques (1952) and Menzies Lyth (1960; 1970) in the UK, and more recently, Hirschhorn (1988), Gould (1993), Diamond (1993), Schwarz, (1990), Schwarz and Clore (2003) among others. Notable among these applications is the

¹² 'Phantasies' spelt in this way refers to those in unconscious experience.

treatment of *the whole organisation as an object which is liable to become incorporated in psychic reality* and towards which the individual may develop relations akin to early relations with significant objects from her environment and hold the 'organisation in the mind' (Armstrong, 2005) which we will discuss in more detail in the context of evidence from the study in Chapter Six.

Figure 2. Social Defences against Anxiety in Organisations



Menzies-Lyth, whose 1960 classic study of nursing staff occupies a privileged position in this literature, was driven by her initial observation that nursing work is highly anxiety-producing. She argued that nurses confront many different emotions from patients and their relatives - gratitude for the care they offer, admiration, envy for their skills and resentment stemming from forced dependence. Such projections create strong feelings in the nurses themselves:

The work situation arouses very strong and mixed feelings in the nurse: pity, compassion and love; guilt and anxiety; hatred and resentment of patients who arouse these strong feelings; envy of the care given to the patient. (Menzies-Lyth, 1988 , p. 46)

Faced with such an emotional cauldron, many nurses re-experience infantile persecutory anxieties, from which they seek to defend themselves, through

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the familiar mechanisms of projection, splitting and denial. Menzies-Lyth's important contribution was to establish how an organisation's own bureaucratic features, its rules and procedures, rotas, task-lists, paperwork, hierarchies and so on, in short '*the system*' acts as a support for the defensive techniques. By allowing for 'ritual task performance', by depersonalizing relations with the patients, by using organisational hierarchies, nurses contained their anxiety. Yet, in Menzies-Lyth's view, such organisational defences against anxiety were ultimately unsuccessful:

The system made little provision for confronting anxiety and working it through, the only way in which a real increase in the capacity to cope with it and personal maturation would take place. As a social defence system, it was ineffectual in containing anxiety. (Menzies-Lyth, 1991, p. 363)

The system's inadequacy in Menzies-Lyth's study is evidenced by its failure to train and retain nurses, the chronically low morale, high levels of stress and burn-out and absence of work satisfaction. By contrast, institutional health is testified not only by performance and output indicators, but also by morale indicators, and individual feelings of growth and maturation. Social defences against anxiety, then, are self-defeating. Instead of *containing* anxiety, they exacerbate it, just as neurotic symptoms far exacerbate the patient's malaise instead of containing it. Since Menzies-Lyth's pioneering work, some attention has been paid to how to support nurses and enable them to contain their emotions, without resorting to depersonalizing social defences. Yet, there is ample evidence that many nurses today continue to struggle with modest support against powerful anxieties (Theodosius, 2006; 2008). It is striking that no single study has sought to examine whether doctors face similar types of anxieties as nurses, whether they resort to similar psychological defences and the extent to which these defences function effectively across different individuals. In Chapter Nine we see evidence that doctors too appear to react similarly when faced with intolerable anxieties.

1.7 Developing our approach to leadership and the NHS

Studies of leadership and organisations such as the NHS clarify that diverse disciplinary perspectives have come together and separated more than once over the past century. The relationship between organisational and social context over that time has impacted on both practices of leadership and empirical and theoretical changes. In the 21st century the rules of scientific management or leader as therapist no-longer apply, and the rapid changes in organisations such as the NHS brought about by economic and technological imperatives, have left many who engage in leadership

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discourses, for practical and academic purposes, moving between the transformational and the post-heroic positions.

We now consider theoretical perspectives, ideas and practices that can potentially be brought together to good effect in this study for the benefit of patients and those who work for their good within the NHS, focusing on some of the recent debates which explore the context of leadership and the place of distributed leadership as they apply to NHS contexts.

1.7.1 The base-line:

- It is now widely acknowledged that organisations, their leaders and followers come together in a highly *emotional context*. How can those who lead and work in such organisations take account of the role of emotion while not being 'emotional' (i.e. making unfair and irrational decisions)? Understanding this is vital for enabling management and leadership particularly in a complex institution which has patient health, safety and care at its cutting edge (Morgan, 2006) .
- The NHS, individual Trusts and Units within these Trusts are constantly engaging staff in *change* (which may be evolutionary and/or politically driven) and which may be motivational and/or stressful or resisted (McNulty & Ferlie, 2002). This further demands emotional and social intelligence and engagement from leaders and followers (Bovey & Hede, 2001).
- The primary *tasks* and related *roles* might conflict at various points as these changes impact emotionally and intellectually on staff performance and service delivery (Zoller & Fairhurst, 2007).
- Organisations have to have leaders but leadership is not necessarily always the province of a small group of individuals but depends on the structure and demands placed on the organisations and the tasks required at any one time (Currie et al., 2009; Day et al., 2006; Harvey, 1989; Michie & West, 2004).
- An emotional context requires attention to both conscious and *unconscious* dimensions of human interaction and power relationships which may come into play in organisations which comprise multiple professional disciplines, different grades of role and people from diverse cultures, sexualities and gender (Ford, 2006; Gabriel, 2004). Acknowledgement of the importance of anxiety, envy, competition, anger and the emotional ties between people needs to be taken into account (see Figure 3 below).

Two models of leadership are therefore examined in this study (see Figure 3 below):

- First, *inspirational and transformative (or engaging) leadership* which has attracted much recent attention in that its absence was seen as a critical factor behind the failure of many organisational innovations. In this approach, leadership hinges on leaders' ability to communicate effectively, relate emotionally with their followers and develop a vision that is both attractive and achievable. The role of transformational leadership then is to lead an organisation towards change and thus some elements of transformational leadership are essential for understanding the practices and needs of the NHS (Alban-Metcalf & Alimo-Metcalf, 2009).
- The second relevant dimension is *distributed leadership* (sometimes called *dispersed, distributive, collective, or supportive 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). A *distributed leadership* approach is consistent with Bailey and Burr's (2005) research on successful NHS Trusts, which states:

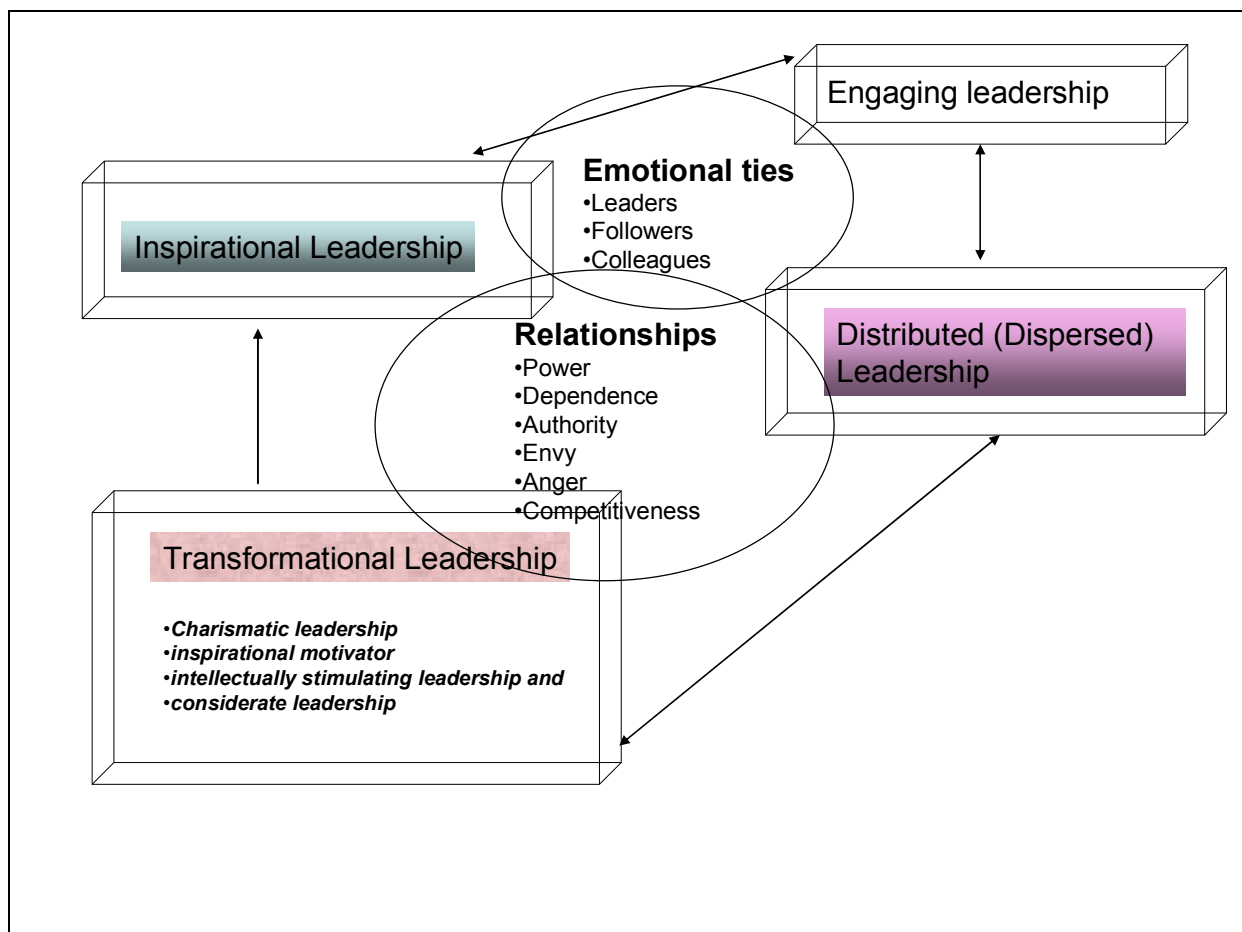
In contrast to the individual, heroic leader concept, leadership is seen in terms of the influence processes that contribute to the collective and individual capacity to work effectively. This idea of collective and distributed leadership is closely associated with the emergence and special requirements of 'new' organisational forms generally and the NHS in particular it is consistent with the agenda for devolved decision – making, empowerment of the frontline, de-centralisation, inclusion and such initiatives as 'Leadership at the Point of Care'.

Thus, distributed leadership is seen by Bailey and Burr (2005, p. 14) as directly linked to patient care.

A combination of these two models might now be seen as 'engaging' leadership as described by Alimo-Metcalf, Alban-Metcalf et al. (2007) and this combination will be explored further in our analysis of the (qualitative) data in particular.

Furthermore the model of the post-industrial/postmodern and or networked organisation will be 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).

Figure 3. Leadership Styles, Followership and Emotion



1.8 Conclusion

In an organisation like the NHS there are opportunities for leadership at all levels, as well as opportunities for success and unforeseen consequences leading to failure. Leaders in the NHS are involved *transformationally* in responding to policy initiatives and government demands, but the NHS is also an organisation that relies on the knowledge, skills and abilities of all its people – leaders and followers.

It would seem that *transformational/engaging and distributed leadership* are particularly useful conceptual resources to deploy in the context of the National Health Service, where a workforce of different ethnic, cultural and

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class backgrounds caters to the needs of a similarly diverse patient population.

Following Alimo-Metcalfe, Alban-Metcalfe et al (2007) "*an engaging 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'*" (2008, p. xi).

As part of the conceptual framework we develop, it is clear that the *emotional links* between individual staff, groups of staff and staff and patients need to be privileged as they play out at various organisational levels. Implicit therefore is that emotions above and below the surface (conscious and unconscious) are taken into account if the leader/follower and staff/patient relationships are to be understood and improved.

2 Aims and Methods

2.1 Introduction

The research questions in this study centre on identifying:

- (a) processes by which leadership is transmitted through health service organisations to effect the delivery of health services, and
- (b) how features of the organisation, the leader, and the service influence these processes.

The focus of this study was to explore the relationship(s) between (good) leadership in NHS organisations and (good) patient care. This demanded consideration not only of leadership characteristics, qualities and styles but the ways in which NHS organisational climate and culture interacted with individual practices and identities of those who worked in them and were patients. The overall plan was, thus, to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery. This research further sought to expand existing knowledge by exploring the following questions.

1. First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
2. Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

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3. Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

2.2 Aims and Objectives

We separated these overarching research questions into aims and objectives thus:

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients;
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts on service delivery;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted through health care organisations to affect service delivery, posits *organisational climate* as one feature of the organisation that could positively or negatively affect the quality and delivery of health services.
- To learn how different stakeholders (specifically, patients, nurses and professions allied with medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care.
- To identify how the need for change in service delivery is identified and what drives the need for change.

2.3 Methods

This multi-method study therefore uses a mixture of qualitative and quantitative methods to enable and support an innovatory approach to examining the psycho-

social and psychodynamic factors intrinsic to the meanings and processes of leadership, organisation and patient care.

Qualitative research methods now have a strong and long-standing profile in social science, particularly sociology and anthropology. But over recent years they have become increasingly relevant in social psychological research.

Furthermore nursing research (Finlay & Ballinger, 2006; Kerr, 2002) and most recently even health services research have begun to take evidence emerging from qualitative methods seriously. Perhaps this began with a series of papers in the British Medical Journal in 1995. Pope and Mays for example leading on this series aptly titled their paper *Reaching the Parts other Methods Cannot Reach* (Pope & Mays, 1995). Noteworthy from this point onwards is that there is no 'one' qualitative method of either data collection or analysis and we draw on several traditions and styles in this study which are outlined below.

Unlike health services research *per se*, but akin to critical social science, there is a powerful tradition in organisational research that has taken account of the diverse nature and intrinsic value of qualitative methodologies to understanding the life of organisations (see for example Cassell and Symon, 1994; Ybema et al., 2009)

What counts of course is choosing methods which meet the demands of the research hypothesis or overarching questions. We thus began from the premise that 'leadership', 'patient care' and 'organisational change' are not objective facts but social or discursive constructions. By this we mean that these concepts are constructed through discourse, i.e. a coherent system of statements which constructs an 'object' (Parker, 2002). In other words, talk about leadership is the process by which leadership is constructed (and thus recognised) as something that happens in organisations such as the NHS.

To capture these constructions we used a range of methods:

- focus groups;
- a survey-based questionnaire including a standardized measure of Organisational Climate;
- ethnographic 'shadowing';
- observations of social places, formal and informal and meetings;
- analysis of 'stories' of leadership collected through in-depth interviews.

2.4 Capturing the data

In what follows we present the outline plans for capturing, managing and analysing the data to meet our aims although as shown in Chapter Three not all of our goals were achieved.

We focused upon three NHS Trusts with at least one being a Foundation Trust specifically to explore whether any variations in the qualities of leadership, organisation and patient care could be distinguished. An

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investigation of three Trusts was considered to be manageable within the time frame and other resources available for the project.

Within each Trust we chose two distinct 'units' to study. We conjectured these would probably to be defined by clinical speciality or site (bearing in mind that many Trusts are organised across more than one hospital/physical space).

We conducted focus groups, an organisational climate survey, story-telling interviews and ethnographic work (observations and shadowing) across these six units with staff and patients.

We employed two researchers¹³ to carry out the majority of this work, but some members of the investigatory team also took an active part in the process.

The qualitative data would by necessity and designed be analysed using a variety of methods:

- a. Thematic analysis (TA)
- b. Critical Discourse Analysis (CDA)
- c. Narrative analysis

Each of these approaches to data analysis, again by necessity and design, was subject to nuances of interpretation, intrinsic to their nature.

¹³ In the event three researchers were involved because of maternity leave and cover.

The flowchart illustrates the research approach, showing the progression from initial application and governance through the Trust and Site A to data collection methods and the final survey.

Initial Steps:

- NRES application** leads to **local governance**.
- Informal and formal approaches to 'gate-keepers' by research team** leads to **local governance** and **The Trust**.

The Trust:

- The Trust** leads to **Site A** and **Site B**.
- Site A** leads to **Unit 1** and **Unit 2 (As Unit 1)**.

Site A and Unit 1:

- Site A** leads to **Unit 1**.
- Unit 1** leads to **Staff** and **Patients**.

Data Collection Methods:

- Staff** and **Patients** lead to **Interviews**, **Focus groups**, **Shadowing**, and **Observations**.
- Other parts of the Trust** lead to **Interviews**, **Focus groups**, **Shadowing**, and **Observations**.

Final Step:

- Organisational Climate Survey** is the final outcome of the research approach.

The Trusts

- they were each different from each other in the image they projected (on their web-sites, in terms of their physical style,

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locality, size and community) and that the sample had to include one Foundation Trust.

- they were in easy reach of London (for practical purposes as the study team were based in London and Surrey).
- we were able to gain access via personal contacts in R & D or senior management (the 'gatekeepers').

The Units

Sampling of the Units in each of the Trusts was achieved through negotiation with the gatekeepers and/ or key informants recommended by the gatekeepers with the intention that a balance might be struck between:

- the specific academic interests of the research team (for example the PI is particularly interested in Obstetrics and Gynaecology services).
- some degree of opportunity for comparison between Trusts, so that if possible some similar Units might be compared across the Trusts.
- and (possibly most influential) the concerns of the gatekeepers and other senior Trust staff.

The Sites

All three Trusts selected for an initial informal approach were on more than one site although the selection of study unit determined whether or not the data was collected on more than one site.

Individual Participants (staff)

Individual participants were to be selected on an 'informed' volunteer basis. That is that via a process of meetings with key informants and presentations to staff-groups individual staff would hear about the study and be offered the opportunity to participate. For those who were not involved in the meetings or presentations a staff e-mail list was used to communicate information about the study and request volunteers to participate in interviews and focus groups. The intention to meet the study aims was to ensure participation from a variety of staff groups and levels of seniority.

Individual Participants (patients)

Patients were to be recruited for interview either by the staff directly caring for them or by the researchers themselves once the staff of each unit had become familiar and accepted the presence of the researchers.

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Survey Respondents (staff)

The Organisational Climate Survey (OCS) was to be administered within the Units that were the focus of the study and, if possible, across other Units in the Trusts. The circulation was to be achieved either through e-mail or through internal mail depending on negotiation with the relevant gate-keepers.

Survey Respondents (patients)

Patients who might complete the patient version of the survey were to be recruited by staff and/or researchers if staff permitted the researchers 'on the ground' access.

Observations and 'Shadowing' (staff and patient-staff interactions)

These methods would require the participants to be familiar and comfortable with the presence of the researchers and familiar with the ongoing research process and also be prepared to co-operate. The rules for engagement in the activities would then be made on a strategic (i.e. the staff and / or situation that would yield the richest source of information) and a pragmatic basis (i.e. the possibility of the situation yielding important data regarding leadership, organisational culture and climate and patient care).

2.6 Ethical considerations

There are clearly considerations about confidentiality and anonymity in all data collection which involves human participants Easily identified in this study (and thus in the NRES application) is the matter of the safe keeping of the raw data including completed questionnaires, any identifying characteristics of these questionnaires, digital recordings, transcripts from focus groups and interviews and the researchers' field notes. It is important to note that this is not necessarily as simple to do as it is to describe particularly because a team of investigators, the researchers themselves and some 'casual' clerical staff ¹⁴all had different types of access to the data.

The solution was to have a shared drive set up by the computer centre at Royal Holloway, University of London (RHUL) on the main site at Egham which could only be accessed by specified investigators identified by the PI. Additionally there was an access pass-code to read the transcripts and the SPSS file.

¹⁴ The sheer volume of data made it necessary to use more than one person to input the data and transcribe the recordings. Two people other than the researchers were engaged to work on this although both were employees of RHUL who knew the importance of keeping the data safe.

Another ethical consideration specific to this project was that because the staff were discussing leadership and being asked to give examples of good and bad leadership, as well as examples of effective and poor patient care, it was inevitable that:

- they would be talking about *other* members of staff. These other staff could not be told that they had been talked about (by definition) leaving them unable to provide their version of the story or aware of the fact they had been discussed.
- the researchers would therefore be 'holding' some knowledge of others which would be 'data'. This fact drew attention to the ethical and empirical complexities of working in an organisation in which data is being collected on human interactions and relationships.

As patients' experiences and views and staff's views of patient care were also part of this investigation, similar issues applied.

Finally, frequently overlooked but nonetheless very important consideration was given to the fact that participants' time should not be wasted. We were confident in the design and our experience as investigators supporting and managing the researchers (who themselves were experienced in this kind of study) that the study was robust enough to adapt to the vagaries and quirks of 'real life' and that the outcome would be valid and add value to existing knowledge.

2.7 Methods of data collection and research instruments

As described above a mixture of qualitative and quantitative methods were used to ensure a full picture of leadership in the organisations to be studied. Collecting data in applied settings, where the participants are also engaged on a day-to-day basis is demanding work which is challenging for researchers involving persistence, social skills, the ability to develop rapport, clarity of purpose combined with flexibility, the skill of 'thinking on your feet' and making practical judgements about what is feasible at any one time. For example, if plans had been set for an interview with a staff member who was then called away for an important work matter, the researcher could arrange other potential participants or be prepared to engage in a period of systematic observation.

Immediately below we describe the methodologies we chose to employ to conduct our investigations which will be described in greater detail where appropriate in the context of specific case studies.

2.7.1 Focus groups

Focus groups, once the province of market researchers, in common with in-depth interviews, are now a popular method of collecting psycho-social data in the area of health research (Nicolson & Anderson, 2003; Nicolson et al., 2008) having gained recognition in social science overall as a robust way of eliciting “*shared and tacit beliefs, and the way these beliefs emerge in interaction with others in a local setting*” (Macnaghten and Myers, 2004, p. 65 in Seale et al) (p.8). In other words focus groups represent a means of gathering a sense of how those who work in an organisation share a sense of their ‘organisation in the mind’ (Armstrong, 2005) which may be mutually accepted, challenged or undermined by the perceptions of colleagues. Focus groups also enable the researchers to check out the quality and effectiveness of the communications themselves between members of the Unit or as Morgan (1998) suggests “*Focus groups are fundamentally a way of listening to people and learning from them* (1998, p. 9).

The process involves one or two researchers meeting with between four and eight participants who share a common situation and the guide lines for the discussion focus on key topics (see Appendices). One researcher takes notes although both are empowered to guide the discussion which is also digitally recorded. One benefit of this means of data collection is that through discussion among peers issues or perspective upon certain issues are brought into focus which might have escaped previous research authors and the researchers themselves (Morgan, 1998).

The *focus group guide* employed a similar structure to the *Interview Guide*.

2.7.2 Organisational climate

The Organisational Climate Questionnaire (OCQ) designed by Stringer (Litwin & Stringer, 1968; Stringer, 2002) also called ‘The Leadership Questionnaire’, was specifically designed to produce a scale to measure leadership in the context of climate albeit in a business rather than NHS setting. To complement the mostly qualitative methods of data gathering and analysis, we developed a questionnaire for staff and patients across the Trusts and used (a slightly adapted form of) Stringer’s measure of leadership and organisational climate, with the expectation that our results might also be linked to other studies undertaken with this measure, which had been used to examine management and leadership in organisations.

It identified six dimensions of organisational climate: *structure, standards, responsibility, recognition, support* and *commitment*, and uses eighteen leadership practices (three for each dimension) to capture how people feel about their jobs, how they are managed, and how things work in a particular organisation. Because this scale is designed to give practical

indicators on how to improve performance, many of the leadership measures are based on management practices, which are equally important to the overall success of an organisation. In general, however, each leadership practice measure is based on the premise that leaders care about arousing the motivation of members in the organisation (Stringer, 2002). The OCS was adapted from to fit a model relevant to NHS Staff working in a hospital setting and another version was adapted to be used with Patients (see Appendices).

2.7.2.1 Measurement tool: Stringer's OCS – Leadership and Organisational Climate

Stringer (2002) defines organisational climate as the "*collection and pattern of the environmental determinants of aroused motivation*" (p. 9) and he takes motivation to be central to the development of his climate questionnaire predominately based on the work of McClelland-Atkinson's framework with regards to intrinsic motivators of work related-behaviour: the need for achievement (nAch), the need for power (nPow), and the need for affiliation (nAff).

Stringer noted that specific dimensions of climate appear to have a predictable impact on motivated behaviour and can be measured and managed by those in senior positions accountable for organisational performance.

The six distinct dimensions identified and measured are:

- 'Structure'
- 'Standards'
- 'Responsibility'
- 'Recognition'
- 'Support'
- 'Commitment'

The statistical data was entered into an SPSS file to seek frequencies, correlations and to explore significance levels of differences and similarities between and within groups of respondents.

2.7.3 The survey structure and items

The survey is structured in two parts:

Part 1: measures *Organisational Climate* or how people perceive the work environment.

Part II: measures *Management Practices* or how people see their own managers behaving.

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Part 1:

This part consists of twenty-four items grouped into the six dimensions - 'structure', 'standards', 'responsibility', 'recognition', 'support' and 'commitment' - designed to measure how people feel about their work environment using a 4 point Likert scale. The directions ask the participants to describe the kind of working climate that has been created in their organisation (defining 'organisation' as the smallest work unit relevant to the participant).

Descriptions of the dimensions are as follows:

1. **'Structure'** pertains to the clarity of roles, responsibilities, accountability and expectations. According to Stringer this is more of a managerial than a leadership issue and one which is more practical than inspirational. It reflects the employees' sense of being well organised and of having a clear definition of his or her roles and responsibilities. *"structure is high when people feel that everyone's job is well defined and is low when there is confusion about who does which tasks and who has decision-making authority"* (Stringer, 2002, p.65).

The following items measure 'structure':

- The jobs in this organisation are clearly defined and logically structured.
- In this organisation, it is sometimes unclear who has the formal authority to make decisions.
- In some of the projects I've been on, I haven't been sure exactly who my boss was.
- Our productivity sometimes suffers from a lack of organisational planning.

2. **'Standards'** is about the need to achieve targets and reach goals. It is the drive to achieve and improve, it includes the 'commitment' and persistence to follow through on set targets. This dimension measures the feeling of pressure to improve performance as well as the degree of pride employees have in doing a good job. When interpreting this measure, high 'standards' indicate that people are always looking for ways to improve performance, whereas, a low score reflects lower expectations for performance.

The following items measure 'standards':

- In this organisation we set very high 'standards' for performance.
- In this organisation people don't seem to take much pride in their performance.
- Around here there is a feeling of pressure to continually improve our personal and group performance.
- Our management believes that no job is so well done that it couldn't be done better (Stringer, 2002, p.65).

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3. **'Responsibility'** is about taking ownership of the work and results which are obtained. Ideally people will be motivated to achieve results and take ownership over these. Where managers delegate and encourage responsibility, workers are more likely to feel a sense of 'responsibility'. It reflects employees' feelings of 'being their own boss' and not having to double-check decisions with others. A sense of high 'responsibility' signifies that employees feel encouraged to solve problems on their own. Low 'responsibility' indicates that risk taking and testing of new approaches tend to be discouraged (Stringer, 2002; p.66).

The following items measure 'responsibility':

- We don't rely too heavily on individual judgment in this organisation almost everything is double checked.
- Around here management resents your checking everything with them if you think you've got the right approach you just go ahead.
- You won't get ahead in the organisation unless you stick your neck out and try things on our own.
- Our philosophy emphasises that people should solve their own problems themselves.

4. **'Recognition'** relates to the relationships between one's performance and associated rewards, as well as broader sense of approval or disapproval of an individual's efforts. It indicates employees' feelings of being rewarded for a job well done. This is a measure of the emphasis placed on reward versus criticism and punishment. High 'recognition' climates are characterised by an appropriate balance of reward and criticism. Low 'recognition' means that good work is inconsistently rewarded (Stringer, 2002, p. 66).

The following items measure 'recognition':

- In this organisation the rewards and encouragements you get usually outweigh the threats and criticisms.
- There is not enough reward and 'recognition' given in this organisation for doing good work.
- We have a promotion system here that helps the best person rise to the top.
- In this organisation people are rewarded in proportion to the excellence of their job performance.

5. **'Support'** is the degree to which there is a sense of warmth and team work, within which the individual feels that they are 'backed up' by others. This will determine the amount of trust and respect amongst team members. It reflects the feelings of trust and mutual 'support' that prevails within a work group. 'Support' is high when employees feel that they are

part of a well-functioning team and when they sense that they can get help (especially from the boss) if they need it. When 'support' is low, employees feel isolated and alone. This dimension of climate has become increasingly important for today's e-business models in which resources are severely constrained and a premium is placed on teamwork (Stringer, 2002, p.66).

The following items measure 'support':

- You don't get much sympathy in this organisation if you make a mistake.
- When I am on a difficult assignment, I can usually count on getting assistance from my boss and co-workers.
- People in this organisation don't really trust each other enough.
- I feel that I am a member of a well-functioning team.

6. **'Commitment'** reflects employees' sense of pride in belonging to the organisation and their degree of 'commitment' to the organisation's goal. Strong feelings of 'commitment' are associated with high levels of personal loyalty. Lower levels of 'commitment' mean that employees feel apathetic toward the organisation and its goals (Stringer, 2002, p. 11).

The following items measure 'commitment':

- Generally, people are highly committed to the goals of this organisation.
- People here feel proud of belonging to this organisation.
- People don't really care what happens to this organisation.
- As far as I can see, there isn't much personal loyalty to the organisation.

Part II:

This part asks the participants to describe the practices of their managers. Using the same six dimensions as in Part I, participants are given eighteen statements which describe the way a manager might perform her or his duty and the respondents are asked to indicate how much he or she agrees with each of the statements. Here a 5 point Likert scale is used.

Once again the six dimensions are used to assess perceptions of managers' practices:

1. 'Structure'

- Establishing clear, specific performance goals for subordinates' job.
- Clarify who is responsible for what within the group.
- Making sure tasks and projects are clearly and thoroughly explained and understood when they are assigned.

2. 'Standards'

- Setting challenging performance goals and 'standards' for subordinates.
- Demonstrating personal 'commitment' to achieving goals.
- Giving subordinates feedback on how they are doing on their job.

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3. 'Responsibility'

- Encouraging subordinates to initiate tasks or projects they think are important.
- Expecting subordinates to find and correct their own errors rather than doing this for them.
- Encouraging innovation and calculated risk in others.

4. 'Recognition'

- Recognizing subordinates for good performance more often than criticizing them for poor performance.
- Using 'recognition', praise and similar methods to reward subordinates for excellent performance.
- Relating the total reward system to performance rather than to the other factors such as seniority or personal relationships.

5. 'Support'

- Being supportive and helpful to subordinates in their day to day activities.
- Going 'to bat' for subordinates with superiors when the manager believes their subordinates are right.
- Conducting team meetings in a way that builds trust and mutual respect.

6. 'Commitment'

- Communicating excitement and enthusiasm about the work.
- Involving people in setting goals.
- Encouraging subordinates to participate in making decisions.

Leadership question

We also asked a single question to capture directly how satisfied an employee is with the leadership they receive from their immediate supervisor. It was a simple statement: *I am satisfied with the quality of the leadership I receive from my immediate manager* which we measured using a 4 point Likert scale.

2.7.4 Ethnographic observations and 'shadowing'

Ethnographic observations and shadowing are especially useful to organisational research because they allow people to *physically* express their inner thoughts, and put ideas into *observable action*, all of which would be inaccessible through the survey or structured interview questions.

Ethnographic observation (often referred to as *participant observation*) has its roots in anthropology but has become increasingly deployed in sociology, cultural and social geographies. In the field (which in this case is a Unit in an NHS Trust) the researcher's aim is to "*understand how the cultures they are studying 'work'*" that is, to grasp "*what the world looks like*" to the

participants in the context being observed (Delamont, 2004, p. 206). In this study observation and shadowing opportunities were (mostly) formally set up and pre-arranged. However, the researchers, through taking their roles as interviewers, focus group leaders and having an every-day presence with key informants, gate-keepers and participants, were able to immerse themselves in the lives and atmosphere of each of the Trusts and Units providing evidence about the processes of leadership and patient care as well as 'climate' (Bloor, 2001; Goffman, 1961).

Shadowing involved the same conceptual framework as ethnographic observation in that the aim was to understand what the world looks like from the perspective of the staff member being shadowed as well as the worlds of the other staff and patients that they engaged with in the course of their work (Czarniawska, 2008; McDonald, 2005). It involved meeting the participant (usually) at 8 am and for one or two days accompany them including at break times until the participant went home. In Trusts where there was more than one site and/or when the nature of the day's work involved meetings outside the hospital (as in nearly every case) then the researcher spent time in a car with the participant and if agreed the conversation was digitally recorded as an *aide memoire* for the field notes. The participant was able to withdraw at any time, or for a period of time, across the shadowing period.

Thus the sense of 'what the Unit world looked like' was recorded in field notes which were then discussed with the other members of the team (who had some familiarity with the relevant part of the Unit/Trust) in a context where the researcher could be reflexive and explore the 'silent space' of the 'ethnographic self' (Coffey, 1999). The researcher's notes and expressed thoughts were then discussed with other members of the team, some of whom were familiar and others not so with the specific context (Barry, 2003). A similar approach was used to discuss the interview material because even though the interviews were digitally recorded and transcribed verbatim, this did not account for the reflexivity that took place following the interview itself and on transcribing and reading the transcript, and therefore featuring in the analysis (Nicolson, 2003).

In this context there was concern to capture the emotional content and atmosphere of the organisations. This meant that ethnographic methodologies were implemented to analyse the emotionality of the interactions (verbal and non-verbal) between patient and practitioner. It was through these observations that the use and importance of the researcher's *body as a 'research instrument'* became palpable, especially for understanding the emotions emerging out of the interactions between patient, relatives and practitioner(s). This process has been proposed as the antithesis of taking for granted that emotion should be removed from

ethnographic investigation and that in fact the research process is highly emotive and far from an emotionally barren terrain (Bondi, Davidson, & Smith, 2005).

As the researcher collects data they move through a continuum of emotions from the euphoric highs of excitement at starting a new research project, sense of achievement and pride as they begin to make contacts and collect initial data, perhaps trepidation, fear and nervousness as they meet new participants or research settings through to the depths of despair, isolation and frustration as the research process (inevitably at times) becomes chaotic and messy. However, these emotions are often neglected, regarded as unimportant to the overall research process and abandoned in the writing up phase. We use these frequently neglected emotions and feelings as part of, and beneficial to, the project as representing a rich source of data.

By being more attentive to their emotions and bodily senses ethnographers also become more sensitive to their environment and their participants thus gaining a greater awareness of what they are observing. In recalling a sound, smell or feeling the ethnographer is able to open up their mind's eye to re-visualise the interaction with greater clarity and accuracy making it more likely that an accurate representation of what was observed will be recorded.

2.7.5 In-depth semi-structured and 'story-telling' interviews

In-depth semi-structured Interviews: Over the past fifteen years this method of qualitative data collection has become increasingly common in health services and health research in general (Pope and Mays, 1995; Kvale, 1996; Grbich, 1999) consistently a method of choice for identifying perceptions, meanings and experiences of dynamic and complex concepts such as 'leadership' and 'patient care' (Rubin and Rubin, 1995; Denzin and Lincoln, 1998; Rapley, in Seale et al, 2004).

The use of such interviews has led to increased levels of sophistication in the interpretation of qualitative in-depth data in the context of historical, cultural and political frameworks demonstrating that in-depth semi-structured interviews (and more generally qualitative research) have capability beyond simply adding rich description to statistical evidence (see Denzin and Lincoln, 2002; Willig, 2008).

Story-Telling: One of the explicit aims of the interviews was to collect a number of stories to reflect critical experiences in the organisations' past and present life. In the field of organisational studies, there is now an extensive literature of how to use stories told by organisational participants

as windows into organisational culture, politics and numerous other phenomena (Gabriel, 2000; Hannabuss, 2000).

The inclusion of story-telling in the context of the in-depth interview increases the scope for making sense of data in ways that delve deeply into the respondents' perceptions and meaning of the *processes* of leadership and patient care. Story-telling also increases the validity of the interview through the use of reflexivity, and positioning the events and 'atmosphere' of the stories in the context of the organisational analysis.

Of particular relevance to this study, stories can instigate insights into the processes of positive or negative social and organisational change and leadership which involves the management of meaning and emotions, both of which rely heavily upon the use of stories, allegories, metaphors, labels and other narrative devices.

The study of *organisational stories* is particularly relevant in health care settings that are liable to unleash strong emotions and fantasies. Hence, hospitals are rich grounds for collecting stories, as numerous researchers have recognized (Kleinman, 1988; Frank, 1998; Greenhalgh, 2002; Hurwitz, 2006; Mattingly, 1998). Storytelling permeates everyday clinical practices and "*medical professionals find ways to 'routinize' their practice and thus, metaphorically at least, bring the unruly and frightening world of illness under control*" (Mattingly 1998, p. 277).

The *interview schedule* (see Appendices) therefore was designed to elicit information on the participant's view of 'leadership' and 'patient care' through 'stories' to provide examples in their opinion that constituted good and poor leadership and good and poor patient care through 'critical incidents'.

As the interviews were semi-structured and in-depth they relied to a great extent on the interviewing skills of the researchers and their ability to establish rapport and consequent willingness of the participants to engage in the process. The early pilot interviews therefore were unlikely to influence the details of the interview schedule itself although the early interviews were planned to enable the research team to identify the best *strategies* to engage participants in the task.

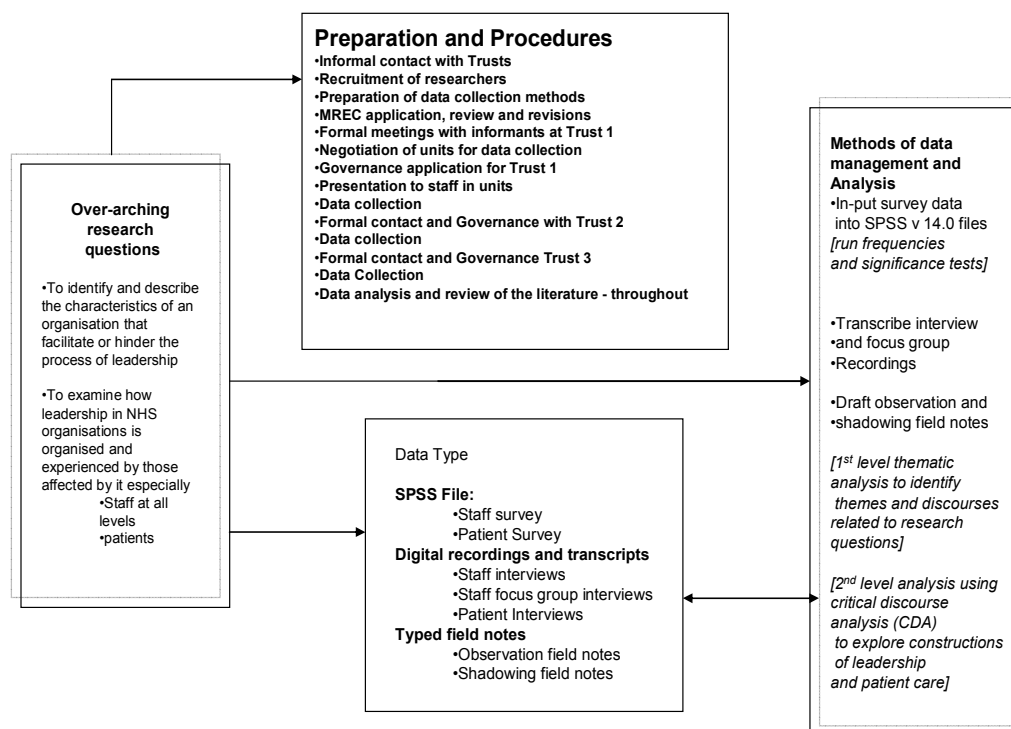
2.8 Data Management

The interviews and focus groups were digitally recorded and transcribed verbatim. The transcripts stored on a password protected Word file (initially on the researchers' PCs but subsequently on the secure shared drive described above) and sound recordings stored on audio files (password protected on the PC of the PI and not on the shared drive).

The OCS data was entered and stored on an SPSS file, password protected and placed on the secure shared drive.

Fieldwork notes from observations and shadowing were similarly password protected stored on the shared drive once they had been prepared by the individual researchers.

Figure 5. Outline of Study Procedures and Methods



2.8.1 Data Analysis

There are effectively therefore three categories of data.

1. Qualitative data representing verbatim 'talk' (digital recordings/transcripts) of interviews and focus groups.
2. Qualitative data from observations, shadowing and other field notes. These were subjective accounts of observations, perceptions, emotions and meanings given to the field work by one researcher. This may have been following discussion with the other researcher on occasions when that person had had access to the same raw

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material. Discussion with another member of the investigatory team (frequently but not always the PI) also took place following the first drafting of the field notes in order to clarify the meanings given to specific behaviours and relate theory and data.

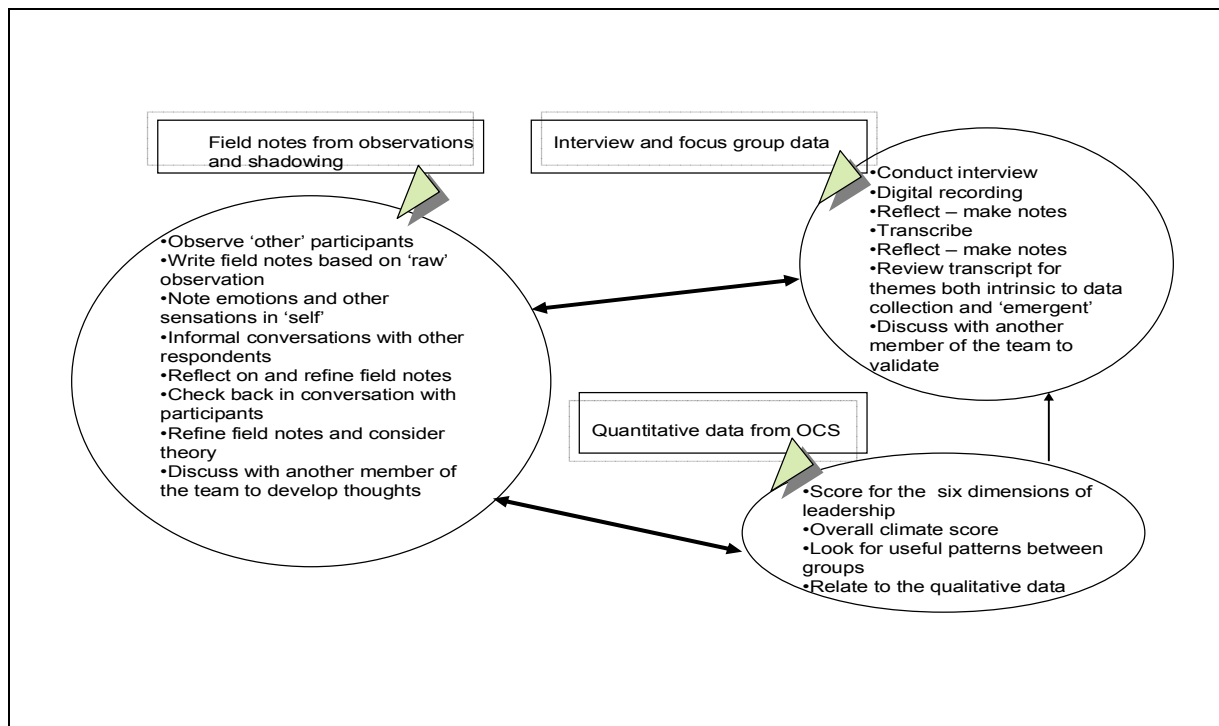
3. Statistical data from the OCS.

2.8.2 Thematic Analysis (TA)

The transcripts and field notes were examined initially for relevant extracts related to the main themes ('leadership', 'organisation' and 'patient care').

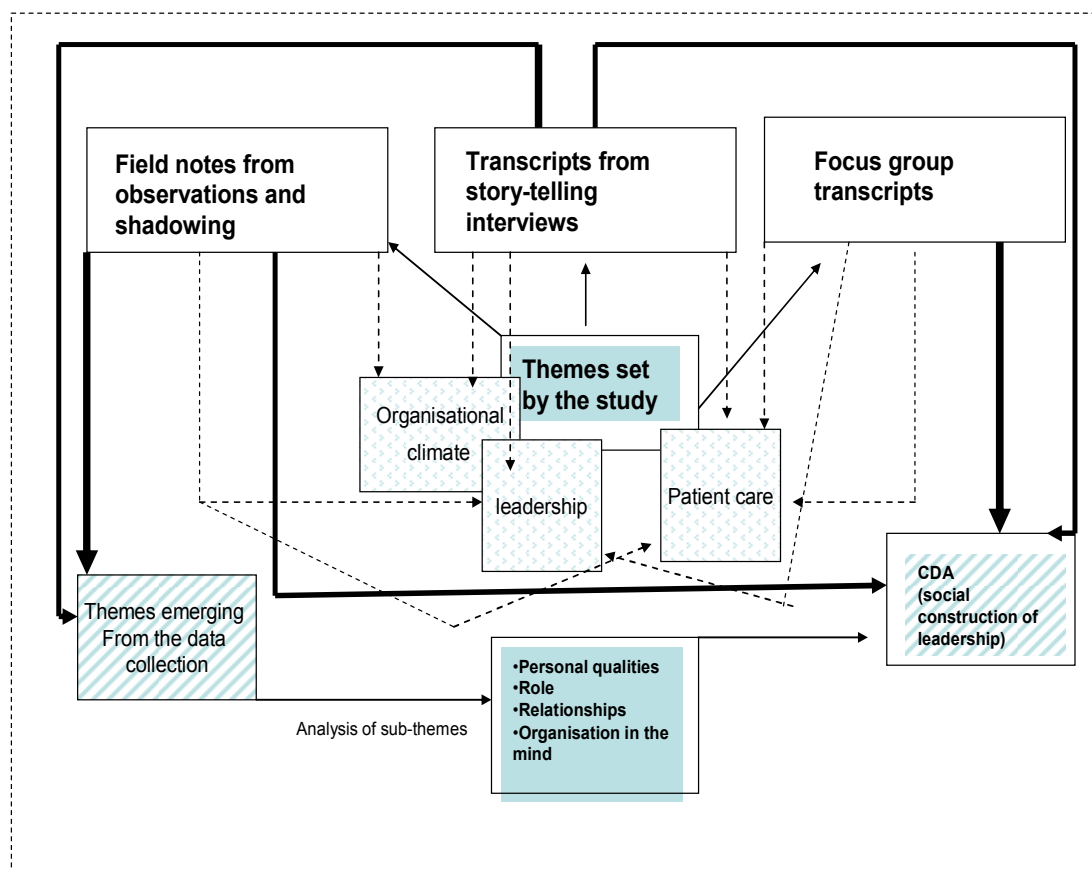
Sub-themes were then to be identified, some of which are likely to relate closely to the previous research literature on leadership and organisational climate, although it is likely that each organisation will demonstrate particular issues that were more difficult to anticipate at the outset.

Figure 6. From data collection to data analysis



Data relating to these themes and sub-themes was to be collated on Word files and where deemed relevant to the study aims, analysed further using the following methods – Discursive Psychology, Critical Discourse Analysis and Narrative Analysis. All these approaches focus on language and the way language is used to construct key concepts (e.g. the organisation) but there are different nuances to each perspective each of which adds an important dimension to the analysis of this data.

Figure 7. Thematic to CDA with Narrative analysis



2.8.3 Discursive Psychology, Discourse Analysis and Critical Discourse Analysis (CDA)

Hepburn and Potter (2004) argue convincingly and with justification that DA has evolved to have several iterations over recent years. One common feature though has been that 'discourse' (i.e. what is said) and 'context' are difficult to separate and it is the ways in which context is worked into the analysis of discourse that distinguishes the character of DA deployed in a particular piece of analysis.

The thematic analysis was a starting point from which to focus in upon the close readings of the texts, which related to the processes of leadership and patient care, as it represents a flexible and clear way of identifying what is emerging from the data and points a way forward with more detailed analysis (Braun and Clarke, 2006)

We argue that leadership is a social construction and there is a growing body of literature providing evidence to support this view. There has also been a recent focus in organisational research and theory to specify an Organisational Discourse Analysis (ODA) (Pritchard, Jones and Stablein, 2004) which involves four approaches i.e. *Narrative*, *Foucauldian*, *Linguistic* and *Deconstruction* which in turn are influenced by a *reflexive awareness* of the organisational culture in which the research is being conducted.

Pritchard et al, (2004) argue further that the exact methodology and approach to the data depends on the 'researcher position' in the organisation being studied. In other words this approach *benefits* from the subjectivity of the researcher's interpretation of what processes mean and specifically from researcher reflexivity about their 'take' on a situation and set of interactions.

To qualify this method of analysis further, a discursive approach means that language is represented not so much as an objective truth but as a means of *constructing* what might be understood (Parker, 1992; Coyle, 2007).

Particularly relevant in this study, in which participants are asked to tell stories and provide evidence to support what is good and bad about both leadership and patient care (and implicitly the organisation in which these actions take place), is discursive psychology (DP) that highlights how "*descriptions of events are bound up with doing actions, such as providing justification for actions and blaming others*" (Hepburn and Potter, 2004, p. 169).

Thus Critical Discourse Analysis (CDA) sees language as a *social practice* and thus considers carefully the context in which language is used (see

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Wodak, 2004). CDA is related to the notion that *power is negotiated through language*. This is particularly apposite in a study of leadership in organisations. Even more so CDA is 'abductive' so that a constant movement between theory and empirical data is needed which suits ethnographic methods such as shadowing and observations enabling the researcher to test out their ideas as they progress with the data collection, and the attempt to understand how cultures work and how the research participants make sense of and experience their worlds.

2.8.4 Narrative Analysis

Narrative approaches to data analysis have been able to cut through the great complexity of the NHS - the intense emotions, positive and negative, it evokes among most of its stakeholders (e.g. Rooksby, Gerry & Smith, 2007; Bryant, 2006; Iedema et al., 2009; Brown et al., 2008; Elkind, 1998; Brooks, 1997). These studies have, for example, addressed power issues in the doctor-patient relationship, exploring communication in a consultation situation. In these analyses, the patient's 'subordinate' narratives have often been neglected or taken over by the doctor's privileged 'medicalizing' discussion (Mattingly, 1998, p. 12; see also Radley, Mayberry & Pearce, 2008). However, there is also a recognition that many of these narratives are co-constructed by patient and physician (Mattingly, 1998, p. 43; Kirkpatrick, 2008); exploring solely the patient voice in isolation and presuming that doctors will at all times occupy a dominant position in this relationship may be missing half of the story - the doctor's experience. As Mattingly (1998) points out, *"[h]ealers too, may be able to give a different kind of voice to their practice when they describe their work in narrative terms rather than the flattened prose of biomedical discourse"* (p. 14).

As a genre, narrative psychology is thriving (Smith & Sparkes 2006). There has been talk of the 'narrative turn in psychotherapy and psychiatry' (Brown, Nolan, Crawford & Lewis, 1996), and Crossley (2003a & 2003b) for example argues strongly for a 'perspective that retains a sense of both psychological and sociological complexity and integrity' noting that narrative psychology is concerned with 'coming to grips with how a person thinks and feels about what is happening to her' (2000, p. 6). She employs a phenomenological framework to explore narratives of 'the voice' of 'the mentally ill' (Crossley & Crossley 2001) and the experience of temporal elements and self/identity of people living with serious illness (HIV, cancer; see also Söderberg, Lundman & Norberg, 1997). Narrative research in health care has also been used to study the lived experience of patients (see for example Hemsley, Balandin & Togher, 2007; Hök, Wachtler, Falkenberg & Tishelman, 2007) and an emerging genre of 'narrative based medicine' seeks to make use of stories in developing a fuller understanding of illness experiences (Launer, 2003; Taylor, 2003; Greenhalgh, 1999).

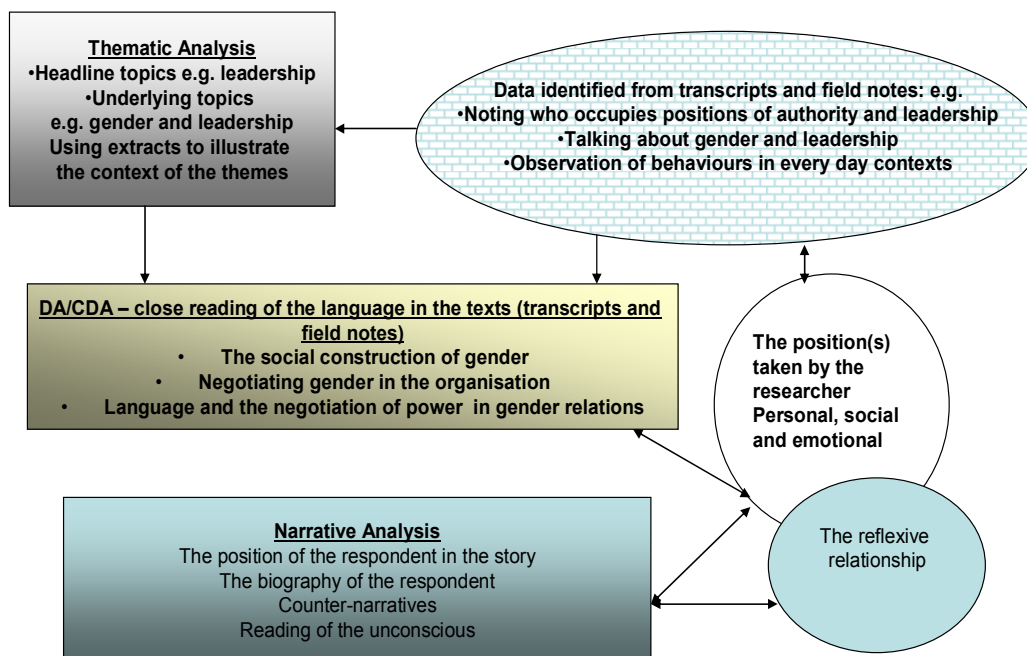
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Narrative based medicine is not merely an insightful way of doing research, but may have powerful policy implications. As Overcash (2003) argues, "*narrative methods are an effective research option that can lead to enhanced patient care*" (p. 179). While interpreting narratives can enhance the possibilities of integrating evidence-based research findings with individual illness experiences, and Winterbottom and colleagues (2008) suggest numerous courses of further research on why and how narratives may influence medical decision making.

Narrative analysis, as with DA, has been approached differently by academics from a range of disciplines so that the ideas surrounding the analysis of *narratives* (or stories told in a sequence) have a variety of emphases. The strength of taking the narrative approach over DA /CDA *per se* is that the 'subject' of the story (the narrator) retains a central role (Crossley, 2007). This can be seen in some detail in subsequent chapters particularly where the accounts of ethnographic observations and shadowing are highlighted where the 'story' becomes that of the researcher herself and with the stories unfolding through the interviews.

Furthermore the narrative analysis places the respondent's story as part of their own *identity construction* which lends an important dimension to the relationship of the story-telling to the teller. Particularly interesting here is Andrews' (Andrews, Sclater-Day et al., 2004) approach which focuses specifically on the elements of stories "*that lie in tension with the ones we are socialised to expect*" (2004, p. 97) or what she calls 'counter-narratives'. Researchers such as Hollway and Jefferson, 2002; Gough, 2003; Sclater, 2004; Allcorn, 2004 and Gabriel, 2004 and 2005, take on board the role of the interlocutor in positioning themselves in their story while considering some of the unconscious and emotional elements both of the story being told and the way that the relationship between the researcher and respondent plays out to construct and limit the story that is told. This dimension is particularly important in the context of this study where emotions are rife at least in part because of the high pressure (exacerbated to some extent by the changing political initiatives directed towards NHS institutions) and the particular nature of the work in caring for ill people (see for example Menzies-Lyth 1960).

Figure 8. Levels of qualitative data analysis e.g. 'gender'



2.8.5 Statistical Analysis

The data from the OCS was coded and in-putted into an SPSS v 14.0 file and significance tests were run (see Chapter Five for the full details).

3 Research Procedure

3.1 Introduction and Overview

The nature of this study, much of which involved the researchers immersing themselves in the 'world' of the participants, meant that it is not possible to provide an authentic *sequential* account of the procedure of data collection except possibly for the administering of the OCS (Organisational Climate Survey).

The bulk of the study, as identified in Chapter Two, comprised multiple methods of collecting different types of data across three Trusts, six Units and five sites.

3.1.1 Negotiating Access

The study took place across a three year period. Negotiation of access was complicated as indicated, although in itself a valuable procedure which occurred at several levels and helped to increase the richness of the team's understanding of leadership, patient care and the context of each organisation.

- Negotiating access began from the 'notional' level while writing the grant application whereby the investigatory team needed to identify whether a project with this design was in fact feasible. We thus made informal inquiries via personal contacts.
- More formal contacts were made once the project was confirmed with the intention to achieve verbal agreement about access for planning the NRES application.
- Following that we met to formalise the details with key informants (i.e. senior clinicians and managers) who had been identified in the previous stage.
- Once we had achieved a favourable NRES review, we pursued local governance applications with the help of the key informants.

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- These stages were managed by approaching one Trust at a time although during the latter part of the study some overlapping negotiations and governance were necessary.
- Part of the formal stage of negotiation concerned consideration of which *Units* could/would form the focus for the study. This was very much two-way but also serendipitous with suggestions from the team of investigators moderated by whichever senior clinical staff the key informants considered would be amenable to 'hosting' the study.
- The key informants then identified opportunities for the team to present the project to staff in the selected Units in 'educational half days' or 'staff meetings' depending upon the local structures.
- These formal presentations only took place in Trusts One and Three however. The procedure in Trust Two (because of the culture, location and structure) was on the basis of a 'tour' (which with permission was digitally recorded) organised by a senior nurse manager so the researchers, one of the co-investigators and the PI could meet various key nursing and medical staff across one of the Trust sites.

Once all that had been achieved it was the researchers on the whole who managed the day-to-day negotiations about who could and would agree to take part in the various elements of the study. This was complicated because of the day-to-day patterns of staff, changes in staff roles, particularly at senior levels, shift patterns and the sheer numbers of staff who may or may not have been aware and willing to allow access to, say, a particular meeting or team for observation or interviews.

Figure 9. Procedures and time-line

	2006/7	2008	2009
Winter	<ul style="list-style-type: none"> •Recruit and prepare researchers •Informal contact with 3 Trusts 1 and 2 •Informal visits to Trusts 1 and 2 •Develop research instruments •Prepare COREC/NRES application •MREC presentation and revisions •MREC approval •Start to review literature on leadership 	<ul style="list-style-type: none"> •Arranging formal contacts with Trust 2 (on 2 sites) •Visit to Site A •Further data collection in Trust 1 •Patient interviews 	<ul style="list-style-type: none"> •Researcher begins maternity leave and new researcher inducted into the team •Data collection in Trust 2 Site 2 •<u>[difficulties gaining access to staff list in Trust 2 for survey]</u> •Presentation to staff in Trust 3 (Unit 1) •Distribution of staff survey (individually handed out) in Trust 3
March - June	<ul style="list-style-type: none"> •Formal meeting with Trust 1 R & D director •Governance application •Formal meetings with senior staff to negotiate units for study •Unit based meetings and introductions •Presentation at educational half day on Unit 1 (obs & gyn) of Trust •Pilot interviews •Pilot staff survey 	<ul style="list-style-type: none"> •Formal meeting in Trust 2. Tour of Site A •Visit to Site 2 •Governance for Trust 2 •Informal meetings •Data collection begins in Trust 2 •<u>Trust 1 staff in Unit 1 return surveys to PI saying they won't give them out</u> 	<ul style="list-style-type: none"> •<u>[further difficulties gaining access to staff list in Trust 2 for survey – now due to key staff transfers]</u> •Preparation and presentation of invited paper to SDO conference in June •Paper preparation and further conference presentations
Summer	<ul style="list-style-type: none"> •Organise, send out and in-put data from staff survey in Trust 1 •Observations and interviews with key staff •Presentation to Unit 2 •Focus groups and interviews on Unit 2 	<ul style="list-style-type: none"> •Application for extension to project (successful) 	<ul style="list-style-type: none"> •Put staff survey on Trust 2's 'intranet' with information about how to complete and return •E-mail staff in Trust 3 who had not received a staff survey •<u>[a low response in both cases]</u>
Autumn	<ul style="list-style-type: none"> •Data collection •Data in-putting from staff survey •Patient survey given to staff on Unit 1 to distribute 	<ul style="list-style-type: none"> •Preparation of journal paper 1 •Further review of literature •Governance for Trust 3 •Identifying key contacts in Trust 3 •Negotiation about Unit 1 (Care of the Elderly) 	<ul style="list-style-type: none"> •Journal paper 1 (anxiety) being revised for publication •Journal paper 2 in preparation (gender) •Journal paper 3 (in preparation) leadership and 'territory') •Presentation prepared and delivered to NHS Surrey and Borders conference •Final draft report

3.1.2 Time frame and Participation of Investigators

We negotiated the formal details of access consecutively in order to make the process manageable. Most data was collected by the researchers (Dr. Fox, Dr. Lokman¹⁵ and Ms. Rowland) although the PI and other investigators made the initial contacts, met with key informants, contributed to the presentations and conducted some of the interviews and focus groups and (Profs. Gabriel and Nicolson, Dr. Heffernan and Mr. Howorth). The PI (Nicolson) and at least one of the researchers was present at all initial meetings with the gate-keepers and key informants.

3.1.3 NRES review

This was prepared and submitted at the end of 2006 and the PI, one of the researchers (Lokman) and another member of the investigation team (Gabriel) attended the appointment with London-Surrey Borders Research Ethics Committee in January 2007.

Annual reports were submitted to the NRES subsequently as required.

3.2 Sample characteristics

The three Trusts, selected as stated above in Chapter Two were each very different from each other, not only in formal terms (size, budget, location and organisational structures) but also informally and culturally and this influenced the 'access pathways'. Thus for example in Trust One our informal and then formal contact was with the R & D director (also a senior clinician) and assistant R & D director, who introduced us to the CEO, the clinical directors and senior nurses.

In Trust Two we had begun with meeting the CEO at the 'notional' phase who then retired in the meantime. This meant starting again with delayed local governance and to accomplish this, we were directed towards a senior clinical manager who then changed their role and location which meant dislocation of our planned procedures.

Trust Three involved a personal contact initially who was directly involved as a clinician in one of the Units who then arranged for us to have a

¹⁵ Dr. Lokman worked on the project for over two years and Dr. Fox took her place.

meeting with another senior clinician who in turn arranged for us to give a presentation to the Care of the Elderly/Geriatric Unit. From there we sought a second Unit for Study independently through contacts made during the course of working in the first Unit.

Trust 1 (One site only) a DGH (District General Hospital)

The Research and Development director here suggested the Units for study to be:

- Unit 1, Obstetrics and Gynaecology
- Unit 2, Cardiology

We were happy with his suggestions, and the staff was generally co-operative and supportive of the researchers.

The Trust itself covers two sites but the choice of these Units meant that all data was collected from one site. This was helpful because it meant the researchers and some of the investigators could spend time familiarising ourselves with the layout of the Units and the Trust site and become familiar 'faces' so that gaining consent from respondents was made easier than it would have been if the researchers and the study itself had to be presented as 'new' on each occasion.

While the study was taking place there were many fears expressed among the staff at all levels that the site we were investigating would become the less powerful with the other site taking over many of the executive functions. While the study team were collecting data on this site however this did not happen and the general 'morale' has improved so that the Trust is currently applying for Foundation Trust statusⁱ.

Self-Description of the hospital

The site we studied had 400 beds and a range of acute care services, including an Accident and Emergency department. It is situated in 52 acres of Green Belt parkland within 40 – 60 minutes of London. Originally it was built to serve casualties of the Second World War. Over the years, the hospital has been rebuilt, developed and extended to include maternity services, a departmental and clinic area, and a new theatre complex. In the early 1990s, the X¹⁶ Wing, which includes a Postgraduate Education Centre and modern well-equipped wards, was opened. A new building for the Accident & Emergency, ITU and Orthopedic Unit opened in the summer of 1998. In addition, comprehensive HIV and genitourinary medicine services are provided in a dedicated building.

¹⁶ We have used 'X' to ensure anonymity.

Obstetrics and Gynaecology

The study territory for this Unit¹⁷ comprised the labour ward, postnatal ward, a general outpatient clinic a dedicated ante-natal clinic and the Maternity Services Administration. The unit offered midwife care for home births, one to one care, water births and there was always a consultant obstetrician available and compared to other local hospitals it gained a score of 3/5 which was joint top score.

Cardiology

This Unit studied comprised one in-patient ward, the Medical Assessment Unit (MAU) and the Critical Care Unit.

In addition we spent time in the Management Suite where five interviews also took place of the CEO, Clinical Director, the Director and Deputy Director of R & D and a middle-ranking manager.

Observations also took place in public and eating spaces and shadowing involved walking around the hospital between different specialty wards and administrative departments.

Trust 2 (2 sites)

The Trust was one of the biggest DGHs in London with 4,200 staff. It had had a history of problems in its financial management and the quality of care but recent information on the web-site and confirmed by the CEO made it clear that:

The Care Quality Commission, the organisation that regulates health care nationally, has awarded the Trust a rating of excellent for the quality of services we provide to our local population. This is the highest possible performance rating in the 2008/09 Care Quality Commission annual national assessment report.

It seems that problems with the financial management remain although improvement had been noted.

The structure and organisation of Trust 2 differed significantly from Trusts 1 and 3. Trust 2 comprised two sites (recently combined into one Trust where one was a teaching hospital) which were at least eight miles apart and it

¹⁷ There were other parts of the Maternity Services at Trust 1 that were not observed directly.

was difficult to travel between one and the other on public transport other than using more than one bus or travelling in and out again from London. The journey by car varied from about thirty minutes upwards depending upon traffic.

Physically the two sites were very different. Site A was a relatively new building designed (as one researcher stated) to look like a motel or contemporary hotel. The other, B, was a traditional middle height rise built in the 1970s on a green site and appeared far more formal with long corridors and many signs to departments. Site A was more 'angular' and you could not walk very far without having to turn a corner which presented a very different 'feel'.

It was not possible, particularly in Site A to select a discrete specialist Unit (unlike Trust 1). Site A focused on acute medicine and care of the elderly and there were no formal divisions in where patients were treated as either in-patients or out-patients. So an older person with 'geriatric' health related problems could be in a bed next to a much younger person. We have identified a Unit as a Site in the case of this Trust. We found it equally difficult to 'pin down' a specialty in Site B as well.

At Site B we collected data from acute medical specialties, obstetrics and gynaecology and therapies (the latter being both physical and psychological).

This was in part because senior management at Site A (who were our key informants and 'gatekeepers') introduced us to staff they considered amenable. Thus for purposes of the study we had to identify Site B as our second Unit. Despite the introductions we managed, via snowballing, to find a range of participants who demonstrated many different view points.

To summarise then in Trust 2 the study was carried out in the following two Units which we have identified as follows:

- Site A / Unit 1 (Acute Medicine; Care of the Elderly)
- Site B / Unit 2 (Acute Medicine; Obstetrics and Gynaecology; Therapies)

We also interviewed a Clinical and Nursing Director both of whom worked across both sites and senior managers including the CEO and deputy CEO.

It became clear very early on that there was intense rivalry, even animosity between the two sites and some of this is explored in later chapters.

Trust 3 (2 sites)

Trust Three, in central London, is a long established hospital and a Foundation Trust with connections to a prestigious medical school. Travel

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between the sites took about twenty to thirty minutes by public transport. 9,000 staff are employed by the Trust with 1,100 beds available across the Trust at any one time.

- Unit 1 (Care of the Elderly, Acute Medicine)
- Unit 2 (Therapies)

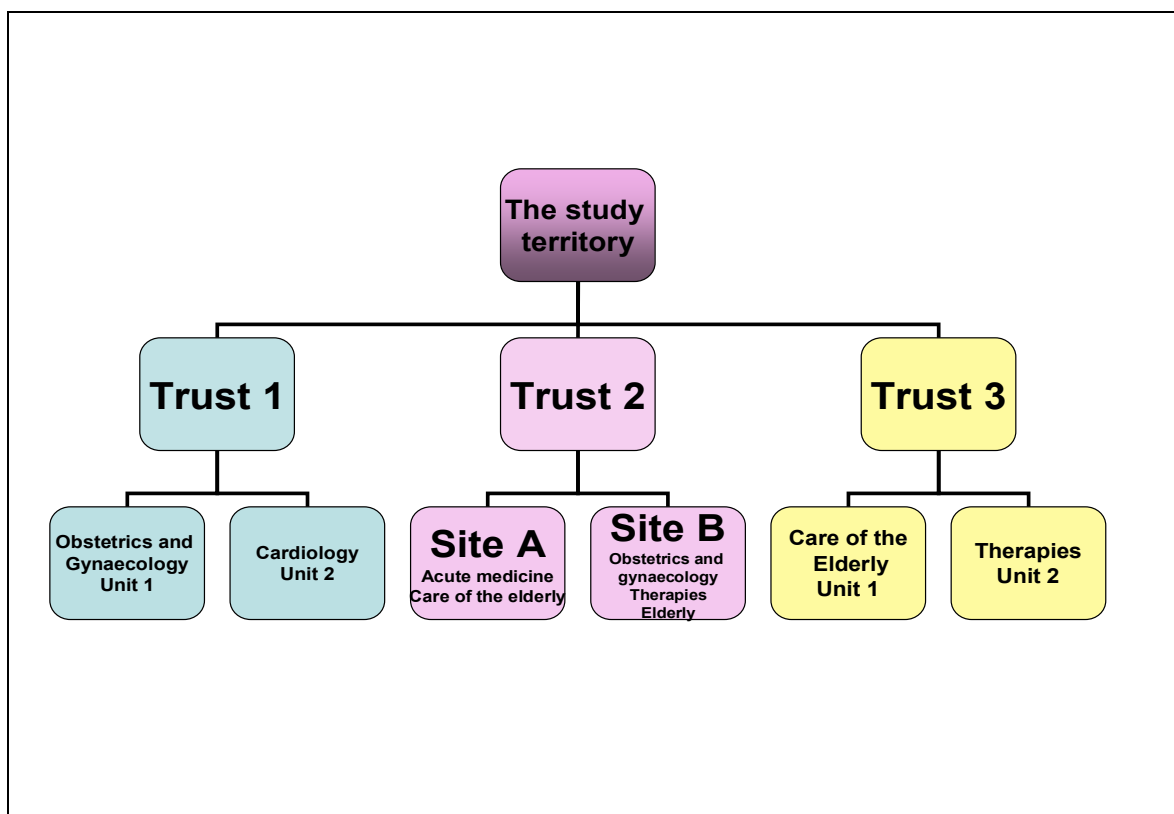
Unit 1 is described on the web-site thus:

Geriatric medicine specializes in the diagnosis and management of common symptoms and diseases in older people, particularly:

- *problems with mobility*
- *falls*
- *continence*
- *difficulties with looking after oneself*

Unit 2 (therapies) which included physiotherapy and psychological therapies spanned both the sites and covered many clinical departments and extended to primary care services especially local GP practices as well.

Figure 10. Participating Trusts and Units



3.2.1 Response rates (qualitative approaches)

It is difficult to identify an accurate response rate for the qualitative components (the majority) of the study because the sampling was conducted in an opportunist manner in many cases – i.e. whether someone agreed to take part in an interview or focus group if the researchers were on site and made a serendipitous approach.

As stated in Chapter Two, much of the qualitative data was collected by virtue of the researchers 'being there' in the right place at the right time and therefore gaining the trust of potential participants. In many cases the researchers were introduced to a member of staff who suggested ways in which other respondents might be accessed. Methods included personal introductions, using e-mail lists or sometimes a staff member knowing what was happening asked the researchers if they might participate in the study.

Overall the majority of staff approached to participate agreed to do so, although circumstances sometimes prevented it (e.g. one focus group was cancelled in Cardiology due to a patient emergency and one observation was cut short because the consultant refused to have the researcher in the ward round, although they had been observing on the ward before the consultant arrived having been given permission by the nursing staff).

Although the key staff across all three Trusts agreed to support the researchers in gaining access to patients for the OCS and interviews, the patient form of OCS was anonymously returned to the PI by someone at Trust 1 saying they did not want patients to participate in that exercise¹⁸.

It proved impossible to administer the patient OCS in the other two Trusts also, because the staff said in advance they were too busy to help and the researchers had difficulty in making contact with individual patients who were always either in busy wards or with a member of staff. Thus interviews and observations were conducted, with patients' consent, during shadowing.

The OCS for the staff is discussed fully in its own right in Chapter Five.

3.2.2 Individual participants

Respondents were either NHS staff or patients so by definition there were elements of uncertainty about whether they would be available at appointed

¹⁸ We sought advice but in line with the NRES review participants could withdraw their consent at any time so we did not feel free to pursue this further.

times and whether (as acknowledged in the NRES consent form) they choose to drop out at any time, even after having agreed to take part.

As shown below in Table 1, forty six respondents took part in in-depth story-telling interviews, thirty nine took part in focus groups. During twenty six days of shadowing of key staff, numerous other staff and patients were involved in data collection and similarly, during the eleven and a half days of observations on wards and in administration areas across the Trusts.

In addition, ten patients consented to be interviewed in depth and, again more staff were involved in the eight meetings that were observed and an introductory walking tour with a staff member in one Trust involved additional staff and patients in the study.

Each of these data collecting encounters represents a different unit of study and a different 'order' of data.

The nature of the study required a commitment of between 30 minutes (for completion of a survey or a short interview) up to two days, in the case of 'shadowing', of respondents time. Most respondents' contributions to the study, however, took about 90 minutes although this also represented an important commitment of their time (and energy).

Table 1. Qualitative Data Collection

Table 1. Qualitative Data by modes of collection							
	Interviews		Focus groups	Shadowing (staff and patients)	Ethnographic observation	Patient interviews	Other meetings and visits
Trust	N = men	N= women	N = Group (n = participants)	N = days	N = days		
1	13	19	5 (15)	5	9	10	4
2	5	9	3 (24)	8	3 x .5 + 1	0	2
3	4	8	0 (0)	13	0	0	2
Totals	22	26	8 (39)	26 days	11.5 days	10	8

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3.2.3 OCS (Organisational Climate Survey)

Trust 1

The staff survey

An administrator in Trust 1 provided a staff list (name and location) from which a random sample (35%) was identified using the SPSS software version 14 providing a list of 939 potential participants from staff across the Trust (including and beyond the Units participating in the main data gathering). The questionnaires were all individually addressed and sent through internal mail.

Of these 223 (24%) individuals returned a completed questionnaire, although ten blank surveys were returned with a note that the intended recipient had left the trust and one said they were unable to read English (1). Thus the final number of participants for Trust 1 was 210.

The patient survey

In Trust 1 we gained agreement from the senior staff on the two study Units (Obstetrics and Gynaecology and Cardiology) that they would arrange wherever possible for patients to complete the patient version of the OCS and would arrange for the researchers to collect the completed forms.

However the full batch of uncompleted patient questionnaires was sent back to the PI at the College several weeks later with an anonymous note stating that the staff did not wish to administer these to the patients. We were unsure how to proceed after this because ethically, although the survey was directed to the patients, the staff had completed consent forms and had copies of participant information sheets, and were aware that they (staff) could withdraw from the study at any time. We considered that this constitute an ethical dilemma for the team.

The researchers made other attempts to hand out the questionnaires directly to patients but found that while some patients were prepared to consent to being interviewed and almost all consented to having a researcher present during patient/doctor/nurse meeting it was not looking possible to obtain a valid sample of questionnaire returns.

Trust 2

Trust two was organised across two distinct sites and although the senior staff work across both sites, as will be made clear from Chapters Three and Four below, each site is very different in its organisation. We initially

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approached the senior staff on Site A first about how to distribute the questionnaires and they referred us to Human Resources on Site B who were the only people with access to a staff list. We did not get any acknowledgement from HR despite several attempts including one visit to the head of HR from one of the researchers. He said he would get back in touch once he had checked whether he could release this list but he did not and we considered there was little more we could do to pursue this particular approach.

The PI then contacted the senior nurse manager, who had been one of our original gatekeepers, for help but found that she had left for another post.

Following the abortive attempts to contact HR (or anyone else who might have been able to help) a PA in one of the many departments we contacted suggested that there was a staff intranet which went out once a week with an 'update' section with news for staff across the Trust. The PI made contact with the editor of this site who agreed to include an electronic version of the OCS.

Consequently, the questionnaire was included on this web-site, with a preamble (adapted from the NRES participant information sheet) on two occasions. However it only produced one reply. We made one final attempt via the PA of the CEO to contact HR for a staff list to no avail.

What was interesting and perplexing though was, that there was no difficulty obtaining a commitment from staff across the Trust to participate in an interview or focus group which was much more time consuming and personally revealing.

By the time we were ready to collect the patient survey data at Trust 2 we already recognised the problems with the responses from the staff. Also, by contrast, we had established the effectiveness of eliciting patient data from the shadowing and observations. We therefore made a decision to focus on this approach to data collection from patients rather than pursue more blind alleys.

Trust 3

In Trust 3 the early signs were that there was no overarching administrative structure from which we could obtain a staff list and nobody we asked could advise on the best way to gain that information. However we did have some 'local' e-mail addresses of the staff in the Units and therefore we e-mailed the OCS to staff on the two study Units and obtained 13 replies all together.

3.2.4 Participant characteristics

There were 224 respondents who completed and returned the questionnaire, of which 77% were women (n = 172) and there were 23% men (n = 49). These included from Trust 1 (n = 210, 93% of respondents), Trust 2 (n=1, 0.4%) and Trust 3 (n= 13, 5.8% of respondents).

The mean age was 46 years, standard deviation 11.1. The majority of respondents were married (62.7%), with a further 7% cohabiting. Twenty percent of respondents were single and almost 10% divorced. The majority of respondents were White (72%), the next biggest group were Asian (18%) and other ethnic minorities such as Black (6.5%) and Oriental (3%) consisted of much smaller groups.

Pay level: most of the respondents had a salary of less than £20k (44.3%) or between £20k- £40k (38.8%). A much smaller percentage (5%) earned between £60k and £90k and a further 2.3% of respondents had a salary exceeding £90k.

3.2.5 Professional demographics

The majority of respondents had been working in the NHS for over 5 years (68%), with a further 26% for between 1-5 years. Only 5.8% reported less than one year's service.

3.2.6 Stability within individual Trusts and Units:

Most respondents had been employed by the same hospital for over 5 years (56%) and another 34% had worked there between 1-5 years. The rest (10%) had been employed by the hospital for less than a year.

Most respondents reported working for the same Unit for over 5 years (45%), a further 43% reported working there for 1-5 years and only 12% reported service of less than 1 year. A similar pattern was seen in terms of length of time in same job. However the majority in this case had been working at the same job for between 1-5 years (45%) and slightly less (41%) had been working in the job for over 5 years. Another 12% had been employed in the same job for less than one year.

3.2.7 Role:

The majority of respondents were nurses, 31%. 13.5% of respondents were managers; 11% consultants/doctors/physicians. Other allied professionals, such as scientists and psychologists made up 10% and support staff made up a further 6%. Clerical staff and 'other' staff (such as porters, maintenance) made up a further 13% each.

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3.3 Data Analysis

This was conducted in the manner described in Chapter Two and the results are discussed separately in the following chapters each of which when relevant provides more context to the conceptual framework and analysis in the substantive area of focus.

3.4 Conclusion

The diverse nature of each of the organisations studied provided valuable information about the different kinds of challenges that different leaders at all levels might face in different institutions across the NHS.

Staff at senior level (particularly non-clinical managers) moved around within and between Trusts. During the course of conducting our study some key gate-keepers and participants left the Trust, others joined and yet others moved position and role even during the relatively short time we collected data there.

In some cases mergers had just taken place or were expected. This was experienced by some as opportunities and others as threats, but in all cases it meant structural reorganisation, staff being re-assigned or choosing to leave for another post.

This has to be taken to be part of the changing face of the NHS overall and central to the culture and climate of the participating Trusts, and can no doubt be generalised to every NHS Trust across the country. In what follows, we have used our different strategies for data capture to examine the relationships between leadership and service delivery in this fluid and (potentially) exciting context.

4 Leadership in the NHS

4.1 Introduction

In any organisation:

Leadership is needed to pull the whole organisation together in a common purpose, to articulate a shared vision, set direction, inspire and command

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commitment, loyalty, and ownership of change efforts (Huffington, 2007, p. 31).

and

Leadership would be easy to achieve and manage if it weren't for the uncomfortable reality that without followership there could be no leadership except, perhaps for the delusional sort. (Obholzer, 2007, p. 33).

In this chapter we examine the ways in which leadership is defined, exercised, experienced and transmitted taking account of how far leadership is perceived as pulling the organisation together to pursue the common purposes of patient care and the relationship between leaders and followers.

We specifically:

- Explore how leadership is defined by different stakeholders and what they see as determining its quality;
- Seek to begin to understand how leadership is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients through examining the data from focus groups and story-telling interviews;
- Using the same data sets, explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted.

4.2 How is leadership defined by different stakeholders and what do they see as determining its quality?

We start this particular exploration with a *thematic analysis* of the qualitative data to identify what themes emerge from the definitions, while also making interpretations using *CDA* and *narrative analysis*. In so doing we pay attention to what Gough has termed 'emotional ruptures' (Gough, 2004) in the text which serve to illuminate some of the subordinated or unconscious information in the stories of the respondents and the subjectivity of the narrator (Frosh, 2003; Frosh, Phoenix, & Pattman, 2003; Hollway & Jefferson, 2000).

In Chapter One we proposed that 'leadership' as a concept has been subjected to continuous scrutiny and moved through different theoretical and paradigmatic iterations. The NHS has identified the qualities it requires in a leader and the role that NHS leaders (at all levels) are expected to strive towards (see Figure 1). We therefore inferred that respondents, imbued in the culture, would focus on 'transformational' or 'distributed'

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explanations and definitions about leaders and leadership because these models are embraced by the style of the coaching and training on offer.

4.3 Definitions

Respondents distinguished between 'leader' and 'leadership'. A 'leader' was described and defined in diverse ways including as:

Obviously strong minded and opinionated (Administrator, T, 2¹⁹).

Particular personality traits - need to be - to have integrity, ((1²⁰)) to ((1)) be clear, err to be facilitative, to have energy to listen, erm, to negotiate, ((2)) to make decisions (Senior Non-clinical Manager, T, 2).

... making sure that you're the person who is erm keeping the team focused getting them to achieve those goals looking at different ways of working (Senior Clinician, Trust 3).

These definitions suggest diverse ways of thinking about the idea of 'leader', indicating that commonality of stakeholder views should not be taken for granted. The qualities a leader has to have are determined in these definitions through having opinions, being strong-minded while also having integrity. A leader also needs to be able to facilitate actions, negotiate and keep the team focused towards the achievement of its goals supporting team-work.

4.3.1 Defining leadership

Leadership in this first definition below was about a formal role and implicitly hierarchical rather than distributed:

I don't think there is anything magical about good leadership. It is about establishing what the organisation wants to do and allowing people to get on and do it (Recently retired CEO with clinical background, T2).

This respondent, who had occupied a senior position, saw the structure and strategic direction of the organisation as fundamental to what works as leadership which was not 'magic'.

¹⁹ In some cases we are able to identify the Trust but where there is any chance of a breach of confidentiality we adjust the 'credit' to ensure anonymity.

²⁰ Where the transcription has included double brackets it denotes pauses timed in seconds.

The following respondent expresses it differently suggesting that it means different things to different people on the one hand, while also being an imponderable (possibly even magical):

Leadership is like love, we all know it exists, but you can't actually prove it, you can't define it, and it comprises of lots of different things that people do, if you demand evidence for everything...you will get rid of leadership eventually (Senior Clinician, T2).

This clinician seems to take distributed leadership for granted in that it is about 'lots of different things that people do'. A warning is expressed it appears, though, that trying to *show* leadership exists across the organisation (perhaps rather than residing in designated roles) might ultimately destroy the possibility of leadership. Following Gronn (Gronn, 2002) this might be a way of suggesting that through concerted action leading to conjoint agency, leadership might not be so obvious (as in the first definition immediately above) but it might be more effective in a hospital where there are different qualities needed to lead in different activities.

Resonating with the view above that a leader has to have integrity, is the view from one leader's experience:

I learnt that it's very important thing for leadership... to not lie, not hide anything and just tell them the reality and be true to yourself, and that's really important (CEO, Non-clinical).

There is an immutable relationship between the leader and the follower. Being true to oneself and honest towards followers must be fundamental to the emotional engagement or attachment between leaders and followers. The significance of emotional engagement as well as emotional and social intelligence was high on many respondents' agendas for determining leadership quality:

... leadership is about having, or being able to demonstrate at any level a coherent vision for where you're trying to go and getting people getting there (Nursing Manager, T 2).

[Leadership in the NHS] is a people focused, leadership job (Senior Non-clinical Manager, T3).

.. it's not always leading from the front (Senior Clinical [therapies] Manager, T 3).

While the leader needs to have vision, these definitions imply that vision alone does not determine how leadership can be exercised or experienced. Leadership will not work unless the leader engages the followers with that vision.

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If leadership fulfils an organisational role ('establishing what the organisation wants') then can it also be 'people focused'? If good leadership is about transparency and honesty is there an assumption that it has not always been so or may not be so at some future time? What does this imply? Does leadership have an 'indefinable' quality' or set of characteristics that work within a specific context but may not be transferable as 'skills'?

Leadership presents dilemmas for the maintenance of personal integrity ('tell them the reality and be true to yourself'), it is a 'job', it requires 'vision' and flexibility and most importantly it seems it is about focusing on people.

4.4 How is leadership in NHS health care organisations exercised and experienced by those affected by it?

Respondents talked about the *role* of the leader as central to the practice of leadership in the organisation. Leadership was understood to be intrinsically linked to particular tasks/goals while necessarily engaging with the followers who had to implement much of these tasks and achieve the goals. There was a sense that many respondents held an idealised view about leadership in their own Trust. Sometimes though the reality for them fell short of expectations because the person occupying that role failed to live up to their hopes.

For example, as the following extended extract illustrates:

.. one of the things about the leadership and management of this Trust is first of all clinical leadership is strong in most places. The clinical directors here have general clout and they are not just figureheads .. and the other bit I think - relationships between general managers and clinicians on the whole are much more positive here than other Trusts (Senior Clinician).

This proposes that strong leadership among clinicians (distributed both horizontally and vertically via the clinical grouping) enables managers to deliver the service to patients. However, this does not in itself identify the characteristics of the links between strong leadership and service delivery.

For many respondents leadership is exercised at least in part through each leader's personal characteristics (good and bad). Almost without exception when asked about the qualities that make a leader, and to 'story' their own explanations, respondents placed a degree of emphasis on the characteristics of an 'ideal type'. The following exemplifies this:

Most important quality is the communication. Being able to listen - hear what is being said and to deliver that--what they want to say, so that it is heard by all. That it be quite quick thinking, being able to develop an idea

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and roll it out, umm being able to think on their feet as well, because sometimes you get things that turn up and you have to deal with it there and then, umm, reasonably personable so people will confide in that person, um also strong so that when things are tough they can um deal with them (Clinical Midwifery Manager, T1).

The comprehensive but daunting picture of how leadership is exercised described above, represents an ideal of distributed leadership as *concerted action* (Gronn, 2002). This type of leadership is exercised through being able to communicate – to listen and to express clearly (so as to be ‘heard’) how action will be taken. ‘Rolling out’ the idea again suggests taking peers and followers along with you and being ‘personable’, so people will confide in that person, further indicates the ability to take the views of others into account calling for both emotional and social intelligence (Amendolair, 2003; George, 2000; Goleman, 2006; Lopes, Grewal, Kadis, Gall, & Salovey, 2006; Riggio & Reichard, 2008). In this model, the multifaceted communications rely on the ability to use the information to think quickly and be strong under ‘tough’ circumstances.

However, in the next extract (from a non-clinical manager) the ideal type of leadership is represented by responding to short and medium term organisational goals (Buchanan, Fitzgerald et al., 2005; Riccucci, Meyers, Lurie, & Han, 2004).

Erm, I think leadership is about erm, encouragement. It is about showing people direction in which you as an organisation and them as individuals engage in. I think it's incredibly important especially in an organisation like the NHS where there are lots of different groups of people and lots of different objectives - sort of daily ones, monthly ones more long term, and you have quite a clear sort of vision of where you're going and I think that the good leaders in the NHS show that, and examples of bad leadership are where that is not so defined. (Middle Manager, T2).

This suggests a *transactional* model of leadership, whereby the good or effective leader offers ‘encouragement’ to the followers in return for people accepting the practices of the wider organisation (Bass, Avolio, Jung, & Berson, 2003; Eagly and Johannesen-Schmidt, 2003)

4.4.1 Exercising leadership through their organisational ‘role’

Leadership is experienced by some as being exercised through the legitimated role. Organisational role in the leadership discourse equates with the leader’s professional position as the respondent below shows clearly:

Who would be a leader to me? I think there's a number of different areas, there's your direct line manager, who's the clinical leader of your department. Who's who in this structure there's line managers above them, and above them and so on. There would be people you would look to within your own specialty clinically who are more experienced than you ((2))²¹ in certain areas, to ask for advice, erm ((1)) and similarly in an academic environment ((1)) there are other people there who have more experience that you would want to take advantage from or advice from. ((2)) And in the wider circle, national or international leaders in the field who are so expert at those things that you also turn to. (Medical Consultant, T3).

While the formal roles and organisational hierarchical structures are taken seriously by this respondent, there is also a clear vision of leadership being exercised through concerted action in collaborations that arise *spontaneously* where clinical and/or experience is valued and sought within this respondent's speciality and sometimes *intuitive* leadership (Day, Gronn, & Salas, 2006; Pearce, 2004). However, there is also a sense that this respondent experiences leadership through the institutionalisation not only of formal roles locally, in the organisation itself, but through the structural relationships with those who are seen as experts in a much wider networked context (Pearce, 2004). This version of leadership is particularly important in that it demonstrates that leadership can be both experienced and exercised beyond the boundary of the organisation and the NHS, based on knowledge and expertise originating outside these systems.

Respondents frequently combined personal qualities with their understanding of the leadership role, particularly related to taking responsibility as part of that role:

It's quite difficult, I mean I think taking responsibility (4) making sure that things happen that are supposed to happen, or don't happen that aren't supposed to happen (3) um.., (6) that's it. (Clinical Medical Consultant, T1).

Not everyone saw leadership in this way. This respondent is talking about their own experience of being in a role in which then 'buck' frequently stops and thus by definition they are in the role of leader.

The exercise of leadership through being a 'role model' (Trevino, Hartman, & Brown, 2000) where qualities of leadership were displayed was important for some:

The leaders that I've worked for and have wanted to follow ... push something in me that says 'I want to be like them' or I completely support

their vision of where they're going or you know so I want to follow that person and I want to do the best that I can do for them because I believe in them and their vision. (Head of Non-Medical Clinical Team, T3)

This explanation has a flavour of heroic or charismatic leadership, although not as a quality that resides in a specific person necessarily, but one that resides in a relationship that 'fires' up both leaders and followers (Klein & House, 1995). Even though the idea of the charismatic leader has been at least partly consigned to the history of the late 20th century organisation, it has not disappeared and needs further thought particularly in an organisation such as the NHS where changes are sometimes rapid and stressful (James, 1999) and internal culture needs to be taken into account (Dopson & Waddington, 1996; Tourish & Vatcha, 2005).

4.4.2 The relationship of the 'leader' to 'followers': how leadership is experienced

While leadership is the focus of the professional and political debates about the NHS and other organisations, until recently, relatively little attention has been paid to followers' experiences of leadership (Avolio et al., 2004; Howell & Hall-Merenda, 1999; Lewis, 2000; Schilling, 2009). From the perspective of a manager taking the position here as 'follower' looking 'upwards' in the organisation:

I think it's, it's providing, you know direction and to lead and that's a leader's main job in my mind. And (2) that's .. what they say for leadership, you must have followers. If nobody's following you, what you are saying then? you are not a good leader. So that's a good, you know, test for a leader to evaluate themselves. That's what they are saying and what they are trying to achieve. Are people behind them or not? If they are not behind the leader there's something wrong with that. (Middle Non-clinical Manager)

From the perspective of a junior doctor taking the 'followership' position:

I think in order for you ... well in my opinion a leader, I have to be able to kind of respect them. If I don't respect or kind of have faith in what they do, then it's, it's a personal authority, so in order, you know in order for me to do that I have to believe in what they say. I mean, I might not always agree with them in my opinion but at the end of the day I have to be able to respect them enough and for them to have certain authority, someone who's probably experienced and gained that knowledge, so yeah. (Junior doctor)

For leadership in the NHS to be exercised effectively then there has to be an engagement between the leader and the followers (Macy & Schneider, 2008) and to understand fully how the engagement takes place, a degree of

emotional engagement and/or attachment to the leader and the organisational vision is fundamental (Riggio & Reichard, 2008; Rubin, Munz, & Bommer, 2005; Vince & Broussine, 1996).

The failure to take followers with you is made explicit here from the perspective of one (designated) leader:

A: I was forced upon them...

Q: that's what I was going to ask. So presumably there was a lot of resentment I guess?

A: Yes.

Q: And how does it manifest itself?

A: Erm, non-cooperation, making life difficult for you sometimes, people talking about erm ((2)) sort of criticising you behind your back and erm playing silly games behind your back that makes management of other people more and more difficult. Erm you know, and yet we sort of have to fight another battle to win hearts and minds, when we, you know, don't really have the time to do that, we have got to have our focus on doing what we are meant to do, which is to manage patients and to manage our beds properly.

This extract from the interview with someone whose role it is to lead change is revealing. The respondent recognises that he is not taking people with him and in his view, the followers appear to eschew co-operation. He also believes they are mocking him and that that mockery is contagious. He may or may not be able to evidence this, but that it is in his mind is potentially detrimental to his experience of leading in his organisation (Stein, 2005). Furthermore, instead of looking at himself, this respondent wants to push the blame for the leadership failures onto the followers (in other words he engages in splitting described in Chapter One) (Klein, 1975; Segal, 1973). Such a process is diametrically opposite to leadership studies that identify authenticity and trust between leaders and followers as being one of the basic qualities for leadership (Avolio et al., 2004; de Raeye, 2002; Novicevic, Harvey, Ronald, & Brown-Radford, 2006).

There is also some evidence of concerted action here, distributed among those who were leaders of the *resistance*, which is not necessarily against the values of the organisation in any negative way, but may be seen as upholding important principles and challenging change (or a particular form of leadership) that might be perceived as counteracting these important values (Collinson, 2005; Zoller & Fairhurst, 2007).

Trust is one important quality in the way leadership is exercised and experienced by followers and developing trust is essential if changes in

practice are to be implemented (Bass & Steidlmeier, 1999; Hunter, 2005). So, for example, 'engaging' with others involves trust:

Yeah definitely there are some good examples of where it's obvious that people have been able to engage lots of different kinds of people in different groups and I think they've done that just by sort of making relationships with them in the first place and then when it comes to having to lead them and be influential then you can see that those relationships are already there and then they can call on that you know, that sort of that trust or that sort of relationship that they've got (Middle Non-clinical Manager, T2).

The same respondent continued with a specific example that aptly demonstrates the links between all the three sub-themes.

Yep, I think Florence who is our head of [a non-clinical department] .. I think she is a very good example of what I'm talking about in terms of her job. And her role relies a lot on other people. Erm so as a personality she is a very responsible person, she gets on with everybody and you can really see how that works for her because when she needs somebody to do something or she needs people to listen they are going to because they have got a good relationship with her and she has taken time to build relationships when it is perhaps not necessary.

To summarise so far - *good* leadership in the NHS is understood by staff at various levels as:

- Taking responsibility
- Being 'given' authority by the followers
- Getting on with the people in the organisation
- Taking time to build relationships
- Being trusted by followers
- Winning hearts and minds
- Having a vision for the organisation
- Taking colleagues with you

4.4.3 Patients' perspectives on how leadership is exercised

While there were several things held in common (particularly 'trust' and 'taking responsibility') with the staff, patients unsurprisingly, considered leadership from a different position, based upon how they themselves had experienced a specific episode of care. One woman, who had had a previous bad experience in the same Trust in which she was now a patient, said:

Well somebody taking responsibility really for erm you know your care, erm especially. I keep going back to the same example but you know someone being responsible for not reading through my notes and if someone had taken that leadership erm and actually said 'right I'm going to look through

these notes', you know they would have obviously seen what they had to see and so basically yeah I think there is a lack of leadership.

The emphasis was on wanting the leader to take responsibility for patient care in contrast to poor practice whereby notes were not read. It was taking responsibility, and reassuring the patient that they were taking responsibility, that could be experienced by patients as good leadership.

Another patient similarly suggested that in their exercising of leadership, the clinical staff need to make sure that they were seen to be acting in the patients' best interest. For example:

When they're explaining their-selves, they do explain their-selves and what they're thinking. And they do tell me like the 'ifs' and 'buts' blah blah blah about this certain thing, but then one says something and [another] one says something else but they do explain themselves and what they're on about.

Also, another patient indicated that there needed to be one person who held overall responsibility for service delivery:

I don't know how it works hierarchy wise, whether there's like a top doctor or whatever, whoever it is somebody really needs to, you know, take a really ((2)) be sort of, you know, held responsible.

It is perhaps worth noting that the patients overall focused on the role of clinical leadership but saw that as being practiced by an individual rather than in a distributed form. There was a general view that individuals needed to be accountable and accountability equated with leadership.

4.5 What are the characteristics of an organisation that facilitate, or hinder, the process of leadership?

Leadership happens in a context and that context can facilitate or hinder leadership processes (Currie et al., 2009) and the influences of the organisation are particularly acute when the environment is changing rapidly (Goodwin, 2000; Michie & West, 2004) as in the NHS.

One respondent felt they no longer knew 'who was who' in the leadership hierarchy but considered it didn't really matter:

..., here is this model that says here is the Board and here is the chief exec and here is whoever else is up there. And there's this, this and this ... and [a colleague suggested] shouldn't we be transparent all the way through and shouldn't everything link? and I thought, this came up somebody legitimately asked the question that people here need to know what is happening here. Why? Why? I don't care. (Clinical Physiotherapist, T3).

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One senior Occupational Therapist, in the same Trust, on the other hand felt that knowledge of the organisation was important to facilitate leadership at every level so that when:

... people feel they are working as part of an organisation that's working for something, as part of a team and are appreciated and valued as part of that and are working for someone as well who feels what they are doing is worthwhile, I think that patient care will be of better quality.

This respondent was also convinced that supervision was part of the process by which an organisation facilitated both leadership and good practice in patient care. *"I have once a month supervision, like set time for supervision so I think that is really good."*

Furthermore, supervision and informal contact with peers facilitated effective distributed leadership which impacted across the organisation: *".. you can go to people informally, your peers erm whenever it's quite flexible like that and even if you're a senior like me you think 'hang on I don't know if I'm on the right track here so am I missing something?' You can just go and speak to you team about it or one of our colleagues downstairs or whatever if you want to.*

More dramatically a senior clinical leader suggested that leadership is facilitated in 'moral' organisations:

A²²: So one thinks they are better than the other, so the seven deadly sins basically...pride, the other one is gluttony, which means excess...one can never have enough, for the sake of it, and then just goes beyond, you know, one million, two million, you know, which kind of greed isn't it...excess basically, and also rushing is in there, doing things too fast. A good system will reduce its workload, yeah? The NHS has a thing of needing to do more and more, erm anyway, I don't know whether you find this useful or not, so greed, gluttony, there's rushing, and then jealousy, which is really envy, which is really competition.

Q: Yeah

A: You need to get rid of competition, and I will tell you in a moment what could replace it, which is basically team work, team work and kindness; how you get on with each other...anger is on the list. Anger is, is blame, and the opposite is blame free culture.

Q: Yeah

²² Q = question, A = answer.

A: Or forgiveness if you want, so you need to forgive mistakes, and you know you will be forgiven...and, erm...erm...next one is laziness, that's obvious, that's hard...people either have it or not, but laziness is joylessness, you need to make sure people enjoy it, and diligence, yeah? So there needs to be something in place of ...and we have that now with trust away days and things like that, but you have to have somebody dedicated to making people understand it's about having fun

Q: Yeah, yeah

A: working is about having fun...yeah? And then its... which comes really from up here, it's just an, an, yeah, can't have enough...which is also, it's also, the opposite is erm...do not take more than you can, do not take more than you need...and that is quite a moral stand ground, more than you need...for everyone

Q: Yeah

A: and if you employ that rule, then the whole organisation becomes so successful that there's masses of money left over ... Everything works well...the problem is everyone doesn't understand that, and believe in that, and then there's a difficulty...so that's moral high ground, very moral high ground, but if you go along those, you actually have all the features of leadership.

For this respondent the organisation needs to focus on patient care, treating patients *and* staff with 'kindness'. This is counter in his view to the process of setting targets for service delivery and organisational growth (or survival) and thus competition between organisations and competition between individual staff or staff teams, which is a force that (it seems) promotes the wrong kind of leadership (Kuokkanen & Katajisto, 2003; Sambrook, 2007). Furthermore, supportive teamwork and 'forgiving' mistakes and preventing the 'blame game' enhances socially and emotionally intelligent leadership distributed responsibility across the organisation and enhancing the culture and climate (Riggio & Reichard, 2008) .

Another senior medical leader and manager (T3) reinforced this idea:

I think the ethos within the hospital, is one that encourages people to develop and grow, and deliver good quality care, you know, so, I mean I think wherever it comes from it is enabled within this organisation, and it works very effectively. One of the features that enables that to happen...it's firstly being an organisation that attracts good people to want to work here in the first place. So you get high quality people applying for the position, be it in medicine, or managing, or nursing or any of the other professions By and large, we're fortunate in that. And that's partly due to the reputation, and partly due to the [location] but I think the ethos that comes

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from the leadership makes it desirable to be here. Erm...so it attracts the right people in, it then enables, it doesn't put the brakes on, it doesn't try to control people too much.

Thus, organisational performance and culture/climate were 'enabled' through a cycle of encouragement, good practice, reputation and a supportive and 'hands-off' approach to leadership. This suggests concerted action, leader/follower engagement and emotionally supportive behaviours at all levels. That the physical location of the hospital is attractive is perhaps but one factor in this equation, although a central location makes it possible to draw on a wide range of staff as opposed to a location which is in a small town or distant suburb.

It is not just features of the organisation itself that impact on leadership. Organisations reflect changing discursive constructions of leadership and the values that underlie what it means to be effective as a leader in that place at that time (Ferlie & Shortell, 2001; Lansisalmi, 2006; Michie & West, 2004; Scott, Mannion, Davies, & Marshall, 2003). As demonstrated in Chapter One theories of leadership have developed and different approaches have become significant at different times as witnessed by the shift from promoting and studying transactional, charismatic and heroic leadership styles to the contemporary emphasis on forms of distributed, networked and transformational leadership (Bryman, 2004; Butterfield et al., 2005).

One dramatic change over the past twenty and more years has been the image of the medical consultant in the public psyche. Thus the 'heroic' leadership of Sir Lancelot Spratt has been firmly (it seems) replaced by the team work in the TV series *Casualty* or *Holby City*. However the image of the rebel Dr. House (played by Hugh Laurie in an American TV series) is described as 'unorthodox' and 'radical' but most definitely a medical hero. Is this the type of leader that some might still long for? While the following comment was atypical of most people's definitions of what makes or fails to make a good leader it raises some interesting points about the contemporary regulatory discourses on leadership. Thus one participant said of another²³:

Now (Dr.) David is a really eccentric so he is not what you would naturally call a leader, erm ((1)) but people are really respectful... Because he really cares for patients ...And if he finds a junior doc, or nurse or anyone who is being unkind to an elderly patient then he is down on them like a ton of bricks but his, his patent commitment to medicine and clinical care just inspires admiration ...And great affection hopefully. But he is very odd. Yes. Erm, so he is like a one off so again there is no single person, you

²³ No identifying information is appropriate here.

know there are, there are, there are different leadership styles which are appropriate in different situations but David of course could never be a chief exec, he just wouldn't be able to do it, so he would be hopeless there.

On the surface this might be explained as a judgement based on 'evidence' and a job description. However, focusing-in on the discursive and regulatory practices with which this extract engages, a different view can be taken. The respondent here, being asked to describe the qualities of leadership, begins by suggesting that taking patient care very seriously is 'eccentric' and the person who does that is a 'one off' and 'odd'. Paradoxically (it is suggested) David inspires affection and admiration but despite the variety of leadership styles David would never make it to be CEO. Whether or not this is the case is irrelevant here because what is at stake are the ways in which discourses around 'leadership' and the qualities of the 'leader' *regulate conduct* setting normative behaviour through the discursive practices. There is little doubt that David would have been considered a leader (perhaps a leader in his field) during a different period when hospitals were smaller and perhaps when there was less specialisation in management.

A learning organisation?

The NHS has declared itself to be an organisation dedicated to learning for at least the last ten years and certain values underlie this declaration (see Davis and Nutley, 2000). It means that:

Although learning is something undertaken and developed by individuals, organisational arrangements can foster or inhibit the process. The organisational culture within which individuals work shapes their engagement with the learning process (p. 998).

In some cases the exercise of leadership clearly facilitated the (potential for) learning and learning facilitated leadership, while in others it did not. The facility for leading change in NHS Trusts is critical and developments in the role of nurses from a range of specialties to support leadership and learning have provided exemplars of how some organisational arrangements support leadership (Bellman, Bywood, & Dale, 2003; Doherty, 2009). However, some have argued that continued changes, the market as a driver and the complexity of the NHS might militate against whole system learning (Sheaff & Pilgrim, 2006). Questions have also been raised about the potential of the new generation of leaders who are expected to be inspirational, drive change and support learning (Phillips, 2005).

One capacity manager, for instance, was very clear that leadership was about enabling appropriate learning and the development of skills:

... probably more about empowerment and not necessarily of oneself but of others. So I think that indeed you need to feel empowered yourself, but I think that leadership, good leadership is about empowering and supporting those people who are not in power so that they are equipped with the skills that are required. some of it is actually around learning, it is about what stage they are at in terms of their learning curve.

This is not only a statement about distributed leadership but about a version of a transformational leadership that transcends individual leaders and requires an organisational culture that both supports individual learning and targeting individuals to ensure, that their learning is recognised and ongoing (Burke et al., 2006; Conger & Kanungo, 1988; Kuokkanen & Katajisto, 2003).

The respondent continues with this theme in a sophisticated, and it seems heartfelt, way:

But I think that sometimes that [learning] is not always consolidated, even those people that have been in that position for years. I think, it is more about the people actually understanding²⁴ what they have done, and almost sometimes talk it through, in basic detail about why they have got to the decision they got to. But just because you have been in a position for a long time doesn't necessarily mean that you have actually learnt erm and you may only then go up to a certain stage in my opinion in terms of your whole learning so then they may be stuck in, not novice, but in that middle stage rather than the expert. Which we would hope that most people would get to.

This suggests that organisations need to be vigilant and to constantly invigorate their members. For the respondent quoted above, an organisation that allows people to stop learning is one in which leaders and potential leaders stagnate (at their peril) (Mark & Scott, 1991).

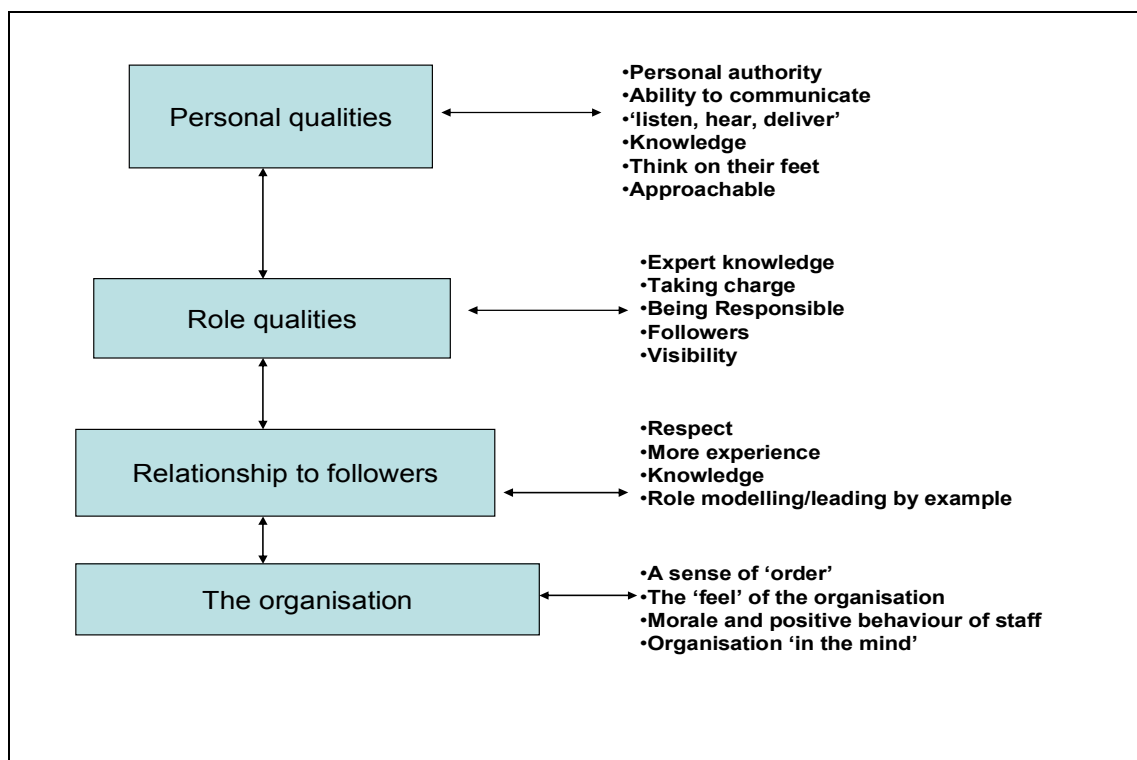
As we discuss again in Chapter Nine, the multi-disciplinary team presents an ideal opportunity for observing leadership (good and bad) and examining the ways in which these teams adhere to organisational norms which might support or inhibit learning (Burke et al., 2006; Day et al., 2004).

One senior non-medical clinical manager in a different Trust also took up the theme of learning and empowerment and specifically how it links to good patient care (Burke et al., 2006; Doherty, 2009; Kuokkanen & Katajisto, 2003).

²⁴ The transcriber who was also the interviewer made it clear that these words were emphasised by the respondent.

... [leadership] is about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is we worked with 'Training and Development' and we came up with a specific programme that was aimed at empowering them [all administrative staff] to improve their service area etc etc and also provided them with some skill sets that they probably didn't have prior to that.

Figure 11. What makes a leader?



4.6 Conclusion

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

Nonetheless, when asked to describe and define leadership, various stakeholders at all levels of the organisation have a view some of which coincides with contemporary NHS discourses and some which seems directly at odds with what the NHS is trying to achieve – that is, to support both

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distributed and transformational leadership that are seen as successful in ensuring effective patient care. However, it is clear that individual personalities and the impact of particular leaders cannot be taken out of the equation.

Leadership is experienced as distributed and transformational but there remains a belief that charismatic and transactional leadership also have their place in complex organisations. While vision is important, no vision can be achieved unless the leader takes 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. Supervision, peer support and informal advice are part of the emotionally intelligent distributed practice of leadership. 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.

In summary, the main ideas that emerged from the respondents' views of how leadership was exercised and experienced were it was about:

- Personal authority
- Ability to communicate
- 'listen', 'hear' 'deliver'
- Thinking on your feet
- Being approachable

Leadership can be exercised in a number of ways and qualities of leadership are seen to reside in different but interlinked 'places'. For example, it is clear that some people are perceived more than others to have the personal qualities that make them a leader, including being able to listen, deliver and be approachable (see Figure 11 above). The assigned/legitimated leadership role is also perceived to be an important quality for a leader, which is interesting, when thinking about the distributed leadership model and particularly the idea of concerted action where people have to work together to 'lead'. This links further to the qualities inherent in leader-follower relations identified as fundamental to the stakeholders interviewed here.

Finally, leadership means holding a sense of the organisation in mind. That is the mental model held by the leader through which they mediate and regulate their vision and actions as leaders, but it also refers to the leader's understanding of morale and the 'feel' of the organisation in which they are working, which itself regulates and constrains the possibilities for growth, development or atrophy.

In this chapter we identified some of the evidence of how organisational contexts evolve and the relationships between organisational culture/climates and the ways in which leadership is practiced. This will be developed across the next four chapters.

5 Leadership and Organisational Climate

5.1 Introduction

Despite its North American origins, where the health care system is fundamentally different from the NHS, Stringer's focus on both leadership and climate nudged us towards choosing an adaptation of his organisational climate survey for this study. We also identified an 'awareness', as he puts it himself, that "*People working in health care systems play drastically different roles that are more diverse than the roles typical in schools and businesses*" (Stringer, 2002, P. 188).

Through adapting the OCS we also captured demographic information from our participants as well as a data about satisfaction with the leadership one receives from his or her immediate supervisor²⁵. Thus, while on the whole Chapter Four dealt with general descriptions, definitions and values, in this Chapter we focus on specific relationships between individuals and the individual and the perception of their organisational climate.

The additional contribution the survey data makes to the overall aims of the study is to relate perceptions of leadership and management directly to organisational climate, thereby providing a triangulation with the story - telling and focus groups to explore the characteristics of organisations that facilitate or hinder leadership and service delivery.

5.2 Results

5.2.1 Normality of data

When normality was examined the KS-Lilifors test was found to be significant over all the scales, indicating that the data were not conforming to assumptions of normal distribution. However, inspection of the histograms and boxplots were found to present an acceptable level of

²⁵ Our version of the survey questionnaire is appended.

normality. Due to the nature of the data it was decided not to transform it, but rather to interpret the results which rely on the assumption of normality with caution.

5.2.2 Cronbach's Alpha

In order to check the reliability and internal consistency of the OCS in this setting we used Cronbach's Alphas (Cronbach, 1970) (See Table 2).

As can be seen from Table 2, the three dimensions of '*commitment*', '*support*' and '*recognition*' were considered to be high on reliability as their scores ranged from .69 to .74. These would be considered acceptable-good level of reliability (George & Mallery, 2003).

In contrast, the three dimensions '*structure*', '*standards*' and '*responsibility*' were low on reliability. This low reliability may be explained by confusing wording of the items, or it is possible that the individual items did not correspond well to one another in this sample. As such it was decided to remove the '*responsibility*' scale from the rest of the analysis. A further check to see whether '*structure*' and '*standards*' could be improved by removing single items, did not show any improvement to the alpha so these were retained in their original form.

Table 2: Cronbach's Alphas for the six dimensions

Scale	Cronbach's Alpha
Commitment	.74
Support	.72
Recognition	.69
Structure	.57
Standards	.43
Responsibility	.14

When managerial dimensions were examined for reliability' these were found to be very high ranging from .86 for '*recognition*' to .79 for '*commitment*' and '*responsibility*' (See Table 4).

Table 3: Cronbach's Alphas for the six Managerial dimensions

Scale	Cronbach's Alpha
Managerial Responsibility	.86
Managerial Recognition	.83
Managerial Standards	.83
Managerial Support	.81
Managerial Commitment	.79
Managerial Structure	.79

Overall scores for organisational dimensions

In order to derive the scores for individual dimensions, all the items on each dimension are summed [this is after all the negatively worded items were reversed].

The following were mean and standard deviations across all the six Organisational scales:

Table 4: Mean and Standard Deviation

Scale	Mean	Std
Commitment	14.82	2.86
Support	14.06	2.80
Responsibility	9.93	1.73
Structure	9.01	1.88
Recognition	8.42	2.55
Standards	8.36	1.69

Stringer, et al (2002) suggest an analysis of percentages of respondents who scored above the mean. In our analysis the following percentages were found:

Table 5: Scores above the mean

Scale	% above the mean
Commitment	60%
Support	47%
Recognition	49%
Standards	49%
Structure	39%
Responsibility	58%

Stringer offers a method of interpreting these percentages, according to benchmarked ratios collected through their extensive research to validate the tool.

High 'commitment' (60%) – In the current sample, there was a high degree of 'commitment' to the organisation and its goals. This would be typical of professional staff working for the NHS. However Stringer asserts that high 'commitment' needs to be accompanied by high 'support' and high 'recognition' – without these individuals will stop engaging with others in the organisation and their team (p.200). As indicated in Chapter Four engagement is crucial if leadership is to be effective.

High 'responsibility' (59%) – Stringer asserts that 'responsibility' is a difficult dimension to interpret within the health care setting. Effective performance in the NHS requires that procedures be double checked, which in many other contexts would put the role of 'responsibility' in an ambiguous position. However this is not the case in complex clinical settings (or for example in other precision performance occupations such as flying aeroplanes for instance). In the case of the current sample 'responsibility' was high, which is related to high sense of 'commitment', but is confused by the limited 'structure' – it is essential that people are clear about their roles, so that they may take charge and 'responsibility'.

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Moderate 'recognition' (49%) - According to Stringer scores lower than 50% may indicate that participants are feeling unappreciated. In this case there is just under the 50% mark, which translates into moderate agreement about the feeling of being rewarded for one's efforts. Having a high sense of 'recognition' in an environment such as this is of crucial importance for motivation, but 50% is within the normal range set out by Stringer. High 'recognition' is indicative of confidence in the organisations performance/reward ratio but in such a diverse setting as a hospital with a diverse staff group responding to the OCS then different groups with different management and professional/occupational structures would have different perceptions and experiences.

Moderate 'standards' (49%) – there is a moderate feeling of pressure - performance 'standards' and expectations are high but not to the point where they are stressful. This falls within an acceptable range. Considering that many of the 'standards' (targets) are set out by government policies rather than directly by Trust management/leaders it is important for these standards to be realistic and achievable.

Moderate 'support' (47%) – this falls within the low but acceptable range for this scale (45%-60%) according to Stringer's benchmarks. This indicates that there is sufficient unity between teams to approach and solve problems, without overly nurturing so as to discourage individual 'responsibility' and undertaking. Team work within the health care system is challenging because of the interdisciplinary nature of teams which inevitably calls upon different management and professional structures and networks for support.

Low - Moderate 'structure' (39%) – Under half of participants felt there was clarity in terms of their roles, responsibility and authority. On the one hand this means that there are less constraints and a less of a 'jobs-worth' approach, on the other hand though it means that there is (potentially) insufficient clarity in roles and responsibility. In an organisation such as the NHS, this may be a considerable shortcoming and Stringer (p.193) suggests that in a health care environment such as a hospital, one would ideally like to have 'structure' scores above the 70s. This is emphasised because of the complex nature of the hospital environment with so many individuals involved – accountability needs to be very clear. The NHS however has gone through so many changes over the previous ten years that it is inevitable that the 'structure' score would be influenced.

Associations between the six dimensions on the organisational level

Pearson's r was utilised to test the relationship between all the Organisational scales. It was found that the majority of scales showed modest, but significant relationships:

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Table 6: Correlations between the six organisational dimensions

	Standards	Structure	Recognition	Support	Commitment
Standards	1.00				
Structure	ns	1.00			
Recognition	.22*	.47**	1.00		
Support	.17*	.42**	.61**	1.00	
Commitment	.30**	.39**	.59**	.67**	1.00

* <.05

** >.001

As can be seen from Table 6, there are a number of high associations between these dimensions. The highest associations are for 'support' and 'commitment' (.67) 'support' and 'recognition' (.61) and 'commitment' and 'recognition' (.59). In other words, participants are reporting that when a feeling of co-operation within teams is present, this is often accompanied by acknowledgement and appreciation and is further related to a greater sense of dedication and 'commitment' to the goals and aims of the team. By definition, the converse also applies: feelings of isolation are more likely to be accompanied by lack of incentives and disenchantment with the objectives of one's team. This is 'supported by Stringer (p.200).

Satisfaction with leadership

When the *organisational dimensions* were examined in relation to satisfaction with the quality of leadership received from the immediate manager, which was asked as a single item, the scales which correlated most highly were 'support' (.61) and 'recognition' (.52). The weakest relationship was to 'standards' and 'structure'.

Table 7: Correlations between organisational dimensions and satisfaction with Leadership

	R (sig)
Standards	.14*
Structure	.30**
Recognition	.52**
Support	.61**
Commitment	.39**

In order to evaluate the individual contribution of each of the organisational dimensions to the overall 'satisfaction with leadership', a regression analysis was conducted, which included all items which were found to correlate significantly with satisfaction, namely 'standards', 'structure', 'support' and 'commitment'.

The total variance accounted for by the model was 40% (Adjusted $R^2 = .38$) therefore variability in 'satisfaction with leadership' is moderately accounted for by this model.

Specifically, of the five predictor variables the two which were found to predict the outcome variable of 'satisfaction with leadership' were 'support' and 'recognition', 'support' being the biggest contributor with a $B = .52$ ($p < .001$) and the other predictor was 'recognition' ($B = .27$, $p < .001$). The other variables were not significant. [Appendix 1 of this chapter].

In other words, feeling supported by one's team and believing that rewards are appropriate to effort, accounts for a significant proportion of an individual's satisfaction with leadership.

Correlations between dimensions on Managerial level

The second part of the questionnaire asked about individual experiences of management. All six dimensions on the managerial level were highly correlated with each other, with strong correlations ranging from $r = .71$ ($p < .001$) between 'structure' and 'responsibility' to a correlation of $.84$ ($p < .001$) between 'commitment' and 'standards'.

Table 8: Correlations between dimensions on Managerial level and Satisfaction with Leadership

	Manager Recognition	Manager Support	Manager standards	Manager structure	Manager Responsibility	Manager Commitment
Manager recognition	1.00					
Manager support	.83**	1.00				
Manager standards	.82**	.83**	1.00			
Manager structure	.73**	.78**	.79**	1.00		
Manager responsibility	.84**	.79**	.79**	.71**	1.00	
Manager commitment	.79**	.83**	.84**	.82**	.79**	1.00
Satisfaction with Leadership	.68**	.76**	.71**	.71**	.65**	.76**

** Significant at .001 level

A single item asked about satisfaction with the quality of leadership received from immediate manager. When this was examined in relation to the six dimensions appropriate to participants' own experience of management practices, it was found to correlate highly and positively with manager 'support' ($r=.76$); management 'structure' ($r=.71$, $p<.001$); manager 'commitment' ($r=.75$, $p<.001$) and 'standards' ($r=.71$, $p<.001$); manager 'recognition' ($r=.68$, $p<.001$); manager 'responsibility' ($r=.65$, $p<.001$);

A multiple regression was carried out to examine the perception of 'satisfaction with leadership', as a dependent variable of management practices. The overall association between management practices and satisfaction with leadership was strong ($R=.80$) with associated variance explained of 63%.

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Table 9: 'Manager' dimensions regressed onto 'satisfaction with leadership'

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	-.054	.226		-.240	.811
Manager Recognition	.001	.039	.002	.025	.980
Manager support	.175	.039	.410	4.501	.000
Manager structure	.060	.027	.177	2.260	.025
Manager responsibility	-.018	.032	-.047	-.559	.577
Manager commitment	.165	.056	.278	2.948	.004
Manager standards	.017	.056	.029	.310	.757

In this case, it was manager 'support' which best predicted satisfaction with leadership ($B=.41$, $p<.001$), next biggest contributor was management 'commitment' ($B=.28$, $p=.001$) and management 'structure' ($B=.177$, $p=.025$). In other words, a large proportion of feeling satisfied with one's leadership, pertained to feelings of being supported and the degree to which one's manager inspires and exudes 'commitment' to common goals. A further important element in the equation is that of 'structure' – where roles and responsibilities are clear, it is associated with greater satisfaction with leadership.

As the biggest predictor of 'satisfaction with leadership' was manager 'support', a further regression was done to look at what organisational dimensions related to having good managerial 'support'.

All the organisational scales were inputted into a regression, excluding organisational 'support', with managerial 'support' as the outcome variable. The following was found:

In total the model accounted for 35% variance in the outcome variable (Adjusted $R^2 = .35$). There were two contributors to the model: the strongest one was 'recognition' ($B = .44$, $p < .001$), i.e. the more employees feel that the organisation rewards and recognises their efforts, the more they feel supported. The other contributor to managerial 'support' was 'commitment' ($B = .20$, $p = .008$). [Appendix 3 of Chapter Five]

These findings indicate that organisational 'recognition' and 'commitment', are organisational climate dimensions which most affect the outcome of managerial 'support', and this in turn has the greatest effect on individual's sense of satisfaction with their leadership. This again corresponds with data discussed in Chapter Four highlighting the importance of the feel of an organisation that provides support at all levels.

Regression of all dimensions onto Satisfaction with leadership

When all the variables previously shown to be significant to Satisfaction with leadership, were entered into the model, from both the organisational and managerial dimensions, namely manager 'support', manager 'commitment' and manager 'structure' as well as organisational 'support' and organisational 'recognition', the following picture emerged:

There was a high degree of variance accounted for by the model - 65% (Adjusted R^2). The model was found to be significant ($F = .80.65$, $p < .001$).

The variables which remained significant, in order of their contribution are: manager 'support' ($B = .34$, $p < .001$), manager 'commitment' ($B = .33$, $p < .001$) and Organisational 'support' ($B = .13$, $p = .03$).

In other words, satisfaction with leadership, in this sample, was predicted by a greater perception of 'support' from management, a feeling that managers demonstrated their 'commitment' to achieving common goals and an atmosphere of 'support' and team-work within the organisation.

Organisational and Managerial dimensions

In order to investigate the relationships between organisational and managerial dimensions, a correlation was performed between all of these variables (Table 10). It was found that:

There were strong correlations between manager and organisational 'recognition', and manager and organisational 'support'. There were moderate correlations between manager and organisational 'commitment' and 'structure'. And there was a weak correlation between manager and

organisational 'standards'. In other words, where the dimensions were correlated weakly or moderately, we can identify that 'standards' of the organisation do not necessarily exist at the same level of managerial 'standards'. The same relationship goes for 'structure' – having organisational 'structure' does not predict clarity in roles, as espoused by one's manager. There is a greater degree of correspondence between organisational and manager 'commitment'. When we look at 'support' and 'recognition', we find that both these dimensions tend to be closely related – one is more likely to feel that both are high, or both are low.

Table 10: Relationship between managerial and organisational dimensions.

	Organisational Recognition	Organisational Support	Organisational standards	Organisational Structure	Organisational Responsibility	Organisational Commitment
Manager recognition	.60**					
Manager support		.65**				
Manager standards			.25**			
Manager structure				.34**		
Manager responsibility					-.02 ns	
Manager commitment						.48**

The significance of Role

The largest group of participants was nurses (31%), then clerical staff (14%), managers and porters (14% each). Doctors/consultants/physicians (11%), other allied professionals (10%) and 'support' staff (6%).

When looking at satisfaction with leadership the following findings were apparent: High satisfaction with leadership was reported in total by 54.3%

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(n=113) of staff. Although there were no significant differences by work role, it can be seen that consultants and doctors reported the highest satisfaction (74%), followed by managers (61%). It can be seen that clerical workers had the least high satisfaction (41%), followed by 'support' staff and other allied professionals (54%). This is significant in terms of the hierarchy within the organisation – the higher the position the more satisfied one is with their leadership.

Table 11: The significance of role and satisfaction with leadership

	n	% positive responses about satisfaction with leadership
Managers	28	60%
Doctors	23	74%
Allied professionals	22	54%
Nursing	65	49%
Support staff/Assistants	13	54%
Clerical	29	41%
Porters/maintenance	28	57%

A further examination of organisational dimensions according to role using a one way ANOVA, revealed the following:

In all there were large differences between respondents in terms of their role, however only two scales exhibited differences which reached significance. The first was 'commitment' – doctors/consultants were found to rate significantly higher than allied health professionals on this scale (mean difference = 2.86) ($p < .01$).

The second was 'recognition' – it was found that doctors were much more likely to rate higher than clerical staff on this scale (mean difference = 2.41) ($p < .01$). Both these findings were apparent even after using the Bonferroni correction.

Comparing doctors (all grades) in Trust 1 and Trust 3

An examination of the responses on the item looking at 'satisfaction with leadership' amongst doctors revealed that doctors at Trust 1 (n= 13) had lower satisfaction (Mean = 3.38, std = 1.38) in comparison to doctors at Trust 3 (n= 10) (Mean = 4.20, std = .42). This difference (.81), whilst small, was found to be approaching significance (t = -2.003, p = .06).

While it is not possible to make an objective comparison between doctors from Trusts 1 and 3 from the qualitative data, there is more evidence in Trust 3 of doctors being both emotionally engaged with both junior doctors and other members of multi-disciplinary teams than in Trust 1 and with distributed leadership. As will be evidenced in Chapter Six doctors and other staff considered 'management' as bureaucratic and distant rather than engaged.

Gender

There were no differences between men and women's scores on 'satisfaction with leadership' (t = 1.71, p = .08).

When examining differences between men and women on the organisational dimension it was found that only one dimension, 'recognition', was perceived significantly differently (t = 3.42, p<.001). Men perceived there to be greater 'recognition' (mean = 9.55) compared to women (mean = 8.13). All other dimensions were not significantly different (see Chapter Eight).

When examining the gender differences on managerial dimensions of the OCS there were trends approaching significance in terms of differences between the genders on managerial dimensions, but these did not reach significance when multiple comparisons were taken into account:

Manager 'recognition' (t = 1.91, p = .06)

Manager 'responsibility' (t = 2.10, p = .03)

Manager 'standards' (t = 2.33, p = .02).

5.3 Conclusions

The difficulty obtaining data across all three participating Trusts has not limited the value of using the OCS to triangulate the qualitative data, particularly because a) the OCS gathered information from staff groups who were not represented in the focus groups, shadowing or story-telling

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interviews and was able to identify generalisable predictors of satisfaction with leadership and management practices, and b) the OCS data captured information from specialty groups outside those involved in the participating Units from which qualitative data was collected.

What emerged here was that on the whole, the same climate variables are important in predicting satisfaction with leadership. Within the organisational domain these are 'support' and 'recognition' while predictors of 'satisfaction with leadership', within managerial practices, are manager 'support', 'commitment' and 'structure'.

Overall, therefore, 'satisfaction with leadership' was highly accounted for by manager 'support', manager 'commitment' and organisational 'support' – i.e. these were the 'ingredients' in this sample which were highly related and were able to predict satisfaction with leadership. This suggests once again that managers/leaders were effective if they engaged with followers and that organisations that supported distributed leadership and emotional engagement were more likely to support effective leadership (see Chapters Four and Six in particular).

In terms of role, the higher the position in the organisational hierarchy the more satisfied a person was likely to be with leadership. This was not necessarily the case though across all organisations in the study. The exploration of the case studies in Chapter Seven – where authority and leadership are discussed – reveals how some of the more senior leaders in organisations found themselves to be highly dissatisfied with leadership in other sectors of their Trust, if there was resistance or negligence of their authority.

Differences in gender were only apparent in terms the organisational dimension 'recognition' – it was only on this scale where women scored significantly lower than men. This may say something about equal opportunities and equal pay for equal work, but it might also relate to perception of 'recognition' between women and men discussed and exemplified in Chapter Eight below.

The overall importance of constructs such as 'support' and 'recognition' across the climate of an organisation, and management practices which demonstrate support and commitment, provide further evidence of the importance in engagement and (probably) emotion (including EI and SI) in an organisation.

6 'Organisation in the Mind': Transmission of Leadership and Organisational Context

6.1 Introduction

Leadership in any organisation is understood in a specific context by those involved as either leaders or followers, and as shown in Chapters Four and Five concepts such as satisfaction, support, responsibility, vision and communication among others are described and evaluated within a cognitive or mental framework within which the organisation itself is understood. It is through making sense of the organisational context that leadership and followership may be enacted and transmitted.

We saw how members of organisations *necessarily* hold in their mind fantasy/imagined understandings or images of the *system* (Morgan, 2006). This informs how they work in, relate to and talk about their organisation, based on their perceptions of their own and others' place and role within the system. For example, it is common to hear employees talk about how 'you can never get management attention in this company' or 'we are all dedicated to putting patients first here' (Armstrong, 2005; Morgan, 2006).

Similarly, the participants who completed the OCS held a view of the leadership and management in their organisations, in order to think about the various ways in which their work was recognised, supported and so on both generally and by their managers. While the focus in that case was upon on measuring the impact of organisational climate and thinking about a relationship with a specific manager, those who completed the survey would have had to hold a perception of what was happening in their department and the Trust overall.

This is apparent in what follows particularly in the ways 'management' is discussed and taking account of these perceptions provides some evidence about the ways in which leadership is transmitted in these particular organisational contexts and in general. The 'organisation in mind' then involves:

- An 'image' of the organisational structure and relationships within that structure
- A sense of your own role and place within it
- An emotional component
- An awareness at a conscious and/or unconscious level of important information below the surface

6.2 Organisation in the mind

The concept of the 'organisation in the mind' was a model developed originally in the early 1990s by organisational and group relations consultants working at the Grubb Institute, the Tavistock Centre and the Tavistock Institute of Human Relations, to refer to what an individual perceives mentally about how organisations, relations in the organisations and the structures are connected. *"It is a model internal to oneself ... which gives rise to images, emotions, values and responses in me, which may consequently be influencing my own management and leadership, positively or adversely"* (Hutton, Bazalgette and Reed, 1997, p. 114 quoted in Armstrong, 2005, p. 4).

In other words, when we talk about our colleagues, guess what the senior management are doing/going to do and have fantasies about how well we fit, or don't fit, into the structure or system we do so in the context of the organisation we 'hold' in our mind which may or may not relate to that which other members of the organisation hold (Pols, 2005).

Organisations are experienced cognitively and emotionally by their members when they think about how their organisations work and are structured (see Lewin, 1947; Armstrong, 2005; Morgan, 2006). As Stokes (1994) explains it, everyone carries a sense of the organisation in their mind but members from different parts of the same organisations may have *"different pictures and these may be in contradiction to one another. Although often partly unconscious, these pictures nevertheless inform and influence the behaviour and feelings of members"*. (p. 121)

Hutton (2000) talks about it as *"a conscious or pre-conscious construct focused around emotional experiences of tasks, roles, purposes, rituals, accountability, competence, failure, success"* (p. 2). Morgan suggests that an organisation may serve as a 'psychic prison' in that the:

...patterns and meanings that shape corporate culture and subculture may also have unconscious significance. The common values that bind an organisation often have their origin in shared concerns that lurk below the surface of conscious awareness. For example, in organisations that project a team image, various kinds of splitting mechanisms are often in operation, idealising the qualities of team members while projecting fears, anger, envy, and other bad impulses onto persons and objects that are not part of the team (Morgan, 2006, p. 226).

Some of this is apparent when talking to NHS staff about the leaders at various levels of their own Trusts and the NHS overall as was seen particularly in Chapter Four.

6.2.1 Organisation under the surface

So, when the respondent immediately below talks about the leader who has a 'really good understanding of the organisation or team' what exactly does that mean? How does that understanding come about? What do the team hold in mind about that particular leader?

Leadership is someone who has a really good understanding of the organisation or team, erm where it's going and where they imagine it to be going, so that sort of vision as well for their team, I think. (Lead Clinical Non-medical Health Professional, T3)

This respondent, referring to the (frequently used) concept 'vision', also identifies this with the *imagination* the leader holds about where the organisation is going. This is not simply a matter of guesswork. It is an intellectual/cognitive and *emotional* sense of an organisation. Indeed to take this slightly further, as Gabriel and Schwartz (2004) propose "... *what goes on at the surface of an organisation is not all that there is, and ... understanding organisations often means comprehending matters that lie beneath the surface*" (Gabriel and Schwartz, 2004, p. 1).

Although not necessarily (in fact mostly not) made explicit, even the most clear thinking senior members of organisations hold an image of the organisation in mind, expressing their fantasy/belief/perception of the organisation based on conscious and unconscious knowledge (Halton, 2007; James & Arroba, 2005). So for instance for this CEO leadership is understood emotionally as it is:

... about the feel of the organisation and what it feels like in terms of how it delivers patient care. Yeah, erm. I can best illustrate that, and interestingly we were thinking about this earlier this morning, so as a group, the executives, we were talking about it. When you walk onto a ward a hospital ward and there is real leadership on that ward, you walk in and there are a number of signals that are given off, which give you a feel. Erm the place looks organised, it has a welcoming feel, the nurses on the ward and the clinical staff greet you as they come into contact with you. They know you from the previous interactions that you have had and when you sit there and listen to what is being said on the ward they will know that the patients, the visitors on the ward, the families that are coming in the junior doctors who are in there in that environment and all of that has a feel²⁶ of a well led ward. (CEO)

²⁶ Respondent's emphasis.

The environment of the well led ward (unit or organisation) is implicitly and unconsciously identified by all who engage with that organisation. The staff communicate effectively (visually, verbally and emotionally) so that the information required is passed on through managers, clinicians to colleagues, patients and relatives. This account, which preceded the extract that focused on strategy, directed to the best patient care for the greatest number of patients, expresses his ideas at an *emotional* level. He also suggests his senior colleagues agree with this. Signals are 'given off', you can 'feel' the organisation and how it delivers patient care and there is a 'welcoming feel'. He also talks about 'empirical' evidence in that staff know the patients, the ward looks organised he remains convinced that there is a 'feel of a well led ward'.

From a slightly different position, a deputy CEO quoted below also holds in mind the fantasy that a manager might think that they run an institution but that such a fantasy might get the manager into trouble. He is suggesting a vision of an organisation in which a manager has very little control, and proposes the need to gain a sense of *reality* by recognising this and taking responsibility for this organisation (Hirschhorn, 1997; Porter-O'Grady, 1995). His perception, again which has an emotional component, is one of a stressful contradiction – responsibility without power or control (de Vries, 2000).

The minute, as a manager, you start to think that you do [run the service without accountability]... erm then you're in trouble. Unfortunately you have still got the accountability for the service but you have very, very little control so it's a whole different leadership and managerial skill that is required I think in terms of recognizing that you have no control over what happens you know across this organisation across the N,000 beds here at [Trust], the thousands of people that go through the organisation everyday, what happens to them is completely outside of my control but if anything goes wrong it is absolutely my responsibility. And that is quite difficult.
(Deputy CEO, T 1)

6.2.2 Structure in the mind

Most recently Laughlin and Sher (Laughlin & Sher, 2010) take up a version of this concept which they name the 'structure-in-the-mind' in their analysis of developing leadership in social care. They reassert, in their model, that not only the local stakeholders (staff and service users) have a sense of the organisation in the mind when considering, for instance, a particular Trust, but the range of stakeholders includes government bodies and service commissioners (in the round). They propose an inter-relationship between perceptions of communications from services (e.g. 'that you [management] don't listen and/or understand') and perceived communications from 'Head

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Office (or government or other bodies that control resources and practices) which include for example 'just do it' 'we know better' and 'be rational'. (p. 9)

What is significant here, in the context of NHS leadership, is that the organisation and/or structure *in the mind* is where the leader and followers 'meet' emotionally as, similarly, do the various levels of leadership and governance bodies. It is a kind of 'virtual' space.

An example of this structure in the mind might be seen through the increase in stress for NHS employees detailed in a recent report by NICE (the National Institute for Clinical Excellence²⁷) where it was revealed that staff absence caused by work related stress costs the UK over £28 billion. It was proposed that a poor working environment characterised by bullying and poor management was at the heart of this problem²⁸ (Edwards & O'Connell, 2007). In a context where there is distributed leadership and a highly trained professional, multi-disciplinary workforce, such mismatches in how to run organisations and departments that lead to staff stress in these ways (e.g. being bullied and bullying) evoke questions about what is happening in the space between those who plan, govern and resource NHS Trusts and those who carry out the work. The emotional elements of leadership and followership relations seem to be neglected to everyone's disadvantage.

The idea of the organisation in the mind raises important questions of how leadership (good and bad) is transmitted across the NHS and its Trusts (Harrison & Carroll, 1991; Walsh & Ungson, 1991). Organisational cultures and climates are reproduced over time despite the coming(s) and going(s) of CEOs. However, organisations also *adapt* and *evolve* as a response to changes in leadership and outside influences (Morgan, 2006).

In what follows we explore the characteristics of the organisations studied here that facilitate or hinder the transmission of leadership through the Trust as a *system* through which culture (e.g. principles and values about leadership) might be transmitted (Hatch, 1993; Schein, 2004).

²⁷ An organisation established to oversee and provide guidance on clinical practice and cost and clinical effectiveness.

²⁸ See news.bbc.co.uk/2/hi/health/8343074.stm and NICE web-site which has a power-point presentation.

6.2.3 Transmission of leadership and Organisational Contexts

What is held in mind about an organisation is often influenced by the formal and informal networks (Balkundi & Kilduff, 2005, 2006; Goodwin, 2000) which characterise complex adaptive systems. Network cognitions in the minds of leaders are embedded in the whole organisation and the inter-organisational linkages formed by leaders as representatives of organisations (Balkundi & Kilduff, 2005).

The context of the NHS seems to have become increasingly complex and chaotic (Currie et al., 2009) which, coupled with a sense of widespread unethical managerial practices, has raised questions about how leadership practices are transmitted through NHS organisations (Bowie & Werhane, 2005; Collier & Esteban, 2000; Huston & Brox, 2004). Bullying and poor management are in part at least a consequence of not taking the emotional context of organisational life seriously (Ashkanasy, Jordan, & James, 2003; Cocco, Gatti, Lima, & Camus, 2003; Johnson, Cooper, Cartwright et al. 2005; James, 1999; Hutchinson, Vickers, Jackson & Wilkes, 2006).

While there is no excuse for bullying or any other unethical management practices, it is necessary to understand what precipitated the relatively recent change in culture which has exacerbated (reports of) bullying. One factor has to be the extent to which top-down, politically driven changes have been forced through the NHS system and other public institutions and the impact that the drivers of these changes have upon the senior levels of management consciously and unconsciously (Christensen & Laegreid, 2003; Dent, 2005; Gabriel, 2004).

These recent developments have influenced the psychological and emotional aspects of working in teams, groups and organisations (Liden & Antonakis, 2009; West & Anderson, 1992) and by implication influenced possibilities for innovation in leadership and the authority of leaders and workers (Lewin, 1947; Miller, 1993; Carter, Garside, & Black, 2003; Hirschorn, 1997; Fineman, 1994, 2000; Payne and Cooper, 2001; Vince, 2002; Carter, Garside, & Black, 2003). Understanding the *context* of leadership, therefore, has become increasingly important as has the need to understand how that context is part of a *system*.

Post industrial (or postmodern) systems (Rose, 1991) have been reconsidered (or 're-described') relatively recently as 'complex adaptive systems' (Collier & Esteban, 2000; Dooley, 1997; Schuster, 2005). Systems that are complex because of multiple interconnecting relationships are liable to evolve through making new connections that increase their complexity (Collier & Esteban, 2000). In the NHS, even though change is structurally driven, the (perhaps unforeseen) consequences of changes have meant that instead of a command-and-control, top-down hierarchies where in particular

clinicians such as consultants and matrons had previously been seen as 'gods' (as with Sir Lancelot Spratt and Dr. Gregory House see Chapter Four) distributed leadership, networks and different statuses attributed to individual Trusts (e.g. Foundation Trusts with relative independence, Mental Health Trusts which have social care and NHS staff and diverse management practices) have evolved within different structures at all levels for coping with service delivery (see Chapter Nine).

6.3 Open systems theory and boundary management

An organisation that *evolves* like an organism and adapts to its environment necessarily has *porous boundaries* so that it can 'take in' and 'put out' beyond itself. This kind of organism is one that changes, develops and grows. A closed system may feel more secure in that it may not have to accede to unwanted influence or demands, but without taking in and providing for the world outside it will atrophy as with any other closed (minded) system (Morgan, 2006). In this way images and cultures of leadership from outside the boundaries might influence the development of leadership practices e.g. data and ideas from education (Currie et al., 2009; Gronn, 2000; Lumby, 2003)

Systemic thinking is a framework, or tool, for observing the way organisations behave (Schein, 1985; Lewin, 1947; Campbell et al, 1994) which evolved from General Systems Theory, (von Bertalanffy, 1956; Miller and Rice, 1967) and focuses upon concepts related to organisational structure particularly 'task', 'role', 'authority' and 'boundary'. There is also a psychodynamic part of the systemic thinking analysis which links with the conscious and unconscious emotional consequences of the systemic properties and the impact of social and personal factors on the functioning of the organisation (James and Huffington, 2004; Laughlin & Sher, 2010)²⁹.

Morgan (2006) identifies how knowledge and power are accessed and maintained through control of organisational boundaries. 'Boundary' is the term used in open-systems theory to describe the interface between different parts of the organisation and the organisation and the outside world. In the case of the NHS this is the physical boundary to the, for example, hospital building, the wards, the web-site, the reception desk, the

²⁹ This issue is further discussed and explained through object relations theory based on the works of Melanie Klein, Elliot Jaques and Isabel Menzies-Lyth which is outlined in detail in Chapter One and operationalised in the description of the role of obstetricians' anxiety in the delivery of patient care discussed in this chapter and below in Chapter Nine).

telephones, e-mail and so on and also between the different roles such as out-patient/ in-patient, staff /patient, clinician/manager and so on. Most leaders in organisations have the knowledge and abilities by definition to manage and negotiate those boundaries. For example, the senior managers relate to government/NHS/DoH in ways that junior nurses do not, but the senior staff are charged with having to manage the boundaries using knowledge and influence across the boundaries – inside with the staff and patients and outside with government and patient pressure groups. Moreover, as evidenced during the conduct of this project, hospitals merge into Trusts and the porosity or opacity of the boundaries between the different organisations that have come together are central to the functioning of leadership at most levels (see Chapter Seven where the limits of authority are discussed in this context).

Stating this in a slightly different way, this approach to the 'organisation in the mind' takes the *personal* (conscious, pre-conscious and unconscious) level of thinking and links it to the *system* in which that person works (systemic thinking). As any organisation comprises systems (with boundaries, in-puts and out-puts), groups and individuals, it follows that a person's experience of an organisation and *experience of themselves* in relation to others who are in the same organisation make up the culture, climate and everyday dynamics of any organisational context. Thus, our respondents' sense of the 'organisation in the mind' is a valuable concept for understanding how leadership relates to service delivery.

6.4 Images of the organisation

In what follows we explore some of the images 'held in mind' by staff across the three Trusts particularly examining the impact of the organisation in the mind on working collaboratively and the influence of this on service delivery and the quality of patient care that results from staff relations and effectiveness.

To begin, we focus on two specific examples that characterise much of what was said by staff across at least two Trusts:

- images (and fantasies) held about 'management' which highlight the construction of 'authority' in the system and its impact on patient care
- images (and fantasies) held about the 'others' (e.g. colleagues in the same Trust but on a different site or a different Unit) which brings boundary management into play
- how these images (and fantasies) facilitate and hinder the transmission of leadership and service delivery

We employ a critical discourse analysis (CDA) approach to the meaning and processes of leadership and organisation exploring how the organisation/system *looks* to the participants and how this in turn impacts upon the system of providing care for its patients.

6.4.1 'Management' in the mind

As in many organisations, rhetoric about 'management' abounds particularly played out as a 'them/us' dynamic as we demonstrated by separate means in Chapters Four and Five. Furthermore, among management, rhetoric about their own practices and role in relation to that of the workforce is equally active (Alvesson & Sveningsson, 2003a; Borins, 2000; Kuokkanen & Katajisto, 2003).

There is general cynicism across all the respondents who defined themselves as non-management *about* management. So for example: *"And you find that when there's a crisis that's when you find your management team will come down and put a policy in place regardless - like the swine flu thing" (Junior Midwife)*. So here managers are described as paying no heed to the routine tasks of the organisation (Cummings, Hayduk, & Estabrooks, 2005b). They are portrayed as simply responding to a crisis and (presumably following orders from the overall leaders of the service). Thus, managers are not seen as managing the boundaries between the Trust and those in overall charge of health care operating outside of the organisation (i.e. at the level of government) effectively for the facilitation of service delivery (Buchanan, Abbott, Bentley, Lanceley, & Meyer, 2005; Kane & Patapan, 2006). This resonates with Laughlin and Sher's (2010) analysis discussed above.

A focus group from one Trust proposed a particularly strident view of management and its relationship to wider bureaucratic imperatives which they saw as going against service delivery and effective patient care. The medical staff here were proposing that management was both absent, in person and from taking responsibility, while also being all controlling of medical care through instigating seemingly pointless rituals which seemed to maintain boundaries.

Consultant: There is a burning example [here] of bad leadership which is the absence of figure heads. Management can never be found which is frustrating.

Registrar: I've been in theatre now for two weeks and two cases were dropped. The doctor has to apologise to the patient but they are the ones [the doctors] who would like to continue. Management say 'NO it is lunch'. They should be the ones taking responsibility for telling the patient but the

doctor has to go back to the patient and look like a donkey saying 'I'm sorry I can't do your operation today'.

The members of this group, who clearly shared the same or similar images of management and its 'idiocy', went on to decry management incompetence across all staffing issues, and the registrar continued, imitating the management in a silly voice: "*he has to stop, that's the rule*" making it very clear that management was perceived by this man and others in this focus group as inflexible (and rather stupid). Here these participants are expressing total lack of faith in the authority of those who manage (rather than lead) them, although in fact it seems that despite this, they abide by the rules which suggests that there is a belief that at some level the managers in question here derive authority from somewhere higher up in the hospital system or from the NHS leadership beyond.

One factor to note, of course though, is that the power of the story in the focus group may belie the views of the whole group in that some would be silenced by the fear of disagreeing with their colleagues (Asch, 1956; Foucault, 1982). Furthermore, the articulation of the behaviour of management in these cases is *actually a form of leadership* and as such might influence the views of the focus group (and subsequently other staff) (Avolio et al., 2004; Pye, 2005).

From a different focus group, this time with junior midwives, it was apparently *giving up their authority* for a while that gained managers some important respect. For instance when a crisis occurred in the organisation (in this case a fire) then managers seemed to behave very differently and even impressively:

1³⁰. Yeah and then the managers - the bed managers - were carrying chairs and everything and you just had people on beanbags on the floor and everybody ...

2. I wasn't here that day I missed that.

1. Well it was a bit stressful but everybody just mucked in and people were just carrying people here and you know....

Q: Well that's really good if everybody even the managers mucked in.

1. Yeah you find in a crisis the managers do come out, the leadership the leaders come out and they have to come out.

3. And people were coming in from home to help that day.

³⁰ The number denotes the speaker.

2. *Why didn't they phone me? I don't know but never mind ...*

1. *No you find that in that kind of crisis everybody from execs downwards pulls rank and everybody comes in and helps out (T 2).*

So the image here is that a crisis brings out the best in everyone (and the boundaries between the groups of staff become temporarily porous). In times of crisis then the tasks (i.e. patient care and running an effective hospital) overcome other elements of potential discord and conflict such as the 'rank' order of 'execs' bed managers and others such as clinical staff.

There are also other times when it is possible for management to be seen as 'on side' as indicated by another nurse in a different site. For example:

Erm ... our manager, she is quite approachable. And she is willing to discuss things with you if you don't feel that something is right and you question it or question her. She is willing to sit down and explain it and sometimes she will say 'I'm not happy with things as well, but the people above me this is what they have decided, this is what we have to go along with. It is government guidelines or targets have to be met'. Although she might feel the same as us she explains why we have to do things in this way. And I think she is very approachable.

This manager above, demonstrates her willingness to communicate and be 'visible' but clearly she has adopted a them/us strategy similar to those who 'oppose' management by positioning herself as managing the boundary from the side of the clinician/nurse's while also at other times presenting herself as mediating between 'government' and clinicians and managing that boundary too (Laughlin & Sher, 2010).

In the example described here, this seems to 'work' as evidence of good leadership for the nurse telling the story, but it involves the manager in question in potentially difficult dynamics and conflicts in her role.

From another focus group discussion that included doctors and nurses the organisation in the mind experienced management as absent and failing in their responsibility (Hogan & Kaiser, 2005):

Absence would be correct. Management are often not there. They need to take command of the situation. Here is the reasoning – management don't take responsibility for their actions and there is a severe lack of managerial leadership.

This is significant in the concept of the organisation in the mind when juxtaposed with the account of the same organisation by the CEO who saw her/himself as seeing good leadership as manifested in:

Visibility in terms of being seen around the place, so go out wandering around the wards. The best part of the role, quite candidly is, the best part about being the chief executive is, you can go out and talk to patients, and that is what I really kind of enjoy. ... so there is something about my presence and my profile. There is also something about being very clear and repeating the message often enough so that it is clear in the organisation about what the organisation is there to do.

So, within the same organisation there is an image that management is invisible and absent, while senior managers see themselves as 'being seen around the place' constituting an important part of what they believe they do and that they see as being vital for effective leadership and patient care (Laughlin & Sher, 2010). Both sides agree on what would be good leadership but each 'side' has a different vision of what is happening in 'reality' (Alvesson & Sveningsson, 2003a; Buchanan et al., 2007).

In the absence of a shared vision of an organisation working together or a set of clear guidelines about how 'this organisation works', there seemed to be a wish from a deputy CEO of another Trust for a hero/charismatic leader to put things to rights and potentially cross the managers/others boundary (Ladkin, 2006; Laughlin & Sher, 2010).

Erm, this is a very complicated organisation, what we haven't got right is we haven't got a bible that says this is how this organisation works and I think that's a problem so, ((1)) so ((1)) it's very easy for ((1)) despite what I've said about how difficult it was to be a leader, erm and the personality of the individuals who are at the top of the tree, makes an enormous difference in how an organisation I think behaves and works. There is a great tendency if you are a very good individual for an organisation to be based around you and when you leave there is a problem, erm and so the best kind of leader, yes they have that aura of it's about them, of course that's what people look up to but they also put in place processes so that things can happen.

This is a view from the top of the organisation which is expressed at least in part as a vision of a (desirable) mechanistic model – an organisation with a 'bible' about how it works - although this participant also desires a charismatic transformation on the part of leaders.

The hero leader would be a 'very good individual for an organisation to be based around you' and also to have 'an aura'. The metaphors in this extract proliferate – the need for a 'messiah' to save the organisation but also a sense of *dependency* – that 'people look up to' this type of leader who (it would appear) single handedly will be able to put processes in place for things to happen. The vision here is though one in which the system is defunct, stagnant and closed.

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6.5 'Out of mind': leadership and the 'other'

Organisational change is frequently resisted, often because of the disruption to individual's *sense of the system* and their place within it (e.g. Hoyle, 2004). It is also related to the emotional involvement many people have in their work and the way they perceive they are valued within (and how they themselves value) a familiar structure and context (Bovey & Hede, 2001; Zoller & Fairhurst, 2007).

Emotional labour, as discussed in Chapter One, is a key feature of the work that many people do, and is an integral part of any job, but particularly so in an institution of the NHS (see for example Gabriel, 2004). Different occupations require different types of 'displays' and following Hochschild (1983) emotional labour requires adopting emotional displays and attitudes appropriate to the role.

Clearly in hospital work all staff have to expend emotional energy on 'caring' and 'kindness' but it is also the case that working in the NHS, with its many changes for (perhaps) better or (maybe) worse, also requires the ability to be able to 'move on' i.e. mourn the loss of the old structure, sets of relationships etc. and embrace the 'new' with some degree of enthusiasm. The failure to do this (or recognise the need to do this) results in emotional resistance to changes and hanging on to the old systems as long as possible which might defeat changes that improve service delivery and benefit patients (Hughes, 2005).

6.5.1 Leading change and transmitting leadership

In one particular case a senior clinical manager Gerald³¹, was charged with integrating clinical practice across two sites, each of which had their own different ways of working, and different relationships to the boundaries between each other and the clinical teams. While the one (where he was based primarily) had accepted quite radical changes to its organisation, the other (apparently) did not "*..because the sort of ethos and the sort of personalities of the two sites are in the background. They are completely different*".

Gerald's view is based on a reality in that the two sites are structured differently, look different from each other in that the buildings are from different eras and in different styles, and they are in physically different locations. They also serve different demographic populations and have different histories. However, Gerald sees the organisation of the different

³¹ Gerald's leadership is discussed in detail in Chapter Seven.

sites as really being about 'ethos' and 'personalities' which must be in the mind (mostly) as there is a system of authority and responsibility in place across the Trust (via the CEO and other senior people including Gerald) that takes up authority and leadership to ensure consistent practices and organisational change.

Thus, we need to ask why one Unit has (apparently) taken new ways of working on board with some enthusiasm while (apparently) there are barriers preventing the other one doing something similar.

For Gerald, management of the boundaries between in-patient care and primary care teams was the source of a key difficulty:

There are groups of people here who are completely behind the concept that we mind about – integration of primary care – joint working between the Trust and the Primary Care Trust. Some departments work extremely well and are keen to move forward and although we do have our minor difficulties - generally there's one or two departments who are completely against change and erm resistant to anything new. Just like any other organisation where you know you are going to get the type of people who actually make life extremely difficult for you and despite that we've proven how much better our system is.

In the extract above he moves from talking about the other *site* (as a whole system) as being the 'bad' resistant one, to identifying *individuals* on his own site within the 'good' system as making life difficult for him personally despite evidence (he and others have provided) to show how integration works better. This respondent's organisation in mind shifts depending on how well one part of the system fits with his particular vision of a good organisation. This *splitting* (see Chapter One) is a mechanism (unconscious) for preventing the overwhelming feeling that can come from persecutory anxieties (Jaques, 1953; Jaques, 1960; Menzies, 1970). In a management role where (for some reason) authority is being undermined, then the resurgence of persecutory anxiety might be dealt with by splitting of the 'bad' site and comforting oneself with the knowledge of a 'good' site where the organisation works as this leader/manager might wish it to do (Laughlin & Sher, 2010).

6.5.2 Resisting change

In the case of a medical secretary, with over twenty years experience of working in the same hospital, the thought of change in the structure of her working relationships was upsetting. She began engaging with the interviewer by talking about how busy she was and when asked if there was any particular reason why she was busy at that particular time she went into an explanation about organisational change. *"It's just generally busy, but we*

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are in teams now, erm couple of them [doctors] are away and one or two have come back, catching up with everything". It seems as if the teams were the problem for her because previously (and for many years) "...it was one secretary to one consultant and his team. Now for instance today I'm actually taking calls for four different consultants". She was asked about the new structure and made it clear:

erm ... I don't think it's going to work as well as the previous one. Because I think you'll be dipping in and out of so many different jobs that instead of concentrating on the ones that you do well and controlling your one doctor, it'll be confusing and I think there will be mistakes made because one person is trying to deal with too many parts of too many jobs.

Her perception that her role in the organisation might happily continue as one in which she controlled one consultant is characteristic of the 'comfort' of the closed system where authority, power and the processes of leadership are condensed and held 'constant' by an individual. As seen in Chapter Four also change is not usually welcomed without at least tacit resistance and in Chapter Seven two of the case studies will explore how leaders as potential change agents experience followers' avoidance or challenge to changes in practices and structure.

Changes in working relationships bring anxieties which need to be understood and anticipated by leaders if they are to support staff to position themselves differently in the system. Hoyle (2004, in Huffington et al) suggests that during any period of organisational change there is potential for heightened creativity which might lead to doing things differently and better. However, change also brings about risk, uncertainty and the chance of failure which can evoke anxiety both in those promoting the changes (the leaders) and those who might fear loss of their job and the loss of known ways of working (see Hoyle, 2004, p.87).

6.6 Conclusions

Understanding an organisation and what facilitates and/or hinders leaders to take up their authority involves considering the organisation systemically. That is taking account of the boundary management and how that relates to the tasks, roles and power/authority of those who work or are 'consumers' of its work.

Leading change depends upon ensuring those within the system have a sense of how the system works and an awareness of the culture that might be tested as a reality or not. This means, once again, that organisations which are learning environments and where emotional intelligence is applied, are more likely to respond to authority and less likely to subvert

leadership, thus distributed leadership/responsibilities may be taken up or shared more widely.

7 Leadership, Authority and Emotion

7.1 Introduction

As argued above, leadership and emotion are fundamentally intertwined in the workplace (Fineman, 2003). Leaders who appropriately manage both their own emotions (Goleman et al., 2001), and those of their followers, experience better leader-follower relationships, greater opportunity for innovation, motivation and productivity, a more positive organisational climate and improvement in employee and customer/patient satisfaction (Ashkanasy et al., 2003; Avolio et al., 2004; Hollander, 2009). Such outcomes can be associated with both *transformational leadership* (Bass et al., 2003; Corrigan & Garman, 1999; Currie & Lockett, 2007) and *distributed leadership* (Bass & Steidlmeier, 1999; Gronn, 2000, 2002; Mehra, Smith, L. Dixon, & Robertson, 2006b) patterns.

It has also been suggested that followers' 'dysfunctional' dependency is a consequence of failure of the leader to *engage* on an emotional level with those whom they lead (Alban-Metcalfe & Alimo-Metcalfe., 2009; Ashforth & Humphrey, 1995; Bion, 1961; George, 2000). There are different types of such engagement, e.g. acknowledging emotions, drawing them out, honouring them, confronting them, and deflecting them, but although this idea of engagement has been described as "*compelling on the surface, the meaning of the employee engagement concept is unclear*". (Macy & Schneider, 2008, p.3) Even so, there is a common view that such engagement is desirable for organisations in that it connotes involvement, commitment, passion, focused effort and energy from staff thus demonstrating both attitudinal and behavioural components for an effective workforce. (Macy & Schneider, 2008)

Studies of leadership and emotion have not typically been combined with attention to the 'authority' of the leader (Ford, 2006; Stein, 2007) or indeed to the concept of 'power', (sometimes seen and experienced interchangeably). (Morgan, 2006) A study combining exploration of the relationship of authority to concepts of both 'emotion' and 'engagement' (Hirschhorn, 1997) is particularly relevant to the agenda of the 'post-modern' organisation where leadership is distributed (Clegg, 1990; Tierney, 1996) and the organisation potentially fragmented, unmanageable and diverse.

The authority invested in a particular role, such as the CEO (Chief Executive Officer) or lead clinician may not explicitly engage emotion. However, in an organisation such as an NHS Trust, where leadership styles are, or at least

intended to be, characterised by distributed or transformational attributes, the concept of authority is more closely linked to *personal* authority whereby individuals “..bring more of themselves – their skills, ideas, feelings, and values – to their work. They are more psychologically present.” (Hirschorn, 1997, p.9). Thus for example clinical skills *and* personal investment are *both* required for someone to take up authority in practice as a clinical leaderⁱⁱ.

In this chapter we delve further into the concepts of leaders and leadership, particularly focusing upon leaders with a ‘mandate’ to lead change through their formal *role*. The group of participants we specifically focus upon here includes clinical and non-clinical senior managers and we examine the ways these individuals construct their role, their relationship to ‘followers’ and how their *authority* is taken up, experienced and constructed in their specific organisational context³². Authority has more than one meaning. It refers to the authority (sometimes seen as power) invested in a particular role.

Analysis of relationships between people who work in the NHS is underpinned by both the *interactional* and the (related) *emotional* contexts of an NHS Trust as a workplace (see for example Liden and Antonakis, 2009). This knowledge is particularly salient because on the surface, many of those occupying the leadership roles were inclined (at least superficially) to deny the role of emotion although analysis of their stories, shadowing and observations, following the pre-existing literature on organisational cultures, including those which study health care settings, indicated that emotion indeed plays a key role in service delivery and the ways leadership and authority are experienced and constructed in relation to patient care (Vince, 2002; Gabriel, 2004; Hirschorn, 1997; Huffington, 2007; Obholzer, 1994; Vega-Roberts, 1994).

7.2 Case studies

Three case studies were selected to examine the meanings given to the relationship between ‘leadership’, ‘emotion’ and ‘authority’ in relative depth. Each one was chosen (through discussion among the research team) to be (potentially) representative of a ‘typical’ approach to emotional management which reflected a personal style of authority (or lack of authority). These particular cases raised subtle but crucial questions about leadership, emotion and authority through exposing both the conscious and *unconscious* qualities which can either underpin or undermine a leadership *role* (Bovey & Hede, 2001).

³² In this chapter we focus specifically on the senior staff’s perspectives. Others’ perceptions of senior staff were discussed in Chapter Six.

1. The first leader, Gerald, had an 'authoritarian' manner (Adorno, 1950). That is, he appeared to believe that because he was in a senior position other staff ought to do what he told them to do. He was a senior clinician [for a group of particular services], relatively young, very enthusiastic and held an uncompromising vision of how a good hospital should be organised. He was interviewed once by a researcher, once by a group including the PI and 'shadowed' for two days by the same researcher.
2. Kerry in many ways held a similar outlook to Gerald, only she *believed* that she attended to the emotions of her staff if not her own. Kerry was Gerald's immediate boss and evidence from the interviews, shadowing and observations in both cases indicates they did not always work effectively together. Kerry was interviewed twice. Once for information as a key informant by two researchers and the second time by the PI and a researcher together. She was also observed by a researcher for an hour.
3. Quentin was a Clinical Director. He made overt efforts to weigh up the emotional 'risks' to his authority and thus seemed more able to engage with the 'followers' (and thus probably survive) in the *role*. At first he was reluctant to take part in the research directly (although he supported his colleagues' participation) but eventually agreed to be interviewed. Two researchers met him before the interview conducted by the PI, in his role as a key informant and observed him and the senior colleagues in their shared office space for about 30 minutes.

7.2.1 'Gerald'

Gerald held a clear vision of how a good hospital should be organised for the benefit of patients. What he appears to find problematic is managing staff who (for whatever reason) have a vested interest in different styles from those he advocates of patient care, working with colleagues and patients, and/or visions for service delivery.

The following extract is from the shadowing of Gerald.

From the two days spent with Gerald it was very clear that he believed that he was one of the main 'leaders' in the Trust and that he had a strong relationship with the middle and upper managers (including the CEO) which he uses to his advantage especially during long discussions regarding the 'new vision' (which appeared to be very much his vision) for the relationship between the two sites.

Gerald did indeed appear to be one of the main leaders. However, it was unclear whether the power and influence in this leadership role was all smoke and mirrors. Does Gerald play the role of the Wizard of Oz? Does he

think he has more power and influence than he actually has? Does he really have a good relationship with the Trust managers and Chief Executive?

The interview with Kerry (the CEO) made it apparent that she did not consider that he was one of the main leaders in the Trust and it was indicated that she didn't think much of him, and that their relationship might have been fraught.

Discussing the researcher's notes some weeks later, one thing that did emerge was that Gerald 'confused' those around him and was apparently unaware of how others saw him and how far his personal authority actually stretched. Hirschorn (1997) in a study of authority in contemporary organisations has suggested that leaders are no longer the old-style authority figures and because of changes in technology and economics "... bosses can no longer project the certainty, confidence and power that once facilitated employees' identification with them when they [employees] were young and dependent. This is why people are so disappointed in leaders today but also so unforgiving of them" (p. 9).

Gerald, although he had a clear management role and mandate to make the changes he focused on, did not get identified by his colleagues as fulfilling the vision of a leader as there is an implication in the observation extract that his authority may have been achieved via 'smoke and mirrors'. Furthermore his appointment (and that of several of his close senior colleagues) predated the appointment of the CEO. Several questions are raised here by the researcher about whether Gerald has been capable of taking up authority when the CEO takes a stance that at least tacitly opposes him. *This has to remain unanswered in the specific context of this Trust but is an important matter to consider in regard to distributed leadership.*

Gerald prefers to position himself as 'evidence-based' (and therefore up-to-date) dealing with practical matters and not positioning himself as an *emotional* leader. In the interview below, thus, he talks about making difficult decisions but paradoxically, almost from the beginning he focuses in upon dramatic inter-personal conflicts - talking about 'facing up to a fight' and declaring that the Trust 'absolutely' does not have the kind of leadership that enables 'direction' or 'vision'. Does this mean the CEO? Does this mean consultants? It may not even be intended so specifically perhaps it is an expression of general frustration that his vision is not shared.

While on the surface he claimed a good sense of what leadership is about he is also revealing in his talk, the opposite position. Taking a team or department in the direction of the vision and making difficult decisions is for him about a relationship with (not) being 'scared' or further down in this extract, (not) 'afraid'.

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Gerald: Erm...good leadership, err having the ability to make difficult decisions, err, not being scared to face up to a fight...erm...being able to be clear about errr, the direction or vision of the trust, where we are going and be able to errr direct your team into the position that everyone errr everyone is meant to be going, erm I think

Q: Yeah...and do you see that kind of leadership in this hospital?

Gerald: No, absolutely not

Q: No? And why, why not? What's the problem to that kind of...

Gerald: I think that in the past, we .. we have been afraid to face up to a fight, and we have shied away from it.

Q: Yeah

Gerald: From making difficult decisions, and err, and we've let too many people get away with undermining the overall plan that we have...'cause we all know how to deliver excellent healthcare, we all have our views of how this is going ahead, but err, and the grand picture has been undermined by a few, and we've not been able to really face up to those people

Gerald believes that while everyone knows how to deliver 'excellent healthcare' a few have undermined the/his 'grand picture'. He also identifies with a group who support his particular vision while not expressing empathy with those who do not. As the interview progresses, Gerald berates the power (rather than leadership qualities) that consultants have had in the past suggesting that they *undermine* changes that he clearly and sincerely holds about what constitutes good patient care.

Gerald however does reflect on what he is being asked as evidence by his suggestion later:

I don't know about what makes a good [leader]...you know, its difficult to say what makes a good leader...because I'm not sure I'm a good leader, because the qualities that I feel perhaps are necessary, I don't perhaps have ...one of those is patience perhaps...err, being able to tolerate people's err err, err stupidity in a nice way, is essential I think, but I don't have that, I don't think...being, having the ability to listen, err, err, err and not judge or criticise too quickly is very important, but then, taking everyone's opinion into account, but then at the end of all that being able to still go your own way, and persuade everyone else that it was their idea in the first place ... Well, I have certain qualities which help me get the goals that I like...erm...whether I have everybody behind me.

This is one (although not the only one) of the more (paradoxically) emotional interviews from among the senior managers in the study. Gerald

recognises, quite passionately, that a leader needs followers and has to be tolerant. Gerald, though, cannot help declaring that those who presumably hold differing opinions to him to be stupid. He also said later in the interview that he believed many people were *against him* when he was appointed to the senior post as the Trust itself changed shape. While he would not it seems position himself as emotional (rather he sees himself as evidence-based) he chooses to talk in emotive ways and reading and hearing what he says is quite exhausting as he uses all his energy in trying to take the organisation where he believes it should go, but through lack of emotional intelligence, many a time he draws a blank.

Gabriel and Hirschorn (2004) might describe Gerald, at least in part, as a 'narcissistic leader' in that he liked to be told he is important and influential but he is also potentially a bully and authoritarian in style (Adorno, 1950). He clearly found criticism intolerable and split off the 'bad' (i.e. the consultants who didn't go along with his changes from the 'good' i.e. the 'we'). Gerald has a dream which he is determined to make into a reality, however, there is a "*delicate balance between feelings of omnipotence and feelings of impotence which leaders must achieve, in order to enhance the chances of turning vision into reality*" (Gabriel and Hirschorn, 2004, p. 144). These authors argue that narcissistic leaders have a particular aptitude for getting this balance wrong and "*Even if they are talented in their field, their judgement increasingly fails them. This is compounded by the collusion of their followers*". This may be Gerald's 'we'. Gerald fails to connect emotionally with his (potential) followers from outside his close-knit 'we' group even though there may be some admiration for his clarity and link with the NHS mandate. This means, in effect, that important changes which may well be for the benefit of patients in the contemporary NHS are being (effectively) resisted because of Gerald's style of leadership. Gerald also appears to have little idea of how others might experience their worlds, including their emotions.

This theory might be borne out by the following participant, a young female career NHS manager just reaching a senior position. She proposed Gerald, unprompted, as an example of a good leader:

I think he's great, he gets a bit of bad press sometimes, I think people get agitated with him, but I think it's because he tries to manage things, and he tries to be very fair, and he tries to solve problems that have been with us for a long time, so again, I think he is a good leader, he is trying to do the right thing for the Trust in the long term. He is erm ... sometimes it's difficult for him to carry people with him, but I think that will pay off in the long run. And I think he's thinking of a long term plan, he's prepared to take a bit of short term flack...but I think it will work out in the end. I think he's going about doing stuff in the right way, he's being fair and he's trying

to be consistent, he's making sure he's got an evidence base for doing things, it's not just a random decision, he's collecting information, and that kind of thing...I think there are a lot of people in this organisation at this point who would say they didn't think he was a good leader, but I think time will tell the story there.

This extract from the interview, while consistent with Gerald's descriptions of his own behaviour, proposes an evaluation of his style which indicates he is likely to be successful in the longer term because he is 'trying to do the right thing for the Trust'. However also she identifies quite clearly that his leadership is failing to take many of the people who matter along with him, she positions herself as sharing his vision for the longer term benefit of the Trust which may reflect her *a priori* engagement with NHS management rather than with a clinical profession as she does not have a clinical background herself. It also seems to reflect collusion with his narcissistic style because she seems to mirror his version of himself. This participant continues:

Sometimes they're [other senior staff particularly doctors] quite quick to criticise without really understanding what the problem is that needs to be solved, and what some of the rules are we can't ignore. Some of the national directives, that we just have to do, there's no point fighting against them, we've got to find a way of implementing them, and I think sometimes he gets a really raw deal...but he's said, he's consistent, he will communicate to people, write to people and speak to people very quickly the minute they raise a problem, and he definitely shows that he is not shying away from difficult problems...I think that's a very strong characteristic.

Her description of the other staff appears to chime with Bion's theory of a fight/flight basic assumption group based on unconscious emotional ties of the group involved which (mostly) represents an anti-task resistance to the leader (Bion, 1961). *This extract above reinforces the possibility that Gerald is emotionally disengaged from his followers* and perceives his Trust to be in line with and in favour of NHS 'national directives'. The participant here who in a way is 'damning' Gerald with *strong* praise may be looking to Gerald as a potential mentor by making it clear that she will support his particular efforts. However when the researcher asked her about her *own* leadership she said:

.... because one of my strengths is pulling people together, one of my strengths is building teams, so I think from that point of view then yes, but then sometimes I look at people like [Gerald and her immediate boss] and I think 'Oh my God'. I've got so much respect for the way they deal with

the very difficult issues. Sometimes I wonder if I really put my neck out enough to say 'Ok, Ok, this is what we all need to be passionately aiming for.' Even if not everybody is quite wanting to do the same thing. I think sometimes I sit back a bit more and wait to see what the general feedback is, rather than stick my neck out and say 'Ok, this is the direction we've got to go in.' And I think as a leader you have to...well, in fact you probably have to do a bit of both.

This participant, it seems, is somehow subjugating her own skills and strengths to those whose skills and strengths do not correspond with what she believes in makes her a good leader and seems to be putting herself down for the skills she has got and does seem to value. Alternatively, she might have realised that her strengths might complement Gerald's and through his own narcissistic valency he may position her as someone to promote.

Finally, in relation to Gerald, whose example she insists on returning to, having described other more emotional and successful clinical leaders in the Trust:

.... And they [other senior staff] make it very evident that they don't support him [Gerald] in his role, and not only do they make it very evident, but they do a lot of stirring behind the scenes, to get up a bit of a frenzy against him And I think there's some very clever leadership involved in that process, and there's a lot of learning, gathering people in, getting them on board and uniting them in a common purpose, and this and that and the other, but it's not constructive.

7.2.2 'Kerry'

Kerry is Gerald's immediate boss (the CEO) and evidence from the interviews, shadowing and observations in both cases indicates they do not always work effectively together³³. Kerry herself has met with similar difficulties which seem to be the outcome of her attempts to encourage distributed leadership in that:

Kerry: Erm, erm, well we set up a process to...we re-wrote the discharge policy here. I chaired the group. I wanted to know what the problem was about discharges, and I was told we needed to rewrite the discharge policy,

³³ Regardless of personal authority in the cases of both Kerry and Gerald, it is clear that the organisation has had its own very particular problems which are *endemic in the system* (see Chapter Six for a more systemic analysis of leadership).

and we'd just done it. People looked at me, and I just said, well I've spent...I've chaired five meetings myself, where we put all the information forward, and all these arrangements in place and nobody's done anything about it. I think that's poor leadership.

Q: So erm...poor leadership on whose part? Because presumably you had people who you delegated this to?

Kerry: So the consultants, the nurse managers, the matrons...all the people that were on the working group really. And they just didn't implement it. Beyond belief really.

This extract reveals several levels of emotion and authority and (as with Gerald's narrative) there is an 'I' who takes action and the 'they' who are against her. Kerry had identified a problem with discharges but had to ask 'them' what it was and was told that 'we' needed to rewrite the policy. She took up the role of chairing five meetings, the group/'we' put the information forward and the arrangements in place (presumably to take action) but 'no-one' did anything. It is not known how she handled this 'failure' of leadership on 'their' part. Kerry appears to be a micro-manager (in that she herself was involved in the meetings). Reflecting on this interview, and reading the text, one of us reported back to the research team that she had misunderstood Kerry, thinking that Kerry had been talking about her *own* case of poor leadership. Perhaps it was as unclear in the action as it was in the telling (thus perhaps on an unconscious level the lack of clarity was communicated in the meetings). Why did Kerry, as the leader, not pick up the group's dependence (or *resistance*) (Bovey & Hede, 2001; Hughes, 2005)? This suggests that she herself had resisted emotional attachment to her 'followers' and failed to engage them on an emotional level during the meetings. One approach that helps to understand the example above of *resistance*, specifically in the context of the five reported meetings, is the idea of '*fight/flight*' from the work of Wilfred Bion (1961/1983). He suggested that a 'group mentality' (or group culture) emerges from the development of a group over time as it continues to meet, because individual contributions conform to this mentality. In brief, the formed 'group culture' unconsciously constrains individual members (see also Sherwood, 1964).

So, in this case it may have been that despite the seniority of the staff involved in rewriting the discharge procedure, the culture that had developed over the course of the five meetings (and possibly prior to this as 'they' had suggested the need to re-write the discharge policy) had *prevented/resisted distributed leadership*. This could have led to the group not making sense of the leader's expectations and reverting to the comfortable pattern of being that had not been challenged possibly (again) because of the leader failing to manage her own emotions or engage with those of her team.

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Bion (1961/86) suggests, that the group mentality exists on both at a conscious and unconscious level so that the team were probably not deliberately, or consciously, going against the leader. It seemed from the leader's description that the team had been almost 'sleep walking' – not recognising that they had already done what they later ignored and suggested needed doing. Dependency, according to Bion, meant dependency on the leader or "... *when all individuals in the group look to myself as a person with whom each has an exclusive relationship*" (Bion, 1961/86: 119). Within this mode there is little connection between the members themselves and there is a '*mass inertia*' (op cit). This links to Klein's depressive position (Gould, 1997). It also raises questions of who is depressed here - Kerry, the group, or the group in Kerry's fantasy? The unconscious resistance and frustration experienced by the leader here demonstrates the fluidity of power and potentially the influence of gender (Fletcher, 2004; Nicolson, 1996; Vince, 2001)

Kerry, however, did claim success in turning around previously identified failings in patient care targets. How did she manage this?

Well I ... I... I mean it requires a great deal of focus, which hasn't been succeeded by other individuals, so...and it's required the organisation to understand its importance, and that it is possible to do. So it's been trying to talk to people about 'OK it's a target, but it's a quality... a patient quality target, so don't look at it in a sort of derogatory manner'.And ((3)) ...so it's a bit of culture about are you being bullied, as a member of staff to achieve the target and if you're not being bullied well then why is important and then well it's important because its patient quality ((1))...and then I suppose, something about... I mean one of the turning points for me is about our reputation as well, which is...well everyone else is achieving it, and we're not, 'why do you want to be in the bottom 20% of the country?'

Resisting her own emotional attachment here she talks in the third person. Rather than saying that as a new senior manager she had managed to engage the staff, which to a point she seems to have accomplished, she states that successfully addressing targets has 'required the organisation to understand its importance'. She clearly perceives senior staff as taking a negative position in relation to government targets and has attempted to persuade people that such targets are about good quality patient care. Another feature of the discourse slips in here – is her style of leadership perceived to be a bullying one? It may be that a group mentality, which takes resistance and dependency to be part of its culture, perceives a leader with a vision, or at least with determination (and 'focus' to quote Kerry) to be bullying them out of their emotional safety. This is a problem for any organisation that suggests to its staff that successful change and development is solely about strong leadership. We have to turn again and again to the clear message emerging from the data that without an

emotional attachment and the ability to manage their own emotions leaders and followers are not going to achieve goals related to patient care.

7.2.3 'Quentin'

Unlike Gerald, Quentin feels that he is succeeding in bringing about change and unlike Kerry he is mostly positive about the impact he is having upon the staff groups. He told two stories, one of which was when his leadership worked, and another where he continues to experience problems although he emphasised (to support his authority) that the latter was not a great a worry to him. In his interview he focused very much on the importance of personal authority: *"I'm still playing the trick of getting people to do things by example"*. He tries to back up his personal authority through making personal contact as much as he can:

You know my job could be answering my e-mails and I'm desperately trying not to. I've made a pact with myself that I will not explain myself in e-mail. If it needs to be explained I will go and explain it [personally].

He distinguished between the roles of the CEO and medical director, which in his opinion were *manager* roles, and that of clinical director which was a *leadership* role.

Quentin moves between the position where:

...people need constantly to be reminded of what they need to achieve ... [in relation to patient care] ...I use the word good care because [they] have the tendency to lapse into what is acceptable or even worse, what they can get away with.

To the position that:

And I think there is some requirement to continually challenge the organisation about what it is providing and sort of have a re-education process. And I guess we all need that – because I need that as well you know and it is one of my roles to keep reminding everybody why they are doing what they are doing.

Quentin sees himself as needing space to reflect upon the aims of the service provision and recognises that he is just as able to lose track of the organisation's main purpose as his colleagues/followers are, given the daily round of work. While Quentin gives an interesting example of how he and the team succeeded in meeting a target for patient waiting times in Accident & Emergency (which involved him engaging personally with the staff in an emergency meeting):

... which was all about persuading your senior contemporaries and peers. It's about the juniors, the people who are actually delivering the services. It's about making a reasoned argument. It's about being visible. It's about being honest and it's about delivering it.

The success, he believes, was about the personal contact and his own visible attachment in trying to change things alongside his colleagues and being very clear that " *...this needs to be achieved at all costs - which was quite liberating*". The rhetoric here is very different from that used by both Gerald and Kerry, who feel their colleagues are letting them down; possibly they are 'splitting' the 'bad' and projecting it into recalcitrant colleagues in order to feel reasonably good about their own positions (Klein 1987, 1983). Quentin is talking about success and success through *taking an emotional risk*. Saying that a change needed to be achieved at all costs (which he described as liberating) could be interpreted as Quentin making an emotional commitment to engage with his followers about something identified by the government, the NHS and his Trust as important. This stands in direct contrast to the experiences and rhetoric of both Gerald and Kerry who express the frustrations at what the 'others' are failing to do. However with what Quentin called a "*slightly different problem*". He has had great difficulty dealing with a doctor who is "*just a very difficult person to manage ... and I need to say to him 'this is crap and needs to be done in a completely different way'. I don't quite know why I haven't done that*". Once again Quentin was expressing an emotion – anger but without pushing/projecting blame on to the other, but being clear what the other person was doing and reflecting on his own sense of why, how and when he might take this issue up with the protagonist.

While Quentin operates with a quiet assurance and takes up his formal authority, and the power that accompanies it, from a classic Kleinian 'depressive position' (Klein, 1975; Segal, 1973), both Gerald and Kerry, despite their formal authority, fail to engage with their followers which leads to their powerlessness and a sense of rage and frustration.

7.3 Conclusion

The interconnections between power, authority and emotion play a complex part in understanding what leadership means to all those involved and in each organisational context. Leadership cannot be understood as something that can be observed and/or measured 'objectively', it is not an essential 'quality' which resides in an individual but is socially constructed, meaning different things to different people at different times. Following Ford (2010) a more contemporary, appropriate and critical approach to the study of leadership "*pays attention to situations, events, institutions, ideas, social practices and processes that may be seen as creating additional repression or discursive disclosure*" (Ford, 2010, p. 51)

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To be specific Rioch (Rioch, 1975), and others had made the point that *"'Leader' is a word which implies a relationship So the word 'leader' does not have any sense without a word like 'follower' implied in it".* (p. 159).

The relationship between leaders and followers might be more or less successful and in order to be a follower a person needs (even on a very temporary basis) to 'give over' something of themselves (i.e. make themselves emotionally open) to the leader for the relationship to have meaning. Being a follower may be both (or either) passive or active and there is the potential for the follower to engage and support, or subvert leadership (Bondi, 1997; Halton, 2007; O'Brien, 1994). Consequently, in order to analyse what it means to 'lead' in an organisation, understanding the practice(s) of emotional management alongside an analysis of power relations is fundamental (Grint, 2005; Schilling, 2009). For Foucault (Burrell, 1988; Foucault, 1982) power *"exists only when it is put into action, even if, of course, it is integrated into a disparate field of possibilities brought to bear upon permanent structures."* (1982, p. 788) Thus, while organisations give formal power to relatively few leaders (including in a distributed model of leadership) consent is still required for the power to be maintained. Furthermore, 'the other' that is the one over whom power is exercised, needs to be *"recognised and maintained to the very end as a person who acts"* (Foucault, 1982, p. 789).

The leaders we have described above all admit falling into traps where their authority has been challenged/resisted and they have been (potentially) made powerless. Quentin alone demonstrated awareness that he was working *with* people rather than treating them as resources. This meant that despite experiencing some frustrations, he managed to continue to *feel* and *think*, and with his colleagues/followers on board, *implement* changes. Kerry and Gerald, while attempting to take up their 'legitimate' power and lead change, both squander their authority through failing to manage and/or engage with their own and their followers' emotions. This is evidenced by their displays of frustration, impatience and anger with those who fail *to do what they are expected/commanded to do*.

Gerald held a classic authoritarian view of power, indicating that whether he takes people with him or not, he intends to get to the *'goals that I like'*. He also sees the resistant followers as stupid. He defines leadership accordingly, in that the leader should *'direct [the] team'* and not be afraid to *'face up to a fight'*.

Kerry sees herself somewhat differently even though she experiences anger and frustration when followers fail to do what she wants and expects. In attempting to empower her subordinates and set up the 'processes' to distribute empowerment (such as the meetings described above) she was left feeling disempowered following an (apparent) breakdown of

communication between herself and the senior team she tried to work with. That one of the interviewers also had to clarify: "*poor leadership on whose part?*" suggested that Kerry possibly re-experienced the rage and frustration she felt at the time of her encounter with the followers in her story when she told it. This rage obscured clear communication both then and in the telling. It might be that the overwhelming need to prevent the Trust from being '*in the bottom 20% of the country*' was a source of anxiety for her and the importance of achieving these specific sets of goals contributed to her impoverished emotional literacy.

Distributed leadership (Gronn, 2002; Mehra et al., 2006b), as a response to 'postmodern' organisations (Tierney, 1996) sets out the changing nature of authority/power. In combination with ideas from the emotional/social intelligence literature, distributed leadership suggests a more relational model of leader/follower relations whereby leadership decisions may represent both outcomes and inputs (Ashkanasy et al., 2003; Wolff, Pescosolido, & Druskat, 2002). A warning note, however, reminds us of the persistence of the patriarchal version of 'the' leader (Ford, 2010; Ford & Harding, 2008) which occupies the dominant discourse within which the notion of 'effectiveness' neglects (if not ignores) the importance of the management of emotions in the leader and followers.

Through the use of innovative research methods and data analysis, which take account of both conscious and unconscious processes through which leadership is socially constructed and exercised, the intrinsic complex connections between authority, power, emotion and leadership in the context of health care can begin to be disentangled.

Leadership that 'works' for an organisation such as the NHS is a multifaceted, emotional *process* in which leaders manoeuvre to manage their own and their followers' emotions and behaviours on both intellectual and emotional levels. To be effective in, what are now seen to be, postmodern organisational contexts, leaders also need to reflect upon themselves in their role and to understand the structural, cultural and emotional expressions of their authority and the authority and power of their followers. The legitimization of emotionally engaged leaders' authority supports effective service delivery across the different levels of the organisation through undermining conscious and unconscious resistance(s) as described in the examples above. Power as a coercive violence (see Foucault, 1982) has been exposed and undermined in such organisations and 'replaced' by concepts of 'distributed' leadership where the persistent claim to power is by definition and necessity more fluid.

8 Gender and Leadership

8.1 Introduction

Gender and leadership is an area that has attracted interest among policy makers and researchers, because the styles of leadership that are currently perceived to be the most effective, such as transformational and distributed, are believed to 'fit' more closely to 'feminine' styles of leadership. Fletcher (2004) notes that traditional 'heroic' leadership is usually associated with masculine traits (rather than men and women *per se*) such as individualism, control, assertiveness advocacy and domination, while 'post heroic leadership traits (such as empathy, community vulnerability, collaboration) are more associated with feminine traits. Ford (Ford, 2010) reconsiders the concept of *effective* leadership which is in fact a patriarchal model perpetuating an exclusionary and privileged view of the leader (metaphorically the 'father' figure).

Traditional research into gender, organisations power and leadership suggests that there are particular 'masculine' and 'feminine' leadership traits that are generally believed to characterise men and women's leadership styles (Rosener, 1990; Collinson and Hearn, 1994; Nicolson, 1996; Carless, 1998). Because women are widely believed to adopt a more democratic leadership style and men believed to adopt a more autocratic one, distributed leadership and concerted action in networked organisations may potentially be more conducive to those (women or men) who can adopt a more traditionally feminine relational style of leadership. Furthermore, feminine styles are more akin to displaying social and/or emotional intelligence (Guy & Newman, 2004; Leon, 2005).

In reality, both men and women display a variety of 'masculine' and 'feminine' leadership styles, depending upon their individual personality, age, position and the situation involved (Cross & Bagilhole, 2002; McDowell, 2001). However, gender *expectations* influence perceptions and beliefs and research suggests that subordinates are often more satisfied with leaders who behave in gender-typical ways than those who go against gender-type (Porter, 1992; Rosener, 1990; Williams, 1993).

Indeed, women in explicit leadership roles often tend to be viewed less positively than men, in the belief that 'masculine' traits (competition, authority, lack of emotion) conform more to expectations of how a 'leader' should behave but not how a woman should (cf. the work of Broverman et al. 1970). The 'paradox' it seems persists in contemporary organisations so that some women leaders feel they have to behave in a 'masculine' way which frequently makes them appear rather heavy-handed and/or as a 'bullying' because these behaviours do not fit with ideas about women (Eagly & Carli, 2003).

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Most of the women and (some) of the men we spoke to during the study, made a point of denying that gender was an issue in today's NHS, indicating that they believed that women and men were treated equally, with an equal chance of success. However, several participants also mentioned gender differences in the negotiation of power and identities describing how either women or men were likely to gain advantage through use of their gender-typed styles (Lewis, 2000; Schnurr, 2008; West, 1984).

Gender and leadership it seems remains a contradiction in people's minds but gender is a fundamental component of the discourses surrounding leadership in the NHS because of the demographic issues in clinical management and leadership (Evans, 1997; Gardiner & Tiggerman, 1999) and as we have shown in Chapters Four to Seven, role models and styles of leader/follower engagement have a major part to play in the transmission and exercise of leadership (Gill, Mills, Franzway, & Sharp, 2008; Greener, 2007).

We want to note here, partly in passing, although an example below (in the interview with 'Jeff')³⁴ demonstrates its importance - that the *researchers'* gender and physical appearance (age, ethnicity, attractiveness) also played an important role in the research process.

8.1.1 Senior women managers: 'we're all the same now'

Women in senior managerial and/or professional positions either deny that being a woman is an issue for them or for their organisation or that they know what they had to do to prevent being seen as a senior '*woman*', rather than a senior leader.

Denying the impact of your own gender on how you are seen and how you manage and lead is not an easy position to maintain and we observed some senior women working hard not to be seen as women even though at the same time they were arguing that *this behaviour was not necessary* because of the way 'things have changed'.

The researcher's observation of a senior female manager (Catherine) indicated that she thought that Catherine was trying to avoid being 'feminine' in her interactions. When the two interviewers were waiting to begin the interview, Catherine's PA came into the room with an important message but was shouted at in front of them. Thus in her notes one researcher judged that Catherine wanted:

....to indicate lack of interest and assume a position of superiority. Catherine was transgressing the boundaries of polite professional behaviour and attempting to define 'her' territory of the hospital. Answers to the

³⁴ Not his real name.

questions were also defensive, perhaps indicating a lack of self-assurance. Despite the tough exterior she obviously felt a need to stamp her authority on people in order to maintain control of the situation. This may partially be related to her gender and need to appear 'more masculine than the men' in a competitive environment.

The researcher following on from her observational notes with comments following the interview suggested that *"whilst she [Catherine] initially denied gender to be a relevant issue [for senior managers in the NHS], she then went on to make reference to 'testosterone' and 'the emotions of females' as problems in managing in her senior role".*

The relevant part of the interview transcript is below:

Q: Ok, so are men a problem? Are women a problem? Are there gender politics? Or am I just old fashioned there?

A: I don't think there are anymore, I think there were. I mean when I was appointed, I could have been one of [only] four [senior] women, so the whole senior management was very ... very 'suitish'. I don't think, no, I don't think it is a problem anymore. No, I think it is, if you talk to people in the north of England, they will say it's still a problem, and I think its a bit more of a problem to get females into acute trusts, big acute trusts, it's a bit of a climate difference. I think there's a lot less testosterone around now, there's a sort of slightly...erm I mean I've got quite a young male management team.

Q: Right

A: I find the testosterone and sort of challenges a bit much from time to time So I mean from that point of view, it is quite interesting, it does manifest itself. As do emotions of females really.

Catherine's somewhat aggressive, or at least uncompromising, behaviour witnessed by the researcher tended to soften after that and she added:

A; So I do think the answer to the question is that there are differences, but I don't think they're... they don't fundamentally affect how you do the job.

Vicki, a senior geriatrician, discussed the question of gender openly and at some length with the researcher who suggested that she had seen both Vicki and Mandy, another senior female consultant geriatrician, being very 'gentle' in their approach to patients and the researcher wanted to know how far this was linked to the fact they were women. Vicki thought though that their approach was not about gender but:

You know it could be a geriatrician thing, I don't know, ((1)) you know you'd automatically say 'it's oh because we're women', but I think it's only when you start following a few men around as well who are doing the specialty as we are, because the thing that attracts us to elderly care rather

than any other specialties in the first place, and that could simply be what you're observing.

It seemed important to Vicki that she was not stereotyped as a woman leader although she was keenly aware that as more women took up medicine and were arriving in senior positions that this demographic change would in some way impact on leadership.

So maybe that's where you've got to go as well as men in geriatrics you actually need to look at women in other specialties and follow them on a ward round and see what they do and that may be a good idea as well for the gender thing. But it's quite important for your study because at the end of the day we're training over 50% of women as doctors and in the future they think that almost all GPs will be women so that will affect the leadership and sort of, that you see in patient care.

So Vicki, while seeing feminine *characteristics* as more important in her clinical specialism than gender *per se*, still believes women doctors (e.g. GPs) will make different kinds of leaders from men.

During her shadowing of Mandy, the researcher noted what she identified as gender-typical behaviour:

Mandy also implements a mothering aspect to her leadership role (also noticed in Vicki) as she is always thoughtful and considerate to her followers, making sure they are comfortable and happy with decisions made and that they are up to speed with their medical knowledge. This mothering role also seeps into the delivery of patient care. Mandy is also a leader that appreciates the help of her followers and always thanks them for their input and help.

While keeping in mind that the researcher herself is making assumptions about what is a 'mothering' style and also recalling Vicki's assertion that it may be more to do with the kind of people who are attracted to geriatrics than gender itself, it is important to note that the researcher spent several days shadowing and observing female *and* male geriatricians. Further, she discussed reflexively what she saw and how she interpreted it with the research team to check out her observations.

8.1.2 Men: the 'natural' leaders?

The researcher who interviewed and observed Catherine also interviewed and observed Jeff (another non-clinical manager) and contrasted their styles of interaction with other people in the organisation, and with her, during the interview. At first Jeff seemed more approachable, relaxed and generally more amenable than Catherine had been:

Jeff was a newly appointed male senior manager. From the outset he displayed supreme confidence in his own authority and power as a 'leader'

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and obviously did not regard a young female researcher as a threat. He was very friendly and personable and happy to open up the space of the hospital for us, answering his own emails rather than through a secretary, coming to collect me personally from the main reception and chatting and joking all the way back to his office. Throughout the interview he showed confidence in his own opinions and was happy to talk in detail about both his own and others' leadership. This confidence may be a result of several factors such as position, age, class, gender or personality. He freely admitted that he did not mind appearing 'hard' or unpopular if it was necessary to get the job done, however he felt that his main asset was his own 'charm' and 'charisma'.

Thus Jeff firmly claimed his place within the (masculine) 'heroic' leadership tradition.

While Catherine was perceived as guarding her territory and demonstrating her power, Jeff appeared to be relaxed, being more approachable and particularly not hiding behind his PA. In fact, his account of himself in the interview was somewhat disarming.

Q And do you see yourself as a leader?

*A: Oh yes certainly. I can remember the time when I realised that I should be in management. I was working in a **** clinic in [a Trust] and it was so inefficiently run and I said as much to the manager. She said 'if you think you can do it better then why don't you manage?' So I said 'OK I will!' And I think I'm pretty damn good at it. I don't play by the rules, I don't have any formal qualifications, but I can get things done. I'm not perfect – I shout, I swear and mostly I'm just very, very cheeky, but I'm good with people and that's what you need in this job. You have to be tough too, take knock-backs and step on people to reach your targets. But mostly I care passionately about the patients. I would never ever chase a target if I didn't think it would improve patient care. So that's why I went into management, and I suppose the other thing is I discovered, I surprised myself actually about, I was going to say how easy it was, it wasn't easy, erm I had a natural aptitude to do it, you know it was something that I was successful in so you know yeah?*

Jeff wanted it made clear that the 'inefficient' manager was a woman and that he himself is 'good' with people (and on the surface the researcher acknowledged this). However, he also valued the tough, target-driven 'stepping on people' (masculine) qualities of his leadership which he believed were important in delivering patient care.

Jeff put his confidence and self-identified ability partly down to personality, but also to his gender and upbringing, adding that certain class backgrounds seem to 'breed' leaders:

I do think that great leaders are kind of born, but my background was that I was at all male public boarding school for 10 years. As my father said 'the biggest waste of money' given my academic erm qualifications at the end of it, erm and there was something there about you know that sort of environment. I mean does it grow leaders? You would think so, you look at the number of public schoolboys that end up as MPs, that's probably not a good analogy

Q:((Laughs))

A: But there is something about that kind of white middle class upper class upbringing that you have, and although I wasn't from that background before I went to the school, erm you learn survival among your peers, you learn I think to survive, you know if you think at the age of eight you are sent away you have to survive you haven't got your infrastructure.

It seems that Jeff is suggesting that leaders are either 'bred' or 'grown' but either way the influence that makes them a leader comes early in their lives. In the example he gives here, 'growing' takes place in a male-only context reinforced by social class, possibly wealth and a general sense of entitlement. This model does not echo the efforts and ambitions of the NHS in everyday practice nor would it appear to be in any way appropriate to the model proposed by the NHS (see Chapter One) which is focused on the type of leadership appropriate to managing and leading 'diversity' and 'difference'.

8.1.3 Gender wars?

Being motherly (like Vicki and Mandy) is not equivalent to being weak or compliant as perhaps some gender stereotypes might describe women (see for example Bem, 1993; Nicolson, 1996). During an observation of Mandy, the researcher identified what she considered to be a 'battle of the sexes':

Gender issues were brought into consideration during the interaction between Mandy, a female consultant and a male consultant. During this interaction a battle of the sexes and power occurred with the two consultants struggling for power in very different ways. The male consultant tried to assert his power through attempting to ignore Mandy's presence, never looking directly at her, but was raising his voice and being rude. On the other hand Mandy was always very polite, looked directly at him, spoke very softly and smiled a lot, although it was quite obvious that behind the soft smile was a vicious bite.

Perhaps this isn't so much a battle of the sexes but an example of how men and women might behave differently towards each other in the course of a power struggle. The detailed observation notes show the encounter move by move:

There are some territory issues with Patient 9 and Mandy is angry that there is a patient on her ward that is being treated by another doctor. She asks why the doctor has continued his care now that the patient has moved ward and suggests that if the doctor feels that he needs to continue with the patient's care then the patient should be kept on one of his wards rather than blocking a bed that could be used for one of her patients. She asks "why can't we look after this patient? We are not supposed to have any outliers on this ward!" Mandy's registrar Melvyn can not, or does not want to answer her questions and simply shakes his head and shrugs. Mandy says she needs to speak with the consultant and asks Melvyn who the patient is under. Melvyn gives the name and admits that he has seen him arrive on the ward a couple of minutes ago, so he should still be there.

Who is Melvyn afraid of here? Or is Melvyn simply not wanting to witness a battle over territory and patient care?

Mandy walks round the other side of the nurse's station to find the [male] consultant with three other doctors/medical students standing some distance away and his registrar to whom he is speaking. Mandy and 'our' group move over to his location and the junior doctors from both groups greet each other and share whispered conversations. Mandy stands patiently at the side of the registrar waiting to speak with the consultant. Although Mandy continues to smile pleasantly I think that she is angry or frustrated on two levels. First because the consultant is on her ward and hasn't come to speak to her and second, because he doesn't seem to have the manners to even acknowledge she is waiting. After the conversation between the consultant and registrar has finished the consultant turns his attention to his paper work and the registrar moves to be with the other doctors (some distance away) Mandy lifts her eyebrows up to Melvyn (clearly annoyed with the male consultant's behaviour) and then asks if she can speak to him about Patient 9. Mandy explains politely that they do not have outliers on this ward and therefore asks whether the patient could be moved to another ward or if this cannot be arranged she take over the care for the patient. While she speaks the consultant doesn't look at her and continues to write, his body language and behaviour are both arrogant and rude. The consultant says that the patient is his and he will not be passing the patient over as she has problems not solely aligned with geriatric care and that she needs a specialist. Although this was clearly a statement to undermine Mandy's capabilities she continues to smile and tell him that the patient will be moved before the weekend so that a patient needing specialist geriatric care can have a bed.

Moving through this detailed account the gender issue becomes obscured by the fact of Mandy's skill as a clinician, a leader, her concern to give appropriate care within a context of limited resources and her ability to handle herself in the face of rudeness and arrogance. These are skills that ensure she will shine through as a leader in any context but particularly one

which is still a man's world. In a socially or emotionally intelligent context where concerted action is seen as important, patience, politeness and clarity of purposes will eventually win out over arrogance and bluster. As we see in the next extract Mandy's 'opponent' does not possess these attributes.

The male consultant becomes angry and raises his voice to Mandy and says there is nowhere else for the patient to go. Mandy lowers her voice and says that the patient must have been on one of his wards before she was moved so she can move back. The other consultant looks swiftly at the group of doctors who are stood behind him (both his own and Mandy's) and then eyes me suspiciously before turning back to Mandy and speaking in a lowered voice. The conversation moves back and forth between Mandy and the other consultant and it is clear that despite his outbursts and undermining statements to Mandy that she has the upper hand and although she continues to smile, she is very forceful and strong in her argument and objectives. To conclude the whispered conversation Mandy raises her voice and tells the group that the patient will be transferred on Friday and that she will be getting a transfer set up straight away. She then thanks the other consultant for understanding and walks back round to the group with a smile on her face and asks Melvyn to set the transfer up.

This is a consummate example of patience, calm and the ability to lead doing what she considers to be the best for her patients, her team and her department. Her skills in continuing to be quiet, calm and smiling have 'seen off' the male consultant in the meantime but reading this it would be surprising if the humiliated man does not try to take revenge. Although there is very little evidence that this is anything other than a 'normal' power struggle it is the case that Mandy is in fact a woman and has played, what is mostly recognized to be, a feminine role.

Returning to male expressions of power it is important to be aware that blatant attacks, such as the one in the encounter above, are not necessarily the only ways of demonstrating confrontational masculinity.

It appeared from the interview with Jeff (discussed above) that he believed he did not need to defend himself in the face of gender stereotyping. He had strong opinions on women's leadership and also on women's 'availability' with no qualms about voicing these which contrasts strongly with women's accounts where they try to underplay gender, that is that many senior women take the view (overtly) that gender is irrelevant.

The researcher's notes about the meeting with Jeff continue describing a dramatic example:

Jeff's supreme confidence meant that whilst he came across well in an interview situation, he crossed boundaries of professionalism in other ways, telling unsuitable stories about staff and inviting me (researcher) out for a drink after the interview, invading my personal space. In the extract below

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he accuses a female colleague of not only being attracted to him, but trying to use her sexuality (unsuccessfully) to get ahead at work, whilst simultaneously flattering me that I am his 'type' by subsequently asking me to meet him for a drink.

And in the interview:

Q: And could you give me some examples of bad leadership that you've seen?

A: Well, Melanie Willson³⁵, have you met her?

Q: No I was meant to but she cancelled the interview three times...

A: Exactly, she probably thought she was too important to talk to you. Now I can tell you an interesting story about her. She's a good looking woman, stunning, very intelligent too. But there's something not quite right, I don't know what it is... really cold. She's got no soul. I appointed her as divisional manager and at first she was doing really well, but then she ran into some problems. She was failing in her job. And that's when she started to flirt outrageously with me. It was like she couldn't beat me intellectually so she was going to do it another way. But, well... she's not my type. And she was really jealous when I got this job, I had Lucy (PA) go and announce it at the morning meeting and you should have seen her face. Anyway I hear she's got a promotion now so she must be doing something right.

Melanie Willson clearly perplexed Jeff – 'stunning' but no 'soul'; 'flirting' to avoid being faced with 'failing' in her job; unable to beat Jeff 'intellectually' and resorting to using her sexual attractiveness. After stating that she was not his type (indicating that the flirting also failed) he then made another woman humiliate Melanie in a public context. The implication of her subsequent promotion being based on something other than ability was also a powerful 'aside'.

Discriminatory comments against women though are perhaps not that commonplace. Jeff's sense of 'entitlement' may be a dying one across most NHS organisations and it is certainly against all stated mores. Discrimination on the basis of gender is more opaque. The researcher interviewed Helen, a senior female consultant, and talked about gender and arrogance of male consultants. The researcher suggested:

... this was possibly seeing me as an ally as a young female professional. In addition to the immediately obvious behavioural differences between women and men she also mentioned unseen discrimination in the form of merit awards at senior levels and problems of combining work and family commitments which may mean female staff are less likely to achieve these.

³⁵ Not her real name.

In the interview Helen responded:

Q: Do you think there are any gender differences in leadership that you have noticed?

A: Yeah, yeah I think, I think so, erm you know the men are more well, can I, the men are less inclusive of a group and they have ((1)) already formed an opinion sometimes and before listening, erm, ((1)) err ((1)) yeah.

Q: Yeah ((laughs))

A: Need I say more ((laughs))? But I think there is a difference ...Competitive, that's what I was saying, there's that competition, yeah competitive, exactly ...Of course not but the insight is very, very small, and then those meetings go on and on and on and it's people trying to get one up on another so... I just want to leave. It's handy having a beep you know you can say 'oh, I've got to be off (laughs)'.

The suggestion here is that men are apt to waste time on each other and power struggles and that for them competition is central to their 'nature'.

8.2 Conclusions

Despite the increased numbers of women who have reached senior leadership positions in the NHS, both as senior managers (clinical and non-clinical) and as senior clinicians *per se*, there were nonetheless some interesting differences between women and men's self-descriptions and perceptions of others as leaders, sometimes made on the basis of gender alone (Gill et al., 2008). Descriptions given of leaders and leadership for members of the 'other' sex were also frequently gender-typed.

It may be that despite valiant and frequently effective attempts to change the culture of NHS Trusts that a 'traditional' view of leadership remains at least in the organisational 'memory'. This might go some way to explaining why women who are clearly powerful and influential are reluctant to identify themselves as taking up these more 'feminine' styles even though they may in fact use the skills associated with these qualities. Eagly and Carli (2003) make a case for women as having a leadership 'advantage' in contemporary organisations where the type of leadership required has changed. However, they argue that in many cases women have to battle against the inherent prejudices in male dominated organisations. Although there is still a reference to gender stereotypes when discussing gender in organisations and gender and leadership as we have seen from the extracts above in this chapter, as Rosener (1990) stated: "*Women managers who have broken the glass ceiling in medium-sized, non-traditional organisations have proven that effective leaders don't come from one mould*" (p. 119).

In Chapter Five the OCS revealed that women across all professions scored lower than men on 'recognition' in that they perceived their managers as

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not recognising their particular attributes as clinicians or managers and they also perceived that the organisational climate was one in which 'recognition' was more likely to be given to men than women. That men did not see this as a problem for them reinforces the view that regardless of trying to establish gender equality across NHS organisations it is still not embedded in the management culture.

As we have seen and has been well documented in the literature, it remains difficult for women to exercise leadership without their behaviours being construed as either 'weak' or 'aggressive'. The paradox is that leadership requiring more 'feminine' characteristics is at least explicitly more desirable in the contemporary NHS.

9 Patient Care, Leadership and Service Delivery

9.1 Introduction

The NHS has a history of reform/modernisation aimed at making patient choice and care more cost and clinically effective by improving the organisational structures through which care is delivered (Bate & Robert, 2002; Becher & Chassin, 2001; Darzi, 2008; Wilson, 2009) .

The NHS remains committed to its original aims of providing a cost and clinically effective patient care (Doherty, 2009; Phillips, 2005), at least partially through the NHS's organisational structures, including the gate keeping function of primary care, while providing a universal service free at the point of delivery. Since the 1990s patient choice has been added to the longer term commitment to efficiency (Bhandari & Naudeer, 2008; Bojke, Gravelle, Hassell, & Whittington, 2004; Bryan, Gill, Greenfield, Gutridge, & Marshall, 2006). And at the same time there has been an explosion in new diagnostic and therapeutic technologies accompanied by a public awareness of the availability, or lack of availability, of those technologies (Aberbach & Christensen, 2005; Greener & Powell, 2003; Mueller, Sillince, Harvey, & Howorth, 2004a).

In this chapter we particularly address:

- what respondents (staff and patients) say about patient care and service delivery based on the interviews and focus groups;

- what we *observed* about service delivery and patient care and particularly the *interactions* between clinical staff and patients *observed* and *described* during the shadowing.

As in Chapter Six the Trusts are conceptualised as open systems whereby high quality patient care (the input) corresponds with effective service delivery (the output) with the primary task defined as caring for sick patients (or those who are giving birth).

9.2 Defining patient care and service delivery

The thematic analysis highlights similarities across all grades, statuses and disciplines of the staff and the patients involved in the study. The themes that emerged consistently from the data that were about good patient care were:

1. Putting the patient first:

...of course patients do come first but actually really, on everything that you do, I mean everything you do you think of the patients (service manager in acute medicine).

2. Thinking about what is good for the patient (all the time):

I still believe and I believe to this day that if you absolutely concentrate on what the patients' needs are, all other things take care of themselves. it's about really showing that you care. I mean genuinely showing that you care about your patients, erm there's a lot of talk about also looking after your staff and caring for your staff. I think that's important but I think the health service has got itself stuck far too many times concentrating on the needs of the staff and not the patients (Chief Operating Officer).

I think that's what you have to make sure is that everyday you are thinking to yourself, 'am I doing this for the good for the patient?' 'is it the right way to do it?' so I think when you get eleven years down the line, one of the things is that you can loose sight of is that, very easily (Matron).

3. Awareness of the diversity in the patient's world (culture, family, age, home and work environments):

..it would be making sure older patients have high quality of care during their surgical admission (senior consultant Geriatrician).

you need to support your staff ... you know and you have to have an awareness of the different culture of the patients (administrator).

4. Making sure the patient received the care that staff would expect for themselves and their relatives:

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I would define patient care that of - if it was one of my relatives who were ill (senior manager).

5. Talking to patients about what has happened, their medical history and their clinical condition:

....if they talk to you one-on-one and you know where you're at (patient).

6. Safety and empowerment of patients:

They [the multidisciplinary care of the elderly team] believe that good patient care sits around ideas of timely discharges, safety, making sure the patient understands their condition and their treatment, empowering patients by allowing them to make their own decisions about their care (to a point), providing the appropriate treatment and care, being responsible for the patient. Examples of bad patient care are viewed as delayed discharges, poor decision making and discontinuous care. (Notes from an observation of a team meeting).

From the descriptions it is clear (and perhaps no surprise) that senior managers, clinicians and patients all hold slightly different perceptions which inform their judgements to give 'patient care' a specific meaning. Some of the judgements are related to their particular clinical specialty or organisational responsibility although generally respondents reiterated that patients need to be at the centre of daily practices. Patients in all cases wanted more than anything to be kept informed about their care, and if possible this should be done by the clinician in charge.

At a more complex level the definitions above reveal a 'vision' of good patient care which links the 'practical', 'professional' and 'political' elements of NHS life. It also links to the 'human' elements associated with the tasks of caring. For example, the Matron (quoted above) shows a revealing insight that the routine *organisational* tasks might take over as a perceived priority from what a person initially knew to be their primary task (i.e. patient care). As she says, several years down the line you might lose sight of what you are really there to do.

9.3 How is good patient care achieved?

9.3.1 Managers

Managers each have different levels of responsibility for delivering good patient care which may differ from priorities expressed by patients and clinicians:

Erm, that's the bit about lifting your eyes up off of the horizon, and lifting the eyes up above the horizon is about looking at the totality because the

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medical, again, the medical management model is very much that you should do what you need to do when the patient is in front of you. The management model, the pure management model is about doing the right thing for the 450,000 patients who were looked after last year, so some of that will be about compromising, and offering the best care to the widest group that you can (CEO).

Immediately this respondent exposes the potential for conflict at senior level in that he/she³⁶ positions the 'medical management model' differently from the 'pure management model'. In the former the patient is a particular individual with a health care problem – the patient 'in front of you'. However for senior management there are many thousands of patients that require good patient care which means (maybe) compromising to provide the best possible care to the greatest number. Despite this, another senior manager had a different 'take' upon good patient care and in answering the question focuses on what they themselves would expect evoking a more individualised model:

I would want good consultant input into my care ((1)) as soon as it was appropriate in the pathway that I was on. I would want to be able to have a conversation about what was wrong with me and what treatments and options there were, ((1)) erm ((1)). I would want the assurances of the people that deliver the care know what they are doing. ((1)) I would want the care to be provided in an environment that was clean and in an ideal world I would want a single ensuite room, err and I would like to choose my own food and all that jazz. ((1)) erm and the erm, ((2)) so really you want the environment to be correct and you want to have the confidence in the clinicians giving care and you want to have had input into what your care should have been (Senior Manager.)

This manager has a very clear model of their 'ideal type' which positions the relationship between the patient and clinician, the skills/expertise of the clinician and the physical space and environment as central to good care. There is awareness here that planning and teamwork are also part of the process of care but particularly important is the knowledge of how to deliver the appropriate care and information in order to facilitate joint decision-making.

³⁶ We do not want to risk identification of any individual participant.

9.3.2 Clinicians

Good quality patient care for most doctors interviewed was:

... making sure that erm the patient achieves the outcome that you would wish them to as a result of either their outpatient visit or their inpatient stay erm and that outcome is kind of on a objective kind of medical measure, erm but it's also in terms of the quality of the care that they've received and whether they are satisfied with the care that they've received. (Senior consultant)

Another senior consultant who is also on the senior management team of the Trust took the concept of patient care further:

... it should be delivered well I think is the answer ((laughs)). I think on the whole we do deliver it well, we have the lowest mortality rate in the country, ((1)) or one of them. I think we do actually and we ((1)) I'm very proud of the care and I think there are two things to be proud of and one is the basic care and ... we do emergency work I am very proud of. Then the other bit of care we're proud of is that ... I think there is a real culture of innovation and I'm trying to do something new up here, and I think that's actually really important in terms of leadership. My job is being able to see a clinician with an idea and then work out of him or her how to turn that idea into a self service innovation. I think that we have created over the last few years a much stronger patient safety culture.

This respondent clearly links leadership and patient care stressing both the relationship between supporting other clinicians in innovations that improve care (particularly attending to safety) while also being proud of the culture across the Trust for low mortality, innovation, and supporting staff. Crucially there is a pride and energy about this account. The culture puts patients first but the staff gain satisfaction and a sense of professional pride from the performance of the Trust as a whole [T3].

The clinician manager below takes up the relationship between staff empowerment (and support which links clearly to the outcomes reported in Chapter Five) and returns us to the focus on staff training and skills, indicating here that if the managers train and empower staff – services to patients will improve.

... it's about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is, we worked with training and development and we came up with a specific programme that was aimed at empowering them to improve their service area etc. etc. and

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also provided them with some skill sets that they probably didn't have prior to that. (Senior Manager, Therapies)

While from a similar perspective the nurse quoted below stresses that team work and morale mark the path towards good patient care and you need to look after *staff* in order to deliver a good service to patients.

... And I think it is also, sort of, taking into account the people they work with, the team members and boost the morale, and that can make a lot of difference to, you know, to have people at work and sort of take the stress levels off and I think, you know, it would sort of, quality certainly would happen, sort of energise them, able to care for the patient. (Nurse, focus group)

9.3.3 Patients

For patients overall it was clear that most of all direct communication and consistency of staff was experienced to be good care:

A: ... I've been transferred here from [another Trust] and there it's a bit more, not one-to-one but you see a lot of different doctors here whilst there [the other Trust] you have only one doctor, your one midwife and your one consultant. Here you see a lot of different people.

Q: And which one do you prefer?

A: I'd say probably just to see the one 'cause lots people tell you different things.

Q: Okay, so it can be a bit confusing?

A: Yeah, sometimes it can be, yeah.

The patient quoted below reinforces the need for clear patient/clinician contact and communication.

For another woman:

Now whilst I'm here my care has been very good especially with the [specialist] who first saw erm, who first flagged up the problem. Erm yep it's been good it's been good since I've been in. It's just the initial communication as an outpatient to an inpatient I should have really - you know that should have been. I don't know where the fault lies but there should have been some communication there between the appropriate people (Maternity patient on postnatal ward).

9.4 Delivering patient care

9.4.1 Doctor-patient interactions

We look firstly at three consultants' (Cameron, Kenneth and Henry) styles across two different Trusts as they interact with patients to explore the importance (or otherwise) of good communication and engagement. What emerges, perhaps unsurprisingly, is that different consultants have different styles of engaging. The style adopted though feeds through to the 'ethos' of the clinical team, relates to, and impacts upon, the culture of the Unit thus affecting the doctor-patient interactions as part of an evolutionary cycle.

9.4.2 Empathy and Communication

9.4.2.1 'Cameron'

From the researcher's notes we gain an impression of Cameron who deals mostly with stroke patients for whom verbal and non-verbal communication may be very restricted:

Cameron offers a very personal and individualised style of patient care to his patients. He is often very tactile often rubbing the tops of their hands, arms and heads to encourage them or to show support when he is discussing difficult problems with them such as their inability to go home, the definition of a stroke and the future impacts of them having a stroke. He also speaks to the patients in a very friendly and informal way and sometimes draws on their mother tongue to say a few phrases to make them feel welcome and at ease.

In his interactions with his patients he is very positive and upbeat, often speaking loudly to encourage and motivate his patients. He also tries to share a few jokes with them and breaks down doctor/patient power relationships by crouching down in front of his patients or sitting on a chair or their bed so that he is always the same height or lower.

This description alone demonstrates how Cameron's *behaviour* relates to several of the descriptions above which identify good patient care in that he:

- communicates (verbally and physically)
- takes care to acknowledge their humanity through recognition of their cultural (linguistic) heritages the fact that they have a life outside the hospital
- attempts to empower them within the relationship (at least via discussion and physical presence and to an extent with knowledge of their condition).

Below is a detailed example of Cameron (and his team's) encounter with an elderly stroke patient (Mrs. D) which is part of the evidence the researcher has employed for her assessment of the processes engaged by Cameron in his provision of patient care:

"Hello Mrs. D? (Patient nods head and smiles) do you have a headache? (Patient nods head) Do you know why? (patient shakes her head staring wide eyed at B). "OK, I'll tell you..." Cameron sits on the edge of the patient's bed and explains that she has had a stroke and she has a headache because sometimes patients who have had strokes will have suffered from headaches due to pressures on the brain. The patient stares and nods her head occasionally as Cameron explains. "Mrs. D, do you understand what I have just told you?" (patient nods her head and then croaks "yes") on this speech Cameron sounds surprised and encourages her to speak again "Oh wow Mrs. D, that sounded good, can you say something else for me?...well done". The patient looks up at the doctor and smiles croaking again "I don't have anything to say doctor", "well never mind Mrs. D, I am sure I can get something out you a bit later!...excellent, your voice seems to be coming back...isn't that good?. We will have you singing in no time!" (Mrs. D. smiles and shakes her head "can't sing" Cameron smiles and laughs.

Despite the clear power differentials, doctor/patient and healthy/unhealthy, in this relationship Cameron is doing what he can to encourage and communicate effectively with the patient. Not only does he literally get down to her level by sitting on the bed but he explains the condition, how it happened and communicates the indicators for (potential) recovery. He is respectful and careful although the intellectual/cultural difference between the patient, Cameron and the care team is exposed by the encounters below.

"Now Mrs. D. can I examine you?" (Patient nods her head) Cameron takes the patients hand and she flinches "cold!" Cameron smiles and apologies saying it that "it is the alcohol" (alcohol gel he had just rubbed into his hand). The patient eyes Cameron suspiciously "have you been drinking?" the group laugh and Cameron explains that it is the hand-wash and she nods slowly and looks at each member of the team for what seems confirmation that this is the truth. Cameron then begins testing the patient's strength. He checks her arms and then her legs with simple strength tests calling out numbers between 1-5 for the SHO to write in the notes. As he instructs the patient with her tests he speaks very slowly and loudly and the instructions are very simple and clear and he often demonstrated his instructions, especially for those patients that have cognition problems. As the patient does the task Cameron is very encouraging shouting words such as "good", "excellent" or "well done after

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each task". After the strength tests Cameron checks the patient's reflexes with a small hammer. Again he shouts out numbers and makes comments about the reflexes that the SHO writes down in the notes. Following the reflexes Cameron checks the patient's facial muscles by asking the patient to smile, grit their teeth, stick out their tongues and move them about. He then checks her speech by asking her to repeat phrases or noises after him. The first phrases or groups of words were given as words that would be familiar to the patient such as the patient's name or names of simple objects such as pens. As the patient is able to say these words he moves on to more complex words such as "hippopotamus" which the patient struggles with. Cameron then checks the patient's ability to co-ordinate by getting the patient to touch her nose and then his finger with her index finger. The patient clearly struggles with this and is very slow and inaccurate.

For a brief moment after the tests Cameron has a quick discussion with L [another doctor] asking him what he thought about the tests and what they would expect to see on the CT scan. Cameron then turns to the patient and says "sorry Mrs. D, just discussing your test results with my colleague, we think that you are progressing very well...there has been much improvement hasn't there?" the patient stares blankly at Cameron for a brief moment before shaking her head "no, you don't think so? Now what about your speech, when you first arrived you couldn't say a word, now listen to you, don't you think you have improved?" patient shrugs her shoulders and looks down at the bed. "Well Mrs. D, we all think you are improving...so well done..." patient looks up and smiles sadly.

The style of meetings between clinical staff and patients was as much a feature of *Unit and team culture* as of a particular clinician's practices. Thus, while Cameron above was engaging with the patient in what appeared to be a *genuinely caring* manner, his colleagues were attentive, while in the background.

9.4.2.2 'Kenneth' and 'Henry'

In what follows two consultants worked together and while Kenneth was the more senior and experienced clinically, Henry held a senior managerial role (as well as being a senior consultant). Kenneth was described by the researcher as:

... a very warm and caring man ... he is very sweet, kind and caring to his patients and makes them feel comfortable and less vulnerable by empathising with them and drawing on his own personal experiences as a patient.

As with Cameron above, Kenneth was also described as 'tactile' and that he took the time to explain things to patients. Kenneth empathised with patients by sharing a joke (as did Cameron):

For example one lady was embarrassed because she had fallen down in her flat and sustained injuries and did not really want to explain how she had fallen over or what she had hurt [to the whole team]. Kenneth then told the patient that he had slipped over in the hospital and in the M&S food section. This meant that she no longer kept quiet through embarrassment and told Kenneth after that exactly what had happened.

However, during the two day shadowing of Kenneth the researcher was particularly:

...struck by how intimidating this group of doctors must be to the patient, especially an elderly or vulnerable patient as a large group of faces arrive at their bedside and close the curtains around them making the space feel incredibly claustrophobic and that the patient's space felt 'invaded'.

While shadowing Kenneth, the researcher was in a position to observe Henry (who was also shadowed for two days on a different occasion). The researcher's notes here, which describe a joint ward round with Kenneth and Henry, state:

I was struck by how impersonal Henry was towards the patients [in direct contrast to Kenneth]. He did not greet them or introduce himself. [In one case] Instead of asking the patient how she was getting on with the oxygen machine Henry asks the SHO how she thought the patient was getting on with the machine. When the patient tried to give reasons they seemed irrelevant to Henry who just told her she must use her oxygen machine every day or she will not get better.

The researcher goes on to describe how Kenneth (the senior clinical consultant although Henry has a senior leadership role) stands quietly behind the junior doctors on the round with Henry at the front of the group talking to the patient. Henry stands up. Kenneth stands at the back of the group with his hands folded behind his back and Henry every so often asks Kenneth if he agrees with Henry's thoughts on the patient's health status and treatment. While Henry is taking the lead in this way the researcher notes:

Not one of the doctors explains to the patients what will be happening to them that day or beyond nor do any of them say goodbye.

One patient on Henry's round is in the bathroom as the team arrive at her bed.

Henry knocks on the door of the bathroom and says "Mrs. X, it's Dr. Henry we are all here to see you". He then asks a nurse if she can hurry the patient along as he is very busy. It seemed strange [to the researcher] that Henry could not have just visited another patient until this patient had finished rather than rushing her. Before the nurse can enter the bathroom another nurse pokes her head out from behind the door and says that she is washing the patient. Henry asks whether this could be finished after he has seen her. The nurse, who looks frustrated, says she will be a minute. The nurse then helps the elderly lady to shuffle to her chair and helps her sit down. Without greeting the patient Henry begins talking over the patient's bed about her X-ray that was taken yesterday and then asks the nurse about the patient's progress.

In the examples above describing both Cameron and Kenneth's interactions with patients there is evidence that the patients were given a chance to explain to their consultant how they felt and either to tell the doctor what had happened to them or to hear the doctor's explanation of why they felt like they did.

The patients were treated in both these examples as human beings and in doing so the doctors themselves positioned themselves in their *clinical role* but also as *people occupying that role*. By acknowledging mutual humanity (albeit in different styles) these doctors were able to *take authority* from their position as medical experts (see Chapter Seven above).

By contrast Henry also took authority but did this by silencing junior colleagues, Kenneth his fellow consultant and most importantly, the patients. While Kenneth and Henry were in the same Unit, the scenario described above suggests that Henry held more power and therefore exercised greater influence on junior colleagues (and this fed into the culture of the Trust).

In what follows we trace how these contrasting styles might link to the culture of the Units and the teams themselves and consider how this fits in with the definitions of good patient care and service delivery.

9.5 Clinical team work and service delivery

9.5.1 Giving patients care

Miller and Gwynne (1972) suggested that a 'warehousing' model of care operates for those who may be institutionalised in the medium to long term which they contrast with the possibility of a 'horticultural' model of care, akin to what might be identified today as a learning environment. Working in the care of the elderly takes its toll on the emotions of all the clinical staff

particularly in the 'horticultural'/learning setting, where efforts are made to ensure two-way communication and mutual understanding and development takes place. This can leave clinical staff open to experiencing directly the pain and distress experienced by their patients (see Menzies-Lyth, 1960 and the 'stories' below).

The following example demonstrates how engagement between clinicians and patients impacts emotionally upon even (and possibly especially) senior experienced staff. The researcher here, shadowing Mandy, a female senior consultant describes the following case:

Whilst cleaning up a suppurating wound an elderly male patient cried. It was a really touching and sad moment and Mandy was clearly distressed that she had hurt the man. On first seeing him cry Mandy appeared to have a moment of shock/panic where she looked amongst her team to find out whether this was normal behaviour for this patient. On hearing the answer was 'no' Mandy tried to soothe the patient and seemed genuinely sorry for hurting him. The nurse who arrived at the scene also appears to be genuinely concerned about the patient and goes over to help Mandy and prevent the patient from crying. This scene was particularly sad because in today's society and especially in the patient's generation it is thought that men don't cry or show emotion. For the man to cry he must have been in severe pain and must have been struggling with himself to prevent the tears. Mandy's genuine empathy and somewhat guilt might have reflected that.

Mandy and the nurse in this context are using emotional intelligence (see Chapter One) in a relevant situation. Mandy also engages in conjoint action with the nurse rather than take action in an autocratic fashion without consultation. Mandy notes the patient's crying with a start (according to the description) and instead of continuing with the work on the wound (which many doctors might well do because it was necessary for a positive health outcome) she immediately appears to take in the context as a whole – thinking about her patient's behaviour and reactions. The nurse in this case mirrors the behaviour of the consultant. This is an important issue for discussions of leadership and patient care in that teams tend to reflect the beliefs and actions of their leaders.

9.5.2 Discussing patient care

In a shadowing the researcher at the start of the observation describes in detail the way two doctors discussed the patients before embarking on the ward round. This is another case of concerted action:

09:00 Breakfast meeting with Cameron [T3]

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Once they have consumed their breakfast Cameron and Mandy turn to business. Cameron begins by asking Mandy's opinion on one of the patients that they had seen on the ward round that morning. They chat for a couple of minutes about the patient before both getting a patient list out and going through the names systematically and discussing their care plan for each patient. Several patients will need to be discussed in a patient case meeting as they have complex discharge problems, others will need to be referred to the CCP so that a greater social package will be considered. Mandy says that she will go and see a few of the patients herself later and occasionally delegates tasks to do for Cameron, but mostly he is autonomous and says what he needs to do for a patient and what he will organise on behalf of the patient.

This is a quiet and supportive meeting between Mandy the senior consultant and Cameron the more junior member of the team. However, the researcher notes the systematic discussion of the patients and their care along with a plan about who Mandy will see and how Cameron's tasks are designated.

A similar atmosphere of calm and authority are evoked by the description of a case meeting with Cameron's team at the start of the first day of shadowing:

I approach the nurse's station and look around to see if I can see Cameron. I spot him at the far end of the ward sat at a computer with a mixed group of staff (doctors, nurses) surrounding him. I approach the group and stand amongst them. Cameron is facing the computer screen and discusses a CT scan with his registrar [L].I notice that as these two doctors discuss the scan a SHO writes notes in the patient's file occasionally craning his neck to look at the scan at certain parts of the discussion. A few nurses also crane their necks at various points but most just stand patiently in silence waiting to visit the patient. Once the discussion draws to a close Cameron turns his head from the computer and asks the team if they have anything to add. ...[later on in the same meeting the researcher listens to a telephone conversation] ...Cameron has rung the wife of a patient to update her on her husband's health. He is very honest with the wife saying that her husband has had a second stroke during the night at that he is now in worse health. Despite the bad news Cameron is very friendly and pleasant with the relative and is very sympathetic to her questions and on several occasions empathises with her. Coming off the phone Cameron returns to the team and gives a brief update to L regarding the conversation with the patient's wife. The SHO writes this summary in the notes. Cameron takes a short sharp breath before asking "shall we go and visit the patient?" Cameron turns quickly on his heels and enters the ward.

The observation here reveals the high workload and 'multi-tasking' undertaken by the team (looking at the computer, discussing scans, taking notes, calling relatives and so on). But there seems to be focused attention on patient care and individual patients. At the end of this extract it also seems that Cameron himself takes the ward rounds very seriously – gathering his mind together and possibly seeking the emotional strength to move from the clinical team and considering evidence from notes and colleagues to imparting and collecting information from the patients.

The same researcher who has shadowed both Kenneth and Henry at a different Trust from Cameron, gives examples of how some of Henry's patients are discussed. For example she describes a meeting to discuss patients chaired by Henry.

Henry criticises the way [Site B] is run and the management of beds and patients by that hospital. He praises the doctors for the current situation on [Site A] where they have spare beds stating that they have done so well in 'kicking them out'. Henry stated during [a previous meeting] that the patients needed to be removed or 'kicked out' of hospital as soon as possible. The rapid turnover of patients may on the surface appear that they are not receiving good care However getting patients home quickly reduces the risk of hospital acquired infections.

And is likely also to be what many patients would want.

As the researcher makes clear, it is important not to confuse the rhetoric with the quality of patient care, but rhetoric does determine and reflect a dominant ward or Unit culture.

9.6 Responsibility for patient care

Responsibility was a key element of the discussions of leadership particularly in Chapters Four and Five. Responsibility for individual patient care is in the hands of clinical teams led by the medical consultant but above that person is the clinical leadership/management (Clinical and Medical Directors) as well as the senior operational managers (CEO and COO and others).

Primary responsibilities for patient care however vary from *individual care* i.e. for both identifying care pathways and day-to-day care to responsibility overall for the care of all the patients. In Chapter Ten we review the findings from this study with some recent cases where responsibility has been mishandled to explore what lessons might be learnt.

In an interview with a consultant:

... we try to just have a really open forum where we can discuss that [specific patient care], just like open it up and letting people put their viewpoints first and then kind of trying to question where they're coming from with that in a positive kind of way but them also laying out where you feel that that might not be the right course of action. Erm and also at the end of that discussion making sure that everyone is happy with the outcome, and sometimes people aren't erm .. but it also realising that it is a consultant's responsibility at the end of the day and making sure that everyone knows that you're happy making that kind of decision and that you are happy to be made accountable for that decision.

9.6.1 Responsibility for emotion

It frequently falls on the clinical leader to cope with their own, the patient's and the relatives' emotional reactions and distress and also with those of the other members of the team. As the researcher noted:

One senior consultant, Tricia, made it clear that as the clinical lead she also took responsibility for talking to patients about DNR³⁷ forms and delivering 'bad news' to patients/ relatives. During the ward round Tricia removed the pressure from a junior member of the team who had been told by a relative that they didn't want their mother to be resuscitated. Being told this information had stressed out this junior member of the team as he was not yet ready for this type of responsibility. Tricia supports her junior colleague saying that he should have never been confronted with this situation.

One question here then is how do the clinical team handle such multi-layered emotional problems? How important is leadership in supporting (and developing) teams to cope?

9.6.2 Responsibility for teaching

Most clinicians in the study from all disciplines were interested in teaching the next generation, and their activities will influence patient care, provide role models for leadership and influence climate and culture of the organisation. The example below is chosen because Dr. Jenkins was very enthusiastic but also demonstrated compassion and courtesy when he was face to face with the patients. The researcher's notes describe this in detail:

Approaching the patient Dr. Jenkins shakes the patients hand and says "how are we doing today?...I see you were referred by your GP...you have a

³⁷ Do not resuscitate.

wonderful GP" (he comments on how wonderfully clear and precise the notes are). "That's not my GP, that's my missus's GP, mine's on holiday...I have Dr. U. U". "What a name! But looks like they have to wonderful GPs at your practice...the notes are seamless...you are lucky!" Jenkins then continues to ask the patient about his medical history. The patient is able to tell the doctor his entire medical in great detail including the drugs [more description from the researcher]. Dr. Jenkins stops the patient and asks the medical student to take a mental note of how a good GP leads to a well informed patient, which helps him (Jenkins) in his (patient's) treatment. He talks about 'aspects of professionalism' and the right ways of informing patients about their treatment and condition, he openly praises the patient for knowing so much about his patient history and tells the students that "medical history in patient care is so important". The patient begins talking about his treatment in the hospital and Dr. Jenkins states that "patient feedback is great, and they like to hear about it...we need to be more professional...primary care pathways are the key to patient care".

Dr. Jenkins behaves with humour towards the patients and the students and junior doctors but does so while continuing with his assessment of the patient, taking the relevant history and trying to impart good practice and professionalism. He manages to balance giving the students and junior a chance to gain hands-on experience while making sure he himself has all the information he needs for the care of the patient.

Dr. Jenkins then checks the patient's lungs and heart asking a SHO, Dr. Williams to check the cardiogram as he can hear an AF flutter. As Dr. Williams looks for the chart the patient tells him that his GP had thought the same and that is why he was thinking of changing his drugs. Dr. Jenkins looks at the students and says "wonderful isn't he?" he continues that the GP must have heard or felt it himself [the heart condition] and now they will need to see the chart to prove it then they can change the drugs as the GP had predicted. After looking at the chart Dr. Jenkins asks Dr. Williams to change the drugs and to get rid of one of the drugs he thinks are unnecessary. Dr Jenkins shakes the patients hand when he leaves and says that one of the juniors will be back later to sign off the new drugs.

Looking over the notes Dr Jenkins spends a lot of time teaching the [medical] students about various medical conditions and treatments that have arisen out of [a particular] patient and asks them to suggest other possible diagnosis and other treatments for his condition. Jenkins is a very enthusiastic teacher and the enthusiasm rubs off on the students who are all eager to share their knowledge and take stabs at questions they don't know. In the middle of the question and answer session he asks one of the students "what year are you in? I don't know how much you guys know already". The student base is a mixture from students from [different

schools] and he relishes the opportunity to teach the students some new medical knowledge. Whilst getting the students to look at the cardiogram he looks up and apologises to Irene [matron] for taking so long on his ward round "Sorry Irene, I will be here all day, this is such a pleasure to have students!" Concluding the teaching session he quotes someone for saying something about the health of gamblers and drinkers and then asks "now who said that?" the students look round each other and then he exclaims "me mother!" all the students laugh including the female registrar and Irene. He then ushers them onto the ward saying that he doesn't want to get in trouble with the matron.

9.6.3 Subverting responsibility

There are diverse ways that staff at both Trusts had for coping with emotional aspects of patient care and resisting authority (and thus taking responsibility for care into their own hands). One way that nurses (including senior nurses) operated was to *subvert* some of the doctors – particularly when the relevant doctors showed little interest. The shadowing of a senior nurse [Irene, the matron] during a ward round produced the case of Lola (described when shadowing Irene):

Irene tells me it is because many of the patients are elderly with complex cases and therefore they tend to stay for a long time. I note that one of the patients has been here for a long time and I ask whether due to the long length of stay on the wards whether she becomes attached to any of the patients, I point particularly to the patient who had been here for three months. Irene says, 'oh that's Lola, mmm has she been here 3 months?...let me check her notes'. Irene leaves the file that she is reading and picks up Lola's file and looks at the admissions page and then states (sounding surprised). That three months is correct. She then continues that she does find herself getting attached to her patients, especially if they have been here as long as Lola. She mentions that Lola should really have been moved to G Ward but she really doesn't want to move her 'she should be elsewhere, but she is ours' (highlighting emotional attachment and the sense of ownership over patients). She tells me that Lola is really sweet and all the nurses really like her and it would be quite strange if she was no longer on the ward as she is a returning patient and 'it is always nice to have her back'.

As we have suggested in Chapter One (and witnessed above), in order to protect one's self against anxiety clinical staff often 'split' patients into 'good' and 'bad'. Here the treatment of Lola indicates that the nurses may be using their care of her to defend themselves against some of the harsh treatment decisions made about other patients (by doctors and managers) particularly when there is pressure to discharge older patients due to bed

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shortages. This might lead them to consciously and unconsciously subvert these authorities when they can and there is a particular pleasure to be gained when they succeed in this 'subversion' with a 'good' patient such as Lola. What remains at stake is whether Lola's stay is actually benefitting her clinically (or even socially) and also whether it is preventing another patient receiving medical care.

9.6.4 Responsibility for end of life decisions

Responsibility for patient care resides not only with the clinical team but is sometimes shared between the team, the patient or the patient's closest relatives which is usually the case with end of life decisions. Sometimes the greatest emotional engagement is with the *relatives* of the patient rather than the patient themselves. This is particularly the case when the patient is likely to die which is particularly sensitive when it is a case of withdrawing life support. The following example of Cameron's Patient G and his daughter brings this into sharp focus.

The biggest emotional situation this day surrounded Patient G, a coma patient and his daughter. Cameron had to encourage the daughter to agree with his plan that her father's treatment should cease and palliative care take over. This is a very emotional situation especially due to the young girl's age but also because she was in 'denial' asserting that her father would get better and this caused her to present a whole range of emotions that Cameron had to deal with.

We enter the side room. The blinds are drawn causing the room to be quite dim. There is a young girl sat up right on a make-shift bed that she has made from four visitor chairs from the lounge. She has a blanket over her legs and is typing on her lap top her mobile phone ear phones in her ears and bags and other items are scattered around her chair. She looks up as we enter and pulls the ear phones from her ears. I am surprised at how young she is, I had expected a daughter of forty something not a teenager of 18 perhaps, but no more than twenty. She pulls the covers off her legs and places her lap top on the window sill. Cameron asks if she is ok and she nods and says she will leave him to it. Cameron says that he will bring her in once he has examined her father, she nods and opens the door pulling her jumper down over her leggings as she leaves. Cameron looks at me and comments (adding to what I was already thinking) "I think she is far too young to be dealing with this on her own....it is not fair".

He turns his attention to the patient and begins speaking loudly to him. He explains that he is a doctor in [Trust 3] hospital and that he wants to examine him. At each point of examination Cameron explains to the patient what he is going to do. Cameron is able to move the patient's limbs like he

is a doll. Each time the limbs are placed in a position they remain there. The patient doesn't respond to any pain stimulus as Cameron pinches the patient's skin and scratches the bottom of his feet with a stick. Cameron then checks the patient's eyes by pulling back the patients eye lids, the eye lids roll from side to side and Cameron explains that it is called a coma roll, which suggests that the patient is in a deep coma. Cameron teaches W by the patient's bedside and talks him through the patient's condition and talks about how the patient's recreational drug habits could probably have contributed to his stroke. Cameron and W engage in a small conversation about the problems of cannabis on the brain.

Cameron made the decision in consultation with his team to discuss with the daughter that they need to end the patient's treatment (and thus in all likelihood, his life). Cameron deals here not only with the daughter's distress but with the daughter's worry that she is involved in the decision to let her father die. Again a high degree of emotional intelligence and leadership as well as clinical knowledge operates in this communication.

While shadowing Owen [Trust 2] the researcher sees that while behaving perfectly correctly he puts emphasis on the clinical and health related aspects in an end of life situation above communication and empathy. He is not unkind but 'misses' the emotional level of communication. Here in the presence of a daughter and father the woman (mother/wife/patient) is clearly dying and being kept alive by the clinical team. Owen:

... talks directly to the daughter stating that her mother is coming to the natural end to her life and therefore she [the mother] is giving up - 'withdrawing from life' and tells the daughter that although they will feed her through a tube she [daughter] should prepare herself and her family for the inevitable. He also says that her mother will also start ripping the feeding tubes out to prevent herself from getting the right nourishment.

The image conjured by the 'withdrawing' from life and 'ripping' feeding tubes is dramatic and seems to give agency to the dying woman – almost indicating that somehow she is to blame as she will prevent herself getting the right nourishment. However, the researcher, as participant in this encounter, is bringing out a sense of the culture of this particular event. While Owen is probably protecting himself emotionally from the loss of life and the sense of clinical 'failure' he does not protect the daughter or the husband from the emotional onslaught of the woman's impending death.

The daughter says that she understands and turns to her father and says 'dad do you understand what the doctor is saying?' the husband paces up and down the side of his wife's bed looking lost and lonely. He looks up at Owen and says that his wife is giving up because someone at the nursing home said she was a burden. The daughter scolds the father for saying that

in front of her mother. She explains to Owen that although she [mother] doesn't say anything she listens to everything and the more her father says it the more she doesn't eat. Owen says he understands and asks how the family is coping.

The daughter here is also protecting Owen from the family's pain by scolding her father even though Owen asks how they are coping. However, although kind and polite, Owen does not seem to operate with emotional intelligence or engagement with others' pain.

The daughter says that her father is finding it very difficult because he is the main carer for her; she herself has taken time off work to care for her when she can to support her father. As she speaks about her father and how upset he is becoming she begins to become tearful. Owen listens to her as she speaks and occasionally asks further questions. The husband continues to potter around the room occasionally touching his wife's head and face. The daughter watches him.

Owen, while allowing the daughter to cry and not acting as if he is irritated or embarrassed, equally pays little heed as he continues to talk of the mother's deterioration.

Owen begins to talk about the deterioration of her mother and what they will be able to do for her. The daughter says that she knows what Owen wants to talk about 'you're talking about DNR aren't you?' Owen says yes he is and the daughter tells him that she knows about it because her friend's mother recently died and this was discussed with her. The daughter says that she knows what she would prefer but they will have to talk this through with her father. The daughter calls her father over and begins explaining DNR. He looks at his daughter, he looks lost and scared and she tells him that it is his decision but she thinks that the doctors should not resuscitate her mother because she will be resuscitated to the same state. Owen inputs that she will be 'worse' than how she is currently because she will be a lot weaker. The daughter says that she will have to talk through this with her father. Owen nods and leaves the room.

9.6.5 Stories of patient care

The following two stories show in detail the ways in which responsibility and power can shift between team members and highlight anxieties faced by doctors about caring for patients.

9.6.5.1 A story of system failure: Cancelled Clinic

The first story is told by a female registrar who describes a situation in which she felt disappointed with patient care due to cancelled clinics. In the

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following account, the narrative is broken down to four moments, and each is discussed to demonstrate how the doctor's anxiety is managed by being linked to a failure in 'the system' that climaxes in her interaction with patients.

Q: What about any time or incident that made you feel disappointed with patient care in this hospital?

A: Lots of times, particularly since we've not had a secretary. Every clinic, every single clinic I send somebody home because the notes aren't there at all. They are supposed to be coming to see the consultant [her immediate superior] and he's not there, and they've been put into my clinic and you look at the letter and it clearly says on the letter 'consultant only to see', and they turn up and he's in Italy, on holiday.

The registrar is expressing frustration. On the surface it is towards a recurring failure in patient care attributed to firstly not having a secretary and secondly because the consultant 'is not here'. The expression of the frustration however is confused; there is no secretary but the patients 'have been put' into her clinic. Furthermore, she sends someone home from each of her clinics because the notes are not there. The letter 'clearly says' the patient is to see the consultant who is not only not there but he's in Italy 'on holiday'. There is a feeling of being overwhelmed, and of rage and envy towards the consultant - and possibly the patients - emerging from this short paragraph (for discussions of workplace envy, see Vidaillet, 2007; Stein, 2000). There is also an expression of omnipotence in that she sends patients home. She has the 'legal' justification to do so because there are no notes and also because their letter says they have to see the consultant and the energy is directed towards this activity rather than getting patient appointments changed. The consultant is on holiday, presumably one to which he is entitled and one which has clear boundaries enabling them and the staff who make the appointments to re-arrange the patient dates.

There is clearly a high degree of frustration and anxiety present in this account; there are too many patients with 'needs' and not enough clinical or support staff backing the work in the way in which the doctor would feel comfortable with. As there is little opportunity either to express or assuage her anxiety so she becomes 'prey' to primitive phantasies and unconscious mechanisms to relieve the anxieties.

The story also sheds some light on doctors' anxieties about working in a multidisciplinary team. Medical education and postgraduate training provide a culture in which doctors believe they can rely on each other through which a sense of being an elite group and confirmation of professional omnipotence and responsibility - particularly of the consultant - arises. However the role of the consultant also brings about a sense of envy and

destructiveness in others which has its origins in the primitive defence mechanism of splitting off the painful parts of one self (e.g. the realisation that you are not omnipotent and that another has the ability to do what you cannot) and projecting them onto others in an envious attack (Klein, 1959).

...and you have to go out and say, 'I know you've waited three months for this appointment but I'm afraid the consultant is not here and he wants to see you personally, so thanks for coming but if you can just go away' and you can't even say to them 'you're getting an appointment for next week' because realistically they're getting an appointment in three months time, and I think that's really disappointing.

'Breaking bad news' is considered to be a difficult task for health professionals and one that is a constant cause of anxiety. In addition to having to find the appropriate means of communicating prospectively devastating prognosis and supporting patient through the immediate emotions, doctors must come to terms with possible changes in how the patients perceive them (Barnett, 2002). Even though the situation described here does not involve delivering bad news about an illness, it is a moment of disappointment for both the patient and the doctor. The patient's anticipation to receive treatment is rejected and the doctor has to acknowledge failure in service delivery. The patient's possible anger and anxiety is directed towards the messenger, who in this case, is unable to offer any practical solution. Instead of being the helpful, trustworthy saviour, the doctor transforms into an envoy of disappointment and will have to see to the patient's emotions as well as her own disappointment, to which there is no external consolation on offer. To alleviate the anxiety caused by the situation, the registrar clings on to a narrative regarding her workplace – she is disappointed in the system.

I feel very disappointed in the system, which, I know the system is a big, wide thing, but ... [it] lets people down from that point of view and, you know, we overbook theatre lists and they get cancelled and then again I feel disappointed.

By seeing the NHS as a faceless, bureaucratic, 'machine-like' (Elkind, 1998) entity, the registrar convinces herself that the situation is not her fault – it is not what she would want for the patients, or for herself. She feels anxiety for she cannot provide the care required, and as a consequence she projects this anxiety through blaming 'the system'; regardless of their individual efforts, doctors are powerless when the system fails. As this registrar said epigrammatically later on in the interview: 'I don't think the NHS works anymore' which at a conscious level represents the impact on her working life of a problematic bureaucracy while at an unconscious level it provides uncontainable stress. The doctor does not have the opportunity to delegate

tasks to her superiors to reduce the 'heavy burden of responsibility' (Menzies, 1960, p. 118) thus feels that she is left to deal with the failure of 'the system', a system, which ironically is set to heal people, not cause them angst.

It's mostly because I'm thinking, how must that patient feel. You know, they've worked themselves up, they've told work they are gonna be off work for three weeks or four weeks or whatever and arranged cover and you go and tell them, sorry, you can't have your operation, you can go back to work tomorrow. That's really disappointing, to do that to people, very much so.

In the conclusion to her story, the doctor moves beyond expressing antagonism to the system to empathising with the patient. Thus, by failing, the system provides the doctor with a social defence mechanism but through empathizing with the victims of the failure, she fails to contain her anxiety.

9.6.5.2 A story of grace in adversity: Supporting the mother of a still-birth baby

The second story is told by a male registrar who describes how he provided good patient care by supporting a mother of a still-birth baby. Despite the plot, the story is not told as a tragic narrative but as a proud patient-care moment, a sequence of events that had thoroughly positive impact on the doctor's perception of himself. This narrative is also analysed in sections.

Q: Could you give an example where you felt that you have given good patient care?

A: I think that one of them was this lady who actually came to the labour ward and told me that she hasn't felt her baby move in the past one day and she had had some bleeding. Obviously there was some concerns on my behalf for the baby, because there could be a problem. This was a very wanted pregnancy because she was quite old and this was an IVF pregnancy. I examined her a little bit and on examining her I found that the baby did not have a heart beat, so she had lost the baby.

Describing the situation at first with the patient as an object helps the doctor to distance himself from the scenario and to do routine checks expected in this kind of situation. In a hospital setting instructions are given about the way each task should be performed and these rituals form a reassuring tool for staff (Menzies, 1960: 121).

I did explain everything to her, and obviously as a doctor responsible for her, I need to follow all the procedures that needed to be done and all the care that she needed to have, you know I explained it to her that, you know this by far something that words, you know cannot express, as you can imagine how

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difficult this situation would be, and if we could make it the slightest bit better, we would try everything in our power, you know, to make the situation a lot more comfortable. I ensured that she was given a quiet room, with a very good midwife looking after her at all times. Obviously I had my duties towards the rest of the labour ward as well. People visiting her room making sure she was ok, making sure the pain relief was ok, we had induced her because we did not want her to go home with a dead baby inside her. It was a very, very painful and stressful scenario, it really, really was, it was horrible, absolutely and it is very distressing, exceedingly, exceedingly distressing because, you know the woman is going through all that pain of labour.

Here, the doctor is empathising with the patient, feeling her emotional pain and in this case is mostly able to contain it through wanting to relieve the situation and then by offering extra care, by 'going an extra mile'. In this extract, there is a clear shift as the doctor uses strong emotional words to describe the crisis. In telling the story, he is projecting his own anxiety on the patient, living the distressing emotions with her and having to remind himself of his position as a medical professional - 'obviously I had my duties towards the rest of the labour ward as well'. By referring to 'all that pain of labour' the doctor enters a relationship with the pain. The phenomenon of pain and our relation to pain, whether someone else's or our own, is more immediate than that of reflective knowledge – we do not think about pain but react to it so the sensation is intersubjective. The person who is not experiencing the pain but affected by it is an 'interlocutor' in the situation (Crossley, 1996, p. 37).

...I tried to make it a point that I was present, present as much as I possibly, feasibly could during her emotional outbursts. I wanted her to have all the support that she needed... I did get attached to the patient, being around her, trying to get her care, even if I was out of hours, which means that when I was not meant to be in the hospital. Now I think that some people will argue that, that is a bit over the top, but I think that, I guess, I guess, that that is medicine for you, you know it is about lives, and sometimes you have to make that extra effort, to make that person feel that little bit more special.

In this excerpt the doctor starts to explain and justify his actions. Through self-reflection he has realised how he acted in a way not normally accepted in the hospital culture, that is, he went against the 'social defence system' to deliver patient care, but also to cope with his own anxiety. He dedicated extended time to his patient even though hospital doctor's time is considered to be 'fast and efficient'; 'doctors move quickly in the hospital wards. Their time is expensive. They cannot afford to linger too long in any one spot' (Mattingly, 1998, p. 21).

Menzies (1960) noted that while institutions have social defence systems, individuals may resort to their own defensive mechanisms, but a membership of an institution 'necessitates an adequate degree of matching

between individual and social defence system'. If the individual and the social defence systems are in disagreement, what follows is some degree of breakdown between them, for example, a doctor's work colleagues might reject them for behaving in an inconsistent or unprofessional way to the system. Consequently, the registrar providing patient care to the mother of the still-born baby is not only coping with anxieties created by that emotionally charged situation, but he also has to think about the culturally accepted limits of caring and possibly negotiate his way with other members of staff. On this occasion, the doctor keeps to his defences and spends extra hours with the patient, without being criticised by his peers.

Well you know that when things get worse, they get worse and they get worse and they get worse. Ultimately what happened with her was that we tried all the induction of labour, we tried everything possible to get that baby out, by induction. And in her case with the induction, it failed as well... and I can't tell you how dreadful that scenario was, that she needed a Caesarean section to have that baby out... I wanted to make sure that I was present at the Caesarean section, as well so that she would have a face that she knows. Once she delivered, you know obviously I was there with her, with the [dead] baby in her arms, and she was happy from the point of view.... and thanking me every now and then, which I said that she shouldn't because it was my job and one should do it. But she kept signalling the fact that not many people would do it the way that I had and I that was very special.

Much hospital work contains a 'constant sense of impending crisis' (Menzies, 1960, p. 26) which creates pressure and anxiety. The level of predictability in medical work is low and – as the registrar expresses it – 'when things get worse, they get worse'. The doctor explains that he attended the Caesarean section for the patient's sake, but this could also be interpreted as his coping mechanism – the need for a closure (Mattingly, 1996: 37). If you only see trauma and dramatic events without closure, the events will stay lingering and cause anxiety, stress and possibly depression. The doctor needed to be there and needed to have closure to be used as a coping mechanism against accumulating anxiety. So far the patient had been in a powerless position while the doctor had presumably been in control of the situation and emotions involved in it. Therefore, when the patient thanks the doctor, he gets confused. The patient had survived through the ordeal and suddenly has the power to relieve the doctor's anxiety, to nurse him (Menzies, 1960). The acute physical and emotional stress is released and the doctor can reflect back on his experiences.

And I think that is something very, very special and dear to my heart. And these are those situations when you sit back and you reflect on your life and

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say, "wow I have done something good, really, really something good and it is wonderful".... I saw her every single day on the post natal ward and obviously I made a point not to neglect her, or neglect her partner because people assume that the only person going through the trauma is the woman who has actually delivered, but they are a couple, and that needs to be understood so that was important as well. And he appreciated that quite a lot. They went home, two weeks later, I did receive a lovely letter, which kind of expressed a lot of gratitude, for what I had done for them.

The thanking letter provides closure for a difficult story, but maybe also goes beyond this. It hints at redemption – instead of a medical tragedy possibly compounded by failure in patient care, the story becomes one of a victory or at least grace under fire, a positive example of the doctor's powers even when he cannot actually perform miracles by restoring life. Anxiety is successfully overcome by the absolution from the patient and the doctor's 'priesthood' (Elkind, 1998) is restored. The letter from the patient acts as the final seal to exalt the extra efforts the doctor put in to solving the problem (Menzies, 1960, p. 31).

I know that I put in extra hours and I KNOW that I shouldn't have been there but no-one complained, because everyone knew that I was helping a situation. It is just an understanding that we have. It would be a terrible job if you were only allowed to work your set number of hours.

A narrative like this one permits people to attach themselves to 'desirable' ends, think well of themselves in moral terms', 'support their needs for autonomy and control', and 'promote feelings of self-worth' (see Baumeister, 1986 in Brown, Stacey & Nandhakumar, 2008, p. 1054). By telling this, not an easy or comfortable story, as a proud moment of good patient care, the registrar restores his professional and personal integrity. There is no 'system' in this story to blame on, no failure to confess, but despite the drama the story draws to a happily-ever-after ending. The story has entailed a narrative for the self (Brown et al., 2008) that has released the anxiety the event contained.

9.7 Conclusions

Patient care is a process and a social construction and as such means different things to different people. Norms and styles of patient care also change across time and differ site to site not only because of differences in beliefs, but also because there are different possibilities (technological advancement, different types and mixes of professional groupings) and different types of constraints on what might be offered. It is not always possible to put a clear value judgement on patient care and one example is to do with 'length of stay'.

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Managers, whose concern is to ensure that beds are not blocked, may or may not be holding in mind the image of an organisation that shares care with agencies and families in the community. They may simply be responding to government targets. They may have their mind fixed on those waiting for beds who have still not received treatment. Patients themselves may want to return home as soon as they can or become bewildered when they are discharged rapidly after treatment.

Working in multi-disciplinary teams with distributed leadership patterns may have improved practices for clinicians. Accountability for patient care still resides with the consultant and the hierarchy who manage the Trust. While senior managers are responsible for ensuring patient safety and preventing negligence to individual patients, they are also responsible for ensuring access to care for the community which involves managing scarce resources such as equipment, pharmaceuticals, beds and staffing.

Not all clinicians appreciated or respected these pressures as we saw particularly in Chapter Six. Nor do patients necessarily agree that good care is anything other than good and consistent communication with specific clinicians.

As demonstrated in Chapters Six and Seven managers are frequently frustrated by demands from staff who may try to subvert managerial targets (set by government and as such fundamental to resourcing of the Trust).

The quality of leadership is intimately linked to patient care. Good patient care relies on effective leadership of the kind that engages with staff and imparts to them the vision that (as far as humanly possible) the patient comes first. That in turn impacts upon the climate, culture and ethos of the Trust. When leadership fails, so does patient care.

10 Leadership and patient care: Assessing the past and thinking of the future

10.1 *Introduction*

Without effective leadership at all levels of the NHS and its various organisations patient care suffers. This knowledge has been evidenced in

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several key studies across recent years as reported above and elsewhere and consequently fed into the NHS Qualities Framework (see Chapter One).

In this report we have critically reviewed the relevant literature on leadership exploring as far as possible the relationship between leadership, followership and service delivery across five hospitals comprising three NHS Trusts (see Chapter Three). We employed different research methodologies (see Chapter Two) to capture data to investigate leadership qualities and their interaction with the climate and culture of the organisation and linked these to service delivery and patient care in different settings (ranging from obstetrics and gynaecology and cardiology to care of the elderly).

10.1.1 The organisational contexts

The organisational contexts of each Trust and each site or unit varied physically, structurally and in 'atmosphere' (the full details are provided in Chapter Three). We have been concerned in the report (and future papers) to steer a path between maintaining anonymity and confidentiality and thus not overtly identifying a Trust or site within a Trust, while also pointing to how the contexts impacted on the practices of leadership and service delivery.

Overall the Foundation Trust (3) in this study, which had not been experiencing mergers or threats of closures, where staff morale was high and where leadership practices were distributed across teams and clinical and management specialties, was clearly the one most conducive to effective communication and leader-follower engagement. There was an 'atmosphere' of connection and pride in belonging to the Trust as evidenced explicitly in Chapters Four and Nine in particular.

Trust 1 was applying for foundation status during the time of the investigation but also threatened by closure of some of its units, and with the senior managers possibly being transferred to the other site which was perceived by the participants as a threat to their status and possibly to resources for service delivery. This did not happen during the course of the investigation. The managers in Trust 1 were committed to their staff and to service delivery although there did appear to be some discontent with senior management from the medical staff. This may have been because most of the distributed leadership involved non-clinical managers and nurse managers with the medical teams appearing to take a more 'traditional' hierarchical stance. Most of the data from the OCS was derived from Trust 1 which demonstrated among other things the importance of management support for identifying good leadership and patient care practices.

In Trust 2 there appeared to be the greatest amount of conflict between groups of staff who sometimes seemed to be leading in different directions.

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Trust 2 was perhaps the 'victim' of a relatively recent merger between two large hospitals (and one or two other smaller units) which were some physical distance apart and had had a different history – one being a DGH and the other a teaching hospital. The DGH appeared at first to have a professionally diverse group of senior managers who distributed their leadership to effect, but one or two figures emerged during the course of the study who transgressed this approach with one person taking a back-seat while another was trying to drive through change in a somewhat cavalier manner. Furthermore in this particular Trust there were changes among the senior managers (some left, others moved to the other site during the course of this study). The CEO also indicated that it was difficult to recruit good middle-range managers and nurses in particular because both sites were away from the centre of the city where most people would look for a promoted post.

10.2 *Limitations of the study methods*

As with any large scale and complex study such as this one not all of our intentions were achievable although some were satisfied beyond our expectations.

We had difficulties capturing data from patients for two main reasons (fully detailed in Chapter Three).

Firstly, the 'gate-keeping' staff working on the Units on a day-to-day basis (as distinct from those who supported overall access to the Trust overall) obstructed data collection.

Secondly, it was also difficult gaining access to patients while they were in hospital because of ward procedures and in other cases the poor health of patients. So in the end we managed to conduct ten patient interviews but were unable to collect organisational climate survey data from patients at all³⁸. To overcome this we gained permission to observe clinicians' interactions with patients in their care and we believe we have managed to do more than compensate, making a contribution to knowledge with important new material to demonstrate patient care in different contexts and the processes involved in patient care and service delivery (see in particular Chapter Nine).

We also met with difficulties, with one Trust in particular, collecting *survey* data from staff although individual staff members proved more than willing

³⁸ These difficulties were reported to SDO in the interim reports and also separately when they arose.

to support the researchers by allowing them to interview, observe and shadow them during their working days. *This is all reported fully in Chapter Three.*

10.3 *Reviewing the findings*

In this final chapter then we draw together the findings from the study and make suggestions as to how they might contribute to policy and practice beyond the participating organisations.

This chapter is organised around the original study aims which were about leadership, organisational climate (culture and context) and how they impact on patient care. The overall plan was to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery.

This research further sought to explore the following broad-based questions.

- First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
- Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?
- Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The specific aims and objectives are listed again below and we conflate these in what follows directing the reader to the relevant chapters.

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines, to patients;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts service delivery;

- To learn how different stakeholders (specifically patients, nurses, members of professions allied to medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care;
- To identify how the need for change in service delivery is identified and what drives the need for change.

10.3.1 How far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?

Throughout the participating Trusts there is evidence of the importance of high quality patient care. Chapter Nine in particular brings this together with quoted respondents emphasising that above all patient care matters to the aims of the organisation and those who work in it. Thus on a basic level, working for patient care is inspiring in itself and staff across the Trusts see good patient care as their *modus operandi*.

Our use of innovative ethnographic methods and story telling were particularly effective in providing the evidence of how patient-clinician relationships were practiced and how staff made sense of their own actions reflexively in the context of caring for patients³⁹.

Chapter Nine provided evidence of the ways in which care is practiced.

We begin here by summarising some of the evidence from the Foundation Trust in this study, which consistently appeared to demonstrate high levels of distributed leadership, emotional engagement and multi-disciplinary working across all levels. The data included several key examples of positive statements about the role and effectiveness of management. We saw, for example a senior clinical manager summarise the issue with reference to his

³⁹ For example, interviews opened with questions about leadership and patient care, and participants were then encouraged to tell 'stories and critical incidents illustrating their experiences'. The early parts of the interviews provided themes and indications of what the clinicians regarded as crucial to delivering good patient care, e.g. 'cleanliness', 'efficient administration', 'communication', 'empathy', 'sympathy', 'knowing the recent developments in your field' and 'everything behind the scenes the patients don't see'. However, it was the stories they relate to that provided us with insights into their core experiences of patient care (see Chapter Nine).

pride in working for the organisation drawing attention to its low mortality rates, and that the high quality staff and its reputation for patient care act to attract others at the top (or with the potential to be at the top) of their specialty.

By contrast, the CEO of one of the other Trusts had made the point in their interview that one of the difficulties they had was attracting high caliber nursing staff, partly because of their location (in the suburbs). In Chapter Four we identified the ways in which an organisation might be seen as a learning organisation as significant in supporting staff to develop their clinical and managerial skills and develop capacity for patient care. Where support for learning was apparent so was the enthusiasm and pride for the organisation and its goals.

What was striking was the way that all respondents who addressed this point were looking to see how patient care could be improved with aspirations that patients were satisfied with more than just the health outcome (although that is the bottom line) but also with the facilities and the atmosphere. In addition, several respondents made the point that they themselves were mindful of delivering (or at least aspiring to deliver) the type of care they themselves would want to receive.

That so many of the staff (clinical and non-clinical) worked long hours in which they were engaged in intensive work with either their clinical or management teams, or their caring for patients with the aim of delivering the best possible care, is yet further evidence of the ways in which patient care is inspirational.

What is most noticeable, however, is how some styles of clinical and managerial leadership appear wanting, when compared with the best. While some respondents are clearly excellent communicators who engage fully with their professional knowledge and with the patients and staff, others - equally expert and equally inspired to provide the best for their patients - seem to fall short in comparison. In Chapter Nine for instance, Cameron and Kenneth engage with their patients in human ways and there are examples in the chapter in which each clinician manages to gain important information from and for their patients by their hard work *and* their humanity. However, in Cameron's case he is supported by a team which has clearly been nourished and inspired by the organisational context (see references to Cameron's work in this report).

Kenneth, while equally able and empathic, from the ethnographic evidence reported in Chapter Nine, appears to be less able to transmit this or influence others to take up his brand of leadership and patient care. He remains slightly in the background while the younger and (it appears) more influential Henry sets the tone. The clinical team give the impression of

being business-like and impersonal and somewhat intimidating when they conduct their ward round. The culture being transmitted to the other clinical staff tends towards Henry's approach rather than Kenneth's. This raises questions about why this Trust and site is different from the FT in which Cameron and Mandy work. These matters were addressed in Chapters Six, Seven and Nine in particular and will be subjected to further analysis in subsequent publications. However the FT is established and settled. The Trust where Kenneth and Henry work was the product of a relatively recent merger and norms and values were still being 'negotiated' (see Chapter Seven and above in this chapter).

Subsequently we see Mandy working directly on a patient's wound not only acting humanely when she hurts the patient but working with the nurse to assess how they might best improve the patient's condition while caring for his mental state and self-esteem.

High quality care and inspiration come together through the ways in which clinicians and managers take responsibility for their work – for managing emotions (their own, their colleagues' and their patients'), teaching, making decisions about end of life care, communication with relatives and coping with everyday situations that raise anxiety levels for patients and staff. The story of the doctor in Trust 1 who cared for a woman with a still-born baby itself demonstrates how he went the extra mile (in his words) inspired by the possibility of providing care in a case where some might have tried to make minimal contact because a still-born baby might be seen as a clinical failure.

Overall emotional engagement with patients and followers leads to people working together in a human, humane and inspired way and impacts on the organisation itself which can become one with which people are proud to be associated.

10.3.2 How do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

This question underpinned the entire study, but specifically we reviewed the relevant research literature on leadership and organisational climate (Chapter One) and discussed this in Chapters Four through to Eight. We began by reviewing the results from the story-telling interviews, focus groups and ethnographic methods (observations and shadowing). A range of potential practices and behaviours were reported to us which suggested where problems might lie in current leadership practices, as well as what many respondents held to be ideal types. What we summarise now represents a combination of what works and what does not although it needs to be noted (as identified in Chapter Nine in particular) that what

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patients see as good leadership (that they received clear and consistent information from one or two key staff) may not always intersect with what staff meant by good patient care or effective leadership and service delivery. The latter was usually seen as best delivered by a well-functioning multi-disciplinary team albeit frequently constrained by limited resources.

The following issues stand out as good practice that could feed into NHS (and local Trust) policy:

Leadership is a complex concept meaning different things to different people. Over recent years leadership in changing contexts such as the NHS has shifted from the 'heroic' model where leadership is hierarchical to a model that is more distributed across different levels and different parts of the organisations. The heroic and hierarchical (related) models frequently depended upon individual characteristics and where the senior managers were indeed heroic and charismatic, leadership might well have led to good patient care. However, this is unreliable and unpredictable and the NHS Qualities Framework which has identified leadership skills is more appropriate to the context (see Chapter One).

Our most important findings, however, make it clear that leadership which is emotionally engaging and distributed is the one which is most likely to lead and support service delivery successfully as well as drive necessary changes.

At the end of Chapter One we focused on contemporary studies of leadership which promoted the importance of *context* and of taking a more discursive stance in the analysis of leader-follower relations. We also drew attention to the revival (and reappraisal) of concepts from organisational studies from the 1960s to the 1990s which took psychodynamic ideas into account and related them to more 'popular' contemporary ideas about the significance of social and emotional intelligence in leader-follower relations. Thus, we explored the ways in which stakeholder accounts of the experiences and exercising of leadership demanded an attachment or engagement at an emotional level, which took account of the unconscious as well as conscious understanding of these experiences. There were several examples offered in the previous chapters of leadership practices that delivered the required services or changes through different types of concerted action and those that didn't. In some cases we were able to show that with the best will in the world if the leader, for whatever reason, was unable to *engage* and thus be supported by the followers, then their leadership failed to deliver.

Recent analyses of distributed leadership styles and organisational contexts show that if such leadership is to work then people need to act and work together and be prepared to both take up and relinquish authority for

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certain tasks and roles at the appropriate intervals. We saw in Chapters Six and Seven for instance that authority is hard to maintain if a leader loses touch with their staff and fails to hold their own organisation 'in mind'. We used the OCS survey results in combination with the data derived from the interviews, focus groups and ethnographies to demonstrate the importance to a positive organisational climate of good leadership. Satisfaction with a manager was predicted by the same variables that identified a positive organisational climate. For staff in the organisations surveyed it was important that managers were committed, responsible and supportive of their staff/followers.

But how were these characteristics demonstrated? Leaders who were experienced as effective, supportive and emotionally engaged with their followers were able to communicate their vision and dedication to improving the quality of care to patients, which in itself co-existed with good staff morale. Such leaders were also good listeners as well as being able to take staff with them when less palatable or unpopular changes were mooted by senior management or government. These effective leaders were closely connected to the way the organisation was structured (physically and emotionally). They were thus able to access the information they needed in order to lead. The evidence for this frequently came from the stories and accounts of staff and observations made by researchers – often of good leadership but perhaps more acutely when leadership was poor. Then there was a jarring effect or mismatch between (local) policy and the attempt to drive changes to meet improvement targets. There was also evidence on occasions of senior clinicians' behaviours being disengaged. Sometimes attempts were made to subvert the senior people when leadership went against the grain. There are examples in Chapters Seven and Nine in particular.

A final comment here is that despite the changes in gender demographics at the top of clinical specialties in medicine, nursing and related professions, as well as in senior management, gender has not 'gone away'. Indeed distributed forms of leadership have (perhaps stereotypically but with some evidence base) been associated with women's behaviours. The OCS (Chapter Five) suggested that women's perception of 'recognition' for their work and achievements was more negative than that of men. Men were either satisfied with the recognition they received or less in need of recognition from their managers within the organisation than were women. In the qualitative data (see Chapter Eight) it was also the case that while senior women were keen to deny the relevance of being female to their professional lives and their career progression per se, women used different strategies and perceived their roles slightly differently than did men, although the point was well made by some respondents that feminine and

masculine choices of specialty may have been more significant predictors of management styles than gender itself.

10.3.3 Do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The contemporary NHS with its (mostly) distributed leadership practices at all levels tends to militate against the possibility of one person's vision being paramount. However, as suggested above in this chapter, there are nuanced influences of leadership style that (may) flow from one or two people's vision and/or style of leadership and patient care that influence organisational approaches.

In Chapter Seven, for example, we explored three senior people's visions and consequent behaviours to consider their authority and influence with the possibility that as opinion leaders they influenced organisational approaches to patient care. Quentin, for example, reflected his role as a senior clinical leader, and although there is no irrefutable evidence that his style was mirrored in the organisation itself, he does provide some evidence that in certain cases in relation to certain actions his vision had an impact on the overall organisational approach.

While the OCS (Chapter Five) captures data from a wider population, the ethnographic methods made a greater contribution to exploring how far an individual's vision influenced the organisations approach to patient care. Again in Chapter Seven we see Kerry battling against a resistant (and probably disillusioned for some reason) senior management team to improve discharge policy and meet government targets. She tries again and again (by her own account) to show her staff that they need to focus on targets because they will lead to improved care quality. She appears to fail (again according to her own standards) and expresses this by almost literally demonstrating that she is banging her head against a brick wall.

Differently with the same effect Gerald is introduced as having a clear vision for patient care in his Trust. However, his inability to take staff (at all levels of the organisation) with him in his vision is attributed in our analysis to his lack of emotional engagement and autocratic (verging on the authoritarian) style of management. His narcissism further ensures his inability to understand how his behaviour is impacting upon staff and he sees himself as having failed to win a 'fight'.

Chapter Six explores the organisation as an open system, and ways in which all stakeholders⁴⁰ hold a vision of the organisation in the mind at a

⁴⁰ Including patients but we cannot really speak definitively here due to lack of data.

conscious and an unconscious/emotional level acting accordingly. Thus, they have an image of the organisation (how well it is managed, how effectively it cares for patients), a sense of their own role and place within the organisation and how well the leadership understands the experiences of staff and patients. Recognition of the primary task, the roles and responsibilities of those who manage it and the (changing or threatened) boundaries of the organisation itself are critical concepts.

No doubt some members of the organisation have more personal and role/task related power and influence than others in the NHS Trust. Furthermore, the NHS as a system is fluid and dynamic, so that there is overall a group influence over the evolution of organisational context (climate and culture) which responds to visions from within and without (government, health care consumers) the wider system.

10.4 *What have we learnt from this study?*

10.4.1 *How leadership relates to patient care*

It is clear, from our empirical work and evidence from previous studies, that leadership is a process and set of practices which generally do not equate with the qualities residing in a particular individual regardless of their authority and formal role and status in the organisation. Leadership that 'works', as seen particularly (but not only) in the case studies in Chapter Seven, involves the person in the leadership role exercising social and emotional intelligence and engaging with their 'followers' (see Chapters One and Four) and offering staff recognition and support (Chapter Five). Moreover the role of leader is particularly effective when it is distributed among those who are best placed to exercise leadership towards the task in hand. So that in the context of an NHS hospital Trust, leadership might be exercised in relation to organising the administration for a unit, running an audit, or developing an innovatory clinical practice. Leadership in such contexts is time/project limited.

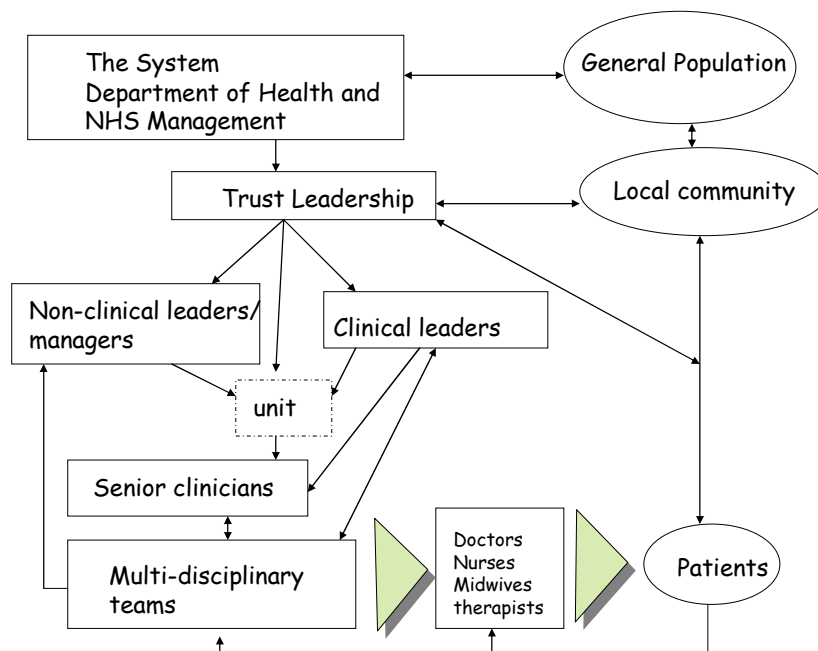
The primary task for NHS Trusts is to deliver a service to patients, as proposed in Chapter Six. All NHS Trusts operate as open systems with porous boundaries which enable change (planned and/or evolved). Leadership therefore can occur throughout the system at different levels including those of ward clerical and cleaning staff and the CEOs who 'manage upwards' and influence NHS/ Department of Health policy. Information of all kinds passes across the various boundaries not simply from the 'top' downwards.

Below in Figure 12 the relationship of the Trust leaders and patients within the NHS system is illustrated. It is also the case, as shown, that policy

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influences individual care, and the quality of that influence depends very much on the quality of leadership again across the system at all levels.

Figure 12. From the DoH to the Patient: An Open System



Patient care is represented here at three levels. The population who influence service delivery and patient care using their vote and/or lobbying through relevant patient groups, the local community who are served by a particular Trust and patients who are actively receiving medical treatment from individual clinical teams.

While on the whole it was the last group who were the main focus in this study some participants, particularly those in senior leadership/management roles, were concerned with service delivery at the local community and population levels. This sometimes meant that senior managers faced the dilemma of how to care for the community while attending to individuals and some individual clinicians were equally concerned about how their interactions with patients were influenced by some of the management dictates which derived from NHS policy that they

found difficult to understand (see Chapter Six and in 10.4.2. below for example).

10.4.2 Systemic dilemmas in patient care: Managing in the NHS

One participant had faced a 'dilemma' in wanting more face-to-face knowledge of patients in the community in order to be a more effective and informed leader, while also as his role required, attending to the demands of working within the wider system of the NHS:

As a chief exec in the NHS it was my privilege to make decisions. That was my privilege to go on and up the ladder. It was that I could go on and make faster and faster decisions. I get in the way I have always got in the way... the thing I would do is go out with the district nurse for the day, because I needed to be grounded in that. (Retired CEO)

Another manager who had previously had a military background advocated (along similar lines) that the best way to lead towards good patient care was to 'walk around' and support the leaders across the different parts of the organisation. In a seminar to clinical staff, which we attended and recorded, he drew participants' attention to the importance of *influencing* policy to achieving good patient care (at the population and community levels).

I hope some of you will find yourself in policy jobs at some point. Totally different, yes it still leads, but the actual process is so ... changing...both the chief executive and I spend a lot of time nurturing relationships which are partly to do with policy, but unless you get it right ... you communicate with them, it won't work.

In other words to be effective and to ensure the best for those in the Trust (staff and patients) a leader has to 'manage upwards' which gains influence. He continued by contrasting the experiences and perceptions of doctors with managers who lead at the macro level, drawing on the example of a recently qualified doctor. When the respondent quoted here asked this man about leadership in the NHS and how it impacts on patients he apparently answered:

'Oh I have got communication skills'. 'Blimey!' I said 'what do you know about the NHS?' And I asked him a couple of questions, nothing! But he hasn't been taught at an academic level about the context in which he is working. I think that is crucial and I know that is not how everyone does things. You know [doctors] keep people alive, but they really ought to have this basis of information about the context in which they are working.

While it is self-evident that the NHS is the context in which patient care is delivered, there is a tension between those who exercise leadership in that context and those who 'keep people alive'. In Chapter Seven, the frustration expressed by Kerry in trying to meet the demands of the government and community by improving the Trust's record of patient care, as well as motivate her senior staff to hold similar ideas, was palpable. From others' perspectives as shown in Chapter Six, there was evidence that 'management' was experienced negatively by several clinical staff when it tried to respond to Department of Health directives.

Managing the numbers

At another level of management good patient care was defined through achievement of returning satisfactory statistics, as this observational note of a meeting between capacity managers and clinicians suggests:

Patient care for the capacity managers appears to be a number crunching exercise. The need to get the patients in the right beds according to government targets meeting four hour waits and single sex bays. However because there is not a shortage of beds on this day, patient care moves from an exercise in numbers to thinking about patients in real human terms.

Sally (the capacity manager) talks about how better patient care can be delivered when there is less pressure on all the staff to meet their targets and get their job done. She talks about how [clinical] staff are then more able to talk to their patients and spend time with them. However, whilst reduced pressure means that for some, numbers translate into real people it is clear that in the capacity meeting that the role of the capacity manager is to think in terms of numbers and beds to deliver good patient care.

There is a potential conflict between the target driven service and the patient-clinician relationship which is about face-to-face contact. Perhaps this is well illustrated in Chapter Nine with the example of the 'grace in adversity' story, whereby the obstetrician spent extra time with a patient while his clinical colleagues turned a sympathetic blind-eye. The story of the patient 'Lola' also discussed in Chapter Nine who had been occupying a bed for three months with the tacit support of nursing staff would also have been anathema to staff responsible for managing targets about capacity.

10.4.3 Who judges what is good leadership and good patient care?

As shown above and throughout this report there is a tension throughout the system. The primary task of senior managers and leaders at and above the level of the Trust is to ensure the demands of the NHS and Department

of Health leadership are met. These are policy driven with differing priorities at any particular time. The general population of (potential) patients has a keen influence on policy in different ways but particularly during local and general elections. For example the recent change from a Labour to the Coalition Government has raised questions about the role of 'targets' for future NHS priorities. Apart from other matters, finance makes a difference as to how priorities for service delivery are set.

Senior management at the Trust level is judged in a number of ways particularly related to how far the Trust meets the national priorities. However there is also pressure on CEOs and senior teams to get direct patient care and safety 'right'. This may be assessed through statistics as in the following example described by a senior midwifery manager:

Between 2002 and 2005 there were ten maternal deaths at [Trust], which exceeded the national figures. So the Healthcare Commission came in and reviewed a number of clinical organisational cultural governance issues, and then actually put the maternity services under special measures

There was a key number of issues then, and an action plan was developed, so actually I was newly appointed at that time, and there was a number of work streams that we had to work on, and it's never happened before, and I don't think its happened since in a maternity unit. So basically, even though that was a very sad event for all the families involved and very tragic for them, it was difficult for the staff, and obviously difficult for the Board in terms of reputation management. The whole action plan was implemented, the unit was turned around, and the special measures were lifted in 2006.

In this case there was a notable failure to deliver maternity care to the standards of safety prescribed by the NHS. Furthermore there was a failure of leadership perceived by this participant in terms of both 'culture' and 'governance' giving rise to the high proportion of maternal deaths and the consequent special measures. This participant also makes clear how much the staff themselves are influenced by events of this kind.

Another member of that staff team praised the changes at the top following these problems and combined the policy, context and face to face care in her assessment of the relationship of good leadership to good patient care:

.... the end goal for us, is ensuring the services we're providing.. the patients, are getting the best service from us on top of meeting all the Trust targets and the Trust strategy...for me really it's about ensuring that the patients are getting the best quality care, which, you know, I think they've got an improved quality of care here, with the team like mine who are here...and I think [leadership] is from the top down, so from Chief

Executive, right down to every level, to leaders in the ward, right down to our portering, to our domestics. Yeah, there certainly is, and we lead by example really don't we? and I think our chief exec, director of ops, deputy chief, they've all got good leadership skills.

Good leadership skills among senior managers can pay dividends in terms of reputation management. For example in August 2010 North Cumbria University Hospitals NHS Trust admitted a series of false positive diagnoses following breast cancer screening⁴¹. The CEO moved quickly to review the situation and apologise publicly. In other cases though, when there have been wrong diagnoses, neglect or medical errors over drug doses senior managers have been blamed for the failures - sometimes warranted and sometimes possibly not so (see below). Anecdotally it appears that leaders who are prepared to acknowledge problems as soon as they appear and deal with them in a transparent and effective way bring about improvements in service delivery and patient care in the ways perhaps that those who try to 'bury' problems might not achieve.

10.4.4 Leadership practices across the organisation

Leadership and patient care are intrinsically linked. Leadership is above all about taking responsibility but with changes in organisational structures, a growing emphasis on networks, open systems with porous boundaries, mergers and changes in the shape, structure and functions of Trusts, it is no longer tenable for leadership to be in the hands of a few. Leadership, then, is about a series of relationships and connections within and without specific organisational boundaries which have the potential for diffusing responsibility or sharing it, and therefore making leadership practices more co-operative.

It is important to focus, as we have done, on the many examples of good and excellent leadership we found within the three Trusts taking part in this study (each of which of course being hospital based and therefore not focused on the role of leadership in primary care). These sit in contrast to the examples of less effective and sometimes failures in leadership that we have cited. The differences crucially were about emotional attachment and engagement between leaders and followers. We did not meet any respondents who were disengaged with the aims of the NHS and none who were uncommitted to deliver the best patient care. But as evidenced above in the report and in this chapter, some leadership practices failed to take

⁴¹ <http://www.bbc.co.uk/news/uk-england-cumbria-10958423>

followers with them because of autocratic, insensitive behaviours and poor communication skills. Leaders need to be able to listen and engage – having a vision is not enough.

Leadership taking the importance of emotional engagement into account also needs to be transmitted across the organisation. This is best accomplished through making full use of individual skills. Clinical staff and managers can be effectively involved in specific change projects. These may be time-limited and/or specialism specific but collaborative concerted action is frequently the most significant way that a system might flourish with the staff taking responsibility and enhancing their sense of commitment.

10.4.5 When leadership fails patient care

The converse of good leadership is potentially catastrophic. The case of Beverly Allitt in the early 1990s, the nurse who murdered children in the Lincolnshire Hospital by injecting them with insulin, went relatively unchallenged because she was poorly supervised. Harold Shipman, a different case in that he was a GP in a sole practice, similarly was eventually thought to have committed over 200 murders of patients throughout his career. However, the report into his murders showed that doctors at Thameside hospital had failed to report suspicions about his prescribing⁴². The Alder Hey organs scandal involved the unauthorised removal, retention and disposal of human tissue, including children's organs during 1988 to 1995 and the Bristol Royal Infirmary inquiry about children's deaths during surgery resulted in doctors being struck off. All these cases represent a failure of leadership in which those who were responsible for patient care at all levels failed to identify and follow up on problems. More recently the independent inquiry into the Airedale NHS Trust, where the late Anne Grigg-Booth continued as night-nurse despite a high proportion of deaths of patients while under her care, identified 'a catalogue of systemic failures' whereby her dangerous behaviour was not spotted.

At the time of writing this report the Prime Minister David Cameron has ordered a full public inquiry into the events at Staffordshire hospital which have led to deaths of patients, it would appear in these cases, more due to negligence than intent. The Francis report which was published in 2009 found that patients were routinely neglected and there were systemic failings in patient care. Managers had been pre-occupied with cost cutting and meeting targets and unable to spot the build up of failures in patient care that were to cost several patients their lives. There were too few

⁴² These cases were subjected to inquiries which exposed a range of complexities which are not relevant here.

nurses, those who were employed were ill-trained, equipment was inadequate and experienced medical cover was not always available. It was a supreme failure of management and leadership. The Trust was poor at identifying when things went wrong and managing risk. Some serious errors happened more than once and there were higher levels of complaints compared with other trusts. Staffordshire was a foundation hospital that had managed to 'tick the boxes' although clearly there were a series of chasms between the clinical and managerial staff.

10.5 *Final thoughts*

By using innovative qualitative methodologies (described fully in Chapter Two) such as story telling, ethnographic observations and shadowing, to both supplement and augment data from interviews and focus groups, we have built up a picture of what happens in the daily lives of NHS staff working both with and as managers and in clinical teams. Using these methods provides opportunities to extend the scope of more traditional in-depth interviews and focus groups. The 'story', because it is chosen by the participant themselves, provides not only detail and depth but demonstrates the specific indices used by each interviewee to make sense of their own and others' behaviours within the organisational context.

The ethnographic observations, and the shadowing in particular, enabled the researchers to gain a sense of what 'a day in the life' of a member of the organisation *feels* like. They can 'experience' the interactions between staff, between staff and patients as well as the frustrations and pleasures of working in that Trust. No other method provides such acute insights. The subjective ingredients in this method enhance the process (i.e. as outlined in Chapter Two whereby the researcher themselves is the 'instrument' through which data is mediated). Moreover, and possibly conversely, the subjective elements are reconciled when the observation notes are discussed by other members of the research team, which again as discussed in Chapter Two is also a source of data (Czarniawska, 2008).

As a qualitative study, the success is proven by the richness of the data, showing the clear emotional connection participants had with the topics of both 'leadership' and 'patient care' (Lincoln & Denzin, 1994, p. 575). From this we were able to make sense of how leadership is experienced and exercised (see Chapters Four and then Six to Eight) and about the practices around patient care and service delivery that support patients to understand the relationship between their particular health-status, quality of life and the care and treatment they are receiving and/or expect (see Chapter Nine in particular).

The statistical analysis of the OCS⁴³ showed that, on the whole, the climate variables, 'support' and 'recognition' from managers and the system overall, predict 'satisfaction' with leadership and management. This reinforces the ideas expressed throughout the report that good practices by managers/leaders are about ongoing engagement with followers with concerted or conjoint leadership processes most likely to promote a sense of being supported and recognised (Roberts et al. 2005).

Thus we have not produced a list of 'good leader' qualities or a similar record of what constitutes 'good patient care', as these would fail to capture the crucial point that both leadership and patient care are experienced as a process. Thus this report aims to delegate *good practices* that were observed during the project, for the use and reflection of any staff member of the NHS – whether a leader, follower or patient.

10.6 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.

⁴³ As made clear above we were unable to capture corresponding data from patients.

- 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.

Appendix 1

Focus Group Questions

1. Leadership means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this hospital?

Prompts

1. Charismatic / Authoritative / Consultative / Directional / Varies – depends on situation/activity etc
2. Can you think of some incidents that sum up for you the way leadership is exercised in this hospital?

Follow-ups

1. Does this type of leadership operate throughout the hospital?
2. Could you give some examples of ways in which leadership is exercised in your team/the hospital
3. Patient care means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this organisation?
4. How important is patient care as a priority in the service that you and your colleagues provide?
5. What are your main priorities in ensuring a high level of patient care in this hospital?
6. Can you think of some incidents that sum up the way you and your colleagues try to deliver patient care?
7. To what extent is leadership reflected in the quality of patient care you and your colleagues provide?
8. Can you think of some incidents that sum up the way that leadership in this hospital approaches the issue of patient care?
9. Can you think of specific incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

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Follow-up

1. What would you suggest to improve this/these situations?
3. Stories and critical incidents
 - a) Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
 - b) Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
 - c) Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

Could you tell me about a time that made you feel disappointed with leadership in this hospital?

- In this unit?

Appendix 2 Interview Questions

Interview

*Introductions, background and experience in relation to patient care and leadership in the organisation

- The interviewees position/level
- Years at the hospital
- Role in the organisation

1. Leadership

'Leadership' means different things to different people.

- a. How would you define it?
 - Do you see that kind of leadership at this hospital? Why/not?
 - What about in this unit?
 - What makes someone a good leader/Qualities of a good leader? Can you give me an example?
 - Who here at work do you see as providing leadership to you personally? Why? Do you have a direct supervisor? Who? Do they have leadership qualities?
- b. Do you see yourself as someone who could be a leader?
 - Why/not?

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- Under what circumstances?
- c. Can you give me an example of leadership in this hospital?

2. Patient care

- a. Like leadership, 'patient care' means different things to different people.
 - How would you define it?
- b. Tell me about patient care in this hospital. How is it defined?
 - Are there differences between units? Tell me about them. Why do you think this is?
 - How would you improve patient care in the hospital?
 - How would you improve patient care in this unit?
- c. How do you [as a hospital worker, nurse, etc.] try to deliver good patient care?
- d. What do you think are some obstacles to delivering the sort of patient care you'd like to see? How could these obstacles be removed?
- e. Do you think leadership could improve patient care in this hospital?
 - Why/not?
 - Do you think that better leadership would improve patient care? Why/not?
 - How does good leadership influence patient care?
 - Has the leadership in this hospital improved patient care since you've been a member of staff? How so? Or why not?

3. Stories and critical incidents

- a. Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
- b. Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
- c. Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

- d. Could you tell me about a time that made you feel disappointed with leadership in this hospital?
- In this unit?

Appendix 3: Focus Group Questions: patients

1. Leadership means different things to different people. What does it mean to you as a patient of this hospital?
2. What is your opinion of the way leadership is exercised in this hospital?
3. Patient care means different things to different people. What does it mean to you as a patient of this hospital?
4. Can you think of some incidents that sum up the kind of patient care that staff in this hospital deliver?
5. Can you think of ways that leadership in this hospital could enhance the quality of patient care, as far as you are concerned?
6. Can you think of some incidents that sum up what else leadership could be doing?
7. Can you think of any other incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

Appendix 4: Staff Organisational Climate Survey

[attached separately]

Appendix 5: Participant Information Sheet

Leadership and Better patient Care: From Idea to Practice

Participant Information Sheet: Staff Interviews

You are being invited to take part in an interview study about leadership and patient care in three different hospital settings. Before you decide to participate in this study it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Contact me (see full contact information at the end of this sheet) if there is anything that is unclear or if you want to know more.

Take time to decide whether or not you wish to take part.

Thank you for reading this.

1. What is the purpose of the study?

The purpose of this study is to try to identify the circumstances under which leadership can be an effective engine for change in the organisation of health care, especially for patient care and service delivery. Although we suspect that leadership motivates workers and affects the climate or atmosphere of the places where people work, leadership can mean different things to different people. The same is true of patient care which can also mean different things to different people. In order to understand how leadership inspires health workers to provide better patient care, we want to learn how nurses, doctors, other medical professionals as well as managers and patients define and understand leadership and patient care. This includes exploring how their perceptions mesh or conflict with one another. It also includes listening to stories of important incidents that describe their experiences of leadership and patient care.

2. Why have I been chosen?

As part of the study we are interviewing staff (clinical, managerial and others) as well as patients to examine what leadership and

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patient care mean to them. You have been chosen as someone whose views represent the views of staff.

3. Do I have to take part?

No

4. What will happen to me if I do take part?

You will participate in a tape-recorded interview with a qualified researcher, which will last under an hour.

5. What do I have to do?

Arrange a mutually convenient time to have the interview.

6. What are the possible disadvantages and risks of taking part?

It is possible that the discussion may stir up distressing feelings you have regarding your organisation, its leadership and the patient care it provides. However, care will be taken to prevent this and you are free to leave the interview at any time. Apart from that, the only disadvantage is that you will be giving up some of your time.

7. What are the possible benefits of taking part?

This study may not directly help you but it is part of a serious initiative to improve the quality of leadership and patient care provided by the NHS.

8. Will my taking part in this study be kept confidential?

Yes. All data will be stored in locked filing cabinet in a locked office. It will be made anonymous and all names will be edited out of the transcripts. Only members of the research team will have access to the data.

9. What will happen to the results of the research study?

They will be published in a report to the funder and also presented in peer reviewed papers and conferences. A copy of the report will be provided for each participant who requests it.

10. Who is organising and funding the research?

The study is funded by the NHS Service Delivery and Organisation (SDO) Research and Development Programme of the National Institute for Health Research (NIHR) Programmes. The NIHR has been established as a part of the government's strategy Best Research for Best Health to provide the framework that will position, manage and maintain the research, research staff and infrastructure of the NHS in England. The study is conducted by a group of researchers from Royal Holloway University of London led by myself, which won the grant following a competitive bid.

11. What if I have any concerns?

If you have any concerns or other questions about this study or the way it has been carried out you should contact me (details below) or you may contact the hospital complaints department.

Contact for further information

Professor Paula Nicolson, Head of Department, Health and Social Care
Royal Holloway University of London, Egham, Surrey, TW20 0EX

Paula.Nicolson@rhul.ac.uk

Tel. 01784 414 470

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Appendix 5: Consent form (generic)

Title of Project: Leadership and Better Patient Care: From Idea to Practice

Name of Researchers: Emma Rowland Paula Lökman

Please initial each box

☐ I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

☐ I understand that some coded extracts from the interviews may be used for the purposes of the research report and academic articles.

☐ I give my consent for quotations to be used in the report and research papers on the understanding that I will not be able to be identified by the use of these in any way.

☐ I agree to take part in the above study.

Name of participant

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Date

Signature

Appendix 6: Patient Organisational Climate Survey

Thank you for agreeing to participate in this study which as you will know is part of a larger study on leadership and patient care in the NHS.

The following questions explore how NHS patients feel about the care they received and how things generally worked in the units where their care was managed.

The survey is anonymous, so please do not put your name on the survey.

If, however, you would like to receive the final results of the survey when the study is completed, please fill in the tear-out form on the questionnaire's last page and submit it to the researcher or the collection box.

It is important that you answer all the questions. This should take you approximately 10 minutes.

Your individual responses will be kept strictly confidential.

Researchers

Dr Paula Lökman

Department of Health and Social Care
Social Care
Royal Holloway University of London

Ms Emma Rowland

Department of Health and
Royal Holloway University of

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Please circle one number that best describes how you feel for each question in relation to the service provided by your NURSE.

1. I feel understood by my nurse.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

2. I am able to be open with my nurse at our meetings.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

3. My nurse has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

4. My nurse encourages me to ask questions.

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1	2	3	4	5	6	7
strongly				neutral		strongly
disagree						agree

5. I trust my nurse.

1	2	3	4	5	6	7
strongly				neutral		strongly
disagree						agree

6. My nurse answers my questions fully and carefully.

1	2	3	4	5	6	7
strongly				neutral		strongly
disagree						agree

7. My nurse deals very well with my emotions.

1	2	3	4	5	6	7
strongly				neutral		strongly
disagree						agree

8. I feel that my nurse cares about me as a person.

1	2	3	4	5	6	7
strongly				neutral		strongly
disagree						agree

9. I don't feel very good about the way my nurse talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

10. My nurse tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

11. The way my nurse interacts with me influences my perception of quality care.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

12. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

Please circle one number that best describes how you feel for each question in relation to the service provided by your DOCTOR.

13. I feel understood by my doctor.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

14. I am able to be open with my doctor at our meetings.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

15. My doctor has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

16. My doctor encourages me to ask questions.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

17. I trust my doctor.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

18. My doctor answers my questions fully and carefully.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

19. My doctor deals very well with my emotions.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

20. I feel that my doctor cares about me as a person.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

21. I don't feel very good about the way my doctor talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

22. My doctor tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

23. The way my doctor interacts with me influences my perception of quality care.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

24. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

25. What would improve the quality of care you receive at this hospital?

26. What services are you using within this hospital?

Demographic Information

27. In which year were you born?

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28. What is your marital or civil partnership status?

- ☐ Single
- ☐ Co-habiting
- ☐ Married
- ☐ Divorced

29. How many children do you have?

30. How would you describe your ethnic background?

31. What is your current salary?

- 1. Less than or around £20,000 per annum
- 2. Between £21,000 and 39,000 per annum
- 3. Between £40,000 and £59,000 per annum
- 4. Between £60,000 and £99,000 per annum
- 5. Above £99,000 per annum

Thank you again for your time. If you have any questions please speak with the researcher or alternatively you can contact Professor Nicolson.

I would like to receive the final results of the survey when the study is completed

Name:

Address:

Contact Telephone:

Please return this form to either the researcher or the collection box.

Appendix 7: Appendices for Chapter Five

[attached separately]

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⁷ There is a parallel ongoing debate as to whether university leaders should be drawn from outside academia.

Addendum:

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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.

Leadership and Better Patient Care: Managing in the NHS

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Executive Summary

The NHS National Leadership Council Website¹ (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)

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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.

Leadership and Better Patient Care: Managing in the NHS

1 Leadership, organisation and the NHS

1.1 Leadership

What is currently known about leaders and leadership? The ongoing attempt to identify the characteristics necessary for effective leadership over recent years has been described as an 'obsession' studied more extensively than almost any other characteristic of human behaviour (Higgs, 2002; Tourish, 2008). Alimo-Metcalfe, Alban-Metcalfe et al. (2007) in their comprehensive review of the literature, show that formal studies of leadership date back (at least) to the beginning of the 20th century. They propose, that despite changes in the way leadership has been studied and the underlying epistemological stance taken by the researchers, *"in all cases, the emphasis has been on identifying those factors that make certain individuals particularly effective in influencing the behaviour of other individuals or groups and in making things happen that would not otherwise occur or preventing undesired outcomes"* (p. 2). As *"many have pointed out, that in spite of the plethora of studies, we still seem to know little about the defining characteristics of effective leadership"* (Higgs, 2002, p.3). Even so this has not appeared to quell the appetite for pursuing an ideal of leadership, impelled by the changing demands of organisations echoed across public sector institutions such as the NHS. These changes are in part the result of technological advancements which impact upon clinical practices, demographic changes both of which have altered the strategic, structural and financial profile of health (and social) care (Tierney, 1996).

The tantalising questions remain though about what those factors might actually be and the significance of the context to 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).

But in addition, or conversely, the context, culture, climate and/or structure of an organisation each have an impact on the performance of the people who lead in it (Carroll, Levy, & Richmond, 2008; Goodwin, 2000; Michie & West, 2004).

Focusing on the relationship(s) between 'leadership' and context has revitalised contemporary research particularly through the development of qualitative research, discursive and social constructionist epistemologies (Grint, 2005; Uhl-Bien, 2006) although it is unclear at this stage how far a connection might be developed between this research and its applications, for example in health care services (Fambrough & Hart, 2008).

In what follows in this chapter we explore the changing ways in which leadership has been conceptualised over the past fifty years, particularly focusing on how it has and *might* be operationalised in the NHS (particularly although not exclusively in a *hospital* context) .

1.2 Background and introduction to the study

The NHS Modernisation Agency Leadership Centre (NHSMALC) website³ had originally suggested that effective leadership is a key ingredient in modernising today's health care services. In its own words:

Effective leadership and management in the healthcare system are key drivers in patient experience. Governance and good environments matter to patients, their visitors and carers and staff.

But how might effective leadership be achieved and sustained? The NHS Leadership Centre commissioned a number of leadership initiatives (Larsen et al., 2005). The NHS Institute for Innovation and Improvement (2005) *NHS Leadership Qualities Framework*⁴ emphasised the *situational* nature of leadership and indicated the circumstances under which different leadership qualities will take precedence.

These comprise fifteen contextualised qualities covering a range of personal, cognitive, and social characteristics arranged in three clusters which are set out in Figure 1:

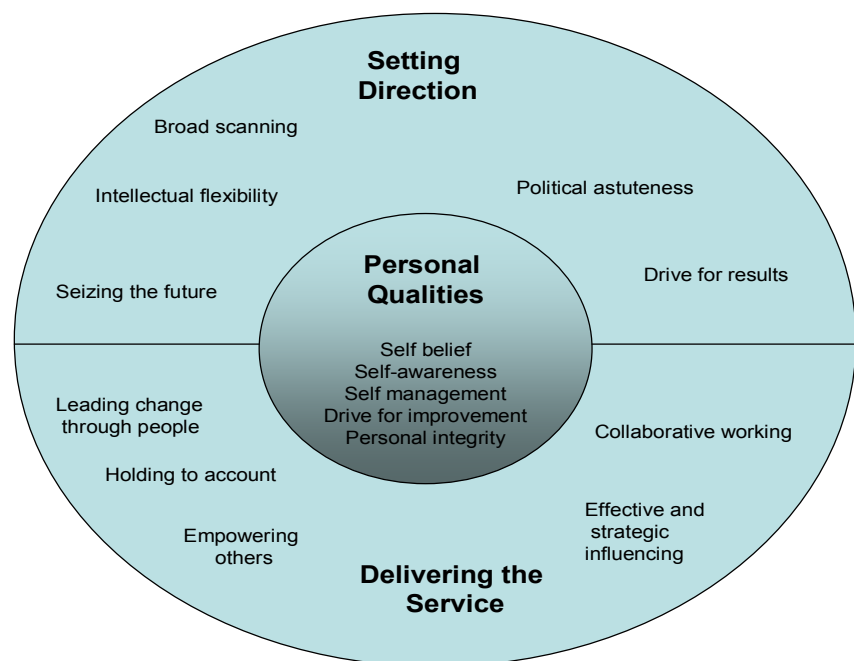
³ <http://www.dh.gov.uk/en/managingyourorganisation/leadershipandmanagement/index.htm>

⁴ <http://www.nhsleadershipqualities.nhs.uk/>

- *Personal Qualities*
- *Setting Direction*
- *Delivering the Service*

Thus, a competent leader enables development in an organisation that is goal directed, geared to developing processes and systems and enables staff at all levels to plan effectively and efficiently towards agreed goals (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Figure 1. The NHS Qualities Framework



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However, these same authors underscore the point that there is something beyond leadership competency that needs to be addressed, particularly in a changing and complex context such as an NHS Trust. *That is that a leader is someone who encourages and enables the development of an organisation in a culture based on integrity, transparency and valuing others. Leaders also need to question, think critically as well as strategically* (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Since the publication of the *NHS Leadership Qualities Framework* in 2005 all efforts have been directed to recognising and discussing leadership qualities and making strides towards their implementation. In 2008 Clare Chapman, Director General of the Department of Health's Workforce declared:

*Leadership is all about creating value for customers and citizens whilst also making work worthwhile for staff. This sounds incredibly straight forward - but it requires courage and resilience, and commitment throughout the entire piece*⁵

David Nicholson the CEO of the NHS in the report *Inspiring Leaders: Leadership for Quality* (January 2009) building on Darzi's *NHS Next Stage Review*⁶ stated:

It is imperative that we align what we are doing on leadership with what we want to achieve on quality. This is what I call leadership with a purpose.

Over the past year, the Department of Health has worked extensively with the NHS and other stakeholders to determine how best to foster talent and leadership development, and it is clear that there is a great deal of enthusiasm for a more systematic approach.

Spotting and developing confident leaders is a priority for us all if improving quality is our shared purpose. This guidance represents our best collective thinking to date. I invite you to use it and contribute to its improvement as we learn how to bring leadership centre stage over the coming months.

Nicholson and his team have charged the Strategic Health Authorities with finding gaps in leadership and systematically nurturing talent across the whole of the NHS. Clearly, the enthusiasm of successive senior officers in

⁵ DH_083353.

⁶ www.dh.gov.uk/en/Healthcare/Highqualitycareforall/index.htm

government and the NHS has been to link effective leadership with good service delivery and patient care as the primary outcome.

1.2.1 Leadership and Better Patient Care in this Study

This rhetoric and confidence about the type of leadership that best suits the NHS from those who lead it gave us pause for thought (Milewa, Valentine, & Calnan, 1998; Mueller, Sillince, Harvey, & Howorth, 2004b). 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 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 aims were overall to seek out the meanings and perceptions of relationships between (effective) 'leadership' and (better) 'patient care' and how leadership is transmitted across organisations to impact upon service delivery, taking account of the mixed methods and specific social science and systemic approaches that the investigatory team proposed. This inevitably has brought certain issues to the fore and (possibly) obscured others.

Our starting point therefore was to hold the NHS model of leadership in mind while calling on our own specific strengths as academics, from a range of social science and methodological backgrounds, to take a cross section of Trusts, clinical specialties, services, staff grades and patient needs, and to observe the *processes of leadership* in everyday working life. From this we proposed it should be possible to determine the ways in which leadership, NHS organisations and patient care were socially and discursively constructed so that links between leadership and patient care might be explored.

In Chapter One we outline some of the important contemporary social science and organisational thinking on leaders and leadership and explore the links between this and the NHS perspectives.

In Chapter Two we set out the innovative methodologies employed to investigate and analyse the research questions. This is followed in Chapter Three with the detailed procedures used for data collection.

The results are presented across four separate chapters. Chapter Four provides the analysis of what leadership means and how it is experienced by staff and patients (Christensen & Laegreid, 2003; Fairhurst, 2005).

Chapter Five presents the results of the Organisational Climate Survey (OCS) (Stringer, 2002). In Chapter Six, open systems theory and the concept of the 'organisation in the mind' are introduced particularly focusing upon the transmission of leadership across organisations. The relationship

between leadership, authority and emotion is discussed in Chapter Seven and in Chapter Eight the role of gender relations and their impact on leadership are reviewed (Begun, Hamilton, Tornabeni, & White, 2006; Ford, 2010; Telford, 2007).

Chapter Nine covers definitions, explanations and experiences of patient care and particularly how it relates to leadership by NHS staff and patients (Begun et al., 2006; Disch, Edwardson, & Adwan, 2004).

Finally in Chapter Ten we summarise our findings, make recommendations and draw conclusions.

Appendices provide copies of the research instruments, additional statistical results and the relevant NRES information.

1.3 Theoretical Approaches to leadership

Leadership research and theory is prolific with the consequence that numerous, frequently overlapping, models of leadership are available to agencies attempting to analyse or train leaders (and indeed managers, as until relatively recently little distinction was made between these two categories, see e.g. Kotter, 1996). Over the past fifty years leadership theories have shifted through different points of focus from the 'trait (or 'great man') approach in the 1940s, through the 'behavioural' perspectives in the 1950s whereby some styles of behaviour were seen as being more or less influential on potential followers. Then since the 1960s and 1970s the focus has been upon 'situational' leadership based mostly upon Fiedler's 'contingency' theory which proposed that different leadership styles were needed for different situations (see Alimo-Metcalfe, Alban-Metcalfe, et al. 2007; Western, 2008 for further details). During the 1970s and 1980s leadership research, albeit prolific, had reached an all time low in terms of its perceived contribution to theory and added value to knowledge for practice, so that as Cummings (1981 p. 366, quoted in a review by Bryman, 2004) asserted:

As we all know, the study and more particularly the results produced by the study, of leadership has been a major disappointment for many of us working within organisational behaviour.

Bryman unpicked the implications of the phrase Cummings used "as we all know" noting that it was "simultaneously sweeping and damning" (2004, p. 730). Bryman also picks out Miner's (1975) suggestion for temporarily abandoning the concept because of its limited utility in helping us understand organisational behaviour. *Why had leadership research reached this nadir during those decades? Why has there been a more recent upsurge of interest in leadership again almost to the point of saturation?*

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Bryman in his review suggests, that the renewed confidence and interest in the study of leadership has come from improved measurement and analytic techniques, greater use of meta-analysis so that more systematic reviews could be compiled, the emphasis on *transformational leadership* and *charismatic leadership* which have provided a fulcrum for the area of research, more and better cross-cultural studies and greater diversity in the types of leadership and organisational contexts that have been studied.

A factor that may also have contributed to the idea that leadership research continues to be fruitful is that a greater diversity of methodological approaches have been added and Bryman's review specifically focused on the value added by qualitative research.

Towards the end of the 1980s and beyond, thinking about the meaning(s) of leadership came to take greater precedence than in the previous two decades, possibly because of a perceived dearth of leadership *per se*.

These deliberations cast light onto the:

- *interactions between leaders and followers* and organisational cultures (Avolio, Gardner, Walumbwa, Luthans, & May, 2004; Lewis, 2000; Schilling, 2009)
- the *management of emotion* (George, 2000; Lewis, 2005; Pescosolido, 2002)
- the *processes* of leadership (Collinson, 2005; Dopson & Waddington, 1996; Vangen & Huxham, 2003)

Even so, or perhaps because of the use of qualitative approaches and related conceptualisation, Alvesson and Sveningsson (2003) were able to entitle a recent paper arising out of their study of leadership in a research and development company: "*The great disappearing act: Difficulties in doing 'leadership'*".

By this they meant that during their study they were able to identify how the existence of the label 'leadership' led to an assumption that the concept had an empirical reality. However the results of their work indicated that leadership might be better explained as a *process or series of processes of interaction*. This conclusion raises questions about mainstream thinking on leadership which presumes observable and possibly measurable characteristics (Alvesson and Sveningsson, 2003, p. 361; see also Ford, 2010).

Most recently there has been reconsideration and development of ideas about leadership in context taking account of the relevance of some earlier studies of organisations (e.g. Lewin, 1947) and open systems theories (see

Chapter Six; Laughlin and Sher, 2010) and new epistemological positions (e.g. Ford, 2010).

In our study, as a consequence of these recent critiques of leadership research and the result of methodological innovation, we approached the concept of 'leadership' as not necessarily a property of one individual (although it can be) or of one specific role, such as Clinical Director or a service manager, but rather we identified leadership as a *process* occurring within a group, organisation or collectivity that *imagines, wills and drives change* (Gabriel, 2004; Gronn, 2002).

1.3.1 Dimensions of Leadership and their Value for the NHS

Leadership, *as a practice*, has been on occasions constructed as 'a beautiful or rarefied ideal' an idea which has little use in the real world particularly as it has been suggested there are at least 350,000 definitions of leadership in the academic literature (Pye, 2005; Tourish, 2008; Western, 2008). *The question for this report is how to identify the literature on leadership and organisation with the most relevance for the contemporary NHS.*

Most discussed in theory and in practice over the past two decades has been the idea of *transformational leadership* (Bass, 1985) a model to explain ways in which a leader can be identified or trained to demonstrate the qualities that enable her/him to *perform beyond expectations*. The phrase 'transformational leadership' was coined originally in 1973 by Downtown but did not gain impetus until 1978 when Burns published his book, *Leadership*, which highlighted the *relationship* between leaders and followers (Burns, 1978).

Until then, as shown above (see Bryman, 2004) there had been little by way of a breakthrough in applicable knowledge. Burns (1978) demonstrated a *psychological* difference between an exchange relationship - where followers respond to leaders because of rewards they might receive - and one in which they respond to leaders who transform their attitudes and behaviours through inspiration and/or charisma (Bass, 1985; Yukl, 1999; Rafferty and Griffin, 2004). Transformational leadership then, is concerned with emotions, values and ethics, standards and long term goals which include assessing followers' moves and satisfying their needs (Currie & Lockett, 2007; Day, Gronn, & Salas, 2006; Eagley & Johannesen-Schmidt, 2003; Northouse, 2004).

Recognition that transformational leadership is not simply an individualistic model but one that *teams* can display (Day et al., 2006; Gronn, 2002; Sivasubramaniam, Murry, Avolio, & Jung, 2002) has shifted the

concentration from individual leaders per se to a more diffuse and distributed model of leadership and organisation context.

1.3.2 What constitutes transformational leadership?

Bass (1985) highlighted several characteristics of *transformational (or transformative) leadership* that allow followers and leaders to achieve far beyond their expectations. These are not discrete categories but given the significance placed upon the ideas behind transformational leadership in the scientific and training literature it is worth outlining the basic ideas behind these characteristics/types which have been identified as:

- Charismatic leadership
- Inspirational motivator
- Intellectually stimulating leadership
- Considerate leadership

Charismatic leadership

Bass (1985) proposed that "*charisma is a necessary component of transformational leadership*" (cited in Yukl 2002, p.261) and that charismatic leaders are endowed with exceptional personal qualities that attract followers. Charisma, a word derived from the Greek, means "*divinely inspired gift*" and is thought to give people the ability to perform miracles or predict the future (Yukl 2002, P. 241).

It is for this reason that charismatic leaders are often regarded as "*visionary, a futuristic, or a catalyst for change*" (Murphy 2005, p. 131; see also Bass 1985; Bennis & Nanus, 1985). Due to their rare personal qualities charismatic leaders are able to convey their visions to their followers in a clear and concise manner allowing them to visualise what they could achieve in the future if they worked together towards a common goal. As the leader's vision is normally realistic yet optimistic, it empowers the followers granting them greater self-esteem, encouraging and inspiring them to achieve the vision (Bennis & Nanus, 1985; Northouse, 2004; Yukl, 2002).

Inspirational motivator

Through their charisma, transformative leaders have the ability to inspire their followers through words of profound wisdom, or at least is what is *perceived* to be profound wisdom, such as with the case of Jim Jones⁷ in the USA or more positively President Obama who has reformed health care and banking legislation in the USA against the odds. Transformative leaders are

⁷ In 1978 Jim Jones persuaded more than 900 members of his People's Temple in Jonestown, Guyana to commit mass suicide.

excellent communicators which allow them to turn their visions into reality. Many use emotional and optimistic speeches to inspire their followers. They usually lead by example and often become role models to their followers who are in awe of their moral and ethical character. Many followers try and emulate their leaders' good qualities and are confident that their leaders will make just decisions on their behalf leading them to a prosperous future (Kellerman, 2004; Rafferty & Griffin, 2004).

Intellectually stimulating leadership

Transformational leaders have the ability to captivate their audience making the most mundane speeches and events interesting. They encourage their followers to be innovative, challenging the status quo and their own values and beliefs (Northouse, 2004). They also encourage their followers to solve problems and take an active role in the organisation, thus enhancing their self-worth and self-esteem, increasing their job satisfaction and productivity.

Considerate leadership

Transformational leaders are often also considerate leaders who are adept at performing mentoring or advisory roles to support their followers' emotional needs (Hiller, Day, & Vance, 2006; Rafferty & Griffin, 2004). Such leaders listen carefully to their followers' needs and desires, empathising with them during difficult periods. Being empathetic also builds a strong bond between leader and follower and thus a strong reciprocal relationship (Simpson & French, 2005).

It is important to note though, despite the wide take-up of transformational leadership as a conceptual model and a *practice*, that there remains uncertainty about the ambiguity of subdivisions and distinctions between elements in the model. Theoretical distinctions between 'charisma' and 'inspirational motivation' have become blurred over time and some theorists have suggested that elements of transformational leadership might also be identified as *transactions* (see Rafferty and Griffin, 2004 for a discussion of the implications).

Further concerns have been raised about how transformational leadership can take place in organisations, particularly public service ones, which are constrained by government initiative and targets and localised regulatory and normative pressures (Currie & Lockett, 2007; McNulty & Ferlie, 2004). However, it may also be that professional staff (rather than leaders/managers) in contexts such as health care, may in fact be more transformational than might be predicted because of their long-term commitment to the organisational goals (McGuire & Kennerly, 2006).

Most recently the notion that transformational leaders are very much 'engaging' leaders has been proposed (Alimo-Metcalfe, Alban-Metcalfe et al, 2007; Alban-Metcalfe & Alimo-Metcalfe, 2009; Macy & Schneider, 2008).

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One further comment here concerns the role of *gender* in styles of leadership and its consequent impact on organisational transformation (Fletcher, 2004; Mandell & Pherwani, 2003). There is evidence that (whether displayed by a woman or a man) feminine styles of leadership may be more related to engagement, emotional and social intelligence and distributed leadership, which may be important for complex organisations such as the NHS (see below).

1.4 Leadership, organisation and emotion at the turn to the 21st Century

Models of leadership and organisation theory have evolved over time and leadership and organisational structures and cultures are intrinsically linked in the literature. Leadership, if it is to motivate, innovate and move organisations to change, has to have an *emotional dimension* and, thus, effective leaders have a clear *emotional agenda* (as well as a strategic and structural one) which is particularly acute in services such as the NHS which is working to serve people's health care needs (Ashforth & Humphrey, 1995; Bolton, 2000; Pye, 2005).

Exploring organisations and leadership at the level of 'emotion' has become contested territory, as recognition, that organisations and their leaders need to take account of emotional engagement (Alban-Metcalf & Alimo-Metcalf, 2009; Vince & Broussine, 1996) at all levels of the work place, has emerged. Prior to the 1980's, organisational literature had been dominated by cognitive orientation (George, 2000) which favoured the rational, 'masculine' and scientific explanations of organisations and their leaders. This notion therefore ignored the (so called) irrational and 'feminine' characteristics of emotion, which were deemed detrimental to productivity and success. At that time emotions were regarded as the culprits that distort an individual's perceptual and cognitive faculties and therefore should be kept under control (Alvesson & Sveningsson, 2003b; Clarke, Hope-Hailey, & Kelliher, 2007; Dasborough, 2006; de Raeye, 2002; Ford, 2006).

As social and occupational psychologists began to study the effects of positive and negative moods on decision making, job satisfaction, choice of work-based activities and organisational climate, however, (Isen & Means, 1983; Rafaeli & Sutton, 1987, 1989) 'emotion' as part of organisational life gained impetus once again. This resurgence coincided with leadership theorists studying how moods and emotions could effect the quality of leadership (George, 2000).

It is possible to trace a rough trajectory from the 'hard nosed' scientific management, with the organisation perceived as a 'machine' in the early twentieth century, through towards a more humanistic, emotional and

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sometimes even spiritual way of thinking about contemporary leadership and organisational metaphors towards the twenty-first century, all of which are potentially transformational, not simply to the individuals concerned, but to the organisational dynamics.

Hochschild's (1983) *The Managed Heart* has been credited with being one of the earliest examples of research into emotions and organisational settings (Ashkanasy, Hartel, & Daus, 2002). She looked particularly at the airline industry and how airline cabin crew managed their emotions for dealing with difficult passengers and to promote a particular airline image. She termed this emotional management '*emotional labour*' (Hochschild, 1983).

Since this publication, the study of emotions in organisations has increased (Ashkanasy et al., 2002) with academics concentrating on key concepts such as emotional labour, emotional intelligence, mood analysis and Affective Events Theory (AET) and most recently a return to psychodynamic understanding of organisations and groups (see Ford, 2010; Schwarz, 1990). Since the 1990's a plethora of literature has emphasised the role of emotional concerns in private sector organisations such as the airline industry (Hochschild, 1983; Taylor & Tyler, 2000; Tyler & Abbott, 1998), service sector (Crang, 1994), merchant banking (McDowell & Court, 1994; Pugh, 2001), law (Harris, 2002) and image consultancy (Bryson & Wellington, 2003; Wellington & Bryson, 2001).

However, emotionality in the public sector was mostly neglected until 2000's when a surge of literature began to be published analysing the NHS (Allan & Smith, 2005; Bolton, 2000; Cummings, Hayduk, & Estabrooks, 2005a; Hunter, 2005; Lewis, 2005; McCreight, 2005; McQueen, 2004; Michie & Gooty, 2005; Michie & West, 2004; Smith, 1992) and the fire service (Archer, 1999; Scott & Myers, 2005; Ward & Winstanley, 2006; Yarnal, Dowler, & Hutchinson, 2004).

1.4.1 Emotional labour, leadership and patient care

Hochschild differentiates between emotional labour and emotional work or 'face-work' (Goffman, 1967). Emotional work has been described as the effort we put into presenting and representing our feelings as well as into feeling what we ought to feel (see Fineman, 2003). For example, a person ought to feel happy at a wedding and sad at a funeral and if their emotions do not match these expectations then a person must perform emotional work to display the appropriate emotion. This is sometimes difficult as people struggle to disguise their true emotions and perform the socially acceptable emotion.

When a person's emotions are appropriated and performed for commercial gain it is known as *emotional labour*. Hochschild states that emotional labour occurs in many occupations. However, she believes it to be more

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prevalent in service industries, such as the airline industry, where workers' emotions are sold as part of a commercial package⁸. Employees working in service industries must be skilled at managing their emotions and facial expressions in order to project the correct emotion to the customer (Crang, 1994; Lewis, 2005). This often means that employees have to suppress their own emotions in order to perform and display emotions that are suitable for commercial gain and in alignment with the organisations' image (McDowell and Court 1994).

Surface acting allows the employee to make up an outward gesture (Hochschild, 1983), to perform emotions that are not actually felt. In contrast, deep acting means that the employee can suppress or become estranged from their true feelings and *actually feel the emotions* that the employer wants them to display. *"One finds that the performer can be fully taken in by his own act, he can sincerely be convinced that the impression of reality which he stages is the real reality"* (Goffman 1990, p.28).

In the NHS, positively managed emotions *could* lead to better patient care, greater patient satisfaction and a relaxed and professional organisational climate (Amendoldair 2003; Bolton 2003). Lewis (2005) highlights how nurses in a special care baby unit appropriately managed their emotions to create a professional organisational climate, in which to offer quality patient care to special needs babies and emotional support to their parents. Lewis suggests that a nurse's job is sometimes very stressful and emotionally destabilising, especially when a baby dies. Nurses need to be conscious of their own emotions and regulate them to prevent causing further distress to the parents by displaying a professional demeanour (Bolton 2001).

However, managing emotions in this way, particularly if they are not felt, comes at a psychological and emotional cost and the whole process would be problematic without attending to emotional intelligence.

1.4.2 Emotional intelligence, leadership and patient care

The 'discovery' of emotional intelligence (EI), despite on-going valid critiques (see below) marked a turning point in contemporary organisational theories and approaches to leadership because of the tradition that emotions represent a threat to rationality – a view that has been widespread particularly in North America and North Western Europe (Fambrough & Hart, 2008; Western, 2008).

⁸ For a critical analysis of Hochschild's dichotomy of emotional labour and work see Bolton 2000 and Bolton and Boyd 2003.

Mayer and Salovey (1995), who conceived the idea of emotional intelligence, defined it as the ability to manage and understand one's own and other people's emotions in a consistent way so as to reflectively promote emotional and intellectual growth. Goleman (1996; 1998) who popularised the concept, identified emotional intelligence as a set of competencies, redefined and restated by George (2000) as follows:

- The expression and appraisal of emotion
- Enhancing cognitive process and decision making
- Emotional knowledge
- Managing emotions

These characteristics appear to have much in common with the rhetoric of transformational qualities of leadership although in many ways EI has become a management 'tool' rather than a critical model. To this end (apparently) Goleman (Goleman, 2000; Goleman, Boyatzis, & McKee, 2001) focused on 'styles' and 'performance' which seem far away from the 'heady' descriptions below of qualities of emotional intelligent leadership, which refer to feelings, empathy and creativity.

The expression and appraisal of emotion

An emotionally intelligent person will be able to understand their own and others' feelings and able to empathise, which may enable them to be manipulative for better or for worse.

Enhancing cognitive processes and decision making

Having emotional intelligence allows a person to use emotion to be creative, solve problems, make decisions and flexible plans for themselves and on the behalf of a group. An emotionally intelligent leader will be able to judge their mood and make decisions accordingly. If the person is in a negative mood this may mean choosing to wait until such negative episodes have past in order to make a comprehensive decision.

Emotional Knowledge

Emotionally intelligent people understand how other people may be affected by their negative moods and therefore may take care not to spread bad feeling around the group.

Managing Emotions

Many leaders are able to manage their followers' emotions as well as their own, but as indicated below, developing the qualities required to manage emotions effectively is highly complex and more about processes than style or performance (Fambrough & Hart, 2008; Hughes, 2005). As Fambrough and Hart argue 'emotional intelligence' has passed into common use among organisational leaders with little recognition of the way it has been identified

as problematic. *What has been so attractive about EI to leaders in health care organisations?*

The idea of emotional intelligence captured the imagination of some training NHS staff as a means to improve staff relationships and enable clinicians to empathise with their patients (Allan & Smith, 2005; Cummings et al., 2005a; McQueen, 2004; Amendolair 2003, Luker et al 2002). McQueen (2004) reflecting on the 1960's when health care workers were encouraged to hide their emotions from their patients, for the sake of maintaining a professional role, suggests that in recent decades this view of nursing has changed and health care workers frequently display emotions to illustrate their commitment to patient care (Williams 2000). McQueen suggests that emotionally intelligent nurses are important for building strong patient-nurse relationships (Conger and Kanungo 1987 and (Lewis, 2005). Nurses with high Emotional Intelligence are able to build rapport quickly with their patients through communication and interactive skills (Schutte et al 2001).

McQueen (2004) also states that "*emotional labour calls upon and engages*" emotional intelligence (2004, p. 103). In order for patients to feel cared for nurses have to constantly *perform* positive emotions and behaviours such as warmth, friendliness and consideration. However, when confronted with a 'difficult' patient nurses may experience negative emotions such as frustration, irritation or anger. The nurses must be emotionally intelligent enough to identify their emotions and then perform emotional labour to submerge the negative emotions in favour of more positive emotions (Bolton 2003).

While EI *per se* needs to be understood more critically (Fambrough & Hart, 2008), the introduction of emotional management and engagement by leaders (and others) in health care organisations needs further scrutiny (see below); despite the best efforts of some management gurus emotion is a fact of personal, interpersonal and organisational life particularly when considering what it means to deliver patient care.

1.4.3 Beyond emotional intelligence

Interest in EI has continued to grow among management and organisational academics with a focus on how to measure it – the conclusions generally indicating the need for caution in measures to predict or to establish baselines for its development among managers (Conte, 2005). The conflation of managerial skills as listed by Mintzberg (Mintzberg, 1973) cited in Riggio and Reichard, (2008) which included the ability to 'deal' with subordinates, 'empathize' with top-level leaders and establish and maintain social networks, alongside managing emotions as a leader, have come to be known as 'people skills'. These are clearly represented in the NHS leadership qualities framework and vital for managing in any organisation (see Figure 1).

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1.4.3.1 Social intelligence (SI) and leadership

In 2006, taking account of advances in neurological psychology, Goleman (Goleman, 2006) proposed that because humans are *designed* for social connection, rapport and supportive emotional interactions enhance performance of managers and leaders. He listed these qualities under the umbrella of 'social intelligence' and identified four dimensions:

- *Synchronization* – whereby matching moods lead to a sense of rapport
- *Attunement* – listening fully
- *Social cognition* – understanding how people interact
- *Social facility* – finding it easy to interact with others

While some people have little difficulty meeting these criteria and mastering their social intelligence, others (such as Narcissists, Machiavellian and Psychopathic types), Goleman argues, do not have the capacity for social intelligence, and thus he proposes a means of *selecting* effective leaders by testing these qualities. This model albeit individualistic has something to offer through extending the theoretical underpinnings of 'people skills' and emphasising the importance of taking followers and colleagues seriously in decision-making.

Following EI and SI in bringing management/organisational theories together with developments in psychology, particularly cognitive neuroscience and evolutionary psychology, is the reconsideration of the role of intuition in understanding leadership and organisational behaviours (Sadler-Smith, 2008). Sadler-Smith brings the idea of the 'gut feeling' into the foreground to explore the influence of this sense upon decision-making particularly under pressure (e.g. many emergency clinical decisions rely on the clinician's instinct of whether the patient should be operated on, admitted to hospital, whether to call for support).

It seems that while there is a continuing trend towards an evidence-based understanding of leadership, success there is also an emergence of features of human life that are difficult to explain and measure, although all the proponents cited above stick to the view that these characteristics are scientifically explicable and measureable despite challenges from both positivist and critical social constructionist positions (Ashforth & Humphrey, 1995; Conte, 2005).

1.4.3.2 Affective Events Theory (AET)

AET predicts that specific features of work (e.g. autonomy) have an impact on the arousal of emotions and moods at work that, in turn, co-determine job satisfaction of employees. AET further proposes that job satisfaction is

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an evaluative judgement that mainly explains cognitive-based behaviour, whereas emotions and moods better predict affective-based behaviour. The results support these assumptions (Jürgen, van Rolf, Fisher et al., 2006). Ashkanasy et al (2002) suggested that AET has two important messages for leaders in an organisation.

- Followers' emotions are heavily influenced by their leaders' emotions and therefore leaders must minimise the 'hassles' that they place on their followers in order to increase job satisfaction and performance. Short-term negativity can be tolerated without much impact on the team or organisation.
- However, if negative events persist it will affect followers' moods leading to negative emotions, poor performance, reduced job satisfaction and in the case of the NHS, (possibly) to poor quality patient care. It is therefore suggested that leaders need to give followers positive feedback regularly to "*ameliorate the daily hassles experienced by employees*" procuring positive behaviours such as team spirit and self-worth (Dasborough 2006, p. 165 ; Weiss & Cropanzano, 1996). The connections between the moods of individuals and their performance may be understood better in terms of emotional engagement between leaders and followers on both conscious and unconscious levels (see below).

1.5 Distributed leadership

The academic study of distributed leadership, that is when at various levels leadership (or influence) behaviour, identity, role and responsibility are distributed to more than one individual or group of individuals, has been at the forefront of much social scientific leadership research over the past ten years (Buchanan, Addicott, Fitzgerald, Ferlie, & Baeza, 2007; Day, Gronn, & Salas, 2004; Gronn, 2002; Mehra, Smith, Dixon, & Robertson, 2006a). The implication of this interest in distributed leadership is, that organisations have changed and previous models - including the charismatic, 'hero' leader and the 'command and control' organisational structures - are dysfunctional in a context where organisational change is rapid and diversification of strategic leadership and management essential (Butterfield, Edwards, & Woodall, 2005; Dent, 2005; Goodwin, 2000). In a competitive, diverse and divergent environment leadership needs to be distributed, in order to enhance democratic governance, thus enhancing legitimacy and increasing survival chances (Currie et al., 2009).

Distributed leadership also implies that organisations where it is practiced have (relatively) flat hierarchies with diverse service needs and expertise across all sectors of the organisation (Huffington, James, & Armstrong, 2007). This model applies to hospitals and primary care settings, where

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distinct professional groups each have their own standards of excellence, while at the same time sharing goals of competence and quality related to the service they provide to patients and how they interrelate to other organisations.

With this shift in focus of many leadership practices and leadership studies the definition of such leadership has been proposed as:

".. a status ascribed to one individual, an aggregate of separate individuals, sets of small numbers of individuals acting in concert or larger plural-member organisational units" (Gronn, 2002, p. 428).

Gronn suggests also that when leadership is distributed it may be that the duration of that influence is limited, perhaps (structurally) to a single project and therefore (psychologically) distributed leadership might mean having to 'give up' leadership as well as take it up (Huffington et al., 2007). Furthermore, according to Gronn (2002) the most common understanding of distributed leadership, witnessed by the growing number of references to it in the research and policy literature, is that it applies to numerous people across an organisation taking some degree of a leadership role or responsibility.

More importantly, Gronn identified distributed leadership as *concerted action* meaning that there are many roles comprising a 'leadership complex' with at least three potential forms:

- *collaborative modes of engagement* which arise spontaneously in the workplace. This suggests that leadership practice is 'stretched over' the context of the organisation and not a function of those in managerial roles such as matron or clinical director. However, if the matron, clinical director and other colleagues who share ideas for change or particular activities they *may "pool their expertise and regularise their conduct to solve a problem after which they may disband"* (Gronn, 2002, p. 430).
- the *intuitive understanding* that develops as part of a close working relationship among colleagues. These relationships tend to happen over time when organisation members come to rely on each other and develop a close working relationship, to solve problems or bring about change and others might be involved in a 'framework of understanding'.
- The variety of *structural relations* and institutionalized arrangements which constitute attempts to regularize distributed action. Thus, for example, if there were dissatisfaction with existing arrangements for particular practices, a team of 'equals'

might emerge to find ways to improve or change the problematic practices.

All of these are apparent particularly, but not exclusively, in Trust Three (the FT) as exemplified in Chapters Four and Nine in particular.

Gronn argues the importance of examination of these different forms of concerted action to understand where influence (and thus leadership and power) might lie in any organisational context. Emotionally, however, these different models of distributed leadership suggest the impact of these structures and practices at a deeper level (Gabriel, 2004) particularly around authority (Halton, 2007; Hirschhorn, 1997) competition (Morgan, 2006) rivalry and envy (James & Arriba, 2005; Stein, 2005)

1.6 Organisational Culture, Climate and Contexts

As introduced above, post-industrial (or even 'post-modern') organisations (Burrell, 1988; Fineman, Sims, & Gabriel, 2005) and networked (Balkundi & Kilduff, 2006; Goodwin, 2000) organisations are changing rapidly and the NHS is clearly among these. Changes in the NHS take place at a number of levels, emerging from the direct policy dictates from central government to become local initiatives. Moreover, the NHS has become increasingly team (and indeed multi-disciplinary team) based over the past two or three decades so that knowledge, influence and leadership for transformation and change are not only moving from a top-down to bottom-up model, but as indicated, to a distributed model which involves lateral influence (Begun et al., 2006; Day et al., 2006; Ferlie & Shortell, 2001).

The type of leadership that is supported and promoted in any organisation and the related concept of the organisational structure depends on and impacts upon organisational climate and culture.

Although research undertaken on organisational *climate* and organisational *culture* comes from different epistemological traditions, since around 1990 the literature and concepts referring to both have been overlapping and/or complementary (Schneider, 1990; Schneider, 2000) and increasingly the terms are used interchangeably (Ashkanasy et al. 2000).

It is, however, generally accepted that 'climate' is a logical extension of what was originally conceptualised as 'psychological' climate, that is, shared psychological meanings in an organisation; so that *organisational* climate is an aggregation of those individual perceptions of a work-place context (James, Choi et al. 2008).

Organisational culture on the other hand has its origins in anthropology and human relations (see Davies, Nutley and Mannion, 2000; Scott, Mannion et

al. 2003). Organisational psychologist Edgar Schein's (1985/2004) ideas about organisational *culture* as a pattern of *shared basic assumptions that have worked well enough and adapt to the external environment and serve internal integration*⁹, is one of the most frequently quoted definitions. Schein takes a systems theory approach to understanding organisations and his work has been built upon by himself and others to develop a variety of typologies which underpin measures of both organisational culture and climate (see Albino-Metcalf, Alban-Metcalf et al. 2008 for a comprehensive overview of this literature).

Organisational climate, with its origins in traditional psychology is *typically* "... the only domain of organisational research that simultaneously examines perceptions of jobs, groups, leaders, and organisational attributes and thus has the unique capacity of being able to decipher common denominators and latent relationships that are not available to those who study only specific domains such as perceived equity" (James et al., 2008, p.27). We therefore made a decision to use a measure of *climate* as a backdrop to this mostly qualitative study, in order to 'triangulate' with our findings on leadership and patient care.

However, we found a competing strand of interest in the measurement of organisational *culture* (e.g. Davies, Nutley and Mannion, 2000; Scott, Mannion, Davies and Marshall, 2003) which more frequently seems to attend to health care settings than studies of climate albeit with some notable exceptions (Dawson, Gonzalez-Roma, Davis and West, 2008).

1.6.1 Emotion and the unconscious in organisations

Organisational climate and/or culture cannot be discussed without acknowledging that organisations are places where both the intellect and emotion are called into play in order to achieve organisational goals and as we have made clear, emotions are intrinsic to service delivery and leader-follower engagement in the NHS. Emotional engagement, while available to human consciousness, also takes place at an unconscious level (Gabriel, 2004; Hugh, 1986; Lyons-Ruth, 1999; Morgan, 2006; Willmott, 1986), and anxiety or stress is particularly salient when having to care for and make potentially life-saving decisions for patients (James & Huffington, 2004; Menzies¹⁰¹¹, 1970).

⁹ A paraphrase.

The ideas that characterise transformational leadership models, such as 'charisma', 'influence', 'inspiration' 'thoughtfulness' and 'consideration', have intellectual roots beyond contemporary management theory and training. They are more closely related to group and organisational theories with late 19th and early 20th century origins (De Board, 1978; Gabriel, 2004) from which much contemporary organisational theory has emerged.

The first significant attempt to analyse group behaviour made at the start of the 20th Century by Le Bon (1917/1920) whose book *The Crowd* illustrated his observation that individuals in a large group can demonstrate a 'collective mind' which emerges when people are bound together in some way. McDougall's book *The Group Mind* (1922/2009) and Sigmund Freud's *Group Psychology and the Analysis of the Ego* (1921/1922) also focused on what would subsequently come to be recognised as unconscious group processes. Freud developed Le Bon's and McDougall's ideas in the context of psychodynamic theory, arguing that the binding force of the group derives from the *emotional* ties of the members, which are expressions of their libido or drive.

Studies of (and human 'experiments' about) group psychology, taking some of this perspective on board, flourished after the Second World War conducted and further developed by psychiatrists in the newly formed NHS. In Britain the work of Wilfred Bion, Tom Main, Maxwell Jones and others led to innovations in both group psychotherapy and the study of organisations. Bion's work on group relations and dynamics which contributed to the development of the Group Relations Training Programme (GRTP) at the Tavistock Institute in 1957 evolved into the Leicester Conferences with other organisations using this model across the world (Miller, 1993). However contemporary knowledge and understanding continues to reflect back upon this early work.

What was learnt during this period about group dynamics and group relations represents an important dimension in the understanding of contemporary organisations and the relationship between leaders and followers. We develop this further in Chapter Seven in particular. It is important to note how the intellectual journey from work on emotional labour to social intelligence and intuition has so far largely neglected to explore the extent to which unconscious processes remain part of the emotional context of human social interaction (Allan and Smith, 2005, p. 21).

¹¹ Isabel Menzies is sometimes referred to as Menzies-Lyth. Her work has been reprinted several times with each name used.

In a hospital environment it is inevitable that negative events such as death occur (see Lewis for discussion on the impact of death on nurses in a special care baby unit taking an 'emotional labour' approach). When death does occur nurses may display emotions (consciously and unconsciously) such as anxiety and fear (Allan & Smith, 2005; Obholzer & Roberts, 1994; Allan 2001; Smith et al 2003). Obholzer asserts that "[he] believes that many of the organisations' difficulties that occur in hospital settings arise from a neglect of the unconscious psychological impact of death and near-death on patients and staff" (1994, p.171). He explains that hospitals are sites where anxieties about social taboos such as death are *contained*, that is that staff and the organisation overall takes away the anxiety and the responsibility for care from the relatives. Patients and staff are socialised to believe that hospitals are institutions where illness is treated and that medical knowledge and practice is infallible. This is illustrated by patients who contend that doctors possess God-like qualities and have the ability to heal all ailments. When death does occur, medical staff and the patient's relatives may feel *duped* by the institution they believed would save their loved one.

At the turn of the 19th to the 20th Centuries psychoanalytic ideas were seen to have something new and important to say, not only about the psychology of the individual and the role of the individual unconscious, but about *unconscious processes when people converge in groups and crowds* as shown above. From psychoanalytic theory we take up ideas again today specifically about the relationships which exist between followers and leaders, made explicit in the paradigm shift from transactional to transformational leadership. Working together and accepting or resisting influence comes not only with an observable set of behaviours and measurable emotions, but with unconscious and 'secret' ones including dependency, envy, power, anger, authority and emotional contagion, which may be either conscious or unconscious but have important consequences for behaviours (Burke et al., 2006; Simpson & French, 2005; Stein, 2005; Whitely, 1997). In Chapter Seven for example we see examples of where two senior managers find themselves unable to influence despite their senior roles, legitimacy and operational power. As Gabriel (2004) has argued "*emotions are no simple side-effects of mental life*" as "*emotion lies at the heart of human motivation*" (p.215).

One key feature of caring for sick patients, managing change and the social context of the NHS Trust then, is the ways in which clinicians and managers manage their anxiety which is fundamental to working in any health care setting. In the section that follows below, we demonstrate how psychoanalytic thinking explains how individual psychology and unconscious defence mechanisms link to the ways in which human beings work in groups and organisations.

In Chapter Nine we attend in more detail to the anxieties involved in obstetrics and more generally on the emotions involved in care of the elderly. In anticipation of these we present the theoretical material in some detail immediately below in this chapter.

1.6.2 Clinicians' anxiety and patient care

To conceptualize anxiety we draw on object relations theory, the branch of psychoanalysis associated with Melanie Klein (1959) and, in particular, the work of scholars who applied object relations to an understanding of groups (Bion, 1961) and organisations (Jaques, 1952; Menzies, 1970; Klein, 1987; 1983) hypothesising that an infant responds from the earliest time to the withdrawal of the maternal breast by experiencing a powerful anxiety of a 'persecutory nature'. Being unable to grasp the separation from the breast intellectually, the infant, unconsciously, feels as if every discomfort were inflicted by hostile forces. A fundamental *splitting* takes place, whereby an object is experienced as two separate objects, one entirely good and one totally bad. Thus there is a good breast (which is always present and nourishing) and a bad breast (withdrawing and denying), a good mother and a bad mother.

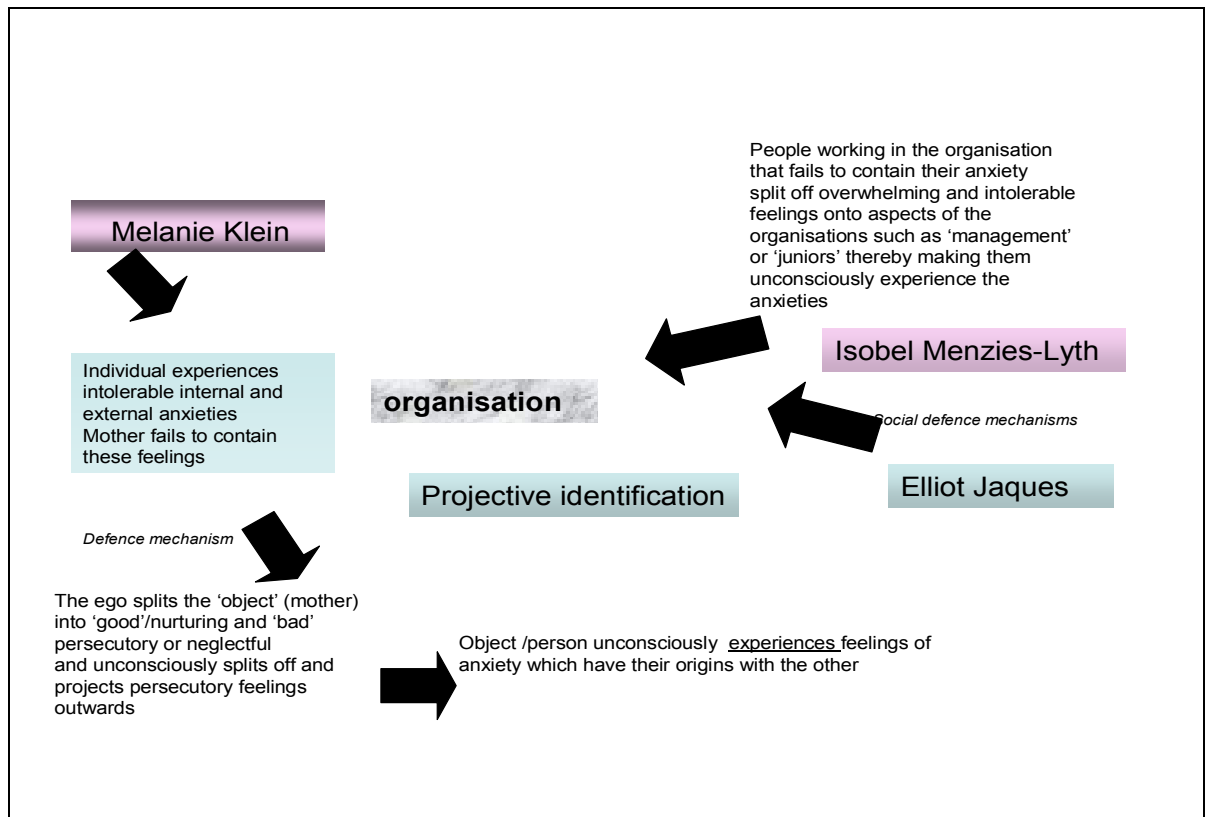
This is a pattern repeated in clinical settings, where patients routinely refer to a 'good nurse' and a 'bad nurse' and, almost identically, clinical staff referred to some patients as 'a good patient' and to others as 'a bad patient' (see Chapter Nine for an example of this). Splitting according to Klein extends in the child's own self – those aspects of him/herself that she cannot bear are projected outwards ("It is not I who is angry/fearful/envious; it is you"). Again this is a phenomenon observed many times in clinical settings. Frustration, discomfort and pain are experienced as persecution from hostile forces and their concomitants (e.g. hate) become destructive impulses which *are still operative in later life*, especially in times of stress and crisis.

Splitting and projection then are seen as fundamental *defences against primitive anxieties* by the object-relations school of psychoanalysis. Within this tradition, objects are not external entities but are shaped by phantasies¹² and feelings, they are *introjected* and projected, they split into good and bad and they constantly define and re-define the ego (or self). Object relations theory has found numerous important applications in the theory of organisations, primarily through the works of Jaques (1952) and Menzies Lyth (1960; 1970) in the UK, and more recently, Hirschhorn (1988), Gould (1993), Diamond (1993), Schwarz, (1990), Schwarz and Clore (2003) among others. Notable among these applications is the

¹² 'Phantasies' spelt in this way refers to those in unconscious experience.

treatment of *the whole organisation as an object which is liable to become incorporated in psychic reality* and towards which the individual may develop relations akin to early relations with significant objects from her environment and hold the 'organisation in the mind' (Armstrong, 2005) which we will discuss in more detail in the context of evidence from the study in Chapter Six.

Figure 2. Social Defences against Anxiety in Organisations



Menzies-Lyth, whose 1960 classic study of nursing staff occupies a privileged position in this literature, was driven by her initial observation that nursing work is highly anxiety-producing. She argued that nurses confront many different emotions from patients and their relatives - gratitude for the care they offer, admiration, envy for their skills and resentment stemming from forced dependence. Such projections create strong feelings in the nurses themselves:

The work situation arouses very strong and mixed feelings in the nurse: pity, compassion and love; guilt and anxiety; hatred and resentment of patients who arouse these strong feelings; envy of the care given to the patient. (Menzies-Lyth, 1988 , p. 46)

Faced with such an emotional cauldron, many nurses re-experience infantile persecutory anxieties, from which they seek to defend themselves, through

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the familiar mechanisms of projection, splitting and denial. Menzies-Lyth's important contribution was to establish how an organisation's own bureaucratic features, its rules and procedures, rotas, task-lists, paperwork, hierarchies and so on, in short '*the system*' acts as a support for the defensive techniques. By allowing for 'ritual task performance', by depersonalizing relations with the patients, by using organisational hierarchies, nurses contained their anxiety. Yet, in Menzies-Lyth's view, such organisational defences against anxiety were ultimately unsuccessful:

The system made little provision for confronting anxiety and working it through, the only way in which a real increase in the capacity to cope with it and personal maturation would take place. As a social defence system, it was ineffectual in containing anxiety. (Menzies-Lyth, 1991, p. 363)

The system's inadequacy in Menzies-Lyth's study is evidenced by its failure to train and retain nurses, the chronically low morale, high levels of stress and burn-out and absence of work satisfaction. By contrast, institutional health is testified not only by performance and output indicators, but also by morale indicators, and individual feelings of growth and maturation. Social defences against anxiety, then, are self-defeating. Instead of *containing* anxiety, they exacerbate it, just as neurotic symptoms far exacerbate the patient's malaise instead of containing it. Since Menzies-Lyth's pioneering work, some attention has been paid to how to support nurses and enable them to contain their emotions, without resorting to depersonalizing social defences. Yet, there is ample evidence that many nurses today continue to struggle with modest support against powerful anxieties (Theodosius, 2006; 2008). It is striking that no single study has sought to examine whether doctors face similar types of anxieties as nurses, whether they resort to similar psychological defences and the extent to which these defences function effectively across different individuals. In Chapter Nine we see evidence that doctors too appear to react similarly when faced with intolerable anxieties.

1.7 Developing our approach to leadership and the NHS

Studies of leadership and organisations such as the NHS clarify that diverse disciplinary perspectives have come together and separated more than once over the past century. The relationship between organisational and social context over that time has impacted on both practices of leadership and empirical and theoretical changes. In the 21st century the rules of scientific management or leader as therapist no-longer apply, and the rapid changes in organisations such as the NHS brought about by economic and technological imperatives, have left many who engage in leadership

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discourses, for practical and academic purposes, moving between the transformational and the post-heroic positions.

We now consider theoretical perspectives, ideas and practices that can potentially be brought together to good effect in this study for the benefit of patients and those who work for their good within the NHS, focusing on some of the recent debates which explore the context of leadership and the place of distributed leadership as they apply to NHS contexts.

1.7.1 The base-line:

- It is now widely acknowledged that organisations, their leaders and followers come together in a highly *emotional context*. How can those who lead and work in such organisations take account of the role of emotion while not being 'emotional' (i.e. making unfair and irrational decisions)? Understanding this is vital for enabling management and leadership particularly in a complex institution which has patient health, safety and care at its cutting edge (Morgan, 2006) .
- The NHS, individual Trusts and Units within these Trusts are constantly engaging staff in *change* (which may be evolutionary and/or politically driven) and which may be motivational and/or stressful or resisted (McNulty & Ferlie, 2002). This further demands emotional and social intelligence and engagement from leaders and followers (Bovey & Hede, 2001).
- The primary *tasks* and related *roles* might conflict at various points as these changes impact emotionally and intellectually on staff performance and service delivery (Zoller & Fairhurst, 2007).
- Organisations have to have leaders but leadership is not necessarily always the province of a small group of individuals but depends on the structure and demands placed on the organisations and the tasks required at any one time (Currie et al., 2009; Day et al., 2006; Harvey, 1989; Michie & West, 2004).
- An emotional context requires attention to both conscious and *unconscious* dimensions of human interaction and power relationships which may come into play in organisations which comprise multiple professional disciplines, different grades of role and people from diverse cultures, sexualities and gender (Ford, 2006; Gabriel, 2004). Acknowledgement of the importance of anxiety, envy, competition, anger and the emotional ties between people needs to be taken into account (see Figure 3 below).

Two models of leadership are therefore examined in this study (see Figure 3 below):

- First, *inspirational and transformative (or engaging) leadership* which has attracted much recent attention in that its absence was seen as a critical factor behind the failure of many organisational innovations. In this approach, leadership hinges on leaders' ability to communicate effectively, relate emotionally with their followers and develop a vision that is both attractive and achievable. The role of transformational leadership then is to lead an organisation towards change and thus some elements of transformational leadership are essential for understanding the practices and needs of the NHS (Alban-Metcalf & Alimo-Metcalf, 2009).
- The second relevant dimension is *distributed leadership* (sometimes called *dispersed, distributive, collective, or supportive 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). A *distributed leadership* approach is consistent with Bailey and Burr's (2005) research on successful NHS Trusts, which states:

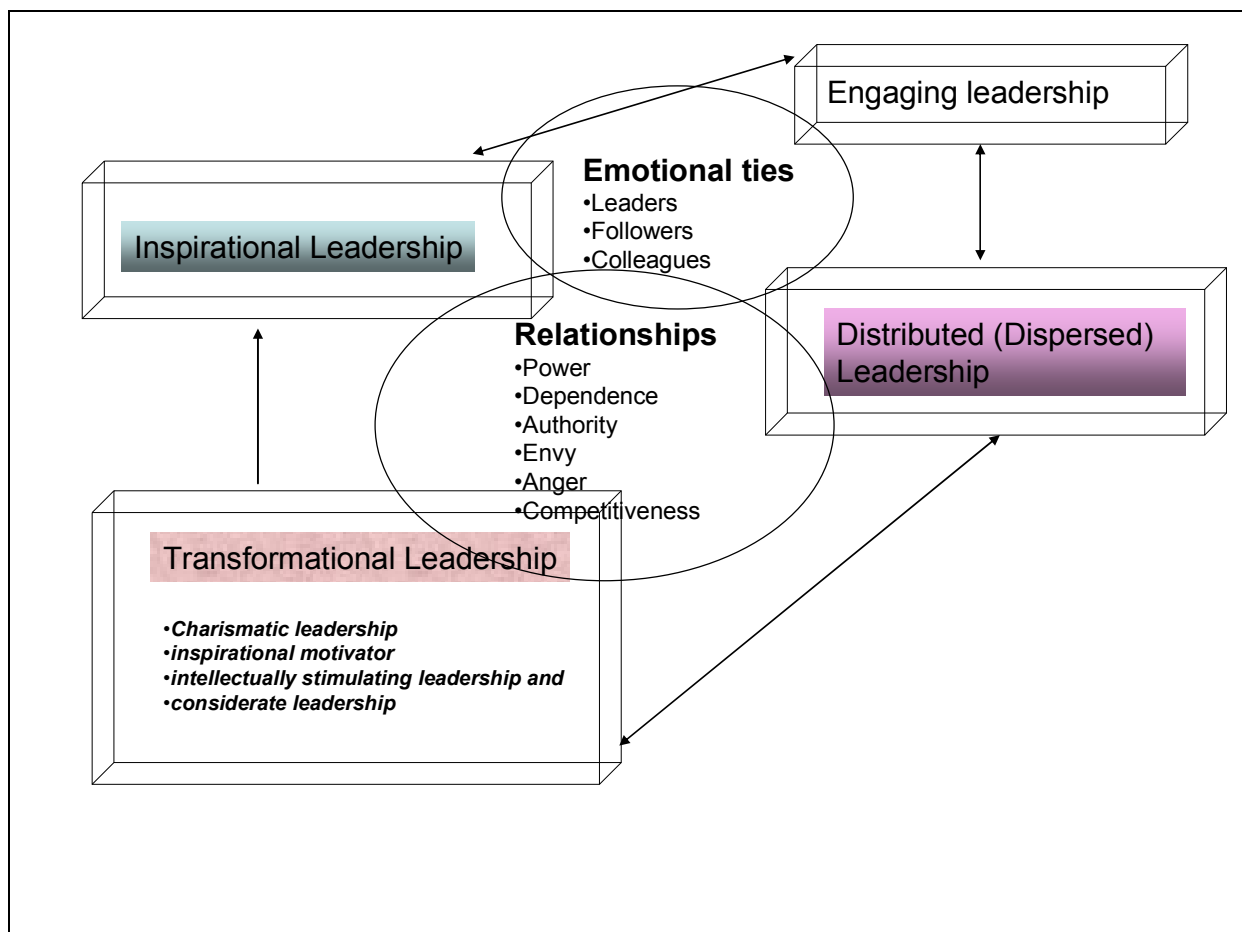
In contrast to the individual, heroic leader concept, leadership is seen in terms of the influence processes that contribute to the collective and individual capacity to work effectively. This idea of collective and distributed leadership is closely associated with the emergence and special requirements of 'new' organisational forms generally and the NHS in particular it is consistent with the agenda for devolved decision – making, empowerment of the frontline, de-centralisation, inclusion and such initiatives as 'Leadership at the Point of Care'.

Thus, distributed leadership is seen by Bailey and Burr (2005, p. 14) as directly linked to patient care.

A combination of these two models might now be seen as 'engaging' leadership as described by Alimo-Metcalf, Alban-Metcalf et al. (2007) and this combination will be explored further in our analysis of the (qualitative) data in particular.

Furthermore the model of the post-industrial/postmodern and or networked organisation will be 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).

Figure 3. Leadership Styles, Followership and Emotion



1.8 Conclusion

In an organisation like the NHS there are opportunities for leadership at all levels, as well as opportunities for success and unforeseen consequences leading to failure. Leaders in the NHS are involved *transformationally* in responding to policy initiatives and government demands, but the NHS is also an organisation that relies on the knowledge, skills and abilities of all its people – leaders and followers.

It would seem that *transformational/engaging and distributed leadership* are particularly useful conceptual resources to deploy in the context of the National Health Service, where a workforce of different ethnic, cultural and

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class backgrounds caters to the needs of a similarly diverse patient population.

Following Alimo-Metcalfe, Alban-Metcalfe et al (2007) "*an engaging 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'*" (2008, p. xi).

As part of the conceptual framework we develop, it is clear that the *emotional links* between individual staff, groups of staff and staff and patients need to be privileged as they play out at various organisational levels. Implicit therefore is that emotions above and below the surface (conscious and unconscious) are taken into account if the leader/follower and staff/patient relationships are to be understood and improved.

2 Aims and Methods

2.1 Introduction

The research questions in this study centre on identifying:

- (a) processes by which leadership is transmitted through health service organisations to effect the delivery of health services, and
- (b) how features of the organisation, the leader, and the service influence these processes.

The focus of this study was to explore the relationship(s) between (good) leadership in NHS organisations and (good) patient care. This demanded consideration not only of leadership characteristics, qualities and styles but the ways in which NHS organisational climate and culture interacted with individual practices and identities of those who worked in them and were patients. The overall plan was, thus, to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery. This research further sought to expand existing knowledge by exploring the following questions.

1. First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
2. Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

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3. Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

2.2 Aims and Objectives

We separated these overarching research questions into aims and objectives thus:

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients;
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts on service delivery;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted through health care organisations to affect service delivery, posits *organisational climate* as one feature of the organisation that could positively or negatively affect the quality and delivery of health services.
- To learn how different stakeholders (specifically, patients, nurses and professions allied with medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care.
- To identify how the need for change in service delivery is identified and what drives the need for change.

2.3 Methods

This multi-method study therefore uses a mixture of qualitative and quantitative methods to enable and support an innovatory approach to examining the psycho-

social and psychodynamic factors intrinsic to the meanings and processes of leadership, organisation and patient care.

Qualitative research methods now have a strong and long-standing profile in social science, particularly sociology and anthropology. But over recent years they have become increasingly relevant in social psychological research.

Furthermore nursing research (Finlay & Ballinger, 2006; Kerr, 2002) and most recently even health services research have begun to take evidence emerging from qualitative methods seriously. Perhaps this began with a series of papers in the British Medical Journal in 1995. Pope and Mays for example leading on this series aptly titled their paper *Reaching the Parts other Methods Cannot Reach* (Pope & Mays, 1995). Noteworthy from this point onwards is that there is no 'one' qualitative method of either data collection or analysis and we draw on several traditions and styles in this study which are outlined below.

Unlike health services research *per se*, but akin to critical social science, there is a powerful tradition in organisational research that has taken account of the diverse nature and intrinsic value of qualitative methodologies to understanding the life of organisations (see for example Cassell and Symon, 1994; Ybema et al., 2009)

What counts of course is choosing methods which meet the demands of the research hypothesis or overarching questions. We thus began from the premise that 'leadership', 'patient care' and 'organisational change' are not objective facts but social or discursive constructions. By this we mean that these concepts are constructed through discourse, i.e. a coherent system of statements which constructs an 'object' (Parker, 2002). In other words, talk about leadership is the process by which leadership is constructed (and thus recognised) as something that happens in organisations such as the NHS.

To capture these constructions we used a range of methods:

- focus groups;
- a survey-based questionnaire including a standardized measure of Organisational Climate;
- ethnographic 'shadowing';
- observations of social places, formal and informal and meetings;
- analysis of 'stories' of leadership collected through in-depth interviews.

2.4 Capturing the data

In what follows we present the outline plans for capturing, managing and analysing the data to meet our aims although as shown in Chapter Three not all of our goals were achieved.

We focused upon three NHS Trusts with at least one being a Foundation Trust specifically to explore whether any variations in the qualities of leadership, organisation and patient care could be distinguished. An

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investigation of three Trusts was considered to be manageable within the time frame and other resources available for the project.

Within each Trust we chose two distinct 'units' to study. We conjectured these would probably to be defined by clinical speciality or site (bearing in mind that many Trusts are organised across more than one hospital/physical space).

We conducted focus groups, an organisational climate survey, story-telling interviews and ethnographic work (observations and shadowing) across these six units with staff and patients.

We employed two researchers¹³ to carry out the majority of this work, but some members of the investigatory team also took an active part in the process.

The qualitative data would by necessity and designed be analysed using a variety of methods:

- a. Thematic analysis (TA)
- b. Critical Discourse Analysis (CDA)
- c. Narrative analysis

Each of these approaches to data analysis, again by necessity and design, was subject to nuances of interpretation, intrinsic to their nature.

¹³ In the event three researchers were involved because of maternity leave and cover.

The flowchart illustrates the research approach, starting with 'NRES application' and 'Informal and formal approaches to 'gate-keepers' by research team'. These lead to 'local governance' and 'The Trust'. 'The Trust' connects to 'Site A' and 'Site B'. 'Site A' connects to 'Unit 1' and 'Unit 2 (As Unit 1)'. 'Unit 1' connects to 'Staff' and 'Patients'. 'Staff' and 'Patients' lead to 'Other parts of the Trust'. 'Other parts of the Trust' leads to 'Organisational Climate Survey'. A central oval lists data collection methods: 'Interviews', 'Focus groups', 'Shadowing', and 'Observations'. A side oval lists 'Key informants at site and Unit level'. A top oval lists 'Introduction to key informants at Trust level', 'Negotiating choice of Unit', and 'Negotiating entry for data collection'. A bottom oval lists 'Meeting staff and negotiating individual arrangements for data collection'.

```

graph TD
    NRES[NRES application] --> LG[local governance]
    LG --> Trust[The Trust]
    LG --> TopOval([Introduction to key informants at Trust level  
•Negotiating choice of Unit  
•Negotiating entry for data collection])
    TopOval --> Trust
    TopOval --> SiteA[Site A]
    TopOval --> Unit1[Unit 1]
    TopOval --> Staff[Staff]
    TopOval --> Patients[Patients]
    TopOval --> OtherParts[Other parts of the Trust]
    TopOval --> OrgClimate[Organisational Climate Survey]
    TopOval --> KeyInformants([Key informants at site and Unit level])
    KeyInformants --> SiteA
    KeyInformants --> Unit1
    KeyInformants --> Staff
    KeyInformants --> Patients
    KeyInformants --> OtherParts
    KeyInformants --> OrgClimate
    KeyInformants --> MeetingStaff([Meeting staff and negotiating individual arrangements for data collection])
    MeetingStaff --> Staff
    MeetingStaff --> Patients
    MeetingStaff --> OtherParts
    MeetingStaff --> OrgClimate
    MeetingStaff --> Interviews[Interviews]
    MeetingStaff --> FocusGroups[Focus groups]
    MeetingStaff --> Shadowing[Shadowing]
    MeetingStaff --> Observations[Observations]
    SiteA --> Unit1
    SiteA --> Unit2[Unit 2  
As Unit 1]
    Unit1 --> Unit2
    Unit1 --> Staff
    Unit1 --> Patients
    Unit1 --> OtherParts
    Unit1 --> OrgClimate
    Unit1 --> Interviews
    Unit1 --> FocusGroups
    Unit1 --> Shadowing
    Unit1 --> Observations
    Unit2 --> OtherParts
    Unit2 --> OrgClimate
    Unit2 --> Interviews
    Unit2 --> FocusGroups
    Unit2 --> Shadowing
    Unit2 --> Observations
    Staff --> Patients
    Staff --> OtherParts
    Staff --> OrgClimate
    Patients --> OtherParts
    Patients --> OrgClimate
    OtherParts --> OrgClimate
    
```

The Trusts

- they were each different from each other in the image they projected (on their web-sites, in terms of their physical style,

50

locality, size and community) and that the sample had to include one Foundation Trust.

- they were in easy reach of London (for practical purposes as the study team were based in London and Surrey).
- we were able to gain access via personal contacts in R & D or senior management (the 'gatekeepers').

The Units

Sampling of the Units in each of the Trusts was achieved through negotiation with the gatekeepers and/ or key informants recommended by the gatekeepers with the intention that a balance might be struck between:

- the specific academic interests of the research team (for example the PI is particularly interested in Obstetrics and Gynaecology services).
- some degree of opportunity for comparison between Trusts, so that if possible some similar Units might be compared across the Trusts.
- and (possibly most influential) the concerns of the gatekeepers and other senior Trust staff.

The Sites

All three Trusts selected for an initial informal approach were on more than one site although the selection of study unit determined whether or not the data was collected on more than one site.

Individual Participants (staff)

Individual participants were to be selected on an 'informed' volunteer basis. That is that via a process of meetings with key informants and presentations to staff-groups individual staff would hear about the study and be offered the opportunity to participate. For those who were not involved in the meetings or presentations a staff e-mail list was used to communicate information about the study and request volunteers to participate in interviews and focus groups. The intention to meet the study aims was to ensure participation from a variety of staff groups and levels of seniority.

Individual Participants (patients)

Patients were to be recruited for interview either by the staff directly caring for them or by the researchers themselves once the staff of each unit had become familiar and accepted the presence of the researchers.

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Survey Respondents (staff)

The Organisational Climate Survey (OCS) was to be administered within the Units that were the focus of the study and, if possible, across other Units in the Trusts. The circulation was to be achieved either through e-mail or through internal mail depending on negotiation with the relevant gate-keepers.

Survey Respondents (patients)

Patients who might complete the patient version of the survey were to be recruited by staff and/or researchers if staff permitted the researchers 'on the ground' access.

Observations and 'Shadowing' (staff and patient-staff interactions)

These methods would require the participants to be familiar and comfortable with the presence of the researchers and familiar with the ongoing research process and also be prepared to co-operate. The rules for engagement in the activities would then be made on a strategic (i.e. the staff and / or situation that would yield the richest source of information) and a pragmatic basis (i.e. the possibility of the situation yielding important data regarding leadership, organisational culture and climate and patient care).

2.6 Ethical considerations

There are clearly considerations about confidentiality and anonymity in all data collection which involves human participants Easily identified in this study (and thus in the NRES application) is the matter of the safe keeping of the raw data including completed questionnaires, any identifying characteristics of these questionnaires, digital recordings, transcripts from focus groups and interviews and the researchers' field notes. It is important to note that this is not necessarily as simple to do as it is to describe particularly because a team of investigators, the researchers themselves and some 'casual' clerical staff ¹⁴all had different types of access to the data.

The solution was to have a shared drive set up by the computer centre at Royal Holloway, University of London (RHUL) on the main site at Egham which could only be accessed by specified investigators identified by the PI. Additionally there was an access pass-code to read the transcripts and the SPSS file.

¹⁴ The sheer volume of data made it necessary to use more than one person to input the data and transcribe the recordings. Two people other than the researchers were engaged to work on this although both were employees of RHUL who knew the importance of keeping the data safe.

Another ethical consideration specific to this project was that because the staff were discussing leadership and being asked to give examples of good and bad leadership, as well as examples of effective and poor patient care, it was inevitable that:

- they would be talking about *other* members of staff. These other staff could not be told that they had been talked about (by definition) leaving them unable to provide their version of the story or aware of the fact they had been discussed.
- the researchers would therefore be 'holding' some knowledge of others which would be 'data'. This fact drew attention to the ethical and empirical complexities of working in an organisation in which data is being collected on human interactions and relationships.

As patients' experiences and views and staff's views of patient care were also part of this investigation, similar issues applied.

Finally, frequently overlooked but nonetheless very important consideration was given to the fact that participants' time should not be wasted. We were confident in the design and our experience as investigators supporting and managing the researchers (who themselves were experienced in this kind of study) that the study was robust enough to adapt to the vagaries and quirks of 'real life' and that the outcome would be valid and add value to existing knowledge.

2.7 Methods of data collection and research instruments

As described above a mixture of qualitative and quantitative methods were used to ensure a full picture of leadership in the organisations to be studied. Collecting data in applied settings, where the participants are also engaged on a day-to-day basis is demanding work which is challenging for researchers involving persistence, social skills, the ability to develop rapport, clarity of purpose combined with flexibility, the skill of 'thinking on your feet' and making practical judgements about what is feasible at any one time. For example, if plans had been set for an interview with a staff member who was then called away for an important work matter, the researcher could arrange other potential participants or be prepared to engage in a period of systematic observation.

Immediately below we describe the methodologies we chose to employ to conduct our investigations which will be described in greater detail where appropriate in the context of specific case studies.

2.7.1 Focus groups

Focus groups, once the province of market researchers, in common with in-depth interviews, are now a popular method of collecting psycho-social data in the area of health research (Nicolson & Anderson, 2003; Nicolson et al., 2008) having gained recognition in social science overall as a robust way of eliciting “*shared and tacit beliefs, and the way these beliefs emerge in interaction with others in a local setting*” (Macnaghten and Myers, 2004, p. 65 in Seale et al) (p.8). In other words focus groups represent a means of gathering a sense of how those who work in an organisation share a sense of their ‘organisation in the mind’ (Armstrong, 2005) which may be mutually accepted, challenged or undermined by the perceptions of colleagues. Focus groups also enable the researchers to check out the quality and effectiveness of the communications themselves between members of the Unit or as Morgan (1998) suggests “*Focus groups are fundamentally a way of listening to people and learning from them* (1998, p. 9).

The process involves one or two researchers meeting with between four and eight participants who share a common situation and the guide lines for the discussion focus on key topics (see Appendices). One researcher takes notes although both are empowered to guide the discussion which is also digitally recorded. One benefit of this means of data collection is that through discussion among peers issues or perspective upon certain issues are brought into focus which might have escaped previous research authors and the researchers themselves (Morgan, 1998).

The *focus group guide* employed a similar structure to the *Interview Guide*.

2.7.2 Organisational climate

The Organisational Climate Questionnaire (OCQ) designed by Stringer (Litwin & Stringer, 1968; Stringer, 2002) also called ‘The Leadership Questionnaire’, was specifically designed to produce a scale to measure leadership in the context of climate albeit in a business rather than NHS setting. To complement the mostly qualitative methods of data gathering and analysis, we developed a questionnaire for staff and patients across the Trusts and used (a slightly adapted form of) Stringer’s measure of leadership and organisational climate, with the expectation that our results might also be linked to other studies undertaken with this measure, which had been used to examine management and leadership in organisations.

It identified six dimensions of organisational climate: *structure, standards, responsibility, recognition, support and commitment*, and uses eighteen leadership practices (three for each dimension) to capture how people feel about their jobs, how they are managed, and how things work in a particular organisation. Because this scale is designed to give practical

indicators on how to improve performance, many of the leadership measures are based on management practices, which are equally important to the overall success of an organisation. In general, however, each leadership practice measure is based on the premise that leaders care about arousing the motivation of members in the organisation (Stringer, 2002). The OCS was adapted from to fit a model relevant to NHS Staff working in a hospital setting and another version was adapted to be used with Patients (see Appendices).

2.7.2.1 Measurement tool: Stringer's OCS – Leadership and Organisational Climate

Stringer (2002) defines organisational climate as the "*collection and pattern of the environmental determinants of aroused motivation*" (p. 9) and he takes motivation to be central to the development of his climate questionnaire predominately based on the work of McClelland-Atkinson's framework with regards to intrinsic motivators of work related-behaviour: the need for achievement (nAch), the need for power (nPow), and the need for affiliation (nAff).

Stringer noted that specific dimensions of climate appear to have a predictable impact on motivated behaviour and can be measured and managed by those in senior positions accountable for organisational performance.

The six distinct dimensions identified and measured are:

- 'Structure'
- 'Standards'
- 'Responsibility'
- 'Recognition'
- 'Support'
- 'Commitment'

The statistical data was entered into an SPSS file to seek frequencies, correlations and to explore significance levels of differences and similarities between and within groups of respondents.

2.7.3 The survey structure and items

The survey is structured in two parts:

Part 1: measures *Organisational Climate* or how people perceive the work environment.

Part II: measures *Management Practices* or how people see their own managers behaving.

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Part 1:

This part consists of twenty-four items grouped into the six dimensions - 'structure', 'standards', 'responsibility', 'recognition', 'support' and 'commitment' - designed to measure how people feel about their work environment using a 4 point Likert scale. The directions ask the participants to describe the kind of working climate that has been created in their organisation (defining 'organisation' as the smallest work unit relevant to the participant).

Descriptions of the dimensions are as follows:

1. **'Structure'** pertains to the clarity of roles, responsibilities, accountability and expectations. According to Stringer this is more of a managerial than a leadership issue and one which is more practical than inspirational. It reflects the employees' sense of being well organised and of having a clear definition of his or her roles and responsibilities. *"structure is high when people feel that everyone's job is well defined and is low when there is confusion about who does which tasks and who has decision-making authority"* (Stringer, 2002, p.65).

The following items measure 'structure':

- The jobs in this organisation are clearly defined and logically structured.
- In this organisation, it is sometimes unclear who has the formal authority to make decisions.
- In some of the projects I've been on, I haven't been sure exactly who my boss was.
- Our productivity sometimes suffers from a lack of organisational planning.

2. **'Standards'** is about the need to achieve targets and reach goals. It is the drive to achieve and improve, it includes the 'commitment' and persistence to follow through on set targets. This dimension measures the feeling of pressure to improve performance as well as the degree of pride employees have in doing a good job. When interpreting this measure, high 'standards' indicate that people are always looking for ways to improve performance, whereas, a low score reflects lower expectations for performance.

The following items measure 'standards':

- In this organisation we set very high 'standards' for performance.
- In this organisation people don't seem to take much pride in their performance.
- Around here there is a feeling of pressure to continually improve our personal and group performance.
- Our management believes that no job is so well done that it couldn't be done better (Stringer, 2002, p.65).

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3. **'Responsibility'** is about taking ownership of the work and results which are obtained. Ideally people will be motivated to achieve results and take ownership over these. Where managers delegate and encourage responsibility, workers are more likely to feel a sense of 'responsibility'. It reflects employees' feelings of 'being their own boss' and not having to double-check decisions with others. A sense of high 'responsibility' signifies that employees feel encouraged to solve problems on their own. Low 'responsibility' indicates that risk taking and testing of new approaches tend to be discouraged (Stringer, 2002; p.66).

The following items measure 'responsibility':

- We don't rely too heavily on individual judgment in this organisation almost everything is double checked.
- Around here management resents your checking everything with them if you think you've got the right approach you just go ahead.
- You won't get ahead in the organisation unless you stick your neck out and try things on our own.
- Our philosophy emphasises that people should solve their own problems themselves.

4. **'Recognition'** relates to the relationships between one's performance and associated rewards, as well as broader sense of approval or disapproval of an individual's efforts. It indicates employees' feelings of being rewarded for a job well done. This is a measure of the emphasis placed on reward versus criticism and punishment. High 'recognition' climates are characterised by an appropriate balance of reward and criticism. Low 'recognition' means that good work is inconsistently rewarded (Stringer, 2002, p. 66).

The following items measure 'recognition':

- In this organisation the rewards and encouragements you get usually outweigh the threats and criticisms.
- There is not enough reward and 'recognition' given in this organisation for doing good work.
- We have a promotion system here that helps the best person rise to the top.
- In this organisation people are rewarded in proportion to the excellence of their job performance.

5. **'Support'** is the degree to which there is a sense of warmth and team work, within which the individual feels that they are 'backed up' by others. This will determine the amount of trust and respect amongst team members. It reflects the feelings of trust and mutual 'support' that prevails within a work group. 'Support' is high when employees feel that they are

part of a well-functioning team and when they sense that they can get help (especially from the boss) if they need it. When 'support' is low, employees feel isolated and alone. This dimension of climate has become increasingly important for today's e-business models in which resources are severely constrained and a premium is placed on teamwork (Stringer, 2002, p.66).

The following items measure 'support':

- You don't get much sympathy in this organisation if you make a mistake.
- When I am on a difficult assignment, I can usually count on getting assistance from my boss and co-workers.
- People in this organisation don't really trust each other enough.
- I feel that I am a member of a well-functioning team.

6. **'Commitment'** reflects employees' sense of pride in belonging to the organisation and their degree of 'commitment' to the organisation's goal. Strong feelings of 'commitment' are associated with high levels of personal loyalty. Lower levels of 'commitment' mean that employees feel apathetic toward the organisation and its goals (Stringer, 2002, p. 11).

The following items measure 'commitment':

- Generally, people are highly committed to the goals of this organisation.
- People here feel proud of belonging to this organisation.
- People don't really care what happens to this organisation.
- As far as I can see, there isn't much personal loyalty to the organisation.

Part II:

This part asks the participants to describe the practices of their managers. Using the same six dimensions as in Part I, participants are given eighteen statements which describe the way a manager might perform her or his duty and the respondents are asked to indicate how much he or she agrees with each of the statements. Here a 5 point Likert scale is used.

Once again the six dimensions are used to assess perceptions of managers' practices:

1. 'Structure'

- Establishing clear, specific performance goals for subordinates' job.
- Clarify who is responsible for what within the group.
- Making sure tasks and projects are clearly and thoroughly explained and understood when they are assigned.

2. 'Standards'

- Setting challenging performance goals and 'standards' for subordinates.
- Demonstrating personal 'commitment' to achieving goals.
- Giving subordinates feedback on how they are doing on their job.

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3. 'Responsibility'

- Encouraging subordinates to initiate tasks or projects they think are important.
- Expecting subordinates to find and correct their own errors rather than doing this for them.
- Encouraging innovation and calculated risk in others.

4. 'Recognition'

- Recognizing subordinates for good performance more often than criticizing them for poor performance.
- Using 'recognition', praise and similar methods to reward subordinates for excellent performance.
- Relating the total reward system to performance rather than to the other factors such as seniority or personal relationships.

5. 'Support'

- Being supportive and helpful to subordinates in their day to day activities.
- Going 'to bat' for subordinates with superiors when the manager believes their subordinates are right.
- Conducting team meetings in a way that builds trust and mutual respect.

6. 'Commitment'

- Communicating excitement and enthusiasm about the work.
- Involving people in setting goals.
- Encouraging subordinates to participate in making decisions.

Leadership question

We also asked a single question to capture directly how satisfied an employee is with the leadership they receive from their immediate supervisor. It was a simple statement: *I am satisfied with the quality of the leadership I receive from my immediate manager* which we measured using a 4 point Likert scale.

2.7.4 Ethnographic observations and 'shadowing'

Ethnographic observations and shadowing are especially useful to organisational research because they allow people to *physically* express their inner thoughts, and put ideas into *observable action*, all of which would be inaccessible through the survey or structured interview questions.

Ethnographic observation (often referred to as *participant observation*) has its roots in anthropology but has become increasingly deployed in sociology, cultural and social geographies. In the field (which in this case is a Unit in an NHS Trust) the researcher's aim is to "*understand how the cultures they are studying 'work'*" that is, to grasp "*what the world looks like*" to the

participants in the context being observed (Delamont, 2004, p. 206). In this study observation and shadowing opportunities were (mostly) formally set up and pre-arranged. However, the researchers, through taking their roles as interviewers, focus group leaders and having an every-day presence with key informants, gate-keepers and participants, were able to immerse themselves in the lives and atmosphere of each of the Trusts and Units providing evidence about the processes of leadership and patient care as well as 'climate' (Bloor, 2001; Goffman, 1961).

Shadowing involved the same conceptual framework as ethnographic observation in that the aim was to understand what the world looks like from the perspective of the staff member being shadowed as well as the worlds of the other staff and patients that they engaged with in the course of their work (Czarniawska, 2008; McDonald, 2005). It involved meeting the participant (usually) at 8 am and for one or two days accompany them including at break times until the participant went home. In Trusts where there was more than one site and/or when the nature of the day's work involved meetings outside the hospital (as in nearly every case) then the researcher spent time in a car with the participant and if agreed the conversation was digitally recorded as an *aide memoire* for the field notes. The participant was able to withdraw at any time, or for a period of time, across the shadowing period.

Thus the sense of 'what the Unit world looked like' was recorded in field notes which were then discussed with the other members of the team (who had some familiarity with the relevant part of the Unit/Trust) in a context where the researcher could be reflexive and explore the 'silent space' of the 'ethnographic self' (Coffey, 1999). The researcher's notes and expressed thoughts were then discussed with other members of the team, some of whom were familiar and others not so with the specific context (Barry, 2003). A similar approach was used to discuss the interview material because even though the interviews were digitally recorded and transcribed verbatim, this did not account for the reflexivity that took place following the interview itself and on transcribing and reading the transcript, and therefore featuring in the analysis (Nicolson, 2003).

In this context there was concern to capture the emotional content and atmosphere of the organisations. This meant that ethnographic methodologies were implemented to analyse the emotionality of the interactions (verbal and non-verbal) between patient and practitioner. It was through these observations that the use and importance of the researcher's *body as a 'research instrument'* became palpable, especially for understanding the emotions emerging out of the interactions between patient, relatives and practitioner(s). This process has been proposed as the antithesis of taking for granted that emotion should be removed from

ethnographic investigation and that in fact the research process is highly emotive and far from an emotionally barren terrain (Bondi, Davidson, & Smith, 2005).

As the researcher collects data they move through a continuum of emotions from the euphoric highs of excitement at starting a new research project, sense of achievement and pride as they begin to make contacts and collect initial data, perhaps trepidation, fear and nervousness as they meet new participants or research settings through to the depths of despair, isolation and frustration as the research process (inevitably at times) becomes chaotic and messy. However, these emotions are often neglected, regarded as unimportant to the overall research process and abandoned in the writing up phase. We use these frequently neglected emotions and feelings as part of, and beneficial to, the project as representing a rich source of data.

By being more attentive to their emotions and bodily senses ethnographers also become more sensitive to their environment and their participants thus gaining a greater awareness of what they are observing. In recalling a sound, smell or feeling the ethnographer is able to open up their mind's eye to re-visualise the interaction with greater clarity and accuracy making it more likely that an accurate representation of what was observed will be recorded.

2.7.5 In-depth semi-structured and 'story-telling' interviews

In-depth semi-structured Interviews: Over the past fifteen years this method of qualitative data collection has become increasingly common in health services and health research in general (Pope and Mays, 1995; Kvale, 1996; Grbich, 1999) consistently a method of choice for identifying perceptions, meanings and experiences of dynamic and complex concepts such as 'leadership' and 'patient care' (Rubin and Rubin, 1995; Denzin and Lincoln, 1998; Rapley, in Seale et al, 2004).

The use of such interviews has led to increased levels of sophistication in the interpretation of qualitative in-depth data in the context of historical, cultural and political frameworks demonstrating that in-depth semi-structured interviews (and more generally qualitative research) have capability beyond simply adding rich description to statistical evidence (see Denzin and Lincoln, 2002; Willig, 2008).

Story-Telling: One of the explicit aims of the interviews was to collect a number of stories to reflect critical experiences in the organisations' past and present life. In the field of organisational studies, there is now an extensive literature of how to use stories told by organisational participants

as windows into organisational culture, politics and numerous other phenomena (Gabriel, 2000; Hannabuss, 2000).

The inclusion of story-telling in the context of the in-depth interview increases the scope for making sense of data in ways that delve deeply into the respondents' perceptions and meaning of the *processes* of leadership and patient care. Story-telling also increases the validity of the interview through the use of reflexivity, and positioning the events and 'atmosphere' of the stories in the context of the organisational analysis.

Of particular relevance to this study, stories can instigate insights into the processes of positive or negative social and organisational change and leadership which involves the management of meaning and emotions, both of which rely heavily upon the use of stories, allegories, metaphors, labels and other narrative devices.

The study of *organisational stories* is particularly relevant in health care settings that are liable to unleash strong emotions and fantasies. Hence, hospitals are rich grounds for collecting stories, as numerous researchers have recognized (Kleinman, 1988; Frank, 1998; Greenhalgh, 2002; Hurwitz, 2006; Mattingly, 1998). Storytelling permeates everyday clinical practices and "*medical professionals find ways to 'routinize' their practice and thus, metaphorically at least, bring the unruly and frightening world of illness under control*" (Mattingly 1998, p. 277).

The *interview schedule* (see Appendices) therefore was designed to elicit information on the participant's view of 'leadership' and 'patient care' through 'stories' to provide examples in their opinion that constituted good and poor leadership and good and poor patient care through 'critical incidents'.

As the interviews were semi-structured and in-depth they relied to a great extent on the interviewing skills of the researchers and their ability to establish rapport and consequent willingness of the participants to engage in the process. The early pilot interviews therefore were unlikely to influence the details of the interview schedule itself although the early interviews were planned to enable the research team to identify the best *strategies* to engage participants in the task.

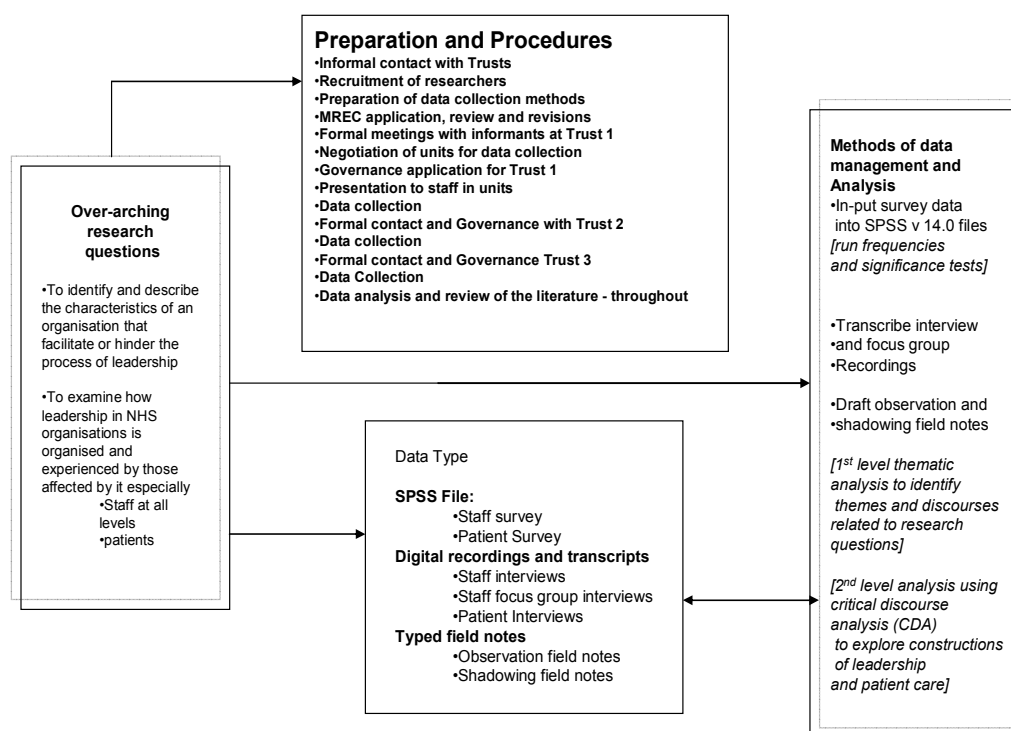
2.8 Data Management

The interviews and focus groups were digitally recorded and transcribed verbatim. The transcripts stored on a password protected Word file (initially on the researchers' PCs but subsequently on the secure shared drive described above) and sound recordings stored on audio files (password protected on the PC of the PI and not on the shared drive).

The OCS data was entered and stored on an SPSS file, password protected and placed on the secure shared drive.

Fieldwork notes from observations and shadowing were similarly password protected stored on the shared drive once they had been prepared by the individual researchers.

Figure 5. Outline of Study Procedures and Methods



2.8.1 Data Analysis

There are effectively therefore three categories of data.

1. Qualitative data representing verbatim 'talk' (digital recordings/transcripts) of interviews and focus groups.
2. Qualitative data from observations, shadowing and other field notes. These were subjective accounts of observations, perceptions, emotions and meanings given to the field work by one researcher. This may have been following discussion with the other researcher on occasions when that person had had access to the same raw

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material. Discussion with another member of the investigatory team (frequently but not always the PI) also took place following the first drafting of the field notes in order to clarify the meanings given to specific behaviours and relate theory and data.

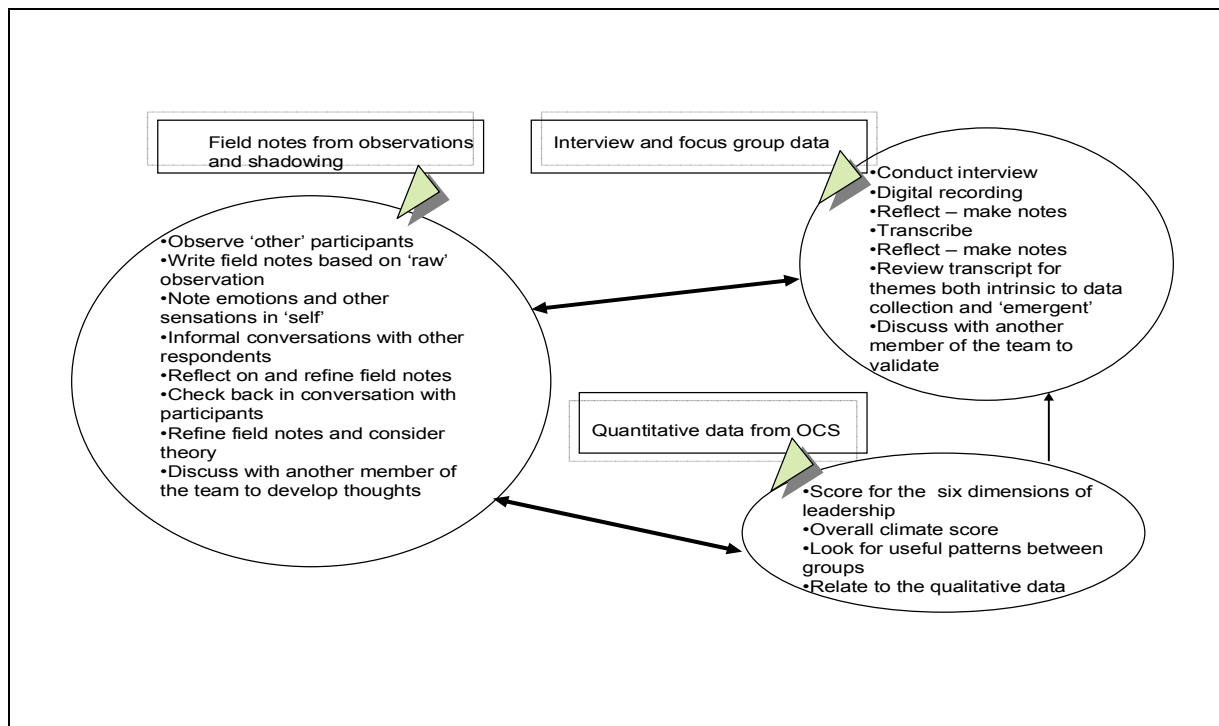
3. Statistical data from the OCS.

2.8.2 Thematic Analysis (TA)

The transcripts and field notes were examined initially for relevant extracts related to the main themes ('leadership', 'organisation' and 'patient care').

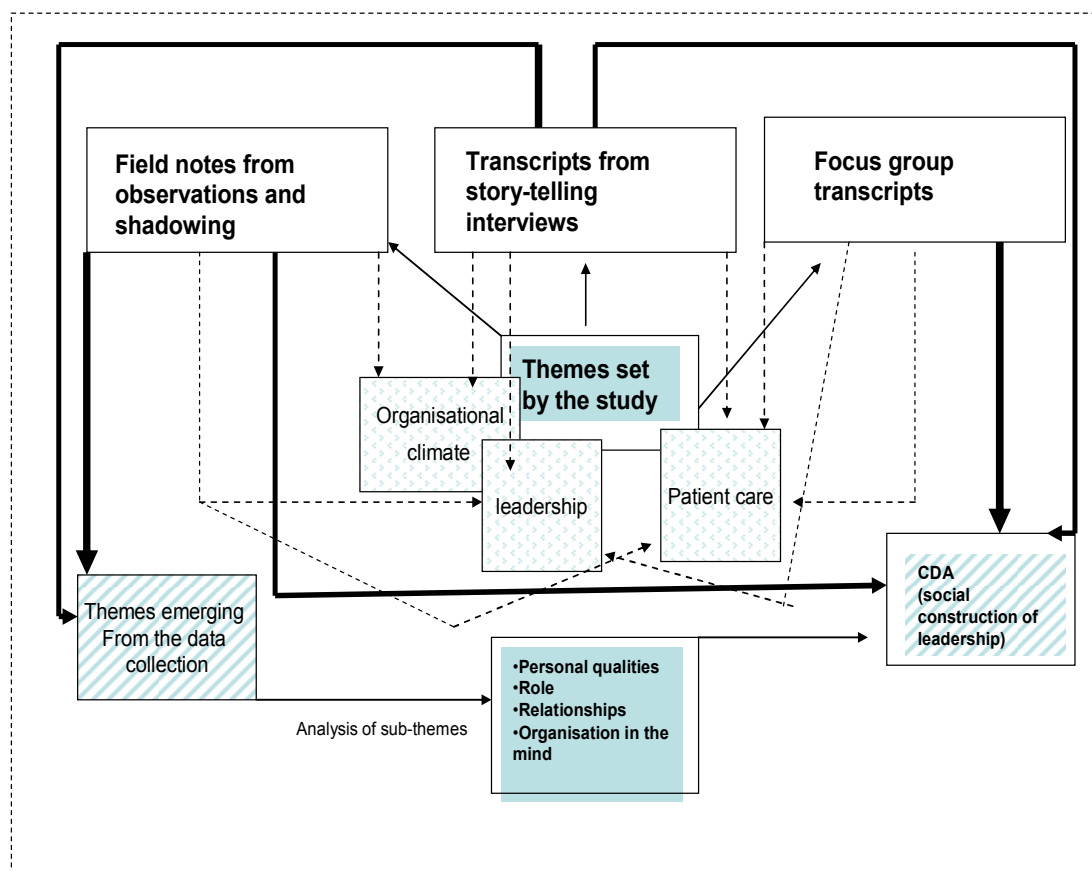
Sub-themes were then to be identified, some of which are likely to relate closely to the previous research literature on leadership and organisational climate, although it is likely that each organisation will demonstrate particular issues that were more difficult to anticipate at the outset.

Figure 6. From data collection to data analysis



Data relating to these themes and sub-themes was to be collated on Word files and where deemed relevant to the study aims, analysed further using the following methods – Discursive Psychology, Critical Discourse Analysis and Narrative Analysis. All these approaches focus on language and the way language is used to construct key concepts (e.g. the organisation) but there are different nuances to each perspective each of which adds an important dimension to the analysis of this data.

Figure 7. Thematic to CDA with Narrative analysis



2.8.3 Discursive Psychology, Discourse Analysis and Critical Discourse Analysis (CDA)

Hepburn and Potter (2004) argue convincingly and with justification that DA has evolved to have several iterations over recent years. One common feature though has been that 'discourse' (i.e. what is said) and 'context' are difficult to separate and it is the ways in which context is worked into the analysis of discourse that distinguishes the character of DA deployed in a particular piece of analysis.

The thematic analysis was a starting point from which to focus in upon the close readings of the texts, which related to the processes of leadership and patient care, as it represents a flexible and clear way of identifying what is emerging from the data and points a way forward with more detailed analysis (Braun and Clarke, 2006)

We argue that leadership is a social construction and there is a growing body of literature providing evidence to support this view. There has also been a recent focus in organisational research and theory to specify an Organisational Discourse Analysis (ODA) (Pritchard, Jones and Stablein, 2004) which involves four approaches i.e. *Narrative*, *Foucauldian*, *Linguistic* and *Deconstruction* which in turn are influenced by a *reflexive awareness* of the organisational culture in which the research is being conducted.

Pritchard et al, (2004) argue further that the exact methodology and approach to the data depends on the 'researcher position' in the organisation being studied. In other words this approach *benefits* from the subjectivity of the researcher's interpretation of what processes mean and specifically from researcher reflexivity about their 'take' on a situation and set of interactions.

To qualify this method of analysis further, a discursive approach means that language is represented not so much as an objective truth but as a means of *constructing* what might be understood (Parker, 1992; Coyle, 2007).

Particularly relevant in this study, in which participants are asked to tell stories and provide evidence to support what is good and bad about both leadership and patient care (and implicitly the organisation in which these actions take place), is discursive psychology (DP) that highlights how "*descriptions of events are bound up with doing actions, such as providing justification for actions and blaming others*" (Hepburn and Potter, 2004, p. 169).

Thus Critical Discourse Analysis (CDA) sees language as a *social practice* and thus considers carefully the context in which language is used (see

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Wodak, 2004). CDA is related to the notion that *power is negotiated through language*. This is particularly apposite in a study of leadership in organisations. Even more so CDA is 'abductive' so that a constant movement between theory and empirical data is needed which suits ethnographic methods such as shadowing and observations enabling the researcher to test out their ideas as they progress with the data collection, and the attempt to understand how cultures work and how the research participants make sense of and experience their worlds.

2.8.4 Narrative Analysis

Narrative approaches to data analysis have been able to cut through the great complexity of the NHS - the intense emotions, positive and negative, it evokes among most of its stakeholders (e.g. Rooksby, Gerry & Smith, 2007; Bryant, 2006; Iedema et al., 2009; Brown et al., 2008; Elkind, 1998; Brooks, 1997). These studies have, for example, addressed power issues in the doctor-patient relationship, exploring communication in a consultation situation. In these analyses, the patient's 'subordinate' narratives have often been neglected or taken over by the doctor's privileged 'medicalizing' discussion (Mattingly, 1998, p. 12; see also Radley, Mayberry & Pearce, 2008). However, there is also a recognition that many of these narratives are co-constructed by patient and physician (Mattingly, 1998, p. 43; Kirkpatrick, 2008); exploring solely the patient voice in isolation and presuming that doctors will at all times occupy a dominant position in this relationship may be missing half of the story - the doctor's experience. As Mattingly (1998) points out, *"[h]ealers too, may be able to give a different kind of voice to their practice when they describe their work in narrative terms rather than the flattened prose of biomedical discourse"* (p. 14).

As a genre, narrative psychology is thriving (Smith & Sparkes 2006). There has been talk of the 'narrative turn in psychotherapy and psychiatry' (Brown, Nolan, Crawford & Lewis, 1996), and Crossley (2003a & 2003b) for example argues strongly for a 'perspective that retains a sense of both psychological and sociological complexity and integrity' noting that narrative psychology is concerned with 'coming to grips with how a person thinks and feels about what is happening to her' (2000, p. 6). She employs a phenomenological framework to explore narratives of 'the voice' of 'the mentally ill' (Crossley & Crossley 2001) and the experience of temporal elements and self/identity of people living with serious illness (HIV, cancer; see also Söderberg, Lundman & Norberg, 1997). Narrative research in health care has also been used to study the lived experience of patients (see for example Hemsley, Balandin & Togher, 2007; Hök, Wachtler, Falkenberg & Tishelman, 2007) and an emerging genre of 'narrative based medicine' seeks to make use of stories in developing a fuller understanding of illness experiences (Launer, 2003; Taylor, 2003; Greenhalgh, 1999).

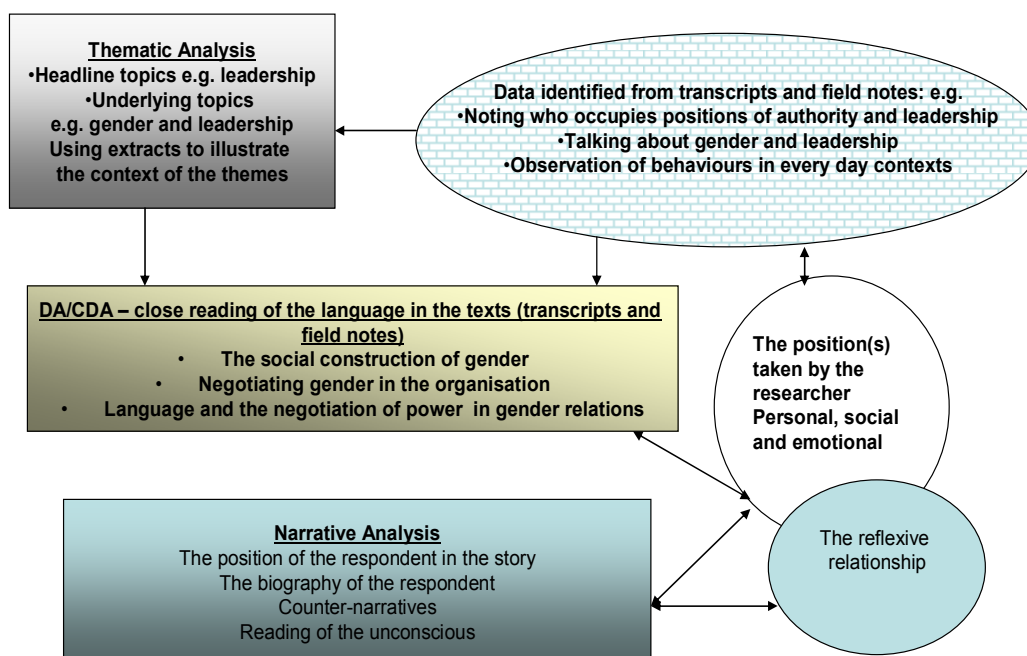
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Narrative based medicine is not merely an insightful way of doing research, but may have powerful policy implications. As Overcash (2003) argues, "*narrative methods are an effective research option that can lead to enhanced patient care*" (p. 179). While interpreting narratives can enhance the possibilities of integrating evidence-based research findings with individual illness experiences, and Winterbottom and colleagues (2008) suggest numerous courses of further research on why and how narratives may influence medical decision making.

Narrative analysis, as with DA, has been approached differently by academics from a range of disciplines so that the ideas surrounding the analysis of *narratives* (or stories told in a sequence) have a variety of emphases. The strength of taking the narrative approach over DA /CDA *per se* is that the 'subject' of the story (the narrator) retains a central role (Crossley, 2007). This can be seen in some detail in subsequent chapters particularly where the accounts of ethnographic observations and shadowing are highlighted where the 'story' becomes that of the researcher herself and with the stories unfolding through the interviews.

Furthermore the narrative analysis places the respondent's story as part of their own *identity construction* which lends an important dimension to the relationship of the story-telling to the teller. Particularly interesting here is Andrews' (Andrews, Sclater-Day et al., 2004) approach which focuses specifically on the elements of stories "*that lie in tension with the ones we are socialised to expect*" (2004, p. 97) or what she calls 'counter-narratives'. Researchers such as Hollway and Jefferson, 2002; Gough, 2003; Sclater, 2004; Allcorn, 2004 and Gabriel, 2004 and 2005, take on board the role of the interlocutor in positioning themselves in their story while considering some of the unconscious and emotional elements both of the story being told and the way that the relationship between the researcher and respondent plays out to construct and limit the story that is told. This dimension is particularly important in the context of this study where emotions are rife at least in part because of the high pressure (exacerbated to some extent by the changing political initiatives directed towards NHS institutions) and the particular nature of the work in caring for ill people (see for example Menzies-Lyth 1960).

Figure 8. Levels of qualitative data analysis e.g. 'gender'



2.8.5 Statistical Analysis

The data from the OCS was coded and in-putted into an SPSS v 14.0 file and significance tests were run (see Chapter Five for the full details).

3 Research Procedure

3.1 Introduction and Overview

The nature of this study, much of which involved the researchers immersing themselves in the 'world' of the participants, meant that it is not possible to provide an authentic *sequential* account of the procedure of data collection except possibly for the administering of the OCS (Organisational Climate Survey).

The bulk of the study, as identified in Chapter Two, comprised multiple methods of collecting different types of data across three Trusts, six Units and five sites.

3.1.1 Negotiating Access

The study took place across a three year period. Negotiation of access was complicated as indicated, although in itself a valuable procedure which occurred at several levels and helped to increase the richness of the team's understanding of leadership, patient care and the context of each organisation.

- Negotiating access began from the 'notional' level while writing the grant application whereby the investigatory team needed to identify whether a project with this design was in fact feasible. We thus made informal inquiries via personal contacts.
- More formal contacts were made once the project was confirmed with the intention to achieve verbal agreement about access for planning the NRES application.
- Following that we met to formalise the details with key informants (i.e. senior clinicians and managers) who had been identified in the previous stage.
- Once we had achieved a favourable NRES review, we pursued local governance applications with the help of the key informants.

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- These stages were managed by approaching one Trust at a time although during the latter part of the study some overlapping negotiations and governance were necessary.
- Part of the formal stage of negotiation concerned consideration of which *Units* could/would form the focus for the study. This was very much two-way but also serendipitous with suggestions from the team of investigators moderated by whichever senior clinical staff the key informants considered would be amenable to 'hosting' the study.
- The key informants then identified opportunities for the team to present the project to staff in the selected Units in 'educational half days' or 'staff meetings' depending upon the local structures.
- These formal presentations only took place in Trusts One and Three however. The procedure in Trust Two (because of the culture, location and structure) was on the basis of a 'tour' (which with permission was digitally recorded) organised by a senior nurse manager so the researchers, one of the co-investigators and the PI could meet various key nursing and medical staff across one of the Trust sites.

Once all that had been achieved it was the researchers on the whole who managed the day-to-day negotiations about who could and would agree to take part in the various elements of the study. This was complicated because of the day-to-day patterns of staff, changes in staff roles, particularly at senior levels, shift patterns and the sheer numbers of staff who may or may not have been aware and willing to allow access to, say, a particular meeting or team for observation or interviews.

Figure 9. Procedures and time-line

	2006/7	2008	2009
Winter	<ul style="list-style-type: none"> •Recruit and prepare researchers •Informal contact with 3 Trusts 1 and 2 •Informal visits to Trusts 1 and 2 •Develop research instruments •Prepare COREC/NRES application •MREC presentation and revisions •MREC approval •Start to review literature on leadership 	<ul style="list-style-type: none"> •Arranging formal contacts with Trust 2 (on 2 sites) •Visit to Site A •Further data collection in Trust 1 •Patient interviews 	<ul style="list-style-type: none"> •Researcher begins maternity leave and new researcher inducted into the team •Data collection in Trust 2 Site 2 •<u>[difficulties gaining access to staff list in Trust 2 for survey]</u> •Presentation to staff in Trust 3 (Unit 1) •Distribution of staff survey (individually handed out) in Trust 3
March - June	<ul style="list-style-type: none"> •Formal meeting with Trust 1 R & D director •Governance application •Formal meetings with senior staff to negotiate units for study •Unit based meetings and introductions •Presentation at educational half day on Unit 1 (obs & gyn) of Trust •Pilot interviews •Pilot staff survey 	<ul style="list-style-type: none"> •Formal meeting in Trust 2. Tour of Site A •Visit to Site 2 •Governance for Trust 2 •Informal meetings •Data collection begins in Trust 2 •<u>Trust 1 staff in Unit 1 return surveys to PI saying they won't give them out</u> 	<ul style="list-style-type: none"> •<u>[further difficulties gaining access to staff list in Trust 2 for survey – now due to key staff transfers]</u> •Preparation and presentation of invited paper to SDO conference in June •Paper preparation and further conference presentations
Summer	<ul style="list-style-type: none"> •Organise, send out and in-put data from staff survey in Trust 1 •Observations and interviews with key staff •Presentation to Unit 2 •Focus groups and interviews on Unit 2 	<ul style="list-style-type: none"> •Application for extension to project (successful) 	<ul style="list-style-type: none"> •Put staff survey on Trust 2's 'intranet' with information about how to complete and return •E-mail staff in Trust 3 who had not received a staff survey •<u>[a low response in both cases]</u>
Autumn	<ul style="list-style-type: none"> •Data collection •Data in-putting from staff survey •Patient survey given to staff on Unit 1 to distribute 	<ul style="list-style-type: none"> •Preparation of journal paper 1 •Further review of literature •Governance for Trust 3 •Identifying key contacts in Trust 3 •Negotiation about Unit 1 (Care of the Elderly) 	<ul style="list-style-type: none"> •Journal paper 1 (anxiety) being revised for publication •Journal paper 2 in preparation (gender) •Journal paper 3 (in preparation) leadership and 'territory') •Presentation prepared and delivered to NHS Surrey and Borders conference •Final draft report

3.1.2 Time frame and Participation of Investigators

We negotiated the formal details of access consecutively in order to make the process manageable. Most data was collected by the researchers (Dr. Fox, Dr. Lokman¹⁵ and Ms. Rowland) although the PI and other investigators made the initial contacts, met with key informants, contributed to the presentations and conducted some of the interviews and focus groups and (Profs. Gabriel and Nicolson, Dr. Heffernan and Mr. Howorth). The PI (Nicolson) and at least one of the researchers was present at all initial meetings with the gate-keepers and key informants.

3.1.3 NRES review

This was prepared and submitted at the end of 2006 and the PI, one of the researchers (Lokman) and another member of the investigation team (Gabriel) attended the appointment with London-Surrey Borders Research Ethics Committee in January 2007.

Annual reports were submitted to the NRES subsequently as required.

3.2 Sample characteristics

The three Trusts, selected as stated above in Chapter Two were each very different from each other, not only in formal terms (size, budget, location and organisational structures) but also informally and culturally and this influenced the 'access pathways'. Thus for example in Trust One our informal and then formal contact was with the R & D director (also a senior clinician) and assistant R & D director, who introduced us to the CEO, the clinical directors and senior nurses.

In Trust Two we had begun with meeting the CEO at the 'notional' phase who then retired in the meantime. This meant starting again with delayed local governance and to accomplish this, we were directed towards a senior clinical manager who then changed their role and location which meant dislocation of our planned procedures.

Trust Three involved a personal contact initially who was directly involved as a clinician in one of the Units who then arranged for us to have a

¹⁵ Dr. Lokman worked on the project for over two years and Dr. Fox took her place.

meeting with another senior clinician who in turn arranged for us to give a presentation to the Care of the Elderly/Geriatric Unit. From there we sought a second Unit for Study independently through contacts made during the course of working in the first Unit.

Trust 1 (One site only) a DGH (District General Hospital)

The Research and Development director here suggested the Units for study to be:

- Unit 1, Obstetrics and Gynaecology
- Unit 2, Cardiology

We were happy with his suggestions, and the staff was generally co-operative and supportive of the researchers.

The Trust itself covers two sites but the choice of these Units meant that all data was collected from one site. This was helpful because it meant the researchers and some of the investigators could spend time familiarising ourselves with the layout of the Units and the Trust site and become familiar 'faces' so that gaining consent from respondents was made easier than it would have been if the researchers and the study itself had to be presented as 'new' on each occasion.

While the study was taking place there were many fears expressed among the staff at all levels that the site we were investigating would become the less powerful with the other site taking over many of the executive functions. While the study team were collecting data on this site however this did not happen and the general 'morale' has improved so that the Trust is currently applying for Foundation Trust statusⁱ.

Self-Description of the hospital

The site we studied had 400 beds and a range of acute care services, including an Accident and Emergency department. It is situated in 52 acres of Green Belt parkland within 40 – 60 minutes of London. Originally it was built to serve casualties of the Second World War. Over the years, the hospital has been rebuilt, developed and extended to include maternity services, a departmental and clinic area, and a new theatre complex. In the early 1990s, the X¹⁶ Wing, which includes a Postgraduate Education Centre and modern well-equipped wards, was opened. A new building for the Accident & Emergency, ITU and Orthopedic Unit opened in the summer of 1998. In addition, comprehensive HIV and genitourinary medicine services are provided in a dedicated building.

¹⁶ We have used 'X' to ensure anonymity.

Obstetrics and Gynaecology

The study territory for this Unit¹⁷ comprised the labour ward, postnatal ward, a general outpatient clinic a dedicated ante-natal clinic and the Maternity Services Administration. The unit offered midwife care for home births, one to one care, water births and there was always a consultant obstetrician available and compared to other local hospitals it gained a score of 3/5 which was joint top score.

Cardiology

This Unit studied comprised one in-patient ward, the Medical Assessment Unit (MAU) and the Critical Care Unit.

In addition we spent time in the Management Suite where five interviews also took place of the CEO, Clinical Director, the Director and Deputy Director of R & D and a middle-ranking manager.

Observations also took place in public and eating spaces and shadowing involved walking around the hospital between different specialty wards and administrative departments.

Trust 2 (2 sites)

The Trust was one of the biggest DGHs in London with 4,200 staff. It had had a history of problems in its financial management and the quality of care but recent information on the web-site and confirmed by the CEO made it clear that:

The Care Quality Commission, the organisation that regulates health care nationally, has awarded the Trust a rating of excellent for the quality of services we provide to our local population. This is the highest possible performance rating in the 2008/09 Care Quality Commission annual national assessment report.

It seems that problems with the financial management remain although improvement had been noted.

The structure and organisation of Trust 2 differed significantly from Trusts 1 and 3. Trust 2 comprised two sites (recently combined into one Trust where one was a teaching hospital) which were at least eight miles apart and it

¹⁷ There were other parts of the Maternity Services at Trust 1 that were not observed directly.

was difficult to travel between one and the other on public transport other than using more than one bus or travelling in and out again from London. The journey by car varied from about thirty minutes upwards depending upon traffic.

Physically the two sites were very different. Site A was a relatively new building designed (as one researcher stated) to look like a motel or contemporary hotel. The other, B, was a traditional middle height rise built in the 1970s on a green site and appeared far more formal with long corridors and many signs to departments. Site A was more 'angular' and you could not walk very far without having to turn a corner which presented a very different 'feel'.

It was not possible, particularly in Site A to select a discrete specialist Unit (unlike Trust 1). Site A focused on acute medicine and care of the elderly and there were no formal divisions in where patients were treated as either in-patients or out-patients. So an older person with 'geriatric' health related problems could be in a bed next to a much younger person. We have identified a Unit as a Site in the case of this Trust. We found it equally difficult to 'pin down' a specialty in Site B as well.

At Site B we collected data from acute medical specialties, obstetrics and gynaecology and therapies (the latter being both physical and psychological).

This was in part because senior management at Site A (who were our key informants and 'gatekeepers') introduced us to staff they considered amenable. Thus for purposes of the study we had to identify Site B as our second Unit. Despite the introductions we managed, via snowballing, to find a range of participants who demonstrated many different view points.

To summarise then in Trust 2 the study was carried out in the following two Units which we have identified as follows:

- Site A / Unit 1 (Acute Medicine; Care of the Elderly)
- Site B / Unit 2 (Acute Medicine; Obstetrics and Gynaecology; Therapies)

We also interviewed a Clinical and Nursing Director both of whom worked across both sites and senior managers including the CEO and deputy CEO.

It became clear very early on that there was intense rivalry, even animosity between the two sites and some of this is explored in later chapters.

Trust 3 (2 sites)

Trust Three, in central London, is a long established hospital and a Foundation Trust with connections to a prestigious medical school. Travel

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between the sites took about twenty to thirty minutes by public transport. 9,000 staff are employed by the Trust with 1,100 beds available across the Trust at any one time.

- Unit 1 (Care of the Elderly, Acute Medicine)
- Unit 2 (Therapies)

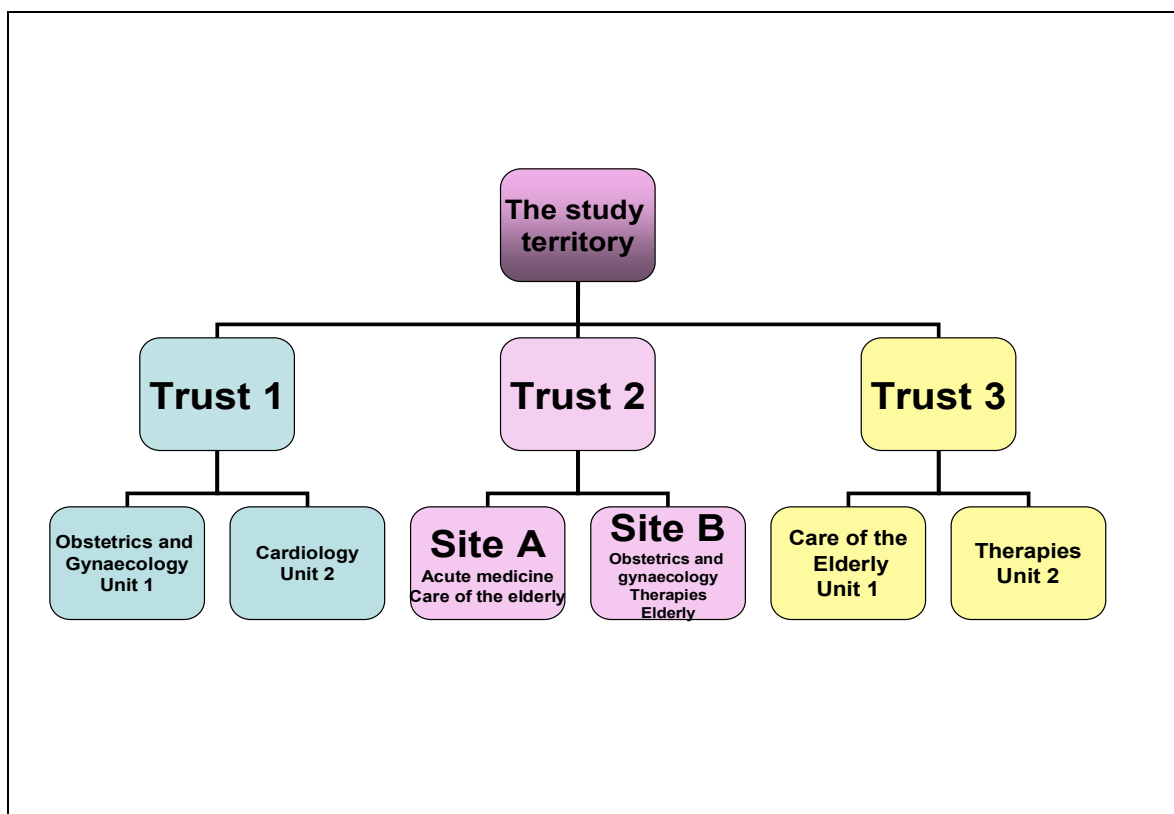
Unit 1 is described on the web-site thus:

Geriatric medicine specializes in the diagnosis and management of common symptoms and diseases in older people, particularly:

- *problems with mobility*
- *falls*
- *continence*
- *difficulties with looking after oneself*

Unit 2 (therapies) which included physiotherapy and psychological therapies spanned both the sites and covered many clinical departments and extended to primary care services especially local GP practices as well.

Figure 10. Participating Trusts and Units



3.2.1 Response rates (qualitative approaches)

It is difficult to identify an accurate response rate for the qualitative components (the majority) of the study because the sampling was conducted in an opportunist manner in many cases – i.e. whether someone agreed to take part in an interview or focus group if the researchers were on site and made a serendipitous approach.

As stated in Chapter Two, much of the qualitative data was collected by virtue of the researchers 'being there' in the right place at the right time and therefore gaining the trust of potential participants. In many cases the researchers were introduced to a member of staff who suggested ways in which other respondents might be accessed. Methods included personal introductions, using e-mail lists or sometimes a staff member knowing what was happening asked the researchers if they might participate in the study.

Overall the majority of staff approached to participate agreed to do so, although circumstances sometimes prevented it (e.g. one focus group was cancelled in Cardiology due to a patient emergency and one observation was cut short because the consultant refused to have the researcher in the ward round, although they had been observing on the ward before the consultant arrived having been given permission by the nursing staff).

Although the key staff across all three Trusts agreed to support the researchers in gaining access to patients for the OCS and interviews, the patient form of OCS was anonymously returned to the PI by someone at Trust 1 saying they did not want patients to participate in that exercise¹⁸.

It proved impossible to administer the patient OCS in the other two Trusts also, because the staff said in advance they were too busy to help and the researchers had difficulty in making contact with individual patients who were always either in busy wards or with a member of staff. Thus interviews and observations were conducted, with patients' consent, during shadowing.

The OCS for the staff is discussed fully in its own right in Chapter Five.

3.2.2 Individual participants

Respondents were either NHS staff or patients so by definition there were elements of uncertainty about whether they would be available at appointed

¹⁸ We sought advice but in line with the NRES review participants could withdraw their consent at any time so we did not feel free to pursue this further.

times and whether (as acknowledged in the NRES consent form) they choose to drop out at any time, even after having agreed to take part.

As shown below in Table 1, forty six respondents took part in in-depth story-telling interviews, thirty nine took part in focus groups. During twenty six days of shadowing of key staff, numerous other staff and patients were involved in data collection and similarly, during the eleven and a half days of observations on wards and in administration areas across the Trusts.

In addition, ten patients consented to be interviewed in depth and, again more staff were involved in the eight meetings that were observed and an introductory walking tour with a staff member in one Trust involved additional staff and patients in the study.

Each of these data collecting encounters represents a different unit of study and a different 'order' of data.

The nature of the study required a commitment of between 30 minutes (for completion of a survey or a short interview) up to two days, in the case of 'shadowing', of respondents time. Most respondents' contributions to the study, however, took about 90 minutes although this also represented an important commitment of their time (and energy).

Table 1. Qualitative Data Collection

Table 1. Qualitative Data by modes of collection							
	Interviews		Focus groups	Shadowing (staff and patients)	Ethnographic observation	Patient interviews	Other meetings and visits
Trust	N = men	N= women	N = Group (n = participants)	N = days	N = days		
1	13	19	5 (15)	5	9	10	4
2	5	9	3 (24)	8	3 x .5 + 1	0	2
3	4	8	0 (0)	13	0	0	2
Totals	22	26	8 (39)	26 days	11.5 days	10	8

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3.2.3 OCS (Organisational Climate Survey)

Trust 1

The staff survey

An administrator in Trust 1 provided a staff list (name and location) from which a random sample (35%) was identified using the SPSS software version 14 providing a list of 939 potential participants from staff across the Trust (including and beyond the Units participating in the main data gathering). The questionnaires were all individually addressed and sent through internal mail.

Of these 223 (24%) individuals returned a completed questionnaire, although ten blank surveys were returned with a note that the intended recipient had left the trust and one said they were unable to read English (1). Thus the final number of participants for Trust 1 was 210.

The patient survey

In Trust 1 we gained agreement from the senior staff on the two study Units (Obstetrics and Gynaecology and Cardiology) that they would arrange wherever possible for patients to complete the patient version of the OCS and would arrange for the researchers to collect the completed forms.

However the full batch of uncompleted patient questionnaires was sent back to the PI at the College several weeks later with an anonymous note stating that the staff did not wish to administer these to the patients. We were unsure how to proceed after this because ethically, although the survey was directed to the patients, the staff had completed consent forms and had copies of participant information sheets, and were aware that they (staff) could withdraw from the study at any time. We considered that this constitute an ethical dilemma for the team.

The researchers made other attempts to hand out the questionnaires directly to patients but found that while some patients were prepared to consent to being interviewed and almost all consented to having a researcher present during patient/doctor/nurse meeting it was not looking possible to obtain a valid sample of questionnaire returns.

Trust 2

Trust two was organised across two distinct sites and although the senior staff work across both sites, as will be made clear from Chapters Three and Four below, each site is very different in its organisation. We initially

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approached the senior staff on Site A first about how to distribute the questionnaires and they referred us to Human Resources on Site B who were the only people with access to a staff list. We did not get any acknowledgement from HR despite several attempts including one visit to the head of HR from one of the researchers. He said he would get back in touch once he had checked whether he could release this list but he did not and we considered there was little more we could do to pursue this particular approach.

The PI then contacted the senior nurse manager, who had been one of our original gatekeepers, for help but found that she had left for another post.

Following the abortive attempts to contact HR (or anyone else who might have been able to help) a PA in one of the many departments we contacted suggested that there was a staff intranet which went out once a week with an 'update' section with news for staff across the Trust. The PI made contact with the editor of this site who agreed to include an electronic version of the OCS.

Consequently, the questionnaire was included on this web-site, with a preamble (adapted from the NRES participant information sheet) on two occasions. However it only produced one reply. We made one final attempt via the PA of the CEO to contact HR for a staff list to no avail.

What was interesting and perplexing though was, that there was no difficulty obtaining a commitment from staff across the Trust to participate in an interview or focus group which was much more time consuming and personally revealing.

By the time we were ready to collect the patient survey data at Trust 2 we already recognised the problems with the responses from the staff. Also, by contrast, we had established the effectiveness of eliciting patient data from the shadowing and observations. We therefore made a decision to focus on this approach to data collection from patients rather than pursue more blind alleys.

Trust 3

In Trust 3 the early signs were that there was no overarching administrative structure from which we could obtain a staff list and nobody we asked could advise on the best way to gain that information. However we did have some 'local' e-mail addresses of the staff in the Units and therefore we e-mailed the OCS to staff on the two study Units and obtained 13 replies all together.

3.2.4 Participant characteristics

There were 224 respondents who completed and returned the questionnaire, of which 77% were women (n = 172) and there were 23% men (n = 49). These included from Trust 1 (n = 210, 93% of respondents), Trust 2 (n=1, 0.4%) and Trust 3 (n= 13, 5.8% of respondents).

The mean age was 46 years, standard deviation 11.1. The majority of respondents were married (62.7%), with a further 7% cohabiting. Twenty percent of respondents were single and almost 10% divorced. The majority of respondents were White (72%), the next biggest group were Asian (18%) and other ethnic minorities such as Black (6.5%) and Oriental (3%) consisted of much smaller groups.

Pay level: most of the respondents had a salary of less than £20k (44.3%) or between £20k- £40k (38.8%). A much smaller percentage (5%) earned between £60k and £90k and a further 2.3% of respondents had a salary exceeding £90k.

3.2.5 Professional demographics

The majority of respondents had been working in the NHS for over 5 years (68%), with a further 26% for between 1-5 years. Only 5.8% reported less than one year's service.

3.2.6 Stability within individual Trusts and Units:

Most respondents had been employed by the same hospital for over 5 years (56%) and another 34% had worked there between 1-5 years. The rest (10%) had been employed by the hospital for less than a year.

Most respondents reported working for the same Unit for over 5 years (45%), a further 43% reported working there for 1-5 years and only 12% reported service of less than 1 year. A similar pattern was seen in terms of length of time in same job. However the majority in this case had been working at the same job for between 1-5 years (45%) and slightly less (41%) had been working in the job for over 5 years. Another 12% had been employed in the same job for less than one year.

3.2.7 Role:

The majority of respondents were nurses, 31%. 13.5% of respondents were managers; 11% consultants/doctors/physicians. Other allied professionals, such as scientists and psychologists made up 10% and support staff made up a further 6%. Clerical staff and 'other' staff (such as porters, maintenance) made up a further 13% each.

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3.3 Data Analysis

This was conducted in the manner described in Chapter Two and the results are discussed separately in the following chapters each of which when relevant provides more context to the conceptual framework and analysis in the substantive area of focus.

3.4 Conclusion

The diverse nature of each of the organisations studied provided valuable information about the different kinds of challenges that different leaders at all levels might face in different institutions across the NHS.

Staff at senior level (particularly non-clinical managers) moved around within and between Trusts. During the course of conducting our study some key gate-keepers and participants left the Trust, others joined and yet others moved position and role even during the relatively short time we collected data there.

In some cases mergers had just taken place or were expected. This was experienced by some as opportunities and others as threats, but in all cases it meant structural reorganisation, staff being re-assigned or choosing to leave for another post.

This has to be taken to be part of the changing face of the NHS overall and central to the culture and climate of the participating Trusts, and can no doubt be generalised to every NHS Trust across the country. In what follows, we have used our different strategies for data capture to examine the relationships between leadership and service delivery in this fluid and (potentially) exciting context.

4 Leadership in the NHS

4.1 Introduction

In any organisation:

Leadership is needed to pull the whole organisation together in a common purpose, to articulate a shared vision, set direction, inspire and command

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commitment, loyalty, and ownership of change efforts (Huffington, 2007, p. 31).

and

Leadership would be easy to achieve and manage if it weren't for the uncomfortable reality that without followership there could be no leadership except, perhaps for the delusional sort. (Obholzer, 2007, p. 33).

In this chapter we examine the ways in which leadership is defined, exercised, experienced and transmitted taking account of how far leadership is perceived as pulling the organisation together to pursue the common purposes of patient care and the relationship between leaders and followers.

We specifically:

- Explore how leadership is defined by different stakeholders and what they see as determining its quality;
- Seek to begin to understand how leadership is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients through examining the data from focus groups and story-telling interviews;
- Using the same data sets, explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted.

4.2 How is leadership defined by different stakeholders and what do they see as determining its quality?

We start this particular exploration with a *thematic analysis* of the qualitative data to identify what themes emerge from the definitions, while also making interpretations using *CDA* and *narrative analysis*. In so doing we pay attention to what Gough has termed 'emotional ruptures' (Gough, 2004) in the text which serve to illuminate some of the subordinated or unconscious information in the stories of the respondents and the subjectivity of the narrator (Frosh, 2003; Frosh, Phoenix, & Pattman, 2003; Hollway & Jefferson, 2000).

In Chapter One we proposed that 'leadership' as a concept has been subjected to continuous scrutiny and moved through different theoretical and paradigmatic iterations. The NHS has identified the qualities it requires in a leader and the role that NHS leaders (at all levels) are expected to strive towards (see Figure 1). We therefore inferred that respondents, imbued in the culture, would focus on 'transformational' or 'distributed'

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explanations and definitions about leaders and leadership because these models are embraced by the style of the coaching and training on offer.

4.3 Definitions

Respondents distinguished between 'leader' and 'leadership'. A 'leader' was described and defined in diverse ways including as:

Obviously strong minded and opinionated (Administrator, T, 2¹⁹).

Particular personality traits - need to be - to have integrity, ((1²⁰)) to ((1)) be clear, err to be facilitative, to have energy to listen, erm, to negotiate, ((2)) to make decisions (Senior Non-clinical Manager, T, 2).

... making sure that you're the person who is erm keeping the team focused getting them to achieve those goals looking at different ways of working (Senior Clinician, Trust 3).

These definitions suggest diverse ways of thinking about the idea of 'leader', indicating that commonality of stakeholder views should not be taken for granted. The qualities a leader has to have are determined in these definitions through having opinions, being strong-minded while also having integrity. A leader also needs to be able to facilitate actions, negotiate and keep the team focused towards the achievement of its goals supporting team-work.

4.3.1 Defining leadership

Leadership in this first definition below was about a formal role and implicitly hierarchical rather than distributed:

I don't think there is anything magical about good leadership. It is about establishing what the organisation wants to do and allowing people to get on and do it (Recently retired CEO with clinical background, T2).

This respondent, who had occupied a senior position, saw the structure and strategic direction of the organisation as fundamental to what works as leadership which was not 'magic'.

¹⁹ In some cases we are able to identify the Trust but where there is any chance of a breach of confidentiality we adjust the 'credit' to ensure anonymity.

²⁰ Where the transcription has included double brackets it denotes pauses timed in seconds.

The following respondent expresses it differently suggesting that it means different things to different people on the one hand, while also being an imponderable (possibly even magical):

Leadership is like love, we all know it exists, but you can't actually prove it, you can't define it, and it comprises of lots of different things that people do, if you demand evidence for everything...you will get rid of leadership eventually (Senior Clinician, T2).

This clinician seems to take distributed leadership for granted in that it is about 'lots of different things that people do'. A warning is expressed it appears, though, that trying to *show* leadership exists across the organisation (perhaps rather than residing in designated roles) might ultimately destroy the possibility of leadership. Following Gronn (Gronn, 2002) this might be a way of suggesting that through concerted action leading to conjoint agency, leadership might not be so obvious (as in the first definition immediately above) but it might be more effective in a hospital where there are different qualities needed to lead in different activities.

Resonating with the view above that a leader has to have integrity, is the view from one leader's experience:

I learnt that it's very important thing for leadership... to not lie, not hide anything and just tell them the reality and be true to yourself, and that's really important (CEO, Non-clinical).

There is an immutable relationship between the leader and the follower. Being true to oneself and honest towards followers must be fundamental to the emotional engagement or attachment between leaders and followers. The significance of emotional engagement as well as emotional and social intelligence was high on many respondents' agendas for determining leadership quality:

... leadership is about having, or being able to demonstrate at any level a coherent vision for where you're trying to go and getting people getting there (Nursing Manager, T 2).

[Leadership in the NHS] is a people focused, leadership job (Senior Non-clinical Manager, T3).

.. it's not always leading from the front (Senior Clinical [therapies] Manager, T 3).

While the leader needs to have vision, these definitions imply that vision alone does not determine how leadership can be exercised or experienced. Leadership will not work unless the leader engages the followers with that vision.

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If leadership fulfils an organisational role ('establishing what the organisation wants') then can it also be 'people focused'? If good leadership is about transparency and honesty is there an assumption that it has not always been so or may not be so at some future time? What does this imply? Does leadership have an 'indefinable' quality' or set of characteristics that work within a specific context but may not be transferable as 'skills'?

Leadership presents dilemmas for the maintenance of personal integrity ('tell them the reality and be true to yourself'), it is a 'job', it requires 'vision' and flexibility and most importantly it seems it is about focusing on people.

4.4 How is leadership in NHS health care organisations exercised and experienced by those affected by it?

Respondents talked about the *role* of the leader as central to the practice of leadership in the organisation. Leadership was understood to be intrinsically linked to particular tasks/goals while necessarily engaging with the followers who had to implement much of these tasks and achieve the goals. There was a sense that many respondents held an idealised view about leadership in their own Trust. Sometimes though the reality for them fell short of expectations because the person occupying that role failed to live up to their hopes.

For example, as the following extended extract illustrates:

.. one of the things about the leadership and management of this Trust is first of all clinical leadership is strong in most places. The clinical directors here have general clout and they are not just figureheads .. and the other bit I think - relationships between general managers and clinicians on the whole are much more positive here than other Trusts (Senior Clinician).

This proposes that strong leadership among clinicians (distributed both horizontally and vertically via the clinical grouping) enables managers to deliver the service to patients. However, this does not in itself identify the characteristics of the links between strong leadership and service delivery.

For many respondents leadership is exercised at least in part through each leader's personal characteristics (good and bad). Almost without exception when asked about the qualities that make a leader, and to 'story' their own explanations, respondents placed a degree of emphasis on the characteristics of an 'ideal type'. The following exemplifies this:

Most important quality is the communication. Being able to listen - hear what is being said and to deliver that--what they want to say, so that it is heard by all. That it be quite quick thinking, being able to develop an idea

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and roll it out, umm being able to think on their feet as well, because sometimes you get things that turn up and you have to deal with it there and then, umm, reasonably personable so people will confide in that person, um also strong so that when things are tough they can um deal with them (Clinical Midwifery Manager, T1).

The comprehensive but daunting picture of how leadership is exercised described above, represents an ideal of distributed leadership as *concerted action* (Gronn, 2002). This type of leadership is exercised through being able to communicate – to listen and to express clearly (so as to be ‘heard’) how action will be taken. ‘Rolling out’ the idea again suggests taking peers and followers along with you and being ‘personable’, so people will confide in that person, further indicates the ability to take the views of others into account calling for both emotional and social intelligence (Amendolair, 2003; George, 2000; Goleman, 2006; Lopes, Grewal, Kadis, Gall, & Salovey, 2006; Riggio & Reichard, 2008). In this model, the multifaceted communications rely on the ability to use the information to think quickly and be strong under ‘tough’ circumstances.

However, in the next extract (from a non-clinical manager) the ideal type of leadership is represented by responding to short and medium term organisational goals (Buchanan, Fitzgerald et al., 2005; Riccucci, Meyers, Lurie, & Han, 2004).

Erm, I think leadership is about erm, encouragement. It is about showing people direction in which you as an organisation and them as individuals engage in. I think it's incredibly important especially in an organisation like the NHS where there are lots of different groups of people and lots of different objectives - sort of daily ones, monthly ones more long term, and you have quite a clear sort of vision of where you're going and I think that the good leaders in the NHS show that, and examples of bad leadership are where that is not so defined. (Middle Manager, T2).

This suggests a *transactional* model of leadership, whereby the good or effective leader offers ‘encouragement’ to the followers in return for people accepting the practices of the wider organisation (Bass, Avolio, Jung, & Berson, 2003; Eagly and Johannesen-Schmidt, 2003)

4.4.1 Exercising leadership through their organisational ‘role’

Leadership is experienced by some as being exercised through the legitimated role. Organisational role in the leadership discourse equates with the leader’s professional position as the respondent below shows clearly:

Who would be a leader to me? I think there's a number of different areas, there's your direct line manager, who's the clinical leader of your department. Who's who in this structure there's line managers above them, and above them and so on. There would be people you would look to within your own specialty clinically who are more experienced than you ((2))²¹ in certain areas, to ask for advice, erm ((1)) and similarly in an academic environment ((1)) there are other people there who have more experience that you would want to take advantage from or advice from. ((2)) And in the wider circle, national or international leaders in the field who are so expert at those things that you also turn to. (Medical Consultant, T3).

While the formal roles and organisational hierarchical structures are taken seriously by this respondent, there is also a clear vision of leadership being exercised through concerted action in collaborations that arise *spontaneously* where clinical and/or experience is valued and sought within this respondent's speciality and sometimes *intuitive* leadership (Day, Gronn, & Salas, 2006; Pearce, 2004). However, there is also a sense that this respondent experiences leadership through the institutionalisation not only of formal roles locally, in the organisation itself, but through the structural relationships with those who are seen as experts in a much wider networked context (Pearce, 2004). This version of leadership is particularly important in that it demonstrates that leadership can be both experienced and exercised beyond the boundary of the organisation and the NHS, based on knowledge and expertise originating outside these systems.

Respondents frequently combined personal qualities with their understanding of the leadership role, particularly related to taking responsibility as part of that role:

It's quite difficult, I mean I think taking responsibility (4) making sure that things happen that are supposed to happen, or don't happen that aren't supposed to happen (3) um.., (6) that's it. (Clinical Medical Consultant, T1).

Not everyone saw leadership in this way. This respondent is talking about their own experience of being in a role in which then 'buck' frequently stops and thus by definition they are in the role of leader.

The exercise of leadership through being a 'role model' (Trevino, Hartman, & Brown, 2000) where qualities of leadership were displayed was important for some:

The leaders that I've worked for and have wanted to follow ... push something in me that says 'I want to be like them' or I completely support

their vision of where they're going or you know so I want to follow that person and I want to do the best that I can do for them because I believe in them and their vision. (Head of Non-Medical Clinical Team, T3)

This explanation has a flavour of heroic or charismatic leadership, although not as a quality that resides in a specific person necessarily, but one that resides in a relationship that 'fires' up both leaders and followers (Klein & House, 1995). Even though the idea of the charismatic leader has been at least partly consigned to the history of the late 20th century organisation, it has not disappeared and needs further thought particularly in an organisation such as the NHS where changes are sometimes rapid and stressful (James, 1999) and internal culture needs to be taken into account (Dopson & Waddington, 1996; Tourish & Vatcha, 2005).

4.4.2 The relationship of the 'leader' to 'followers': how leadership is experienced

While leadership is the focus of the professional and political debates about the NHS and other organisations, until recently, relatively little attention has been paid to followers' experiences of leadership (Avolio et al., 2004; Howell & Hall-Merenda, 1999; Lewis, 2000; Schilling, 2009). From the perspective of a manager taking the position here as 'follower' looking 'upwards' in the organisation:

I think it's, it's providing, you know direction and to lead and that's a leader's main job in my mind. And (2) that's .. what they say for leadership, you must have followers. If nobody's following you, what you are saying then? you are not a good leader. So that's a good, you know, test for a leader to evaluate themselves. That's what they are saying and what they are trying to achieve. Are people behind them or not? If they are not behind the leader there's something wrong with that. (Middle Non-clinical Manager)

From the perspective of a junior doctor taking the 'followership' position:

I think in order for you ... well in my opinion a leader, I have to be able to kind of respect them. If I don't respect or kind of have faith in what they do, then it's, it's a personal authority, so in order, you know in order for me to do that I have to believe in what they say. I mean, I might not always agree with them in my opinion but at the end of the day I have to be able to respect them enough and for them to have certain authority, someone who's probably experienced and gained that knowledge, so yeah. (Junior doctor)

For leadership in the NHS to be exercised effectively then there has to be an engagement between the leader and the followers (Macy & Schneider, 2008) and to understand fully how the engagement takes place, a degree of

emotional engagement and/or attachment to the leader and the organisational vision is fundamental (Riggio & Reichard, 2008; Rubin, Munz, & Bommer, 2005; Vince & Broussine, 1996).

The failure to take followers with you is made explicit here from the perspective of one (designated) leader:

A: I was forced upon them...

Q: that's what I was going to ask. So presumably there was a lot of resentment I guess?

A: Yes.

Q: And how does it manifest itself?

A: Erm, non-cooperation, making life difficult for you sometimes, people talking about erm ((2)) sort of criticising you behind your back and erm playing silly games behind your back that makes management of other people more and more difficult. Erm you know, and yet we sort of have to fight another battle to win hearts and minds, when we, you know, don't really have the time to do that, we have got to have our focus on doing what we are meant to do, which is to manage patients and to manage our beds properly.

This extract from the interview with someone whose role it is to lead change is revealing. The respondent recognises that he is not taking people with him and in his view, the followers appear to eschew co-operation. He also believes they are mocking him and that that mockery is contagious. He may or may not be able to evidence this, but that it is in his mind is potentially detrimental to his experience of leading in his organisation (Stein, 2005). Furthermore, instead of looking at himself, this respondent wants to push the blame for the leadership failures onto the followers (in other words he engages in splitting described in Chapter One) (Klein, 1975; Segal, 1973). Such a process is diametrically opposite to leadership studies that identify authenticity and trust between leaders and followers as being one of the basic qualities for leadership (Avolio et al., 2004; de Raeye, 2002; Novicevic, Harvey, Ronald, & Brown-Radford, 2006).

There is also some evidence of concerted action here, distributed among those who were leaders of the *resistance*, which is not necessarily against the values of the organisation in any negative way, but may be seen as upholding important principles and challenging change (or a particular form of leadership) that might be perceived as counteracting these important values (Collinson, 2005; Zoller & Fairhurst, 2007).

Trust is one important quality in the way leadership is exercised and experienced by followers and developing trust is essential if changes in

practice are to be implemented (Bass & Steidlmeier, 1999; Hunter, 2005). So, for example, 'engaging' with others involves trust:

Yeah definitely there are some good examples of where it's obvious that people have been able to engage lots of different kinds of people in different groups and I think they've done that just by sort of making relationships with them in the first place and then when it comes to having to lead them and be influential then you can see that those relationships are already there and then they can call on that you know, that sort of that trust or that sort of relationship that they've got (Middle Non-clinical Manager, T2).

The same respondent continued with a specific example that aptly demonstrates the links between all the three sub-themes.

Yep, I think Florence who is our head of [a non-clinical department] .. I think she is a very good example of what I'm talking about in terms of her job. And her role relies a lot on other people. Erm so as a personality she is a very responsible person, she gets on with everybody and you can really see how that works for her because when she needs somebody to do something or she needs people to listen they are going to because they have got a good relationship with her and she has taken time to build relationships when it is perhaps not necessary.

To summarise so far - *good* leadership in the NHS is understood by staff at various levels as:

- Taking responsibility
- Being 'given' authority by the followers
- Getting on with the people in the organisation
- Taking time to build relationships
- Being trusted by followers
- Winning hearts and minds
- Having a vision for the organisation
- Taking colleagues with you

4.4.3 Patients' perspectives on how leadership is exercised

While there were several things held in common (particularly 'trust' and 'taking responsibility') with the staff, patients unsurprisingly, considered leadership from a different position, based upon how they themselves had experienced a specific episode of care. One woman, who had had a previous bad experience in the same Trust in which she was now a patient, said:

Well somebody taking responsibility really for erm you know your care, erm especially. I keep going back to the same example but you know someone being responsible for not reading through my notes and if someone had taken that leadership erm and actually said 'right I'm going to look through

these notes', you know they would have obviously seen what they had to see and so basically yeah I think there is a lack of leadership.

The emphasis was on wanting the leader to take responsibility for patient care in contrast to poor practice whereby notes were not read. It was taking responsibility, and reassuring the patient that they were taking responsibility, that could be experienced by patients as good leadership.

Another patient similarly suggested that in their exercising of leadership, the clinical staff need to make sure that they were seen to be acting in the patients' best interest. For example:

When they're explaining their-selves, they do explain their-selves and what they're thinking. And they do tell me like the 'ifs' and 'buts' blah blah blah about this certain thing, but then one says something and [another] one says something else but they do explain themselves and what they're on about.

Also, another patient indicated that there needed to be one person who held overall responsibility for service delivery:

I don't know how it works hierarchy wise, whether there's like a top doctor or whatever, whoever it is somebody really needs to, you know, take a really ((2)) be sort of, you know, held responsible.

It is perhaps worth noting that the patients overall focused on the role of clinical leadership but saw that as being practiced by an individual rather than in a distributed form. There was a general view that individuals needed to be accountable and accountability equated with leadership.

4.5 What are the characteristics of an organisation that facilitate, or hinder, the process of leadership?

Leadership happens in a context and that context can facilitate or hinder leadership processes (Currie et al., 2009) and the influences of the organisation are particularly acute when the environment is changing rapidly (Goodwin, 2000; Michie & West, 2004) as in the NHS.

One respondent felt they no longer knew 'who was who' in the leadership hierarchy but considered it didn't really matter:

..., here is this model that says here is the Board and here is the chief exec and here is whoever else is up there. And there's this, this and this ... and [a colleague suggested] shouldn't we be transparent all the way through and shouldn't everything link? and I thought, this came up somebody legitimately asked the question that people here need to know what is happening here. Why? Why? I don't care. (Clinical Physiotherapist, T3).

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One senior Occupational Therapist, in the same Trust, on the other hand felt that knowledge of the organisation was important to facilitate leadership at every level so that when:

... people feel they are working as part of an organisation that's working for something, as part of a team and are appreciated and valued as part of that and are working for someone as well who feels what they are doing is worthwhile, I think that patient care will be of better quality.

This respondent was also convinced that supervision was part of the process by which an organisation facilitated both leadership and good practice in patient care. *"I have once a month supervision, like set time for supervision so I think that is really good."*

Furthermore, supervision and informal contact with peers facilitated effective distributed leadership which impacted across the organisation: *".. you can go to people informally, your peers erm whenever it's quite flexible like that and even if you're a senior like me you think 'hang on I don't know if I'm on the right track here so am I missing something?' You can just go and speak to you team about it or one of our colleagues downstairs or whatever if you want to.*

More dramatically a senior clinical leader suggested that leadership is facilitated in 'moral' organisations:

A²²: So one thinks they are better than the other, so the seven deadly sins basically...pride, the other one is gluttony, which means excess...one can never have enough, for the sake of it, and then just goes beyond, you know, one million, two million, you know, which kind of greed isn't it...excess basically, and also rushing is in there, doing things too fast. A good system will reduce its workload, yeah? The NHS has a thing of needing to do more and more, erm anyway, I don't know whether you find this useful or not, so greed, gluttony, there's rushing, and then jealousy, which is really envy, which is really competition.

Q: Yeah

A: You need to get rid of competition, and I will tell you in a moment what could replace it, which is basically team work, team work and kindness; how you get on with each other...anger is on the list. Anger is, is blame, and the opposite is blame free culture.

Q: Yeah

²² Q = question, A = answer.

A: Or forgiveness if you want, so you need to forgive mistakes, and you know you will be forgiven...and, erm...erm...next one is laziness, that's obvious, that's hard...people either have it or not, but laziness is joylessness, you need to make sure people enjoy it, and diligence, yeah? So there needs to be something in place of ...and we have that now with trust away days and things like that, but you have to have somebody dedicated to making people understand it's about having fun

Q: Yeah, yeah

A: working is about having fun...yeah? And then its... which comes really from up here, it's just an, an, yeah, can't have enough...which is also, it's also, the opposite is erm...do not take more than you can, do not take more than you need...and that is quite a moral stand ground, more than you need...for everyone

Q: Yeah

A: and if you employ that rule, then the whole organisation becomes so successful that there's masses of money left over ... Everything works well...the problem is everyone doesn't understand that, and believe in that, and then there's a difficulty...so that's moral high ground, very moral high ground, but if you go along those, you actually have all the features of leadership.

For this respondent the organisation needs to focus on patient care, treating patients *and* staff with 'kindness'. This is counter in his view to the process of setting targets for service delivery and organisational growth (or survival) and thus competition between organisations and competition between individual staff or staff teams, which is a force that (it seems) promotes the wrong kind of leadership (Kuokkanen & Katajisto, 2003; Sambrook, 2007). Furthermore, supportive teamwork and 'forgiving' mistakes and preventing the 'blame game' enhances socially and emotionally intelligent leadership distributed responsibility across the organisation and enhancing the culture and climate (Riggio & Reichard, 2008) .

Another senior medical leader and manager (T3) reinforced this idea:

I think the ethos within the hospital, is one that encourages people to develop and grow, and deliver good quality care, you know, so, I mean I think wherever it comes from it is enabled within this organisation, and it works very effectively. One of the features that enables that to happen...it's firstly being an organisation that attracts good people to want to work here in the first place. So you get high quality people applying for the position, be it in medicine, or managing, or nursing or any of the other professions By and large, we're fortunate in that. And that's partly due to the reputation, and partly due to the [location] but I think the ethos that comes

from the leadership makes it desirable to be here. Erm...so it attracts the right people in, it then enables, it doesn't put the brakes on, it doesn't try to control people too much.

Thus, organisational performance and culture/climate were 'enabled' through a cycle of encouragement, good practice, reputation and a supportive and 'hands-off' approach to leadership. This suggests concerted action, leader/follower engagement and emotionally supportive behaviours at all levels. That the physical location of the hospital is attractive is perhaps but one factor in this equation, although a central location makes it possible to draw on a wide range of staff as opposed to a location which is in a small town or distant suburb.

It is not just features of the organisation itself that impact on leadership. Organisations reflect changing discursive constructions of leadership and the values that underlie what it means to be effective as a leader in that place at that time (Ferlie & Shortell, 2001; Lansisalmi, 2006; Michie & West, 2004; Scott, Mannion, Davies, & Marshall, 2003). As demonstrated in Chapter One theories of leadership have developed and different approaches have become significant at different times as witnessed by the shift from promoting and studying transactional, charismatic and heroic leadership styles to the contemporary emphasis on forms of distributed, networked and transformational leadership (Bryman, 2004; Butterfield et al., 2005).

One dramatic change over the past twenty and more years has been the image of the medical consultant in the public psyche. Thus the 'heroic' leadership of Sir Lancelot Spratt has been firmly (it seems) replaced by the team work in the TV series *Casualty* or *Holby City*. However the image of the rebel Dr. House (played by Hugh Laurie in an American TV series) is described as 'unorthodox' and 'radical' but most definitely a medical hero. Is this the type of leader that some might still long for? While the following comment was atypical of most people's definitions of what makes or fails to make a good leader it raises some interesting points about the contemporary regulatory discourses on leadership. Thus one participant said of another²³:

Now (Dr.) David is a really eccentric so he is not what you would naturally call a leader, erm ((1)) but people are really respectful... Because he really cares for patients ...And if he finds a junior doc, or nurse or anyone who is being unkind to an elderly patient then he is down on them like a ton of bricks but his, his patent commitment to medicine and clinical care just inspires admiration ...And great affection hopefully. But he is very odd. Yes. Erm, so he is like a one off so again there is no single person, you

²³ No identifying information is appropriate here.

know there are, there are, there are different leadership styles which are appropriate in different situations but David of course could never be a chief exec, he just wouldn't be able to do it, so he would be hopeless there.

On the surface this might be explained as a judgement based on 'evidence' and a job description. However, focusing-in on the discursive and regulatory practices with which this extract engages, a different view can be taken. The respondent here, being asked to describe the qualities of leadership, begins by suggesting that taking patient care very seriously is 'eccentric' and the person who does that is a 'one off' and 'odd'. Paradoxically (it is suggested) David inspires affection and admiration but despite the variety of leadership styles David would never make it to be CEO. Whether or not this is the case is irrelevant here because what is at stake are the ways in which discourses around 'leadership' and the qualities of the 'leader' *regulate conduct* setting normative behaviour through the discursive practices. There is little doubt that David would have been considered a leader (perhaps a leader in his field) during a different period when hospitals were smaller and perhaps when there was less specialisation in management.

A learning organisation?

The NHS has declared itself to be an organisation dedicated to learning for at least the last ten years and certain values underlie this declaration (see Davis and Nutley, 2000). It means that:

Although learning is something undertaken and developed by individuals, organisational arrangements can foster or inhibit the process. The organisational culture within which individuals work shapes their engagement with the learning process (p. 998).

In some cases the exercise of leadership clearly facilitated the (potential for) learning and learning facilitated leadership, while in others it did not. The facility for leading change in NHS Trusts is critical and developments in the role of nurses from a range of specialties to support leadership and learning have provided exemplars of how some organisational arrangements support leadership (Bellman, Bywood, & Dale, 2003; Doherty, 2009). However, some have argued that continued changes, the market as a driver and the complexity of the NHS might militate against whole system learning (Sheaff & Pilgrim, 2006). Questions have also been raised about the potential of the new generation of leaders who are expected to be inspirational, drive change and support learning (Phillips, 2005).

One capacity manager, for instance, was very clear that leadership was about enabling appropriate learning and the development of skills:

... probably more about empowerment and not necessarily of oneself but of others. So I think that indeed you need to feel empowered yourself, but I think that leadership, good leadership is about empowering and supporting those people who are not in power so that they are equipped with the skills that are required. some of it is actually around learning, it is about what stage they are at in terms of their learning curve.

This is not only a statement about distributed leadership but about a version of a transformational leadership that transcends individual leaders and requires an organisational culture that both supports individual learning and targeting individuals to ensure, that their learning is recognised and ongoing (Burke et al., 2006; Conger & Kanungo, 1988; Kuokkanen & Katajisto, 2003).

The respondent continues with this theme in a sophisticated, and it seems heartfelt, way:

But I think that sometimes that [learning] is not always consolidated, even those people that have been in that position for years. I think, it is more about the people actually understanding²⁴ what they have done, and almost sometimes talk it through, in basic detail about why they have got to the decision they got to. But just because you have been in a position for a long time doesn't necessarily mean that you have actually learnt erm and you may only then go up to a certain stage in my opinion in terms of your whole learning so then they may be stuck in, not novice, but in that middle stage rather than the expert. Which we would hope that most people would get to.

This suggests that organisations need to be vigilant and to constantly invigorate their members. For the respondent quoted above, an organisation that allows people to stop learning is one in which leaders and potential leaders stagnate (at their peril) (Mark & Scott, 1991).

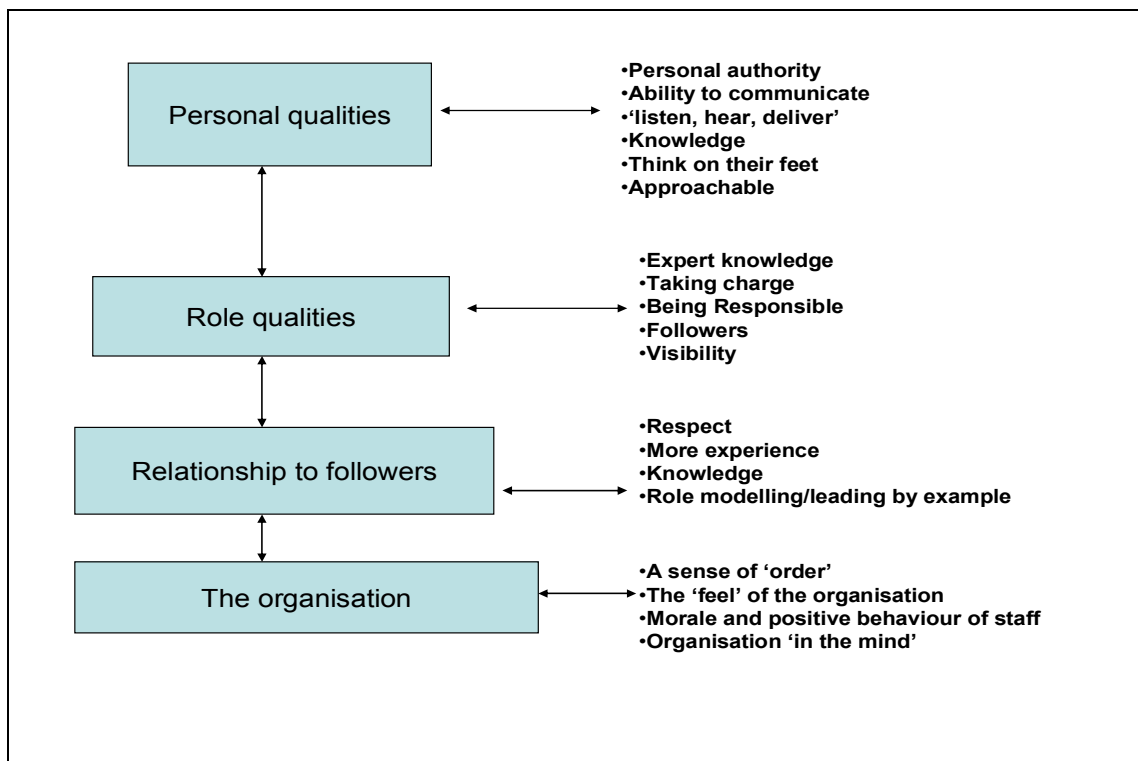
As we discuss again in Chapter Nine, the multi-disciplinary team presents an ideal opportunity for observing leadership (good and bad) and examining the ways in which these teams adhere to organisational norms which might support or inhibit learning (Burke et al., 2006; Day et al., 2004).

One senior non-medical clinical manager in a different Trust also took up the theme of learning and empowerment and specifically how it links to good patient care (Burke et al., 2006; Doherty, 2009; Kuokkanen & Katajisto, 2003).

²⁴ The transcriber who was also the interviewer made it clear that these words were emphasised by the respondent.

... [leadership] is about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is we worked with 'Training and Development' and we came up with a specific programme that was aimed at empowering them [all administrative staff] to improve their service area etc etc and also provided them with some skill sets that they probably didn't have prior to that.

Figure 11. What makes a leader?



4.6 Conclusion

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

Nonetheless, when asked to describe and define leadership, various stakeholders at all levels of the organisation have a view some of which coincides with contemporary NHS discourses and some which seems directly at odds with what the NHS is trying to achieve – that is, to support both

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distributed and transformational leadership that are seen as successful in ensuring effective patient care. However, it is clear that individual personalities and the impact of particular leaders cannot be taken out of the equation.

Leadership is experienced as distributed and transformational but there remains a belief that charismatic and transactional leadership also have their place in complex organisations. While vision is important, no vision can be achieved unless the leader takes 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. Supervision, peer support and informal advice are part of the emotionally intelligent distributed practice of leadership. 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.

In summary, the main ideas that emerged from the respondents' views of how leadership was exercised and experienced were it was about:

- Personal authority
- Ability to communicate
- 'listen', 'hear' 'deliver'
- Thinking on your feet
- Being approachable

Leadership can be exercised in a number of ways and qualities of leadership are seen to reside in different but interlinked 'places'. For example, it is clear that some people are perceived more than others to have the personal qualities that make them a leader, including being able to listen, deliver and be approachable (see Figure 11 above). The assigned/legitimated leadership role is also perceived to be an important quality for a leader, which is interesting, when thinking about the distributed leadership model and particularly the idea of concerted action where people have to work together to 'lead'. This links further to the qualities inherent in leader-follower relations identified as fundamental to the stakeholders interviewed here.

Finally, leadership means holding a sense of the organisation in mind. That is the mental model held by the leader through which they mediate and regulate their vision and actions as leaders, but it also refers to the leader's understanding of morale and the 'feel' of the organisation in which they are working, which itself regulates and constrains the possibilities for growth, development or atrophy.

In this chapter we identified some of the evidence of how organisational contexts evolve and the relationships between organisational culture/climates and the ways in which leadership is practiced. This will be developed across the next four chapters.

5 Leadership and Organisational Climate

5.1 Introduction

Despite its North American origins, where the health care system is fundamentally different from the NHS, Stringer's focus on both leadership and climate nudged us towards choosing an adaptation of his organisational climate survey for this study. We also identified an 'awareness', as he puts it himself, that "*People working in health care systems play drastically different roles that are more diverse than the roles typical in schools and businesses*" (Stringer, 2002, P. 188).

Through adapting the OCS we also captured demographic information from our participants as well as a data about satisfaction with the leadership one receives from his or her immediate supervisor²⁵. Thus, while on the whole Chapter Four dealt with general descriptions, definitions and values, in this Chapter we focus on specific relationships between individuals and the individual and the perception of their organisational climate.

The additional contribution the survey data makes to the overall aims of the study is to relate perceptions of leadership and management directly to organisational climate, thereby providing a triangulation with the story - telling and focus groups to explore the characteristics of organisations that facilitate or hinder leadership and service delivery.

5.2 Results

5.2.1 Normality of data

When normality was examined the KS-Lilifors test was found to be significant over all the scales, indicating that the data were not conforming to assumptions of normal distribution. However, inspection of the histograms and boxplots were found to present an acceptable level of

²⁵ Our version of the survey questionnaire is appended.

normality. Due to the nature of the data it was decided not to transform it, but rather to interpret the results which rely on the assumption of normality with caution.

5.2.2 Cronbach's Alpha

In order to check the reliability and internal consistency of the OCS in this setting we used Cronbach's Alphas (Cronbach, 1970) (See Table 2).

As can be seen from Table 2, the three dimensions of '*commitment*', '*support*' and '*recognition*' were considered to be high on reliability as their scores ranged from .69 to .74. These would be considered acceptable-good level of reliability (George & Mallery, 2003).

In contrast, the three dimensions '*structure*', '*standards*' and '*responsibility*' were low on reliability. This low reliability may be explained by confusing wording of the items, or it is possible that the individual items did not correspond well to one another in this sample. As such it was decided to remove the '*responsibility*' scale from the rest of the analysis. A further check to see whether '*structure*' and '*standards*' could be improved by removing single items, did not show any improvement to the alpha so these were retained in their original form.

Table 2: Cronbach's Alphas for the six dimensions

Scale	Cronbach's Alpha
Commitment	.74
Support	.72
Recognition	.69
Structure	.57
Standards	.43
Responsibility	.14

When managerial dimensions were examined for reliability' these were found to be very high ranging from .86 for '*recognition*' to .79 for '*commitment*' and '*responsibility*' (See Table 4).

Table 3: Cronbach's Alphas for the six Managerial dimensions

Scale	Cronbach's Alpha
Managerial Responsibility	.86
Managerial Recognition	.83
Managerial Standards	.83
Managerial Support	.81
Managerial Commitment	.79
Managerial Structure	.79

Overall scores for organisational dimensions

In order to derive the scores for individual dimensions, all the items on each dimension are summed [this is after all the negatively worded items were reversed].

The following were mean and standard deviations across all the six Organisational scales:

Table 4: Mean and Standard Deviation

Scale	Mean	Std
Commitment	14.82	2.86
Support	14.06	2.80
Responsibility	9.93	1.73
Structure	9.01	1.88
Recognition	8.42	2.55
Standards	8.36	1.69

Stringer, et al (2002) suggest an analysis of percentages of respondents who scored above the mean. In our analysis the following percentages were found:

Table 5: Scores above the mean

Scale	% above the mean
Commitment	60%
Support	47%
Recognition	49%
Standards	49%
Structure	39%
Responsibility	58%

Stringer offers a method of interpreting these percentages, according to benchmarked ratios collected through their extensive research to validate the tool.

High 'commitment' (60%) – In the current sample, there was a high degree of 'commitment' to the organisation and its goals. This would be typical of professional staff working for the NHS. However Stringer asserts that high 'commitment' needs to be accompanied by high 'support' and high 'recognition' – without these individuals will stop engaging with others in the organisation and their team (p.200). As indicated in Chapter Four engagement is crucial if leadership is to be effective.

High 'responsibility' (59%) – Stringer asserts that 'responsibility' is a difficult dimension to interpret within the health care setting. Effective performance in the NHS requires that procedures be double checked, which in many other contexts would put the role of 'responsibility' in an ambiguous position. However this is not the case in complex clinical settings (or for example in other precision performance occupations such as flying aeroplanes for instance). In the case of the current sample 'responsibility' was high, which is related to high sense of 'commitment', but is confused by the limited 'structure' – it is essential that people are clear about their roles, so that they may take charge and 'responsibility'.

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Moderate 'recognition' (49%) - According to Stringer scores lower than 50% may indicate that participants are feeling unappreciated. In this case there is just under the 50% mark, which translates into moderate agreement about the feeling of being rewarded for one's efforts. Having a high sense of 'recognition' in an environment such as this is of crucial importance for motivation, but 50% is within the normal range set out by Stringer. High 'recognition' is indicative of confidence in the organisations performance/reward ratio but in such a diverse setting as a hospital with a diverse staff group responding to the OCS then different groups with different management and professional/occupational structures would have different perceptions and experiences.

Moderate 'standards' (49%) – there is a moderate feeling of pressure - performance 'standards' and expectations are high but not to the point where they are stressful. This falls within an acceptable range. Considering that many of the 'standards' (targets) are set out by government policies rather than directly by Trust management/leaders it is important for these standards to be realistic and achievable.

Moderate 'support' (47%) – this falls within the low but acceptable range for this scale (45%-60%) according to Stringer's benchmarks. This indicates that there is sufficient unity between teams to approach and solve problems, without overly nurturing so as to discourage individual 'responsibility' and undertaking. Team work within the health care system is challenging because of the interdisciplinary nature of teams which inevitably calls upon different management and professional structures and networks for support.

Low - Moderate 'structure' (39%) – Under half of participants felt there was clarity in terms of their roles, responsibility and authority. On the one hand this means that there are less constraints and a less of a 'jobs-worth' approach, on the other hand though it means that there is (potentially) insufficient clarity in roles and responsibility. In an organisation such as the NHS, this may be a considerable shortcoming and Stringer (p.193) suggests that in a health care environment such as a hospital, one would ideally like to have 'structure' scores above the 70s. This is emphasised because of the complex nature of the hospital environment with so many individuals involved – accountability needs to be very clear. The NHS however has gone through so many changes over the previous ten years that it is inevitable that the 'structure' score would be influenced.

Associations between the six dimensions on the organisational level

Pearson's r was utilised to test the relationship between all the Organisational scales. It was found that the majority of scales showed modest, but significant relationships:

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Table 6: Correlations between the six organisational dimensions

	Standards	Structure	Recognition	Support	Commitment
Standards	1.00				
Structure	ns	1.00			
Recognition	.22*	.47**	1.00		
Support	.17*	.42**	.61**	1.00	
Commitment	.30**	.39**	.59**	.67**	1.00

* <.05

** >.001

As can be seen from Table 6, there are a number of high associations between these dimensions. The highest associations are for 'support' and 'commitment' (.67) 'support' and 'recognition' (.61) and 'commitment' and 'recognition' (.59). In other words, participants are reporting that when a feeling of co-operation within teams is present, this is often accompanied by acknowledgement and appreciation and is further related to a greater sense of dedication and 'commitment' to the goals and aims of the team. By definition, the converse also applies: feelings of isolation are more likely to be accompanied by lack of incentives and disenchantment with the objectives of one's team. This is 'supported by Stringer (p.200).

Satisfaction with leadership

When the *organisational dimensions* were examined in relation to satisfaction with the quality of leadership received from the immediate manager, which was asked as a single item, the scales which correlated most highly were 'support' (.61) and 'recognition' (.52). The weakest relationship was to 'standards' and 'structure'.

Table 7: Correlations between organisational dimensions and satisfaction with Leadership

	R (sig)
Standards	.14*
Structure	.30**
Recognition	.52**
Support	.61**
Commitment	.39**

In order to evaluate the individual contribution of each of the organisational dimensions to the overall 'satisfaction with leadership', a regression analysis was conducted, which included all items which were found to correlate significantly with satisfaction, namely 'standards', 'structure', 'support' and 'commitment'.

The total variance accounted for by the model was 40% (Adjusted $R^2 = .38$) therefore variability in 'satisfaction with leadership' is moderately accounted for by this model.

Specifically, of the five predictor variables the two which were found to predict the outcome variable of 'satisfaction with leadership' were 'support' and 'recognition', 'support' being the biggest contributor with a $B = .52$ ($p < .001$) and the other predictor was 'recognition' ($B = .27$, $p < .001$). The other variables were not significant. [Appendix 1 of this chapter].

In other words, feeling supported by one's team and believing that rewards are appropriate to effort, accounts for a significant proportion of an individual's satisfaction with leadership.

Correlations between dimensions on Managerial level

The second part of the questionnaire asked about individual experiences of management. All six dimensions on the managerial level were highly correlated with each other, with strong correlations ranging from $r = .71$ ($p < .001$) between 'structure' and 'responsibility' to a correlation of $.84$ ($p < .001$) between 'commitment' and 'standards'.

Table 8: Correlations between dimensions on Managerial level and Satisfaction with Leadership

	Manager Recognition	Manager Support	Manager standards	Manager structure	Manager Responsibility	Manager Commitment
Manager recognition	1.00					
Manager support	.83**	1.00				
Manager standards	.82**	.83**	1.00			
Manager structure	.73**	.78**	.79**	1.00		
Manager responsibility	.84**	.79**	.79**	.71**	1.00	
Manager commitment	.79**	.83**	.84**	.82**	.79**	1.00
Satisfaction with Leadership	.68**	.76**	.71**	.71**	.65**	.76**

** Significant at .001 level

A single item asked about satisfaction with the quality of leadership received from immediate manager. When this was examined in relation to the six dimensions appropriate to participants' own experience of management practices, it was found to correlate highly and positively with manager 'support' ($r=.76$); management 'structure' ($r=.71$, $p<.001$); manager 'commitment' ($r=.75$, $p<.001$) and 'standards' ($r=.71$, $p<.001$); manager 'recognition' ($r=.68$, $p<.001$); manager 'responsibility' ($r=.65$, $p<.001$);

A multiple regression was carried out to examine the perception of 'satisfaction with leadership', as a dependent variable of management practices. The overall association between management practices and satisfaction with leadership was strong ($R=.80$) with associated variance explained of 63%.

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Table 9: 'Manager' dimensions regressed onto 'satisfaction with leadership'

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	-.054	.226		-.240	.811
Manager Recognition	.001	.039	.002	.025	.980
Manager support	.175	.039	.410	4.501	.000
Manager structure	.060	.027	.177	2.260	.025
Manager responsibility	-.018	.032	-.047	-.559	.577
Manager commitment	.165	.056	.278	2.948	.004
Manager standards	.017	.056	.029	.310	.757

In this case, it was manager 'support' which best predicted satisfaction with leadership ($B=.41$, $p<.001$), next biggest contributor was management 'commitment' ($B=.28$, $p=.001$) and management 'structure' ($B=.177$, $p=.025$). In other words, a large proportion of feeling satisfied with one's leadership, pertained to feelings of being supported and the degree to which one's manager inspires and exudes 'commitment' to common goals. A further important element in the equation is that of 'structure' – where roles and responsibilities are clear, it is associated with greater satisfaction with leadership.

As the biggest predictor of 'satisfaction with leadership' was manager 'support', a further regression was done to look at what organisational dimensions related to having good managerial 'support'.

All the organisational scales were inputted into a regression, excluding organisational 'support', with managerial 'support' as the outcome variable. The following was found:

In total the model accounted for 35% variance in the outcome variable (Adjusted $R^2 = .35$). There were two contributors to the model: the strongest one was 'recognition' ($B = .44$, $p < .001$), i.e. the more employees feel that the organisation rewards and recognises their efforts, the more they feel supported. The other contributor to managerial 'support' was 'commitment' ($B = .20$, $p = .008$). [Appendix 3 of Chapter Five]

These findings indicate that organisational 'recognition' and 'commitment', are organisational climate dimensions which most affect the outcome of managerial 'support', and this in turn has the greatest effect on individual's sense of satisfaction with their leadership. This again corresponds with data discussed in Chapter Four highlighting the importance of the feel of an organisation that provides support at all levels.

Regression of all dimensions onto Satisfaction with leadership

When all the variables previously shown to be significant to Satisfaction with leadership, were entered into the model, from both the organisational and managerial dimensions, namely manager 'support', manager 'commitment' and manager 'structure' as well as organisational 'support' and organisational 'recognition', the following picture emerged:

There was a high degree of variance accounted for by the model - 65% (Adjusted R^2). The model was found to be significant ($F = .80.65$, $p < .001$).

The variables which remained significant, in order of their contribution are: manager 'support' ($B = .34$, $p < .001$), manager 'commitment' ($B = .33$, $p < .001$) and Organisational 'support' ($B = .13$, $p = .03$).

In other words, satisfaction with leadership, in this sample, was predicted by a greater perception of 'support' from management, a feeling that managers demonstrated their 'commitment' to achieving common goals and an atmosphere of 'support' and team-work within the organisation.

Organisational and Managerial dimensions

In order to investigate the relationships between organisational and managerial dimensions, a correlation was performed between all of these variables (Table 10). It was found that:

There were strong correlations between manager and organisational 'recognition', and manager and organisational 'support'. There were moderate correlations between manager and organisational 'commitment' and 'structure'. And there was a weak correlation between manager and

organisational 'standards'. In other words, where the dimensions were correlated weakly or moderately, we can identify that 'standards' of the organisation do not necessarily exist at the same level of managerial 'standards'. The same relationship goes for 'structure' – having organisational 'structure' does not predict clarity in roles, as espoused by one's manager. There is a greater degree of correspondence between organisational and manager 'commitment'. When we look at 'support' and 'recognition', we find that both these dimensions tend to be closely related – one is more likely to feel that both are high, or both are low.

Table 10: Relationship between managerial and organisational dimensions.

	Organisational Recognition	Organisational Support	Organisational standards	Organisational Structure	Organisational Responsibility	Organisational Commitment
Manager recognition	.60**					
Manager support		.65**				
Manager standards			.25**			
Manager structure				.34**		
Manager responsibility					-.02 ns	
Manager commitment						.48**

The significance of Role

The largest group of participants was nurses (31%), then clerical staff (14%), managers and porters (14% each). Doctors/consultants/physicians (11%), other allied professionals (10%) and 'support' staff (6%).

When looking at satisfaction with leadership the following findings were apparent: High satisfaction with leadership was reported in total by 54.3%

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(n=113) of staff. Although there were no significant differences by work role, it can be seen that consultants and doctors reported the highest satisfaction (74%), followed by managers (61%). It can be seen that clerical workers had the least high satisfaction (41%), followed by 'support' staff and other allied professionals (54%). This is significant in terms of the hierarchy within the organisation – the higher the position the more satisfied one is with their leadership.

Table 11: The significance of role and satisfaction with leadership

	n	% positive responses about satisfaction with leadership
Managers	28	60%
Doctors	23	74%
Allied professionals	22	54%
Nursing	65	49%
Support staff/Assistants	13	54%
Clerical	29	41%
Porters/maintenance	28	57%

A further examination of organisational dimensions according to role using a one way ANOVA, revealed the following:

In all there were large differences between respondents in terms of their role, however only two scales exhibited differences which reached significance. The first was 'commitment' – doctors/consultants were found to rate significantly higher than allied health professionals on this scale (mean difference = 2.86) ($p < .01$).

The second was 'recognition' – it was found that doctors were much more likely to rate higher than clerical staff on this scale (mean difference = 2.41) ($p < .01$). Both these findings were apparent even after using the Bonferroni correction.

Comparing doctors (all grades) in Trust 1 and Trust 3

An examination of the responses on the item looking at 'satisfaction with leadership' amongst doctors revealed that doctors at Trust 1 (n= 13) had lower satisfaction (Mean = 3.38, std = 1.38) in comparison to doctors at Trust 3 (n= 10) (Mean = 4.20, std = .42). This difference (.81), whilst small, was found to be approaching significance (t = -2.003, p = .06).

While it is not possible to make an objective comparison between doctors from Trusts 1 and 3 from the qualitative data, there is more evidence in Trust 3 of doctors being both emotionally engaged with both junior doctors and other members of multi-disciplinary teams than in Trust 1 and with distributed leadership. As will be evidenced in Chapter Six doctors and other staff considered 'management' as bureaucratic and distant rather than engaged.

Gender

There were no differences between men and women's scores on 'satisfaction with leadership' (t = 1.71, p = .08).

When examining differences between men and women on the organisational dimension it was found that only one dimension, 'recognition', was perceived significantly differently (t = 3.42, p<.001). Men perceived there to be greater 'recognition' (mean = 9.55) compared to women (mean = 8.13). All other dimensions were not significantly different (see Chapter Eight).

When examining the gender differences on managerial dimensions of the OCS there were trends approaching significance in terms of differences between the genders on managerial dimensions, but these did not reach significance when multiple comparisons were taken into account:

Manager 'recognition' (t = 1.91, p = .06)

Manager 'responsibility' (t = 2.10, p = .03)

Manager 'standards' (t = 2.33, p = .02).

5.3 Conclusions

The difficulty obtaining data across all three participating Trusts has not limited the value of using the OCS to triangulate the qualitative data, particularly because a) the OCS gathered information from staff groups who were not represented in the focus groups, shadowing or story-telling

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interviews and was able to identify generalisable predictors of satisfaction with leadership and management practices, and b) the OCS data captured information from specialty groups outside those involved in the participating Units from which qualitative data was collected.

What emerged here was that on the whole, the same climate variables are important in predicting satisfaction with leadership. Within the organisational domain these are 'support' and 'recognition' while predictors of 'satisfaction with leadership', within managerial practices, are manager 'support', 'commitment' and 'structure'.

Overall, therefore, 'satisfaction with leadership' was highly accounted for by manager 'support', manager 'commitment' and organisational 'support' – i.e. these were the 'ingredients' in this sample which were highly related and were able to predict satisfaction with leadership. This suggests once again that managers/leaders were effective if they engaged with followers and that organisations that supported distributed leadership and emotional engagement were more likely to support effective leadership (see Chapters Four and Six in particular).

In terms of role, the higher the position in the organisational hierarchy the more satisfied a person was likely to be with leadership. This was not necessarily the case though across all organisations in the study. The exploration of the case studies in Chapter Seven – where authority and leadership are discussed – reveals how some of the more senior leaders in organisations found themselves to be highly dissatisfied with leadership in other sectors of their Trust, if there was resistance or negligence of their authority.

Differences in gender were only apparent in terms the organisational dimension 'recognition' – it was only on this scale where women scored significantly lower than men. This may say something about equal opportunities and equal pay for equal work, but it might also relate to perception of 'recognition' between women and men discussed and exemplified in Chapter Eight below.

The overall importance of constructs such as 'support' and 'recognition' across the climate of an organisation, and management practices which demonstrate support and commitment, provide further evidence of the importance in engagement and (probably) emotion (including EI and SI) in an organisation.

6 'Organisation in the Mind': Transmission of Leadership and Organisational Context

6.1 Introduction

Leadership in any organisation is understood in a specific context by those involved as either leaders or followers, and as shown in Chapters Four and Five concepts such as satisfaction, support, responsibility, vision and communication among others are described and evaluated within a cognitive or mental framework within which the organisation itself is understood. It is through making sense of the organisational context that leadership and followership may be enacted and transmitted.

We saw how members of organisations *necessarily* hold in their mind fantasy/imagined understandings or images of the *system* (Morgan, 2006). This informs how they work in, relate to and talk about their organisation, based on their perceptions of their own and others' place and role within the system. For example, it is common to hear employees talk about how 'you can never get management attention in this company' or 'we are all dedicated to putting patients first here' (Armstrong, 2005; Morgan, 2006).

Similarly, the participants who completed the OCS held a view of the leadership and management in their organisations, in order to think about the various ways in which their work was recognised, supported and so on both generally and by their managers. While the focus in that case was upon on measuring the impact of organisational climate and thinking about a relationship with a specific manager, those who completed the survey would have had to hold a perception of what was happening in their department and the Trust overall.

This is apparent in what follows particularly in the ways 'management' is discussed and taking account of these perceptions provides some evidence about the ways in which leadership is transmitted in these particular organisational contexts and in general. The 'organisation in mind' then involves:

- An 'image' of the organisational structure and relationships within that structure
- A sense of your own role and place within it
- An emotional component
- An awareness at a conscious and/or unconscious level of important information below the surface

6.2 Organisation in the mind

The concept of the 'organisation in the mind' was a model developed originally in the early 1990s by organisational and group relations consultants working at the Grubb Institute, the Tavistock Centre and the Tavistock Institute of Human Relations, to refer to what an individual perceives mentally about how organisations, relations in the organisations and the structures are connected. *"It is a model internal to oneself ... which gives rise to images, emotions, values and responses in me, which may consequently be influencing my own management and leadership, positively or adversely"* (Hutton, Bazalgette and Reed, 1997, p. 114 quoted in Armstrong, 2005, p. 4).

In other words, when we talk about our colleagues, guess what the senior management are doing/going to do and have fantasies about how well we fit, or don't fit, into the structure or system we do so in the context of the organisation we 'hold' in our mind which may or may not relate to that which other members of the organisation hold (Pols, 2005).

Organisations are experienced cognitively and emotionally by their members when they think about how their organisations work and are structured (see Lewin, 1947; Armstrong, 2005; Morgan, 2006). As Stokes (1994) explains it, everyone carries a sense of the organisation in their mind but members from different parts of the same organisations may have *"different pictures and these may be in contradiction to one another. Although often partly unconscious, these pictures nevertheless inform and influence the behaviour and feelings of members"*. (p. 121)

Hutton (2000) talks about it as *"a conscious or pre-conscious construct focused around emotional experiences of tasks, roles, purposes, rituals, accountability, competence, failure, success"* (p. 2). Morgan suggests that an organisation may serve as a 'psychic prison' in that the:

...patterns and meanings that shape corporate culture and subculture may also have unconscious significance. The common values that bind an organisation often have their origin in shared concerns that lurk below the surface of conscious awareness. For example, in organisations that project a team image, various kinds of splitting mechanisms are often in operation, idealising the qualities of team members while projecting fears, anger, envy, and other bad impulses onto persons and objects that are not part of the team (Morgan, 2006, p. 226).

Some of this is apparent when talking to NHS staff about the leaders at various levels of their own Trusts and the NHS overall as was seen particularly in Chapter Four.

6.2.1 Organisation under the surface

So, when the respondent immediately below talks about the leader who has a 'really good understanding of the organisation or team' what exactly does that mean? How does that understanding come about? What do the team hold in mind about that particular leader?

Leadership is someone who has a really good understanding of the organisation or team, erm where it's going and where they imagine it to be going, so that sort of vision as well for their team, I think. (Lead Clinical Non-medical Health Professional, T3)

This respondent, referring to the (frequently used) concept 'vision', also identifies this with the *imagination* the leader holds about where the organisation is going. This is not simply a matter of guesswork. It is an intellectual/cognitive and *emotional* sense of an organisation. Indeed to take this slightly further, as Gabriel and Schwartz (2004) propose "... *what goes on at the surface of an organisation is not all that there is, and ... understanding organisations often means comprehending matters that lie beneath the surface*" (Gabriel and Schwartz, 2004, p. 1).

Although not necessarily (in fact mostly not) made explicit, even the most clear thinking senior members of organisations hold an image of the organisation in mind, expressing their fantasy/belief/perception of the organisation based on conscious and unconscious knowledge (Halton, 2007; James & Arroba, 2005). So for instance for this CEO leadership is understood emotionally as it is:

... about the feel of the organisation and what it feels like in terms of how it delivers patient care. Yeah, erm. I can best illustrate that, and interestingly we were thinking about this earlier this morning, so as a group, the executives, we were talking about it. When you walk onto a ward a hospital ward and there is real leadership on that ward, you walk in and there are a number of signals that are given off, which give you a feel. Erm the place looks organised, it has a welcoming feel, the nurses on the ward and the clinical staff greet you as they come into contact with you. They know you from the previous interactions that you have had and when you sit there and listen to what is being said on the ward they will know that the patients, the visitors on the ward, the families that are coming in the junior doctors who are in there in that environment and all of that has a feel²⁶ of a well led ward. (CEO)

²⁶ Respondent's emphasis.

The environment of the well led ward (unit or organisation) is implicitly and unconsciously identified by all who engage with that organisation. The staff communicate effectively (visually, verbally and emotionally) so that the information required is passed on through managers, clinicians to colleagues, patients and relatives. This account, which preceded the extract that focused on strategy, directed to the best patient care for the greatest number of patients, expresses his ideas at an *emotional* level. He also suggests his senior colleagues agree with this. Signals are 'given off', you can 'feel' the organisation and how it delivers patient care and there is a 'welcoming feel'. He also talks about 'empirical' evidence in that staff know the patients, the ward looks organised he remains convinced that there is a 'feel of a well led ward'.

From a slightly different position, a deputy CEO quoted below also holds in mind the fantasy that a manager might think that they run an institution but that such a fantasy might get the manager into trouble. He is suggesting a vision of an organisation in which a manager has very little control, and proposes the need to gain a sense of *reality* by recognising this and taking responsibility for this organisation (Hirschhorn, 1997; Porter-O'Grady, 1995). His perception, again which has an emotional component, is one of a stressful contradiction – responsibility without power or control (de Vries, 2000).

The minute, as a manager, you start to think that you do [run the service without accountability]... erm then you're in trouble. Unfortunately you have still got the accountability for the service but you have very, very little control so it's a whole different leadership and managerial skill that is required I think in terms of recognizing that you have no control over what happens you know across this organisation across the N,000 beds here at [Trust], the thousands of people that go through the organisation everyday, what happens to them is completely outside of my control but if anything goes wrong it is absolutely my responsibility. And that is quite difficult.
(Deputy CEO, T 1)

6.2.2 Structure in the mind

Most recently Laughlin and Sher (Laughlin & Sher, 2010) take up a version of this concept which they name the 'structure-in-the-mind' in their analysis of developing leadership in social care. They reassert, in their model, that not only the local stakeholders (staff and service users) have a sense of the organisation in the mind when considering, for instance, a particular Trust, but the range of stakeholders includes government bodies and service commissioners (in the round). They propose an inter-relationship between perceptions of communications from services (e.g. 'that you [management] don't listen and/or understand') and perceived communications from 'Head

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Office (or government or other bodies that control resources and practices) which include for example 'just do it' 'we know better' and 'be rational'. (p. 9)

What is significant here, in the context of NHS leadership, is that the organisation and/or structure *in the mind* is where the leader and followers 'meet' emotionally as, similarly, do the various levels of leadership and governance bodies. It is a kind of 'virtual' space.

An example of this structure in the mind might be seen through the increase in stress for NHS employees detailed in a recent report by NICE (the National Institute for Clinical Excellence²⁷) where it was revealed that staff absence caused by work related stress costs the UK over £28 billion. It was proposed that a poor working environment characterised by bullying and poor management was at the heart of this problem²⁸ (Edwards & O'Connell, 2007). In a context where there is distributed leadership and a highly trained professional, multi-disciplinary workforce, such mismatches in how to run organisations and departments that lead to staff stress in these ways (e.g. being bullied and bullying) evoke questions about what is happening in the space between those who plan, govern and resource NHS Trusts and those who carry out the work. The emotional elements of leadership and followership relations seem to be neglected to everyone's disadvantage.

The idea of the organisation in the mind raises important questions of how leadership (good and bad) is transmitted across the NHS and its Trusts (Harrison & Carroll, 1991; Walsh & Ungson, 1991). Organisational cultures and climates are reproduced over time despite the coming(s) and going(s) of CEOs. However, organisations also *adapt* and *evolve* as a response to changes in leadership and outside influences (Morgan, 2006).

In what follows we explore the characteristics of the organisations studied here that facilitate or hinder the transmission of leadership through the Trust as a *system* through which culture (e.g. principles and values about leadership) might be transmitted (Hatch, 1993; Schein, 2004).

²⁷ An organisation established to oversee and provide guidance on clinical practice and cost and clinical effectiveness.

²⁸ See news.bbc.co.uk/2/hi/health/8343074.stm and NICE web-site which has a power-point presentation.

6.2.3 Transmission of leadership and Organisational Contexts

What is held in mind about an organisation is often influenced by the formal and informal networks (Balkundi & Kilduff, 2005, 2006; Goodwin, 2000) which characterise complex adaptive systems. Network cognitions in the minds of leaders are embedded in the whole organisation and the inter-organisational linkages formed by leaders as representatives of organisations (Balkundi & Kilduff, 2005).

The context of the NHS seems to have become increasingly complex and chaotic (Currie et al., 2009) which, coupled with a sense of widespread unethical managerial practices, has raised questions about how leadership practices are transmitted through NHS organisations (Bowie & Werhane, 2005; Collier & Esteban, 2000; Huston & Brox, 2004). Bullying and poor management are in part at least a consequence of not taking the emotional context of organisational life seriously (Ashkanasy, Jordan, & James, 2003; Cocco, Gatti, Lima, & Camus, 2003; Johnson, Cooper, Cartwright et al. 2005; James, 1999; Hutchinson, Vickers, Jackson & Wilkes, 2006).

While there is no excuse for bullying or any other unethical management practices, it is necessary to understand what precipitated the relatively recent change in culture which has exacerbated (reports of) bullying. One factor has to be the extent to which top-down, politically driven changes have been forced through the NHS system and other public institutions and the impact that the drivers of these changes have upon the senior levels of management consciously and unconsciously (Christensen & Laegreid, 2003; Dent, 2005; Gabriel, 2004).

These recent developments have influenced the psychological and emotional aspects of working in teams, groups and organisations (Liden & Antonakis, 2009; West & Anderson, 1992) and by implication influenced possibilities for innovation in leadership and the authority of leaders and workers (Lewin, 1947; Miller, 1993; Carter, Garside, & Black, 2003; Hirschorn, 1997; Fineman, 1994, 2000; Payne and Cooper, 2001; Vince, 2002; Carter, Garside, & Black, 2003). Understanding the *context* of leadership, therefore, has become increasingly important as has the need to understand how that context is part of a *system*.

Post industrial (or postmodern) systems (Rose, 1991) have been reconsidered (or 're-described') relatively recently as 'complex adaptive systems' (Collier & Esteban, 2000; Dooley, 1997; Schuster, 2005). Systems that are complex because of multiple interconnecting relationships are liable to evolve through making new connections that increase their complexity (Collier & Esteban, 2000). In the NHS, even though change is structurally driven, the (perhaps unforeseen) consequences of changes have meant that instead of a command-and-control, top-down hierarchies where in particular

clinicians such as consultants and matrons had previously been seen as 'gods' (as with Sir Lancelot Spratt and Dr. Gregory House see Chapter Four) distributed leadership, networks and different statuses attributed to individual Trusts (e.g. Foundation Trusts with relative independence, Mental Health Trusts which have social care and NHS staff and diverse management practices) have evolved within different structures at all levels for coping with service delivery (see Chapter Nine).

6.3 Open systems theory and boundary management

An organisation that *evolves* like an organism and adapts to its environment necessarily has *porous boundaries* so that it can 'take in' and 'put out' beyond itself. This kind of organism is one that changes, develops and grows. A closed system may feel more secure in that it may not have to accede to unwanted influence or demands, but without taking in and providing for the world outside it will atrophy as with any other closed (minded) system (Morgan, 2006). In this way images and cultures of leadership from outside the boundaries might influence the development of leadership practices e.g. data and ideas from education (Currie et al., 2009; Gronn, 2000; Lumby, 2003)

Systemic thinking is a framework, or tool, for observing the way organisations behave (Schein, 1985; Lewin, 1947; Campbell et al, 1994) which evolved from General Systems Theory, (von Bertalanffy, 1956; Miller and Rice, 1967) and focuses upon concepts related to organisational structure particularly 'task', 'role', 'authority' and 'boundary'. There is also a psychodynamic part of the systemic thinking analysis which links with the conscious and unconscious emotional consequences of the systemic properties and the impact of social and personal factors on the functioning of the organisation (James and Huffington, 2004; Laughlin & Sher, 2010)²⁹.

Morgan (2006) identifies how knowledge and power are accessed and maintained through control of organisational boundaries. 'Boundary' is the term used in open-systems theory to describe the interface between different parts of the organisation and the organisation and the outside world. In the case of the NHS this is the physical boundary to the, for example, hospital building, the wards, the web-site, the reception desk, the

²⁹ This issue is further discussed and explained through object relations theory based on the works of Melanie Klein, Elliot Jaques and Isabel Menzies-Lyth which is outlined in detail in Chapter One and operationalised in the description of the role of obstetricians' anxiety in the delivery of patient care discussed in this chapter and below in Chapter Nine).

telephones, e-mail and so on and also between the different roles such as out-patient/ in-patient, staff /patient, clinician/manager and so on. Most leaders in organisations have the knowledge and abilities by definition to manage and negotiate those boundaries. For example, the senior managers relate to government/NHS/DoH in ways that junior nurses do not, but the senior staff are charged with having to manage the boundaries using knowledge and influence across the boundaries – inside with the staff and patients and outside with government and patient pressure groups. Moreover, as evidenced during the conduct of this project, hospitals merge into Trusts and the porosity or opacity of the boundaries between the different organisations that have come together are central to the functioning of leadership at most levels (see Chapter Seven where the limits of authority are discussed in this context).

Stating this in a slightly different way, this approach to the 'organisation in the mind' takes the *personal* (conscious, pre-conscious and unconscious) level of thinking and links it to the *system* in which that person works (systemic thinking). As any organisation comprises systems (with boundaries, in-puts and out-puts), groups and individuals, it follows that a person's experience of an organisation and *experience of themselves* in relation to others who are in the same organisation make up the culture, climate and everyday dynamics of any organisational context. Thus, our respondents' sense of the 'organisation in the mind' is a valuable concept for understanding how leadership relates to service delivery.

6.4 Images of the organisation

In what follows we explore some of the images 'held in mind' by staff across the three Trusts particularly examining the impact of the organisation in the mind on working collaboratively and the influence of this on service delivery and the quality of patient care that results from staff relations and effectiveness.

To begin, we focus on two specific examples that characterise much of what was said by staff across at least two Trusts:

- images (and fantasies) held about 'management' which highlight the construction of 'authority' in the system and its impact on patient care
- images (and fantasies) held about the 'others' (e.g. colleagues in the same Trust but on a different site or a different Unit) which brings boundary management into play
- how these images (and fantasies) facilitate and hinder the transmission of leadership and service delivery

We employ a critical discourse analysis (CDA) approach to the meaning and processes of leadership and organisation exploring how the organisation/system *looks* to the participants and how this in turn impacts upon the system of providing care for its patients.

6.4.1 'Management' in the mind

As in many organisations, rhetoric about 'management' abounds particularly played out as a 'them/us' dynamic as we demonstrated by separate means in Chapters Four and Five. Furthermore, among management, rhetoric about their own practices and role in relation to that of the workforce is equally active (Alvesson & Sveningsson, 2003a; Borins, 2000; Kuokkanen & Katajisto, 2003).

There is general cynicism across all the respondents who defined themselves as non-management *about* management. So for example: *"And you find that when there's a crisis that's when you find your management team will come down and put a policy in place regardless - like the swine flu thing" (Junior Midwife)*. So here managers are described as paying no heed to the routine tasks of the organisation (Cummings, Hayduk, & Estabrooks, 2005b). They are portrayed as simply responding to a crisis and (presumably following orders from the overall leaders of the service). Thus, managers are not seen as managing the boundaries between the Trust and those in overall charge of health care operating outside of the organisation (i.e. at the level of government) effectively for the facilitation of service delivery (Buchanan, Abbott, Bentley, Lanceley, & Meyer, 2005; Kane & Patapan, 2006). This resonates with Laughlin and Sher's (2010) analysis discussed above.

A focus group from one Trust proposed a particularly strident view of management and its relationship to wider bureaucratic imperatives which they saw as going against service delivery and effective patient care. The medical staff here were proposing that management was both absent, in person and from taking responsibility, while also being all controlling of medical care through instigating seemingly pointless rituals which seemed to maintain boundaries.

Consultant: There is a burning example [here] of bad leadership which is the absence of figure heads. Management can never be found which is frustrating.

Registrar: I've been in theatre now for two weeks and two cases were dropped. The doctor has to apologise to the patient but they are the ones [the doctors] who would like to continue. Management say 'NO it is lunch'. They should be the ones taking responsibility for telling the patient but the

doctor has to go back to the patient and look like a donkey saying 'I'm sorry I can't do your operation today'.

The members of this group, who clearly shared the same or similar images of management and its 'idiocy', went on to decry management incompetence across all staffing issues, and the registrar continued, imitating the management in a silly voice: "*he has to stop, that's the rule*" making it very clear that management was perceived by this man and others in this focus group as inflexible (and rather stupid). Here these participants are expressing total lack of faith in the authority of those who manage (rather than lead) them, although in fact it seems that despite this, they abide by the rules which suggests that there is a belief that at some level the managers in question here derive authority from somewhere higher up in the hospital system or from the NHS leadership beyond.

One factor to note, of course though, is that the power of the story in the focus group may belie the views of the whole group in that some would be silenced by the fear of disagreeing with their colleagues (Asch, 1956; Foucault, 1982). Furthermore, the articulation of the behaviour of management in these cases is *actually a form of leadership* and as such might influence the views of the focus group (and subsequently other staff) (Avolio et al., 2004; Pye, 2005).

From a different focus group, this time with junior midwives, it was apparently *giving up their authority* for a while that gained managers some important respect. For instance when a crisis occurred in the organisation (in this case a fire) then managers seemed to behave very differently and even impressively:

1³⁰. Yeah and then the managers - the bed managers - were carrying chairs and everything and you just had people on beanbags on the floor and everybody ...

2. I wasn't here that day I missed that.

1. Well it was a bit stressful but everybody just mucked in and people were just carrying people here and you know....

Q: Well that's really good if everybody even the managers mucked in.

1. Yeah you find in a crisis the managers do come out, the leadership the leaders come out and they have to come out.

3. And people were coming in from home to help that day.

³⁰ The number denotes the speaker.

2. *Why didn't they phone me? I don't know but never mind ...*

1. *No you find that in that kind of crisis everybody from execs downwards pulls rank and everybody comes in and helps out (T 2).*

So the image here is that a crisis brings out the best in everyone (and the boundaries between the groups of staff become temporarily porous). In times of crisis then the tasks (i.e. patient care and running an effective hospital) overcome other elements of potential discord and conflict such as the 'rank' order of 'execs' bed managers and others such as clinical staff.

There are also other times when it is possible for management to be seen as 'on side' as indicated by another nurse in a different site. For example:

Erm ... our manager, she is quite approachable. And she is willing to discuss things with you if you don't feel that something is right and you question it or question her. She is willing to sit down and explain it and sometimes she will say 'I'm not happy with things as well, but the people above me this is what they have decided, this is what we have to go along with. It is government guidelines or targets have to be met'. Although she might feel the same as us she explains why we have to do things in this way. And I think she is very approachable.

This manager above, demonstrates her willingness to communicate and be 'visible' but clearly she has adopted a them/us strategy similar to those who 'oppose' management by positioning herself as managing the boundary from the side of the clinician/nurse's while also at other times presenting herself as mediating between 'government' and clinicians and managing that boundary too (Laughlin & Sher, 2010).

In the example described here, this seems to 'work' as evidence of good leadership for the nurse telling the story, but it involves the manager in question in potentially difficult dynamics and conflicts in her role.

From another focus group discussion that included doctors and nurses the organisation in the mind experienced management as absent and failing in their responsibility (Hogan & Kaiser, 2005):

Absence would be correct. Management are often not there. They need to take command of the situation. Here is the reasoning – management don't take responsibility for their actions and there is a severe lack of managerial leadership.

This is significant in the concept of the organisation in the mind when juxtaposed with the account of the same organisation by the CEO who saw her/himself as seeing good leadership as manifested in:

Visibility in terms of being seen around the place, so go out wandering around the wards. The best part of the role, quite candidly is, the best part about being the chief executive is, you can go out and talk to patients, and that is what I really kind of enjoy. ... so there is something about my presence and my profile. There is also something about being very clear and repeating the message often enough so that it is clear in the organisation about what the organisation is there to do.

So, within the same organisation there is an image that management is invisible and absent, while senior managers see themselves as 'being seen around the place' constituting an important part of what they believe they do and that they see as being vital for effective leadership and patient care (Laughlin & Sher, 2010). Both sides agree on what would be good leadership but each 'side' has a different vision of what is happening in 'reality' (Alvesson & Sveningsson, 2003a; Buchanan et al., 2007).

In the absence of a shared vision of an organisation working together or a set of clear guidelines about how 'this organisation works', there seemed to be a wish from a deputy CEO of another Trust for a hero/charismatic leader to put things to rights and potentially cross the managers/others boundary (Ladkin, 2006; Laughlin & Sher, 2010).

Erm, this is a very complicated organisation, what we haven't got right is we haven't got a bible that says this is how this organisation works and I think that's a problem so, ((1)) so ((1)) it's very easy for ((1)) despite what I've said about how difficult it was to be a leader, erm and the personality of the individuals who are at the top of the tree, makes an enormous difference in how an organisation I think behaves and works. There is a great tendency if you are a very good individual for an organisation to be based around you and when you leave there is a problem, erm and so the best kind of leader, yes they have that aura of it's about them, of course that's what people look up to but they also put in place processes so that things can happen.

This is a view from the top of the organisation which is expressed at least in part as a vision of a (desirable) mechanistic model – an organisation with a 'bible' about how it works - although this participant also desires a charismatic transformation on the part of leaders.

The hero leader would be a 'very good individual for an organisation to be based around you' and also to have 'an aura'. The metaphors in this extract proliferate – the need for a 'messiah' to save the organisation but also a sense of *dependency* – that 'people look up to' this type of leader who (it would appear) single handedly will be able to put processes in place for things to happen. The vision here is though one in which the system is defunct, stagnant and closed.

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6.5 'Out of mind': leadership and the 'other'

Organisational change is frequently resisted, often because of the disruption to individual's *sense of the system* and their place within it (e.g. Hoyle, 2004). It is also related to the emotional involvement many people have in their work and the way they perceive they are valued within (and how they themselves value) a familiar structure and context (Bovey & Hede, 2001; Zoller & Fairhurst, 2007).

Emotional labour, as discussed in Chapter One, is a key feature of the work that many people do, and is an integral part of any job, but particularly so in an institution of the NHS (see for example Gabriel, 2004). Different occupations require different types of 'displays' and following Hochschild (1983) emotional labour requires adopting emotional displays and attitudes appropriate to the role.

Clearly in hospital work all staff have to expend emotional energy on 'caring' and 'kindness' but it is also the case that working in the NHS, with its many changes for (perhaps) better or (maybe) worse, also requires the ability to be able to 'move on' i.e. mourn the loss of the old structure, sets of relationships etc. and embrace the 'new' with some degree of enthusiasm. The failure to do this (or recognise the need to do this) results in emotional resistance to changes and hanging on to the old systems as long as possible which might defeat changes that improve service delivery and benefit patients (Hughes, 2005).

6.5.1 Leading change and transmitting leadership

In one particular case a senior clinical manager Gerald³¹, was charged with integrating clinical practice across two sites, each of which had their own different ways of working, and different relationships to the boundaries between each other and the clinical teams. While the one (where he was based primarily) had accepted quite radical changes to its organisation, the other (apparently) did not "*..because the sort of ethos and the sort of personalities of the two sites are in the background. They are completely different*".

Gerald's view is based on a reality in that the two sites are structured differently, look different from each other in that the buildings are from different eras and in different styles, and they are in physically different locations. They also serve different demographic populations and have different histories. However, Gerald sees the organisation of the different

³¹ Gerald's leadership is discussed in detail in Chapter Seven.

sites as really being about 'ethos' and 'personalities' which must be in the mind (mostly) as there is a system of authority and responsibility in place across the Trust (via the CEO and other senior people including Gerald) that takes up authority and leadership to ensure consistent practices and organisational change.

Thus, we need to ask why one Unit has (apparently) taken new ways of working on board with some enthusiasm while (apparently) there are barriers preventing the other one doing something similar.

For Gerald, management of the boundaries between in-patient care and primary care teams was the source of a key difficulty:

There are groups of people here who are completely behind the concept that we mind about – integration of primary care – joint working between the Trust and the Primary Care Trust. Some departments work extremely well and are keen to move forward and although we do have our minor difficulties - generally there's one or two departments who are completely against change and erm resistant to anything new. Just like any other organisation where you know you are going to get the type of people who actually make life extremely difficult for you and despite that we've proven how much better our system is.

In the extract above he moves from talking about the other *site* (as a whole system) as being the 'bad' resistant one, to identifying *individuals* on his own site within the 'good' system as making life difficult for him personally despite evidence (he and others have provided) to show how integration works better. This respondent's organisation in mind shifts depending on how well one part of the system fits with his particular vision of a good organisation. This *splitting* (see Chapter One) is a mechanism (unconscious) for preventing the overwhelming feeling that can come from persecutory anxieties (Jaques, 1953; Jaques, 1960; Menzies, 1970). In a management role where (for some reason) authority is being undermined, then the resurgence of persecutory anxiety might be dealt with by splitting of the 'bad' site and comforting oneself with the knowledge of a 'good' site where the organisation works as this leader/manager might wish it to do (Laughlin & Sher, 2010).

6.5.2 Resisting change

In the case of a medical secretary, with over twenty years experience of working in the same hospital, the thought of change in the structure of her working relationships was upsetting. She began engaging with the interviewer by talking about how busy she was and when asked if there was any particular reason why she was busy at that particular time she went into an explanation about organisational change. *"It's just generally busy, but we*

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are in teams now, erm couple of them [doctors] are away and one or two have come back, catching up with everything". It seems as if the teams were the problem for her because previously (and for many years) "...it was one secretary to one consultant and his team. Now for instance today I'm actually taking calls for four different consultants". She was asked about the new structure and made it clear:

erm ... I don't think it's going to work as well as the previous one. Because I think you'll be dipping in and out of so many different jobs that instead of concentrating on the ones that you do well and controlling your one doctor, it'll be confusing and I think there will be mistakes made because one person is trying to deal with too many parts of too many jobs.

Her perception that her role in the organisation might happily continue as one in which she controlled one consultant is characteristic of the 'comfort' of the closed system where authority, power and the processes of leadership are condensed and held 'constant' by an individual. As seen in Chapter Four also change is not usually welcomed without at least tacit resistance and in Chapter Seven two of the case studies will explore how leaders as potential change agents experience followers' avoidance or challenge to changes in practices and structure.

Changes in working relationships bring anxieties which need to be understood and anticipated by leaders if they are to support staff to position themselves differently in the system. Hoyle (2004, in Huffington et al) suggests that during any period of organisational change there is potential for heightened creativity which might lead to doing things differently and better. However, change also brings about risk, uncertainty and the chance of failure which can evoke anxiety both in those promoting the changes (the leaders) and those who might fear loss of their job and the loss of known ways of working (see Hoyle, 2004, p.87).

6.6 Conclusions

Understanding an organisation and what facilitates and/or hinders leaders to take up their authority involves considering the organisation systemically. That is taking account of the boundary management and how that relates to the tasks, roles and power/authority of those who work or are 'consumers' of its work.

Leading change depends upon ensuring those within the system have a sense of how the system works and an awareness of the culture that might be tested as a reality or not. This means, once again, that organisations which are learning environments and where emotional intelligence is applied, are more likely to respond to authority and less likely to subvert

leadership, thus distributed leadership/responsibilities may be taken up or shared more widely.

7 Leadership, Authority and Emotion

7.1 Introduction

As argued above, leadership and emotion are fundamentally intertwined in the workplace (Fineman, 2003). Leaders who appropriately manage both their own emotions (Goleman et al., 2001), and those of their followers, experience better leader-follower relationships, greater opportunity for innovation, motivation and productivity, a more positive organisational climate and improvement in employee and customer/patient satisfaction (Ashkanasy et al., 2003; Avolio et al., 2004; Hollander, 2009). Such outcomes can be associated with both *transformational leadership* (Bass et al., 2003; Corrigan & Garman, 1999; Currie & Lockett, 2007) and *distributed leadership* (Bass & Steidlmeier, 1999; Gronn, 2000, 2002; Mehra, Smith, L. Dixon, & Robertson, 2006b) patterns.

It has also been suggested that followers' 'dysfunctional' dependency is a consequence of failure of the leader to *engage* on an emotional level with those whom they lead (Alban-Metcalfe & Alimo-Metcalfe., 2009; Ashforth & Humphrey, 1995; Bion, 1961; George, 2000). There are different types of such engagement, e.g. acknowledging emotions, drawing them out, honouring them, confronting them, and deflecting them, but although this idea of engagement has been described as "*compelling on the surface, the meaning of the employee engagement concept is unclear*". (Macy & Schneider, 2008, p.3) Even so, there is a common view that such engagement is desirable for organisations in that it connotes involvement, commitment, passion, focused effort and energy from staff thus demonstrating both attitudinal and behavioural components for an effective workforce. (Macy & Schneider, 2008)

Studies of leadership and emotion have not typically been combined with attention to the 'authority' of the leader (Ford, 2006; Stein, 2007) or indeed to the concept of 'power', (sometimes seen and experienced interchangeably). (Morgan, 2006) A study combining exploration of the relationship of authority to concepts of both 'emotion' and 'engagement' (Hirschhorn, 1997) is particularly relevant to the agenda of the 'post-modern' organisation where leadership is distributed (Clegg, 1990; Tierney, 1996) and the organisation potentially fragmented, unmanageable and diverse.

The authority invested in a particular role, such as the CEO (Chief Executive Officer) or lead clinician may not explicitly engage emotion. However, in an organisation such as an NHS Trust, where leadership styles are, or at least

intended to be, characterised by distributed or transformational attributes, the concept of authority is more closely linked to *personal* authority whereby individuals “..bring more of themselves – their skills, ideas, feelings, and values – to their work. They are more psychologically present.” (Hirschorn, 1997, p.9). Thus for example clinical skills *and* personal investment are *both* required for someone to take up authority in practice as a clinical leaderⁱⁱ.

In this chapter we delve further into the concepts of leaders and leadership, particularly focusing upon leaders with a ‘mandate’ to lead change through their formal *role*. The group of participants we specifically focus upon here includes clinical and non-clinical senior managers and we examine the ways these individuals construct their role, their relationship to ‘followers’ and how their *authority* is taken up, experienced and constructed in their specific organisational context³². Authority has more than one meaning. It refers to the authority (sometimes seen as power) invested in a particular role.

Analysis of relationships between people who work in the NHS is underpinned by both the *interactional* and the (related) *emotional* contexts of an NHS Trust as a workplace (see for example Liden and Antonakis, 2009). This knowledge is particularly salient because on the surface, many of those occupying the leadership roles were inclined (at least superficially) to deny the role of emotion although analysis of their stories, shadowing and observations, following the pre-existing literature on organisational cultures, including those which study health care settings, indicated that emotion indeed plays a key role in service delivery and the ways leadership and authority are experienced and constructed in relation to patient care (Vince, 2002; Gabriel, 2004; Hirschorn, 1997; Huffington, 2007; Obholzer, 1994; Vega-Roberts, 1994).

7.2 Case studies

Three case studies were selected to examine the meanings given to the relationship between ‘leadership’, ‘emotion’ and ‘authority’ in relative depth. Each one was chosen (through discussion among the research team) to be (potentially) representative of a ‘typical’ approach to emotional management which reflected a personal style of authority (or lack of authority). These particular cases raised subtle but crucial questions about leadership, emotion and authority through exposing both the conscious and *unconscious* qualities which can either underpin or undermine a leadership *role* (Bovey & Hede, 2001).

³² In this chapter we focus specifically on the senior staff’s perspectives. Others’ perceptions of senior staff were discussed in Chapter Six.

1. The first leader, Gerald, had an 'authoritarian' manner (Adorno, 1950). That is, he appeared to believe that because he was in a senior position other staff ought to do what he told them to do. He was a senior clinician [for a group of particular services], relatively young, very enthusiastic and held an uncompromising vision of how a good hospital should be organised. He was interviewed once by a researcher, once by a group including the PI and 'shadowed' for two days by the same researcher.
2. Kerry in many ways held a similar outlook to Gerald, only she *believed* that she attended to the emotions of her staff if not her own. Kerry was Gerald's immediate boss and evidence from the interviews, shadowing and observations in both cases indicates they did not always work effectively together. Kerry was interviewed twice. Once for information as a key informant by two researchers and the second time by the PI and a researcher together. She was also observed by a researcher for an hour.
3. Quentin was a Clinical Director. He made overt efforts to weigh up the emotional 'risks' to his authority and thus seemed more able to engage with the 'followers' (and thus probably survive) in the *role*. At first he was reluctant to take part in the research directly (although he supported his colleagues' participation) but eventually agreed to be interviewed. Two researchers met him before the interview conducted by the PI, in his role as a key informant and observed him and the senior colleagues in their shared office space for about 30 minutes.

7.2.1 'Gerald'

Gerald held a clear vision of how a good hospital should be organised for the benefit of patients. What he appears to find problematic is managing staff who (for whatever reason) have a vested interest in different styles from those he advocates of patient care, working with colleagues and patients, and/or visions for service delivery.

The following extract is from the shadowing of Gerald.

From the two days spent with Gerald it was very clear that he believed that he was one of the main 'leaders' in the Trust and that he had a strong relationship with the middle and upper managers (including the CEO) which he uses to his advantage especially during long discussions regarding the 'new vision' (which appeared to be very much his vision) for the relationship between the two sites.

Gerald did indeed appear to be one of the main leaders. However, it was unclear whether the power and influence in this leadership role was all smoke and mirrors. Does Gerald play the role of the Wizard of Oz? Does he

think he has more power and influence than he actually has? Does he really have a good relationship with the Trust managers and Chief Executive?

The interview with Kerry (the CEO) made it apparent that she did not consider that he was one of the main leaders in the Trust and it was indicated that she didn't think much of him, and that their relationship might have been fraught.

Discussing the researcher's notes some weeks later, one thing that did emerge was that Gerald 'confused' those around him and was apparently unaware of how others saw him and how far his personal authority actually stretched. Hirschorn (1997) in a study of authority in contemporary organisations has suggested that leaders are no longer the old-style authority figures and because of changes in technology and economics "... bosses can no longer project the certainty, confidence and power that once facilitated employees' identification with them when they [employees] were young and dependent. This is why people are so disappointed in leaders today but also so unforgiving of them" (p. 9).

Gerald, although he had a clear management role and mandate to make the changes he focused on, did not get identified by his colleagues as fulfilling the vision of a leader as there is an implication in the observation extract that his authority may have been achieved via 'smoke and mirrors'. Furthermore his appointment (and that of several of his close senior colleagues) predated the appointment of the CEO. Several questions are raised here by the researcher about whether Gerald has been capable of taking up authority when the CEO takes a stance that at least tacitly opposes him. *This has to remain unanswered in the specific context of this Trust but is an important matter to consider in regard to distributed leadership.*

Gerald prefers to position himself as 'evidence-based' (and therefore up-to-date) dealing with practical matters and not positioning himself as an *emotional* leader. In the interview below, thus, he talks about making difficult decisions but paradoxically, almost from the beginning he focuses in upon dramatic inter-personal conflicts - talking about 'facing up to a fight' and declaring that the Trust 'absolutely' does not have the kind of leadership that enables 'direction' or 'vision'. Does this mean the CEO? Does this mean consultants? It may not even be intended so specifically perhaps it is an expression of general frustration that his vision is not shared.

While on the surface he claimed a good sense of what leadership is about he is also revealing in his talk, the opposite position. Taking a team or department in the direction of the vision and making difficult decisions is for him about a relationship with (not) being 'scared' or further down in this extract, (not) 'afraid'.

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Gerald: Erm...good leadership, err having the ability to make difficult decisions, err, not being scared to face up to a fight...erm...being able to be clear about errr, the direction or vision of the trust, where we are going and be able to errr direct your team into the position that everyone errr everyone is meant to be going, erm I think

Q: Yeah...and do you see that kind of leadership in this hospital?

Gerald: No, absolutely not

Q: No? And why, why not? What's the problem to that kind of...

Gerald: I think that in the past, we .. we have been afraid to face up to a fight, and we have shied away from it.

Q: Yeah

Gerald: From making difficult decisions, and err, and we've let too many people get away with undermining the overall plan that we have...'cause we all know how to deliver excellent healthcare, we all have our views of how this is going ahead, but err, and the grand picture has been undermined by a few, and we've not been able to really face up to those people

Gerald believes that while everyone knows how to deliver 'excellent healthcare' a few have undermined the/his 'grand picture'. He also identifies with a group who support his particular vision while not expressing empathy with those who do not. As the interview progresses, Gerald berates the power (rather than leadership qualities) that consultants have had in the past suggesting that they *undermine* changes that he clearly and sincerely holds about what constitutes good patient care.

Gerald however does reflect on what he is being asked as evidence by his suggestion later:

I don't know about what makes a good [leader]...you know, its difficult to say what makes a good leader...because I'm not sure I'm a good leader, because the qualities that I feel perhaps are necessary, I don't perhaps have ...one of those is patience perhaps...err, being able to tolerate people's err err, err stupidity in a nice way, is essential I think, but I don't have that, I don't think...being, having the ability to listen, err, err, err and not judge or criticise too quickly is very important, but then, taking everyone's opinion into account, but then at the end of all that being able to still go your own way, and persuade everyone else that it was their idea in the first place ... Well, I have certain qualities which help me get the goals that I like...erm...whether I have everybody behind me.

This is one (although not the only one) of the more (paradoxically) emotional interviews from among the senior managers in the study. Gerald

recognises, quite passionately, that a leader needs followers and has to be tolerant. Gerald, though, cannot help declaring that those who presumably hold differing opinions to him to be stupid. He also said later in the interview that he believed many people were *against him* when he was appointed to the senior post as the Trust itself changed shape. While he would not it seems position himself as emotional (rather he sees himself as evidence-based) he chooses to talk in emotive ways and reading and hearing what he says is quite exhausting as he uses all his energy in trying to take the organisation where he believes it should go, but through lack of emotional intelligence, many a time he draws a blank.

Gabriel and Hirschorn (2004) might describe Gerald, at least in part, as a 'narcissistic leader' in that he liked to be told he is important and influential but he is also potentially a bully and authoritarian in style (Adorno, 1950). He clearly found criticism intolerable and split off the 'bad' (i.e. the consultants who didn't go along with his changes from the 'good' i.e. the 'we'). Gerald has a dream which he is determined to make into a reality, however, there is a "*delicate balance between feelings of omnipotence and feelings of impotence which leaders must achieve, in order to enhance the chances of turning vision into reality*" (Gabriel and Hirschorn, 2004, p. 144). These authors argue that narcissistic leaders have a particular aptitude for getting this balance wrong and "*Even if they are talented in their field, their judgement increasingly fails them. This is compounded by the collusion of their followers*". This may be Gerald's 'we'. Gerald fails to connect emotionally with his (potential) followers from outside his close-knit 'we' group even though there may be some admiration for his clarity and link with the NHS mandate. This means, in effect, that important changes which may well be for the benefit of patients in the contemporary NHS are being (effectively) resisted because of Gerald's style of leadership. Gerald also appears to have little idea of how others might experience their worlds, including their emotions.

This theory might be borne out by the following participant, a young female career NHS manager just reaching a senior position. She proposed Gerald, unprompted, as an example of a good leader:

I think he's great, he gets a bit of bad press sometimes, I think people get agitated with him, but I think it's because he tries to manage things, and he tries to be very fair, and he tries to solve problems that have been with us for a long time, so again, I think he is a good leader, he is trying to do the right thing for the Trust in the long term. He is erm ... sometimes it's difficult for him to carry people with him, but I think that will pay off in the long run. And I think he's thinking of a long term plan, he's prepared to take a bit of short term flack...but I think it will work out in the end. I think he's going about doing stuff in the right way, he's being fair and he's trying

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to be consistent, he's making sure he's got an evidence base for doing things, it's not just a random decision, he's collecting information, and that kind of thing...I think there are a lot of people in this organisation at this point who would say they didn't think he was a good leader, but I think time will tell the story there.

This extract from the interview, while consistent with Gerald's descriptions of his own behaviour, proposes an evaluation of his style which indicates he is likely to be successful in the longer term because he is 'trying to do the right thing for the Trust'. However also she identifies quite clearly that his leadership is failing to take many of the people who matter along with him, she positions herself as sharing his vision for the longer term benefit of the Trust which may reflect her *a priori* engagement with NHS management rather than with a clinical profession as she does not have a clinical background herself. It also seems to reflect collusion with his narcissistic style because she seems to mirror his version of himself. This participant continues:

Sometimes they're [other senior staff particularly doctors] quite quick to criticise without really understanding what the problem is that needs to be solved, and what some of the rules are we can't ignore. Some of the national directives, that we just have to do, there's no point fighting against them, we've got to find a way of implementing them, and I think sometimes he gets a really raw deal...but he's said, he's consistent, he will communicate to people, write to people and speak to people very quickly the minute they raise a problem, and he definitely shows that he is not shying away from difficult problems...I think that's a very strong characteristic.

Her description of the other staff appears to chime with Bion's theory of a fight/flight basic assumption group based on unconscious emotional ties of the group involved which (mostly) represents an anti-task resistance to the leader (Bion, 1961). *This extract above reinforces the possibility that Gerald is emotionally disengaged from his followers* and perceives his Trust to be in line with and in favour of NHS 'national directives'. The participant here who in a way is 'damning' Gerald with *strong* praise may be looking to Gerald as a potential mentor by making it clear that she will support his particular efforts. However when the researcher asked her about her *own* leadership she said:

.... because one of my strengths is pulling people together, one of my strengths is building teams, so I think from that point of view then yes, but then sometimes I look at people like [Gerald and her immediate boss] and I think 'Oh my God'. I've got so much respect for the way they deal with

the very difficult issues. Sometimes I wonder if I really put my neck out enough to say 'Ok, Ok, this is what we all need to be passionately aiming for.' Even if not everybody is quite wanting to do the same thing. I think sometimes I sit back a bit more and wait to see what the general feedback is, rather than stick my neck out and say 'Ok, this is the direction we've got to go in.' And I think as a leader you have to...well, in fact you probably have to do a bit of both.

This participant, it seems, is somehow subjugating her own skills and strengths to those whose skills and strengths do not correspond with what she believes in makes her a good leader and seems to be putting herself down for the skills she has got and does seem to value. Alternatively, she might have realised that her strengths might complement Gerald's and through his own narcissistic valency he may position her as someone to promote.

Finally, in relation to Gerald, whose example she insists on returning to, having described other more emotional and successful clinical leaders in the Trust:

.... And they [other senior staff] make it very evident that they don't support him [Gerald] in his role, and not only do they make it very evident, but they do a lot of stirring behind the scenes, to get up a bit of a frenzy against him And I think there's some very clever leadership involved in that process, and there's a lot of learning, gathering people in, getting them on board and uniting them in a common purpose, and this and that and the other, but it's not constructive.

7.2.2 'Kerry'

Kerry is Gerald's immediate boss (the CEO) and evidence from the interviews, shadowing and observations in both cases indicates they do not always work effectively together³³. Kerry herself has met with similar difficulties which seem to be the outcome of her attempts to encourage distributed leadership in that:

Kerry: Erm, erm, well we set up a process to...we re-wrote the discharge policy here. I chaired the group. I wanted to know what the problem was about discharges, and I was told we needed to rewrite the discharge policy,

³³ Regardless of personal authority in the cases of both Kerry and Gerald, it is clear that the organisation has had its own very particular problems which are *endemic in the system* (see Chapter Six for a more systemic analysis of leadership).

and we'd just done it. People looked at me, and I just said, well I've spent...I've chaired five meetings myself, where we put all the information forward, and all these arrangements in place and nobody's done anything about it. I think that's poor leadership.

Q: So erm...poor leadership on whose part? Because presumably you had people who you delegated this to?

Kerry: So the consultants, the nurse managers, the matrons...all the people that were on the working group really. And they just didn't implement it. Beyond belief really.

This extract reveals several levels of emotion and authority and (as with Gerald's narrative) there is an 'I' who takes action and the 'they' who are against her. Kerry had identified a problem with discharges but had to ask 'them' what it was and was told that 'we' needed to rewrite the policy. She took up the role of chairing five meetings, the group/'we' put the information forward and the arrangements in place (presumably to take action) but 'no-one' did anything. It is not known how she handled this 'failure' of leadership on 'their' part. Kerry appears to be a micro-manager (in that she herself was involved in the meetings). Reflecting on this interview, and reading the text, one of us reported back to the research team that she had misunderstood Kerry, thinking that Kerry had been talking about her *own* case of poor leadership. Perhaps it was as unclear in the action as it was in the telling (thus perhaps on an unconscious level the lack of clarity was communicated in the meetings). Why did Kerry, as the leader, not pick up the group's dependence (or *resistance*) (Bovey & Hede, 2001; Hughes, 2005)? This suggests that she herself had resisted emotional attachment to her 'followers' and failed to engage them on an emotional level during the meetings. One approach that helps to understand the example above of *resistance*, specifically in the context of the five reported meetings, is the idea of '*fight/flight*' from the work of Wilfred Bion (1961/1983). He suggested that a 'group mentality' (or group culture) emerges from the development of a group over time as it continues to meet, because individual contributions conform to this mentality. In brief, the formed 'group culture' unconsciously constrains individual members (see also Sherwood, 1964).

So, in this case it may have been that despite the seniority of the staff involved in rewriting the discharge procedure, the culture that had developed over the course of the five meetings (and possibly prior to this as 'they' had suggested the need to re-write the discharge policy) had *prevented/resisted distributed leadership*. This could have led to the group not making sense of the leader's expectations and reverting to the comfortable pattern of being that had not been challenged possibly (again) because of the leader failing to manage her own emotions or engage with those of her team.

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Bion (1961/86) suggests, that the group mentality exists on both at a conscious and unconscious level so that the team were probably not deliberately, or consciously, going against the leader. It seemed from the leader's description that the team had been almost 'sleep walking' – not recognising that they had already done what they later ignored and suggested needed doing. Dependency, according to Bion, meant dependency on the leader or "... *when all individuals in the group look to myself as a person with whom each has an exclusive relationship*" (Bion, 1961/86: 119). Within this mode there is little connection between the members themselves and there is a '*mass inertia*' (op cit). This links to Klein's depressive position (Gould, 1997). It also raises questions of who is depressed here - Kerry, the group, or the group in Kerry's fantasy? The unconscious resistance and frustration experienced by the leader here demonstrates the fluidity of power and potentially the influence of gender (Fletcher, 2004; Nicolson, 1996; Vince, 2001)

Kerry, however, did claim success in turning around previously identified failings in patient care targets. How did she manage this?

Well I ... I... I mean it requires a great deal of focus, which hasn't been succeeded by other individuals, so...and it's required the organisation to understand its importance, and that it is possible to do. So it's been trying to talk to people about 'OK it's a target, but it's a quality... a patient quality target, so don't look at it in a sort of derogatory manner'.And ((3)) ...so it's a bit of culture about are you being bullied, as a member of staff to achieve the target and if you're not being bullied well then why is important and then well it's important because its patient quality ((1))...and then I suppose, something about... I mean one of the turning points for me is about our reputation as well, which is...well everyone else is achieving it, and we're not, 'why do you want to be in the bottom 20% of the country?'

Resisting her own emotional attachment here she talks in the third person. Rather than saying that as a new senior manager she had managed to engage the staff, which to a point she seems to have accomplished, she states that successfully addressing targets has 'required the organisation to understand its importance'. She clearly perceives senior staff as taking a negative position in relation to government targets and has attempted to persuade people that such targets are about good quality patient care. Another feature of the discourse slips in here – is her style of leadership perceived to be a bullying one? It may be that a group mentality, which takes resistance and dependency to be part of its culture, perceives a leader with a vision, or at least with determination (and 'focus' to quote Kerry) to be bullying them out of their emotional safety. This is a problem for any organisation that suggests to its staff that successful change and development is solely about strong leadership. We have to turn again and again to the clear message emerging from the data that without an

emotional attachment and the ability to manage their own emotions leaders and followers are not going to achieve goals related to patient care.

7.2.3 'Quentin'

Unlike Gerald, Quentin feels that he is succeeding in bringing about change and unlike Kerry he is mostly positive about the impact he is having upon the staff groups. He told two stories, one of which was when his leadership worked, and another where he continues to experience problems although he emphasised (to support his authority) that the latter was not a great a worry to him. In his interview he focused very much on the importance of personal authority: *"I'm still playing the trick of getting people to do things by example"*. He tries to back up his personal authority through making personal contact as much as he can:

You know my job could be answering my e-mails and I'm desperately trying not to. I've made a pact with myself that I will not explain myself in e-mail. If it needs to be explained I will go and explain it [personally].

He distinguished between the roles of the CEO and medical director, which in his opinion were *manager* roles, and that of clinical director which was a *leadership* role.

Quentin moves between the position where:

...people need constantly to be reminded of what they need to achieve ... [in relation to patient care] ...I use the word good care because [they] have the tendency to lapse into what is acceptable or even worse, what they can get away with.

To the position that:

And I think there is some requirement to continually challenge the organisation about what it is providing and sort of have a re-education process. And I guess we all need that – because I need that as well you know and it is one of my roles to keep reminding everybody why they are doing what they are doing.

Quentin sees himself as needing space to reflect upon the aims of the service provision and recognises that he is just as able to lose track of the organisation's main purpose as his colleagues/followers are, given the daily round of work. While Quentin gives an interesting example of how he and the team succeeded in meeting a target for patient waiting times in Accident & Emergency (which involved him engaging personally with the staff in an emergency meeting):

... which was all about persuading your senior contemporaries and peers. It's about the juniors, the people who are actually delivering the services. It's about making a reasoned argument. It's about being visible. It's about being honest and it's about delivering it.

The success, he believes, was about the personal contact and his own visible attachment in trying to change things alongside his colleagues and being very clear that " *...this needs to be achieved at all costs - which was quite liberating*". The rhetoric here is very different from that used by both Gerald and Kerry, who feel their colleagues are letting them down; possibly they are 'splitting' the 'bad' and projecting it into recalcitrant colleagues in order to feel reasonably good about their own positions (Klein 1987, 1983). Quentin is talking about success and success through *taking an emotional risk*. Saying that a change needed to be achieved at all costs (which he described as liberating) could be interpreted as Quentin making an emotional commitment to engage with his followers about something identified by the government, the NHS and his Trust as important. This stands in direct contrast to the experiences and rhetoric of both Gerald and Kerry who express the frustrations at what the 'others' are failing to do. However with what Quentin called a "*slightly different problem*". He has had great difficulty dealing with a doctor who is "*just a very difficult person to manage ... and I need to say to him 'this is crap and needs to be done in a completely different way'. I don't quite know why I haven't done that*". Once again Quentin was expressing an emotion – anger but without pushing/projecting blame on to the other, but being clear what the other person was doing and reflecting on his own sense of why, how and when he might take this issue up with the protagonist.

While Quentin operates with a quiet assurance and takes up his formal authority, and the power that accompanies it, from a classic Kleinian 'depressive position' (Klein, 1975; Segal, 1973), both Gerald and Kerry, despite their formal authority, fail to engage with their followers which leads to their powerlessness and a sense of rage and frustration.

7.3 Conclusion

The interconnections between power, authority and emotion play a complex part in understanding what leadership means to all those involved and in each organisational context. Leadership cannot be understood as something that can be observed and/or measured 'objectively', it is not an essential 'quality' which resides in an individual but is socially constructed, meaning different things to different people at different times. Following Ford (2010) a more contemporary, appropriate and critical approach to the study of leadership "*pays attention to situations, events, institutions, ideas, social practices and processes that may be seen as creating additional repression or discursive disclosure*" (Ford, 2010, p. 51)

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To be specific Rioch (Rioch, 1975), and others had made the point that *"'Leader' is a word which implies a relationship So the word 'leader' does not have any sense without a word like 'follower' implied in it".* (p. 159).

The relationship between leaders and followers might be more or less successful and in order to be a follower a person needs (even on a very temporary basis) to 'give over' something of themselves (i.e. make themselves emotionally open) to the leader for the relationship to have meaning. Being a follower may be both (or either) passive or active and there is the potential for the follower to engage and support, or subvert leadership (Bondi, 1997; Halton, 2007; O'Brien, 1994). Consequently, in order to analyse what it means to 'lead' in an organisation, understanding the practice(s) of emotional management alongside an analysis of power relations is fundamental (Grint, 2005; Schilling, 2009). For Foucault (Burrell, 1988; Foucault, 1982) power *"exists only when it is put into action, even if, of course, it is integrated into a disparate field of possibilities brought to bear upon permanent structures."* (1982, p. 788) Thus, while organisations give formal power to relatively few leaders (including in a distributed model of leadership) consent is still required for the power to be maintained. Furthermore, 'the other' that is the one over whom power is exercised, needs to be *"recognised and maintained to the very end as a person who acts"* (Foucault, 1982, p. 789).

The leaders we have described above all admit falling into traps where their authority has been challenged/resisted and they have been (potentially) made powerless. Quentin alone demonstrated awareness that he was working *with* people rather than treating them as resources. This meant that despite experiencing some frustrations, he managed to continue to *feel* and *think*, and with his colleagues/followers on board, *implement* changes. Kerry and Gerald, while attempting to take up their 'legitimate' power and lead change, both squander their authority through failing to manage and/or engage with their own and their followers' emotions. This is evidenced by their displays of frustration, impatience and anger with those who fail *to do what they are expected/commanded to do*.

Gerald held a classic authoritarian view of power, indicating that whether he takes people with him or not, he intends to get to the *'goals that I like'*. He also sees the resistant followers as stupid. He defines leadership accordingly, in that the leader should *'direct [the] team'* and not be afraid to *'face up to a fight'*.

Kerry sees herself somewhat differently even though she experiences anger and frustration when followers fail to do what she wants and expects. In attempting to empower her subordinates and set up the 'processes' to distribute empowerment (such as the meetings described above) she was left feeling disempowered following an (apparent) breakdown of

communication between herself and the senior team she tried to work with. That one of the interviewers also had to clarify: "*poor leadership on whose part?*" suggested that Kerry possibly re-experienced the rage and frustration she felt at the time of her encounter with the followers in her story when she told it. This rage obscured clear communication both then and in the telling. It might be that the overwhelming need to prevent the Trust from being '*in the bottom 20% of the country*' was a source of anxiety for her and the importance of achieving these specific sets of goals contributed to her impoverished emotional literacy.

Distributed leadership (Gronn, 2002; Mehra et al., 2006b), as a response to 'postmodern' organisations (Tierney, 1996) sets out the changing nature of authority/power. In combination with ideas from the emotional/social intelligence literature, distributed leadership suggests a more relational model of leader/follower relations whereby leadership decisions may represent both outcomes and inputs (Ashkanasy et al., 2003; Wolff, Pescosolido, & Druskat, 2002). A warning note, however, reminds us of the persistence of the patriarchal version of 'the' leader (Ford, 2010; Ford & Harding, 2008) which occupies the dominant discourse within which the notion of 'effectiveness' neglects (if not ignores) the importance of the management of emotions in the leader and followers.

Through the use of innovative research methods and data analysis, which take account of both conscious and unconscious processes through which leadership is socially constructed and exercised, the intrinsic complex connections between authority, power, emotion and leadership in the context of health care can begin to be disentangled.

Leadership that 'works' for an organisation such as the NHS is a multifaceted, emotional *process* in which leaders manoeuvre to manage their own and their followers' emotions and behaviours on both intellectual and emotional levels. To be effective in, what are now seen to be, postmodern organisational contexts, leaders also need to reflect upon themselves in their role and to understand the structural, cultural and emotional expressions of their authority and the authority and power of their followers. The legitimization of emotionally engaged leaders' authority supports effective service delivery across the different levels of the organisation through undermining conscious and unconscious resistance(s) as described in the examples above. Power as a coercive violence (see Foucault, 1982) has been exposed and undermined in such organisations and 'replaced' by concepts of 'distributed' leadership where the persistent claim to power is by definition and necessity more fluid.

8 Gender and Leadership

8.1 Introduction

Gender and leadership is an area that has attracted interest among policy makers and researchers, because the styles of leadership that are currently perceived to be the most effective, such as transformational and distributed, are believed to 'fit' more closely to 'feminine' styles of leadership. Fletcher (2004) notes that traditional 'heroic' leadership is usually associated with masculine traits (rather than men and women *per se*) such as individualism, control, assertiveness advocacy and domination, while 'post heroic leadership traits (such as empathy, community vulnerability, collaboration) are more associated with feminine traits. Ford (Ford, 2010) reconsiders the concept of *effective* leadership which is in fact a patriarchal model perpetuating an exclusionary and privileged view of the leader (metaphorically the 'father' figure).

Traditional research into gender, organisations power and leadership suggests that there are particular 'masculine' and 'feminine' leadership traits that are generally believed to characterise men and women's leadership styles (Rosener, 1990; Collinson and Hearn, 1994; Nicolson, 1996; Carless, 1998). Because women are widely believed to adopt a more democratic leadership style and men believed to adopt a more autocratic one, distributed leadership and concerted action in networked organisations may potentially be more conducive to those (women or men) who can adopt a more traditionally feminine relational style of leadership. Furthermore, feminine styles are more akin to displaying social and/or emotional intelligence (Guy & Newman, 2004; Leon, 2005).

In reality, both men and women display a variety of 'masculine' and 'feminine' leadership styles, depending upon their individual personality, age, position and the situation involved (Cross & Bagilhole, 2002; McDowell, 2001). However, gender *expectations* influence perceptions and beliefs and research suggests that subordinates are often more satisfied with leaders who behave in gender-typical ways than those who go against gender-type (Porter, 1992; Rosener, 1990; Williams, 1993).

Indeed, women in explicit leadership roles often tend to be viewed less positively than men, in the belief that 'masculine' traits (competition, authority, lack of emotion) conform more to expectations of how a 'leader' should behave but not how a woman should (cf. the work of Broverman et al. 1970). The 'paradox' it seems persists in contemporary organisations so that some women leaders feel they have to behave in a 'masculine' way which frequently makes them appear rather heavy-handed and/or as a 'bullying' because these behaviours do not fit with ideas about women (Eagly & Carli, 2003).

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Most of the women and (some) of the men we spoke to during the study, made a point of denying that gender was an issue in today's NHS, indicating that they believed that women and men were treated equally, with an equal chance of success. However, several participants also mentioned gender differences in the negotiation of power and identities describing how either women or men were likely to gain advantage through use of their gender-typed styles (Lewis, 2000; Schnurr, 2008; West, 1984).

Gender and leadership it seems remains a contradiction in people's minds but gender is a fundamental component of the discourses surrounding leadership in the NHS because of the demographic issues in clinical management and leadership (Evans, 1997; Gardiner & Tiggerman, 1999) and as we have shown in Chapters Four to Seven, role models and styles of leader/follower engagement have a major part to play in the transmission and exercise of leadership (Gill, Mills, Franzway, & Sharp, 2008; Greener, 2007).

We want to note here, partly in passing, although an example below (in the interview with 'Jeff')³⁴ demonstrates its importance - that the *researchers'* gender and physical appearance (age, ethnicity, attractiveness) also played an important role in the research process.

8.1.1 Senior women managers: 'we're all the same now'

Women in senior managerial and/or professional positions either deny that being a woman is an issue for them or for their organisation or that they know what they had to do to prevent being seen as a senior '*woman*', rather than a senior leader.

Denying the impact of your own gender on how you are seen and how you manage and lead is not an easy position to maintain and we observed some senior women working hard not to be seen as women even though at the same time they were arguing that *this behaviour was not necessary* because of the way 'things have changed'.

The researcher's observation of a senior female manager (Catherine) indicated that she thought that Catherine was trying to avoid being 'feminine' in her interactions. When the two interviewers were waiting to begin the interview, Catherine's PA came into the room with an important message but was shouted at in front of them. Thus in her notes one researcher judged that Catherine wanted:

....to indicate lack of interest and assume a position of superiority. Catherine was transgressing the boundaries of polite professional behaviour and attempting to define 'her' territory of the hospital. Answers to the

³⁴ Not his real name.

questions were also defensive, perhaps indicating a lack of self-assurance. Despite the tough exterior she obviously felt a need to stamp her authority on people in order to maintain control of the situation. This may partially be related to her gender and need to appear 'more masculine than the men' in a competitive environment.

The researcher following on from her observational notes with comments following the interview suggested that *"whilst she [Catherine] initially denied gender to be a relevant issue [for senior managers in the NHS], she then went on to make reference to 'testosterone' and 'the emotions of females' as problems in managing in her senior role".*

The relevant part of the interview transcript is below:

Q: Ok, so are men a problem? Are women a problem? Are there gender politics? Or am I just old fashioned there?

A: I don't think there are anymore, I think there were. I mean when I was appointed, I could have been one of [only] four [senior] women, so the whole senior management was very ... very 'suitish'. I don't think, no, I don't think it is a problem anymore. No, I think it is, if you talk to people in the north of England, they will say it's still a problem, and I think its a bit more of a problem to get females into acute trusts, big acute trusts, it's a bit of a climate difference. I think there's a lot less testosterone around now, there's a sort of slightly...erm I mean I've got quite a young male management team.

Q: Right

A: I find the testosterone and sort of challenges a bit much from time to time So I mean from that point of view, it is quite interesting, it does manifest itself. As do emotions of females really.

Catherine's somewhat aggressive, or at least uncompromising, behaviour witnessed by the researcher tended to soften after that and she added:

A; So I do think the answer to the question is that there are differences, but I don't think they're... they don't fundamentally affect how you do the job.

Vicki, a senior geriatrician, discussed the question of gender openly and at some length with the researcher who suggested that she had seen both Vicki and Mandy, another senior female consultant geriatrician, being very 'gentle' in their approach to patients and the researcher wanted to know how far this was linked to the fact they were women. Vicki thought though that their approach was not about gender but:

You know it could be a geriatrician thing, I don't know, ((1)) you know you'd automatically say 'it's oh because we're women', but I think it's only when you start following a few men around as well who are doing the specialty as we are, because the thing that attracts us to elderly care rather

than any other specialties in the first place, and that could simply be what you're observing.

It seemed important to Vicki that she was not stereotyped as a woman leader although she was keenly aware that as more women took up medicine and were arriving in senior positions that this demographic change would in some way impact on leadership.

So maybe that's where you've got to go as well as men in geriatrics you actually need to look at women in other specialties and follow them on a ward round and see what they do and that may be a good idea as well for the gender thing. But it's quite important for your study because at the end of the day we're training over 50% of women as doctors and in the future they think that almost all GPs will be women so that will affect the leadership and sort of, that you see in patient care.

So Vicki, while seeing feminine *characteristics* as more important in her clinical specialism than gender *per se*, still believes women doctors (e.g. GPs) will make different kinds of leaders from men.

During her shadowing of Mandy, the researcher noted what she identified as gender-typical behaviour:

Mandy also implements a mothering aspect to her leadership role (also noticed in Vicki) as she is always thoughtful and considerate to her followers, making sure they are comfortable and happy with decisions made and that they are up to speed with their medical knowledge. This mothering role also seeps into the delivery of patient care. Mandy is also a leader that appreciates the help of her followers and always thanks them for their input and help.

While keeping in mind that the researcher herself is making assumptions about what is a 'mothering' style and also recalling Vicki's assertion that it may be more to do with the kind of people who are attracted to geriatrics than gender itself, it is important to note that the researcher spent several days shadowing and observing female *and* male geriatricians. Further, she discussed reflexively what she saw and how she interpreted it with the research team to check out her observations.

8.1.2 Men: the 'natural' leaders?

The researcher who interviewed and observed Catherine also interviewed and observed Jeff (another non-clinical manager) and contrasted their styles of interaction with other people in the organisation, and with her, during the interview. At first Jeff seemed more approachable, relaxed and generally more amenable than Catherine had been:

Jeff was a newly appointed male senior manager. From the outset he displayed supreme confidence in his own authority and power as a 'leader'

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and obviously did not regard a young female researcher as a threat. He was very friendly and personable and happy to open up the space of the hospital for us, answering his own emails rather than through a secretary, coming to collect me personally from the main reception and chatting and joking all the way back to his office. Throughout the interview he showed confidence in his own opinions and was happy to talk in detail about both his own and others' leadership. This confidence may be a result of several factors such as position, age, class, gender or personality. He freely admitted that he did not mind appearing 'hard' or unpopular if it was necessary to get the job done, however he felt that his main asset was his own 'charm' and 'charisma'.

Thus Jeff firmly claimed his place within the (masculine) 'heroic' leadership tradition.

While Catherine was perceived as guarding her territory and demonstrating her power, Jeff appeared to be relaxed, being more approachable and particularly not hiding behind his PA. In fact, his account of himself in the interview was somewhat disarming.

Q And do you see yourself as a leader?

*A: Oh yes certainly. I can remember the time when I realised that I should be in management. I was working in a **** clinic in [a Trust] and it was so inefficiently run and I said as much to the manager. She said 'if you think you can do it better then why don't you manage?' So I said 'OK I will!' And I think I'm pretty damn good at it. I don't play by the rules, I don't have any formal qualifications, but I can get things done. I'm not perfect – I shout, I swear and mostly I'm just very, very cheeky, but I'm good with people and that's what you need in this job. You have to be tough too, take knock-backs and step on people to reach your targets. But mostly I care passionately about the patients. I would never ever chase a target if I didn't think it would improve patient care. So that's why I went into management, and I suppose the other thing is I discovered, I surprised myself actually about, I was going to say how easy it was, it wasn't easy, erm I had a natural aptitude to do it, you know it was something that I was successful in so you know yeah?*

Jeff wanted it made clear that the 'inefficient' manager was a woman and that he himself is 'good' with people (and on the surface the researcher acknowledged this). However, he also valued the tough, target-driven 'stepping on people' (masculine) qualities of his leadership which he believed were important in delivering patient care.

Jeff put his confidence and self-identified ability partly down to personality, but also to his gender and upbringing, adding that certain class backgrounds seem to 'breed' leaders:

I do think that great leaders are kind of born, but my background was that I was at all male public boarding school for 10 years. As my father said 'the biggest waste of money' given my academic erm qualifications at the end of it, erm and there was something there about you know that sort of environment. I mean does it grow leaders? You would think so, you look at the number of public schoolboys that end up as MPs, that's probably not a good analogy

Q:((Laughs))

A: But there is something about that kind of white middle class upper class upbringing that you have, and although I wasn't from that background before I went to the school, erm you learn survival among your peers, you learn I think to survive, you know if you think at the age of eight you are sent away you have to survive you haven't got your infrastructure.

It seems that Jeff is suggesting that leaders are either 'bred' or 'grown' but either way the influence that makes them a leader comes early in their lives. In the example he gives here, 'growing' takes place in a male-only context reinforced by social class, possibly wealth and a general sense of entitlement. This model does not echo the efforts and ambitions of the NHS in everyday practice nor would it appear to be in any way appropriate to the model proposed by the NHS (see Chapter One) which is focused on the type of leadership appropriate to managing and leading 'diversity' and 'difference'.

8.1.3 Gender wars?

Being motherly (like Vicki and Mandy) is not equivalent to being weak or compliant as perhaps some gender stereotypes might describe women (see for example Bem, 1993; Nicolson, 1996). During an observation of Mandy, the researcher identified what she considered to be a 'battle of the sexes':

Gender issues were brought into consideration during the interaction between Mandy, a female consultant and a male consultant. During this interaction a battle of the sexes and power occurred with the two consultants struggling for power in very different ways. The male consultant tried to assert his power through attempting to ignore Mandy's presence, never looking directly at her, but was raising his voice and being rude. On the other hand Mandy was always very polite, looked directly at him, spoke very softly and smiled a lot, although it was quite obvious that behind the soft smile was a vicious bite.

Perhaps this isn't so much a battle of the sexes but an example of how men and women might behave differently towards each other in the course of a power struggle. The detailed observation notes show the encounter move by move:

There are some territory issues with Patient 9 and Mandy is angry that there is a patient on her ward that is being treated by another doctor. She asks why the doctor has continued his care now that the patient has moved ward and suggests that if the doctor feels that he needs to continue with the patient's care then the patient should be kept on one of his wards rather than blocking a bed that could be used for one of her patients. She asks "why can't we look after this patient? We are not supposed to have any outliers on this ward!" Mandy's registrar Melvyn can not, or does not want to answer her questions and simply shakes his head and shrugs. Mandy says she needs to speak with the consultant and asks Melvyn who the patient is under. Melvyn gives the name and admits that he has seen him arrive on the ward a couple of minutes ago, so he should still be there.

Who is Melvyn afraid of here? Or is Melvyn simply not wanting to witness a battle over territory and patient care?

Mandy walks round the other side of the nurse's station to find the [male] consultant with three other doctors/medical students standing some distance away and his registrar to whom he is speaking. Mandy and 'our' group move over to his location and the junior doctors from both groups greet each other and share whispered conversations. Mandy stands patiently at the side of the registrar waiting to speak with the consultant. Although Mandy continues to smile pleasantly I think that she is angry or frustrated on two levels. First because the consultant is on her ward and hasn't come to speak to her and second, because he doesn't seem to have the manners to even acknowledge she is waiting. After the conversation between the consultant and registrar has finished the consultant turns his attention to his paper work and the registrar moves to be with the other doctors (some distance away) Mandy lifts her eyebrows up to Melvyn (clearly annoyed with the male consultant's behaviour) and then asks if she can speak to him about Patient 9. Mandy explains politely that they do not have outliers on this ward and therefore asks whether the patient could be moved to another ward or if this cannot be arranged she take over the care for the patient. While she speaks the consultant doesn't look at her and continues to write, his body language and behaviour are both arrogant and rude. The consultant says that the patient is his and he will not be passing the patient over as she has problems not solely aligned with geriatric care and that she needs a specialist. Although this was clearly a statement to undermine Mandy's capabilities she continues to smile and tell him that the patient will be moved before the weekend so that a patient needing specialist geriatric care can have a bed.

Moving through this detailed account the gender issue becomes obscured by the fact of Mandy's skill as a clinician, a leader, her concern to give appropriate care within a context of limited resources and her ability to handle herself in the face of rudeness and arrogance. These are skills that ensure she will shine through as a leader in any context but particularly one

which is still a man's world. In a socially or emotionally intelligent context where concerted action is seen as important, patience, politeness and clarity of purposes will eventually win out over arrogance and bluster. As we see in the next extract Mandy's 'opponent' does not possess these attributes.

The male consultant becomes angry and raises his voice to Mandy and says there is nowhere else for the patient to go. Mandy lowers her voice and says that the patient must have been on one of his wards before she was moved so she can move back. The other consultant looks swiftly at the group of doctors who are stood behind him (both his own and Mandy's) and then eyes me suspiciously before turning back to Mandy and speaking in a lowered voice. The conversation moves back and forth between Mandy and the other consultant and it is clear that despite his outbursts and undermining statements to Mandy that she has the upper hand and although she continues to smile, she is very forceful and strong in her argument and objectives. To conclude the whispered conversation Mandy raises her voice and tells the group that the patient will be transferred on Friday and that she will be getting a transfer set up straight away. She then thanks the other consultant for understanding and walks back round to the group with a smile on her face and asks Melvyn to set the transfer up.

This is a consummate example of patience, calm and the ability to lead doing what she considers to be the best for her patients, her team and her department. Her skills in continuing to be quiet, calm and smiling have 'seen off' the male consultant in the meantime but reading this it would be surprising if the humiliated man does not try to take revenge. Although there is very little evidence that this is anything other than a 'normal' power struggle it is the case that Mandy is in fact a woman and has played, what is mostly recognized to be, a feminine role.

Returning to male expressions of power it is important to be aware that blatant attacks, such as the one in the encounter above, are not necessarily the only ways of demonstrating confrontational masculinity.

It appeared from the interview with Jeff (discussed above) that he believed he did not need to defend himself in the face of gender stereotyping. He had strong opinions on women's leadership and also on women's 'availability' with no qualms about voicing these which contrasts strongly with women's accounts where they try to underplay gender, that is that many senior women take the view (overtly) that gender is irrelevant.

The researcher's notes about the meeting with Jeff continue describing a dramatic example:

Jeff's supreme confidence meant that whilst he came across well in an interview situation, he crossed boundaries of professionalism in other ways, telling unsuitable stories about staff and inviting me (researcher) out for a drink after the interview, invading my personal space. In the extract below

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he accuses a female colleague of not only being attracted to him, but trying to use her sexuality (unsuccessfully) to get ahead at work, whilst simultaneously flattering me that I am his 'type' by subsequently asking me to meet him for a drink.

And in the interview:

Q: And could you give me some examples of bad leadership that you've seen?

A: Well, Melanie Willson³⁵, have you met her?

Q: No I was meant to but she cancelled the interview three times...

A: Exactly, she probably thought she was too important to talk to you. Now I can tell you an interesting story about her. She's a good looking woman, stunning, very intelligent too. But there's something not quite right, I don't know what it is... really cold. She's got no soul. I appointed her as divisional manager and at first she was doing really well, but then she ran into some problems. She was failing in her job. And that's when she started to flirt outrageously with me. It was like she couldn't beat me intellectually so she was going to do it another way. But, well... she's not my type. And she was really jealous when I got this job, I had Lucy (PA) go and announce it at the morning meeting and you should have seen her face. Anyway I hear she's got a promotion now so she must be doing something right.

Melanie Willson clearly perplexed Jeff – 'stunning' but no 'soul'; 'flirting' to avoid being faced with 'failing' in her job; unable to beat Jeff 'intellectually' and resorting to using her sexual attractiveness. After stating that she was not his type (indicating that the flirting also failed) he then made another woman humiliate Melanie in a public context. The implication of her subsequent promotion being based on something other than ability was also a powerful 'aside'.

Discriminatory comments against women though are perhaps not that commonplace. Jeff's sense of 'entitlement' may be a dying one across most NHS organisations and it is certainly against all stated mores. Discrimination on the basis of gender is more opaque. The researcher interviewed Helen, a senior female consultant, and talked about gender and arrogance of male consultants. The researcher suggested:

... this was possibly seeing me as an ally as a young female professional. In addition to the immediately obvious behavioural differences between women and men she also mentioned unseen discrimination in the form of merit awards at senior levels and problems of combining work and family commitments which may mean female staff are less likely to achieve these.

³⁵ Not her real name.

In the interview Helen responded:

Q: Do you think there are any gender differences in leadership that you have noticed?

A: Yeah, yeah I think, I think so, erm you know the men are more well, can I, the men are less inclusive of a group and they have ((1)) already formed an opinion sometimes and before listening, erm, ((1)) err ((1)) yeah.

Q: Yeah ((laughs))

A: Need I say more ((laughs))? But I think there is a difference ...Competitive, that's what I was saying, there's that competition, yeah competitive, exactly ...Of course not but the insight is very, very small, and then those meetings go on and on and on and it's people trying to get one up on another so... I just want to leave. It's handy having a beep you know you can say 'oh, I've got to be off (laughs)'.

The suggestion here is that men are apt to waste time on each other and power struggles and that for them competition is central to their 'nature'.

8.2 Conclusions

Despite the increased numbers of women who have reached senior leadership positions in the NHS, both as senior managers (clinical and non-clinical) and as senior clinicians *per se*, there were nonetheless some interesting differences between women and men's self-descriptions and perceptions of others as leaders, sometimes made on the basis of gender alone (Gill et al., 2008). Descriptions given of leaders and leadership for members of the 'other' sex were also frequently gender-typed.

It may be that despite valiant and frequently effective attempts to change the culture of NHS Trusts that a 'traditional' view of leadership remains at least in the organisational 'memory'. This might go some way to explaining why women who are clearly powerful and influential are reluctant to identify themselves as taking up these more 'feminine' styles even though they may in fact use the skills associated with these qualities. Eagly and Carli (2003) make a case for women as having a leadership 'advantage' in contemporary organisations where the type of leadership required has changed. However, they argue that in many cases women have to battle against the inherent prejudices in male dominated organisations. Although there is still a reference to gender stereotypes when discussing gender in organisations and gender and leadership as we have seen from the extracts above in this chapter, as Rosener (1990) stated: "*Women managers who have broken the glass ceiling in medium-sized, non-traditional organisations have proven that effective leaders don't come from one mould*" (p. 119).

In Chapter Five the OCS revealed that women across all professions scored lower than men on 'recognition' in that they perceived their managers as

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not recognising their particular attributes as clinicians or managers and they also perceived that the organisational climate was one in which 'recognition' was more likely to be given to men than women. That men did not see this as a problem for them reinforces the view that regardless of trying to establish gender equality across NHS organisations it is still not embedded in the management culture.

As we have seen and has been well documented in the literature, it remains difficult for women to exercise leadership without their behaviours being construed as either 'weak' or 'aggressive'. The paradox is that leadership requiring more 'feminine' characteristics is at least explicitly more desirable in the contemporary NHS.

9 Patient Care, Leadership and Service Delivery

9.1 Introduction

The NHS has a history of reform/modernisation aimed at making patient choice and care more cost and clinically effective by improving the organisational structures through which care is delivered (Bate & Robert, 2002; Becher & Chassin, 2001; Darzi, 2008; Wilson, 2009) .

The NHS remains committed to its original aims of providing a cost and clinically effective patient care (Doherty, 2009; Phillips, 2005), at least partially through the NHS's organisational structures, including the gate keeping function of primary care, while providing a universal service free at the point of delivery. Since the 1990s patient choice has been added to the longer term commitment to efficiency (Bhandari & Naudeer, 2008; Bojke, Gravelle, Hassell, & Whittington, 2004; Bryan, Gill, Greenfield, Gutridge, & Marshall, 2006). And at the same time there has been an explosion in new diagnostic and therapeutic technologies accompanied by a public awareness of the availability, or lack of availability, of those technologies (Aberbach & Christensen, 2005; Greener & Powell, 2003; Mueller, Sillince, Harvey, & Howorth, 2004a).

In this chapter we particularly address:

- what respondents (staff and patients) say about patient care and service delivery based on the interviews and focus groups;

- what we *observed* about service delivery and patient care and particularly the *interactions* between clinical staff and patients *observed* and *described* during the shadowing.

As in Chapter Six the Trusts are conceptualised as open systems whereby high quality patient care (the input) corresponds with effective service delivery (the output) with the primary task defined as caring for sick patients (or those who are giving birth).

9.2 Defining patient care and service delivery

The thematic analysis highlights similarities across all grades, statuses and disciplines of the staff and the patients involved in the study. The themes that emerged consistently from the data that were about good patient care were:

1. Putting the patient first:

...of course patients do come first but actually really, on everything that you do, I mean everything you do you think of the patients (service manager in acute medicine).

2. Thinking about what is good for the patient (all the time):

I still believe and I believe to this day that if you absolutely concentrate on what the patients' needs are, all other things take care of themselves. it's about really showing that you care. I mean genuinely showing that you care about your patients, erm there's a lot of talk about also looking after your staff and caring for your staff. I think that's important but I think the health service has got itself stuck far too many times concentrating on the needs of the staff and not the patients (Chief Operating Officer).

I think that's what you have to make sure is that everyday you are thinking to yourself, 'am I doing this for the good for the patient?' 'is it the right way to do it?' so I think when you get eleven years down the line, one of the things is that you can loose sight of is that, very easily (Matron).

3. Awareness of the diversity in the patient's world (culture, family, age, home and work environments):

..it would be making sure older patients have high quality of care during their surgical admission (senior consultant Geriatrician).

you need to support your staff ... you know and you have to have an awareness of the different culture of the patients (administrator).

4. Making sure the patient received the care that staff would expect for themselves and their relatives:

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I would define patient care that of - if it was one of my relatives who were ill (senior manager).

5. Talking to patients about what has happened, their medical history and their clinical condition:

....if they talk to you one-on-one and you know where you're at (patient).

6. Safety and empowerment of patients:

They [the multidisciplinary care of the elderly team] believe that good patient care sits around ideas of timely discharges, safety, making sure the patient understands their condition and their treatment, empowering patients by allowing them to make their own decisions about their care (to a point), providing the appropriate treatment and care, being responsible for the patient. Examples of bad patient care are viewed as delayed discharges, poor decision making and discontinuous care. (Notes from an observation of a team meeting).

From the descriptions it is clear (and perhaps no surprise) that senior managers, clinicians and patients all hold slightly different perceptions which inform their judgements to give 'patient care' a specific meaning. Some of the judgements are related to their particular clinical specialty or organisational responsibility although generally respondents reiterated that patients need to be at the centre of daily practices. Patients in all cases wanted more than anything to be kept informed about their care, and if possible this should be done by the clinician in charge.

At a more complex level the definitions above reveal a 'vision' of good patient care which links the 'practical', 'professional' and 'political' elements of NHS life. It also links to the 'human' elements associated with the tasks of caring. For example, the Matron (quoted above) shows a revealing insight that the routine *organisational* tasks might take over as a perceived priority from what a person initially knew to be their primary task (i.e. patient care). As she says, several years down the line you might lose sight of what you are really there to do.

9.3 How is good patient care achieved?

9.3.1 Managers

Managers each have different levels of responsibility for delivering good patient care which may differ from priorities expressed by patients and clinicians:

Erm, that's the bit about lifting your eyes up off of the horizon, and lifting the eyes up above the horizon is about looking at the totality because the

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medical, again, the medical management model is very much that you should do what you need to do when the patient is in front of you. The management model, the pure management model is about doing the right thing for the 450,000 patients who were looked after last year, so some of that will be about compromising, and offering the best care to the widest group that you can (CEO).

Immediately this respondent exposes the potential for conflict at senior level in that he/she³⁶ positions the 'medical management model' differently from the 'pure management model'. In the former the patient is a particular individual with a health care problem – the patient 'in front of you'. However for senior management there are many thousands of patients that require good patient care which means (maybe) compromising to provide the best possible care to the greatest number. Despite this, another senior manager had a different 'take' upon good patient care and in answering the question focuses on what they themselves would expect evoking a more individualised model:

I would want good consultant input into my care ((1)) as soon as it was appropriate in the pathway that I was on. I would want to be able to have a conversation about what was wrong with me and what treatments and options there were, ((1)) erm ((1)). I would want the assurances of the people that deliver the care know what they are doing. ((1)) I would want the care to be provided in an environment that was clean and in an ideal world I would want a single ensuite room, err and I would like to choose my own food and all that jazz. ((1)) erm and the erm, ((2)) so really you want the environment to be correct and you want to have the confidence in the clinicians giving care and you want to have had input into what your care should have been (Senior Manager.)

This manager has a very clear model of their 'ideal type' which positions the relationship between the patient and clinician, the skills/expertise of the clinician and the physical space and environment as central to good care. There is awareness here that planning and teamwork are also part of the process of care but particularly important is the knowledge of how to deliver the appropriate care and information in order to facilitate joint decision-making.

³⁶ We do not want to risk identification of any individual participant.

9.3.2 Clinicians

Good quality patient care for most doctors interviewed was:

... making sure that erm the patient achieves the outcome that you would wish them to as a result of either their outpatient visit or their inpatient stay erm and that outcome is kind of on a objective kind of medical measure, erm but it's also in terms of the quality of the care that they've received and whether they are satisfied with the care that they've received. (Senior consultant)

Another senior consultant who is also on the senior management team of the Trust took the concept of patient care further:

... it should be delivered well I think is the answer ((laughs)). I think on the whole we do deliver it well, we have the lowest mortality rate in the country, ((1)) or one of them. I think we do actually and we ((1)) I'm very proud of the care and I think there are two things to be proud of and one is the basic care and ... we do emergency work I am very proud of. Then the other bit of care we're proud of is that ... I think there is a real culture of innovation and I'm trying to do something new up here, and I think that's actually really important in terms of leadership. My job is being able to see a clinician with an idea and then work out of him or her how to turn that idea into a self service innovation. I think that we have created over the last few years a much stronger patient safety culture.

This respondent clearly links leadership and patient care stressing both the relationship between supporting other clinicians in innovations that improve care (particularly attending to safety) while also being proud of the culture across the Trust for low mortality, innovation, and supporting staff. Crucially there is a pride and energy about this account. The culture puts patients first but the staff gain satisfaction and a sense of professional pride from the performance of the Trust as a whole [T3].

The clinician manager below takes up the relationship between staff empowerment (and support which links clearly to the outcomes reported in Chapter Five) and returns us to the focus on staff training and skills, indicating here that if the managers train and empower staff – services to patients will improve.

... it's about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is, we worked with training and development and we came up with a specific programme that was aimed at empowering them to improve their service area etc. etc. and

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also provided them with some skill sets that they probably didn't have prior to that. (Senior Manager, Therapies)

While from a similar perspective the nurse quoted below stresses that team work and morale mark the path towards good patient care and you need to look after *staff* in order to deliver a good service to patients.

... And I think it is also, sort of, taking into account the people they work with, the team members and boost the morale, and that can make a lot of difference to, you know, to have people at work and sort of take the stress levels off and I think, you know, it would sort of, quality certainly would happen, sort of energise them, able to care for the patient. (Nurse, focus group)

9.3.3 Patients

For patients overall it was clear that most of all direct communication and consistency of staff was experienced to be good care:

A: ... I've been transferred here from [another Trust] and there it's a bit more, not one-to-one but you see a lot of different doctors here whilst there [the other Trust] you have only one doctor, your one midwife and your one consultant. Here you see a lot of different people.

Q: And which one do you prefer?

A: I'd say probably just to see the one 'cause lots people tell you different things.

Q: Okay, so it can be a bit confusing?

A: Yeah, sometimes it can be, yeah.

The patient quoted below reinforces the need for clear patient/clinician contact and communication.

For another woman:

Now whilst I'm here my care has been very good especially with the [specialist] who first saw erm, who first flagged up the problem. Erm yep it's been good it's been good since I've been in. It's just the initial communication as an outpatient to an inpatient I should have really - you know that should have been. I don't know where the fault lies but there should have been some communication there between the appropriate people (Maternity patient on postnatal ward).

9.4 Delivering patient care

9.4.1 Doctor-patient interactions

We look firstly at three consultants' (Cameron, Kenneth and Henry) styles across two different Trusts as they interact with patients to explore the importance (or otherwise) of good communication and engagement. What emerges, perhaps unsurprisingly, is that different consultants have different styles of engaging. The style adopted though feeds through to the 'ethos' of the clinical team, relates to, and impacts upon, the culture of the Unit thus affecting the doctor-patient interactions as part of an evolutionary cycle.

9.4.2 Empathy and Communication

9.4.2.1 'Cameron'

From the researcher's notes we gain an impression of Cameron who deals mostly with stroke patients for whom verbal and non-verbal communication may be very restricted:

Cameron offers a very personal and individualised style of patient care to his patients. He is often very tactile often rubbing the tops of their hands, arms and heads to encourage them or to show support when he is discussing difficult problems with them such as their inability to go home, the definition of a stroke and the future impacts of them having a stroke. He also speaks to the patients in a very friendly and informal way and sometimes draws on their mother tongue to say a few phrases to make them feel welcome and at ease.

In his interactions with his patients he is very positive and upbeat, often speaking loudly to encourage and motivate his patients. He also tries to share a few jokes with them and breaks down doctor/patient power relationships by crouching down in front of his patients or sitting on a chair or their bed so that he is always the same height or lower.

This description alone demonstrates how Cameron's *behaviour* relates to several of the descriptions above which identify good patient care in that he:

- communicates (verbally and physically)
- takes care to acknowledge their humanity through recognition of their cultural (linguistic) heritages the fact that they have a life outside the hospital
- attempts to empower them within the relationship (at least via discussion and physical presence and to an extent with knowledge of their condition).

Below is a detailed example of Cameron (and his team's) encounter with an elderly stroke patient (Mrs. D) which is part of the evidence the researcher has employed for her assessment of the processes engaged by Cameron in his provision of patient care:

"Hello Mrs. D? (Patient nods head and smiles) do you have a headache? (Patient nods head) Do you know why? (patient shakes her head staring wide eyed at B). "OK, I'll tell you..." Cameron sits on the edge of the patient's bed and explains that she has had a stroke and she has a headache because sometimes patients who have had strokes will have suffered from headaches due to pressures on the brain. The patient stares and nods her head occasionally as Cameron explains. "Mrs. D, do you understand what I have just told you?" (patient nods her head and then croaks "yes") on this speech Cameron sounds surprised and encourages her to speak again "Oh wow Mrs. D, that sounded good, can you say something else for me?...well done". The patient looks up at the doctor and smiles croaking again "I don't have anything to say doctor", "well never mind Mrs. D, I am sure I can get something out you a bit later!...excellent, your voice seems to be coming back...isn't that good?. We will have you singing in no time!" (Mrs. D. smiles and shakes her head "can't sing" Cameron smiles and laughs.

Despite the clear power differentials, doctor/patient and healthy/unhealthy, in this relationship Cameron is doing what he can to encourage and communicate effectively with the patient. Not only does he literally get down to her level by sitting on the bed but he explains the condition, how it happened and communicates the indicators for (potential) recovery. He is respectful and careful although the intellectual/cultural difference between the patient, Cameron and the care team is exposed by the encounters below.

"Now Mrs. D. can I examine you?" (Patient nods her head) Cameron takes the patients hand and she flinches "cold!" Cameron smiles and apologies saying it that "it is the alcohol" (alcohol gel he had just rubbed into his hand). The patient eyes Cameron suspiciously "have you been drinking?" the group laugh and Cameron explains that it is the hand-wash and she nods slowly and looks at each member of the team for what seems confirmation that this is the truth. Cameron then begins testing the patient's strength. He checks her arms and then her legs with simple strength tests calling out numbers between 1-5 for the SHO to write in the notes. As he instructs the patient with her tests he speaks very slowly and loudly and the instructions are very simple and clear and he often demonstrated his instructions, especially for those patients that have cognition problems. As the patient does the task Cameron is very encouraging shouting words such as "good", "excellent" or "well done after

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each task". After the strength tests Cameron checks the patient's reflexes with a small hammer. Again he shouts out numbers and makes comments about the reflexes that the SHO writes down in the notes. Following the reflexes Cameron checks the patient's facial muscles by asking the patient to smile, grit their teeth, stick out their tongues and move them about. He then checks her speech by asking her to repeat phrases or noises after him. The first phrases or groups of words were given as words that would be familiar to the patient such as the patient's name or names of simple objects such as pens. As the patient is able to say these words he moves on to more complex words such as "hippopotamus" which the patient struggles with. Cameron then checks the patient's ability to co-ordinate by getting the patient to touch her nose and then his finger with her index finger. The patient clearly struggles with this and is very slow and inaccurate.

For a brief moment after the tests Cameron has a quick discussion with L [another doctor] asking him what he thought about the tests and what they would expect to see on the CT scan. Cameron then turns to the patient and says "sorry Mrs. D, just discussing your test results with my colleague, we think that you are progressing very well...there has been much improvement hasn't there?" the patient stares blankly at Cameron for a brief moment before shaking her head "no, you don't think so? Now what about your speech, when you first arrived you couldn't say a word, now listen to you, don't you think you have improved?" patient shrugs her shoulders and looks down at the bed. "Well Mrs. D, we all think you are improving...so well done..." patient looks up and smiles sadly.

The style of meetings between clinical staff and patients was as much a feature of *Unit and team culture* as of a particular clinician's practices. Thus, while Cameron above was engaging with the patient in what appeared to be a *genuinely caring* manner, his colleagues were attentive, while in the background.

9.4.2.2 'Kenneth' and 'Henry'

In what follows two consultants worked together and while Kenneth was the more senior and experienced clinically, Henry held a senior managerial role (as well as being a senior consultant). Kenneth was described by the researcher as:

... a very warm and caring man ... he is very sweet, kind and caring to his patients and makes them feel comfortable and less vulnerable by empathising with them and drawing on his own personal experiences as a patient.

As with Cameron above, Kenneth was also described as 'tactile' and that he took the time to explain things to patients. Kenneth empathised with patients by sharing a joke (as did Cameron):

For example one lady was embarrassed because she had fallen down in her flat and sustained injuries and did not really want to explain how she had fallen over or what she had hurt [to the whole team]. Kenneth then told the patient that he had slipped over in the hospital and in the M&S food section. This meant that she no longer kept quiet through embarrassment and told Kenneth after that exactly what had happened.

However, during the two day shadowing of Kenneth the researcher was particularly:

...struck by how intimidating this group of doctors must be to the patient, especially an elderly or vulnerable patient as a large group of faces arrive at their bedside and close the curtains around them making the space feel incredibly claustrophobic and that the patient's space felt 'invaded'.

While shadowing Kenneth, the researcher was in a position to observe Henry (who was also shadowed for two days on a different occasion). The researcher's notes here, which describe a joint ward round with Kenneth and Henry, state:

I was struck by how impersonal Henry was towards the patients [in direct contrast to Kenneth]. He did not greet them or introduce himself. [In one case] Instead of asking the patient how she was getting on with the oxygen machine Henry asks the SHO how she thought the patient was getting on with the machine. When the patient tried to give reasons they seemed irrelevant to Henry who just told her she must use her oxygen machine every day or she will not get better.

The researcher goes on to describe how Kenneth (the senior clinical consultant although Henry has a senior leadership role) stands quietly behind the junior doctors on the round with Henry at the front of the group talking to the patient. Henry stands up. Kenneth stands at the back of the group with his hands folded behind his back and Henry every so often asks Kenneth if he agrees with Henry's thoughts on the patient's health status and treatment. While Henry is taking the lead in this way the researcher notes:

Not one of the doctors explains to the patients what will be happening to them that day or beyond nor do any of them say goodbye.

One patient on Henry's round is in the bathroom as the team arrive at her bed.

Henry knocks on the door of the bathroom and says "Mrs. X, it's Dr. Henry we are all here to see you". He then asks a nurse if she can hurry the patient along as he is very busy. It seemed strange [to the researcher] that Henry could not have just visited another patient until this patient had finished rather than rushing her. Before the nurse can enter the bathroom another nurse pokes her head out from behind the door and says that she is washing the patient. Henry asks whether this could be finished after he has seen her. The nurse, who looks frustrated, says she will be a minute. The nurse then helps the elderly lady to shuffle to her chair and helps her sit down. Without greeting the patient Henry begins talking over the patient's bed about her X-ray that was taken yesterday and then asks the nurse about the patient's progress.

In the examples above describing both Cameron and Kenneth's interactions with patients there is evidence that the patients were given a chance to explain to their consultant how they felt and either to tell the doctor what had happened to them or to hear the doctor's explanation of why they felt like they did.

The patients were treated in both these examples as human beings and in doing so the doctors themselves positioned themselves in their *clinical role* but also as *people occupying that role*. By acknowledging mutual humanity (albeit in different styles) these doctors were able to *take authority* from their position as medical experts (see Chapter Seven above).

By contrast Henry also took authority but did this by silencing junior colleagues, Kenneth his fellow consultant and most importantly, the patients. While Kenneth and Henry were in the same Unit, the scenario described above suggests that Henry held more power and therefore exercised greater influence on junior colleagues (and this fed into the culture of the Trust).

In what follows we trace how these contrasting styles might link to the culture of the Units and the teams themselves and consider how this fits in with the definitions of good patient care and service delivery.

9.5 Clinical team work and service delivery

9.5.1 Giving patients care

Miller and Gwynne (1972) suggested that a 'warehousing' model of care operates for those who may be institutionalised in the medium to long term which they contrast with the possibility of a 'horticultural' model of care, akin to what might be identified today as a learning environment. Working in the care of the elderly takes its toll on the emotions of all the clinical staff

particularly in the 'horticultural'/learning setting, where efforts are made to ensure two-way communication and mutual understanding and development takes place. This can leave clinical staff open to experiencing directly the pain and distress experienced by their patients (see Menzies-Lyth, 1960 and the 'stories' below).

The following example demonstrates how engagement between clinicians and patients impacts emotionally upon even (and possibly especially) senior experienced staff. The researcher here, shadowing Mandy, a female senior consultant describes the following case:

Whilst cleaning up a suppurating wound an elderly male patient cried. It was a really touching and sad moment and Mandy was clearly distressed that she had hurt the man. On first seeing him cry Mandy appeared to have a moment of shock/panic where she looked amongst her team to find out whether this was normal behaviour for this patient. On hearing the answer was 'no' Mandy tried to soothe the patient and seemed genuinely sorry for hurting him. The nurse who arrived at the scene also appears to be genuinely concerned about the patient and goes over to help Mandy and prevent the patient from crying. This scene was particularly sad because in today's society and especially in the patient's generation it is thought that men don't cry or show emotion. For the man to cry he must have been in severe pain and must have been struggling with himself to prevent the tears. Mandy's genuine empathy and somewhat guilt might have reflected that.

Mandy and the nurse in this context are using emotional intelligence (see Chapter One) in a relevant situation. Mandy also engages in conjoint action with the nurse rather than take action in an autocratic fashion without consultation. Mandy notes the patient's crying with a start (according to the description) and instead of continuing with the work on the wound (which many doctors might well do because it was necessary for a positive health outcome) she immediately appears to take in the context as a whole – thinking about her patient's behaviour and reactions. The nurse in this case mirrors the behaviour of the consultant. This is an important issue for discussions of leadership and patient care in that teams tend to reflect the beliefs and actions of their leaders.

9.5.2 Discussing patient care

In a shadowing the researcher at the start of the observation describes in detail the way two doctors discussed the patients before embarking on the ward round. This is another case of concerted action:

09:00 Breakfast meeting with Cameron [T3]

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Once they have consumed their breakfast Cameron and Mandy turn to business. Cameron begins by asking Mandy's opinion on one of the patients that they had seen on the ward round that morning. They chat for a couple of minutes about the patient before both getting a patient list out and going through the names systematically and discussing their care plan for each patient. Several patients will need to be discussed in a patient case meeting as they have complex discharge problems, others will need to be referred to the CCP so that a greater social package will be considered. Mandy says that she will go and see a few of the patients herself later and occasionally delegates tasks to do for Cameron, but mostly he is autonomous and says what he needs to do for a patient and what he will organise on behalf of the patient.

This is a quiet and supportive meeting between Mandy the senior consultant and Cameron the more junior member of the team. However, the researcher notes the systematic discussion of the patients and their care along with a plan about who Mandy will see and how Cameron's tasks are designated.

A similar atmosphere of calm and authority are evoked by the description of a case meeting with Cameron's team at the start of the first day of shadowing:

I approach the nurse's station and look around to see if I can see Cameron. I spot him at the far end of the ward sat at a computer with a mixed group of staff (doctors, nurses) surrounding him. I approach the group and stand amongst them. Cameron is facing the computer screen and discusses a CT scan with his registrar [L].I notice that as these two doctors discuss the scan a SHO writes notes in the patient's file occasionally craning his neck to look at the scan at certain parts of the discussion. A few nurses also crane their necks at various points but most just stand patiently in silence waiting to visit the patient. Once the discussion draws to a close Cameron turns his head from the computer and asks the team if they have anything to add. ...[later on in the same meeting the researcher listens to a telephone conversation] ...Cameron has rung the wife of a patient to update her on her husband's health. He is very honest with the wife saying that her husband has had a second stroke during the night at that he is now in worse health. Despite the bad news Cameron is very friendly and pleasant with the relative and is very sympathetic to her questions and on several occasions empathises with her. Coming off the phone Cameron returns to the team and gives a brief update to L regarding the conversation with the patient's wife. The SHO writes this summary in the notes. Cameron takes a short sharp breath before asking "shall we go and visit the patient?" Cameron turns quickly on his heels and enters the ward.

The observation here reveals the high workload and 'multi-tasking' undertaken by the team (looking at the computer, discussing scans, taking notes, calling relatives and so on). But there seems to be focused attention on patient care and individual patients. At the end of this extract it also seems that Cameron himself takes the ward rounds very seriously – gathering his mind together and possibly seeking the emotional strength to move from the clinical team and considering evidence from notes and colleagues to imparting and collecting information from the patients.

The same researcher who has shadowed both Kenneth and Henry at a different Trust from Cameron, gives examples of how some of Henry's patients are discussed. For example she describes a meeting to discuss patients chaired by Henry.

Henry criticises the way [Site B] is run and the management of beds and patients by that hospital. He praises the doctors for the current situation on [Site A] where they have spare beds stating that they have done so well in 'kicking them out'. Henry stated during [a previous meeting] that the patients needed to be removed or 'kicked out' of hospital as soon as possible. The rapid turnover of patients may on the surface appear that they are not receiving good care However getting patients home quickly reduces the risk of hospital acquired infections.

And is likely also to be what many patients would want.

As the researcher makes clear, it is important not to confuse the rhetoric with the quality of patient care, but rhetoric does determine and reflect a dominant ward or Unit culture.

9.6 Responsibility for patient care

Responsibility was a key element of the discussions of leadership particularly in Chapters Four and Five. Responsibility for individual patient care is in the hands of clinical teams led by the medical consultant but above that person is the clinical leadership/management (Clinical and Medical Directors) as well as the senior operational managers (CEO and COO and others).

Primary responsibilities for patient care however vary from *individual care* i.e. for both identifying care pathways and day-to-day care to responsibility overall for the care of all the patients. In Chapter Ten we review the findings from this study with some recent cases where responsibility has been mishandled to explore what lessons might be learnt.

In an interview with a consultant:

... we try to just have a really open forum where we can discuss that [specific patient care], just like open it up and letting people put their viewpoints first and then kind of trying to question where they're coming from with that in a positive kind of way but them also laying out where you feel that that might not be the right course of action. Erm and also at the end of that discussion making sure that everyone is happy with the outcome, and sometimes people aren't erm .. but it also realising that it is a consultant's responsibility at the end of the day and making sure that everyone knows that you're happy making that kind of decision and that you are happy to be made accountable for that decision.

9.6.1 Responsibility for emotion

It frequently falls on the clinical leader to cope with their own, the patient's and the relatives' emotional reactions and distress and also with those of the other members of the team. As the researcher noted:

One senior consultant, Tricia, made it clear that as the clinical lead she also took responsibility for talking to patients about DNR³⁷ forms and delivering 'bad news' to patients/ relatives. During the ward round Tricia removed the pressure from a junior member of the team who had been told by a relative that they didn't want their mother to be resuscitated. Being told this information had stressed out this junior member of the team as he was not yet ready for this type of responsibility. Tricia supports her junior colleague saying that he should have never been confronted with this situation.

One question here then is how do the clinical team handle such multi-layered emotional problems? How important is leadership in supporting (and developing) teams to cope?

9.6.2 Responsibility for teaching

Most clinicians in the study from all disciplines were interested in teaching the next generation, and their activities will influence patient care, provide role models for leadership and influence climate and culture of the organisation. The example below is chosen because Dr. Jenkins was very enthusiastic but also demonstrated compassion and courtesy when he was face to face with the patients. The researcher's notes describe this in detail:

Approaching the patient Dr. Jenkins shakes the patients hand and says "how are we doing today?...I see you were referred by your GP...you have a

³⁷ Do not resuscitate.

wonderful GP" (he comments on how wonderfully clear and precise the notes are). "That's not my GP, that's my missus's GP, mine's on holiday...I have Dr. U. U". "What a name! But looks like they have to wonderful GPs at your practice...the notes are seamless...you are lucky!" Jenkins then continues to ask the patient about his medical history. The patient is able to tell the doctor his entire medical in great detail including the drugs [more description from the researcher]. Dr. Jenkins stops the patient and asks the medical student to take a mental note of how a good GP leads to a well informed patient, which helps him (Jenkins) in his (patient's) treatment. He talks about 'aspects of professionalism' and the right ways of informing patients about their treatment and condition, he openly praises the patient for knowing so much about his patient history and tells the students that "medical history in patient care is so important". The patient begins talking about his treatment in the hospital and Dr. Jenkins states that "patient feedback is great, and they like to hear about it...we need to be more professional...primary care pathways are the key to patient care".

Dr. Jenkins behaves with humour towards the patients and the students and junior doctors but does so while continuing with his assessment of the patient, taking the relevant history and trying to impart good practice and professionalism. He manages to balance giving the students and junior a chance to gain hands-on experience while making sure he himself has all the information he needs for the care of the patient.

Dr. Jenkins then checks the patient's lungs and heart asking a SHO, Dr. Williams to check the cardiogram as he can hear an AF flutter. As Dr. Williams looks for the chart the patient tells him that his GP had thought the same and that is why he was thinking of changing his drugs. Dr. Jenkins looks at the students and says "wonderful isn't he?" he continues that the GP must have heard or felt it himself [the heart condition] and now they will need to see the chart to prove it then they can change the drugs as the GP had predicted. After looking at the chart Dr. Jenkins asks Dr. Williams to change the drugs and to get rid of one of the drugs he thinks are unnecessary. Dr Jenkins shakes the patients hand when he leaves and says that one of the juniors will be back later to sign off the new drugs.

Looking over the notes Dr Jenkins spends a lot of time teaching the [medical] students about various medical conditions and treatments that have arisen out of [a particular] patient and asks them to suggest other possible diagnosis and other treatments for his condition. Jenkins is a very enthusiastic teacher and the enthusiasm rubs off on the students who are all eager to share their knowledge and take stabs at questions they don't know. In the middle of the question and answer session he asks one of the students "what year are you in? I don't know how much you guys know already". The student base is a mixture from students from [different

schools] and he relishes the opportunity to teach the students some new medical knowledge. Whilst getting the students to look at the cardiogram he looks up and apologises to Irene [matron] for taking so long on his ward round "Sorry Irene, I will be here all day, this is such a pleasure to have students!" Concluding the teaching session he quotes someone for saying something about the health of gamblers and drinkers and then asks "now who said that?" the students look round each other and then he exclaims "me mother!" all the students laugh including the female registrar and Irene. He then ushers them onto the ward saying that he doesn't want to get in trouble with the matron.

9.6.3 Subverting responsibility

There are diverse ways that staff at both Trusts had for coping with emotional aspects of patient care and resisting authority (and thus taking responsibility for care into their own hands). One way that nurses (including senior nurses) operated was to *subvert* some of the doctors – particularly when the relevant doctors showed little interest. The shadowing of a senior nurse [Irene, the matron] during a ward round produced the case of Lola (described when shadowing Irene):

Irene tells me it is because many of the patients are elderly with complex cases and therefore they tend to stay for a long time. I note that one of the patients has been here for a long time and I ask whether due to the long length of stay on the wards whether she becomes attached to any of the patients, I point particularly to the patient who had been here for three months. Irene says, 'oh that's Lola, mmm has she been here 3 months?...let me check her notes'. Irene leaves the file that she is reading and picks up Lola's file and looks at the admissions page and then states (sounding surprised). That three months is correct. She then continues that she does find herself getting attached to her patients, especially if they have been here as long as Lola. She mentions that Lola should really have been moved to G Ward but she really doesn't want to move her 'she should be elsewhere, but she is ours' (highlighting emotional attachment and the sense of ownership over patients). She tells me that Lola is really sweet and all the nurses really like her and it would be quite strange if she was no longer on the ward as she is a returning patient and 'it is always nice to have her back'.

As we have suggested in Chapter One (and witnessed above), in order to protect one's self against anxiety clinical staff often 'split' patients into 'good' and 'bad'. Here the treatment of Lola indicates that the nurses may be using their care of her to defend themselves against some of the harsh treatment decisions made about other patients (by doctors and managers) particularly when there is pressure to discharge older patients due to bed

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shortages. This might lead them to consciously and unconsciously subvert these authorities when they can and there is a particular pleasure to be gained when they succeed in this 'subversion' with a 'good' patient such as Lola. What remains at stake is whether Lola's stay is actually benefitting her clinically (or even socially) and also whether it is preventing another patient receiving medical care.

9.6.4 Responsibility for end of life decisions

Responsibility for patient care resides not only with the clinical team but is sometimes shared between the team, the patient or the patient's closest relatives which is usually the case with end of life decisions. Sometimes the greatest emotional engagement is with the *relatives* of the patient rather than the patient themselves. This is particularly the case when the patient is likely to die which is particularly sensitive when it is a case of withdrawing life support. The following example of Cameron's Patient G and his daughter brings this into sharp focus.

The biggest emotional situation this day surrounded Patient G, a coma patient and his daughter. Cameron had to encourage the daughter to agree with his plan that her father's treatment should cease and palliative care take over. This is a very emotional situation especially due to the young girl's age but also because she was in 'denial' asserting that her father would get better and this caused her to present a whole range of emotions that Cameron had to deal with.

We enter the side room. The blinds are drawn causing the room to be quite dim. There is a young girl sat up right on a make-shift bed that she has made from four visitor chairs from the lounge. She has a blanket over her legs and is typing on her lap top her mobile phone ear phones in her ears and bags and other items are scattered around her chair. She looks up as we enter and pulls the ear phones from her ears. I am surprised at how young she is, I had expected a daughter of forty something not a teenager of 18 perhaps, but no more than twenty. She pulls the covers off her legs and places her lap top on the window sill. Cameron asks if she is ok and she nods and says she will leave him to it. Cameron says that he will bring her in once he has examined her father, she nods and opens the door pulling her jumper down over her leggings as she leaves. Cameron looks at me and comments (adding to what I was already thinking) "I think she is far too young to be dealing with this on her own....it is not fair".

He turns his attention to the patient and begins speaking loudly to him. He explains that he is a doctor in [Trust 3] hospital and that he wants to examine him. At each point of examination Cameron explains to the patient what he is going to do. Cameron is able to move the patient's limbs like he

is a doll. Each time the limbs are placed in a position they remain there. The patient doesn't respond to any pain stimulus as Cameron pinches the patient's skin and scratches the bottom of his feet with a stick. Cameron then checks the patient's eyes by pulling back the patients eye lids, the eye lids roll from side to side and Cameron explains that it is called a coma roll, which suggests that the patient is in a deep coma. Cameron teaches W by the patient's bedside and talks him through the patient's condition and talks about how the patient's recreational drug habits could probably have contributed to his stroke. Cameron and W engage in a small conversation about the problems of cannabis on the brain.

Cameron made the decision in consultation with his team to discuss with the daughter that they need to end the patient's treatment (and thus in all likelihood, his life). Cameron deals here not only with the daughter's distress but with the daughter's worry that she is involved in the decision to let her father die. Again a high degree of emotional intelligence and leadership as well as clinical knowledge operates in this communication.

While shadowing Owen [Trust 2] the researcher sees that while behaving perfectly correctly he puts emphasis on the clinical and health related aspects in an end of life situation above communication and empathy. He is not unkind but 'misses' the emotional level of communication. Here in the presence of a daughter and father the woman (mother/wife/patient) is clearly dying and being kept alive by the clinical team. Owen:

... talks directly to the daughter stating that her mother is coming to the natural end to her life and therefore she [the mother] is giving up - 'withdrawing from life' and tells the daughter that although they will feed her through a tube she [daughter] should prepare herself and her family for the inevitable. He also says that her mother will also start ripping the feeding tubes out to prevent herself from getting the right nourishment.

The image conjured by the 'withdrawing' from life and 'ripping' feeding tubes is dramatic and seems to give agency to the dying woman – almost indicating that somehow she is to blame as she will prevent herself getting the right nourishment. However, the researcher, as participant in this encounter, is bringing out a sense of the culture of this particular event. While Owen is probably protecting himself emotionally from the loss of life and the sense of clinical 'failure' he does not protect the daughter or the husband from the emotional onslaught of the woman's impending death.

The daughter says that she understands and turns to her father and says 'dad do you understand what the doctor is saying?' the husband paces up and down the side of his wife's bed looking lost and lonely. He looks up at Owen and says that his wife is giving up because someone at the nursing home said she was a burden. The daughter scolds the father for saying that

in front of her mother. She explains to Owen that although she [mother] doesn't say anything she listens to everything and the more her father says it the more she doesn't eat. Owen says he understands and asks how the family is coping.

The daughter here is also protecting Owen from the family's pain by scolding her father even though Owen asks how they are coping. However, although kind and polite, Owen does not seem to operate with emotional intelligence or engagement with others' pain.

The daughter says that her father is finding it very difficult because he is the main carer for her; she herself has taken time off work to care for her when she can to support her father. As she speaks about her father and how upset he is becoming she begins to become tearful. Owen listens to her as she speaks and occasionally asks further questions. The husband continues to potter around the room occasionally touching his wife's head and face. The daughter watches him.

Owen, while allowing the daughter to cry and not acting as if he is irritated or embarrassed, equally pays little heed as he continues to talk of the mother's deterioration.

Owen begins to talk about the deterioration of her mother and what they will be able to do for her. The daughter says that she knows what Owen wants to talk about 'you're talking about DNR aren't you?' Owen says yes he is and the daughter tells him that she knows about it because her friend's mother recently died and this was discussed with her. The daughter says that she knows what she would prefer but they will have to talk this through with her father. The daughter calls her father over and begins explaining DNR. He looks at his daughter, he looks lost and scared and she tells him that it is his decision but she thinks that the doctors should not resuscitate her mother because she will be resuscitated to the same state. Owen inputs that she will be 'worse' than how she is currently because she will be a lot weaker. The daughter says that she will have to talk through this with her father. Owen nods and leaves the room.

9.6.5 Stories of patient care

The following two stories show in detail the ways in which responsibility and power can shift between team members and highlight anxieties faced by doctors about caring for patients.

9.6.5.1 A story of system failure: Cancelled Clinic

The first story is told by a female registrar who describes a situation in which she felt disappointed with patient care due to cancelled clinics. In the

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following account, the narrative is broken down to four moments, and each is discussed to demonstrate how the doctor's anxiety is managed by being linked to a failure in 'the system' that climaxes in her interaction with patients.

Q: What about any time or incident that made you feel disappointed with patient care in this hospital?

A: Lots of times, particularly since we've not had a secretary. Every clinic, every single clinic I send somebody home because the notes aren't there at all. They are supposed to be coming to see the consultant [her immediate superior] and he's not there, and they've been put into my clinic and you look at the letter and it clearly says on the letter 'consultant only to see', and they turn up and he's in Italy, on holiday.

The registrar is expressing frustration. On the surface it is towards a recurring failure in patient care attributed to firstly not having a secretary and secondly because the consultant 'is not here'. The expression of the frustration however is confused; there is no secretary but the patients 'have been put' into her clinic. Furthermore, she sends someone home from each of her clinics because the notes are not there. The letter 'clearly says' the patient is to see the consultant who is not only not there but he's in Italy 'on holiday'. There is a feeling of being overwhelmed, and of rage and envy towards the consultant - and possibly the patients - emerging from this short paragraph (for discussions of workplace envy, see Vidaillet, 2007; Stein, 2000). There is also an expression of omnipotence in that she sends patients home. She has the 'legal' justification to do so because there are no notes and also because their letter says they have to see the consultant and the energy is directed towards this activity rather than getting patient appointments changed. The consultant is on holiday, presumably one to which he is entitled and one which has clear boundaries enabling them and the staff who make the appointments to re-arrange the patient dates.

There is clearly a high degree of frustration and anxiety present in this account; there are too many patients with 'needs' and not enough clinical or support staff backing the work in the way in which the doctor would feel comfortable with. As there is little opportunity either to express or assuage her anxiety so she becomes 'prey' to primitive phantasies and unconscious mechanisms to relieve the anxieties.

The story also sheds some light on doctors' anxieties about working in a multidisciplinary team. Medical education and postgraduate training provide a culture in which doctors believe they can rely on each other through which a sense of being an elite group and confirmation of professional omnipotence and responsibility - particularly of the consultant - arises. However the role of the consultant also brings about a sense of envy and

destructiveness in others which has its origins in the primitive defence mechanism of splitting off the painful parts of one self (e.g. the realisation that you are not omnipotent and that another has the ability to do what you cannot) and projecting them onto others in an envious attack (Klein, 1959).

...and you have to go out and say, 'I know you've waited three months for this appointment but I'm afraid the consultant is not here and he wants to see you personally, so thanks for coming but if you can just go away' and you can't even say to them 'you're getting an appointment for next week' because realistically they're getting an appointment in three months time, and I think that's really disappointing.

'Breaking bad news' is considered to be a difficult task for health professionals and one that is a constant cause of anxiety. In addition to having to find the appropriate means of communicating prospectively devastating prognosis and supporting patient through the immediate emotions, doctors must come to terms with possible changes in how the patients perceive them (Barnett, 2002). Even though the situation described here does not involve delivering bad news about an illness, it is a moment of disappointment for both the patient and the doctor. The patient's anticipation to receive treatment is rejected and the doctor has to acknowledge failure in service delivery. The patient's possible anger and anxiety is directed towards the messenger, who in this case, is unable to offer any practical solution. Instead of being the helpful, trustworthy saviour, the doctor transforms into an envoy of disappointment and will have to see to the patient's emotions as well as her own disappointment, to which there is no external consolation on offer. To alleviate the anxiety caused by the situation, the registrar clings on to a narrative regarding her workplace – she is disappointed in the system.

I feel very disappointed in the system, which, I know the system is a big, wide thing, but ... [it] lets people down from that point of view and, you know, we overbook theatre lists and they get cancelled and then again I feel disappointed.

By seeing the NHS as a faceless, bureaucratic, 'machine-like' (Elkind, 1998) entity, the registrar convinces herself that the situation is not her fault – it is not what she would want for the patients, or for herself. She feels anxiety for she cannot provide the care required, and as a consequence she projects this anxiety through blaming 'the system'; regardless of their individual efforts, doctors are powerless when the system fails. As this registrar said epigrammatically later on in the interview: 'I don't think the NHS works anymore' which at a conscious level represents the impact on her working life of a problematic bureaucracy while at an unconscious level it provides uncontainable stress. The doctor does not have the opportunity to delegate

tasks to her superiors to reduce the 'heavy burden of responsibility' (Menzies, 1960, p. 118) thus feels that she is left to deal with the failure of 'the system', a system, which ironically is set to heal people, not cause them angst.

It's mostly because I'm thinking, how must that patient feel. You know, they've worked themselves up, they've told work they are gonna be off work for three weeks or four weeks or whatever and arranged cover and you go and tell them, sorry, you can't have your operation, you can go back to work tomorrow. That's really disappointing, to do that to people, very much so.

In the conclusion to her story, the doctor moves beyond expressing antagonism to the system to empathising with the patient. Thus, by failing, the system provides the doctor with a social defence mechanism but through empathizing with the victims of the failure, she fails to contain her anxiety.

9.6.5.2 A story of grace in adversity: Supporting the mother of a still-birth baby

The second story is told by a male registrar who describes how he provided good patient care by supporting a mother of a still-birth baby. Despite the plot, the story is not told as a tragic narrative but as a proud patient-care moment, a sequence of events that had thoroughly positive impact on the doctor's perception of himself. This narrative is also analysed in sections.

Q: Could you give an example where you felt that you have given good patient care?

A: I think that one of them was this lady who actually came to the labour ward and told me that she hasn't felt her baby move in the past one day and she had had some bleeding. Obviously there was some concerns on my behalf for the baby, because there could be a problem. This was a very wanted pregnancy because she was quite old and this was an IVF pregnancy. I examined her a little bit and on examining her I found that the baby did not have a heart beat, so she had lost the baby.

Describing the situation at first with the patient as an object helps the doctor to distance himself from the scenario and to do routine checks expected in this kind of situation. In a hospital setting instructions are given about the way each task should be performed and these rituals form a reassuring tool for staff (Menzies, 1960: 121).

I did explain everything to her, and obviously as a doctor responsible for her, I need to follow all the procedures that needed to be done and all the care that she needed to have, you know I explained it to her that, you know this by far something that words, you know cannot express, as you can imagine how

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difficult this situation would be, and if we could make it the slightest bit better, we would try everything in our power, you know, to make the situation a lot more comfortable. I ensured that she was given a quiet room, with a very good midwife looking after her at all times. Obviously I had my duties towards the rest of the labour ward as well. People visiting her room making sure she was ok, making sure the pain relief was ok, we had induced her because we did not want her to go home with a dead baby inside her. It was a very, very painful and stressful scenario, it really, really was, it was horrible, absolutely and it is very distressing, exceedingly, exceedingly distressing because, you know the woman is going through all that pain of labour.

Here, the doctor is empathising with the patient, feeling her emotional pain and in this case is mostly able to contain it through wanting to relieve the situation and then by offering extra care, by 'going an extra mile'. In this extract, there is a clear shift as the doctor uses strong emotional words to describe the crisis. In telling the story, he is projecting his own anxiety on the patient, living the distressing emotions with her and having to remind himself of his position as a medical professional - 'obviously I had my duties towards the rest of the labour ward as well'. By referring to 'all that pain of labour' the doctor enters a relationship with the pain. The phenomenon of pain and our relation to pain, whether someone else's or our own, is more immediate than that of reflective knowledge – we do not think about pain but react to it so the sensation is intersubjective. The person who is not experiencing the pain but affected by it is an 'interlocutor' in the situation (Crossley, 1996, p. 37).

...I tried to make it a point that I was present, present as much as I possibly, feasibly could during her emotional outbursts. I wanted her to have all the support that she needed... I did get attached to the patient, being around her, trying to get her care, even if I was out of hours, which means that when I was not meant to be in the hospital. Now I think that some people will argue that, that is a bit over the top, but I think that, I guess, I guess, that that is medicine for you, you know it is about lives, and sometimes you have to make that extra effort, to make that person feel that little bit more special.

In this excerpt the doctor starts to explain and justify his actions. Through self-reflection he has realised how he acted in a way not normally accepted in the hospital culture, that is, he went against the 'social defence system' to deliver patient care, but also to cope with his own anxiety. He dedicated extended time to his patient even though hospital doctor's time is considered to be 'fast and efficient'; 'doctors move quickly in the hospital wards. Their time is expensive. They cannot afford to linger too long in any one spot' (Mattingly, 1998, p. 21).

Menzies (1960) noted that while institutions have social defence systems, individuals may resort to their own defensive mechanisms, but a membership of an institution 'necessitates an adequate degree of matching

between individual and social defence system'. If the individual and the social defence systems are in disagreement, what follows is some degree of breakdown between them, for example, a doctor's work colleagues might reject them for behaving in an inconsistent or unprofessional way to the system. Consequently, the registrar providing patient care to the mother of the still-born baby is not only coping with anxieties created by that emotionally charged situation, but he also has to think about the culturally accepted limits of caring and possibly negotiate his way with other members of staff. On this occasion, the doctor keeps to his defences and spends extra hours with the patient, without being criticised by his peers.

Well you know that when things get worse, they get worse and they get worse and they get worse. Ultimately what happened with her was that we tried all the induction of labour, we tried everything possible to get that baby out, by induction. And in her case with the induction, it failed as well... and I can't tell you how dreadful that scenario was, that she needed a Caesarean section to have that baby out... I wanted to make sure that I was present at the Caesarean section, as well so that she would have a face that she knows. Once she delivered, you know obviously I was there with her, with the [dead] baby in her arms, and she was happy from the point of view.... and thanking me every now and then, which I said that she shouldn't because it was my job and one should do it. But she kept signalling the fact that not many people would do it the way that I had and I that was very special.

Much hospital work contains a 'constant sense of impending crisis' (Menzies, 1960, p. 26) which creates pressure and anxiety. The level of predictability in medical work is low and – as the registrar expresses it – 'when things get worse, they get worse'. The doctor explains that he attended the Caesarean section for the patient's sake, but this could also be interpreted as his coping mechanism – the need for a closure (Mattingly, 1996: 37). If you only see trauma and dramatic events without closure, the events will stay lingering and cause anxiety, stress and possibly depression. The doctor needed to be there and needed to have closure to be used as a coping mechanism against accumulating anxiety. So far the patient had been in a powerless position while the doctor had presumably been in control of the situation and emotions involved in it. Therefore, when the patient thanks the doctor, he gets confused. The patient had survived through the ordeal and suddenly has the power to relieve the doctor's anxiety, to nurse him (Menzies, 1960). The acute physical and emotional stress is released and the doctor can reflect back on his experiences.

And I think that is something very, very special and dear to my heart. And these are those situations when you sit back and you reflect on your life and

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say, "wow I have done something good, really, really something good and it is wonderful".... I saw her every single day on the post natal ward and obviously I made a point not to neglect her, or neglect her partner because people assume that the only person going through the trauma is the woman who has actually delivered, but they are a couple, and that needs to be understood so that was important as well. And he appreciated that quite a lot. They went home, two weeks later, I did receive a lovely letter, which kind of expressed a lot of gratitude, for what I had done for them.

The thanking letter provides closure for a difficult story, but maybe also goes beyond this. It hints at redemption – instead of a medical tragedy possibly compounded by failure in patient care, the story becomes one of a victory or at least grace under fire, a positive example of the doctor's powers even when he cannot actually perform miracles by restoring life. Anxiety is successfully overcome by the absolution from the patient and the doctor's 'priesthood' (Elkind, 1998) is restored. The letter from the patient acts as the final seal to exalt the extra efforts the doctor put in to solving the problem (Menzies, 1960, p. 31).

I know that I put in extra hours and I KNOW that I shouldn't have been there but no-one complained, because everyone knew that I was helping a situation. It is just an understanding that we have. It would be a terrible job if you were only allowed to work your set number of hours.

A narrative like this one permits people to attach themselves to 'desirable' ends, think well of themselves in moral terms', 'support their needs for autonomy and control', and 'promote feelings of self-worth' (see Baumeister, 1986 in Brown, Stacey & Nandhakumar, 2008, p. 1054). By telling this, not an easy or comfortable story, as a proud moment of good patient care, the registrar restores his professional and personal integrity. There is no 'system' in this story to blame on, no failure to confess, but despite the drama the story draws to a happily-ever-after ending. The story has entailed a narrative for the self (Brown et al., 2008) that has released the anxiety the event contained.

9.7 Conclusions

Patient care is a process and a social construction and as such means different things to different people. Norms and styles of patient care also change across time and differ site to site not only because of differences in beliefs, but also because there are different possibilities (technological advancement, different types and mixes of professional groupings) and different types of constraints on what might be offered. It is not always possible to put a clear value judgement on patient care and one example is to do with 'length of stay'.

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Managers, whose concern is to ensure that beds are not blocked, may or may not be holding in mind the image of an organisation that shares care with agencies and families in the community. They may simply be responding to government targets. They may have their mind fixed on those waiting for beds who have still not received treatment. Patients themselves may want to return home as soon as they can or become bewildered when they are discharged rapidly after treatment.

Working in multi-disciplinary teams with distributed leadership patterns may have improved practices for clinicians. Accountability for patient care still resides with the consultant and the hierarchy who manage the Trust. While senior managers are responsible for ensuring patient safety and preventing negligence to individual patients, they are also responsible for ensuring access to care for the community which involves managing scarce resources such as equipment, pharmaceuticals, beds and staffing.

Not all clinicians appreciated or respected these pressures as we saw particularly in Chapter Six. Nor do patients necessarily agree that good care is anything other than good and consistent communication with specific clinicians.

As demonstrated in Chapters Six and Seven managers are frequently frustrated by demands from staff who may try to subvert managerial targets (set by government and as such fundamental to resourcing of the Trust).

The quality of leadership is intimately linked to patient care. Good patient care relies on effective leadership of the kind that engages with staff and imparts to them the vision that (as far as humanly possible) the patient comes first. That in turn impacts upon the climate, culture and ethos of the Trust. When leadership fails, so does patient care.

10 Leadership and patient care: Assessing the past and thinking of the future

10.1 *Introduction*

Without effective leadership at all levels of the NHS and its various organisations patient care suffers. This knowledge has been evidenced in

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several key studies across recent years as reported above and elsewhere and consequently fed into the NHS Qualities Framework (see Chapter One).

In this report we have critically reviewed the relevant literature on leadership exploring as far as possible the relationship between leadership, followership and service delivery across five hospitals comprising three NHS Trusts (see Chapter Three). We employed different research methodologies (see Chapter Two) to capture data to investigate leadership qualities and their interaction with the climate and culture of the organisation and linked these to service delivery and patient care in different settings (ranging from obstetrics and gynaecology and cardiology to care of the elderly).

10.1.1 The organisational contexts

The organisational contexts of each Trust and each site or unit varied physically, structurally and in 'atmosphere' (the full details are provided in Chapter Three). We have been concerned in the report (and future papers) to steer a path between maintaining anonymity and confidentiality and thus not overtly identifying a Trust or site within a Trust, while also pointing to how the contexts impacted on the practices of leadership and service delivery.

Overall the Foundation Trust (3) in this study, which had not been experiencing mergers or threats of closures, where staff morale was high and where leadership practices were distributed across teams and clinical and management specialties, was clearly the one most conducive to effective communication and leader-follower engagement. There was an 'atmosphere' of connection and pride in belonging to the Trust as evidenced explicitly in Chapters Four and Nine in particular.

Trust 1 was applying for foundation status during the time of the investigation but also threatened by closure of some of its units, and with the senior managers possibly being transferred to the other site which was perceived by the participants as a threat to their status and possibly to resources for service delivery. This did not happen during the course of the investigation. The managers in Trust 1 were committed to their staff and to service delivery although there did appear to be some discontent with senior management from the medical staff. This may have been because most of the distributed leadership involved non-clinical managers and nurse managers with the medical teams appearing to take a more 'traditional' hierarchical stance. Most of the data from the OCS was derived from Trust 1 which demonstrated among other things the importance of management support for identifying good leadership and patient care practices.

In Trust 2 there appeared to be the greatest amount of conflict between groups of staff who sometimes seemed to be leading in different directions.

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Trust 2 was perhaps the 'victim' of a relatively recent merger between two large hospitals (and one or two other smaller units) which were some physical distance apart and had had a different history – one being a DGH and the other a teaching hospital. The DGH appeared at first to have a professionally diverse group of senior managers who distributed their leadership to effect, but one or two figures emerged during the course of the study who transgressed this approach with one person taking a back-seat while another was trying to drive through change in a somewhat cavalier manner. Furthermore in this particular Trust there were changes among the senior managers (some left, others moved to the other site during the course of this study). The CEO also indicated that it was difficult to recruit good middle-range managers and nurses in particular because both sites were away from the centre of the city where most people would look for a promoted post.

10.2 *Limitations of the study methods*

As with any large scale and complex study such as this one not all of our intentions were achievable although some were satisfied beyond our expectations.

We had difficulties capturing data from patients for two main reasons (fully detailed in Chapter Three).

Firstly, the 'gate-keeping' staff working on the Units on a day-to-day basis (as distinct from those who supported overall access to the Trust overall) obstructed data collection.

Secondly, it was also difficult gaining access to patients while they were in hospital because of ward procedures and in other cases the poor health of patients. So in the end we managed to conduct ten patient interviews but were unable to collect organisational climate survey data from patients at all³⁸. To overcome this we gained permission to observe clinicians' interactions with patients in their care and we believe we have managed to do more than compensate, making a contribution to knowledge with important new material to demonstrate patient care in different contexts and the processes involved in patient care and service delivery (see in particular Chapter Nine).

We also met with difficulties, with one Trust in particular, collecting *survey* data from staff although individual staff members proved more than willing

³⁸ These difficulties were reported to SDO in the interim reports and also separately when they arose.

to support the researchers by allowing them to interview, observe and shadow them during their working days. *This is all reported fully in Chapter Three.*

10.3 *Reviewing the findings*

In this final chapter then we draw together the findings from the study and make suggestions as to how they might contribute to policy and practice beyond the participating organisations.

This chapter is organised around the original study aims which were about leadership, organisational climate (culture and context) and how they impact on patient care. The overall plan was to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery.

This research further sought to explore the following broad-based questions.

- First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
- Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?
- Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The specific aims and objectives are listed again below and we conflate these in what follows directing the reader to the relevant chapters.

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines, to patients;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts service delivery;

- To learn how different stakeholders (specifically patients, nurses, members of professions allied to medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care;
- To identify how the need for change in service delivery is identified and what drives the need for change.

10.3.1 How far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?

Throughout the participating Trusts there is evidence of the importance of high quality patient care. Chapter Nine in particular brings this together with quoted respondents emphasising that above all patient care matters to the aims of the organisation and those who work in it. Thus on a basic level, working for patient care is inspiring in itself and staff across the Trusts see good patient care as their *modus operandi*.

Our use of innovative ethnographic methods and story telling were particularly effective in providing the evidence of how patient-clinician relationships were practiced and how staff made sense of their own actions reflexively in the context of caring for patients³⁹.

Chapter Nine provided evidence of the ways in which care is practiced.

We begin here by summarising some of the evidence from the Foundation Trust in this study, which consistently appeared to demonstrate high levels of distributed leadership, emotional engagement and multi-disciplinary working across all levels. The data included several key examples of positive statements about the role and effectiveness of management. We saw, for example a senior clinical manager summarise the issue with reference to his

³⁹ For example, interviews opened with questions about leadership and patient care, and participants were then encouraged to tell 'stories and critical incidents illustrating their experiences'. The early parts of the interviews provided themes and indications of what the clinicians regarded as crucial to delivering good patient care, e.g. 'cleanliness', 'efficient administration', 'communication', 'empathy', 'sympathy', 'knowing the recent developments in your field' and 'everything behind the scenes the patients don't see'. However, it was the stories they relate to that provided us with insights into their core experiences of patient care (see Chapter Nine).

pride in working for the organisation drawing attention to its low mortality rates, and that the high quality staff and its reputation for patient care act to attract others at the top (or with the potential to be at the top) of their specialty.

By contrast, the CEO of one of the other Trusts had made the point in their interview that one of the difficulties they had was attracting high caliber nursing staff, partly because of their location (in the suburbs). In Chapter Four we identified the ways in which an organisation might be seen as a learning organisation as significant in supporting staff to develop their clinical and managerial skills and develop capacity for patient care. Where support for learning was apparent so was the enthusiasm and pride for the organisation and its goals.

What was striking was the way that all respondents who addressed this point were looking to see how patient care could be improved with aspirations that patients were satisfied with more than just the health outcome (although that is the bottom line) but also with the facilities and the atmosphere. In addition, several respondents made the point that they themselves were mindful of delivering (or at least aspiring to deliver) the type of care they themselves would want to receive.

That so many of the staff (clinical and non-clinical) worked long hours in which they were engaged in intensive work with either their clinical or management teams, or their caring for patients with the aim of delivering the best possible care, is yet further evidence of the ways in which patient care is inspirational.

What is most noticeable, however, is how some styles of clinical and managerial leadership appear wanting, when compared with the best. While some respondents are clearly excellent communicators who engage fully with their professional knowledge and with the patients and staff, others - equally expert and equally inspired to provide the best for their patients - seem to fall short in comparison. In Chapter Nine for instance, Cameron and Kenneth engage with their patients in human ways and there are examples in the chapter in which each clinician manages to gain important information from and for their patients by their hard work *and* their humanity. However, in Cameron's case he is supported by a team which has clearly been nourished and inspired by the organisational context (see references to Cameron's work in this report).

Kenneth, while equally able and empathic, from the ethnographic evidence reported in Chapter Nine, appears to be less able to transmit this or influence others to take up his brand of leadership and patient care. He remains slightly in the background while the younger and (it appears) more influential Henry sets the tone. The clinical team give the impression of

being business-like and impersonal and somewhat intimidating when they conduct their ward round. The culture being transmitted to the other clinical staff tends towards Henry's approach rather than Kenneth's. This raises questions about why this Trust and site is different from the FT in which Cameron and Mandy work. These matters were addressed in Chapters Six, Seven and Nine in particular and will be subjected to further analysis in subsequent publications. However the FT is established and settled. The Trust where Kenneth and Henry work was the product of a relatively recent merger and norms and values were still being 'negotiated' (see Chapter Seven and above in this chapter).

Subsequently we see Mandy working directly on a patient's wound not only acting humanely when she hurts the patient but working with the nurse to assess how they might best improve the patient's condition while caring for his mental state and self-esteem.

High quality care and inspiration come together through the ways in which clinicians and managers take responsibility for their work – for managing emotions (their own, their colleagues' and their patients'), teaching, making decisions about end of life care, communication with relatives and coping with everyday situations that raise anxiety levels for patients and staff. The story of the doctor in Trust 1 who cared for a woman with a still-born baby itself demonstrates how he went the extra mile (in his words) inspired by the possibility of providing care in a case where some might have tried to make minimal contact because a still-born baby might be seen as a clinical failure.

Overall emotional engagement with patients and followers leads to people working together in a human, humane and inspired way and impacts on the organisation itself which can become one with which people are proud to be associated.

10.3.2 How do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

This question underpinned the entire study, but specifically we reviewed the relevant research literature on leadership and organisational climate (Chapter One) and discussed this in Chapters Four through to Eight. We began by reviewing the results from the story-telling interviews, focus groups and ethnographic methods (observations and shadowing). A range of potential practices and behaviours were reported to us which suggested where problems might lie in current leadership practices, as well as what many respondents held to be ideal types. What we summarise now represents a combination of what works and what does not although it needs to be noted (as identified in Chapter Nine in particular) that what

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patients see as good leadership (that they received clear and consistent information from one or two key staff) may not always intersect with what staff meant by good patient care or effective leadership and service delivery. The latter was usually seen as best delivered by a well-functioning multi-disciplinary team albeit frequently constrained by limited resources.

The following issues stand out as good practice that could feed into NHS (and local Trust) policy:

Leadership is a complex concept meaning different things to different people. Over recent years leadership in changing contexts such as the NHS has shifted from the 'heroic' model where leadership is hierarchical to a model that is more distributed across different levels and different parts of the organisations. The heroic and hierarchical (related) models frequently depended upon individual characteristics and where the senior managers were indeed heroic and charismatic, leadership might well have led to good patient care. However, this is unreliable and unpredictable and the NHS Qualities Framework which has identified leadership skills is more appropriate to the context (see Chapter One).

Our most important findings, however, make it clear that leadership which is emotionally engaging and distributed is the one which is most likely to lead and support service delivery successfully as well as drive necessary changes.

At the end of Chapter One we focused on contemporary studies of leadership which promoted the importance of *context* and of taking a more discursive stance in the analysis of leader-follower relations. We also drew attention to the revival (and reappraisal) of concepts from organisational studies from the 1960s to the 1990s which took psychodynamic ideas into account and related them to more 'popular' contemporary ideas about the significance of social and emotional intelligence in leader-follower relations. Thus, we explored the ways in which stakeholder accounts of the experiences and exercising of leadership demanded an attachment or engagement at an emotional level, which took account of the unconscious as well as conscious understanding of these experiences. There were several examples offered in the previous chapters of leadership practices that delivered the required services or changes through different types of concerted action and those that didn't. In some cases we were able to show that with the best will in the world if the leader, for whatever reason, was unable to *engage* and thus be supported by the followers, then their leadership failed to deliver.

Recent analyses of distributed leadership styles and organisational contexts show that if such leadership is to work then people need to act and work together and be prepared to both take up and relinquish authority for

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certain tasks and roles at the appropriate intervals. We saw in Chapters Six and Seven for instance that authority is hard to maintain if a leader loses touch with their staff and fails to hold their own organisation 'in mind'. We used the OCS survey results in combination with the data derived from the interviews, focus groups and ethnographies to demonstrate the importance to a positive organisational climate of good leadership. Satisfaction with a manager was predicted by the same variables that identified a positive organisational climate. For staff in the organisations surveyed it was important that managers were committed, responsible and supportive of their staff/followers.

But how were these characteristics demonstrated? Leaders who were experienced as effective, supportive and emotionally engaged with their followers were able to communicate their vision and dedication to improving the quality of care to patients, which in itself co-existed with good staff morale. Such leaders were also good listeners as well as being able to take staff with them when less palatable or unpopular changes were mooted by senior management or government. These effective leaders were closely connected to the way the organisation was structured (physically and emotionally). They were thus able to access the information they needed in order to lead. The evidence for this frequently came from the stories and accounts of staff and observations made by researchers – often of good leadership but perhaps more acutely when leadership was poor. Then there was a jarring effect or mismatch between (local) policy and the attempt to drive changes to meet improvement targets. There was also evidence on occasions of senior clinicians' behaviours being disengaged. Sometimes attempts were made to subvert the senior people when leadership went against the grain. There are examples in Chapters Seven and Nine in particular.

A final comment here is that despite the changes in gender demographics at the top of clinical specialties in medicine, nursing and related professions, as well as in senior management, gender has not 'gone away'. Indeed distributed forms of leadership have (perhaps stereotypically but with some evidence base) been associated with women's behaviours. The OCS (Chapter Five) suggested that women's perception of 'recognition' for their work and achievements was more negative than that of men. Men were either satisfied with the recognition they received or less in need of recognition from their managers within the organisation than were women. In the qualitative data (see Chapter Eight) it was also the case that while senior women were keen to deny the relevance of being female to their professional lives and their career progression per se, women used different strategies and perceived their roles slightly differently than did men, although the point was well made by some respondents that feminine and

masculine choices of specialty may have been more significant predictors of management styles than gender itself.

10.3.3 Do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The contemporary NHS with its (mostly) distributed leadership practices at all levels tends to militate against the possibility of one person's vision being paramount. However, as suggested above in this chapter, there are nuanced influences of leadership style that (may) flow from one or two people's vision and/or style of leadership and patient care that influence organisational approaches.

In Chapter Seven, for example, we explored three senior people's visions and consequent behaviours to consider their authority and influence with the possibility that as opinion leaders they influenced organisational approaches to patient care. Quentin, for example, reflected his role as a senior clinical leader, and although there is no irrefutable evidence that his style was mirrored in the organisation itself, he does provide some evidence that in certain cases in relation to certain actions his vision had an impact on the overall organisational approach.

While the OCS (Chapter Five) captures data from a wider population, the ethnographic methods made a greater contribution to exploring how far an individual's vision influenced the organisations approach to patient care. Again in Chapter Seven we see Kerry battling against a resistant (and probably disillusioned for some reason) senior management team to improve discharge policy and meet government targets. She tries again and again (by her own account) to show her staff that they need to focus on targets because they will lead to improved care quality. She appears to fail (again according to her own standards) and expresses this by almost literally demonstrating that she is banging her head against a brick wall.

Differently with the same effect Gerald is introduced as having a clear vision for patient care in his Trust. However, his inability to take staff (at all levels of the organisation) with him in his vision is attributed in our analysis to his lack of emotional engagement and autocratic (verging on the authoritarian) style of management. His narcissism further ensures his inability to understand how his behaviour is impacting upon staff and he sees himself as having failed to win a 'fight'.

Chapter Six explores the organisation as an open system, and ways in which all stakeholders⁴⁰ hold a vision of the organisation in the mind at a

⁴⁰ Including patients but we cannot really speak definitively here due to lack of data.

conscious and an unconscious/emotional level acting accordingly. Thus, they have an image of the organisation (how well it is managed, how effectively it cares for patients), a sense of their own role and place within the organisation and how well the leadership understands the experiences of staff and patients. Recognition of the primary task, the roles and responsibilities of those who manage it and the (changing or threatened) boundaries of the organisation itself are critical concepts.

No doubt some members of the organisation have more personal and role/task related power and influence than others in the NHS Trust. Furthermore, the NHS as a system is fluid and dynamic, so that there is overall a group influence over the evolution of organisational context (climate and culture) which responds to visions from within and without (government, health care consumers) the wider system.

10.4 *What have we learnt from this study?*

10.4.1 How leadership relates to patient care

It is clear, from our empirical work and evidence from previous studies, that leadership is a process and set of practices which generally do not equate with the qualities residing in a particular individual regardless of their authority and formal role and status in the organisation. Leadership that 'works', as seen particularly (but not only) in the case studies in Chapter Seven, involves the person in the leadership role exercising social and emotional intelligence and engaging with their 'followers' (see Chapters One and Four) and offering staff recognition and support (Chapter Five). Moreover the role of leader is particularly effective when it is distributed among those who are best placed to exercise leadership towards the task in hand. So that in the context of an NHS hospital Trust, leadership might be exercised in relation to organising the administration for a unit, running an audit, or developing an innovatory clinical practice. Leadership in such contexts is time/project limited.

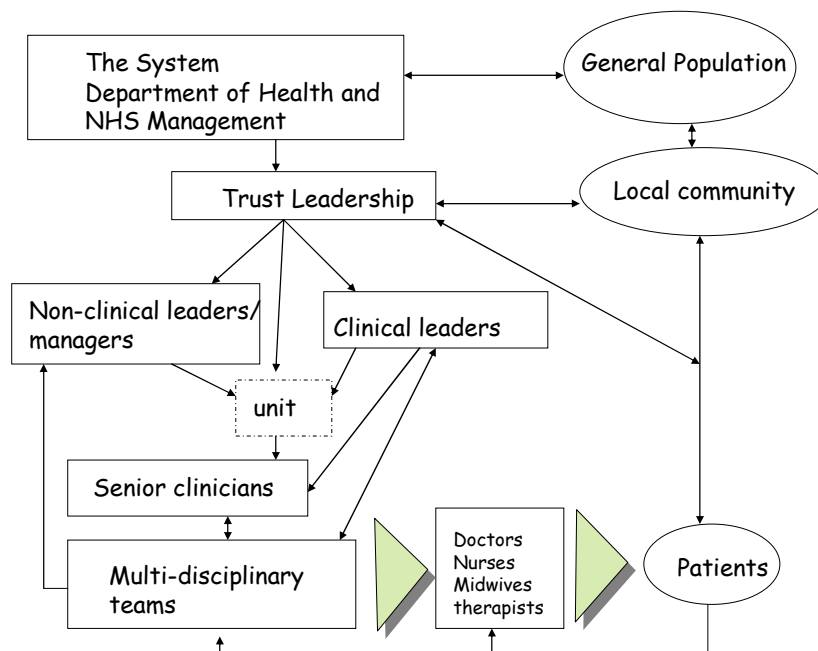
The primary task for NHS Trusts is to deliver a service to patients, as proposed in Chapter Six. All NHS Trusts operate as open systems with porous boundaries which enable change (planned and/or evolved). Leadership therefore can occur throughout the system at different levels including those of ward clerical and cleaning staff and the CEOs who 'manage upwards' and influence NHS/ Department of Health policy. Information of all kinds passes across the various boundaries not simply from the 'top' downwards.

Below in Figure 12 the relationship of the Trust leaders and patients within the NHS system is illustrated. It is also the case, as shown, that policy

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influences individual care, and the quality of that influence depends very much on the quality of leadership again across the system at all levels.

Figure 12. From the DoH to the Patient: An Open System



Patient care is represented here at three levels. The population who influence service delivery and patient care using their vote and/or lobbying through relevant patient groups, the local community who are served by a particular Trust and patients who are actively receiving medical treatment from individual clinical teams.

While on the whole it was the last group who were the main focus in this study some participants, particularly those in senior leadership/management roles, were concerned with service delivery at the local community and population levels. This sometimes meant that senior managers faced the dilemma of how to care for the community while attending to individuals and some individual clinicians were equally concerned about how their interactions with patients were influenced by some of the management dictates which derived from NHS policy that they

found difficult to understand (see Chapter Six and in 10.4.2. below for example).

10.4.2 Systemic dilemmas in patient care: Managing in the NHS

One participant had faced a 'dilemma' in wanting more face-to-face knowledge of patients in the community in order to be a more effective and informed leader, while also as his role required, attending to the demands of working within the wider system of the NHS:

As a chief exec in the NHS it was my privilege to make decisions. That was my privilege to go on and up the ladder. It was that I could go on and make faster and faster decisions. I get in the way I have always got in the way... the thing I would do is go out with the district nurse for the day, because I needed to be grounded in that. (Retired CEO)

Another manager who had previously had a military background advocated (along similar lines) that the best way to lead towards good patient care was to 'walk around' and support the leaders across the different parts of the organisation. In a seminar to clinical staff, which we attended and recorded, he drew participants' attention to the importance of *influencing* policy to achieving good patient care (at the population and community levels).

I hope some of you will find yourself in policy jobs at some point. Totally different, yes it still leads, but the actual process is so ... changing...both the chief executive and I spend a lot of time nurturing relationships which are partly to do with policy, but unless you get it right ... you communicate with them, it won't work.

In other words to be effective and to ensure the best for those in the Trust (staff and patients) a leader has to 'manage upwards' which gains influence. He continued by contrasting the experiences and perceptions of doctors with managers who lead at the macro level, drawing on the example of a recently qualified doctor. When the respondent quoted here asked this man about leadership in the NHS and how it impacts on patients he apparently answered:

'Oh I have got communication skills'. 'Blimey!' I said 'what do you know about the NHS?' And I asked him a couple of questions, nothing! But he hasn't been taught at an academic level about the context in which he is working. I think that is crucial and I know that is not how everyone does things. You know [doctors] keep people alive, but they really ought to have this basis of information about the context in which they are working.

While it is self-evident that the NHS is the context in which patient care is delivered, there is a tension between those who exercise leadership in that context and those who 'keep people alive'. In Chapter Seven, the frustration expressed by Kerry in trying to meet the demands of the government and community by improving the Trust's record of patient care, as well as motivate her senior staff to hold similar ideas, was palpable. From others' perspectives as shown in Chapter Six, there was evidence that 'management' was experienced negatively by several clinical staff when it tried to respond to Department of Health directives.

Managing the numbers

At another level of management good patient care was defined through achievement of returning satisfactory statistics, as this observational note of a meeting between capacity managers and clinicians suggests:

Patient care for the capacity managers appears to be a number crunching exercise. The need to get the patients in the right beds according to government targets meeting four hour waits and single sex bays. However because there is not a shortage of beds on this day, patient care moves from an exercise in numbers to thinking about patients in real human terms.

Sally (the capacity manager) talks about how better patient care can be delivered when there is less pressure on all the staff to meet their targets and get their job done. She talks about how [clinical] staff are then more able to talk to their patients and spend time with them. However, whilst reduced pressure means that for some, numbers translate into real people it is clear that in the capacity meeting that the role of the capacity manager is to think in terms of numbers and beds to deliver good patient care.

There is a potential conflict between the target driven service and the patient-clinician relationship which is about face-to-face contact. Perhaps this is well illustrated in Chapter Nine with the example of the 'grace in adversity' story, whereby the obstetrician spent extra time with a patient while his clinical colleagues turned a sympathetic blind-eye. The story of the patient 'Lola' also discussed in Chapter Nine who had been occupying a bed for three months with the tacit support of nursing staff would also have been anathema to staff responsible for managing targets about capacity.

10.4.3 Who judges what is good leadership and good patient care?

As shown above and throughout this report there is a tension throughout the system. The primary task of senior managers and leaders at and above the level of the Trust is to ensure the demands of the NHS and Department

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of Health leadership are met. These are policy driven with differing priorities at any particular time. The general population of (potential) patients has a keen influence on policy in different ways but particularly during local and general elections. For example the recent change from a Labour to the Coalition Government has raised questions about the role of 'targets' for future NHS priorities. Apart from other matters, finance makes a difference as to how priorities for service delivery are set.

Senior management at the Trust level is judged in a number of ways particularly related to how far the Trust meets the national priorities. However there is also pressure on CEOs and senior teams to get direct patient care and safety 'right'. This may be assessed through statistics as in the following example described by a senior midwifery manager:

Between 2002 and 2005 there were ten maternal deaths at [Trust], which exceeded the national figures. So the Healthcare Commission came in and reviewed a number of clinical organisational cultural governance issues, and then actually put the maternity services under special measures

There was a key number of issues then, and an action plan was developed, so actually I was newly appointed at that time, and there was a number of work streams that we had to work on, and it's never happened before, and I don't think its happened since in a maternity unit. So basically, even though that was a very sad event for all the families involved and very tragic for them, it was difficult for the staff, and obviously difficult for the Board in terms of reputation management. The whole action plan was implemented, the unit was turned around, and the special measures were lifted in 2006.

In this case there was a notable failure to deliver maternity care to the standards of safety prescribed by the NHS. Furthermore there was a failure of leadership perceived by this participant in terms of both 'culture' and 'governance' giving rise to the high proportion of maternal deaths and the consequent special measures. This participant also makes clear how much the staff themselves are influenced by events of this kind.

Another member of that staff team praised the changes at the top following these problems and combined the policy, context and face to face care in her assessment of the relationship of good leadership to good patient care:

.... the end goal for us, is ensuring the services we're providing.. the patients, are getting the best service from us on top of meeting all the Trust targets and the Trust strategy...for me really it's about ensuring that the patients are getting the best quality care, which, you know, I think they've got an improved quality of care here, with the team like mine who are here...and I think [leadership] is from the top down, so from Chief

Executive, right down to every level, to leaders in the ward, right down to our portering, to our domestics. Yeah, there certainly is, and we lead by example really don't we? and I think our chief exec, director of ops, deputy chief, they've all got good leadership skills.

Good leadership skills among senior managers can pay dividends in terms of reputation management. For example in August 2010 North Cumbria University Hospitals NHS Trust admitted a series of false positive diagnoses following breast cancer screening⁴¹. The CEO moved quickly to review the situation and apologise publicly. In other cases though, when there have been wrong diagnoses, neglect or medical errors over drug doses senior managers have been blamed for the failures - sometimes warranted and sometimes possibly not so (see below). Anecdotally it appears that leaders who are prepared to acknowledge problems as soon as they appear and deal with them in a transparent and effective way bring about improvements in service delivery and patient care in the ways perhaps that those who try to 'bury' problems might not achieve.

10.4.4 Leadership practices across the organisation

Leadership and patient care are intrinsically linked. Leadership is above all about taking responsibility but with changes in organisational structures, a growing emphasis on networks, open systems with porous boundaries, mergers and changes in the shape, structure and functions of Trusts, it is no longer tenable for leadership to be in the hands of a few. Leadership, then, is about a series of relationships and connections within and without specific organisational boundaries which have the potential for diffusing responsibility or sharing it, and therefore making leadership practices more co-operative.

It is important to focus, as we have done, on the many examples of good and excellent leadership we found within the three Trusts taking part in this study (each of which of course being hospital based and therefore not focused on the role of leadership in primary care). These sit in contrast to the examples of less effective and sometimes failures in leadership that we have cited. The differences crucially were about emotional attachment and engagement between leaders and followers. We did not meet any respondents who were disengaged with the aims of the NHS and none who were uncommitted to deliver the best patient care. But as evidenced above in the report and in this chapter, some leadership practices failed to take

⁴¹ <http://www.bbc.co.uk/news/uk-england-cumbria-10958423>

followers with them because of autocratic, insensitive behaviours and poor communication skills. Leaders need to be able to listen and engage – having a vision is not enough.

Leadership taking the importance of emotional engagement into account also needs to be transmitted across the organisation. This is best accomplished through making full use of individual skills. Clinical staff and managers can be effectively involved in specific change projects. These may be time-limited and/or specialism specific but collaborative concerted action is frequently the most significant way that a system might flourish with the staff taking responsibility and enhancing their sense of commitment.

10.4.5 When leadership fails patient care

The converse of good leadership is potentially catastrophic. The case of Beverly Allitt in the early 1990s, the nurse who murdered children in the Lincolnshire Hospital by injecting them with insulin, went relatively unchallenged because she was poorly supervised. Harold Shipman, a different case in that he was a GP in a sole practice, similarly was eventually thought to have committed over 200 murders of patients throughout his career. However, the report into his murders showed that doctors at Thameside hospital had failed to report suspicions about his prescribing⁴². The Alder Hey organs scandal involved the unauthorised removal, retention and disposal of human tissue, including children's organs during 1988 to 1995 and the Bristol Royal Infirmary inquiry about children's deaths during surgery resulted in doctors being struck off. All these cases represent a failure of leadership in which those who were responsible for patient care at all levels failed to identify and follow up on problems. More recently the independent inquiry into the Airedale NHS Trust, where the late Anne Grigg-Booth continued as night-nurse despite a high proportion of deaths of patients while under her care, identified 'a catalogue of systemic failures' whereby her dangerous behaviour was not spotted.

At the time of writing this report the Prime Minister David Cameron has ordered a full public inquiry into the events at Staffordshire hospital which have led to deaths of patients, it would appear in these cases, more due to negligence than intent. The Francis report which was published in 2009 found that patients were routinely neglected and there were systemic failings in patient care. Managers had been pre-occupied with cost cutting and meeting targets and unable to spot the build up of failures in patient care that were to cost several patients their lives. There were too few

⁴² These cases were subjected to inquiries which exposed a range of complexities which are not relevant here.

nurses, those who were employed were ill-trained, equipment was inadequate and experienced medical cover was not always available. It was a supreme failure of management and leadership. The Trust was poor at identifying when things went wrong and managing risk. Some serious errors happened more than once and there were higher levels of complaints compared with other trusts. Staffordshire was a foundation hospital that had managed to 'tick the boxes' although clearly there were a series of chasms between the clinical and managerial staff.

10.5 *Final thoughts*

By using innovative qualitative methodologies (described fully in Chapter Two) such as story telling, ethnographic observations and shadowing, to both supplement and augment data from interviews and focus groups, we have built up a picture of what happens in the daily lives of NHS staff working both with and as managers and in clinical teams. Using these methods provides opportunities to extend the scope of more traditional in-depth interviews and focus groups. The 'story', because it is chosen by the participant themselves, provides not only detail and depth but demonstrates the specific indices used by each interviewee to make sense of their own and others' behaviours within the organisational context.

The ethnographic observations, and the shadowing in particular, enabled the researchers to gain a sense of what 'a day in the life' of a member of the organisation *feels* like. They can 'experience' the interactions between staff, between staff and patients as well as the frustrations and pleasures of working in that Trust. No other method provides such acute insights. The subjective ingredients in this method enhance the process (i.e. as outlined in Chapter Two whereby the researcher themselves is the 'instrument' through which data is mediated). Moreover, and possibly conversely, the subjective elements are reconciled when the observation notes are discussed by other members of the research team, which again as discussed in Chapter Two is also a source of data (Czarniawska, 2008).

As a qualitative study, the success is proven by the richness of the data, showing the clear emotional connection participants had with the topics of both 'leadership' and 'patient care' (Lincoln & Denzin, 1994, p. 575). From this we were able to make sense of how leadership is experienced and exercised (see Chapters Four and then Six to Eight) and about the practices around patient care and service delivery that support patients to understand the relationship between their particular health-status, quality of life and the care and treatment they are receiving and/or expect (see Chapter Nine in particular).

The statistical analysis of the OCS⁴³ showed that, on the whole, the climate variables, 'support' and 'recognition' from managers and the system overall, predict 'satisfaction' with leadership and management. This reinforces the ideas expressed throughout the report that good practices by managers/leaders are about ongoing engagement with followers with concerted or conjoint leadership processes most likely to promote a sense of being supported and recognised (Roberts et al. 2005).

Thus we have not produced a list of 'good leader' qualities or a similar record of what constitutes 'good patient care', as these would fail to capture the crucial point that both leadership and patient care are experienced as a process. Thus this report aims to delegate *good practices* that were observed during the project, for the use and reflection of any staff member of the NHS – whether a leader, follower or patient.

10.6 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.

⁴³ As made clear above we were unable to capture corresponding data from patients.

- 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.

Appendix 1

Focus Group Questions

1. Leadership means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this hospital?

Prompts

1. Charismatic / Authoritative / Consultative / Directional / Varies – depends on situation/activity etc
2. Can you think of some incidents that sum up for you the way leadership is exercised in this hospital?

Follow-ups

1. Does this type of leadership operate throughout the hospital?
2. Could you give some examples of ways in which leadership is exercised in your team/the hospital
3. Patient care means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this organisation?
4. How important is patient care as a priority in the service that you and your colleagues provide?
5. What are your main priorities in ensuring a high level of patient care in this hospital?
6. Can you think of some incidents that sum up the way you and your colleagues try to deliver patient care?
7. To what extent is leadership reflected in the quality of patient care you and your colleagues provide?
8. Can you think of some incidents that sum up the way that leadership in this hospital approaches the issue of patient care?
9. Can you think of specific incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

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Follow-up

1. What would you suggest to improve this/these situations?
3. Stories and critical incidents
 - a) Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
 - b) Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
 - c) Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

Could you tell me about a time that made you feel disappointed with leadership in this hospital?

- In this unit?

Appendix 2 Interview Questions

Interview

*Introductions, background and experience in relation to patient care and leadership in the organisation

- The interviewees position/level
- Years at the hospital
- Role in the organisation

1. Leadership

'Leadership' means different things to different people.

- a. How would you define it?
 - Do you see that kind of leadership at this hospital? Why/not?
 - What about in this unit?
 - What makes someone a good leader/Qualities of a good leader? Can you give me an example?
 - Who here at work do you see as providing leadership to you personally? Why? Do you have a direct supervisor? Who? Do they have leadership qualities?
- b. Do you see yourself as someone who could be a leader?
 - Why/not?

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- Under what circumstances?
- c. Can you give me an example of leadership in this hospital?

2. Patient care

- a. Like leadership, 'patient care' means different things to different people.
 - How would you define it?
- b. Tell me about patient care in this hospital. How is it defined?
 - Are there differences between units? Tell me about them. Why do you think this is?
 - How would you improve patient care in the hospital?
 - How would you improve patient care in this unit?
- c. How do you [as a hospital worker, nurse, etc.] try to deliver good patient care?
- d. What do you think are some obstacles to delivering the sort of patient care you'd like to see? How could these obstacles be removed?
- e. Do you think leadership could improve patient care in this hospital?
 - Why/not?
 - Do you think that better leadership would improve patient care? Why/not?
 - How does good leadership influence patient care?
 - Has the leadership in this hospital improved patient care since you've been a member of staff? How so? Or why not?

3. Stories and critical incidents

- a. Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
- b. Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
- c. Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

- d. Could you tell me about a time that made you feel disappointed with leadership in this hospital?
- In this unit?

Appendix 3: Focus Group Questions: patients

1. Leadership means different things to different people. What does it mean to you as a patient of this hospital?
2. What is your opinion of the way leadership is exercised in this hospital?
3. Patient care means different things to different people. What does it mean to you as a patient of this hospital?
4. Can you think of some incidents that sum up the kind of patient care that staff in this hospital deliver?
5. Can you think of ways that leadership in this hospital could enhance the quality of patient care, as far as you are concerned?
6. Can you think of some incidents that sum up what else leadership could be doing?
7. Can you think of any other incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

Appendix 4: Staff Organisational Climate Survey

[attached separately]

Appendix 5: Participant Information Sheet

Leadership and Better patient Care: From Idea to Practice

Participant Information Sheet: Staff Interviews

You are being invited to take part in an interview study about leadership and patient care in three different hospital settings. Before you decide to participate in this study it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Contact me (see full contact information at the end of this sheet) if there is anything that is unclear or if you want to know more.

Take time to decide whether or not you wish to take part.

Thank you for reading this.

1. What is the purpose of the study?

The purpose of this study is to try to identify the circumstances under which leadership can be an effective engine for change in the organisation of health care, especially for patient care and service delivery. Although we suspect that leadership motivates workers and affects the climate or atmosphere of the places where people work, leadership can mean different things to different people. The same is true of patient care which can also mean different things to different people. In order to understand how leadership inspires health workers to provide better patient care, we want to learn how nurses, doctors, other medical professionals as well as managers and patients define and understand leadership and patient care. This includes exploring how their perceptions mesh or conflict with one another. It also includes listening to stories of important incidents that describe their experiences of leadership and patient care.

2. Why have I been chosen?

As part of the study we are interviewing staff (clinical, managerial and others) as well as patients to examine what leadership and

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patient care mean to them. You have been chosen as someone whose views represent the views of staff.

3. Do I have to take part?

No

4. What will happen to me if I do take part?

You will participate in a tape-recorded interview with a qualified researcher, which will last under an hour.

5. What do I have to do?

Arrange a mutually convenient time to have the interview.

6. What are the possible disadvantages and risks of taking part?

It is possible that the discussion may stir up distressing feelings you have regarding your organisation, its leadership and the patient care it provides. However, care will be taken to prevent this and you are free to leave the interview at any time. Apart from that, the only disadvantage is that you will be giving up some of your time.

7. What are the possible benefits of taking part?

This study may not directly help you but it is part of a serious initiative to improve the quality of leadership and patient care provided by the NHS.

8. Will my taking part in this study be kept confidential?

Yes. All data will be stored in locked filing cabinet in a locked office. It will be made anonymous and all names will be edited out of the transcripts. Only members of the research team will have access to the data.

9. What will happen to the results of the research study?

They will be published in a report to the funder and also presented in peer reviewed papers and conferences. A copy of the report will be provided for each participant who requests it.

10. Who is organising and funding the research?

The study is funded by the NHS Service Delivery and Organisation (SDO) Research and Development Programme of the National Institute for Health Research (NIHR) Programmes. The NIHR has been established as a part of the government's strategy Best Research for Best Health to provide the framework that will position, manage and maintain the research, research staff and infrastructure of the NHS in England. The study is conducted by a group of researchers from Royal Holloway University of London led by myself, which won the grant following a competitive bid.

11. What if I have any concerns?

If you have any concerns or other questions about this study or the way it has been carried out you should contact me (details below) or you may contact the hospital complaints department.

Contact for further information

Professor Paula Nicolson, Head of Department, Health and Social Care
Royal Holloway University of London, Egham, Surrey, TW20 0EX

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Tel. 01784 414 470

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Appendix 5: Consent form (generic)

Title of Project: Leadership and Better Patient Care: From Idea to Practice

Name of Researchers: Emma Rowland Paula Lökman

Please initial each box

☐ I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

☐ I understand that some coded extracts from the interviews may be used for the purposes of the research report and academic articles.

☐ I give my consent for quotations to be used in the report and research papers on the understanding that I will not be able to be identified by the use of these in any way.

☐ I agree to take part in the above study.

Name of participant

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Date

Signature

Appendix 6: Patient Organisational Climate Survey

Thank you for agreeing to participate in this study which as you will know is part of a larger study on leadership and patient care in the NHS.

The following questions explore how NHS patients feel about the care they received and how things generally worked in the units where their care was managed.

The survey is anonymous, so please do not put your name on the survey.

If, however, you would like to receive the final results of the survey when the study is completed, please fill in the tear-out form on the questionnaire's last page and submit it to the researcher or the collection box.

It is important that you answer all the questions. This should take you approximately 10 minutes.

Your individual responses will be kept strictly confidential.

Researchers

Dr Paula Lökman

Department of Health and Social Care
Social Care
Royal Holloway University of London

Ms Emma Rowland

Department of Health and
Royal Holloway University of

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Please circle one number that best describes how you feel for each question in relation to the service provided by your NURSE.

1. I feel understood by my nurse.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

2. I am able to be open with my nurse at our meetings.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

3. My nurse has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

4. My nurse encourages me to ask questions.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

5. I trust my nurse.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

6. My nurse answers my questions fully and carefully.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

7. My nurse deals very well with my emotions.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

8. I feel that my nurse cares about me as a person.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

9. I don't feel very good about the way my nurse talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

10. My nurse tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

11. The way my nurse interacts with me influences my perception of quality care.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

12. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

Please circle one number that best describes how you feel for each question in relation to the service provided by your DOCTOR.

13. I feel understood by my doctor.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

14. I am able to be open with my doctor at our meetings.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

15. My doctor has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

16. My doctor encourages me to ask questions.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

17. I trust my doctor.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

18. My doctor answers my questions fully and carefully.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

19. My doctor deals very well with my emotions.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

20. I feel that my doctor cares about me as a person.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

21. I don't feel very good about the way my doctor talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

22. My doctor tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

23. The way my doctor interacts with me influences my perception of quality care.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

24. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

25. What would improve the quality of care you receive at this hospital?

26. What services are you using within this hospital?

Demographic Information

27. In which year were you born?

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28. What is your marital or civil partnership status?

- ☐ Single
- ☐ Co-habiting
- ☐ Married
- ☐ Divorced

29. How many children do you have?

30. How would you describe your ethnic background?

31. What is your current salary?

- 1. Less than or around £20,000 per annum
- 2. Between £21,000 and 39,000 per annum
- 3. Between £40,000 and £59,000 per annum
- 4. Between £60,000 and £99,000 per annum
- 5. Above £99,000 per annum

Thank you again for your time. If you have any questions please speak with the researcher or alternatively you can contact Professor Nicolson.

I would like to receive the final results of the survey when the study is completed

Name:

Address:

Contact Telephone:

Please return this form to either the researcher or the collection box.

Appendix 7: Appendices for Chapter Five

[attached separately]

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⁷ There is a parallel ongoing debate as to whether university leaders should be drawn from outside academia.

Addendum:

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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.

Leadership and Better Patient Care: Managing in the NHS

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Executive Summary

The NHS National Leadership Council Website¹ (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)

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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.

Leadership and Better Patient Care: Managing in the NHS

1 Leadership, organisation and the NHS

1.1 Leadership

What is currently known about leaders and leadership? The ongoing attempt to identify the characteristics necessary for effective leadership over recent years has been described as an 'obsession' studied more extensively than almost any other characteristic of human behaviour (Higgs, 2002; Tourish, 2008). Alimo-Metcalfe, Alban-Metcalfe et al. (2007) in their comprehensive review of the literature, show that formal studies of leadership date back (at least) to the beginning of the 20th century. They propose, that despite changes in the way leadership has been studied and the underlying epistemological stance taken by the researchers, *"in all cases, the emphasis has been on identifying those factors that make certain individuals particularly effective in influencing the behaviour of other individuals or groups and in making things happen that would not otherwise occur or preventing undesired outcomes"* (p. 2). As *"many have pointed out, that in spite of the plethora of studies, we still seem to know little about the defining characteristics of effective leadership"* (Higgs, 2002, p.3). Even so this has not appeared to quell the appetite for pursuing an ideal of leadership, impelled by the changing demands of organisations echoed across public sector institutions such as the NHS. These changes are in part the result of technological advancements which impact upon clinical practices, demographic changes both of which have altered the strategic, structural and financial profile of health (and social) care (Tierney, 1996).

The tantalising questions remain though about what those factors might actually be and the significance of the context to 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).

But in addition, or conversely, the context, culture, climate and/or structure of an organisation each have an impact on the performance of the people who lead in it (Carroll, Levy, & Richmond, 2008; Goodwin, 2000; Michie & West, 2004).

Focusing on the relationship(s) between 'leadership' and context has revitalised contemporary research particularly through the development of qualitative research, discursive and social constructionist epistemologies (Grint, 2005; Uhl-Bien, 2006) although it is unclear at this stage how far a connection might be developed between this research and its applications, for example in health care services (Fambrough & Hart, 2008).

In what follows in this chapter we explore the changing ways in which leadership has been conceptualised over the past fifty years, particularly focusing on how it has and *might* be operationalised in the NHS (particularly although not exclusively in a *hospital* context) .

1.2 Background and introduction to the study

The NHS Modernisation Agency Leadership Centre (NHSMALC) website³ had originally suggested that effective leadership is a key ingredient in modernising today's health care services. In its own words:

Effective leadership and management in the healthcare system are key drivers in patient experience. Governance and good environments matter to patients, their visitors and carers and staff.

But how might effective leadership be achieved and sustained? The NHS Leadership Centre commissioned a number of leadership initiatives (Larsen et al., 2005). The NHS Institute for Innovation and Improvement (2005) *NHS Leadership Qualities Framework*⁴ emphasised the *situational* nature of leadership and indicated the circumstances under which different leadership qualities will take precedence.

These comprise fifteen contextualised qualities covering a range of personal, cognitive, and social characteristics arranged in three clusters which are set out in Figure 1:

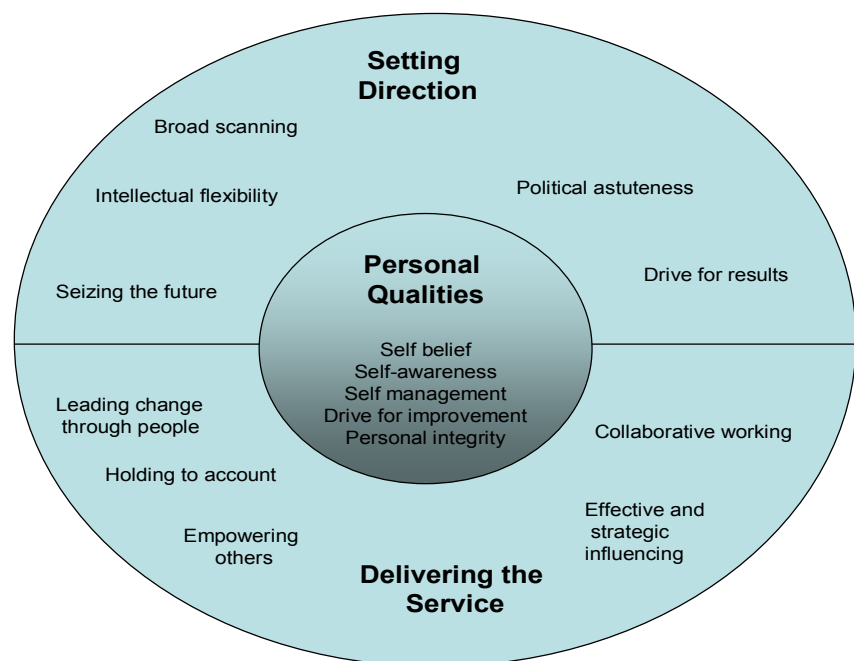
³ <http://www.dh.gov.uk/en/managingyourorganisation/leadershipandmanagement/index.htm>

⁴ <http://www.nhsleadershipqualities.nhs.uk/>

- *Personal Qualities*
- *Setting Direction*
- *Delivering the Service*

Thus, a competent leader enables development in an organisation that is goal directed, geared to developing processes and systems and enables staff at all levels to plan effectively and efficiently towards agreed goals (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Figure 1. The NHS Qualities Framework



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However, these same authors underscore the point that there is something beyond leadership competency that needs to be addressed, particularly in a changing and complex context such as an NHS Trust. *That is that a leader is someone who encourages and enables the development of an organisation in a culture based on integrity, transparency and valuing others. Leaders also need to question, think critically as well as strategically* (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Since the publication of the *NHS Leadership Qualities Framework* in 2005 all efforts have been directed to recognising and discussing leadership qualities and making strides towards their implementation. In 2008 Clare Chapman, Director General of the Department of Health's Workforce declared:

*Leadership is all about creating value for customers and citizens whilst also making work worthwhile for staff. This sounds incredibly straight forward - but it requires courage and resilience, and commitment throughout the entire piece*⁵

David Nicholson the CEO of the NHS in the report *Inspiring Leaders: Leadership for Quality* (January 2009) building on Darzi's *NHS Next Stage Review*⁶ stated:

It is imperative that we align what we are doing on leadership with what we want to achieve on quality. This is what I call leadership with a purpose.

Over the past year, the Department of Health has worked extensively with the NHS and other stakeholders to determine how best to foster talent and leadership development, and it is clear that there is a great deal of enthusiasm for a more systematic approach.

Spotting and developing confident leaders is a priority for us all if improving quality is our shared purpose. This guidance represents our best collective thinking to date. I invite you to use it and contribute to its improvement as we learn how to bring leadership centre stage over the coming months.

Nicholson and his team have charged the Strategic Health Authorities with finding gaps in leadership and systematically nurturing talent across the whole of the NHS. Clearly, the enthusiasm of successive senior officers in

⁵ DH_083353.

⁶ www.dh.gov.uk/en/Healthcare/Highqualitycareforall/index.htm

government and the NHS has been to link effective leadership with good service delivery and patient care as the primary outcome.

1.2.1 Leadership and Better Patient Care in this Study

This rhetoric and confidence about the type of leadership that best suits the NHS from those who lead it gave us pause for thought (Milewa, Valentine, & Calnan, 1998; Mueller, Sillince, Harvey, & Howorth, 2004b). 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 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 aims were overall to seek out the meanings and perceptions of relationships between (effective) 'leadership' and (better) 'patient care' and how leadership is transmitted across organisations to impact upon service delivery, taking account of the mixed methods and specific social science and systemic approaches that the investigatory team proposed. This inevitably has brought certain issues to the fore and (possibly) obscured others.

Our starting point therefore was to hold the NHS model of leadership in mind while calling on our own specific strengths as academics, from a range of social science and methodological backgrounds, to take a cross section of Trusts, clinical specialties, services, staff grades and patient needs, and to observe the *processes of leadership* in everyday working life. From this we proposed it should be possible to determine the ways in which leadership, NHS organisations and patient care were socially and discursively constructed so that links between leadership and patient care might be explored.

In Chapter One we outline some of the important contemporary social science and organisational thinking on leaders and leadership and explore the links between this and the NHS perspectives.

In Chapter Two we set out the innovative methodologies employed to investigate and analyse the research questions. This is followed in Chapter Three with the detailed procedures used for data collection.

The results are presented across four separate chapters. Chapter Four provides the analysis of what leadership means and how it is experienced by staff and patients (Christensen & Laegreid, 2003; Fairhurst, 2005).

Chapter Five presents the results of the Organisational Climate Survey (OCS) (Stringer, 2002). In Chapter Six, open systems theory and the concept of the 'organisation in the mind' are introduced particularly focusing upon the transmission of leadership across organisations. The relationship

between leadership, authority and emotion is discussed in Chapter Seven and in Chapter Eight the role of gender relations and their impact on leadership are reviewed (Begun, Hamilton, Tornabeni, & White, 2006; Ford, 2010; Telford, 2007).

Chapter Nine covers definitions, explanations and experiences of patient care and particularly how it relates to leadership by NHS staff and patients (Begun et al., 2006; Disch, Edwardson, & Adwan, 2004).

Finally in Chapter Ten we summarise our findings, make recommendations and draw conclusions.

Appendices provide copies of the research instruments, additional statistical results and the relevant NRES information.

1.3 Theoretical Approaches to leadership

Leadership research and theory is prolific with the consequence that numerous, frequently overlapping, models of leadership are available to agencies attempting to analyse or train leaders (and indeed managers, as until relatively recently little distinction was made between these two categories, see e.g. Kotter, 1996). Over the past fifty years leadership theories have shifted through different points of focus from the 'trait (or 'great man') approach in the 1940s, through the 'behavioural' perspectives in the 1950s whereby some styles of behaviour were seen as being more or less influential on potential followers. Then since the 1960s and 1970s the focus has been upon 'situational' leadership based mostly upon Fiedler's 'contingency' theory which proposed that different leadership styles were needed for different situations (see Alimo-Metcalfe, Alban-Metcalfe, et al. 2007; Western, 2008 for further details). During the 1970s and 1980s leadership research, albeit prolific, had reached an all time low in terms of its perceived contribution to theory and added value to knowledge for practice, so that as Cummings (1981 p. 366, quoted in a review by Bryman, 2004) asserted:

As we all know, the study and more particularly the results produced by the study, of leadership has been a major disappointment for many of us working within organisational behaviour.

Bryman unpicked the implications of the phrase Cummings used "as we all know" noting that it was "simultaneously sweeping and damning" (2004, p. 730). Bryman also picks out Miner's (1975) suggestion for temporarily abandoning the concept because of its limited utility in helping us understand organisational behaviour. *Why had leadership research reached this nadir during those decades? Why has there been a more recent upsurge of interest in leadership again almost to the point of saturation?*

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Bryman in his review suggests, that the renewed confidence and interest in the study of leadership has come from improved measurement and analytic techniques, greater use of meta-analysis so that more systematic reviews could be compiled, the emphasis on *transformational leadership* and *charismatic leadership* which have provided a fulcrum for the area of research, more and better cross-cultural studies and greater diversity in the types of leadership and organisational contexts that have been studied.

A factor that may also have contributed to the idea that leadership research continues to be fruitful is that a greater diversity of methodological approaches have been added and Bryman's review specifically focused on the value added by qualitative research.

Towards the end of the 1980s and beyond, thinking about the meaning(s) of leadership came to take greater precedence than in the previous two decades, possibly because of a perceived dearth of leadership *per se*.

These deliberations cast light onto the:

- *interactions between leaders and followers* and organisational cultures (Avolio, Gardner, Walumbwa, Luthans, & May, 2004; Lewis, 2000; Schilling, 2009)
- the *management of emotion* (George, 2000; Lewis, 2005; Pescosolido, 2002)
- the *processes* of leadership (Collinson, 2005; Dopson & Waddington, 1996; Vangen & Huxham, 2003)

Even so, or perhaps because of the use of qualitative approaches and related conceptualisation, Alvesson and Sveningsson (2003) were able to entitle a recent paper arising out of their study of leadership in a research and development company: "*The great disappearing act: Difficulties in doing 'leadership'*".

By this they meant that during their study they were able to identify how the existence of the label 'leadership' led to an assumption that the concept had an empirical reality. However the results of their work indicated that leadership might be better explained as a *process or series of processes of interaction*. This conclusion raises questions about mainstream thinking on leadership which presumes observable and possibly measurable characteristics (Alvesson and Sveningsson, 2003, p. 361; see also Ford, 2010).

Most recently there has been reconsideration and development of ideas about leadership in context taking account of the relevance of some earlier studies of organisations (e.g. Lewin, 1947) and open systems theories (see

Chapter Six; Laughlin and Sher, 2010) and new epistemological positions (e.g. Ford, 2010).

In our study, as a consequence of these recent critiques of leadership research and the result of methodological innovation, we approached the concept of 'leadership' as not necessarily a property of one individual (although it can be) or of one specific role, such as Clinical Director or a service manager, but rather we identified leadership as a *process* occurring within a group, organisation or collectivity that *imagines, wills and drives change* (Gabriel, 2004; Gronn, 2002).

1.3.1 Dimensions of Leadership and their Value for the NHS

Leadership, *as a practice*, has been on occasions constructed as 'a beautiful or rarefied ideal' an idea which has little use in the real world particularly as it has been suggested there are at least 350,000 definitions of leadership in the academic literature (Pye, 2005; Tourish, 2008; Western, 2008). *The question for this report is how to identify the literature on leadership and organisation with the most relevance for the contemporary NHS.*

Most discussed in theory and in practice over the past two decades has been the idea of *transformational leadership* (Bass, 1985) a model to explain ways in which a leader can be identified or trained to demonstrate the qualities that enable her/him to *perform beyond expectations*. The phrase 'transformational leadership' was coined originally in 1973 by Downtown but did not gain impetus until 1978 when Burns published his book, *Leadership*, which highlighted the *relationship* between leaders and followers (Burns, 1978).

Until then, as shown above (see Bryman, 2004) there had been little by way of a breakthrough in applicable knowledge. Burns (1978) demonstrated a *psychological* difference between an exchange relationship - where followers respond to leaders because of rewards they might receive - and one in which they respond to leaders who transform their attitudes and behaviours through inspiration and/or charisma (Bass, 1985; Yukl, 1999; Rafferty and Griffin, 2004). Transformational leadership then, is concerned with emotions, values and ethics, standards and long term goals which include assessing followers' moves and satisfying their needs (Currie & Lockett, 2007; Day, Gronn, & Salas, 2006; Eagley & Johannesen-Schmidt, 2003; Northouse, 2004).

Recognition that transformational leadership is not simply an individualistic model but one that *teams* can display (Day et al., 2006; Gronn, 2002; Sivasubramaniam, Murry, Avolio, & Jung, 2002) has shifted the

concentration from individual leaders per se to a more diffuse and distributed model of leadership and organisation context.

1.3.2 What constitutes transformational leadership?

Bass (1985) highlighted several characteristics of *transformational (or transformative) leadership* that allow followers and leaders to achieve far beyond their expectations. These are not discrete categories but given the significance placed upon the ideas behind transformational leadership in the scientific and training literature it is worth outlining the basic ideas behind these characteristics/types which have been identified as:

- Charismatic leadership
- Inspirational motivator
- Intellectually stimulating leadership
- Considerate leadership

Charismatic leadership

Bass (1985) proposed that "*charisma is a necessary component of transformational leadership*" (cited in Yukl 2002, p.261) and that charismatic leaders are endowed with exceptional personal qualities that attract followers. Charisma, a word derived from the Greek, means "*divinely inspired gift*" and is thought to give people the ability to perform miracles or predict the future (Yukl 2002, P. 241).

It is for this reason that charismatic leaders are often regarded as "*visionary, a futuristic, or a catalyst for change*" (Murphy 2005, p. 131; see also Bass 1985; Bennis & Nanus, 1985). Due to their rare personal qualities charismatic leaders are able to convey their visions to their followers in a clear and concise manner allowing them to visualise what they could achieve in the future if they worked together towards a common goal. As the leader's vision is normally realistic yet optimistic, it empowers the followers granting them greater self-esteem, encouraging and inspiring them to achieve the vision (Bennis & Nanus, 1985; Northouse, 2004; Yukl, 2002).

Inspirational motivator

Through their charisma, transformative leaders have the ability to inspire their followers through words of profound wisdom, or at least is what is *perceived* to be profound wisdom, such as with the case of Jim Jones⁷ in the USA or more positively President Obama who has reformed health care and banking legislation in the USA against the odds. Transformative leaders are

⁷ In 1978 Jim Jones persuaded more than 900 members of his People's Temple in Jonestown, Guyana to commit mass suicide.

excellent communicators which allow them to turn their visions into reality. Many use emotional and optimistic speeches to inspire their followers. They usually lead by example and often become role models to their followers who are in awe of their moral and ethical character. Many followers try and emulate their leaders' good qualities and are confident that their leaders will make just decisions on their behalf leading them to a prosperous future (Kellerman, 2004; Rafferty & Griffin, 2004).

Intellectually stimulating leadership

Transformational leaders have the ability to captivate their audience making the most mundane speeches and events interesting. They encourage their followers to be innovative, challenging the status quo and their own values and beliefs (Northouse, 2004). They also encourage their followers to solve problems and take an active role in the organisation, thus enhancing their self-worth and self-esteem, increasing their job satisfaction and productivity.

Considerate leadership

Transformational leaders are often also considerate leaders who are adept at performing mentoring or advisory roles to support their followers' emotional needs (Hiller, Day, & Vance, 2006; Rafferty & Griffin, 2004). Such leaders listen carefully to their followers' needs and desires, empathising with them during difficult periods. Being empathetic also builds a strong bond between leader and follower and thus a strong reciprocal relationship (Simpson & French, 2005).

It is important to note though, despite the wide take-up of transformational leadership as a conceptual model and a *practice*, that there remains uncertainty about the ambiguity of subdivisions and distinctions between elements in the model. Theoretical distinctions between 'charisma' and 'inspirational motivation' have become blurred over time and some theorists have suggested that elements of transformational leadership might also be identified as *transactions* (see Rafferty and Griffin, 2004 for a discussion of the implications).

Further concerns have been raised about how transformational leadership can take place in organisations, particularly public service ones, which are constrained by government initiative and targets and localised regulatory and normative pressures (Currie & Lockett, 2007; McNulty & Ferlie, 2004). However, it may also be that professional staff (rather than leaders/managers) in contexts such as health care, may in fact be more transformational than might be predicted because of their long-term commitment to the organisational goals (McGuire & Kennerly, 2006).

Most recently the notion that transformational leaders are very much 'engaging' leaders has been proposed (Alimo-Metcalfe, Alban-Metcalfe et al, 2007; Alban-Metcalfe & Alimo-Metcalfe, 2009; Macy & Schneider, 2008).

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One further comment here concerns the role of *gender* in styles of leadership and its consequent impact on organisational transformation (Fletcher, 2004; Mandell & Pherwani, 2003). There is evidence that (whether displayed by a woman or a man) feminine styles of leadership may be more related to engagement, emotional and social intelligence and distributed leadership, which may be important for complex organisations such as the NHS (see below).

1.4 Leadership, organisation and emotion at the turn to the 21st Century

Models of leadership and organisation theory have evolved over time and leadership and organisational structures and cultures are intrinsically linked in the literature. Leadership, if it is to motivate, innovate and move organisations to change, has to have an *emotional dimension* and, thus, effective leaders have a clear *emotional agenda* (as well as a strategic and structural one) which is particularly acute in services such as the NHS which is working to serve people's health care needs (Ashforth & Humphrey, 1995; Bolton, 2000; Pye, 2005).

Exploring organisations and leadership at the level of 'emotion' has become contested territory, as recognition, that organisations and their leaders need to take account of emotional engagement (Alban-Metcalf & Alimo-Metcalf, 2009; Vince & Broussine, 1996) at all levels of the work place, has emerged. Prior to the 1980's, organisational literature had been dominated by cognitive orientation (George, 2000) which favoured the rational, 'masculine' and scientific explanations of organisations and their leaders. This notion therefore ignored the (so called) irrational and 'feminine' characteristics of emotion, which were deemed detrimental to productivity and success. At that time emotions were regarded as the culprits that distort an individual's perceptual and cognitive faculties and therefore should be kept under control (Alvesson & Sveningsson, 2003b; Clarke, Hope-Hailey, & Kelliher, 2007; Dasborough, 2006; de Raeye, 2002; Ford, 2006).

As social and occupational psychologists began to study the effects of positive and negative moods on decision making, job satisfaction, choice of work-based activities and organisational climate, however, (Isen & Means, 1983; Rafaeli & Sutton, 1987, 1989) 'emotion' as part of organisational life gained impetus once again. This resurgence coincided with leadership theorists studying how moods and emotions could effect the quality of leadership (George, 2000).

It is possible to trace a rough trajectory from the 'hard nosed' scientific management, with the organisation perceived as a 'machine' in the early twentieth century, through towards a more humanistic, emotional and

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sometimes even spiritual way of thinking about contemporary leadership and organisational metaphors towards the twenty-first century, all of which are potentially transformational, not simply to the individuals concerned, but to the organisational dynamics.

Hochschild's (1983) *The Managed Heart* has been credited with being one of the earliest examples of research into emotions and organisational settings (Ashkanasy, Hartel, & Daus, 2002). She looked particularly at the airline industry and how airline cabin crew managed their emotions for dealing with difficult passengers and to promote a particular airline image. She termed this emotional management '*emotional labour*' (Hochschild, 1983).

Since this publication, the study of emotions in organisations has increased (Ashkanasy et al., 2002) with academics concentrating on key concepts such as emotional labour, emotional intelligence, mood analysis and Affective Events Theory (AET) and most recently a return to psychodynamic understanding of organisations and groups (see Ford, 2010; Schwarz, 1990). Since the 1990's a plethora of literature has emphasised the role of emotional concerns in private sector organisations such as the airline industry (Hochschild, 1983; Taylor & Tyler, 2000; Tyler & Abbott, 1998), service sector (Crang, 1994), merchant banking (McDowell & Court, 1994; Pugh, 2001), law (Harris, 2002) and image consultancy (Bryson & Wellington, 2003; Wellington & Bryson, 2001).

However, emotionality in the public sector was mostly neglected until 2000's when a surge of literature began to be published analysing the NHS (Allan & Smith, 2005; Bolton, 2000; Cummings, Hayduk, & Estabrooks, 2005a; Hunter, 2005; Lewis, 2005; McCreight, 2005; McQueen, 2004; Michie & Gooty, 2005; Michie & West, 2004; Smith, 1992) and the fire service (Archer, 1999; Scott & Myers, 2005; Ward & Winstanley, 2006; Yarnal, Dowler, & Hutchinson, 2004).

1.4.1 Emotional labour, leadership and patient care

Hochschild differentiates between emotional labour and emotional work or 'face-work' (Goffman, 1967). Emotional work has been described as the effort we put into presenting and representing our feelings as well as into feeling what we ought to feel (see Fineman, 2003). For example, a person ought to feel happy at a wedding and sad at a funeral and if their emotions do not match these expectations then a person must perform emotional work to display the appropriate emotion. This is sometimes difficult as people struggle to disguise their true emotions and perform the socially acceptable emotion.

When a person's emotions are appropriated and performed for commercial gain it is known as *emotional labour*. Hochschild states that emotional labour occurs in many occupations. However, she believes it to be more

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prevalent in service industries, such as the airline industry, where workers' emotions are sold as part of a commercial package⁸. Employees working in service industries must be skilled at managing their emotions and facial expressions in order to project the correct emotion to the customer (Crang, 1994; Lewis, 2005). This often means that employees have to suppress their own emotions in order to perform and display emotions that are suitable for commercial gain and in alignment with the organisations' image (McDowell and Court 1994).

Surface acting allows the employee to make up an outward gesture (Hochschild, 1983), to perform emotions that are not actually felt. In contrast, deep acting means that the employee can suppress or become estranged from their true feelings and *actually feel the emotions* that the employer wants them to display. *"One finds that the performer can be fully taken in by his own act, he can sincerely be convinced that the impression of reality which he stages is the real reality"* (Goffman 1990, p.28).

In the NHS, positively managed emotions *could* lead to better patient care, greater patient satisfaction and a relaxed and professional organisational climate (Amendoldair 2003; Bolton 2003). Lewis (2005) highlights how nurses in a special care baby unit appropriately managed their emotions to create a professional organisational climate, in which to offer quality patient care to special needs babies and emotional support to their parents. Lewis suggests that a nurse's job is sometimes very stressful and emotionally destabilising, especially when a baby dies. Nurses need to be conscious of their own emotions and regulate them to prevent causing further distress to the parents by displaying a professional demeanour (Bolton 2001).

However, managing emotions in this way, particularly if they are not felt, comes at a psychological and emotional cost and the whole process would be problematic without attending to emotional intelligence.

1.4.2 Emotional intelligence, leadership and patient care

The 'discovery' of emotional intelligence (EI), despite on-going valid critiques (see below) marked a turning point in contemporary organisational theories and approaches to leadership because of the tradition that emotions represent a threat to rationality – a view that has been widespread particularly in North America and North Western Europe (Fambrough & Hart, 2008; Western, 2008).

⁸ For a critical analysis of Hochschild's dichotomy of emotional labour and work see Bolton 2000 and Bolton and Boyd 2003.

Mayer and Salovey (1995), who conceived the idea of emotional intelligence, defined it as the ability to manage and understand one's own and other people's emotions in a consistent way so as to reflectively promote emotional and intellectual growth. Goleman (1996; 1998) who popularised the concept, identified emotional intelligence as a set of competencies, redefined and restated by George (2000) as follows:

- The expression and appraisal of emotion
- Enhancing cognitive process and decision making
- Emotional knowledge
- Managing emotions

These characteristics appear to have much in common with the rhetoric of transformational qualities of leadership although in many ways EI has become a management 'tool' rather than a critical model. To this end (apparently) Goleman (Goleman, 2000; Goleman, Boyatzis, & McKee, 2001) focused on 'styles' and 'performance' which seem far away from the 'heady' descriptions below of qualities of emotional intelligent leadership, which refer to feelings, empathy and creativity.

The expression and appraisal of emotion

An emotionally intelligent person will be able to understand their own and others' feelings and able to empathise, which may enable them to be manipulative for better or for worse.

Enhancing cognitive processes and decision making

Having emotional intelligence allows a person to use emotion to be creative, solve problems, make decisions and flexible plans for themselves and on the behalf of a group. An emotionally intelligent leader will be able to judge their mood and make decisions accordingly. If the person is in a negative mood this may mean choosing to wait until such negative episodes have past in order to make a comprehensive decision.

Emotional Knowledge

Emotionally intelligent people understand how other people may be affected by their negative moods and therefore may take care not to spread bad feeling around the group.

Managing Emotions

Many leaders are able to manage their followers' emotions as well as their own, but as indicated below, developing the qualities required to manage emotions effectively is highly complex and more about processes than style or performance (Fambrough & Hart, 2008; Hughes, 2005). As Fambrough and Hart argue 'emotional intelligence' has passed into common use among organisational leaders with little recognition of the way it has been identified

as problematic. *What has been so attractive about EI to leaders in health care organisations?*

The idea of emotional intelligence captured the imagination of some training NHS staff as a means to improve staff relationships and enable clinicians to empathise with their patients (Allan & Smith, 2005; Cummings et al., 2005a; McQueen, 2004; Amendolair 2003, Luker et al 2002). McQueen (2004) reflecting on the 1960's when health care workers were encouraged to hide their emotions from their patients, for the sake of maintaining a professional role, suggests that in recent decades this view of nursing has changed and health care workers frequently display emotions to illustrate their commitment to patient care (Williams 2000). McQueen suggests that emotionally intelligent nurses are important for building strong patient-nurse relationships (Conger and Kanungo 1987 and (Lewis, 2005). Nurses with high Emotional Intelligence are able to build rapport quickly with their patients through communication and interactive skills (Schutte et al 2001).

McQueen (2004) also states that "*emotional labour calls upon and engages*" emotional intelligence (2004, p. 103). In order for patients to feel cared for nurses have to constantly *perform* positive emotions and behaviours such as warmth, friendliness and consideration. However, when confronted with a 'difficult' patient nurses may experience negative emotions such as frustration, irritation or anger. The nurses must be emotionally intelligent enough to identify their emotions and then perform emotional labour to submerge the negative emotions in favour of more positive emotions (Bolton 2003).

While EI *per se* needs to be understood more critically (Fambrough & Hart, 2008), the introduction of emotional management and engagement by leaders (and others) in health care organisations needs further scrutiny (see below); despite the best efforts of some management gurus emotion is a fact of personal, interpersonal and organisational life particularly when considering what it means to deliver patient care.

1.4.3 Beyond emotional intelligence

Interest in EI has continued to grow among management and organisational academics with a focus on how to measure it – the conclusions generally indicating the need for caution in measures to predict or to establish baselines for its development among managers (Conte, 2005). The conflation of managerial skills as listed by Mintzberg (Mintzberg, 1973) cited in Riggio and Reichard, (2008) which included the ability to 'deal' with subordinates, 'empathize' with top-level leaders and establish and maintain social networks, alongside managing emotions as a leader, have come to be known as 'people skills'. These are clearly represented in the NHS leadership qualities framework and vital for managing in any organisation (see Figure 1).

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1.4.3.1 Social intelligence (SI) and leadership

In 2006, taking account of advances in neurological psychology, Goleman (Goleman, 2006) proposed that because humans are *designed* for social connection, rapport and supportive emotional interactions enhance performance of managers and leaders. He listed these qualities under the umbrella of 'social intelligence' and identified four dimensions:

- *Synchronization* – whereby matching moods lead to a sense of rapport
- *Attunement* – listening fully
- *Social cognition* – understanding how people interact
- *Social facility* – finding it easy to interact with others

While some people have little difficulty meeting these criteria and mastering their social intelligence, others (such as Narcissists, Machiavellian and Psychopathic types), Goleman argues, do not have the capacity for social intelligence, and thus he proposes a means of *selecting* effective leaders by testing these qualities. This model albeit individualistic has something to offer through extending the theoretical underpinnings of 'people skills' and emphasising the importance of taking followers and colleagues seriously in decision-making.

Following EI and SI in bringing management/organisational theories together with developments in psychology, particularly cognitive neuroscience and evolutionary psychology, is the reconsideration of the role of intuition in understanding leadership and organisational behaviours (Sadler-Smith, 2008). Sadler-Smith brings the idea of the 'gut feeling' into the foreground to explore the influence of this sense upon decision-making particularly under pressure (e.g. many emergency clinical decisions rely on the clinician's instinct of whether the patient should be operated on, admitted to hospital, whether to call for support).

It seems that while there is a continuing trend towards an evidence-based understanding of leadership, success there is also an emergence of features of human life that are difficult to explain and measure, although all the proponents cited above stick to the view that these characteristics are scientifically explicable and measureable despite challenges from both positivist and critical social constructionist positions (Ashforth & Humphrey, 1995; Conte, 2005).

1.4.3.2 Affective Events Theory (AET)

AET predicts that specific features of work (e.g. autonomy) have an impact on the arousal of emotions and moods at work that, in turn, co-determine job satisfaction of employees. AET further proposes that job satisfaction is

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an evaluative judgement that mainly explains cognitive-based behaviour, whereas emotions and moods better predict affective-based behaviour. The results support these assumptions (Jürgen, van Rolf, Fisher et al., 2006). Ashkanasy et al (2002) suggested that AET has two important messages for leaders in an organisation.

- Followers' emotions are heavily influenced by their leaders' emotions and therefore leaders must minimise the 'hassles' that they place on their followers in order to increase job satisfaction and performance. Short-term negativity can be tolerated without much impact on the team or organisation.
- However, if negative events persist it will affect followers' moods leading to negative emotions, poor performance, reduced job satisfaction and in the case of the NHS, (possibly) to poor quality patient care. It is therefore suggested that leaders need to give followers positive feedback regularly to "*ameliorate the daily hassles experienced by employees*" procuring positive behaviours such as team spirit and self-worth (Dasborough 2006, p. 165 ; Weiss & Cropanzano, 1996). The connections between the moods of individuals and their performance may be understood better in terms of emotional engagement between leaders and followers on both conscious and unconscious levels (see below).

1.5 Distributed leadership

The academic study of distributed leadership, that is when at various levels leadership (or influence) behaviour, identity, role and responsibility are distributed to more than one individual or group of individuals, has been at the forefront of much social scientific leadership research over the past ten years (Buchanan, Addicott, Fitzgerald, Ferlie, & Baeza, 2007; Day, Gronn, & Salas, 2004; Gronn, 2002; Mehra, Smith, Dixon, & Robertson, 2006a). The implication of this interest in distributed leadership is, that organisations have changed and previous models - including the charismatic, 'hero' leader and the 'command and control' organisational structures - are dysfunctional in a context where organisational change is rapid and diversification of strategic leadership and management essential (Butterfield, Edwards, & Woodall, 2005; Dent, 2005; Goodwin, 2000). In a competitive, diverse and divergent environment leadership needs to be distributed, in order to enhance democratic governance, thus enhancing legitimacy and increasing survival chances (Currie et al., 2009).

Distributed leadership also implies that organisations where it is practiced have (relatively) flat hierarchies with diverse service needs and expertise across all sectors of the organisation (Huffington, James, & Armstrong, 2007). This model applies to hospitals and primary care settings, where

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distinct professional groups each have their own standards of excellence, while at the same time sharing goals of competence and quality related to the service they provide to patients and how they interrelate to other organisations.

With this shift in focus of many leadership practices and leadership studies the definition of such leadership has been proposed as:

".. a status ascribed to one individual, an aggregate of separate individuals, sets of small numbers of individuals acting in concert or larger plural-member organisational units" (Gronn, 2002, p. 428).

Gronn suggests also that when leadership is distributed it may be that the duration of that influence is limited, perhaps (structurally) to a single project and therefore (psychologically) distributed leadership might mean having to 'give up' leadership as well as take it up (Huffington et al., 2007). Furthermore, according to Gronn (2002) the most common understanding of distributed leadership, witnessed by the growing number of references to it in the research and policy literature, is that it applies to numerous people across an organisation taking some degree of a leadership role or responsibility.

More importantly, Gronn identified distributed leadership as *concerted action* meaning that there are many roles comprising a 'leadership complex' with at least three potential forms:

- *collaborative modes of engagement* which arise spontaneously in the workplace. This suggests that leadership practice is 'stretched over' the context of the organisation and not a function of those in managerial roles such as matron or clinical director. However, if the matron, clinical director and other colleagues who share ideas for change or particular activities they *may "pool their expertise and regularise their conduct to solve a problem after which they may disband"* (Gronn, 2002, p. 430).
- the *intuitive understanding* that develops as part of a close working relationship among colleagues. These relationships tend to happen over time when organisation members come to rely on each other and develop a close working relationship, to solve problems or bring about change and others might be involved in a 'framework of understanding'.
- The variety of *structural relations* and institutionalized arrangements which constitute attempts to regularize distributed action. Thus, for example, if there were dissatisfaction with existing arrangements for particular practices, a team of 'equals'

might emerge to find ways to improve or change the problematic practices.

All of these are apparent particularly, but not exclusively, in Trust Three (the FT) as exemplified in Chapters Four and Nine in particular.

Gronn argues the importance of examination of these different forms of concerted action to understand where influence (and thus leadership and power) might lie in any organisational context. Emotionally, however, these different models of distributed leadership suggest the impact of these structures and practices at a deeper level (Gabriel, 2004) particularly around authority (Halton, 2007; Hirschhorn, 1997) competition (Morgan, 2006) rivalry and envy (James & Arriba, 2005; Stein, 2005)

1.6 Organisational Culture, Climate and Contexts

As introduced above, post-industrial (or even 'post-modern') organisations (Burrell, 1988; Fineman, Sims, & Gabriel, 2005) and networked (Balkundi & Kilduff, 2006; Goodwin, 2000) organisations are changing rapidly and the NHS is clearly among these. Changes in the NHS take place at a number of levels, emerging from the direct policy dictates from central government to become local initiatives. Moreover, the NHS has become increasingly team (and indeed multi-disciplinary team) based over the past two or three decades so that knowledge, influence and leadership for transformation and change are not only moving from a top-down to bottom-up model, but as indicated, to a distributed model which involves lateral influence (Begun et al., 2006; Day et al., 2006; Ferlie & Shortell, 2001).

The type of leadership that is supported and promoted in any organisation and the related concept of the organisational structure depends on and impacts upon organisational climate and culture.

Although research undertaken on organisational *climate* and organisational *culture* comes from different epistemological traditions, since around 1990 the literature and concepts referring to both have been overlapping and/or complementary (Schneider, 1990; Schneider, 2000) and increasingly the terms are used interchangeably (Ashkanasy et al. 2000).

It is, however, generally accepted that 'climate' is a logical extension of what was originally conceptualised as 'psychological' climate, that is, shared psychological meanings in an organisation; so that *organisational* climate is an aggregation of those individual perceptions of a work-place context (James, Choi et al. 2008).

Organisational culture on the other hand has its origins in anthropology and human relations (see Davies, Nutley and Mannion, 2000; Scott, Mannion et

al. 2003). Organisational psychologist Edgar Schein's (1985/2004) ideas about organisational *culture* as a pattern of *shared basic assumptions that have worked well enough and adapt to the external environment and serve internal integration*⁹, is one of the most frequently quoted definitions. Schein takes a systems theory approach to understanding organisations and his work has been built upon by himself and others to develop a variety of typologies which underpin measures of both organisational culture and climate (see Albino-Metcalf, Alban-Metcalf et al. 2008 for a comprehensive overview of this literature).

Organisational climate, with its origins in traditional psychology is *typically* "... the only domain of organisational research that simultaneously examines perceptions of jobs, groups, leaders, and organisational attributes and thus has the unique capacity of being able to decipher common denominators and latent relationships that are not available to those who study only specific domains such as perceived equity" (James et al., 2008, p.27). We therefore made a decision to use a measure of *climate* as a backdrop to this mostly qualitative study, in order to 'triangulate' with our findings on leadership and patient care.

However, we found a competing strand of interest in the measurement of organisational *culture* (e.g. Davies, Nutley and Mannion, 2000; Scott, Mannion, Davies and Marshall, 2003) which more frequently seems to attend to health care settings than studies of climate albeit with some notable exceptions (Dawson, Gonzalez-Roma, Davis and West, 2008).

1.6.1 Emotion and the unconscious in organisations

Organisational climate and/or culture cannot be discussed without acknowledging that organisations are places where both the intellect and emotion are called into play in order to achieve organisational goals and as we have made clear, emotions are intrinsic to service delivery and leader-follower engagement in the NHS. Emotional engagement, while available to human consciousness, also takes place at an unconscious level (Gabriel, 2004; Hugh, 1986; Lyons-Ruth, 1999; Morgan, 2006; Willmott, 1986), and anxiety or stress is particularly salient when having to care for and make potentially life-saving decisions for patients (James & Huffington, 2004; Menzies¹⁰¹¹, 1970).

⁹ A paraphrase.

The ideas that characterise transformational leadership models, such as 'charisma', 'influence', 'inspiration' 'thoughtfulness' and 'consideration', have intellectual roots beyond contemporary management theory and training. They are more closely related to group and organisational theories with late 19th and early 20th century origins (De Board, 1978; Gabriel, 2004) from which much contemporary organisational theory has emerged.

The first significant attempt to analyse group behaviour made at the start of the 20th Century by Le Bon (1917/1920) whose book *The Crowd* illustrated his observation that individuals in a large group can demonstrate a 'collective mind' which emerges when people are bound together in some way. McDougall's book *The Group Mind* (1922/2009) and Sigmund Freud's *Group Psychology and the Analysis of the Ego* (1921/1922) also focused on what would subsequently come to be recognised as unconscious group processes. Freud developed Le Bon's and McDougall's ideas in the context of psychodynamic theory, arguing that the binding force of the group derives from the *emotional* ties of the members, which are expressions of their libido or drive.

Studies of (and human 'experiments' about) group psychology, taking some of this perspective on board, flourished after the Second World War conducted and further developed by psychiatrists in the newly formed NHS. In Britain the work of Wilfred Bion, Tom Main, Maxwell Jones and others led to innovations in both group psychotherapy and the study of organisations. Bion's work on group relations and dynamics which contributed to the development of the Group Relations Training Programme (GRTP) at the Tavistock Institute in 1957 evolved into the Leicester Conferences with other organisations using this model across the world (Miller, 1993). However contemporary knowledge and understanding continues to reflect back upon this early work.

What was learnt during this period about group dynamics and group relations represents an important dimension in the understanding of contemporary organisations and the relationship between leaders and followers. We develop this further in Chapter Seven in particular. It is important to note how the intellectual journey from work on emotional labour to social intelligence and intuition has so far largely neglected to explore the extent to which unconscious processes remain part of the emotional context of human social interaction (Allan and Smith, 2005, p. 21).

¹¹ Isabel Menzies is sometimes referred to as Menzies-Lyth. Her work has been reprinted several times with each name used.

In a hospital environment it is inevitable that negative events such as death occur (see Lewis for discussion on the impact of death on nurses in a special care baby unit taking an 'emotional labour' approach). When death does occur nurses may display emotions (consciously and unconsciously) such as anxiety and fear (Allan & Smith, 2005; Obholzer & Roberts, 1994; Allan 2001; Smith et al 2003). Obholzer asserts that "[he] believes that many of the organisations' difficulties that occur in hospital settings arise from a neglect of the unconscious psychological impact of death and near-death on patients and staff" (1994, p.171). He explains that hospitals are sites where anxieties about social taboos such as death are *contained*, that is that staff and the organisation overall takes away the anxiety and the responsibility for care from the relatives. Patients and staff are socialised to believe that hospitals are institutions where illness is treated and that medical knowledge and practice is infallible. This is illustrated by patients who contend that doctors possess God-like qualities and have the ability to heal all ailments. When death does occur, medical staff and the patient's relatives may feel *duped* by the institution they believed would save their loved one.

At the turn of the 19th to the 20th Centuries psychoanalytic ideas were seen to have something new and important to say, not only about the psychology of the individual and the role of the individual unconscious, but about *unconscious processes when people converge in groups and crowds* as shown above. From psychoanalytic theory we take up ideas again today specifically about the relationships which exist between followers and leaders, made explicit in the paradigm shift from transactional to transformational leadership. Working together and accepting or resisting influence comes not only with an observable set of behaviours and measurable emotions, but with unconscious and 'secret' ones including dependency, envy, power, anger, authority and emotional contagion, which may be either conscious or unconscious but have important consequences for behaviours (Burke et al., 2006; Simpson & French, 2005; Stein, 2005; Whitely, 1997). In Chapter Seven for example we see examples of where two senior managers find themselves unable to influence despite their senior roles, legitimacy and operational power. As Gabriel (2004) has argued "*emotions are no simple side-effects of mental life*" as "*emotion lies at the heart of human motivation*" (p.215).

One key feature of caring for sick patients, managing change and the social context of the NHS Trust then, is the ways in which clinicians and managers manage their anxiety which is fundamental to working in any health care setting. In the section that follows below, we demonstrate how psychoanalytic thinking explains how individual psychology and unconscious defence mechanisms link to the ways in which human beings work in groups and organisations.

In Chapter Nine we attend in more detail to the anxieties involved in obstetrics and more generally on the emotions involved in care of the elderly. In anticipation of these we present the theoretical material in some detail immediately below in this chapter.

1.6.2 Clinicians' anxiety and patient care

To conceptualize anxiety we draw on object relations theory, the branch of psychoanalysis associated with Melanie Klein (1959) and, in particular, the work of scholars who applied object relations to an understanding of groups (Bion, 1961) and organisations (Jaques, 1952; Menzies, 1970; Klein, 1987; 1983) hypothesising that an infant responds from the earliest time to the withdrawal of the maternal breast by experiencing a powerful anxiety of a 'persecutory nature'. Being unable to grasp the separation from the breast intellectually, the infant, unconsciously, feels as if every discomfort were inflicted by hostile forces. A fundamental *splitting* takes place, whereby an object is experienced as two separate objects, one entirely good and one totally bad. Thus there is a good breast (which is always present and nourishing) and a bad breast (withdrawing and denying), a good mother and a bad mother.

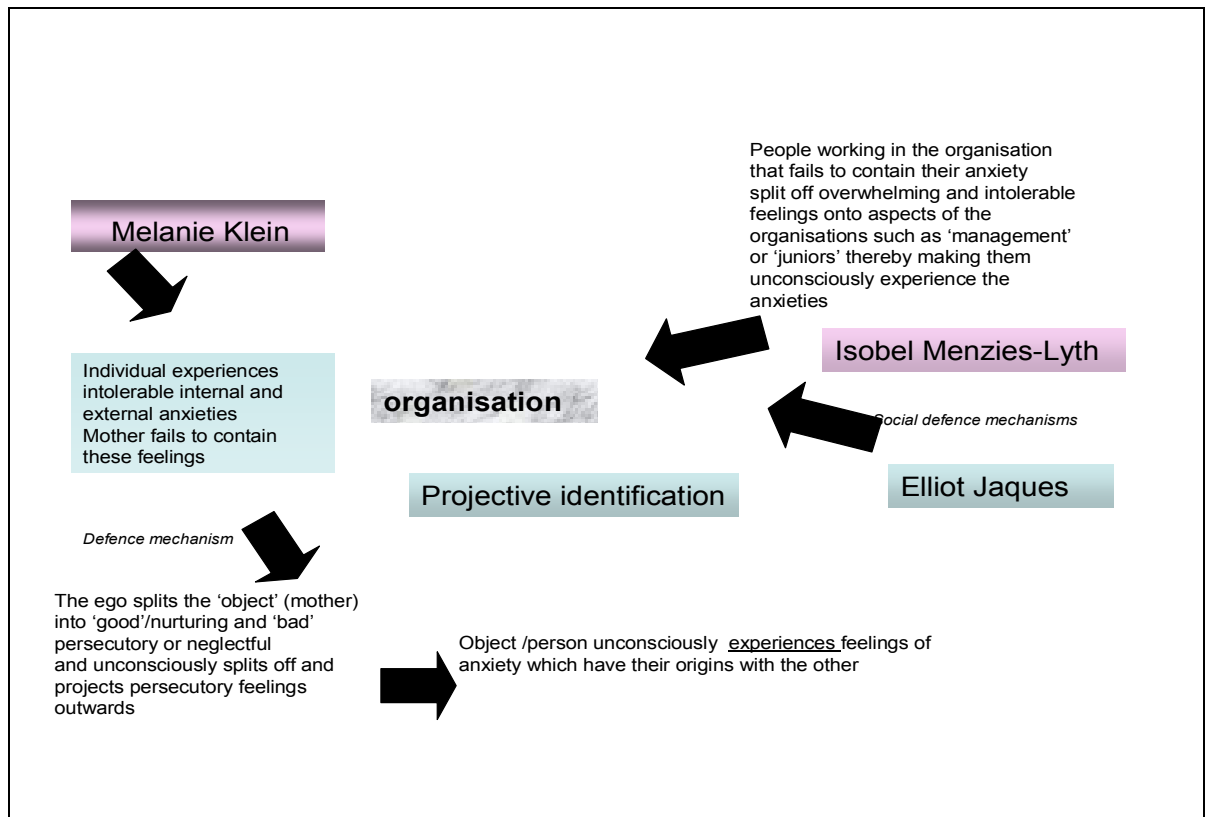
This is a pattern repeated in clinical settings, where patients routinely refer to a 'good nurse' and a 'bad nurse' and, almost identically, clinical staff referred to some patients as 'a good patient' and to others as 'a bad patient' (see Chapter Nine for an example of this). Splitting according to Klein extends in the child's own self – those aspects of him/herself that she cannot bear are projected outwards ("It is not I who is angry/fearful/envious; it is you"). Again this is a phenomenon observed many times in clinical settings. Frustration, discomfort and pain are experienced as persecution from hostile forces and their concomitants (e.g. hate) become destructive impulses which *are still operative in later life*, especially in times of stress and crisis.

Splitting and projection then are seen as fundamental *defences against primitive anxieties* by the object-relations school of psychoanalysis. Within this tradition, objects are not external entities but are shaped by phantasies¹² and feelings, they are *introjected* and projected, they split into good and bad and they constantly define and re-define the ego (or self). Object relations theory has found numerous important applications in the theory of organisations, primarily through the works of Jaques (1952) and Menzies Lyth (1960; 1970) in the UK, and more recently, Hirschhorn (1988), Gould (1993), Diamond (1993), Schwarz, (1990), Schwarz and Clore (2003) among others. Notable among these applications is the

¹² 'Phantasies' spelt in this way refers to those in unconscious experience.

treatment of *the whole organisation as an object which is liable to become incorporated in psychic reality* and towards which the individual may develop relations akin to early relations with significant objects from her environment and hold the 'organisation in the mind' (Armstrong, 2005) which we will discuss in more detail in the context of evidence from the study in Chapter Six.

Figure 2. Social Defences against Anxiety in Organisations



Menzies-Lyth, whose 1960 classic study of nursing staff occupies a privileged position in this literature, was driven by her initial observation that nursing work is highly anxiety-producing. She argued that nurses confront many different emotions from patients and their relatives - gratitude for the care they offer, admiration, envy for their skills and resentment stemming from forced dependence. Such projections create strong feelings in the nurses themselves:

The work situation arouses very strong and mixed feelings in the nurse: pity, compassion and love; guilt and anxiety; hatred and resentment of patients who arouse these strong feelings; envy of the care given to the patient. (Menzies-Lyth, 1988 , p. 46)

Faced with such an emotional cauldron, many nurses re-experience infantile persecutory anxieties, from which they seek to defend themselves, through

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the familiar mechanisms of projection, splitting and denial. Menzies-Lyth's important contribution was to establish how an organisation's own bureaucratic features, its rules and procedures, rotas, task-lists, paperwork, hierarchies and so on, in short '*the system*' acts as a support for the defensive techniques. By allowing for 'ritual task performance', by depersonalizing relations with the patients, by using organisational hierarchies, nurses contained their anxiety. Yet, in Menzies-Lyth's view, such organisational defences against anxiety were ultimately unsuccessful:

The system made little provision for confronting anxiety and working it through, the only way in which a real increase in the capacity to cope with it and personal maturation would take place. As a social defence system, it was ineffectual in containing anxiety. (Menzies-Lyth, 1991, p. 363)

The system's inadequacy in Menzies-Lyth's study is evidenced by its failure to train and retain nurses, the chronically low morale, high levels of stress and burn-out and absence of work satisfaction. By contrast, institutional health is testified not only by performance and output indicators, but also by morale indicators, and individual feelings of growth and maturation. Social defences against anxiety, then, are self-defeating. Instead of *containing* anxiety, they exacerbate it, just as neurotic symptoms far exacerbate the patient's malaise instead of containing it. Since Menzies-Lyth's pioneering work, some attention has been paid to how to support nurses and enable them to contain their emotions, without resorting to depersonalizing social defences. Yet, there is ample evidence that many nurses today continue to struggle with modest support against powerful anxieties (Theodosius, 2006; 2008). It is striking that no single study has sought to examine whether doctors face similar types of anxieties as nurses, whether they resort to similar psychological defences and the extent to which these defences function effectively across different individuals. In Chapter Nine we see evidence that doctors too appear to react similarly when faced with intolerable anxieties.

1.7 Developing our approach to leadership and the NHS

Studies of leadership and organisations such as the NHS clarify that diverse disciplinary perspectives have come together and separated more than once over the past century. The relationship between organisational and social context over that time has impacted on both practices of leadership and empirical and theoretical changes. In the 21st century the rules of scientific management or leader as therapist no-longer apply, and the rapid changes in organisations such as the NHS brought about by economic and technological imperatives, have left many who engage in leadership

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discourses, for practical and academic purposes, moving between the transformational and the post-heroic positions.

We now consider theoretical perspectives, ideas and practices that can potentially be brought together to good effect in this study for the benefit of patients and those who work for their good within the NHS, focusing on some of the recent debates which explore the context of leadership and the place of distributed leadership as they apply to NHS contexts.

1.7.1 The base-line:

- It is now widely acknowledged that organisations, their leaders and followers come together in a highly *emotional context*. How can those who lead and work in such organisations take account of the role of emotion while not being 'emotional' (i.e. making unfair and irrational decisions)? Understanding this is vital for enabling management and leadership particularly in a complex institution which has patient health, safety and care at its cutting edge (Morgan, 2006) .
- The NHS, individual Trusts and Units within these Trusts are constantly engaging staff in *change* (which may be evolutionary and/or politically driven) and which may be motivational and/or stressful or resisted (McNulty & Ferlie, 2002). This further demands emotional and social intelligence and engagement from leaders and followers (Bovey & Hede, 2001).
- The primary *tasks* and related *roles* might conflict at various points as these changes impact emotionally and intellectually on staff performance and service delivery (Zoller & Fairhurst, 2007).
- Organisations have to have leaders but leadership is not necessarily always the province of a small group of individuals but depends on the structure and demands placed on the organisations and the tasks required at any one time (Currie et al., 2009; Day et al., 2006; Harvey, 1989; Michie & West, 2004).
- An emotional context requires attention to both conscious and *unconscious* dimensions of human interaction and power relationships which may come into play in organisations which comprise multiple professional disciplines, different grades of role and people from diverse cultures, sexualities and gender (Ford, 2006; Gabriel, 2004). Acknowledgement of the importance of anxiety, envy, competition, anger and the emotional ties between people needs to be taken into account (see Figure 3 below).

Two models of leadership are therefore examined in this study (see Figure 3 below):

- First, *inspirational and transformative (or engaging) leadership* which has attracted much recent attention in that its absence was seen as a critical factor behind the failure of many organisational innovations. In this approach, leadership hinges on leaders' ability to communicate effectively, relate emotionally with their followers and develop a vision that is both attractive and achievable. The role of transformational leadership then is to lead an organisation towards change and thus some elements of transformational leadership are essential for understanding the practices and needs of the NHS (Alban-Metcalf & Alimo-Metcalf, 2009).
- The second relevant dimension is *distributed leadership* (sometimes called *dispersed, distributive, collective, or supportive 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). A *distributed leadership* approach is consistent with Bailey and Burr's (2005) research on successful NHS Trusts, which states:

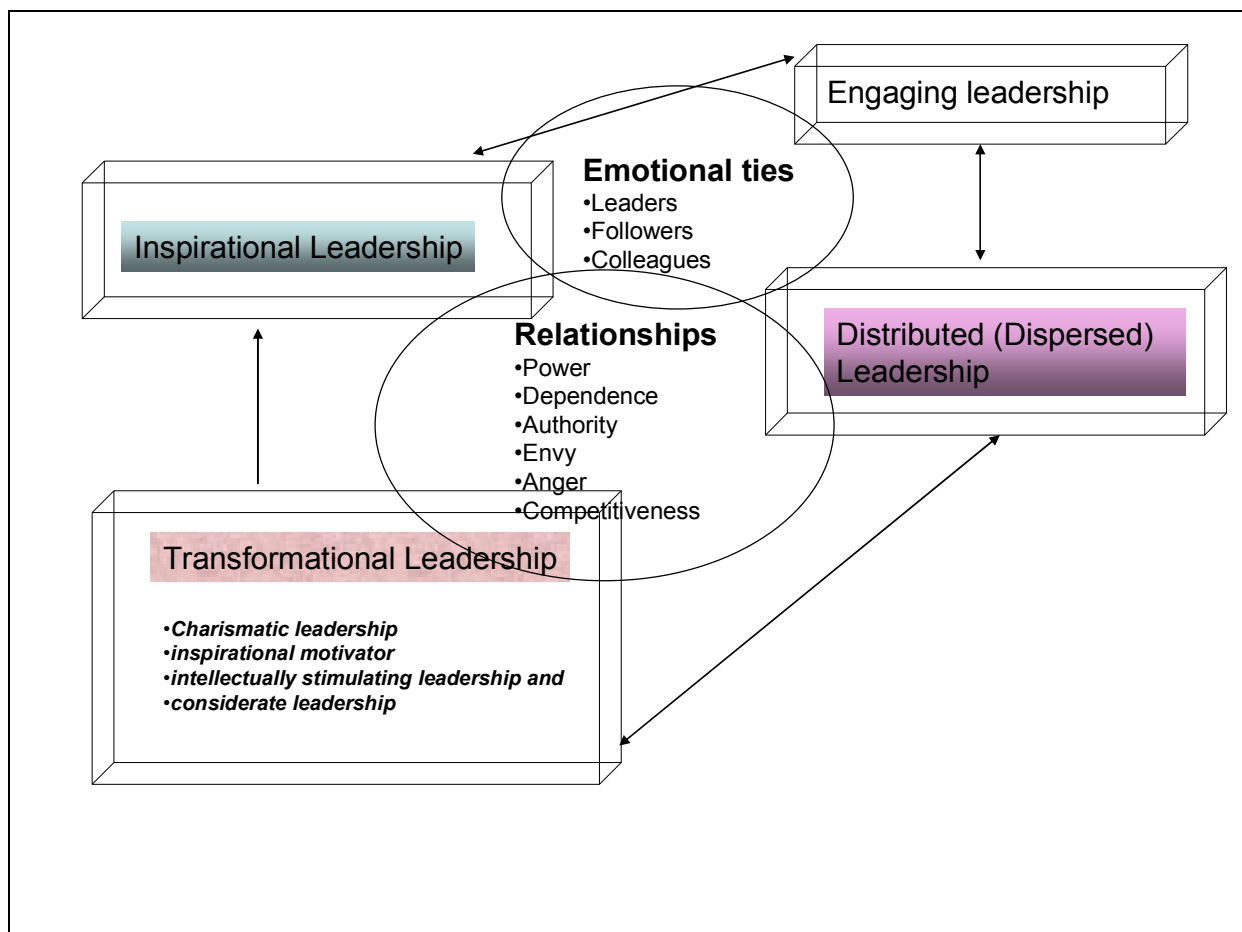
In contrast to the individual, heroic leader concept, leadership is seen in terms of the influence processes that contribute to the collective and individual capacity to work effectively. This idea of collective and distributed leadership is closely associated with the emergence and special requirements of 'new' organisational forms generally and the NHS in particular it is consistent with the agenda for devolved decision – making, empowerment of the frontline, de-centralisation, inclusion and such initiatives as 'Leadership at the Point of Care'.

Thus, distributed leadership is seen by Bailey and Burr (2005, p. 14) as directly linked to patient care.

A combination of these two models might now be seen as 'engaging' leadership as described by Alimo-Metcalf, Alban-Metcalf et al. (2007) and this combination will be explored further in our analysis of the (qualitative) data in particular.

Furthermore the model of the post-industrial/postmodern and or networked organisation will be 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).

Figure 3. Leadership Styles, Followership and Emotion



1.8 Conclusion

In an organisation like the NHS there are opportunities for leadership at all levels, as well as opportunities for success and unforeseen consequences leading to failure. Leaders in the NHS are involved *transformationally* in responding to policy initiatives and government demands, but the NHS is also an organisation that relies on the knowledge, skills and abilities of all its people – leaders and followers.

It would seem that *transformational/engaging and distributed leadership* are particularly useful conceptual resources to deploy in the context of the National Health Service, where a workforce of different ethnic, cultural and

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class backgrounds caters to the needs of a similarly diverse patient population.

Following Alimo-Metcalfe, Alban-Metcalfe et al (2007) "*an engaging 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'*" (2008, p. xi).

As part of the conceptual framework we develop, it is clear that the *emotional links* between individual staff, groups of staff and staff and patients need to be privileged as they play out at various organisational levels. Implicit therefore is that emotions above and below the surface (conscious and unconscious) are taken into account if the leader/follower and staff/patient relationships are to be understood and improved.

2 Aims and Methods

2.1 Introduction

The research questions in this study centre on identifying:

- (a) processes by which leadership is transmitted through health service organisations to effect the delivery of health services, and
- (b) how features of the organisation, the leader, and the service influence these processes.

The focus of this study was to explore the relationship(s) between (good) leadership in NHS organisations and (good) patient care. This demanded consideration not only of leadership characteristics, qualities and styles but the ways in which NHS organisational climate and culture interacted with individual practices and identities of those who worked in them and were patients. The overall plan was, thus, to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery. This research further sought to expand existing knowledge by exploring the following questions.

1. First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
2. Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

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3. Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

2.2 Aims and Objectives

We separated these overarching research questions into aims and objectives thus:

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients;
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts on service delivery;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted through health care organisations to affect service delivery, posits *organisational climate* as one feature of the organisation that could positively or negatively affect the quality and delivery of health services.
- To learn how different stakeholders (specifically, patients, nurses and professions allied with medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care.
- To identify how the need for change in service delivery is identified and what drives the need for change.

2.3 Methods

This multi-method study therefore uses a mixture of qualitative and quantitative methods to enable and support an innovatory approach to examining the psycho-

social and psychodynamic factors intrinsic to the meanings and processes of leadership, organisation and patient care.

Qualitative research methods now have a strong and long-standing profile in social science, particularly sociology and anthropology. But over recent years they have become increasingly relevant in social psychological research.

Furthermore nursing research (Finlay & Ballinger, 2006; Kerr, 2002) and most recently even health services research have begun to take evidence emerging from qualitative methods seriously. Perhaps this began with a series of papers in the British Medical Journal in 1995. Pope and Mays for example leading on this series aptly titled their paper *Reaching the Parts other Methods Cannot Reach* (Pope & Mays, 1995). Noteworthy from this point onwards is that there is no 'one' qualitative method of either data collection or analysis and we draw on several traditions and styles in this study which are outlined below.

Unlike health services research *per se*, but akin to critical social science, there is a powerful tradition in organisational research that has taken account of the diverse nature and intrinsic value of qualitative methodologies to understanding the life of organisations (see for example Cassell and Symon, 1994; Ybema et al., 2009)

What counts of course is choosing methods which meet the demands of the research hypothesis or overarching questions. We thus began from the premise that 'leadership', 'patient care' and 'organisational change' are not objective facts but social or discursive constructions. By this we mean that these concepts are constructed through discourse, i.e. a coherent system of statements which constructs an 'object' (Parker, 2002). In other words, talk about leadership is the process by which leadership is constructed (and thus recognised) as something that happens in organisations such as the NHS.

To capture these constructions we used a range of methods:

- focus groups;
- a survey-based questionnaire including a standardized measure of Organisational Climate;
- ethnographic 'shadowing';
- observations of social places, formal and informal and meetings;
- analysis of 'stories' of leadership collected through in-depth interviews.

2.4 Capturing the data

In what follows we present the outline plans for capturing, managing and analysing the data to meet our aims although as shown in Chapter Three not all of our goals were achieved.

We focused upon three NHS Trusts with at least one being a Foundation Trust specifically to explore whether any variations in the qualities of leadership, organisation and patient care could be distinguished. An

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investigation of three Trusts was considered to be manageable within the time frame and other resources available for the project.

Within each Trust we chose two distinct 'units' to study. We conjectured these would probably to be defined by clinical speciality or site (bearing in mind that many Trusts are organised across more than one hospital/physical space).

We conducted focus groups, an organisational climate survey, story-telling interviews and ethnographic work (observations and shadowing) across these six units with staff and patients.

We employed two researchers¹³ to carry out the majority of this work, but some members of the investigatory team also took an active part in the process.

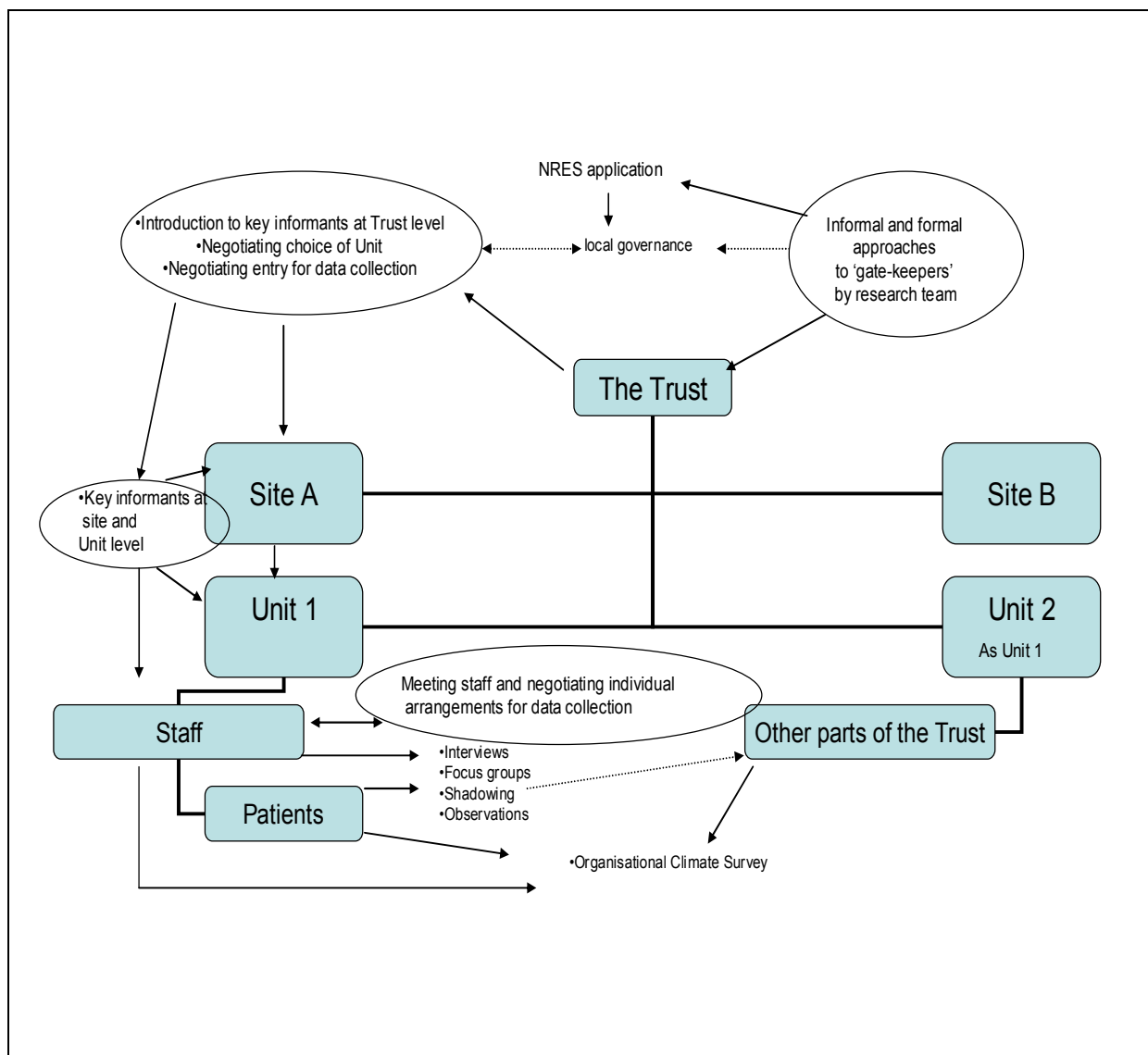
The qualitative data would by necessity and designed be analysed using a variety of methods:

- a. Thematic analysis (TA)
- b. Critical Discourse Analysis (CDA)
- c. Narrative analysis

Each of these approaches to data analysis, again by necessity and design, was subject to nuances of interpretation, intrinsic to their nature.

¹³ In the event three researchers were involved because of maternity leave and cover.

Figure 4. Access Pathways, Sampling Procedure and Data Collection Process



2.5 Sampling

The Trusts

Sampling the Trusts was decided according to three criteria that:

- they were each different from each other in the image they projected (on their web-sites, in terms of their physical style,

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locality, size and community) and that the sample had to include one Foundation Trust.

- they were in easy reach of London (for practical purposes as the study team were based in London and Surrey).
- we were able to gain access via personal contacts in R & D or senior management (the 'gatekeepers').

The Units

Sampling of the Units in each of the Trusts was achieved through negotiation with the gatekeepers and/ or key informants recommended by the gatekeepers with the intention that a balance might be struck between:

- the specific academic interests of the research team (for example the PI is particularly interested in Obstetrics and Gynaecology services).
- some degree of opportunity for comparison between Trusts, so that if possible some similar Units might be compared across the Trusts.
- and (possibly most influential) the concerns of the gatekeepers and other senior Trust staff.

The Sites

All three Trusts selected for an initial informal approach were on more than one site although the selection of study unit determined whether or not the data was collected on more than one site.

Individual Participants (staff)

Individual participants were to be selected on an 'informed' volunteer basis. That is that via a process of meetings with key informants and presentations to staff-groups individual staff would hear about the study and be offered the opportunity to participate. For those who were not involved in the meetings or presentations a staff e-mail list was used to communicate information about the study and request volunteers to participate in interviews and focus groups. The intention to meet the study aims was to ensure participation from a variety of staff groups and levels of seniority.

Individual Participants (patients)

Patients were to be recruited for interview either by the staff directly caring for them or by the researchers themselves once the staff of each unit had become familiar and accepted the presence of the researchers.

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Survey Respondents (staff)

The Organisational Climate Survey (OCS) was to be administered within the Units that were the focus of the study and, if possible, across other Units in the Trusts. The circulation was to be achieved either through e-mail or through internal mail depending on negotiation with the relevant gate-keepers.

Survey Respondents (patients)

Patients who might complete the patient version of the survey were to be recruited by staff and/or researchers if staff permitted the researchers 'on the ground' access.

Observations and 'Shadowing' (staff and patient-staff interactions)

These methods would require the participants to be familiar and comfortable with the presence of the researchers and familiar with the ongoing research process and also be prepared to co-operate. The rules for engagement in the activities would then be made on a strategic (i.e. the staff and / or situation that would yield the richest source of information) and a pragmatic basis (i.e. the possibility of the situation yielding important data regarding leadership, organisational culture and climate and patient care).

2.6 Ethical considerations

There are clearly considerations about confidentiality and anonymity in all data collection which involves human participants Easily identified in this study (and thus in the NRES application) is the matter of the safe keeping of the raw data including completed questionnaires, any identifying characteristics of these questionnaires, digital recordings, transcripts from focus groups and interviews and the researchers' field notes. It is important to note that this is not necessarily as simple to do as it is to describe particularly because a team of investigators, the researchers themselves and some 'casual' clerical staff ¹⁴all had different types of access to the data.

The solution was to have a shared drive set up by the computer centre at Royal Holloway, University of London (RHUL) on the main site at Egham which could only be accessed by specified investigators identified by the PI. Additionally there was an access pass-code to read the transcripts and the SPSS file.

¹⁴ The sheer volume of data made it necessary to use more than one person to input the data and transcribe the recordings. Two people other than the researchers were engaged to work on this although both were employees of RHUL who knew the importance of keeping the data safe.

Another ethical consideration specific to this project was that because the staff were discussing leadership and being asked to give examples of good and bad leadership, as well as examples of effective and poor patient care, it was inevitable that:

- they would be talking about *other* members of staff. These other staff could not be told that they had been talked about (by definition) leaving them unable to provide their version of the story or aware of the fact they had been discussed.
- the researchers would therefore be 'holding' some knowledge of others which would be 'data'. This fact drew attention to the ethical and empirical complexities of working in an organisation in which data is being collected on human interactions and relationships.

As patients' experiences and views and staff's views of patient care were also part of this investigation, similar issues applied.

Finally, frequently overlooked but nonetheless very important consideration was given to the fact that participants' time should not be wasted. We were confident in the design and our experience as investigators supporting and managing the researchers (who themselves were experienced in this kind of study) that the study was robust enough to adapt to the vagaries and quirks of 'real life' and that the outcome would be valid and add value to existing knowledge.

2.7 Methods of data collection and research instruments

As described above a mixture of qualitative and quantitative methods were used to ensure a full picture of leadership in the organisations to be studied. Collecting data in applied settings, where the participants are also engaged on a day-to-day basis is demanding work which is challenging for researchers involving persistence, social skills, the ability to develop rapport, clarity of purpose combined with flexibility, the skill of 'thinking on your feet' and making practical judgements about what is feasible at any one time. For example, if plans had been set for an interview with a staff member who was then called away for an important work matter, the researcher could arrange other potential participants or be prepared to engage in a period of systematic observation.

Immediately below we describe the methodologies we chose to employ to conduct our investigations which will be described in greater detail where appropriate in the context of specific case studies.

2.7.1 Focus groups

Focus groups, once the province of market researchers, in common with in-depth interviews, are now a popular method of collecting psycho-social data in the area of health research (Nicolson & Anderson, 2003; Nicolson et al., 2008) having gained recognition in social science overall as a robust way of eliciting “*shared and tacit beliefs, and the way these beliefs emerge in interaction with others in a local setting*” (Macnaghten and Myers, 2004, p. 65 in Seale et al) (p.8). In other words focus groups represent a means of gathering a sense of how those who work in an organisation share a sense of their ‘organisation in the mind’ (Armstrong, 2005) which may be mutually accepted, challenged or undermined by the perceptions of colleagues. Focus groups also enable the researchers to check out the quality and effectiveness of the communications themselves between members of the Unit or as Morgan (1998) suggests “*Focus groups are fundamentally a way of listening to people and learning from them* (1998, p. 9).

The process involves one or two researchers meeting with between four and eight participants who share a common situation and the guide lines for the discussion focus on key topics (see Appendices). One researcher takes notes although both are empowered to guide the discussion which is also digitally recorded. One benefit of this means of data collection is that through discussion among peers issues or perspective upon certain issues are brought into focus which might have escaped previous research authors and the researchers themselves (Morgan, 1998).

The *focus group guide* employed a similar structure to the *Interview Guide*.

2.7.2 Organisational climate

The Organisational Climate Questionnaire (OCQ) designed by Stringer (Litwin & Stringer, 1968; Stringer, 2002) also called ‘The Leadership Questionnaire’, was specifically designed to produce a scale to measure leadership in the context of climate albeit in a business rather than NHS setting. To complement the mostly qualitative methods of data gathering and analysis, we developed a questionnaire for staff and patients across the Trusts and used (a slightly adapted form of) Stringer’s measure of leadership and organisational climate, with the expectation that our results might also be linked to other studies undertaken with this measure, which had been used to examine management and leadership in organisations.

It identified six dimensions of organisational climate: *structure, standards, responsibility, recognition, support and commitment*, and uses eighteen leadership practices (three for each dimension) to capture how people feel about their jobs, how they are managed, and how things work in a particular organisation. Because this scale is designed to give practical

indicators on how to improve performance, many of the leadership measures are based on management practices, which are equally important to the overall success of an organisation. In general, however, each leadership practice measure is based on the premise that leaders care about arousing the motivation of members in the organisation (Stringer, 2002). The OCS was adapted from to fit a model relevant to NHS Staff working in a hospital setting and another version was adapted to be used with Patients (see Appendices).

2.7.2.1 Measurement tool: Stringer's OCS – Leadership and Organisational Climate

Stringer (2002) defines organisational climate as the "*collection and pattern of the environmental determinants of aroused motivation*" (p. 9) and he takes motivation to be central to the development of his climate questionnaire predominately based on the work of McClelland-Atkinson's framework with regards to intrinsic motivators of work related-behaviour: the need for achievement (nAch), the need for power (nPow), and the need for affiliation (nAff).

Stringer noted that specific dimensions of climate appear to have a predictable impact on motivated behaviour and can be measured and managed by those in senior positions accountable for organisational performance.

The six distinct dimensions identified and measured are:

- 'Structure'
- 'Standards'
- 'Responsibility'
- 'Recognition'
- 'Support'
- 'Commitment'

The statistical data was entered into an SPSS file to seek frequencies, correlations and to explore significance levels of differences and similarities between and within groups of respondents.

2.7.3 The survey structure and items

The survey is structured in two parts:

Part 1: measures *Organisational Climate* or how people perceive the work environment.

Part II: measures *Management Practices* or how people see their own managers behaving.

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Part 1:

This part consists of twenty-four items grouped into the six dimensions - 'structure', 'standards', 'responsibility', 'recognition', 'support' and 'commitment' - designed to measure how people feel about their work environment using a 4 point Likert scale. The directions ask the participants to describe the kind of working climate that has been created in their organisation (defining 'organisation' as the smallest work unit relevant to the participant).

Descriptions of the dimensions are as follows:

1. **'Structure'** pertains to the clarity of roles, responsibilities, accountability and expectations. According to Stringer this is more of a managerial than a leadership issue and one which is more practical than inspirational. It reflects the employees' sense of being well organised and of having a clear definition of his or her roles and responsibilities. *"structure is high when people feel that everyone's job is well defined and is low when there is confusion about who does which tasks and who has decision-making authority"* (Stringer, 2002, p.65).

The following items measure 'structure':

- The jobs in this organisation are clearly defined and logically structured.
- In this organisation, it is sometimes unclear who has the formal authority to make decisions.
- In some of the projects I've been on, I haven't been sure exactly who my boss was.
- Our productivity sometimes suffers from a lack of organisational planning.

2. **'Standards'** is about the need to achieve targets and reach goals. It is the drive to achieve and improve, it includes the 'commitment' and persistence to follow through on set targets. This dimension measures the feeling of pressure to improve performance as well as the degree of pride employees have in doing a good job. When interpreting this measure, high 'standards' indicate that people are always looking for ways to improve performance, whereas, a low score reflects lower expectations for performance.

The following items measure 'standards':

- In this organisation we set very high 'standards' for performance.
- In this organisation people don't seem to take much pride in their performance.
- Around here there is a feeling of pressure to continually improve our personal and group performance.
- Our management believes that no job is so well done that it couldn't be done better (Stringer, 2002, p.65).

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3. **'Responsibility'** is about taking ownership of the work and results which are obtained. Ideally people will be motivated to achieve results and take ownership over these. Where managers delegate and encourage responsibility, workers are more likely to feel a sense of 'responsibility'. It reflects employees' feelings of 'being their own boss' and not having to double-check decisions with others. A sense of high 'responsibility' signifies that employees feel encouraged to solve problems on their own. Low 'responsibility' indicates that risk taking and testing of new approaches tend to be discouraged (Stringer, 2002; p.66).

The following items measure 'responsibility':

- We don't rely too heavily on individual judgment in this organisation almost everything is double checked.
- Around here management resents your checking everything with them if you think you've got the right approach you just go ahead.
- You won't get ahead in the organisation unless you stick your neck out and try things on our own.
- Our philosophy emphasises that people should solve their own problems themselves.

4. **'Recognition'** relates to the relationships between one's performance and associated rewards, as well as broader sense of approval or disapproval of an individual's efforts. It indicates employees' feelings of being rewarded for a job well done. This is a measure of the emphasis placed on reward versus criticism and punishment. High 'recognition' climates are characterised by an appropriate balance of reward and criticism. Low 'recognition' means that good work is inconsistently rewarded (Stringer, 2002, p. 66).

The following items measure 'recognition':

- In this organisation the rewards and encouragements you get usually outweigh the threats and criticisms.
- There is not enough reward and 'recognition' given in this organisation for doing good work.
- We have a promotion system here that helps the best person rise to the top.
- In this organisation people are rewarded in proportion to the excellence of their job performance.

5. **'Support'** is the degree to which there is a sense of warmth and team work, within which the individual feels that they are 'backed up' by others. This will determine the amount of trust and respect amongst team members. It reflects the feelings of trust and mutual 'support' that prevails within a work group. 'Support' is high when employees feel that they are

part of a well-functioning team and when they sense that they can get help (especially from the boss) if they need it. When 'support' is low, employees feel isolated and alone. This dimension of climate has become increasingly important for today's e-business models in which resources are severely constrained and a premium is placed on teamwork (Stringer, 2002, p.66).

The following items measure 'support':

- You don't get much sympathy in this organisation if you make a mistake.
- When I am on a difficult assignment, I can usually count on getting assistance from my boss and co-workers.
- People in this organisation don't really trust each other enough.
- I feel that I am a member of a well-functioning team.

6. **'Commitment'** reflects employees' sense of pride in belonging to the organisation and their degree of 'commitment' to the organisation's goal. Strong feelings of 'commitment' are associated with high levels of personal loyalty. Lower levels of 'commitment' mean that employees feel apathetic toward the organisation and its goals (Stringer, 2002, p. 11).

The following items measure 'commitment':

- Generally, people are highly committed to the goals of this organisation.
- People here feel proud of belonging to this organisation.
- People don't really care what happens to this organisation.
- As far as I can see, there isn't much personal loyalty to the organisation.

Part II:

This part asks the participants to describe the practices of their managers. Using the same six dimensions as in Part I, participants are given eighteen statements which describe the way a manager might perform her or his duty and the respondents are asked to indicate how much he or she agrees with each of the statements. Here a 5 point Likert scale is used.

Once again the six dimensions are used to assess perceptions of managers' practices:

1. 'Structure'

- Establishing clear, specific performance goals for subordinates' job.
- Clarify who is responsible for what within the group.
- Making sure tasks and projects are clearly and thoroughly explained and understood when they are assigned.

2. 'Standards'

- Setting challenging performance goals and 'standards' for subordinates.
- Demonstrating personal 'commitment' to achieving goals.
- Giving subordinates feedback on how they are doing on their job.

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3. 'Responsibility'

- Encouraging subordinates to initiate tasks or projects they think are important.
- Expecting subordinates to find and correct their own errors rather than doing this for them.
- Encouraging innovation and calculated risk in others.

4. 'Recognition'

- Recognizing subordinates for good performance more often than criticizing them for poor performance.
- Using 'recognition', praise and similar methods to reward subordinates for excellent performance.
- Relating the total reward system to performance rather than to the other factors such as seniority or personal relationships.

5. 'Support'

- Being supportive and helpful to subordinates in their day to day activities.
- Going 'to bat' for subordinates with superiors when the manager believes their subordinates are right.
- Conducting team meetings in a way that builds trust and mutual respect.

6. 'Commitment'

- Communicating excitement and enthusiasm about the work.
- Involving people in setting goals.
- Encouraging subordinates to participate in making decisions.

Leadership question

We also asked a single question to capture directly how satisfied an employee is with the leadership they receive from their immediate supervisor. It was a simple statement: *I am satisfied with the quality of the leadership I receive from my immediate manager* which we measured using a 4 point Likert scale.

2.7.4 Ethnographic observations and 'shadowing'

Ethnographic observations and shadowing are especially useful to organisational research because they allow people to *physically* express their inner thoughts, and put ideas into *observable action*, all of which would be inaccessible through the survey or structured interview questions.

Ethnographic observation (often referred to as *participant observation*) has its roots in anthropology but has become increasingly deployed in sociology, cultural and social geographies. In the field (which in this case is a Unit in an NHS Trust) the researcher's aim is to "*understand how the cultures they are studying 'work'*" that is, to grasp "*what the world looks like*" to the

participants in the context being observed (Delamont, 2004, p. 206). In this study observation and shadowing opportunities were (mostly) formally set up and pre-arranged. However, the researchers, through taking their roles as interviewers, focus group leaders and having an every-day presence with key informants, gate-keepers and participants, were able to immerse themselves in the lives and atmosphere of each of the Trusts and Units providing evidence about the processes of leadership and patient care as well as 'climate' (Bloor, 2001; Goffman, 1961).

Shadowing involved the same conceptual framework as ethnographic observation in that the aim was to understand what the world looks like from the perspective of the staff member being shadowed as well as the worlds of the other staff and patients that they engaged with in the course of their work (Czarniawska, 2008; McDonald, 2005). It involved meeting the participant (usually) at 8 am and for one or two days accompany them including at break times until the participant went home. In Trusts where there was more than one site and/or when the nature of the day's work involved meetings outside the hospital (as in nearly every case) then the researcher spent time in a car with the participant and if agreed the conversation was digitally recorded as an *aide memoire* for the field notes. The participant was able to withdraw at any time, or for a period of time, across the shadowing period.

Thus the sense of 'what the Unit world looked like' was recorded in field notes which were then discussed with the other members of the team (who had some familiarity with the relevant part of the Unit/Trust) in a context where the researcher could be reflexive and explore the 'silent space' of the 'ethnographic self' (Coffey, 1999). The researcher's notes and expressed thoughts were then discussed with other members of the team, some of whom were familiar and others not so with the specific context (Barry, 2003). A similar approach was used to discuss the interview material because even though the interviews were digitally recorded and transcribed verbatim, this did not account for the reflexivity that took place following the interview itself and on transcribing and reading the transcript, and therefore featuring in the analysis (Nicolson, 2003).

In this context there was concern to capture the emotional content and atmosphere of the organisations. This meant that ethnographic methodologies were implemented to analyse the emotionality of the interactions (verbal and non-verbal) between patient and practitioner. It was through these observations that the use and importance of the researcher's *body as a 'research instrument'* became palpable, especially for understanding the emotions emerging out of the interactions between patient, relatives and practitioner(s). This process has been proposed as the antithesis of taking for granted that emotion should be removed from

ethnographic investigation and that in fact the research process is highly emotive and far from an emotionally barren terrain (Bondi, Davidson, & Smith, 2005).

As the researcher collects data they move through a continuum of emotions from the euphoric highs of excitement at starting a new research project, sense of achievement and pride as they begin to make contacts and collect initial data, perhaps trepidation, fear and nervousness as they meet new participants or research settings through to the depths of despair, isolation and frustration as the research process (inevitably at times) becomes chaotic and messy. However, these emotions are often neglected, regarded as unimportant to the overall research process and abandoned in the writing up phase. We use these frequently neglected emotions and feelings as part of, and beneficial to, the project as representing a rich source of data.

By being more attentive to their emotions and bodily senses ethnographers also become more sensitive to their environment and their participants thus gaining a greater awareness of what they are observing. In recalling a sound, smell or feeling the ethnographer is able to open up their mind's eye to re-visualise the interaction with greater clarity and accuracy making it more likely that an accurate representation of what was observed will be recorded.

2.7.5 In-depth semi-structured and 'story-telling' interviews

In-depth semi-structured Interviews: Over the past fifteen years this method of qualitative data collection has become increasingly common in health services and health research in general (Pope and Mays, 1995; Kvale, 1996; Grbich, 1999) consistently a method of choice for identifying perceptions, meanings and experiences of dynamic and complex concepts such as 'leadership' and 'patient care' (Rubin and Rubin, 1995; Denzin and Lincoln, 1998; Rapley, in Seale et al, 2004).

The use of such interviews has led to increased levels of sophistication in the interpretation of qualitative in-depth data in the context of historical, cultural and political frameworks demonstrating that in-depth semi-structured interviews (and more generally qualitative research) have capability beyond simply adding rich description to statistical evidence (see Denzin and Lincoln, 2002; Willig, 2008).

Story-Telling: One of the explicit aims of the interviews was to collect a number of stories to reflect critical experiences in the organisations' past and present life. In the field of organisational studies, there is now an extensive literature of how to use stories told by organisational participants

as windows into organisational culture, politics and numerous other phenomena (Gabriel, 2000; Hannabuss, 2000).

The inclusion of story-telling in the context of the in-depth interview increases the scope for making sense of data in ways that delve deeply into the respondents' perceptions and meaning of the *processes* of leadership and patient care. Story-telling also increases the validity of the interview through the use of reflexivity, and positioning the events and 'atmosphere' of the stories in the context of the organisational analysis.

Of particular relevance to this study, stories can instigate insights into the processes of positive or negative social and organisational change and leadership which involves the management of meaning and emotions, both of which rely heavily upon the use of stories, allegories, metaphors, labels and other narrative devices.

The study of *organisational stories* is particularly relevant in health care settings that are liable to unleash strong emotions and fantasies. Hence, hospitals are rich grounds for collecting stories, as numerous researchers have recognized (Kleinman, 1988; Frank, 1998; Greenhalgh, 2002; Hurwitz, 2006; Mattingly, 1998). Storytelling permeates everyday clinical practices and "*medical professionals find ways to 'routinize' their practice and thus, metaphorically at least, bring the unruly and frightening world of illness under control*" (Mattingly 1998, p. 277).

The *interview schedule* (see Appendices) therefore was designed to elicit information on the participant's view of 'leadership' and 'patient care' through 'stories' to provide examples in their opinion that constituted good and poor leadership and good and poor patient care through 'critical incidents'.

As the interviews were semi-structured and in-depth they relied to a great extent on the interviewing skills of the researchers and their ability to establish rapport and consequent willingness of the participants to engage in the process. The early pilot interviews therefore were unlikely to influence the details of the interview schedule itself although the early interviews were planned to enable the research team to identify the best *strategies* to engage participants in the task.

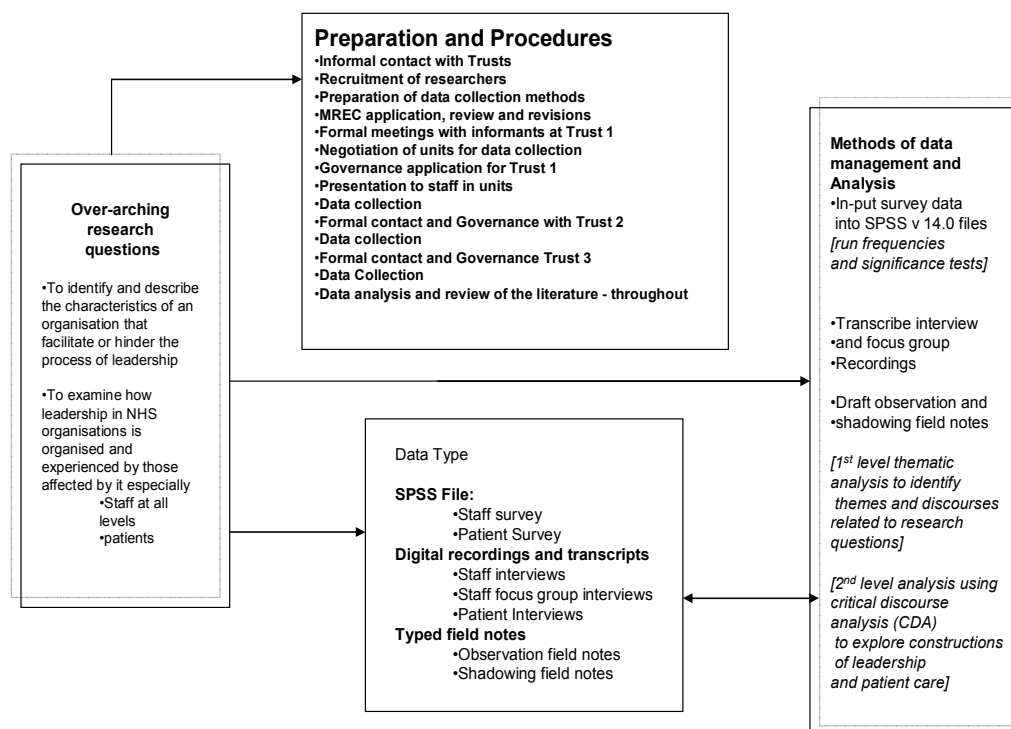
2.8 Data Management

The interviews and focus groups were digitally recorded and transcribed verbatim. The transcripts stored on a password protected Word file (initially on the researchers' PCs but subsequently on the secure shared drive described above) and sound recordings stored on audio files (password protected on the PC of the PI and not on the shared drive).

The OCS data was entered and stored on an SPSS file, password protected and placed on the secure shared drive.

Fieldwork notes from observations and shadowing were similarly password protected stored on the shared drive once they had been prepared by the individual researchers.

Figure 5. Outline of Study Procedures and Methods



2.8.1 Data Analysis

There are effectively therefore three categories of data.

1. Qualitative data representing verbatim 'talk' (digital recordings/transcripts) of interviews and focus groups.
2. Qualitative data from observations, shadowing and other field notes. These were subjective accounts of observations, perceptions, emotions and meanings given to the field work by one researcher. This may have been following discussion with the other researcher on occasions when that person had had access to the same raw

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material. Discussion with another member of the investigatory team (frequently but not always the PI) also took place following the first drafting of the field notes in order to clarify the meanings given to specific behaviours and relate theory and data.

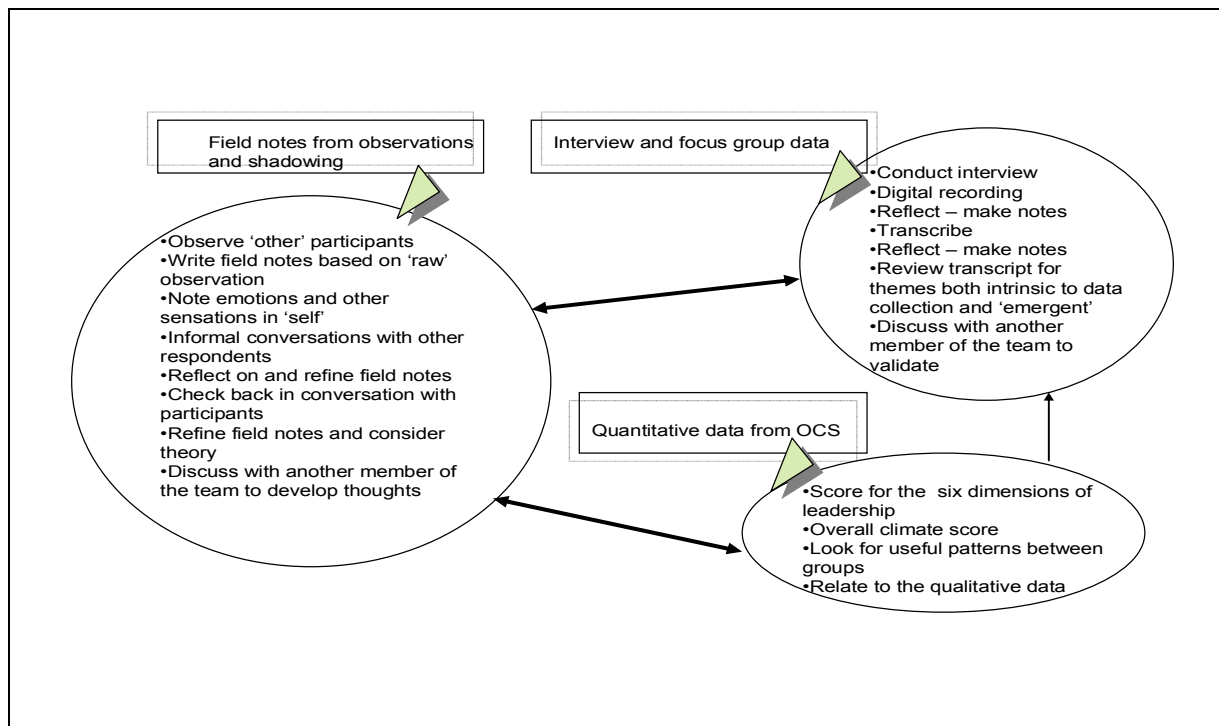
3. Statistical data from the OCS.

2.8.2 Thematic Analysis (TA)

The transcripts and field notes were examined initially for relevant extracts related to the main themes ('leadership', 'organisation' and 'patient care').

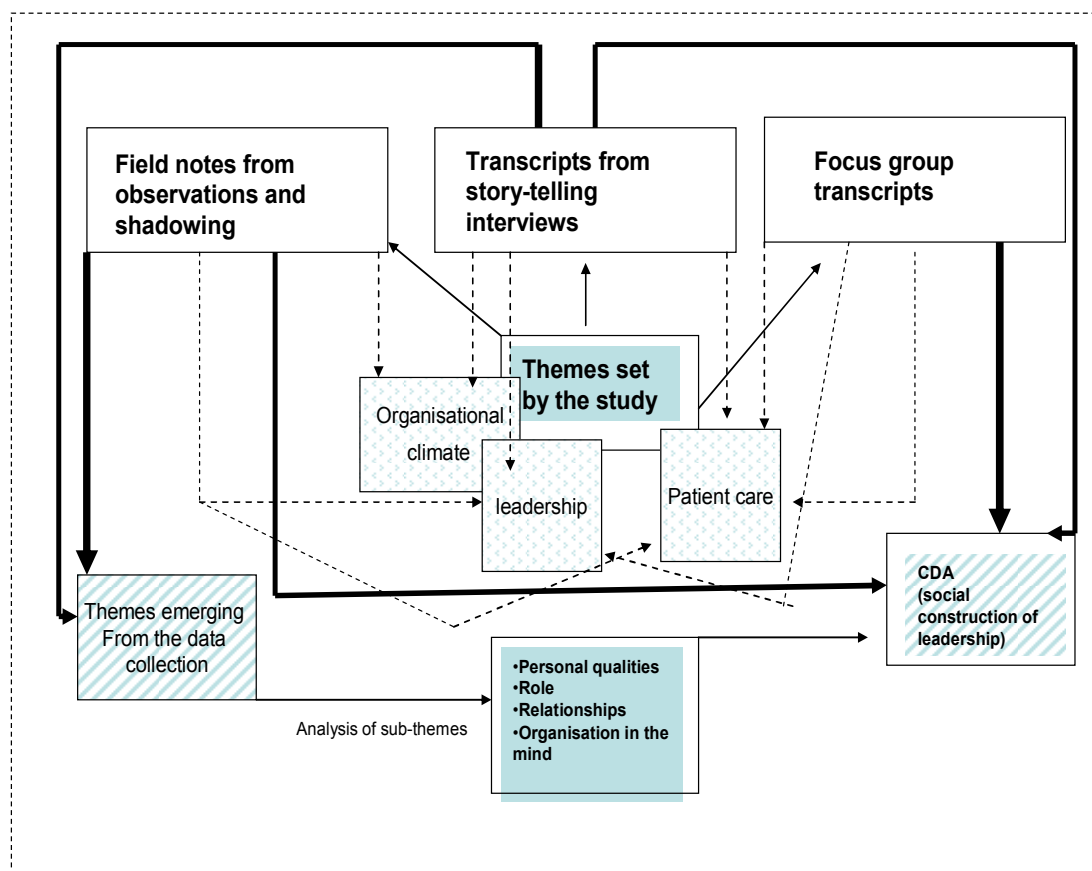
Sub-themes were then to be identified, some of which are likely to relate closely to the previous research literature on leadership and organisational climate, although it is likely that each organisation will demonstrate particular issues that were more difficult to anticipate at the outset.

Figure 6. From data collection to data analysis



Data relating to these themes and sub-themes was to be collated on Word files and where deemed relevant to the study aims, analysed further using the following methods – Discursive Psychology, Critical Discourse Analysis and Narrative Analysis. All these approaches focus on language and the way language is used to construct key concepts (e.g. the organisation) but there are different nuances to each perspective each of which adds an important dimension to the analysis of this data.

Figure 7. Thematic to CDA with Narrative analysis



2.8.3 Discursive Psychology, Discourse Analysis and Critical Discourse Analysis (CDA)

Hepburn and Potter (2004) argue convincingly and with justification that DA has evolved to have several iterations over recent years. One common feature though has been that 'discourse' (i.e. what is said) and 'context' are difficult to separate and it is the ways in which context is worked into the analysis of discourse that distinguishes the character of DA deployed in a particular piece of analysis.

The thematic analysis was a starting point from which to focus in upon the close readings of the texts, which related to the processes of leadership and patient care, as it represents a flexible and clear way of identifying what is emerging from the data and points a way forward with more detailed analysis (Braun and Clarke, 2006)

We argue that leadership is a social construction and there is a growing body of literature providing evidence to support this view. There has also been a recent focus in organisational research and theory to specify an Organisational Discourse Analysis (ODA) (Pritchard, Jones and Stablein, 2004) which involves four approaches i.e. *Narrative*, *Foucauldian*, *Linguistic* and *Deconstruction* which in turn are influenced by a *reflexive awareness* of the organisational culture in which the research is being conducted.

Pritchard et al, (2004) argue further that the exact methodology and approach to the data depends on the 'researcher position' in the organisation being studied. In other words this approach *benefits* from the subjectivity of the researcher's interpretation of what processes mean and specifically from researcher reflexivity about their 'take' on a situation and set of interactions.

To qualify this method of analysis further, a discursive approach means that language is represented not so much as an objective truth but as a means of *constructing* what might be understood (Parker, 1992; Coyle, 2007).

Particularly relevant in this study, in which participants are asked to tell stories and provide evidence to support what is good and bad about both leadership and patient care (and implicitly the organisation in which these actions take place), is discursive psychology (DP) that highlights how "*descriptions of events are bound up with doing actions, such as providing justification for actions and blaming others*" (Hepburn and Potter, 2004, p. 169).

Thus Critical Discourse Analysis (CDA) sees language as a *social practice* and thus considers carefully the context in which language is used (see

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Wodak, 2004). CDA is related to the notion that *power is negotiated through language*. This is particularly apposite in a study of leadership in organisations. Even more so CDA is 'abductive' so that a constant movement between theory and empirical data is needed which suits ethnographic methods such as shadowing and observations enabling the researcher to test out their ideas as they progress with the data collection, and the attempt to understand how cultures work and how the research participants make sense of and experience their worlds.

2.8.4 Narrative Analysis

Narrative approaches to data analysis have been able to cut through the great complexity of the NHS - the intense emotions, positive and negative, it evokes among most of its stakeholders (e.g. Rooksby, Gerry & Smith, 2007; Bryant, 2006; Iedema et al., 2009; Brown et al., 2008; Elkind, 1998; Brooks, 1997). These studies have, for example, addressed power issues in the doctor-patient relationship, exploring communication in a consultation situation. In these analyses, the patient's 'subordinate' narratives have often been neglected or taken over by the doctor's privileged 'medicalizing' discussion (Mattingly, 1998, p. 12; see also Radley, Mayberry & Pearce, 2008). However, there is also a recognition that many of these narratives are co-constructed by patient and physician (Mattingly, 1998, p. 43; Kirkpatrick, 2008); exploring solely the patient voice in isolation and presuming that doctors will at all times occupy a dominant position in this relationship may be missing half of the story - the doctor's experience. As Mattingly (1998) points out, *"[h]ealers too, may be able to give a different kind of voice to their practice when they describe their work in narrative terms rather than the flattened prose of biomedical discourse"* (p. 14).

As a genre, narrative psychology is thriving (Smith & Sparkes 2006). There has been talk of the 'narrative turn in psychotherapy and psychiatry' (Brown, Nolan, Crawford & Lewis, 1996), and Crossley (2003a & 2003b) for example argues strongly for a 'perspective that retains a sense of both psychological and sociological complexity and integrity' noting that narrative psychology is concerned with 'coming to grips with how a person thinks and feels about what is happening to her' (2000, p. 6). She employs a phenomenological framework to explore narratives of 'the voice' of 'the mentally ill' (Crossley & Crossley 2001) and the experience of temporal elements and self/identity of people living with serious illness (HIV, cancer; see also Söderberg, Lundman & Norberg, 1997). Narrative research in health care has also been used to study the lived experience of patients (see for example Hemsley, Balandin & Togher, 2007; Hök, Wachtler, Falkenberg & Tishelman, 2007) and an emerging genre of 'narrative based medicine' seeks to make use of stories in developing a fuller understanding of illness experiences (Launer, 2003; Taylor, 2003; Greenhalgh, 1999).

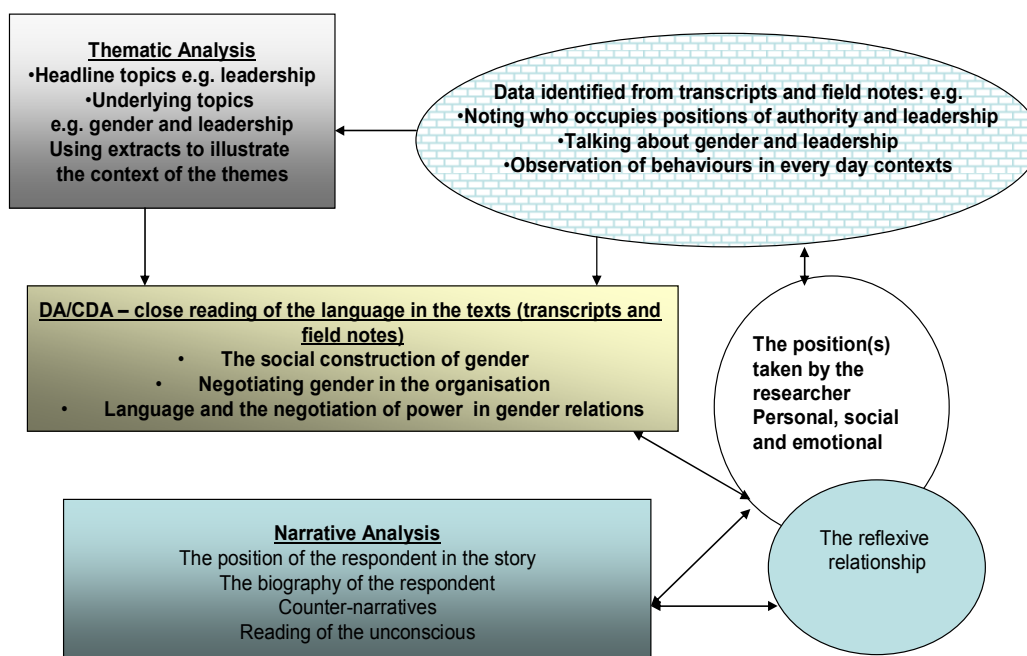
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Narrative based medicine is not merely an insightful way of doing research, but may have powerful policy implications. As Overcash (2003) argues, "*narrative methods are an effective research option that can lead to enhanced patient care*" (p. 179). While interpreting narratives can enhance the possibilities of integrating evidence-based research findings with individual illness experiences, and Winterbottom and colleagues (2008) suggest numerous courses of further research on why and how narratives may influence medical decision making.

Narrative analysis, as with DA, has been approached differently by academics from a range of disciplines so that the ideas surrounding the analysis of *narratives* (or stories told in a sequence) have a variety of emphases. The strength of taking the narrative approach over DA /CDA *per se* is that the 'subject' of the story (the narrator) retains a central role (Crossley, 2007). This can be seen in some detail in subsequent chapters particularly where the accounts of ethnographic observations and shadowing are highlighted where the 'story' becomes that of the researcher herself and with the stories unfolding through the interviews.

Furthermore the narrative analysis places the respondent's story as part of their own *identity construction* which lends an important dimension to the relationship of the story-telling to the teller. Particularly interesting here is Andrews' (Andrews, Sclater-Day et al., 2004) approach which focuses specifically on the elements of stories "*that lie in tension with the ones we are socialised to expect*" (2004, p. 97) or what she calls 'counter-narratives'. Researchers such as Hollway and Jefferson, 2002; Gough, 2003; Sclater, 2004; Allcorn, 2004 and Gabriel, 2004 and 2005, take on board the role of the interlocutor in positioning themselves in their story while considering some of the unconscious and emotional elements both of the story being told and the way that the relationship between the researcher and respondent plays out to construct and limit the story that is told. This dimension is particularly important in the context of this study where emotions are rife at least in part because of the high pressure (exacerbated to some extent by the changing political initiatives directed towards NHS institutions) and the particular nature of the work in caring for ill people (see for example Menzies-Lyth 1960).

Figure 8. Levels of qualitative data analysis e.g. 'gender'



2.8.5 Statistical Analysis

The data from the OCS was coded and in-putted into an SPSS v 14.0 file and significance tests were run (see Chapter Five for the full details).

3 Research Procedure

3.1 Introduction and Overview

The nature of this study, much of which involved the researchers immersing themselves in the 'world' of the participants, meant that it is not possible to provide an authentic *sequential* account of the procedure of data collection except possibly for the administering of the OCS (Organisational Climate Survey).

The bulk of the study, as identified in Chapter Two, comprised multiple methods of collecting different types of data across three Trusts, six Units and five sites.

3.1.1 Negotiating Access

The study took place across a three year period. Negotiation of access was complicated as indicated, although in itself a valuable procedure which occurred at several levels and helped to increase the richness of the team's understanding of leadership, patient care and the context of each organisation.

- Negotiating access began from the 'notional' level while writing the grant application whereby the investigatory team needed to identify whether a project with this design was in fact feasible. We thus made informal inquiries via personal contacts.
- More formal contacts were made once the project was confirmed with the intention to achieve verbal agreement about access for planning the NRES application.
- Following that we met to formalise the details with key informants (i.e. senior clinicians and managers) who had been identified in the previous stage.
- Once we had achieved a favourable NRES review, we pursued local governance applications with the help of the key informants.

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- These stages were managed by approaching one Trust at a time although during the latter part of the study some overlapping negotiations and governance were necessary.
- Part of the formal stage of negotiation concerned consideration of which *Units* could/would form the focus for the study. This was very much two-way but also serendipitous with suggestions from the team of investigators moderated by whichever senior clinical staff the key informants considered would be amenable to 'hosting' the study.
- The key informants then identified opportunities for the team to present the project to staff in the selected Units in 'educational half days' or 'staff meetings' depending upon the local structures.
- These formal presentations only took place in Trusts One and Three however. The procedure in Trust Two (because of the culture, location and structure) was on the basis of a 'tour' (which with permission was digitally recorded) organised by a senior nurse manager so the researchers, one of the co-investigators and the PI could meet various key nursing and medical staff across one of the Trust sites.

Once all that had been achieved it was the researchers on the whole who managed the day-to-day negotiations about who could and would agree to take part in the various elements of the study. This was complicated because of the day-to-day patterns of staff, changes in staff roles, particularly at senior levels, shift patterns and the sheer numbers of staff who may or may not have been aware and willing to allow access to, say, a particular meeting or team for observation or interviews.

Figure 9. Procedures and time-line

	2006/7	2008	2009
Winter	<ul style="list-style-type: none"> •Recruit and prepare researchers •Informal contact with 3 Trusts 1 and 2 •Informal visits to Trusts 1 and 2 •Develop research instruments •Prepare COREC/NRES application •MREC presentation and revisions •MREC approval •Start to review literature on leadership 	<ul style="list-style-type: none"> •Arranging formal contacts with Trust 2 (on 2 sites) •Visit to Site A •Further data collection in Trust 1 •Patient interviews 	<ul style="list-style-type: none"> •Researcher begins maternity leave and new researcher inducted into the team •Data collection in Trust 2 Site 2 •<u>[difficulties gaining access to staff list in Trust 2 for survey]</u> •Presentation to staff in Trust 3 (Unit 1) •Distribution of staff survey (individually handed out) in Trust 3
March - June	<ul style="list-style-type: none"> •Formal meeting with Trust 1 R & D director •Governance application •Formal meetings with senior staff to negotiate units for study •Unit based meetings and introductions •Presentation at educational half day on Unit 1 (obs & gyn) of Trust •Pilot interviews •Pilot staff survey 	<ul style="list-style-type: none"> •Formal meeting in Trust 2. Tour of Site A •Visit to Site 2 •Governance for Trust 2 •Informal meetings •Data collection begins in Trust 2 •<u>Trust 1 staff in Unit 1 return surveys to PI saying they won't give them out</u> 	<ul style="list-style-type: none"> •<u>[further difficulties gaining access to staff list in Trust 2 for survey – now due to key staff transfers]</u> •Preparation and presentation of invited paper to SDO conference in June •Paper preparation and further conference presentations
Summer	<ul style="list-style-type: none"> •Organise, send out and in-put data from staff survey in Trust 1 •Observations and interviews with key staff •Presentation to Unit 2 •Focus groups and interviews on Unit 2 	<ul style="list-style-type: none"> •Application for extension to project (successful) 	<ul style="list-style-type: none"> •Put staff survey on Trust 2's 'intranet' with information about how to complete and return •E-mail staff in Trust 3 who had not received a staff survey •<u>[a low response in both cases]</u>
Autumn	<ul style="list-style-type: none"> •Data collection •Data in-putting from staff survey •Patient survey given to staff on Unit 1 to distribute 	<ul style="list-style-type: none"> •Preparation of journal paper 1 •Further review of literature •Governance for Trust 3 •Identifying key contacts in Trust 3 •Negotiation about Unit 1 (Care of the Elderly) 	<ul style="list-style-type: none"> •Journal paper 1 (anxiety) being revised for publication •Journal paper 2 in preparation (gender) •Journal paper 3 (in preparation) leadership and 'territory') •Presentation prepared and delivered to NHS Surrey and Borders conference •Final draft report

3.1.2 Time frame and Participation of Investigators

We negotiated the formal details of access consecutively in order to make the process manageable. Most data was collected by the researchers (Dr. Fox, Dr. Lokman¹⁵ and Ms. Rowland) although the PI and other investigators made the initial contacts, met with key informants, contributed to the presentations and conducted some of the interviews and focus groups and (Profs. Gabriel and Nicolson, Dr. Heffernan and Mr. Howorth). The PI (Nicolson) and at least one of the researchers was present at all initial meetings with the gate-keepers and key informants.

3.1.3 NRES review

This was prepared and submitted at the end of 2006 and the PI, one of the researchers (Lokman) and another member of the investigation team (Gabriel) attended the appointment with London-Surrey Borders Research Ethics Committee in January 2007.

Annual reports were submitted to the NRES subsequently as required.

3.2 Sample characteristics

The three Trusts, selected as stated above in Chapter Two were each very different from each other, not only in formal terms (size, budget, location and organisational structures) but also informally and culturally and this influenced the 'access pathways'. Thus for example in Trust One our informal and then formal contact was with the R & D director (also a senior clinician) and assistant R & D director, who introduced us to the CEO, the clinical directors and senior nurses.

In Trust Two we had begun with meeting the CEO at the 'notional' phase who then retired in the meantime. This meant starting again with delayed local governance and to accomplish this, we were directed towards a senior clinical manager who then changed their role and location which meant dislocation of our planned procedures.

Trust Three involved a personal contact initially who was directly involved as a clinician in one of the Units who then arranged for us to have a

¹⁵ Dr. Lokman worked on the project for over two years and Dr. Fox took her place.

meeting with another senior clinician who in turn arranged for us to give a presentation to the Care of the Elderly/Geriatric Unit. From there we sought a second Unit for Study independently through contacts made during the course of working in the first Unit.

Trust 1 (One site only) a DGH (District General Hospital)

The Research and Development director here suggested the Units for study to be:

- Unit 1, Obstetrics and Gynaecology
- Unit 2, Cardiology

We were happy with his suggestions, and the staff was generally co-operative and supportive of the researchers.

The Trust itself covers two sites but the choice of these Units meant that all data was collected from one site. This was helpful because it meant the researchers and some of the investigators could spend time familiarising ourselves with the layout of the Units and the Trust site and become familiar 'faces' so that gaining consent from respondents was made easier than it would have been if the researchers and the study itself had to be presented as 'new' on each occasion.

While the study was taking place there were many fears expressed among the staff at all levels that the site we were investigating would become the less powerful with the other site taking over many of the executive functions. While the study team were collecting data on this site however this did not happen and the general 'morale' has improved so that the Trust is currently applying for Foundation Trust statusⁱ.

Self-Description of the hospital

The site we studied had 400 beds and a range of acute care services, including an Accident and Emergency department. It is situated in 52 acres of Green Belt parkland within 40 – 60 minutes of London. Originally it was built to serve casualties of the Second World War. Over the years, the hospital has been rebuilt, developed and extended to include maternity services, a departmental and clinic area, and a new theatre complex. In the early 1990s, the X¹⁶ Wing, which includes a Postgraduate Education Centre and modern well-equipped wards, was opened. A new building for the Accident & Emergency, ITU and Orthopedic Unit opened in the summer of 1998. In addition, comprehensive HIV and genitourinary medicine services are provided in a dedicated building.

¹⁶ We have used 'X' to ensure anonymity.

Obstetrics and Gynaecology

The study territory for this Unit¹⁷ comprised the labour ward, postnatal ward, a general outpatient clinic a dedicated ante-natal clinic and the Maternity Services Administration. The unit offered midwife care for home births, one to one care, water births and there was always a consultant obstetrician available and compared to other local hospitals it gained a score of 3/5 which was joint top score.

Cardiology

This Unit studied comprised one in-patient ward, the Medical Assessment Unit (MAU) and the Critical Care Unit.

In addition we spent time in the Management Suite where five interviews also took place of the CEO, Clinical Director, the Director and Deputy Director of R & D and a middle-ranking manager.

Observations also took place in public and eating spaces and shadowing involved walking around the hospital between different specialty wards and administrative departments.

Trust 2 (2 sites)

The Trust was one of the biggest DGHs in London with 4,200 staff. It had had a history of problems in its financial management and the quality of care but recent information on the web-site and confirmed by the CEO made it clear that:

The Care Quality Commission, the organisation that regulates health care nationally, has awarded the Trust a rating of excellent for the quality of services we provide to our local population. This is the highest possible performance rating in the 2008/09 Care Quality Commission annual national assessment report.

It seems that problems with the financial management remain although improvement had been noted.

The structure and organisation of Trust 2 differed significantly from Trusts 1 and 3. Trust 2 comprised two sites (recently combined into one Trust where one was a teaching hospital) which were at least eight miles apart and it

¹⁷ There were other parts of the Maternity Services at Trust 1 that were not observed directly.

was difficult to travel between one and the other on public transport other than using more than one bus or travelling in and out again from London. The journey by car varied from about thirty minutes upwards depending upon traffic.

Physically the two sites were very different. Site A was a relatively new building designed (as one researcher stated) to look like a motel or contemporary hotel. The other, B, was a traditional middle height rise built in the 1970s on a green site and appeared far more formal with long corridors and many signs to departments. Site A was more 'angular' and you could not walk very far without having to turn a corner which presented a very different 'feel'.

It was not possible, particularly in Site A to select a discrete specialist Unit (unlike Trust 1). Site A focused on acute medicine and care of the elderly and there were no formal divisions in where patients were treated as either in-patients or out-patients. So an older person with 'geriatric' health related problems could be in a bed next to a much younger person. We have identified a Unit as a Site in the case of this Trust. We found it equally difficult to 'pin down' a specialty in Site B as well.

At Site B we collected data from acute medical specialties, obstetrics and gynaecology and therapies (the latter being both physical and psychological).

This was in part because senior management at Site A (who were our key informants and 'gatekeepers') introduced us to staff they considered amenable. Thus for purposes of the study we had to identify Site B as our second Unit. Despite the introductions we managed, via snowballing, to find a range of participants who demonstrated many different view points.

To summarise then in Trust 2 the study was carried out in the following two Units which we have identified as follows:

- Site A / Unit 1 (Acute Medicine; Care of the Elderly)
- Site B / Unit 2 (Acute Medicine; Obstetrics and Gynaecology; Therapies)

We also interviewed a Clinical and Nursing Director both of whom worked across both sites and senior managers including the CEO and deputy CEO.

It became clear very early on that there was intense rivalry, even animosity between the two sites and some of this is explored in later chapters.

Trust 3 (2 sites)

Trust Three, in central London, is a long established hospital and a Foundation Trust with connections to a prestigious medical school. Travel

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between the sites took about twenty to thirty minutes by public transport. 9,000 staff are employed by the Trust with 1,100 beds available across the Trust at any one time.

- Unit 1 (Care of the Elderly, Acute Medicine)
- Unit 2 (Therapies)

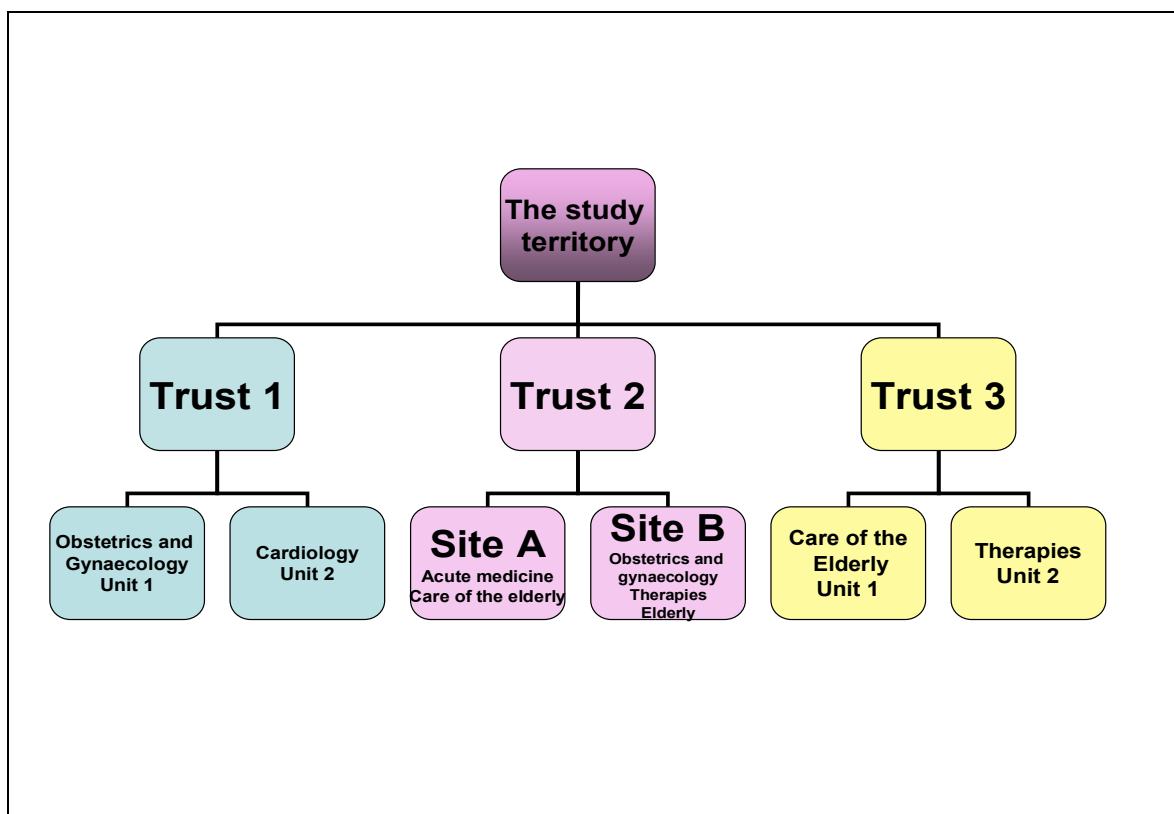
Unit 1 is described on the web-site thus:

Geriatric medicine specializes in the diagnosis and management of common symptoms and diseases in older people, particularly:

- *problems with mobility*
- *falls*
- *continence*
- *difficulties with looking after oneself*

Unit 2 (therapies) which included physiotherapy and psychological therapies spanned both the sites and covered many clinical departments and extended to primary care services especially local GP practices as well.

Figure 10. Participating Trusts and Units



3.2.1 Response rates (qualitative approaches)

It is difficult to identify an accurate response rate for the qualitative components (the majority) of the study because the sampling was conducted in an opportunist manner in many cases – i.e. whether someone agreed to take part in an interview or focus group if the researchers were on site and made a serendipitous approach.

As stated in Chapter Two, much of the qualitative data was collected by virtue of the researchers 'being there' in the right place at the right time and therefore gaining the trust of potential participants. In many cases the researchers were introduced to a member of staff who suggested ways in which other respondents might be accessed. Methods included personal introductions, using e-mail lists or sometimes a staff member knowing what was happening asked the researchers if they might participate in the study.

Overall the majority of staff approached to participate agreed to do so, although circumstances sometimes prevented it (e.g. one focus group was cancelled in Cardiology due to a patient emergency and one observation was cut short because the consultant refused to have the researcher in the ward round, although they had been observing on the ward before the consultant arrived having been given permission by the nursing staff).

Although the key staff across all three Trusts agreed to support the researchers in gaining access to patients for the OCS and interviews, the patient form of OCS was anonymously returned to the PI by someone at Trust 1 saying they did not want patients to participate in that exercise¹⁸.

It proved impossible to administer the patient OCS in the other two Trusts also, because the staff said in advance they were too busy to help and the researchers had difficulty in making contact with individual patients who were always either in busy wards or with a member of staff. Thus interviews and observations were conducted, with patients' consent, during shadowing.

The OCS for the staff is discussed fully in its own right in Chapter Five.

3.2.2 Individual participants

Respondents were either NHS staff or patients so by definition there were elements of uncertainty about whether they would be available at appointed

¹⁸ We sought advice but in line with the NRES review participants could withdraw their consent at any time so we did not feel free to pursue this further.

times and whether (as acknowledged in the NRES consent form) they choose to drop out at any time, even after having agreed to take part.

As shown below in Table 1, forty six respondents took part in in-depth story-telling interviews, thirty nine took part in focus groups. During twenty six days of shadowing of key staff, numerous other staff and patients were involved in data collection and similarly, during the eleven and a half days of observations on wards and in administration areas across the Trusts.

In addition, ten patients consented to be interviewed in depth and, again more staff were involved in the eight meetings that were observed and an introductory walking tour with a staff member in one Trust involved additional staff and patients in the study.

Each of these data collecting encounters represents a different unit of study and a different 'order' of data.

The nature of the study required a commitment of between 30 minutes (for completion of a survey or a short interview) up to two days, in the case of 'shadowing', of respondents time. Most respondents' contributions to the study, however, took about 90 minutes although this also represented an important commitment of their time (and energy).

Table 1. Qualitative Data Collection

Table 1. Qualitative Data by modes of collection							
	Interviews		Focus groups	Shadowing (staff and patients)	Ethnographic observation	Patient interviews	Other meetings and visits
Trust	N = men	N= women	N = Group (n = participants)	N = days	N = days		
1	13	19	5 (15)	5	9	10	4
2	5	9	3 (24)	8	3 x .5 + 1	0	2
3	4	8	0 (0)	13	0	0	2
Totals	22	26	8 (39)	26 days	11.5 days	10	8

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3.2.3 OCS (Organisational Climate Survey)

Trust 1

The staff survey

An administrator in Trust 1 provided a staff list (name and location) from which a random sample (35%) was identified using the SPSS software version 14 providing a list of 939 potential participants from staff across the Trust (including and beyond the Units participating in the main data gathering). The questionnaires were all individually addressed and sent through internal mail.

Of these 223 (24%) individuals returned a completed questionnaire, although ten blank surveys were returned with a note that the intended recipient had left the trust and one said they were unable to read English (1). Thus the final number of participants for Trust 1 was 210.

The patient survey

In Trust 1 we gained agreement from the senior staff on the two study Units (Obstetrics and Gynaecology and Cardiology) that they would arrange wherever possible for patients to complete the patient version of the OCS and would arrange for the researchers to collect the completed forms.

However the full batch of uncompleted patient questionnaires was sent back to the PI at the College several weeks later with an anonymous note stating that the staff did not wish to administer these to the patients. We were unsure how to proceed after this because ethically, although the survey was directed to the patients, the staff had completed consent forms and had copies of participant information sheets, and were aware that they (staff) could withdraw from the study at any time. We considered that this constitute an ethical dilemma for the team.

The researchers made other attempts to hand out the questionnaires directly to patients but found that while some patients were prepared to consent to being interviewed and almost all consented to having a researcher present during patient/doctor/nurse meeting it was not looking possible to obtain a valid sample of questionnaire returns.

Trust 2

Trust two was organised across two distinct sites and although the senior staff work across both sites, as will be made clear from Chapters Three and Four below, each site is very different in its organisation. We initially

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approached the senior staff on Site A first about how to distribute the questionnaires and they referred us to Human Resources on Site B who were the only people with access to a staff list. We did not get any acknowledgement from HR despite several attempts including one visit to the head of HR from one of the researchers. He said he would get back in touch once he had checked whether he could release this list but he did not and we considered there was little more we could do to pursue this particular approach.

The PI then contacted the senior nurse manager, who had been one of our original gatekeepers, for help but found that she had left for another post.

Following the abortive attempts to contact HR (or anyone else who might have been able to help) a PA in one of the many departments we contacted suggested that there was a staff intranet which went out once a week with an 'update' section with news for staff across the Trust. The PI made contact with the editor of this site who agreed to include an electronic version of the OCS.

Consequently, the questionnaire was included on this web-site, with a preamble (adapted from the NRES participant information sheet) on two occasions. However it only produced one reply. We made one final attempt via the PA of the CEO to contact HR for a staff list to no avail.

What was interesting and perplexing though was, that there was no difficulty obtaining a commitment from staff across the Trust to participate in an interview or focus group which was much more time consuming and personally revealing.

By the time we were ready to collect the patient survey data at Trust 2 we already recognised the problems with the responses from the staff. Also, by contrast, we had established the effectiveness of eliciting patient data from the shadowing and observations. We therefore made a decision to focus on this approach to data collection from patients rather than pursue more blind alleys.

Trust 3

In Trust 3 the early signs were that there was no overarching administrative structure from which we could obtain a staff list and nobody we asked could advise on the best way to gain that information. However we did have some 'local' e-mail addresses of the staff in the Units and therefore we e-mailed the OCS to staff on the two study Units and obtained 13 replies all together.

3.2.4 Participant characteristics

There were 224 respondents who completed and returned the questionnaire, of which 77% were women (n = 172) and there were 23% men (n = 49). These included from Trust 1 (n = 210, 93% of respondents), Trust 2 (n=1, 0.4%) and Trust 3 (n= 13, 5.8% of respondents).

The mean age was 46 years, standard deviation 11.1. The majority of respondents were married (62.7%), with a further 7% cohabiting. Twenty percent of respondents were single and almost 10% divorced. The majority of respondents were White (72%), the next biggest group were Asian (18%) and other ethnic minorities such as Black (6.5%) and Oriental (3%) consisted of much smaller groups.

Pay level: most of the respondents had a salary of less than £20k (44.3%) or between £20k- £40k (38.8%). A much smaller percentage (5%) earned between £60k and £90k and a further 2.3% of respondents had a salary exceeding £90k.

3.2.5 Professional demographics

The majority of respondents had been working in the NHS for over 5 years (68%), with a further 26% for between 1-5 years. Only 5.8% reported less than one year's service.

3.2.6 Stability within individual Trusts and Units:

Most respondents had been employed by the same hospital for over 5 years (56%) and another 34% had worked there between 1-5 years. The rest (10%) had been employed by the hospital for less than a year.

Most respondents reported working for the same Unit for over 5 years (45%), a further 43% reported working there for 1-5 years and only 12% reported service of less than 1 year. A similar pattern was seen in terms of length of time in same job. However the majority in this case had been working at the same job for between 1-5 years (45%) and slightly less (41%) had been working in the job for over 5 years. Another 12% had been employed in the same job for less than one year.

3.2.7 Role:

The majority of respondents were nurses, 31%. 13.5% of respondents were managers; 11% consultants/doctors/physicians. Other allied professionals, such as scientists and psychologists made up 10% and support staff made up a further 6%. Clerical staff and 'other' staff (such as porters, maintenance) made up a further 13% each.

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3.3 Data Analysis

This was conducted in the manner described in Chapter Two and the results are discussed separately in the following chapters each of which when relevant provides more context to the conceptual framework and analysis in the substantive area of focus.

3.4 Conclusion

The diverse nature of each of the organisations studied provided valuable information about the different kinds of challenges that different leaders at all levels might face in different institutions across the NHS.

Staff at senior level (particularly non-clinical managers) moved around within and between Trusts. During the course of conducting our study some key gate-keepers and participants left the Trust, others joined and yet others moved position and role even during the relatively short time we collected data there.

In some cases mergers had just taken place or were expected. This was experienced by some as opportunities and others as threats, but in all cases it meant structural reorganisation, staff being re-assigned or choosing to leave for another post.

This has to be taken to be part of the changing face of the NHS overall and central to the culture and climate of the participating Trusts, and can no doubt be generalised to every NHS Trust across the country. In what follows, we have used our different strategies for data capture to examine the relationships between leadership and service delivery in this fluid and (potentially) exciting context.

4 Leadership in the NHS

4.1 Introduction

In any organisation:

Leadership is needed to pull the whole organisation together in a common purpose, to articulate a shared vision, set direction, inspire and command

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commitment, loyalty, and ownership of change efforts (Huffington, 2007, p. 31).

and

Leadership would be easy to achieve and manage if it weren't for the uncomfortable reality that without followership there could be no leadership except, perhaps for the delusional sort. (Obholzer, 2007, p. 33).

In this chapter we examine the ways in which leadership is defined, exercised, experienced and transmitted taking account of how far leadership is perceived as pulling the organisation together to pursue the common purposes of patient care and the relationship between leaders and followers.

We specifically:

- Explore how leadership is defined by different stakeholders and what they see as determining its quality;
- Seek to begin to understand how leadership is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients through examining the data from focus groups and story-telling interviews;
- Using the same data sets, explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted.

4.2 How is leadership defined by different stakeholders and what do they see as determining its quality?

We start this particular exploration with a *thematic analysis* of the qualitative data to identify what themes emerge from the definitions, while also making interpretations using *CDA* and *narrative analysis*. In so doing we pay attention to what Gough has termed 'emotional ruptures' (Gough, 2004) in the text which serve to illuminate some of the subordinated or unconscious information in the stories of the respondents and the subjectivity of the narrator (Frosh, 2003; Frosh, Phoenix, & Pattman, 2003; Hollway & Jefferson, 2000).

In Chapter One we proposed that 'leadership' as a concept has been subjected to continuous scrutiny and moved through different theoretical and paradigmatic iterations. The NHS has identified the qualities it requires in a leader and the role that NHS leaders (at all levels) are expected to strive towards (see Figure 1). We therefore inferred that respondents, imbued in the culture, would focus on 'transformational' or 'distributed'

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explanations and definitions about leaders and leadership because these models are embraced by the style of the coaching and training on offer.

4.3 Definitions

Respondents distinguished between 'leader' and 'leadership'. A 'leader' was described and defined in diverse ways including as:

Obviously strong minded and opinionated (Administrator, T, 2¹⁹).

Particular personality traits - need to be - to have integrity, ((1²⁰)) to ((1)) be clear, err to be facilitative, to have energy to listen, erm, to negotiate, ((2)) to make decisions (Senior Non-clinical Manager, T, 2).

... making sure that you're the person who is erm keeping the team focused getting them to achieve those goals looking at different ways of working (Senior Clinician, Trust 3).

These definitions suggest diverse ways of thinking about the idea of 'leader', indicating that commonality of stakeholder views should not be taken for granted. The qualities a leader has to have are determined in these definitions through having opinions, being strong-minded while also having integrity. A leader also needs to be able to facilitate actions, negotiate and keep the team focused towards the achievement of its goals supporting team-work.

4.3.1 Defining leadership

Leadership in this first definition below was about a formal role and implicitly hierarchical rather than distributed:

I don't think there is anything magical about good leadership. It is about establishing what the organisation wants to do and allowing people to get on and do it (Recently retired CEO with clinical background, T2).

This respondent, who had occupied a senior position, saw the structure and strategic direction of the organisation as fundamental to what works as leadership which was not 'magic'.

¹⁹ In some cases we are able to identify the Trust but where there is any chance of a breach of confidentiality we adjust the 'credit' to ensure anonymity.

²⁰ Where the transcription has included double brackets it denotes pauses timed in seconds.

The following respondent expresses it differently suggesting that it means different things to different people on the one hand, while also being an imponderable (possibly even magical):

Leadership is like love, we all know it exists, but you can't actually prove it, you can't define it, and it comprises of lots of different things that people do, if you demand evidence for everything...you will get rid of leadership eventually (Senior Clinician, T2).

This clinician seems to take distributed leadership for granted in that it is about 'lots of different things that people do'. A warning is expressed it appears, though, that trying to *show* leadership exists across the organisation (perhaps rather than residing in designated roles) might ultimately destroy the possibility of leadership. Following Gronn (Gronn, 2002) this might be a way of suggesting that through concerted action leading to conjoint agency, leadership might not be so obvious (as in the first definition immediately above) but it might be more effective in a hospital where there are different qualities needed to lead in different activities.

Resonating with the view above that a leader has to have integrity, is the view from one leader's experience:

I learnt that it's very important thing for leadership... to not lie, not hide anything and just tell them the reality and be true to yourself, and that's really important (CEO, Non-clinical).

There is an immutable relationship between the leader and the follower. Being true to oneself and honest towards followers must be fundamental to the emotional engagement or attachment between leaders and followers. The significance of emotional engagement as well as emotional and social intelligence was high on many respondents' agendas for determining leadership quality:

... leadership is about having, or being able to demonstrate at any level a coherent vision for where you're trying to go and getting people getting there (Nursing Manager, T 2).

[Leadership in the NHS] is a people focused, leadership job (Senior Non-clinical Manager, T3).

.. it's not always leading from the front (Senior Clinical [therapies] Manager, T 3).

While the leader needs to have vision, these definitions imply that vision alone does not determine how leadership can be exercised or experienced. Leadership will not work unless the leader engages the followers with that vision.

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If leadership fulfils an organisational role ('establishing what the organisation wants') then can it also be 'people focused'? If good leadership is about transparency and honesty is there an assumption that it has not always been so or may not be so at some future time? What does this imply? Does leadership have an 'indefinable' quality' or set of characteristics that work within a specific context but may not be transferable as 'skills'?

Leadership presents dilemmas for the maintenance of personal integrity ('tell them the reality and be true to yourself'), it is a 'job', it requires 'vision' and flexibility and most importantly it seems it is about focusing on people.

4.4 How is leadership in NHS health care organisations exercised and experienced by those affected by it?

Respondents talked about the *role* of the leader as central to the practice of leadership in the organisation. Leadership was understood to be intrinsically linked to particular tasks/goals while necessarily engaging with the followers who had to implement much of these tasks and achieve the goals. There was a sense that many respondents held an idealised view about leadership in their own Trust. Sometimes though the reality for them fell short of expectations because the person occupying that role failed to live up to their hopes.

For example, as the following extended extract illustrates:

.. one of the things about the leadership and management of this Trust is first of all clinical leadership is strong in most places. The clinical directors here have general clout and they are not just figureheads .. and the other bit I think - relationships between general managers and clinicians on the whole are much more positive here than other Trusts (Senior Clinician).

This proposes that strong leadership among clinicians (distributed both horizontally and vertically via the clinical grouping) enables managers to deliver the service to patients. However, this does not in itself identify the characteristics of the links between strong leadership and service delivery.

For many respondents leadership is exercised at least in part through each leader's personal characteristics (good and bad). Almost without exception when asked about the qualities that make a leader, and to 'story' their own explanations, respondents placed a degree of emphasis on the characteristics of an 'ideal type'. The following exemplifies this:

Most important quality is the communication. Being able to listen - hear what is being said and to deliver that--what they want to say, so that it is heard by all. That it be quite quick thinking, being able to develop an idea

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and roll it out, umm being able to think on their feet as well, because sometimes you get things that turn up and you have to deal with it there and then, umm, reasonably personable so people will confide in that person, um also strong so that when things are tough they can um deal with them (Clinical Midwifery Manager, T1).

The comprehensive but daunting picture of how leadership is exercised described above, represents an ideal of distributed leadership as *concerted action* (Gronn, 2002). This type of leadership is exercised through being able to communicate – to listen and to express clearly (so as to be ‘heard’) how action will be taken. ‘Rolling out’ the idea again suggests taking peers and followers along with you and being ‘personable’, so people will confide in that person, further indicates the ability to take the views of others into account calling for both emotional and social intelligence (Amendolair, 2003; George, 2000; Goleman, 2006; Lopes, Grewal, Kadis, Gall, & Salovey, 2006; Riggio & Reichard, 2008). In this model, the multifaceted communications rely on the ability to use the information to think quickly and be strong under ‘tough’ circumstances.

However, in the next extract (from a non-clinical manager) the ideal type of leadership is represented by responding to short and medium term organisational goals (Buchanan, Fitzgerald et al., 2005; Riccucci, Meyers, Lurie, & Han, 2004).

Erm, I think leadership is about erm, encouragement. It is about showing people direction in which you as an organisation and them as individuals engage in. I think it's incredibly important especially in an organisation like the NHS where there are lots of different groups of people and lots of different objectives - sort of daily ones, monthly ones more long term, and you have quite a clear sort of vision of where you're going and I think that the good leaders in the NHS show that, and examples of bad leadership are where that is not so defined. (Middle Manager, T2).

This suggests a *transactional* model of leadership, whereby the good or effective leader offers ‘encouragement’ to the followers in return for people accepting the practices of the wider organisation (Bass, Avolio, Jung, & Berson, 2003; Eagly and Johannesen-Schmidt, 2003)

4.4.1 Exercising leadership through their organisational ‘role’

Leadership is experienced by some as being exercised through the legitimated role. Organisational role in the leadership discourse equates with the leader’s professional position as the respondent below shows clearly:

Who would be a leader to me? I think there's a number of different areas, there's your direct line manager, who's the clinical leader of your department. Who's who in this structure there's line managers above them, and above them and so on. There would be people you would look to within your own specialty clinically who are more experienced than you ((2))²¹ in certain areas, to ask for advice, erm ((1)) and similarly in an academic environment ((1)) there are other people there who have more experience that you would want to take advantage from or advice from. ((2)) And in the wider circle, national or international leaders in the field who are so expert at those things that you also turn to. (Medical Consultant, T3).

While the formal roles and organisational hierarchical structures are taken seriously by this respondent, there is also a clear vision of leadership being exercised through concerted action in collaborations that arise *spontaneously* where clinical and/or experience is valued and sought within this respondent's speciality and sometimes *intuitive* leadership (Day, Gronn, & Salas, 2006; Pearce, 2004). However, there is also a sense that this respondent experiences leadership through the institutionalisation not only of formal roles locally, in the organisation itself, but through the structural relationships with those who are seen as experts in a much wider networked context (Pearce, 2004). This version of leadership is particularly important in that it demonstrates that leadership can be both experienced and exercised beyond the boundary of the organisation and the NHS, based on knowledge and expertise originating outside these systems.

Respondents frequently combined personal qualities with their understanding of the leadership role, particularly related to taking responsibility as part of that role:

It's quite difficult, I mean I think taking responsibility (4) making sure that things happen that are supposed to happen, or don't happen that aren't supposed to happen (3) um.., (6) that's it. (Clinical Medical Consultant, T1).

Not everyone saw leadership in this way. This respondent is talking about their own experience of being in a role in which then 'buck' frequently stops and thus by definition they are in the role of leader.

The exercise of leadership through being a 'role model' (Trevino, Hartman, & Brown, 2000) where qualities of leadership were displayed was important for some:

The leaders that I've worked for and have wanted to follow ... push something in me that says 'I want to be like them' or I completely support

their vision of where they're going or you know so I want to follow that person and I want to do the best that I can do for them because I believe in them and their vision. (Head of Non-Medical Clinical Team, T3)

This explanation has a flavour of heroic or charismatic leadership, although not as a quality that resides in a specific person necessarily, but one that resides in a relationship that 'fires' up both leaders and followers (Klein & House, 1995). Even though the idea of the charismatic leader has been at least partly consigned to the history of the late 20th century organisation, it has not disappeared and needs further thought particularly in an organisation such as the NHS where changes are sometimes rapid and stressful (James, 1999) and internal culture needs to be taken into account (Dopson & Waddington, 1996; Tourish & Vatcha, 2005).

4.4.2 The relationship of the 'leader' to 'followers': how leadership is experienced

While leadership is the focus of the professional and political debates about the NHS and other organisations, until recently, relatively little attention has been paid to followers' experiences of leadership (Avolio et al., 2004; Howell & Hall-Merenda, 1999; Lewis, 2000; Schilling, 2009). From the perspective of a manager taking the position here as 'follower' looking 'upwards' in the organisation:

I think it's, it's providing, you know direction and to lead and that's a leader's main job in my mind. And (2) that's .. what they say for leadership, you must have followers. If nobody's following you, what you are saying then? you are not a good leader. So that's a good, you know, test for a leader to evaluate themselves. That's what they are saying and what they are trying to achieve. Are people behind them or not? If they are not behind the leader there's something wrong with that. (Middle Non-clinical Manager)

From the perspective of a junior doctor taking the 'followership' position:

I think in order for you ... well in my opinion a leader, I have to be able to kind of respect them. If I don't respect or kind of have faith in what they do, then it's, it's a personal authority, so in order, you know in order for me to do that I have to believe in what they say. I mean, I might not always agree with them in my opinion but at the end of the day I have to be able to respect them enough and for them to have certain authority, someone who's probably experienced and gained that knowledge, so yeah. (Junior doctor)

For leadership in the NHS to be exercised effectively then there has to be an engagement between the leader and the followers (Macy & Schneider, 2008) and to understand fully how the engagement takes place, a degree of

emotional engagement and/or attachment to the leader and the organisational vision is fundamental (Riggio & Reichard, 2008; Rubin, Munz, & Bommer, 2005; Vince & Broussine, 1996).

The failure to take followers with you is made explicit here from the perspective of one (designated) leader:

A: I was forced upon them...

Q: that's what I was going to ask. So presumably there was a lot of resentment I guess?

A: Yes.

Q: And how does it manifest itself?

A: Erm, non-cooperation, making life difficult for you sometimes, people talking about erm ((2)) sort of criticising you behind your back and erm playing silly games behind your back that makes management of other people more and more difficult. Erm you know, and yet we sort of have to fight another battle to win hearts and minds, when we, you know, don't really have the time to do that, we have got to have our focus on doing what we are meant to do, which is to manage patients and to manage our beds properly.

This extract from the interview with someone whose role it is to lead change is revealing. The respondent recognises that he is not taking people with him and in his view, the followers appear to eschew co-operation. He also believes they are mocking him and that that mockery is contagious. He may or may not be able to evidence this, but that it is in his mind is potentially detrimental to his experience of leading in his organisation (Stein, 2005). Furthermore, instead of looking at himself, this respondent wants to push the blame for the leadership failures onto the followers (in other words he engages in splitting described in Chapter One) (Klein, 1975; Segal, 1973). Such a process is diametrically opposite to leadership studies that identify authenticity and trust between leaders and followers as being one of the basic qualities for leadership (Avolio et al., 2004; de Raeye, 2002; Novicevic, Harvey, Ronald, & Brown-Radford, 2006).

There is also some evidence of concerted action here, distributed among those who were leaders of the *resistance*, which is not necessarily against the values of the organisation in any negative way, but may be seen as upholding important principles and challenging change (or a particular form of leadership) that might be perceived as counteracting these important values (Collinson, 2005; Zoller & Fairhurst, 2007).

Trust is one important quality in the way leadership is exercised and experienced by followers and developing trust is essential if changes in

practice are to be implemented (Bass & Steidlmeier, 1999; Hunter, 2005). So, for example, 'engaging' with others involves trust:

Yeah definitely there are some good examples of where it's obvious that people have been able to engage lots of different kinds of people in different groups and I think they've done that just by sort of making relationships with them in the first place and then when it comes to having to lead them and be influential then you can see that those relationships are already there and then they can call on that you know, that sort of that trust or that sort of relationship that they've got (Middle Non-clinical Manager, T2).

The same respondent continued with a specific example that aptly demonstrates the links between all the three sub-themes.

Yep, I think Florence who is our head of [a non-clinical department] .. I think she is a very good example of what I'm talking about in terms of her job. And her role relies a lot on other people. Erm so as a personality she is a very responsible person, she gets on with everybody and you can really see how that works for her because when she needs somebody to do something or she needs people to listen they are going to because they have got a good relationship with her and she has taken time to build relationships when it is perhaps not necessary.

To summarise so far - *good* leadership in the NHS is understood by staff at various levels as:

- Taking responsibility
- Being 'given' authority by the followers
- Getting on with the people in the organisation
- Taking time to build relationships
- Being trusted by followers
- Winning hearts and minds
- Having a vision for the organisation
- Taking colleagues with you

4.4.3 Patients' perspectives on how leadership is exercised

While there were several things held in common (particularly 'trust' and 'taking responsibility') with the staff, patients unsurprisingly, considered leadership from a different position, based upon how they themselves had experienced a specific episode of care. One woman, who had had a previous bad experience in the same Trust in which she was now a patient, said:

Well somebody taking responsibility really for erm you know your care, erm especially. I keep going back to the same example but you know someone being responsible for not reading through my notes and if someone had taken that leadership erm and actually said 'right I'm going to look through

these notes', you know they would have obviously seen what they had to see and so basically yeah I think there is a lack of leadership.

The emphasis was on wanting the leader to take responsibility for patient care in contrast to poor practice whereby notes were not read. It was taking responsibility, and reassuring the patient that they were taking responsibility, that could be experienced by patients as good leadership.

Another patient similarly suggested that in their exercising of leadership, the clinical staff need to make sure that they were seen to be acting in the patients' best interest. For example:

When they're explaining their-selves, they do explain their-selves and what they're thinking. And they do tell me like the 'ifs' and 'buts' blah blah blah about this certain thing, but then one says something and [another] one says something else but they do explain themselves and what they're on about.

Also, another patient indicated that there needed to be one person who held overall responsibility for service delivery:

I don't know how it works hierarchy wise, whether there's like a top doctor or whatever, whoever it is somebody really needs to, you know, take a really ((2)) be sort of, you know, held responsible.

It is perhaps worth noting that the patients overall focused on the role of clinical leadership but saw that as being practiced by an individual rather than in a distributed form. There was a general view that individuals needed to be accountable and accountability equated with leadership.

4.5 What are the characteristics of an organisation that facilitate, or hinder, the process of leadership?

Leadership happens in a context and that context can facilitate or hinder leadership processes (Currie et al., 2009) and the influences of the organisation are particularly acute when the environment is changing rapidly (Goodwin, 2000; Michie & West, 2004) as in the NHS.

One respondent felt they no longer knew 'who was who' in the leadership hierarchy but considered it didn't really matter:

..., here is this model that says here is the Board and here is the chief exec and here is whoever else is up there. And there's this, this and this ... and [a colleague suggested] shouldn't we be transparent all the way through and shouldn't everything link? and I thought, this came up somebody legitimately asked the question that people here need to know what is happening here. Why? Why? I don't care. (Clinical Physiotherapist, T3).

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One senior Occupational Therapist, in the same Trust, on the other hand felt that knowledge of the organisation was important to facilitate leadership at every level so that when:

... people feel they are working as part of an organisation that's working for something, as part of a team and are appreciated and valued as part of that and are working for someone as well who feels what they are doing is worthwhile, I think that patient care will be of better quality.

This respondent was also convinced that supervision was part of the process by which an organisation facilitated both leadership and good practice in patient care. *"I have once a month supervision, like set time for supervision so I think that is really good."*

Furthermore, supervision and informal contact with peers facilitated effective distributed leadership which impacted across the organisation: *".. you can go to people informally, your peers erm whenever it's quite flexible like that and even if you're a senior like me you think 'hang on I don't know if I'm on the right track here so am I missing something?' You can just go and speak to you team about it or one of our colleagues downstairs or whatever if you want to.*

More dramatically a senior clinical leader suggested that leadership is facilitated in 'moral' organisations:

A²²: So one thinks they are better than the other, so the seven deadly sins basically...pride, the other one is gluttony, which means excess...one can never have enough, for the sake of it, and then just goes beyond, you know, one million, two million, you know, which kind of greed isn't it...excess basically, and also rushing is in there, doing things too fast. A good system will reduce its workload, yeah? The NHS has a thing of needing to do more and more, erm anyway, I don't know whether you find this useful or not, so greed, gluttony, there's rushing, and then jealousy, which is really envy, which is really competition.

Q: Yeah

A: You need to get rid of competition, and I will tell you in a moment what could replace it, which is basically team work, team work and kindness; how you get on with each other...anger is on the list. Anger is, is blame, and the opposite is blame free culture.

Q: Yeah

²² Q = question, A = answer.

A: Or forgiveness if you want, so you need to forgive mistakes, and you know you will be forgiven...and, erm...erm...next one is laziness, that's obvious, that's hard...people either have it or not, but laziness is joylessness, you need to make sure people enjoy it, and diligence, yeah? So there needs to be something in place of ...and we have that now with trust away days and things like that, but you have to have somebody dedicated to making people understand it's about having fun

Q: Yeah, yeah

A: working is about having fun...yeah? And then its... which comes really from up here, it's just an, an, yeah, can't have enough...which is also, it's also, the opposite is erm...do not take more than you can, do not take more than you need...and that is quite a moral stand ground, more than you need...for everyone

Q: Yeah

A: and if you employ that rule, then the whole organisation becomes so successful that there's masses of money left over ... Everything works well...the problem is everyone doesn't understand that, and believe in that, and then there's a difficulty...so that's moral high ground, very moral high ground, but if you go along those, you actually have all the features of leadership.

For this respondent the organisation needs to focus on patient care, treating patients *and* staff with 'kindness'. This is counter in his view to the process of setting targets for service delivery and organisational growth (or survival) and thus competition between organisations and competition between individual staff or staff teams, which is a force that (it seems) promotes the wrong kind of leadership (Kuokkanen & Katajisto, 2003; Sambrook, 2007). Furthermore, supportive teamwork and 'forgiving' mistakes and preventing the 'blame game' enhances socially and emotionally intelligent leadership distributed responsibility across the organisation and enhancing the culture and climate (Riggio & Reichard, 2008) .

Another senior medical leader and manager (T3) reinforced this idea:

I think the ethos within the hospital, is one that encourages people to develop and grow, and deliver good quality care, you know, so, I mean I think wherever it comes from it is enabled within this organisation, and it works very effectively. One of the features that enables that to happen...it's firstly being an organisation that attracts good people to want to work here in the first place. So you get high quality people applying for the position, be it in medicine, or managing, or nursing or any of the other professions By and large, we're fortunate in that. And that's partly due to the reputation, and partly due to the [location] but I think the ethos that comes

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from the leadership makes it desirable to be here. Erm...so it attracts the right people in, it then enables, it doesn't put the brakes on, it doesn't try to control people too much.

Thus, organisational performance and culture/climate were 'enabled' through a cycle of encouragement, good practice, reputation and a supportive and 'hands-off' approach to leadership. This suggests concerted action, leader/follower engagement and emotionally supportive behaviours at all levels. That the physical location of the hospital is attractive is perhaps but one factor in this equation, although a central location makes it possible to draw on a wide range of staff as opposed to a location which is in a small town or distant suburb.

It is not just features of the organisation itself that impact on leadership. Organisations reflect changing discursive constructions of leadership and the values that underlie what it means to be effective as a leader in that place at that time (Ferlie & Shortell, 2001; Lansisalmi, 2006; Michie & West, 2004; Scott, Mannion, Davies, & Marshall, 2003). As demonstrated in Chapter One theories of leadership have developed and different approaches have become significant at different times as witnessed by the shift from promoting and studying transactional, charismatic and heroic leadership styles to the contemporary emphasis on forms of distributed, networked and transformational leadership (Bryman, 2004; Butterfield et al., 2005).

One dramatic change over the past twenty and more years has been the image of the medical consultant in the public psyche. Thus the 'heroic' leadership of Sir Lancelot Spratt has been firmly (it seems) replaced by the team work in the TV series *Casualty* or *Holby City*. However the image of the rebel Dr. House (played by Hugh Laurie in an American TV series) is described as 'unorthodox' and 'radical' but most definitely a medical hero. Is this the type of leader that some might still long for? While the following comment was atypical of most people's definitions of what makes or fails to make a good leader it raises some interesting points about the contemporary regulatory discourses on leadership. Thus one participant said of another²³:

Now (Dr.) David is a really eccentric so he is not what you would naturally call a leader, erm ((1)) but people are really respectful... Because he really cares for patients ...And if he finds a junior doc, or nurse or anyone who is being unkind to an elderly patient then he is down on them like a ton of bricks but his, his patent commitment to medicine and clinical care just inspires admiration ...And great affection hopefully. But he is very odd. Yes. Erm, so he is like a one off so again there is no single person, you

²³ No identifying information is appropriate here.

know there are, there are, there are different leadership styles which are appropriate in different situations but David of course could never be a chief exec, he just wouldn't be able to do it, so he would be hopeless there.

On the surface this might be explained as a judgement based on 'evidence' and a job description. However, focusing-in on the discursive and regulatory practices with which this extract engages, a different view can be taken. The respondent here, being asked to describe the qualities of leadership, begins by suggesting that taking patient care very seriously is 'eccentric' and the person who does that is a 'one off' and 'odd'. Paradoxically (it is suggested) David inspires affection and admiration but despite the variety of leadership styles David would never make it to be CEO. Whether or not this is the case is irrelevant here because what is at stake are the ways in which discourses around 'leadership' and the qualities of the 'leader' *regulate conduct* setting normative behaviour through the discursive practices. There is little doubt that David would have been considered a leader (perhaps a leader in his field) during a different period when hospitals were smaller and perhaps when there was less specialisation in management.

A learning organisation?

The NHS has declared itself to be an organisation dedicated to learning for at least the last ten years and certain values underlie this declaration (see Davis and Nutley, 2000). It means that:

Although learning is something undertaken and developed by individuals, organisational arrangements can foster or inhibit the process. The organisational culture within which individuals work shapes their engagement with the learning process (p. 998).

In some cases the exercise of leadership clearly facilitated the (potential for) learning and learning facilitated leadership, while in others it did not. The facility for leading change in NHS Trusts is critical and developments in the role of nurses from a range of specialties to support leadership and learning have provided exemplars of how some organisational arrangements support leadership (Bellman, Bywood, & Dale, 2003; Doherty, 2009). However, some have argued that continued changes, the market as a driver and the complexity of the NHS might militate against whole system learning (Sheaff & Pilgrim, 2006). Questions have also been raised about the potential of the new generation of leaders who are expected to be inspirational, drive change and support learning (Phillips, 2005).

One capacity manager, for instance, was very clear that leadership was about enabling appropriate learning and the development of skills:

... probably more about empowerment and not necessarily of oneself but of others. So I think that indeed you need to feel empowered yourself, but I think that leadership, good leadership is about empowering and supporting those people who are not in power so that they are equipped with the skills that are required. some of it is actually around learning, it is about what stage they are at in terms of their learning curve.

This is not only a statement about distributed leadership but about a version of a transformational leadership that transcends individual leaders and requires an organisational culture that both supports individual learning and targeting individuals to ensure, that their learning is recognised and ongoing (Burke et al., 2006; Conger & Kanungo, 1988; Kuokkanen & Katajisto, 2003).

The respondent continues with this theme in a sophisticated, and it seems heartfelt, way:

But I think that sometimes that [learning] is not always consolidated, even those people that have been in that position for years. I think, it is more about the people actually understanding²⁴ what they have done, and almost sometimes talk it through, in basic detail about why they have got to the decision they got to. But just because you have been in a position for a long time doesn't necessarily mean that you have actually learnt erm and you may only then go up to a certain stage in my opinion in terms of your whole learning so then they may be stuck in, not novice, but in that middle stage rather than the expert. Which we would hope that most people would get to.

This suggests that organisations need to be vigilant and to constantly invigorate their members. For the respondent quoted above, an organisation that allows people to stop learning is one in which leaders and potential leaders stagnate (at their peril) (Mark & Scott, 1991).

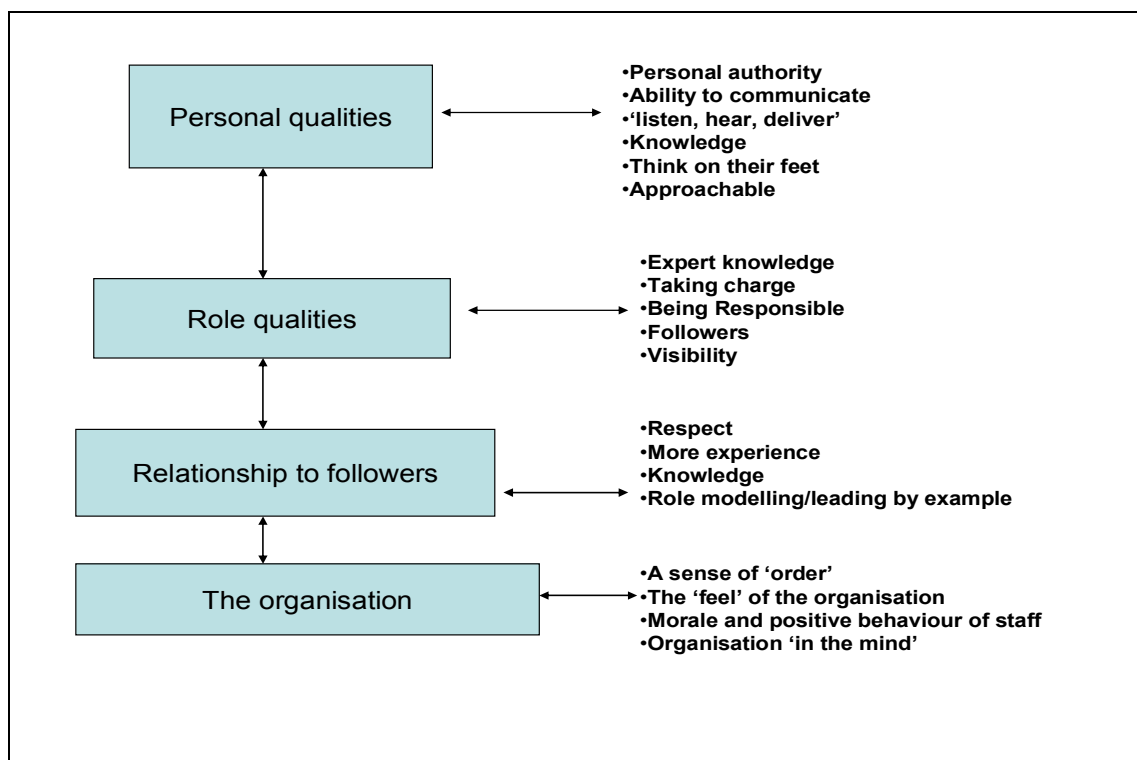
As we discuss again in Chapter Nine, the multi-disciplinary team presents an ideal opportunity for observing leadership (good and bad) and examining the ways in which these teams adhere to organisational norms which might support or inhibit learning (Burke et al., 2006; Day et al., 2004).

One senior non-medical clinical manager in a different Trust also took up the theme of learning and empowerment and specifically how it links to good patient care (Burke et al., 2006; Doherty, 2009; Kuokkanen & Katajisto, 2003).

²⁴ The transcriber who was also the interviewer made it clear that these words were emphasised by the respondent.

... [leadership] is about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is we worked with 'Training and Development' and we came up with a specific programme that was aimed at empowering them [all administrative staff] to improve their service area etc etc and also provided them with some skill sets that they probably didn't have prior to that.

Figure 11. What makes a leader?



4.6 Conclusion

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

Nonetheless, when asked to describe and define leadership, various stakeholders at all levels of the organisation have a view some of which coincides with contemporary NHS discourses and some which seems directly at odds with what the NHS is trying to achieve – that is, to support both

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distributed and transformational leadership that are seen as successful in ensuring effective patient care. However, it is clear that individual personalities and the impact of particular leaders cannot be taken out of the equation.

Leadership is experienced as distributed and transformational but there remains a belief that charismatic and transactional leadership also have their place in complex organisations. While vision is important, no vision can be achieved unless the leader takes 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. Supervision, peer support and informal advice are part of the emotionally intelligent distributed practice of leadership. 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.

In summary, the main ideas that emerged from the respondents' views of how leadership was exercised and experienced were it was about:

- Personal authority
- Ability to communicate
- 'listen', 'hear' 'deliver'
- Thinking on your feet
- Being approachable

Leadership can be exercised in a number of ways and qualities of leadership are seen to reside in different but interlinked 'places'. For example, it is clear that some people are perceived more than others to have the personal qualities that make them a leader, including being able to listen, deliver and be approachable (see Figure 11 above). The assigned/legitimated leadership role is also perceived to be an important quality for a leader, which is interesting, when thinking about the distributed leadership model and particularly the idea of concerted action where people have to work together to 'lead'. This links further to the qualities inherent in leader-follower relations identified as fundamental to the stakeholders interviewed here.

Finally, leadership means holding a sense of the organisation in mind. That is the mental model held by the leader through which they mediate and regulate their vision and actions as leaders, but it also refers to the leader's understanding of morale and the 'feel' of the organisation in which they are working, which itself regulates and constrains the possibilities for growth, development or atrophy.

In this chapter we identified some of the evidence of how organisational contexts evolve and the relationships between organisational culture/climates and the ways in which leadership is practiced. This will be developed across the next four chapters.

5 Leadership and Organisational Climate

5.1 Introduction

Despite its North American origins, where the health care system is fundamentally different from the NHS, Stringer's focus on both leadership and climate nudged us towards choosing an adaptation of his organisational climate survey for this study. We also identified an 'awareness', as he puts it himself, that "*People working in health care systems play drastically different roles that are more diverse than the roles typical in schools and businesses*" (Stringer, 2002, P. 188).

Through adapting the OCS we also captured demographic information from our participants as well as a data about satisfaction with the leadership one receives from his or her immediate supervisor²⁵. Thus, while on the whole Chapter Four dealt with general descriptions, definitions and values, in this Chapter we focus on specific relationships between individuals and the individual and the perception of their organisational climate.

The additional contribution the survey data makes to the overall aims of the study is to relate perceptions of leadership and management directly to organisational climate, thereby providing a triangulation with the story - telling and focus groups to explore the characteristics of organisations that facilitate or hinder leadership and service delivery.

5.2 Results

5.2.1 Normality of data

When normality was examined the KS-Lilifors test was found to be significant over all the scales, indicating that the data were not conforming to assumptions of normal distribution. However, inspection of the histograms and boxplots were found to present an acceptable level of

²⁵ Our version of the survey questionnaire is appended.

normality. Due to the nature of the data it was decided not to transform it, but rather to interpret the results which rely on the assumption of normality with caution.

5.2.2 Cronbach's Alpha

In order to check the reliability and internal consistency of the OCS in this setting we used Cronbach's Alphas (Cronbach, 1970) (See Table 2).

As can be seen from Table 2, the three dimensions of '*commitment*', '*support*' and '*recognition*' were considered to be high on reliability as their scores ranged from .69 to .74. These would be considered acceptable-good level of reliability (George & Mallery, 2003).

In contrast, the three dimensions '*structure*', '*standards*' and '*responsibility*' were low on reliability. This low reliability may be explained by confusing wording of the items, or it is possible that the individual items did not correspond well to one another in this sample. As such it was decided to remove the '*responsibility*' scale from the rest of the analysis. A further check to see whether '*structure*' and '*standards*' could be improved by removing single items, did not show any improvement to the alpha so these were retained in their original form.

Table 2: Cronbach's Alphas for the six dimensions

Scale	Cronbach's Alpha
Commitment	.74
Support	.72
Recognition	.69
Structure	.57
Standards	.43
Responsibility	.14

When managerial dimensions were examined for reliability' these were found to be very high ranging from .86 for '*recognition*' to .79 for '*commitment*' and '*responsibility*' (See Table 4).

Table 3: Cronbach's Alphas for the six Managerial dimensions

Scale	Cronbach's Alpha
Managerial Responsibility	.86
Managerial Recognition	.83
Managerial Standards	.83
Managerial Support	.81
Managerial Commitment	.79
Managerial Structure	.79

Overall scores for organisational dimensions

In order to derive the scores for individual dimensions, all the items on each dimension are summed [this is after all the negatively worded items were reversed].

The following were mean and standard deviations across all the six Organisational scales:

Table 4: Mean and Standard Deviation

Scale	Mean	Std
Commitment	14.82	2.86
Support	14.06	2.80
Responsibility	9.93	1.73
Structure	9.01	1.88
Recognition	8.42	2.55
Standards	8.36	1.69

Stringer, et al (2002) suggest an analysis of percentages of respondents who scored above the mean. In our analysis the following percentages were found:

Table 5: Scores above the mean

Scale	% above the mean
Commitment	60%
Support	47%
Recognition	49%
Standards	49%
Structure	39%
Responsibility	58%

Stringer offers a method of interpreting these percentages, according to benchmarked ratios collected through their extensive research to validate the tool.

High 'commitment' (60%) – In the current sample, there was a high degree of 'commitment' to the organisation and its goals. This would be typical of professional staff working for the NHS. However Stringer asserts that high 'commitment' needs to be accompanied by high 'support' and high 'recognition' – without these individuals will stop engaging with others in the organisation and their team (p.200). As indicated in Chapter Four engagement is crucial if leadership is to be effective.

High 'responsibility' (59%) – Stringer asserts that 'responsibility' is a difficult dimension to interpret within the health care setting. Effective performance in the NHS requires that procedures be double checked, which in many other contexts would put the role of 'responsibility' in an ambiguous position. However this is not the case in complex clinical settings (or for example in other precision performance occupations such as flying aeroplanes for instance). In the case of the current sample 'responsibility' was high, which is related to high sense of 'commitment', but is confused by the limited 'structure' – it is essential that people are clear about their roles, so that they may take charge and 'responsibility'.

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Moderate 'recognition' (49%) - According to Stringer scores lower than 50% may indicate that participants are feeling unappreciated. In this case there is just under the 50% mark, which translates into moderate agreement about the feeling of being rewarded for one's efforts. Having a high sense of 'recognition' in an environment such as this is of crucial importance for motivation, but 50% is within the normal range set out by Stringer. High 'recognition' is indicative of confidence in the organisations performance/reward ratio but in such a diverse setting as a hospital with a diverse staff group responding to the OCS then different groups with different management and professional/occupational structures would have different perceptions and experiences.

Moderate 'standards' (49%) – there is a moderate feeling of pressure - performance 'standards' and expectations are high but not to the point where they are stressful. This falls within an acceptable range. Considering that many of the 'standards' (targets) are set out by government policies rather than directly by Trust management/leaders it is important for these standards to be realistic and achievable.

Moderate 'support' (47%) – this falls within the low but acceptable range for this scale (45%-60%) according to Stringer's benchmarks. This indicates that there is sufficient unity between teams to approach and solve problems, without overly nurturing so as to discourage individual 'responsibility' and undertaking. Team work within the health care system is challenging because of the interdisciplinary nature of teams which inevitably calls upon different management and professional structures and networks for support.

Low - Moderate 'structure' (39%) – Under half of participants felt there was clarity in terms of their roles, responsibility and authority. On the one hand this means that there are less constraints and a less of a 'jobs-worth' approach, on the other hand though it means that there is (potentially) insufficient clarity in roles and responsibility. In an organisation such as the NHS, this may be a considerable shortcoming and Stringer (p.193) suggests that in a health care environment such as a hospital, one would ideally like to have 'structure' scores above the 70s. This is emphasised because of the complex nature of the hospital environment with so many individuals involved – accountability needs to be very clear. The NHS however has gone through so many changes over the previous ten years that it is inevitable that the 'structure' score would be influenced.

Associations between the six dimensions on the organisational level

Pearson's r was utilised to test the relationship between all the Organisational scales. It was found that the majority of scales showed modest, but significant relationships:

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Table 6: Correlations between the six organisational dimensions

	Standards	Structure	Recognition	Support	Commitment
Standards	1.00				
Structure	ns	1.00			
Recognition	.22*	.47**	1.00		
Support	.17*	.42**	.61**	1.00	
Commitment	.30**	.39**	.59**	.67**	1.00

* <.05

** >.001

As can be seen from Table 6, there are a number of high associations between these dimensions. The highest associations are for 'support' and 'commitment' (.67) 'support' and 'recognition' (.61) and 'commitment' and 'recognition' (.59). In other words, participants are reporting that when a feeling of co-operation within teams is present, this is often accompanied by acknowledgement and appreciation and is further related to a greater sense of dedication and 'commitment' to the goals and aims of the team. By definition, the converse also applies: feelings of isolation are more likely to be accompanied by lack of incentives and disenchantment with the objectives of one's team. This is 'supported by Stringer (p.200).

Satisfaction with leadership

When the *organisational dimensions* were examined in relation to satisfaction with the quality of leadership received from the immediate manager, which was asked as a single item, the scales which correlated most highly were 'support' (.61) and 'recognition' (.52). The weakest relationship was to 'standards' and 'structure'.

Table 7: Correlations between organisational dimensions and satisfaction with Leadership

	R (sig)
Standards	.14*
Structure	.30**
Recognition	.52**
Support	.61**
Commitment	.39**

In order to evaluate the individual contribution of each of the organisational dimensions to the overall 'satisfaction with leadership', a regression analysis was conducted, which included all items which were found to correlate significantly with satisfaction, namely 'standards', 'structure', 'support' and 'commitment'.

The total variance accounted for by the model was 40% (Adjusted $R^2 = .38$) therefore variability in 'satisfaction with leadership' is moderately accounted for by this model.

Specifically, of the five predictor variables the two which were found to predict the outcome variable of 'satisfaction with leadership' were 'support' and 'recognition', 'support' being the biggest contributor with a $B = .52$ ($p < .001$) and the other predictor was 'recognition' ($B = .27$, $p < .001$). The other variables were not significant. [Appendix 1 of this chapter].

In other words, feeling supported by one's team and believing that rewards are appropriate to effort, accounts for a significant proportion of an individual's satisfaction with leadership.

Correlations between dimensions on Managerial level

The second part of the questionnaire asked about individual experiences of management. All six dimensions on the managerial level were highly correlated with each other, with strong correlations ranging from $r = .71$ ($p < .001$) between 'structure' and 'responsibility' to a correlation of $.84$ ($p < .001$) between 'commitment' and 'standards'.

Table 8: Correlations between dimensions on Managerial level and Satisfaction with Leadership

	Manager Recognition	Manager Support	Manager standards	Manager structure	Manager Responsibility	Manager Commitment
Manager recognition	1.00					
Manager support	.83**	1.00				
Manager standards	.82**	.83**	1.00			
Manager structure	.73**	.78**	.79**	1.00		
Manager responsibility	.84**	.79**	.79**	.71**	1.00	
Manager commitment	.79**	.83**	.84**	.82**	.79**	1.00
Satisfaction with Leadership	.68**	.76**	.71**	.71**	.65**	.76**

** Significant at .001 level

A single item asked about satisfaction with the quality of leadership received from immediate manager. When this was examined in relation to the six dimensions appropriate to participants' own experience of management practices, it was found to correlate highly and positively with manager 'support' ($r=.76$); management 'structure' ($r=.71$, $p<.001$); manager 'commitment' ($r=.75$, $p<.001$) and 'standards' ($r=.71$, $p<.001$); manager 'recognition' ($r=.68$, $p<.001$); manager 'responsibility' ($r=.65$, $p<.001$);

A multiple regression was carried out to examine the perception of 'satisfaction with leadership', as a dependent variable of management practices. The overall association between management practices and satisfaction with leadership was strong ($R=.80$) with associated variance explained of 63%.

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Table 9: 'Manager' dimensions regressed onto 'satisfaction with leadership'

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	-.054	.226		-.240	.811
Manager Recognition	.001	.039	.002	.025	.980
Manager support	.175	.039	.410	4.501	.000
Manager structure	.060	.027	.177	2.260	.025
Manager responsibility	-.018	.032	-.047	-.559	.577
Manager commitment	.165	.056	.278	2.948	.004
Manager standards	.017	.056	.029	.310	.757

In this case, it was manager 'support' which best predicted satisfaction with leadership ($B=.41$, $p<.001$), next biggest contributor was management 'commitment' ($B=.28$, $p=.001$) and management 'structure' ($B=.177$, $p=.025$). In other words, a large proportion of feeling satisfied with one's leadership, pertained to feelings of being supported and the degree to which one's manager inspires and exudes 'commitment' to common goals. A further important element in the equation is that of 'structure' – where roles and responsibilities are clear, it is associated with greater satisfaction with leadership.

As the biggest predictor of 'satisfaction with leadership' was manager 'support', a further regression was done to look at what organisational dimensions related to having good managerial 'support'.

All the organisational scales were inputted into a regression, excluding organisational 'support', with managerial 'support' as the outcome variable. The following was found:

In total the model accounted for 35% variance in the outcome variable (Adjusted $R^2 = .35$). There were two contributors to the model: the strongest one was 'recognition' ($B = .44$, $p < .001$), i.e. the more employees feel that the organisation rewards and recognises their efforts, the more they feel supported. The other contributor to managerial 'support' was 'commitment' ($B = .20$, $p = .008$). [Appendix 3 of Chapter Five]

These findings indicate that organisational 'recognition' and 'commitment', are organisational climate dimensions which most affect the outcome of managerial 'support', and this in turn has the greatest effect on individual's sense of satisfaction with their leadership. This again corresponds with data discussed in Chapter Four highlighting the importance of the feel of an organisation that provides support at all levels.

Regression of all dimensions onto Satisfaction with leadership

When all the variables previously shown to be significant to Satisfaction with leadership, were entered into the model, from both the organisational and managerial dimensions, namely manager 'support', manager 'commitment' and manager 'structure' as well as organisational 'support' and organisational 'recognition', the following picture emerged:

There was a high degree of variance accounted for by the model - 65% (Adjusted R^2). The model was found to be significant ($F = .80.65$, $p < .001$).

The variables which remained significant, in order of their contribution are: manager 'support' ($B = .34$, $p < .001$), manager 'commitment' ($B = .33$, $p < .001$) and Organisational 'support' ($B = .13$, $p = .03$).

In other words, satisfaction with leadership, in this sample, was predicted by a greater perception of 'support' from management, a feeling that managers demonstrated their 'commitment' to achieving common goals and an atmosphere of 'support' and team-work within the organisation.

Organisational and Managerial dimensions

In order to investigate the relationships between organisational and managerial dimensions, a correlation was performed between all of these variables (Table 10). It was found that:

There were strong correlations between manager and organisational 'recognition', and manager and organisational 'support'. There were moderate correlations between manager and organisational 'commitment' and 'structure'. And there was a weak correlation between manager and

organisational 'standards'. In other words, where the dimensions were correlated weakly or moderately, we can identify that 'standards' of the organisation do not necessarily exist at the same level of managerial 'standards'. The same relationship goes for 'structure' – having organisational 'structure' does not predict clarity in roles, as espoused by one's manager. There is a greater degree of correspondence between organisational and manager 'commitment'. When we look at 'support' and 'recognition', we find that both these dimensions tend to be closely related – one is more likely to feel that both are high, or both are low.

Table 10: Relationship between managerial and organisational dimensions.

	Organisational Recognition	Organisational Support	Organisational standards	Organisational Structure	Organisational Responsibility	Organisational Commitment
Manager recognition	.60**					
Manager support		.65**				
Manager standards			.25**			
Manager structure				.34**		
Manager responsibility					-.02 ns	
Manager commitment						.48**

The significance of Role

The largest group of participants was nurses (31%), then clerical staff (14%), managers and porters (14% each). Doctors/consultants/physicians (11%), other allied professionals (10%) and 'support' staff (6%).

When looking at satisfaction with leadership the following findings were apparent: High satisfaction with leadership was reported in total by 54.3%

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(n=113) of staff. Although there were no significant differences by work role, it can be seen that consultants and doctors reported the highest satisfaction (74%), followed by managers (61%). It can be seen that clerical workers had the least high satisfaction (41%), followed by 'support' staff and other allied professionals (54%). This is significant in terms of the hierarchy within the organisation – the higher the position the more satisfied one is with their leadership.

Table 11: The significance of role and satisfaction with leadership

	n	% positive responses about satisfaction with leadership
Managers	28	60%
Doctors	23	74%
Allied professionals	22	54%
Nursing	65	49%
Support staff/Assistants	13	54%
Clerical	29	41%
Porters/maintenance	28	57%

A further examination of organisational dimensions according to role using a one way ANOVA, revealed the following:

In all there were large differences between respondents in terms of their role, however only two scales exhibited differences which reached significance. The first was 'commitment' – doctors/consultants were found to rate significantly higher than allied health professionals on this scale (mean difference = 2.86) ($p < .01$).

The second was 'recognition' – it was found that doctors were much more likely to rate higher than clerical staff on this scale (mean difference = 2.41) ($p < .01$). Both these findings were apparent even after using the Bonferroni correction.

Comparing doctors (all grades) in Trust 1 and Trust 3

An examination of the responses on the item looking at 'satisfaction with leadership' amongst doctors revealed that doctors at Trust 1 (n= 13) had lower satisfaction (Mean = 3.38, std = 1.38) in comparison to doctors at Trust 3 (n= 10) (Mean = 4.20, std = .42). This difference (.81), whilst small, was found to be approaching significance (t = -2.003, p = .06).

While it is not possible to make an objective comparison between doctors from Trusts 1 and 3 from the qualitative data, there is more evidence in Trust 3 of doctors being both emotionally engaged with both junior doctors and other members of multi-disciplinary teams than in Trust 1 and with distributed leadership. As will be evidenced in Chapter Six doctors and other staff considered 'management' as bureaucratic and distant rather than engaged.

Gender

There were no differences between men and women's scores on 'satisfaction with leadership' (t = 1.71, p = .08).

When examining differences between men and women on the organisational dimension it was found that only one dimension, 'recognition', was perceived significantly differently (t = 3.42, p<.001). Men perceived there to be greater 'recognition' (mean = 9.55) compared to women (mean = 8.13). All other dimensions were not significantly different (see Chapter Eight).

When examining the gender differences on managerial dimensions of the OCS there were trends approaching significance in terms of differences between the genders on managerial dimensions, but these did not reach significance when multiple comparisons were taken into account:

Manager 'recognition' (t = 1.91, p = .06)

Manager 'responsibility' (t = 2.10, p = .03)

Manager 'standards' (t = 2.33, p = .02).

5.3 Conclusions

The difficulty obtaining data across all three participating Trusts has not limited the value of using the OCS to triangulate the qualitative data, particularly because a) the OCS gathered information from staff groups who were not represented in the focus groups, shadowing or story-telling

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interviews and was able to identify generalisable predictors of satisfaction with leadership and management practices, and b) the OCS data captured information from specialty groups outside those involved in the participating Units from which qualitative data was collected.

What emerged here was that on the whole, the same climate variables are important in predicting satisfaction with leadership. Within the organisational domain these are 'support' and 'recognition' while predictors of 'satisfaction with leadership', within managerial practices, are manager 'support', 'commitment' and 'structure'.

Overall, therefore, 'satisfaction with leadership' was highly accounted for by manager 'support', manager 'commitment' and organisational 'support' – i.e. these were the 'ingredients' in this sample which were highly related and were able to predict satisfaction with leadership. This suggests once again that managers/leaders were effective if they engaged with followers and that organisations that supported distributed leadership and emotional engagement were more likely to support effective leadership (see Chapters Four and Six in particular).

In terms of role, the higher the position in the organisational hierarchy the more satisfied a person was likely to be with leadership. This was not necessarily the case though across all organisations in the study. The exploration of the case studies in Chapter Seven – where authority and leadership are discussed – reveals how some of the more senior leaders in organisations found themselves to be highly dissatisfied with leadership in other sectors of their Trust, if there was resistance or negligence of their authority.

Differences in gender were only apparent in terms the organisational dimension 'recognition' – it was only on this scale where women scored significantly lower than men. This may say something about equal opportunities and equal pay for equal work, but it might also relate to perception of 'recognition' between women and men discussed and exemplified in Chapter Eight below.

The overall importance of constructs such as 'support' and 'recognition' across the climate of an organisation, and management practices which demonstrate support and commitment, provide further evidence of the importance in engagement and (probably) emotion (including EI and SI) in an organisation.

6 'Organisation in the Mind': Transmission of Leadership and Organisational Context

6.1 Introduction

Leadership in any organisation is understood in a specific context by those involved as either leaders or followers, and as shown in Chapters Four and Five concepts such as satisfaction, support, responsibility, vision and communication among others are described and evaluated within a cognitive or mental framework within which the organisation itself is understood. It is through making sense of the organisational context that leadership and followership may be enacted and transmitted.

We saw how members of organisations *necessarily* hold in their mind fantasy/imagined understandings or images of the *system* (Morgan, 2006). This informs how they work in, relate to and talk about their organisation, based on their perceptions of their own and others' place and role within the system. For example, it is common to hear employees talk about how 'you can never get management attention in this company' or 'we are all dedicated to putting patients first here' (Armstrong, 2005; Morgan, 2006).

Similarly, the participants who completed the OCS held a view of the leadership and management in their organisations, in order to think about the various ways in which their work was recognised, supported and so on both generally and by their managers. While the focus in that case was upon on measuring the impact of organisational climate and thinking about a relationship with a specific manager, those who completed the survey would have had to hold a perception of what was happening in their department and the Trust overall.

This is apparent in what follows particularly in the ways 'management' is discussed and taking account of these perceptions provides some evidence about the ways in which leadership is transmitted in these particular organisational contexts and in general. The 'organisation in mind' then involves:

- An 'image' of the organisational structure and relationships within that structure
- A sense of your own role and place within it
- An emotional component
- An awareness at a conscious and/or unconscious level of important information below the surface

6.2 Organisation in the mind

The concept of the 'organisation in the mind' was a model developed originally in the early 1990s by organisational and group relations consultants working at the Grubb Institute, the Tavistock Centre and the Tavistock Institute of Human Relations, to refer to what an individual perceives mentally about how organisations, relations in the organisations and the structures are connected. *"It is a model internal to oneself ... which gives rise to images, emotions, values and responses in me, which may consequently be influencing my own management and leadership, positively or adversely"* (Hutton, Bazalgette and Reed, 1997, p. 114 quoted in Armstrong, 2005, p. 4).

In other words, when we talk about our colleagues, guess what the senior management are doing/going to do and have fantasies about how well we fit, or don't fit, into the structure or system we do so in the context of the organisation we 'hold' in our mind which may or may not relate to that which other members of the organisation hold (Pols, 2005).

Organisations are experienced cognitively and emotionally by their members when they think about how their organisations work and are structured (see Lewin, 1947; Armstrong, 2005; Morgan, 2006). As Stokes (1994) explains it, everyone carries a sense of the organisation in their mind but members from different parts of the same organisations may have *"different pictures and these may be in contradiction to one another. Although often partly unconscious, these pictures nevertheless inform and influence the behaviour and feelings of members"*. (p. 121)

Hutton (2000) talks about it as *"a conscious or pre-conscious construct focused around emotional experiences of tasks, roles, purposes, rituals, accountability, competence, failure, success"* (p. 2). Morgan suggests that an organisation may serve as a 'psychic prison' in that the:

...patterns and meanings that shape corporate culture and subculture may also have unconscious significance. The common values that bind an organisation often have their origin in shared concerns that lurk below the surface of conscious awareness. For example, in organisations that project a team image, various kinds of splitting mechanisms are often in operation, idealising the qualities of team members while projecting fears, anger, envy, and other bad impulses onto persons and objects that are not part of the team (Morgan, 2006, p. 226).

Some of this is apparent when talking to NHS staff about the leaders at various levels of their own Trusts and the NHS overall as was seen particularly in Chapter Four.

6.2.1 Organisation under the surface

So, when the respondent immediately below talks about the leader who has a 'really good understanding of the organisation or team' what exactly does that mean? How does that understanding come about? What do the team hold in mind about that particular leader?

Leadership is someone who has a really good understanding of the organisation or team, erm where it's going and where they imagine it to be going, so that sort of vision as well for their team, I think. (Lead Clinical Non-medical Health Professional, T3)

This respondent, referring to the (frequently used) concept 'vision', also identifies this with the *imagination* the leader holds about where the organisation is going. This is not simply a matter of guesswork. It is an intellectual/cognitive and *emotional* sense of an organisation. Indeed to take this slightly further, as Gabriel and Schwartz (2004) propose "... *what goes on at the surface of an organisation is not all that there is, and ... understanding organisations often means comprehending matters that lie beneath the surface*" (Gabriel and Schwartz, 2004, p. 1).

Although not necessarily (in fact mostly not) made explicit, even the most clear thinking senior members of organisations hold an image of the organisation in mind, expressing their fantasy/belief/perception of the organisation based on conscious and unconscious knowledge (Halton, 2007; James & Arroba, 2005). So for instance for this CEO leadership is understood emotionally as it is:

... about the feel of the organisation and what it feels like in terms of how it delivers patient care. Yeah, erm. I can best illustrate that, and interestingly we were thinking about this earlier this morning, so as a group, the executives, we were talking about it. When you walk onto a ward a hospital ward and there is real leadership on that ward, you walk in and there are a number of signals that are given off, which give you a feel. Erm the place looks organised, it has a welcoming feel, the nurses on the ward and the clinical staff greet you as they come into contact with you. They know you from the previous interactions that you have had and when you sit there and listen to what is being said on the ward they will know that the patients, the visitors on the ward, the families that are coming in the junior doctors who are in there in that environment and all of that has a feel²⁶ of a well led ward. (CEO)

²⁶ Respondent's emphasis.

The environment of the well led ward (unit or organisation) is implicitly and unconsciously identified by all who engage with that organisation. The staff communicate effectively (visually, verbally and emotionally) so that the information required is passed on through managers, clinicians to colleagues, patients and relatives. This account, which preceded the extract that focused on strategy, directed to the best patient care for the greatest number of patients, expresses his ideas at an *emotional* level. He also suggests his senior colleagues agree with this. Signals are 'given off', you can 'feel' the organisation and how it delivers patient care and there is a 'welcoming feel'. He also talks about 'empirical' evidence in that staff know the patients, the ward looks organised he remains convinced that there is a 'feel of a well led ward'.

From a slightly different position, a deputy CEO quoted below also holds in mind the fantasy that a manager might think that they run an institution but that such a fantasy might get the manager into trouble. He is suggesting a vision of an organisation in which a manager has very little control, and proposes the need to gain a sense of *reality* by recognising this and taking responsibility for this organisation (Hirschhorn, 1997; Porter-O'Grady, 1995). His perception, again which has an emotional component, is one of a stressful contradiction – responsibility without power or control (de Vries, 2000).

The minute, as a manager, you start to think that you do [run the service without accountability]... erm then you're in trouble. Unfortunately you have still got the accountability for the service but you have very, very little control so it's a whole different leadership and managerial skill that is required I think in terms of recognizing that you have no control over what happens you know across this organisation across the N,000 beds here at [Trust], the thousands of people that go through the organisation everyday, what happens to them is completely outside of my control but if anything goes wrong it is absolutely my responsibility. And that is quite difficult.
(Deputy CEO, T 1)

6.2.2 Structure in the mind

Most recently Laughlin and Sher (Laughlin & Sher, 2010) take up a version of this concept which they name the 'structure-in-the-mind' in their analysis of developing leadership in social care. They reassert, in their model, that not only the local stakeholders (staff and service users) have a sense of the organisation in the mind when considering, for instance, a particular Trust, but the range of stakeholders includes government bodies and service commissioners (in the round). They propose an inter-relationship between perceptions of communications from services (e.g. 'that you [management] don't listen and/or understand') and perceived communications from 'Head

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Office (or government or other bodies that control resources and practices) which include for example 'just do it' 'we know better' and 'be rational'. (p. 9)

What is significant here, in the context of NHS leadership, is that the organisation and/or structure *in the mind* is where the leader and followers 'meet' emotionally as, similarly, do the various levels of leadership and governance bodies. It is a kind of 'virtual' space.

An example of this structure in the mind might be seen through the increase in stress for NHS employees detailed in a recent report by NICE (the National Institute for Clinical Excellence²⁷) where it was revealed that staff absence caused by work related stress costs the UK over £28 billion. It was proposed that a poor working environment characterised by bullying and poor management was at the heart of this problem²⁸ (Edwards & O'Connell, 2007). In a context where there is distributed leadership and a highly trained professional, multi-disciplinary workforce, such mismatches in how to run organisations and departments that lead to staff stress in these ways (e.g. being bullied and bullying) evoke questions about what is happening in the space between those who plan, govern and resource NHS Trusts and those who carry out the work. The emotional elements of leadership and followership relations seem to be neglected to everyone's disadvantage.

The idea of the organisation in the mind raises important questions of how leadership (good and bad) is transmitted across the NHS and its Trusts (Harrison & Carroll, 1991; Walsh & Ungson, 1991). Organisational cultures and climates are reproduced over time despite the coming(s) and going(s) of CEOs. However, organisations also *adapt* and *evolve* as a response to changes in leadership and outside influences (Morgan, 2006).

In what follows we explore the characteristics of the organisations studied here that facilitate or hinder the transmission of leadership through the Trust as a *system* through which culture (e.g. principles and values about leadership) might be transmitted (Hatch, 1993; Schein, 2004).

²⁷ An organisation established to oversee and provide guidance on clinical practice and cost and clinical effectiveness.

²⁸ See news.bbc.co.uk/2/hi/health/8343074.stm and NICE web-site which has a power-point presentation.

6.2.3 Transmission of leadership and Organisational Contexts

What is held in mind about an organisation is often influenced by the formal and informal networks (Balkundi & Kilduff, 2005, 2006; Goodwin, 2000) which characterise complex adaptive systems. Network cognitions in the minds of leaders are embedded in the whole organisation and the inter-organisational linkages formed by leaders as representatives of organisations (Balkundi & Kilduff, 2005).

The context of the NHS seems to have become increasingly complex and chaotic (Currie et al., 2009) which, coupled with a sense of widespread unethical managerial practices, has raised questions about how leadership practices are transmitted through NHS organisations (Bowie & Werhane, 2005; Collier & Esteban, 2000; Huston & Brox, 2004). Bullying and poor management are in part at least a consequence of not taking the emotional context of organisational life seriously (Ashkanasy, Jordan, & James, 2003; Cocco, Gatti, Lima, & Camus, 2003; Johnson, Cooper, Cartwright et al. 2005; James, 1999; Hutchinson, Vickers, Jackson & Wilkes, 2006).

While there is no excuse for bullying or any other unethical management practices, it is necessary to understand what precipitated the relatively recent change in culture which has exacerbated (reports of) bullying. One factor has to be the extent to which top-down, politically driven changes have been forced through the NHS system and other public institutions and the impact that the drivers of these changes have upon the senior levels of management consciously and unconsciously (Christensen & Laegreid, 2003; Dent, 2005; Gabriel, 2004).

These recent developments have influenced the psychological and emotional aspects of working in teams, groups and organisations (Liden & Antonakis, 2009; West & Anderson, 1992) and by implication influenced possibilities for innovation in leadership and the authority of leaders and workers (Lewin, 1947; Miller, 1993; Carter, Garside, & Black, 2003; Hirschorn, 1997; Fineman, 1994, 2000; Payne and Cooper, 2001; Vince, 2002; Carter, Garside, & Black, 2003). Understanding the *context* of leadership, therefore, has become increasingly important as has the need to understand how that context is part of a *system*.

Post industrial (or postmodern) systems (Rose, 1991) have been reconsidered (or 're-described') relatively recently as 'complex adaptive systems' (Collier & Esteban, 2000; Dooley, 1997; Schuster, 2005). Systems that are complex because of multiple interconnecting relationships are liable to evolve through making new connections that increase their complexity (Collier & Esteban, 2000). In the NHS, even though change is structurally driven, the (perhaps unforeseen) consequences of changes have meant that instead of a command-and-control, top-down hierarchies where in particular

clinicians such as consultants and matrons had previously been seen as 'gods' (as with Sir Lancelot Spratt and Dr. Gregory House see Chapter Four) distributed leadership, networks and different statuses attributed to individual Trusts (e.g. Foundation Trusts with relative independence, Mental Health Trusts which have social care and NHS staff and diverse management practices) have evolved within different structures at all levels for coping with service delivery (see Chapter Nine).

6.3 Open systems theory and boundary management

An organisation that *evolves* like an organism and adapts to its environment necessarily has *porous boundaries* so that it can 'take in' and 'put out' beyond itself. This kind of organism is one that changes, develops and grows. A closed system may feel more secure in that it may not have to accede to unwanted influence or demands, but without taking in and providing for the world outside it will atrophy as with any other closed (minded) system (Morgan, 2006). In this way images and cultures of leadership from outside the boundaries might influence the development of leadership practices e.g. data and ideas from education (Currie et al., 2009; Gronn, 2000; Lumby, 2003)

Systemic thinking is a framework, or tool, for observing the way organisations behave (Schein, 1985; Lewin, 1947; Campbell et al, 1994) which evolved from General Systems Theory, (von Bertalanffy, 1956; Miller and Rice, 1967) and focuses upon concepts related to organisational structure particularly 'task', 'role', 'authority' and 'boundary'. There is also a psychodynamic part of the systemic thinking analysis which links with the conscious and unconscious emotional consequences of the systemic properties and the impact of social and personal factors on the functioning of the organisation (James and Huffington, 2004; Laughlin & Sher, 2010)²⁹.

Morgan (2006) identifies how knowledge and power are accessed and maintained through control of organisational boundaries. 'Boundary' is the term used in open-systems theory to describe the interface between different parts of the organisation and the organisation and the outside world. In the case of the NHS this is the physical boundary to the, for example, hospital building, the wards, the web-site, the reception desk, the

²⁹ This issue is further discussed and explained through object relations theory based on the works of Melanie Klein, Elliot Jaques and Isabel Menzies-Lyth which is outlined in detail in Chapter One and operationalised in the description of the role of obstetricians' anxiety in the delivery of patient care discussed in this chapter and below in Chapter Nine).

telephones, e-mail and so on and also between the different roles such as out-patient/ in-patient, staff /patient, clinician/manager and so on. Most leaders in organisations have the knowledge and abilities by definition to manage and negotiate those boundaries. For example, the senior managers relate to government/NHS/DoH in ways that junior nurses do not, but the senior staff are charged with having to manage the boundaries using knowledge and influence across the boundaries – inside with the staff and patients and outside with government and patient pressure groups. Moreover, as evidenced during the conduct of this project, hospitals merge into Trusts and the porosity or opacity of the boundaries between the different organisations that have come together are central to the functioning of leadership at most levels (see Chapter Seven where the limits of authority are discussed in this context).

Stating this in a slightly different way, this approach to the 'organisation in the mind' takes the *personal* (conscious, pre-conscious and unconscious) level of thinking and links it to the *system* in which that person works (systemic thinking). As any organisation comprises systems (with boundaries, in-puts and out-puts), groups and individuals, it follows that a person's experience of an organisation and *experience of themselves* in relation to others who are in the same organisation make up the culture, climate and everyday dynamics of any organisational context. Thus, our respondents' sense of the 'organisation in the mind' is a valuable concept for understanding how leadership relates to service delivery.

6.4 Images of the organisation

In what follows we explore some of the images 'held in mind' by staff across the three Trusts particularly examining the impact of the organisation in the mind on working collaboratively and the influence of this on service delivery and the quality of patient care that results from staff relations and effectiveness.

To begin, we focus on two specific examples that characterise much of what was said by staff across at least two Trusts:

- images (and fantasies) held about 'management' which highlight the construction of 'authority' in the system and its impact on patient care
- images (and fantasies) held about the 'others' (e.g. colleagues in the same Trust but on a different site or a different Unit) which brings boundary management into play
- how these images (and fantasies) facilitate and hinder the transmission of leadership and service delivery

We employ a critical discourse analysis (CDA) approach to the meaning and processes of leadership and organisation exploring how the organisation/system *looks* to the participants and how this in turn impacts upon the system of providing care for its patients.

6.4.1 'Management' in the mind

As in many organisations, rhetoric about 'management' abounds particularly played out as a 'them/us' dynamic as we demonstrated by separate means in Chapters Four and Five. Furthermore, among management, rhetoric about their own practices and role in relation to that of the workforce is equally active (Alvesson & Sveningsson, 2003a; Borins, 2000; Kuokkanen & Katajisto, 2003).

There is general cynicism across all the respondents who defined themselves as non-management *about* management. So for example: *"And you find that when there's a crisis that's when you find your management team will come down and put a policy in place regardless - like the swine flu thing" (Junior Midwife)*. So here managers are described as paying no heed to the routine tasks of the organisation (Cummings, Hayduk, & Estabrooks, 2005b). They are portrayed as simply responding to a crisis and (presumably following orders from the overall leaders of the service). Thus, managers are not seen as managing the boundaries between the Trust and those in overall charge of health care operating outside of the organisation (i.e. at the level of government) effectively for the facilitation of service delivery (Buchanan, Abbott, Bentley, Lanceley, & Meyer, 2005; Kane & Patapan, 2006). This resonates with Laughlin and Sher's (2010) analysis discussed above.

A focus group from one Trust proposed a particularly strident view of management and its relationship to wider bureaucratic imperatives which they saw as going against service delivery and effective patient care. The medical staff here were proposing that management was both absent, in person and from taking responsibility, while also being all controlling of medical care through instigating seemingly pointless rituals which seemed to maintain boundaries.

Consultant: There is a burning example [here] of bad leadership which is the absence of figure heads. Management can never be found which is frustrating.

Registrar: I've been in theatre now for two weeks and two cases were dropped. The doctor has to apologise to the patient but they are the ones [the doctors] who would like to continue. Management say 'NO it is lunch'. They should be the ones taking responsibility for telling the patient but the

doctor has to go back to the patient and look like a donkey saying 'I'm sorry I can't do your operation today'.

The members of this group, who clearly shared the same or similar images of management and its 'idiocy', went on to decry management incompetence across all staffing issues, and the registrar continued, imitating the management in a silly voice: "*he has to stop, that's the rule*" making it very clear that management was perceived by this man and others in this focus group as inflexible (and rather stupid). Here these participants are expressing total lack of faith in the authority of those who manage (rather than lead) them, although in fact it seems that despite this, they abide by the rules which suggests that there is a belief that at some level the managers in question here derive authority from somewhere higher up in the hospital system or from the NHS leadership beyond.

One factor to note, of course though, is that the power of the story in the focus group may belie the views of the whole group in that some would be silenced by the fear of disagreeing with their colleagues (Asch, 1956; Foucault, 1982). Furthermore, the articulation of the behaviour of management in these cases is *actually a form of leadership* and as such might influence the views of the focus group (and subsequently other staff) (Avolio et al., 2004; Pye, 2005).

From a different focus group, this time with junior midwives, it was apparently *giving up their authority* for a while that gained managers some important respect. For instance when a crisis occurred in the organisation (in this case a fire) then managers seemed to behave very differently and even impressively:

1³⁰. Yeah and then the managers - the bed managers - were carrying chairs and everything and you just had people on beanbags on the floor and everybody ...

2. I wasn't here that day I missed that.

1. Well it was a bit stressful but everybody just mucked in and people were just carrying people here and you know....

Q: Well that's really good if everybody even the managers mucked in.

1. Yeah you find in a crisis the managers do come out, the leadership the leaders come out and they have to come out.

3. And people were coming in from home to help that day.

³⁰ The number denotes the speaker.

2. *Why didn't they phone me? I don't know but never mind ...*

1. *No you find that in that kind of crisis everybody from execs downwards pulls rank and everybody comes in and helps out (T 2).*

So the image here is that a crisis brings out the best in everyone (and the boundaries between the groups of staff become temporarily porous). In times of crisis then the tasks (i.e. patient care and running an effective hospital) overcome other elements of potential discord and conflict such as the 'rank' order of 'execs' bed managers and others such as clinical staff.

There are also other times when it is possible for management to be seen as 'on side' as indicated by another nurse in a different site. For example:

Erm ... our manager, she is quite approachable. And she is willing to discuss things with you if you don't feel that something is right and you question it or question her. She is willing to sit down and explain it and sometimes she will say 'I'm not happy with things as well, but the people above me this is what they have decided, this is what we have to go along with. It is government guidelines or targets have to be met'. Although she might feel the same as us she explains why we have to do things in this way. And I think she is very approachable.

This manager above, demonstrates her willingness to communicate and be 'visible' but clearly she has adopted a them/us strategy similar to those who 'oppose' management by positioning herself as managing the boundary from the side of the clinician/nurse's while also at other times presenting herself as mediating between 'government' and clinicians and managing that boundary too (Laughlin & Sher, 2010).

In the example described here, this seems to 'work' as evidence of good leadership for the nurse telling the story, but it involves the manager in question in potentially difficult dynamics and conflicts in her role.

From another focus group discussion that included doctors and nurses the organisation in the mind experienced management as absent and failing in their responsibility (Hogan & Kaiser, 2005):

Absence would be correct. Management are often not there. They need to take command of the situation. Here is the reasoning – management don't take responsibility for their actions and there is a severe lack of managerial leadership.

This is significant in the concept of the organisation in the mind when juxtaposed with the account of the same organisation by the CEO who saw her/himself as seeing good leadership as manifested in:

Visibility in terms of being seen around the place, so go out wandering around the wards. The best part of the role, quite candidly is, the best part about being the chief executive is, you can go out and talk to patients, and that is what I really kind of enjoy. ... so there is something about my presence and my profile. There is also something about being very clear and repeating the message often enough so that it is clear in the organisation about what the organisation is there to do.

So, within the same organisation there is an image that management is invisible and absent, while senior managers see themselves as 'being seen around the place' constituting an important part of what they believe they do and that they see as being vital for effective leadership and patient care (Laughlin & Sher, 2010). Both sides agree on what would be good leadership but each 'side' has a different vision of what is happening in 'reality' (Alvesson & Sveningsson, 2003a; Buchanan et al., 2007).

In the absence of a shared vision of an organisation working together or a set of clear guidelines about how 'this organisation works', there seemed to be a wish from a deputy CEO of another Trust for a hero/charismatic leader to put things to rights and potentially cross the managers/others boundary (Ladkin, 2006; Laughlin & Sher, 2010).

Erm, this is a very complicated organisation, what we haven't got right is we haven't got a bible that says this is how this organisation works and I think that's a problem so, ((1)) so ((1)) it's very easy for ((1)) despite what I've said about how difficult it was to be a leader, erm and the personality of the individuals who are at the top of the tree, makes an enormous difference in how an organisation I think behaves and works. There is a great tendency if you are a very good individual for an organisation to be based around you and when you leave there is a problem, erm and so the best kind of leader, yes they have that aura of it's about them, of course that's what people look up to but they also put in place processes so that things can happen.

This is a view from the top of the organisation which is expressed at least in part as a vision of a (desirable) mechanistic model – an organisation with a 'bible' about how it works - although this participant also desires a charismatic transformation on the part of leaders.

The hero leader would be a 'very good individual for an organisation to be based around you' and also to have 'an aura'. The metaphors in this extract proliferate – the need for a 'messiah' to save the organisation but also a sense of *dependency* – that 'people look up to' this type of leader who (it would appear) single handedly will be able to put processes in place for things to happen. The vision here is though one in which the system is defunct, stagnant and closed.

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6.5 'Out of mind': leadership and the 'other'

Organisational change is frequently resisted, often because of the disruption to individual's *sense of the system* and their place within it (e.g. Hoyle, 2004). It is also related to the emotional involvement many people have in their work and the way they perceive they are valued within (and how they themselves value) a familiar structure and context (Bovey & Hede, 2001; Zoller & Fairhurst, 2007).

Emotional labour, as discussed in Chapter One, is a key feature of the work that many people do, and is an integral part of any job, but particularly so in an institution of the NHS (see for example Gabriel, 2004). Different occupations require different types of 'displays' and following Hochschild (1983) emotional labour requires adopting emotional displays and attitudes appropriate to the role.

Clearly in hospital work all staff have to expend emotional energy on 'caring' and 'kindness' but it is also the case that working in the NHS, with its many changes for (perhaps) better or (maybe) worse, also requires the ability to be able to 'move on' i.e. mourn the loss of the old structure, sets of relationships etc. and embrace the 'new' with some degree of enthusiasm. The failure to do this (or recognise the need to do this) results in emotional resistance to changes and hanging on to the old systems as long as possible which might defeat changes that improve service delivery and benefit patients (Hughes, 2005).

6.5.1 Leading change and transmitting leadership

In one particular case a senior clinical manager Gerald³¹, was charged with integrating clinical practice across two sites, each of which had their own different ways of working, and different relationships to the boundaries between each other and the clinical teams. While the one (where he was based primarily) had accepted quite radical changes to its organisation, the other (apparently) did not "*..because the sort of ethos and the sort of personalities of the two sites are in the background. They are completely different*".

Gerald's view is based on a reality in that the two sites are structured differently, look different from each other in that the buildings are from different eras and in different styles, and they are in physically different locations. They also serve different demographic populations and have different histories. However, Gerald sees the organisation of the different

³¹ Gerald's leadership is discussed in detail in Chapter Seven.

sites as really being about 'ethos' and 'personalities' which must be in the mind (mostly) as there is a system of authority and responsibility in place across the Trust (via the CEO and other senior people including Gerald) that takes up authority and leadership to ensure consistent practices and organisational change.

Thus, we need to ask why one Unit has (apparently) taken new ways of working on board with some enthusiasm while (apparently) there are barriers preventing the other one doing something similar.

For Gerald, management of the boundaries between in-patient care and primary care teams was the source of a key difficulty:

There are groups of people here who are completely behind the concept that we mind about – integration of primary care – joint working between the Trust and the Primary Care Trust. Some departments work extremely well and are keen to move forward and although we do have our minor difficulties - generally there's one or two departments who are completely against change and erm resistant to anything new. Just like any other organisation where you know you are going to get the type of people who actually make life extremely difficult for you and despite that we've proven how much better our system is.

In the extract above he moves from talking about the other *site* (as a whole system) as being the 'bad' resistant one, to identifying *individuals* on his own site within the 'good' system as making life difficult for him personally despite evidence (he and others have provided) to show how integration works better. This respondent's organisation in mind shifts depending on how well one part of the system fits with his particular vision of a good organisation. This *splitting* (see Chapter One) is a mechanism (unconscious) for preventing the overwhelming feeling that can come from persecutory anxieties (Jaques, 1953; Jaques, 1960; Menzies, 1970). In a management role where (for some reason) authority is being undermined, then the resurgence of persecutory anxiety might be dealt with by splitting of the 'bad' site and comforting oneself with the knowledge of a 'good' site where the organisation works as this leader/manager might wish it to do (Laughlin & Sher, 2010).

6.5.2 Resisting change

In the case of a medical secretary, with over twenty years experience of working in the same hospital, the thought of change in the structure of her working relationships was upsetting. She began engaging with the interviewer by talking about how busy she was and when asked if there was any particular reason why she was busy at that particular time she went into an explanation about organisational change. *"It's just generally busy, but we*

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are in teams now, erm couple of them [doctors] are away and one or two have come back, catching up with everything". It seems as if the teams were the problem for her because previously (and for many years) "...it was one secretary to one consultant and his team. Now for instance today I'm actually taking calls for four different consultants". She was asked about the new structure and made it clear:

erm ... I don't think it's going to work as well as the previous one. Because I think you'll be dipping in and out of so many different jobs that instead of concentrating on the ones that you do well and controlling your one doctor, it'll be confusing and I think there will be mistakes made because one person is trying to deal with too many parts of too many jobs.

Her perception that her role in the organisation might happily continue as one in which she controlled one consultant is characteristic of the 'comfort' of the closed system where authority, power and the processes of leadership are condensed and held 'constant' by an individual. As seen in Chapter Four also change is not usually welcomed without at least tacit resistance and in Chapter Seven two of the case studies will explore how leaders as potential change agents experience followers' avoidance or challenge to changes in practices and structure.

Changes in working relationships bring anxieties which need to be understood and anticipated by leaders if they are to support staff to position themselves differently in the system. Hoyle (2004, in Huffington et al) suggests that during any period of organisational change there is potential for heightened creativity which might lead to doing things differently and better. However, change also brings about risk, uncertainty and the chance of failure which can evoke anxiety both in those promoting the changes (the leaders) and those who might fear loss of their job and the loss of known ways of working (see Hoyle, 2004, p.87).

6.6 Conclusions

Understanding an organisation and what facilitates and/or hinders leaders to take up their authority involves considering the organisation systemically. That is taking account of the boundary management and how that relates to the tasks, roles and power/authority of those who work or are 'consumers' of its work.

Leading change depends upon ensuring those within the system have a sense of how the system works and an awareness of the culture that might be tested as a reality or not. This means, once again, that organisations which are learning environments and where emotional intelligence is applied, are more likely to respond to authority and less likely to subvert

leadership, thus distributed leadership/responsibilities may be taken up or shared more widely.

7 Leadership, Authority and Emotion

7.1 Introduction

As argued above, leadership and emotion are fundamentally intertwined in the workplace (Fineman, 2003). Leaders who appropriately manage both their own emotions (Goleman et al., 2001), and those of their followers, experience better leader-follower relationships, greater opportunity for innovation, motivation and productivity, a more positive organisational climate and improvement in employee and customer/patient satisfaction (Ashkanasy et al., 2003; Avolio et al., 2004; Hollander, 2009). Such outcomes can be associated with both *transformational leadership* (Bass et al., 2003; Corrigan & Garman, 1999; Currie & Lockett, 2007) and *distributed leadership* (Bass & Steidlmeier, 1999; Gronn, 2000, 2002; Mehra, Smith, L. Dixon, & Robertson, 2006b) patterns.

It has also been suggested that followers' 'dysfunctional' dependency is a consequence of failure of the leader to *engage* on an emotional level with those whom they lead (Alban-Metcalfe & Alimo-Metcalfe., 2009; Ashforth & Humphrey, 1995; Bion, 1961; George, 2000). There are different types of such engagement, e.g. acknowledging emotions, drawing them out, honouring them, confronting them, and deflecting them, but although this idea of engagement has been described as "*compelling on the surface, the meaning of the employee engagement concept is unclear*". (Macy & Schneider, 2008, p.3) Even so, there is a common view that such engagement is desirable for organisations in that it connotes involvement, commitment, passion, focused effort and energy from staff thus demonstrating both attitudinal and behavioural components for an effective workforce. (Macy & Schneider, 2008)

Studies of leadership and emotion have not typically been combined with attention to the 'authority' of the leader (Ford, 2006; Stein, 2007) or indeed to the concept of 'power', (sometimes seen and experienced interchangeably). (Morgan, 2006) A study combining exploration of the relationship of authority to concepts of both 'emotion' and 'engagement' (Hirschhorn, 1997) is particularly relevant to the agenda of the 'post-modern' organisation where leadership is distributed (Clegg, 1990; Tierney, 1996) and the organisation potentially fragmented, unmanageable and diverse.

The authority invested in a particular role, such as the CEO (Chief Executive Officer) or lead clinician may not explicitly engage emotion. However, in an organisation such as an NHS Trust, where leadership styles are, or at least

intended to be, characterised by distributed or transformational attributes, the concept of authority is more closely linked to *personal* authority whereby individuals “..bring more of themselves – their skills, ideas, feelings, and values – to their work. They are more psychologically present.” (Hirschorn, 1997, p.9). Thus for example clinical skills *and* personal investment are *both* required for someone to take up authority in practice as a clinical leaderⁱⁱ.

In this chapter we delve further into the concepts of leaders and leadership, particularly focusing upon leaders with a ‘mandate’ to lead change through their formal *role*. The group of participants we specifically focus upon here includes clinical and non-clinical senior managers and we examine the ways these individuals construct their role, their relationship to ‘followers’ and how their *authority* is taken up, experienced and constructed in their specific organisational context³². Authority has more than one meaning. It refers to the authority (sometimes seen as power) invested in a particular role.

Analysis of relationships between people who work in the NHS is underpinned by both the *interactional* and the (related) *emotional* contexts of an NHS Trust as a workplace (see for example Liden and Antonakis, 2009). This knowledge is particularly salient because on the surface, many of those occupying the leadership roles were inclined (at least superficially) to deny the role of emotion although analysis of their stories, shadowing and observations, following the pre-existing literature on organisational cultures, including those which study health care settings, indicated that emotion indeed plays a key role in service delivery and the ways leadership and authority are experienced and constructed in relation to patient care (Vince, 2002; Gabriel, 2004; Hirschorn, 1997; Huffington, 2007; Obholzer, 1994; Vega-Roberts, 1994).

7.2 Case studies

Three case studies were selected to examine the meanings given to the relationship between ‘leadership’, ‘emotion’ and ‘authority’ in relative depth. Each one was chosen (through discussion among the research team) to be (potentially) representative of a ‘typical’ approach to emotional management which reflected a personal style of authority (or lack of authority). These particular cases raised subtle but crucial questions about leadership, emotion and authority through exposing both the conscious and *unconscious* qualities which can either underpin or undermine a leadership *role* (Bovey & Hede, 2001).

³² In this chapter we focus specifically on the senior staff’s perspectives. Others’ perceptions of senior staff were discussed in Chapter Six.

1. The first leader, Gerald, had an 'authoritarian' manner (Adorno, 1950). That is, he appeared to believe that because he was in a senior position other staff ought to do what he told them to do. He was a senior clinician [for a group of particular services], relatively young, very enthusiastic and held an uncompromising vision of how a good hospital should be organised. He was interviewed once by a researcher, once by a group including the PI and 'shadowed' for two days by the same researcher.
2. Kerry in many ways held a similar outlook to Gerald, only she *believed* that she attended to the emotions of her staff if not her own. Kerry was Gerald's immediate boss and evidence from the interviews, shadowing and observations in both cases indicates they did not always work effectively together. Kerry was interviewed twice. Once for information as a key informant by two researchers and the second time by the PI and a researcher together. She was also observed by a researcher for an hour.
3. Quentin was a Clinical Director. He made overt efforts to weigh up the emotional 'risks' to his authority and thus seemed more able to engage with the 'followers' (and thus probably survive) in the *role*. At first he was reluctant to take part in the research directly (although he supported his colleagues' participation) but eventually agreed to be interviewed. Two researchers met him before the interview conducted by the PI, in his role as a key informant and observed him and the senior colleagues in their shared office space for about 30 minutes.

7.2.1 'Gerald'

Gerald held a clear vision of how a good hospital should be organised for the benefit of patients. What he appears to find problematic is managing staff who (for whatever reason) have a vested interest in different styles from those he advocates of patient care, working with colleagues and patients, and/or visions for service delivery.

The following extract is from the shadowing of Gerald.

From the two days spent with Gerald it was very clear that he believed that he was one of the main 'leaders' in the Trust and that he had a strong relationship with the middle and upper managers (including the CEO) which he uses to his advantage especially during long discussions regarding the 'new vision' (which appeared to be very much his vision) for the relationship between the two sites.

Gerald did indeed appear to be one of the main leaders. However, it was unclear whether the power and influence in this leadership role was all smoke and mirrors. Does Gerald play the role of the Wizard of Oz? Does he

think he has more power and influence than he actually has? Does he really have a good relationship with the Trust managers and Chief Executive?

The interview with Kerry (the CEO) made it apparent that she did not consider that he was one of the main leaders in the Trust and it was indicated that she didn't think much of him, and that their relationship might have been fraught.

Discussing the researcher's notes some weeks later, one thing that did emerge was that Gerald 'confused' those around him and was apparently unaware of how others saw him and how far his personal authority actually stretched. Hirschorn (1997) in a study of authority in contemporary organisations has suggested that leaders are no longer the old-style authority figures and because of changes in technology and economics "... bosses can no longer project the certainty, confidence and power that once facilitated employees' identification with them when they [employees] were young and dependent. This is why people are so disappointed in leaders today but also so unforgiving of them" (p. 9).

Gerald, although he had a clear management role and mandate to make the changes he focused on, did not get identified by his colleagues as fulfilling the vision of a leader as there is an implication in the observation extract that his authority may have been achieved via 'smoke and mirrors'. Furthermore his appointment (and that of several of his close senior colleagues) predated the appointment of the CEO. Several questions are raised here by the researcher about whether Gerald has been capable of taking up authority when the CEO takes a stance that at least tacitly opposes him. *This has to remain unanswered in the specific context of this Trust but is an important matter to consider in regard to distributed leadership.*

Gerald prefers to position himself as 'evidence-based' (and therefore up-to-date) dealing with practical matters and not positioning himself as an *emotional* leader. In the interview below, thus, he talks about making difficult decisions but paradoxically, almost from the beginning he focuses in upon dramatic inter-personal conflicts - talking about 'facing up to a fight' and declaring that the Trust 'absolutely' does not have the kind of leadership that enables 'direction' or 'vision'. Does this mean the CEO? Does this mean consultants? It may not even be intended so specifically perhaps it is an expression of general frustration that his vision is not shared.

While on the surface he claimed a good sense of what leadership is about he is also revealing in his talk, the opposite position. Taking a team or department in the direction of the vision and making difficult decisions is for him about a relationship with (not) being 'scared' or further down in this extract, (not) 'afraid'.

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Gerald: Erm...good leadership, err having the ability to make difficult decisions, err, not being scared to face up to a fight...erm...being able to be clear about errr, the direction or vision of the trust, where we are going and be able to errr direct your team into the position that everyone errr everyone is meant to be going, erm I think

Q: Yeah...and do you see that kind of leadership in this hospital?

Gerald: No, absolutely not

Q: No? And why, why not? What's the problem to that kind of...

Gerald: I think that in the past, we .. we have been afraid to face up to a fight, and we have shied away from it.

Q: Yeah

Gerald: From making difficult decisions, and err, and we've let too many people get away with undermining the overall plan that we have...'cause we all know how to deliver excellent healthcare, we all have our views of how this is going ahead, but err, and the grand picture has been undermined by a few, and we've not been able to really face up to those people

Gerald believes that while everyone knows how to deliver 'excellent healthcare' a few have undermined the/his 'grand picture'. He also identifies with a group who support his particular vision while not expressing empathy with those who do not. As the interview progresses, Gerald berates the power (rather than leadership qualities) that consultants have had in the past suggesting that they *undermine* changes that he clearly and sincerely holds about what constitutes good patient care.

Gerald however does reflect on what he is being asked as evidence by his suggestion later:

I don't know about what makes a good [leader]...you know, its difficult to say what makes a good leader...because I'm not sure I'm a good leader, because the qualities that I feel perhaps are necessary, I don't perhaps have ...one of those is patience perhaps...err, being able to tolerate people's err err, err stupidity in a nice way, is essential I think, but I don't have that, I don't think...being, having the ability to listen, err, err, err and not judge or criticise too quickly is very important, but then, taking everyone's opinion into account, but then at the end of all that being able to still go your own way, and persuade everyone else that it was their idea in the first place ... Well, I have certain qualities which help me get the goals that I like...erm...whether I have everybody behind me.

This is one (although not the only one) of the more (paradoxically) emotional interviews from among the senior managers in the study. Gerald

recognises, quite passionately, that a leader needs followers and has to be tolerant. Gerald, though, cannot help declaring that those who presumably hold differing opinions to him to be stupid. He also said later in the interview that he believed many people were *against him* when he was appointed to the senior post as the Trust itself changed shape. While he would not it seems position himself as emotional (rather he sees himself as evidence-based) he chooses to talk in emotive ways and reading and hearing what he says is quite exhausting as he uses all his energy in trying to take the organisation where he believes it should go, but through lack of emotional intelligence, many a time he draws a blank.

Gabriel and Hirschorn (2004) might describe Gerald, at least in part, as a 'narcissistic leader' in that he liked to be told he is important and influential but he is also potentially a bully and authoritarian in style (Adorno, 1950). He clearly found criticism intolerable and split off the 'bad' (i.e. the consultants who didn't go along with his changes from the 'good' i.e. the 'we'). Gerald has a dream which he is determined to make into a reality, however, there is a "*delicate balance between feelings of omnipotence and feelings of impotence which leaders must achieve, in order to enhance the chances of turning vision into reality*" (Gabriel and Hirschorn, 2004, p. 144). These authors argue that narcissistic leaders have a particular aptitude for getting this balance wrong and "*Even if they are talented in their field, their judgement increasingly fails them. This is compounded by the collusion of their followers*". This may be Gerald's 'we'. Gerald fails to connect emotionally with his (potential) followers from outside his close-knit 'we' group even though there may be some admiration for his clarity and link with the NHS mandate. This means, in effect, that important changes which may well be for the benefit of patients in the contemporary NHS are being (effectively) resisted because of Gerald's style of leadership. Gerald also appears to have little idea of how others might experience their worlds, including their emotions.

This theory might be borne out by the following participant, a young female career NHS manager just reaching a senior position. She proposed Gerald, unprompted, as an example of a good leader:

I think he's great, he gets a bit of bad press sometimes, I think people get agitated with him, but I think it's because he tries to manage things, and he tries to be very fair, and he tries to solve problems that have been with us for a long time, so again, I think he is a good leader, he is trying to do the right thing for the Trust in the long term. He is erm ... sometimes it's difficult for him to carry people with him, but I think that will pay off in the long run. And I think he's thinking of a long term plan, he's prepared to take a bit of short term flack...but I think it will work out in the end. I think he's going about doing stuff in the right way, he's being fair and he's trying

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to be consistent, he's making sure he's got an evidence base for doing things, it's not just a random decision, he's collecting information, and that kind of thing...I think there are a lot of people in this organisation at this point who would say they didn't think he was a good leader, but I think time will tell the story there.

This extract from the interview, while consistent with Gerald's descriptions of his own behaviour, proposes an evaluation of his style which indicates he is likely to be successful in the longer term because he is 'trying to do the right thing for the Trust'. However also she identifies quite clearly that his leadership is failing to take many of the people who matter along with him, she positions herself as sharing his vision for the longer term benefit of the Trust which may reflect her *a priori* engagement with NHS management rather than with a clinical profession as she does not have a clinical background herself. It also seems to reflect collusion with his narcissistic style because she seems to mirror his version of himself. This participant continues:

Sometimes they're [other senior staff particularly doctors] quite quick to criticise without really understanding what the problem is that needs to be solved, and what some of the rules are we can't ignore. Some of the national directives, that we just have to do, there's no point fighting against them, we've got to find a way of implementing them, and I think sometimes he gets a really raw deal...but he's said, he's consistent, he will communicate to people, write to people and speak to people very quickly the minute they raise a problem, and he definitely shows that he is not shying away from difficult problems...I think that's a very strong characteristic.

Her description of the other staff appears to chime with Bion's theory of a fight/flight basic assumption group based on unconscious emotional ties of the group involved which (mostly) represents an anti-task resistance to the leader (Bion, 1961). *This extract above reinforces the possibility that Gerald is emotionally disengaged from his followers* and perceives his Trust to be in line with and in favour of NHS 'national directives'. The participant here who in a way is 'damning' Gerald with *strong* praise may be looking to Gerald as a potential mentor by making it clear that she will support his particular efforts. However when the researcher asked her about her *own* leadership she said:

.... because one of my strengths is pulling people together, one of my strengths is building teams, so I think from that point of view then yes, but then sometimes I look at people like [Gerald and her immediate boss] and I think 'Oh my God'. I've got so much respect for the way they deal with

the very difficult issues. Sometimes I wonder if I really put my neck out enough to say 'Ok, Ok, this is what we all need to be passionately aiming for.' Even if not everybody is quite wanting to do the same thing. I think sometimes I sit back a bit more and wait to see what the general feedback is, rather than stick my neck out and say 'Ok, this is the direction we've got to go in.' And I think as a leader you have to...well, in fact you probably have to do a bit of both.

This participant, it seems, is somehow subjugating her own skills and strengths to those whose skills and strengths do not correspond with what she believes in makes her a good leader and seems to be putting herself down for the skills she has got and does seem to value. Alternatively, she might have realised that her strengths might complement Gerald's and through his own narcissistic valency he may position her as someone to promote.

Finally, in relation to Gerald, whose example she insists on returning to, having described other more emotional and successful clinical leaders in the Trust:

.... And they [other senior staff] make it very evident that they don't support him [Gerald] in his role, and not only do they make it very evident, but they do a lot of stirring behind the scenes, to get up a bit of a frenzy against him And I think there's some very clever leadership involved in that process, and there's a lot of learning, gathering people in, getting them on board and uniting them in a common purpose, and this and that and the other, but it's not constructive.

7.2.2 'Kerry'

Kerry is Gerald's immediate boss (the CEO) and evidence from the interviews, shadowing and observations in both cases indicates they do not always work effectively together³³. Kerry herself has met with similar difficulties which seem to be the outcome of her attempts to encourage distributed leadership in that:

Kerry: Erm, erm, well we set up a process to...we re-wrote the discharge policy here. I chaired the group. I wanted to know what the problem was about discharges, and I was told we needed to rewrite the discharge policy,

³³ Regardless of personal authority in the cases of both Kerry and Gerald, it is clear that the organisation has had its own very particular problems which are *endemic in the system* (see Chapter Six for a more systemic analysis of leadership).

and we'd just done it. People looked at me, and I just said, well I've spent...I've chaired five meetings myself, where we put all the information forward, and all these arrangements in place and nobody's done anything about it. I think that's poor leadership.

Q: So erm...poor leadership on whose part? Because presumably you had people who you delegated this to?

Kerry: So the consultants, the nurse managers, the matrons...all the people that were on the working group really. And they just didn't implement it. Beyond belief really.

This extract reveals several levels of emotion and authority and (as with Gerald's narrative) there is an 'I' who takes action and the 'they' who are against her. Kerry had identified a problem with discharges but had to ask 'them' what it was and was told that 'we' needed to rewrite the policy. She took up the role of chairing five meetings, the group/'we' put the information forward and the arrangements in place (presumably to take action) but 'no-one' did anything. It is not known how she handled this 'failure' of leadership on 'their' part. Kerry appears to be a micro-manager (in that she herself was involved in the meetings). Reflecting on this interview, and reading the text, one of us reported back to the research team that she had misunderstood Kerry, thinking that Kerry had been talking about her *own* case of poor leadership. Perhaps it was as unclear in the action as it was in the telling (thus perhaps on an unconscious level the lack of clarity was communicated in the meetings). Why did Kerry, as the leader, not pick up the group's dependence (or *resistance*) (Bovey & Hede, 2001; Hughes, 2005)? This suggests that she herself had resisted emotional attachment to her 'followers' and failed to engage them on an emotional level during the meetings. One approach that helps to understand the example above of *resistance*, specifically in the context of the five reported meetings, is the idea of 'fight/flight' from the work of Wilfred Bion (1961/1983). He suggested that a 'group mentality' (or group culture) emerges from the development of a group over time as it continues to meet, because individual contributions conform to this mentality. In brief, the formed 'group culture' unconsciously constrains individual members (see also Sherwood, 1964).

So, in this case it may have been that despite the seniority of the staff involved in rewriting the discharge procedure, the culture that had developed over the course of the five meetings (and possibly prior to this as 'they' had suggested the need to re-write the discharge policy) had *prevented/resisted distributed leadership*. This could have led to the group not making sense of the leader's expectations and reverting to the comfortable pattern of being that had not been challenged possibly (again) because of the leader failing to manage her own emotions or engage with those of her team.

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Bion (1961/86) suggests, that the group mentality exists on both at a conscious and unconscious level so that the team were probably not deliberately, or consciously, going against the leader. It seemed from the leader's description that the team had been almost 'sleep walking' – not recognising that they had already done what they later ignored and suggested needed doing. Dependency, according to Bion, meant dependency on the leader or "... *when all individuals in the group look to myself as a person with whom each has an exclusive relationship*" (Bion, 1961/86: 119). Within this mode there is little connection between the members themselves and there is a '*mass inertia*' (op cit). This links to Klein's depressive position (Gould, 1997). It also raises questions of who is depressed here - Kerry, the group, or the group in Kerry's fantasy? The unconscious resistance and frustration experienced by the leader here demonstrates the fluidity of power and potentially the influence of gender (Fletcher, 2004; Nicolson, 1996; Vince, 2001)

Kerry, however, did claim success in turning around previously identified failings in patient care targets. How did she manage this?

Well I ... I... I mean it requires a great deal of focus, which hasn't been succeeded by other individuals, so...and it's required the organisation to understand its importance, and that it is possible to do. So it's been trying to talk to people about 'OK it's a target, but it's a quality... a patient quality target, so don't look at it in a sort of derogatory manner'.And ((3)) ...so it's a bit of culture about are you being bullied, as a member of staff to achieve the target and if you're not being bullied well then why is important and then well it's important because its patient quality ((1))...and then I suppose, something about... I mean one of the turning points for me is about our reputation as well, which is...well everyone else is achieving it, and we're not, 'why do you want to be in the bottom 20% of the country?'

Resisting her own emotional attachment here she talks in the third person. Rather than saying that as a new senior manager she had managed to engage the staff, which to a point she seems to have accomplished, she states that successfully addressing targets has 'required the organisation to understand its importance'. She clearly perceives senior staff as taking a negative position in relation to government targets and has attempted to persuade people that such targets are about good quality patient care. Another feature of the discourse slips in here – is her style of leadership perceived to be a bullying one? It may be that a group mentality, which takes resistance and dependency to be part of its culture, perceives a leader with a vision, or at least with determination (and 'focus' to quote Kerry) to be bullying them out of their emotional safety. This is a problem for any organisation that suggests to its staff that successful change and development is solely about strong leadership. We have to turn again and again to the clear message emerging from the data that without an

emotional attachment and the ability to manage their own emotions leaders and followers are not going to achieve goals related to patient care.

7.2.3 'Quentin'

Unlike Gerald, Quentin feels that he is succeeding in bringing about change and unlike Kerry he is mostly positive about the impact he is having upon the staff groups. He told two stories, one of which was when his leadership worked, and another where he continues to experience problems although he emphasised (to support his authority) that the latter was not a great a worry to him. In his interview he focused very much on the importance of personal authority: *"I'm still playing the trick of getting people to do things by example"*. He tries to back up his personal authority through making personal contact as much as he can:

You know my job could be answering my e-mails and I'm desperately trying not to. I've made a pact with myself that I will not explain myself in e-mail. If it needs to be explained I will go and explain it [personally].

He distinguished between the roles of the CEO and medical director, which in his opinion were *manager* roles, and that of clinical director which was a *leadership* role.

Quentin moves between the position where:

...people need constantly to be reminded of what they need to achieve ... [in relation to patient care] ...I use the word good care because [they] have the tendency to lapse into what is acceptable or even worse, what they can get away with.

To the position that:

And I think there is some requirement to continually challenge the organisation about what it is providing and sort of have a re-education process. And I guess we all need that – because I need that as well you know and it is one of my roles to keep reminding everybody why they are doing what they are doing.

Quentin sees himself as needing space to reflect upon the aims of the service provision and recognises that he is just as able to lose track of the organisation's main purpose as his colleagues/followers are, given the daily round of work. While Quentin gives an interesting example of how he and the team succeeded in meeting a target for patient waiting times in Accident & Emergency (which involved him engaging personally with the staff in an emergency meeting):

... which was all about persuading your senior contemporaries and peers. It's about the juniors, the people who are actually delivering the services. It's about making a reasoned argument. It's about being visible. It's about being honest and it's about delivering it.

The success, he believes, was about the personal contact and his own visible attachment in trying to change things alongside his colleagues and being very clear that " *...this needs to be achieved at all costs - which was quite liberating*". The rhetoric here is very different from that used by both Gerald and Kerry, who feel their colleagues are letting them down; possibly they are 'splitting' the 'bad' and projecting it into recalcitrant colleagues in order to feel reasonably good about their own positions (Klein 1987, 1983). Quentin is talking about success and success through *taking an emotional risk*. Saying that a change needed to be achieved at all costs (which he described as liberating) could be interpreted as Quentin making an emotional commitment to engage with his followers about something identified by the government, the NHS and his Trust as important. This stands in direct contrast to the experiences and rhetoric of both Gerald and Kerry who express the frustrations at what the 'others' are failing to do. However with what Quentin called a "*slightly different problem*". He has had great difficulty dealing with a doctor who is "*just a very difficult person to manage ... and I need to say to him 'this is crap and needs to be done in a completely different way'. I don't quite know why I haven't done that*". Once again Quentin was expressing an emotion – anger but without pushing/projecting blame on to the other, but being clear what the other person was doing and reflecting on his own sense of why, how and when he might take this issue up with the protagonist.

While Quentin operates with a quiet assurance and takes up his formal authority, and the power that accompanies it, from a classic Kleinian 'depressive position' (Klein, 1975; Segal, 1973), both Gerald and Kerry, despite their formal authority, fail to engage with their followers which leads to their powerlessness and a sense of rage and frustration.

7.3 Conclusion

The interconnections between power, authority and emotion play a complex part in understanding what leadership means to all those involved and in each organisational context. Leadership cannot be understood as something that can be observed and/or measured 'objectively', it is not an essential 'quality' which resides in an individual but is socially constructed, meaning different things to different people at different times. Following Ford (2010) a more contemporary, appropriate and critical approach to the study of leadership "*pays attention to situations, events, institutions, ideas, social practices and processes that may be seen as creating additional repression or discursive disclosure*" (Ford, 2010, p. 51)

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To be specific Rioch (Rioch, 1975), and others had made the point that *"'Leader' is a word which implies a relationship So the word 'leader' does not have any sense without a word like 'follower' implied in it".* (p. 159).

The relationship between leaders and followers might be more or less successful and in order to be a follower a person needs (even on a very temporary basis) to 'give over' something of themselves (i.e. make themselves emotionally open) to the leader for the relationship to have meaning. Being a follower may be both (or either) passive or active and there is the potential for the follower to engage and support, or subvert leadership (Bondi, 1997; Halton, 2007; O'Brien, 1994). Consequently, in order to analyse what it means to 'lead' in an organisation, understanding the practice(s) of emotional management alongside an analysis of power relations is fundamental (Grint, 2005; Schilling, 2009). For Foucault (Burrell, 1988; Foucault, 1982) power *"exists only when it is put into action, even if, of course, it is integrated into a disparate field of possibilities brought to bear upon permanent structures."* (1982, p. 788) Thus, while organisations give formal power to relatively few leaders (including in a distributed model of leadership) consent is still required for the power to be maintained. Furthermore, 'the other' that is the one over whom power is exercised, needs to be *"recognised and maintained to the very end as a person who acts"* (Foucault, 1982, p. 789).

The leaders we have described above all admit falling into traps where their authority has been challenged/resisted and they have been (potentially) made powerless. Quentin alone demonstrated awareness that he was working *with* people rather than treating them as resources. This meant that despite experiencing some frustrations, he managed to continue to *feel* and *think*, and with his colleagues/followers on board, *implement* changes. Kerry and Gerald, while attempting to take up their 'legitimate' power and lead change, both squander their authority through failing to manage and/or engage with their own and their followers' emotions. This is evidenced by their displays of frustration, impatience and anger with those who fail *to do what they are expected/commanded to do*.

Gerald held a classic authoritarian view of power, indicating that whether he takes people with him or not, he intends to get to the *'goals that I like'*. He also sees the resistant followers as stupid. He defines leadership accordingly, in that the leader should *'direct [the] team'* and not be afraid to *'face up to a fight'*.

Kerry sees herself somewhat differently even though she experiences anger and frustration when followers fail to do what she wants and expects. In attempting to empower her subordinates and set up the 'processes' to distribute empowerment (such as the meetings described above) she was left feeling disempowered following an (apparent) breakdown of

communication between herself and the senior team she tried to work with. That one of the interviewers also had to clarify: "*poor leadership on whose part?*" suggested that Kerry possibly re-experienced the rage and frustration she felt at the time of her encounter with the followers in her story when she told it. This rage obscured clear communication both then and in the telling. It might be that the overwhelming need to prevent the Trust from being '*in the bottom 20% of the country*' was a source of anxiety for her and the importance of achieving these specific sets of goals contributed to her impoverished emotional literacy.

Distributed leadership (Gronn, 2002; Mehra et al., 2006b), as a response to 'postmodern' organisations (Tierney, 1996) sets out the changing nature of authority/power. In combination with ideas from the emotional/social intelligence literature, distributed leadership suggests a more relational model of leader/follower relations whereby leadership decisions may represent both outcomes and inputs (Ashkanasy et al., 2003; Wolff, Pescosolido, & Druskat, 2002). A warning note, however, reminds us of the persistence of the patriarchal version of 'the' leader (Ford, 2010; Ford & Harding, 2008) which occupies the dominant discourse within which the notion of 'effectiveness' neglects (if not ignores) the importance of the management of emotions in the leader and followers.

Through the use of innovative research methods and data analysis, which take account of both conscious and unconscious processes through which leadership is socially constructed and exercised, the intrinsic complex connections between authority, power, emotion and leadership in the context of health care can begin to be disentangled.

Leadership that 'works' for an organisation such as the NHS is a multifaceted, emotional *process* in which leaders manoeuvre to manage their own and their followers' emotions and behaviours on both intellectual and emotional levels. To be effective in, what are now seen to be, postmodern organisational contexts, leaders also need to reflect upon themselves in their role and to understand the structural, cultural and emotional expressions of their authority and the authority and power of their followers. The legitimization of emotionally engaged leaders' authority supports effective service delivery across the different levels of the organisation through undermining conscious and unconscious resistance(s) as described in the examples above. Power as a coercive violence (see Foucault, 1982) has been exposed and undermined in such organisations and 'replaced' by concepts of 'distributed' leadership where the persistent claim to power is by definition and necessity more fluid.

8 Gender and Leadership

8.1 Introduction

Gender and leadership is an area that has attracted interest among policy makers and researchers, because the styles of leadership that are currently perceived to be the most effective, such as transformational and distributed, are believed to 'fit' more closely to 'feminine' styles of leadership. Fletcher (2004) notes that traditional 'heroic' leadership is usually associated with masculine traits (rather than men and women *per se*) such as individualism, control, assertiveness advocacy and domination, while 'post heroic leadership traits (such as empathy, community vulnerability, collaboration) are more associated with feminine traits. Ford (Ford, 2010) reconsiders the concept of *effective* leadership which is in fact a patriarchal model perpetuating an exclusionary and privileged view of the leader (metaphorically the 'father' figure).

Traditional research into gender, organisations power and leadership suggests that there are particular 'masculine' and 'feminine' leadership traits that are generally believed to characterise men and women's leadership styles (Rosener, 1990; Collinson and Hearn, 1994; Nicolson, 1996; Carless, 1998). Because women are widely believed to adopt a more democratic leadership style and men believed to adopt a more autocratic one, distributed leadership and concerted action in networked organisations may potentially be more conducive to those (women or men) who can adopt a more traditionally feminine relational style of leadership. Furthermore, feminine styles are more akin to displaying social and/or emotional intelligence (Guy & Newman, 2004; Leon, 2005).

In reality, both men and women display a variety of 'masculine' and 'feminine' leadership styles, depending upon their individual personality, age, position and the situation involved (Cross & Bagilhole, 2002; McDowell, 2001). However, gender *expectations* influence perceptions and beliefs and research suggests that subordinates are often more satisfied with leaders who behave in gender-typical ways than those who go against gender-type (Porter, 1992; Rosener, 1990; Williams, 1993).

Indeed, women in explicit leadership roles often tend to be viewed less positively than men, in the belief that 'masculine' traits (competition, authority, lack of emotion) conform more to expectations of how a 'leader' should behave but not how a woman should (cf. the work of Broverman et al. 1970). The 'paradox' it seems persists in contemporary organisations so that some women leaders feel they have to behave in a 'masculine' way which frequently makes them appear rather heavy-handed and/or as a 'bullying' because these behaviours do not fit with ideas about women (Eagly & Carli, 2003).

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Most of the women and (some) of the men we spoke to during the study, made a point of denying that gender was an issue in today's NHS, indicating that they believed that women and men were treated equally, with an equal chance of success. However, several participants also mentioned gender differences in the negotiation of power and identities describing how either women or men were likely to gain advantage through use of their gender-typed styles (Lewis, 2000; Schnurr, 2008; West, 1984).

Gender and leadership it seems remains a contradiction in people's minds but gender is a fundamental component of the discourses surrounding leadership in the NHS because of the demographic issues in clinical management and leadership (Evans, 1997; Gardiner & Tiggerman, 1999) and as we have shown in Chapters Four to Seven, role models and styles of leader/follower engagement have a major part to play in the transmission and exercise of leadership (Gill, Mills, Franzway, & Sharp, 2008; Greener, 2007).

We want to note here, partly in passing, although an example below (in the interview with 'Jeff')³⁴ demonstrates its importance - that the *researchers'* gender and physical appearance (age, ethnicity, attractiveness) also played an important role in the research process.

8.1.1 Senior women managers: 'we're all the same now'

Women in senior managerial and/or professional positions either deny that being a woman is an issue for them or for their organisation or that they know what they had to do to prevent being seen as a senior '*woman*', rather than a senior leader.

Denying the impact of your own gender on how you are seen and how you manage and lead is not an easy position to maintain and we observed some senior women working hard not to be seen as women even though at the same time they were arguing that *this behaviour was not necessary* because of the way 'things have changed'.

The researcher's observation of a senior female manager (Catherine) indicated that she thought that Catherine was trying to avoid being 'feminine' in her interactions. When the two interviewers were waiting to begin the interview, Catherine's PA came into the room with an important message but was shouted at in front of them. Thus in her notes one researcher judged that Catherine wanted:

....to indicate lack of interest and assume a position of superiority. Catherine was transgressing the boundaries of polite professional behaviour and attempting to define 'her' territory of the hospital. Answers to the

³⁴ Not his real name.

questions were also defensive, perhaps indicating a lack of self-assurance. Despite the tough exterior she obviously felt a need to stamp her authority on people in order to maintain control of the situation. This may partially be related to her gender and need to appear 'more masculine than the men' in a competitive environment.

The researcher following on from her observational notes with comments following the interview suggested that *"whilst she [Catherine] initially denied gender to be a relevant issue [for senior managers in the NHS], she then went on to make reference to 'testosterone' and 'the emotions of females' as problems in managing in her senior role".*

The relevant part of the interview transcript is below:

Q: Ok, so are men a problem? Are women a problem? Are there gender politics? Or am I just old fashioned there?

A: I don't think there are anymore, I think there were. I mean when I was appointed, I could have been one of [only] four [senior] women, so the whole senior management was very ... very 'suitish'. I don't think, no, I don't think it is a problem anymore. No, I think it is, if you talk to people in the north of England, they will say it's still a problem, and I think its a bit more of a problem to get females into acute trusts, big acute trusts, it's a bit of a climate difference. I think there's a lot less testosterone around now, there's a sort of slightly...erm I mean I've got quite a young male management team.

Q: Right

A: I find the testosterone and sort of challenges a bit much from time to time So I mean from that point of view, it is quite interesting, it does manifest itself. As do emotions of females really.

Catherine's somewhat aggressive, or at least uncompromising, behaviour witnessed by the researcher tended to soften after that and she added:

A; So I do think the answer to the question is that there are differences, but I don't think they're... they don't fundamentally affect how you do the job.

Vicki, a senior geriatrician, discussed the question of gender openly and at some length with the researcher who suggested that she had seen both Vicki and Mandy, another senior female consultant geriatrician, being very 'gentle' in their approach to patients and the researcher wanted to know how far this was linked to the fact they were women. Vicki thought though that their approach was not about gender but:

You know it could be a geriatrician thing, I don't know, ((1)) you know you'd automatically say 'it's oh because we're women', but I think it's only when you start following a few men around as well who are doing the specialty as we are, because the thing that attracts us to elderly care rather

than any other specialties in the first place, and that could simply be what you're observing.

It seemed important to Vicki that she was not stereotyped as a woman leader although she was keenly aware that as more women took up medicine and were arriving in senior positions that this demographic change would in some way impact on leadership.

So maybe that's where you've got to go as well as men in geriatrics you actually need to look at women in other specialties and follow them on a ward round and see what they do and that may be a good idea as well for the gender thing. But it's quite important for your study because at the end of the day we're training over 50% of women as doctors and in the future they think that almost all GPs will be women so that will affect the leadership and sort of, that you see in patient care.

So Vicki, while seeing feminine *characteristics* as more important in her clinical specialism than gender *per se*, still believes women doctors (e.g. GPs) will make different kinds of leaders from men.

During her shadowing of Mandy, the researcher noted what she identified as gender-typical behaviour:

Mandy also implements a mothering aspect to her leadership role (also noticed in Vicki) as she is always thoughtful and considerate to her followers, making sure they are comfortable and happy with decisions made and that they are up to speed with their medical knowledge. This mothering role also seeps into the delivery of patient care. Mandy is also a leader that appreciates the help of her followers and always thanks them for their input and help.

While keeping in mind that the researcher herself is making assumptions about what is a 'mothering' style and also recalling Vicki's assertion that it may be more to do with the kind of people who are attracted to geriatrics than gender itself, it is important to note that the researcher spent several days shadowing and observing female *and* male geriatricians. Further, she discussed reflexively what she saw and how she interpreted it with the research team to check out her observations.

8.1.2 Men: the 'natural' leaders?

The researcher who interviewed and observed Catherine also interviewed and observed Jeff (another non-clinical manager) and contrasted their styles of interaction with other people in the organisation, and with her, during the interview. At first Jeff seemed more approachable, relaxed and generally more amenable than Catherine had been:

Jeff was a newly appointed male senior manager. From the outset he displayed supreme confidence in his own authority and power as a 'leader'

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and obviously did not regard a young female researcher as a threat. He was very friendly and personable and happy to open up the space of the hospital for us, answering his own emails rather than through a secretary, coming to collect me personally from the main reception and chatting and joking all the way back to his office. Throughout the interview he showed confidence in his own opinions and was happy to talk in detail about both his own and others' leadership. This confidence may be a result of several factors such as position, age, class, gender or personality. He freely admitted that he did not mind appearing 'hard' or unpopular if it was necessary to get the job done, however he felt that his main asset was his own 'charm' and 'charisma'.

Thus Jeff firmly claimed his place within the (masculine) 'heroic' leadership tradition.

While Catherine was perceived as guarding her territory and demonstrating her power, Jeff appeared to be relaxed, being more approachable and particularly not hiding behind his PA. In fact, his account of himself in the interview was somewhat disarming.

Q And do you see yourself as a leader?

*A: Oh yes certainly. I can remember the time when I realised that I should be in management. I was working in a **** clinic in [a Trust] and it was so inefficiently run and I said as much to the manager. She said 'if you think you can do it better then why don't you manage?' So I said 'OK I will!' And I think I'm pretty damn good at it. I don't play by the rules, I don't have any formal qualifications, but I can get things done. I'm not perfect – I shout, I swear and mostly I'm just very, very cheeky, but I'm good with people and that's what you need in this job. You have to be tough too, take knock-backs and step on people to reach your targets. But mostly I care passionately about the patients. I would never ever chase a target if I didn't think it would improve patient care. So that's why I went into management, and I suppose the other thing is I discovered, I surprised myself actually about, I was going to say how easy it was, it wasn't easy, erm I had a natural aptitude to do it, you know it was something that I was successful in so you know yeah?*

Jeff wanted it made clear that the 'inefficient' manager was a woman and that he himself is 'good' with people (and on the surface the researcher acknowledged this). However, he also valued the tough, target-driven 'stepping on people' (masculine) qualities of his leadership which he believed were important in delivering patient care.

Jeff put his confidence and self-identified ability partly down to personality, but also to his gender and upbringing, adding that certain class backgrounds seem to 'breed' leaders:

I do think that great leaders are kind of born, but my background was that I was at all male public boarding school for 10 years. As my father said 'the biggest waste of money' given my academic erm qualifications at the end of it, erm and there was something there about you know that sort of environment. I mean does it grow leaders? You would think so, you look at the number of public schoolboys that end up as MPs, that's probably not a good analogy

Q:((Laughs))

A: But there is something about that kind of white middle class upper class upbringing that you have, and although I wasn't from that background before I went to the school, erm you learn survival among your peers, you learn I think to survive, you know if you think at the age of eight you are sent away you have to survive you haven't got your infrastructure.

It seems that Jeff is suggesting that leaders are either 'bred' or 'grown' but either way the influence that makes them a leader comes early in their lives. In the example he gives here, 'growing' takes place in a male-only context reinforced by social class, possibly wealth and a general sense of entitlement. This model does not echo the efforts and ambitions of the NHS in everyday practice nor would it appear to be in any way appropriate to the model proposed by the NHS (see Chapter One) which is focused on the type of leadership appropriate to managing and leading 'diversity' and 'difference'.

8.1.3 Gender wars?

Being motherly (like Vicki and Mandy) is not equivalent to being weak or compliant as perhaps some gender stereotypes might describe women (see for example Bem, 1993; Nicolson, 1996). During an observation of Mandy, the researcher identified what she considered to be a 'battle of the sexes':

Gender issues were brought into consideration during the interaction between Mandy, a female consultant and a male consultant. During this interaction a battle of the sexes and power occurred with the two consultants struggling for power in very different ways. The male consultant tried to assert his power through attempting to ignore Mandy's presence, never looking directly at her, but was raising his voice and being rude. On the other hand Mandy was always very polite, looked directly at him, spoke very softly and smiled a lot, although it was quite obvious that behind the soft smile was a vicious bite.

Perhaps this isn't so much a battle of the sexes but an example of how men and women might behave differently towards each other in the course of a power struggle. The detailed observation notes show the encounter move by move:

There are some territory issues with Patient 9 and Mandy is angry that there is a patient on her ward that is being treated by another doctor. She asks why the doctor has continued his care now that the patient has moved ward and suggests that if the doctor feels that he needs to continue with the patient's care then the patient should be kept on one of his wards rather than blocking a bed that could be used for one of her patients. She asks "why can't we look after this patient? We are not supposed to have any outliers on this ward!" Mandy's registrar Melvyn can not, or does not want to answer her questions and simply shakes his head and shrugs. Mandy says she needs to speak with the consultant and asks Melvyn who the patient is under. Melvyn gives the name and admits that he has seen him arrive on the ward a couple of minutes ago, so he should still be there.

Who is Melvyn afraid of here? Or is Melvyn simply not wanting to witness a battle over territory and patient care?

Mandy walks round the other side of the nurse's station to find the [male] consultant with three other doctors/medical students standing some distance away and his registrar to whom he is speaking. Mandy and 'our' group move over to his location and the junior doctors from both groups greet each other and share whispered conversations. Mandy stands patiently at the side of the registrar waiting to speak with the consultant. Although Mandy continues to smile pleasantly I think that she is angry or frustrated on two levels. First because the consultant is on her ward and hasn't come to speak to her and second, because he doesn't seem to have the manners to even acknowledge she is waiting. After the conversation between the consultant and registrar has finished the consultant turns his attention to his paper work and the registrar moves to be with the other doctors (some distance away) Mandy lifts her eyebrows up to Melvyn (clearly annoyed with the male consultant's behaviour) and then asks if she can speak to him about Patient 9. Mandy explains politely that they do not have outliers on this ward and therefore asks whether the patient could be moved to another ward or if this cannot be arranged she take over the care for the patient. While she speaks the consultant doesn't look at her and continues to write, his body language and behaviour are both arrogant and rude. The consultant says that the patient is his and he will not be passing the patient over as she has problems not solely aligned with geriatric care and that she needs a specialist. Although this was clearly a statement to undermine Mandy's capabilities she continues to smile and tell him that the patient will be moved before the weekend so that a patient needing specialist geriatric care can have a bed.

Moving through this detailed account the gender issue becomes obscured by the fact of Mandy's skill as a clinician, a leader, her concern to give appropriate care within a context of limited resources and her ability to handle herself in the face of rudeness and arrogance. These are skills that ensure she will shine through as a leader in any context but particularly one

which is still a man's world. In a socially or emotionally intelligent context where concerted action is seen as important, patience, politeness and clarity of purposes will eventually win out over arrogance and bluster. As we see in the next extract Mandy's 'opponent' does not possess these attributes.

The male consultant becomes angry and raises his voice to Mandy and says there is nowhere else for the patient to go. Mandy lowers her voice and says that the patient must have been on one of his wards before she was moved so she can move back. The other consultant looks swiftly at the group of doctors who are stood behind him (both his own and Mandy's) and then eyes me suspiciously before turning back to Mandy and speaking in a lowered voice. The conversation moves back and forth between Mandy and the other consultant and it is clear that despite his outbursts and undermining statements to Mandy that she has the upper hand and although she continues to smile, she is very forceful and strong in her argument and objectives. To conclude the whispered conversation Mandy raises her voice and tells the group that the patient will be transferred on Friday and that she will be getting a transfer set up straight away. She then thanks the other consultant for understanding and walks back round to the group with a smile on her face and asks Melvyn to set the transfer up.

This is a consummate example of patience, calm and the ability to lead doing what she considers to be the best for her patients, her team and her department. Her skills in continuing to be quiet, calm and smiling have 'seen off' the male consultant in the meantime but reading this it would be surprising if the humiliated man does not try to take revenge. Although there is very little evidence that this is anything other than a 'normal' power struggle it is the case that Mandy is in fact a woman and has played, what is mostly recognized to be, a feminine role.

Returning to male expressions of power it is important to be aware that blatant attacks, such as the one in the encounter above, are not necessarily the only ways of demonstrating confrontational masculinity.

It appeared from the interview with Jeff (discussed above) that he believed he did not need to defend himself in the face of gender stereotyping. He had strong opinions on women's leadership and also on women's 'availability' with no qualms about voicing these which contrasts strongly with women's accounts where they try to underplay gender, that is that many senior women take the view (overtly) that gender is irrelevant.

The researcher's notes about the meeting with Jeff continue describing a dramatic example:

Jeff's supreme confidence meant that whilst he came across well in an interview situation, he crossed boundaries of professionalism in other ways, telling unsuitable stories about staff and inviting me (researcher) out for a drink after the interview, invading my personal space. In the extract below

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he accuses a female colleague of not only being attracted to him, but trying to use her sexuality (unsuccessfully) to get ahead at work, whilst simultaneously flattering me that I am his 'type' by subsequently asking me to meet him for a drink.

And in the interview:

Q: And could you give me some examples of bad leadership that you've seen?

A: Well, Melanie Willson³⁵, have you met her?

Q: No I was meant to but she cancelled the interview three times...

A: Exactly, she probably thought she was too important to talk to you. Now I can tell you an interesting story about her. She's a good looking woman, stunning, very intelligent too. But there's something not quite right, I don't know what it is... really cold. She's got no soul. I appointed her as divisional manager and at first she was doing really well, but then she ran into some problems. She was failing in her job. And that's when she started to flirt outrageously with me. It was like she couldn't beat me intellectually so she was going to do it another way. But, well... she's not my type. And she was really jealous when I got this job, I had Lucy (PA) go and announce it at the morning meeting and you should have seen her face. Anyway I hear she's got a promotion now so she must be doing something right.

Melanie Willson clearly perplexed Jeff – 'stunning' but no 'soul'; 'flirting' to avoid being faced with 'failing' in her job; unable to beat Jeff 'intellectually' and resorting to using her sexual attractiveness. After stating that she was not his type (indicating that the flirting also failed) he then made another woman humiliate Melanie in a public context. The implication of her subsequent promotion being based on something other than ability was also a powerful 'aside'.

Discriminatory comments against women though are perhaps not that commonplace. Jeff's sense of 'entitlement' may be a dying one across most NHS organisations and it is certainly against all stated mores. Discrimination on the basis of gender is more opaque. The researcher interviewed Helen, a senior female consultant, and talked about gender and arrogance of male consultants. The researcher suggested:

... this was possibly seeing me as an ally as a young female professional. In addition to the immediately obvious behavioural differences between women and men she also mentioned unseen discrimination in the form of merit awards at senior levels and problems of combining work and family commitments which may mean female staff are less likely to achieve these.

³⁵ Not her real name.

In the interview Helen responded:

Q: Do you think there are any gender differences in leadership that you have noticed?

A: Yeah, yeah I think, I think so, erm you know the men are more well, can I, the men are less inclusive of a group and they have ((1)) already formed an opinion sometimes and before listening, erm, ((1)) err ((1)) yeah.

Q: Yeah ((laughs))

A: Need I say more ((laughs))? But I think there is a difference ...Competitive, that's what I was saying, there's that competition, yeah competitive, exactly ...Of course not but the insight is very, very small, and then those meetings go on and on and on and it's people trying to get one up on another so... I just want to leave. It's handy having a beep you know you can say 'oh, I've got to be off (laughs)'.

The suggestion here is that men are apt to waste time on each other and power struggles and that for them competition is central to their 'nature'.

8.2 Conclusions

Despite the increased numbers of women who have reached senior leadership positions in the NHS, both as senior managers (clinical and non-clinical) and as senior clinicians *per se*, there were nonetheless some interesting differences between women and men's self-descriptions and perceptions of others as leaders, sometimes made on the basis of gender alone (Gill et al., 2008). Descriptions given of leaders and leadership for members of the 'other' sex were also frequently gender-typed.

It may be that despite valiant and frequently effective attempts to change the culture of NHS Trusts that a 'traditional' view of leadership remains at least in the organisational 'memory'. This might go some way to explaining why women who are clearly powerful and influential are reluctant to identify themselves as taking up these more 'feminine' styles even though they may in fact use the skills associated with these qualities. Eagly and Carli (2003) make a case for women as having a leadership 'advantage' in contemporary organisations where the type of leadership required has changed. However, they argue that in many cases women have to battle against the inherent prejudices in male dominated organisations. Although there is still a reference to gender stereotypes when discussing gender in organisations and gender and leadership as we have seen from the extracts above in this chapter, as Rosener (1990) stated: "*Women managers who have broken the glass ceiling in medium-sized, non-traditional organisations have proven that effective leaders don't come from one mould*" (p. 119).

In Chapter Five the OCS revealed that women across all professions scored lower than men on 'recognition' in that they perceived their managers as

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not recognising their particular attributes as clinicians or managers and they also perceived that the organisational climate was one in which 'recognition' was more likely to be given to men than women. That men did not see this as a problem for them reinforces the view that regardless of trying to establish gender equality across NHS organisations it is still not embedded in the management culture.

As we have seen and has been well documented in the literature, it remains difficult for women to exercise leadership without their behaviours being construed as either 'weak' or 'aggressive'. The paradox is that leadership requiring more 'feminine' characteristics is at least explicitly more desirable in the contemporary NHS.

9 Patient Care, Leadership and Service Delivery

9.1 Introduction

The NHS has a history of reform/modernisation aimed at making patient choice and care more cost and clinically effective by improving the organisational structures through which care is delivered (Bate & Robert, 2002; Becher & Chassin, 2001; Darzi, 2008; Wilson, 2009) .

The NHS remains committed to its original aims of providing a cost and clinically effective patient care (Doherty, 2009; Phillips, 2005), at least partially through the NHS's organisational structures, including the gate keeping function of primary care, while providing a universal service free at the point of delivery. Since the 1990s patient choice has been added to the longer term commitment to efficiency (Bhandari & Naudeer, 2008; Bojke, Gravelle, Hassell, & Whittington, 2004; Bryan, Gill, Greenfield, Gutridge, & Marshall, 2006). And at the same time there has been an explosion in new diagnostic and therapeutic technologies accompanied by a public awareness of the availability, or lack of availability, of those technologies (Aberbach & Christensen, 2005; Greener & Powell, 2003; Mueller, Sillince, Harvey, & Howorth, 2004a).

In this chapter we particularly address:

- what respondents (staff and patients) say about patient care and service delivery based on the interviews and focus groups;

- what we *observed* about service delivery and patient care and particularly the *interactions* between clinical staff and patients *observed* and *described* during the shadowing.

As in Chapter Six the Trusts are conceptualised as open systems whereby high quality patient care (the input) corresponds with effective service delivery (the output) with the primary task defined as caring for sick patients (or those who are giving birth).

9.2 Defining patient care and service delivery

The thematic analysis highlights similarities across all grades, statuses and disciplines of the staff and the patients involved in the study. The themes that emerged consistently from the data that were about good patient care were:

1. Putting the patient first:

...of course patients do come first but actually really, on everything that you do, I mean everything you do you think of the patients (service manager in acute medicine).

2. Thinking about what is good for the patient (all the time):

I still believe and I believe to this day that if you absolutely concentrate on what the patients' needs are, all other things take care of themselves. it's about really showing that you care. I mean genuinely showing that you care about your patients, erm there's a lot of talk about also looking after your staff and caring for your staff. I think that's important but I think the health service has got itself stuck far too many times concentrating on the needs of the staff and not the patients (Chief Operating Officer).

I think that's what you have to make sure is that everyday you are thinking to yourself, 'am I doing this for the good for the patient?' 'is it the right way to do it?' so I think when you get eleven years down the line, one of the things is that you can loose sight of is that, very easily (Matron).

3. Awareness of the diversity in the patient's world (culture, family, age, home and work environments):

..it would be making sure older patients have high quality of care during their surgical admission (senior consultant Geriatrician).

you need to support your staff ... you know and you have to have an awareness of the different culture of the patients (administrator).

4. Making sure the patient received the care that staff would expect for themselves and their relatives:

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I would define patient care that of - if it was one of my relatives who were ill (senior manager).

5. Talking to patients about what has happened, their medical history and their clinical condition:

....if they talk to you one-on-one and you know where you're at (patient).

6. Safety and empowerment of patients:

They [the multidisciplinary care of the elderly team] believe that good patient care sits around ideas of timely discharges, safety, making sure the patient understands their condition and their treatment, empowering patients by allowing them to make their own decisions about their care (to a point), providing the appropriate treatment and care, being responsible for the patient. Examples of bad patient care are viewed as delayed discharges, poor decision making and discontinuous care. (Notes from an observation of a team meeting).

From the descriptions it is clear (and perhaps no surprise) that senior managers, clinicians and patients all hold slightly different perceptions which inform their judgements to give 'patient care' a specific meaning. Some of the judgements are related to their particular clinical specialty or organisational responsibility although generally respondents reiterated that patients need to be at the centre of daily practices. Patients in all cases wanted more than anything to be kept informed about their care, and if possible this should be done by the clinician in charge.

At a more complex level the definitions above reveal a 'vision' of good patient care which links the 'practical', 'professional' and 'political' elements of NHS life. It also links to the 'human' elements associated with the tasks of caring. For example, the Matron (quoted above) shows a revealing insight that the routine *organisational* tasks might take over as a perceived priority from what a person initially knew to be their primary task (i.e. patient care). As she says, several years down the line you might lose sight of what you are really there to do.

9.3 How is good patient care achieved?

9.3.1 Managers

Managers each have different levels of responsibility for delivering good patient care which may differ from priorities expressed by patients and clinicians:

Erm, that's the bit about lifting your eyes up off of the horizon, and lifting the eyes up above the horizon is about looking at the totality because the

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medical, again, the medical management model is very much that you should do what you need to do when the patient is in front of you. The management model, the pure management model is about doing the right thing for the 450,000 patients who were looked after last year, so some of that will be about compromising, and offering the best care to the widest group that you can (CEO).

Immediately this respondent exposes the potential for conflict at senior level in that he/she³⁶ positions the 'medical management model' differently from the 'pure management model'. In the former the patient is a particular individual with a health care problem – the patient 'in front of you'. However for senior management there are many thousands of patients that require good patient care which means (maybe) compromising to provide the best possible care to the greatest number. Despite this, another senior manager had a different 'take' upon good patient care and in answering the question focuses on what they themselves would expect evoking a more individualised model:

I would want good consultant input into my care ((1)) as soon as it was appropriate in the pathway that I was on. I would want to be able to have a conversation about what was wrong with me and what treatments and options there were, ((1)) erm ((1)). I would want the assurances of the people that deliver the care know what they are doing. ((1)) I would want the care to be provided in an environment that was clean and in an ideal world I would want a single ensuite room, err and I would like to choose my own food and all that jazz. ((1)) erm and the erm, ((2)) so really you want the environment to be correct and you want to have the confidence in the clinicians giving care and you want to have had input into what your care should have been (Senior Manager.)

This manager has a very clear model of their 'ideal type' which positions the relationship between the patient and clinician, the skills/expertise of the clinician and the physical space and environment as central to good care. There is awareness here that planning and teamwork are also part of the process of care but particularly important is the knowledge of how to deliver the appropriate care and information in order to facilitate joint decision-making.

³⁶ We do not want to risk identification of any individual participant.

9.3.2 Clinicians

Good quality patient care for most doctors interviewed was:

... making sure that erm the patient achieves the outcome that you would wish them to as a result of either their outpatient visit or their inpatient stay erm and that outcome is kind of on a objective kind of medical measure, erm but it's also in terms of the quality of the care that they've received and whether they are satisfied with the care that they've received. (Senior consultant)

Another senior consultant who is also on the senior management team of the Trust took the concept of patient care further:

... it should be delivered well I think is the answer ((laughs)). I think on the whole we do deliver it well, we have the lowest mortality rate in the country, ((1)) or one of them. I think we do actually and we ((1)) I'm very proud of the care and I think there are two things to be proud of and one is the basic care and ... we do emergency work I am very proud of. Then the other bit of care we're proud of is that ... I think there is a real culture of innovation and I'm trying to do something new up here, and I think that's actually really important in terms of leadership. My job is being able to see a clinician with an idea and then work out of him or her how to turn that idea into a self service innovation. I think that we have created over the last few years a much stronger patient safety culture.

This respondent clearly links leadership and patient care stressing both the relationship between supporting other clinicians in innovations that improve care (particularly attending to safety) while also being proud of the culture across the Trust for low mortality, innovation, and supporting staff. Crucially there is a pride and energy about this account. The culture puts patients first but the staff gain satisfaction and a sense of professional pride from the performance of the Trust as a whole [T3].

The clinician manager below takes up the relationship between staff empowerment (and support which links clearly to the outcomes reported in Chapter Five) and returns us to the focus on staff training and skills, indicating here that if the managers train and empower staff – services to patients will improve.

... it's about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is, we worked with training and development and we came up with a specific programme that was aimed at empowering them to improve their service area etc. etc. and

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also provided them with some skill sets that they probably didn't have prior to that. (Senior Manager, Therapies)

While from a similar perspective the nurse quoted below stresses that team work and morale mark the path towards good patient care and you need to look after *staff* in order to deliver a good service to patients.

... And I think it is also, sort of, taking into account the people they work with, the team members and boost the morale, and that can make a lot of difference to, you know, to have people at work and sort of take the stress levels off and I think, you know, it would sort of, quality certainly would happen, sort of energise them, able to care for the patient. (Nurse, focus group)

9.3.3 Patients

For patients overall it was clear that most of all direct communication and consistency of staff was experienced to be good care:

A: ... I've been transferred here from [another Trust] and there it's a bit more, not one-to-one but you see a lot of different doctors here whilst there [the other Trust] you have only one doctor, your one midwife and your one consultant. Here you see a lot of different people.

Q: And which one do you prefer?

A: I'd say probably just to see the one 'cause lots people tell you different things.

Q: Okay, so it can be a bit confusing?

A: Yeah, sometimes it can be, yeah.

The patient quoted below reinforces the need for clear patient/clinician contact and communication.

For another woman:

Now whilst I'm here my care has been very good especially with the [specialist] who first saw erm, who first flagged up the problem. Erm yep it's been good it's been good since I've been in. It's just the initial communication as an outpatient to an inpatient I should have really - you know that should have been. I don't know where the fault lies but there should have been some communication there between the appropriate people (Maternity patient on postnatal ward).

9.4 Delivering patient care

9.4.1 Doctor-patient interactions

We look firstly at three consultants' (Cameron, Kenneth and Henry) styles across two different Trusts as they interact with patients to explore the importance (or otherwise) of good communication and engagement. What emerges, perhaps unsurprisingly, is that different consultants have different styles of engaging. The style adopted though feeds through to the 'ethos' of the clinical team, relates to, and impacts upon, the culture of the Unit thus affecting the doctor-patient interactions as part of an evolutionary cycle.

9.4.2 Empathy and Communication

9.4.2.1 'Cameron'

From the researcher's notes we gain an impression of Cameron who deals mostly with stroke patients for whom verbal and non-verbal communication may be very restricted:

Cameron offers a very personal and individualised style of patient care to his patients. He is often very tactile often rubbing the tops of their hands, arms and heads to encourage them or to show support when he is discussing difficult problems with them such as their inability to go home, the definition of a stroke and the future impacts of them having a stroke. He also speaks to the patients in a very friendly and informal way and sometimes draws on their mother tongue to say a few phrases to make them feel welcome and at ease.

In his interactions with his patients he is very positive and upbeat, often speaking loudly to encourage and motivate his patients. He also tries to share a few jokes with them and breaks down doctor/patient power relationships by crouching down in front of his patients or sitting on a chair or their bed so that he is always the same height or lower.

This description alone demonstrates how Cameron's *behaviour* relates to several of the descriptions above which identify good patient care in that he:

- communicates (verbally and physically)
- takes care to acknowledge their humanity through recognition of their cultural (linguistic) heritages the fact that they have a life outside the hospital
- attempts to empower them within the relationship (at least via discussion and physical presence and to an extent with knowledge of their condition).

Below is a detailed example of Cameron (and his team's) encounter with an elderly stroke patient (Mrs. D) which is part of the evidence the researcher has employed for her assessment of the processes engaged by Cameron in his provision of patient care:

"Hello Mrs. D? (Patient nods head and smiles) do you have a headache? (Patient nods head) Do you know why? (patient shakes her head staring wide eyed at B). "OK, I'll tell you..." Cameron sits on the edge of the patient's bed and explains that she has had a stroke and she has a headache because sometimes patients who have had strokes will have suffered from headaches due to pressures on the brain. The patient stares and nods her head occasionally as Cameron explains. "Mrs. D, do you understand what I have just told you?" (patient nods her head and then croaks "yes") on this speech Cameron sounds surprised and encourages her to speak again "Oh wow Mrs. D, that sounded good, can you say something else for me?...well done". The patient looks up at the doctor and smiles croaking again "I don't have anything to say doctor", "well never mind Mrs. D, I am sure I can get something out you a bit later!...excellent, your voice seems to be coming back...isn't that good?. We will have you singing in no time!" (Mrs. D. smiles and shakes her head "can't sing" Cameron smiles and laughs.

Despite the clear power differentials, doctor/patient and healthy/unhealthy, in this relationship Cameron is doing what he can to encourage and communicate effectively with the patient. Not only does he literally get down to her level by sitting on the bed but he explains the condition, how it happened and communicates the indicators for (potential) recovery. He is respectful and careful although the intellectual/cultural difference between the patient, Cameron and the care team is exposed by the encounters below.

"Now Mrs. D. can I examine you?" (Patient nods her head) Cameron takes the patients hand and she flinches "cold!" Cameron smiles and apologies saying it that "it is the alcohol" (alcohol gel he had just rubbed into his hand). The patient eyes Cameron suspiciously "have you been drinking?" the group laugh and Cameron explains that it is the hand-wash and she nods slowly and looks at each member of the team for what seems confirmation that this is the truth. Cameron then begins testing the patient's strength. He checks her arms and then her legs with simple strength tests calling out numbers between 1-5 for the SHO to write in the notes. As he instructs the patient with her tests he speaks very slowly and loudly and the instructions are very simple and clear and he often demonstrated his instructions, especially for those patients that have cognition problems. As the patient does the task Cameron is very encouraging shouting words such as "good", "excellent" or "well done after

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each task". After the strength tests Cameron checks the patient's reflexes with a small hammer. Again he shouts out numbers and makes comments about the reflexes that the SHO writes down in the notes. Following the reflexes Cameron checks the patient's facial muscles by asking the patient to smile, grit their teeth, stick out their tongues and move them about. He then checks her speech by asking her to repeat phrases or noises after him. The first phrases or groups of words were given as words that would be familiar to the patient such as the patient's name or names of simple objects such as pens. As the patient is able to say these words he moves on to more complex words such as "hippopotamus" which the patient struggles with. Cameron then checks the patient's ability to co-ordinate by getting the patient to touch her nose and then his finger with her index finger. The patient clearly struggles with this and is very slow and inaccurate.

For a brief moment after the tests Cameron has a quick discussion with L [another doctor] asking him what he thought about the tests and what they would expect to see on the CT scan. Cameron then turns to the patient and says "sorry Mrs. D, just discussing your test results with my colleague, we think that you are progressing very well...there has been much improvement hasn't there?" the patient stares blankly at Cameron for a brief moment before shaking her head "no, you don't think so? Now what about your speech, when you first arrived you couldn't say a word, now listen to you, don't you think you have improved?" patient shrugs her shoulders and looks down at the bed. "Well Mrs. D, we all think you are improving...so well done..." patient looks up and smiles sadly.

The style of meetings between clinical staff and patients was as much a feature of *Unit and team culture* as of a particular clinician's practices. Thus, while Cameron above was engaging with the patient in what appeared to be a *genuinely caring* manner, his colleagues were attentive, while in the background.

9.4.2.2 'Kenneth' and 'Henry'

In what follows two consultants worked together and while Kenneth was the more senior and experienced clinically, Henry held a senior managerial role (as well as being a senior consultant). Kenneth was described by the researcher as:

... a very warm and caring man ... he is very sweet, kind and caring to his patients and makes them feel comfortable and less vulnerable by empathising with them and drawing on his own personal experiences as a patient.

As with Cameron above, Kenneth was also described as 'tactile' and that he took the time to explain things to patients. Kenneth empathised with patients by sharing a joke (as did Cameron):

For example one lady was embarrassed because she had fallen down in her flat and sustained injuries and did not really want to explain how she had fallen over or what she had hurt [to the whole team]. Kenneth then told the patient that he had slipped over in the hospital and in the M&S food section. This meant that she no longer kept quiet through embarrassment and told Kenneth after that exactly what had happened.

However, during the two day shadowing of Kenneth the researcher was particularly:

...struck by how intimidating this group of doctors must be to the patient, especially an elderly or vulnerable patient as a large group of faces arrive at their bedside and close the curtains around them making the space feel incredibly claustrophobic and that the patient's space felt 'invaded'.

While shadowing Kenneth, the researcher was in a position to observe Henry (who was also shadowed for two days on a different occasion). The researcher's notes here, which describe a joint ward round with Kenneth and Henry, state:

I was struck by how impersonal Henry was towards the patients [in direct contrast to Kenneth]. He did not greet them or introduce himself. [In one case] Instead of asking the patient how she was getting on with the oxygen machine Henry asks the SHO how she thought the patient was getting on with the machine. When the patient tried to give reasons they seemed irrelevant to Henry who just told her she must use her oxygen machine every day or she will not get better.

The researcher goes on to describe how Kenneth (the senior clinical consultant although Henry has a senior leadership role) stands quietly behind the junior doctors on the round with Henry at the front of the group talking to the patient. Henry stands up. Kenneth stands at the back of the group with his hands folded behind his back and Henry every so often asks Kenneth if he agrees with Henry's thoughts on the patient's health status and treatment. While Henry is taking the lead in this way the researcher notes:

Not one of the doctors explains to the patients what will be happening to them that day or beyond nor do any of them say goodbye.

One patient on Henry's round is in the bathroom as the team arrive at her bed.

Henry knocks on the door of the bathroom and says "Mrs. X, it's Dr. Henry we are all here to see you". He then asks a nurse if she can hurry the patient along as he is very busy. It seemed strange [to the researcher] that Henry could not have just visited another patient until this patient had finished rather than rushing her. Before the nurse can enter the bathroom another nurse pokes her head out from behind the door and says that she is washing the patient. Henry asks whether this could be finished after he has seen her. The nurse, who looks frustrated, says she will be a minute. The nurse then helps the elderly lady to shuffle to her chair and helps her sit down. Without greeting the patient Henry begins talking over the patient's bed about her X-ray that was taken yesterday and then asks the nurse about the patient's progress.

In the examples above describing both Cameron and Kenneth's interactions with patients there is evidence that the patients were given a chance to explain to their consultant how they felt and either to tell the doctor what had happened to them or to hear the doctor's explanation of why they felt like they did.

The patients were treated in both these examples as human beings and in doing so the doctors themselves positioned themselves in their *clinical role* but also as *people occupying that role*. By acknowledging mutual humanity (albeit in different styles) these doctors were able to *take authority* from their position as medical experts (see Chapter Seven above).

By contrast Henry also took authority but did this by silencing junior colleagues, Kenneth his fellow consultant and most importantly, the patients. While Kenneth and Henry were in the same Unit, the scenario described above suggests that Henry held more power and therefore exercised greater influence on junior colleagues (and this fed into the culture of the Trust).

In what follows we trace how these contrasting styles might link to the culture of the Units and the teams themselves and consider how this fits in with the definitions of good patient care and service delivery.

9.5 Clinical team work and service delivery

9.5.1 Giving patients care

Miller and Gwynne (1972) suggested that a 'warehousing' model of care operates for those who may be institutionalised in the medium to long term which they contrast with the possibility of a 'horticultural' model of care, akin to what might be identified today as a learning environment. Working in the care of the elderly takes its toll on the emotions of all the clinical staff

particularly in the 'horticultural'/learning setting, where efforts are made to ensure two-way communication and mutual understanding and development takes place. This can leave clinical staff open to experiencing directly the pain and distress experienced by their patients (see Menzies-Lyth, 1960 and the 'stories' below).

The following example demonstrates how engagement between clinicians and patients impacts emotionally upon even (and possibly especially) senior experienced staff. The researcher here, shadowing Mandy, a female senior consultant describes the following case:

Whilst cleaning up a suppurating wound an elderly male patient cried. It was a really touching and sad moment and Mandy was clearly distressed that she had hurt the man. On first seeing him cry Mandy appeared to have a moment of shock/panic where she looked amongst her team to find out whether this was normal behaviour for this patient. On hearing the answer was 'no' Mandy tried to soothe the patient and seemed genuinely sorry for hurting him. The nurse who arrived at the scene also appears to be genuinely concerned about the patient and goes over to help Mandy and prevent the patient from crying. This scene was particularly sad because in today's society and especially in the patient's generation it is thought that men don't cry or show emotion. For the man to cry he must have been in severe pain and must have been struggling with himself to prevent the tears. Mandy's genuine empathy and somewhat guilt might have reflected that.

Mandy and the nurse in this context are using emotional intelligence (see Chapter One) in a relevant situation. Mandy also engages in conjoint action with the nurse rather than take action in an autocratic fashion without consultation. Mandy notes the patient's crying with a start (according to the description) and instead of continuing with the work on the wound (which many doctors might well do because it was necessary for a positive health outcome) she immediately appears to take in the context as a whole – thinking about her patient's behaviour and reactions. The nurse in this case mirrors the behaviour of the consultant. This is an important issue for discussions of leadership and patient care in that teams tend to reflect the beliefs and actions of their leaders.

9.5.2 Discussing patient care

In a shadowing the researcher at the start of the observation describes in detail the way two doctors discussed the patients before embarking on the ward round. This is another case of concerted action:

09:00 Breakfast meeting with Cameron [T3]

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Once they have consumed their breakfast Cameron and Mandy turn to business. Cameron begins by asking Mandy's opinion on one of the patients that they had seen on the ward round that morning. They chat for a couple of minutes about the patient before both getting a patient list out and going through the names systematically and discussing their care plan for each patient. Several patients will need to be discussed in a patient case meeting as they have complex discharge problems, others will need to be referred to the CCP so that a greater social package will be considered. Mandy says that she will go and see a few of the patients herself later and occasionally delegates tasks to do for Cameron, but mostly he is autonomous and says what he needs to do for a patient and what he will organise on behalf of the patient.

This is a quiet and supportive meeting between Mandy the senior consultant and Cameron the more junior member of the team. However, the researcher notes the systematic discussion of the patients and their care along with a plan about who Mandy will see and how Cameron's tasks are designated.

A similar atmosphere of calm and authority are evoked by the description of a case meeting with Cameron's team at the start of the first day of shadowing:

I approach the nurse's station and look around to see if I can see Cameron. I spot him at the far end of the ward sat at a computer with a mixed group of staff (doctors, nurses) surrounding him. I approach the group and stand amongst them. Cameron is facing the computer screen and discusses a CT scan with his registrar [L].I notice that as these two doctors discuss the scan a SHO writes notes in the patient's file occasionally craning his neck to look at the scan at certain parts of the discussion. A few nurses also crane their necks at various points but most just stand patiently in silence waiting to visit the patient. Once the discussion draws to a close Cameron turns his head from the computer and asks the team if they have anything to add. ...[later on in the same meeting the researcher listens to a telephone conversation] ...Cameron has rung the wife of a patient to update her on her husband's health. He is very honest with the wife saying that her husband has had a second stroke during the night at that he is now in worse health. Despite the bad news Cameron is very friendly and pleasant with the relative and is very sympathetic to her questions and on several occasions empathises with her. Coming off the phone Cameron returns to the team and gives a brief update to L regarding the conversation with the patient's wife. The SHO writes this summary in the notes. Cameron takes a short sharp breath before asking "shall we go and visit the patient?" Cameron turns quickly on his heels and enters the ward.

The observation here reveals the high workload and 'multi-tasking' undertaken by the team (looking at the computer, discussing scans, taking notes, calling relatives and so on). But there seems to be focused attention on patient care and individual patients. At the end of this extract it also seems that Cameron himself takes the ward rounds very seriously – gathering his mind together and possibly seeking the emotional strength to move from the clinical team and considering evidence from notes and colleagues to imparting and collecting information from the patients.

The same researcher who has shadowed both Kenneth and Henry at a different Trust from Cameron, gives examples of how some of Henry's patients are discussed. For example she describes a meeting to discuss patients chaired by Henry.

Henry criticises the way [Site B] is run and the management of beds and patients by that hospital. He praises the doctors for the current situation on [Site A] where they have spare beds stating that they have done so well in 'kicking them out'. Henry stated during [a previous meeting] that the patients needed to be removed or 'kicked out' of hospital as soon as possible. The rapid turnover of patients may on the surface appear that they are not receiving good care However getting patients home quickly reduces the risk of hospital acquired infections.

And is likely also to be what many patients would want.

As the researcher makes clear, it is important not to confuse the rhetoric with the quality of patient care, but rhetoric does determine and reflect a dominant ward or Unit culture.

9.6 Responsibility for patient care

Responsibility was a key element of the discussions of leadership particularly in Chapters Four and Five. Responsibility for individual patient care is in the hands of clinical teams led by the medical consultant but above that person is the clinical leadership/management (Clinical and Medical Directors) as well as the senior operational managers (CEO and COO and others).

Primary responsibilities for patient care however vary from *individual care* i.e. for both identifying care pathways and day-to-day care to responsibility overall for the care of all the patients. In Chapter Ten we review the findings from this study with some recent cases where responsibility has been mishandled to explore what lessons might be learnt.

In an interview with a consultant:

... we try to just have a really open forum where we can discuss that [specific patient care], just like open it up and letting people put their viewpoints first and then kind of trying to question where they're coming from with that in a positive kind of way but them also laying out where you feel that that might not be the right course of action. Erm and also at the end of that discussion making sure that everyone is happy with the outcome, and sometimes people aren't erm .. but it also realising that it is a consultant's responsibility at the end of the day and making sure that everyone knows that you're happy making that kind of decision and that you are happy to be made accountable for that decision.

9.6.1 Responsibility for emotion

It frequently falls on the clinical leader to cope with their own, the patient's and the relatives' emotional reactions and distress and also with those of the other members of the team. As the researcher noted:

One senior consultant, Tricia, made it clear that as the clinical lead she also took responsibility for talking to patients about DNR³⁷ forms and delivering 'bad news' to patients/ relatives. During the ward round Tricia removed the pressure from a junior member of the team who had been told by a relative that they didn't want their mother to be resuscitated. Being told this information had stressed out this junior member of the team as he was not yet ready for this type of responsibility. Tricia supports her junior colleague saying that he should have never been confronted with this situation.

One question here then is how do the clinical team handle such multi-layered emotional problems? How important is leadership in supporting (and developing) teams to cope?

9.6.2 Responsibility for teaching

Most clinicians in the study from all disciplines were interested in teaching the next generation, and their activities will influence patient care, provide role models for leadership and influence climate and culture of the organisation. The example below is chosen because Dr. Jenkins was very enthusiastic but also demonstrated compassion and courtesy when he was face to face with the patients. The researcher's notes describe this in detail:

Approaching the patient Dr. Jenkins shakes the patients hand and says "how are we doing today?...I see you were referred by your GP...you have a

³⁷ Do not resuscitate.

wonderful GP" (he comments on how wonderfully clear and precise the notes are). "That's not my GP, that's my missus's GP, mine's on holiday...I have Dr. U. U". "What a name! But looks like they have to wonderful GPs at your practice...the notes are seamless...you are lucky!" Jenkins then continues to ask the patient about his medical history. The patient is able to tell the doctor his entire medical in great detail including the drugs [more description from the researcher]. Dr. Jenkins stops the patient and asks the medical student to take a mental note of how a good GP leads to a well informed patient, which helps him (Jenkins) in his (patient's) treatment. He talks about 'aspects of professionalism' and the right ways of informing patients about their treatment and condition, he openly praises the patient for knowing so much about his patient history and tells the students that "medical history in patient care is so important". The patient begins talking about his treatment in the hospital and Dr. Jenkins states that "patient feedback is great, and they like to hear about it...we need to be more professional...primary care pathways are the key to patient care".

Dr. Jenkins behaves with humour towards the patients and the students and junior doctors but does so while continuing with his assessment of the patient, taking the relevant history and trying to impart good practice and professionalism. He manages to balance giving the students and junior a chance to gain hands-on experience while making sure he himself has all the information he needs for the care of the patient.

Dr. Jenkins then checks the patient's lungs and heart asking a SHO, Dr. Williams to check the cardiogram as he can hear an AF flutter. As Dr. Williams looks for the chart the patient tells him that his GP had thought the same and that is why he was thinking of changing his drugs. Dr. Jenkins looks at the students and says "wonderful isn't he?" he continues that the GP must have heard or felt it himself [the heart condition] and now they will need to see the chart to prove it then they can change the drugs as the GP had predicted. After looking at the chart Dr. Jenkins asks Dr. Williams to change the drugs and to get rid of one of the drugs he thinks are unnecessary. Dr Jenkins shakes the patients hand when he leaves and says that one of the juniors will be back later to sign off the new drugs.

Looking over the notes Dr Jenkins spends a lot of time teaching the [medical] students about various medical conditions and treatments that have arisen out of [a particular] patient and asks them to suggest other possible diagnosis and other treatments for his condition. Jenkins is a very enthusiastic teacher and the enthusiasm rubs off on the students who are all eager to share their knowledge and take stabs at questions they don't know. In the middle of the question and answer session he asks one of the students "what year are you in? I don't know how much you guys know already". The student base is a mixture from students from [different

schools] and he relishes the opportunity to teach the students some new medical knowledge. Whilst getting the students to look at the cardiogram he looks up and apologises to Irene [matron] for taking so long on his ward round "Sorry Irene, I will be here all day, this is such a pleasure to have students!" Concluding the teaching session he quotes someone for saying something about the health of gamblers and drinkers and then asks "now who said that?" the students look round each other and then he exclaims "me mother!" all the students laugh including the female registrar and Irene. He then ushers them onto the ward saying that he doesn't want to get in trouble with the matron.

9.6.3 Subverting responsibility

There are diverse ways that staff at both Trusts had for coping with emotional aspects of patient care and resisting authority (and thus taking responsibility for care into their own hands). One way that nurses (including senior nurses) operated was to *subvert* some of the doctors – particularly when the relevant doctors showed little interest. The shadowing of a senior nurse [Irene, the matron] during a ward round produced the case of Lola (described when shadowing Irene):

Irene tells me it is because many of the patients are elderly with complex cases and therefore they tend to stay for a long time. I note that one of the patients has been here for a long time and I ask whether due to the long length of stay on the wards whether she becomes attached to any of the patients, I point particularly to the patient who had been here for three months. Irene says, 'oh that's Lola, mmm has she been here 3 months?...let me check her notes'. Irene leaves the file that she is reading and picks up Lola's file and looks at the admissions page and then states (sounding surprised). That three months is correct. She then continues that she does find herself getting attached to her patients, especially if they have been here as long as Lola. She mentions that Lola should really have been moved to G Ward but she really doesn't want to move her 'she should be elsewhere, but she is ours' (highlighting emotional attachment and the sense of ownership over patients). She tells me that Lola is really sweet and all the nurses really like her and it would be quite strange if she was no longer on the ward as she is a returning patient and 'it is always nice to have her back'.

As we have suggested in Chapter One (and witnessed above), in order to protect one's self against anxiety clinical staff often 'split' patients into 'good' and 'bad'. Here the treatment of Lola indicates that the nurses may be using their care of her to defend themselves against some of the harsh treatment decisions made about other patients (by doctors and managers) particularly when there is pressure to discharge older patients due to bed

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shortages. This might lead them to consciously and unconsciously subvert these authorities when they can and there is a particular pleasure to be gained when they succeed in this 'subversion' with a 'good' patient such as Lola. What remains at stake is whether Lola's stay is actually benefitting her clinically (or even socially) and also whether it is preventing another patient receiving medical care.

9.6.4 Responsibility for end of life decisions

Responsibility for patient care resides not only with the clinical team but is sometimes shared between the team, the patient or the patient's closest relatives which is usually the case with end of life decisions. Sometimes the greatest emotional engagement is with the *relatives* of the patient rather than the patient themselves. This is particularly the case when the patient is likely to die which is particularly sensitive when it is a case of withdrawing life support. The following example of Cameron's Patient G and his daughter brings this into sharp focus.

The biggest emotional situation this day surrounded Patient G, a coma patient and his daughter. Cameron had to encourage the daughter to agree with his plan that her father's treatment should cease and palliative care take over. This is a very emotional situation especially due to the young girl's age but also because she was in 'denial' asserting that her father would get better and this caused her to present a whole range of emotions that Cameron had to deal with.

We enter the side room. The blinds are drawn causing the room to be quite dim. There is a young girl sat up right on a make-shift bed that she has made from four visitor chairs from the lounge. She has a blanket over her legs and is typing on her lap top her mobile phone ear phones in her ears and bags and other items are scattered around her chair. She looks up as we enter and pulls the ear phones from her ears. I am surprised at how young she is, I had expected a daughter of forty something not a teenager of 18 perhaps, but no more than twenty. She pulls the covers off her legs and places her lap top on the window sill. Cameron asks if she is ok and she nods and says she will leave him to it. Cameron says that he will bring her in once he has examined her father, she nods and opens the door pulling her jumper down over her leggings as she leaves. Cameron looks at me and comments (adding to what I was already thinking) "I think she is far too young to be dealing with this on her own....it is not fair".

He turns his attention to the patient and begins speaking loudly to him. He explains that he is a doctor in [Trust 3] hospital and that he wants to examine him. At each point of examination Cameron explains to the patient what he is going to do. Cameron is able to move the patient's limbs like he

is a doll. Each time the limbs are placed in a position they remain there. The patient doesn't respond to any pain stimulus as Cameron pinches the patient's skin and scratches the bottom of his feet with a stick. Cameron then checks the patient's eyes by pulling back the patients eye lids, the eye lids roll from side to side and Cameron explains that it is called a coma roll, which suggests that the patient is in a deep coma. Cameron teaches W by the patient's bedside and talks him through the patient's condition and talks about how the patient's recreational drug habits could probably have contributed to his stroke. Cameron and W engage in a small conversation about the problems of cannabis on the brain.

Cameron made the decision in consultation with his team to discuss with the daughter that they need to end the patient's treatment (and thus in all likelihood, his life). Cameron deals here not only with the daughter's distress but with the daughter's worry that she is involved in the decision to let her father die. Again a high degree of emotional intelligence and leadership as well as clinical knowledge operates in this communication.

While shadowing Owen [Trust 2] the researcher sees that while behaving perfectly correctly he puts emphasis on the clinical and health related aspects in an end of life situation above communication and empathy. He is not unkind but 'misses' the emotional level of communication. Here in the presence of a daughter and father the woman (mother/wife/patient) is clearly dying and being kept alive by the clinical team. Owen:

... talks directly to the daughter stating that her mother is coming to the natural end to her life and therefore she [the mother] is giving up - 'withdrawing from life' and tells the daughter that although they will feed her through a tube she [daughter] should prepare herself and her family for the inevitable. He also says that her mother will also start ripping the feeding tubes out to prevent herself from getting the right nourishment.

The image conjured by the 'withdrawing' from life and 'ripping' feeding tubes is dramatic and seems to give agency to the dying woman – almost indicating that somehow she is to blame as she will prevent herself getting the right nourishment. However, the researcher, as participant in this encounter, is bringing out a sense of the culture of this particular event. While Owen is probably protecting himself emotionally from the loss of life and the sense of clinical 'failure' he does not protect the daughter or the husband from the emotional onslaught of the woman's impending death.

The daughter says that she understands and turns to her father and says 'dad do you understand what the doctor is saying?' the husband paces up and down the side of his wife's bed looking lost and lonely. He looks up at Owen and says that his wife is giving up because someone at the nursing home said she was a burden. The daughter scolds the father for saying that

in front of her mother. She explains to Owen that although she [mother] doesn't say anything she listens to everything and the more her father says it the more she doesn't eat. Owen says he understands and asks how the family is coping.

The daughter here is also protecting Owen from the family's pain by scolding her father even though Owen asks how they are coping. However, although kind and polite, Owen does not seem to operate with emotional intelligence or engagement with others' pain.

The daughter says that her father is finding it very difficult because he is the main carer for her; she herself has taken time off work to care for her when she can to support her father. As she speaks about her father and how upset he is becoming she begins to become tearful. Owen listens to her as she speaks and occasionally asks further questions. The husband continues to potter around the room occasionally touching his wife's head and face. The daughter watches him.

Owen, while allowing the daughter to cry and not acting as if he is irritated or embarrassed, equally pays little heed as he continues to talk of the mother's deterioration.

Owen begins to talk about the deterioration of her mother and what they will be able to do for her. The daughter says that she knows what Owen wants to talk about 'you're talking about DNR aren't you?' Owen says yes he is and the daughter tells him that she knows about it because her friend's mother recently died and this was discussed with her. The daughter says that she knows what she would prefer but they will have to talk this through with her father. The daughter calls her father over and begins explaining DNR. He looks at his daughter, he looks lost and scared and she tells him that it is his decision but she thinks that the doctors should not resuscitate her mother because she will be resuscitated to the same state. Owen inputs that she will be 'worse' than how she is currently because she will be a lot weaker. The daughter says that she will have to talk through this with her father. Owen nods and leaves the room.

9.6.5 Stories of patient care

The following two stories show in detail the ways in which responsibility and power can shift between team members and highlight anxieties faced by doctors about caring for patients.

9.6.5.1 A story of system failure: Cancelled Clinic

The first story is told by a female registrar who describes a situation in which she felt disappointed with patient care due to cancelled clinics. In the

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following account, the narrative is broken down to four moments, and each is discussed to demonstrate how the doctor's anxiety is managed by being linked to a failure in 'the system' that climaxes in her interaction with patients.

Q: What about any time or incident that made you feel disappointed with patient care in this hospital?

A: Lots of times, particularly since we've not had a secretary. Every clinic, every single clinic I send somebody home because the notes aren't there at all. They are supposed to be coming to see the consultant [her immediate superior] and he's not there, and they've been put into my clinic and you look at the letter and it clearly says on the letter 'consultant only to see', and they turn up and he's in Italy, on holiday.

The registrar is expressing frustration. On the surface it is towards a recurring failure in patient care attributed to firstly not having a secretary and secondly because the consultant 'is not here'. The expression of the frustration however is confused; there is no secretary but the patients 'have been put' into her clinic. Furthermore, she sends someone home from each of her clinics because the notes are not there. The letter 'clearly says' the patient is to see the consultant who is not only not there but he's in Italy 'on holiday'. There is a feeling of being overwhelmed, and of rage and envy towards the consultant - and possibly the patients - emerging from this short paragraph (for discussions of workplace envy, see Vidaillet, 2007; Stein, 2000). There is also an expression of omnipotence in that she sends patients home. She has the 'legal' justification to do so because there are no notes and also because their letter says they have to see the consultant and the energy is directed towards this activity rather than getting patient appointments changed. The consultant is on holiday, presumably one to which he is entitled and one which has clear boundaries enabling them and the staff who make the appointments to re-arrange the patient dates.

There is clearly a high degree of frustration and anxiety present in this account; there are too many patients with 'needs' and not enough clinical or support staff backing the work in the way in which the doctor would feel comfortable with. As there is little opportunity either to express or assuage her anxiety so she becomes 'prey' to primitive phantasies and unconscious mechanisms to relieve the anxieties.

The story also sheds some light on doctors' anxieties about working in a multidisciplinary team. Medical education and postgraduate training provide a culture in which doctors believe they can rely on each other through which a sense of being an elite group and confirmation of professional omnipotence and responsibility - particularly of the consultant - arises. However the role of the consultant also brings about a sense of envy and

destructiveness in others which has its origins in the primitive defence mechanism of splitting off the painful parts of one self (e.g. the realisation that you are not omnipotent and that another has the ability to do what you cannot) and projecting them onto others in an envious attack (Klein, 1959).

...and you have to go out and say, 'I know you've waited three months for this appointment but I'm afraid the consultant is not here and he wants to see you personally, so thanks for coming but if you can just go away' and you can't even say to them 'you're getting an appointment for next week' because realistically they're getting an appointment in three months time, and I think that's really disappointing.

'Breaking bad news' is considered to be a difficult task for health professionals and one that is a constant cause of anxiety. In addition to having to find the appropriate means of communicating prospectively devastating prognosis and supporting patient through the immediate emotions, doctors must come to terms with possible changes in how the patients perceive them (Barnett, 2002). Even though the situation described here does not involve delivering bad news about an illness, it is a moment of disappointment for both the patient and the doctor. The patient's anticipation to receive treatment is rejected and the doctor has to acknowledge failure in service delivery. The patient's possible anger and anxiety is directed towards the messenger, who in this case, is unable to offer any practical solution. Instead of being the helpful, trustworthy saviour, the doctor transforms into an envoy of disappointment and will have to see to the patient's emotions as well as her own disappointment, to which there is no external consolation on offer. To alleviate the anxiety caused by the situation, the registrar clings on to a narrative regarding her workplace – she is disappointed in the system.

I feel very disappointed in the system, which, I know the system is a big, wide thing, but ... [it] lets people down from that point of view and, you know, we overbook theatre lists and they get cancelled and then again I feel disappointed.

By seeing the NHS as a faceless, bureaucratic, 'machine-like' (Elkind, 1998) entity, the registrar convinces herself that the situation is not her fault – it is not what she would want for the patients, or for herself. She feels anxiety for she cannot provide the care required, and as a consequence she projects this anxiety through blaming 'the system'; regardless of their individual efforts, doctors are powerless when the system fails. As this registrar said epigrammatically later on in the interview: 'I don't think the NHS works anymore' which at a conscious level represents the impact on her working life of a problematic bureaucracy while at an unconscious level it provides uncontainable stress. The doctor does not have the opportunity to delegate

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tasks to her superiors to reduce the 'heavy burden of responsibility' (Menzies, 1960, p. 118) thus feels that she is left to deal with the failure of 'the system', a system, which ironically is set to heal people, not cause them angst.

It's mostly because I'm thinking, how must that patient feel. You know, they've worked themselves up, they've told work they are gonna be off work for three weeks or four weeks or whatever and arranged cover and you go and tell them, sorry, you can't have your operation, you can go back to work tomorrow. That's really disappointing, to do that to people, very much so.

In the conclusion to her story, the doctor moves beyond expressing antagonism to the system to empathising with the patient. Thus, by failing, the system provides the doctor with a social defence mechanism but through empathizing with the victims of the failure, she fails to contain her anxiety.

9.6.5.2 A story of grace in adversity: Supporting the mother of a still-birth baby

The second story is told by a male registrar who describes how he provided good patient care by supporting a mother of a still-birth baby. Despite the plot, the story is not told as a tragic narrative but as a proud patient-care moment, a sequence of events that had thoroughly positive impact on the doctor's perception of himself. This narrative is also analysed in sections.

Q: Could you give an example where you felt that you have given good patient care?

A: I think that one of them was this lady who actually came to the labour ward and told me that she hasn't felt her baby move in the past one day and she had had some bleeding. Obviously there was some concerns on my behalf for the baby, because there could be a problem. This was a very wanted pregnancy because she was quite old and this was an IVF pregnancy. I examined her a little bit and on examining her I found that the baby did not have a heart beat, so she had lost the baby.

Describing the situation at first with the patient as an object helps the doctor to distance himself from the scenario and to do routine checks expected in this kind of situation. In a hospital setting instructions are given about the way each task should be performed and these rituals form a reassuring tool for staff (Menzies, 1960: 121).

I did explain everything to her, and obviously as a doctor responsible for her, I need to follow all the procedures that needed to be done and all the care that she needed to have, you know I explained it to her that, you know this by far something that words, you know cannot express, as you can imagine how

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difficult this situation would be, and if we could make it the slightest bit better, we would try everything in our power, you know, to make the situation a lot more comfortable. I ensured that she was given a quiet room, with a very good midwife looking after her at all times. Obviously I had my duties towards the rest of the labour ward as well. People visiting her room making sure she was ok, making sure the pain relief was ok, we had induced her because we did not want her to go home with a dead baby inside her. It was a very, very painful and stressful scenario, it really, really was, it was horrible, absolutely and it is very distressing, exceedingly, exceedingly distressing because, you know the woman is going through all that pain of labour.

Here, the doctor is empathising with the patient, feeling her emotional pain and in this case is mostly able to contain it through wanting to relieve the situation and then by offering extra care, by 'going an extra mile'. In this extract, there is a clear shift as the doctor uses strong emotional words to describe the crisis. In telling the story, he is projecting his own anxiety on the patient, living the distressing emotions with her and having to remind himself of his position as a medical professional - 'obviously I had my duties towards the rest of the labour ward as well'. By referring to 'all that pain of labour' the doctor enters a relationship with the pain. The phenomenon of pain and our relation to pain, whether someone else's or our own, is more immediate than that of reflective knowledge – we do not think about pain but react to it so the sensation is intersubjective. The person who is not experiencing the pain but affected by it is an 'interlocutor' in the situation (Crossley, 1996, p. 37).

...I tried to make it a point that I was present, present as much as I possibly, feasibly could during her emotional outbursts. I wanted her to have all the support that she needed... I did get attached to the patient, being around her, trying to get her care, even if I was out of hours, which means that when I was not meant to be in the hospital. Now I think that some people will argue that, that is a bit over the top, but I think that, I guess, I guess, that that is medicine for you, you know it is about lives, and sometimes you have to make that extra effort, to make that person feel that little bit more special.

In this excerpt the doctor starts to explain and justify his actions. Through self-reflection he has realised how he acted in a way not normally accepted in the hospital culture, that is, he went against the 'social defence system' to deliver patient care, but also to cope with his own anxiety. He dedicated extended time to his patient even though hospital doctor's time is considered to be 'fast and efficient'; 'doctors move quickly in the hospital wards. Their time is expensive. They cannot afford to linger too long in any one spot' (Mattingly, 1998, p. 21).

Menzies (1960) noted that while institutions have social defence systems, individuals may resort to their own defensive mechanisms, but a membership of an institution 'necessitates an adequate degree of matching

between individual and social defence system'. If the individual and the social defence systems are in disagreement, what follows is some degree of breakdown between them, for example, a doctor's work colleagues might reject them for behaving in an inconsistent or unprofessional way to the system. Consequently, the registrar providing patient care to the mother of the still-born baby is not only coping with anxieties created by that emotionally charged situation, but he also has to think about the culturally accepted limits of caring and possibly negotiate his way with other members of staff. On this occasion, the doctor keeps to his defences and spends extra hours with the patient, without being criticised by his peers.

Well you know that when things get worse, they get worse and they get worse and they get worse. Ultimately what happened with her was that we tried all the induction of labour, we tried everything possible to get that baby out, by induction. And in her case with the induction, it failed as well... and I can't tell you how dreadful that scenario was, that she needed a Caesarean section to have that baby out... I wanted to make sure that I was present at the Caesarean section, as well so that she would have a face that she knows. Once she delivered, you know obviously I was there with her, with the [dead] baby in her arms, and she was happy from the point of view.... and thanking me every now and then, which I said that she shouldn't because it was my job and one should do it. But she kept signalling the fact that not many people would do it the way that I had and I that was very special.

Much hospital work contains a 'constant sense of impending crisis' (Menzies, 1960, p. 26) which creates pressure and anxiety. The level of predictability in medical work is low and – as the registrar expresses it – 'when things get worse, they get worse'. The doctor explains that he attended the Caesarean section for the patient's sake, but this could also be interpreted as his coping mechanism – the need for a closure (Mattingly, 1996: 37). If you only see trauma and dramatic events without closure, the events will stay lingering and cause anxiety, stress and possibly depression. The doctor needed to be there and needed to have closure to be used as a coping mechanism against accumulating anxiety. So far the patient had been in a powerless position while the doctor had presumably been in control of the situation and emotions involved in it. Therefore, when the patient thanks the doctor, he gets confused. The patient had survived through the ordeal and suddenly has the power to relieve the doctor's anxiety, to nurse him (Menzies, 1960). The acute physical and emotional stress is released and the doctor can reflect back on his experiences.

And I think that is something very, very special and dear to my heart. And these are those situations when you sit back and you reflect on your life and

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say, "wow I have done something good, really, really something good and it is wonderful".... I saw her every single day on the post natal ward and obviously I made a point not to neglect her, or neglect her partner because people assume that the only person going through the trauma is the woman who has actually delivered, but they are a couple, and that needs to be understood so that was important as well. And he appreciated that quite a lot. They went home, two weeks later, I did receive a lovely letter, which kind of expressed a lot of gratitude, for what I had done for them.

The thanking letter provides closure for a difficult story, but maybe also goes beyond this. It hints at redemption – instead of a medical tragedy possibly compounded by failure in patient care, the story becomes one of a victory or at least grace under fire, a positive example of the doctor's powers even when he cannot actually perform miracles by restoring life. Anxiety is successfully overcome by the absolution from the patient and the doctor's 'priesthood' (Elkind, 1998) is restored. The letter from the patient acts as the final seal to exalt the extra efforts the doctor put in to solving the problem (Menzies, 1960, p. 31).

I know that I put in extra hours and I KNOW that I shouldn't have been there but no-one complained, because everyone knew that I was helping a situation. It is just an understanding that we have. It would be a terrible job if you were only allowed to work your set number of hours.

A narrative like this one permits people to attach themselves to 'desirable' ends, think well of themselves in moral terms', 'support their needs for autonomy and control', and 'promote feelings of self-worth' (see Baumeister, 1986 in Brown, Stacey & Nandhakumar, 2008, p. 1054). By telling this, not an easy or comfortable story, as a proud moment of good patient care, the registrar restores his professional and personal integrity. There is no 'system' in this story to blame on, no failure to confess, but despite the drama the story draws to a happily-ever-after ending. The story has entailed a narrative for the self (Brown et al., 2008) that has released the anxiety the event contained.

9.7 Conclusions

Patient care is a process and a social construction and as such means different things to different people. Norms and styles of patient care also change across time and differ site to site not only because of differences in beliefs, but also because there are different possibilities (technological advancement, different types and mixes of professional groupings) and different types of constraints on what might be offered. It is not always possible to put a clear value judgement on patient care and one example is to do with 'length of stay'.

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Managers, whose concern is to ensure that beds are not blocked, may or may not be holding in mind the image of an organisation that shares care with agencies and families in the community. They may simply be responding to government targets. They may have their mind fixed on those waiting for beds who have still not received treatment. Patients themselves may want to return home as soon as they can or become bewildered when they are discharged rapidly after treatment.

Working in multi-disciplinary teams with distributed leadership patterns may have improved practices for clinicians. Accountability for patient care still resides with the consultant and the hierarchy who manage the Trust. While senior managers are responsible for ensuring patient safety and preventing negligence to individual patients, they are also responsible for ensuring access to care for the community which involves managing scarce resources such as equipment, pharmaceuticals, beds and staffing.

Not all clinicians appreciated or respected these pressures as we saw particularly in Chapter Six. Nor do patients necessarily agree that good care is anything other than good and consistent communication with specific clinicians.

As demonstrated in Chapters Six and Seven managers are frequently frustrated by demands from staff who may try to subvert managerial targets (set by government and as such fundamental to resourcing of the Trust).

The quality of leadership is intimately linked to patient care. Good patient care relies on effective leadership of the kind that engages with staff and imparts to them the vision that (as far as humanly possible) the patient comes first. That in turn impacts upon the climate, culture and ethos of the Trust. When leadership fails, so does patient care.

10 Leadership and patient care: Assessing the past and thinking of the future

10.1 *Introduction*

Without effective leadership at all levels of the NHS and its various organisations patient care suffers. This knowledge has been evidenced in

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several key studies across recent years as reported above and elsewhere and consequently fed into the NHS Qualities Framework (see Chapter One).

In this report we have critically reviewed the relevant literature on leadership exploring as far as possible the relationship between leadership, followership and service delivery across five hospitals comprising three NHS Trusts (see Chapter Three). We employed different research methodologies (see Chapter Two) to capture data to investigate leadership qualities and their interaction with the climate and culture of the organisation and linked these to service delivery and patient care in different settings (ranging from obstetrics and gynaecology and cardiology to care of the elderly).

10.1.1 The organisational contexts

The organisational contexts of each Trust and each site or unit varied physically, structurally and in 'atmosphere' (the full details are provided in Chapter Three). We have been concerned in the report (and future papers) to steer a path between maintaining anonymity and confidentiality and thus not overtly identifying a Trust or site within a Trust, while also pointing to how the contexts impacted on the practices of leadership and service delivery.

Overall the Foundation Trust (3) in this study, which had not been experiencing mergers or threats of closures, where staff morale was high and where leadership practices were distributed across teams and clinical and management specialties, was clearly the one most conducive to effective communication and leader-follower engagement. There was an 'atmosphere' of connection and pride in belonging to the Trust as evidenced explicitly in Chapters Four and Nine in particular.

Trust 1 was applying for foundation status during the time of the investigation but also threatened by closure of some of its units, and with the senior managers possibly being transferred to the other site which was perceived by the participants as a threat to their status and possibly to resources for service delivery. This did not happen during the course of the investigation. The managers in Trust 1 were committed to their staff and to service delivery although there did appear to be some discontent with senior management from the medical staff. This may have been because most of the distributed leadership involved non-clinical managers and nurse managers with the medical teams appearing to take a more 'traditional' hierarchical stance. Most of the data from the OCS was derived from Trust 1 which demonstrated among other things the importance of management support for identifying good leadership and patient care practices.

In Trust 2 there appeared to be the greatest amount of conflict between groups of staff who sometimes seemed to be leading in different directions.

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Trust 2 was perhaps the 'victim' of a relatively recent merger between two large hospitals (and one or two other smaller units) which were some physical distance apart and had had a different history – one being a DGH and the other a teaching hospital. The DGH appeared at first to have a professionally diverse group of senior managers who distributed their leadership to effect, but one or two figures emerged during the course of the study who transgressed this approach with one person taking a back-seat while another was trying to drive through change in a somewhat cavalier manner. Furthermore in this particular Trust there were changes among the senior managers (some left, others moved to the other site during the course of this study). The CEO also indicated that it was difficult to recruit good middle-range managers and nurses in particular because both sites were away from the centre of the city where most people would look for a promoted post.

10.2 *Limitations of the study methods*

As with any large scale and complex study such as this one not all of our intentions were achievable although some were satisfied beyond our expectations.

We had difficulties capturing data from patients for two main reasons (fully detailed in Chapter Three).

Firstly, the 'gate-keeping' staff working on the Units on a day-to-day basis (as distinct from those who supported overall access to the Trust overall) obstructed data collection.

Secondly, it was also difficult gaining access to patients while they were in hospital because of ward procedures and in other cases the poor health of patients. So in the end we managed to conduct ten patient interviews but were unable to collect organisational climate survey data from patients at all³⁸. To overcome this we gained permission to observe clinicians' interactions with patients in their care and we believe we have managed to do more than compensate, making a contribution to knowledge with important new material to demonstrate patient care in different contexts and the processes involved in patient care and service delivery (see in particular Chapter Nine).

We also met with difficulties, with one Trust in particular, collecting *survey* data from staff although individual staff members proved more than willing

³⁸ These difficulties were reported to SDO in the interim reports and also separately when they arose.

to support the researchers by allowing them to interview, observe and shadow them during their working days. *This is all reported fully in Chapter Three.*

10.3 *Reviewing the findings*

In this final chapter then we draw together the findings from the study and make suggestions as to how they might contribute to policy and practice beyond the participating organisations.

This chapter is organised around the original study aims which were about leadership, organisational climate (culture and context) and how they impact on patient care. The overall plan was to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery.

This research further sought to explore the following broad-based questions.

- First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
- Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?
- Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The specific aims and objectives are listed again below and we conflate these in what follows directing the reader to the relevant chapters.

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines, to patients;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts service delivery;

- To learn how different stakeholders (specifically patients, nurses, members of professions allied to medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care;
- To identify how the need for change in service delivery is identified and what drives the need for change.

10.3.1 How far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?

Throughout the participating Trusts there is evidence of the importance of high quality patient care. Chapter Nine in particular brings this together with quoted respondents emphasising that above all patient care matters to the aims of the organisation and those who work in it. Thus on a basic level, working for patient care is inspiring in itself and staff across the Trusts see good patient care as their *modus operandi*.

Our use of innovative ethnographic methods and story telling were particularly effective in providing the evidence of how patient-clinician relationships were practiced and how staff made sense of their own actions reflexively in the context of caring for patients³⁹.

Chapter Nine provided evidence of the ways in which care is practiced.

We begin here by summarising some of the evidence from the Foundation Trust in this study, which consistently appeared to demonstrate high levels of distributed leadership, emotional engagement and multi-disciplinary working across all levels. The data included several key examples of positive statements about the role and effectiveness of management. We saw, for example a senior clinical manager summarise the issue with reference to his

³⁹ For example, interviews opened with questions about leadership and patient care, and participants were then encouraged to tell 'stories and critical incidents illustrating their experiences'. The early parts of the interviews provided themes and indications of what the clinicians regarded as crucial to delivering good patient care, e.g. 'cleanliness', 'efficient administration', 'communication', 'empathy', 'sympathy', 'knowing the recent developments in your field' and 'everything behind the scenes the patients don't see'. However, it was the stories they relate to that provided us with insights into their core experiences of patient care (see Chapter Nine).

pride in working for the organisation drawing attention to its low mortality rates, and that the high quality staff and its reputation for patient care act to attract others at the top (or with the potential to be at the top) of their specialty.

By contrast, the CEO of one of the other Trusts had made the point in their interview that one of the difficulties they had was attracting high caliber nursing staff, partly because of their location (in the suburbs). In Chapter Four we identified the ways in which an organisation might be seen as a learning organisation as significant in supporting staff to develop their clinical and managerial skills and develop capacity for patient care. Where support for learning was apparent so was the enthusiasm and pride for the organisation and its goals.

What was striking was the way that all respondents who addressed this point were looking to see how patient care could be improved with aspirations that patients were satisfied with more than just the health outcome (although that is the bottom line) but also with the facilities and the atmosphere. In addition, several respondents made the point that they themselves were mindful of delivering (or at least aspiring to deliver) the type of care they themselves would want to receive.

That so many of the staff (clinical and non-clinical) worked long hours in which they were engaged in intensive work with either their clinical or management teams, or their caring for patients with the aim of delivering the best possible care, is yet further evidence of the ways in which patient care is inspirational.

What is most noticeable, however, is how some styles of clinical and managerial leadership appear wanting, when compared with the best. While some respondents are clearly excellent communicators who engage fully with their professional knowledge and with the patients and staff, others - equally expert and equally inspired to provide the best for their patients - seem to fall short in comparison. In Chapter Nine for instance, Cameron and Kenneth engage with their patients in human ways and there are examples in the chapter in which each clinician manages to gain important information from and for their patients by their hard work *and* their humanity. However, in Cameron's case he is supported by a team which has clearly been nourished and inspired by the organisational context (see references to Cameron's work in this report).

Kenneth, while equally able and empathic, from the ethnographic evidence reported in Chapter Nine, appears to be less able to transmit this or influence others to take up his brand of leadership and patient care. He remains slightly in the background while the younger and (it appears) more influential Henry sets the tone. The clinical team give the impression of

being business-like and impersonal and somewhat intimidating when they conduct their ward round. The culture being transmitted to the other clinical staff tends towards Henry's approach rather than Kenneth's. This raises questions about why this Trust and site is different from the FT in which Cameron and Mandy work. These matters were addressed in Chapters Six, Seven and Nine in particular and will be subjected to further analysis in subsequent publications. However the FT is established and settled. The Trust where Kenneth and Henry work was the product of a relatively recent merger and norms and values were still being 'negotiated' (see Chapter Seven and above in this chapter).

Subsequently we see Mandy working directly on a patient's wound not only acting humanely when she hurts the patient but working with the nurse to assess how they might best improve the patient's condition while caring for his mental state and self-esteem.

High quality care and inspiration come together through the ways in which clinicians and managers take responsibility for their work – for managing emotions (their own, their colleagues' and their patients'), teaching, making decisions about end of life care, communication with relatives and coping with everyday situations that raise anxiety levels for patients and staff. The story of the doctor in Trust 1 who cared for a woman with a still-born baby itself demonstrates how he went the extra mile (in his words) inspired by the possibility of providing care in a case where some might have tried to make minimal contact because a still-born baby might be seen as a clinical failure.

Overall emotional engagement with patients and followers leads to people working together in a human, humane and inspired way and impacts on the organisation itself which can become one with which people are proud to be associated.

10.3.2 How do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

This question underpinned the entire study, but specifically we reviewed the relevant research literature on leadership and organisational climate (Chapter One) and discussed this in Chapters Four through to Eight. We began by reviewing the results from the story-telling interviews, focus groups and ethnographic methods (observations and shadowing). A range of potential practices and behaviours were reported to us which suggested where problems might lie in current leadership practices, as well as what many respondents held to be ideal types. What we summarise now represents a combination of what works and what does not although it needs to be noted (as identified in Chapter Nine in particular) that what

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patients see as good leadership (that they received clear and consistent information from one or two key staff) may not always intersect with what staff meant by good patient care or effective leadership and service delivery. The latter was usually seen as best delivered by a well-functioning multi-disciplinary team albeit frequently constrained by limited resources.

The following issues stand out as good practice that could feed into NHS (and local Trust) policy:

Leadership is a complex concept meaning different things to different people. Over recent years leadership in changing contexts such as the NHS has shifted from the 'heroic' model where leadership is hierarchical to a model that is more distributed across different levels and different parts of the organisations. The heroic and hierarchical (related) models frequently depended upon individual characteristics and where the senior managers were indeed heroic and charismatic, leadership might well have led to good patient care. However, this is unreliable and unpredictable and the NHS Qualities Framework which has identified leadership skills is more appropriate to the context (see Chapter One).

Our most important findings, however, make it clear that leadership which is emotionally engaging and distributed is the one which is most likely to lead and support service delivery successfully as well as drive necessary changes.

At the end of Chapter One we focused on contemporary studies of leadership which promoted the importance of *context* and of taking a more discursive stance in the analysis of leader-follower relations. We also drew attention to the revival (and reappraisal) of concepts from organisational studies from the 1960s to the 1990s which took psychodynamic ideas into account and related them to more 'popular' contemporary ideas about the significance of social and emotional intelligence in leader-follower relations. Thus, we explored the ways in which stakeholder accounts of the experiences and exercising of leadership demanded an attachment or engagement at an emotional level, which took account of the unconscious as well as conscious understanding of these experiences. There were several examples offered in the previous chapters of leadership practices that delivered the required services or changes through different types of concerted action and those that didn't. In some cases we were able to show that with the best will in the world if the leader, for whatever reason, was unable to *engage* and thus be supported by the followers, then their leadership failed to deliver.

Recent analyses of distributed leadership styles and organisational contexts show that if such leadership is to work then people need to act and work together and be prepared to both take up and relinquish authority for

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certain tasks and roles at the appropriate intervals. We saw in Chapters Six and Seven for instance that authority is hard to maintain if a leader loses touch with their staff and fails to hold their own organisation 'in mind'. We used the OCS survey results in combination with the data derived from the interviews, focus groups and ethnographies to demonstrate the importance to a positive organisational climate of good leadership. Satisfaction with a manager was predicted by the same variables that identified a positive organisational climate. For staff in the organisations surveyed it was important that managers were committed, responsible and supportive of their staff/followers.

But how were these characteristics demonstrated? Leaders who were experienced as effective, supportive and emotionally engaged with their followers were able to communicate their vision and dedication to improving the quality of care to patients, which in itself co-existed with good staff morale. Such leaders were also good listeners as well as being able to take staff with them when less palatable or unpopular changes were mooted by senior management or government. These effective leaders were closely connected to the way the organisation was structured (physically and emotionally). They were thus able to access the information they needed in order to lead. The evidence for this frequently came from the stories and accounts of staff and observations made by researchers – often of good leadership but perhaps more acutely when leadership was poor. Then there was a jarring effect or mismatch between (local) policy and the attempt to drive changes to meet improvement targets. There was also evidence on occasions of senior clinicians' behaviours being disengaged. Sometimes attempts were made to subvert the senior people when leadership went against the grain. There are examples in Chapters Seven and Nine in particular.

A final comment here is that despite the changes in gender demographics at the top of clinical specialties in medicine, nursing and related professions, as well as in senior management, gender has not 'gone away'. Indeed distributed forms of leadership have (perhaps stereotypically but with some evidence base) been associated with women's behaviours. The OCS (Chapter Five) suggested that women's perception of 'recognition' for their work and achievements was more negative than that of men. Men were either satisfied with the recognition they received or less in need of recognition from their managers within the organisation than were women. In the qualitative data (see Chapter Eight) it was also the case that while senior women were keen to deny the relevance of being female to their professional lives and their career progression per se, women used different strategies and perceived their roles slightly differently than did men, although the point was well made by some respondents that feminine and

masculine choices of specialty may have been more significant predictors of management styles than gender itself.

10.3.3 Do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The contemporary NHS with its (mostly) distributed leadership practices at all levels tends to militate against the possibility of one person's vision being paramount. However, as suggested above in this chapter, there are nuanced influences of leadership style that (may) flow from one or two people's vision and/or style of leadership and patient care that influence organisational approaches.

In Chapter Seven, for example, we explored three senior people's visions and consequent behaviours to consider their authority and influence with the possibility that as opinion leaders they influenced organisational approaches to patient care. Quentin, for example, reflected his role as a senior clinical leader, and although there is no irrefutable evidence that his style was mirrored in the organisation itself, he does provide some evidence that in certain cases in relation to certain actions his vision had an impact on the overall organisational approach.

While the OCS (Chapter Five) captures data from a wider population, the ethnographic methods made a greater contribution to exploring how far an individual's vision influenced the organisations approach to patient care. Again in Chapter Seven we see Kerry battling against a resistant (and probably disillusioned for some reason) senior management team to improve discharge policy and meet government targets. She tries again and again (by her own account) to show her staff that they need to focus on targets because they will lead to improved care quality. She appears to fail (again according to her own standards) and expresses this by almost literally demonstrating that she is banging her head against a brick wall.

Differently with the same effect Gerald is introduced as having a clear vision for patient care in his Trust. However, his inability to take staff (at all levels of the organisation) with him in his vision is attributed in our analysis to his lack of emotional engagement and autocratic (verging on the authoritarian) style of management. His narcissism further ensures his inability to understand how his behaviour is impacting upon staff and he sees himself as having failed to win a 'fight'.

Chapter Six explores the organisation as an open system, and ways in which all stakeholders⁴⁰ hold a vision of the organisation in the mind at a

⁴⁰ Including patients but we cannot really speak definitively here due to lack of data.

conscious and an unconscious/emotional level acting accordingly. Thus, they have an image of the organisation (how well it is managed, how effectively it cares for patients), a sense of their own role and place within the organisation and how well the leadership understands the experiences of staff and patients. Recognition of the primary task, the roles and responsibilities of those who manage it and the (changing or threatened) boundaries of the organisation itself are critical concepts.

No doubt some members of the organisation have more personal and role/task related power and influence than others in the NHS Trust. Furthermore, the NHS as a system is fluid and dynamic, so that there is overall a group influence over the evolution of organisational context (climate and culture) which responds to visions from within and without (government, health care consumers) the wider system.

10.4 *What have we learnt from this study?*

10.4.1 How leadership relates to patient care

It is clear, from our empirical work and evidence from previous studies, that leadership is a process and set of practices which generally do not equate with the qualities residing in a particular individual regardless of their authority and formal role and status in the organisation. Leadership that 'works', as seen particularly (but not only) in the case studies in Chapter Seven, involves the person in the leadership role exercising social and emotional intelligence and engaging with their 'followers' (see Chapters One and Four) and offering staff recognition and support (Chapter Five). Moreover the role of leader is particularly effective when it is distributed among those who are best placed to exercise leadership towards the task in hand. So that in the context of an NHS hospital Trust, leadership might be exercised in relation to organising the administration for a unit, running an audit, or developing an innovatory clinical practice. Leadership in such contexts is time/project limited.

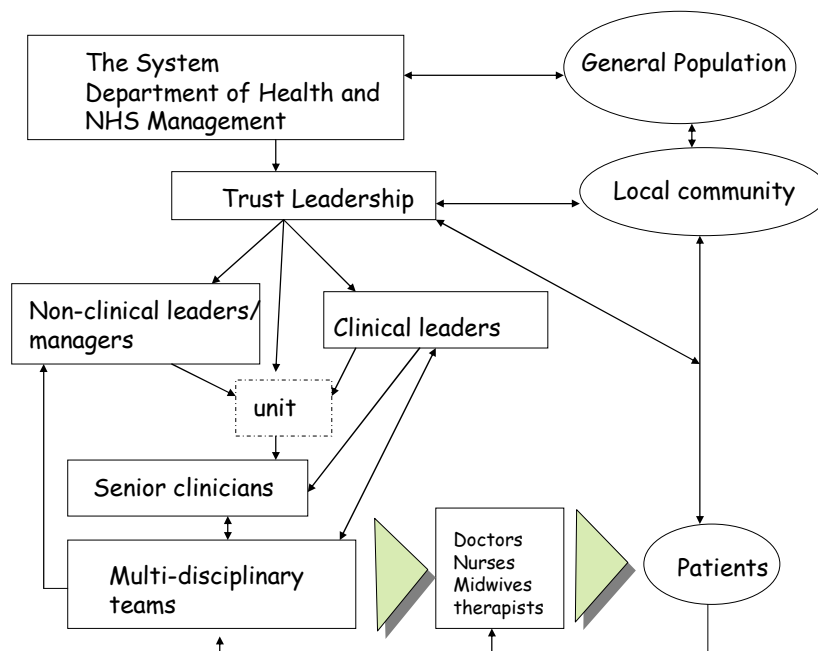
The primary task for NHS Trusts is to deliver a service to patients, as proposed in Chapter Six. All NHS Trusts operate as open systems with porous boundaries which enable change (planned and/or evolved). Leadership therefore can occur throughout the system at different levels including those of ward clerical and cleaning staff and the CEOs who 'manage upwards' and influence NHS/ Department of Health policy. Information of all kinds passes across the various boundaries not simply from the 'top' downwards.

Below in Figure 12 the relationship of the Trust leaders and patients within the NHS system is illustrated. It is also the case, as shown, that policy

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influences individual care, and the quality of that influence depends very much on the quality of leadership again across the system at all levels.

Figure 12. From the DoH to the Patient: An Open System



Patient care is represented here at three levels. The population who influence service delivery and patient care using their vote and/or lobbying through relevant patient groups, the local community who are served by a particular Trust and patients who are actively receiving medical treatment from individual clinical teams.

While on the whole it was the last group who were the main focus in this study some participants, particularly those in senior leadership/management roles, were concerned with service delivery at the local community and population levels. This sometimes meant that senior managers faced the dilemma of how to care for the community while attending to individuals and some individual clinicians were equally concerned about how their interactions with patients were influenced by some of the management dictates which derived from NHS policy that they

found difficult to understand (see Chapter Six and in 10.4.2. below for example).

10.4.2 Systemic dilemmas in patient care: Managing in the NHS

One participant had faced a 'dilemma' in wanting more face-to-face knowledge of patients in the community in order to be a more effective and informed leader, while also as his role required, attending to the demands of working within the wider system of the NHS:

As a chief exec in the NHS it was my privilege to make decisions. That was my privilege to go on and up the ladder. It was that I could go on and make faster and faster decisions. I get in the way I have always got in the way... the thing I would do is go out with the district nurse for the day, because I needed to be grounded in that. (Retired CEO)

Another manager who had previously had a military background advocated (along similar lines) that the best way to lead towards good patient care was to 'walk around' and support the leaders across the different parts of the organisation. In a seminar to clinical staff, which we attended and recorded, he drew participants' attention to the importance of *influencing* policy to achieving good patient care (at the population and community levels).

I hope some of you will find yourself in policy jobs at some point. Totally different, yes it still leads, but the actual process is so ... changing...both the chief executive and I spend a lot of time nurturing relationships which are partly to do with policy, but unless you get it right ... you communicate with them, it won't work.

In other words to be effective and to ensure the best for those in the Trust (staff and patients) a leader has to 'manage upwards' which gains influence. He continued by contrasting the experiences and perceptions of doctors with managers who lead at the macro level, drawing on the example of a recently qualified doctor. When the respondent quoted here asked this man about leadership in the NHS and how it impacts on patients he apparently answered:

'Oh I have got communication skills'. 'Blimey!' I said 'what do you know about the NHS?' And I asked him a couple of questions, nothing! But he hasn't been taught at an academic level about the context in which he is working. I think that is crucial and I know that is not how everyone does things. You know [doctors] keep people alive, but they really ought to have this basis of information about the context in which they are working.

While it is self-evident that the NHS is the context in which patient care is delivered, there is a tension between those who exercise leadership in that context and those who 'keep people alive'. In Chapter Seven, the frustration expressed by Kerry in trying to meet the demands of the government and community by improving the Trust's record of patient care, as well as motivate her senior staff to hold similar ideas, was palpable. From others' perspectives as shown in Chapter Six, there was evidence that 'management' was experienced negatively by several clinical staff when it tried to respond to Department of Health directives.

Managing the numbers

At another level of management good patient care was defined through achievement of returning satisfactory statistics, as this observational note of a meeting between capacity managers and clinicians suggests:

Patient care for the capacity managers appears to be a number crunching exercise. The need to get the patients in the right beds according to government targets meeting four hour waits and single sex bays. However because there is not a shortage of beds on this day, patient care moves from an exercise in numbers to thinking about patients in real human terms.

Sally (the capacity manager) talks about how better patient care can be delivered when there is less pressure on all the staff to meet their targets and get their job done. She talks about how [clinical] staff are then more able to talk to their patients and spend time with them. However, whilst reduced pressure means that for some, numbers translate into real people it is clear that in the capacity meeting that the role of the capacity manager is to think in terms of numbers and beds to deliver good patient care.

There is a potential conflict between the target driven service and the patient-clinician relationship which is about face-to-face contact. Perhaps this is well illustrated in Chapter Nine with the example of the 'grace in adversity' story, whereby the obstetrician spent extra time with a patient while his clinical colleagues turned a sympathetic blind-eye. The story of the patient 'Lola' also discussed in Chapter Nine who had been occupying a bed for three months with the tacit support of nursing staff would also have been anathema to staff responsible for managing targets about capacity.

10.4.3 Who judges what is good leadership and good patient care?

As shown above and throughout this report there is a tension throughout the system. The primary task of senior managers and leaders at and above the level of the Trust is to ensure the demands of the NHS and Department

of Health leadership are met. These are policy driven with differing priorities at any particular time. The general population of (potential) patients has a keen influence on policy in different ways but particularly during local and general elections. For example the recent change from a Labour to the Coalition Government has raised questions about the role of 'targets' for future NHS priorities. Apart from other matters, finance makes a difference as to how priorities for service delivery are set.

Senior management at the Trust level is judged in a number of ways particularly related to how far the Trust meets the national priorities. However there is also pressure on CEOs and senior teams to get direct patient care and safety 'right'. This may be assessed through statistics as in the following example described by a senior midwifery manager:

Between 2002 and 2005 there were ten maternal deaths at [Trust], which exceeded the national figures. So the Healthcare Commission came in and reviewed a number of clinical organisational cultural governance issues, and then actually put the maternity services under special measures

There was a key number of issues then, and an action plan was developed, so actually I was newly appointed at that time, and there was a number of work streams that we had to work on, and it's never happened before, and I don't think its happened since in a maternity unit. So basically, even though that was a very sad event for all the families involved and very tragic for them, it was difficult for the staff, and obviously difficult for the Board in terms of reputation management. The whole action plan was implemented, the unit was turned around, and the special measures were lifted in 2006.

In this case there was a notable failure to deliver maternity care to the standards of safety prescribed by the NHS. Furthermore there was a failure of leadership perceived by this participant in terms of both 'culture' and 'governance' giving rise to the high proportion of maternal deaths and the consequent special measures. This participant also makes clear how much the staff themselves are influenced by events of this kind.

Another member of that staff team praised the changes at the top following these problems and combined the policy, context and face to face care in her assessment of the relationship of good leadership to good patient care:

.... the end goal for us, is ensuring the services we're providing.. the patients, are getting the best service from us on top of meeting all the Trust targets and the Trust strategy...for me really it's about ensuring that the patients are getting the best quality care, which, you know, I think they've got an improved quality of care here, with the team like mine who are here...and I think [leadership] is from the top down, so from Chief

Executive, right down to every level, to leaders in the ward, right down to our portering, to our domestics. Yeah, there certainly is, and we lead by example really don't we? and I think our chief exec, director of ops, deputy chief, they've all got good leadership skills.

Good leadership skills among senior managers can pay dividends in terms of reputation management. For example in August 2010 North Cumbria University Hospitals NHS Trust admitted a series of false positive diagnoses following breast cancer screening⁴¹. The CEO moved quickly to review the situation and apologise publicly. In other cases though, when there have been wrong diagnoses, neglect or medical errors over drug doses senior managers have been blamed for the failures - sometimes warranted and sometimes possibly not so (see below). Anecdotally it appears that leaders who are prepared to acknowledge problems as soon as they appear and deal with them in a transparent and effective way bring about improvements in service delivery and patient care in the ways perhaps that those who try to 'bury' problems might not achieve.

10.4.4 Leadership practices across the organisation

Leadership and patient care are intrinsically linked. Leadership is above all about taking responsibility but with changes in organisational structures, a growing emphasis on networks, open systems with porous boundaries, mergers and changes in the shape, structure and functions of Trusts, it is no longer tenable for leadership to be in the hands of a few. Leadership, then, is about a series of relationships and connections within and without specific organisational boundaries which have the potential for diffusing responsibility or sharing it, and therefore making leadership practices more co-operative.

It is important to focus, as we have done, on the many examples of good and excellent leadership we found within the three Trusts taking part in this study (each of which of course being hospital based and therefore not focused on the role of leadership in primary care). These sit in contrast to the examples of less effective and sometimes failures in leadership that we have cited. The differences crucially were about emotional attachment and engagement between leaders and followers. We did not meet any respondents who were disengaged with the aims of the NHS and none who were uncommitted to deliver the best patient care. But as evidenced above in the report and in this chapter, some leadership practices failed to take

⁴¹ <http://www.bbc.co.uk/news/uk-england-cumbria-10958423>

followers with them because of autocratic, insensitive behaviours and poor communication skills. Leaders need to be able to listen and engage – having a vision is not enough.

Leadership taking the importance of emotional engagement into account also needs to be transmitted across the organisation. This is best accomplished through making full use of individual skills. Clinical staff and managers can be effectively involved in specific change projects. These may be time-limited and/or specialism specific but collaborative concerted action is frequently the most significant way that a system might flourish with the staff taking responsibility and enhancing their sense of commitment.

10.4.5 When leadership fails patient care

The converse of good leadership is potentially catastrophic. The case of Beverly Allitt in the early 1990s, the nurse who murdered children in the Lincolnshire Hospital by injecting them with insulin, went relatively unchallenged because she was poorly supervised. Harold Shipman, a different case in that he was a GP in a sole practice, similarly was eventually thought to have committed over 200 murders of patients throughout his career. However, the report into his murders showed that doctors at Thameside hospital had failed to report suspicions about his prescribing⁴². The Alder Hey organs scandal involved the unauthorised removal, retention and disposal of human tissue, including children's organs during 1988 to 1995 and the Bristol Royal Infirmary inquiry about children's deaths during surgery resulted in doctors being struck off. All these cases represent a failure of leadership in which those who were responsible for patient care at all levels failed to identify and follow up on problems. More recently the independent inquiry into the Airedale NHS Trust, where the late Anne Grigg-Booth continued as night-nurse despite a high proportion of deaths of patients while under her care, identified 'a catalogue of systemic failures' whereby her dangerous behaviour was not spotted.

At the time of writing this report the Prime Minister David Cameron has ordered a full public inquiry into the events at Staffordshire hospital which have led to deaths of patients, it would appear in these cases, more due to negligence than intent. The Francis report which was published in 2009 found that patients were routinely neglected and there were systemic failings in patient care. Managers had been pre-occupied with cost cutting and meeting targets and unable to spot the build up of failures in patient care that were to cost several patients their lives. There were too few

⁴² These cases were subjected to inquiries which exposed a range of complexities which are not relevant here.

nurses, those who were employed were ill-trained, equipment was inadequate and experienced medical cover was not always available. It was a supreme failure of management and leadership. The Trust was poor at identifying when things went wrong and managing risk. Some serious errors happened more than once and there were higher levels of complaints compared with other trusts. Staffordshire was a foundation hospital that had managed to 'tick the boxes' although clearly there were a series of chasms between the clinical and managerial staff.

10.5 *Final thoughts*

By using innovative qualitative methodologies (described fully in Chapter Two) such as story telling, ethnographic observations and shadowing, to both supplement and augment data from interviews and focus groups, we have built up a picture of what happens in the daily lives of NHS staff working both with and as managers and in clinical teams. Using these methods provides opportunities to extend the scope of more traditional in-depth interviews and focus groups. The 'story', because it is chosen by the participant themselves, provides not only detail and depth but demonstrates the specific indices used by each interviewee to make sense of their own and others' behaviours within the organisational context.

The ethnographic observations, and the shadowing in particular, enabled the researchers to gain a sense of what 'a day in the life' of a member of the organisation *feels* like. They can 'experience' the interactions between staff, between staff and patients as well as the frustrations and pleasures of working in that Trust. No other method provides such acute insights. The subjective ingredients in this method enhance the process (i.e. as outlined in Chapter Two whereby the researcher themselves is the 'instrument' through which data is mediated). Moreover, and possibly conversely, the subjective elements are reconciled when the observation notes are discussed by other members of the research team, which again as discussed in Chapter Two is also a source of data (Czarniawska, 2008).

As a qualitative study, the success is proven by the richness of the data, showing the clear emotional connection participants had with the topics of both 'leadership' and 'patient care' (Lincoln & Denzin, 1994, p. 575). From this we were able to make sense of how leadership is experienced and exercised (see Chapters Four and then Six to Eight) and about the practices around patient care and service delivery that support patients to understand the relationship between their particular health-status, quality of life and the care and treatment they are receiving and/or expect (see Chapter Nine in particular).

The statistical analysis of the OCS⁴³ showed that, on the whole, the climate variables, 'support' and 'recognition' from managers and the system overall, predict 'satisfaction' with leadership and management. This reinforces the ideas expressed throughout the report that good practices by managers/leaders are about ongoing engagement with followers with concerted or conjoint leadership processes most likely to promote a sense of being supported and recognised (Roberts et al. 2005).

Thus we have not produced a list of 'good leader' qualities or a similar record of what constitutes 'good patient care', as these would fail to capture the crucial point that both leadership and patient care are experienced as a process. Thus this report aims to delegate *good practices* that were observed during the project, for the use and reflection of any staff member of the NHS – whether a leader, follower or patient.

10.6 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.

⁴³ As made clear above we were unable to capture corresponding data from patients.

- 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.

Appendix 1

Focus Group Questions

1. Leadership means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this hospital?

Prompts

1. Charismatic / Authoritative / Consultative / Directional / Varies – depends on situation/activity etc
2. Can you think of some incidents that sum up for you the way leadership is exercised in this hospital?

Follow-ups

1. Does this type of leadership operate throughout the hospital?
2. Could you give some examples of ways in which leadership is exercised in your team/the hospital
3. Patient care means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this organisation?
4. How important is patient care as a priority in the service that you and your colleagues provide?
5. What are your main priorities in ensuring a high level of patient care in this hospital?
6. Can you think of some incidents that sum up the way you and your colleagues try to deliver patient care?
7. To what extent is leadership reflected in the quality of patient care you and your colleagues provide?
8. Can you think of some incidents that sum up the way that leadership in this hospital approaches the issue of patient care?
9. Can you think of specific incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

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Follow-up

1. What would you suggest to improve this/these situations?
3. Stories and critical incidents
 - a) Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
 - b) Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
 - c) Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

Could you tell me about a time that made you feel disappointed with leadership in this hospital?

- In this unit?

Appendix 2 Interview Questions

Interview

*Introductions, background and experience in relation to patient care and leadership in the organisation

- The interviewees position/level
- Years at the hospital
- Role in the organisation

1. Leadership

'Leadership' means different things to different people.

- a. How would you define it?
 - Do you see that kind of leadership at this hospital? Why/not?
 - What about in this unit?
 - What makes someone a good leader/Qualities of a good leader? Can you give me an example?
 - Who here at work do you see as providing leadership to you personally? Why? Do you have a direct supervisor? Who? Do they have leadership qualities?
- b. Do you see yourself as someone who could be a leader?
 - Why/not?

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- Under what circumstances?
- c. Can you give me an example of leadership in this hospital?

2. Patient care

- a. Like leadership, 'patient care' means different things to different people.
 - How would you define it?
- b. Tell me about patient care in this hospital. How is it defined?
 - Are there differences between units? Tell me about them. Why do you think this is?
 - How would you improve patient care in the hospital?
 - How would you improve patient care in this unit?
- c. How do you [as a hospital worker, nurse, etc.] try to deliver good patient care?
- d. What do you think are some obstacles to delivering the sort of patient care you'd like to see? How could these obstacles be removed?
- e. Do you think leadership could improve patient care in this hospital?
 - Why/not?
 - Do you think that better leadership would improve patient care? Why/not?
 - How does good leadership influence patient care?
 - Has the leadership in this hospital improved patient care since you've been a member of staff? How so? Or why not?

3. Stories and critical incidents

- a. Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
- b. Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
- c. Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

- d. Could you tell me about a time that made you feel disappointed with leadership in this hospital?
- In this unit?

Appendix 3: Focus Group Questions: patients

1. Leadership means different things to different people. What does it mean to you as a patient of this hospital?
2. What is your opinion of the way leadership is exercised in this hospital?
3. Patient care means different things to different people. What does it mean to you as a patient of this hospital?
4. Can you think of some incidents that sum up the kind of patient care that staff in this hospital deliver?
5. Can you think of ways that leadership in this hospital could enhance the quality of patient care, as far as you are concerned?
6. Can you think of some incidents that sum up what else leadership could be doing?
7. Can you think of any other incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

Appendix 4: Staff Organisational Climate Survey

[attached separately]

Appendix 5: Participant Information Sheet

Leadership and Better patient Care: From Idea to Practice

Participant Information Sheet: Staff Interviews

You are being invited to take part in an interview study about leadership and patient care in three different hospital settings. Before you decide to participate in this study it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Contact me (see full contact information at the end of this sheet) if there is anything that is unclear or if you want to know more.

Take time to decide whether or not you wish to take part.

Thank you for reading this.

1. What is the purpose of the study?

The purpose of this study is to try to identify the circumstances under which leadership can be an effective engine for change in the organisation of health care, especially for patient care and service delivery. Although we suspect that leadership motivates workers and affects the climate or atmosphere of the places where people work, leadership can mean different things to different people. The same is true of patient care which can also mean different things to different people. In order to understand how leadership inspires health workers to provide better patient care, we want to learn how nurses, doctors, other medical professionals as well as managers and patients define and understand leadership and patient care. This includes exploring how their perceptions mesh or conflict with one another. It also includes listening to stories of important incidents that describe their experiences of leadership and patient care.

2. Why have I been chosen?

As part of the study we are interviewing staff (clinical, managerial and others) as well as patients to examine what leadership and

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patient care mean to them. You have been chosen as someone whose views represent the views of staff.

3. Do I have to take part?

No

4. What will happen to me if I do take part?

You will participate in a tape-recorded interview with a qualified researcher, which will last under an hour.

5. What do I have to do?

Arrange a mutually convenient time to have the interview.

6. What are the possible disadvantages and risks of taking part?

It is possible that the discussion may stir up distressing feelings you have regarding your organisation, its leadership and the patient care it provides. However, care will be taken to prevent this and you are free to leave the interview at any time. Apart from that, the only disadvantage is that you will be giving up some of your time.

7. What are the possible benefits of taking part?

This study may not directly help you but it is part of a serious initiative to improve the quality of leadership and patient care provided by the NHS.

8. Will my taking part in this study be kept confidential?

Yes. All data will be stored in locked filing cabinet in a locked office. It will be made anonymous and all names will be edited out of the transcripts. Only members of the research team will have access to the data.

9. What will happen to the results of the research study?

They will be published in a report to the funder and also presented in peer reviewed papers and conferences. A copy of the report will be provided for each participant who requests it.

10. Who is organising and funding the research?

The study is funded by the NHS Service Delivery and Organisation (SDO) Research and Development Programme of the National Institute for Health Research (NIHR) Programmes. The NIHR has been established as a part of the government's strategy Best Research for Best Health to provide the framework that will position, manage and maintain the research, research staff and infrastructure of the NHS in England. The study is conducted by a group of researchers from Royal Holloway University of London led by myself, which won the grant following a competitive bid.

11. What if I have any concerns?

If you have any concerns or other questions about this study or the way it has been carried out you should contact me (details below) or you may contact the hospital complaints department.

Contact for further information

Professor Paula Nicolson, Head of Department, Health and Social Care
Royal Holloway University of London, Egham, Surrey, TW20 0EX

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Appendix 5: Consent form (generic)

Title of Project: Leadership and Better Patient Care: From Idea to Practice

Name of Researchers: Emma Rowland Paula Lökman

Please initial each box

☐ I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

☐ I understand that some coded extracts from the interviews may be used for the purposes of the research report and academic articles.

☐ I give my consent for quotations to be used in the report and research papers on the understanding that I will not be able to be identified by the use of these in any way.

☐ I agree to take part in the above study.

Name of participant

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Date

Signature

Appendix 6: Patient Organisational Climate Survey

Thank you for agreeing to participate in this study which as you will know is part of a larger study on leadership and patient care in the NHS.

The following questions explore how NHS patients feel about the care they received and how things generally worked in the units where their care was managed.

The survey is anonymous, so please do not put your name on the survey.

If, however, you would like to receive the final results of the survey when the study is completed, please fill in the tear-out form on the questionnaire's last page and submit it to the researcher or the collection box.

It is important that you answer all the questions. This should take you approximately 10 minutes.

Your individual responses will be kept strictly confidential.

Researchers

Dr Paula Lökman

Department of Health and Social Care
Social Care
Royal Holloway University of London

Ms Emma Rowland

Department of Health and
Royal Holloway University of

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Please circle one number that best describes how you feel for each question in relation to the service provided by your NURSE.

1. I feel understood by my nurse.

1	2	3	4	5	6	7
strongly				neutral		strongly
disagree						agree

2. I am able to be open with my nurse at our meetings.

1	2	3	4	5	6	7
strongly				neutral		strongly
disagree						agree

3. My nurse has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7
strongly				neutral		strongly
disagree						agree

4. My nurse encourages me to ask questions.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

5. I trust my nurse.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

6. My nurse answers my questions fully and carefully.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

7. My nurse deals very well with my emotions.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

8. I feel that my nurse cares about me as a person.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

9. I don't feel very good about the way my nurse talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

10. My nurse tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

11. The way my nurse interacts with me influences my perception of quality care.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

12. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

Please circle one number that best describes how you feel for each question in relation to the service provided by your DOCTOR.

13. I feel understood by my doctor.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

14. I am able to be open with my doctor at our meetings.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

15. My doctor has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

16. My doctor encourages me to ask questions.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

17. I trust my doctor.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

18. My doctor answers my questions fully and carefully.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

19. My doctor deals very well with my emotions.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

20. I feel that my doctor cares about me as a person.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

21. I don't feel very good about the way my doctor talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

22. My doctor tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

23. The way my doctor interacts with me influences my perception of quality care.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

24. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

25. What would improve the quality of care you receive at this hospital?

26. What services are you using within this hospital?

Demographic Information

27. In which year were you born?

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28. What is your marital or civil partnership status?

- ☐ Single
- ☐ Co-habiting
- ☐ Married
- ☐ Divorced

29. How many children do you have?

30. How would you describe your ethnic background?

31. What is your current salary?

- 1. Less than or around £20,000 per annum
- 2. Between £21,000 and 39,000 per annum
- 3. Between £40,000 and £59,000 per annum
- 4. Between £60,000 and £99,000 per annum
- 5. Above £99,000 per annum

Thank you again for your time. If you have any questions please speak with the researcher or alternatively you can contact Professor Nicolson.

I would like to receive the final results of the survey when the study is completed

Name:

Address:

Contact Telephone:

Please return this form to either the researcher or the collection box.

Appendix 7: Appendices for Chapter Five

[attached separately]

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⁷ There is a parallel ongoing debate as to whether university leaders should be drawn from outside academia.

Addendum:

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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.

Leadership and Better Patient Care: Managing in the NHS

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Finally each one of us has a commitment to the future of the NHS and we are therefore optimistic that at least some of the content of this report will contribute to future planning and development to benefit staff and patients.

Executive Summary

The NHS National Leadership Council Website¹ (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)

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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.

Leadership and Better Patient Care: Managing in the NHS

1 Leadership, organisation and the NHS

1.1 Leadership

What is currently known about leaders and leadership? The ongoing attempt to identify the characteristics necessary for effective leadership over recent years has been described as an 'obsession' studied more extensively than almost any other characteristic of human behaviour (Higgs, 2002; Tourish, 2008). Alimo-Metcalfe, Alban-Metcalfe et al. (2007) in their comprehensive review of the literature, show that formal studies of leadership date back (at least) to the beginning of the 20th century. They propose, that despite changes in the way leadership has been studied and the underlying epistemological stance taken by the researchers, *"in all cases, the emphasis has been on identifying those factors that make certain individuals particularly effective in influencing the behaviour of other individuals or groups and in making things happen that would not otherwise occur or preventing undesired outcomes"* (p. 2). As *"many have pointed out, that in spite of the plethora of studies, we still seem to know little about the defining characteristics of effective leadership"* (Higgs, 2002, p.3). Even so this has not appeared to quell the appetite for pursuing an ideal of leadership, impelled by the changing demands of organisations echoed across public sector institutions such as the NHS. These changes are in part the result of technological advancements which impact upon clinical practices, demographic changes both of which have altered the strategic, structural and financial profile of health (and social) care (Tierney, 1996).

The tantalising questions remain though about what those factors might actually be and the significance of the context to 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).

But in addition, or conversely, the context, culture, climate and/or structure of an organisation each have an impact on the performance of the people who lead in it (Carroll, Levy, & Richmond, 2008; Goodwin, 2000; Michie & West, 2004).

Focusing on the relationship(s) between 'leadership' and context has revitalised contemporary research particularly through the development of qualitative research, discursive and social constructionist epistemologies (Grint, 2005; Uhl-Bien, 2006) although it is unclear at this stage how far a connection might be developed between this research and its applications, for example in health care services (Fambrough & Hart, 2008).

In what follows in this chapter we explore the changing ways in which leadership has been conceptualised over the past fifty years, particularly focusing on how it has and *might* be operationalised in the NHS (particularly although not exclusively in a *hospital* context) .

1.2 Background and introduction to the study

The NHS Modernisation Agency Leadership Centre (NHSMALC) website³ had originally suggested that effective leadership is a key ingredient in modernising today's health care services. In its own words:

Effective leadership and management in the healthcare system are key drivers in patient experience. Governance and good environments matter to patients, their visitors and carers and staff.

But how might effective leadership be achieved and sustained? The NHS Leadership Centre commissioned a number of leadership initiatives (Larsen et al., 2005). The NHS Institute for Innovation and Improvement (2005) *NHS Leadership Qualities Framework*⁴ emphasised the *situational* nature of leadership and indicated the circumstances under which different leadership qualities will take precedence.

These comprise fifteen contextualised qualities covering a range of personal, cognitive, and social characteristics arranged in three clusters which are set out in Figure 1:

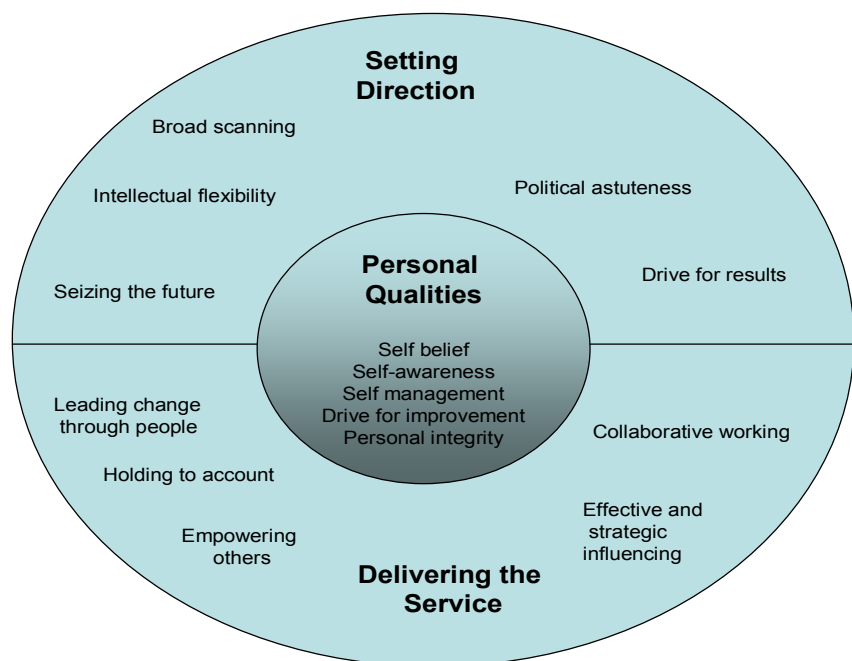
³ <http://www.dh.gov.uk/en/managingyourorganisation/leadershipandmanagement/index.htm>

⁴ <http://www.nhsleadershipqualities.nhs.uk/>

- *Personal Qualities*
- *Setting Direction*
- *Delivering the Service*

Thus, a competent leader enables development in an organisation that is goal directed, geared to developing processes and systems and enables staff at all levels to plan effectively and efficiently towards agreed goals (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Figure 1. The NHS Qualities Framework



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However, these same authors underscore the point that there is something beyond leadership competency that needs to be addressed, particularly in a changing and complex context such as an NHS Trust. *That is that a leader is someone who encourages and enables the development of an organisation in a culture based on integrity, transparency and valuing others. Leaders also need to question, think critically as well as strategically* (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Since the publication of the *NHS Leadership Qualities Framework* in 2005 all efforts have been directed to recognising and discussing leadership qualities and making strides towards their implementation. In 2008 Clare Chapman, Director General of the Department of Health's Workforce declared:

*Leadership is all about creating value for customers and citizens whilst also making work worthwhile for staff. This sounds incredibly straight forward - but it requires courage and resilience, and commitment throughout the entire piece*⁵

David Nicholson the CEO of the NHS in the report *Inspiring Leaders: Leadership for Quality* (January 2009) building on Darzi's *NHS Next Stage Review*⁶ stated:

It is imperative that we align what we are doing on leadership with what we want to achieve on quality. This is what I call leadership with a purpose.

Over the past year, the Department of Health has worked extensively with the NHS and other stakeholders to determine how best to foster talent and leadership development, and it is clear that there is a great deal of enthusiasm for a more systematic approach.

Spotting and developing confident leaders is a priority for us all if improving quality is our shared purpose. This guidance represents our best collective thinking to date. I invite you to use it and contribute to its improvement as we learn how to bring leadership centre stage over the coming months.

Nicholson and his team have charged the Strategic Health Authorities with finding gaps in leadership and systematically nurturing talent across the whole of the NHS. Clearly, the enthusiasm of successive senior officers in

⁵ DH_083353.

⁶ www.dh.gov.uk/en/Healthcare/Highqualitycareforall/index.htm

government and the NHS has been to link effective leadership with good service delivery and patient care as the primary outcome.

1.2.1 Leadership and Better Patient Care in this Study

This rhetoric and confidence about the type of leadership that best suits the NHS from those who lead it gave us pause for thought (Milewa, Valentine, & Calnan, 1998; Mueller, Sillince, Harvey, & Howorth, 2004b). 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 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 aims were overall to seek out the meanings and perceptions of relationships between (effective) 'leadership' and (better) 'patient care' and how leadership is transmitted across organisations to impact upon service delivery, taking account of the mixed methods and specific social science and systemic approaches that the investigatory team proposed. This inevitably has brought certain issues to the fore and (possibly) obscured others.

Our starting point therefore was to hold the NHS model of leadership in mind while calling on our own specific strengths as academics, from a range of social science and methodological backgrounds, to take a cross section of Trusts, clinical specialties, services, staff grades and patient needs, and to observe the *processes of leadership* in everyday working life. From this we proposed it should be possible to determine the ways in which leadership, NHS organisations and patient care were socially and discursively constructed so that links between leadership and patient care might be explored.

In Chapter One we outline some of the important contemporary social science and organisational thinking on leaders and leadership and explore the links between this and the NHS perspectives.

In Chapter Two we set out the innovative methodologies employed to investigate and analyse the research questions. This is followed in Chapter Three with the detailed procedures used for data collection.

The results are presented across four separate chapters. Chapter Four provides the analysis of what leadership means and how it is experienced by staff and patients (Christensen & Laegreid, 2003; Fairhurst, 2005).

Chapter Five presents the results of the Organisational Climate Survey (OCS) (Stringer, 2002). In Chapter Six, open systems theory and the concept of the 'organisation in the mind' are introduced particularly focusing upon the transmission of leadership across organisations. The relationship

between leadership, authority and emotion is discussed in Chapter Seven and in Chapter Eight the role of gender relations and their impact on leadership are reviewed (Begun, Hamilton, Tornabeni, & White, 2006; Ford, 2010; Telford, 2007).

Chapter Nine covers definitions, explanations and experiences of patient care and particularly how it relates to leadership by NHS staff and patients (Begun et al., 2006; Disch, Edwardson, & Adwan, 2004).

Finally in Chapter Ten we summarise our findings, make recommendations and draw conclusions.

Appendices provide copies of the research instruments, additional statistical results and the relevant NRES information.

1.3 Theoretical Approaches to leadership

Leadership research and theory is prolific with the consequence that numerous, frequently overlapping, models of leadership are available to agencies attempting to analyse or train leaders (and indeed managers, as until relatively recently little distinction was made between these two categories, see e.g. Kotter, 1996). Over the past fifty years leadership theories have shifted through different points of focus from the 'trait (or 'great man') approach in the 1940s, through the 'behavioural' perspectives in the 1950s whereby some styles of behaviour were seen as being more or less influential on potential followers. Then since the 1960s and 1970s the focus has been upon 'situational' leadership based mostly upon Fiedler's 'contingency' theory which proposed that different leadership styles were needed for different situations (see Alimo-Metcalfe, Alban-Metcalfe, et al. 2007; Western, 2008 for further details). During the 1970s and 1980s leadership research, albeit prolific, had reached an all time low in terms of its perceived contribution to theory and added value to knowledge for practice, so that as Cummings (1981 p. 366, quoted in a review by Bryman, 2004) asserted:

As we all know, the study and more particularly the results produced by the study, of leadership has been a major disappointment for many of us working within organisational behaviour.

Bryman unpicked the implications of the phrase Cummings used "as we all know" noting that it was "simultaneously sweeping and damning" (2004, p. 730). Bryman also picks out Miner's (1975) suggestion for temporarily abandoning the concept because of its limited utility in helping us understand organisational behaviour. *Why had leadership research reached this nadir during those decades? Why has there been a more recent upsurge of interest in leadership again almost to the point of saturation?*

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Bryman in his review suggests, that the renewed confidence and interest in the study of leadership has come from improved measurement and analytic techniques, greater use of meta-analysis so that more systematic reviews could be compiled, the emphasis on *transformational leadership* and *charismatic leadership* which have provided a fulcrum for the area of research, more and better cross-cultural studies and greater diversity in the types of leadership and organisational contexts that have been studied.

A factor that may also have contributed to the idea that leadership research continues to be fruitful is that a greater diversity of methodological approaches have been added and Bryman's review specifically focused on the value added by qualitative research.

Towards the end of the 1980s and beyond, thinking about the meaning(s) of leadership came to take greater precedence than in the previous two decades, possibly because of a perceived dearth of leadership *per se*.

These deliberations cast light onto the:

- *interactions between leaders and followers* and organisational cultures (Avolio, Gardner, Walumbwa, Luthans, & May, 2004; Lewis, 2000; Schilling, 2009)
- the *management of emotion* (George, 2000; Lewis, 2005; Pescosolido, 2002)
- the *processes* of leadership (Collinson, 2005; Dopson & Waddington, 1996; Vangen & Huxham, 2003)

Even so, or perhaps because of the use of qualitative approaches and related conceptualisation, Alvesson and Sveningsson (2003) were able to entitle a recent paper arising out of their study of leadership in a research and development company: "*The great disappearing act: Difficulties in doing 'leadership'*".

By this they meant that during their study they were able to identify how the existence of the label 'leadership' led to an assumption that the concept had an empirical reality. However the results of their work indicated that leadership might be better explained as a *process or series of processes of interaction*. This conclusion raises questions about mainstream thinking on leadership which presumes observable and possibly measurable characteristics (Alvesson and Sveningsson, 2003, p. 361; see also Ford, 2010).

Most recently there has been reconsideration and development of ideas about leadership in context taking account of the relevance of some earlier studies of organisations (e.g. Lewin, 1947) and open systems theories (see

Chapter Six; Laughlin and Sher, 2010) and new epistemological positions (e.g. Ford, 2010).

In our study, as a consequence of these recent critiques of leadership research and the result of methodological innovation, we approached the concept of 'leadership' as not necessarily a property of one individual (although it can be) or of one specific role, such as Clinical Director or a service manager, but rather we identified leadership as a *process* occurring within a group, organisation or collectivity that *imagines, wills and drives change* (Gabriel, 2004; Gronn, 2002).

1.3.1 Dimensions of Leadership and their Value for the NHS

Leadership, *as a practice*, has been on occasions constructed as 'a beautiful or rarefied ideal' an idea which has little use in the real world particularly as it has been suggested there are at least 350,000 definitions of leadership in the academic literature (Pye, 2005; Tourish, 2008; Western, 2008). *The question for this report is how to identify the literature on leadership and organisation with the most relevance for the contemporary NHS.*

Most discussed in theory and in practice over the past two decades has been the idea of *transformational leadership* (Bass, 1985) a model to explain ways in which a leader can be identified or trained to demonstrate the qualities that enable her/him to *perform beyond expectations*. The phrase 'transformational leadership' was coined originally in 1973 by Downtown but did not gain impetus until 1978 when Burns published his book, *Leadership*, which highlighted the *relationship* between leaders and followers (Burns, 1978).

Until then, as shown above (see Bryman, 2004) there had been little by way of a breakthrough in applicable knowledge. Burns (1978) demonstrated a *psychological* difference between an exchange relationship - where followers respond to leaders because of rewards they might receive - and one in which they respond to leaders who transform their attitudes and behaviours through inspiration and/or charisma (Bass, 1985; Yukl, 1999; Rafferty and Griffin, 2004). Transformational leadership then, is concerned with emotions, values and ethics, standards and long term goals which include assessing followers' moves and satisfying their needs (Currie & Lockett, 2007; Day, Gronn, & Salas, 2006; Eagley & Johannesen-Schmidt, 2003; Northouse, 2004).

Recognition that transformational leadership is not simply an individualistic model but one that *teams* can display (Day et al., 2006; Gronn, 2002; Sivasubramaniam, Murry, Avolio, & Jung, 2002) has shifted the

concentration from individual leaders per se to a more diffuse and distributed model of leadership and organisation context.

1.3.2 What constitutes transformational leadership?

Bass (1985) highlighted several characteristics of *transformational (or transformative) leadership* that allow followers and leaders to achieve far beyond their expectations. These are not discrete categories but given the significance placed upon the ideas behind transformational leadership in the scientific and training literature it is worth outlining the basic ideas behind these characteristics/types which have been identified as:

- Charismatic leadership
- Inspirational motivator
- Intellectually stimulating leadership
- Considerate leadership

Charismatic leadership

Bass (1985) proposed that "*charisma is a necessary component of transformational leadership*" (cited in Yukl 2002, p.261) and that charismatic leaders are endowed with exceptional personal qualities that attract followers. Charisma, a word derived from the Greek, means "*divinely inspired gift*" and is thought to give people the ability to perform miracles or predict the future (Yukl 2002, P. 241).

It is for this reason that charismatic leaders are often regarded as "*visionary, a futuristic, or a catalyst for change*" (Murphy 2005, p. 131; see also Bass 1985; Bennis & Nanus, 1985). Due to their rare personal qualities charismatic leaders are able to convey their visions to their followers in a clear and concise manner allowing them to visualise what they could achieve in the future if they worked together towards a common goal. As the leader's vision is normally realistic yet optimistic, it empowers the followers granting them greater self-esteem, encouraging and inspiring them to achieve the vision (Bennis & Nanus, 1985; Northouse, 2004; Yukl, 2002).

Inspirational motivator

Through their charisma, transformative leaders have the ability to inspire their followers through words of profound wisdom, or at least is what is *perceived* to be profound wisdom, such as with the case of Jim Jones⁷ in the USA or more positively President Obama who has reformed health care and banking legislation in the USA against the odds. Transformative leaders are

⁷ In 1978 Jim Jones persuaded more than 900 members of his People's Temple in Jonestown, Guyana to commit mass suicide.

excellent communicators which allow them to turn their visions into reality. Many use emotional and optimistic speeches to inspire their followers. They usually lead by example and often become role models to their followers who are in awe of their moral and ethical character. Many followers try and emulate their leaders' good qualities and are confident that their leaders will make just decisions on their behalf leading them to a prosperous future (Kellerman, 2004; Rafferty & Griffin, 2004).

Intellectually stimulating leadership

Transformational leaders have the ability to captivate their audience making the most mundane speeches and events interesting. They encourage their followers to be innovative, challenging the status quo and their own values and beliefs (Northouse, 2004). They also encourage their followers to solve problems and take an active role in the organisation, thus enhancing their self-worth and self-esteem, increasing their job satisfaction and productivity.

Considerate leadership

Transformational leaders are often also considerate leaders who are adept at performing mentoring or advisory roles to support their followers' emotional needs (Hiller, Day, & Vance, 2006; Rafferty & Griffin, 2004). Such leaders listen carefully to their followers' needs and desires, empathising with them during difficult periods. Being empathetic also builds a strong bond between leader and follower and thus a strong reciprocal relationship (Simpson & French, 2005).

It is important to note though, despite the wide take-up of transformational leadership as a conceptual model and a *practice*, that there remains uncertainty about the ambiguity of subdivisions and distinctions between elements in the model. Theoretical distinctions between 'charisma' and 'inspirational motivation' have become blurred over time and some theorists have suggested that elements of transformational leadership might also be identified as *transactions* (see Rafferty and Griffin, 2004 for a discussion of the implications).

Further concerns have been raised about how transformational leadership can take place in organisations, particularly public service ones, which are constrained by government initiative and targets and localised regulatory and normative pressures (Currie & Lockett, 2007; McNulty & Ferlie, 2004). However, it may also be that professional staff (rather than leaders/managers) in contexts such as health care, may in fact be more transformational than might be predicted because of their long-term commitment to the organisational goals (McGuire & Kennerly, 2006).

Most recently the notion that transformational leaders are very much 'engaging' leaders has been proposed (Alimo-Metcalfe, Alban-Metcalfe et al, 2007; Alban-Metcalfe & Alimo-Metcalfe, 2009; Macy & Schneider, 2008).

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One further comment here concerns the role of *gender* in styles of leadership and its consequent impact on organisational transformation (Fletcher, 2004; Mandell & Pherwani, 2003). There is evidence that (whether displayed by a woman or a man) feminine styles of leadership may be more related to engagement, emotional and social intelligence and distributed leadership, which may be important for complex organisations such as the NHS (see below).

1.4 Leadership, organisation and emotion at the turn to the 21st Century

Models of leadership and organisation theory have evolved over time and leadership and organisational structures and cultures are intrinsically linked in the literature. Leadership, if it is to motivate, innovate and move organisations to change, has to have an *emotional dimension* and, thus, effective leaders have a clear *emotional agenda* (as well as a strategic and structural one) which is particularly acute in services such as the NHS which is working to serve people's health care needs (Ashforth & Humphrey, 1995; Bolton, 2000; Pye, 2005).

Exploring organisations and leadership at the level of 'emotion' has become contested territory, as recognition, that organisations and their leaders need to take account of emotional engagement (Alban-Metcalf & Alimo-Metcalf, 2009; Vince & Broussine, 1996) at all levels of the work place, has emerged. Prior to the 1980's, organisational literature had been dominated by cognitive orientation (George, 2000) which favoured the rational, 'masculine' and scientific explanations of organisations and their leaders. This notion therefore ignored the (so called) irrational and 'feminine' characteristics of emotion, which were deemed detrimental to productivity and success. At that time emotions were regarded as the culprits that distort an individual's perceptual and cognitive faculties and therefore should be kept under control (Alvesson & Sveningsson, 2003b; Clarke, Hope-Hailey, & Kelliher, 2007; Dasborough, 2006; de Raeye, 2002; Ford, 2006).

As social and occupational psychologists began to study the effects of positive and negative moods on decision making, job satisfaction, choice of work-based activities and organisational climate, however, (Isen & Means, 1983; Rafaeli & Sutton, 1987, 1989) 'emotion' as part of organisational life gained impetus once again. This resurgence coincided with leadership theorists studying how moods and emotions could effect the quality of leadership (George, 2000).

It is possible to trace a rough trajectory from the 'hard nosed' scientific management, with the organisation perceived as a 'machine' in the early twentieth century, through towards a more humanistic, emotional and

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sometimes even spiritual way of thinking about contemporary leadership and organisational metaphors towards the twenty-first century, all of which are potentially transformational, not simply to the individuals concerned, but to the organisational dynamics.

Hochschild's (1983) *The Managed Heart* has been credited with being one of the earliest examples of research into emotions and organisational settings (Ashkanasy, Hartel, & Daus, 2002). She looked particularly at the airline industry and how airline cabin crew managed their emotions for dealing with difficult passengers and to promote a particular airline image. She termed this emotional management '*emotional labour*' (Hochschild, 1983).

Since this publication, the study of emotions in organisations has increased (Ashkanasy et al., 2002) with academics concentrating on key concepts such as emotional labour, emotional intelligence, mood analysis and Affective Events Theory (AET) and most recently a return to psychodynamic understanding of organisations and groups (see Ford, 2010; Schwarz, 1990). Since the 1990's a plethora of literature has emphasised the role of emotional concerns in private sector organisations such as the airline industry (Hochschild, 1983; Taylor & Tyler, 2000; Tyler & Abbott, 1998), service sector (Crang, 1994), merchant banking (McDowell & Court, 1994; Pugh, 2001), law (Harris, 2002) and image consultancy (Bryson & Wellington, 2003; Wellington & Bryson, 2001).

However, emotionality in the public sector was mostly neglected until 2000's when a surge of literature began to be published analysing the NHS (Allan & Smith, 2005; Bolton, 2000; Cummings, Hayduk, & Estabrooks, 2005a; Hunter, 2005; Lewis, 2005; McCreight, 2005; McQueen, 2004; Michie & Gooty, 2005; Michie & West, 2004; Smith, 1992) and the fire service (Archer, 1999; Scott & Myers, 2005; Ward & Winstanley, 2006; Yarnal, Dowler, & Hutchinson, 2004).

1.4.1 Emotional labour, leadership and patient care

Hochschild differentiates between emotional labour and emotional work or 'face-work' (Goffman, 1967). Emotional work has been described as the effort we put into presenting and representing our feelings as well as into feeling what we ought to feel (see Fineman, 2003). For example, a person ought to feel happy at a wedding and sad at a funeral and if their emotions do not match these expectations then a person must perform emotional work to display the appropriate emotion. This is sometimes difficult as people struggle to disguise their true emotions and perform the socially acceptable emotion.

When a person's emotions are appropriated and performed for commercial gain it is known as *emotional labour*. Hochschild states that emotional labour occurs in many occupations. However, she believes it to be more

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prevalent in service industries, such as the airline industry, where workers' emotions are sold as part of a commercial package⁸. Employees working in service industries must be skilled at managing their emotions and facial expressions in order to project the correct emotion to the customer (Crang, 1994; Lewis, 2005). This often means that employees have to suppress their own emotions in order to perform and display emotions that are suitable for commercial gain and in alignment with the organisations' image (McDowell and Court 1994).

Surface acting allows the employee to make up an outward gesture (Hochschild, 1983), to perform emotions that are not actually felt. In contrast, deep acting means that the employee can suppress or become estranged from their true feelings and *actually feel the emotions* that the employer wants them to display. *"One finds that the performer can be fully taken in by his own act, he can sincerely be convinced that the impression of reality which he stages is the real reality"* (Goffman 1990, p.28).

In the NHS, positively managed emotions *could* lead to better patient care, greater patient satisfaction and a relaxed and professional organisational climate (Amendoldair 2003; Bolton 2003). Lewis (2005) highlights how nurses in a special care baby unit appropriately managed their emotions to create a professional organisational climate, in which to offer quality patient care to special needs babies and emotional support to their parents. Lewis suggests that a nurse's job is sometimes very stressful and emotionally destabilising, especially when a baby dies. Nurses need to be conscious of their own emotions and regulate them to prevent causing further distress to the parents by displaying a professional demeanour (Bolton 2001).

However, managing emotions in this way, particularly if they are not felt, comes at a psychological and emotional cost and the whole process would be problematic without attending to emotional intelligence.

1.4.2 Emotional intelligence, leadership and patient care

The 'discovery' of emotional intelligence (EI), despite on-going valid critiques (see below) marked a turning point in contemporary organisational theories and approaches to leadership because of the tradition that emotions represent a threat to rationality – a view that has been widespread particularly in North America and North Western Europe (Fambrough & Hart, 2008; Western, 2008).

⁸ For a critical analysis of Hochschild's dichotomy of emotional labour and work see Bolton 2000 and Bolton and Boyd 2003.

Mayer and Salovey (1995), who conceived the idea of emotional intelligence, defined it as the ability to manage and understand one's own and other people's emotions in a consistent way so as to reflectively promote emotional and intellectual growth. Goleman (1996; 1998) who popularised the concept, identified emotional intelligence as a set of competencies, redefined and restated by George (2000) as follows:

- The expression and appraisal of emotion
- Enhancing cognitive process and decision making
- Emotional knowledge
- Managing emotions

These characteristics appear to have much in common with the rhetoric of transformational qualities of leadership although in many ways EI has become a management 'tool' rather than a critical model. To this end (apparently) Goleman (Goleman, 2000; Goleman, Boyatzis, & McKee, 2001) focused on 'styles' and 'performance' which seem far away from the 'heady' descriptions below of qualities of emotional intelligent leadership, which refer to feelings, empathy and creativity.

The expression and appraisal of emotion

An emotionally intelligent person will be able to understand their own and others' feelings and able to empathise, which may enable them to be manipulative for better or for worse.

Enhancing cognitive processes and decision making

Having emotional intelligence allows a person to use emotion to be creative, solve problems, make decisions and flexible plans for themselves and on the behalf of a group. An emotionally intelligent leader will be able to judge their mood and make decisions accordingly. If the person is in a negative mood this may mean choosing to wait until such negative episodes have past in order to make a comprehensive decision.

Emotional Knowledge

Emotionally intelligent people understand how other people may be affected by their negative moods and therefore may take care not to spread bad feeling around the group.

Managing Emotions

Many leaders are able to manage their followers' emotions as well as their own, but as indicated below, developing the qualities required to manage emotions effectively is highly complex and more about processes than style or performance (Fambrough & Hart, 2008; Hughes, 2005). As Fambrough and Hart argue 'emotional intelligence' has passed into common use among organisational leaders with little recognition of the way it has been identified

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as problematic. *What has been so attractive about EI to leaders in health care organisations?*

The idea of emotional intelligence captured the imagination of some training NHS staff as a means to improve staff relationships and enable clinicians to empathise with their patients (Allan & Smith, 2005; Cummings et al., 2005a; McQueen, 2004; Amendolair 2003, Luker et al 2002). McQueen (2004) reflecting on the 1960's when health care workers were encouraged to hide their emotions from their patients, for the sake of maintaining a professional role, suggests that in recent decades this view of nursing has changed and health care workers frequently display emotions to illustrate their commitment to patient care (Williams 2000). McQueen suggests that emotionally intelligent nurses are important for building strong patient-nurse relationships (Conger and Kanungo 1987 and (Lewis, 2005). Nurses with high Emotional Intelligence are able to build rapport quickly with their patients through communication and interactive skills (Schutte et al 2001).

McQueen (2004) also states that "*emotional labour calls upon and engages*" emotional intelligence (2004, p. 103). In order for patients to feel cared for nurses have to constantly *perform* positive emotions and behaviours such as warmth, friendliness and consideration. However, when confronted with a 'difficult' patient nurses may experience negative emotions such as frustration, irritation or anger. The nurses must be emotionally intelligent enough to identify their emotions and then perform emotional labour to submerge the negative emotions in favour of more positive emotions (Bolton 2003).

While EI *per se* needs to be understood more critically (Fambrough & Hart, 2008), the introduction of emotional management and engagement by leaders (and others) in health care organisations needs further scrutiny (see below); despite the best efforts of some management gurus emotion is a fact of personal, interpersonal and organisational life particularly when considering what it means to deliver patient care.

1.4.3 Beyond emotional intelligence

Interest in EI has continued to grow among management and organisational academics with a focus on how to measure it – the conclusions generally indicating the need for caution in measures to predict or to establish baselines for its development among managers (Conte, 2005). The conflation of managerial skills as listed by Mintzberg (Mintzberg, 1973) cited in Riggio and Reichard, (2008) which included the ability to 'deal' with subordinates, 'empathize' with top-level leaders and establish and maintain social networks, alongside managing emotions as a leader, have come to be known as 'people skills'. These are clearly represented in the NHS leadership qualities framework and vital for managing in any organisation (see Figure 1).

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1.4.3.1 Social intelligence (SI) and leadership

In 2006, taking account of advances in neurological psychology, Goleman (Goleman, 2006) proposed that because humans are *designed* for social connection, rapport and supportive emotional interactions enhance performance of managers and leaders. He listed these qualities under the umbrella of 'social intelligence' and identified four dimensions:

- *Synchronization* – whereby matching moods lead to a sense of rapport
- *Attunement* – listening fully
- *Social cognition* – understanding how people interact
- *Social facility* – finding it easy to interact with others

While some people have little difficulty meeting these criteria and mastering their social intelligence, others (such as Narcissists, Machiavellian and Psychopathic types), Goleman argues, do not have the capacity for social intelligence, and thus he proposes a means of *selecting* effective leaders by testing these qualities. This model albeit individualistic has something to offer through extending the theoretical underpinnings of 'people skills' and emphasising the importance of taking followers and colleagues seriously in decision-making.

Following EI and SI in bringing management/organisational theories together with developments in psychology, particularly cognitive neuroscience and evolutionary psychology, is the reconsideration of the role of intuition in understanding leadership and organisational behaviours (Sadler-Smith, 2008). Sadler-Smith brings the idea of the 'gut feeling' into the foreground to explore the influence of this sense upon decision-making particularly under pressure (e.g. many emergency clinical decisions rely on the clinician's instinct of whether the patient should be operated on, admitted to hospital, whether to call for support).

It seems that while there is a continuing trend towards an evidence-based understanding of leadership, success there is also an emergence of features of human life that are difficult to explain and measure, although all the proponents cited above stick to the view that these characteristics are scientifically explicable and measureable despite challenges from both positivist and critical social constructionist positions (Ashforth & Humphrey, 1995; Conte, 2005).

1.4.3.2 Affective Events Theory (AET)

AET predicts that specific features of work (e.g. autonomy) have an impact on the arousal of emotions and moods at work that, in turn, co-determine job satisfaction of employees. AET further proposes that job satisfaction is

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an evaluative judgement that mainly explains cognitive-based behaviour, whereas emotions and moods better predict affective-based behaviour. The results support these assumptions (Jürgen, van Rolf, Fisher et al., 2006). Ashkanasy et al (2002) suggested that AET has two important messages for leaders in an organisation.

- Followers' emotions are heavily influenced by their leaders' emotions and therefore leaders must minimise the 'hassles' that they place on their followers in order to increase job satisfaction and performance. Short-term negativity can be tolerated without much impact on the team or organisation.
- However, if negative events persist it will affect followers' moods leading to negative emotions, poor performance, reduced job satisfaction and in the case of the NHS, (possibly) to poor quality patient care. It is therefore suggested that leaders need to give followers positive feedback regularly to "*ameliorate the daily hassles experienced by employees*" procuring positive behaviours such as team spirit and self-worth (Dasborough 2006, p. 165 ; Weiss & Cropanzano, 1996). The connections between the moods of individuals and their performance may be understood better in terms of emotional engagement between leaders and followers on both conscious and unconscious levels (see below).

1.5 Distributed leadership

The academic study of distributed leadership, that is when at various levels leadership (or influence) behaviour, identity, role and responsibility are distributed to more than one individual or group of individuals, has been at the forefront of much social scientific leadership research over the past ten years (Buchanan, Addicott, Fitzgerald, Ferlie, & Baeza, 2007; Day, Gronn, & Salas, 2004; Gronn, 2002; Mehra, Smith, Dixon, & Robertson, 2006a). The implication of this interest in distributed leadership is, that organisations have changed and previous models - including the charismatic, 'hero' leader and the 'command and control' organisational structures - are dysfunctional in a context where organisational change is rapid and diversification of strategic leadership and management essential (Butterfield, Edwards, & Woodall, 2005; Dent, 2005; Goodwin, 2000). In a competitive, diverse and divergent environment leadership needs to be distributed, in order to enhance democratic governance, thus enhancing legitimacy and increasing survival chances (Currie et al., 2009).

Distributed leadership also implies that organisations where it is practiced have (relatively) flat hierarchies with diverse service needs and expertise across all sectors of the organisation (Huffington, James, & Armstrong, 2007). This model applies to hospitals and primary care settings, where

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distinct professional groups each have their own standards of excellence, while at the same time sharing goals of competence and quality related to the service they provide to patients and how they interrelate to other organisations.

With this shift in focus of many leadership practices and leadership studies the definition of such leadership has been proposed as:

".. a status ascribed to one individual, an aggregate of separate individuals, sets of small numbers of individuals acting in concert or larger plural-member organisational units" (Gronn, 2002, p. 428).

Gronn suggests also that when leadership is distributed it may be that the duration of that influence is limited, perhaps (structurally) to a single project and therefore (psychologically) distributed leadership might mean having to 'give up' leadership as well as take it up (Huffington et al., 2007). Furthermore, according to Gronn (2002) the most common understanding of distributed leadership, witnessed by the growing number of references to it in the research and policy literature, is that it applies to numerous people across an organisation taking some degree of a leadership role or responsibility.

More importantly, Gronn identified distributed leadership as *concerted action* meaning that there are many roles comprising a 'leadership complex' with at least three potential forms:

- *collaborative modes of engagement* which arise spontaneously in the workplace. This suggests that leadership practice is 'stretched over' the context of the organisation and not a function of those in managerial roles such as matron or clinical director. However, if the matron, clinical director and other colleagues who share ideas for change or particular activities they *may "pool their expertise and regularise their conduct to solve a problem after which they may disband"* (Gronn, 2002, p. 430).
- the *intuitive understanding* that develops as part of a close working relationship among colleagues. These relationships tend to happen over time when organisation members come to rely on each other and develop a close working relationship, to solve problems or bring about change and others might be involved in a 'framework of understanding'.
- The variety of *structural relations* and institutionalized arrangements which constitute attempts to regularize distributed action. Thus, for example, if there were dissatisfaction with existing arrangements for particular practices, a team of 'equals'

might emerge to find ways to improve or change the problematic practices.

All of these are apparent particularly, but not exclusively, in Trust Three (the FT) as exemplified in Chapters Four and Nine in particular.

Gronn argues the importance of examination of these different forms of concerted action to understand where influence (and thus leadership and power) might lie in any organisational context. Emotionally, however, these different models of distributed leadership suggest the impact of these structures and practices at a deeper level (Gabriel, 2004) particularly around authority (Halton, 2007; Hirschhorn, 1997) competition (Morgan, 2006) rivalry and envy (James & Arriba, 2005; Stein, 2005)

1.6 Organisational Culture, Climate and Contexts

As introduced above, post-industrial (or even 'post-modern') organisations (Burrell, 1988; Fineman, Sims, & Gabriel, 2005) and networked (Balkundi & Kilduff, 2006; Goodwin, 2000) organisations are changing rapidly and the NHS is clearly among these. Changes in the NHS take place at a number of levels, emerging from the direct policy dictates from central government to become local initiatives. Moreover, the NHS has become increasingly team (and indeed multi-disciplinary team) based over the past two or three decades so that knowledge, influence and leadership for transformation and change are not only moving from a top-down to bottom-up model, but as indicated, to a distributed model which involves lateral influence (Begun et al., 2006; Day et al., 2006; Ferlie & Shortell, 2001).

The type of leadership that is supported and promoted in any organisation and the related concept of the organisational structure depends on and impacts upon organisational climate and culture.

Although research undertaken on organisational *climate* and organisational *culture* comes from different epistemological traditions, since around 1990 the literature and concepts referring to both have been overlapping and/or complementary (Schneider, 1990; Schneider, 2000) and increasingly the terms are used interchangeably (Ashkanasy et al. 2000).

It is, however, generally accepted that 'climate' is a logical extension of what was originally conceptualised as 'psychological' climate, that is, shared psychological meanings in an organisation; so that *organisational* climate is an aggregation of those individual perceptions of a work-place context (James, Choi et al. 2008).

Organisational culture on the other hand has its origins in anthropology and human relations (see Davies, Nutley and Mannion, 2000; Scott, Mannion et

al. 2003). Organisational psychologist Edgar Schein's (1985/2004) ideas about organisational *culture* as a pattern of *shared basic assumptions that have worked well enough and adapt to the external environment and serve internal integration*⁹, is one of the most frequently quoted definitions. Schein takes a systems theory approach to understanding organisations and his work has been built upon by himself and others to develop a variety of typologies which underpin measures of both organisational culture and climate (see Albino-Metcalf, Alban-Metcalf et al. 2008 for a comprehensive overview of this literature).

Organisational climate, with its origins in traditional psychology is *typically* "... the only domain of organisational research that simultaneously examines perceptions of jobs, groups, leaders, and organisational attributes and thus has the unique capacity of being able to decipher common denominators and latent relationships that are not available to those who study only specific domains such as perceived equity" (James et al., 2008, p.27). We therefore made a decision to use a measure of *climate* as a backdrop to this mostly qualitative study, in order to 'triangulate' with our findings on leadership and patient care.

However, we found a competing strand of interest in the measurement of organisational *culture* (e.g. Davies, Nutley and Mannion, 2000; Scott, Mannion, Davies and Marshall, 2003) which more frequently seems to attend to health care settings than studies of climate albeit with some notable exceptions (Dawson, Gonzalez-Roma, Davis and West, 2008).

1.6.1 Emotion and the unconscious in organisations

Organisational climate and/or culture cannot be discussed without acknowledging that organisations are places where both the intellect and emotion are called into play in order to achieve organisational goals and as we have made clear, emotions are intrinsic to service delivery and leader-follower engagement in the NHS. Emotional engagement, while available to human consciousness, also takes place at an unconscious level (Gabriel, 2004; Hugh, 1986; Lyons-Ruth, 1999; Morgan, 2006; Willmott, 1986), and anxiety or stress is particularly salient when having to care for and make potentially life-saving decisions for patients (James & Huffington, 2004; Menzies¹⁰¹¹, 1970).

⁹ A paraphrase.

The ideas that characterise transformational leadership models, such as 'charisma', 'influence', 'inspiration' 'thoughtfulness' and 'consideration', have intellectual roots beyond contemporary management theory and training. They are more closely related to group and organisational theories with late 19th and early 20th century origins (De Board, 1978; Gabriel, 2004) from which much contemporary organisational theory has emerged.

The first significant attempt to analyse group behaviour made at the start of the 20th Century by Le Bon (1917/1920) whose book *The Crowd* illustrated his observation that individuals in a large group can demonstrate a 'collective mind' which emerges when people are bound together in some way. McDougall's book *The Group Mind* (1922/2009) and Sigmund Freud's *Group Psychology and the Analysis of the Ego* (1921/1922) also focused on what would subsequently come to be recognised as unconscious group processes. Freud developed Le Bon's and McDougall's ideas in the context of psychodynamic theory, arguing that the binding force of the group derives from the *emotional* ties of the members, which are expressions of their libido or drive.

Studies of (and human 'experiments' about) group psychology, taking some of this perspective on board, flourished after the Second World War conducted and further developed by psychiatrists in the newly formed NHS. In Britain the work of Wilfred Bion, Tom Main, Maxwell Jones and others led to innovations in both group psychotherapy and the study of organisations. Bion's work on group relations and dynamics which contributed to the development of the Group Relations Training Programme (GRTP) at the Tavistock Institute in 1957 evolved into the Leicester Conferences with other organisations using this model across the world (Miller, 1993). However contemporary knowledge and understanding continues to reflect back upon this early work.

What was learnt during this period about group dynamics and group relations represents an important dimension in the understanding of contemporary organisations and the relationship between leaders and followers. We develop this further in Chapter Seven in particular. It is important to note how the intellectual journey from work on emotional labour to social intelligence and intuition has so far largely neglected to explore the extent to which unconscious processes remain part of the emotional context of human social interaction (Allan and Smith, 2005, p. 21).

¹¹ Isabel Menzies is sometimes referred to as Menzies-Lyth. Her work has been reprinted several times with each name used.

In a hospital environment it is inevitable that negative events such as death occur (see Lewis for discussion on the impact of death on nurses in a special care baby unit taking an 'emotional labour' approach). When death does occur nurses may display emotions (consciously and unconsciously) such as anxiety and fear (Allan & Smith, 2005; Obholzer & Roberts, 1994; Allan 2001; Smith et al 2003). Obholzer asserts that "[he] believes that many of the organisations' difficulties that occur in hospital settings arise from a neglect of the unconscious psychological impact of death and near-death on patients and staff" (1994, p.171). He explains that hospitals are sites where anxieties about social taboos such as death are *contained*, that is that staff and the organisation overall takes away the anxiety and the responsibility for care from the relatives. Patients and staff are socialised to believe that hospitals are institutions where illness is treated and that medical knowledge and practice is infallible. This is illustrated by patients who contend that doctors possess God-like qualities and have the ability to heal all ailments. When death does occur, medical staff and the patient's relatives may feel *duped* by the institution they believed would save their loved one.

At the turn of the 19th to the 20th Centuries psychoanalytic ideas were seen to have something new and important to say, not only about the psychology of the individual and the role of the individual unconscious, but about *unconscious processes when people converge in groups and crowds* as shown above. From psychoanalytic theory we take up ideas again today specifically about the relationships which exist between followers and leaders, made explicit in the paradigm shift from transactional to transformational leadership. Working together and accepting or resisting influence comes not only with an observable set of behaviours and measurable emotions, but with unconscious and 'secret' ones including dependency, envy, power, anger, authority and emotional contagion, which may be either conscious or unconscious but have important consequences for behaviours (Burke et al., 2006; Simpson & French, 2005; Stein, 2005; Whitely, 1997). In Chapter Seven for example we see examples of where two senior managers find themselves unable to influence despite their senior roles, legitimacy and operational power. As Gabriel (2004) has argued "*emotions are no simple side-effects of mental life*" as "*emotion lies at the heart of human motivation*" (p.215).

One key feature of caring for sick patients, managing change and the social context of the NHS Trust then, is the ways in which clinicians and managers manage their anxiety which is fundamental to working in any health care setting. In the section that follows below, we demonstrate how psychoanalytic thinking explains how individual psychology and unconscious defence mechanisms link to the ways in which human beings work in groups and organisations.

In Chapter Nine we attend in more detail to the anxieties involved in obstetrics and more generally on the emotions involved in care of the elderly. In anticipation of these we present the theoretical material in some detail immediately below in this chapter.

1.6.2 Clinicians' anxiety and patient care

To conceptualize anxiety we draw on object relations theory, the branch of psychoanalysis associated with Melanie Klein (1959) and, in particular, the work of scholars who applied object relations to an understanding of groups (Bion, 1961) and organisations (Jaques, 1952; Menzies, 1970; Klein, 1987; 1983) hypothesising that an infant responds from the earliest time to the withdrawal of the maternal breast by experiencing a powerful anxiety of a 'persecutory nature'. Being unable to grasp the separation from the breast intellectually, the infant, unconsciously, feels as if every discomfort were inflicted by hostile forces. A fundamental *splitting* takes place, whereby an object is experienced as two separate objects, one entirely good and one totally bad. Thus there is a good breast (which is always present and nourishing) and a bad breast (withdrawing and denying), a good mother and a bad mother.

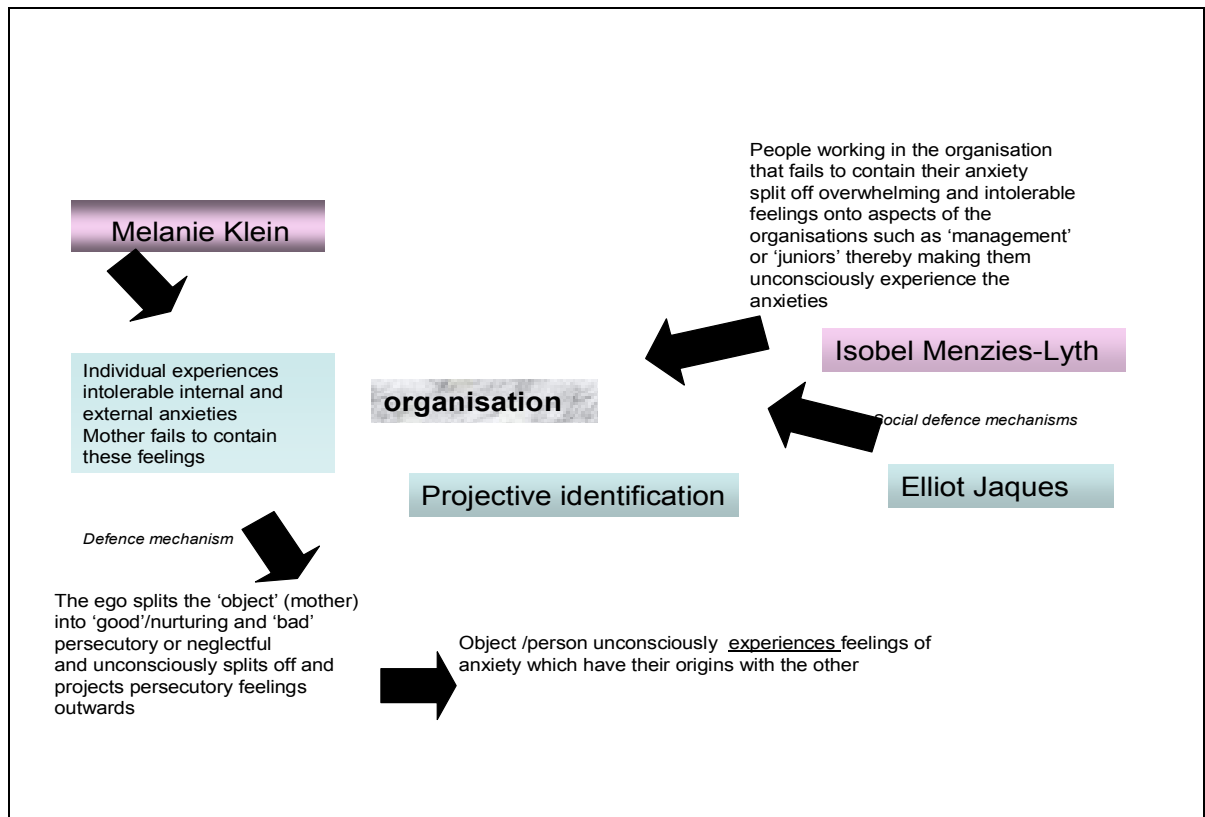
This is a pattern repeated in clinical settings, where patients routinely refer to a 'good nurse' and a 'bad nurse' and, almost identically, clinical staff referred to some patients as 'a good patient' and to others as 'a bad patient' (see Chapter Nine for an example of this). Splitting according to Klein extends in the child's own self – those aspects of him/herself that she cannot bear are projected outwards ("It is not I who is angry/fearful/envious; it is you"). Again this is a phenomenon observed many times in clinical settings. Frustration, discomfort and pain are experienced as persecution from hostile forces and their concomitants (e.g. hate) become destructive impulses which *are still operative in later life*, especially in times of stress and crisis.

Splitting and projection then are seen as fundamental *defences against primitive anxieties* by the object-relations school of psychoanalysis. Within this tradition, objects are not external entities but are shaped by phantasies¹² and feelings, they are *introjected* and projected, they split into good and bad and they constantly define and re-define the ego (or self). Object relations theory has found numerous important applications in the theory of organisations, primarily through the works of Jaques (1952) and Menzies Lyth (1960; 1970) in the UK, and more recently, Hirschhorn (1988), Gould (1993), Diamond (1993), Schwarz, (1990), Schwarz and Clore (2003) among others. Notable among these applications is the

¹² 'Phantasies' spelt in this way refers to those in unconscious experience.

treatment of *the whole organisation as an object which is liable to become incorporated in psychic reality* and towards which the individual may develop relations akin to early relations with significant objects from her environment and hold the 'organisation in the mind' (Armstrong, 2005) which we will discuss in more detail in the context of evidence from the study in Chapter Six.

Figure 2. Social Defences against Anxiety in Organisations



Menzies-Lyth, whose 1960 classic study of nursing staff occupies a privileged position in this literature, was driven by her initial observation that nursing work is highly anxiety-producing. She argued that nurses confront many different emotions from patients and their relatives - gratitude for the care they offer, admiration, envy for their skills and resentment stemming from forced dependence. Such projections create strong feelings in the nurses themselves:

The work situation arouses very strong and mixed feelings in the nurse: pity, compassion and love; guilt and anxiety; hatred and resentment of patients who arouse these strong feelings; envy of the care given to the patient. (Menzies-Lyth, 1988 , p. 46)

Faced with such an emotional cauldron, many nurses re-experience infantile persecutory anxieties, from which they seek to defend themselves, through

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the familiar mechanisms of projection, splitting and denial. Menzies-Lyth's important contribution was to establish how an organisation's own bureaucratic features, its rules and procedures, rotas, task-lists, paperwork, hierarchies and so on, in short '*the system*' acts as a support for the defensive techniques. By allowing for 'ritual task performance', by depersonalizing relations with the patients, by using organisational hierarchies, nurses contained their anxiety. Yet, in Menzies-Lyth's view, such organisational defences against anxiety were ultimately unsuccessful:

The system made little provision for confronting anxiety and working it through, the only way in which a real increase in the capacity to cope with it and personal maturation would take place. As a social defence system, it was ineffectual in containing anxiety. (Menzies-Lyth, 1991, p. 363)

The system's inadequacy in Menzies-Lyth's study is evidenced by its failure to train and retain nurses, the chronically low morale, high levels of stress and burn-out and absence of work satisfaction. By contrast, institutional health is testified not only by performance and output indicators, but also by morale indicators, and individual feelings of growth and maturation. Social defences against anxiety, then, are self-defeating. Instead of *containing* anxiety, they exacerbate it, just as neurotic symptoms far exacerbate the patient's malaise instead of containing it. Since Menzies-Lyth's pioneering work, some attention has been paid to how to support nurses and enable them to contain their emotions, without resorting to depersonalizing social defences. Yet, there is ample evidence that many nurses today continue to struggle with modest support against powerful anxieties (Theodosius, 2006; 2008). It is striking that no single study has sought to examine whether doctors face similar types of anxieties as nurses, whether they resort to similar psychological defences and the extent to which these defences function effectively across different individuals. In Chapter Nine we see evidence that doctors too appear to react similarly when faced with intolerable anxieties.

1.7 Developing our approach to leadership and the NHS

Studies of leadership and organisations such as the NHS clarify that diverse disciplinary perspectives have come together and separated more than once over the past century. The relationship between organisational and social context over that time has impacted on both practices of leadership and empirical and theoretical changes. In the 21st century the rules of scientific management or leader as therapist no-longer apply, and the rapid changes in organisations such as the NHS brought about by economic and technological imperatives, have left many who engage in leadership

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discourses, for practical and academic purposes, moving between the transformational and the post-heroic positions.

We now consider theoretical perspectives, ideas and practices that can potentially be brought together to good effect in this study for the benefit of patients and those who work for their good within the NHS, focusing on some of the recent debates which explore the context of leadership and the place of distributed leadership as they apply to NHS contexts.

1.7.1 The base-line:

- It is now widely acknowledged that organisations, their leaders and followers come together in a highly *emotional context*. How can those who lead and work in such organisations take account of the role of emotion while not being 'emotional' (i.e. making unfair and irrational decisions)? Understanding this is vital for enabling management and leadership particularly in a complex institution which has patient health, safety and care at its cutting edge (Morgan, 2006) .
- The NHS, individual Trusts and Units within these Trusts are constantly engaging staff in *change* (which may be evolutionary and/or politically driven) and which may be motivational and/or stressful or resisted (McNulty & Ferlie, 2002). This further demands emotional and social intelligence and engagement from leaders and followers (Bovey & Hede, 2001).
- The primary *tasks* and related *roles* might conflict at various points as these changes impact emotionally and intellectually on staff performance and service delivery (Zoller & Fairhurst, 2007).
- Organisations have to have leaders but leadership is not necessarily always the province of a small group of individuals but depends on the structure and demands placed on the organisations and the tasks required at any one time (Currie et al., 2009; Day et al., 2006; Harvey, 1989; Michie & West, 2004).
- An emotional context requires attention to both conscious and *unconscious* dimensions of human interaction and power relationships which may come into play in organisations which comprise multiple professional disciplines, different grades of role and people from diverse cultures, sexualities and gender (Ford, 2006; Gabriel, 2004). Acknowledgement of the importance of anxiety, envy, competition, anger and the emotional ties between people needs to be taken into account (see Figure 3 below).

Two models of leadership are therefore examined in this study (see Figure 3 below):

- First, *inspirational and transformative (or engaging) leadership* which has attracted much recent attention in that its absence was seen as a critical factor behind the failure of many organisational innovations. In this approach, leadership hinges on leaders' ability to communicate effectively, relate emotionally with their followers and develop a vision that is both attractive and achievable. The role of transformational leadership then is to lead an organisation towards change and thus some elements of transformational leadership are essential for understanding the practices and needs of the NHS (Alban-Metcalf & Alimo-Metcalf, 2009).
- The second relevant dimension is *distributed leadership* (sometimes called *dispersed, distributive, collective, or supportive 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). A *distributed leadership* approach is consistent with Bailey and Burr's (2005) research on successful NHS Trusts, which states:

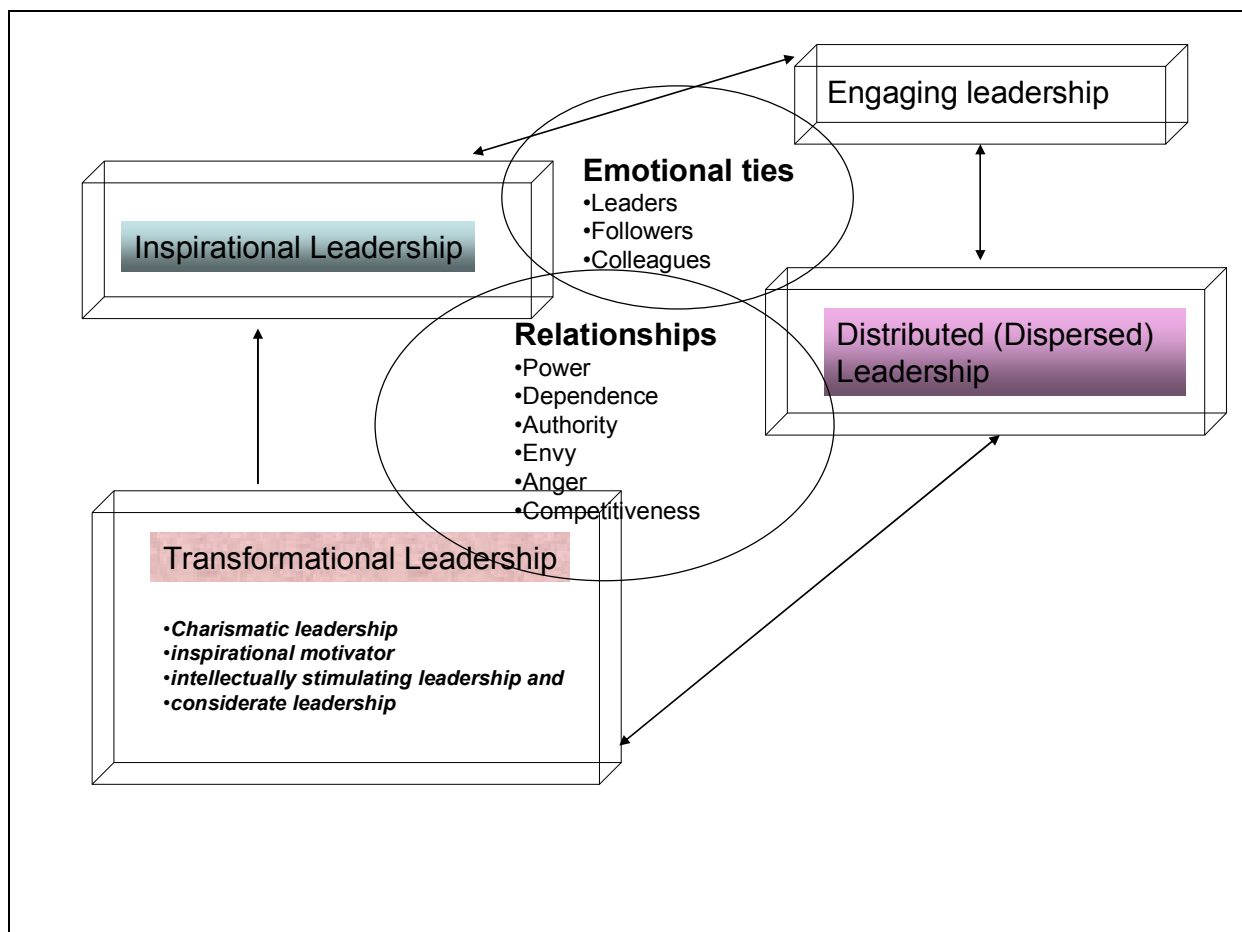
In contrast to the individual, heroic leader concept, leadership is seen in terms of the influence processes that contribute to the collective and individual capacity to work effectively. This idea of collective and distributed leadership is closely associated with the emergence and special requirements of 'new' organisational forms generally and the NHS in particular it is consistent with the agenda for devolved decision – making, empowerment of the frontline, de-centralisation, inclusion and such initiatives as 'Leadership at the Point of Care'.

Thus, distributed leadership is seen by Bailey and Burr (2005, p. 14) as directly linked to patient care.

A combination of these two models might now be seen as 'engaging' leadership as described by Alimo-Metcalf, Alban-Metcalf et al. (2007) and this combination will be explored further in our analysis of the (qualitative) data in particular.

Furthermore the model of the post-industrial/postmodern and or networked organisation will be 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).

Figure 3. Leadership Styles, Followership and Emotion



1.8 Conclusion

In an organisation like the NHS there are opportunities for leadership at all levels, as well as opportunities for success and unforeseen consequences leading to failure. Leaders in the NHS are involved *transformationally* in responding to policy initiatives and government demands, but the NHS is also an organisation that relies on the knowledge, skills and abilities of all its people – leaders and followers.

It would seem that *transformational/engaging and distributed leadership* are particularly useful conceptual resources to deploy in the context of the National Health Service, where a workforce of different ethnic, cultural and

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class backgrounds caters to the needs of a similarly diverse patient population.

Following Alimo-Metcalfe, Alban-Metcalfe et al (2007) "*an engaging 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'*" (2008, p. xi).

As part of the conceptual framework we develop, it is clear that the *emotional links* between individual staff, groups of staff and staff and patients need to be privileged as they play out at various organisational levels. Implicit therefore is that emotions above and below the surface (conscious and unconscious) are taken into account if the leader/follower and staff/patient relationships are to be understood and improved.

2 Aims and Methods

2.1 Introduction

The research questions in this study centre on identifying:

- (a) processes by which leadership is transmitted through health service organisations to effect the delivery of health services, and
- (b) how features of the organisation, the leader, and the service influence these processes.

The focus of this study was to explore the relationship(s) between (good) leadership in NHS organisations and (good) patient care. This demanded consideration not only of leadership characteristics, qualities and styles but the ways in which NHS organisational climate and culture interacted with individual practices and identities of those who worked in them and were patients. The overall plan was, thus, to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery. This research further sought to expand existing knowledge by exploring the following questions.

1. First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
2. Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

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3. Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

2.2 Aims and Objectives

We separated these overarching research questions into aims and objectives thus:

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients;
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts on service delivery;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted through health care organisations to affect service delivery, posits *organisational climate* as one feature of the organisation that could positively or negatively affect the quality and delivery of health services.
- To learn how different stakeholders (specifically, patients, nurses and professions allied with medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care.
- To identify how the need for change in service delivery is identified and what drives the need for change.

2.3 Methods

This multi-method study therefore uses a mixture of qualitative and quantitative methods to enable and support an innovatory approach to examining the psycho-

social and psychodynamic factors intrinsic to the meanings and processes of leadership, organisation and patient care.

Qualitative research methods now have a strong and long-standing profile in social science, particularly sociology and anthropology. But over recent years they have become increasingly relevant in social psychological research.

Furthermore nursing research (Finlay & Ballinger, 2006; Kerr, 2002) and most recently even health services research have begun to take evidence emerging from qualitative methods seriously. Perhaps this began with a series of papers in the British Medical Journal in 1995. Pope and Mays for example leading on this series aptly titled their paper *Reaching the Parts other Methods Cannot Reach* (Pope & Mays, 1995). Noteworthy from this point onwards is that there is no 'one' qualitative method of either data collection or analysis and we draw on several traditions and styles in this study which are outlined below.

Unlike health services research *per se*, but akin to critical social science, there is a powerful tradition in organisational research that has taken account of the diverse nature and intrinsic value of qualitative methodologies to understanding the life of organisations (see for example Cassell and Symon, 1994; Ybema et al., 2009)

What counts of course is choosing methods which meet the demands of the research hypothesis or overarching questions. We thus began from the premise that 'leadership', 'patient care' and 'organisational change' are not objective facts but social or discursive constructions. By this we mean that these concepts are constructed through discourse, i.e. a coherent system of statements which constructs an 'object' (Parker, 2002). In other words, talk about leadership is the process by which leadership is constructed (and thus recognised) as something that happens in organisations such as the NHS.

To capture these constructions we used a range of methods:

- focus groups;
- a survey-based questionnaire including a standardized measure of Organisational Climate;
- ethnographic 'shadowing';
- observations of social places, formal and informal and meetings;
- analysis of 'stories' of leadership collected through in-depth interviews.

2.4 Capturing the data

In what follows we present the outline plans for capturing, managing and analysing the data to meet our aims although as shown in Chapter Three not all of our goals were achieved.

We focused upon three NHS Trusts with at least one being a Foundation Trust specifically to explore whether any variations in the qualities of leadership, organisation and patient care could be distinguished. An

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investigation of three Trusts was considered to be manageable within the time frame and other resources available for the project.

Within each Trust we chose two distinct 'units' to study. We conjectured these would probably to be defined by clinical speciality or site (bearing in mind that many Trusts are organised across more than one hospital/physical space).

We conducted focus groups, an organisational climate survey, story-telling interviews and ethnographic work (observations and shadowing) across these six units with staff and patients.

We employed two researchers¹³ to carry out the majority of this work, but some members of the investigatory team also took an active part in the process.

The qualitative data would by necessity and designed be analysed using a variety of methods:

- a. Thematic analysis (TA)
- b. Critical Discourse Analysis (CDA)
- c. Narrative analysis

Each of these approaches to data analysis, again by necessity and design, was subject to nuances of interpretation, intrinsic to their nature.

¹³ In the event three researchers were involved because of maternity leave and cover.

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graph TD
    NRES[NRES application] --> Local[local governance]
    Informal[Informal and formal approaches to 'gate-keepers' by research team] --> Local
    Local -.-> Trust[The Trust]
    Trust --> Local
    Trust --> SiteA[Site A]
    Trust --> SiteB[Site B]
    Trust --> Unit1[Unit 1]
    Trust --> Unit2[Unit 2  
As Unit 1]
    Trust --> Other[Other parts of the Trust]
    SiteA --> Unit1
    Unit1 --> Staff[Staff]
    Unit1 --> Patients[Patients]
    Unit1 --> Other
    Unit2 --> Other
    Staff --> Other
    Patients --> Other
    Other --> Survey[Organisational Climate Survey]
    Informal --> Intro([Introduction to key informants at Trust level  
•Negotiating choice of Unit  
•Negotiating entry for data collection])
    Intro --> SiteA
    Intro --> Unit1
    Intro --> Staff
    Intro --> Patients
    Intro --> Other
    Intro --> Survey
    
```

The flowchart illustrates the research approach, starting with the NRES application and local governance. The research team uses informal and formal approaches to 'gate-keepers' to gain access to the Trust. The Trust is the central entity, leading to Site A, Site B, Unit 1, Unit 2 (As Unit 1), and Other parts of the Trust. Site A leads to Unit 1, which then leads to Staff and Patients. Staff and Patients lead to the Organisational Climate Survey. The Trust also leads to the Organisational Climate Survey. The Trust also leads to the Meeting staff and negotiating individual arrangements for data collection, which leads to the Organisational Climate Survey. The Trust also leads to the Meeting staff and negotiating individual arrangements for data collection, which leads to the Organisational Climate Survey. The Trust also leads to the Meeting staff and negotiating individual arrangements for data collection, which leads to the Organisational Climate Survey.

The Trusts

- they were each different from each other in the image they projected (on their web-sites, in terms of their physical style,

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locality, size and community) and that the sample had to include one Foundation Trust.

- they were in easy reach of London (for practical purposes as the study team were based in London and Surrey).
- we were able to gain access via personal contacts in R & D or senior management (the 'gatekeepers').

The Units

Sampling of the Units in each of the Trusts was achieved through negotiation with the gatekeepers and/ or key informants recommended by the gatekeepers with the intention that a balance might be struck between:

- the specific academic interests of the research team (for example the PI is particularly interested in Obstetrics and Gynaecology services).
- some degree of opportunity for comparison between Trusts, so that if possible some similar Units might be compared across the Trusts.
- and (possibly most influential) the concerns of the gatekeepers and other senior Trust staff.

The Sites

All three Trusts selected for an initial informal approach were on more than one site although the selection of study unit determined whether or not the data was collected on more than one site.

Individual Participants (staff)

Individual participants were to be selected on an 'informed' volunteer basis. That is that via a process of meetings with key informants and presentations to staff-groups individual staff would hear about the study and be offered the opportunity to participate. For those who were not involved in the meetings or presentations a staff e-mail list was used to communicate information about the study and request volunteers to participate in interviews and focus groups. The intention to meet the study aims was to ensure participation from a variety of staff groups and levels of seniority.

Individual Participants (patients)

Patients were to be recruited for interview either by the staff directly caring for them or by the researchers themselves once the staff of each unit had become familiar and accepted the presence of the researchers.

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Survey Respondents (staff)

The Organisational Climate Survey (OCS) was to be administered within the Units that were the focus of the study and, if possible, across other Units in the Trusts. The circulation was to be achieved either through e-mail or through internal mail depending on negotiation with the relevant gate-keepers.

Survey Respondents (patients)

Patients who might complete the patient version of the survey were to be recruited by staff and/or researchers if staff permitted the researchers 'on the ground' access.

Observations and 'Shadowing' (staff and patient-staff interactions)

These methods would require the participants to be familiar and comfortable with the presence of the researchers and familiar with the ongoing research process and also be prepared to co-operate. The rules for engagement in the activities would then be made on a strategic (i.e. the staff and / or situation that would yield the richest source of information) and a pragmatic basis (i.e. the possibility of the situation yielding important data regarding leadership, organisational culture and climate and patient care).

2.6 Ethical considerations

There are clearly considerations about confidentiality and anonymity in all data collection which involves human participants Easily identified in this study (and thus in the NRES application) is the matter of the safe keeping of the raw data including completed questionnaires, any identifying characteristics of these questionnaires, digital recordings, transcripts from focus groups and interviews and the researchers' field notes. It is important to note that this is not necessarily as simple to do as it is to describe particularly because a team of investigators, the researchers themselves and some 'casual' clerical staff ¹⁴all had different types of access to the data.

The solution was to have a shared drive set up by the computer centre at Royal Holloway, University of London (RHUL) on the main site at Egham which could only be accessed by specified investigators identified by the PI. Additionally there was an access pass-code to read the transcripts and the SPSS file.

¹⁴ The sheer volume of data made it necessary to use more than one person to input the data and transcribe the recordings. Two people other than the researchers were engaged to work on this although both were employees of RHUL who knew the importance of keeping the data safe.

Another ethical consideration specific to this project was that because the staff were discussing leadership and being asked to give examples of good and bad leadership, as well as examples of effective and poor patient care, it was inevitable that:

- they would be talking about *other* members of staff. These other staff could not be told that they had been talked about (by definition) leaving them unable to provide their version of the story or aware of the fact they had been discussed.
- the researchers would therefore be 'holding' some knowledge of others which would be 'data'. This fact drew attention to the ethical and empirical complexities of working in an organisation in which data is being collected on human interactions and relationships.

As patients' experiences and views and staff's views of patient care were also part of this investigation, similar issues applied.

Finally, frequently overlooked but nonetheless very important consideration was given to the fact that participants' time should not be wasted. We were confident in the design and our experience as investigators supporting and managing the researchers (who themselves were experienced in this kind of study) that the study was robust enough to adapt to the vagaries and quirks of 'real life' and that the outcome would be valid and add value to existing knowledge.

2.7 Methods of data collection and research instruments

As described above a mixture of qualitative and quantitative methods were used to ensure a full picture of leadership in the organisations to be studied. Collecting data in applied settings, where the participants are also engaged on a day-to-day basis is demanding work which is challenging for researchers involving persistence, social skills, the ability to develop rapport, clarity of purpose combined with flexibility, the skill of 'thinking on your feet' and making practical judgements about what is feasible at any one time. For example, if plans had been set for an interview with a staff member who was then called away for an important work matter, the researcher could arrange other potential participants or be prepared to engage in a period of systematic observation.

Immediately below we describe the methodologies we chose to employ to conduct our investigations which will be described in greater detail where appropriate in the context of specific case studies.

2.7.1 Focus groups

Focus groups, once the province of market researchers, in common with in-depth interviews, are now a popular method of collecting psycho-social data in the area of health research (Nicolson & Anderson, 2003; Nicolson et al., 2008) having gained recognition in social science overall as a robust way of eliciting “*shared and tacit beliefs, and the way these beliefs emerge in interaction with others in a local setting*” (Macnaghten and Myers, 2004, p. 65 in Seale et al) (p.8). In other words focus groups represent a means of gathering a sense of how those who work in an organisation share a sense of their ‘organisation in the mind’ (Armstrong, 2005) which may be mutually accepted, challenged or undermined by the perceptions of colleagues. Focus groups also enable the researchers to check out the quality and effectiveness of the communications themselves between members of the Unit or as Morgan (1998) suggests “*Focus groups are fundamentally a way of listening to people and learning from them* (1998, p. 9).

The process involves one or two researchers meeting with between four and eight participants who share a common situation and the guide lines for the discussion focus on key topics (see Appendices). One researcher takes notes although both are empowered to guide the discussion which is also digitally recorded. One benefit of this means of data collection is that through discussion among peers issues or perspective upon certain issues are brought into focus which might have escaped previous research authors and the researchers themselves (Morgan, 1998).

The *focus group guide* employed a similar structure to the *Interview Guide*.

2.7.2 Organisational climate

The Organisational Climate Questionnaire (OCQ) designed by Stringer (Litwin & Stringer, 1968; Stringer, 2002) also called ‘The Leadership Questionnaire’, was specifically designed to produce a scale to measure leadership in the context of climate albeit in a business rather than NHS setting. To complement the mostly qualitative methods of data gathering and analysis, we developed a questionnaire for staff and patients across the Trusts and used (a slightly adapted form of) Stringer’s measure of leadership and organisational climate, with the expectation that our results might also be linked to other studies undertaken with this measure, which had been used to examine management and leadership in organisations.

It identified six dimensions of organisational climate: *structure, standards, responsibility, recognition, support* and *commitment*, and uses eighteen leadership practices (three for each dimension) to capture how people feel about their jobs, how they are managed, and how things work in a particular organisation. Because this scale is designed to give practical

indicators on how to improve performance, many of the leadership measures are based on management practices, which are equally important to the overall success of an organisation. In general, however, each leadership practice measure is based on the premise that leaders care about arousing the motivation of members in the organisation (Stringer, 2002). The OCS was adapted from to fit a model relevant to NHS Staff working in a hospital setting and another version was adapted to be used with Patients (see Appendices).

2.7.2.1 Measurement tool: Stringer's OCS – Leadership and Organisational Climate

Stringer (2002) defines organisational climate as the "*collection and pattern of the environmental determinants of aroused motivation*" (p. 9) and he takes motivation to be central to the development of his climate questionnaire predominately based on the work of McClelland-Atkinson's framework with regards to intrinsic motivators of work related-behaviour: the need for achievement (nAch), the need for power (nPow), and the need for affiliation (nAff).

Stringer noted that specific dimensions of climate appear to have a predictable impact on motivated behaviour and can be measured and managed by those in senior positions accountable for organisational performance.

The six distinct dimensions identified and measured are:

- 'Structure'
- 'Standards'
- 'Responsibility'
- 'Recognition'
- 'Support'
- 'Commitment'

The statistical data was entered into an SPSS file to seek frequencies, correlations and to explore significance levels of differences and similarities between and within groups of respondents.

2.7.3 The survey structure and items

The survey is structured in two parts:

Part 1: measures *Organisational Climate* or how people perceive the work environment.

Part II: measures *Management Practices* or how people see their own managers behaving.

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Part 1:

This part consists of twenty-four items grouped into the six dimensions - 'structure', 'standards', 'responsibility', 'recognition', 'support' and 'commitment' - designed to measure how people feel about their work environment using a 4 point Likert scale. The directions ask the participants to describe the kind of working climate that has been created in their organisation (defining 'organisation' as the smallest work unit relevant to the participant).

Descriptions of the dimensions are as follows:

1. **'Structure'** pertains to the clarity of roles, responsibilities, accountability and expectations. According to Stringer this is more of a managerial than a leadership issue and one which is more practical than inspirational. It reflects the employees' sense of being well organised and of having a clear definition of his or her roles and responsibilities. *"structure is high when people feel that everyone's job is well defined and is low when there is confusion about who does which tasks and who has decision-making authority"* (Stringer, 2002, p.65).

The following items measure 'structure':

- The jobs in this organisation are clearly defined and logically structured.
- In this organisation, it is sometimes unclear who has the formal authority to make decisions.
- In some of the projects I've been on, I haven't been sure exactly who my boss was.
- Our productivity sometimes suffers from a lack of organisational planning.

2. **'Standards'** is about the need to achieve targets and reach goals. It is the drive to achieve and improve, it includes the 'commitment' and persistence to follow through on set targets. This dimension measures the feeling of pressure to improve performance as well as the degree of pride employees have in doing a good job. When interpreting this measure, high 'standards' indicate that people are always looking for ways to improve performance, whereas, a low score reflects lower expectations for performance.

The following items measure 'standards':

- In this organisation we set very high 'standards' for performance.
- In this organisation people don't seem to take much pride in their performance.
- Around here there is a feeling of pressure to continually improve our personal and group performance.
- Our management believes that no job is so well done that it couldn't be done better (Stringer, 2002, p.65).

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3. **'Responsibility'** is about taking ownership of the work and results which are obtained. Ideally people will be motivated to achieve results and take ownership over these. Where managers delegate and encourage responsibility, workers are more likely to feel a sense of 'responsibility'. It reflects employees' feelings of 'being their own boss' and not having to double-check decisions with others. A sense of high 'responsibility' signifies that employees feel encouraged to solve problems on their own. Low 'responsibility' indicates that risk taking and testing of new approaches tend to be discouraged (Stringer, 2002; p.66).

The following items measure 'responsibility':

- We don't rely too heavily on individual judgment in this organisation almost everything is double checked.
- Around here management resents your checking everything with them if you think you've got the right approach you just go ahead.
- You won't get ahead in the organisation unless you stick your neck out and try things on our own.
- Our philosophy emphasises that people should solve their own problems themselves.

4. **'Recognition'** relates to the relationships between one's performance and associated rewards, as well as broader sense of approval or disapproval of an individual's efforts. It indicates employees' feelings of being rewarded for a job well done. This is a measure of the emphasis placed on reward versus criticism and punishment. High 'recognition' climates are characterised by an appropriate balance of reward and criticism. Low 'recognition' means that good work is inconsistently rewarded (Stringer, 2002, p. 66).

The following items measure 'recognition':

- In this organisation the rewards and encouragements you get usually outweigh the threats and criticisms.
- There is not enough reward and 'recognition' given in this organisation for doing good work.
- We have a promotion system here that helps the best person rise to the top.
- In this organisation people are rewarded in proportion to the excellence of their job performance.

5. **'Support'** is the degree to which there is a sense of warmth and team work, within which the individual feels that they are 'backed up' by others. This will determine the amount of trust and respect amongst team members. It reflects the feelings of trust and mutual 'support' that prevails within a work group. 'Support' is high when employees feel that they are

part of a well-functioning team and when they sense that they can get help (especially from the boss) if they need it. When 'support' is low, employees feel isolated and alone. This dimension of climate has become increasingly important for today's e-business models in which resources are severely constrained and a premium is placed on teamwork (Stringer, 2002, p.66).

The following items measure 'support':

- You don't get much sympathy in this organisation if you make a mistake.
- When I am on a difficult assignment, I can usually count on getting assistance from my boss and co-workers.
- People in this organisation don't really trust each other enough.
- I feel that I am a member of a well-functioning team.

6. **'Commitment'** reflects employees' sense of pride in belonging to the organisation and their degree of 'commitment' to the organisation's goal. Strong feelings of 'commitment' are associated with high levels of personal loyalty. Lower levels of 'commitment' mean that employees feel apathetic toward the organisation and its goals (Stringer, 2002, p. 11).

The following items measure 'commitment':

- Generally, people are highly committed to the goals of this organisation.
- People here feel proud of belonging to this organisation.
- People don't really care what happens to this organisation.
- As far as I can see, there isn't much personal loyalty to the organisation.

Part II:

This part asks the participants to describe the practices of their managers. Using the same six dimensions as in Part I, participants are given eighteen statements which describe the way a manager might perform her or his duty and the respondents are asked to indicate how much he or she agrees with each of the statements. Here a 5 point Likert scale is used.

Once again the six dimensions are used to assess perceptions of managers' practices:

1. 'Structure'

- Establishing clear, specific performance goals for subordinates' job.
- Clarify who is responsible for what within the group.
- Making sure tasks and projects are clearly and thoroughly explained and understood when they are assigned.

2. 'Standards'

- Setting challenging performance goals and 'standards' for subordinates.
- Demonstrating personal 'commitment' to achieving goals.
- Giving subordinates feedback on how they are doing on their job.

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3. 'Responsibility'

- Encouraging subordinates to initiate tasks or projects they think are important.
- Expecting subordinates to find and correct their own errors rather than doing this for them.
- Encouraging innovation and calculated risk in others.

4. 'Recognition'

- Recognizing subordinates for good performance more often than criticizing them for poor performance.
- Using 'recognition', praise and similar methods to reward subordinates for excellent performance.
- Relating the total reward system to performance rather than to the other factors such as seniority or personal relationships.

5. 'Support'

- Being supportive and helpful to subordinates in their day to day activities.
- Going 'to bat' for subordinates with superiors when the manager believes their subordinates are right.
- Conducting team meetings in a way that builds trust and mutual respect.

6. 'Commitment'

- Communicating excitement and enthusiasm about the work.
- Involving people in setting goals.
- Encouraging subordinates to participate in making decisions.

Leadership question

We also asked a single question to capture directly how satisfied an employee is with the leadership they receive from their immediate supervisor. It was a simple statement: *I am satisfied with the quality of the leadership I receive from my immediate manager* which we measured using a 4 point Likert scale.

2.7.4 Ethnographic observations and 'shadowing'

Ethnographic observations and shadowing are especially useful to organisational research because they allow people to *physically* express their inner thoughts, and put ideas into *observable action*, all of which would be inaccessible through the survey or structured interview questions.

Ethnographic observation (often referred to as *participant observation*) has its roots in anthropology but has become increasingly deployed in sociology, cultural and social geographies. In the field (which in this case is a Unit in an NHS Trust) the researcher's aim is to "*understand how the cultures they are studying 'work'*" that is, to grasp "*what the world looks like*" to the

participants in the context being observed (Delamont, 2004, p. 206). In this study observation and shadowing opportunities were (mostly) formally set up and pre-arranged. However, the researchers, through taking their roles as interviewers, focus group leaders and having an every-day presence with key informants, gate-keepers and participants, were able to immerse themselves in the lives and atmosphere of each of the Trusts and Units providing evidence about the processes of leadership and patient care as well as 'climate' (Bloor, 2001; Goffman, 1961).

Shadowing involved the same conceptual framework as ethnographic observation in that the aim was to understand what the world looks like from the perspective of the staff member being shadowed as well as the worlds of the other staff and patients that they engaged with in the course of their work (Czarniawska, 2008; McDonald, 2005). It involved meeting the participant (usually) at 8 am and for one or two days accompany them including at break times until the participant went home. In Trusts where there was more than one site and/or when the nature of the day's work involved meetings outside the hospital (as in nearly every case) then the researcher spent time in a car with the participant and if agreed the conversation was digitally recorded as an *aide memoire* for the field notes. The participant was able to withdraw at any time, or for a period of time, across the shadowing period.

Thus the sense of 'what the Unit world looked like' was recorded in field notes which were then discussed with the other members of the team (who had some familiarity with the relevant part of the Unit/Trust) in a context where the researcher could be reflexive and explore the 'silent space' of the 'ethnographic self' (Coffey, 1999). The researcher's notes and expressed thoughts were then discussed with other members of the team, some of whom were familiar and others not so with the specific context (Barry, 2003). A similar approach was used to discuss the interview material because even though the interviews were digitally recorded and transcribed verbatim, this did not account for the reflexivity that took place following the interview itself and on transcribing and reading the transcript, and therefore featuring in the analysis (Nicolson, 2003).

In this context there was concern to capture the emotional content and atmosphere of the organisations. This meant that ethnographic methodologies were implemented to analyse the emotionality of the interactions (verbal and non-verbal) between patient and practitioner. It was through these observations that the use and importance of the researcher's *body as a 'research instrument'* became palpable, especially for understanding the emotions emerging out of the interactions between patient, relatives and practitioner(s). This process has been proposed as the antithesis of taking for granted that emotion should be removed from

ethnographic investigation and that in fact the research process is highly emotive and far from an emotionally barren terrain (Bondi, Davidson, & Smith, 2005).

As the researcher collects data they move through a continuum of emotions from the euphoric highs of excitement at starting a new research project, sense of achievement and pride as they begin to make contacts and collect initial data, perhaps trepidation, fear and nervousness as they meet new participants or research settings through to the depths of despair, isolation and frustration as the research process (inevitably at times) becomes chaotic and messy. However, these emotions are often neglected, regarded as unimportant to the overall research process and abandoned in the writing up phase. We use these frequently neglected emotions and feelings as part of, and beneficial to, the project as representing a rich source of data.

By being more attentive to their emotions and bodily senses ethnographers also become more sensitive to their environment and their participants thus gaining a greater awareness of what they are observing. In recalling a sound, smell or feeling the ethnographer is able to open up their mind's eye to re-visualise the interaction with greater clarity and accuracy making it more likely that an accurate representation of what was observed will be recorded.

2.7.5 In-depth semi-structured and 'story-telling' interviews

In-depth semi-structured Interviews: Over the past fifteen years this method of qualitative data collection has become increasingly common in health services and health research in general (Pope and Mays, 1995; Kvale, 1996; Grbich, 1999) consistently a method of choice for identifying perceptions, meanings and experiences of dynamic and complex concepts such as 'leadership' and 'patient care' (Rubin and Rubin, 1995; Denzin and Lincoln, 1998; Rapley, in Seale et al, 2004).

The use of such interviews has led to increased levels of sophistication in the interpretation of qualitative in-depth data in the context of historical, cultural and political frameworks demonstrating that in-depth semi-structured interviews (and more generally qualitative research) have capability beyond simply adding rich description to statistical evidence (see Denzin and Lincoln, 2002; Willig, 2008).

Story-Telling: One of the explicit aims of the interviews was to collect a number of stories to reflect critical experiences in the organisations' past and present life. In the field of organisational studies, there is now an extensive literature of how to use stories told by organisational participants

as windows into organisational culture, politics and numerous other phenomena (Gabriel, 2000; Hannabuss, 2000).

The inclusion of story-telling in the context of the in-depth interview increases the scope for making sense of data in ways that delve deeply into the respondents' perceptions and meaning of the *processes* of leadership and patient care. Story-telling also increases the validity of the interview through the use of reflexivity, and positioning the events and 'atmosphere' of the stories in the context of the organisational analysis.

Of particular relevance to this study, stories can instigate insights into the processes of positive or negative social and organisational change and leadership which involves the management of meaning and emotions, both of which rely heavily upon the use of stories, allegories, metaphors, labels and other narrative devices.

The study of *organisational stories* is particularly relevant in health care settings that are liable to unleash strong emotions and fantasies. Hence, hospitals are rich grounds for collecting stories, as numerous researchers have recognized (Kleinman, 1988; Frank, 1998; Greenhalgh, 2002; Hurwitz, 2006; Mattingly, 1998). Storytelling permeates everyday clinical practices and "*medical professionals find ways to 'routinize' their practice and thus, metaphorically at least, bring the unruly and frightening world of illness under control*" (Mattingly 1998, p. 277).

The *interview schedule* (see Appendices) therefore was designed to elicit information on the participant's view of 'leadership' and 'patient care' through 'stories' to provide examples in their opinion that constituted good and poor leadership and good and poor patient care through 'critical incidents'.

As the interviews were semi-structured and in-depth they relied to a great extent on the interviewing skills of the researchers and their ability to establish rapport and consequent willingness of the participants to engage in the process. The early pilot interviews therefore were unlikely to influence the details of the interview schedule itself although the early interviews were planned to enable the research team to identify the best *strategies* to engage participants in the task.

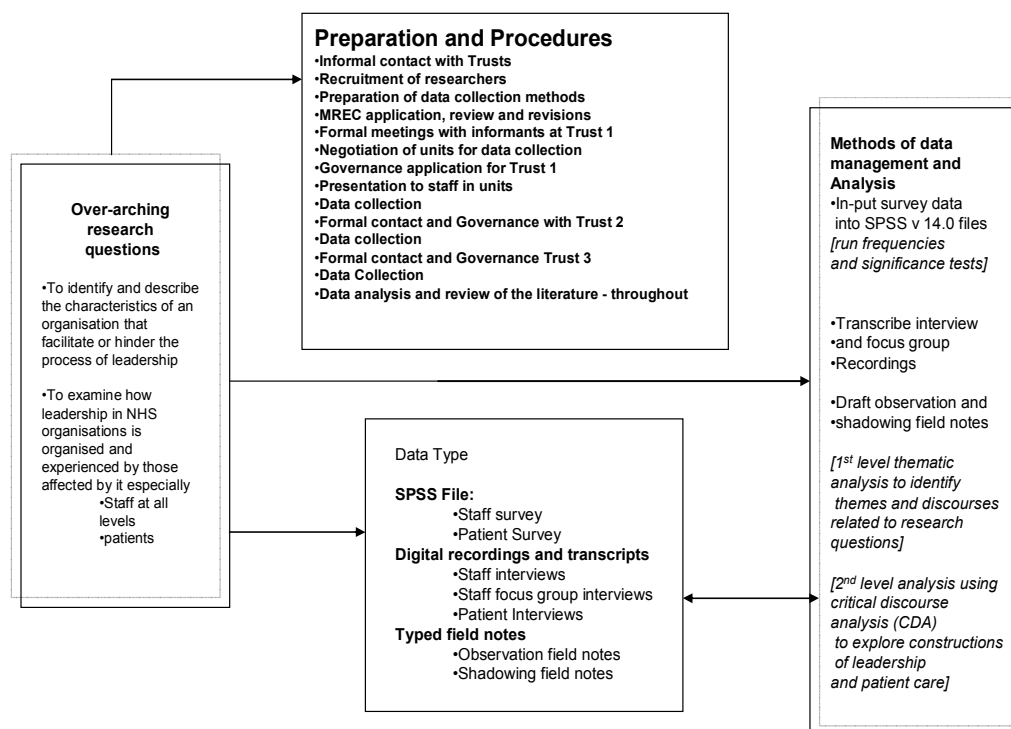
2.8 Data Management

The interviews and focus groups were digitally recorded and transcribed verbatim. The transcripts stored on a password protected Word file (initially on the researchers' PCs but subsequently on the secure shared drive described above) and sound recordings stored on audio files (password protected on the PC of the PI and not on the shared drive).

The OCS data was entered and stored on an SPSS file, password protected and placed on the secure shared drive.

Fieldwork notes from observations and shadowing were similarly password protected stored on the shared drive once they had been prepared by the individual researchers.

Figure 5. Outline of Study Procedures and Methods



2.8.1 Data Analysis

There are effectively therefore three categories of data.

1. Qualitative data representing verbatim 'talk' (digital recordings/transcripts) of interviews and focus groups.
2. Qualitative data from observations, shadowing and other field notes. These were subjective accounts of observations, perceptions, emotions and meanings given to the field work by one researcher. This may have been following discussion with the other researcher on occasions when that person had had access to the same raw

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material. Discussion with another member of the investigatory team (frequently but not always the PI) also took place following the first drafting of the field notes in order to clarify the meanings given to specific behaviours and relate theory and data.

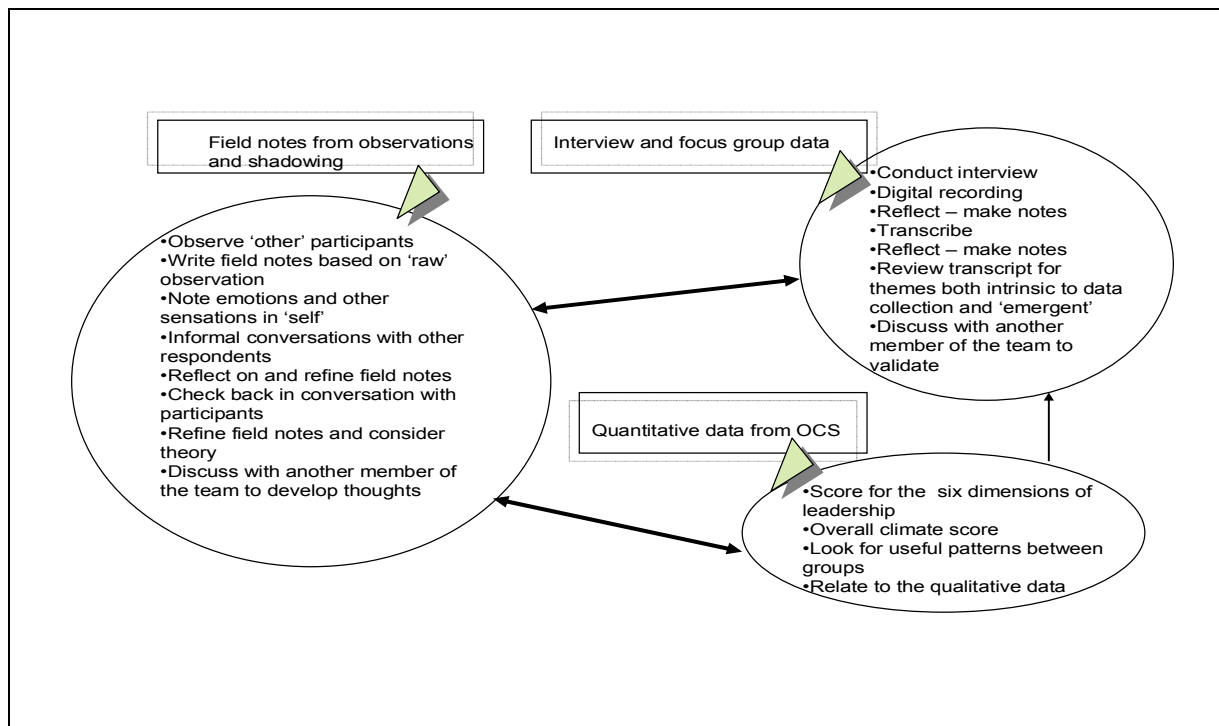
3. Statistical data from the OCS.

2.8.2 Thematic Analysis (TA)

The transcripts and field notes were examined initially for relevant extracts related to the main themes ('leadership', 'organisation' and 'patient care').

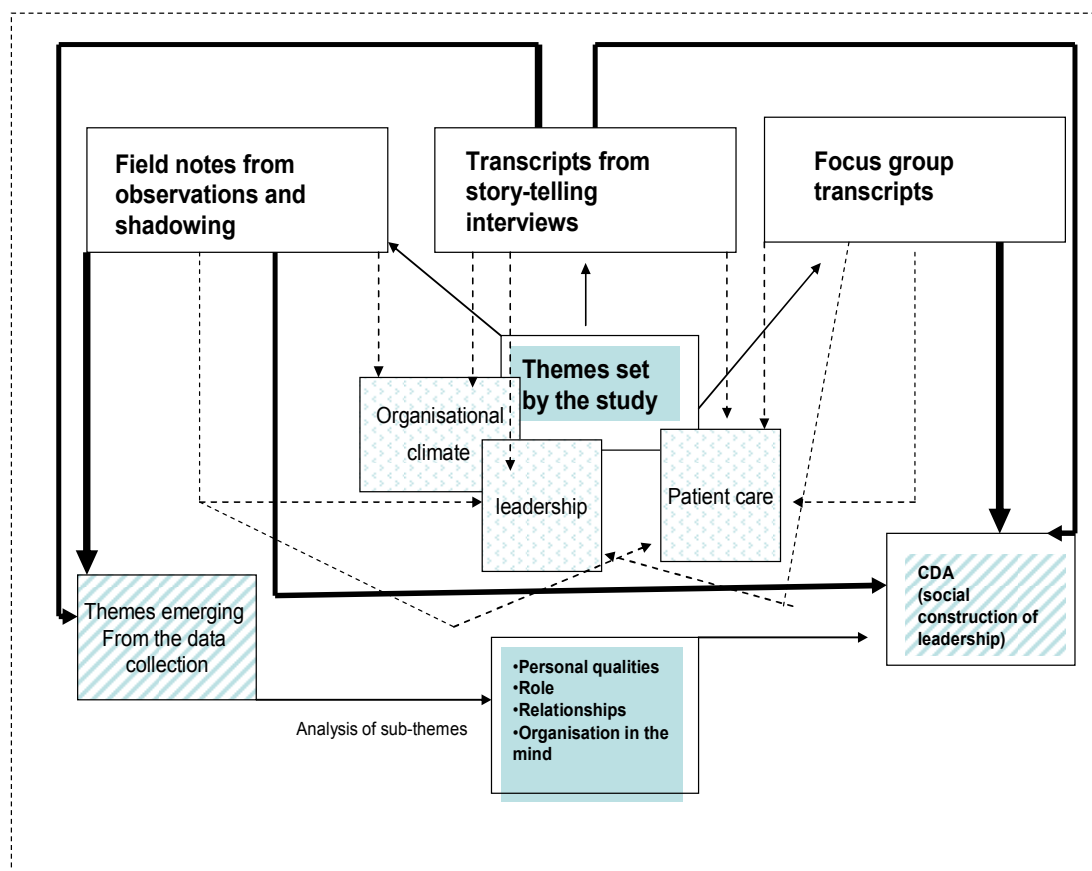
Sub-themes were then to be identified, some of which are likely to relate closely to the previous research literature on leadership and organisational climate, although it is likely that each organisation will demonstrate particular issues that were more difficult to anticipate at the outset.

Figure 6. From data collection to data analysis



Data relating to these themes and sub-themes was to be collated on Word files and where deemed relevant to the study aims, analysed further using the following methods – Discursive Psychology, Critical Discourse Analysis and Narrative Analysis. All these approaches focus on language and the way language is used to construct key concepts (e.g. the organisation) but there are different nuances to each perspective each of which adds an important dimension to the analysis of this data.

Figure 7. Thematic to CDA with Narrative analysis



2.8.3 Discursive Psychology, Discourse Analysis and Critical Discourse Analysis (CDA)

Hepburn and Potter (2004) argue convincingly and with justification that DA has evolved to have several iterations over recent years. One common feature though has been that 'discourse' (i.e. what is said) and 'context' are difficult to separate and it is the ways in which context is worked into the analysis of discourse that distinguishes the character of DA deployed in a particular piece of analysis.

The thematic analysis was a starting point from which to focus in upon the close readings of the texts, which related to the processes of leadership and patient care, as it represents a flexible and clear way of identifying what is emerging from the data and points a way forward with more detailed analysis (Braun and Clarke, 2006)

We argue that leadership is a social construction and there is a growing body of literature providing evidence to support this view. There has also been a recent focus in organisational research and theory to specify an Organisational Discourse Analysis (ODA) (Pritchard, Jones and Stablein, 2004) which involves four approaches i.e. *Narrative*, *Foucauldian*, *Linguistic* and *Deconstruction* which in turn are influenced by a *reflexive awareness* of the organisational culture in which the research is being conducted.

Pritchard et al, (2004) argue further that the exact methodology and approach to the data depends on the 'researcher position' in the organisation being studied. In other words this approach *benefits* from the subjectivity of the researcher's interpretation of what processes mean and specifically from researcher reflexivity about their 'take' on a situation and set of interactions.

To qualify this method of analysis further, a discursive approach means that language is represented not so much as an objective truth but as a means of *constructing* what might be understood (Parker, 1992; Coyle, 2007).

Particularly relevant in this study, in which participants are asked to tell stories and provide evidence to support what is good and bad about both leadership and patient care (and implicitly the organisation in which these actions take place), is discursive psychology (DP) that highlights how "*descriptions of events are bound up with doing actions, such as providing justification for actions and blaming others*" (Hepburn and Potter, 2004, p. 169).

Thus Critical Discourse Analysis (CDA) sees language as a *social practice* and thus considers carefully the context in which language is used (see

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Wodak, 2004). CDA is related to the notion that *power is negotiated through language*. This is particularly apposite in a study of leadership in organisations. Even more so CDA is 'abductive' so that a constant movement between theory and empirical data is needed which suits ethnographic methods such as shadowing and observations enabling the researcher to test out their ideas as they progress with the data collection, and the attempt to understand how cultures work and how the research participants make sense of and experience their worlds.

2.8.4 Narrative Analysis

Narrative approaches to data analysis have been able to cut through the great complexity of the NHS - the intense emotions, positive and negative, it evokes among most of its stakeholders (e.g. Rooksby, Gerry & Smith, 2007; Bryant, 2006; Iedema et al., 2009; Brown et al., 2008; Elkind, 1998; Brooks, 1997). These studies have, for example, addressed power issues in the doctor-patient relationship, exploring communication in a consultation situation. In these analyses, the patient's 'subordinate' narratives have often been neglected or taken over by the doctor's privileged 'medicalizing' discussion (Mattingly, 1998, p. 12; see also Radley, Mayberry & Pearce, 2008). However, there is also a recognition that many of these narratives are co-constructed by patient and physician (Mattingly, 1998, p. 43; Kirkpatrick, 2008); exploring solely the patient voice in isolation and presuming that doctors will at all times occupy a dominant position in this relationship may be missing half of the story - the doctor's experience. As Mattingly (1998) points out, *"[h]ealers too, may be able to give a different kind of voice to their practice when they describe their work in narrative terms rather than the flattened prose of biomedical discourse"* (p. 14).

As a genre, narrative psychology is thriving (Smith & Sparkes 2006). There has been talk of the 'narrative turn in psychotherapy and psychiatry' (Brown, Nolan, Crawford & Lewis, 1996), and Crossley (2003a & 2003b) for example argues strongly for a 'perspective that retains a sense of both psychological and sociological complexity and integrity' noting that narrative psychology is concerned with 'coming to grips with how a person thinks and feels about what is happening to her' (2000, p. 6). She employs a phenomenological framework to explore narratives of 'the voice' of 'the mentally ill' (Crossley & Crossley 2001) and the experience of temporal elements and self/identity of people living with serious illness (HIV, cancer; see also Söderberg, Lundman & Norberg, 1997). Narrative research in health care has also been used to study the lived experience of patients (see for example Hemsley, Balandin & Togher, 2007; Hök, Wachtler, Falkenberg & Tishelman, 2007) and an emerging genre of 'narrative based medicine' seeks to make use of stories in developing a fuller understanding of illness experiences (Launer, 2003; Taylor, 2003; Greenhalgh, 1999).

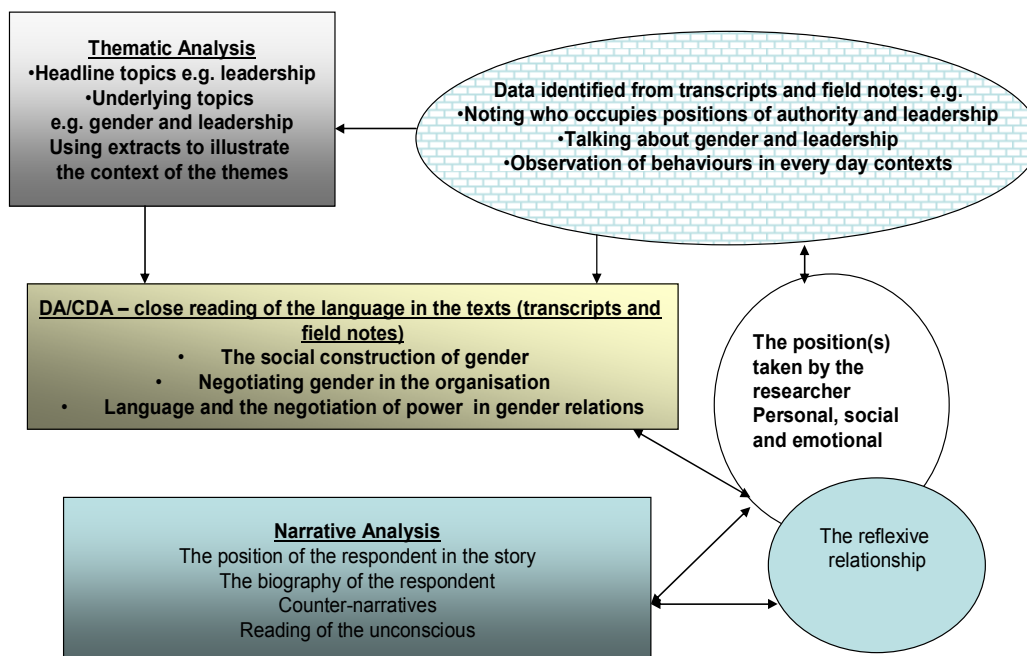
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Narrative based medicine is not merely an insightful way of doing research, but may have powerful policy implications. As Overcash (2003) argues, "*narrative methods are an effective research option that can lead to enhanced patient care*" (p. 179). While interpreting narratives can enhance the possibilities of integrating evidence-based research findings with individual illness experiences, and Winterbottom and colleagues (2008) suggest numerous courses of further research on why and how narratives may influence medical decision making.

Narrative analysis, as with DA, has been approached differently by academics from a range of disciplines so that the ideas surrounding the analysis of *narratives* (or stories told in a sequence) have a variety of emphases. The strength of taking the narrative approach over DA /CDA *per se* is that the 'subject' of the story (the narrator) retains a central role (Crossley, 2007). This can be seen in some detail in subsequent chapters particularly where the accounts of ethnographic observations and shadowing are highlighted where the 'story' becomes that of the researcher herself and with the stories unfolding through the interviews.

Furthermore the narrative analysis places the respondent's story as part of their own *identity construction* which lends an important dimension to the relationship of the story-telling to the teller. Particularly interesting here is Andrews' (Andrews, Sclater-Day et al., 2004) approach which focuses specifically on the elements of stories "*that lie in tension with the ones we are socialised to expect*" (2004, p. 97) or what she calls 'counter-narratives'. Researchers such as Hollway and Jefferson, 2002; Gough, 2003; Sclater, 2004; Allcorn, 2004 and Gabriel, 2004 and 2005, take on board the role of the interlocutor in positioning themselves in their story while considering some of the unconscious and emotional elements both of the story being told and the way that the relationship between the researcher and respondent plays out to construct and limit the story that is told. This dimension is particularly important in the context of this study where emotions are rife at least in part because of the high pressure (exacerbated to some extent by the changing political initiatives directed towards NHS institutions) and the particular nature of the work in caring for ill people (see for example Menzies-Lyth 1960).

Figure 8. Levels of qualitative data analysis e.g. 'gender'



2.8.5 Statistical Analysis

The data from the OCS was coded and in-putted into an SPSS v 14.0 file and significance tests were run (see Chapter Five for the full details).

3 Research Procedure

3.1 Introduction and Overview

The nature of this study, much of which involved the researchers immersing themselves in the 'world' of the participants, meant that it is not possible to provide an authentic *sequential* account of the procedure of data collection except possibly for the administering of the OCS (Organisational Climate Survey).

The bulk of the study, as identified in Chapter Two, comprised multiple methods of collecting different types of data across three Trusts, six Units and five sites.

3.1.1 Negotiating Access

The study took place across a three year period. Negotiation of access was complicated as indicated, although in itself a valuable procedure which occurred at several levels and helped to increase the richness of the team's understanding of leadership, patient care and the context of each organisation.

- Negotiating access began from the 'notional' level while writing the grant application whereby the investigatory team needed to identify whether a project with this design was in fact feasible. We thus made informal inquiries via personal contacts.
- More formal contacts were made once the project was confirmed with the intention to achieve verbal agreement about access for planning the NRES application.
- Following that we met to formalise the details with key informants (i.e. senior clinicians and managers) who had been identified in the previous stage.
- Once we had achieved a favourable NRES review, we pursued local governance applications with the help of the key informants.

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- These stages were managed by approaching one Trust at a time although during the latter part of the study some overlapping negotiations and governance were necessary.
- Part of the formal stage of negotiation concerned consideration of which *Units* could/would form the focus for the study. This was very much two-way but also serendipitous with suggestions from the team of investigators moderated by whichever senior clinical staff the key informants considered would be amenable to 'hosting' the study.
- The key informants then identified opportunities for the team to present the project to staff in the selected Units in 'educational half days' or 'staff meetings' depending upon the local structures.
- These formal presentations only took place in Trusts One and Three however. The procedure in Trust Two (because of the culture, location and structure) was on the basis of a 'tour' (which with permission was digitally recorded) organised by a senior nurse manager so the researchers, one of the co-investigators and the PI could meet various key nursing and medical staff across one of the Trust sites.

Once all that had been achieved it was the researchers on the whole who managed the day-to-day negotiations about who could and would agree to take part in the various elements of the study. This was complicated because of the day-to-day patterns of staff, changes in staff roles, particularly at senior levels, shift patterns and the sheer numbers of staff who may or may not have been aware and willing to allow access to, say, a particular meeting or team for observation or interviews.

Figure 9. Procedures and time-line

	2006/7	2008	2009
Winter	<ul style="list-style-type: none"> •Recruit and prepare researchers •Informal contact with 3 Trusts 1 and 2 •Informal visits to Trusts 1 and 2 •Develop research instruments •Prepare COREC/NRES application •MREC presentation and revisions •MREC approval •Start to review literature on leadership 	<ul style="list-style-type: none"> •Arranging formal contacts with Trust 2 (on 2 sites) •Visit to Site A •Further data collection in Trust 1 •Patient interviews 	<ul style="list-style-type: none"> •Researcher begins maternity leave and new researcher inducted into the team •Data collection in Trust 2 Site 2 •<u>[difficulties gaining access to staff list in Trust 2 for survey]</u> •Presentation to staff in Trust 3 (Unit 1) •Distribution of staff survey (individually handed out) in Trust 3
March - June	<ul style="list-style-type: none"> •Formal meeting with Trust 1 R & D director •Governance application •Formal meetings with senior staff to negotiate units for study •Unit based meetings and introductions •Presentation at educational half day on Unit 1 (obs & gyn) of Trust •Pilot interviews •Pilot staff survey 	<ul style="list-style-type: none"> •Formal meeting in Trust 2. Tour of Site A •Visit to Site 2 •Governance for Trust 2 •Informal meetings •Data collection begins in Trust 2 •<u>Trust 1 staff in Unit 1 return surveys to PI saying they won't give them out</u> 	<ul style="list-style-type: none"> •<u>[further difficulties gaining access to staff list in Trust 2 for survey – now due to key staff transfers]</u> •Preparation and presentation of invited paper to SDO conference in June •Paper preparation and further conference presentations
Summer	<ul style="list-style-type: none"> •Organise, send out and in-put data from staff survey in Trust 1 •Observations and interviews with key staff •Presentation to Unit 2 •Focus groups and interviews on Unit 2 	<ul style="list-style-type: none"> •Application for extension to project (successful) 	<ul style="list-style-type: none"> •Put staff survey on Trust 2's 'intranet' with information about how to complete and return •E-mail staff in Trust 3 who had not received a staff survey •<u>[a low response in both cases]</u>
Autumn	<ul style="list-style-type: none"> •Data collection •Data in-putting from staff survey •Patient survey given to staff on Unit 1 to distribute 	<ul style="list-style-type: none"> •Preparation of journal paper 1 •Further review of literature •Governance for Trust 3 •Identifying key contacts in Trust 3 •Negotiation about Unit 1 (Care of the Elderly) 	<ul style="list-style-type: none"> •Journal paper 1 (anxiety) being revised for publication •Journal paper 2 in preparation (gender) •Journal paper 3 (in preparation) leadership and 'territory') •Presentation prepared and delivered to NHS Surrey and Borders conference •Final draft report

3.1.2 Time frame and Participation of Investigators

We negotiated the formal details of access consecutively in order to make the process manageable. Most data was collected by the researchers (Dr. Fox, Dr. Lokman¹⁵ and Ms. Rowland) although the PI and other investigators made the initial contacts, met with key informants, contributed to the presentations and conducted some of the interviews and focus groups and (Profs. Gabriel and Nicolson, Dr. Heffernan and Mr. Howorth). The PI (Nicolson) and at least one of the researchers was present at all initial meetings with the gate-keepers and key informants.

3.1.3 NRES review

This was prepared and submitted at the end of 2006 and the PI, one of the researchers (Lokman) and another member of the investigation team (Gabriel) attended the appointment with London-Surrey Borders Research Ethics Committee in January 2007.

Annual reports were submitted to the NRES subsequently as required.

3.2 Sample characteristics

The three Trusts, selected as stated above in Chapter Two were each very different from each other, not only in formal terms (size, budget, location and organisational structures) but also informally and culturally and this influenced the 'access pathways'. Thus for example in Trust One our informal and then formal contact was with the R & D director (also a senior clinician) and assistant R & D director, who introduced us to the CEO, the clinical directors and senior nurses.

In Trust Two we had begun with meeting the CEO at the 'notional' phase who then retired in the meantime. This meant starting again with delayed local governance and to accomplish this, we were directed towards a senior clinical manager who then changed their role and location which meant dislocation of our planned procedures.

Trust Three involved a personal contact initially who was directly involved as a clinician in one of the Units who then arranged for us to have a

¹⁵ Dr. Lokman worked on the project for over two years and Dr. Fox took her place.

meeting with another senior clinician who in turn arranged for us to give a presentation to the Care of the Elderly/Geriatric Unit. From there we sought a second Unit for Study independently through contacts made during the course of working in the first Unit.

Trust 1 (One site only) a DGH (District General Hospital)

The Research and Development director here suggested the Units for study to be:

- Unit 1, Obstetrics and Gynaecology
- Unit 2, Cardiology

We were happy with his suggestions, and the staff was generally co-operative and supportive of the researchers.

The Trust itself covers two sites but the choice of these Units meant that all data was collected from one site. This was helpful because it meant the researchers and some of the investigators could spend time familiarising ourselves with the layout of the Units and the Trust site and become familiar 'faces' so that gaining consent from respondents was made easier than it would have been if the researchers and the study itself had to be presented as 'new' on each occasion.

While the study was taking place there were many fears expressed among the staff at all levels that the site we were investigating would become the less powerful with the other site taking over many of the executive functions. While the study team were collecting data on this site however this did not happen and the general 'morale' has improved so that the Trust is currently applying for Foundation Trust statusⁱ.

Self-Description of the hospital

The site we studied had 400 beds and a range of acute care services, including an Accident and Emergency department. It is situated in 52 acres of Green Belt parkland within 40 – 60 minutes of London. Originally it was built to serve casualties of the Second World War. Over the years, the hospital has been rebuilt, developed and extended to include maternity services, a departmental and clinic area, and a new theatre complex. In the early 1990s, the X¹⁶ Wing, which includes a Postgraduate Education Centre and modern well-equipped wards, was opened. A new building for the Accident & Emergency, ITU and Orthopedic Unit opened in the summer of 1998. In addition, comprehensive HIV and genitourinary medicine services are provided in a dedicated building.

¹⁶ We have used 'X' to ensure anonymity.

Obstetrics and Gynaecology

The study territory for this Unit¹⁷ comprised the labour ward, postnatal ward, a general outpatient clinic a dedicated ante-natal clinic and the Maternity Services Administration. The unit offered midwife care for home births, one to one care, water births and there was always a consultant obstetrician available and compared to other local hospitals it gained a score of 3/5 which was joint top score.

Cardiology

This Unit studied comprised one in-patient ward, the Medical Assessment Unit (MAU) and the Critical Care Unit.

In addition we spent time in the Management Suite where five interviews also took place of the CEO, Clinical Director, the Director and Deputy Director of R & D and a middle-ranking manager.

Observations also took place in public and eating spaces and shadowing involved walking around the hospital between different specialty wards and administrative departments.

Trust 2 (2 sites)

The Trust was one of the biggest DGHs in London with 4,200 staff. It had had a history of problems in its financial management and the quality of care but recent information on the web-site and confirmed by the CEO made it clear that:

The Care Quality Commission, the organisation that regulates health care nationally, has awarded the Trust a rating of excellent for the quality of services we provide to our local population. This is the highest possible performance rating in the 2008/09 Care Quality Commission annual national assessment report.

It seems that problems with the financial management remain although improvement had been noted.

The structure and organisation of Trust 2 differed significantly from Trusts 1 and 3. Trust 2 comprised two sites (recently combined into one Trust where one was a teaching hospital) which were at least eight miles apart and it

¹⁷ There were other parts of the Maternity Services at Trust 1 that were not observed directly.

was difficult to travel between one and the other on public transport other than using more than one bus or travelling in and out again from London. The journey by car varied from about thirty minutes upwards depending upon traffic.

Physically the two sites were very different. Site A was a relatively new building designed (as one researcher stated) to look like a motel or contemporary hotel. The other, B, was a traditional middle height rise built in the 1970s on a green site and appeared far more formal with long corridors and many signs to departments. Site A was more 'angular' and you could not walk very far without having to turn a corner which presented a very different 'feel'.

It was not possible, particularly in Site A to select a discrete specialist Unit (unlike Trust 1). Site A focused on acute medicine and care of the elderly and there were no formal divisions in where patients were treated as either in-patients or out-patients. So an older person with 'geriatric' health related problems could be in a bed next to a much younger person. We have identified a Unit as a Site in the case of this Trust. We found it equally difficult to 'pin down' a specialty in Site B as well.

At Site B we collected data from acute medical specialties, obstetrics and gynaecology and therapies (the latter being both physical and psychological).

This was in part because senior management at Site A (who were our key informants and 'gatekeepers') introduced us to staff they considered amenable. Thus for purposes of the study we had to identify Site B as our second Unit. Despite the introductions we managed, via snowballing, to find a range of participants who demonstrated many different view points.

To summarise then in Trust 2 the study was carried out in the following two Units which we have identified as follows:

- Site A / Unit 1 (Acute Medicine; Care of the Elderly)
- Site B / Unit 2 (Acute Medicine; Obstetrics and Gynaecology; Therapies)

We also interviewed a Clinical and Nursing Director both of whom worked across both sites and senior managers including the CEO and deputy CEO.

It became clear very early on that there was intense rivalry, even animosity between the two sites and some of this is explored in later chapters.

Trust 3 (2 sites)

Trust Three, in central London, is a long established hospital and a Foundation Trust with connections to a prestigious medical school. Travel

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between the sites took about twenty to thirty minutes by public transport. 9,000 staff are employed by the Trust with 1,100 beds available across the Trust at any one time.

- Unit 1 (Care of the Elderly, Acute Medicine)
- Unit 2 (Therapies)

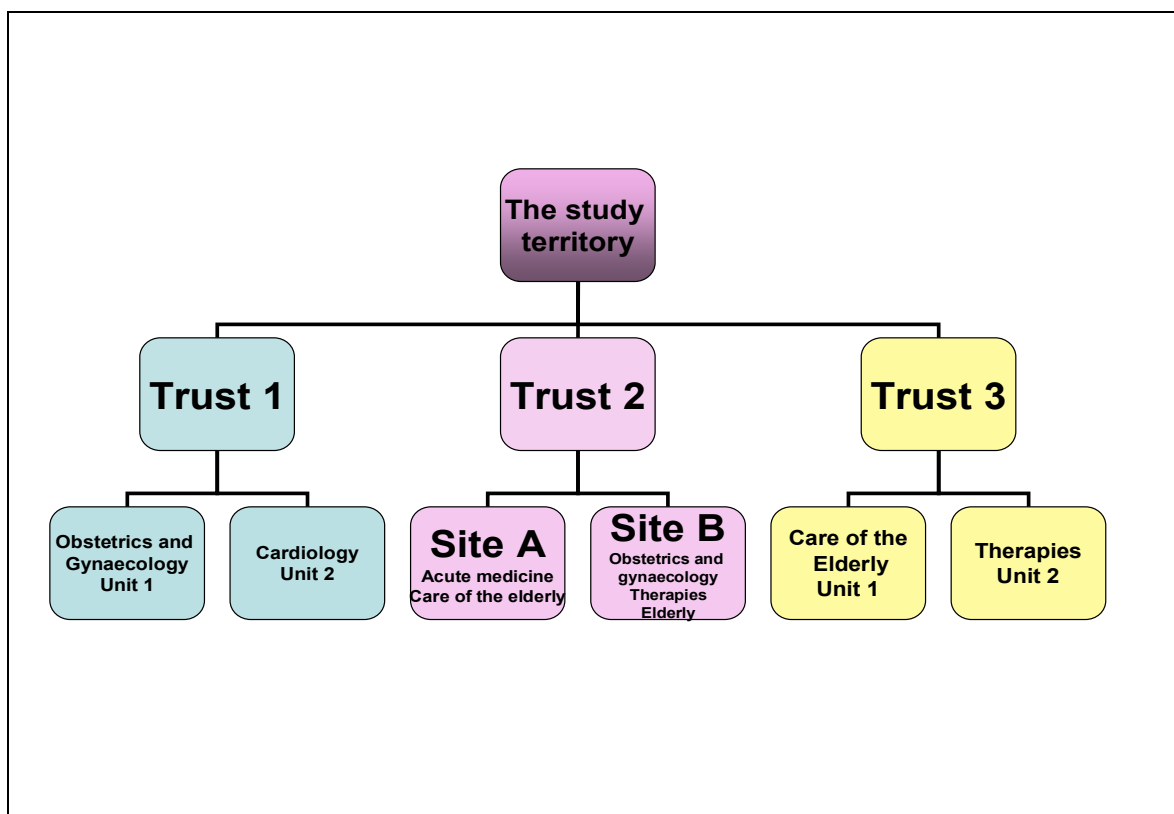
Unit 1 is described on the web-site thus:

Geriatric medicine specializes in the diagnosis and management of common symptoms and diseases in older people, particularly:

- *problems with mobility*
- *falls*
- *continence*
- *difficulties with looking after oneself*

Unit 2 (therapies) which included physiotherapy and psychological therapies spanned both the sites and covered many clinical departments and extended to primary care services especially local GP practices as well.

Figure 10. Participating Trusts and Units



3.2.1 Response rates (qualitative approaches)

It is difficult to identify an accurate response rate for the qualitative components (the majority) of the study because the sampling was conducted in an opportunist manner in many cases – i.e. whether someone agreed to take part in an interview or focus group if the researchers were on site and made a serendipitous approach.

As stated in Chapter Two, much of the qualitative data was collected by virtue of the researchers 'being there' in the right place at the right time and therefore gaining the trust of potential participants. In many cases the researchers were introduced to a member of staff who suggested ways in which other respondents might be accessed. Methods included personal introductions, using e-mail lists or sometimes a staff member knowing what was happening asked the researchers if they might participate in the study.

Overall the majority of staff approached to participate agreed to do so, although circumstances sometimes prevented it (e.g. one focus group was cancelled in Cardiology due to a patient emergency and one observation was cut short because the consultant refused to have the researcher in the ward round, although they had been observing on the ward before the consultant arrived having been given permission by the nursing staff).

Although the key staff across all three Trusts agreed to support the researchers in gaining access to patients for the OCS and interviews, the patient form of OCS was anonymously returned to the PI by someone at Trust 1 saying they did not want patients to participate in that exercise¹⁸.

It proved impossible to administer the patient OCS in the other two Trusts also, because the staff said in advance they were too busy to help and the researchers had difficulty in making contact with individual patients who were always either in busy wards or with a member of staff. Thus interviews and observations were conducted, with patients' consent, during shadowing.

The OCS for the staff is discussed fully in its own right in Chapter Five.

3.2.2 Individual participants

Respondents were either NHS staff or patients so by definition there were elements of uncertainty about whether they would be available at appointed

¹⁸ We sought advice but in line with the NRES review participants could withdraw their consent at any time so we did not feel free to pursue this further.

times and whether (as acknowledged in the NRES consent form) they choose to drop out at any time, even after having agreed to take part.

As shown below in Table 1, forty six respondents took part in in-depth story-telling interviews, thirty nine took part in focus groups. During twenty six days of shadowing of key staff, numerous other staff and patients were involved in data collection and similarly, during the eleven and a half days of observations on wards and in administration areas across the Trusts.

In addition, ten patients consented to be interviewed in depth and, again more staff were involved in the eight meetings that were observed and an introductory walking tour with a staff member in one Trust involved additional staff and patients in the study.

Each of these data collecting encounters represents a different unit of study and a different 'order' of data.

The nature of the study required a commitment of between 30 minutes (for completion of a survey or a short interview) up to two days, in the case of 'shadowing', of respondents time. Most respondents' contributions to the study, however, took about 90 minutes although this also represented an important commitment of their time (and energy).

Table 1. Qualitative Data Collection

Table 1. Qualitative Data by modes of collection							
	Interviews		Focus groups	Shadowing (staff and patients)	Ethnographic observation	Patient interviews	Other meetings and visits
Trust	N = men	N= women	N = Group (n = participants)	N = days	N = days		
1	13	19	5 (15)	5	9	10	4
2	5	9	3 (24)	8	3 x .5 + 1	0	2
3	4	8	0 (0)	13	0	0	2
Totals	22	26	8 (39)	26 days	11.5 days	10	8

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3.2.3 OCS (Organisational Climate Survey)

Trust 1

The staff survey

An administrator in Trust 1 provided a staff list (name and location) from which a random sample (35%) was identified using the SPSS software version 14 providing a list of 939 potential participants from staff across the Trust (including and beyond the Units participating in the main data gathering). The questionnaires were all individually addressed and sent through internal mail.

Of these 223 (24%) individuals returned a completed questionnaire, although ten blank surveys were returned with a note that the intended recipient had left the trust and one said they were unable to read English (1). Thus the final number of participants for Trust 1 was 210.

The patient survey

In Trust 1 we gained agreement from the senior staff on the two study Units (Obstetrics and Gynaecology and Cardiology) that they would arrange wherever possible for patients to complete the patient version of the OCS and would arrange for the researchers to collect the completed forms.

However the full batch of uncompleted patient questionnaires was sent back to the PI at the College several weeks later with an anonymous note stating that the staff did not wish to administer these to the patients. We were unsure how to proceed after this because ethically, although the survey was directed to the patients, the staff had completed consent forms and had copies of participant information sheets, and were aware that they (staff) could withdraw from the study at any time. We considered that this constitute an ethical dilemma for the team.

The researchers made other attempts to hand out the questionnaires directly to patients but found that while some patients were prepared to consent to being interviewed and almost all consented to having a researcher present during patient/doctor/nurse meeting it was not looking possible to obtain a valid sample of questionnaire returns.

Trust 2

Trust two was organised across two distinct sites and although the senior staff work across both sites, as will be made clear from Chapters Three and Four below, each site is very different in its organisation. We initially

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approached the senior staff on Site A first about how to distribute the questionnaires and they referred us to Human Resources on Site B who were the only people with access to a staff list. We did not get any acknowledgement from HR despite several attempts including one visit to the head of HR from one of the researchers. He said he would get back in touch once he had checked whether he could release this list but he did not and we considered there was little more we could do to pursue this particular approach.

The PI then contacted the senior nurse manager, who had been one of our original gatekeepers, for help but found that she had left for another post.

Following the abortive attempts to contact HR (or anyone else who might have been able to help) a PA in one of the many departments we contacted suggested that there was a staff intranet which went out once a week with an 'update' section with news for staff across the Trust. The PI made contact with the editor of this site who agreed to include an electronic version of the OCS.

Consequently, the questionnaire was included on this web-site, with a preamble (adapted from the NRES participant information sheet) on two occasions. However it only produced one reply. We made one final attempt via the PA of the CEO to contact HR for a staff list to no avail.

What was interesting and perplexing though was, that there was no difficulty obtaining a commitment from staff across the Trust to participate in an interview or focus group which was much more time consuming and personally revealing.

By the time we were ready to collect the patient survey data at Trust 2 we already recognised the problems with the responses from the staff. Also, by contrast, we had established the effectiveness of eliciting patient data from the shadowing and observations. We therefore made a decision to focus on this approach to data collection from patients rather than pursue more blind alleys.

Trust 3

In Trust 3 the early signs were that there was no overarching administrative structure from which we could obtain a staff list and nobody we asked could advise on the best way to gain that information. However we did have some 'local' e-mail addresses of the staff in the Units and therefore we e-mailed the OCS to staff on the two study Units and obtained 13 replies all together.

3.2.4 Participant characteristics

There were 224 respondents who completed and returned the questionnaire, of which 77% were women (n = 172) and there were 23% men (n = 49). These included from Trust 1 (n = 210, 93% of respondents), Trust 2 (n=1, 0.4%) and Trust 3 (n= 13, 5.8% of respondents).

The mean age was 46 years, standard deviation 11.1. The majority of respondents were married (62.7%), with a further 7% cohabiting. Twenty percent of respondents were single and almost 10% divorced. The majority of respondents were White (72%), the next biggest group were Asian (18%) and other ethnic minorities such as Black (6.5%) and Oriental (3%) consisted of much smaller groups.

Pay level: most of the respondents had a salary of less than £20k (44.3%) or between £20k- £40k (38.8%). A much smaller percentage (5%) earned between £60k and £90k and a further 2.3% of respondents had a salary exceeding £90k.

3.2.5 Professional demographics

The majority of respondents had been working in the NHS for over 5 years (68%), with a further 26% for between 1-5 years. Only 5.8% reported less than one year's service.

3.2.6 Stability within individual Trusts and Units:

Most respondents had been employed by the same hospital for over 5 years (56%) and another 34% had worked there between 1-5 years. The rest (10%) had been employed by the hospital for less than a year.

Most respondents reported working for the same Unit for over 5 years (45%), a further 43% reported working there for 1-5 years and only 12% reported service of less than 1 year. A similar pattern was seen in terms of length of time in same job. However the majority in this case had been working at the same job for between 1-5 years (45%) and slightly less (41%) had been working in the job for over 5 years. Another 12% had been employed in the same job for less than one year.

3.2.7 Role:

The majority of respondents were nurses, 31%. 13.5% of respondents were managers; 11% consultants/doctors/physicians. Other allied professionals, such as scientists and psychologists made up 10% and support staff made up a further 6%. Clerical staff and 'other' staff (such as porters, maintenance) made up a further 13% each.

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3.3 Data Analysis

This was conducted in the manner described in Chapter Two and the results are discussed separately in the following chapters each of which when relevant provides more context to the conceptual framework and analysis in the substantive area of focus.

3.4 Conclusion

The diverse nature of each of the organisations studied provided valuable information about the different kinds of challenges that different leaders at all levels might face in different institutions across the NHS.

Staff at senior level (particularly non-clinical managers) moved around within and between Trusts. During the course of conducting our study some key gate-keepers and participants left the Trust, others joined and yet others moved position and role even during the relatively short time we collected data there.

In some cases mergers had just taken place or were expected. This was experienced by some as opportunities and others as threats, but in all cases it meant structural reorganisation, staff being re-assigned or choosing to leave for another post.

This has to be taken to be part of the changing face of the NHS overall and central to the culture and climate of the participating Trusts, and can no doubt be generalised to every NHS Trust across the country. In what follows, we have used our different strategies for data capture to examine the relationships between leadership and service delivery in this fluid and (potentially) exciting context.

4 Leadership in the NHS

4.1 Introduction

In any organisation:

Leadership is needed to pull the whole organisation together in a common purpose, to articulate a shared vision, set direction, inspire and command

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commitment, loyalty, and ownership of change efforts (Huffington, 2007, p. 31).

and

Leadership would be easy to achieve and manage if it weren't for the uncomfortable reality that without followership there could be no leadership except, perhaps for the delusional sort. (Obholzer, 2007, p. 33).

In this chapter we examine the ways in which leadership is defined, exercised, experienced and transmitted taking account of how far leadership is perceived as pulling the organisation together to pursue the common purposes of patient care and the relationship between leaders and followers.

We specifically:

- Explore how leadership is defined by different stakeholders and what they see as determining its quality;
- Seek to begin to understand how leadership is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients through examining the data from focus groups and story-telling interviews;
- Using the same data sets, explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted.

4.2 How is leadership defined by different stakeholders and what do they see as determining its quality?

We start this particular exploration with a *thematic analysis* of the qualitative data to identify what themes emerge from the definitions, while also making interpretations using *CDA* and *narrative analysis*. In so doing we pay attention to what Gough has termed 'emotional ruptures' (Gough, 2004) in the text which serve to illuminate some of the subordinated or unconscious information in the stories of the respondents and the subjectivity of the narrator (Frosh, 2003; Frosh, Phoenix, & Pattman, 2003; Hollway & Jefferson, 2000).

In Chapter One we proposed that 'leadership' as a concept has been subjected to continuous scrutiny and moved through different theoretical and paradigmatic iterations. The NHS has identified the qualities it requires in a leader and the role that NHS leaders (at all levels) are expected to strive towards (see Figure 1). We therefore inferred that respondents, imbued in the culture, would focus on 'transformational' or 'distributed'

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explanations and definitions about leaders and leadership because these models are embraced by the style of the coaching and training on offer.

4.3 Definitions

Respondents distinguished between 'leader' and 'leadership'. A 'leader' was described and defined in diverse ways including as:

Obviously strong minded and opinionated (Administrator, T, 2¹⁹).

Particular personality traits - need to be - to have integrity, ((1²⁰)) to ((1)) be clear, err to be facilitative, to have energy to listen, erm, to negotiate, ((2)) to make decisions (Senior Non-clinical Manager, T, 2).

... making sure that you're the person who is erm keeping the team focused getting them to achieve those goals looking at different ways of working (Senior Clinician, Trust 3).

These definitions suggest diverse ways of thinking about the idea of 'leader', indicating that commonality of stakeholder views should not be taken for granted. The qualities a leader has to have are determined in these definitions through having opinions, being strong-minded while also having integrity. A leader also needs to be able to facilitate actions, negotiate and keep the team focused towards the achievement of its goals supporting team-work.

4.3.1 Defining leadership

Leadership in this first definition below was about a formal role and implicitly hierarchical rather than distributed:

I don't think there is anything magical about good leadership. It is about establishing what the organisation wants to do and allowing people to get on and do it (Recently retired CEO with clinical background, T2).

This respondent, who had occupied a senior position, saw the structure and strategic direction of the organisation as fundamental to what works as leadership which was not 'magic'.

¹⁹ In some cases we are able to identify the Trust but where there is any chance of a breach of confidentiality we adjust the 'credit' to ensure anonymity.

²⁰ Where the transcription has included double brackets it denotes pauses timed in seconds.

The following respondent expresses it differently suggesting that it means different things to different people on the one hand, while also being an imponderable (possibly even magical):

Leadership is like love, we all know it exists, but you can't actually prove it, you can't define it, and it comprises of lots of different things that people do, if you demand evidence for everything...you will get rid of leadership eventually (Senior Clinician, T2).

This clinician seems to take distributed leadership for granted in that it is about 'lots of different things that people do'. A warning is expressed it appears, though, that trying to *show* leadership exists across the organisation (perhaps rather than residing in designated roles) might ultimately destroy the possibility of leadership. Following Gronn (Gronn, 2002) this might be a way of suggesting that through concerted action leading to conjoint agency, leadership might not be so obvious (as in the first definition immediately above) but it might be more effective in a hospital where there are different qualities needed to lead in different activities.

Resonating with the view above that a leader has to have integrity, is the view from one leader's experience:

I learnt that it's very important thing for leadership... to not lie, not hide anything and just tell them the reality and be true to yourself, and that's really important (CEO, Non-clinical).

There is an immutable relationship between the leader and the follower. Being true to oneself and honest towards followers must be fundamental to the emotional engagement or attachment between leaders and followers. The significance of emotional engagement as well as emotional and social intelligence was high on many respondents' agendas for determining leadership quality:

... leadership is about having, or being able to demonstrate at any level a coherent vision for where you're trying to go and getting people getting there (Nursing Manager, T 2).

[Leadership in the NHS] is a people focused, leadership job (Senior Non-clinical Manager, T3).

.. it's not always leading from the front (Senior Clinical [therapies] Manager, T 3).

While the leader needs to have vision, these definitions imply that vision alone does not determine how leadership can be exercised or experienced. Leadership will not work unless the leader engages the followers with that vision.

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If leadership fulfils an organisational role ('establishing what the organisation wants') then can it also be 'people focused'? If good leadership is about transparency and honesty is there an assumption that it has not always been so or may not be so at some future time? What does this imply? Does leadership have an 'indefinable' quality' or set of characteristics that work within a specific context but may not be transferable as 'skills'?

Leadership presents dilemmas for the maintenance of personal integrity ('tell them the reality and be true to yourself'), it is a 'job', it requires 'vision' and flexibility and most importantly it seems it is about focusing on people.

4.4 How is leadership in NHS health care organisations exercised and experienced by those affected by it?

Respondents talked about the *role* of the leader as central to the practice of leadership in the organisation. Leadership was understood to be intrinsically linked to particular tasks/goals while necessarily engaging with the followers who had to implement much of these tasks and achieve the goals. There was a sense that many respondents held an idealised view about leadership in their own Trust. Sometimes though the reality for them fell short of expectations because the person occupying that role failed to live up to their hopes.

For example, as the following extended extract illustrates:

.. one of the things about the leadership and management of this Trust is first of all clinical leadership is strong in most places. The clinical directors here have general clout and they are not just figureheads .. and the other bit I think - relationships between general managers and clinicians on the whole are much more positive here than other Trusts (Senior Clinician).

This proposes that strong leadership among clinicians (distributed both horizontally and vertically via the clinical grouping) enables managers to deliver the service to patients. However, this does not in itself identify the characteristics of the links between strong leadership and service delivery.

For many respondents leadership is exercised at least in part through each leader's personal characteristics (good and bad). Almost without exception when asked about the qualities that make a leader, and to 'story' their own explanations, respondents placed a degree of emphasis on the characteristics of an 'ideal type'. The following exemplifies this:

Most important quality is the communication. Being able to listen - hear what is being said and to deliver that--what they want to say, so that it is heard by all. That it be quite quick thinking, being able to develop an idea

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and roll it out, umm being able to think on their feet as well, because sometimes you get things that turn up and you have to deal with it there and then, umm, reasonably personable so people will confide in that person, um also strong so that when things are tough they can um deal with them (Clinical Midwifery Manager, T1).

The comprehensive but daunting picture of how leadership is exercised described above, represents an ideal of distributed leadership as *concerted action* (Gronn, 2002). This type of leadership is exercised through being able to communicate – to listen and to express clearly (so as to be ‘heard’) how action will be taken. ‘Rolling out’ the idea again suggests taking peers and followers along with you and being ‘personable’, so people will confide in that person, further indicates the ability to take the views of others into account calling for both emotional and social intelligence (Amendolair, 2003; George, 2000; Goleman, 2006; Lopes, Grewal, Kadis, Gall, & Salovey, 2006; Riggio & Reichard, 2008). In this model, the multifaceted communications rely on the ability to use the information to think quickly and be strong under ‘tough’ circumstances.

However, in the next extract (from a non-clinical manager) the ideal type of leadership is represented by responding to short and medium term organisational goals (Buchanan, Fitzgerald et al., 2005; Riccucci, Meyers, Lurie, & Han, 2004).

Erm, I think leadership is about erm, encouragement. It is about showing people direction in which you as an organisation and them as individuals engage in. I think it's incredibly important especially in an organisation like the NHS where there are lots of different groups of people and lots of different objectives - sort of daily ones, monthly ones more long term, and you have quite a clear sort of vision of where you're going and I think that the good leaders in the NHS show that, and examples of bad leadership are where that is not so defined. (Middle Manager, T2).

This suggests a *transactional* model of leadership, whereby the good or effective leader offers ‘encouragement’ to the followers in return for people accepting the practices of the wider organisation (Bass, Avolio, Jung, & Berson, 2003; Eagly and Johannesen-Schmidt, 2003)

4.4.1 Exercising leadership through their organisational ‘role’

Leadership is experienced by some as being exercised through the legitimated role. Organisational role in the leadership discourse equates with the leader’s professional position as the respondent below shows clearly:

Who would be a leader to me? I think there's a number of different areas, there's your direct line manager, who's the clinical leader of your department. Who's who in this structure there's line managers above them, and above them and so on. There would be people you would look to within your own specialty clinically who are more experienced than you ((2))²¹ in certain areas, to ask for advice, erm ((1)) and similarly in an academic environment ((1)) there are other people there who have more experience that you would want to take advantage from or advice from. ((2)) And in the wider circle, national or international leaders in the field who are so expert at those things that you also turn to. (Medical Consultant, T3).

While the formal roles and organisational hierarchical structures are taken seriously by this respondent, there is also a clear vision of leadership being exercised through concerted action in collaborations that arise *spontaneously* where clinical and/or experience is valued and sought within this respondent's speciality and sometimes *intuitive* leadership (Day, Gronn, & Salas, 2006; Pearce, 2004). However, there is also a sense that this respondent experiences leadership through the institutionalisation not only of formal roles locally, in the organisation itself, but through the structural relationships with those who are seen as experts in a much wider networked context (Pearce, 2004). This version of leadership is particularly important in that it demonstrates that leadership can be both experienced and exercised beyond the boundary of the organisation and the NHS, based on knowledge and expertise originating outside these systems.

Respondents frequently combined personal qualities with their understanding of the leadership role, particularly related to taking responsibility as part of that role:

It's quite difficult, I mean I think taking responsibility (4) making sure that things happen that are supposed to happen, or don't happen that aren't supposed to happen (3) um.., (6) that's it. (Clinical Medical Consultant, T1).

Not everyone saw leadership in this way. This respondent is talking about their own experience of being in a role in which then 'buck' frequently stops and thus by definition they are in the role of leader.

The exercise of leadership through being a 'role model' (Trevino, Hartman, & Brown, 2000) where qualities of leadership were displayed was important for some:

The leaders that I've worked for and have wanted to follow ... push something in me that says 'I want to be like them' or I completely support

their vision of where they're going or you know so I want to follow that person and I want to do the best that I can do for them because I believe in them and their vision. (Head of Non-Medical Clinical Team, T3)

This explanation has a flavour of heroic or charismatic leadership, although not as a quality that resides in a specific person necessarily, but one that resides in a relationship that 'fires' up both leaders and followers (Klein & House, 1995). Even though the idea of the charismatic leader has been at least partly consigned to the history of the late 20th century organisation, it has not disappeared and needs further thought particularly in an organisation such as the NHS where changes are sometimes rapid and stressful (James, 1999) and internal culture needs to be taken into account (Dopson & Waddington, 1996; Tourish & Vatcha, 2005).

4.4.2 The relationship of the 'leader' to 'followers': how leadership is experienced

While leadership is the focus of the professional and political debates about the NHS and other organisations, until recently, relatively little attention has been paid to followers' experiences of leadership (Avolio et al., 2004; Howell & Hall-Merenda, 1999; Lewis, 2000; Schilling, 2009). From the perspective of a manager taking the position here as 'follower' looking 'upwards' in the organisation:

I think it's, it's providing, you know direction and to lead and that's a leader's main job in my mind. And (2) that's .. what they say for leadership, you must have followers. If nobody's following you, what you are saying then? you are not a good leader. So that's a good, you know, test for a leader to evaluate themselves. That's what they are saying and what they are trying to achieve. Are people behind them or not? If they are not behind the leader there's something wrong with that. (Middle Non-clinical Manager)

From the perspective of a junior doctor taking the 'followership' position:

I think in order for you ... well in my opinion a leader, I have to be able to kind of respect them. If I don't respect or kind of have faith in what they do, then it's, it's a personal authority, so in order, you know in order for me to do that I have to believe in what they say. I mean, I might not always agree with them in my opinion but at the end of the day I have to be able to respect them enough and for them to have certain authority, someone who's probably experienced and gained that knowledge, so yeah. (Junior doctor)

For leadership in the NHS to be exercised effectively then there has to be an engagement between the leader and the followers (Macy & Schneider, 2008) and to understand fully how the engagement takes place, a degree of

emotional engagement and/or attachment to the leader and the organisational vision is fundamental (Riggio & Reichard, 2008; Rubin, Munz, & Bommer, 2005; Vince & Broussine, 1996).

The failure to take followers with you is made explicit here from the perspective of one (designated) leader:

A: I was forced upon them...

Q: that's what I was going to ask. So presumably there was a lot of resentment I guess?

A: Yes.

Q: And how does it manifest itself?

A: Erm, non-cooperation, making life difficult for you sometimes, people talking about erm ((2)) sort of criticising you behind your back and erm playing silly games behind your back that makes management of other people more and more difficult. Erm you know, and yet we sort of have to fight another battle to win hearts and minds, when we, you know, don't really have the time to do that, we have got to have our focus on doing what we are meant to do, which is to manage patients and to manage our beds properly.

This extract from the interview with someone whose role it is to lead change is revealing. The respondent recognises that he is not taking people with him and in his view, the followers appear to eschew co-operation. He also believes they are mocking him and that that mockery is contagious. He may or may not be able to evidence this, but that it is in his mind is potentially detrimental to his experience of leading in his organisation (Stein, 2005). Furthermore, instead of looking at himself, this respondent wants to push the blame for the leadership failures onto the followers (in other words he engages in splitting described in Chapter One) (Klein, 1975; Segal, 1973). Such a process is diametrically opposite to leadership studies that identify authenticity and trust between leaders and followers as being one of the basic qualities for leadership (Avolio et al., 2004; de Raeye, 2002; Novicevic, Harvey, Ronald, & Brown-Radford, 2006).

There is also some evidence of concerted action here, distributed among those who were leaders of the *resistance*, which is not necessarily against the values of the organisation in any negative way, but may be seen as upholding important principles and challenging change (or a particular form of leadership) that might be perceived as counteracting these important values (Collinson, 2005; Zoller & Fairhurst, 2007).

Trust is one important quality in the way leadership is exercised and experienced by followers and developing trust is essential if changes in

practice are to be implemented (Bass & Steidlmeier, 1999; Hunter, 2005). So, for example, 'engaging' with others involves trust:

Yeah definitely there are some good examples of where it's obvious that people have been able to engage lots of different kinds of people in different groups and I think they've done that just by sort of making relationships with them in the first place and then when it comes to having to lead them and be influential then you can see that those relationships are already there and then they can call on that you know, that sort of that trust or that sort of relationship that they've got (Middle Non-clinical Manager, T2).

The same respondent continued with a specific example that aptly demonstrates the links between all the three sub-themes.

Yep, I think Florence who is our head of [a non-clinical department] .. I think she is a very good example of what I'm talking about in terms of her job. And her role relies a lot on other people. Erm so as a personality she is a very responsible person, she gets on with everybody and you can really see how that works for her because when she needs somebody to do something or she needs people to listen they are going to because they have got a good relationship with her and she has taken time to build relationships when it is perhaps not necessary.

To summarise so far - *good* leadership in the NHS is understood by staff at various levels as:

- Taking responsibility
- Being 'given' authority by the followers
- Getting on with the people in the organisation
- Taking time to build relationships
- Being trusted by followers
- Winning hearts and minds
- Having a vision for the organisation
- Taking colleagues with you

4.4.3 Patients' perspectives on how leadership is exercised

While there were several things held in common (particularly 'trust' and 'taking responsibility') with the staff, patients unsurprisingly, considered leadership from a different position, based upon how they themselves had experienced a specific episode of care. One woman, who had had a previous bad experience in the same Trust in which she was now a patient, said:

Well somebody taking responsibility really for erm you know your care, erm especially. I keep going back to the same example but you know someone being responsible for not reading through my notes and if someone had taken that leadership erm and actually said 'right I'm going to look through

these notes', you know they would have obviously seen what they had to see and so basically yeah I think there is a lack of leadership.

The emphasis was on wanting the leader to take responsibility for patient care in contrast to poor practice whereby notes were not read. It was taking responsibility, and reassuring the patient that they were taking responsibility, that could be experienced by patients as good leadership.

Another patient similarly suggested that in their exercising of leadership, the clinical staff need to make sure that they were seen to be acting in the patients' best interest. For example:

When they're explaining their-selves, they do explain their-selves and what they're thinking. And they do tell me like the 'ifs' and 'buts' blah blah blah about this certain thing, but then one says something and [another] one says something else but they do explain themselves and what they're on about.

Also, another patient indicated that there needed to be one person who held overall responsibility for service delivery:

I don't know how it works hierarchy wise, whether there's like a top doctor or whatever, whoever it is somebody really needs to, you know, take a really ((2)) be sort of, you know, held responsible.

It is perhaps worth noting that the patients overall focused on the role of clinical leadership but saw that as being practiced by an individual rather than in a distributed form. There was a general view that individuals needed to be accountable and accountability equated with leadership.

4.5 What are the characteristics of an organisation that facilitate, or hinder, the process of leadership?

Leadership happens in a context and that context can facilitate or hinder leadership processes (Currie et al., 2009) and the influences of the organisation are particularly acute when the environment is changing rapidly (Goodwin, 2000; Michie & West, 2004) as in the NHS.

One respondent felt they no longer knew 'who was who' in the leadership hierarchy but considered it didn't really matter:

..., here is this model that says here is the Board and here is the chief exec and here is whoever else is up there. And there's this, this and this ... and [a colleague suggested] shouldn't we be transparent all the way through and shouldn't everything link? and I thought, this came up somebody legitimately asked the question that people here need to know what is happening here. Why? Why? I don't care. (Clinical Physiotherapist, T3).

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One senior Occupational Therapist, in the same Trust, on the other hand felt that knowledge of the organisation was important to facilitate leadership at every level so that when:

... people feel they are working as part of an organisation that's working for something, as part of a team and are appreciated and valued as part of that and are working for someone as well who feels what they are doing is worthwhile, I think that patient care will be of better quality.

This respondent was also convinced that supervision was part of the process by which an organisation facilitated both leadership and good practice in patient care. *"I have once a month supervision, like set time for supervision so I think that is really good."*

Furthermore, supervision and informal contact with peers facilitated effective distributed leadership which impacted across the organisation: *".. you can go to people informally, your peers erm whenever it's quite flexible like that and even if you're a senior like me you think 'hang on I don't know if I'm on the right track here so am I missing something?' You can just go and speak to you team about it or one of our colleagues downstairs or whatever if you want to.*

More dramatically a senior clinical leader suggested that leadership is facilitated in 'moral' organisations:

A²²: So one thinks they are better than the other, so the seven deadly sins basically...pride, the other one is gluttony, which means excess...one can never have enough, for the sake of it, and then just goes beyond, you know, one million, two million, you know, which kind of greed isn't it...excess basically, and also rushing is in there, doing things too fast. A good system will reduce its workload, yeah? The NHS has a thing of needing to do more and more, erm anyway, I don't know whether you find this useful or not, so greed, gluttony, there's rushing, and then jealousy, which is really envy, which is really competition.

Q: Yeah

A: You need to get rid of competition, and I will tell you in a moment what could replace it, which is basically team work, team work and kindness; how you get on with each other...anger is on the list. Anger is, is blame, and the opposite is blame free culture.

Q: Yeah

²² Q = question, A = answer.

A: Or forgiveness if you want, so you need to forgive mistakes, and you know you will be forgiven...and, erm...erm...next one is laziness, that's obvious, that's hard...people either have it or not, but laziness is joylessness, you need to make sure people enjoy it, and diligence, yeah? So there needs to be something in place of ...and we have that now with trust away days and things like that, but you have to have somebody dedicated to making people understand it's about having fun

Q: Yeah, yeah

A: working is about having fun...yeah? And then its... which comes really from up here, it's just an, an, yeah, can't have enough...which is also, it's also, the opposite is erm...do not take more than you can, do not take more than you need...and that is quite a moral stand ground, more than you need...for everyone

Q: Yeah

A: and if you employ that rule, then the whole organisation becomes so successful that there's masses of money left over ... Everything works well...the problem is everyone doesn't understand that, and believe in that, and then there's a difficulty...so that's moral high ground, very moral high ground, but if you go along those, you actually have all the features of leadership.

For this respondent the organisation needs to focus on patient care, treating patients *and* staff with 'kindness'. This is counter in his view to the process of setting targets for service delivery and organisational growth (or survival) and thus competition between organisations and competition between individual staff or staff teams, which is a force that (it seems) promotes the wrong kind of leadership (Kuokkanen & Katajisto, 2003; Sambrook, 2007). Furthermore, supportive teamwork and 'forgiving' mistakes and preventing the 'blame game' enhances socially and emotionally intelligent leadership distributed responsibility across the organisation and enhancing the culture and climate (Riggio & Reichard, 2008) .

Another senior medical leader and manager (T3) reinforced this idea:

I think the ethos within the hospital, is one that encourages people to develop and grow, and deliver good quality care, you know, so, I mean I think wherever it comes from it is enabled within this organisation, and it works very effectively. One of the features that enables that to happen...it's firstly being an organisation that attracts good people to want to work here in the first place. So you get high quality people applying for the position, be it in medicine, or managing, or nursing or any of the other professions By and large, we're fortunate in that. And that's partly due to the reputation, and partly due to the [location] but I think the ethos that comes

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from the leadership makes it desirable to be here. Erm...so it attracts the right people in, it then enables, it doesn't put the brakes on, it doesn't try to control people too much.

Thus, organisational performance and culture/climate were 'enabled' through a cycle of encouragement, good practice, reputation and a supportive and 'hands-off' approach to leadership. This suggests concerted action, leader/follower engagement and emotionally supportive behaviours at all levels. That the physical location of the hospital is attractive is perhaps but one factor in this equation, although a central location makes it possible to draw on a wide range of staff as opposed to a location which is in a small town or distant suburb.

It is not just features of the organisation itself that impact on leadership. Organisations reflect changing discursive constructions of leadership and the values that underlie what it means to be effective as a leader in that place at that time (Ferlie & Shortell, 2001; Lansisalmi, 2006; Michie & West, 2004; Scott, Mannion, Davies, & Marshall, 2003). As demonstrated in Chapter One theories of leadership have developed and different approaches have become significant at different times as witnessed by the shift from promoting and studying transactional, charismatic and heroic leadership styles to the contemporary emphasis on forms of distributed, networked and transformational leadership (Bryman, 2004; Butterfield et al., 2005).

One dramatic change over the past twenty and more years has been the image of the medical consultant in the public psyche. Thus the 'heroic' leadership of Sir Lancelot Spratt has been firmly (it seems) replaced by the team work in the TV series *Casualty* or *Holby City*. However the image of the rebel Dr. House (played by Hugh Laurie in an American TV series) is described as 'unorthodox' and 'radical' but most definitely a medical hero. Is this the type of leader that some might still long for? While the following comment was atypical of most people's definitions of what makes or fails to make a good leader it raises some interesting points about the contemporary regulatory discourses on leadership. Thus one participant said of another²³:

Now (Dr.) David is a really eccentric so he is not what you would naturally call a leader, erm ((1)) but people are really respectful... Because he really cares for patients ...And if he finds a junior doc, or nurse or anyone who is being unkind to an elderly patient then he is down on them like a ton of bricks but his, his patent commitment to medicine and clinical care just inspires admiration ...And great affection hopefully. But he is very odd. Yes. Erm, so he is like a one off so again there is no single person, you

²³ No identifying information is appropriate here.

know there are, there are, there are different leadership styles which are appropriate in different situations but David of course could never be a chief exec, he just wouldn't be able to do it, so he would be hopeless there.

On the surface this might be explained as a judgement based on 'evidence' and a job description. However, focusing-in on the discursive and regulatory practices with which this extract engages, a different view can be taken. The respondent here, being asked to describe the qualities of leadership, begins by suggesting that taking patient care very seriously is 'eccentric' and the person who does that is a 'one off' and 'odd'. Paradoxically (it is suggested) David inspires affection and admiration but despite the variety of leadership styles David would never make it to be CEO. Whether or not this is the case is irrelevant here because what is at stake are the ways in which discourses around 'leadership' and the qualities of the 'leader' *regulate conduct* setting normative behaviour through the discursive practices. There is little doubt that David would have been considered a leader (perhaps a leader in his field) during a different period when hospitals were smaller and perhaps when there was less specialisation in management.

A learning organisation?

The NHS has declared itself to be an organisation dedicated to learning for at least the last ten years and certain values underlie this declaration (see Davis and Nutley, 2000). It means that:

Although learning is something undertaken and developed by individuals, organisational arrangements can foster or inhibit the process. The organisational culture within which individuals work shapes their engagement with the learning process (p. 998).

In some cases the exercise of leadership clearly facilitated the (potential for) learning and learning facilitated leadership, while in others it did not. The facility for leading change in NHS Trusts is critical and developments in the role of nurses from a range of specialties to support leadership and learning have provided exemplars of how some organisational arrangements support leadership (Bellman, Bywood, & Dale, 2003; Doherty, 2009). However, some have argued that continued changes, the market as a driver and the complexity of the NHS might militate against whole system learning (Sheaff & Pilgrim, 2006). Questions have also been raised about the potential of the new generation of leaders who are expected to be inspirational, drive change and support learning (Phillips, 2005).

One capacity manager, for instance, was very clear that leadership was about enabling appropriate learning and the development of skills:

... probably more about empowerment and not necessarily of oneself but of others. So I think that indeed you need to feel empowered yourself, but I think that leadership, good leadership is about empowering and supporting those people who are not in power so that they are equipped with the skills that are required. some of it is actually around learning, it is about what stage they are at in terms of their learning curve.

This is not only a statement about distributed leadership but about a version of a transformational leadership that transcends individual leaders and requires an organisational culture that both supports individual learning and targeting individuals to ensure, that their learning is recognised and ongoing (Burke et al., 2006; Conger & Kanungo, 1988; Kuokkanen & Katajisto, 2003).

The respondent continues with this theme in a sophisticated, and it seems heartfelt, way:

But I think that sometimes that [learning] is not always consolidated, even those people that have been in that position for years. I think, it is more about the people actually understanding²⁴ what they have done, and almost sometimes talk it through, in basic detail about why they have got to the decision they got to. But just because you have been in a position for a long time doesn't necessarily mean that you have actually learnt erm and you may only then go up to a certain stage in my opinion in terms of your whole learning so then they may be stuck in, not novice, but in that middle stage rather than the expert. Which we would hope that most people would get to.

This suggests that organisations need to be vigilant and to constantly invigorate their members. For the respondent quoted above, an organisation that allows people to stop learning is one in which leaders and potential leaders stagnate (at their peril) (Mark & Scott, 1991).

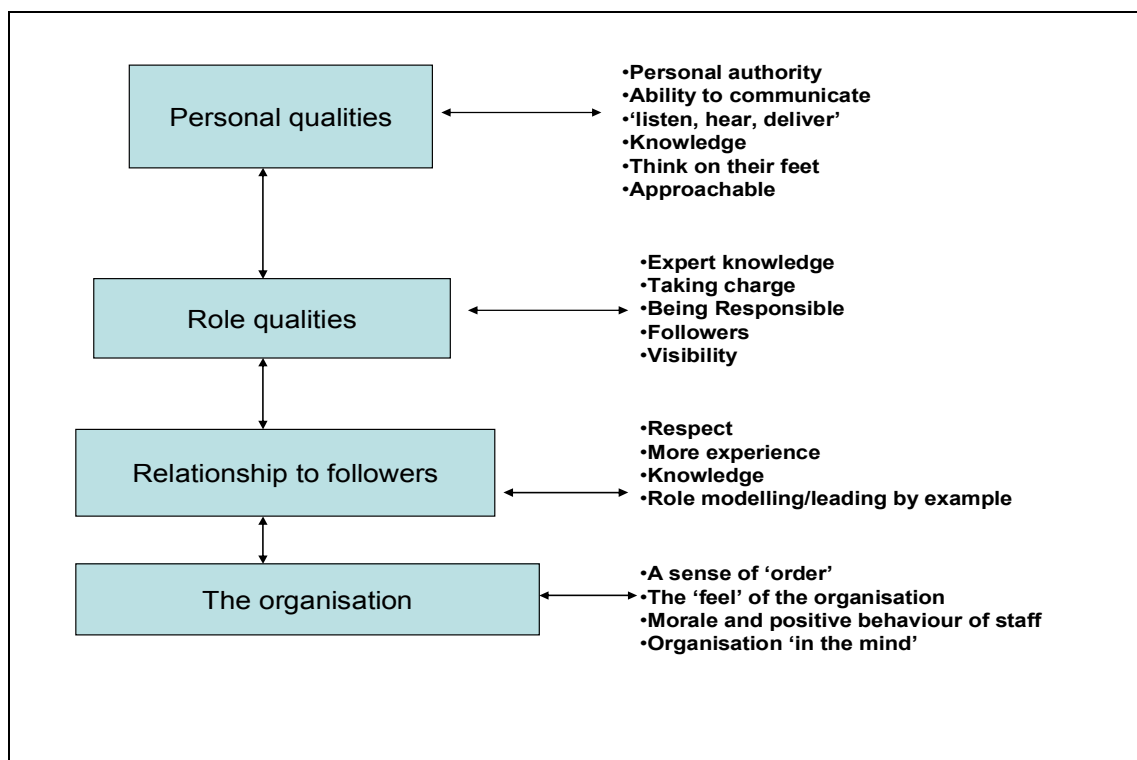
As we discuss again in Chapter Nine, the multi-disciplinary team presents an ideal opportunity for observing leadership (good and bad) and examining the ways in which these teams adhere to organisational norms which might support or inhibit learning (Burke et al., 2006; Day et al., 2004).

One senior non-medical clinical manager in a different Trust also took up the theme of learning and empowerment and specifically how it links to good patient care (Burke et al., 2006; Doherty, 2009; Kuokkanen & Katajisto, 2003).

²⁴ The transcriber who was also the interviewer made it clear that these words were emphasised by the respondent.

... [leadership] is about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is we worked with 'Training and Development' and we came up with a specific programme that was aimed at empowering them [all administrative staff] to improve their service area etc etc and also provided them with some skill sets that they probably didn't have prior to that.

Figure 11. What makes a leader?



4.6 Conclusion

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

Nonetheless, when asked to describe and define leadership, various stakeholders at all levels of the organisation have a view some of which coincides with contemporary NHS discourses and some which seems directly at odds with what the NHS is trying to achieve – that is, to support both

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distributed and transformational leadership that are seen as successful in ensuring effective patient care. However, it is clear that individual personalities and the impact of particular leaders cannot be taken out of the equation.

Leadership is experienced as distributed and transformational but there remains a belief that charismatic and transactional leadership also have their place in complex organisations. While vision is important, no vision can be achieved unless the leader takes 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. Supervision, peer support and informal advice are part of the emotionally intelligent distributed practice of leadership. 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.

In summary, the main ideas that emerged from the respondents' views of how leadership was exercised and experienced were it was about:

- Personal authority
- Ability to communicate
- 'listen', 'hear' 'deliver'
- Thinking on your feet
- Being approachable

Leadership can be exercised in a number of ways and qualities of leadership are seen to reside in different but interlinked 'places'. For example, it is clear that some people are perceived more than others to have the personal qualities that make them a leader, including being able to listen, deliver and be approachable (see Figure 11 above). The assigned/legitimated leadership role is also perceived to be an important quality for a leader, which is interesting, when thinking about the distributed leadership model and particularly the idea of concerted action where people have to work together to 'lead'. This links further to the qualities inherent in leader-follower relations identified as fundamental to the stakeholders interviewed here.

Finally, leadership means holding a sense of the organisation in mind. That is the mental model held by the leader through which they mediate and regulate their vision and actions as leaders, but it also refers to the leader's understanding of morale and the 'feel' of the organisation in which they are working, which itself regulates and constrains the possibilities for growth, development or atrophy.

In this chapter we identified some of the evidence of how organisational contexts evolve and the relationships between organisational culture/climates and the ways in which leadership is practiced. This will be developed across the next four chapters.

5 Leadership and Organisational Climate

5.1 Introduction

Despite its North American origins, where the health care system is fundamentally different from the NHS, Stringer's focus on both leadership and climate nudged us towards choosing an adaptation of his organisational climate survey for this study. We also identified an 'awareness', as he puts it himself, that "*People working in health care systems play drastically different roles that are more diverse than the roles typical in schools and businesses*" (Stringer, 2002, P. 188).

Through adapting the OCS we also captured demographic information from our participants as well as a data about satisfaction with the leadership one receives from his or her immediate supervisor²⁵. Thus, while on the whole Chapter Four dealt with general descriptions, definitions and values, in this Chapter we focus on specific relationships between individuals and the individual and the perception of their organisational climate.

The additional contribution the survey data makes to the overall aims of the study is to relate perceptions of leadership and management directly to organisational climate, thereby providing a triangulation with the story - telling and focus groups to explore the characteristics of organisations that facilitate or hinder leadership and service delivery.

5.2 Results

5.2.1 Normality of data

When normality was examined the KS-Lilifors test was found to be significant over all the scales, indicating that the data were not conforming to assumptions of normal distribution. However, inspection of the histograms and boxplots were found to present an acceptable level of

²⁵ Our version of the survey questionnaire is appended.

normality. Due to the nature of the data it was decided not to transform it, but rather to interpret the results which rely on the assumption of normality with caution.

5.2.2 Cronbach's Alpha

In order to check the reliability and internal consistency of the OCS in this setting we used Cronbach's Alphas (Cronbach, 1970) (See Table 2).

As can be seen from Table 2, the three dimensions of '*commitment*', '*support*' and '*recognition*' were considered to be high on reliability as their scores ranged from .69 to .74. These would be considered acceptable-good level of reliability (George & Mallery, 2003).

In contrast, the three dimensions '*structure*', '*standards*' and '*responsibility*' were low on reliability. This low reliability may be explained by confusing wording of the items, or it is possible that the individual items did not correspond well to one another in this sample. As such it was decided to remove the '*responsibility*' scale from the rest of the analysis. A further check to see whether '*structure*' and '*standards*' could be improved by removing single items, did not show any improvement to the alpha so these were retained in their original form.

Table 2: Cronbach's Alphas for the six dimensions

Scale	Cronbach's Alpha
Commitment	.74
Support	.72
Recognition	.69
Structure	.57
Standards	.43
Responsibility	.14

When managerial dimensions were examined for reliability' these were found to be very high ranging from .86 for '*recognition*' to .79 for '*commitment*' and '*responsibility*' (See Table 4).

Table 3: Cronbach's Alphas for the six Managerial dimensions

Scale	Cronbach's Alpha
Managerial Responsibility	.86
Managerial Recognition	.83
Managerial Standards	.83
Managerial Support	.81
Managerial Commitment	.79
Managerial Structure	.79

Overall scores for organisational dimensions

In order to derive the scores for individual dimensions, all the items on each dimension are summed [this is after all the negatively worded items were reversed].

The following were mean and standard deviations across all the six Organisational scales:

Table 4: Mean and Standard Deviation

Scale	Mean	Std
Commitment	14.82	2.86
Support	14.06	2.80
Responsibility	9.93	1.73
Structure	9.01	1.88
Recognition	8.42	2.55
Standards	8.36	1.69

Stringer, et al (2002) suggest an analysis of percentages of respondents who scored above the mean. In our analysis the following percentages were found:

Table 5: Scores above the mean

Scale	% above the mean
Commitment	60%
Support	47%
Recognition	49%
Standards	49%
Structure	39%
Responsibility	58%

Stringer offers a method of interpreting these percentages, according to benchmarked ratios collected through their extensive research to validate the tool.

High 'commitment' (60%) – In the current sample, there was a high degree of 'commitment' to the organisation and its goals. This would be typical of professional staff working for the NHS. However Stringer asserts that high 'commitment' needs to be accompanied by high 'support' and high 'recognition' – without these individuals will stop engaging with others in the organisation and their team (p.200). As indicated in Chapter Four engagement is crucial if leadership is to be effective.

High 'responsibility' (59%) – Stringer asserts that 'responsibility' is a difficult dimension to interpret within the health care setting. Effective performance in the NHS requires that procedures be double checked, which in many other contexts would put the role of 'responsibility' in an ambiguous position. However this is not the case in complex clinical settings (or for example in other precision performance occupations such as flying aeroplanes for instance). In the case of the current sample 'responsibility' was high, which is related to high sense of 'commitment', but is confused by the limited 'structure' – it is essential that people are clear about their roles, so that they may take charge and 'responsibility'.

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Moderate 'recognition' (49%) - According to Stringer scores lower than 50% may indicate that participants are feeling unappreciated. In this case there is just under the 50% mark, which translates into moderate agreement about the feeling of being rewarded for one's efforts. Having a high sense of 'recognition' in an environment such as this is of crucial importance for motivation, but 50% is within the normal range set out by Stringer. High 'recognition' is indicative of confidence in the organisations performance/reward ratio but in such a diverse setting as a hospital with a diverse staff group responding to the OCS then different groups with different management and professional/occupational structures would have different perceptions and experiences.

Moderate 'standards' (49%) – there is a moderate feeling of pressure - performance 'standards' and expectations are high but not to the point where they are stressful. This falls within an acceptable range. Considering that many of the 'standards' (targets) are set out by government policies rather than directly by Trust management/leaders it is important for these standards to be realistic and achievable.

Moderate 'support' (47%) – this falls within the low but acceptable range for this scale (45%-60%) according to Stringer's benchmarks. This indicates that there is sufficient unity between teams to approach and solve problems, without overly nurturing so as to discourage individual 'responsibility' and undertaking. Team work within the health care system is challenging because of the interdisciplinary nature of teams which inevitably calls upon different management and professional structures and networks for support.

Low - Moderate 'structure' (39%) – Under half of participants felt there was clarity in terms of their roles, responsibility and authority. On the one hand this means that there are less constraints and a less of a 'jobs-worth' approach, on the other hand though it means that there is (potentially) insufficient clarity in roles and responsibility. In an organisation such as the NHS, this may be a considerable shortcoming and Stringer (p.193) suggests that in a health care environment such as a hospital, one would ideally like to have 'structure' scores above the 70s. This is emphasised because of the complex nature of the hospital environment with so many individuals involved – accountability needs to be very clear. The NHS however has gone through so many changes over the previous ten years that it is inevitable that the 'structure' score would be influenced.

Associations between the six dimensions on the organisational level

Pearson's r was utilised to test the relationship between all the Organisational scales. It was found that the majority of scales showed modest, but significant relationships:

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Table 6: Correlations between the six organisational dimensions

	Standards	Structure	Recognition	Support	Commitment
Standards	1.00				
Structure	ns	1.00			
Recognition	.22*	.47**	1.00		
Support	.17*	.42**	.61**	1.00	
Commitment	.30**	.39**	.59**	.67**	1.00

* <.05

** >.001

As can be seen from Table 6, there are a number of high associations between these dimensions. The highest associations are for 'support' and 'commitment' (.67) 'support' and 'recognition' (.61) and 'commitment' and 'recognition' (.59). In other words, participants are reporting that when a feeling of co-operation within teams is present, this is often accompanied by acknowledgement and appreciation and is further related to a greater sense of dedication and 'commitment' to the goals and aims of the team. By definition, the converse also applies: feelings of isolation are more likely to be accompanied by lack of incentives and disenchantment with the objectives of one's team. This is 'supported by Stringer (p.200).

Satisfaction with leadership

When the *organisational dimensions* were examined in relation to satisfaction with the quality of leadership received from the immediate manager, which was asked as a single item, the scales which correlated most highly were 'support' (.61) and 'recognition' (.52). The weakest relationship was to 'standards' and 'structure'.

Table 7: Correlations between organisational dimensions and satisfaction with Leadership

	R (sig)
Standards	.14*
Structure	.30**
Recognition	.52**
Support	.61**
Commitment	.39**

In order to evaluate the individual contribution of each of the organisational dimensions to the overall 'satisfaction with leadership', a regression analysis was conducted, which included all items which were found to correlate significantly with satisfaction, namely 'standards', 'structure', 'support' and 'commitment'.

The total variance accounted for by the model was 40% (Adjusted $R^2 = .38$) therefore variability in 'satisfaction with leadership' is moderately accounted for by this model.

Specifically, of the five predictor variables the two which were found to predict the outcome variable of 'satisfaction with leadership' were 'support' and 'recognition', 'support' being the biggest contributor with a $B = .52$ ($p < .001$) and the other predictor was 'recognition' ($B = .27$, $p < .001$). The other variables were not significant. [Appendix 1 of this chapter].

In other words, feeling supported by one's team and believing that rewards are appropriate to effort, accounts for a significant proportion of an individual's satisfaction with leadership.

Correlations between dimensions on Managerial level

The second part of the questionnaire asked about individual experiences of management. All six dimensions on the managerial level were highly correlated with each other, with strong correlations ranging from $r = .71$ ($p < .001$) between 'structure' and 'responsibility' to a correlation of $.84$ ($p < .001$) between 'commitment' and 'standards'.

Table 8: Correlations between dimensions on Managerial level and Satisfaction with Leadership

	Manager Recognition	Manager Support	Manager standards	Manager structure	Manager Responsibility	Manager Commitment
Manager recognition	1.00					
Manager support	.83**	1.00				
Manager standards	.82**	.83**	1.00			
Manager structure	.73**	.78**	.79**	1.00		
Manager responsibility	.84**	.79**	.79**	.71**	1.00	
Manager commitment	.79**	.83**	.84**	.82**	.79**	1.00
Satisfaction with Leadership	.68**	.76**	.71**	.71**	.65**	.76**

** Significant at .001 level

A single item asked about satisfaction with the quality of leadership received from immediate manager. When this was examined in relation to the six dimensions appropriate to participants' own experience of management practices, it was found to correlate highly and positively with manager 'support' ($r=.76$); management 'structure' ($r=.71$, $p<.001$); manager 'commitment' ($r=.75$, $p<.001$) and 'standards' ($r=.71$, $p<.001$); manager 'recognition' ($r=.68$, $p<.001$); manager 'responsibility' ($r=.65$, $p<.001$);

A multiple regression was carried out to examine the perception of 'satisfaction with leadership', as a dependent variable of management practices. The overall association between management practices and satisfaction with leadership was strong ($R=.80$) with associated variance explained of 63%.

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Table 9: 'Manager' dimensions regressed onto 'satisfaction with leadership'

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	-.054	.226		-.240	.811
Manager Recognition	.001	.039	.002	.025	.980
Manager support	.175	.039	.410	4.501	.000
Manager structure	.060	.027	.177	2.260	.025
Manager responsibility	-.018	.032	-.047	-.559	.577
Manager commitment	.165	.056	.278	2.948	.004
Manager standards	.017	.056	.029	.310	.757

In this case, it was manager 'support' which best predicted satisfaction with leadership ($B=.41$, $p<.001$), next biggest contributor was management 'commitment' ($B=.28$, $p=.001$) and management 'structure' ($B=.177$, $p=.025$). In other words, a large proportion of feeling satisfied with one's leadership, pertained to feelings of being supported and the degree to which one's manager inspires and exudes 'commitment' to common goals. A further important element in the equation is that of 'structure' – where roles and responsibilities are clear, it is associated with greater satisfaction with leadership.

As the biggest predictor of 'satisfaction with leadership' was manager 'support', a further regression was done to look at what organisational dimensions related to having good managerial 'support'.

All the organisational scales were inputted into a regression, excluding organisational 'support', with managerial 'support' as the outcome variable. The following was found:

In total the model accounted for 35% variance in the outcome variable (Adjusted $R^2 = .35$). There were two contributors to the model: the strongest one was 'recognition' ($B = .44$, $p < .001$), i.e. the more employees feel that the organisation rewards and recognises their efforts, the more they feel supported. The other contributor to managerial 'support' was 'commitment' ($B = .20$, $p = .008$). [Appendix 3 of Chapter Five]

These findings indicate that organisational 'recognition' and 'commitment', are organisational climate dimensions which most affect the outcome of managerial 'support', and this in turn has the greatest effect on individual's sense of satisfaction with their leadership. This again corresponds with data discussed in Chapter Four highlighting the importance of the feel of an organisation that provides support at all levels.

Regression of all dimensions onto Satisfaction with leadership

When all the variables previously shown to be significant to Satisfaction with leadership, were entered into the model, from both the organisational and managerial dimensions, namely manager 'support', manager 'commitment' and manager 'structure' as well as organisational 'support' and organisational 'recognition', the following picture emerged:

There was a high degree of variance accounted for by the model - 65% (Adjusted R^2). The model was found to be significant ($F = .80.65$, $p < .001$).

The variables which remained significant, in order of their contribution are: manager 'support' ($B = .34$, $p < .001$), manager 'commitment' ($B = .33$, $p < .001$) and Organisational 'support' ($B = .13$, $p = .03$).

In other words, satisfaction with leadership, in this sample, was predicted by a greater perception of 'support' from management, a feeling that managers demonstrated their 'commitment' to achieving common goals and an atmosphere of 'support' and team-work within the organisation.

Organisational and Managerial dimensions

In order to investigate the relationships between organisational and managerial dimensions, a correlation was performed between all of these variables (Table 10). It was found that:

There were strong correlations between manager and organisational 'recognition', and manager and organisational 'support'. There were moderate correlations between manager and organisational 'commitment' and 'structure'. And there was a weak correlation between manager and

organisational 'standards'. In other words, where the dimensions were correlated weakly or moderately, we can identify that 'standards' of the organisation do not necessarily exist at the same level of managerial 'standards'. The same relationship goes for 'structure' – having organisational 'structure' does not predict clarity in roles, as espoused by one's manager. There is a greater degree of correspondence between organisational and manager 'commitment'. When we look at 'support' and 'recognition', we find that both these dimensions tend to be closely related – one is more likely to feel that both are high, or both are low.

Table 10: Relationship between managerial and organisational dimensions.

	Organisational Recognition	Organisational Support	Organisational standards	Organisational Structure	Organisational Responsibility	Organisational Commitment
Manager recognition	.60**					
Manager support		.65**				
Manager standards			.25**			
Manager structure				.34**		
Manager responsibility					-.02 ns	
Manager commitment						.48**

The significance of Role

The largest group of participants was nurses (31%), then clerical staff (14%), managers and porters (14% each). Doctors/consultants/physicians (11%), other allied professionals (10%) and 'support' staff (6%).

When looking at satisfaction with leadership the following findings were apparent: High satisfaction with leadership was reported in total by 54.3%

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(n=113) of staff. Although there were no significant differences by work role, it can be seen that consultants and doctors reported the highest satisfaction (74%), followed by managers (61%). It can be seen that clerical workers had the least high satisfaction (41%), followed by 'support' staff and other allied professionals (54%). This is significant in terms of the hierarchy within the organisation – the higher the position the more satisfied one is with their leadership.

Table 11: The significance of role and satisfaction with leadership

	n	% positive responses about satisfaction with leadership
Managers	28	60%
Doctors	23	74%
Allied professionals	22	54%
Nursing	65	49%
Support staff/Assistants	13	54%
Clerical	29	41%
Porters/maintenance	28	57%

A further examination of organisational dimensions according to role using a one way ANOVA, revealed the following:

In all there were large differences between respondents in terms of their role, however only two scales exhibited differences which reached significance. The first was 'commitment' – doctors/consultants were found to rate significantly higher than allied health professionals on this scale (mean difference = 2.86) ($p < .01$).

The second was 'recognition' – it was found that doctors were much more likely to rate higher than clerical staff on this scale (mean difference = 2.41) ($p < .01$). Both these findings were apparent even after using the Bonferroni correction.

Comparing doctors (all grades) in Trust 1 and Trust 3

An examination of the responses on the item looking at 'satisfaction with leadership' amongst doctors revealed that doctors at Trust 1 (n= 13) had lower satisfaction (Mean = 3.38, std = 1.38) in comparison to doctors at Trust 3 (n= 10) (Mean = 4.20, std = .42). This difference (.81), whilst small, was found to be approaching significance ($t = -2.003$, $p = .06$).

While it is not possible to make an objective comparison between doctors from Trusts 1 and 3 from the qualitative data, there is more evidence in Trust 3 of doctors being both emotionally engaged with both junior doctors and other members of multi-disciplinary teams than in Trust 1 and with distributed leadership. As will be evidenced in Chapter Six doctors and other staff considered 'management' as bureaucratic and distant rather than engaged.

Gender

There were no differences between men and women's scores on 'satisfaction with leadership' ($t = 1.71$, $p = .08$).

When examining differences between men and women on the organisational dimension it was found that only one dimension, 'recognition', was perceived significantly differently ($t = 3.42$, $p < .001$). Men perceived there to be greater 'recognition' (mean = 9.55) compared to women (mean = 8.13). All other dimensions were not significantly different (see Chapter Eight).

When examining the gender differences on managerial dimensions of the OCS there were trends approaching significance in terms of differences between the genders on managerial dimensions, but these did not reach significance when multiple comparisons were taken into account:

Manager 'recognition' ($t = 1.91$, $p = .06$)

Manager 'responsibility' ($t = 2.10$, $p = .03$)

Manager 'standards' ($t = 2.33$, $p = .02$).

5.3 Conclusions

The difficulty obtaining data across all three participating Trusts has not limited the value of using the OCS to triangulate the qualitative data, particularly because a) the OCS gathered information from staff groups who were not represented in the focus groups, shadowing or story-telling

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interviews and was able to identify generalisable predictors of satisfaction with leadership and management practices, and b) the OCS data captured information from specialty groups outside those involved in the participating Units from which qualitative data was collected.

What emerged here was that on the whole, the same climate variables are important in predicting satisfaction with leadership. Within the organisational domain these are 'support' and 'recognition' while predictors of 'satisfaction with leadership', within managerial practices, are manager 'support', 'commitment' and 'structure'.

Overall, therefore, 'satisfaction with leadership' was highly accounted for by manager 'support', manager 'commitment' and organisational 'support' – i.e. these were the 'ingredients' in this sample which were highly related and were able to predict satisfaction with leadership. This suggests once again that managers/leaders were effective if they engaged with followers and that organisations that supported distributed leadership and emotional engagement were more likely to support effective leadership (see Chapters Four and Six in particular).

In terms of role, the higher the position in the organisational hierarchy the more satisfied a person was likely to be with leadership. This was not necessarily the case though across all organisations in the study. The exploration of the case studies in Chapter Seven – where authority and leadership are discussed – reveals how some of the more senior leaders in organisations found themselves to be highly dissatisfied with leadership in other sectors of their Trust, if there was resistance or negligence of their authority.

Differences in gender were only apparent in terms the organisational dimension 'recognition' – it was only on this scale where women scored significantly lower than men. This may say something about equal opportunities and equal pay for equal work, but it might also relate to perception of 'recognition' between women and men discussed and exemplified in Chapter Eight below.

The overall importance of constructs such as 'support' and 'recognition' across the climate of an organisation, and management practices which demonstrate support and commitment, provide further evidence of the importance in engagement and (probably) emotion (including EI and SI) in an organisation.

6 'Organisation in the Mind': Transmission of Leadership and Organisational Context

6.1 Introduction

Leadership in any organisation is understood in a specific context by those involved as either leaders or followers, and as shown in Chapters Four and Five concepts such as satisfaction, support, responsibility, vision and communication among others are described and evaluated within a cognitive or mental framework within which the organisation itself is understood. It is through making sense of the organisational context that leadership and followership may be enacted and transmitted.

We saw how members of organisations *necessarily* hold in their mind fantasy/imagined understandings or images of the *system* (Morgan, 2006). This informs how they work in, relate to and talk about their organisation, based on their perceptions of their own and others' place and role within the system. For example, it is common to hear employees talk about how 'you can never get management attention in this company' or 'we are all dedicated to putting patients first here' (Armstrong, 2005; Morgan, 2006).

Similarly, the participants who completed the OCS held a view of the leadership and management in their organisations, in order to think about the various ways in which their work was recognised, supported and so on both generally and by their managers. While the focus in that case was upon on measuring the impact of organisational climate and thinking about a relationship with a specific manager, those who completed the survey would have had to hold a perception of what was happening in their department and the Trust overall.

This is apparent in what follows particularly in the ways 'management' is discussed and taking account of these perceptions provides some evidence about the ways in which leadership is transmitted in these particular organisational contexts and in general. The 'organisation in mind' then involves:

- An 'image' of the organisational structure and relationships within that structure
- A sense of your own role and place within it
- An emotional component
- An awareness at a conscious and/or unconscious level of important information below the surface

6.2 Organisation in the mind

The concept of the 'organisation in the mind' was a model developed originally in the early 1990s by organisational and group relations consultants working at the Grubb Institute, the Tavistock Centre and the Tavistock Institute of Human Relations, to refer to what an individual perceives mentally about how organisations, relations in the organisations and the structures are connected. *"It is a model internal to oneself ... which gives rise to images, emotions, values and responses in me, which may consequently be influencing my own management and leadership, positively or adversely"* (Hutton, Bazalgette and Reed, 1997, p. 114 quoted in Armstrong, 2005, p. 4).

In other words, when we talk about our colleagues, guess what the senior management are doing/going to do and have fantasies about how well we fit, or don't fit, into the structure or system we do so in the context of the organisation we 'hold' in our mind which may or may not relate to that which other members of the organisation hold (Pols, 2005).

Organisations are experienced cognitively and emotionally by their members when they think about how their organisations work and are structured (see Lewin, 1947; Armstrong, 2005; Morgan, 2006). As Stokes (1994) explains it, everyone carries a sense of the organisation in their mind but members from different parts of the same organisations may have *"different pictures and these may be in contradiction to one another. Although often partly unconscious, these pictures nevertheless inform and influence the behaviour and feelings of members"*. (p. 121)

Hutton (2000) talks about it as *"a conscious or pre-conscious construct focused around emotional experiences of tasks, roles, purposes, rituals, accountability, competence, failure, success"* (p. 2). Morgan suggests that an organisation may serve as a 'psychic prison' in that the:

...patterns and meanings that shape corporate culture and subculture may also have unconscious significance. The common values that bind an organisation often have their origin in shared concerns that lurk below the surface of conscious awareness. For example, in organisations that project a team image, various kinds of splitting mechanisms are often in operation, idealising the qualities of team members while projecting fears, anger, envy, and other bad impulses onto persons and objects that are not part of the team (Morgan, 2006, p. 226).

Some of this is apparent when talking to NHS staff about the leaders at various levels of their own Trusts and the NHS overall as was seen particularly in Chapter Four.

6.2.1 Organisation under the surface

So, when the respondent immediately below talks about the leader who has a 'really good understanding of the organisation or team' what exactly does that mean? How does that understanding come about? What do the team hold in mind about that particular leader?

Leadership is someone who has a really good understanding of the organisation or team, erm where it's going and where they imagine it to be going, so that sort of vision as well for their team, I think. (Lead Clinical Non-medical Health Professional, T3)

This respondent, referring to the (frequently used) concept 'vision', also identifies this with the *imagination* the leader holds about where the organisation is going. This is not simply a matter of guesswork. It is an intellectual/cognitive and *emotional* sense of an organisation. Indeed to take this slightly further, as Gabriel and Schwartz (2004) propose "... *what goes on at the surface of an organisation is not all that there is, and ... understanding organisations often means comprehending matters that lie beneath the surface*" (Gabriel and Schwartz, 2004, p. 1).

Although not necessarily (in fact mostly not) made explicit, even the most clear thinking senior members of organisations hold an image of the organisation in mind, expressing their fantasy/belief/perception of the organisation based on conscious and unconscious knowledge (Halton, 2007; James & Arroba, 2005). So for instance for this CEO leadership is understood emotionally as it is:

... about the feel of the organisation and what it feels like in terms of how it delivers patient care. Yeah, erm. I can best illustrate that, and interestingly we were thinking about this earlier this morning, so as a group, the executives, we were talking about it. When you walk onto a ward a hospital ward and there is real leadership on that ward, you walk in and there are a number of signals that are given off, which give you a feel. Erm the place looks organised, it has a welcoming feel, the nurses on the ward and the clinical staff greet you as they come into contact with you. They know you from the previous interactions that you have had and when you sit there and listen to what is being said on the ward they will know that the patients, the visitors on the ward, the families that are coming in the junior doctors who are in there in that environment and all of that has a feel²⁶ of a well led ward. (CEO)

²⁶ Respondent's emphasis.

The environment of the well led ward (unit or organisation) is implicitly and unconsciously identified by all who engage with that organisation. The staff communicate effectively (visually, verbally and emotionally) so that the information required is passed on through managers, clinicians to colleagues, patients and relatives. This account, which preceded the extract that focused on strategy, directed to the best patient care for the greatest number of patients, expresses his ideas at an *emotional* level. He also suggests his senior colleagues agree with this. Signals are 'given off', you can 'feel' the organisation and how it delivers patient care and there is a 'welcoming feel'. He also talks about 'empirical' evidence in that staff know the patients, the ward looks organised he remains convinced that there is a 'feel of a well led ward'.

From a slightly different position, a deputy CEO quoted below also holds in mind the fantasy that a manager might think that they run an institution but that such a fantasy might get the manager into trouble. He is suggesting a vision of an organisation in which a manager has very little control, and proposes the need to gain a sense of *reality* by recognising this and taking responsibility for this organisation (Hirschhorn, 1997; Porter-O'Grady, 1995). His perception, again which has an emotional component, is one of a stressful contradiction – responsibility without power or control (de Vries, 2000).

The minute, as a manager, you start to think that you do [run the service without accountability]... erm then you're in trouble. Unfortunately you have still got the accountability for the service but you have very, very little control so it's a whole different leadership and managerial skill that is required I think in terms of recognizing that you have no control over what happens you know across this organisation across the N,000 beds here at [Trust], the thousands of people that go through the organisation everyday, what happens to them is completely outside of my control but if anything goes wrong it is absolutely my responsibility. And that is quite difficult.
(Deputy CEO, T 1)

6.2.2 Structure in the mind

Most recently Laughlin and Sher (Laughlin & Sher, 2010) take up a version of this concept which they name the 'structure-in-the-mind' in their analysis of developing leadership in social care. They reassert, in their model, that not only the local stakeholders (staff and service users) have a sense of the organisation in the mind when considering, for instance, a particular Trust, but the range of stakeholders includes government bodies and service commissioners (in the round). They propose an inter-relationship between perceptions of communications from services (e.g. 'that you [management] don't listen and/or understand') and perceived communications from 'Head

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Office (or government or other bodies that control resources and practices) which include for example 'just do it' 'we know better' and 'be rational'. (p. 9)

What is significant here, in the context of NHS leadership, is that the organisation and/or structure *in the mind* is where the leader and followers 'meet' emotionally as, similarly, do the various levels of leadership and governance bodies. It is a kind of 'virtual' space.

An example of this structure in the mind might be seen through the increase in stress for NHS employees detailed in a recent report by NICE (the National Institute for Clinical Excellence²⁷) where it was revealed that staff absence caused by work related stress costs the UK over £28 billion. It was proposed that a poor working environment characterised by bullying and poor management was at the heart of this problem²⁸ (Edwards & O'Connell, 2007). In a context where there is distributed leadership and a highly trained professional, multi-disciplinary workforce, such mismatches in how to run organisations and departments that lead to staff stress in these ways (e.g. being bullied and bullying) evoke questions about what is happening in the space between those who plan, govern and resource NHS Trusts and those who carry out the work. The emotional elements of leadership and followership relations seem to be neglected to everyone's disadvantage.

The idea of the organisation in the mind raises important questions of how leadership (good and bad) is transmitted across the NHS and its Trusts (Harrison & Carroll, 1991; Walsh & Ungson, 1991). Organisational cultures and climates are reproduced over time despite the coming(s) and going(s) of CEOs. However, organisations also *adapt* and *evolve* as a response to changes in leadership and outside influences (Morgan, 2006).

In what follows we explore the characteristics of the organisations studied here that facilitate or hinder the transmission of leadership through the Trust as a *system* through which culture (e.g. principles and values about leadership) might be transmitted (Hatch, 1993; Schein, 2004).

²⁷ An organisation established to oversee and provide guidance on clinical practice and cost and clinical effectiveness.

²⁸ See news.bbc.co.uk/2/hi/health/8343074.stm and NICE web-site which has a power-point presentation.

6.2.3 Transmission of leadership and Organisational Contexts

What is held in mind about an organisation is often influenced by the formal and informal networks (Balkundi & Kilduff, 2005, 2006; Goodwin, 2000) which characterise complex adaptive systems. Network cognitions in the minds of leaders are embedded in the whole organisation and the inter-organisational linkages formed by leaders as representatives of organisations (Balkundi & Kilduff, 2005).

The context of the NHS seems to have become increasingly complex and chaotic (Currie et al., 2009) which, coupled with a sense of widespread unethical managerial practices, has raised questions about how leadership practices are transmitted through NHS organisations (Bowie & Werhane, 2005; Collier & Esteban, 2000; Huston & Brox, 2004). Bullying and poor management are in part at least a consequence of not taking the emotional context of organisational life seriously (Ashkanasy, Jordan, & James, 2003; Cocco, Gatti, Lima, & Camus, 2003; Johnson, Cooper, Cartwright et al. 2005; James, 1999; Hutchinson, Vickers, Jackson & Wilkes, 2006).

While there is no excuse for bullying or any other unethical management practices, it is necessary to understand what precipitated the relatively recent change in culture which has exacerbated (reports of) bullying. One factor has to be the extent to which top-down, politically driven changes have been forced through the NHS system and other public institutions and the impact that the drivers of these changes have upon the senior levels of management consciously and unconsciously (Christensen & Laegreid, 2003; Dent, 2005; Gabriel, 2004).

These recent developments have influenced the psychological and emotional aspects of working in teams, groups and organisations (Liden & Antonakis, 2009; West & Anderson, 1992) and by implication influenced possibilities for innovation in leadership and the authority of leaders and workers (Lewin, 1947; Miller, 1993; Carter, Garside, & Black, 2003; Hirschorn, 1997; Fineman, 1994, 2000; Payne and Cooper, 2001; Vince, 2002; Carter, Garside, & Black, 2003). Understanding the *context* of leadership, therefore, has become increasingly important as has the need to understand how that context is part of a *system*.

Post industrial (or postmodern) systems (Rose, 1991) have been reconsidered (or 're-described') relatively recently as 'complex adaptive systems' (Collier & Esteban, 2000; Dooley, 1997; Schuster, 2005). Systems that are complex because of multiple interconnecting relationships are liable to evolve through making new connections that increase their complexity (Collier & Esteban, 2000). In the NHS, even though change is structurally driven, the (perhaps unforeseen) consequences of changes have meant that instead of a command-and-control, top-down hierarchies where in particular

clinicians such as consultants and matrons had previously been seen as 'gods' (as with Sir Lancelot Spratt and Dr. Gregory House see Chapter Four) distributed leadership, networks and different statuses attributed to individual Trusts (e.g. Foundation Trusts with relative independence, Mental Health Trusts which have social care and NHS staff and diverse management practices) have evolved within different structures at all levels for coping with service delivery (see Chapter Nine).

6.3 Open systems theory and boundary management

An organisation that *evolves* like an organism and adapts to its environment necessarily has *porous boundaries* so that it can 'take in' and 'put out' beyond itself. This kind of organism is one that changes, develops and grows. A closed system may feel more secure in that it may not have to accede to unwanted influence or demands, but without taking in and providing for the world outside it will atrophy as with any other closed (minded) system (Morgan, 2006). In this way images and cultures of leadership from outside the boundaries might influence the development of leadership practices e.g. data and ideas from education (Currie et al., 2009; Gronn, 2000; Lumby, 2003)

Systemic thinking is a framework, or tool, for observing the way organisations behave (Schein, 1985; Lewin, 1947; Campbell et al, 1994) which evolved from General Systems Theory, (von Bertalanffy, 1956; Miller and Rice, 1967) and focuses upon concepts related to organisational structure particularly 'task', 'role', 'authority' and 'boundary'. There is also a psychodynamic part of the systemic thinking analysis which links with the conscious and unconscious emotional consequences of the systemic properties and the impact of social and personal factors on the functioning of the organisation (James and Huffington, 2004; Laughlin & Sher, 2010)²⁹.

Morgan (2006) identifies how knowledge and power are accessed and maintained through control of organisational boundaries. 'Boundary' is the term used in open-systems theory to describe the interface between different parts of the organisation and the organisation and the outside world. In the case of the NHS this is the physical boundary to the, for example, hospital building, the wards, the web-site, the reception desk, the

²⁹ This issue is further discussed and explained through object relations theory based on the works of Melanie Klein, Elliot Jaques and Isabel Menzies-Lyth which is outlined in detail in Chapter One and operationalised in the description of the role of obstetricians' anxiety in the delivery of patient care discussed in this chapter and below in Chapter Nine).

telephones, e-mail and so on and also between the different roles such as out-patient/ in-patient, staff /patient, clinician/manager and so on. Most leaders in organisations have the knowledge and abilities by definition to manage and negotiate those boundaries. For example, the senior managers relate to government/NHS/DoH in ways that junior nurses do not, but the senior staff are charged with having to manage the boundaries using knowledge and influence across the boundaries – inside with the staff and patients and outside with government and patient pressure groups. Moreover, as evidenced during the conduct of this project, hospitals merge into Trusts and the porosity or opacity of the boundaries between the different organisations that have come together are central to the functioning of leadership at most levels (see Chapter Seven where the limits of authority are discussed in this context).

Stating this in a slightly different way, this approach to the 'organisation in the mind' takes the *personal* (conscious, pre-conscious and unconscious) level of thinking and links it to the *system* in which that person works (systemic thinking). As any organisation comprises systems (with boundaries, in-puts and out-puts), groups and individuals, it follows that a person's experience of an organisation and *experience of themselves* in relation to others who are in the same organisation make up the culture, climate and everyday dynamics of any organisational context. Thus, our respondents' sense of the 'organisation in the mind' is a valuable concept for understanding how leadership relates to service delivery.

6.4 Images of the organisation

In what follows we explore some of the images 'held in mind' by staff across the three Trusts particularly examining the impact of the organisation in the mind on working collaboratively and the influence of this on service delivery and the quality of patient care that results from staff relations and effectiveness.

To begin, we focus on two specific examples that characterise much of what was said by staff across at least two Trusts:

- images (and fantasies) held about 'management' which highlight the construction of 'authority' in the system and its impact on patient care
- images (and fantasies) held about the 'others' (e.g. colleagues in the same Trust but on a different site or a different Unit) which brings boundary management into play
- how these images (and fantasies) facilitate and hinder the transmission of leadership and service delivery

We employ a critical discourse analysis (CDA) approach to the meaning and processes of leadership and organisation exploring how the organisation/system *looks* to the participants and how this in turn impacts upon the system of providing care for its patients.

6.4.1 'Management' in the mind

As in many organisations, rhetoric about 'management' abounds particularly played out as a 'them/us' dynamic as we demonstrated by separate means in Chapters Four and Five. Furthermore, among management, rhetoric about their own practices and role in relation to that of the workforce is equally active (Alvesson & Sveningsson, 2003a; Borins, 2000; Kuokkanen & Katajisto, 2003).

There is general cynicism across all the respondents who defined themselves as non-management *about* management. So for example: *"And you find that when there's a crisis that's when you find your management team will come down and put a policy in place regardless - like the swine flu thing" (Junior Midwife)*. So here managers are described as paying no heed to the routine tasks of the organisation (Cummings, Hayduk, & Estabrooks, 2005b). They are portrayed as simply responding to a crisis and (presumably following orders from the overall leaders of the service). Thus, managers are not seen as managing the boundaries between the Trust and those in overall charge of health care operating outside of the organisation (i.e. at the level of government) effectively for the facilitation of service delivery (Buchanan, Abbott, Bentley, Lanceley, & Meyer, 2005; Kane & Patapan, 2006). This resonates with Laughlin and Sher's (2010) analysis discussed above.

A focus group from one Trust proposed a particularly strident view of management and its relationship to wider bureaucratic imperatives which they saw as going against service delivery and effective patient care. The medical staff here were proposing that management was both absent, in person and from taking responsibility, while also being all controlling of medical care through instigating seemingly pointless rituals which seemed to maintain boundaries.

Consultant: There is a burning example [here] of bad leadership which is the absence of figure heads. Management can never be found which is frustrating.

Registrar: I've been in theatre now for two weeks and two cases were dropped. The doctor has to apologise to the patient but they are the ones [the doctors] who would like to continue. Management say 'NO it is lunch'. They should be the ones taking responsibility for telling the patient but the

doctor has to go back to the patient and look like a donkey saying 'I'm sorry I can't do your operation today'.

The members of this group, who clearly shared the same or similar images of management and its 'idiocy', went on to decry management incompetence across all staffing issues, and the registrar continued, imitating the management in a silly voice: "*he has to stop, that's the rule*" making it very clear that management was perceived by this man and others in this focus group as inflexible (and rather stupid). Here these participants are expressing total lack of faith in the authority of those who manage (rather than lead) them, although in fact it seems that despite this, they abide by the rules which suggests that there is a belief that at some level the managers in question here derive authority from somewhere higher up in the hospital system or from the NHS leadership beyond.

One factor to note, of course though, is that the power of the story in the focus group may belie the views of the whole group in that some would be silenced by the fear of disagreeing with their colleagues (Asch, 1956; Foucault, 1982). Furthermore, the articulation of the behaviour of management in these cases is *actually a form of leadership* and as such might influence the views of the focus group (and subsequently other staff) (Avolio et al., 2004; Pye, 2005).

From a different focus group, this time with junior midwives, it was apparently *giving up their authority* for a while that gained managers some important respect. For instance when a crisis occurred in the organisation (in this case a fire) then managers seemed to behave very differently and even impressively:

1³⁰. Yeah and then the managers - the bed managers - were carrying chairs and everything and you just had people on beanbags on the floor and everybody ...

2. I wasn't here that day I missed that.

1. Well it was a bit stressful but everybody just mucked in and people were just carrying people here and you know....

Q: Well that's really good if everybody even the managers mucked in.

1. Yeah you find in a crisis the managers do come out, the leadership the leaders come out and they have to come out.

3. And people were coming in from home to help that day.

³⁰ The number denotes the speaker.

2. *Why didn't they phone me? I don't know but never mind ...*

1. *No you find that in that kind of crisis everybody from execs downwards pulls rank and everybody comes in and helps out (T 2).*

So the image here is that a crisis brings out the best in everyone (and the boundaries between the groups of staff become temporarily porous). In times of crisis then the tasks (i.e. patient care and running an effective hospital) overcome other elements of potential discord and conflict such as the 'rank' order of 'execs' bed managers and others such as clinical staff.

There are also other times when it is possible for management to be seen as 'on side' as indicated by another nurse in a different site. For example:

Erm ... our manager, she is quite approachable. And she is willing to discuss things with you if you don't feel that something is right and you question it or question her. She is willing to sit down and explain it and sometimes she will say 'I'm not happy with things as well, but the people above me this is what they have decided, this is what we have to go along with. It is government guidelines or targets have to be met'. Although she might feel the same as us she explains why we have to do things in this way. And I think she is very approachable.

This manager above, demonstrates her willingness to communicate and be 'visible' but clearly she has adopted a them/us strategy similar to those who 'oppose' management by positioning herself as managing the boundary from the side of the clinician/nurse's while also at other times presenting herself as mediating between 'government' and clinicians and managing that boundary too (Laughlin & Sher, 2010).

In the example described here, this seems to 'work' as evidence of good leadership for the nurse telling the story, but it involves the manager in question in potentially difficult dynamics and conflicts in her role.

From another focus group discussion that included doctors and nurses the organisation in the mind experienced management as absent and failing in their responsibility (Hogan & Kaiser, 2005):

Absence would be correct. Management are often not there. They need to take command of the situation. Here is the reasoning – management don't take responsibility for their actions and there is a severe lack of managerial leadership.

This is significant in the concept of the organisation in the mind when juxtaposed with the account of the same organisation by the CEO who saw her/himself as seeing good leadership as manifested in:

Visibility in terms of being seen around the place, so go out wandering around the wards. The best part of the role, quite candidly is, the best part about being the chief executive is, you can go out and talk to patients, and that is what I really kind of enjoy. ... so there is something about my presence and my profile. There is also something about being very clear and repeating the message often enough so that it is clear in the organisation about what the organisation is there to do.

So, within the same organisation there is an image that management is invisible and absent, while senior managers see themselves as 'being seen around the place' constituting an important part of what they believe they do and that they see as being vital for effective leadership and patient care (Laughlin & Sher, 2010). Both sides agree on what would be good leadership but each 'side' has a different vision of what is happening in 'reality' (Alvesson & Sveningsson, 2003a; Buchanan et al., 2007).

In the absence of a shared vision of an organisation working together or a set of clear guidelines about how 'this organisation works', there seemed to be a wish from a deputy CEO of another Trust for a hero/charismatic leader to put things to rights and potentially cross the managers/others boundary (Ladkin, 2006; Laughlin & Sher, 2010).

Erm, this is a very complicated organisation, what we haven't got right is we haven't got a bible that says this is how this organisation works and I think that's a problem so, ((1)) so ((1)) it's very easy for ((1)) despite what I've said about how difficult it was to be a leader, erm and the personality of the individuals who are at the top of the tree, makes an enormous difference in how an organisation I think behaves and works. There is a great tendency if you are a very good individual for an organisation to be based around you and when you leave there is a problem, erm and so the best kind of leader, yes they have that aura of it's about them, of course that's what people look up to but they also put in place processes so that things can happen.

This is a view from the top of the organisation which is expressed at least in part as a vision of a (desirable) mechanistic model – an organisation with a 'bible' about how it works - although this participant also desires a charismatic transformation on the part of leaders.

The hero leader would be a 'very good individual for an organisation to be based around you' and also to have 'an aura'. The metaphors in this extract proliferate – the need for a 'messiah' to save the organisation but also a sense of *dependency* – that 'people look up to' this type of leader who (it would appear) single handedly will be able to put processes in place for things to happen. The vision here is though one in which the system is defunct, stagnant and closed.

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6.5 'Out of mind': leadership and the 'other'

Organisational change is frequently resisted, often because of the disruption to individual's *sense of the system* and their place within it (e.g. Hoyle, 2004). It is also related to the emotional involvement many people have in their work and the way they perceive they are valued within (and how they themselves value) a familiar structure and context (Bovey & Hede, 2001; Zoller & Fairhurst, 2007).

Emotional labour, as discussed in Chapter One, is a key feature of the work that many people do, and is an integral part of any job, but particularly so in an institution of the NHS (see for example Gabriel, 2004). Different occupations require different types of 'displays' and following Hochschild (1983) emotional labour requires adopting emotional displays and attitudes appropriate to the role.

Clearly in hospital work all staff have to expend emotional energy on 'caring' and 'kindness' but it is also the case that working in the NHS, with its many changes for (perhaps) better or (maybe) worse, also requires the ability to be able to 'move on' i.e. mourn the loss of the old structure, sets of relationships etc. and embrace the 'new' with some degree of enthusiasm. The failure to do this (or recognise the need to do this) results in emotional resistance to changes and hanging on to the old systems as long as possible which might defeat changes that improve service delivery and benefit patients (Hughes, 2005).

6.5.1 Leading change and transmitting leadership

In one particular case a senior clinical manager Gerald³¹, was charged with integrating clinical practice across two sites, each of which had their own different ways of working, and different relationships to the boundaries between each other and the clinical teams. While the one (where he was based primarily) had accepted quite radical changes to its organisation, the other (apparently) did not "*..because the sort of ethos and the sort of personalities of the two sites are in the background. They are completely different*".

Gerald's view is based on a reality in that the two sites are structured differently, look different from each other in that the buildings are from different eras and in different styles, and they are in physically different locations. They also serve different demographic populations and have different histories. However, Gerald sees the organisation of the different

³¹ Gerald's leadership is discussed in detail in Chapter Seven.

sites as really being about 'ethos' and 'personalities' which must be in the mind (mostly) as there is a system of authority and responsibility in place across the Trust (via the CEO and other senior people including Gerald) that takes up authority and leadership to ensure consistent practices and organisational change.

Thus, we need to ask why one Unit has (apparently) taken new ways of working on board with some enthusiasm while (apparently) there are barriers preventing the other one doing something similar.

For Gerald, management of the boundaries between in-patient care and primary care teams was the source of a key difficulty:

There are groups of people here who are completely behind the concept that we mind about – integration of primary care – joint working between the Trust and the Primary Care Trust. Some departments work extremely well and are keen to move forward and although we do have our minor difficulties - generally there's one or two departments who are completely against change and erm resistant to anything new. Just like any other organisation where you know you are going to get the type of people who actually make life extremely difficult for you and despite that we've proven how much better our system is.

In the extract above he moves from talking about the other *site* (as a whole system) as being the 'bad' resistant one, to identifying *individuals* on his own site within the 'good' system as making life difficult for him personally despite evidence (he and others have provided) to show how integration works better. This respondent's organisation in mind shifts depending on how well one part of the system fits with his particular vision of a good organisation. This *splitting* (see Chapter One) is a mechanism (unconscious) for preventing the overwhelming feeling that can come from persecutory anxieties (Jaques, 1953; Jaques, 1960; Menzies, 1970). In a management role where (for some reason) authority is being undermined, then the resurgence of persecutory anxiety might be dealt with by splitting of the 'bad' site and comforting oneself with the knowledge of a 'good' site where the organisation works as this leader/manager might wish it to do (Laughlin & Sher, 2010).

6.5.2 Resisting change

In the case of a medical secretary, with over twenty years experience of working in the same hospital, the thought of change in the structure of her working relationships was upsetting. She began engaging with the interviewer by talking about how busy she was and when asked if there was any particular reason why she was busy at that particular time she went into an explanation about organisational change. *"It's just generally busy, but we*

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are in teams now, erm couple of them [doctors] are away and one or two have come back, catching up with everything". It seems as if the teams were the problem for her because previously (and for many years) "...it was one secretary to one consultant and his team. Now for instance today I'm actually taking calls for four different consultants". She was asked about the new structure and made it clear:

erm ... I don't think it's going to work as well as the previous one. Because I think you'll be dipping in and out of so many different jobs that instead of concentrating on the ones that you do well and controlling your one doctor, it'll be confusing and I think there will be mistakes made because one person is trying to deal with too many parts of too many jobs.

Her perception that her role in the organisation might happily continue as one in which she controlled one consultant is characteristic of the 'comfort' of the closed system where authority, power and the processes of leadership are condensed and held 'constant' by an individual. As seen in Chapter Four also change is not usually welcomed without at least tacit resistance and in Chapter Seven two of the case studies will explore how leaders as potential change agents experience followers' avoidance or challenge to changes in practices and structure.

Changes in working relationships bring anxieties which need to be understood and anticipated by leaders if they are to support staff to position themselves differently in the system. Hoyle (2004, in Huffington et al) suggests that during any period of organisational change there is potential for heightened creativity which might lead to doing things differently and better. However, change also brings about risk, uncertainty and the chance of failure which can evoke anxiety both in those promoting the changes (the leaders) and those who might fear loss of their job and the loss of known ways of working (see Hoyle, 2004, p.87).

6.6 Conclusions

Understanding an organisation and what facilitates and/or hinders leaders to take up their authority involves considering the organisation systemically. That is taking account of the boundary management and how that relates to the tasks, roles and power/authority of those who work or are 'consumers' of its work.

Leading change depends upon ensuring those within the system have a sense of how the system works and an awareness of the culture that might be tested as a reality or not. This means, once again, that organisations which are learning environments and where emotional intelligence is applied, are more likely to respond to authority and less likely to subvert

leadership, thus distributed leadership/responsibilities may be taken up or shared more widely.

7 Leadership, Authority and Emotion

7.1 Introduction

As argued above, leadership and emotion are fundamentally intertwined in the workplace (Fineman, 2003). Leaders who appropriately manage both their own emotions (Goleman et al., 2001), and those of their followers, experience better leader-follower relationships, greater opportunity for innovation, motivation and productivity, a more positive organisational climate and improvement in employee and customer/patient satisfaction (Ashkanasy et al., 2003; Avolio et al., 2004; Hollander, 2009). Such outcomes can be associated with both *transformational leadership* (Bass et al., 2003; Corrigan & Garman, 1999; Currie & Lockett, 2007) and *distributed leadership* (Bass & Steidlmeier, 1999; Gronn, 2000, 2002; Mehra, Smith, L. Dixon, & Robertson, 2006b) patterns.

It has also been suggested that followers' 'dysfunctional' dependency is a consequence of failure of the leader to *engage* on an emotional level with those whom they lead (Alban-Metcalfe & Alimo-Metcalfe., 2009; Ashforth & Humphrey, 1995; Bion, 1961; George, 2000). There are different types of such engagement, e.g. acknowledging emotions, drawing them out, honouring them, confronting them, and deflecting them, but although this idea of engagement has been described as "*compelling on the surface, the meaning of the employee engagement concept is unclear*". (Macy & Schneider, 2008, p.3) Even so, there is a common view that such engagement is desirable for organisations in that it connotes involvement, commitment, passion, focused effort and energy from staff thus demonstrating both attitudinal and behavioural components for an effective workforce. (Macy & Schneider, 2008)

Studies of leadership and emotion have not typically been combined with attention to the 'authority' of the leader (Ford, 2006; Stein, 2007) or indeed to the concept of 'power', (sometimes seen and experienced interchangeably). (Morgan, 2006) A study combining exploration of the relationship of authority to concepts of both 'emotion' and 'engagement' (Hirschhorn, 1997) is particularly relevant to the agenda of the 'post-modern' organisation where leadership is distributed (Clegg, 1990; Tierney, 1996) and the organisation potentially fragmented, unmanageable and diverse.

The authority invested in a particular role, such as the CEO (Chief Executive Officer) or lead clinician may not explicitly engage emotion. However, in an organisation such as an NHS Trust, where leadership styles are, or at least

intended to be, characterised by distributed or transformational attributes, the concept of authority is more closely linked to *personal* authority whereby individuals “..bring more of themselves – their skills, ideas, feelings, and values – to their work. They are more psychologically present.” (Hirschorn, 1997, p.9). Thus for example clinical skills *and* personal investment are *both* required for someone to take up authority in practice as a clinical leaderⁱⁱ.

In this chapter we delve further into the concepts of leaders and leadership, particularly focusing upon leaders with a ‘mandate’ to lead change through their formal *role*. The group of participants we specifically focus upon here includes clinical and non-clinical senior managers and we examine the ways these individuals construct their role, their relationship to ‘followers’ and how their *authority* is taken up, experienced and constructed in their specific organisational context³². Authority has more than one meaning. It refers to the authority (sometimes seen as power) invested in a particular role.

Analysis of relationships between people who work in the NHS is underpinned by both the *interactional* and the (related) *emotional* contexts of an NHS Trust as a workplace (see for example Liden and Antonakis, 2009). This knowledge is particularly salient because on the surface, many of those occupying the leadership roles were inclined (at least superficially) to deny the role of emotion although analysis of their stories, shadowing and observations, following the pre-existing literature on organisational cultures, including those which study health care settings, indicated that emotion indeed plays a key role in service delivery and the ways leadership and authority are experienced and constructed in relation to patient care (Vince, 2002; Gabriel, 2004; Hirschorn, 1997; Huffington, 2007; Obholzer, 1994; Vega-Roberts, 1994).

7.2 Case studies

Three case studies were selected to examine the meanings given to the relationship between ‘leadership’, ‘emotion’ and ‘authority’ in relative depth. Each one was chosen (through discussion among the research team) to be (potentially) representative of a ‘typical’ approach to emotional management which reflected a personal style of authority (or lack of authority). These particular cases raised subtle but crucial questions about leadership, emotion and authority through exposing both the conscious and *unconscious* qualities which can either underpin or undermine a leadership *role* (Bovey & Hede, 2001).

³² In this chapter we focus specifically on the senior staff’s perspectives. Others’ perceptions of senior staff were discussed in Chapter Six.

1. The first leader, Gerald, had an 'authoritarian' manner (Adorno, 1950). That is, he appeared to believe that because he was in a senior position other staff ought to do what he told them to do. He was a senior clinician [for a group of particular services], relatively young, very enthusiastic and held an uncompromising vision of how a good hospital should be organised. He was interviewed once by a researcher, once by a group including the PI and 'shadowed' for two days by the same researcher.
2. Kerry in many ways held a similar outlook to Gerald, only she *believed* that she attended to the emotions of her staff if not her own. Kerry was Gerald's immediate boss and evidence from the interviews, shadowing and observations in both cases indicates they did not always work effectively together. Kerry was interviewed twice. Once for information as a key informant by two researchers and the second time by the PI and a researcher together. She was also observed by a researcher for an hour.
3. Quentin was a Clinical Director. He made overt efforts to weigh up the emotional 'risks' to his authority and thus seemed more able to engage with the 'followers' (and thus probably survive) in the *role*. At first he was reluctant to take part in the research directly (although he supported his colleagues' participation) but eventually agreed to be interviewed. Two researchers met him before the interview conducted by the PI, in his role as a key informant and observed him and the senior colleagues in their shared office space for about 30 minutes.

7.2.1 'Gerald'

Gerald held a clear vision of how a good hospital should be organised for the benefit of patients. What he appears to find problematic is managing staff who (for whatever reason) have a vested interest in different styles from those he advocates of patient care, working with colleagues and patients, and/or visions for service delivery.

The following extract is from the shadowing of Gerald.

From the two days spent with Gerald it was very clear that he believed that he was one of the main 'leaders' in the Trust and that he had a strong relationship with the middle and upper managers (including the CEO) which he uses to his advantage especially during long discussions regarding the 'new vision' (which appeared to be very much his vision) for the relationship between the two sites.

Gerald did indeed appear to be one of the main leaders. However, it was unclear whether the power and influence in this leadership role was all smoke and mirrors. Does Gerald play the role of the Wizard of Oz? Does he

think he has more power and influence than he actually has? Does he really have a good relationship with the Trust managers and Chief Executive?

The interview with Kerry (the CEO) made it apparent that she did not consider that he was one of the main leaders in the Trust and it was indicated that she didn't think much of him, and that their relationship might have been fraught.

Discussing the researcher's notes some weeks later, one thing that did emerge was that Gerald 'confused' those around him and was apparently unaware of how others saw him and how far his personal authority actually stretched. Hirschorn (1997) in a study of authority in contemporary organisations has suggested that leaders are no longer the old-style authority figures and because of changes in technology and economics "... bosses can no longer project the certainty, confidence and power that once facilitated employees' identification with them when they [employees] were young and dependent. This is why people are so disappointed in leaders today but also so unforgiving of them" (p. 9).

Gerald, although he had a clear management role and mandate to make the changes he focused on, did not get identified by his colleagues as fulfilling the vision of a leader as there is an implication in the observation extract that his authority may have been achieved via 'smoke and mirrors'. Furthermore his appointment (and that of several of his close senior colleagues) predated the appointment of the CEO. Several questions are raised here by the researcher about whether Gerald has been capable of taking up authority when the CEO takes a stance that at least tacitly opposes him. *This has to remain unanswered in the specific context of this Trust but is an important matter to consider in regard to distributed leadership.*

Gerald prefers to position himself as 'evidence-based' (and therefore up-to-date) dealing with practical matters and not positioning himself as an *emotional* leader. In the interview below, thus, he talks about making difficult decisions but paradoxically, almost from the beginning he focuses in upon dramatic inter-personal conflicts - talking about 'facing up to a fight' and declaring that the Trust 'absolutely' does not have the kind of leadership that enables 'direction' or 'vision'. Does this mean the CEO? Does this mean consultants? It may not even be intended so specifically perhaps it is an expression of general frustration that his vision is not shared.

While on the surface he claimed a good sense of what leadership is about he is also revealing in his talk, the opposite position. Taking a team or department in the direction of the vision and making difficult decisions is for him about a relationship with (not) being 'scared' or further down in this extract, (not) 'afraid'.

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Gerald: Erm...good leadership, err having the ability to make difficult decisions, err, not being scared to face up to a fight...erm...being able to be clear about errr, the direction or vision of the trust, where we are going and be able to errr direct your team into the position that everyone errr everyone is meant to be going, erm I think

Q: Yeah...and do you see that kind of leadership in this hospital?

Gerald: No, absolutely not

Q: No? And why, why not? What's the problem to that kind of...

Gerald: I think that in the past, we .. we have been afraid to face up to a fight, and we have shied away from it.

Q: Yeah

Gerald: From making difficult decisions, and err, and we've let too many people get away with undermining the overall plan that we have...'cause we all know how to deliver excellent healthcare, we all have our views of how this is going ahead, but err, and the grand picture has been undermined by a few, and we've not been able to really face up to those people

Gerald believes that while everyone knows how to deliver 'excellent healthcare' a few have undermined the/his 'grand picture'. He also identifies with a group who support his particular vision while not expressing empathy with those who do not. As the interview progresses, Gerald berates the power (rather than leadership qualities) that consultants have had in the past suggesting that they *undermine* changes that he clearly and sincerely holds about what constitutes good patient care.

Gerald however does reflect on what he is being asked as evidence by his suggestion later:

I don't know about what makes a good [leader]...you know, its difficult to say what makes a good leader...because I'm not sure I'm a good leader, because the qualities that I feel perhaps are necessary, I don't perhaps have ...one of those is patience perhaps...err, being able to tolerate people's err err, err stupidity in a nice way, is essential I think, but I don't have that, I don't think...being, having the ability to listen, err, err, err and not judge or criticise too quickly is very important, but then, taking everyone's opinion into account, but then at the end of all that being able to still go your own way, and persuade everyone else that it was their idea in the first place ... Well, I have certain qualities which help me get the goals that I like...erm...whether I have everybody behind me.

This is one (although not the only one) of the more (paradoxically) emotional interviews from among the senior managers in the study. Gerald

recognises, quite passionately, that a leader needs followers and has to be tolerant. Gerald, though, cannot help declaring that those who presumably hold differing opinions to him to be stupid. He also said later in the interview that he believed many people were *against him* when he was appointed to the senior post as the Trust itself changed shape. While he would not it seems position himself as emotional (rather he sees himself as evidence-based) he chooses to talk in emotive ways and reading and hearing what he says is quite exhausting as he uses all his energy in trying to take the organisation where he believes it should go, but through lack of emotional intelligence, many a time he draws a blank.

Gabriel and Hirschorn (2004) might describe Gerald, at least in part, as a 'narcissistic leader' in that he liked to be told he is important and influential but he is also potentially a bully and authoritarian in style (Adorno, 1950). He clearly found criticism intolerable and split off the 'bad' (i.e. the consultants who didn't go along with his changes from the 'good' i.e. the 'we'). Gerald has a dream which he is determined to make into a reality, however, there is a "*delicate balance between feelings of omnipotence and feelings of impotence which leaders must achieve, in order to enhance the chances of turning vision into reality*" (Gabriel and Hirschorn, 2004, p. 144). These authors argue that narcissistic leaders have a particular aptitude for getting this balance wrong and "*Even if they are talented in their field, their judgement increasingly fails them. This is compounded by the collusion of their followers*". This may be Gerald's 'we'. Gerald fails to connect emotionally with his (potential) followers from outside his close-knit 'we' group even though there may be some admiration for his clarity and link with the NHS mandate. This means, in effect, that important changes which may well be for the benefit of patients in the contemporary NHS are being (effectively) resisted because of Gerald's style of leadership. Gerald also appears to have little idea of how others might experience their worlds, including their emotions.

This theory might be borne out by the following participant, a young female career NHS manager just reaching a senior position. She proposed Gerald, unprompted, as an example of a good leader:

I think he's great, he gets a bit of bad press sometimes, I think people get agitated with him, but I think it's because he tries to manage things, and he tries to be very fair, and he tries to solve problems that have been with us for a long time, so again, I think he is a good leader, he is trying to do the right thing for the Trust in the long term. He is erm ... sometimes it's difficult for him to carry people with him, but I think that will pay off in the long run. And I think he's thinking of a long term plan, he's prepared to take a bit of short term flack...but I think it will work out in the end. I think he's going about doing stuff in the right way, he's being fair and he's trying

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to be consistent, he's making sure he's got an evidence base for doing things, it's not just a random decision, he's collecting information, and that kind of thing...I think there are a lot of people in this organisation at this point who would say they didn't think he was a good leader, but I think time will tell the story there.

This extract from the interview, while consistent with Gerald's descriptions of his own behaviour, proposes an evaluation of his style which indicates he is likely to be successful in the longer term because he is 'trying to do the right thing for the Trust'. However also she identifies quite clearly that his leadership is failing to take many of the people who matter along with him, she positions herself as sharing his vision for the longer term benefit of the Trust which may reflect her *a priori* engagement with NHS management rather than with a clinical profession as she does not have a clinical background herself. It also seems to reflect collusion with his narcissistic style because she seems to mirror his version of himself. This participant continues:

Sometimes they're [other senior staff particularly doctors] quite quick to criticise without really understanding what the problem is that needs to be solved, and what some of the rules are we can't ignore. Some of the national directives, that we just have to do, there's no point fighting against them, we've got to find a way of implementing them, and I think sometimes he gets a really raw deal...but he's said, he's consistent, he will communicate to people, write to people and speak to people very quickly the minute they raise a problem, and he definitely shows that he is not shying away from difficult problems...I think that's a very strong characteristic.

Her description of the other staff appears to chime with Bion's theory of a fight/flight basic assumption group based on unconscious emotional ties of the group involved which (mostly) represents an anti-task resistance to the leader (Bion, 1961). *This extract above reinforces the possibility that Gerald is emotionally disengaged from his followers* and perceives his Trust to be in line with and in favour of NHS 'national directives'. The participant here who in a way is 'damning' Gerald with *strong* praise may be looking to Gerald as a potential mentor by making it clear that she will support his particular efforts. However when the researcher asked her about her *own* leadership she said:

.... because one of my strengths is pulling people together, one of my strengths is building teams, so I think from that point of view then yes, but then sometimes I look at people like [Gerald and her immediate boss] and I think 'Oh my God'. I've got so much respect for the way they deal with

the very difficult issues. Sometimes I wonder if I really put my neck out enough to say 'Ok, Ok, this is what we all need to be passionately aiming for.' Even if not everybody is quite wanting to do the same thing. I think sometimes I sit back a bit more and wait to see what the general feedback is, rather than stick my neck out and say 'Ok, this is the direction we've got to go in.' And I think as a leader you have to...well, in fact you probably have to do a bit of both.

This participant, it seems, is somehow subjugating her own skills and strengths to those whose skills and strengths do not correspond with what she believes in makes her a good leader and seems to be putting herself down for the skills she has got and does seem to value. Alternatively, she might have realised that her strengths might complement Gerald's and through his own narcissistic valency he may position her as someone to promote.

Finally, in relation to Gerald, whose example she insists on returning to, having described other more emotional and successful clinical leaders in the Trust:

.... And they [other senior staff] make it very evident that they don't support him [Gerald] in his role, and not only do they make it very evident, but they do a lot of stirring behind the scenes, to get up a bit of a frenzy against him And I think there's some very clever leadership involved in that process, and there's a lot of learning, gathering people in, getting them on board and uniting them in a common purpose, and this and that and the other, but it's not constructive.

7.2.2 'Kerry'

Kerry is Gerald's immediate boss (the CEO) and evidence from the interviews, shadowing and observations in both cases indicates they do not always work effectively together³³. Kerry herself has met with similar difficulties which seem to be the outcome of her attempts to encourage distributed leadership in that:

Kerry: Erm, erm, well we set up a process to...we re-wrote the discharge policy here. I chaired the group. I wanted to know what the problem was about discharges, and I was told we needed to rewrite the discharge policy,

³³ Regardless of personal authority in the cases of both Kerry and Gerald, it is clear that the organisation has had its own very particular problems which are *endemic in the system* (see Chapter Six for a more systemic analysis of leadership).

and we'd just done it. People looked at me, and I just said, well I've spent...I've chaired five meetings myself, where we put all the information forward, and all these arrangements in place and nobody's done anything about it. I think that's poor leadership.

Q: So erm...poor leadership on whose part? Because presumably you had people who you delegated this to?

Kerry: So the consultants, the nurse managers, the matrons...all the people that were on the working group really. And they just didn't implement it. Beyond belief really.

This extract reveals several levels of emotion and authority and (as with Gerald's narrative) there is an 'I' who takes action and the 'they' who are against her. Kerry had identified a problem with discharges but had to ask 'them' what it was and was told that 'we' needed to rewrite the policy. She took up the role of chairing five meetings, the group/'we' put the information forward and the arrangements in place (presumably to take action) but 'no-one' did anything. It is not known how she handled this 'failure' of leadership on 'their' part. Kerry appears to be a micro-manager (in that she herself was involved in the meetings). Reflecting on this interview, and reading the text, one of us reported back to the research team that she had misunderstood Kerry, thinking that Kerry had been talking about her *own* case of poor leadership. Perhaps it was as unclear in the action as it was in the telling (thus perhaps on an unconscious level the lack of clarity was communicated in the meetings). Why did Kerry, as the leader, not pick up the group's dependence (or *resistance*) (Bovey & Hede, 2001; Hughes, 2005)? This suggests that she herself had resisted emotional attachment to her 'followers' and failed to engage them on an emotional level during the meetings. One approach that helps to understand the example above of *resistance*, specifically in the context of the five reported meetings, is the idea of '*fight/flight*' from the work of Wilfred Bion (1961/1983). He suggested that a 'group mentality' (or group culture) emerges from the development of a group over time as it continues to meet, because individual contributions conform to this mentality. In brief, the formed 'group culture' unconsciously constrains individual members (see also Sherwood, 1964).

So, in this case it may have been that despite the seniority of the staff involved in rewriting the discharge procedure, the culture that had developed over the course of the five meetings (and possibly prior to this as 'they' had suggested the need to re-write the discharge policy) had *prevented/resisted distributed leadership*. This could have led to the group not making sense of the leader's expectations and reverting to the comfortable pattern of being that had not been challenged possibly (again) because of the leader failing to manage her own emotions or engage with those of her team.

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Bion (1961/86) suggests, that the group mentality exists on both at a conscious and unconscious level so that the team were probably not deliberately, or consciously, going against the leader. It seemed from the leader's description that the team had been almost 'sleep walking' – not recognising that they had already done what they later ignored and suggested needed doing. Dependency, according to Bion, meant dependency on the leader or "... *when all individuals in the group look to myself as a person with whom each has an exclusive relationship*" (Bion, 1961/86: 119). Within this mode there is little connection between the members themselves and there is a '*mass inertia*' (op cit). This links to Klein's depressive position (Gould, 1997). It also raises questions of who is depressed here - Kerry, the group, or the group in Kerry's fantasy? The unconscious resistance and frustration experienced by the leader here demonstrates the fluidity of power and potentially the influence of gender (Fletcher, 2004; Nicolson, 1996; Vince, 2001)

Kerry, however, did claim success in turning around previously identified failings in patient care targets. How did she manage this?

Well I ... I... I mean it requires a great deal of focus, which hasn't been succeeded by other individuals, so...and it's required the organisation to understand its importance, and that it is possible to do. So it's been trying to talk to people about 'OK it's a target, but it's a quality... a patient quality target, so don't look at it in a sort of derogatory manner'.And ((3)) ...so it's a bit of culture about are you being bullied, as a member of staff to achieve the target and if you're not being bullied well then why is important and then well it's important because its patient quality ((1))...and then I suppose, something about... I mean one of the turning points for me is about our reputation as well, which is...well everyone else is achieving it, and we're not, 'why do you want to be in the bottom 20% of the country?'

Resisting her own emotional attachment here she talks in the third person. Rather than saying that as a new senior manager she had managed to engage the staff, which to a point she seems to have accomplished, she states that successfully addressing targets has 'required the organisation to understand its importance'. She clearly perceives senior staff as taking a negative position in relation to government targets and has attempted to persuade people that such targets are about good quality patient care. Another feature of the discourse slips in here – is her style of leadership perceived to be a bullying one? It may be that a group mentality, which takes resistance and dependency to be part of its culture, perceives a leader with a vision, or at least with determination (and 'focus' to quote Kerry) to be bullying them out of their emotional safety. This is a problem for any organisation that suggests to its staff that successful change and development is solely about strong leadership. We have to turn again and again to the clear message emerging from the data that without an

emotional attachment and the ability to manage their own emotions leaders and followers are not going to achieve goals related to patient care.

7.2.3 'Quentin'

Unlike Gerald, Quentin feels that he is succeeding in bringing about change and unlike Kerry he is mostly positive about the impact he is having upon the staff groups. He told two stories, one of which was when his leadership worked, and another where he continues to experience problems although he emphasised (to support his authority) that the latter was not a great a worry to him. In his interview he focused very much on the importance of personal authority: *"I'm still playing the trick of getting people to do things by example"*. He tries to back up his personal authority through making personal contact as much as he can:

You know my job could be answering my e-mails and I'm desperately trying not to. I've made a pact with myself that I will not explain myself in e-mail. If it needs to be explained I will go and explain it [personally].

He distinguished between the roles of the CEO and medical director, which in his opinion were *manager* roles, and that of clinical director which was a *leadership* role.

Quentin moves between the position where:

...people need constantly to be reminded of what they need to achieve ... [in relation to patient care] ...I use the word good care because [they] have the tendency to lapse into what is acceptable or even worse, what they can get away with.

To the position that:

And I think there is some requirement to continually challenge the organisation about what it is providing and sort of have a re-education process. And I guess we all need that – because I need that as well you know and it is one of my roles to keep reminding everybody why they are doing what they are doing.

Quentin sees himself as needing space to reflect upon the aims of the service provision and recognises that he is just as able to lose track of the organisation's main purpose as his colleagues/followers are, given the daily round of work. While Quentin gives an interesting example of how he and the team succeeded in meeting a target for patient waiting times in Accident & Emergency (which involved him engaging personally with the staff in an emergency meeting):

... which was all about persuading your senior contemporaries and peers. It's about the juniors, the people who are actually delivering the services. It's about making a reasoned argument. It's about being visible. It's about being honest and it's about delivering it.

The success, he believes, was about the personal contact and his own visible attachment in trying to change things alongside his colleagues and being very clear that " *...this needs to be achieved at all costs - which was quite liberating*". The rhetoric here is very different from that used by both Gerald and Kerry, who feel their colleagues are letting them down; possibly they are 'splitting' the 'bad' and projecting it into recalcitrant colleagues in order to feel reasonably good about their own positions (Klein 1987, 1983). Quentin is talking about success and success through *taking an emotional risk*. Saying that a change needed to be achieved at all costs (which he described as liberating) could be interpreted as Quentin making an emotional commitment to engage with his followers about something identified by the government, the NHS and his Trust as important. This stands in direct contrast to the experiences and rhetoric of both Gerald and Kerry who express the frustrations at what the 'others' are failing to do. However with what Quentin called a "*slightly different problem*". He has had great difficulty dealing with a doctor who is "*just a very difficult person to manage ... and I need to say to him 'this is crap and needs to be done in a completely different way'. I don't quite know why I haven't done that*". Once again Quentin was expressing an emotion – anger but without pushing/projecting blame on to the other, but being clear what the other person was doing and reflecting on his own sense of why, how and when he might take this issue up with the protagonist.

While Quentin operates with a quiet assurance and takes up his formal authority, and the power that accompanies it, from a classic Kleinian 'depressive position' (Klein, 1975; Segal, 1973), both Gerald and Kerry, despite their formal authority, fail to engage with their followers which leads to their powerlessness and a sense of rage and frustration.

7.3 Conclusion

The interconnections between power, authority and emotion play a complex part in understanding what leadership means to all those involved and in each organisational context. Leadership cannot be understood as something that can be observed and/or measured 'objectively', it is not an essential 'quality' which resides in an individual but is socially constructed, meaning different things to different people at different times. Following Ford (2010) a more contemporary, appropriate and critical approach to the study of leadership "*pays attention to situations, events, institutions, ideas, social practices and processes that may be seen as creating additional repression or discursive disclosure*" (Ford, 2010, p. 51)

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To be specific Rioch (Rioch, 1975), and others had made the point that *"'Leader' is a word which implies a relationship So the word 'leader' does not have any sense without a word like 'follower' implied in it".* (p. 159).

The relationship between leaders and followers might be more or less successful and in order to be a follower a person needs (even on a very temporary basis) to 'give over' something of themselves (i.e. make themselves emotionally open) to the leader for the relationship to have meaning. Being a follower may be both (or either) passive or active and there is the potential for the follower to engage and support, or subvert leadership (Bondi, 1997; Halton, 2007; O'Brien, 1994). Consequently, in order to analyse what it means to 'lead' in an organisation, understanding the practice(s) of emotional management alongside an analysis of power relations is fundamental (Grint, 2005; Schilling, 2009). For Foucault (Burrell, 1988; Foucault, 1982) power *"exists only when it is put into action, even if, of course, it is integrated into a disparate field of possibilities brought to bear upon permanent structures."* (1982, p. 788) Thus, while organisations give formal power to relatively few leaders (including in a distributed model of leadership) consent is still required for the power to be maintained. Furthermore, 'the other' that is the one over whom power is exercised, needs to be *"recognised and maintained to the very end as a person who acts"* (Foucault, 1982, p. 789).

The leaders we have described above all admit falling into traps where their authority has been challenged/resisted and they have been (potentially) made powerless. Quentin alone demonstrated awareness that he was working *with* people rather than treating them as resources. This meant that despite experiencing some frustrations, he managed to continue to *feel* and *think*, and with his colleagues/followers on board, *implement* changes. Kerry and Gerald, while attempting to take up their 'legitimate' power and lead change, both squander their authority through failing to manage and/or engage with their own and their followers' emotions. This is evidenced by their displays of frustration, impatience and anger with those who fail *to do what they are expected/commanded to do*.

Gerald held a classic authoritarian view of power, indicating that whether he takes people with him or not, he intends to get to the *'goals that I like'*. He also sees the resistant followers as stupid. He defines leadership accordingly, in that the leader should *'direct [the] team'* and not be afraid to *'face up to a fight'*.

Kerry sees herself somewhat differently even though she experiences anger and frustration when followers fail to do what she wants and expects. In attempting to empower her subordinates and set up the 'processes' to distribute empowerment (such as the meetings described above) she was left feeling disempowered following an (apparent) breakdown of

communication between herself and the senior team she tried to work with. That one of the interviewers also had to clarify: "*poor leadership on whose part?*" suggested that Kerry possibly re-experienced the rage and frustration she felt at the time of her encounter with the followers in her story when she told it. This rage obscured clear communication both then and in the telling. It might be that the overwhelming need to prevent the Trust from being '*in the bottom 20% of the country*' was a source of anxiety for her and the importance of achieving these specific sets of goals contributed to her impoverished emotional literacy.

Distributed leadership (Gronn, 2002; Mehra et al., 2006b), as a response to 'postmodern' organisations (Tierney, 1996) sets out the changing nature of authority/power. In combination with ideas from the emotional/social intelligence literature, distributed leadership suggests a more relational model of leader/follower relations whereby leadership decisions may represent both outcomes and inputs (Ashkanasy et al., 2003; Wolff, Pescosolido, & Druskat, 2002). A warning note, however, reminds us of the persistence of the patriarchal version of 'the' leader (Ford, 2010; Ford & Harding, 2008) which occupies the dominant discourse within which the notion of 'effectiveness' neglects (if not ignores) the importance of the management of emotions in the leader and followers.

Through the use of innovative research methods and data analysis, which take account of both conscious and unconscious processes through which leadership is socially constructed and exercised, the intrinsic complex connections between authority, power, emotion and leadership in the context of health care can begin to be disentangled.

Leadership that 'works' for an organisation such as the NHS is a multifaceted, emotional *process* in which leaders manoeuvre to manage their own and their followers' emotions and behaviours on both intellectual and emotional levels. To be effective in, what are now seen to be, postmodern organisational contexts, leaders also need to reflect upon themselves in their role and to understand the structural, cultural and emotional expressions of their authority and the authority and power of their followers. The legitimization of emotionally engaged leaders' authority supports effective service delivery across the different levels of the organisation through undermining conscious and unconscious resistance(s) as described in the examples above. Power as a coercive violence (see Foucault, 1982) has been exposed and undermined in such organisations and 'replaced' by concepts of 'distributed' leadership where the persistent claim to power is by definition and necessity more fluid.

8 Gender and Leadership

8.1 Introduction

Gender and leadership is an area that has attracted interest among policy makers and researchers, because the styles of leadership that are currently perceived to be the most effective, such as transformational and distributed, are believed to 'fit' more closely to 'feminine' styles of leadership. Fletcher (2004) notes that traditional 'heroic' leadership is usually associated with masculine traits (rather than men and women *per se*) such as individualism, control, assertiveness advocacy and domination, while 'post heroic leadership traits (such as empathy, community vulnerability, collaboration) are more associated with feminine traits. Ford (Ford, 2010) reconsiders the concept of *effective* leadership which is in fact a patriarchal model perpetuating an exclusionary and privileged view of the leader (metaphorically the 'father' figure).

Traditional research into gender, organisations power and leadership suggests that there are particular 'masculine' and 'feminine' leadership traits that are generally believed to characterise men and women's leadership styles (Rosener, 1990; Collinson and Hearn, 1994; Nicolson, 1996; Carless, 1998). Because women are widely believed to adopt a more democratic leadership style and men believed to adopt a more autocratic one, distributed leadership and concerted action in networked organisations may potentially be more conducive to those (women or men) who can adopt a more traditionally feminine relational style of leadership. Furthermore, feminine styles are more akin to displaying social and/or emotional intelligence (Guy & Newman, 2004; Leon, 2005).

In reality, both men and women display a variety of 'masculine' and 'feminine' leadership styles, depending upon their individual personality, age, position and the situation involved (Cross & Bagilhole, 2002; McDowell, 2001). However, gender *expectations* influence perceptions and beliefs and research suggests that subordinates are often more satisfied with leaders who behave in gender-typical ways than those who go against gender-type (Porter, 1992; Rosener, 1990; Williams, 1993).

Indeed, women in explicit leadership roles often tend to be viewed less positively than men, in the belief that 'masculine' traits (competition, authority, lack of emotion) conform more to expectations of how a 'leader' should behave but not how a woman should (cf. the work of Broverman et al. 1970). The 'paradox' it seems persists in contemporary organisations so that some women leaders feel they have to behave in a 'masculine' way which frequently makes them appear rather heavy-handed and/or as a 'bullying' because these behaviours do not fit with ideas about women (Eagly & Carli, 2003).

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Most of the women and (some) of the men we spoke to during the study, made a point of denying that gender was an issue in today's NHS, indicating that they believed that women and men were treated equally, with an equal chance of success. However, several participants also mentioned gender differences in the negotiation of power and identities describing how either women or men were likely to gain advantage through use of their gender-typed styles (Lewis, 2000; Schnurr, 2008; West, 1984).

Gender and leadership it seems remains a contradiction in people's minds but gender is a fundamental component of the discourses surrounding leadership in the NHS because of the demographic issues in clinical management and leadership (Evans, 1997; Gardiner & Tiggerman, 1999) and as we have shown in Chapters Four to Seven, role models and styles of leader/follower engagement have a major part to play in the transmission and exercise of leadership (Gill, Mills, Franzway, & Sharp, 2008; Greener, 2007).

We want to note here, partly in passing, although an example below (in the interview with 'Jeff')³⁴ demonstrates its importance - that the *researchers'* gender and physical appearance (age, ethnicity, attractiveness) also played an important role in the research process.

8.1.1 Senior women managers: 'we're all the same now'

Women in senior managerial and/or professional positions either deny that being a woman is an issue for them or for their organisation or that they know what they had to do to prevent being seen as a senior '*woman*', rather than a senior leader.

Denying the impact of your own gender on how you are seen and how you manage and lead is not an easy position to maintain and we observed some senior women working hard not to be seen as women even though at the same time they were arguing that *this behaviour was not necessary* because of the way 'things have changed'.

The researcher's observation of a senior female manager (Catherine) indicated that she thought that Catherine was trying to avoid being 'feminine' in her interactions. When the two interviewers were waiting to begin the interview, Catherine's PA came into the room with an important message but was shouted at in front of them. Thus in her notes one researcher judged that Catherine wanted:

....to indicate lack of interest and assume a position of superiority. Catherine was transgressing the boundaries of polite professional behaviour and attempting to define 'her' territory of the hospital. Answers to the

³⁴ Not his real name.

questions were also defensive, perhaps indicating a lack of self-assurance. Despite the tough exterior she obviously felt a need to stamp her authority on people in order to maintain control of the situation. This may partially be related to her gender and need to appear 'more masculine than the men' in a competitive environment.

The researcher following on from her observational notes with comments following the interview suggested that *"whilst she [Catherine] initially denied gender to be a relevant issue [for senior managers in the NHS], she then went on to make reference to 'testosterone' and 'the emotions of females' as problems in managing in her senior role".*

The relevant part of the interview transcript is below:

Q: Ok, so are men a problem? Are women a problem? Are there gender politics? Or am I just old fashioned there?

A: I don't think there are anymore, I think there were. I mean when I was appointed, I could have been one of [only] four [senior] women, so the whole senior management was very ... very 'suitish'. I don't think, no, I don't think it is a problem anymore. No, I think it is, if you talk to people in the north of England, they will say it's still a problem, and I think its a bit more of a problem to get females into acute trusts, big acute trusts, it's a bit of a climate difference. I think there's a lot less testosterone around now, there's a sort of slightly...erm I mean I've got quite a young male management team.

Q: Right

A: I find the testosterone and sort of challenges a bit much from time to time So I mean from that point of view, it is quite interesting, it does manifest itself. As do emotions of females really.

Catherine's somewhat aggressive, or at least uncompromising, behaviour witnessed by the researcher tended to soften after that and she added:

A; So I do think the answer to the question is that there are differences, but I don't think they're... they don't fundamentally affect how you do the job.

Vicki, a senior geriatrician, discussed the question of gender openly and at some length with the researcher who suggested that she had seen both Vicki and Mandy, another senior female consultant geriatrician, being very 'gentle' in their approach to patients and the researcher wanted to know how far this was linked to the fact they were women. Vicki thought though that their approach was not about gender but:

You know it could be a geriatrician thing, I don't know, ((1)) you know you'd automatically say 'it's oh because we're women', but I think it's only when you start following a few men around as well who are doing the specialty as we are, because the thing that attracts us to elderly care rather

than any other specialties in the first place, and that could simply be what you're observing.

It seemed important to Vicki that she was not stereotyped as a woman leader although she was keenly aware that as more women took up medicine and were arriving in senior positions that this demographic change would in some way impact on leadership.

So maybe that's where you've got to go as well as men in geriatrics you actually need to look at women in other specialties and follow them on a ward round and see what they do and that may be a good idea as well for the gender thing. But it's quite important for your study because at the end of the day we're training over 50% of women as doctors and in the future they think that almost all GPs will be women so that will affect the leadership and sort of, that you see in patient care.

So Vicki, while seeing feminine *characteristics* as more important in her clinical specialism than gender *per se*, still believes women doctors (e.g. GPs) will make different kinds of leaders from men.

During her shadowing of Mandy, the researcher noted what she identified as gender-typical behaviour:

Mandy also implements a mothering aspect to her leadership role (also noticed in Vicki) as she is always thoughtful and considerate to her followers, making sure they are comfortable and happy with decisions made and that they are up to speed with their medical knowledge. This mothering role also seeps into the delivery of patient care. Mandy is also a leader that appreciates the help of her followers and always thanks them for their input and help.

While keeping in mind that the researcher herself is making assumptions about what is a 'mothering' style and also recalling Vicki's assertion that it may be more to do with the kind of people who are attracted to geriatrics than gender itself, it is important to note that the researcher spent several days shadowing and observing female *and* male geriatricians. Further, she discussed reflexively what she saw and how she interpreted it with the research team to check out her observations.

8.1.2 Men: the 'natural' leaders?

The researcher who interviewed and observed Catherine also interviewed and observed Jeff (another non-clinical manager) and contrasted their styles of interaction with other people in the organisation, and with her, during the interview. At first Jeff seemed more approachable, relaxed and generally more amenable than Catherine had been:

Jeff was a newly appointed male senior manager. From the outset he displayed supreme confidence in his own authority and power as a 'leader'

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and obviously did not regard a young female researcher as a threat. He was very friendly and personable and happy to open up the space of the hospital for us, answering his own emails rather than through a secretary, coming to collect me personally from the main reception and chatting and joking all the way back to his office. Throughout the interview he showed confidence in his own opinions and was happy to talk in detail about both his own and others' leadership. This confidence may be a result of several factors such as position, age, class, gender or personality. He freely admitted that he did not mind appearing 'hard' or unpopular if it was necessary to get the job done, however he felt that his main asset was his own 'charm' and 'charisma'.

Thus Jeff firmly claimed his place within the (masculine) 'heroic' leadership tradition.

While Catherine was perceived as guarding her territory and demonstrating her power, Jeff appeared to be relaxed, being more approachable and particularly not hiding behind his PA. In fact, his account of himself in the interview was somewhat disarming.

Q And do you see yourself as a leader?

*A: Oh yes certainly. I can remember the time when I realised that I should be in management. I was working in a **** clinic in [a Trust] and it was so inefficiently run and I said as much to the manager. She said 'if you think you can do it better then why don't you manage?' So I said 'OK I will!' And I think I'm pretty damn good at it. I don't play by the rules, I don't have any formal qualifications, but I can get things done. I'm not perfect – I shout, I swear and mostly I'm just very, very cheeky, but I'm good with people and that's what you need in this job. You have to be tough too, take knock-backs and step on people to reach your targets. But mostly I care passionately about the patients. I would never ever chase a target if I didn't think it would improve patient care. So that's why I went into management, and I suppose the other thing is I discovered, I surprised myself actually about, I was going to say how easy it was, it wasn't easy, erm I had a natural aptitude to do it, you know it was something that I was successful in so you know yeah?*

Jeff wanted it made clear that the 'inefficient' manager was a woman and that he himself is 'good' with people (and on the surface the researcher acknowledged this). However, he also valued the tough, target-driven 'stepping on people' (masculine) qualities of his leadership which he believed were important in delivering patient care.

Jeff put his confidence and self-identified ability partly down to personality, but also to his gender and upbringing, adding that certain class backgrounds seem to 'breed' leaders:

I do think that great leaders are kind of born, but my background was that I was at all male public boarding school for 10 years. As my father said 'the biggest waste of money' given my academic erm qualifications at the end of it, erm and there was something there about you know that sort of environment. I mean does it grow leaders? You would think so, you look at the number of public schoolboys that end up as MPs, that's probably not a good analogy

Q:((Laughs))

A: But there is something about that kind of white middle class upper class upbringing that you have, and although I wasn't from that background before I went to the school, erm you learn survival among your peers, you learn I think to survive, you know if you think at the age of eight you are sent away you have to survive you haven't got your infrastructure.

It seems that Jeff is suggesting that leaders are either 'bred' or 'grown' but either way the influence that makes them a leader comes early in their lives. In the example he gives here, 'growing' takes place in a male-only context reinforced by social class, possibly wealth and a general sense of entitlement. This model does not echo the efforts and ambitions of the NHS in everyday practice nor would it appear to be in any way appropriate to the model proposed by the NHS (see Chapter One) which is focused on the type of leadership appropriate to managing and leading 'diversity' and 'difference'.

8.1.3 Gender wars?

Being motherly (like Vicki and Mandy) is not equivalent to being weak or compliant as perhaps some gender stereotypes might describe women (see for example Bem, 1993; Nicolson, 1996). During an observation of Mandy, the researcher identified what she considered to be a 'battle of the sexes':

Gender issues were brought into consideration during the interaction between Mandy, a female consultant and a male consultant. During this interaction a battle of the sexes and power occurred with the two consultants struggling for power in very different ways. The male consultant tried to assert his power through attempting to ignore Mandy's presence, never looking directly at her, but was raising his voice and being rude. On the other hand Mandy was always very polite, looked directly at him, spoke very softly and smiled a lot, although it was quite obvious that behind the soft smile was a vicious bite.

Perhaps this isn't so much a battle of the sexes but an example of how men and women might behave differently towards each other in the course of a power struggle. The detailed observation notes show the encounter move by move:

There are some territory issues with Patient 9 and Mandy is angry that there is a patient on her ward that is being treated by another doctor. She asks why the doctor has continued his care now that the patient has moved ward and suggests that if the doctor feels that he needs to continue with the patient's care then the patient should be kept on one of his wards rather than blocking a bed that could be used for one of her patients. She asks "why can't we look after this patient? We are not supposed to have any outliers on this ward!" Mandy's registrar Melvyn can not, or does not want to answer her questions and simply shakes his head and shrugs. Mandy says she needs to speak with the consultant and asks Melvyn who the patient is under. Melvyn gives the name and admits that he has seen him arrive on the ward a couple of minutes ago, so he should still be there.

Who is Melvyn afraid of here? Or is Melvyn simply not wanting to witness a battle over territory and patient care?

Mandy walks round the other side of the nurse's station to find the [male] consultant with three other doctors/medical students standing some distance away and his registrar to whom he is speaking. Mandy and 'our' group move over to his location and the junior doctors from both groups greet each other and share whispered conversations. Mandy stands patiently at the side of the registrar waiting to speak with the consultant. Although Mandy continues to smile pleasantly I think that she is angry or frustrated on two levels. First because the consultant is on her ward and hasn't come to speak to her and second, because he doesn't seem to have the manners to even acknowledge she is waiting. After the conversation between the consultant and registrar has finished the consultant turns his attention to his paper work and the registrar moves to be with the other doctors (some distance away) Mandy lifts her eyebrows up to Melvyn (clearly annoyed with the male consultant's behaviour) and then asks if she can speak to him about Patient 9. Mandy explains politely that they do not have outliers on this ward and therefore asks whether the patient could be moved to another ward or if this cannot be arranged she take over the care for the patient. While she speaks the consultant doesn't look at her and continues to write, his body language and behaviour are both arrogant and rude. The consultant says that the patient is his and he will not be passing the patient over as she has problems not solely aligned with geriatric care and that she needs a specialist. Although this was clearly a statement to undermine Mandy's capabilities she continues to smile and tell him that the patient will be moved before the weekend so that a patient needing specialist geriatric care can have a bed.

Moving through this detailed account the gender issue becomes obscured by the fact of Mandy's skill as a clinician, a leader, her concern to give appropriate care within a context of limited resources and her ability to handle herself in the face of rudeness and arrogance. These are skills that ensure she will shine through as a leader in any context but particularly one

which is still a man's world. In a socially or emotionally intelligent context where concerted action is seen as important, patience, politeness and clarity of purposes will eventually win out over arrogance and bluster. As we see in the next extract Mandy's 'opponent' does not possess these attributes.

The male consultant becomes angry and raises his voice to Mandy and says there is nowhere else for the patient to go. Mandy lowers her voice and says that the patient must have been on one of his wards before she was moved so she can move back. The other consultant looks swiftly at the group of doctors who are stood behind him (both his own and Mandy's) and then eyes me suspiciously before turning back to Mandy and speaking in a lowered voice. The conversation moves back and forth between Mandy and the other consultant and it is clear that despite his outbursts and undermining statements to Mandy that she has the upper hand and although she continues to smile, she is very forceful and strong in her argument and objectives. To conclude the whispered conversation Mandy raises her voice and tells the group that the patient will be transferred on Friday and that she will be getting a transfer set up straight away. She then thanks the other consultant for understanding and walks back round to the group with a smile on her face and asks Melvyn to set the transfer up.

This is a consummate example of patience, calm and the ability to lead doing what she considers to be the best for her patients, her team and her department. Her skills in continuing to be quiet, calm and smiling have 'seen off' the male consultant in the meantime but reading this it would be surprising if the humiliated man does not try to take revenge. Although there is very little evidence that this is anything other than a 'normal' power struggle it is the case that Mandy is in fact a woman and has played, what is mostly recognized to be, a feminine role.

Returning to male expressions of power it is important to be aware that blatant attacks, such as the one in the encounter above, are not necessarily the only ways of demonstrating confrontational masculinity.

It appeared from the interview with Jeff (discussed above) that he believed he did not need to defend himself in the face of gender stereotyping. He had strong opinions on women's leadership and also on women's 'availability' with no qualms about voicing these which contrasts strongly with women's accounts where they try to underplay gender, that is that many senior women take the view (overtly) that gender is irrelevant.

The researcher's notes about the meeting with Jeff continue describing a dramatic example:

Jeff's supreme confidence meant that whilst he came across well in an interview situation, he crossed boundaries of professionalism in other ways, telling unsuitable stories about staff and inviting me (researcher) out for a drink after the interview, invading my personal space. In the extract below

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he accuses a female colleague of not only being attracted to him, but trying to use her sexuality (unsuccessfully) to get ahead at work, whilst simultaneously flattering me that I am his 'type' by subsequently asking me to meet him for a drink.

And in the interview:

Q: And could you give me some examples of bad leadership that you've seen?

A: Well, Melanie Willson³⁵, have you met her?

Q: No I was meant to but she cancelled the interview three times...

A: Exactly, she probably thought she was too important to talk to you. Now I can tell you an interesting story about her. She's a good looking woman, stunning, very intelligent too. But there's something not quite right, I don't know what it is... really cold. She's got no soul. I appointed her as divisional manager and at first she was doing really well, but then she ran into some problems. She was failing in her job. And that's when she started to flirt outrageously with me. It was like she couldn't beat me intellectually so she was going to do it another way. But, well... she's not my type. And she was really jealous when I got this job, I had Lucy (PA) go and announce it at the morning meeting and you should have seen her face. Anyway I hear she's got a promotion now so she must be doing something right.

Melanie Willson clearly perplexed Jeff – 'stunning' but no 'soul'; 'flirting' to avoid being faced with 'failing' in her job; unable to beat Jeff 'intellectually' and resorting to using her sexual attractiveness. After stating that she was not his type (indicating that the flirting also failed) he then made another woman humiliate Melanie in a public context. The implication of her subsequent promotion being based on something other than ability was also a powerful 'aside'.

Discriminatory comments against women though are perhaps not that commonplace. Jeff's sense of 'entitlement' may be a dying one across most NHS organisations and it is certainly against all stated mores. Discrimination on the basis of gender is more opaque. The researcher interviewed Helen, a senior female consultant, and talked about gender and arrogance of male consultants. The researcher suggested:

... this was possibly seeing me as an ally as a young female professional. In addition to the immediately obvious behavioural differences between women and men she also mentioned unseen discrimination in the form of merit awards at senior levels and problems of combining work and family commitments which may mean female staff are less likely to achieve these.

³⁵ Not her real name.

In the interview Helen responded:

Q: Do you think there are any gender differences in leadership that you have noticed?

A: Yeah, yeah I think, I think so, erm you know the men are more well, can I, the men are less inclusive of a group and they have ((1)) already formed an opinion sometimes and before listening, erm, ((1)) err ((1)) yeah.

Q: Yeah ((laughs))

A: Need I say more ((laughs))? But I think there is a difference ...Competitive, that's what I was saying, there's that competition, yeah competitive, exactly ...Of course not but the insight is very, very small, and then those meetings go on and on and on and it's people trying to get one up on another so... I just want to leave. It's handy having a beep you know you can say 'oh, I've got to be off (laughs)'.

The suggestion here is that men are apt to waste time on each other and power struggles and that for them competition is central to their 'nature'.

8.2 Conclusions

Despite the increased numbers of women who have reached senior leadership positions in the NHS, both as senior managers (clinical and non-clinical) and as senior clinicians *per se*, there were nonetheless some interesting differences between women and men's self-descriptions and perceptions of others as leaders, sometimes made on the basis of gender alone (Gill et al., 2008). Descriptions given of leaders and leadership for members of the 'other' sex were also frequently gender-typed.

It may be that despite valiant and frequently effective attempts to change the culture of NHS Trusts that a 'traditional' view of leadership remains at least in the organisational 'memory'. This might go some way to explaining why women who are clearly powerful and influential are reluctant to identify themselves as taking up these more 'feminine' styles even though they may in fact use the skills associated with these qualities. Eagly and Carli (2003) make a case for women as having a leadership 'advantage' in contemporary organisations where the type of leadership required has changed. However, they argue that in many cases women have to battle against the inherent prejudices in male dominated organisations. Although there is still a reference to gender stereotypes when discussing gender in organisations and gender and leadership as we have seen from the extracts above in this chapter, as Rosener (1990) stated: "*Women managers who have broken the glass ceiling in medium-sized, non-traditional organisations have proven that effective leaders don't come from one mould*" (p. 119).

In Chapter Five the OCS revealed that women across all professions scored lower than men on 'recognition' in that they perceived their managers as

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not recognising their particular attributes as clinicians or managers and they also perceived that the organisational climate was one in which 'recognition' was more likely to be given to men than women. That men did not see this as a problem for them reinforces the view that regardless of trying to establish gender equality across NHS organisations it is still not embedded in the management culture.

As we have seen and has been well documented in the literature, it remains difficult for women to exercise leadership without their behaviours being construed as either 'weak' or 'aggressive'. The paradox is that leadership requiring more 'feminine' characteristics is at least explicitly more desirable in the contemporary NHS.

9 Patient Care, Leadership and Service Delivery

9.1 Introduction

The NHS has a history of reform/modernisation aimed at making patient choice and care more cost and clinically effective by improving the organisational structures through which care is delivered (Bate & Robert, 2002; Becher & Chassin, 2001; Darzi, 2008; Wilson, 2009) .

The NHS remains committed to its original aims of providing a cost and clinically effective patient care (Doherty, 2009; Phillips, 2005), at least partially through the NHS's organisational structures, including the gate keeping function of primary care, while providing a universal service free at the point of delivery. Since the 1990s patient choice has been added to the longer term commitment to efficiency (Bhandari & Naudeer, 2008; Bojke, Gravelle, Hassell, & Whittington, 2004; Bryan, Gill, Greenfield, Gutridge, & Marshall, 2006). And at the same time there has been an explosion in new diagnostic and therapeutic technologies accompanied by a public awareness of the availability, or lack of availability, of those technologies (Aberbach & Christensen, 2005; Greener & Powell, 2003; Mueller, Sillince, Harvey, & Howorth, 2004a).

In this chapter we particularly address:

- what respondents (staff and patients) say about patient care and service delivery based on the interviews and focus groups;

- what we *observed* about service delivery and patient care and particularly the *interactions* between clinical staff and patients *observed* and *described* during the shadowing.

As in Chapter Six the Trusts are conceptualised as open systems whereby high quality patient care (the input) corresponds with effective service delivery (the output) with the primary task defined as caring for sick patients (or those who are giving birth).

9.2 Defining patient care and service delivery

The thematic analysis highlights similarities across all grades, statuses and disciplines of the staff and the patients involved in the study. The themes that emerged consistently from the data that were about good patient care were:

1. Putting the patient first:

...of course patients do come first but actually really, on everything that you do, I mean everything you do you think of the patients (service manager in acute medicine).

2. Thinking about what is good for the patient (all the time):

I still believe and I believe to this day that if you absolutely concentrate on what the patients' needs are, all other things take care of themselves. it's about really showing that you care. I mean genuinely showing that you care about your patients, erm there's a lot of talk about also looking after your staff and caring for your staff. I think that's important but I think the health service has got itself stuck far too many times concentrating on the needs of the staff and not the patients (Chief Operating Officer).

I think that's what you have to make sure is that everyday you are thinking to yourself, 'am I doing this for the good for the patient?' 'is it the right way to do it?' so I think when you get eleven years down the line, one of the things is that you can loose sight of is that, very easily (Matron).

3. Awareness of the diversity in the patient's world (culture, family, age, home and work environments):

..it would be making sure older patients have high quality of care during their surgical admission (senior consultant Geriatrician).

you need to support your staff ... you know and you have to have an awareness of the different culture of the patients (administrator).

4. Making sure the patient received the care that staff would expect for themselves and their relatives:

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I would define patient care that of - if it was one of my relatives who were ill (senior manager).

5. Talking to patients about what has happened, their medical history and their clinical condition:

....if they talk to you one-on-one and you know where you're at (patient).

6. Safety and empowerment of patients:

They [the multidisciplinary care of the elderly team] believe that good patient care sits around ideas of timely discharges, safety, making sure the patient understands their condition and their treatment, empowering patients by allowing them to make their own decisions about their care (to a point), providing the appropriate treatment and care, being responsible for the patient. Examples of bad patient care are viewed as delayed discharges, poor decision making and discontinuous care. (Notes from an observation of a team meeting).

From the descriptions it is clear (and perhaps no surprise) that senior managers, clinicians and patients all hold slightly different perceptions which inform their judgements to give 'patient care' a specific meaning. Some of the judgements are related to their particular clinical specialty or organisational responsibility although generally respondents reiterated that patients need to be at the centre of daily practices. Patients in all cases wanted more than anything to be kept informed about their care, and if possible this should be done by the clinician in charge.

At a more complex level the definitions above reveal a 'vision' of good patient care which links the 'practical', 'professional' and 'political' elements of NHS life. It also links to the 'human' elements associated with the tasks of caring. For example, the Matron (quoted above) shows a revealing insight that the routine *organisational* tasks might take over as a perceived priority from what a person initially knew to be their primary task (i.e. patient care). As she says, several years down the line you might lose sight of what you are really there to do.

9.3 How is good patient care achieved?

9.3.1 Managers

Managers each have different levels of responsibility for delivering good patient care which may differ from priorities expressed by patients and clinicians:

Erm, that's the bit about lifting your eyes up off of the horizon, and lifting the eyes up above the horizon is about looking at the totality because the

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medical, again, the medical management model is very much that you should do what you need to do when the patient is in front of you. The management model, the pure management model is about doing the right thing for the 450,000 patients who were looked after last year, so some of that will be about compromising, and offering the best care to the widest group that you can (CEO).

Immediately this respondent exposes the potential for conflict at senior level in that he/she³⁶ positions the 'medical management model' differently from the 'pure management model'. In the former the patient is a particular individual with a health care problem – the patient 'in front of you'. However for senior management there are many thousands of patients that require good patient care which means (maybe) compromising to provide the best possible care to the greatest number. Despite this, another senior manager had a different 'take' upon good patient care and in answering the question focuses on what they themselves would expect evoking a more individualised model:

I would want good consultant input into my care ((1)) as soon as it was appropriate in the pathway that I was on. I would want to be able to have a conversation about what was wrong with me and what treatments and options there were, ((1)) erm ((1)). I would want the assurances of the people that deliver the care know what they are doing. ((1)) I would want the care to be provided in an environment that was clean and in an ideal world I would want a single ensuite room, err and I would like to choose my own food and all that jazz. ((1)) erm and the erm, ((2)) so really you want the environment to be correct and you want to have the confidence in the clinicians giving care and you want to have had input into what your care should have been (Senior Manager.)

This manager has a very clear model of their 'ideal type' which positions the relationship between the patient and clinician, the skills/expertise of the clinician and the physical space and environment as central to good care. There is awareness here that planning and teamwork are also part of the process of care but particularly important is the knowledge of how to deliver the appropriate care and information in order to facilitate joint decision-making.

³⁶ We do not want to risk identification of any individual participant.

9.3.2 Clinicians

Good quality patient care for most doctors interviewed was:

... making sure that erm the patient achieves the outcome that you would wish them to as a result of either their outpatient visit or their inpatient stay erm and that outcome is kind of on a objective kind of medical measure, erm but it's also in terms of the quality of the care that they've received and whether they are satisfied with the care that they've received. (Senior consultant)

Another senior consultant who is also on the senior management team of the Trust took the concept of patient care further:

... it should be delivered well I think is the answer ((laughs)). I think on the whole we do deliver it well, we have the lowest mortality rate in the country, ((1)) or one of them. I think we do actually and we ((1)) I'm very proud of the care and I think there are two things to be proud of and one is the basic care and ... we do emergency work I am very proud of. Then the other bit of care we're proud of is that ... I think there is a real culture of innovation and I'm trying to do something new up here, and I think that's actually really important in terms of leadership. My job is being able to see a clinician with an idea and then work out of him or her how to turn that idea into a self service innovation. I think that we have created over the last few years a much stronger patient safety culture.

This respondent clearly links leadership and patient care stressing both the relationship between supporting other clinicians in innovations that improve care (particularly attending to safety) while also being proud of the culture across the Trust for low mortality, innovation, and supporting staff. Crucially there is a pride and energy about this account. The culture puts patients first but the staff gain satisfaction and a sense of professional pride from the performance of the Trust as a whole [T3].

The clinician manager below takes up the relationship between staff empowerment (and support which links clearly to the outcomes reported in Chapter Five) and returns us to the focus on staff training and skills, indicating here that if the managers train and empower staff – services to patients will improve.

... it's about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is, we worked with training and development and we came up with a specific programme that was aimed at empowering them to improve their service area etc. etc. and

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also provided them with some skill sets that they probably didn't have prior to that. (Senior Manager, Therapies)

While from a similar perspective the nurse quoted below stresses that team work and morale mark the path towards good patient care and you need to look after *staff* in order to deliver a good service to patients.

... And I think it is also, sort of, taking into account the people they work with, the team members and boost the morale, and that can make a lot of difference to, you know, to have people at work and sort of take the stress levels off and I think, you know, it would sort of, quality certainly would happen, sort of energise them, able to care for the patient. (Nurse, focus group)

9.3.3 Patients

For patients overall it was clear that most of all direct communication and consistency of staff was experienced to be good care:

A: ... I've been transferred here from [another Trust] and there it's a bit more, not one-to-one but you see a lot of different doctors here whilst there [the other Trust] you have only one doctor, your one midwife and your one consultant. Here you see a lot of different people.

Q: And which one do you prefer?

A: I'd say probably just to see the one 'cause lots people tell you different things.

Q: Okay, so it can be a bit confusing?

A: Yeah, sometimes it can be, yeah.

The patient quoted below reinforces the need for clear patient/clinician contact and communication.

For another woman:

Now whilst I'm here my care has been very good especially with the [specialist] who first saw erm, who first flagged up the problem. Erm yep it's been good it's been good since I've been in. It's just the initial communication as an outpatient to an inpatient I should have really - you know that should have been. I don't know where the fault lies but there should have been some communication there between the appropriate people (Maternity patient on postnatal ward).

9.4 Delivering patient care

9.4.1 Doctor-patient interactions

We look firstly at three consultants' (Cameron, Kenneth and Henry) styles across two different Trusts as they interact with patients to explore the importance (or otherwise) of good communication and engagement. What emerges, perhaps unsurprisingly, is that different consultants have different styles of engaging. The style adopted though feeds through to the 'ethos' of the clinical team, relates to, and impacts upon, the culture of the Unit thus affecting the doctor-patient interactions as part of an evolutionary cycle.

9.4.2 Empathy and Communication

9.4.2.1 'Cameron'

From the researcher's notes we gain an impression of Cameron who deals mostly with stroke patients for whom verbal and non-verbal communication may be very restricted:

Cameron offers a very personal and individualised style of patient care to his patients. He is often very tactile often rubbing the tops of their hands, arms and heads to encourage them or to show support when he is discussing difficult problems with them such as their inability to go home, the definition of a stroke and the future impacts of them having a stroke. He also speaks to the patients in a very friendly and informal way and sometimes draws on their mother tongue to say a few phrases to make them feel welcome and at ease.

In his interactions with his patients he is very positive and upbeat, often speaking loudly to encourage and motivate his patients. He also tries to share a few jokes with them and breaks down doctor/patient power relationships by crouching down in front of his patients or sitting on a chair or their bed so that he is always the same height or lower.

This description alone demonstrates how Cameron's *behaviour* relates to several of the descriptions above which identify good patient care in that he:

- communicates (verbally and physically)
- takes care to acknowledge their humanity through recognition of their cultural (linguistic) heritages the fact that they have a life outside the hospital
- attempts to empower them within the relationship (at least via discussion and physical presence and to an extent with knowledge of their condition).

Below is a detailed example of Cameron (and his team's) encounter with an elderly stroke patient (Mrs. D) which is part of the evidence the researcher has employed for her assessment of the processes engaged by Cameron in his provision of patient care:

"Hello Mrs. D? (Patient nods head and smiles) do you have a headache? (Patient nods head) Do you know why? (patient shakes her head staring wide eyed at B). "OK, I'll tell you..." Cameron sits on the edge of the patient's bed and explains that she has had a stroke and she has a headache because sometimes patients who have had strokes will have suffered from headaches due to pressures on the brain. The patient stares and nods her head occasionally as Cameron explains. "Mrs. D, do you understand what I have just told you?" (patient nods her head and then croaks "yes") on this speech Cameron sounds surprised and encourages her to speak again "Oh wow Mrs. D, that sounded good, can you say something else for me?...well done". The patient looks up at the doctor and smiles croaking again "I don't have anything to say doctor", "well never mind Mrs. D, I am sure I can get something out you a bit later!...excellent, your voice seems to be coming back...isn't that good?. We will have you singing in no time!" (Mrs. D. smiles and shakes her head "can't sing" Cameron smiles and laughs.

Despite the clear power differentials, doctor/patient and healthy/unhealthy, in this relationship Cameron is doing what he can to encourage and communicate effectively with the patient. Not only does he literally get down to her level by sitting on the bed but he explains the condition, how it happened and communicates the indicators for (potential) recovery. He is respectful and careful although the intellectual/cultural difference between the patient, Cameron and the care team is exposed by the encounters below.

"Now Mrs. D. can I examine you?" (Patient nods her head) Cameron takes the patients hand and she flinches "cold!" Cameron smiles and apologies saying it that "it is the alcohol" (alcohol gel he had just rubbed into his hand). The patient eyes Cameron suspiciously "have you been drinking?" the group laugh and Cameron explains that it is the hand-wash and she nods slowly and looks at each member of the team for what seems confirmation that this is the truth. Cameron then begins testing the patient's strength. He checks her arms and then her legs with simple strength tests calling out numbers between 1-5 for the SHO to write in the notes. As he instructs the patient with her tests he speaks very slowly and loudly and the instructions are very simple and clear and he often demonstrated his instructions, especially for those patients that have cognition problems. As the patient does the task Cameron is very encouraging shouting words such as "good", "excellent" or "well done after

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each task". After the strength tests Cameron checks the patient's reflexes with a small hammer. Again he shouts out numbers and makes comments about the reflexes that the SHO writes down in the notes. Following the reflexes Cameron checks the patient's facial muscles by asking the patient to smile, grit their teeth, stick out their tongues and move them about. He then checks her speech by asking her to repeat phrases or noises after him. The first phrases or groups of words were given as words that would be familiar to the patient such as the patient's name or names of simple objects such as pens. As the patient is able to say these words he moves on to more complex words such as "hippopotamus" which the patient struggles with. Cameron then checks the patient's ability to co-ordinate by getting the patient to touch her nose and then his finger with her index finger. The patient clearly struggles with this and is very slow and inaccurate.

For a brief moment after the tests Cameron has a quick discussion with L [another doctor] asking him what he thought about the tests and what they would expect to see on the CT scan. Cameron then turns to the patient and says "sorry Mrs. D, just discussing your test results with my colleague, we think that you are progressing very well...there has been much improvement hasn't there?" the patient stares blankly at Cameron for a brief moment before shaking her head "no, you don't think so? Now what about your speech, when you first arrived you couldn't say a word, now listen to you, don't you think you have improved?" patient shrugs her shoulders and looks down at the bed. "Well Mrs. D, we all think you are improving...so well done..." patient looks up and smiles sadly.

The style of meetings between clinical staff and patients was as much a feature of *Unit and team culture* as of a particular clinician's practices. Thus, while Cameron above was engaging with the patient in what appeared to be a *genuinely caring* manner, his colleagues were attentive, while in the background.

9.4.2.2 'Kenneth' and 'Henry'

In what follows two consultants worked together and while Kenneth was the more senior and experienced clinically, Henry held a senior managerial role (as well as being a senior consultant). Kenneth was described by the researcher as:

... a very warm and caring man ... he is very sweet, kind and caring to his patients and makes them feel comfortable and less vulnerable by empathising with them and drawing on his own personal experiences as a patient.

As with Cameron above, Kenneth was also described as 'tactile' and that he took the time to explain things to patients. Kenneth empathised with patients by sharing a joke (as did Cameron):

For example one lady was embarrassed because she had fallen down in her flat and sustained injuries and did not really want to explain how she had fallen over or what she had hurt [to the whole team]. Kenneth then told the patient that he had slipped over in the hospital and in the M&S food section. This meant that she no longer kept quiet through embarrassment and told Kenneth after that exactly what had happened.

However, during the two day shadowing of Kenneth the researcher was particularly:

...struck by how intimidating this group of doctors must be to the patient, especially an elderly or vulnerable patient as a large group of faces arrive at their bedside and close the curtains around them making the space feel incredibly claustrophobic and that the patient's space felt 'invaded'.

While shadowing Kenneth, the researcher was in a position to observe Henry (who was also shadowed for two days on a different occasion). The researcher's notes here, which describe a joint ward round with Kenneth and Henry, state:

I was struck by how impersonal Henry was towards the patients [in direct contrast to Kenneth]. He did not greet them or introduce himself. [In one case] Instead of asking the patient how she was getting on with the oxygen machine Henry asks the SHO how she thought the patient was getting on with the machine. When the patient tried to give reasons they seemed irrelevant to Henry who just told her she must use her oxygen machine every day or she will not get better.

The researcher goes on to describe how Kenneth (the senior clinical consultant although Henry has a senior leadership role) stands quietly behind the junior doctors on the round with Henry at the front of the group talking to the patient. Henry stands up. Kenneth stands at the back of the group with his hands folded behind his back and Henry every so often asks Kenneth if he agrees with Henry's thoughts on the patient's health status and treatment. While Henry is taking the lead in this way the researcher notes:

Not one of the doctors explains to the patients what will be happening to them that day or beyond nor do any of them say goodbye.

One patient on Henry's round is in the bathroom as the team arrive at her bed.

Henry knocks on the door of the bathroom and says "Mrs. X, it's Dr. Henry we are all here to see you". He then asks a nurse if she can hurry the patient along as he is very busy. It seemed strange [to the researcher] that Henry could not have just visited another patient until this patient had finished rather than rushing her. Before the nurse can enter the bathroom another nurse pokes her head out from behind the door and says that she is washing the patient. Henry asks whether this could be finished after he has seen her. The nurse, who looks frustrated, says she will be a minute. The nurse then helps the elderly lady to shuffle to her chair and helps her sit down. Without greeting the patient Henry begins talking over the patient's bed about her X-ray that was taken yesterday and then asks the nurse about the patient's progress.

In the examples above describing both Cameron and Kenneth's interactions with patients there is evidence that the patients were given a chance to explain to their consultant how they felt and either to tell the doctor what had happened to them or to hear the doctor's explanation of why they felt like they did.

The patients were treated in both these examples as human beings and in doing so the doctors themselves positioned themselves in their *clinical role* but also as *people occupying that role*. By acknowledging mutual humanity (albeit in different styles) these doctors were able to *take authority* from their position as medical experts (see Chapter Seven above).

By contrast Henry also took authority but did this by silencing junior colleagues, Kenneth his fellow consultant and most importantly, the patients. While Kenneth and Henry were in the same Unit, the scenario described above suggests that Henry held more power and therefore exercised greater influence on junior colleagues (and this fed into the culture of the Trust).

In what follows we trace how these contrasting styles might link to the culture of the Units and the teams themselves and consider how this fits in with the definitions of good patient care and service delivery.

9.5 Clinical team work and service delivery

9.5.1 Giving patients care

Miller and Gwynne (1972) suggested that a 'warehousing' model of care operates for those who may be institutionalised in the medium to long term which they contrast with the possibility of a 'horticultural' model of care, akin to what might be identified today as a learning environment. Working in the care of the elderly takes its toll on the emotions of all the clinical staff

particularly in the 'horticultural'/learning setting, where efforts are made to ensure two-way communication and mutual understanding and development takes place. This can leave clinical staff open to experiencing directly the pain and distress experienced by their patients (see Menzies-Lyth, 1960 and the 'stories' below).

The following example demonstrates how engagement between clinicians and patients impacts emotionally upon even (and possibly especially) senior experienced staff. The researcher here, shadowing Mandy, a female senior consultant describes the following case:

Whilst cleaning up a suppurating wound an elderly male patient cried. It was a really touching and sad moment and Mandy was clearly distressed that she had hurt the man. On first seeing him cry Mandy appeared to have a moment of shock/panic where she looked amongst her team to find out whether this was normal behaviour for this patient. On hearing the answer was 'no' Mandy tried to soothe the patient and seemed genuinely sorry for hurting him. The nurse who arrived at the scene also appears to be genuinely concerned about the patient and goes over to help Mandy and prevent the patient from crying. This scene was particularly sad because in today's society and especially in the patient's generation it is thought that men don't cry or show emotion. For the man to cry he must have been in severe pain and must have been struggling with himself to prevent the tears. Mandy's genuine empathy and somewhat guilt might have reflected that.

Mandy and the nurse in this context are using emotional intelligence (see Chapter One) in a relevant situation. Mandy also engages in conjoint action with the nurse rather than take action in an autocratic fashion without consultation. Mandy notes the patient's crying with a start (according to the description) and instead of continuing with the work on the wound (which many doctors might well do because it was necessary for a positive health outcome) she immediately appears to take in the context as a whole – thinking about her patient's behaviour and reactions. The nurse in this case mirrors the behaviour of the consultant. This is an important issue for discussions of leadership and patient care in that teams tend to reflect the beliefs and actions of their leaders.

9.5.2 Discussing patient care

In a shadowing the researcher at the start of the observation describes in detail the way two doctors discussed the patients before embarking on the ward round. This is another case of concerted action:

09:00 Breakfast meeting with Cameron [T3]

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Once they have consumed their breakfast Cameron and Mandy turn to business. Cameron begins by asking Mandy's opinion on one of the patients that they had seen on the ward round that morning. They chat for a couple of minutes about the patient before both getting a patient list out and going through the names systematically and discussing their care plan for each patient. Several patients will need to be discussed in a patient case meeting as they have complex discharge problems, others will need to be referred to the CCP so that a greater social package will be considered. Mandy says that she will go and see a few of the patients herself later and occasionally delegates tasks to do for Cameron, but mostly he is autonomous and says what he needs to do for a patient and what he will organise on behalf of the patient.

This is a quiet and supportive meeting between Mandy the senior consultant and Cameron the more junior member of the team. However, the researcher notes the systematic discussion of the patients and their care along with a plan about who Mandy will see and how Cameron's tasks are designated.

A similar atmosphere of calm and authority are evoked by the description of a case meeting with Cameron's team at the start of the first day of shadowing:

I approach the nurse's station and look around to see if I can see Cameron. I spot him at the far end of the ward sat at a computer with a mixed group of staff (doctors, nurses) surrounding him. I approach the group and stand amongst them. Cameron is facing the computer screen and discusses a CT scan with his registrar [L].I notice that as these two doctors discuss the scan a SHO writes notes in the patient's file occasionally craning his neck to look at the scan at certain parts of the discussion. A few nurses also crane their necks at various points but most just stand patiently in silence waiting to visit the patient. Once the discussion draws to a close Cameron turns his head from the computer and asks the team if they have anything to add. ...[later on in the same meeting the researcher listens to a telephone conversation] ...Cameron has rung the wife of a patient to update her on her husband's health. He is very honest with the wife saying that her husband has had a second stroke during the night at that he is now in worse health. Despite the bad news Cameron is very friendly and pleasant with the relative and is very sympathetic to her questions and on several occasions empathises with her. Coming off the phone Cameron returns to the team and gives a brief update to L regarding the conversation with the patient's wife. The SHO writes this summary in the notes. Cameron takes a short sharp breath before asking "shall we go and visit the patient?" Cameron turns quickly on his heels and enters the ward.

The observation here reveals the high workload and 'multi-tasking' undertaken by the team (looking at the computer, discussing scans, taking notes, calling relatives and so on). But there seems to be focused attention on patient care and individual patients. At the end of this extract it also seems that Cameron himself takes the ward rounds very seriously – gathering his mind together and possibly seeking the emotional strength to move from the clinical team and considering evidence from notes and colleagues to imparting and collecting information from the patients.

The same researcher who has shadowed both Kenneth and Henry at a different Trust from Cameron, gives examples of how some of Henry's patients are discussed. For example she describes a meeting to discuss patients chaired by Henry.

Henry criticises the way [Site B] is run and the management of beds and patients by that hospital. He praises the doctors for the current situation on [Site A] where they have spare beds stating that they have done so well in 'kicking them out'. Henry stated during [a previous meeting] that the patients needed to be removed or 'kicked out' of hospital as soon as possible. The rapid turnover of patients may on the surface appear that they are not receiving good care However getting patients home quickly reduces the risk of hospital acquired infections.

And is likely also to be what many patients would want.

As the researcher makes clear, it is important not to confuse the rhetoric with the quality of patient care, but rhetoric does determine and reflect a dominant ward or Unit culture.

9.6 Responsibility for patient care

Responsibility was a key element of the discussions of leadership particularly in Chapters Four and Five. Responsibility for individual patient care is in the hands of clinical teams led by the medical consultant but above that person is the clinical leadership/management (Clinical and Medical Directors) as well as the senior operational managers (CEO and COO and others).

Primary responsibilities for patient care however vary from *individual care* i.e. for both identifying care pathways and day-to-day care to responsibility overall for the care of all the patients. In Chapter Ten we review the findings from this study with some recent cases where responsibility has been mishandled to explore what lessons might be learnt.

In an interview with a consultant:

... we try to just have a really open forum where we can discuss that [specific patient care], just like open it up and letting people put their viewpoints first and then kind of trying to question where they're coming from with that in a positive kind of way but then also laying out where you feel that that might not be the right course of action. Erm and also at the end of that discussion making sure that everyone is happy with the outcome, and sometimes people aren't erm .. but it also realising that it is a consultant's responsibility at the end of the day and making sure that everyone knows that you're happy making that kind of decision and that you are happy to be made accountable for that decision.

9.6.1 Responsibility for emotion

It frequently falls on the clinical leader to cope with their own, the patient's and the relatives' emotional reactions and distress and also with those of the other members of the team. As the researcher noted:

One senior consultant, Tricia, made it clear that as the clinical lead she also took responsibility for talking to patients about DNR³⁷ forms and delivering 'bad news' to patients/ relatives. During the ward round Tricia removed the pressure from a junior member of the team who had been told by a relative that they didn't want their mother to be resuscitated. Being told this information had stressed out this junior member of the team as he was not yet ready for this type of responsibility. Tricia supports her junior colleague saying that he should have never been confronted with this situation.

One question here then is how do the clinical team handle such multi-layered emotional problems? How important is leadership in supporting (and developing) teams to cope?

9.6.2 Responsibility for teaching

Most clinicians in the study from all disciplines were interested in teaching the next generation, and their activities will influence patient care, provide role models for leadership and influence climate and culture of the organisation. The example below is chosen because Dr. Jenkins was very enthusiastic but also demonstrated compassion and courtesy when he was face to face with the patients. The researcher's notes describe this in detail:

Approaching the patient Dr. Jenkins shakes the patients hand and says "how are we doing today?...I see you were referred by your GP...you have a

³⁷ Do not resuscitate.

wonderful GP" (he comments on how wonderfully clear and precise the notes are). "That's not my GP, that's my missus's GP, mine's on holiday...I have Dr. U. U". "What a name! But looks like they have to wonderful GPs at your practice...the notes are seamless...you are lucky!" Jenkins then continues to ask the patient about his medical history. The patient is able to tell the doctor his entire medical in great detail including the drugs [more description from the researcher]. Dr. Jenkins stops the patient and asks the medical student to take a mental note of how a good GP leads to a well informed patient, which helps him (Jenkins) in his (patient's) treatment. He talks about 'aspects of professionalism' and the right ways of informing patients about their treatment and condition, he openly praises the patient for knowing so much about his patient history and tells the students that "medical history in patient care is so important". The patient begins talking about his treatment in the hospital and Dr. Jenkins states that "patient feedback is great, and they like to hear about it...we need to be more professional...primary care pathways are the key to patient care".

Dr. Jenkins behaves with humour towards the patients and the students and junior doctors but does so while continuing with his assessment of the patient, taking the relevant history and trying to impart good practice and professionalism. He manages to balance giving the students and junior a chance to gain hands-on experience while making sure he himself has all the information he needs for the care of the patient.

Dr. Jenkins then checks the patient's lungs and heart asking a SHO, Dr. Williams to check the cardiogram as he can hear an AF flutter. As Dr. Williams looks for the chart the patient tells him that his GP had thought the same and that is why he was thinking of changing his drugs. Dr. Jenkins looks at the students and says "wonderful isn't he?" he continues that the GP must have heard or felt it himself [the heart condition] and now they will need to see the chart to prove it then they can change the drugs as the GP had predicted. After looking at the chart Dr. Jenkins asks Dr. Williams to change the drugs and to get rid of one of the drugs he thinks are unnecessary. Dr Jenkins shakes the patients hand when he leaves and says that one of the juniors will be back later to sign off the new drugs.

Looking over the notes Dr Jenkins spends a lot of time teaching the [medical] students about various medical conditions and treatments that have arisen out of [a particular] patient and asks them to suggest other possible diagnosis and other treatments for his condition. Jenkins is a very enthusiastic teacher and the enthusiasm rubs off on the students who are all eager to share their knowledge and take stabs at questions they don't know. In the middle of the question and answer session he asks one of the students "what year are you in? I don't know how much you guys know already". The student base is a mixture from students from [different

schools] and he relishes the opportunity to teach the students some new medical knowledge. Whilst getting the students to look at the cardiogram he looks up and apologises to Irene [matron] for taking so long on his ward round "Sorry Irene, I will be here all day, this is such a pleasure to have students!" Concluding the teaching session he quotes someone for saying something about the health of gamblers and drinkers and then asks "now who said that?" the students look round each other and then he exclaims "me mother!" all the students laugh including the female registrar and Irene. He then ushers them onto the ward saying that he doesn't want to get in trouble with the matron.

9.6.3 Subverting responsibility

There are diverse ways that staff at both Trusts had for coping with emotional aspects of patient care and resisting authority (and thus taking responsibility for care into their own hands). One way that nurses (including senior nurses) operated was to *subvert* some of the doctors – particularly when the relevant doctors showed little interest. The shadowing of a senior nurse [Irene, the matron] during a ward round produced the case of Lola (described when shadowing Irene):

Irene tells me it is because many of the patients are elderly with complex cases and therefore they tend to stay for a long time. I note that one of the patients has been here for a long time and I ask whether due to the long length of stay on the wards whether she becomes attached to any of the patients, I point particularly to the patient who had been here for three months. Irene says, 'oh that's Lola, mmm has she been here 3 months?...let me check her notes'. Irene leaves the file that she is reading and picks up Lola's file and looks at the admissions page and then states (sounding surprised). That three months is correct. She then continues that she does find herself getting attached to her patients, especially if they have been here as long as Lola. She mentions that Lola should really have been moved to G Ward but she really doesn't want to move her 'she should be elsewhere, but she is ours' (highlighting emotional attachment and the sense of ownership over patients). She tells me that Lola is really sweet and all the nurses really like her and it would be quite strange if she was no longer on the ward as she is a returning patient and 'it is always nice to have her back'.

As we have suggested in Chapter One (and witnessed above), in order to protect one's self against anxiety clinical staff often 'split' patients into 'good' and 'bad'. Here the treatment of Lola indicates that the nurses may be using their care of her to defend themselves against some of the harsh treatment decisions made about other patients (by doctors and managers) particularly when there is pressure to discharge older patients due to bed

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shortages. This might lead them to consciously and unconsciously subvert these authorities when they can and there is a particular pleasure to be gained when they succeed in this 'subversion' with a 'good' patient such as Lola. What remains at stake is whether Lola's stay is actually benefitting her clinically (or even socially) and also whether it is preventing another patient receiving medical care.

9.6.4 Responsibility for end of life decisions

Responsibility for patient care resides not only with the clinical team but is sometimes shared between the team, the patient or the patient's closest relatives which is usually the case with end of life decisions. Sometimes the greatest emotional engagement is with the *relatives* of the patient rather than the patient themselves. This is particularly the case when the patient is likely to die which is particularly sensitive when it is a case of withdrawing life support. The following example of Cameron's Patient G and his daughter brings this into sharp focus.

The biggest emotional situation this day surrounded Patient G, a coma patient and his daughter. Cameron had to encourage the daughter to agree with his plan that her father's treatment should cease and palliative care take over. This is a very emotional situation especially due to the young girl's age but also because she was in 'denial' asserting that her father would get better and this caused her to present a whole range of emotions that Cameron had to deal with.

We enter the side room. The blinds are drawn causing the room to be quite dim. There is a young girl sat up right on a make-shift bed that she has made from four visitor chairs from the lounge. She has a blanket over her legs and is typing on her lap top her mobile phone ear phones in her ears and bags and other items are scattered around her chair. She looks up as we enter and pulls the ear phones from her ears. I am surprised at how young she is, I had expected a daughter of forty something not a teenager of 18 perhaps, but no more than twenty. She pulls the covers off her legs and places her lap top on the window sill. Cameron asks if she is ok and she nods and says she will leave him to it. Cameron says that he will bring her in once he has examined her father, she nods and opens the door pulling her jumper down over her leggings as she leaves. Cameron looks at me and comments (adding to what I was already thinking) "I think she is far too young to be dealing with this on her own....it is not fair".

He turns his attention to the patient and begins speaking loudly to him. He explains that he is a doctor in [Trust 3] hospital and that he wants to examine him. At each point of examination Cameron explains to the patient what he is going to do. Cameron is able to move the patient's limbs like he

is a doll. Each time the limbs are placed in a position they remain there. The patient doesn't respond to any pain stimulus as Cameron pinches the patient's skin and scratches the bottom of his feet with a stick. Cameron then checks the patient's eyes by pulling back the patients eye lids, the eye lids roll from side to side and Cameron explains that it is called a coma roll, which suggests that the patient is in a deep coma. Cameron teaches W by the patient's bedside and talks him through the patient's condition and talks about how the patient's recreational drug habits could probably have contributed to his stroke. Cameron and W engage in a small conversation about the problems of cannabis on the brain.

Cameron made the decision in consultation with his team to discuss with the daughter that they need to end the patient's treatment (and thus in all likelihood, his life). Cameron deals here not only with the daughter's distress but with the daughter's worry that she is involved in the decision to let her father die. Again a high degree of emotional intelligence and leadership as well as clinical knowledge operates in this communication.

While shadowing Owen [Trust 2] the researcher sees that while behaving perfectly correctly he puts emphasis on the clinical and health related aspects in an end of life situation above communication and empathy. He is not unkind but 'misses' the emotional level of communication. Here in the presence of a daughter and father the woman (mother/wife/patient) is clearly dying and being kept alive by the clinical team. Owen:

... talks directly to the daughter stating that her mother is coming to the natural end to her life and therefore she [the mother] is giving up - 'withdrawing from life' and tells the daughter that although they will feed her through a tube she [daughter] should prepare herself and her family for the inevitable. He also says that her mother will also start ripping the feeding tubes out to prevent herself from getting the right nourishment.

The image conjured by the 'withdrawing' from life and 'ripping' feeding tubes is dramatic and seems to give agency to the dying woman – almost indicating that somehow she is to blame as she will prevent herself getting the right nourishment. However, the researcher, as participant in this encounter, is bringing out a sense of the culture of this particular event. While Owen is probably protecting himself emotionally from the loss of life and the sense of clinical 'failure' he does not protect the daughter or the husband from the emotional onslaught of the woman's impending death.

The daughter says that she understands and turns to her father and says 'dad do you understand what the doctor is saying?' the husband paces up and down the side of his wife's bed looking lost and lonely. He looks up at Owen and says that his wife is giving up because someone at the nursing home said she was a burden. The daughter scolds the father for saying that

in front of her mother. She explains to Owen that although she [mother] doesn't say anything she listens to everything and the more her father says it the more she doesn't eat. Owen says he understands and asks how the family is coping.

The daughter here is also protecting Owen from the family's pain by scolding her father even though Owen asks how they are coping. However, although kind and polite, Owen does not seem to operate with emotional intelligence or engagement with others' pain.

The daughter says that her father is finding it very difficult because he is the main carer for her; she herself has taken time off work to care for her when she can to support her father. As she speaks about her father and how upset he is becoming she begins to become tearful. Owen listens to her as she speaks and occasionally asks further questions. The husband continues to potter around the room occasionally touching his wife's head and face. The daughter watches him.

Owen, while allowing the daughter to cry and not acting as if he is irritated or embarrassed, equally pays little heed as he continues to talk of the mother's deterioration.

Owen begins to talk about the deterioration of her mother and what they will be able to do for her. The daughter says that she knows what Owen wants to talk about 'you're talking about DNR aren't you?' Owen says yes he is and the daughter tells him that she knows about it because her friend's mother recently died and this was discussed with her. The daughter says that she knows what she would prefer but they will have to talk this through with her father. The daughter calls her father over and begins explaining DNR. He looks at his daughter, he looks lost and scared and she tells him that it is his decision but she thinks that the doctors should not resuscitate her mother because she will be resuscitated to the same state. Owen inputs that she will be 'worse' than how she is currently because she will be a lot weaker. The daughter says that she will have to talk through this with her father. Owen nods and leaves the room.

9.6.5 Stories of patient care

The following two stories show in detail the ways in which responsibility and power can shift between team members and highlight anxieties faced by doctors about caring for patients.

9.6.5.1 A story of system failure: Cancelled Clinic

The first story is told by a female registrar who describes a situation in which she felt disappointed with patient care due to cancelled clinics. In the

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following account, the narrative is broken down to four moments, and each is discussed to demonstrate how the doctor's anxiety is managed by being linked to a failure in 'the system' that climaxes in her interaction with patients.

Q: What about any time or incident that made you feel disappointed with patient care in this hospital?

A: Lots of times, particularly since we've not had a secretary. Every clinic, every single clinic I send somebody home because the notes aren't there at all. They are supposed to be coming to see the consultant [her immediate superior] and he's not there, and they've been put into my clinic and you look at the letter and it clearly says on the letter 'consultant only to see', and they turn up and he's in Italy, on holiday.

The registrar is expressing frustration. On the surface it is towards a recurring failure in patient care attributed to firstly not having a secretary and secondly because the consultant 'is not here'. The expression of the frustration however is confused; there is no secretary but the patients 'have been put' into her clinic. Furthermore, she sends someone home from each of her clinics because the notes are not there. The letter 'clearly says' the patient is to see the consultant who is not only not there but he's in Italy 'on holiday'. There is a feeling of being overwhelmed, and of rage and envy towards the consultant - and possibly the patients - emerging from this short paragraph (for discussions of workplace envy, see Vidaillet, 2007; Stein, 2000). There is also an expression of omnipotence in that she sends patients home. She has the 'legal' justification to do so because there are no notes and also because their letter says they have to see the consultant and the energy is directed towards this activity rather than getting patient appointments changed. The consultant is on holiday, presumably one to which he is entitled and one which has clear boundaries enabling them and the staff who make the appointments to re-arrange the patient dates.

There is clearly a high degree of frustration and anxiety present in this account; there are too many patients with 'needs' and not enough clinical or support staff backing the work in the way in which the doctor would feel comfortable with. As there is little opportunity either to express or assuage her anxiety so she becomes 'prey' to primitive phantasies and unconscious mechanisms to relieve the anxieties.

The story also sheds some light on doctors' anxieties about working in a multidisciplinary team. Medical education and postgraduate training provide a culture in which doctors believe they can rely on each other through which a sense of being an elite group and confirmation of professional omnipotence and responsibility - particularly of the consultant - arises. However the role of the consultant also brings about a sense of envy and

destructiveness in others which has its origins in the primitive defence mechanism of splitting off the painful parts of one self (e.g. the realisation that you are not omnipotent and that another has the ability to do what you cannot) and projecting them onto others in an envious attack (Klein, 1959).

...and you have to go out and say, 'I know you've waited three months for this appointment but I'm afraid the consultant is not here and he wants to see you personally, so thanks for coming but if you can just go away' and you can't even say to them 'you're getting an appointment for next week' because realistically they're getting an appointment in three months time, and I think that's really disappointing.

'Breaking bad news' is considered to be a difficult task for health professionals and one that is a constant cause of anxiety. In addition to having to find the appropriate means of communicating prospectively devastating prognosis and supporting patient through the immediate emotions, doctors must come to terms with possible changes in how the patients perceive them (Barnett, 2002). Even though the situation described here does not involve delivering bad news about an illness, it is a moment of disappointment for both the patient and the doctor. The patient's anticipation to receive treatment is rejected and the doctor has to acknowledge failure in service delivery. The patient's possible anger and anxiety is directed towards the messenger, who in this case, is unable to offer any practical solution. Instead of being the helpful, trustworthy saviour, the doctor transforms into an envoy of disappointment and will have to see to the patient's emotions as well as her own disappointment, to which there is no external consolation on offer. To alleviate the anxiety caused by the situation, the registrar clings on to a narrative regarding her workplace – she is disappointed in the system.

I feel very disappointed in the system, which, I know the system is a big, wide thing, but ... [it] lets people down from that point of view and, you know, we overbook theatre lists and they get cancelled and then again I feel disappointed.

By seeing the NHS as a faceless, bureaucratic, 'machine-like' (Elkind, 1998) entity, the registrar convinces herself that the situation is not her fault - it is not what she would want for the patients, or for herself. She feels anxiety for she cannot provide the care required, and as a consequence she projects this anxiety through blaming 'the system'; regardless of their individual efforts, doctors are powerless when the system fails. As this registrar said epigrammatically later on in the interview: 'I don't think the NHS works anymore' which at a conscious level represents the impact on her working life of a problematic bureaucracy while at an unconscious level it provides un-containable stress. The doctor does not have the opportunity to delegate

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tasks to her superiors to reduce the 'heavy burden of responsibility' (Menzies, 1960, p. 118) thus feels that she is left to deal with the failure of 'the system', a system, which ironically is set to heal people, not cause them angst.

It's mostly because I'm thinking, how must that patient feel. You know, they've worked themselves up, they've told work they are gonna be off work for three weeks or four weeks or whatever and arranged cover and you go and tell them, sorry, you can't have your operation, you can go back to work tomorrow. That's really disappointing, to do that to people, very much so.

In the conclusion to her story, the doctor moves beyond expressing antagonism to the system to empathising with the patient. Thus, by failing, the system provides the doctor with a social defence mechanism but through empathizing with the victims of the failure, she fails to contain her anxiety.

9.6.5.2 A story of grace in adversity: Supporting the mother of a still-birth baby

The second story is told by a male registrar who describes how he provided good patient care by supporting a mother of a still-birth baby. Despite the plot, the story is not told as a tragic narrative but as a proud patient-care moment, a sequence of events that had thoroughly positive impact on the doctor's perception of himself. This narrative is also analysed in sections.

Q: Could you give an example where you felt that you have given good patient care?

A: I think that one of them was this lady who actually came to the labour ward and told me that she hasn't felt her baby move in the past one day and she had had some bleeding. Obviously there was some concerns on my behalf for the baby, because there could be a problem. This was a very wanted pregnancy because she was quite old and this was an IVF pregnancy. I examined her a little bit and on examining her I found that the baby did not have a heart beat, so she had lost the baby.

Describing the situation at first with the patient as an object helps the doctor to distance himself from the scenario and to do routine checks expected in this kind of situation. In a hospital setting instructions are given about the way each task should be performed and these rituals form a reassuring tool for staff (Menzies, 1960: 121).

I did explain everything to her, and obviously as a doctor responsible for her, I need to follow all the procedures that needed to be done and all the care that she needed to have, you know I explained it to her that, you know this by far something that words, you know cannot express, as you can imagine how

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difficult this situation would be, and if we could make it the slightest bit better, we would try everything in our power, you know, to make the situation a lot more comfortable. I ensured that she was given a quiet room, with a very good midwife looking after her at all times. Obviously I had my duties towards the rest of the labour ward as well. People visiting her room making sure she was ok, making sure the pain relief was ok, we had induced her because we did not want her to go home with a dead baby inside her. It was a very, very painful and stressful scenario, it really, really was, it was horrible, absolutely and it is very distressing, exceedingly, exceedingly distressing because, you know the woman is going through all that pain of labour.

Here, the doctor is empathising with the patient, feeling her emotional pain and in this case is mostly able to contain it through wanting to relieve the situation and then by offering extra care, by 'going an extra mile'. In this extract, there is a clear shift as the doctor uses strong emotional words to describe the crisis. In telling the story, he is projecting his own anxiety on the patient, living the distressing emotions with her and having to remind himself of his position as a medical professional - 'obviously I had my duties towards the rest of the labour ward as well'. By referring to 'all that pain of labour' the doctor enters a relationship with the pain. The phenomenon of pain and our relation to pain, whether someone else's or our own, is more immediate than that of reflective knowledge – we do not think about pain but react to it so the sensation is intersubjective. The person who is not experiencing the pain but affected by it is an 'interlocutor' in the situation (Crossley, 1996, p. 37).

...I tried to make it a point that I was present, present as much as I possibly, feasibly could during her emotional outbursts. I wanted her to have all the support that she needed... I did get attached to the patient, being around her, trying to get her care, even if I was out of hours, which means that when I was not meant to be in the hospital. Now I think that some people will argue that, that is a bit over the top, but I think that, I guess, I guess, that that is medicine for you, you know it is about lives, and sometimes you have to make that extra effort, to make that person feel that little bit more special.

In this excerpt the doctor starts to explain and justify his actions. Through self-reflection he has realised how he acted in a way not normally accepted in the hospital culture, that is, he went against the 'social defence system' to deliver patient care, but also to cope with his own anxiety. He dedicated extended time to his patient even though hospital doctor's time is considered to be 'fast and efficient'; 'doctors move quickly in the hospital wards. Their time is expensive. They cannot afford to linger too long in any one spot' (Mattingly, 1998, p. 21).

Menzies (1960) noted that while institutions have social defence systems, individuals may resort to their own defensive mechanisms, but a membership of an institution 'necessitates an adequate degree of matching

between individual and social defence system'. If the individual and the social defence systems are in disagreement, what follows is some degree of breakdown between them, for example, a doctor's work colleagues might reject them for behaving in an inconsistent or unprofessional way to the system. Consequently, the registrar providing patient care to the mother of the still-born baby is not only coping with anxieties created by that emotionally charged situation, but he also has to think about the culturally accepted limits of caring and possibly negotiate his way with other members of staff. On this occasion, the doctor keeps to his defences and spends extra hours with the patient, without being criticised by his peers.

Well you know that when things get worse, they get worse and they get worse and they get worse. Ultimately what happened with her was that we tried all the induction of labour, we tried everything possible to get that baby out, by induction. And in her case with the induction, it failed as well... and I can't tell you how dreadful that scenario was, that she needed a Caesarean section to have that baby out... I wanted to make sure that I was present at the Caesarean section, as well so that she would have a face that she knows. Once she delivered, you know obviously I was there with her, with the [dead] baby in her arms, and she was happy from the point of view.... and thanking me every now and then, which I said that she shouldn't because it was my job and one should do it. But she kept signalling the fact that not many people would do it the way that I had and I that was very special.

Much hospital work contains a 'constant sense of impending crisis' (Menzies, 1960, p. 26) which creates pressure and anxiety. The level of predictability in medical work is low and – as the registrar expresses it – 'when things get worse, they get worse'. The doctor explains that he attended the Caesarean section for the patient's sake, but this could also be interpreted as his coping mechanism – the need for a closure (Mattingly, 1996: 37). If you only see trauma and dramatic events without closure, the events will stay lingering and cause anxiety, stress and possibly depression. The doctor needed to be there and needed to have closure to be used as a coping mechanism against accumulating anxiety. So far the patient had been in a powerless position while the doctor had presumably been in control of the situation and emotions involved in it. Therefore, when the patient thanks the doctor, he gets confused. The patient had survived through the ordeal and suddenly has the power to relieve the doctor's anxiety, to nurse him (Menzies, 1960). The acute physical and emotional stress is released and the doctor can reflect back on his experiences.

And I think that is something very, very special and dear to my heart. And these are those situations when you sit back and you reflect on your life and

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say, "wow I have done something good, really, really something good and it is wonderful".... I saw her every single day on the post natal ward and obviously I made a point not to neglect her, or neglect her partner because people assume that the only person going through the trauma is the woman who has actually delivered, but they are a couple, and that needs to be understood so that was important as well. And he appreciated that quite a lot. They went home, two weeks later, I did receive a lovely letter, which kind of expressed a lot of gratitude, for what I had done for them.

The thanking letter provides closure for a difficult story, but maybe also goes beyond this. It hints at redemption – instead of a medical tragedy possibly compounded by failure in patient care, the story becomes one of a victory or at least grace under fire, a positive example of the doctor's powers even when he cannot actually perform miracles by restoring life. Anxiety is successfully overcome by the absolution from the patient and the doctor's 'priesthood' (Elkind, 1998) is restored. The letter from the patient acts as the final seal to exalt the extra efforts the doctor put in to solving the problem (Menzies, 1960, p. 31).

I know that I put in extra hours and I KNOW that I shouldn't have been there but no-one complained, because everyone knew that I was helping a situation. It is just an understanding that we have. It would be a terrible job if you were only allowed to work your set number of hours.

A narrative like this one permits people to attach themselves to 'desirable' ends, think well of themselves in moral terms', 'support their needs for autonomy and control', and 'promote feelings of self-worth' (see Baumeister, 1986 in Brown, Stacey & Nandhakumar, 2008, p. 1054). By telling this, not an easy or comfortable story, as a proud moment of good patient care, the registrar restores his professional and personal integrity. There is no 'system' in this story to blame on, no failure to confess, but despite the drama the story draws to a happily-ever-after ending. The story has entailed a narrative for the self (Brown et al., 2008) that has released the anxiety the event contained.

9.7 Conclusions

Patient care is a process and a social construction and as such means different things to different people. Norms and styles of patient care also change across time and differ site to site not only because of differences in beliefs, but also because there are different possibilities (technological advancement, different types and mixes of professional groupings) and different types of constraints on what might be offered. It is not always possible to put a clear value judgement on patient care and one example is to do with 'length of stay'.

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Managers, whose concern is to ensure that beds are not blocked, may or may not be holding in mind the image of an organisation that shares care with agencies and families in the community. They may simply be responding to government targets. They may have their mind fixed on those waiting for beds who have still not received treatment. Patients themselves may want to return home as soon as they can or become bewildered when they are discharged rapidly after treatment.

Working in multi-disciplinary teams with distributed leadership patterns may have improved practices for clinicians. Accountability for patient care still resides with the consultant and the hierarchy who manage the Trust. While senior managers are responsible for ensuring patient safety and preventing negligence to individual patients, they are also responsible for ensuring access to care for the community which involves managing scarce resources such as equipment, pharmaceuticals, beds and staffing.

Not all clinicians appreciated or respected these pressures as we saw particularly in Chapter Six. Nor do patients necessarily agree that good care is anything other than good and consistent communication with specific clinicians.

As demonstrated in Chapters Six and Seven managers are frequently frustrated by demands from staff who may try to subvert managerial targets (set by government and as such fundamental to resourcing of the Trust).

The quality of leadership is intimately linked to patient care. Good patient care relies on effective leadership of the kind that engages with staff and imparts to them the vision that (as far as humanly possible) the patient comes first. That in turn impacts upon the climate, culture and ethos of the Trust. When leadership fails, so does patient care.

10 Leadership and patient care: Assessing the past and thinking of the future

10.1 *Introduction*

Without effective leadership at all levels of the NHS and its various organisations patient care suffers. This knowledge has been evidenced in

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several key studies across recent years as reported above and elsewhere and consequently fed into the NHS Qualities Framework (see Chapter One).

In this report we have critically reviewed the relevant literature on leadership exploring as far as possible the relationship between leadership, followership and service delivery across five hospitals comprising three NHS Trusts (see Chapter Three). We employed different research methodologies (see Chapter Two) to capture data to investigate leadership qualities and their interaction with the climate and culture of the organisation and linked these to service delivery and patient care in different settings (ranging from obstetrics and gynaecology and cardiology to care of the elderly).

10.1.1 The organisational contexts

The organisational contexts of each Trust and each site or unit varied physically, structurally and in 'atmosphere' (the full details are provided in Chapter Three). We have been concerned in the report (and future papers) to steer a path between maintaining anonymity and confidentiality and thus not overtly identifying a Trust or site within a Trust, while also pointing to how the contexts impacted on the practices of leadership and service delivery.

Overall the Foundation Trust (3) in this study, which had not been experiencing mergers or threats of closures, where staff morale was high and where leadership practices were distributed across teams and clinical and management specialties, was clearly the one most conducive to effective communication and leader-follower engagement. There was an 'atmosphere' of connection and pride in belonging to the Trust as evidenced explicitly in Chapters Four and Nine in particular.

Trust 1 was applying for foundation status during the time of the investigation but also threatened by closure of some of its units, and with the senior managers possibly being transferred to the other site which was perceived by the participants as a threat to their status and possibly to resources for service delivery. This did not happen during the course of the investigation. The managers in Trust 1 were committed to their staff and to service delivery although there did appear to be some discontent with senior management from the medical staff. This may have been because most of the distributed leadership involved non-clinical managers and nurse managers with the medical teams appearing to take a more 'traditional' hierarchical stance. Most of the data from the OCS was derived from Trust 1 which demonstrated among other things the importance of management support for identifying good leadership and patient care practices.

In Trust 2 there appeared to be the greatest amount of conflict between groups of staff who sometimes seemed to be leading in different directions.

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Trust 2 was perhaps the 'victim' of a relatively recent merger between two large hospitals (and one or two other smaller units) which were some physical distance apart and had had a different history – one being a DGH and the other a teaching hospital. The DGH appeared at first to have a professionally diverse group of senior managers who distributed their leadership to effect, but one or two figures emerged during the course of the study who transgressed this approach with one person taking a back-seat while another was trying to drive through change in a somewhat cavalier manner. Furthermore in this particular Trust there were changes among the senior managers (some left, others moved to the other site during the course of this study). The CEO also indicated that it was difficult to recruit good middle-range managers and nurses in particular because both sites were away from the centre of the city where most people would look for a promoted post.

10.2 *Limitations of the study methods*

As with any large scale and complex study such as this one not all of our intentions were achievable although some were satisfied beyond our expectations.

We had difficulties capturing data from patients for two main reasons (fully detailed in Chapter Three).

Firstly, the 'gate-keeping' staff working on the Units on a day-to-day basis (as distinct from those who supported overall access to the Trust overall) obstructed data collection.

Secondly, it was also difficult gaining access to patients while they were in hospital because of ward procedures and in other cases the poor health of patients. So in the end we managed to conduct ten patient interviews but were unable to collect organisational climate survey data from patients at all³⁸. To overcome this we gained permission to observe clinicians' interactions with patients in their care and we believe we have managed to do more than compensate, making a contribution to knowledge with important new material to demonstrate patient care in different contexts and the processes involved in patient care and service delivery (see in particular Chapter Nine).

We also met with difficulties, with one Trust in particular, collecting *survey* data from staff although individual staff members proved more than willing

³⁸ These difficulties were reported to SDO in the interim reports and also separately when they arose.

to support the researchers by allowing them to interview, observe and shadow them during their working days. *This is all reported fully in Chapter Three.*

10.3 *Reviewing the findings*

In this final chapter then we draw together the findings from the study and make suggestions as to how they might contribute to policy and practice beyond the participating organisations.

This chapter is organised around the original study aims which were about leadership, organisational climate (culture and context) and how they impact on patient care. The overall plan was to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery.

This research further sought to explore the following broad-based questions.

- First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
- Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?
- Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The specific aims and objectives are listed again below and we conflate these in what follows directing the reader to the relevant chapters.

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines, to patients;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts service delivery;

- To learn how different stakeholders (specifically patients, nurses, members of professions allied to medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care;
- To identify how the need for change in service delivery is identified and what drives the need for change.

10.3.1 How far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?

Throughout the participating Trusts there is evidence of the importance of high quality patient care. Chapter Nine in particular brings this together with quoted respondents emphasising that above all patient care matters to the aims of the organisation and those who work in it. Thus on a basic level, working for patient care is inspiring in itself and staff across the Trusts see good patient care as their *modus operandi*.

Our use of innovative ethnographic methods and story telling were particularly effective in providing the evidence of how patient-clinician relationships were practiced and how staff made sense of their own actions reflexively in the context of caring for patients³⁹.

Chapter Nine provided evidence of the ways in which care is practiced.

We begin here by summarising some of the evidence from the Foundation Trust in this study, which consistently appeared to demonstrate high levels of distributed leadership, emotional engagement and multi-disciplinary working across all levels. The data included several key examples of positive statements about the role and effectiveness of management. We saw, for example a senior clinical manager summarise the issue with reference to his

³⁹ For example, interviews opened with questions about leadership and patient care, and participants were then encouraged to tell 'stories and critical incidents illustrating their experiences'. The early parts of the interviews provided themes and indications of what the clinicians regarded as crucial to delivering good patient care, e.g. 'cleanliness', 'efficient administration', 'communication', 'empathy', 'sympathy', 'knowing the recent developments in your field' and 'everything behind the scenes the patients don't see'. However, it was the stories they relate to that provided us with insights into their core experiences of patient care (see Chapter Nine).

pride in working for the organisation drawing attention to its low mortality rates, and that the high quality staff and its reputation for patient care act to attract others at the top (or with the potential to be at the top) of their specialty.

By contrast, the CEO of one of the other Trusts had made the point in their interview that one of the difficulties they had was attracting high caliber nursing staff, partly because of their location (in the suburbs). In Chapter Four we identified the ways in which an organisation might be seen as a learning organisation as significant in supporting staff to develop their clinical and managerial skills and develop capacity for patient care. Where support for learning was apparent so was the enthusiasm and pride for the organisation and its goals.

What was striking was the way that all respondents who addressed this point were looking to see how patient care could be improved with aspirations that patients were satisfied with more than just the health outcome (although that is the bottom line) but also with the facilities and the atmosphere. In addition, several respondents made the point that they themselves were mindful of delivering (or at least aspiring to deliver) the type of care they themselves would want to receive.

That so many of the staff (clinical and non-clinical) worked long hours in which they were engaged in intensive work with either their clinical or management teams, or their caring for patients with the aim of delivering the best possible care, is yet further evidence of the ways in which patient care is inspirational.

What is most noticeable, however, is how some styles of clinical and managerial leadership appear wanting, when compared with the best. While some respondents are clearly excellent communicators who engage fully with their professional knowledge and with the patients and staff, others - equally expert and equally inspired to provide the best for their patients - seem to fall short in comparison. In Chapter Nine for instance, Cameron and Kenneth engage with their patients in human ways and there are examples in the chapter in which each clinician manages to gain important information from and for their patients by their hard work *and* their humanity. However, in Cameron's case he is supported by a team which has clearly been nourished and inspired by the organisational context (see references to Cameron's work in this report).

Kenneth, while equally able and empathic, from the ethnographic evidence reported in Chapter Nine, appears to be less able to transmit this or influence others to take up his brand of leadership and patient care. He remains slightly in the background while the younger and (it appears) more influential Henry sets the tone. The clinical team give the impression of

being business-like and impersonal and somewhat intimidating when they conduct their ward round. The culture being transmitted to the other clinical staff tends towards Henry's approach rather than Kenneth's. This raises questions about why this Trust and site is different from the FT in which Cameron and Mandy work. These matters were addressed in Chapters Six, Seven and Nine in particular and will be subjected to further analysis in subsequent publications. However the FT is established and settled. The Trust where Kenneth and Henry work was the product of a relatively recent merger and norms and values were still being 'negotiated' (see Chapter Seven and above in this chapter).

Subsequently we see Mandy working directly on a patient's wound not only acting humanely when she hurts the patient but working with the nurse to assess how they might best improve the patient's condition while caring for his mental state and self-esteem.

High quality care and inspiration come together through the ways in which clinicians and managers take responsibility for their work – for managing emotions (their own, their colleagues' and their patients'), teaching, making decisions about end of life care, communication with relatives and coping with everyday situations that raise anxiety levels for patients and staff. The story of the doctor in Trust 1 who cared for a woman with a still-born baby itself demonstrates how he went the extra mile (in his words) inspired by the possibility of providing care in a case where some might have tried to make minimal contact because a still-born baby might be seen as a clinical failure.

Overall emotional engagement with patients and followers leads to people working together in a human, humane and inspired way and impacts on the organisation itself which can become one with which people are proud to be associated.

10.3.2 How do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

This question underpinned the entire study, but specifically we reviewed the relevant research literature on leadership and organisational climate (Chapter One) and discussed this in Chapters Four through to Eight. We began by reviewing the results from the story-telling interviews, focus groups and ethnographic methods (observations and shadowing). A range of potential practices and behaviours were reported to us which suggested where problems might lie in current leadership practices, as well as what many respondents held to be ideal types. What we summarise now represents a combination of what works and what does not although it needs to be noted (as identified in Chapter Nine in particular) that what

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patients see as good leadership (that they received clear and consistent information from one or two key staff) may not always intersect with what staff meant by good patient care or effective leadership and service delivery. The latter was usually seen as best delivered by a well-functioning multi-disciplinary team albeit frequently constrained by limited resources.

The following issues stand out as good practice that could feed into NHS (and local Trust) policy:

Leadership is a complex concept meaning different things to different people. Over recent years leadership in changing contexts such as the NHS has shifted from the 'heroic' model where leadership is hierarchical to a model that is more distributed across different levels and different parts of the organisations. The heroic and hierarchical (related) models frequently depended upon individual characteristics and where the senior managers were indeed heroic and charismatic, leadership might well have led to good patient care. However, this is unreliable and unpredictable and the NHS Qualities Framework which has identified leadership skills is more appropriate to the context (see Chapter One).

Our most important findings, however, make it clear that leadership which is emotionally engaging and distributed is the one which is most likely to lead and support service delivery successfully as well as drive necessary changes.

At the end of Chapter One we focused on contemporary studies of leadership which promoted the importance of *context* and of taking a more discursive stance in the analysis of leader-follower relations. We also drew attention to the revival (and reappraisal) of concepts from organisational studies from the 1960s to the 1990s which took psychodynamic ideas into account and related them to more 'popular' contemporary ideas about the significance of social and emotional intelligence in leader-follower relations. Thus, we explored the ways in which stakeholder accounts of the experiences and exercising of leadership demanded an attachment or engagement at an emotional level, which took account of the unconscious as well as conscious understanding of these experiences. There were several examples offered in the previous chapters of leadership practices that delivered the required services or changes through different types of concerted action and those that didn't. In some cases we were able to show that with the best will in the world if the leader, for whatever reason, was unable to *engage* and thus be supported by the followers, then their leadership failed to deliver.

Recent analyses of distributed leadership styles and organisational contexts show that if such leadership is to work then people need to act and work together and be prepared to both take up and relinquish authority for

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certain tasks and roles at the appropriate intervals. We saw in Chapters Six and Seven for instance that authority is hard to maintain if a leader loses touch with their staff and fails to hold their own organisation 'in mind'. We used the OCS survey results in combination with the data derived from the interviews, focus groups and ethnographies to demonstrate the importance to a positive organisational climate of good leadership. Satisfaction with a manager was predicted by the same variables that identified a positive organisational climate. For staff in the organisations surveyed it was important that managers were committed, responsible and supportive of their staff/followers.

But how were these characteristics demonstrated? Leaders who were experienced as effective, supportive and emotionally engaged with their followers were able to communicate their vision and dedication to improving the quality of care to patients, which in itself co-existed with good staff morale. Such leaders were also good listeners as well as being able to take staff with them when less palatable or unpopular changes were mooted by senior management or government. These effective leaders were closely connected to the way the organisation was structured (physically and emotionally). They were thus able to access the information they needed in order to lead. The evidence for this frequently came from the stories and accounts of staff and observations made by researchers – often of good leadership but perhaps more acutely when leadership was poor. Then there was a jarring effect or mismatch between (local) policy and the attempt to drive changes to meet improvement targets. There was also evidence on occasions of senior clinicians' behaviours being disengaged. Sometimes attempts were made to subvert the senior people when leadership went against the grain. There are examples in Chapters Seven and Nine in particular.

A final comment here is that despite the changes in gender demographics at the top of clinical specialties in medicine, nursing and related professions, as well as in senior management, gender has not 'gone away'. Indeed distributed forms of leadership have (perhaps stereotypically but with some evidence base) been associated with women's behaviours. The OCS (Chapter Five) suggested that women's perception of 'recognition' for their work and achievements was more negative than that of men. Men were either satisfied with the recognition they received or less in need of recognition from their managers within the organisation than were women. In the qualitative data (see Chapter Eight) it was also the case that while senior women were keen to deny the relevance of being female to their professional lives and their career progression per se, women used different strategies and perceived their roles slightly differently than did men, although the point was well made by some respondents that feminine and

masculine choices of specialty may have been more significant predictors of management styles than gender itself.

10.3.3 Do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The contemporary NHS with its (mostly) distributed leadership practices at all levels tends to militate against the possibility of one person's vision being paramount. However, as suggested above in this chapter, there are nuanced influences of leadership style that (may) flow from one or two people's vision and/or style of leadership and patient care that influence organisational approaches.

In Chapter Seven, for example, we explored three senior people's visions and consequent behaviours to consider their authority and influence with the possibility that as opinion leaders they influenced organisational approaches to patient care. Quentin, for example, reflected his role as a senior clinical leader, and although there is no irrefutable evidence that his style was mirrored in the organisation itself, he does provide some evidence that in certain cases in relation to certain actions his vision had an impact on the overall organisational approach.

While the OCS (Chapter Five) captures data from a wider population, the ethnographic methods made a greater contribution to exploring how far an individual's vision influenced the organisations approach to patient care. Again in Chapter Seven we see Kerry battling against a resistant (and probably disillusioned for some reason) senior management team to improve discharge policy and meet government targets. She tries again and again (by her own account) to show her staff that they need to focus on targets because they will lead to improved care quality. She appears to fail (again according to her own standards) and expresses this by almost literally demonstrating that she is banging her head against a brick wall.

Differently with the same effect Gerald is introduced as having a clear vision for patient care in his Trust. However, his inability to take staff (at all levels of the organisation) with him in his vision is attributed in our analysis to his lack of emotional engagement and autocratic (verging on the authoritarian) style of management. His narcissism further ensures his inability to understand how his behaviour is impacting upon staff and he sees himself as having failed to win a 'fight'.

Chapter Six explores the organisation as an open system, and ways in which all stakeholders⁴⁰ hold a vision of the organisation in the mind at a

⁴⁰ Including patients but we cannot really speak definitively here due to lack of data.

conscious and an unconscious/emotional level acting accordingly. Thus, they have an image of the organisation (how well it is managed, how effectively it cares for patients), a sense of their own role and place within the organisation and how well the leadership understands the experiences of staff and patients. Recognition of the primary task, the roles and responsibilities of those who manage it and the (changing or threatened) boundaries of the organisation itself are critical concepts.

No doubt some members of the organisation have more personal and role/task related power and influence than others in the NHS Trust. Furthermore, the NHS as a system is fluid and dynamic, so that there is overall a group influence over the evolution of organisational context (climate and culture) which responds to visions from within and without (government, health care consumers) the wider system.

10.4 *What have we learnt from this study?*

10.4.1 *How leadership relates to patient care*

It is clear, from our empirical work and evidence from previous studies, that leadership is a process and set of practices which generally do not equate with the qualities residing in a particular individual regardless of their authority and formal role and status in the organisation. Leadership that 'works', as seen particularly (but not only) in the case studies in Chapter Seven, involves the person in the leadership role exercising social and emotional intelligence and engaging with their 'followers' (see Chapters One and Four) and offering staff recognition and support (Chapter Five). Moreover the role of leader is particularly effective when it is distributed among those who are best placed to exercise leadership towards the task in hand. So that in the context of an NHS hospital Trust, leadership might be exercised in relation to organising the administration for a unit, running an audit, or developing an innovatory clinical practice. Leadership in such contexts is time/project limited.

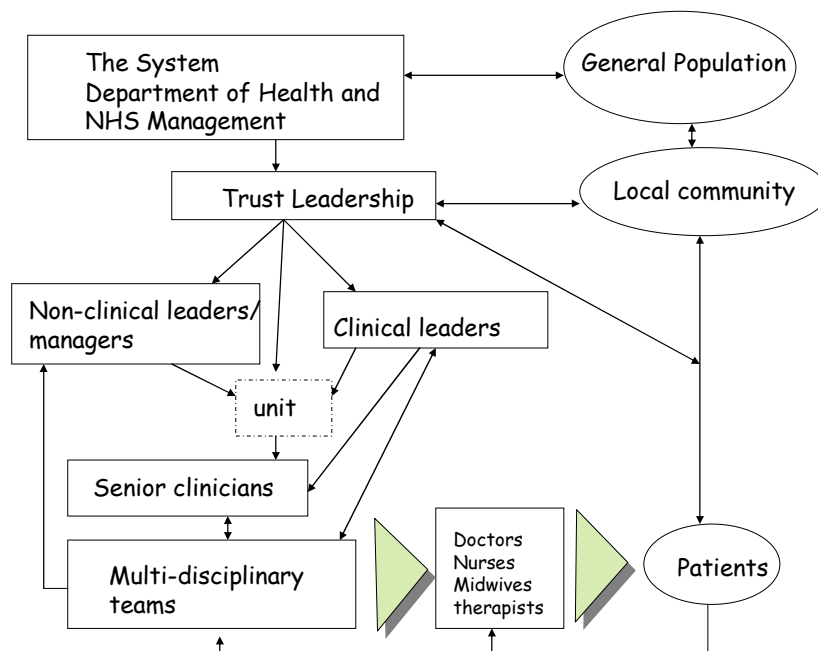
The primary task for NHS Trusts is to deliver a service to patients, as proposed in Chapter Six. All NHS Trusts operate as open systems with porous boundaries which enable change (planned and/or evolved). Leadership therefore can occur throughout the system at different levels including those of ward clerical and cleaning staff and the CEOs who 'manage upwards' and influence NHS/ Department of Health policy. Information of all kinds passes across the various boundaries not simply from the 'top' downwards.

Below in Figure 12 the relationship of the Trust leaders and patients within the NHS system is illustrated. It is also the case, as shown, that policy

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influences individual care, and the quality of that influence depends very much on the quality of leadership again across the system at all levels.

Figure 12. From the DoH to the Patient: An Open System



Patient care is represented here at three levels. The population who influence service delivery and patient care using their vote and/or lobbying through relevant patient groups, the local community who are served by a particular Trust and patients who are actively receiving medical treatment from individual clinical teams.

While on the whole it was the last group who were the main focus in this study some participants, particularly those in senior leadership/management roles, were concerned with service delivery at the local community and population levels. This sometimes meant that senior managers faced the dilemma of how to care for the community while attending to individuals and some individual clinicians were equally concerned about how their interactions with patients were influenced by some of the management dictates which derived from NHS policy that they

found difficult to understand (see Chapter Six and in 10.4.2. below for example).

10.4.2 Systemic dilemmas in patient care: Managing in the NHS

One participant had faced a 'dilemma' in wanting more face-to-face knowledge of patients in the community in order to be a more effective and informed leader, while also as his role required, attending to the demands of working within the wider system of the NHS:

As a chief exec in the NHS it was my privilege to make decisions. That was my privilege to go on and up the ladder. It was that I could go on and make faster and faster decisions. I get in the way I have always got in the way... the thing I would do is go out with the district nurse for the day, because I needed to be grounded in that. (Retired CEO)

Another manager who had previously had a military background advocated (along similar lines) that the best way to lead towards good patient care was to 'walk around' and support the leaders across the different parts of the organisation. In a seminar to clinical staff, which we attended and recorded, he drew participants' attention to the importance of *influencing* policy to achieving good patient care (at the population and community levels).

I hope some of you will find yourself in policy jobs at some point. Totally different, yes it still leads, but the actual process is so ... changing...both the chief executive and I spend a lot of time nurturing relationships which are partly to do with policy, but unless you get it right ... you communicate with them, it won't work.

In other words to be effective and to ensure the best for those in the Trust (staff and patients) a leader has to 'manage upwards' which gains influence. He continued by contrasting the experiences and perceptions of doctors with managers who lead at the macro level, drawing on the example of a recently qualified doctor. When the respondent quoted here asked this man about leadership in the NHS and how it impacts on patients he apparently answered:

'Oh I have got communication skills'. 'Blimey!' I said 'what do you know about the NHS?' And I asked him a couple of questions, nothing! But he hasn't been taught at an academic level about the context in which he is working. I think that is crucial and I know that is not how everyone does things. You know [doctors] keep people alive, but they really ought to have this basis of information about the context in which they are working.

While it is self-evident that the NHS is the context in which patient care is delivered, there is a tension between those who exercise leadership in that context and those who 'keep people alive'. In Chapter Seven, the frustration expressed by Kerry in trying to meet the demands of the government and community by improving the Trust's record of patient care, as well as motivate her senior staff to hold similar ideas, was palpable. From others' perspectives as shown in Chapter Six, there was evidence that 'management' was experienced negatively by several clinical staff when it tried to respond to Department of Health directives.

Managing the numbers

At another level of management good patient care was defined through achievement of returning satisfactory statistics, as this observational note of a meeting between capacity managers and clinicians suggests:

Patient care for the capacity managers appears to be a number crunching exercise. The need to get the patients in the right beds according to government targets meeting four hour waits and single sex bays. However because there is not a shortage of beds on this day, patient care moves from an exercise in numbers to thinking about patients in real human terms.

Sally (the capacity manager) talks about how better patient care can be delivered when there is less pressure on all the staff to meet their targets and get their job done. She talks about how [clinical] staff are then more able to talk to their patients and spend time with them. However, whilst reduced pressure means that for some, numbers translate into real people it is clear that in the capacity meeting that the role of the capacity manager is to think in terms of numbers and beds to deliver good patient care.

There is a potential conflict between the target driven service and the patient-clinician relationship which is about face-to-face contact. Perhaps this is well illustrated in Chapter Nine with the example of the 'grace in adversity' story, whereby the obstetrician spent extra time with a patient while his clinical colleagues turned a sympathetic blind-eye. The story of the patient 'Lola' also discussed in Chapter Nine who had been occupying a bed for three months with the tacit support of nursing staff would also have been anathema to staff responsible for managing targets about capacity.

10.4.3 Who judges what is good leadership and good patient care?

As shown above and throughout this report there is a tension throughout the system. The primary task of senior managers and leaders at and above the level of the Trust is to ensure the demands of the NHS and Department

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of Health leadership are met. These are policy driven with differing priorities at any particular time. The general population of (potential) patients has a keen influence on policy in different ways but particularly during local and general elections. For example the recent change from a Labour to the Coalition Government has raised questions about the role of 'targets' for future NHS priorities. Apart from other matters, finance makes a difference as to how priorities for service delivery are set.

Senior management at the Trust level is judged in a number of ways particularly related to how far the Trust meets the national priorities. However there is also pressure on CEOs and senior teams to get direct patient care and safety 'right'. This may be assessed through statistics as in the following example described by a senior midwifery manager:

Between 2002 and 2005 there were ten maternal deaths at [Trust], which exceeded the national figures. So the Healthcare Commission came in and reviewed a number of clinical organisational cultural governance issues, and then actually put the maternity services under special measures

There was a key number of issues then, and an action plan was developed, so actually I was newly appointed at that time, and there was a number of work streams that we had to work on, and it's never happened before, and I don't think its happened since in a maternity unit. So basically, even though that was a very sad event for all the families involved and very tragic for them, it was difficult for the staff, and obviously difficult for the Board in terms of reputation management. The whole action plan was implemented, the unit was turned around, and the special measures were lifted in 2006.

In this case there was a notable failure to deliver maternity care to the standards of safety prescribed by the NHS. Furthermore there was a failure of leadership perceived by this participant in terms of both 'culture' and 'governance' giving rise to the high proportion of maternal deaths and the consequent special measures. This participant also makes clear how much the staff themselves are influenced by events of this kind.

Another member of that staff team praised the changes at the top following these problems and combined the policy, context and face to face care in her assessment of the relationship of good leadership to good patient care:

.... the end goal for us, is ensuring the services we're providing.. the patients, are getting the best service from us on top of meeting all the Trust targets and the Trust strategy...for me really it's about ensuring that the patients are getting the best quality care, which, you know, I think they've got an improved quality of care here, with the team like mine who are here...and I think [leadership] is from the top down, so from Chief

Executive, right down to every level, to leaders in the ward, right down to our portering, to our domestics. Yeah, there certainly is, and we lead by example really don't we? and I think our chief exec, director of ops, deputy chief, they've all got good leadership skills.

Good leadership skills among senior managers can pay dividends in terms of reputation management. For example in August 2010 North Cumbria University Hospitals NHS Trust admitted a series of false positive diagnoses following breast cancer screening⁴¹. The CEO moved quickly to review the situation and apologise publicly. In other cases though, when there have been wrong diagnoses, neglect or medical errors over drug doses senior managers have been blamed for the failures - sometimes warranted and sometimes possibly not so (see below). Anecdotally it appears that leaders who are prepared to acknowledge problems as soon as they appear and deal with them in a transparent and effective way bring about improvements in service delivery and patient care in the ways perhaps that those who try to 'bury' problems might not achieve.

10.4.4 Leadership practices across the organisation

Leadership and patient care are intrinsically linked. Leadership is above all about taking responsibility but with changes in organisational structures, a growing emphasis on networks, open systems with porous boundaries, mergers and changes in the shape, structure and functions of Trusts, it is no longer tenable for leadership to be in the hands of a few. Leadership, then, is about a series of relationships and connections within and without specific organisational boundaries which have the potential for diffusing responsibility or sharing it, and therefore making leadership practices more co-operative.

It is important to focus, as we have done, on the many examples of good and excellent leadership we found within the three Trusts taking part in this study (each of which of course being hospital based and therefore not focused on the role of leadership in primary care). These sit in contrast to the examples of less effective and sometimes failures in leadership that we have cited. The differences crucially were about emotional attachment and engagement between leaders and followers. We did not meet any respondents who were disengaged with the aims of the NHS and none who were uncommitted to deliver the best patient care. But as evidenced above in the report and in this chapter, some leadership practices failed to take

⁴¹ <http://www.bbc.co.uk/news/uk-england-cumbria-10958423>

followers with them because of autocratic, insensitive behaviours and poor communication skills. Leaders need to be able to listen and engage – having a vision is not enough.

Leadership taking the importance of emotional engagement into account also needs to be transmitted across the organisation. This is best accomplished through making full use of individual skills. Clinical staff and managers can be effectively involved in specific change projects. These may be time-limited and/or specialism specific but collaborative concerted action is frequently the most significant way that a system might flourish with the staff taking responsibility and enhancing their sense of commitment.

10.4.5 When leadership fails patient care

The converse of good leadership is potentially catastrophic. The case of Beverly Allitt in the early 1990s, the nurse who murdered children in the Lincolnshire Hospital by injecting them with insulin, went relatively unchallenged because she was poorly supervised. Harold Shipman, a different case in that he was a GP in a sole practice, similarly was eventually thought to have committed over 200 murders of patients throughout his career. However, the report into his murders showed that doctors at Thameside hospital had failed to report suspicions about his prescribing⁴². The Alder Hey organs scandal involved the unauthorised removal, retention and disposal of human tissue, including children's organs during 1988 to 1995 and the Bristol Royal Infirmary inquiry about children's deaths during surgery resulted in doctors being struck off. All these cases represent a failure of leadership in which those who were responsible for patient care at all levels failed to identify and follow up on problems. More recently the independent inquiry into the Airedale NHS Trust, where the late Anne Grigg-Booth continued as night-nurse despite a high proportion of deaths of patients while under her care, identified 'a catalogue of systemic failures' whereby her dangerous behaviour was not spotted.

At the time of writing this report the Prime Minister David Cameron has ordered a full public inquiry into the events at Staffordshire hospital which have led to deaths of patients, it would appear in these cases, more due to negligence than intent. The Francis report which was published in 2009 found that patients were routinely neglected and there were systemic failings in patient care. Managers had been pre-occupied with cost cutting and meeting targets and unable to spot the build up of failures in patient care that were to cost several patients their lives. There were too few

⁴² These cases were subjected to inquiries which exposed a range of complexities which are not relevant here.

nurses, those who were employed were ill-trained, equipment was inadequate and experienced medical cover was not always available. It was a supreme failure of management and leadership. The Trust was poor at identifying when things went wrong and managing risk. Some serious errors happened more than once and there were higher levels of complaints compared with other trusts. Staffordshire was a foundation hospital that had managed to 'tick the boxes' although clearly there were a series of chasms between the clinical and managerial staff.

10.5 *Final thoughts*

By using innovative qualitative methodologies (described fully in Chapter Two) such as story telling, ethnographic observations and shadowing, to both supplement and augment data from interviews and focus groups, we have built up a picture of what happens in the daily lives of NHS staff working both with and as managers and in clinical teams. Using these methods provides opportunities to extend the scope of more traditional in-depth interviews and focus groups. The 'story', because it is chosen by the participant themselves, provides not only detail and depth but demonstrates the specific indices used by each interviewee to make sense of their own and others' behaviours within the organisational context.

The ethnographic observations, and the shadowing in particular, enabled the researchers to gain a sense of what 'a day in the life' of a member of the organisation *feels* like. They can 'experience' the interactions between staff, between staff and patients as well as the frustrations and pleasures of working in that Trust. No other method provides such acute insights. The subjective ingredients in this method enhance the process (i.e. as outlined in Chapter Two whereby the researcher themselves is the 'instrument' through which data is mediated). Moreover, and possibly conversely, the subjective elements are reconciled when the observation notes are discussed by other members of the research team, which again as discussed in Chapter Two is also a source of data (Czarniawska, 2008).

As a qualitative study, the success is proven by the richness of the data, showing the clear emotional connection participants had with the topics of both 'leadership' and 'patient care' (Lincoln & Denzin, 1994, p. 575). From this we were able to make sense of how leadership is experienced and exercised (see Chapters Four and then Six to Eight) and about the practices around patient care and service delivery that support patients to understand the relationship between their particular health-status, quality of life and the care and treatment they are receiving and/or expect (see Chapter Nine in particular).

The statistical analysis of the OCS⁴³ showed that, on the whole, the climate variables, 'support' and 'recognition' from managers and the system overall, predict 'satisfaction' with leadership and management. This reinforces the ideas expressed throughout the report that good practices by managers/leaders are about ongoing engagement with followers with concerted or conjoint leadership processes most likely to promote a sense of being supported and recognised (Roberts et al. 2005).

Thus we have not produced a list of 'good leader' qualities or a similar record of what constitutes 'good patient care', as these would fail to capture the crucial point that both leadership and patient care are experienced as a process. Thus this report aims to delegate *good practices* that were observed during the project, for the use and reflection of any staff member of the NHS – whether a leader, follower or patient.

10.6 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.

⁴³ As made clear above we were unable to capture corresponding data from patients.

- 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.

Appendix 1

Focus Group Questions

1. Leadership means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this hospital?

Prompts

1. Charismatic / Authoritative / Consultative / Directional / Varies – depends on situation/activity etc
2. Can you think of some incidents that sum up for you the way leadership is exercised in this hospital?

Follow-ups

1. Does this type of leadership operate throughout the hospital?
2. Could you give some examples of ways in which leadership is exercised in your team/the hospital
3. Patient care means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this organisation?
4. How important is patient care as a priority in the service that you and your colleagues provide?
5. What are your main priorities in ensuring a high level of patient care in this hospital?
6. Can you think of some incidents that sum up the way you and your colleagues try to deliver patient care?
7. To what extent is leadership reflected in the quality of patient care you and your colleagues provide?
8. Can you think of some incidents that sum up the way that leadership in this hospital approaches the issue of patient care?
9. Can you think of specific incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

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Follow-up

1. What would you suggest to improve this/these situations?
3. Stories and critical incidents
 - a) Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
 - b) Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
 - c) Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

Could you tell me about a time that made you feel disappointed with leadership in this hospital?

- In this unit?

Appendix 2 Interview Questions

Interview

*Introductions, background and experience in relation to patient care and leadership in the organisation

- The interviewees position/level
- Years at the hospital
- Role in the organisation

1. Leadership

'Leadership' means different things to different people.

- a. How would you define it?
 - Do you see that kind of leadership at this hospital? Why/not?
 - What about in this unit?
 - What makes someone a good leader/Qualities of a good leader? Can you give me an example?
 - Who here at work do you see as providing leadership to you personally? Why? Do you have a direct supervisor? Who? Do they have leadership qualities?
- b. Do you see yourself as someone who could be a leader?
 - Why/not?

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- Under what circumstances?
- c. Can you give me an example of leadership in this hospital?

2. Patient care

- a. Like leadership, 'patient care' means different things to different people.
 - How would you define it?
- b. Tell me about patient care in this hospital. How is it defined?
 - Are there differences between units? Tell me about them. Why do you think this is?
 - How would you improve patient care in the hospital?
 - How would you improve patient care in this unit?
- c. How do you [as a hospital worker, nurse, etc.] try to deliver good patient care?
- d. What do you think are some obstacles to delivering the sort of patient care you'd like to see? How could these obstacles be removed?
- e. Do you think leadership could improve patient care in this hospital?
 - Why/not?
 - Do you think that better leadership would improve patient care? Why/not?
 - How does good leadership influence patient care?
 - Has the leadership in this hospital improved patient care since you've been a member of staff? How so? Or why not?

3. Stories and critical incidents

- a. Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
- b. Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
- c. Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

- d. Could you tell me about a time that made you feel disappointed with leadership in this hospital?
- In this unit?

Appendix 3: Focus Group Questions: patients

1. Leadership means different things to different people. What does it mean to you as a patient of this hospital?
2. What is your opinion of the way leadership is exercised in this hospital?
3. Patient care means different things to different people. What does it mean to you as a patient of this hospital?
4. Can you think of some incidents that sum up the kind of patient care that staff in this hospital deliver?
5. Can you think of ways that leadership in this hospital could enhance the quality of patient care, as far as you are concerned?
6. Can you think of some incidents that sum up what else leadership could be doing?
7. Can you think of any other incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

Appendix 4: Staff Organisational Climate Survey

[attached separately]

Appendix 5: Participant Information Sheet

Leadership and Better patient Care: From Idea to Practice

Participant Information Sheet: Staff Interviews

You are being invited to take part in an interview study about leadership and patient care in three different hospital settings. Before you decide to participate in this study it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Contact me (see full contact information at the end of this sheet) if there is anything that is unclear or if you want to know more.

Take time to decide whether or not you wish to take part.

Thank you for reading this.

1. What is the purpose of the study?

The purpose of this study is to try to identify the circumstances under which leadership can be an effective engine for change in the organisation of health care, especially for patient care and service delivery. Although we suspect that leadership motivates workers and affects the climate or atmosphere of the places where people work, leadership can mean different things to different people. The same is true of patient care which can also mean different things to different people. In order to understand how leadership inspires health workers to provide better patient care, we want to learn how nurses, doctors, other medical professionals as well as managers and patients define and understand leadership and patient care. This includes exploring how their perceptions mesh or conflict with one another. It also includes listening to stories of important incidents that describe their experiences of leadership and patient care.

2. Why have I been chosen?

As part of the study we are interviewing staff (clinical, managerial and others) as well as patients to examine what leadership and

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patient care mean to them. You have been chosen as someone whose views represent the views of staff.

3. Do I have to take part?

No

4. What will happen to me if I do take part?

You will participate in a tape-recorded interview with a qualified researcher, which will last under an hour.

5. What do I have to do?

Arrange a mutually convenient time to have the interview.

6. What are the possible disadvantages and risks of taking part?

It is possible that the discussion may stir up distressing feelings you have regarding your organisation, its leadership and the patient care it provides. However, care will be taken to prevent this and you are free to leave the interview at any time. Apart from that, the only disadvantage is that you will be giving up some of your time.

7. What are the possible benefits of taking part?

This study may not directly help you but it is part of a serious initiative to improve the quality of leadership and patient care provided by the NHS.

8. Will my taking part in this study be kept confidential?

Yes. All data will be stored in locked filing cabinet in a locked office. It will be made anonymous and all names will be edited out of the transcripts. Only members of the research team will have access to the data.

9. What will happen to the results of the research study?

They will be published in a report to the funder and also presented in peer reviewed papers and conferences. A copy of the report will be provided for each participant who requests it.

10. Who is organising and funding the research?

The study is funded by the NHS Service Delivery and Organisation (SDO) Research and Development Programme of the National Institute for Health Research (NIHR) Programmes. The NIHR has been established as a part of the government's strategy Best Research for Best Health to provide the framework that will position, manage and maintain the research, research staff and infrastructure of the NHS in England. The study is conducted by a group of researchers from Royal Holloway University of London led by myself, which won the grant following a competitive bid.

11. What if I have any concerns?

If you have any concerns or other questions about this study or the way it has been carried out you should contact me (details below) or you may contact the hospital complaints department.

Contact for further information

Professor Paula Nicolson, Head of Department, Health and Social Care
Royal Holloway University of London, Egham, Surrey, TW20 0EX

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Appendix 5: Consent form (generic)

Title of Project: Leadership and Better Patient Care: From Idea to Practice

Name of Researchers: Emma Rowland Paula Lökman

Please initial each box

☐ I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

☐ I understand that some coded extracts from the interviews may be used for the purposes of the research report and academic articles.

☐ I give my consent for quotations to be used in the report and research papers on the understanding that I will not be able to be identified by the use of these in any way.

☐ I agree to take part in the above study.

Name of participant

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Date

Signature

Appendix 6: Patient Organisational Climate Survey

Thank you for agreeing to participate in this study which as you will know is part of a larger study on leadership and patient care in the NHS.

The following questions explore how NHS patients feel about the care they received and how things generally worked in the units where their care was managed.

The survey is anonymous, so please do not put your name on the survey.

If, however, you would like to receive the final results of the survey when the study is completed, please fill in the tear-out form on the questionnaire's last page and submit it to the researcher or the collection box.

It is important that you answer all the questions. This should take you approximately 10 minutes.

Your individual responses will be kept strictly confidential.

Researchers

Dr Paula Lökman

Department of Health and Social Care
Social Care
Royal Holloway University of London

Ms Emma Rowland

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Royal Holloway University of

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Please circle one number that best describes how you feel for each question in relation to the service provided by your NURSE.

1. I feel understood by my nurse.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

2. I am able to be open with my nurse at our meetings.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

3. My nurse has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

4. My nurse encourages me to ask questions.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

5. I trust my nurse.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

6. My nurse answers my questions fully and carefully.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

7. My nurse deals very well with my emotions.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

8. I feel that my nurse cares about me as a person.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

9. I don't feel very good about the way my nurse talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

10. My nurse tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

11. The way my nurse interacts with me influences my perception of quality care.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

12. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

Please circle one number that best describes how you feel for each question in relation to the service provided by your DOCTOR.

13. I feel understood by my doctor.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

14. I am able to be open with my doctor at our meetings.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

15. My doctor has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

16. My doctor encourages me to ask questions.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

17. I trust my doctor.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

18. My doctor answers my questions fully and carefully.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

19. My doctor deals very well with my emotions.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

20. I feel that my doctor cares about me as a person.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

21. I don't feel very good about the way my doctor talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

22. My doctor tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

23. The way my doctor interacts with me influences my perception of quality care.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

24. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1 2 3 4
strongly
disagree

5 6 7
neutral

strongly
agree

25. What would improve the quality of care you receive at this hospital?

26. What services are you using within this hospital?

Demographic Information

27. In which year were you born?

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28. What is your marital or civil partnership status?

- ☐ Single
- ☐ Co-habiting
- ☐ Married
- ☐ Divorced

29. How many children do you have?

30. How would you describe your ethnic background?

31. What is your current salary?

- 1. Less than or around £20,000 per annum
- 2. Between £21,000 and 39,000 per annum
- 3. Between £40,000 and £59,000 per annum
- 4. Between £60,000 and £99,000 per annum
- 5. Above £99,000 per annum

Thank you again for your time. If you have any questions please speak with the researcher or alternatively you can contact Professor Nicolson.

I would like to receive the final results of the survey when the study is completed

Name:

Address:

Contact Telephone:

Please return this form to either the researcher or the collection box.

Appendix 7: Appendices for Chapter Five

[attached separately]

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⁷ There is a parallel ongoing debate as to whether university leaders should be drawn from outside academia.

Addendum:

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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.

Leadership and Better Patient Care: Managing in the NHS

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Finally each one of us has a commitment to the future of the NHS and we are therefore optimistic that at least some of the content of this report will contribute to future planning and development to benefit staff and patients.

Executive Summary

The NHS National Leadership Council Website¹ (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)

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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.

Leadership and Better Patient Care: Managing in the NHS

1 Leadership, organisation and the NHS

1.1 Leadership

What is currently known about leaders and leadership? The ongoing attempt to identify the characteristics necessary for effective leadership over recent years has been described as an 'obsession' studied more extensively than almost any other characteristic of human behaviour (Higgs, 2002; Tourish, 2008). Alimo-Metcalfe, Alban-Metcalfe et al. (2007) in their comprehensive review of the literature, show that formal studies of leadership date back (at least) to the beginning of the 20th century. They propose, that despite changes in the way leadership has been studied and the underlying epistemological stance taken by the researchers, *"in all cases, the emphasis has been on identifying those factors that make certain individuals particularly effective in influencing the behaviour of other individuals or groups and in making things happen that would not otherwise occur or preventing undesired outcomes"* (p. 2). As *"many have pointed out, that in spite of the plethora of studies, we still seem to know little about the defining characteristics of effective leadership"* (Higgs, 2002, p.3). Even so this has not appeared to quell the appetite for pursuing an ideal of leadership, impelled by the changing demands of organisations echoed across public sector institutions such as the NHS. These changes are in part the result of technological advancements which impact upon clinical practices, demographic changes both of which have altered the strategic, structural and financial profile of health (and social) care (Tierney, 1996).

The tantalising questions remain though about what those factors might actually be and the significance of the context to 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).

But in addition, or conversely, the context, culture, climate and/or structure of an organisation each have an impact on the performance of the people who lead in it (Carroll, Levy, & Richmond, 2008; Goodwin, 2000; Michie & West, 2004).

Focusing on the relationship(s) between 'leadership' and context has revitalised contemporary research particularly through the development of qualitative research, discursive and social constructionist epistemologies (Grint, 2005; Uhl-Bien, 2006) although it is unclear at this stage how far a connection might be developed between this research and its applications, for example in health care services (Fambrough & Hart, 2008).

In what follows in this chapter we explore the changing ways in which leadership has been conceptualised over the past fifty years, particularly focusing on how it has and *might* be operationalised in the NHS (particularly although not exclusively in a *hospital* context) .

1.2 Background and introduction to the study

The NHS Modernisation Agency Leadership Centre (NHSMALC) website³ had originally suggested that effective leadership is a key ingredient in modernising today's health care services. In its own words:

Effective leadership and management in the healthcare system are key drivers in patient experience. Governance and good environments matter to patients, their visitors and carers and staff.

But how might effective leadership be achieved and sustained? The NHS Leadership Centre commissioned a number of leadership initiatives (Larsen et al., 2005). The NHS Institute for Innovation and Improvement (2005) *NHS Leadership Qualities Framework*⁴ emphasised the *situational* nature of leadership and indicated the circumstances under which different leadership qualities will take precedence.

These comprise fifteen contextualised qualities covering a range of personal, cognitive, and social characteristics arranged in three clusters which are set out in Figure 1:

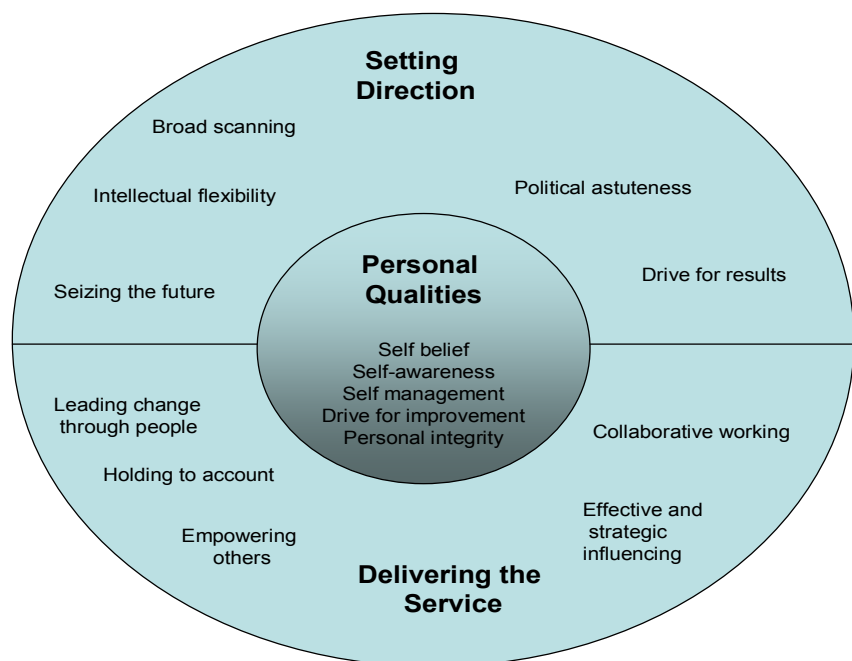
³ <http://www.dh.gov.uk/en/managingyourorganisation/leadershipandmanagement/index.htm>

⁴ <http://www.nhsleadershipqualities.nhs.uk/>

- *Personal Qualities*
- *Setting Direction*
- *Delivering the Service*

Thus, a competent leader enables development in an organisation that is goal directed, geared to developing processes and systems and enables staff at all levels to plan effectively and efficiently towards agreed goals (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Figure 1. The NHS Qualities Framework



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However, these same authors underscore the point that there is something beyond leadership competency that needs to be addressed, particularly in a changing and complex context such as an NHS Trust. *That is that a leader is someone who encourages and enables the development of an organisation in a culture based on integrity, transparency and valuing others. Leaders also need to question, think critically as well as strategically* (Alimo-Metcalfe, Alban-Metcalfe et al. 2007).

Since the publication of the *NHS Leadership Qualities Framework* in 2005 all efforts have been directed to recognising and discussing leadership qualities and making strides towards their implementation. In 2008 Clare Chapman, Director General of the Department of Health's Workforce declared:

*Leadership is all about creating value for customers and citizens whilst also making work worthwhile for staff. This sounds incredibly straight forward - but it requires courage and resilience, and commitment throughout the entire piece*⁵

David Nicholson the CEO of the NHS in the report *Inspiring Leaders: Leadership for Quality* (January 2009) building on Darzi's *NHS Next Stage Review*⁶ stated:

It is imperative that we align what we are doing on leadership with what we want to achieve on quality. This is what I call leadership with a purpose.

Over the past year, the Department of Health has worked extensively with the NHS and other stakeholders to determine how best to foster talent and leadership development, and it is clear that there is a great deal of enthusiasm for a more systematic approach.

Spotting and developing confident leaders is a priority for us all if improving quality is our shared purpose. This guidance represents our best collective thinking to date. I invite you to use it and contribute to its improvement as we learn how to bring leadership centre stage over the coming months.

Nicholson and his team have charged the Strategic Health Authorities with finding gaps in leadership and systematically nurturing talent across the whole of the NHS. Clearly, the enthusiasm of successive senior officers in

⁵ DH_083353.

⁶ www.dh.gov.uk/en/Healthcare/Highqualitycareforall/index.htm

government and the NHS has been to link effective leadership with good service delivery and patient care as the primary outcome.

1.2.1 Leadership and Better Patient Care in this Study

This rhetoric and confidence about the type of leadership that best suits the NHS from those who lead it gave us pause for thought (Milewa, Valentine, & Calnan, 1998; Mueller, Sillince, Harvey, & Howorth, 2004b). 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 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 aims were overall to seek out the meanings and perceptions of relationships between (effective) 'leadership' and (better) 'patient care' and how leadership is transmitted across organisations to impact upon service delivery, taking account of the mixed methods and specific social science and systemic approaches that the investigatory team proposed. This inevitably has brought certain issues to the fore and (possibly) obscured others.

Our starting point therefore was to hold the NHS model of leadership in mind while calling on our own specific strengths as academics, from a range of social science and methodological backgrounds, to take a cross section of Trusts, clinical specialties, services, staff grades and patient needs, and to observe the *processes of leadership* in everyday working life. From this we proposed it should be possible to determine the ways in which leadership, NHS organisations and patient care were socially and discursively constructed so that links between leadership and patient care might be explored.

In Chapter One we outline some of the important contemporary social science and organisational thinking on leaders and leadership and explore the links between this and the NHS perspectives.

In Chapter Two we set out the innovative methodologies employed to investigate and analyse the research questions. This is followed in Chapter Three with the detailed procedures used for data collection.

The results are presented across four separate chapters. Chapter Four provides the analysis of what leadership means and how it is experienced by staff and patients (Christensen & Laegreid, 2003; Fairhurst, 2005).

Chapter Five presents the results of the Organisational Climate Survey (OCS) (Stringer, 2002). In Chapter Six, open systems theory and the concept of the 'organisation in the mind' are introduced particularly focusing upon the transmission of leadership across organisations. The relationship

between leadership, authority and emotion is discussed in Chapter Seven and in Chapter Eight the role of gender relations and their impact on leadership are reviewed (Begun, Hamilton, Tornabeni, & White, 2006; Ford, 2010; Telford, 2007).

Chapter Nine covers definitions, explanations and experiences of patient care and particularly how it relates to leadership by NHS staff and patients (Begun et al., 2006; Disch, Edwardson, & Adwan, 2004).

Finally in Chapter Ten we summarise our findings, make recommendations and draw conclusions.

Appendices provide copies of the research instruments, additional statistical results and the relevant NRES information.

1.3 Theoretical Approaches to leadership

Leadership research and theory is prolific with the consequence that numerous, frequently overlapping, models of leadership are available to agencies attempting to analyse or train leaders (and indeed managers, as until relatively recently little distinction was made between these two categories, see e.g. Kotter, 1996). Over the past fifty years leadership theories have shifted through different points of focus from the 'trait (or 'great man') approach in the 1940s, through the 'behavioural' perspectives in the 1950s whereby some styles of behaviour were seen as being more or less influential on potential followers. Then since the 1960s and 1970s the focus has been upon 'situational' leadership based mostly upon Fiedler's 'contingency' theory which proposed that different leadership styles were needed for different situations (see Alimo-Metcalfe, Alban-Metcalfe, et al. 2007; Western, 2008 for further details). During the 1970s and 1980s leadership research, albeit prolific, had reached an all time low in terms of its perceived contribution to theory and added value to knowledge for practice, so that as Cummings (1981 p. 366, quoted in a review by Bryman, 2004) asserted:

As we all know, the study and more particularly the results produced by the study, of leadership has been a major disappointment for many of us working within organisational behaviour.

Bryman unpicked the implications of the phrase Cummings used "as we all know" noting that it was "simultaneously sweeping and damning" (2004, p. 730). Bryman also picks out Miner's (1975) suggestion for temporarily abandoning the concept because of its limited utility in helping us understand organisational behaviour. *Why had leadership research reached this nadir during those decades? Why has there been a more recent upsurge of interest in leadership again almost to the point of saturation?*

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Bryman in his review suggests, that the renewed confidence and interest in the study of leadership has come from improved measurement and analytic techniques, greater use of meta-analysis so that more systematic reviews could be compiled, the emphasis on *transformational leadership* and *charismatic leadership* which have provided a fulcrum for the area of research, more and better cross-cultural studies and greater diversity in the types of leadership and organisational contexts that have been studied.

A factor that may also have contributed to the idea that leadership research continues to be fruitful is that a greater diversity of methodological approaches have been added and Bryman's review specifically focused on the value added by qualitative research.

Towards the end of the 1980s and beyond, thinking about the meaning(s) of leadership came to take greater precedence than in the previous two decades, possibly because of a perceived dearth of leadership *per se*.

These deliberations cast light onto the:

- *interactions between leaders and followers* and organisational cultures (Avolio, Gardner, Walumbwa, Luthans, & May, 2004; Lewis, 2000; Schilling, 2009)
- the *management of emotion* (George, 2000; Lewis, 2005; Pescosolido, 2002)
- the *processes* of leadership (Collinson, 2005; Dopson & Waddington, 1996; Vangen & Huxham, 2003)

Even so, or perhaps because of the use of qualitative approaches and related conceptualisation, Alvesson and Sveningsson (2003) were able to entitle a recent paper arising out of their study of leadership in a research and development company: "*The great disappearing act: Difficulties in doing 'leadership'*".

By this they meant that during their study they were able to identify how the existence of the label 'leadership' led to an assumption that the concept had an empirical reality. However the results of their work indicated that leadership might be better explained as a *process or series of processes of interaction*. This conclusion raises questions about mainstream thinking on leadership which presumes observable and possibly measurable characteristics (Alvesson and Sveningsson, 2003, p. 361; see also Ford, 2010).

Most recently there has been reconsideration and development of ideas about leadership in context taking account of the relevance of some earlier studies of organisations (e.g. Lewin, 1947) and open systems theories (see

Chapter Six; Laughlin and Sher, 2010) and new epistemological positions (e.g. Ford, 2010).

In our study, as a consequence of these recent critiques of leadership research and the result of methodological innovation, we approached the concept of 'leadership' as not necessarily a property of one individual (although it can be) or of one specific role, such as Clinical Director or a service manager, but rather we identified leadership as a *process* occurring within a group, organisation or collectivity that *imagines, wills and drives change* (Gabriel, 2004; Gronn, 2002).

1.3.1 Dimensions of Leadership and their Value for the NHS

Leadership, *as a practice*, has been on occasions constructed as 'a beautiful or rarefied ideal' an idea which has little use in the real world particularly as it has been suggested there are at least 350,000 definitions of leadership in the academic literature (Pye, 2005; Tourish, 2008; Western, 2008). *The question for this report is how to identify the literature on leadership and organisation with the most relevance for the contemporary NHS.*

Most discussed in theory and in practice over the past two decades has been the idea of *transformational leadership* (Bass, 1985) a model to explain ways in which a leader can be identified or trained to demonstrate the qualities that enable her/him to *perform beyond expectations*. The phrase 'transformational leadership' was coined originally in 1973 by Downtown but did not gain impetus until 1978 when Burns published his book, *Leadership*, which highlighted the *relationship* between leaders and followers (Burns, 1978).

Until then, as shown above (see Bryman, 2004) there had been little by way of a breakthrough in applicable knowledge. Burns (1978) demonstrated a *psychological* difference between an exchange relationship - where followers respond to leaders because of rewards they might receive - and one in which they respond to leaders who transform their attitudes and behaviours through inspiration and/or charisma (Bass, 1985; Yukl, 1999; Rafferty and Griffin, 2004). Transformational leadership then, is concerned with emotions, values and ethics, standards and long term goals which include assessing followers' moves and satisfying their needs (Currie & Lockett, 2007; Day, Gronn, & Salas, 2006; Eagley & Johannesen-Schmidt, 2003; Northouse, 2004).

Recognition that transformational leadership is not simply an individualistic model but one that *teams* can display (Day et al., 2006; Gronn, 2002; Sivasubramaniam, Murry, Avolio, & Jung, 2002) has shifted the

concentration from individual leaders per se to a more diffuse and distributed model of leadership and organisation context.

1.3.2 What constitutes transformational leadership?

Bass (1985) highlighted several characteristics of *transformational (or transformative) leadership* that allow followers and leaders to achieve far beyond their expectations. These are not discrete categories but given the significance placed upon the ideas behind transformational leadership in the scientific and training literature it is worth outlining the basic ideas behind these characteristics/types which have been identified as:

- Charismatic leadership
- Inspirational motivator
- Intellectually stimulating leadership
- Considerate leadership

Charismatic leadership

Bass (1985) proposed that "*charisma is a necessary component of transformational leadership*" (cited in Yukl 2002, p.261) and that charismatic leaders are endowed with exceptional personal qualities that attract followers. Charisma, a word derived from the Greek, means "*divinely inspired gift*" and is thought to give people the ability to perform miracles or predict the future (Yukl 2002, P. 241).

It is for this reason that charismatic leaders are often regarded as "*visionary, a futuristic, or a catalyst for change*" (Murphy 2005, p. 131; see also Bass 1985; Bennis & Nanus, 1985). Due to their rare personal qualities charismatic leaders are able to convey their visions to their followers in a clear and concise manner allowing them to visualise what they could achieve in the future if they worked together towards a common goal. As the leader's vision is normally realistic yet optimistic, it empowers the followers granting them greater self-esteem, encouraging and inspiring them to achieve the vision (Bennis & Nanus, 1985; Northouse, 2004; Yukl, 2002).

Inspirational motivator

Through their charisma, transformative leaders have the ability to inspire their followers through words of profound wisdom, or at least is what is *perceived* to be profound wisdom, such as with the case of Jim Jones⁷ in the USA or more positively President Obama who has reformed health care and banking legislation in the USA against the odds. Transformative leaders are

⁷ In 1978 Jim Jones persuaded more than 900 members of his People's Temple in Jonestown, Guyana to commit mass suicide.

excellent communicators which allow them to turn their visions into reality. Many use emotional and optimistic speeches to inspire their followers. They usually lead by example and often become role models to their followers who are in awe of their moral and ethical character. Many followers try and emulate their leaders' good qualities and are confident that their leaders will make just decisions on their behalf leading them to a prosperous future (Kellerman, 2004; Rafferty & Griffin, 2004).

Intellectually stimulating leadership

Transformational leaders have the ability to captivate their audience making the most mundane speeches and events interesting. They encourage their followers to be innovative, challenging the status quo and their own values and beliefs (Northouse, 2004). They also encourage their followers to solve problems and take an active role in the organisation, thus enhancing their self-worth and self-esteem, increasing their job satisfaction and productivity.

Considerate leadership

Transformational leaders are often also considerate leaders who are adept at performing mentoring or advisory roles to support their followers' emotional needs (Hiller, Day, & Vance, 2006; Rafferty & Griffin, 2004). Such leaders listen carefully to their followers' needs and desires, empathising with them during difficult periods. Being empathetic also builds a strong bond between leader and follower and thus a strong reciprocal relationship (Simpson & French, 2005).

It is important to note though, despite the wide take-up of transformational leadership as a conceptual model and a *practice*, that there remains uncertainty about the ambiguity of subdivisions and distinctions between elements in the model. Theoretical distinctions between 'charisma' and 'inspirational motivation' have become blurred over time and some theorists have suggested that elements of transformational leadership might also be identified as *transactions* (see Rafferty and Griffin, 2004 for a discussion of the implications).

Further concerns have been raised about how transformational leadership can take place in organisations, particularly public service ones, which are constrained by government initiative and targets and localised regulatory and normative pressures (Currie & Lockett, 2007; McNulty & Ferlie, 2004). However, it may also be that professional staff (rather than leaders/managers) in contexts such as health care, may in fact be more transformational than might be predicted because of their long-term commitment to the organisational goals (McGuire & Kennerly, 2006).

Most recently the notion that transformational leaders are very much 'engaging' leaders has been proposed (Alimo-Metcalfe, Alban-Metcalfe et al, 2007; Alban-Metcalfe & Alimo-Metcalfe, 2009; Macy & Schneider, 2008).

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One further comment here concerns the role of *gender* in styles of leadership and its consequent impact on organisational transformation (Fletcher, 2004; Mandell & Pherwani, 2003). There is evidence that (whether displayed by a woman or a man) feminine styles of leadership may be more related to engagement, emotional and social intelligence and distributed leadership, which may be important for complex organisations such as the NHS (see below).

1.4 Leadership, organisation and emotion at the turn to the 21st Century

Models of leadership and organisation theory have evolved over time and leadership and organisational structures and cultures are intrinsically linked in the literature. Leadership, if it is to motivate, innovate and move organisations to change, has to have an *emotional dimension* and, thus, effective leaders have a clear *emotional agenda* (as well as a strategic and structural one) which is particularly acute in services such as the NHS which is working to serve people's health care needs (Ashforth & Humphrey, 1995; Bolton, 2000; Pye, 2005).

Exploring organisations and leadership at the level of 'emotion' has become contested territory, as recognition, that organisations and their leaders need to take account of emotional engagement (Alban-Metcalf & Alimo-Metcalf, 2009; Vince & Broussine, 1996) at all levels of the work place, has emerged. Prior to the 1980's, organisational literature had been dominated by cognitive orientation (George, 2000) which favoured the rational, 'masculine' and scientific explanations of organisations and their leaders. This notion therefore ignored the (so called) irrational and 'feminine' characteristics of emotion, which were deemed detrimental to productivity and success. At that time emotions were regarded as the culprits that distort an individual's perceptual and cognitive faculties and therefore should be kept under control (Alvesson & Sveningsson, 2003b; Clarke, Hope-Hailey, & Kelliher, 2007; Dasborough, 2006; de Raeve, 2002; Ford, 2006).

As social and occupational psychologists began to study the effects of positive and negative moods on decision making, job satisfaction, choice of work-based activities and organisational climate, however, (Isen & Means, 1983; Rafaeli & Sutton, 1987, 1989) 'emotion' as part of organisational life gained impetus once again. This resurgence coincided with leadership theorists studying how moods and emotions could effect the quality of leadership (George, 2000).

It is possible to trace a rough trajectory from the 'hard nosed' scientific management, with the organisation perceived as a 'machine' in the early twentieth century, through towards a more humanistic, emotional and

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sometimes even spiritual way of thinking about contemporary leadership and organisational metaphors towards the twenty-first century, all of which are potentially transformational, not simply to the individuals concerned, but to the organisational dynamics.

Hochschild's (1983) *The Managed Heart* has been credited with being one of the earliest examples of research into emotions and organisational settings (Ashkanasy, Hartel, & Daus, 2002). She looked particularly at the airline industry and how airline cabin crew managed their emotions for dealing with difficult passengers and to promote a particular airline image. She termed this emotional management '*emotional labour*' (Hochschild, 1983).

Since this publication, the study of emotions in organisations has increased (Ashkanasy et al., 2002) with academics concentrating on key concepts such as emotional labour, emotional intelligence, mood analysis and Affective Events Theory (AET) and most recently a return to psychodynamic understanding of organisations and groups (see Ford, 2010; Schwarz, 1990). Since the 1990's a plethora of literature has emphasised the role of emotional concerns in private sector organisations such as the airline industry (Hochschild, 1983; Taylor & Tyler, 2000; Tyler & Abbott, 1998), service sector (Crang, 1994), merchant banking (McDowell & Court, 1994; Pugh, 2001), law (Harris, 2002) and image consultancy (Bryson & Wellington, 2003; Wellington & Bryson, 2001).

However, emotionality in the public sector was mostly neglected until 2000's when a surge of literature began to be published analysing the NHS (Allan & Smith, 2005; Bolton, 2000; Cummings, Hayduk, & Estabrooks, 2005a; Hunter, 2005; Lewis, 2005; McCreight, 2005; McQueen, 2004; Michie & Gooty, 2005; Michie & West, 2004; Smith, 1992) and the fire service (Archer, 1999; Scott & Myers, 2005; Ward & Winstanley, 2006; Yarnal, Dowler, & Hutchinson, 2004).

1.4.1 Emotional labour, leadership and patient care

Hochschild differentiates between emotional labour and emotional work or 'face-work' (Goffman, 1967). Emotional work has been described as the effort we put into presenting and representing our feelings as well as into feeling what we ought to feel (see Fineman, 2003). For example, a person ought to feel happy at a wedding and sad at a funeral and if their emotions do not match these expectations then a person must perform emotional work to display the appropriate emotion. This is sometimes difficult as people struggle to disguise their true emotions and perform the socially acceptable emotion.

When a person's emotions are appropriated and performed for commercial gain it is known as *emotional labour*. Hochschild states that emotional labour occurs in many occupations. However, she believes it to be more

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prevalent in service industries, such as the airline industry, where workers' emotions are sold as part of a commercial package⁸. Employees working in service industries must be skilled at managing their emotions and facial expressions in order to project the correct emotion to the customer (Crang, 1994; Lewis, 2005). This often means that employees have to suppress their own emotions in order to perform and display emotions that are suitable for commercial gain and in alignment with the organisations' image (McDowell and Court 1994).

Surface acting allows the employee to make up an outward gesture (Hochschild, 1983), to perform emotions that are not actually felt. In contrast, deep acting means that the employee can suppress or become estranged from their true feelings and *actually feel the emotions* that the employer wants them to display. *"One finds that the performer can be fully taken in by his own act, he can sincerely be convinced that the impression of reality which he stages is the real reality"* (Goffman 1990, p.28).

In the NHS, positively managed emotions *could* lead to better patient care, greater patient satisfaction and a relaxed and professional organisational climate (Amendoldair 2003; Bolton 2003). Lewis (2005) highlights how nurses in a special care baby unit appropriately managed their emotions to create a professional organisational climate, in which to offer quality patient care to special needs babies and emotional support to their parents. Lewis suggests that a nurse's job is sometimes very stressful and emotionally destabilising, especially when a baby dies. Nurses need to be conscious of their own emotions and regulate them to prevent causing further distress to the parents by displaying a professional demeanour (Bolton 2001).

However, managing emotions in this way, particularly if they are not felt, comes at a psychological and emotional cost and the whole process would be problematic without attending to emotional intelligence.

1.4.2 Emotional intelligence, leadership and patient care

The 'discovery' of emotional intelligence (EI), despite on-going valid critiques (see below) marked a turning point in contemporary organisational theories and approaches to leadership because of the tradition that emotions represent a threat to rationality – a view that has been widespread particularly in North America and North Western Europe (Fambrough & Hart, 2008; Western, 2008).

⁸ For a critical analysis of Hochschild's dichotomy of emotional labour and work see Bolton 2000 and Bolton and Boyd 2003.

Mayer and Salovey (1995), who conceived the idea of emotional intelligence, defined it as the ability to manage and understand one's own and other people's emotions in a consistent way so as to reflectively promote emotional and intellectual growth. Goleman (1996; 1998) who popularised the concept, identified emotional intelligence as a set of competencies, redefined and restated by George (2000) as follows:

- The expression and appraisal of emotion
- Enhancing cognitive process and decision making
- Emotional knowledge
- Managing emotions

These characteristics appear to have much in common with the rhetoric of transformational qualities of leadership although in many ways EI has become a management 'tool' rather than a critical model. To this end (apparently) Goleman (Goleman, 2000; Goleman, Boyatzis, & McKee, 2001) focused on 'styles' and 'performance' which seem far away from the 'heady' descriptions below of qualities of emotional intelligent leadership, which refer to feelings, empathy and creativity.

The expression and appraisal of emotion

An emotionally intelligent person will be able to understand their own and others' feelings and able to empathise, which may enable them to be manipulative for better or for worse.

Enhancing cognitive processes and decision making

Having emotional intelligence allows a person to use emotion to be creative, solve problems, make decisions and flexible plans for themselves and on the behalf of a group. An emotionally intelligent leader will be able to judge their mood and make decisions accordingly. If the person is in a negative mood this may mean choosing to wait until such negative episodes have past in order to make a comprehensive decision.

Emotional Knowledge

Emotionally intelligent people understand how other people may be affected by their negative moods and therefore may take care not to spread bad feeling around the group.

Managing Emotions

Many leaders are able to manage their followers' emotions as well as their own, but as indicated below, developing the qualities required to manage emotions effectively is highly complex and more about processes than style or performance (Fambrough & Hart, 2008; Hughes, 2005). As Fambrough and Hart argue 'emotional intelligence' has passed into common use among organisational leaders with little recognition of the way it has been identified

as problematic. *What has been so attractive about EI to leaders in health care organisations?*

The idea of emotional intelligence captured the imagination of some training NHS staff as a means to improve staff relationships and enable clinicians to empathise with their patients (Allan & Smith, 2005; Cummings et al., 2005a; McQueen, 2004; Amendolair 2003, Luker et al 2002). McQueen (2004) reflecting on the 1960's when health care workers were encouraged to hide their emotions from their patients, for the sake of maintaining a professional role, suggests that in recent decades this view of nursing has changed and health care workers frequently display emotions to illustrate their commitment to patient care (Williams 2000). McQueen suggests that emotionally intelligent nurses are important for building strong patient-nurse relationships (Conger and Kanungo 1987 and (Lewis, 2005). Nurses with high Emotional Intelligence are able to build rapport quickly with their patients through communication and interactive skills (Schutte et al 2001).

McQueen (2004) also states that "*emotional labour calls upon and engages*" emotional intelligence (2004, p. 103). In order for patients to feel cared for nurses have to constantly *perform* positive emotions and behaviours such as warmth, friendliness and consideration. However, when confronted with a 'difficult' patient nurses may experience negative emotions such as frustration, irritation or anger. The nurses must be emotionally intelligent enough to identify their emotions and then perform emotional labour to submerge the negative emotions in favour of more positive emotions (Bolton 2003).

While EI *per se* needs to be understood more critically (Fambrough & Hart, 2008), the introduction of emotional management and engagement by leaders (and others) in health care organisations needs further scrutiny (see below); despite the best efforts of some management gurus emotion is a fact of personal, interpersonal and organisational life particularly when considering what it means to deliver patient care.

1.4.3 Beyond emotional intelligence

Interest in EI has continued to grow among management and organisational academics with a focus on how to measure it – the conclusions generally indicating the need for caution in measures to predict or to establish baselines for its development among managers (Conte, 2005). The conflation of managerial skills as listed by Mintzberg (Mintzberg, 1973) cited in Riggio and Reichard, (2008) which included the ability to 'deal' with subordinates, 'empathize' with top-level leaders and establish and maintain social networks, alongside managing emotions as a leader, have come to be known as 'people skills'. These are clearly represented in the NHS leadership qualities framework and vital for managing in any organisation (see Figure 1).

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1.4.3.1 Social intelligence (SI) and leadership

In 2006, taking account of advances in neurological psychology, Goleman (Goleman, 2006) proposed that because humans are *designed* for social connection, rapport and supportive emotional interactions enhance performance of managers and leaders. He listed these qualities under the umbrella of 'social intelligence' and identified four dimensions:

- *Synchronization* – whereby matching moods lead to a sense of rapport
- *Attunement* – listening fully
- *Social cognition* – understanding how people interact
- *Social facility* – finding it easy to interact with others

While some people have little difficulty meeting these criteria and mastering their social intelligence, others (such as Narcissists, Machiavellian and Psychopathic types), Goleman argues, do not have the capacity for social intelligence, and thus he proposes a means of *selecting* effective leaders by testing these qualities. This model albeit individualistic has something to offer through extending the theoretical underpinnings of 'people skills' and emphasising the importance of taking followers and colleagues seriously in decision-making.

Following EI and SI in bringing management/organisational theories together with developments in psychology, particularly cognitive neuroscience and evolutionary psychology, is the reconsideration of the role of intuition in understanding leadership and organisational behaviours (Sadler-Smith, 2008). Sadler-Smith brings the idea of the 'gut feeling' into the foreground to explore the influence of this sense upon decision-making particularly under pressure (e.g. many emergency clinical decisions rely on the clinician's instinct of whether the patient should be operated on, admitted to hospital, whether to call for support).

It seems that while there is a continuing trend towards an evidence-based understanding of leadership, success there is also an emergence of features of human life that are difficult to explain and measure, although all the proponents cited above stick to the view that these characteristics are scientifically explicable and measureable despite challenges from both positivist and critical social constructionist positions (Ashforth & Humphrey, 1995; Conte, 2005).

1.4.3.2 Affective Events Theory (AET)

AET predicts that specific features of work (e.g. autonomy) have an impact on the arousal of emotions and moods at work that, in turn, co-determine job satisfaction of employees. AET further proposes that job satisfaction is

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an evaluative judgement that mainly explains cognitive-based behaviour, whereas emotions and moods better predict affective-based behaviour. The results support these assumptions (Jürgen, van Rolf, Fisher et al., 2006). Ashkanasy et al (2002) suggested that AET has two important messages for leaders in an organisation.

- Followers' emotions are heavily influenced by their leaders' emotions and therefore leaders must minimise the 'hassles' that they place on their followers in order to increase job satisfaction and performance. Short-term negativity can be tolerated without much impact on the team or organisation.
- However, if negative events persist it will affect followers' moods leading to negative emotions, poor performance, reduced job satisfaction and in the case of the NHS, (possibly) to poor quality patient care. It is therefore suggested that leaders need to give followers positive feedback regularly to "*ameliorate the daily hassles experienced by employees*" procuring positive behaviours such as team spirit and self-worth (Dasborough 2006, p. 165 ; Weiss & Cropanzano, 1996). The connections between the moods of individuals and their performance may be understood better in terms of emotional engagement between leaders and followers on both conscious and unconscious levels (see below).

1.5 Distributed leadership

The academic study of distributed leadership, that is when at various levels leadership (or influence) behaviour, identity, role and responsibility are distributed to more than one individual or group of individuals, has been at the forefront of much social scientific leadership research over the past ten years (Buchanan, Addicott, Fitzgerald, Ferlie, & Baeza, 2007; Day, Gronn, & Salas, 2004; Gronn, 2002; Mehra, Smith, Dixon, & Robertson, 2006a). The implication of this interest in distributed leadership is, that organisations have changed and previous models - including the charismatic, 'hero' leader and the 'command and control' organisational structures - are dysfunctional in a context where organisational change is rapid and diversification of strategic leadership and management essential (Butterfield, Edwards, & Woodall, 2005; Dent, 2005; Goodwin, 2000). In a competitive, diverse and divergent environment leadership needs to be distributed, in order to enhance democratic governance, thus enhancing legitimacy and increasing survival chances (Currie et al., 2009).

Distributed leadership also implies that organisations where it is practiced have (relatively) flat hierarchies with diverse service needs and expertise across all sectors of the organisation (Huffington, James, & Armstrong, 2007). This model applies to hospitals and primary care settings, where

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distinct professional groups each have their own standards of excellence, while at the same time sharing goals of competence and quality related to the service they provide to patients and how they interrelate to other organisations.

With this shift in focus of many leadership practices and leadership studies the definition of such leadership has been proposed as:

".. a status ascribed to one individual, an aggregate of separate individuals, sets of small numbers of individuals acting in concert or larger plural-member organisational units" (Gronn, 2002, p. 428).

Gronn suggests also that when leadership is distributed it may be that the duration of that influence is limited, perhaps (structurally) to a single project and therefore (psychologically) distributed leadership might mean having to 'give up' leadership as well as take it up (Huffington et al., 2007). Furthermore, according to Gronn (2002) the most common understanding of distributed leadership, witnessed by the growing number of references to it in the research and policy literature, is that it applies to numerous people across an organisation taking some degree of a leadership role or responsibility.

More importantly, Gronn identified distributed leadership as *concerted action* meaning that there are many roles comprising a 'leadership complex' with at least three potential forms:

- *collaborative modes of engagement* which arise spontaneously in the workplace. This suggests that leadership practice is 'stretched over' the context of the organisation and not a function of those in managerial roles such as matron or clinical director. However, if the matron, clinical director and other colleagues who share ideas for change or particular activities they *may "pool their expertise and regularise their conduct to solve a problem after which they may disband"* (Gronn, 2002, p. 430).
- the *intuitive understanding* that develops as part of a close working relationship among colleagues. These relationships tend to happen over time when organisation members come to rely on each other and develop a close working relationship, to solve problems or bring about change and others might be involved in a 'framework of understanding'.
- The variety of *structural relations* and institutionalized arrangements which constitute attempts to regularize distributed action. Thus, for example, if there were dissatisfaction with existing arrangements for particular practices, a team of 'equals'

might emerge to find ways to improve or change the problematic practices.

All of these are apparent particularly, but not exclusively, in Trust Three (the FT) as exemplified in Chapters Four and Nine in particular.

Gronn argues the importance of examination of these different forms of concerted action to understand where influence (and thus leadership and power) might lie in any organisational context. Emotionally, however, these different models of distributed leadership suggest the impact of these structures and practices at a deeper level (Gabriel, 2004) particularly around authority (Halton, 2007; Hirschhorn, 1997) competition (Morgan, 2006) rivalry and envy (James & Arriba, 2005; Stein, 2005)

1.6 Organisational Culture, Climate and Contexts

As introduced above, post-industrial (or even 'post-modern') organisations (Burrell, 1988; Fineman, Sims, & Gabriel, 2005) and networked (Balkundi & Kilduff, 2006; Goodwin, 2000) organisations are changing rapidly and the NHS is clearly among these. Changes in the NHS take place at a number of levels, emerging from the direct policy dictates from central government to become local initiatives. Moreover, the NHS has become increasingly team (and indeed multi-disciplinary team) based over the past two or three decades so that knowledge, influence and leadership for transformation and change are not only moving from a top-down to bottom-up model, but as indicated, to a distributed model which involves lateral influence (Begun et al., 2006; Day et al., 2006; Ferlie & Shortell, 2001).

The type of leadership that is supported and promoted in any organisation and the related concept of the organisational structure depends on and impacts upon organisational climate and culture.

Although research undertaken on organisational *climate* and organisational *culture* comes from different epistemological traditions, since around 1990 the literature and concepts referring to both have been overlapping and/or complementary (Schneider, 1990; Schneider, 2000) and increasingly the terms are used interchangeably (Ashkanasy et al. 2000).

It is, however, generally accepted that 'climate' is a logical extension of what was originally conceptualised as 'psychological' climate, that is, shared psychological meanings in an organisation; so that *organisational* climate is an aggregation of those individual perceptions of a work-place context (James, Choi et al. 2008).

Organisational culture on the other hand has its origins in anthropology and human relations (see Davies, Nutley and Mannion, 2000; Scott, Mannion et

al. 2003). Organisational psychologist Edgar Schein's (1985/2004) ideas about organisational *culture* as a pattern of *shared basic assumptions that have worked well enough and adapt to the external environment and serve internal integration*⁹, is one of the most frequently quoted definitions. Schein takes a systems theory approach to understanding organisations and his work has been built upon by himself and others to develop a variety of typologies which underpin measures of both organisational culture and climate (see Albino-Metcalf, Alban-Metcalf et al. 2008 for a comprehensive overview of this literature).

Organisational climate, with its origins in traditional psychology is *typically* "... the only domain of organisational research that simultaneously examines perceptions of jobs, groups, leaders, and organisational attributes and thus has the unique capacity of being able to decipher common denominators and latent relationships that are not available to those who study only specific domains such as perceived equity" (James et al., 2008, p.27). We therefore made a decision to use a measure of *climate* as a backdrop to this mostly qualitative study, in order to 'triangulate' with our findings on leadership and patient care.

However, we found a competing strand of interest in the measurement of organisational *culture* (e.g. Davies, Nutley and Mannion, 2000; Scott, Mannion, Davies and Marshall, 2003) which more frequently seems to attend to health care settings than studies of climate albeit with some notable exceptions (Dawson, Gonzalez-Roma, Davis and West, 2008).

1.6.1 Emotion and the unconscious in organisations

Organisational climate and/or culture cannot be discussed without acknowledging that organisations are places where both the intellect and emotion are called into play in order to achieve organisational goals and as we have made clear, emotions are intrinsic to service delivery and leader-follower engagement in the NHS. Emotional engagement, while available to human consciousness, also takes place at an unconscious level (Gabriel, 2004; Hugh, 1986; Lyons-Ruth, 1999; Morgan, 2006; Willmott, 1986), and anxiety or stress is particularly salient when having to care for and make potentially life-saving decisions for patients (James & Huffington, 2004; Menzies¹⁰¹¹, 1970).

⁹ A paraphrase.

The ideas that characterise transformational leadership models, such as 'charisma', 'influence', 'inspiration' 'thoughtfulness' and 'consideration', have intellectual roots beyond contemporary management theory and training. They are more closely related to group and organisational theories with late 19th and early 20th century origins (De Board, 1978; Gabriel, 2004) from which much contemporary organisational theory has emerged.

The first significant attempt to analyse group behaviour made at the start of the 20th Century by Le Bon (1917/1920) whose book *The Crowd* illustrated his observation that individuals in a large group can demonstrate a 'collective mind' which emerges when people are bound together in some way. McDougall's book *The Group Mind* (1922/2009) and Sigmund Freud's *Group Psychology and the Analysis of the Ego* (1921/1922) also focused on what would subsequently come to be recognised as unconscious group processes. Freud developed Le Bon's and McDougall's ideas in the context of psychodynamic theory, arguing that the binding force of the group derives from the *emotional* ties of the members, which are expressions of their libido or drive.

Studies of (and human 'experiments' about) group psychology, taking some of this perspective on board, flourished after the Second World War conducted and further developed by psychiatrists in the newly formed NHS. In Britain the work of Wilfred Bion, Tom Main, Maxwell Jones and others led to innovations in both group psychotherapy and the study of organisations. Bion's work on group relations and dynamics which contributed to the development of the Group Relations Training Programme (GRTP) at the Tavistock Institute in 1957 evolved into the Leicester Conferences with other organisations using this model across the world (Miller, 1993). However contemporary knowledge and understanding continues to reflect back upon this early work.

What was learnt during this period about group dynamics and group relations represents an important dimension in the understanding of contemporary organisations and the relationship between leaders and followers. We develop this further in Chapter Seven in particular. It is important to note how the intellectual journey from work on emotional labour to social intelligence and intuition has so far largely neglected to explore the extent to which unconscious processes remain part of the emotional context of human social interaction (Allan and Smith, 2005, p. 21).

¹¹ Isabel Menzies is sometimes referred to as Menzies-Lyth. Her work has been reprinted several times with each name used.

In a hospital environment it is inevitable that negative events such as death occur (see Lewis for discussion on the impact of death on nurses in a special care baby unit taking an 'emotional labour' approach). When death does occur nurses may display emotions (consciously and unconsciously) such as anxiety and fear (Allan & Smith, 2005; Obholzer & Roberts, 1994; Allan 2001; Smith et al 2003). Obholzer asserts that "[he] believes that many of the organisations' difficulties that occur in hospital settings arise from a neglect of the unconscious psychological impact of death and near-death on patients and staff" (1994, p.171). He explains that hospitals are sites where anxieties about social taboos such as death are *contained*, that is that staff and the organisation overall takes away the anxiety and the responsibility for care from the relatives. Patients and staff are socialised to believe that hospitals are institutions where illness is treated and that medical knowledge and practice is infallible. This is illustrated by patients who contend that doctors possess God-like qualities and have the ability to heal all ailments. When death does occur, medical staff and the patient's relatives may feel *duped* by the institution they believed would save their loved one.

At the turn of the 19th to the 20th Centuries psychoanalytic ideas were seen to have something new and important to say, not only about the psychology of the individual and the role of the individual unconscious, but about *unconscious processes when people converge in groups and crowds* as shown above. From psychoanalytic theory we take up ideas again today specifically about the relationships which exist between followers and leaders, made explicit in the paradigm shift from transactional to transformational leadership. Working together and accepting or resisting influence comes not only with an observable set of behaviours and measurable emotions, but with unconscious and 'secret' ones including dependency, envy, power, anger, authority and emotional contagion, which may be either conscious or unconscious but have important consequences for behaviours (Burke et al., 2006; Simpson & French, 2005; Stein, 2005; Whitely, 1997). In Chapter Seven for example we see examples of where two senior managers find themselves unable to influence despite their senior roles, legitimacy and operational power. As Gabriel (2004) has argued "*emotions are no simple side-effects of mental life*" as "*emotion lies at the heart of human motivation*" (p.215).

One key feature of caring for sick patients, managing change and the social context of the NHS Trust then, is the ways in which clinicians and managers manage their anxiety which is fundamental to working in any health care setting. In the section that follows below, we demonstrate how psychoanalytic thinking explains how individual psychology and unconscious defence mechanisms link to the ways in which human beings work in groups and organisations.

In Chapter Nine we attend in more detail to the anxieties involved in obstetrics and more generally on the emotions involved in care of the elderly. In anticipation of these we present the theoretical material in some detail immediately below in this chapter.

1.6.2 Clinicians' anxiety and patient care

To conceptualize anxiety we draw on object relations theory, the branch of psychoanalysis associated with Melanie Klein (1959) and, in particular, the work of scholars who applied object relations to an understanding of groups (Bion, 1961) and organisations (Jaques, 1952; Menzies, 1970; Klein, 1987; 1983) hypothesising that an infant responds from the earliest time to the withdrawal of the maternal breast by experiencing a powerful anxiety of a 'persecutory nature'. Being unable to grasp the separation from the breast intellectually, the infant, unconsciously, feels as if every discomfort were inflicted by hostile forces. A fundamental *splitting* takes place, whereby an object is experienced as two separate objects, one entirely good and one totally bad. Thus there is a good breast (which is always present and nourishing) and a bad breast (withdrawing and denying), a good mother and a bad mother.

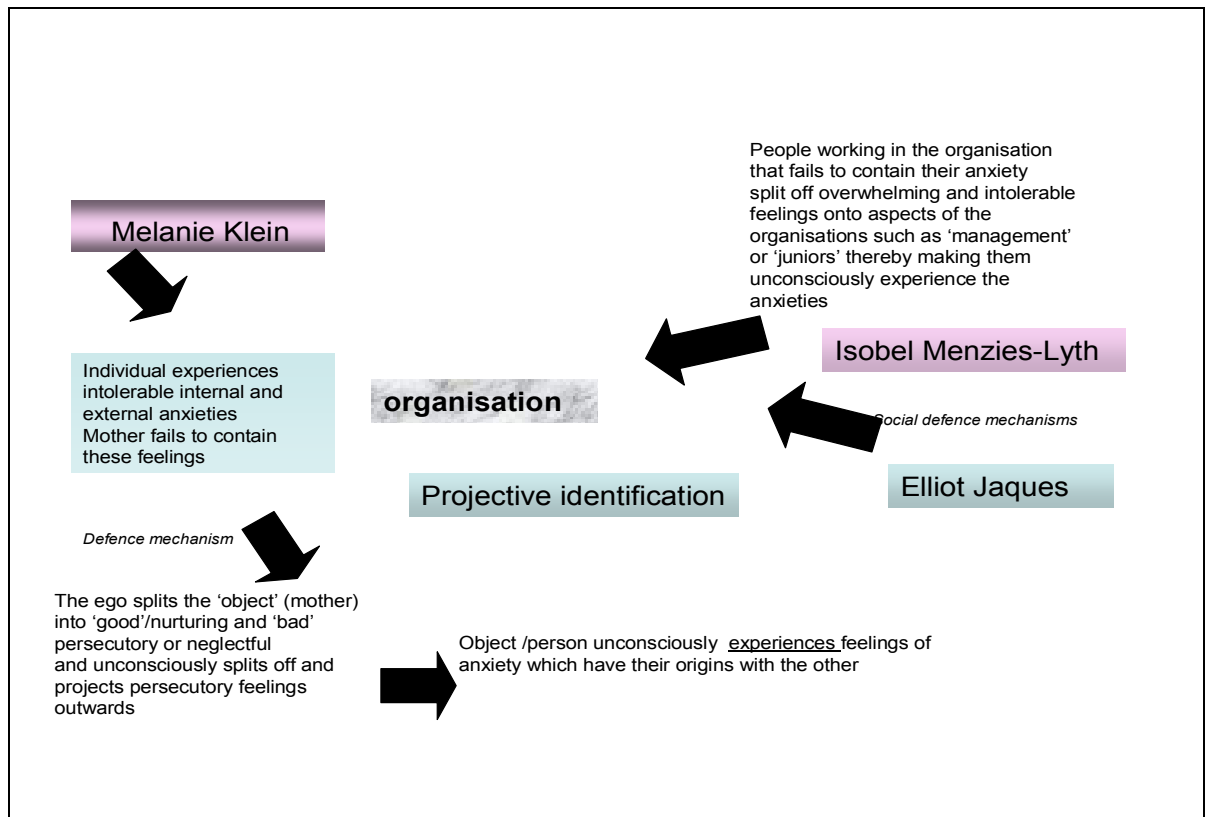
This is a pattern repeated in clinical settings, where patients routinely refer to a 'good nurse' and a 'bad nurse' and, almost identically, clinical staff referred to some patients as 'a good patient' and to others as 'a bad patient' (see Chapter Nine for an example of this). Splitting according to Klein extends in the child's own self – those aspects of him/herself that she cannot bear are projected outwards ("It is not I who is angry/fearful/envious; it is you"). Again this is a phenomenon observed many times in clinical settings. Frustration, discomfort and pain are experienced as persecution from hostile forces and their concomitants (e.g. hate) become destructive impulses which *are still operative in later life*, especially in times of stress and crisis.

Splitting and projection then are seen as fundamental *defences against primitive anxieties* by the object-relations school of psychoanalysis. Within this tradition, objects are not external entities but are shaped by phantasies¹² and feelings, they are *introjected* and projected, they split into good and bad and they constantly define and re-define the ego (or self). Object relations theory has found numerous important applications in the theory of organisations, primarily through the works of Jaques (1952) and Menzies Lyth (1960; 1970) in the UK, and more recently, Hirschhorn (1988), Gould (1993), Diamond (1993), Schwarz, (1990), Schwarz and Clore (2003) among others. Notable among these applications is the

¹² 'Phantasies' spelt in this way refers to those in unconscious experience.

treatment of *the whole organisation as an object which is liable to become incorporated in psychic reality* and towards which the individual may develop relations akin to early relations with significant objects from her environment and hold the 'organisation in the mind' (Armstrong, 2005) which we will discuss in more detail in the context of evidence from the study in Chapter Six.

Figure 2. Social Defences against Anxiety in Organisations



Menzies-Lyth, whose 1960 classic study of nursing staff occupies a privileged position in this literature, was driven by her initial observation that nursing work is highly anxiety-producing. She argued that nurses confront many different emotions from patients and their relatives - gratitude for the care they offer, admiration, envy for their skills and resentment stemming from forced dependence. Such projections create strong feelings in the nurses themselves:

The work situation arouses very strong and mixed feelings in the nurse: pity, compassion and love; guilt and anxiety; hatred and resentment of patients who arouse these strong feelings; envy of the care given to the patient. (Menzies-Lyth, 1988 , p. 46)

Faced with such an emotional cauldron, many nurses re-experience infantile persecutory anxieties, from which they seek to defend themselves, through

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the familiar mechanisms of projection, splitting and denial. Menzies-Lyth's important contribution was to establish how an organisation's own bureaucratic features, its rules and procedures, rotas, task-lists, paperwork, hierarchies and so on, in short '*the system*' acts as a support for the defensive techniques. By allowing for 'ritual task performance', by depersonalizing relations with the patients, by using organisational hierarchies, nurses contained their anxiety. Yet, in Menzies-Lyth's view, such organisational defences against anxiety were ultimately unsuccessful:

The system made little provision for confronting anxiety and working it through, the only way in which a real increase in the capacity to cope with it and personal maturation would take place. As a social defence system, it was ineffectual in containing anxiety. (Menzies-Lyth, 1991, p. 363)

The system's inadequacy in Menzies-Lyth's study is evidenced by its failure to train and retain nurses, the chronically low morale, high levels of stress and burn-out and absence of work satisfaction. By contrast, institutional health is testified not only by performance and output indicators, but also by morale indicators, and individual feelings of growth and maturation. Social defences against anxiety, then, are self-defeating. Instead of *containing* anxiety, they exacerbate it, just as neurotic symptoms far exacerbate the patient's malaise instead of containing it. Since Menzies-Lyth's pioneering work, some attention has been paid to how to support nurses and enable them to contain their emotions, without resorting to depersonalizing social defences. Yet, there is ample evidence that many nurses today continue to struggle with modest support against powerful anxieties (Theodosius, 2006; 2008). It is striking that no single study has sought to examine whether doctors face similar types of anxieties as nurses, whether they resort to similar psychological defences and the extent to which these defences function effectively across different individuals. In Chapter Nine we see evidence that doctors too appear to react similarly when faced with intolerable anxieties.

1.7 Developing our approach to leadership and the NHS

Studies of leadership and organisations such as the NHS clarify that diverse disciplinary perspectives have come together and separated more than once over the past century. The relationship between organisational and social context over that time has impacted on both practices of leadership and empirical and theoretical changes. In the 21st century the rules of scientific management or leader as therapist no-longer apply, and the rapid changes in organisations such as the NHS brought about by economic and technological imperatives, have left many who engage in leadership

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discourses, for practical and academic purposes, moving between the transformational and the post-heroic positions.

We now consider theoretical perspectives, ideas and practices that can potentially be brought together to good effect in this study for the benefit of patients and those who work for their good within the NHS, focusing on some of the recent debates which explore the context of leadership and the place of distributed leadership as they apply to NHS contexts.

1.7.1 The base-line:

- It is now widely acknowledged that organisations, their leaders and followers come together in a highly *emotional context*. How can those who lead and work in such organisations take account of the role of emotion while not being 'emotional' (i.e. making unfair and irrational decisions)? Understanding this is vital for enabling management and leadership particularly in a complex institution which has patient health, safety and care at its cutting edge (Morgan, 2006) .
- The NHS, individual Trusts and Units within these Trusts are constantly engaging staff in *change* (which may be evolutionary and/or politically driven) and which may be motivational and/or stressful or resisted (McNulty & Ferlie, 2002). This further demands emotional and social intelligence and engagement from leaders and followers (Bovey & Hede, 2001).
- The primary *tasks* and related *roles* might conflict at various points as these changes impact emotionally and intellectually on staff performance and service delivery (Zoller & Fairhurst, 2007).
- Organisations have to have leaders but leadership is not necessarily always the province of a small group of individuals but depends on the structure and demands placed on the organisations and the tasks required at any one time (Currie et al., 2009; Day et al., 2006; Harvey, 1989; Michie & West, 2004).
- An emotional context requires attention to both conscious and *unconscious* dimensions of human interaction and power relationships which may come into play in organisations which comprise multiple professional disciplines, different grades of role and people from diverse cultures, sexualities and gender (Ford, 2006; Gabriel, 2004). Acknowledgement of the importance of anxiety, envy, competition, anger and the emotional ties between people needs to be taken into account (see Figure 3 below).

Two models of leadership are therefore examined in this study (see Figure 3 below):

- First, *inspirational and transformative (or engaging) leadership* which has attracted much recent attention in that its absence was seen as a critical factor behind the failure of many organisational innovations. In this approach, leadership hinges on leaders' ability to communicate effectively, relate emotionally with their followers and develop a vision that is both attractive and achievable. The role of transformational leadership then is to lead an organisation towards change and thus some elements of transformational leadership are essential for understanding the practices and needs of the NHS (Alban-Metcalf & Alimo-Metcalf, 2009).
- The second relevant dimension is *distributed leadership* (sometimes called *dispersed, distributive, collective, or supportive 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). A *distributed leadership* approach is consistent with Bailey and Burr's (2005) research on successful NHS Trusts, which states:

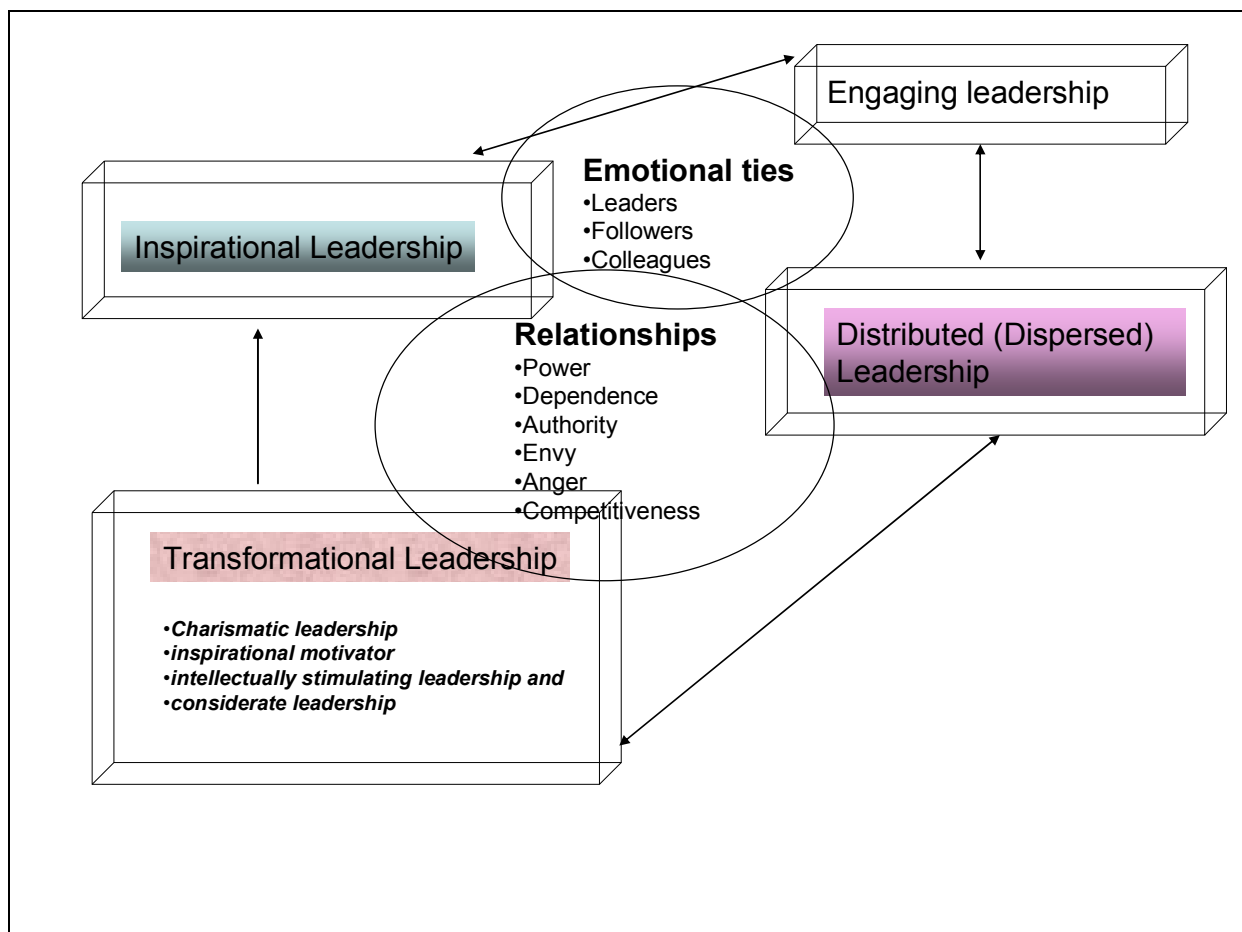
In contrast to the individual, heroic leader concept, leadership is seen in terms of the influence processes that contribute to the collective and individual capacity to work effectively. This idea of collective and distributed leadership is closely associated with the emergence and special requirements of 'new' organisational forms generally and the NHS in particular it is consistent with the agenda for devolved decision – making, empowerment of the frontline, de-centralisation, inclusion and such initiatives as 'Leadership at the Point of Care'.

Thus, distributed leadership is seen by Bailey and Burr (2005, p. 14) as directly linked to patient care.

A combination of these two models might now be seen as 'engaging' leadership as described by Alimo-Metcalf, Alban-Metcalf et al. (2007) and this combination will be explored further in our analysis of the (qualitative) data in particular.

Furthermore the model of the post-industrial/postmodern and or networked organisation will be 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).

Figure 3. Leadership Styles, Followership and Emotion



1.8 Conclusion

In an organisation like the NHS there are opportunities for leadership at all levels, as well as opportunities for success and unforeseen consequences leading to failure. Leaders in the NHS are involved *transformationally* in responding to policy initiatives and government demands, but the NHS is also an organisation that relies on the knowledge, skills and abilities of all its people – leaders and followers.

It would seem that *transformational/engaging and distributed leadership* are particularly useful conceptual resources to deploy in the context of the National Health Service, where a workforce of different ethnic, cultural and

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class backgrounds caters to the needs of a similarly diverse patient population.

Following Alimo-Metcalfe, Alban-Metcalfe et al (2007) "*an engaging 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'*" (2008, p. xi).

As part of the conceptual framework we develop, it is clear that the *emotional links* between individual staff, groups of staff and staff and patients need to be privileged as they play out at various organisational levels. Implicit therefore is that emotions above and below the surface (conscious and unconscious) are taken into account if the leader/follower and staff/patient relationships are to be understood and improved.

2 Aims and Methods

2.1 Introduction

The research questions in this study centre on identifying:

- (a) processes by which leadership is transmitted through health service organisations to effect the delivery of health services, and
- (b) how features of the organisation, the leader, and the service influence these processes.

The focus of this study was to explore the relationship(s) between (good) leadership in NHS organisations and (good) patient care. This demanded consideration not only of leadership characteristics, qualities and styles but the ways in which NHS organisational climate and culture interacted with individual practices and identities of those who worked in them and were patients. The overall plan was, thus, to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery. This research further sought to expand existing knowledge by exploring the following questions.

1. First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
2. Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

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3. Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

2.2 Aims and Objectives

We separated these overarching research questions into aims and objectives thus:

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients;
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts on service delivery;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted through health care organisations to affect service delivery, posits *organisational climate* as one feature of the organisation that could positively or negatively affect the quality and delivery of health services.
- To learn how different stakeholders (specifically, patients, nurses and professions allied with medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care.
- To identify how the need for change in service delivery is identified and what drives the need for change.

2.3 Methods

This multi-method study therefore uses a mixture of qualitative and quantitative methods to enable and support an innovatory approach to examining the psycho-

social and psychodynamic factors intrinsic to the meanings and processes of leadership, organisation and patient care.

Qualitative research methods now have a strong and long-standing profile in social science, particularly sociology and anthropology. But over recent years they have become increasingly relevant in social psychological research.

Furthermore nursing research (Finlay & Ballinger, 2006; Kerr, 2002) and most recently even health services research have begun to take evidence emerging from qualitative methods seriously. Perhaps this began with a series of papers in the British Medical Journal in 1995. Pope and Mays for example leading on this series aptly titled their paper *Reaching the Parts other Methods Cannot Reach* (Pope & Mays, 1995). Noteworthy from this point onwards is that there is no 'one' qualitative method of either data collection or analysis and we draw on several traditions and styles in this study which are outlined below.

Unlike health services research *per se*, but akin to critical social science, there is a powerful tradition in organisational research that has taken account of the diverse nature and intrinsic value of qualitative methodologies to understanding the life of organisations (see for example Cassell and Symon, 1994; Ybema et al., 2009)

What counts of course is choosing methods which meet the demands of the research hypothesis or overarching questions. We thus began from the premise that 'leadership', 'patient care' and 'organisational change' are not objective facts but social or discursive constructions. By this we mean that these concepts are constructed through discourse, i.e. a coherent system of statements which constructs an 'object' (Parker, 2002). In other words, talk about leadership is the process by which leadership is constructed (and thus recognised) as something that happens in organisations such as the NHS.

To capture these constructions we used a range of methods:

- focus groups;
- a survey-based questionnaire including a standardized measure of Organisational Climate;
- ethnographic 'shadowing';
- observations of social places, formal and informal and meetings;
- analysis of 'stories' of leadership collected through in-depth interviews.

2.4 Capturing the data

In what follows we present the outline plans for capturing, managing and analysing the data to meet our aims although as shown in Chapter Three not all of our goals were achieved.

We focused upon three NHS Trusts with at least one being a Foundation Trust specifically to explore whether any variations in the qualities of leadership, organisation and patient care could be distinguished. An

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investigation of three Trusts was considered to be manageable within the time frame and other resources available for the project.

Within each Trust we chose two distinct 'units' to study. We conjectured these would probably to be defined by clinical speciality or site (bearing in mind that many Trusts are organised across more than one hospital/physical space).

We conducted focus groups, an organisational climate survey, story-telling interviews and ethnographic work (observations and shadowing) across these six units with staff and patients.

We employed two researchers¹³ to carry out the majority of this work, but some members of the investigatory team also took an active part in the process.

The qualitative data would by necessity and designed be analysed using a variety of methods:

- a. Thematic analysis (TA)
- b. Critical Discourse Analysis (CDA)
- c. Narrative analysis

Each of these approaches to data analysis, again by necessity and design, was subject to nuances of interpretation, intrinsic to their nature.

¹³ In the event three researchers were involved because of maternity leave and cover.

locality, size and community) and that the sample had to include one Foundation Trust.

- they were in easy reach of London (for practical purposes as the study team were based in London and Surrey).
- we were able to gain access via personal contacts in R & D or senior management (the 'gatekeepers').

The Units

Sampling of the Units in each of the Trusts was achieved through negotiation with the gatekeepers and/ or key informants recommended by the gatekeepers with the intention that a balance might be struck between:

- the specific academic interests of the research team (for example the PI is particularly interested in Obstetrics and Gynaecology services).
- some degree of opportunity for comparison between Trusts, so that if possible some similar Units might be compared across the Trusts.
- and (possibly most influential) the concerns of the gatekeepers and other senior Trust staff.

The Sites

All three Trusts selected for an initial informal approach were on more than one site although the selection of study unit determined whether or not the data was collected on more than one site.

Individual Participants (staff)

Individual participants were to be selected on an 'informed' volunteer basis. That is that via a process of meetings with key informants and presentations to staff-groups individual staff would hear about the study and be offered the opportunity to participate. For those who were not involved in the meetings or presentations a staff e-mail list was used to communicate information about the study and request volunteers to participate in interviews and focus groups. The intention to meet the study aims was to ensure participation from a variety of staff groups and levels of seniority.

Individual Participants (patients)

Patients were to be recruited for interview either by the staff directly caring for them or by the researchers themselves once the staff of each unit had become familiar and accepted the presence of the researchers.

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Survey Respondents (staff)

The Organisational Climate Survey (OCS) was to be administered within the Units that were the focus of the study and, if possible, across other Units in the Trusts. The circulation was to be achieved either through e-mail or through internal mail depending on negotiation with the relevant gate-keepers.

Survey Respondents (patients)

Patients who might complete the patient version of the survey were to be recruited by staff and/or researchers if staff permitted the researchers 'on the ground' access.

Observations and 'Shadowing' (staff and patient-staff interactions)

These methods would require the participants to be familiar and comfortable with the presence of the researchers and familiar with the ongoing research process and also be prepared to co-operate. The rules for engagement in the activities would then be made on a strategic (i.e. the staff and / or situation that would yield the richest source of information) and a pragmatic basis (i.e. the possibility of the situation yielding important data regarding leadership, organisational culture and climate and patient care).

2.6 Ethical considerations

There are clearly considerations about confidentiality and anonymity in all data collection which involves human participants Easily identified in this study (and thus in the NRES application) is the matter of the safe keeping of the raw data including completed questionnaires, any identifying characteristics of these questionnaires, digital recordings, transcripts from focus groups and interviews and the researchers' field notes. It is important to note that this is not necessarily as simple to do as it is to describe particularly because a team of investigators, the researchers themselves and some 'casual' clerical staff ¹⁴all had different types of access to the data.

The solution was to have a shared drive set up by the computer centre at Royal Holloway, University of London (RHUL) on the main site at Egham which could only be accessed by specified investigators identified by the PI. Additionally there was an access pass-code to read the transcripts and the SPSS file.

¹⁴ The sheer volume of data made it necessary to use more than one person to input the data and transcribe the recordings. Two people other than the researchers were engaged to work on this although both were employees of RHUL who knew the importance of keeping the data safe.

Another ethical consideration specific to this project was that because the staff were discussing leadership and being asked to give examples of good and bad leadership, as well as examples of effective and poor patient care, it was inevitable that:

- they would be talking about *other* members of staff. These other staff could not be told that they had been talked about (by definition) leaving them unable to provide their version of the story or aware of the fact they had been discussed.
- the researchers would therefore be 'holding' some knowledge of others which would be 'data'. This fact drew attention to the ethical and empirical complexities of working in an organisation in which data is being collected on human interactions and relationships.

As patients' experiences and views and staff's views of patient care were also part of this investigation, similar issues applied.

Finally, frequently overlooked but nonetheless very important consideration was given to the fact that participants' time should not be wasted. We were confident in the design and our experience as investigators supporting and managing the researchers (who themselves were experienced in this kind of study) that the study was robust enough to adapt to the vagaries and quirks of 'real life' and that the outcome would be valid and add value to existing knowledge.

2.7 Methods of data collection and research instruments

As described above a mixture of qualitative and quantitative methods were used to ensure a full picture of leadership in the organisations to be studied. Collecting data in applied settings, where the participants are also engaged on a day-to-day basis is demanding work which is challenging for researchers involving persistence, social skills, the ability to develop rapport, clarity of purpose combined with flexibility, the skill of 'thinking on your feet' and making practical judgements about what is feasible at any one time. For example, if plans had been set for an interview with a staff member who was then called away for an important work matter, the researcher could arrange other potential participants or be prepared to engage in a period of systematic observation.

Immediately below we describe the methodologies we chose to employ to conduct our investigations which will be described in greater detail where appropriate in the context of specific case studies.

2.7.1 Focus groups

Focus groups, once the province of market researchers, in common with in-depth interviews, are now a popular method of collecting psycho-social data in the area of health research (Nicolson & Anderson, 2003; Nicolson et al., 2008) having gained recognition in social science overall as a robust way of eliciting “*shared and tacit beliefs, and the way these beliefs emerge in interaction with others in a local setting*” (Macnaghten and Myers, 2004, p. 65 in Seale et al) (p.8). In other words focus groups represent a means of gathering a sense of how those who work in an organisation share a sense of their ‘organisation in the mind’ (Armstrong, 2005) which may be mutually accepted, challenged or undermined by the perceptions of colleagues. Focus groups also enable the researchers to check out the quality and effectiveness of the communications themselves between members of the Unit or as Morgan (1998) suggests “*Focus groups are fundamentally a way of listening to people and learning from them* (1998, p. 9).

The process involves one or two researchers meeting with between four and eight participants who share a common situation and the guide lines for the discussion focus on key topics (see Appendices). One researcher takes notes although both are empowered to guide the discussion which is also digitally recorded. One benefit of this means of data collection is that through discussion among peers issues or perspective upon certain issues are brought into focus which might have escaped previous research authors and the researchers themselves (Morgan, 1998).

The *focus group guide* employed a similar structure to the *Interview Guide*.

2.7.2 Organisational climate

The Organisational Climate Questionnaire (OCQ) designed by Stringer (Litwin & Stringer, 1968; Stringer, 2002) also called ‘The Leadership Questionnaire’, was specifically designed to produce a scale to measure leadership in the context of climate albeit in a business rather than NHS setting. To complement the mostly qualitative methods of data gathering and analysis, we developed a questionnaire for staff and patients across the Trusts and used (a slightly adapted form of) Stringer’s measure of leadership and organisational climate, with the expectation that our results might also be linked to other studies undertaken with this measure, which had been used to examine management and leadership in organisations.

It identified six dimensions of organisational climate: *structure, standards, responsibility, recognition, support* and *commitment*, and uses eighteen leadership practices (three for each dimension) to capture how people feel about their jobs, how they are managed, and how things work in a particular organisation. Because this scale is designed to give practical

indicators on how to improve performance, many of the leadership measures are based on management practices, which are equally important to the overall success of an organisation. In general, however, each leadership practice measure is based on the premise that leaders care about arousing the motivation of members in the organisation (Stringer, 2002). The OCS was adapted from to fit a model relevant to NHS Staff working in a hospital setting and another version was adapted to be used with Patients (see Appendices).

2.7.2.1 Measurement tool: Stringer's OCS – Leadership and Organisational Climate

Stringer (2002) defines organisational climate as the "*collection and pattern of the environmental determinants of aroused motivation*" (p. 9) and he takes motivation to be central to the development of his climate questionnaire predominately based on the work of McClelland-Atkinson's framework with regards to intrinsic motivators of work related-behaviour: the need for achievement (nAch), the need for power (nPow), and the need for affiliation (nAff).

Stringer noted that specific dimensions of climate appear to have a predictable impact on motivated behaviour and can be measured and managed by those in senior positions accountable for organisational performance.

The six distinct dimensions identified and measured are:

- 'Structure'
- 'Standards'
- 'Responsibility'
- 'Recognition'
- 'Support'
- 'Commitment'

The statistical data was entered into an SPSS file to seek frequencies, correlations and to explore significance levels of differences and similarities between and within groups of respondents.

2.7.3 The survey structure and items

The survey is structured in two parts:

Part 1: measures *Organisational Climate* or how people perceive the work environment.

Part II: measures *Management Practices* or how people see their own managers behaving.

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Part 1:

This part consists of twenty-four items grouped into the six dimensions - 'structure', 'standards', 'responsibility', 'recognition', 'support' and 'commitment' - designed to measure how people feel about their work environment using a 4 point Likert scale. The directions ask the participants to describe the kind of working climate that has been created in their organisation (defining 'organisation' as the smallest work unit relevant to the participant).

Descriptions of the dimensions are as follows:

1. **'Structure'** pertains to the clarity of roles, responsibilities, accountability and expectations. According to Stringer this is more of a managerial than a leadership issue and one which is more practical than inspirational. It reflects the employees' sense of being well organised and of having a clear definition of his or her roles and responsibilities. *"structure is high when people feel that everyone's job is well defined and is low when there is confusion about who does which tasks and who has decision-making authority"* (Stringer, 2002, p.65).

The following items measure 'structure':

- The jobs in this organisation are clearly defined and logically structured.
- In this organisation, it is sometimes unclear who has the formal authority to make decisions.
- In some of the projects I've been on, I haven't been sure exactly who my boss was.
- Our productivity sometimes suffers from a lack of organisational planning.

2. **'Standards'** is about the need to achieve targets and reach goals. It is the drive to achieve and improve, it includes the 'commitment' and persistence to follow through on set targets. This dimension measures the feeling of pressure to improve performance as well as the degree of pride employees have in doing a good job. When interpreting this measure, high 'standards' indicate that people are always looking for ways to improve performance, whereas, a low score reflects lower expectations for performance.

The following items measure 'standards':

- In this organisation we set very high 'standards' for performance.
- In this organisation people don't seem to take much pride in their performance.
- Around here there is a feeling of pressure to continually improve our personal and group performance.
- Our management believes that no job is so well done that it couldn't be done better (Stringer, 2002, p.65).

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3. **'Responsibility'** is about taking ownership of the work and results which are obtained. Ideally people will be motivated to achieve results and take ownership over these. Where managers delegate and encourage responsibility, workers are more likely to feel a sense of 'responsibility'. It reflects employees' feelings of 'being their own boss' and not having to double-check decisions with others. A sense of high 'responsibility' signifies that employees feel encouraged to solve problems on their own. Low 'responsibility' indicates that risk taking and testing of new approaches tend to be discouraged (Stringer, 2002; p.66).

The following items measure 'responsibility':

- We don't rely too heavily on individual judgment in this organisation almost everything is double checked.
- Around here management resents your checking everything with them if you think you've got the right approach you just go ahead.
- You won't get ahead in the organisation unless you stick your neck out and try things on our own.
- Our philosophy emphasises that people should solve their own problems themselves.

4. **'Recognition'** relates to the relationships between one's performance and associated rewards, as well as broader sense of approval or disapproval of an individual's efforts. It indicates employees' feelings of being rewarded for a job well done. This is a measure of the emphasis placed on reward versus criticism and punishment. High 'recognition' climates are characterised by an appropriate balance of reward and criticism. Low 'recognition' means that good work is inconsistently rewarded (Stringer, 2002, p. 66).

The following items measure 'recognition':

- In this organisation the rewards and encouragements you get usually outweigh the threats and criticisms.
- There is not enough reward and 'recognition' given in this organisation for doing good work.
- We have a promotion system here that helps the best person rise to the top.
- In this organisation people are rewarded in proportion to the excellence of their job performance.

5. **'Support'** is the degree to which there is a sense of warmth and team work, within which the individual feels that they are 'backed up' by others. This will determine the amount of trust and respect amongst team members. It reflects the feelings of trust and mutual 'support' that prevails within a work group. 'Support' is high when employees feel that they are

part of a well-functioning team and when they sense that they can get help (especially from the boss) if they need it. When 'support' is low, employees feel isolated and alone. This dimension of climate has become increasingly important for today's e-business models in which resources are severely constrained and a premium is placed on teamwork (Stringer, 2002, p.66).

The following items measure 'support':

- You don't get much sympathy in this organisation if you make a mistake.
- When I am on a difficult assignment, I can usually count on getting assistance from my boss and co-workers.
- People in this organisation don't really trust each other enough.
- I feel that I am a member of a well-functioning team.

6. **'Commitment'** reflects employees' sense of pride in belonging to the organisation and their degree of 'commitment' to the organisation's goal. Strong feelings of 'commitment' are associated with high levels of personal loyalty. Lower levels of 'commitment' mean that employees feel apathetic toward the organisation and its goals (Stringer, 2002, p. 11).

The following items measure 'commitment':

- Generally, people are highly committed to the goals of this organisation.
- People here feel proud of belonging to this organisation.
- People don't really care what happens to this organisation.
- As far as I can see, there isn't much personal loyalty to the organisation.

Part II:

This part asks the participants to describe the practices of their managers. Using the same six dimensions as in Part I, participants are given eighteen statements which describe the way a manager might perform her or his duty and the respondents are asked to indicate how much he or she agrees with each of the statements. Here a 5 point Likert scale is used.

Once again the six dimensions are used to assess perceptions of managers' practices:

1. 'Structure'

- Establishing clear, specific performance goals for subordinates' job.
- Clarify who is responsible for what within the group.
- Making sure tasks and projects are clearly and thoroughly explained and understood when they are assigned.

2. 'Standards'

- Setting challenging performance goals and 'standards' for subordinates.
- Demonstrating personal 'commitment' to achieving goals.
- Giving subordinates feedback on how they are doing on their job.

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3. 'Responsibility'

- Encouraging subordinates to initiate tasks or projects they think are important.
- Expecting subordinates to find and correct their own errors rather than doing this for them.
- Encouraging innovation and calculated risk in others.

4. 'Recognition'

- Recognizing subordinates for good performance more often than criticizing them for poor performance.
- Using 'recognition', praise and similar methods to reward subordinates for excellent performance.
- Relating the total reward system to performance rather than to the other factors such as seniority or personal relationships.

5. 'Support'

- Being supportive and helpful to subordinates in their day to day activities.
- Going 'to bat' for subordinates with superiors when the manager believes their subordinates are right.
- Conducting team meetings in a way that builds trust and mutual respect.

6. 'Commitment'

- Communicating excitement and enthusiasm about the work.
- Involving people in setting goals.
- Encouraging subordinates to participate in making decisions.

Leadership question

We also asked a single question to capture directly how satisfied an employee is with the leadership they receive from their immediate supervisor. It was a simple statement: *I am satisfied with the quality of the leadership I receive from my immediate manager* which we measured using a 4 point Likert scale.

2.7.4 Ethnographic observations and 'shadowing'

Ethnographic observations and shadowing are especially useful to organisational research because they allow people to *physically* express their inner thoughts, and put ideas into *observable action*, all of which would be inaccessible through the survey or structured interview questions.

Ethnographic observation (often referred to as *participant observation*) has its roots in anthropology but has become increasingly deployed in sociology, cultural and social geographies. In the field (which in this case is a Unit in an NHS Trust) the researcher's aim is to "*understand how the cultures they are studying 'work'*" that is, to grasp "*what the world looks like*" to the

participants in the context being observed (Delamont, 2004, p. 206). In this study observation and shadowing opportunities were (mostly) formally set up and pre-arranged. However, the researchers, through taking their roles as interviewers, focus group leaders and having an every-day presence with key informants, gate-keepers and participants, were able to immerse themselves in the lives and atmosphere of each of the Trusts and Units providing evidence about the processes of leadership and patient care as well as 'climate' (Bloor, 2001; Goffman, 1961).

Shadowing involved the same conceptual framework as ethnographic observation in that the aim was to understand what the world looks like from the perspective of the staff member being shadowed as well as the worlds of the other staff and patients that they engaged with in the course of their work (Czarniawska, 2008; McDonald, 2005). It involved meeting the participant (usually) at 8 am and for one or two days accompany them including at break times until the participant went home. In Trusts where there was more than one site and/or when the nature of the day's work involved meetings outside the hospital (as in nearly every case) then the researcher spent time in a car with the participant and if agreed the conversation was digitally recorded as an *aide memoire* for the field notes. The participant was able to withdraw at any time, or for a period of time, across the shadowing period.

Thus the sense of 'what the Unit world looked like' was recorded in field notes which were then discussed with the other members of the team (who had some familiarity with the relevant part of the Unit/Trust) in a context where the researcher could be reflexive and explore the 'silent space' of the 'ethnographic self' (Coffey, 1999). The researcher's notes and expressed thoughts were then discussed with other members of the team, some of whom were familiar and others not so with the specific context (Barry, 2003). A similar approach was used to discuss the interview material because even though the interviews were digitally recorded and transcribed verbatim, this did not account for the reflexivity that took place following the interview itself and on transcribing and reading the transcript, and therefore featuring in the analysis (Nicolson, 2003).

In this context there was concern to capture the emotional content and atmosphere of the organisations. This meant that ethnographic methodologies were implemented to analyse the emotionality of the interactions (verbal and non-verbal) between patient and practitioner. It was through these observations that the use and importance of the researcher's *body as a 'research instrument'* became palpable, especially for understanding the emotions emerging out of the interactions between patient, relatives and practitioner(s). This process has been proposed as the antithesis of taking for granted that emotion should be removed from

ethnographic investigation and that in fact the research process is highly emotive and far from an emotionally barren terrain (Bondi, Davidson, & Smith, 2005).

As the researcher collects data they move through a continuum of emotions from the euphoric highs of excitement at starting a new research project, sense of achievement and pride as they begin to make contacts and collect initial data, perhaps trepidation, fear and nervousness as they meet new participants or research settings through to the depths of despair, isolation and frustration as the research process (inevitably at times) becomes chaotic and messy. However, these emotions are often neglected, regarded as unimportant to the overall research process and abandoned in the writing up phase. We use these frequently neglected emotions and feelings as part of, and beneficial to, the project as representing a rich source of data.

By being more attentive to their emotions and bodily senses ethnographers also become more sensitive to their environment and their participants thus gaining a greater awareness of what they are observing. In recalling a sound, smell or feeling the ethnographer is able to open up their mind's eye to re-visualise the interaction with greater clarity and accuracy making it more likely that an accurate representation of what was observed will be recorded.

2.7.5 In-depth semi-structured and 'story-telling' interviews

In-depth semi-structured Interviews: Over the past fifteen years this method of qualitative data collection has become increasingly common in health services and health research in general (Pope and Mays, 1995; Kvale, 1996; Grbich, 1999) consistently a method of choice for identifying perceptions, meanings and experiences of dynamic and complex concepts such as 'leadership' and 'patient care' (Rubin and Rubin, 1995; Denzin and Lincoln, 1998; Rapley, in Seale et al, 2004).

The use of such interviews has led to increased levels of sophistication in the interpretation of qualitative in-depth data in the context of historical, cultural and political frameworks demonstrating that in-depth semi-structured interviews (and more generally qualitative research) have capability beyond simply adding rich description to statistical evidence (see Denzin and Lincoln, 2002; Willig, 2008).

Story-Telling: One of the explicit aims of the interviews was to collect a number of stories to reflect critical experiences in the organisations' past and present life. In the field of organisational studies, there is now an extensive literature of how to use stories told by organisational participants

as windows into organisational culture, politics and numerous other phenomena (Gabriel, 2000; Hannabuss, 2000).

The inclusion of story-telling in the context of the in-depth interview increases the scope for making sense of data in ways that delve deeply into the respondents' perceptions and meaning of the *processes* of leadership and patient care. Story-telling also increases the validity of the interview through the use of reflexivity, and positioning the events and 'atmosphere' of the stories in the context of the organisational analysis.

Of particular relevance to this study, stories can instigate insights into the processes of positive or negative social and organisational change and leadership which involves the management of meaning and emotions, both of which rely heavily upon the use of stories, allegories, metaphors, labels and other narrative devices.

The study of *organisational stories* is particularly relevant in health care settings that are liable to unleash strong emotions and fantasies. Hence, hospitals are rich grounds for collecting stories, as numerous researchers have recognized (Kleinman, 1988; Frank, 1998; Greenhalgh, 2002; Hurwitz, 2006; Mattingly, 1998). Storytelling permeates everyday clinical practices and "*medical professionals find ways to 'routinize' their practice and thus, metaphorically at least, bring the unruly and frightening world of illness under control*" (Mattingly 1998, p. 277).

The *interview schedule* (see Appendices) therefore was designed to elicit information on the participant's view of 'leadership' and 'patient care' through 'stories' to provide examples in their opinion that constituted good and poor leadership and good and poor patient care through 'critical incidents'.

As the interviews were semi-structured and in-depth they relied to a great extent on the interviewing skills of the researchers and their ability to establish rapport and consequent willingness of the participants to engage in the process. The early pilot interviews therefore were unlikely to influence the details of the interview schedule itself although the early interviews were planned to enable the research team to identify the best *strategies* to engage participants in the task.

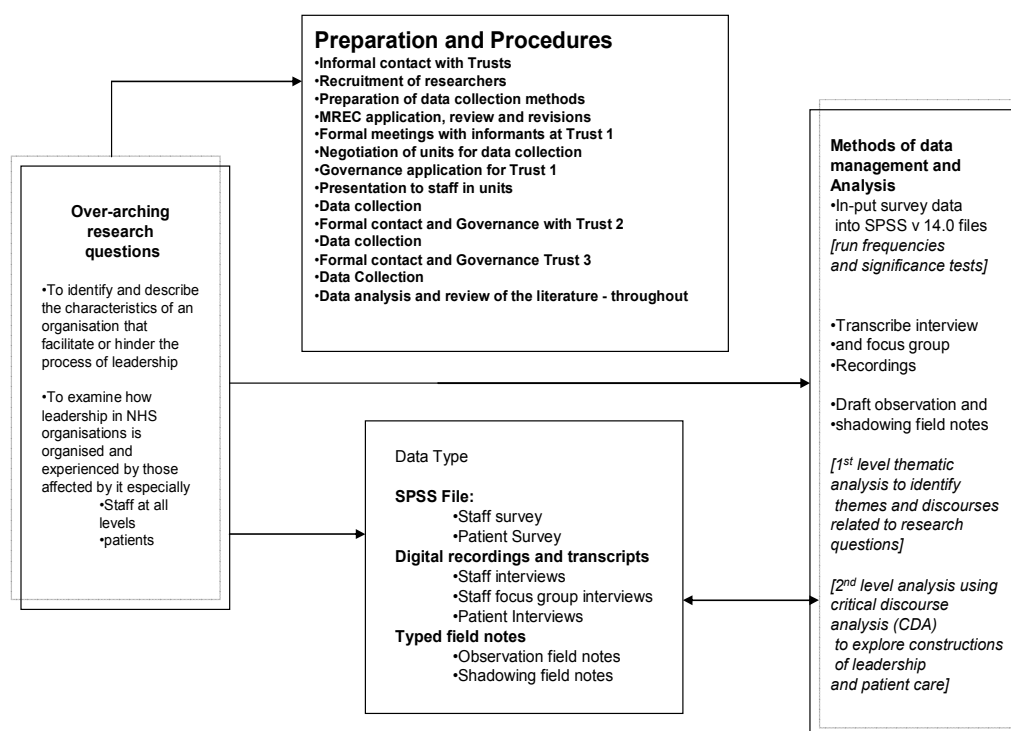
2.8 Data Management

The interviews and focus groups were digitally recorded and transcribed verbatim. The transcripts stored on a password protected Word file (initially on the researchers' PCs but subsequently on the secure shared drive described above) and sound recordings stored on audio files (password protected on the PC of the PI and not on the shared drive).

The OCS data was entered and stored on an SPSS file, password protected and placed on the secure shared drive.

Fieldwork notes from observations and shadowing were similarly password protected stored on the shared drive once they had been prepared by the individual researchers.

Figure 5. Outline of Study Procedures and Methods



2.8.1 Data Analysis

There are effectively therefore three categories of data.

1. Qualitative data representing verbatim 'talk' (digital recordings/transcripts) of interviews and focus groups.
2. Qualitative data from observations, shadowing and other field notes. These were subjective accounts of observations, perceptions, emotions and meanings given to the field work by one researcher. This may have been following discussion with the other researcher on occasions when that person had had access to the same raw

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material. Discussion with another member of the investigatory team (frequently but not always the PI) also took place following the first drafting of the field notes in order to clarify the meanings given to specific behaviours and relate theory and data.

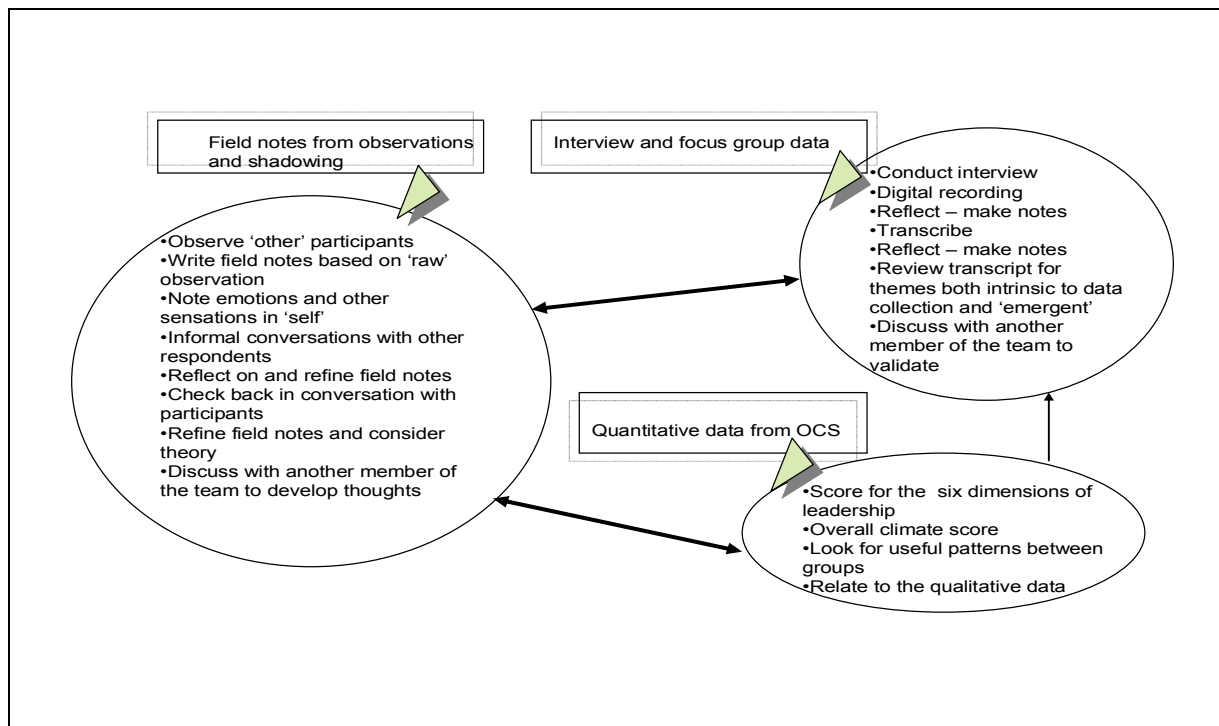
3. Statistical data from the OCS.

2.8.2 Thematic Analysis (TA)

The transcripts and field notes were examined initially for relevant extracts related to the main themes ('leadership', 'organisation' and 'patient care').

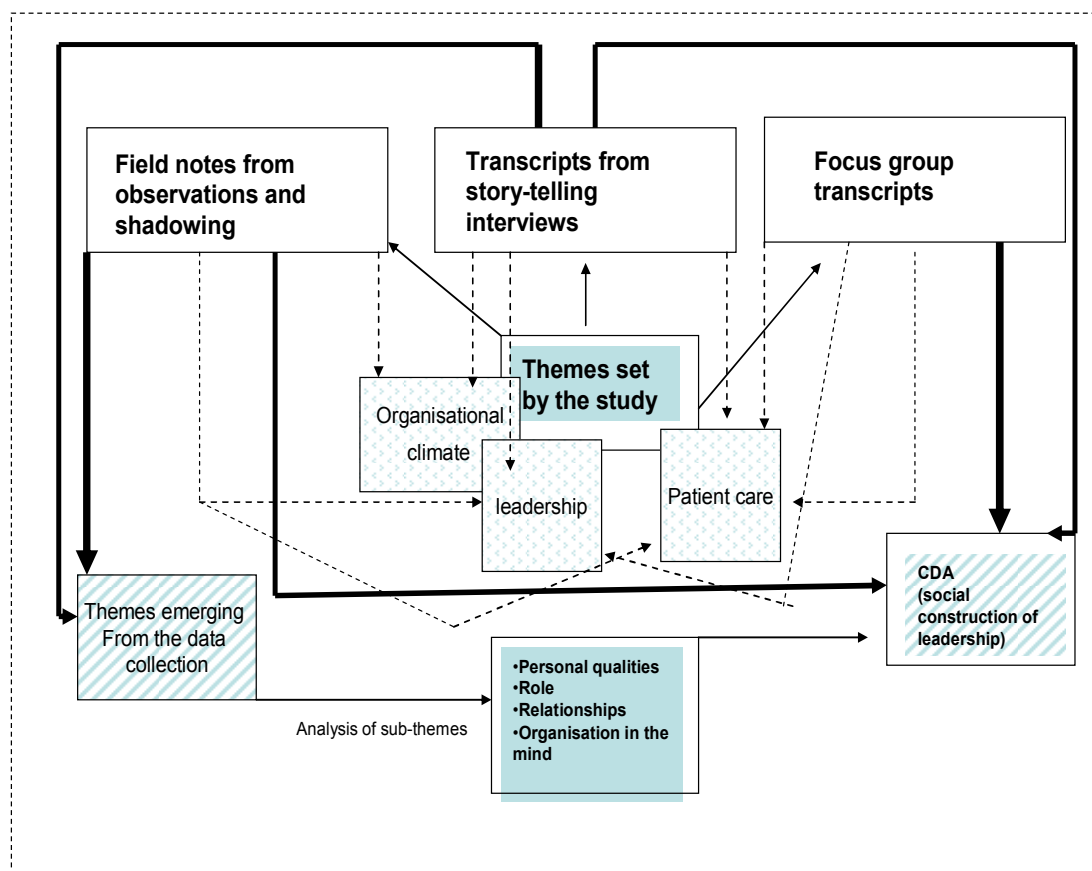
Sub-themes were then to be identified, some of which are likely to relate closely to the previous research literature on leadership and organisational climate, although it is likely that each organisation will demonstrate particular issues that were more difficult to anticipate at the outset.

Figure 6. From data collection to data analysis



Data relating to these themes and sub-themes was to be collated on Word files and where deemed relevant to the study aims, analysed further using the following methods – Discursive Psychology, Critical Discourse Analysis and Narrative Analysis. All these approaches focus on language and the way language is used to construct key concepts (e.g. the organisation) but there are different nuances to each perspective each of which adds an important dimension to the analysis of this data.

Figure 7. Thematic to CDA with Narrative analysis



2.8.3 Discursive Psychology, Discourse Analysis and Critical Discourse Analysis (CDA)

Hepburn and Potter (2004) argue convincingly and with justification that DA has evolved to have several iterations over recent years. One common feature though has been that 'discourse' (i.e. what is said) and 'context' are difficult to separate and it is the ways in which context is worked into the analysis of discourse that distinguishes the character of DA deployed in a particular piece of analysis.

The thematic analysis was a starting point from which to focus in upon the close readings of the texts, which related to the processes of leadership and patient care, as it represents a flexible and clear way of identifying what is emerging from the data and points a way forward with more detailed analysis (Braun and Clarke, 2006)

We argue that leadership is a social construction and there is a growing body of literature providing evidence to support this view. There has also been a recent focus in organisational research and theory to specify an Organisational Discourse Analysis (ODA) (Pritchard, Jones and Stablein, 2004) which involves four approaches i.e. *Narrative*, *Foucauldian*, *Linguistic* and *Deconstruction* which in turn are influenced by a *reflexive awareness* of the organisational culture in which the research is being conducted.

Pritchard et al, (2004) argue further that the exact methodology and approach to the data depends on the 'researcher position' in the organisation being studied. In other words this approach *benefits* from the subjectivity of the researcher's interpretation of what processes mean and specifically from researcher reflexivity about their 'take' on a situation and set of interactions.

To qualify this method of analysis further, a discursive approach means that language is represented not so much as an objective truth but as a means of *constructing* what might be understood (Parker, 1992; Coyle, 2007).

Particularly relevant in this study, in which participants are asked to tell stories and provide evidence to support what is good and bad about both leadership and patient care (and implicitly the organisation in which these actions take place), is discursive psychology (DP) that highlights how "*descriptions of events are bound up with doing actions, such as providing justification for actions and blaming others*" (Hepburn and Potter, 2004, p. 169).

Thus Critical Discourse Analysis (CDA) sees language as a *social practice* and thus considers carefully the context in which language is used (see

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Wodak, 2004). CDA is related to the notion that *power is negotiated through language*. This is particularly apposite in a study of leadership in organisations. Even more so CDA is 'abductive' so that a constant movement between theory and empirical data is needed which suits ethnographic methods such as shadowing and observations enabling the researcher to test out their ideas as they progress with the data collection, and the attempt to understand how cultures work and how the research participants make sense of and experience their worlds.

2.8.4 Narrative Analysis

Narrative approaches to data analysis have been able to cut through the great complexity of the NHS - the intense emotions, positive and negative, it evokes among most of its stakeholders (e.g. Rooksby, Gerry & Smith, 2007; Bryant, 2006; Iedema et al., 2009; Brown et al., 2008; Elkind, 1998; Brooks, 1997). These studies have, for example, addressed power issues in the doctor-patient relationship, exploring communication in a consultation situation. In these analyses, the patient's 'subordinate' narratives have often been neglected or taken over by the doctor's privileged 'medicalizing' discussion (Mattingly, 1998, p. 12; see also Radley, Mayberry & Pearce, 2008). However, there is also a recognition that many of these narratives are co-constructed by patient and physician (Mattingly, 1998, p. 43; Kirkpatrick, 2008); exploring solely the patient voice in isolation and presuming that doctors will at all times occupy a dominant position in this relationship may be missing half of the story - the doctor's experience. As Mattingly (1998) points out, *"[h]ealers too, may be able to give a different kind of voice to their practice when they describe their work in narrative terms rather than the flattened prose of biomedical discourse"* (p. 14).

As a genre, narrative psychology is thriving (Smith & Sparkes 2006). There has been talk of the 'narrative turn in psychotherapy and psychiatry' (Brown, Nolan, Crawford & Lewis, 1996), and Crossley (2003a & 2003b) for example argues strongly for a 'perspective that retains a sense of both psychological and sociological complexity and integrity' noting that narrative psychology is concerned with 'coming to grips with how a person thinks and feels about what is happening to her' (2000, p. 6). She employs a phenomenological framework to explore narratives of 'the voice' of 'the mentally ill' (Crossley & Crossley 2001) and the experience of temporal elements and self/identity of people living with serious illness (HIV, cancer; see also Söderberg, Lundman & Norberg, 1997). Narrative research in health care has also been used to study the lived experience of patients (see for example Hemsley, Balandin & Togher, 2007; Hök, Wachtler, Falkenberg & Tishelman, 2007) and an emerging genre of 'narrative based medicine' seeks to make use of stories in developing a fuller understanding of illness experiences (Launer, 2003; Taylor, 2003; Greenhalgh, 1999).

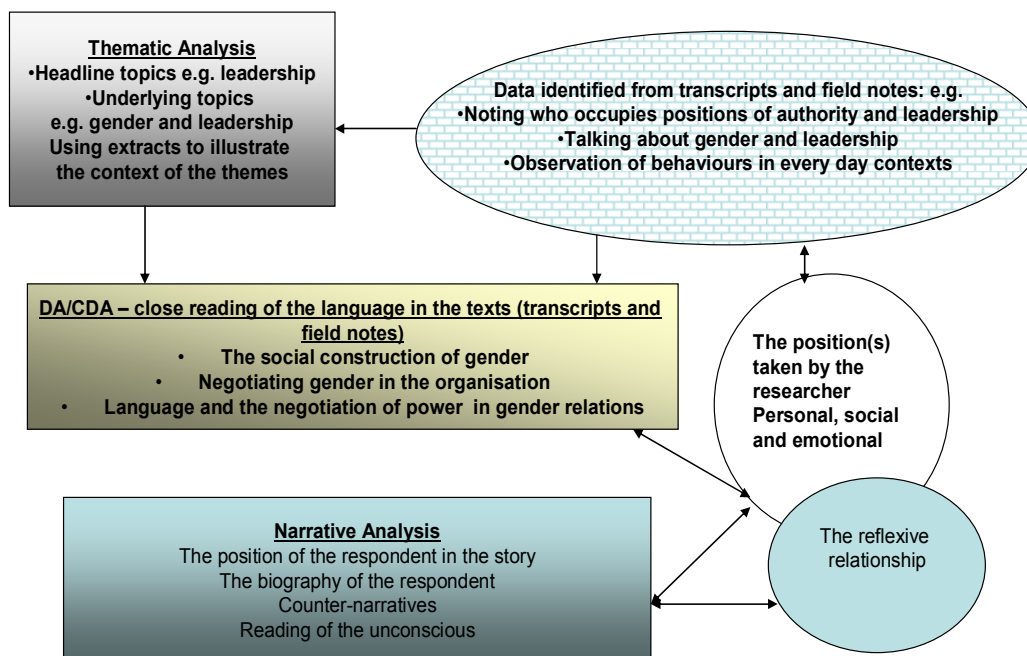
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Narrative based medicine is not merely an insightful way of doing research, but may have powerful policy implications. As Overcash (2003) argues, "*narrative methods are an effective research option that can lead to enhanced patient care*" (p. 179). While interpreting narratives can enhance the possibilities of integrating evidence-based research findings with individual illness experiences, and Winterbottom and colleagues (2008) suggest numerous courses of further research on why and how narratives may influence medical decision making.

Narrative analysis, as with DA, has been approached differently by academics from a range of disciplines so that the ideas surrounding the analysis of *narratives* (or stories told in a sequence) have a variety of emphases. The strength of taking the narrative approach over DA /CDA *per se* is that the 'subject' of the story (the narrator) retains a central role (Crossley, 2007). This can be seen in some detail in subsequent chapters particularly where the accounts of ethnographic observations and shadowing are highlighted where the 'story' becomes that of the researcher herself and with the stories unfolding through the interviews.

Furthermore the narrative analysis places the respondent's story as part of their own *identity construction* which lends an important dimension to the relationship of the story-telling to the teller. Particularly interesting here is Andrews' (Andrews, Sclater-Day et al., 2004) approach which focuses specifically on the elements of stories "*that lie in tension with the ones we are socialised to expect*" (2004, p. 97) or what she calls 'counter-narratives'. Researchers such as Hollway and Jefferson, 2002; Gough, 2003; Sclater, 2004; Allcorn, 2004 and Gabriel, 2004 and 2005, take on board the role of the interlocutor in positioning themselves in their story while considering some of the unconscious and emotional elements both of the story being told and the way that the relationship between the researcher and respondent plays out to construct and limit the story that is told. This dimension is particularly important in the context of this study where emotions are rife at least in part because of the high pressure (exacerbated to some extent by the changing political initiatives directed towards NHS institutions) and the particular nature of the work in caring for ill people (see for example Menzies-Lyth 1960).

Figure 8. Levels of qualitative data analysis e.g. 'gender'



2.8.5 Statistical Analysis

The data from the OCS was coded and in-putted into an SPSS v 14.0 file and significance tests were run (see Chapter Five for the full details).

3 Research Procedure

3.1 Introduction and Overview

The nature of this study, much of which involved the researchers immersing themselves in the 'world' of the participants, meant that it is not possible to provide an authentic *sequential* account of the procedure of data collection except possibly for the administering of the OCS (Organisational Climate Survey).

The bulk of the study, as identified in Chapter Two, comprised multiple methods of collecting different types of data across three Trusts, six Units and five sites.

3.1.1 Negotiating Access

The study took place across a three year period. Negotiation of access was complicated as indicated, although in itself a valuable procedure which occurred at several levels and helped to increase the richness of the team's understanding of leadership, patient care and the context of each organisation.

- Negotiating access began from the 'notional' level while writing the grant application whereby the investigatory team needed to identify whether a project with this design was in fact feasible. We thus made informal inquiries via personal contacts.
- More formal contacts were made once the project was confirmed with the intention to achieve verbal agreement about access for planning the NRES application.
- Following that we met to formalise the details with key informants (i.e. senior clinicians and managers) who had been identified in the previous stage.
- Once we had achieved a favourable NRES review, we pursued local governance applications with the help of the key informants.

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- These stages were managed by approaching one Trust at a time although during the latter part of the study some overlapping negotiations and governance were necessary.
- Part of the formal stage of negotiation concerned consideration of which *Units* could/would form the focus for the study. This was very much two-way but also serendipitous with suggestions from the team of investigators moderated by whichever senior clinical staff the key informants considered would be amenable to 'hosting' the study.
- The key informants then identified opportunities for the team to present the project to staff in the selected Units in 'educational half days' or 'staff meetings' depending upon the local structures.
- These formal presentations only took place in Trusts One and Three however. The procedure in Trust Two (because of the culture, location and structure) was on the basis of a 'tour' (which with permission was digitally recorded) organised by a senior nurse manager so the researchers, one of the co-investigators and the PI could meet various key nursing and medical staff across one of the Trust sites.

Once all that had been achieved it was the researchers on the whole who managed the day-to-day negotiations about who could and would agree to take part in the various elements of the study. This was complicated because of the day-to-day patterns of staff, changes in staff roles, particularly at senior levels, shift patterns and the sheer numbers of staff who may or may not have been aware and willing to allow access to, say, a particular meeting or team for observation or interviews.

Figure 9. Procedures and time-line

	2006/7	2008	2009
Winter	<ul style="list-style-type: none"> •Recruit and prepare researchers •Informal contact with 3 Trusts 1 and 2 •Informal visits to Trusts 1 and 2 •Develop research instruments •Prepare COREC/NRES application •MREC presentation and revisions •MREC approval •Start to review literature on leadership 	<ul style="list-style-type: none"> •Arranging formal contacts with Trust 2 (on 2 sites) •Visit to Site A •Further data collection in Trust 1 •Patient interviews 	<ul style="list-style-type: none"> •Researcher begins maternity leave and new researcher inducted into the team •Data collection in Trust 2 Site 2 •<u>[difficulties gaining access to staff list in Trust 2 for survey]</u> •Presentation to staff in Trust 3 (Unit 1) •Distribution of staff survey (individually handed out) in Trust 3
March - June	<ul style="list-style-type: none"> •Formal meeting with Trust 1 R & D director •Governance application •Formal meetings with senior staff to negotiate units for study •Unit based meetings and introductions •Presentation at educational half day on Unit 1 (obs & gyn) of Trust •Pilot interviews •Pilot staff survey 	<ul style="list-style-type: none"> •Formal meeting in Trust 2. Tour of Site A •Visit to Site 2 •Governance for Trust 2 •Informal meetings •Data collection begins in Trust 2 •<u>Trust 1 staff in Unit 1 return surveys to PI saying they won't give them out</u> 	<ul style="list-style-type: none"> •<u>[further difficulties gaining access to staff list in Trust 2 for survey – now due to key staff transfers]</u> •Preparation and presentation of invited paper to SDO conference in June •Paper preparation and further conference presentations
Summer	<ul style="list-style-type: none"> •Organise, send out and in-put data from staff survey in Trust 1 •Observations and interviews with key staff •Presentation to Unit 2 •Focus groups and interviews on Unit 2 	<ul style="list-style-type: none"> •Application for extension to project (successful) 	<ul style="list-style-type: none"> •Put staff survey on Trust 2's 'intranet' with information about how to complete and return •E-mail staff in Trust 3 who had not received a staff survey •<u>[a low response in both cases]</u>
Autumn	<ul style="list-style-type: none"> •Data collection •Data in-putting from staff survey •Patient survey given to staff on Unit 1 to distribute 	<ul style="list-style-type: none"> •Preparation of journal paper 1 •Further review of literature •Governance for Trust 3 •Identifying key contacts in Trust 3 •Negotiation about Unit 1 (Care of the Elderly) 	<ul style="list-style-type: none"> •Journal paper 1 (anxiety) being revised for publication •Journal paper 2 in preparation (gender) •Journal paper 3 (in preparation) leadership and 'territory') •Presentation prepared and delivered to NHS Surrey and Borders conference •Final draft report

3.1.2 Time frame and Participation of Investigators

We negotiated the formal details of access consecutively in order to make the process manageable. Most data was collected by the researchers (Dr. Fox, Dr. Lokman¹⁵ and Ms. Rowland) although the PI and other investigators made the initial contacts, met with key informants, contributed to the presentations and conducted some of the interviews and focus groups and (Profs. Gabriel and Nicolson, Dr. Heffernan and Mr. Howorth). The PI (Nicolson) and at least one of the researchers was present at all initial meetings with the gate-keepers and key informants.

3.1.3 NRES review

This was prepared and submitted at the end of 2006 and the PI, one of the researchers (Lokman) and another member of the investigation team (Gabriel) attended the appointment with London-Surrey Borders Research Ethics Committee in January 2007.

Annual reports were submitted to the NRES subsequently as required.

3.2 Sample characteristics

The three Trusts, selected as stated above in Chapter Two were each very different from each other, not only in formal terms (size, budget, location and organisational structures) but also informally and culturally and this influenced the 'access pathways'. Thus for example in Trust One our informal and then formal contact was with the R & D director (also a senior clinician) and assistant R & D director, who introduced us to the CEO, the clinical directors and senior nurses.

In Trust Two we had begun with meeting the CEO at the 'notional' phase who then retired in the meantime. This meant starting again with delayed local governance and to accomplish this, we were directed towards a senior clinical manager who then changed their role and location which meant dislocation of our planned procedures.

Trust Three involved a personal contact initially who was directly involved as a clinician in one of the Units who then arranged for us to have a

¹⁵ Dr. Lokman worked on the project for over two years and Dr. Fox took her place.

meeting with another senior clinician who in turn arranged for us to give a presentation to the Care of the Elderly/Geriatric Unit. From there we sought a second Unit for Study independently through contacts made during the course of working in the first Unit.

Trust 1 (One site only) a DGH (District General Hospital)

The Research and Development director here suggested the Units for study to be:

- Unit 1, Obstetrics and Gynaecology
- Unit 2, Cardiology

We were happy with his suggestions, and the staff was generally co-operative and supportive of the researchers.

The Trust itself covers two sites but the choice of these Units meant that all data was collected from one site. This was helpful because it meant the researchers and some of the investigators could spend time familiarising ourselves with the layout of the Units and the Trust site and become familiar 'faces' so that gaining consent from respondents was made easier than it would have been if the researchers and the study itself had to be presented as 'new' on each occasion.

While the study was taking place there were many fears expressed among the staff at all levels that the site we were investigating would become the less powerful with the other site taking over many of the executive functions. While the study team were collecting data on this site however this did not happen and the general 'morale' has improved so that the Trust is currently applying for Foundation Trust statusⁱ.

Self-Description of the hospital

The site we studied had 400 beds and a range of acute care services, including an Accident and Emergency department. It is situated in 52 acres of Green Belt parkland within 40 – 60 minutes of London. Originally it was built to serve casualties of the Second World War. Over the years, the hospital has been rebuilt, developed and extended to include maternity services, a departmental and clinic area, and a new theatre complex. In the early 1990s, the X¹⁶ Wing, which includes a Postgraduate Education Centre and modern well-equipped wards, was opened. A new building for the Accident & Emergency, ITU and Orthopedic Unit opened in the summer of 1998. In addition, comprehensive HIV and genitourinary medicine services are provided in a dedicated building.

¹⁶ We have used 'X' to ensure anonymity.

Obstetrics and Gynaecology

The study territory for this Unit¹⁷ comprised the labour ward, postnatal ward, a general outpatient clinic a dedicated ante-natal clinic and the Maternity Services Administration. The unit offered midwife care for home births, one to one care, water births and there was always a consultant obstetrician available and compared to other local hospitals it gained a score of 3/5 which was joint top score.

Cardiology

This Unit studied comprised one in-patient ward, the Medical Assessment Unit (MAU) and the Critical Care Unit.

In addition we spent time in the Management Suite where five interviews also took place of the CEO, Clinical Director, the Director and Deputy Director of R & D and a middle-ranking manager.

Observations also took place in public and eating spaces and shadowing involved walking around the hospital between different specialty wards and administrative departments.

Trust 2 (2 sites)

The Trust was one of the biggest DGHs in London with 4,200 staff. It had had a history of problems in its financial management and the quality of care but recent information on the web-site and confirmed by the CEO made it clear that:

The Care Quality Commission, the organisation that regulates health care nationally, has awarded the Trust a rating of excellent for the quality of services we provide to our local population. This is the highest possible performance rating in the 2008/09 Care Quality Commission annual national assessment report.

It seems that problems with the financial management remain although improvement had been noted.

The structure and organisation of Trust 2 differed significantly from Trusts 1 and 3. Trust 2 comprised two sites (recently combined into one Trust where one was a teaching hospital) which were at least eight miles apart and it

¹⁷ There were other parts of the Maternity Services at Trust 1 that were not observed directly.

was difficult to travel between one and the other on public transport other than using more than one bus or travelling in and out again from London. The journey by car varied from about thirty minutes upwards depending upon traffic.

Physically the two sites were very different. Site A was a relatively new building designed (as one researcher stated) to look like a motel or contemporary hotel. The other, B, was a traditional middle height rise built in the 1970s on a green site and appeared far more formal with long corridors and many signs to departments. Site A was more 'angular' and you could not walk very far without having to turn a corner which presented a very different 'feel'.

It was not possible, particularly in Site A to select a discrete specialist Unit (unlike Trust 1). Site A focused on acute medicine and care of the elderly and there were no formal divisions in where patients were treated as either in-patients or out-patients. So an older person with 'geriatric' health related problems could be in a bed next to a much younger person. We have identified a Unit as a Site in the case of this Trust. We found it equally difficult to 'pin down' a specialty in Site B as well.

At Site B we collected data from acute medical specialties, obstetrics and gynaecology and therapies (the latter being both physical and psychological).

This was in part because senior management at Site A (who were our key informants and 'gatekeepers') introduced us to staff they considered amenable. Thus for purposes of the study we had to identify Site B as our second Unit. Despite the introductions we managed, via snowballing, to find a range of participants who demonstrated many different view points.

To summarise then in Trust 2 the study was carried out in the following two Units which we have identified as follows:

- Site A / Unit 1 (Acute Medicine; Care of the Elderly)
- Site B / Unit 2 (Acute Medicine; Obstetrics and Gynaecology; Therapies)

We also interviewed a Clinical and Nursing Director both of whom worked across both sites and senior managers including the CEO and deputy CEO.

It became clear very early on that there was intense rivalry, even animosity between the two sites and some of this is explored in later chapters.

Trust 3 (2 sites)

Trust Three, in central London, is a long established hospital and a Foundation Trust with connections to a prestigious medical school. Travel

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between the sites took about twenty to thirty minutes by public transport. 9,000 staff are employed by the Trust with 1,100 beds available across the Trust at any one time.

- Unit 1 (Care of the Elderly, Acute Medicine)
- Unit 2 (Therapies)

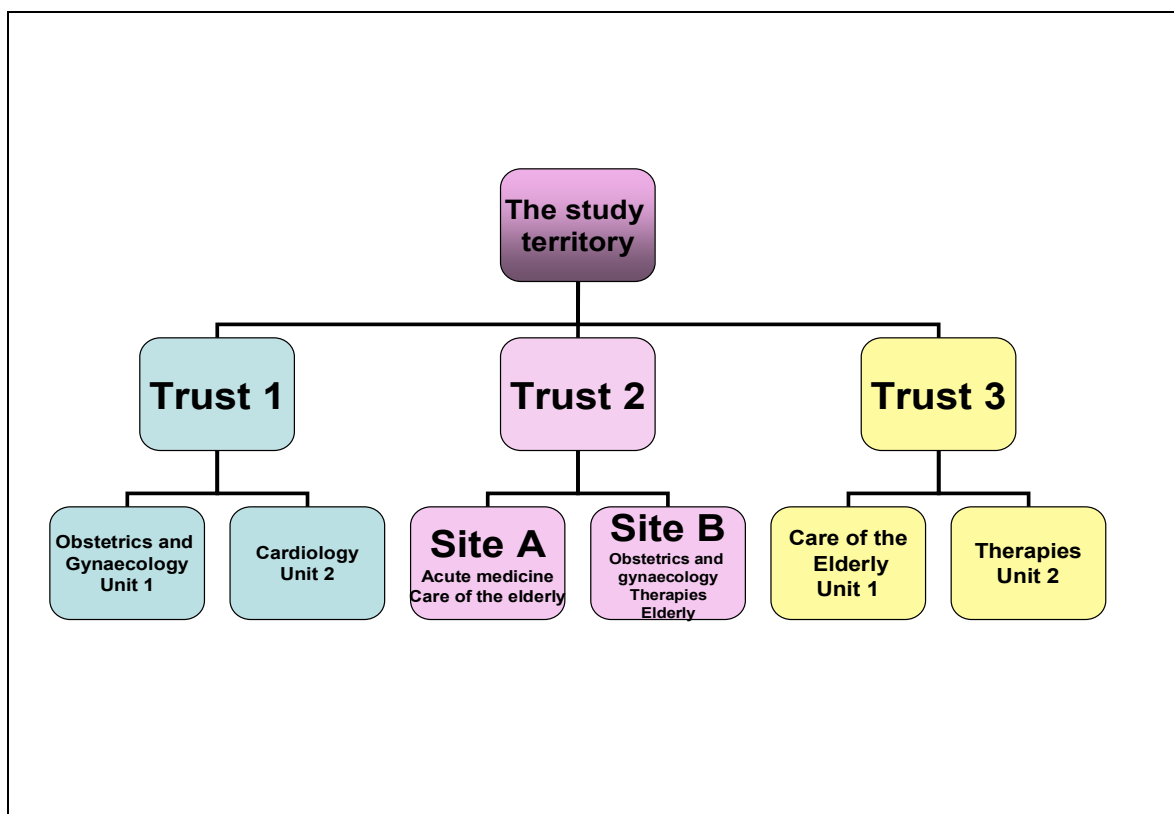
Unit 1 is described on the web-site thus:

Geriatric medicine specializes in the diagnosis and management of common symptoms and diseases in older people, particularly:

- *problems with mobility*
- *falls*
- *continence*
- *difficulties with looking after oneself*

Unit 2 (therapies) which included physiotherapy and psychological therapies spanned both the sites and covered many clinical departments and extended to primary care services especially local GP practices as well.

Figure 10. Participating Trusts and Units



3.2.1 Response rates (qualitative approaches)

It is difficult to identify an accurate response rate for the qualitative components (the majority) of the study because the sampling was conducted in an opportunist manner in many cases – i.e. whether someone agreed to take part in an interview or focus group if the researchers were on site and made a serendipitous approach.

As stated in Chapter Two, much of the qualitative data was collected by virtue of the researchers 'being there' in the right place at the right time and therefore gaining the trust of potential participants. In many cases the researchers were introduced to a member of staff who suggested ways in which other respondents might be accessed. Methods included personal introductions, using e-mail lists or sometimes a staff member knowing what was happening asked the researchers if they might participate in the study.

Overall the majority of staff approached to participate agreed to do so, although circumstances sometimes prevented it (e.g. one focus group was cancelled in Cardiology due to a patient emergency and one observation was cut short because the consultant refused to have the researcher in the ward round, although they had been observing on the ward before the consultant arrived having been given permission by the nursing staff).

Although the key staff across all three Trusts agreed to support the researchers in gaining access to patients for the OCS and interviews, the patient form of OCS was anonymously returned to the PI by someone at Trust 1 saying they did not want patients to participate in that exercise¹⁸.

It proved impossible to administer the patient OCS in the other two Trusts also, because the staff said in advance they were too busy to help and the researchers had difficulty in making contact with individual patients who were always either in busy wards or with a member of staff. Thus interviews and observations were conducted, with patients' consent, during shadowing.

The OCS for the staff is discussed fully in its own right in Chapter Five.

3.2.2 Individual participants

Respondents were either NHS staff or patients so by definition there were elements of uncertainty about whether they would be available at appointed

¹⁸ We sought advice but in line with the NRES review participants could withdraw their consent at any time so we did not feel free to pursue this further.

times and whether (as acknowledged in the NRES consent form) they choose to drop out at any time, even after having agreed to take part.

As shown below in Table 1, forty six respondents took part in in-depth story-telling interviews, thirty nine took part in focus groups. During twenty six days of shadowing of key staff, numerous other staff and patients were involved in data collection and similarly, during the eleven and a half days of observations on wards and in administration areas across the Trusts.

In addition, ten patients consented to be interviewed in depth and, again more staff were involved in the eight meetings that were observed and an introductory walking tour with a staff member in one Trust involved additional staff and patients in the study.

Each of these data collecting encounters represents a different unit of study and a different 'order' of data.

The nature of the study required a commitment of between 30 minutes (for completion of a survey or a short interview) up to two days, in the case of 'shadowing', of respondents time. Most respondents' contributions to the study, however, took about 90 minutes although this also represented an important commitment of their time (and energy).

Table 1. Qualitative Data Collection

Table 1. Qualitative Data by modes of collection							
	Interviews		Focus groups	Shadowing (staff and patients)	Ethnographic observation	Patient interviews	Other meetings and visits
Trust	N = men	N= women	N = Group (n = participants)	N = days	N = days		
1	13	19	5 (15)	5	9	10	4
2	5	9	3 (24)	8	3 x .5 + 1	0	2
3	4	8	0 (0)	13	0	0	2
Totals	22	26	8 (39)	26 days	11.5 days	10	8

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3.2.3 OCS (Organisational Climate Survey)

Trust 1

The staff survey

An administrator in Trust 1 provided a staff list (name and location) from which a random sample (35%) was identified using the SPSS software version 14 providing a list of 939 potential participants from staff across the Trust (including and beyond the Units participating in the main data gathering). The questionnaires were all individually addressed and sent through internal mail.

Of these 223 (24%) individuals returned a completed questionnaire, although ten blank surveys were returned with a note that the intended recipient had left the trust and one said they were unable to read English (1). Thus the final number of participants for Trust 1 was 210.

The patient survey

In Trust 1 we gained agreement from the senior staff on the two study Units (Obstetrics and Gynaecology and Cardiology) that they would arrange wherever possible for patients to complete the patient version of the OCS and would arrange for the researchers to collect the completed forms.

However the full batch of uncompleted patient questionnaires was sent back to the PI at the College several weeks later with an anonymous note stating that the staff did not wish to administer these to the patients. We were unsure how to proceed after this because ethically, although the survey was directed to the patients, the staff had completed consent forms and had copies of participant information sheets, and were aware that they (staff) could withdraw from the study at any time. We considered that this constitute an ethical dilemma for the team.

The researchers made other attempts to hand out the questionnaires directly to patients but found that while some patients were prepared to consent to being interviewed and almost all consented to having a researcher present during patient/doctor/nurse meeting it was not looking possible to obtain a valid sample of questionnaire returns.

Trust 2

Trust two was organised across two distinct sites and although the senior staff work across both sites, as will be made clear from Chapters Three and Four below, each site is very different in its organisation. We initially

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approached the senior staff on Site A first about how to distribute the questionnaires and they referred us to Human Resources on Site B who were the only people with access to a staff list. We did not get any acknowledgement from HR despite several attempts including one visit to the head of HR from one of the researchers. He said he would get back in touch once he had checked whether he could release this list but he did not and we considered there was little more we could do to pursue this particular approach.

The PI then contacted the senior nurse manager, who had been one of our original gatekeepers, for help but found that she had left for another post.

Following the abortive attempts to contact HR (or anyone else who might have been able to help) a PA in one of the many departments we contacted suggested that there was a staff intranet which went out once a week with an 'update' section with news for staff across the Trust. The PI made contact with the editor of this site who agreed to include an electronic version of the OCS.

Consequently, the questionnaire was included on this web-site, with a preamble (adapted from the NRES participant information sheet) on two occasions. However it only produced one reply. We made one final attempt via the PA of the CEO to contact HR for a staff list to no avail.

What was interesting and perplexing though was, that there was no difficulty obtaining a commitment from staff across the Trust to participate in an interview or focus group which was much more time consuming and personally revealing.

By the time we were ready to collect the patient survey data at Trust 2 we already recognised the problems with the responses from the staff. Also, by contrast, we had established the effectiveness of eliciting patient data from the shadowing and observations. We therefore made a decision to focus on this approach to data collection from patients rather than pursue more blind alleys.

Trust 3

In Trust 3 the early signs were that there was no overarching administrative structure from which we could obtain a staff list and nobody we asked could advise on the best way to gain that information. However we did have some 'local' e-mail addresses of the staff in the Units and therefore we e-mailed the OCS to staff on the two study Units and obtained 13 replies all together.

3.2.4 Participant characteristics

There were 224 respondents who completed and returned the questionnaire, of which 77% were women (n = 172) and there were 23% men (n = 49). These included from Trust 1 (n = 210, 93% of respondents), Trust 2 (n=1, 0.4%) and Trust 3 (n= 13, 5.8% of respondents).

The mean age was 46 years, standard deviation 11.1. The majority of respondents were married (62.7%), with a further 7% cohabiting. Twenty percent of respondents were single and almost 10% divorced. The majority of respondents were White (72%), the next biggest group were Asian (18%) and other ethnic minorities such as Black (6.5%) and Oriental (3%) consisted of much smaller groups.

Pay level: most of the respondents had a salary of less than £20k (44.3%) or between £20k- £40k (38.8%). A much smaller percentage (5%) earned between £60k and £90k and a further 2.3% of respondents had a salary exceeding £90k.

3.2.5 Professional demographics

The majority of respondents had been working in the NHS for over 5 years (68%), with a further 26% for between 1-5 years. Only 5.8% reported less than one year's service.

3.2.6 Stability within individual Trusts and Units:

Most respondents had been employed by the same hospital for over 5 years (56%) and another 34% had worked there between 1-5 years. The rest (10%) had been employed by the hospital for less than a year.

Most respondents reported working for the same Unit for over 5 years (45%), a further 43% reported working there for 1-5 years and only 12% reported service of less than 1 year. A similar pattern was seen in terms of length of time in same job. However the majority in this case had been working at the same job for between 1-5 years (45%) and slightly less (41%) had been working in the job for over 5 years. Another 12% had been employed in the same job for less than one year.

3.2.7 Role:

The majority of respondents were nurses, 31%. 13.5% of respondents were managers; 11% consultants/doctors/physicians. Other allied professionals, such as scientists and psychologists made up 10% and support staff made up a further 6%. Clerical staff and 'other' staff (such as porters, maintenance) made up a further 13% each.

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3.3 Data Analysis

This was conducted in the manner described in Chapter Two and the results are discussed separately in the following chapters each of which when relevant provides more context to the conceptual framework and analysis in the substantive area of focus.

3.4 Conclusion

The diverse nature of each of the organisations studied provided valuable information about the different kinds of challenges that different leaders at all levels might face in different institutions across the NHS.

Staff at senior level (particularly non-clinical managers) moved around within and between Trusts. During the course of conducting our study some key gate-keepers and participants left the Trust, others joined and yet others moved position and role even during the relatively short time we collected data there.

In some cases mergers had just taken place or were expected. This was experienced by some as opportunities and others as threats, but in all cases it meant structural reorganisation, staff being re-assigned or choosing to leave for another post.

This has to be taken to be part of the changing face of the NHS overall and central to the culture and climate of the participating Trusts, and can no doubt be generalised to every NHS Trust across the country. In what follows, we have used our different strategies for data capture to examine the relationships between leadership and service delivery in this fluid and (potentially) exciting context.

4 Leadership in the NHS

4.1 Introduction

In any organisation:

Leadership is needed to pull the whole organisation together in a common purpose, to articulate a shared vision, set direction, inspire and command

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commitment, loyalty, and ownership of change efforts (Huffington, 2007, p. 31).

and

Leadership would be easy to achieve and manage if it weren't for the uncomfortable reality that without followership there could be no leadership except, perhaps for the delusional sort. (Obholzer, 2007, p. 33).

In this chapter we examine the ways in which leadership is defined, exercised, experienced and transmitted taking account of how far leadership is perceived as pulling the organisation together to pursue the common purposes of patient care and the relationship between leaders and followers.

We specifically:

- Explore how leadership is defined by different stakeholders and what they see as determining its quality;
- Seek to begin to understand how leadership is exercised and experienced by those affected by it, from staff across all levels and disciplines to patients through examining the data from focus groups and story-telling interviews;
- Using the same data sets, explore the characteristics of the organisation that facilitate or hinder the processes by which leadership is transmitted.

4.2 How is leadership defined by different stakeholders and what do they see as determining its quality?

We start this particular exploration with a *thematic analysis* of the qualitative data to identify what themes emerge from the definitions, while also making interpretations using *CDA* and *narrative analysis*. In so doing we pay attention to what Gough has termed 'emotional ruptures' (Gough, 2004) in the text which serve to illuminate some of the subordinated or unconscious information in the stories of the respondents and the subjectivity of the narrator (Frosh, 2003; Frosh, Phoenix, & Pattman, 2003; Hollway & Jefferson, 2000).

In Chapter One we proposed that 'leadership' as a concept has been subjected to continuous scrutiny and moved through different theoretical and paradigmatic iterations. The NHS has identified the qualities it requires in a leader and the role that NHS leaders (at all levels) are expected to strive towards (see Figure 1). We therefore inferred that respondents, imbued in the culture, would focus on 'transformational' or 'distributed'

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explanations and definitions about leaders and leadership because these models are embraced by the style of the coaching and training on offer.

4.3 Definitions

Respondents distinguished between 'leader' and 'leadership'. A 'leader' was described and defined in diverse ways including as:

Obviously strong minded and opinionated (Administrator, T, 2¹⁹).

Particular personality traits - need to be - to have integrity, ((1²⁰)) to ((1)) be clear, err to be facilitative, to have energy to listen, erm, to negotiate, ((2)) to make decisions (Senior Non-clinical Manager, T, 2).

... making sure that you're the person who is erm keeping the team focused getting them to achieve those goals looking at different ways of working (Senior Clinician, Trust 3).

These definitions suggest diverse ways of thinking about the idea of 'leader', indicating that commonality of stakeholder views should not be taken for granted. The qualities a leader has to have are determined in these definitions through having opinions, being strong-minded while also having integrity. A leader also needs to be able to facilitate actions, negotiate and keep the team focused towards the achievement of its goals supporting team-work.

4.3.1 Defining leadership

Leadership in this first definition below was about a formal role and implicitly hierarchical rather than distributed:

I don't think there is anything magical about good leadership. It is about establishing what the organisation wants to do and allowing people to get on and do it (Recently retired CEO with clinical background, T2).

This respondent, who had occupied a senior position, saw the structure and strategic direction of the organisation as fundamental to what works as leadership which was not 'magic'.

¹⁹ In some cases we are able to identify the Trust but where there is any chance of a breach of confidentiality we adjust the 'credit' to ensure anonymity.

²⁰ Where the transcription has included double brackets it denotes pauses timed in seconds.

The following respondent expresses it differently suggesting that it means different things to different people on the one hand, while also being an imponderable (possibly even magical):

Leadership is like love, we all know it exists, but you can't actually prove it, you can't define it, and it comprises of lots of different things that people do, if you demand evidence for everything...you will get rid of leadership eventually (Senior Clinician, T2).

This clinician seems to take distributed leadership for granted in that it is about 'lots of different things that people do'. A warning is expressed it appears, though, that trying to *show* leadership exists across the organisation (perhaps rather than residing in designated roles) might ultimately destroy the possibility of leadership. Following Gronn (Gronn, 2002) this might be a way of suggesting that through concerted action leading to conjoint agency, leadership might not be so obvious (as in the first definition immediately above) but it might be more effective in a hospital where there are different qualities needed to lead in different activities.

Resonating with the view above that a leader has to have integrity, is the view from one leader's experience:

I learnt that it's very important thing for leadership... to not lie, not hide anything and just tell them the reality and be true to yourself, and that's really important (CEO, Non-clinical).

There is an immutable relationship between the leader and the follower. Being true to oneself and honest towards followers must be fundamental to the emotional engagement or attachment between leaders and followers. The significance of emotional engagement as well as emotional and social intelligence was high on many respondents' agendas for determining leadership quality:

... leadership is about having, or being able to demonstrate at any level a coherent vision for where you're trying to go and getting people getting there (Nursing Manager, T 2).

[Leadership in the NHS] is a people focused, leadership job (Senior Non-clinical Manager, T3).

.. it's not always leading from the front (Senior Clinical [therapies] Manager, T 3).

While the leader needs to have vision, these definitions imply that vision alone does not determine how leadership can be exercised or experienced. Leadership will not work unless the leader engages the followers with that vision.

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If leadership fulfils an organisational role ('establishing what the organisation wants') then can it also be 'people focused'? If good leadership is about transparency and honesty is there an assumption that it has not always been so or may not be so at some future time? What does this imply? Does leadership have an 'indefinable' quality' or set of characteristics that work within a specific context but may not be transferable as 'skills'?

Leadership presents dilemmas for the maintenance of personal integrity ('tell them the reality and be true to yourself'), it is a 'job', it requires 'vision' and flexibility and most importantly it seems it is about focusing on people.

4.4 How is leadership in NHS health care organisations exercised and experienced by those affected by it?

Respondents talked about the *role* of the leader as central to the practice of leadership in the organisation. Leadership was understood to be intrinsically linked to particular tasks/goals while necessarily engaging with the followers who had to implement much of these tasks and achieve the goals. There was a sense that many respondents held an idealised view about leadership in their own Trust. Sometimes though the reality for them fell short of expectations because the person occupying that role failed to live up to their hopes.

For example, as the following extended extract illustrates:

.. one of the things about the leadership and management of this Trust is first of all clinical leadership is strong in most places. The clinical directors here have general clout and they are not just figureheads .. and the other bit I think - relationships between general managers and clinicians on the whole are much more positive here than other Trusts (Senior Clinician).

This proposes that strong leadership among clinicians (distributed both horizontally and vertically via the clinical grouping) enables managers to deliver the service to patients. However, this does not in itself identify the characteristics of the links between strong leadership and service delivery.

For many respondents leadership is exercised at least in part through each leader's personal characteristics (good and bad). Almost without exception when asked about the qualities that make a leader, and to 'story' their own explanations, respondents placed a degree of emphasis on the characteristics of an 'ideal type'. The following exemplifies this:

Most important quality is the communication. Being able to listen - hear what is being said and to deliver that--what they want to say, so that it is heard by all. That it be quite quick thinking, being able to develop an idea

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and roll it out, umm being able to think on their feet as well, because sometimes you get things that turn up and you have to deal with it there and then, umm, reasonably personable so people will confide in that person, um also strong so that when things are tough they can um deal with them (Clinical Midwifery Manager, T1).

The comprehensive but daunting picture of how leadership is exercised described above, represents an ideal of distributed leadership as *concerted action* (Gronn, 2002). This type of leadership is exercised through being able to communicate – to listen and to express clearly (so as to be ‘heard’) how action will be taken. ‘Rolling out’ the idea again suggests taking peers and followers along with you and being ‘personable’, so people will confide in that person, further indicates the ability to take the views of others into account calling for both emotional and social intelligence (Amendolair, 2003; George, 2000; Goleman, 2006; Lopes, Grewal, Kadis, Gall, & Salovey, 2006; Riggio & Reichard, 2008). In this model, the multifaceted communications rely on the ability to use the information to think quickly and be strong under ‘tough’ circumstances.

However, in the next extract (from a non-clinical manager) the ideal type of leadership is represented by responding to short and medium term organisational goals (Buchanan, Fitzgerald et al., 2005; Riccucci, Meyers, Lurie, & Han, 2004).

Erm, I think leadership is about erm, encouragement. It is about showing people direction in which you as an organisation and them as individuals engage in. I think it's incredibly important especially in an organisation like the NHS where there are lots of different groups of people and lots of different objectives - sort of daily ones, monthly ones more long term, and you have quite a clear sort of vision of where you're going and I think that the good leaders in the NHS show that, and examples of bad leadership are where that is not so defined. (Middle Manager, T2).

This suggests a *transactional* model of leadership, whereby the good or effective leader offers ‘encouragement’ to the followers in return for people accepting the practices of the wider organisation (Bass, Avolio, Jung, & Berson, 2003; Eagly and Johannesen-Schmidt, 2003)

4.4.1 Exercising leadership through their organisational ‘role’

Leadership is experienced by some as being exercised through the legitimated role. Organisational role in the leadership discourse equates with the leader’s professional position as the respondent below shows clearly:

Who would be a leader to me? I think there's a number of different areas, there's your direct line manager, who's the clinical leader of your department. Who's who in this structure there's line managers above them, and above them and so on. There would be people you would look to within your own specialty clinically who are more experienced than you ((2))²¹ in certain areas, to ask for advice, erm ((1)) and similarly in an academic environment ((1)) there are other people there who have more experience that you would want to take advantage from or advice from. ((2)) And in the wider circle, national or international leaders in the field who are so expert at those things that you also turn to. (Medical Consultant, T3).

While the formal roles and organisational hierarchical structures are taken seriously by this respondent, there is also a clear vision of leadership being exercised through concerted action in collaborations that arise *spontaneously* where clinical and/or experience is valued and sought within this respondent's speciality and sometimes *intuitive* leadership (Day, Gronn, & Salas, 2006; Pearce, 2004). However, there is also a sense that this respondent experiences leadership through the institutionalisation not only of formal roles locally, in the organisation itself, but through the structural relationships with those who are seen as experts in a much wider networked context (Pearce, 2004). This version of leadership is particularly important in that it demonstrates that leadership can be both experienced and exercised beyond the boundary of the organisation and the NHS, based on knowledge and expertise originating outside these systems.

Respondents frequently combined personal qualities with their understanding of the leadership role, particularly related to taking responsibility as part of that role:

It's quite difficult, I mean I think taking responsibility (4) making sure that things happen that are supposed to happen, or don't happen that aren't supposed to happen (3) um.., (6) that's it. (Clinical Medical Consultant, T1).

Not everyone saw leadership in this way. This respondent is talking about their own experience of being in a role in which then 'buck' frequently stops and thus by definition they are in the role of leader.

The exercise of leadership through being a 'role model' (Trevino, Hartman, & Brown, 2000) where qualities of leadership were displayed was important for some:

The leaders that I've worked for and have wanted to follow ... push something in me that says 'I want to be like them' or I completely support

their vision of where they're going or you know so I want to follow that person and I want to do the best that I can do for them because I believe in them and their vision. (Head of Non-Medical Clinical Team, T3)

This explanation has a flavour of heroic or charismatic leadership, although not as a quality that resides in a specific person necessarily, but one that resides in a relationship that 'fires' up both leaders and followers (Klein & House, 1995). Even though the idea of the charismatic leader has been at least partly consigned to the history of the late 20th century organisation, it has not disappeared and needs further thought particularly in an organisation such as the NHS where changes are sometimes rapid and stressful (James, 1999) and internal culture needs to be taken into account (Dopson & Waddington, 1996; Tourish & Vatcha, 2005).

4.4.2 The relationship of the 'leader' to 'followers': how leadership is experienced

While leadership is the focus of the professional and political debates about the NHS and other organisations, until recently, relatively little attention has been paid to followers' experiences of leadership (Avolio et al., 2004; Howell & Hall-Merenda, 1999; Lewis, 2000; Schilling, 2009). From the perspective of a manager taking the position here as 'follower' looking 'upwards' in the organisation:

I think it's, it's providing, you know direction and to lead and that's a leader's main job in my mind. And (2) that's .. what they say for leadership, you must have followers. If nobody's following you, what you are saying then? you are not a good leader. So that's a good, you know, test for a leader to evaluate themselves. That's what they are saying and what they are trying to achieve. Are people behind them or not? If they are not behind the leader there's something wrong with that. (Middle Non-clinical Manager)

From the perspective of a junior doctor taking the 'followership' position:

I think in order for you ... well in my opinion a leader, I have to be able to kind of respect them. If I don't respect or kind of have faith in what they do, then it's, it's a personal authority, so in order, you know in order for me to do that I have to believe in what they say. I mean, I might not always agree with them in my opinion but at the end of the day I have to be able to respect them enough and for them to have certain authority, someone who's probably experienced and gained that knowledge, so yeah. (Junior doctor)

For leadership in the NHS to be exercised effectively then there has to be an engagement between the leader and the followers (Macy & Schneider, 2008) and to understand fully how the engagement takes place, a degree of

emotional engagement and/or attachment to the leader and the organisational vision is fundamental (Riggio & Reichard, 2008; Rubin, Munz, & Bommer, 2005; Vince & Broussine, 1996).

The failure to take followers with you is made explicit here from the perspective of one (designated) leader:

A: I was forced upon them...

Q: that's what I was going to ask. So presumably there was a lot of resentment I guess?

A: Yes.

Q: And how does it manifest itself?

A: Erm, non-cooperation, making life difficult for you sometimes, people talking about erm ((2)) sort of criticising you behind your back and erm playing silly games behind your back that makes management of other people more and more difficult. Erm you know, and yet we sort of have to fight another battle to win hearts and minds, when we, you know, don't really have the time to do that, we have got to have our focus on doing what we are meant to do, which is to manage patients and to manage our beds properly.

This extract from the interview with someone whose role it is to lead change is revealing. The respondent recognises that he is not taking people with him and in his view, the followers appear to eschew co-operation. He also believes they are mocking him and that that mockery is contagious. He may or may not be able to evidence this, but that it is in his mind is potentially detrimental to his experience of leading in his organisation (Stein, 2005). Furthermore, instead of looking at himself, this respondent wants to push the blame for the leadership failures onto the followers (in other words he engages in splitting described in Chapter One) (Klein, 1975; Segal, 1973). Such a process is diametrically opposite to leadership studies that identify authenticity and trust between leaders and followers as being one of the basic qualities for leadership (Avolio et al., 2004; de Raeye, 2002; Novicevic, Harvey, Ronald, & Brown-Radford, 2006).

There is also some evidence of concerted action here, distributed among those who were leaders of the *resistance*, which is not necessarily against the values of the organisation in any negative way, but may be seen as upholding important principles and challenging change (or a particular form of leadership) that might be perceived as counteracting these important values (Collinson, 2005; Zoller & Fairhurst, 2007).

Trust is one important quality in the way leadership is exercised and experienced by followers and developing trust is essential if changes in

practice are to be implemented (Bass & Steidlmeier, 1999; Hunter, 2005). So, for example, 'engaging' with others involves trust:

Yeah definitely there are some good examples of where it's obvious that people have been able to engage lots of different kinds of people in different groups and I think they've done that just by sort of making relationships with them in the first place and then when it comes to having to lead them and be influential then you can see that those relationships are already there and then they can call on that you know, that sort of that trust or that sort of relationship that they've got (Middle Non-clinical Manager, T2).

The same respondent continued with a specific example that aptly demonstrates the links between all the three sub-themes.

Yep, I think Florence who is our head of [a non-clinical department] .. I think she is a very good example of what I'm talking about in terms of her job. And her role relies a lot on other people. Erm so as a personality she is a very responsible person, she gets on with everybody and you can really see how that works for her because when she needs somebody to do something or she needs people to listen they are going to because they have got a good relationship with her and she has taken time to build relationships when it is perhaps not necessary.

To summarise so far - *good* leadership in the NHS is understood by staff at various levels as:

- Taking responsibility
- Being 'given' authority by the followers
- Getting on with the people in the organisation
- Taking time to build relationships
- Being trusted by followers
- Winning hearts and minds
- Having a vision for the organisation
- Taking colleagues with you

4.4.3 Patients' perspectives on how leadership is exercised

While there were several things held in common (particularly 'trust' and 'taking responsibility') with the staff, patients unsurprisingly, considered leadership from a different position, based upon how they themselves had experienced a specific episode of care. One woman, who had had a previous bad experience in the same Trust in which she was now a patient, said:

Well somebody taking responsibility really for erm you know your care, erm especially. I keep going back to the same example but you know someone being responsible for not reading through my notes and if someone had taken that leadership erm and actually said 'right I'm going to look through

these notes', you know they would have obviously seen what they had to see and so basically yeah I think there is a lack of leadership.

The emphasis was on wanting the leader to take responsibility for patient care in contrast to poor practice whereby notes were not read. It was taking responsibility, and reassuring the patient that they were taking responsibility, that could be experienced by patients as good leadership.

Another patient similarly suggested that in their exercising of leadership, the clinical staff need to make sure that they were seen to be acting in the patients' best interest. For example:

When they're explaining their-selves, they do explain their-selves and what they're thinking. And they do tell me like the 'ifs' and 'buts' blah blah blah about this certain thing, but then one says something and [another] one says something else but they do explain themselves and what they're on about.

Also, another patient indicated that there needed to be one person who held overall responsibility for service delivery:

I don't know how it works hierarchy wise, whether there's like a top doctor or whatever, whoever it is somebody really needs to, you know, take a really ((2)) be sort of, you know, held responsible.

It is perhaps worth noting that the patients overall focused on the role of clinical leadership but saw that as being practiced by an individual rather than in a distributed form. There was a general view that individuals needed to be accountable and accountability equated with leadership.

4.5 What are the characteristics of an organisation that facilitate, or hinder, the process of leadership?

Leadership happens in a context and that context can facilitate or hinder leadership processes (Currie et al., 2009) and the influences of the organisation are particularly acute when the environment is changing rapidly (Goodwin, 2000; Michie & West, 2004) as in the NHS.

One respondent felt they no longer knew 'who was who' in the leadership hierarchy but considered it didn't really matter:

..., here is this model that says here is the Board and here is the chief exec and here is whoever else is up there. And there's this, this and this ... and [a colleague suggested] shouldn't we be transparent all the way through and shouldn't everything link? and I thought, this came up somebody legitimately asked the question that people here need to know what is happening here. Why? Why? I don't care. (Clinical Physiotherapist, T3).

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One senior Occupational Therapist, in the same Trust, on the other hand felt that knowledge of the organisation was important to facilitate leadership at every level so that when:

... people feel they are working as part of an organisation that's working for something, as part of a team and are appreciated and valued as part of that and are working for someone as well who feels what they are doing is worthwhile, I think that patient care will be of better quality.

This respondent was also convinced that supervision was part of the process by which an organisation facilitated both leadership and good practice in patient care. *"I have once a month supervision, like set time for supervision so I think that is really good."*

Furthermore, supervision and informal contact with peers facilitated effective distributed leadership which impacted across the organisation: *".. you can go to people informally, your peers erm whenever it's quite flexible like that and even if you're a senior like me you think 'hang on I don't know if I'm on the right track here so am I missing something?' You can just go and speak to you team about it or one of our colleagues downstairs or whatever if you want to.*

More dramatically a senior clinical leader suggested that leadership is facilitated in 'moral' organisations:

A²²: So one thinks they are better than the other, so the seven deadly sins basically...pride, the other one is gluttony, which means excess...one can never have enough, for the sake of it, and then just goes beyond, you know, one million, two million, you know, which kind of greed isn't it...excess basically, and also rushing is in there, doing things too fast. A good system will reduce its workload, yeah? The NHS has a thing of needing to do more and more, erm anyway, I don't know whether you find this useful or not, so greed, gluttony, there's rushing, and then jealousy, which is really envy, which is really competition.

Q: Yeah

A: You need to get rid of competition, and I will tell you in a moment what could replace it, which is basically team work, team work and kindness; how you get on with each other...anger is on the list. Anger is, is blame, and the opposite is blame free culture.

Q: Yeah

²² Q = question, A = answer.

A: Or forgiveness if you want, so you need to forgive mistakes, and you know you will be forgiven...and, erm...erm...next one is laziness, that's obvious, that's hard...people either have it or not, but laziness is joylessness, you need to make sure people enjoy it, and diligence, yeah? So there needs to be something in place of ...and we have that now with trust away days and things like that, but you have to have somebody dedicated to making people understand it's about having fun

Q: Yeah, yeah

A: working is about having fun...yeah? And then its... which comes really from up here, it's just an, an, yeah, can't have enough...which is also, it's also, the opposite is erm...do not take more than you can, do not take more than you need...and that is quite a moral stand ground, more than you need...for everyone

Q: Yeah

A: and if you employ that rule, then the whole organisation becomes so successful that there's masses of money left over ... Everything works well...the problem is everyone doesn't understand that, and believe in that, and then there's a difficulty...so that's moral high ground, very moral high ground, but if you go along those, you actually have all the features of leadership.

For this respondent the organisation needs to focus on patient care, treating patients *and* staff with 'kindness'. This is counter in his view to the process of setting targets for service delivery and organisational growth (or survival) and thus competition between organisations and competition between individual staff or staff teams, which is a force that (it seems) promotes the wrong kind of leadership (Kuokkanen & Katajisto, 2003; Sambrook, 2007). Furthermore, supportive teamwork and 'forgiving' mistakes and preventing the 'blame game' enhances socially and emotionally intelligent leadership distributed responsibility across the organisation and enhancing the culture and climate (Riggio & Reichard, 2008) .

Another senior medical leader and manager (T3) reinforced this idea:

I think the ethos within the hospital, is one that encourages people to develop and grow, and deliver good quality care, you know, so, I mean I think wherever it comes from it is enabled within this organisation, and it works very effectively. One of the features that enables that to happen...it's firstly being an organisation that attracts good people to want to work here in the first place. So you get high quality people applying for the position, be it in medicine, or managing, or nursing or any of the other professions By and large, we're fortunate in that. And that's partly due to the reputation, and partly due to the [location] but I think the ethos that comes

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from the leadership makes it desirable to be here. Erm...so it attracts the right people in, it then enables, it doesn't put the brakes on, it doesn't try to control people too much.

Thus, organisational performance and culture/climate were 'enabled' through a cycle of encouragement, good practice, reputation and a supportive and 'hands-off' approach to leadership. This suggests concerted action, leader/follower engagement and emotionally supportive behaviours at all levels. That the physical location of the hospital is attractive is perhaps but one factor in this equation, although a central location makes it possible to draw on a wide range of staff as opposed to a location which is in a small town or distant suburb.

It is not just features of the organisation itself that impact on leadership. Organisations reflect changing discursive constructions of leadership and the values that underlie what it means to be effective as a leader in that place at that time (Ferlie & Shortell, 2001; Lansisalmi, 2006; Michie & West, 2004; Scott, Mannion, Davies, & Marshall, 2003). As demonstrated in Chapter One theories of leadership have developed and different approaches have become significant at different times as witnessed by the shift from promoting and studying transactional, charismatic and heroic leadership styles to the contemporary emphasis on forms of distributed, networked and transformational leadership (Bryman, 2004; Butterfield et al., 2005).

One dramatic change over the past twenty and more years has been the image of the medical consultant in the public psyche. Thus the 'heroic' leadership of Sir Lancelot Spratt has been firmly (it seems) replaced by the team work in the TV series *Casualty* or *Holby City*. However the image of the rebel Dr. House (played by Hugh Laurie in an American TV series) is described as 'unorthodox' and 'radical' but most definitely a medical hero. Is this the type of leader that some might still long for? While the following comment was atypical of most people's definitions of what makes or fails to make a good leader it raises some interesting points about the contemporary regulatory discourses on leadership. Thus one participant said of another²³:

Now (Dr.) David is a really eccentric so he is not what you would naturally call a leader, erm ((1)) but people are really respectful... Because he really cares for patients ...And if he finds a junior doc, or nurse or anyone who is being unkind to an elderly patient then he is down on them like a ton of bricks but his, his patent commitment to medicine and clinical care just inspires admiration ...And great affection hopefully. But he is very odd. Yes. Erm, so he is like a one off so again there is no single person, you

²³ No identifying information is appropriate here.

know there are, there are, there are different leadership styles which are appropriate in different situations but David of course could never be a chief exec, he just wouldn't be able to do it, so he would be hopeless there.

On the surface this might be explained as a judgement based on 'evidence' and a job description. However, focusing-in on the discursive and regulatory practices with which this extract engages, a different view can be taken. The respondent here, being asked to describe the qualities of leadership, begins by suggesting that taking patient care very seriously is 'eccentric' and the person who does that is a 'one off' and 'odd'. Paradoxically (it is suggested) David inspires affection and admiration but despite the variety of leadership styles David would never make it to be CEO. Whether or not this is the case is irrelevant here because what is at stake are the ways in which discourses around 'leadership' and the qualities of the 'leader' *regulate conduct* setting normative behaviour through the discursive practices. There is little doubt that David would have been considered a leader (perhaps a leader in his field) during a different period when hospitals were smaller and perhaps when there was less specialisation in management.

A learning organisation?

The NHS has declared itself to be an organisation dedicated to learning for at least the last ten years and certain values underlie this declaration (see Davis and Nutley, 2000). It means that:

Although learning is something undertaken and developed by individuals, organisational arrangements can foster or inhibit the process. The organisational culture within which individuals work shapes their engagement with the learning process (p. 998).

In some cases the exercise of leadership clearly facilitated the (potential for) learning and learning facilitated leadership, while in others it did not. The facility for leading change in NHS Trusts is critical and developments in the role of nurses from a range of specialties to support leadership and learning have provided exemplars of how some organisational arrangements support leadership (Bellman, Bywood, & Dale, 2003; Doherty, 2009). However, some have argued that continued changes, the market as a driver and the complexity of the NHS might militate against whole system learning (Sheaff & Pilgrim, 2006). Questions have also been raised about the potential of the new generation of leaders who are expected to be inspirational, drive change and support learning (Phillips, 2005).

One capacity manager, for instance, was very clear that leadership was about enabling appropriate learning and the development of skills:

... probably more about empowerment and not necessarily of oneself but of others. So I think that indeed you need to feel empowered yourself, but I think that leadership, good leadership is about empowering and supporting those people who are not in power so that they are equipped with the skills that are required. some of it is actually around learning, it is about what stage they are at in terms of their learning curve.

This is not only a statement about distributed leadership but about a version of a transformational leadership that transcends individual leaders and requires an organisational culture that both supports individual learning and targeting individuals to ensure, that their learning is recognised and ongoing (Burke et al., 2006; Conger & Kanungo, 1988; Kuokkanen & Katajisto, 2003).

The respondent continues with this theme in a sophisticated, and it seems heartfelt, way:

But I think that sometimes that [learning] is not always consolidated, even those people that have been in that position for years. I think, it is more about the people actually understanding²⁴ what they have done, and almost sometimes talk it through, in basic detail about why they have got to the decision they got to. But just because you have been in a position for a long time doesn't necessarily mean that you have actually learnt erm and you may only then go up to a certain stage in my opinion in terms of your whole learning so then they may be stuck in, not novice, but in that middle stage rather than the expert. Which we would hope that most people would get to.

This suggests that organisations need to be vigilant and to constantly invigorate their members. For the respondent quoted above, an organisation that allows people to stop learning is one in which leaders and potential leaders stagnate (at their peril) (Mark & Scott, 1991).

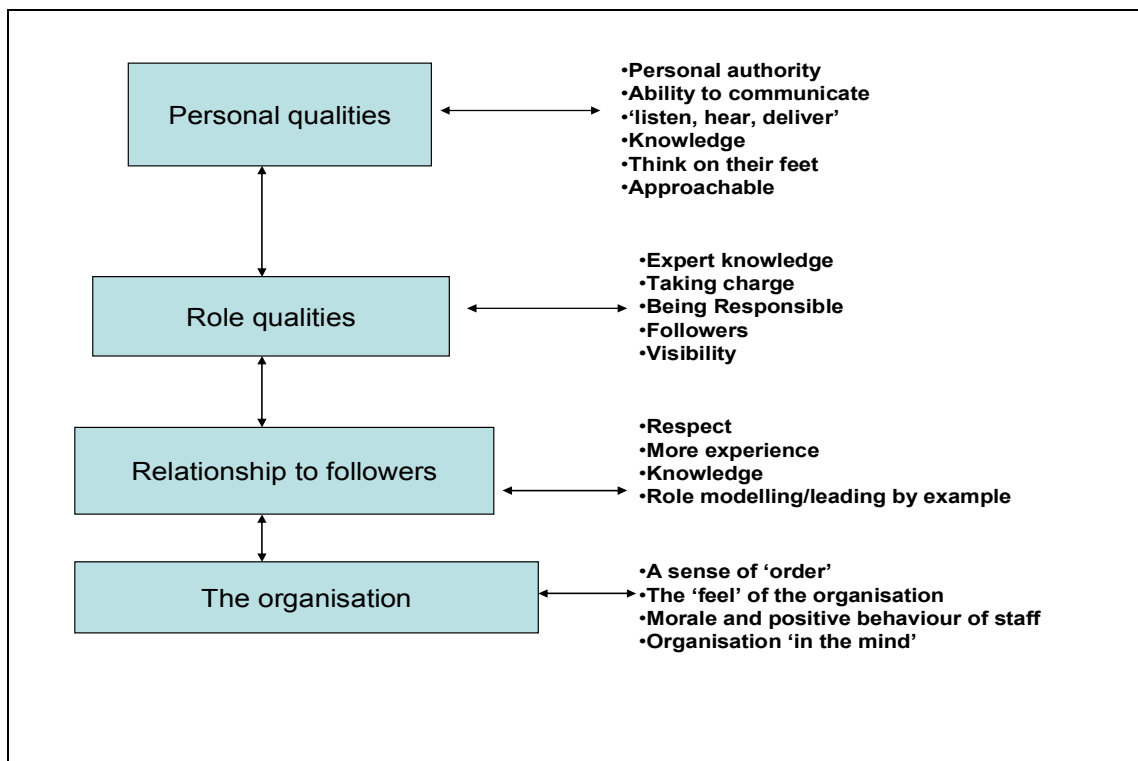
As we discuss again in Chapter Nine, the multi-disciplinary team presents an ideal opportunity for observing leadership (good and bad) and examining the ways in which these teams adhere to organisational norms which might support or inhibit learning (Burke et al., 2006; Day et al., 2004).

One senior non-medical clinical manager in a different Trust also took up the theme of learning and empowerment and specifically how it links to good patient care (Burke et al., 2006; Doherty, 2009; Kuokkanen & Katajisto, 2003).

²⁴ The transcriber who was also the interviewer made it clear that these words were emphasised by the respondent.

... [leadership] is about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is we worked with 'Training and Development' and we came up with a specific programme that was aimed at empowering them [all administrative staff] to improve their service area etc etc and also provided them with some skill sets that they probably didn't have prior to that.

Figure 11. What makes a leader?



4.6 Conclusion

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

Nonetheless, when asked to describe and define leadership, various stakeholders at all levels of the organisation have a view some of which coincides with contemporary NHS discourses and some which seems directly at odds with what the NHS is trying to achieve – that is, to support both

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distributed and transformational leadership that are seen as successful in ensuring effective patient care. However, it is clear that individual personalities and the impact of particular leaders cannot be taken out of the equation.

Leadership is experienced as distributed and transformational but there remains a belief that charismatic and transactional leadership also have their place in complex organisations. While vision is important, no vision can be achieved unless the leader takes 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. Supervision, peer support and informal advice are part of the emotionally intelligent distributed practice of leadership. 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.

In summary, the main ideas that emerged from the respondents' views of how leadership was exercised and experienced were it was about:

- Personal authority
- Ability to communicate
- 'listen', 'hear' 'deliver'
- Thinking on your feet
- Being approachable

Leadership can be exercised in a number of ways and qualities of leadership are seen to reside in different but interlinked 'places'. For example, it is clear that some people are perceived more than others to have the personal qualities that make them a leader, including being able to listen, deliver and be approachable (see Figure 11 above). The assigned/legitimated leadership role is also perceived to be an important quality for a leader, which is interesting, when thinking about the distributed leadership model and particularly the idea of concerted action where people have to work together to 'lead'. This links further to the qualities inherent in leader-follower relations identified as fundamental to the stakeholders interviewed here.

Finally, leadership means holding a sense of the organisation in mind. That is the mental model held by the leader through which they mediate and regulate their vision and actions as leaders, but it also refers to the leader's understanding of morale and the 'feel' of the organisation in which they are working, which itself regulates and constrains the possibilities for growth, development or atrophy.

In this chapter we identified some of the evidence of how organisational contexts evolve and the relationships between organisational culture/climates and the ways in which leadership is practiced. This will be developed across the next four chapters.

5 Leadership and Organisational Climate

5.1 Introduction

Despite its North American origins, where the health care system is fundamentally different from the NHS, Stringer's focus on both leadership and climate nudged us towards choosing an adaptation of his organisational climate survey for this study. We also identified an 'awareness', as he puts it himself, that "*People working in health care systems play drastically different roles that are more diverse than the roles typical in schools and businesses*" (Stringer, 2002, P. 188).

Through adapting the OCS we also captured demographic information from our participants as well as a data about satisfaction with the leadership one receives from his or her immediate supervisor²⁵. Thus, while on the whole Chapter Four dealt with general descriptions, definitions and values, in this Chapter we focus on specific relationships between individuals and the individual and the perception of their organisational climate.

The additional contribution the survey data makes to the overall aims of the study is to relate perceptions of leadership and management directly to organisational climate, thereby providing a triangulation with the story - telling and focus groups to explore the characteristics of organisations that facilitate or hinder leadership and service delivery.

5.2 Results

5.2.1 Normality of data

When normality was examined the KS-Lilifors test was found to be significant over all the scales, indicating that the data were not conforming to assumptions of normal distribution. However, inspection of the histograms and boxplots were found to present an acceptable level of

²⁵ Our version of the survey questionnaire is appended.

normality. Due to the nature of the data it was decided not to transform it, but rather to interpret the results which rely on the assumption of normality with caution.

5.2.2 Cronbach's Alpha

In order to check the reliability and internal consistency of the OCS in this setting we used Cronbach's Alphas (Cronbach, 1970) (See Table 2).

As can be seen from Table 2, the three dimensions of '*commitment*', '*support*' and '*recognition*' were considered to be high on reliability as their scores ranged from .69 to .74. These would be considered acceptable-good level of reliability (George & Mallery, 2003).

In contrast, the three dimensions '*structure*', '*standards*' and '*responsibility*' were low on reliability. This low reliability may be explained by confusing wording of the items, or it is possible that the individual items did not correspond well to one another in this sample. As such it was decided to remove the '*responsibility*' scale from the rest of the analysis. A further check to see whether '*structure*' and '*standards*' could be improved by removing single items, did not show any improvement to the alpha so these were retained in their original form.

Table 2: Cronbach's Alphas for the six dimensions

Scale	Cronbach's Alpha
Commitment	.74
Support	.72
Recognition	.69
Structure	.57
Standards	.43
Responsibility	.14

When managerial dimensions were examined for reliability' these were found to be very high ranging from .86 for '*recognition*' to .79 for '*commitment*' and '*responsibility*' (See Table 4).

Table 3: Cronbach's Alphas for the six Managerial dimensions

Scale	Cronbach's Alpha
Managerial Responsibility	.86
Managerial Recognition	.83
Managerial Standards	.83
Managerial Support	.81
Managerial Commitment	.79
Managerial Structure	.79

Overall scores for organisational dimensions

In order to derive the scores for individual dimensions, all the items on each dimension are summed [this is after all the negatively worded items were reversed].

The following were mean and standard deviations across all the six Organisational scales:

Table 4: Mean and Standard Deviation

Scale	Mean	Std
Commitment	14.82	2.86
Support	14.06	2.80
Responsibility	9.93	1.73
Structure	9.01	1.88
Recognition	8.42	2.55
Standards	8.36	1.69

Stringer, et al (2002) suggest an analysis of percentages of respondents who scored above the mean. In our analysis the following percentages were found:

Table 5: Scores above the mean

Scale	% above the mean
Commitment	60%
Support	47%
Recognition	49%
Standards	49%
Structure	39%
Responsibility	58%

Stringer offers a method of interpreting these percentages, according to benchmarked ratios collected through their extensive research to validate the tool.

High 'commitment' (60%) – In the current sample, there was a high degree of 'commitment' to the organisation and its goals. This would be typical of professional staff working for the NHS. However Stringer asserts that high 'commitment' needs to be accompanied by high 'support' and high 'recognition' – without these individuals will stop engaging with others in the organisation and their team (p.200). As indicated in Chapter Four engagement is crucial if leadership is to be effective.

High 'responsibility' (59%) – Stringer asserts that 'responsibility' is a difficult dimension to interpret within the health care setting. Effective performance in the NHS requires that procedures be double checked, which in many other contexts would put the role of 'responsibility' in an ambiguous position. However this is not the case in complex clinical settings (or for example in other precision performance occupations such as flying aeroplanes for instance). In the case of the current sample 'responsibility' was high, which is related to high sense of 'commitment', but is confused by the limited 'structure' – it is essential that people are clear about their roles, so that they may take charge and 'responsibility'.

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Moderate 'recognition' (49%) - According to Stringer scores lower than 50% may indicate that participants are feeling unappreciated. In this case there is just under the 50% mark, which translates into moderate agreement about the feeling of being rewarded for one's efforts. Having a high sense of 'recognition' in an environment such as this is of crucial importance for motivation, but 50% is within the normal range set out by Stringer. High 'recognition' is indicative of confidence in the organisations performance/reward ratio but in such a diverse setting as a hospital with a diverse staff group responding to the OCS then different groups with different management and professional/occupational structures would have different perceptions and experiences.

Moderate 'standards' (49%) – there is a moderate feeling of pressure - performance 'standards' and expectations are high but not to the point where they are stressful. This falls within an acceptable range. Considering that many of the 'standards' (targets) are set out by government policies rather than directly by Trust management/leaders it is important for these standards to be realistic and achievable.

Moderate 'support' (47%) – this falls within the low but acceptable range for this scale (45%-60%) according to Stringer's benchmarks. This indicates that there is sufficient unity between teams to approach and solve problems, without overly nurturing so as to discourage individual 'responsibility' and undertaking. Team work within the health care system is challenging because of the interdisciplinary nature of teams which inevitably calls upon different management and professional structures and networks for support.

Low - Moderate 'structure' (39%) – Under half of participants felt there was clarity in terms of their roles, responsibility and authority. On the one hand this means that there are less constraints and a less of a 'jobs-worth' approach, on the other hand though it means that there is (potentially) insufficient clarity in roles and responsibility. In an organisation such as the NHS, this may be a considerable shortcoming and Stringer (p.193) suggests that in a health care environment such as a hospital, one would ideally like to have 'structure' scores above the 70s. This is emphasised because of the complex nature of the hospital environment with so many individuals involved – accountability needs to be very clear. The NHS however has gone through so many changes over the previous ten years that it is inevitable that the 'structure' score would be influenced.

Associations between the six dimensions on the organisational level

Pearson's r was utilised to test the relationship between all the Organisational scales. It was found that the majority of scales showed modest, but significant relationships:

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Table 6: Correlations between the six organisational dimensions

	Standards	Structure	Recognition	Support	Commitment
Standards	1.00				
Structure	ns	1.00			
Recognition	.22*	.47**	1.00		
Support	.17*	.42**	.61**	1.00	
Commitment	.30**	.39**	.59**	.67**	1.00

* <.05

** >.001

As can be seen from Table 6, there are a number of high associations between these dimensions. The highest associations are for 'support' and 'commitment' (.67) 'support' and 'recognition' (.61) and 'commitment' and 'recognition' (.59). In other words, participants are reporting that when a feeling of co-operation within teams is present, this is often accompanied by acknowledgement and appreciation and is further related to a greater sense of dedication and 'commitment' to the goals and aims of the team. By definition, the converse also applies: feelings of isolation are more likely to be accompanied by lack of incentives and disenchantment with the objectives of one's team. This is 'supported by Stringer (p.200).

Satisfaction with leadership

When the *organisational dimensions* were examined in relation to satisfaction with the quality of leadership received from the immediate manager, which was asked as a single item, the scales which correlated most highly were 'support' (.61) and 'recognition' (.52). The weakest relationship was to 'standards' and 'structure'.

Table 7: Correlations between organisational dimensions and satisfaction with Leadership

	R (sig)
Standards	.14*
Structure	.30**
Recognition	.52**
Support	.61**
Commitment	.39**

In order to evaluate the individual contribution of each of the organisational dimensions to the overall 'satisfaction with leadership', a regression analysis was conducted, which included all items which were found to correlate significantly with satisfaction, namely 'standards', 'structure', 'support' and 'commitment'.

The total variance accounted for by the model was 40% (Adjusted $R^2 = .38$) therefore variability in 'satisfaction with leadership' is moderately accounted for by this model.

Specifically, of the five predictor variables the two which were found to predict the outcome variable of 'satisfaction with leadership' were 'support' and 'recognition', 'support' being the biggest contributor with a $B = .52$ ($p < .001$) and the other predictor was 'recognition' ($B = .27$, $p < .001$). The other variables were not significant. [Appendix 1 of this chapter].

In other words, feeling supported by one's team and believing that rewards are appropriate to effort, accounts for a significant proportion of an individual's satisfaction with leadership.

Correlations between dimensions on Managerial level

The second part of the questionnaire asked about individual experiences of management. All six dimensions on the managerial level were highly correlated with each other, with strong correlations ranging from $r = .71$ ($p < .001$) between 'structure' and 'responsibility' to a correlation of $.84$ ($p < .001$) between 'commitment' and 'standards'.

Table 8: Correlations between dimensions on Managerial level and Satisfaction with Leadership

	Manager Recognition	Manager Support	Manager standards	Manager structure	Manager Responsibility	Manager Commitment
Manager recognition	1.00					
Manager support	.83**	1.00				
Manager standards	.82**	.83**	1.00			
Manager structure	.73**	.78**	.79**	1.00		
Manager responsibility	.84**	.79**	.79**	.71**	1.00	
Manager commitment	.79**	.83**	.84**	.82**	.79**	1.00
Satisfaction with Leadership	.68**	.76**	.71**	.71**	.65**	.76**

** Significant at .001 level

A single item asked about satisfaction with the quality of leadership received from immediate manager. When this was examined in relation to the six dimensions appropriate to participants' own experience of management practices, it was found to correlate highly and positively with manager 'support' ($r=.76$); management 'structure' ($r=.71$, $p<.001$); manager 'commitment' ($r=.75$, $p<.001$) and 'standards' ($r=.71$, $p<.001$); manager 'recognition' ($r=.68$, $p<.001$); manager 'responsibility' ($r=.65$, $p<.001$);

A multiple regression was carried out to examine the perception of 'satisfaction with leadership', as a dependent variable of management practices. The overall association between management practices and satisfaction with leadership was strong ($R=.80$) with associated variance explained of 63%.

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Table 9: 'Manager' dimensions regressed onto 'satisfaction with leadership'

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	-.054	.226		-.240	.811
Manager Recognition	.001	.039	.002	.025	.980
Manager support	.175	.039	.410	4.501	.000
Manager structure	.060	.027	.177	2.260	.025
Manager responsibility	-.018	.032	-.047	-.559	.577
Manager commitment	.165	.056	.278	2.948	.004
Manager standards	.017	.056	.029	.310	.757

In this case, it was manager 'support' which best predicted satisfaction with leadership ($B=.41$, $p<.001$), next biggest contributor was management 'commitment' ($B=.28$, $p=.001$) and management 'structure' ($B=.177$, $p=.025$). In other words, a large proportion of feeling satisfied with one's leadership, pertained to feelings of being supported and the degree to which one's manager inspires and exudes 'commitment' to common goals. A further important element in the equation is that of 'structure' – where roles and responsibilities are clear, it is associated with greater satisfaction with leadership.

As the biggest predictor of 'satisfaction with leadership' was manager 'support', a further regression was done to look at what organisational dimensions related to having good managerial 'support'.

All the organisational scales were inputted into a regression, excluding organisational 'support', with managerial 'support' as the outcome variable. The following was found:

In total the model accounted for 35% variance in the outcome variable (Adjusted $R^2 = .35$). There were two contributors to the model: the strongest one was 'recognition' ($B = .44$, $p < .001$), i.e. the more employees feel that the organisation rewards and recognises their efforts, the more they feel supported. The other contributor to managerial 'support' was 'commitment' ($B = .20$, $p = .008$). [Appendix 3 of Chapter Five]

These findings indicate that organisational 'recognition' and 'commitment', are organisational climate dimensions which most affect the outcome of managerial 'support', and this in turn has the greatest effect on individual's sense of satisfaction with their leadership. This again corresponds with data discussed in Chapter Four highlighting the importance of the feel of an organisation that provides support at all levels.

Regression of all dimensions onto Satisfaction with leadership

When all the variables previously shown to be significant to Satisfaction with leadership, were entered into the model, from both the organisational and managerial dimensions, namely manager 'support', manager 'commitment' and manager 'structure' as well as organisational 'support' and organisational 'recognition', the following picture emerged:

There was a high degree of variance accounted for by the model - 65% (Adjusted R^2). The model was found to be significant ($F = .80.65$, $p < .001$).

The variables which remained significant, in order of their contribution are: manager 'support' ($B = .34$, $p < .001$), manager 'commitment' ($B = .33$, $p < .001$) and Organisational 'support' ($B = .13$, $p = .03$).

In other words, satisfaction with leadership, in this sample, was predicted by a greater perception of 'support' from management, a feeling that managers demonstrated their 'commitment' to achieving common goals and an atmosphere of 'support' and team-work within the organisation.

Organisational and Managerial dimensions

In order to investigate the relationships between organisational and managerial dimensions, a correlation was performed between all of these variables (Table 10). It was found that:

There were strong correlations between manager and organisational 'recognition', and manager and organisational 'support'. There were moderate correlations between manager and organisational 'commitment' and 'structure'. And there was a weak correlation between manager and

organisational 'standards'. In other words, where the dimensions were correlated weakly or moderately, we can identify that 'standards' of the organisation do not necessarily exist at the same level of managerial 'standards'. The same relationship goes for 'structure' – having organisational 'structure' does not predict clarity in roles, as espoused by one's manager. There is a greater degree of correspondence between organisational and manager 'commitment'. When we look at 'support' and 'recognition', we find that both these dimensions tend to be closely related – one is more likely to feel that both are high, or both are low.

Table 10: Relationship between managerial and organisational dimensions.

	Organisational Recognition	Organisational Support	Organisational standards	Organisational Structure	Organisational Responsibility	Organisational Commitment
Manager recognition	.60**					
Manager support		.65**				
Manager standards			.25**			
Manager structure				.34**		
Manager responsibility					-.02 ns	
Manager commitment						.48**

The significance of Role

The largest group of participants was nurses (31%), then clerical staff (14%), managers and porters (14% each). Doctors/consultants/physicians (11%), other allied professionals (10%) and 'support' staff (6%).

When looking at satisfaction with leadership the following findings were apparent: High satisfaction with leadership was reported in total by 54.3%

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(n=113) of staff. Although there were no significant differences by work role, it can be seen that consultants and doctors reported the highest satisfaction (74%), followed by managers (61%). It can be seen that clerical workers had the least high satisfaction (41%), followed by 'support' staff and other allied professionals (54%). This is significant in terms of the hierarchy within the organisation – the higher the position the more satisfied one is with their leadership.

Table 11: The significance of role and satisfaction with leadership

	n	% positive responses about satisfaction with leadership
Managers	28	60%
Doctors	23	74%
Allied professionals	22	54%
Nursing	65	49%
Support staff/Assistants	13	54%
Clerical	29	41%
Porters/maintenance	28	57%

A further examination of organisational dimensions according to role using a one way ANOVA, revealed the following:

In all there were large differences between respondents in terms of their role, however only two scales exhibited differences which reached significance. The first was 'commitment' – doctors/consultants were found to rate significantly higher than allied health professionals on this scale (mean difference = 2.86) ($p < .01$).

The second was 'recognition' – it was found that doctors were much more likely to rate higher than clerical staff on this scale (mean difference = 2.41) ($p < .01$). Both these findings were apparent even after using the Bonferroni correction.

Comparing doctors (all grades) in Trust 1 and Trust 3

An examination of the responses on the item looking at 'satisfaction with leadership' amongst doctors revealed that doctors at Trust 1 (n= 13) had lower satisfaction (Mean = 3.38, std = 1.38) in comparison to doctors at Trust 3 (n= 10) (Mean = 4.20, std = .42). This difference (.81), whilst small, was found to be approaching significance (t = -2.003, p = .06).

While it is not possible to make an objective comparison between doctors from Trusts 1 and 3 from the qualitative data, there is more evidence in Trust 3 of doctors being both emotionally engaged with both junior doctors and other members of multi-disciplinary teams than in Trust 1 and with distributed leadership. As will be evidenced in Chapter Six doctors and other staff considered 'management' as bureaucratic and distant rather than engaged.

Gender

There were no differences between men and women's scores on 'satisfaction with leadership' (t = 1.71, p = .08).

When examining differences between men and women on the organisational dimension it was found that only one dimension, 'recognition', was perceived significantly differently (t = 3.42, p<.001). Men perceived there to be greater 'recognition' (mean = 9.55) compared to women (mean = 8.13). All other dimensions were not significantly different (see Chapter Eight).

When examining the gender differences on managerial dimensions of the OCS there were trends approaching significance in terms of differences between the genders on managerial dimensions, but these did not reach significance when multiple comparisons were taken into account:

Manager 'recognition' (t = 1.91, p = .06)

Manager 'responsibility' (t = 2.10, p = .03)

Manager 'standards' (t = 2.33, p = .02).

5.3 Conclusions

The difficulty obtaining data across all three participating Trusts has not limited the value of using the OCS to triangulate the qualitative data, particularly because a) the OCS gathered information from staff groups who were not represented in the focus groups, shadowing or story-telling

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interviews and was able to identify generalisable predictors of satisfaction with leadership and management practices, and b) the OCS data captured information from specialty groups outside those involved in the participating Units from which qualitative data was collected.

What emerged here was that on the whole, the same climate variables are important in predicting satisfaction with leadership. Within the organisational domain these are 'support' and 'recognition' while predictors of 'satisfaction with leadership', within managerial practices, are manager 'support', 'commitment' and 'structure'.

Overall, therefore, 'satisfaction with leadership' was highly accounted for by manager 'support', manager 'commitment' and organisational 'support' – i.e. these were the 'ingredients' in this sample which were highly related and were able to predict satisfaction with leadership. This suggests once again that managers/leaders were effective if they engaged with followers and that organisations that supported distributed leadership and emotional engagement were more likely to support effective leadership (see Chapters Four and Six in particular).

In terms of role, the higher the position in the organisational hierarchy the more satisfied a person was likely to be with leadership. This was not necessarily the case though across all organisations in the study. The exploration of the case studies in Chapter Seven – where authority and leadership are discussed – reveals how some of the more senior leaders in organisations found themselves to be highly dissatisfied with leadership in other sectors of their Trust, if there was resistance or negligence of their authority.

Differences in gender were only apparent in terms the organisational dimension 'recognition' – it was only on this scale where women scored significantly lower than men. This may say something about equal opportunities and equal pay for equal work, but it might also relate to perception of 'recognition' between women and men discussed and exemplified in Chapter Eight below.

The overall importance of constructs such as 'support' and 'recognition' across the climate of an organisation, and management practices which demonstrate support and commitment, provide further evidence of the importance in engagement and (probably) emotion (including EI and SI) in an organisation.

6 'Organisation in the Mind': Transmission of Leadership and Organisational Context

6.1 Introduction

Leadership in any organisation is understood in a specific context by those involved as either leaders or followers, and as shown in Chapters Four and Five concepts such as satisfaction, support, responsibility, vision and communication among others are described and evaluated within a cognitive or mental framework within which the organisation itself is understood. It is through making sense of the organisational context that leadership and followership may be enacted and transmitted.

We saw how members of organisations *necessarily* hold in their mind fantasy/imagined understandings or images of the *system* (Morgan, 2006). This informs how they work in, relate to and talk about their organisation, based on their perceptions of their own and others' place and role within the system. For example, it is common to hear employees talk about how 'you can never get management attention in this company' or 'we are all dedicated to putting patients first here' (Armstrong, 2005; Morgan, 2006).

Similarly, the participants who completed the OCS held a view of the leadership and management in their organisations, in order to think about the various ways in which their work was recognised, supported and so on both generally and by their managers. While the focus in that case was upon on measuring the impact of organisational climate and thinking about a relationship with a specific manager, those who completed the survey would have had to hold a perception of what was happening in their department and the Trust overall.

This is apparent in what follows particularly in the ways 'management' is discussed and taking account of these perceptions provides some evidence about the ways in which leadership is transmitted in these particular organisational contexts and in general. The 'organisation in mind' then involves:

- An 'image' of the organisational structure and relationships within that structure
- A sense of your own role and place within it
- An emotional component
- An awareness at a conscious and/or unconscious level of important information below the surface

6.2 Organisation in the mind

The concept of the 'organisation in the mind' was a model developed originally in the early 1990s by organisational and group relations consultants working at the Grubb Institute, the Tavistock Centre and the Tavistock Institute of Human Relations, to refer to what an individual perceives mentally about how organisations, relations in the organisations and the structures are connected. *"It is a model internal to oneself ... which gives rise to images, emotions, values and responses in me, which may consequently be influencing my own management and leadership, positively or adversely"* (Hutton, Bazalgette and Reed, 1997, p. 114 quoted in Armstrong, 2005, p. 4).

In other words, when we talk about our colleagues, guess what the senior management are doing/going to do and have fantasies about how well we fit, or don't fit, into the structure or system we do so in the context of the organisation we 'hold' in our mind which may or may not relate to that which other members of the organisation hold (Pols, 2005).

Organisations are experienced cognitively and emotionally by their members when they think about how their organisations work and are structured (see Lewin, 1947; Armstrong, 2005; Morgan, 2006). As Stokes (1994) explains it, everyone carries a sense of the organisation in their mind but members from different parts of the same organisations may have *"different pictures and these may be in contradiction to one another. Although often partly unconscious, these pictures nevertheless inform and influence the behaviour and feelings of members"*. (p. 121)

Hutton (2000) talks about it as *"a conscious or pre-conscious construct focused around emotional experiences of tasks, roles, purposes, rituals, accountability, competence, failure, success"* (p. 2). Morgan suggests that an organisation may serve as a 'psychic prison' in that the:

...patterns and meanings that shape corporate culture and subculture may also have unconscious significance. The common values that bind an organisation often have their origin in shared concerns that lurk below the surface of conscious awareness. For example, in organisations that project a team image, various kinds of splitting mechanisms are often in operation, idealising the qualities of team members while projecting fears, anger, envy, and other bad impulses onto persons and objects that are not part of the team (Morgan, 2006, p. 226).

Some of this is apparent when talking to NHS staff about the leaders at various levels of their own Trusts and the NHS overall as was seen particularly in Chapter Four.

6.2.1 Organisation under the surface

So, when the respondent immediately below talks about the leader who has a 'really good understanding of the organisation or team' what exactly does that mean? How does that understanding come about? What do the team hold in mind about that particular leader?

Leadership is someone who has a really good understanding of the organisation or team, erm where it's going and where they imagine it to be going, so that sort of vision as well for their team, I think. (Lead Clinical Non-medical Health Professional, T3)

This respondent, referring to the (frequently used) concept 'vision', also identifies this with the *imagination* the leader holds about where the organisation is going. This is not simply a matter of guesswork. It is an intellectual/cognitive and *emotional* sense of an organisation. Indeed to take this slightly further, as Gabriel and Schwartz (2004) propose "... *what goes on at the surface of an organisation is not all that there is, and ... understanding organisations often means comprehending matters that lie beneath the surface*" (Gabriel and Schwartz, 2004, p. 1).

Although not necessarily (in fact mostly not) made explicit, even the most clear thinking senior members of organisations hold an image of the organisation in mind, expressing their fantasy/belief/perception of the organisation based on conscious and unconscious knowledge (Halton, 2007; James & Arroba, 2005). So for instance for this CEO leadership is understood emotionally as it is:

... about the feel of the organisation and what it feels like in terms of how it delivers patient care. Yeah, erm. I can best illustrate that, and interestingly we were thinking about this earlier this morning, so as a group, the executives, we were talking about it. When you walk onto a ward a hospital ward and there is real leadership on that ward, you walk in and there are a number of signals that are given off, which give you a feel. Erm the place looks organised, it has a welcoming feel, the nurses on the ward and the clinical staff greet you as they come into contact with you. They know you from the previous interactions that you have had and when you sit there and listen to what is being said on the ward they will know that the patients, the visitors on the ward, the families that are coming in the junior doctors who are in there in that environment and all of that has a feel²⁶ of a well led ward. (CEO)

²⁶ Respondent's emphasis.

The environment of the well led ward (unit or organisation) is implicitly and unconsciously identified by all who engage with that organisation. The staff communicate effectively (visually, verbally and emotionally) so that the information required is passed on through managers, clinicians to colleagues, patients and relatives. This account, which preceded the extract that focused on strategy, directed to the best patient care for the greatest number of patients, expresses his ideas at an *emotional* level. He also suggests his senior colleagues agree with this. Signals are 'given off', you can 'feel' the organisation and how it delivers patient care and there is a 'welcoming feel'. He also talks about 'empirical' evidence in that staff know the patients, the ward looks organised he remains convinced that there is a 'feel of a well led ward'.

From a slightly different position, a deputy CEO quoted below also holds in mind the fantasy that a manager might think that they run an institution but that such a fantasy might get the manager into trouble. He is suggesting a vision of an organisation in which a manager has very little control, and proposes the need to gain a sense of *reality* by recognising this and taking responsibility for this organisation (Hirschhorn, 1997; Porter-O'Grady, 1995). His perception, again which has an emotional component, is one of a stressful contradiction – responsibility without power or control (de Vries, 2000).

The minute, as a manager, you start to think that you do [run the service without accountability]... erm then you're in trouble. Unfortunately you have still got the accountability for the service but you have very, very little control so it's a whole different leadership and managerial skill that is required I think in terms of recognizing that you have no control over what happens you know across this organisation across the N,000 beds here at [Trust], the thousands of people that go through the organisation everyday, what happens to them is completely outside of my control but if anything goes wrong it is absolutely my responsibility. And that is quite difficult.
(Deputy CEO, T 1)

6.2.2 Structure in the mind

Most recently Laughlin and Sher (Laughlin & Sher, 2010) take up a version of this concept which they name the 'structure-in-the-mind' in their analysis of developing leadership in social care. They reassert, in their model, that not only the local stakeholders (staff and service users) have a sense of the organisation in the mind when considering, for instance, a particular Trust, but the range of stakeholders includes government bodies and service commissioners (in the round). They propose an inter-relationship between perceptions of communications from services (e.g. 'that you [management] don't listen and/or understand') and perceived communications from 'Head

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Office (or government or other bodies that control resources and practices) which include for example 'just do it' 'we know better' and 'be rational'. (p. 9)

What is significant here, in the context of NHS leadership, is that the organisation and/or structure *in the mind* is where the leader and followers 'meet' emotionally as, similarly, do the various levels of leadership and governance bodies. It is a kind of 'virtual' space.

An example of this structure in the mind might be seen through the increase in stress for NHS employees detailed in a recent report by NICE (the National Institute for Clinical Excellence²⁷) where it was revealed that staff absence caused by work related stress costs the UK over £28 billion. It was proposed that a poor working environment characterised by bullying and poor management was at the heart of this problem²⁸ (Edwards & O'Connell, 2007). In a context where there is distributed leadership and a highly trained professional, multi-disciplinary workforce, such mismatches in how to run organisations and departments that lead to staff stress in these ways (e.g. being bullied and bullying) evoke questions about what is happening in the space between those who plan, govern and resource NHS Trusts and those who carry out the work. The emotional elements of leadership and followership relations seem to be neglected to everyone's disadvantage.

The idea of the organisation in the mind raises important questions of how leadership (good and bad) is transmitted across the NHS and its Trusts (Harrison & Carroll, 1991; Walsh & Ungson, 1991). Organisational cultures and climates are reproduced over time despite the coming(s) and going(s) of CEOs. However, organisations also *adapt* and *evolve* as a response to changes in leadership and outside influences (Morgan, 2006).

In what follows we explore the characteristics of the organisations studied here that facilitate or hinder the transmission of leadership through the Trust as a *system* through which culture (e.g. principles and values about leadership) might be transmitted (Hatch, 1993; Schein, 2004).

²⁷ An organisation established to oversee and provide guidance on clinical practice and cost and clinical effectiveness.

²⁸ See news.bbc.co.uk/2/hi/health/8343074.stm and NICE web-site which has a power-point presentation.

6.2.3 Transmission of leadership and Organisational Contexts

What is held in mind about an organisation is often influenced by the formal and informal networks (Balkundi & Kilduff, 2005, 2006; Goodwin, 2000) which characterise complex adaptive systems. Network cognitions in the minds of leaders are embedded in the whole organisation and the inter-organisational linkages formed by leaders as representatives of organisations (Balkundi & Kilduff, 2005).

The context of the NHS seems to have become increasingly complex and chaotic (Currie et al., 2009) which, coupled with a sense of widespread unethical managerial practices, has raised questions about how leadership practices are transmitted through NHS organisations (Bowie & Werhane, 2005; Collier & Esteban, 2000; Huston & Brox, 2004). Bullying and poor management are in part at least a consequence of not taking the emotional context of organisational life seriously (Ashkanasy, Jordan, & James, 2003; Cocco, Gatti, Lima, & Camus, 2003; Johnson, Cooper, Cartwright et al. 2005; James, 1999; Hutchinson, Vickers, Jackson & Wilkes, 2006).

While there is no excuse for bullying or any other unethical management practices, it is necessary to understand what precipitated the relatively recent change in culture which has exacerbated (reports of) bullying. One factor has to be the extent to which top-down, politically driven changes have been forced through the NHS system and other public institutions and the impact that the drivers of these changes have upon the senior levels of management consciously and unconsciously (Christensen & Laegreid, 2003; Dent, 2005; Gabriel, 2004).

These recent developments have influenced the psychological and emotional aspects of working in teams, groups and organisations (Liden & Antonakis, 2009; West & Anderson, 1992) and by implication influenced possibilities for innovation in leadership and the authority of leaders and workers (Lewin, 1947; Miller, 1993; Carter, Garside, & Black, 2003; Hirschorn, 1997; Fineman, 1994, 2000; Payne and Cooper, 2001; Vince, 2002; Carter, Garside, & Black, 2003). Understanding the *context* of leadership, therefore, has become increasingly important as has the need to understand how that context is part of a *system*.

Post industrial (or postmodern) systems (Rose, 1991) have been reconsidered (or 're-described') relatively recently as 'complex adaptive systems' (Collier & Esteban, 2000; Dooley, 1997; Schuster, 2005). Systems that are complex because of multiple interconnecting relationships are liable to evolve through making new connections that increase their complexity (Collier & Esteban, 2000). In the NHS, even though change is structurally driven, the (perhaps unforeseen) consequences of changes have meant that instead of a command-and-control, top-down hierarchies where in particular

clinicians such as consultants and matrons had previously been seen as 'gods' (as with Sir Lancelot Spratt and Dr. Gregory House see Chapter Four) distributed leadership, networks and different statuses attributed to individual Trusts (e.g. Foundation Trusts with relative independence, Mental Health Trusts which have social care and NHS staff and diverse management practices) have evolved within different structures at all levels for coping with service delivery (see Chapter Nine).

6.3 Open systems theory and boundary management

An organisation that *evolves* like an organism and adapts to its environment necessarily has *porous boundaries* so that it can 'take in' and 'put out' beyond itself. This kind of organism is one that changes, develops and grows. A closed system may feel more secure in that it may not have to accede to unwanted influence or demands, but without taking in and providing for the world outside it will atrophy as with any other closed (minded) system (Morgan, 2006). In this way images and cultures of leadership from outside the boundaries might influence the development of leadership practices e.g. data and ideas from education (Currie et al., 2009; Gronn, 2000; Lumby, 2003)

Systemic thinking is a framework, or tool, for observing the way organisations behave (Schein, 1985; Lewin, 1947; Campbell et al, 1994) which evolved from General Systems Theory, (von Bertalanffy, 1956; Miller and Rice, 1967) and focuses upon concepts related to organisational structure particularly 'task', 'role', 'authority' and 'boundary'. There is also a psychodynamic part of the systemic thinking analysis which links with the conscious and unconscious emotional consequences of the systemic properties and the impact of social and personal factors on the functioning of the organisation (James and Huffington, 2004; Laughlin & Sher, 2010)²⁹.

Morgan (2006) identifies how knowledge and power are accessed and maintained through control of organisational boundaries. 'Boundary' is the term used in open-systems theory to describe the interface between different parts of the organisation and the organisation and the outside world. In the case of the NHS this is the physical boundary to the, for example, hospital building, the wards, the web-site, the reception desk, the

²⁹ This issue is further discussed and explained through object relations theory based on the works of Melanie Klein, Elliot Jaques and Isabel Menzies-Lyth which is outlined in detail in Chapter One and operationalised in the description of the role of obstetricians' anxiety in the delivery of patient care discussed in this chapter and below in Chapter Nine).

telephones, e-mail and so on and also between the different roles such as out-patient/ in-patient, staff /patient, clinician/manager and so on. Most leaders in organisations have the knowledge and abilities by definition to manage and negotiate those boundaries. For example, the senior managers relate to government/NHS/DoH in ways that junior nurses do not, but the senior staff are charged with having to manage the boundaries using knowledge and influence across the boundaries – inside with the staff and patients and outside with government and patient pressure groups. Moreover, as evidenced during the conduct of this project, hospitals merge into Trusts and the porosity or opacity of the boundaries between the different organisations that have come together are central to the functioning of leadership at most levels (see Chapter Seven where the limits of authority are discussed in this context).

Stating this in a slightly different way, this approach to the 'organisation in the mind' takes the *personal* (conscious, pre-conscious and unconscious) level of thinking and links it to the *system* in which that person works (systemic thinking). As any organisation comprises systems (with boundaries, in-puts and out-puts), groups and individuals, it follows that a person's experience of an organisation and *experience of themselves* in relation to others who are in the same organisation make up the culture, climate and everyday dynamics of any organisational context. Thus, our respondents' sense of the 'organisation in the mind' is a valuable concept for understanding how leadership relates to service delivery.

6.4 Images of the organisation

In what follows we explore some of the images 'held in mind' by staff across the three Trusts particularly examining the impact of the organisation in the mind on working collaboratively and the influence of this on service delivery and the quality of patient care that results from staff relations and effectiveness.

To begin, we focus on two specific examples that characterise much of what was said by staff across at least two Trusts:

- images (and fantasies) held about 'management' which highlight the construction of 'authority' in the system and its impact on patient care
- images (and fantasies) held about the 'others' (e.g. colleagues in the same Trust but on a different site or a different Unit) which brings boundary management into play
- how these images (and fantasies) facilitate and hinder the transmission of leadership and service delivery

We employ a critical discourse analysis (CDA) approach to the meaning and processes of leadership and organisation exploring how the organisation/system *looks* to the participants and how this in turn impacts upon the system of providing care for its patients.

6.4.1 'Management' in the mind

As in many organisations, rhetoric about 'management' abounds particularly played out as a 'them/us' dynamic as we demonstrated by separate means in Chapters Four and Five. Furthermore, among management, rhetoric about their own practices and role in relation to that of the workforce is equally active (Alvesson & Sveningsson, 2003a; Borins, 2000; Kuokkanen & Katajisto, 2003).

There is general cynicism across all the respondents who defined themselves as non-management *about* management. So for example: *"And you find that when there's a crisis that's when you find your management team will come down and put a policy in place regardless - like the swine flu thing" (Junior Midwife)*. So here managers are described as paying no heed to the routine tasks of the organisation (Cummings, Hayduk, & Estabrooks, 2005b). They are portrayed as simply responding to a crisis and (presumably following orders from the overall leaders of the service). Thus, managers are not seen as managing the boundaries between the Trust and those in overall charge of health care operating outside of the organisation (i.e. at the level of government) effectively for the facilitation of service delivery (Buchanan, Abbott, Bentley, Lanceley, & Meyer, 2005; Kane & Patapan, 2006). This resonates with Laughlin and Sher's (2010) analysis discussed above.

A focus group from one Trust proposed a particularly strident view of management and its relationship to wider bureaucratic imperatives which they saw as going against service delivery and effective patient care. The medical staff here were proposing that management was both absent, in person and from taking responsibility, while also being all controlling of medical care through instigating seemingly pointless rituals which seemed to maintain boundaries.

Consultant: There is a burning example [here] of bad leadership which is the absence of figure heads. Management can never be found which is frustrating.

Registrar: I've been in theatre now for two weeks and two cases were dropped. The doctor has to apologise to the patient but they are the ones [the doctors] who would like to continue. Management say 'NO it is lunch'. They should be the ones taking responsibility for telling the patient but the

doctor has to go back to the patient and look like a donkey saying 'I'm sorry I can't do your operation today'.

The members of this group, who clearly shared the same or similar images of management and its 'idiocy', went on to decry management incompetence across all staffing issues, and the registrar continued, imitating the management in a silly voice: "*he has to stop, that's the rule*" making it very clear that management was perceived by this man and others in this focus group as inflexible (and rather stupid). Here these participants are expressing total lack of faith in the authority of those who manage (rather than lead) them, although in fact it seems that despite this, they abide by the rules which suggests that there is a belief that at some level the managers in question here derive authority from somewhere higher up in the hospital system or from the NHS leadership beyond.

One factor to note, of course though, is that the power of the story in the focus group may belie the views of the whole group in that some would be silenced by the fear of disagreeing with their colleagues (Asch, 1956; Foucault, 1982). Furthermore, the articulation of the behaviour of management in these cases is *actually a form of leadership* and as such might influence the views of the focus group (and subsequently other staff) (Avolio et al., 2004; Pye, 2005).

From a different focus group, this time with junior midwives, it was apparently *giving up their authority* for a while that gained managers some important respect. For instance when a crisis occurred in the organisation (in this case a fire) then managers seemed to behave very differently and even impressively:

1³⁰. Yeah and then the managers - the bed managers - were carrying chairs and everything and you just had people on beanbags on the floor and everybody ...

2. I wasn't here that day I missed that.

1. Well it was a bit stressful but everybody just mucked in and people were just carrying people here and you know....

Q: Well that's really good if everybody even the managers mucked in.

1. Yeah you find in a crisis the managers do come out, the leadership the leaders come out and they have to come out.

3. And people were coming in from home to help that day.

³⁰ The number denotes the speaker.

2. *Why didn't they phone me? I don't know but never mind ...*

1. *No you find that in that kind of crisis everybody from execs downwards pulls rank and everybody comes in and helps out (T 2).*

So the image here is that a crisis brings out the best in everyone (and the boundaries between the groups of staff become temporarily porous). In times of crisis then the tasks (i.e. patient care and running an effective hospital) overcome other elements of potential discord and conflict such as the 'rank' order of 'execs' bed managers and others such as clinical staff.

There are also other times when it is possible for management to be seen as 'on side' as indicated by another nurse in a different site. For example:

Erm ... our manager, she is quite approachable. And she is willing to discuss things with you if you don't feel that something is right and you question it or question her. She is willing to sit down and explain it and sometimes she will say 'I'm not happy with things as well, but the people above me this is what they have decided, this is what we have to go along with. It is government guidelines or targets have to be met'. Although she might feel the same as us she explains why we have to do things in this way. And I think she is very approachable.

This manager above, demonstrates her willingness to communicate and be 'visible' but clearly she has adopted a them/us strategy similar to those who 'oppose' management by positioning herself as managing the boundary from the side of the clinician/nurse's while also at other times presenting herself as mediating between 'government' and clinicians and managing that boundary too (Laughlin & Sher, 2010).

In the example described here, this seems to 'work' as evidence of good leadership for the nurse telling the story, but it involves the manager in question in potentially difficult dynamics and conflicts in her role.

From another focus group discussion that included doctors and nurses the organisation in the mind experienced management as absent and failing in their responsibility (Hogan & Kaiser, 2005):

Absence would be correct. Management are often not there. They need to take command of the situation. Here is the reasoning – management don't take responsibility for their actions and there is a severe lack of managerial leadership.

This is significant in the concept of the organisation in the mind when juxtaposed with the account of the same organisation by the CEO who saw her/himself as seeing good leadership as manifested in:

Visibility in terms of being seen around the place, so go out wandering around the wards. The best part of the role, quite candidly is, the best part about being the chief executive is, you can go out and talk to patients, and that is what I really kind of enjoy. ... so there is something about my presence and my profile. There is also something about being very clear and repeating the message often enough so that it is clear in the organisation about what the organisation is there to do.

So, within the same organisation there is an image that management is invisible and absent, while senior managers see themselves as 'being seen around the place' constituting an important part of what they believe they do and that they see as being vital for effective leadership and patient care (Laughlin & Sher, 2010). Both sides agree on what would be good leadership but each 'side' has a different vision of what is happening in 'reality' (Alvesson & Sveningsson, 2003a; Buchanan et al., 2007).

In the absence of a shared vision of an organisation working together or a set of clear guidelines about how 'this organisation works', there seemed to be a wish from a deputy CEO of another Trust for a hero/charismatic leader to put things to rights and potentially cross the managers/others boundary (Ladkin, 2006; Laughlin & Sher, 2010).

Erm, this is a very complicated organisation, what we haven't got right is we haven't got a bible that says this is how this organisation works and I think that's a problem so, ((1)) so ((1)) it's very easy for ((1)) despite what I've said about how difficult it was to be a leader, erm and the personality of the individuals who are at the top of the tree, makes an enormous difference in how an organisation I think behaves and works. There is a great tendency if you are a very good individual for an organisation to be based around you and when you leave there is a problem, erm and so the best kind of leader, yes they have that aura of it's about them, of course that's what people look up to but they also put in place processes so that things can happen.

This is a view from the top of the organisation which is expressed at least in part as a vision of a (desirable) mechanistic model – an organisation with a 'bible' about how it works - although this participant also desires a charismatic transformation on the part of leaders.

The hero leader would be a 'very good individual for an organisation to be based around you' and also to have 'an aura'. The metaphors in this extract proliferate – the need for a 'messiah' to save the organisation but also a sense of *dependency* – that 'people look up to' this type of leader who (it would appear) single handedly will be able to put processes in place for things to happen. The vision here is though one in which the system is defunct, stagnant and closed.

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6.5 'Out of mind': leadership and the 'other'

Organisational change is frequently resisted, often because of the disruption to individual's *sense of the system* and their place within it (e.g. Hoyle, 2004). It is also related to the emotional involvement many people have in their work and the way they perceive they are valued within (and how they themselves value) a familiar structure and context (Bovey & Hede, 2001; Zoller & Fairhurst, 2007).

Emotional labour, as discussed in Chapter One, is a key feature of the work that many people do, and is an integral part of any job, but particularly so in an institution of the NHS (see for example Gabriel, 2004). Different occupations require different types of 'displays' and following Hochschild (1983) emotional labour requires adopting emotional displays and attitudes appropriate to the role.

Clearly in hospital work all staff have to expend emotional energy on 'caring' and 'kindness' but it is also the case that working in the NHS, with its many changes for (perhaps) better or (maybe) worse, also requires the ability to be able to 'move on' i.e. mourn the loss of the old structure, sets of relationships etc. and embrace the 'new' with some degree of enthusiasm. The failure to do this (or recognise the need to do this) results in emotional resistance to changes and hanging on to the old systems as long as possible which might defeat changes that improve service delivery and benefit patients (Hughes, 2005).

6.5.1 Leading change and transmitting leadership

In one particular case a senior clinical manager Gerald³¹, was charged with integrating clinical practice across two sites, each of which had their own different ways of working, and different relationships to the boundaries between each other and the clinical teams. While the one (where he was based primarily) had accepted quite radical changes to its organisation, the other (apparently) did not "*..because the sort of ethos and the sort of personalities of the two sites are in the background. They are completely different*".

Gerald's view is based on a reality in that the two sites are structured differently, look different from each other in that the buildings are from different eras and in different styles, and they are in physically different locations. They also serve different demographic populations and have different histories. However, Gerald sees the organisation of the different

³¹ Gerald's leadership is discussed in detail in Chapter Seven.

sites as really being about 'ethos' and 'personalities' which must be in the mind (mostly) as there is a system of authority and responsibility in place across the Trust (via the CEO and other senior people including Gerald) that takes up authority and leadership to ensure consistent practices and organisational change.

Thus, we need to ask why one Unit has (apparently) taken new ways of working on board with some enthusiasm while (apparently) there are barriers preventing the other one doing something similar.

For Gerald, management of the boundaries between in-patient care and primary care teams was the source of a key difficulty:

There are groups of people here who are completely behind the concept that we mind about – integration of primary care – joint working between the Trust and the Primary Care Trust. Some departments work extremely well and are keen to move forward and although we do have our minor difficulties - generally there's one or two departments who are completely against change and erm resistant to anything new. Just like any other organisation where you know you are going to get the type of people who actually make life extremely difficult for you and despite that we've proven how much better our system is.

In the extract above he moves from talking about the other *site* (as a whole system) as being the 'bad' resistant one, to identifying *individuals* on his own site within the 'good' system as making life difficult for him personally despite evidence (he and others have provided) to show how integration works better. This respondent's organisation in mind shifts depending on how well one part of the system fits with his particular vision of a good organisation. This *splitting* (see Chapter One) is a mechanism (unconscious) for preventing the overwhelming feeling that can come from persecutory anxieties (Jaques, 1953; Jaques, 1960; Menzies, 1970). In a management role where (for some reason) authority is being undermined, then the resurgence of persecutory anxiety might be dealt with by splitting of the 'bad' site and comforting oneself with the knowledge of a 'good' site where the organisation works as this leader/manager might wish it to do (Laughlin & Sher, 2010).

6.5.2 Resisting change

In the case of a medical secretary, with over twenty years experience of working in the same hospital, the thought of change in the structure of her working relationships was upsetting. She began engaging with the interviewer by talking about how busy she was and when asked if there was any particular reason why she was busy at that particular time she went into an explanation about organisational change. *"It's just generally busy, but we*

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are in teams now, erm couple of them [doctors] are away and one or two have come back, catching up with everything". It seems as if the teams were the problem for her because previously (and for many years) "...it was one secretary to one consultant and his team. Now for instance today I'm actually taking calls for four different consultants". She was asked about the new structure and made it clear:

erm ... I don't think it's going to work as well as the previous one. Because I think you'll be dipping in and out of so many different jobs that instead of concentrating on the ones that you do well and controlling your one doctor, it'll be confusing and I think there will be mistakes made because one person is trying to deal with too many parts of too many jobs.

Her perception that her role in the organisation might happily continue as one in which she controlled one consultant is characteristic of the 'comfort' of the closed system where authority, power and the processes of leadership are condensed and held 'constant' by an individual. As seen in Chapter Four also change is not usually welcomed without at least tacit resistance and in Chapter Seven two of the case studies will explore how leaders as potential change agents experience followers' avoidance or challenge to changes in practices and structure.

Changes in working relationships bring anxieties which need to be understood and anticipated by leaders if they are to support staff to position themselves differently in the system. Hoyle (2004, in Huffington et al) suggests that during any period of organisational change there is potential for heightened creativity which might lead to doing things differently and better. However, change also brings about risk, uncertainty and the chance of failure which can evoke anxiety both in those promoting the changes (the leaders) and those who might fear loss of their job and the loss of known ways of working (see Hoyle, 2004, p.87).

6.6 Conclusions

Understanding an organisation and what facilitates and/or hinders leaders to take up their authority involves considering the organisation systemically. That is taking account of the boundary management and how that relates to the tasks, roles and power/authority of those who work or are 'consumers' of its work.

Leading change depends upon ensuring those within the system have a sense of how the system works and an awareness of the culture that might be tested as a reality or not. This means, once again, that organisations which are learning environments and where emotional intelligence is applied, are more likely to respond to authority and less likely to subvert

leadership, thus distributed leadership/responsibilities may be taken up or shared more widely.

7 Leadership, Authority and Emotion

7.1 Introduction

As argued above, leadership and emotion are fundamentally intertwined in the workplace (Fineman, 2003). Leaders who appropriately manage both their own emotions (Goleman et al., 2001), and those of their followers, experience better leader-follower relationships, greater opportunity for innovation, motivation and productivity, a more positive organisational climate and improvement in employee and customer/patient satisfaction (Ashkanasy et al., 2003; Avolio et al., 2004; Hollander, 2009). Such outcomes can be associated with both *transformational leadership* (Bass et al., 2003; Corrigan & Garman, 1999; Currie & Lockett, 2007) and *distributed leadership* (Bass & Steidlmeier, 1999; Gronn, 2000, 2002; Mehra, Smith, L. Dixon, & Robertson, 2006b) patterns.

It has also been suggested that followers' 'dysfunctional' dependency is a consequence of failure of the leader to *engage* on an emotional level with those whom they lead (Alban-Metcalfe & Alimo-Metcalfe., 2009; Ashforth & Humphrey, 1995; Bion, 1961; George, 2000). There are different types of such engagement, e.g. acknowledging emotions, drawing them out, honouring them, confronting them, and deflecting them, but although this idea of engagement has been described as "*compelling on the surface, the meaning of the employee engagement concept is unclear*". (Macy & Schneider, 2008, p.3) Even so, there is a common view that such engagement is desirable for organisations in that it connotes involvement, commitment, passion, focused effort and energy from staff thus demonstrating both attitudinal and behavioural components for an effective workforce. (Macy & Schneider, 2008)

Studies of leadership and emotion have not typically been combined with attention to the 'authority' of the leader (Ford, 2006; Stein, 2007) or indeed to the concept of 'power', (sometimes seen and experienced interchangeably). (Morgan, 2006) A study combining exploration of the relationship of authority to concepts of both 'emotion' and 'engagement' (Hirschhorn, 1997) is particularly relevant to the agenda of the 'post-modern' organisation where leadership is distributed (Clegg, 1990; Tierney, 1996) and the organisation potentially fragmented, unmanageable and diverse.

The authority invested in a particular role, such as the CEO (Chief Executive Officer) or lead clinician may not explicitly engage emotion. However, in an organisation such as an NHS Trust, where leadership styles are, or at least

intended to be, characterised by distributed or transformational attributes, the concept of authority is more closely linked to *personal* authority whereby individuals “..bring more of themselves – their skills, ideas, feelings, and values – to their work. They are more psychologically present.” (Hirschorn, 1997, p.9). Thus for example clinical skills *and* personal investment are *both* required for someone to take up authority in practice as a clinical leaderⁱⁱ.

In this chapter we delve further into the concepts of leaders and leadership, particularly focusing upon leaders with a ‘mandate’ to lead change through their formal *role*. The group of participants we specifically focus upon here includes clinical and non-clinical senior managers and we examine the ways these individuals construct their role, their relationship to ‘followers’ and how their *authority* is taken up, experienced and constructed in their specific organisational context³². Authority has more than one meaning. It refers to the authority (sometimes seen as power) invested in a particular role.

Analysis of relationships between people who work in the NHS is underpinned by both the *interactional* and the (related) *emotional* contexts of an NHS Trust as a workplace (see for example Liden and Antonakis, 2009). This knowledge is particularly salient because on the surface, many of those occupying the leadership roles were inclined (at least superficially) to deny the role of emotion although analysis of their stories, shadowing and observations, following the pre-existing literature on organisational cultures, including those which study health care settings, indicated that emotion indeed plays a key role in service delivery and the ways leadership and authority are experienced and constructed in relation to patient care (Vince, 2002; Gabriel, 2004; Hirschorn, 1997; Huffington, 2007; Obholzer, 1994; Vega-Roberts, 1994).

7.2 Case studies

Three case studies were selected to examine the meanings given to the relationship between ‘leadership’, ‘emotion’ and ‘authority’ in relative depth. Each one was chosen (through discussion among the research team) to be (potentially) representative of a ‘typical’ approach to emotional management which reflected a personal style of authority (or lack of authority). These particular cases raised subtle but crucial questions about leadership, emotion and authority through exposing both the conscious and *unconscious* qualities which can either underpin or undermine a leadership *role* (Bovey & Hede, 2001).

³² In this chapter we focus specifically on the senior staff’s perspectives. Others’ perceptions of senior staff were discussed in Chapter Six.

1. The first leader, Gerald, had an 'authoritarian' manner (Adorno, 1950). That is, he appeared to believe that because he was in a senior position other staff ought to do what he told them to do. He was a senior clinician [for a group of particular services], relatively young, very enthusiastic and held an uncompromising vision of how a good hospital should be organised. He was interviewed once by a researcher, once by a group including the PI and 'shadowed' for two days by the same researcher.
2. Kerry in many ways held a similar outlook to Gerald, only she *believed* that she attended to the emotions of her staff if not her own. Kerry was Gerald's immediate boss and evidence from the interviews, shadowing and observations in both cases indicates they did not always work effectively together. Kerry was interviewed twice. Once for information as a key informant by two researchers and the second time by the PI and a researcher together. She was also observed by a researcher for an hour.
3. Quentin was a Clinical Director. He made overt efforts to weigh up the emotional 'risks' to his authority and thus seemed more able to engage with the 'followers' (and thus probably survive) in the *role*. At first he was reluctant to take part in the research directly (although he supported his colleagues' participation) but eventually agreed to be interviewed. Two researchers met him before the interview conducted by the PI, in his role as a key informant and observed him and the senior colleagues in their shared office space for about 30 minutes.

7.2.1 'Gerald'

Gerald held a clear vision of how a good hospital should be organised for the benefit of patients. What he appears to find problematic is managing staff who (for whatever reason) have a vested interest in different styles from those he advocates of patient care, working with colleagues and patients, and/or visions for service delivery.

The following extract is from the shadowing of Gerald.

From the two days spent with Gerald it was very clear that he believed that he was one of the main 'leaders' in the Trust and that he had a strong relationship with the middle and upper managers (including the CEO) which he uses to his advantage especially during long discussions regarding the 'new vision' (which appeared to be very much his vision) for the relationship between the two sites.

Gerald did indeed appear to be one of the main leaders. However, it was unclear whether the power and influence in this leadership role was all smoke and mirrors. Does Gerald play the role of the Wizard of Oz? Does he

think he has more power and influence than he actually has? Does he really have a good relationship with the Trust managers and Chief Executive?

The interview with Kerry (the CEO) made it apparent that she did not consider that he was one of the main leaders in the Trust and it was indicated that she didn't think much of him, and that their relationship might have been fraught.

Discussing the researcher's notes some weeks later, one thing that did emerge was that Gerald 'confused' those around him and was apparently unaware of how others saw him and how far his personal authority actually stretched. Hirschorn (1997) in a study of authority in contemporary organisations has suggested that leaders are no longer the old-style authority figures and because of changes in technology and economics "... bosses can no longer project the certainty, confidence and power that once facilitated employees' identification with them when they [employees] were young and dependent. This is why people are so disappointed in leaders today but also so unforgiving of them" (p. 9).

Gerald, although he had a clear management role and mandate to make the changes he focused on, did not get identified by his colleagues as fulfilling the vision of a leader as there is an implication in the observation extract that his authority may have been achieved via 'smoke and mirrors'. Furthermore his appointment (and that of several of his close senior colleagues) predated the appointment of the CEO. Several questions are raised here by the researcher about whether Gerald has been capable of taking up authority when the CEO takes a stance that at least tacitly opposes him. *This has to remain unanswered in the specific context of this Trust but is an important matter to consider in regard to distributed leadership.*

Gerald prefers to position himself as 'evidence-based' (and therefore up-to-date) dealing with practical matters and not positioning himself as an *emotional* leader. In the interview below, thus, he talks about making difficult decisions but paradoxically, almost from the beginning he focuses in upon dramatic inter-personal conflicts - talking about 'facing up to a fight' and declaring that the Trust 'absolutely' does not have the kind of leadership that enables 'direction' or 'vision'. Does this mean the CEO? Does this mean consultants? It may not even be intended so specifically perhaps it is an expression of general frustration that his vision is not shared.

While on the surface he claimed a good sense of what leadership is about he is also revealing in his talk, the opposite position. Taking a team or department in the direction of the vision and making difficult decisions is for him about a relationship with (not) being 'scared' or further down in this extract, (not) 'afraid'.

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Gerald: *Erm...good leadership, err having the ability to make difficult decisions, err, not being scared to face up to a fight...erm...being able to be clear about errr, the direction or vision of the trust, where we are going and be able to errr direct your team into the position that everyone errr everyone is meant to be going, erm I think*

Q: *Yeah...and do you see that kind of leadership in this hospital?*

Gerald: *No, absolutely not*

Q: *No? And why, why not? What's the problem to that kind of...*

Gerald: *I think that in the past, we .. we have been afraid to face up to a fight, and we have shied away from it.*

Q: *Yeah*

Gerald: *From making difficult decisions, and err, and we've let too many people get away with undermining the overall plan that we have...'cause we all know how to deliver excellent healthcare, we all have our views of how this is going ahead, but err, and the grand picture has been undermined by a few, and we've not been able to really face up to those people*

Gerald believes that while everyone knows how to deliver 'excellent healthcare' a few have undermined the/his 'grand picture'. He also identifies with a group who support his particular vision while not expressing empathy with those who do not. As the interview progresses, Gerald berates the power (rather than leadership qualities) that consultants have had in the past suggesting that they *undermine* changes that he clearly and sincerely holds about what constitutes good patient care.

Gerald however does reflect on what he is being asked as evidence by his suggestion later:

I don't know about what makes a good [leader]...you know, its difficult to say what makes a good leader...because I'm not sure I'm a good leader, because the qualities that I feel perhaps are necessary, I don't perhaps have ...one of those is patience perhaps...err, being able to tolerate people's err err, err stupidity in a nice way, is essential I think, but I don't have that, I don't think...being, having the ability to listen, err, err, err and not judge or criticise too quickly is very important, but then, taking everyone's opinion into account, but then at the end of all that being able to still go your own way, and persuade everyone else that it was their idea in the first place ... Well, I have certain qualities which help me get the goals that I like...erm...whether I have everybody behind me.

This is one (although not the only one) of the more (paradoxically) emotional interviews from among the senior managers in the study. Gerald

recognises, quite passionately, that a leader needs followers and has to be tolerant. Gerald, though, cannot help declaring that those who presumably hold differing opinions to him to be stupid. He also said later in the interview that he believed many people were *against him* when he was appointed to the senior post as the Trust itself changed shape. While he would not it seems position himself as emotional (rather he sees himself as evidence-based) he chooses to talk in emotive ways and reading and hearing what he says is quite exhausting as he uses all his energy in trying to take the organisation where he believes it should go, but through lack of emotional intelligence, many a time he draws a blank.

Gabriel and Hirschorn (2004) might describe Gerald, at least in part, as a 'narcissistic leader' in that he liked to be told he is important and influential but he is also potentially a bully and authoritarian in style (Adorno, 1950). He clearly found criticism intolerable and split off the 'bad' (i.e. the consultants who didn't go along with his changes from the 'good' i.e. the 'we'). Gerald has a dream which he is determined to make into a reality, however, there is a "*delicate balance between feelings of omnipotence and feelings of impotence which leaders must achieve, in order to enhance the chances of turning vision into reality*" (Gabriel and Hirschorn, 2004, p. 144). These authors argue that narcissistic leaders have a particular aptitude for getting this balance wrong and "*Even if they are talented in their field, their judgement increasingly fails them. This is compounded by the collusion of their followers*". This may be Gerald's 'we'. Gerald fails to connect emotionally with his (potential) followers from outside his close-knit 'we' group even though there may be some admiration for his clarity and link with the NHS mandate. This means, in effect, that important changes which may well be for the benefit of patients in the contemporary NHS are being (effectively) resisted because of Gerald's style of leadership. Gerald also appears to have little idea of how others might experience their worlds, including their emotions.

This theory might be borne out by the following participant, a young female career NHS manager just reaching a senior position. She proposed Gerald, unprompted, as an example of a good leader:

I think he's great, he gets a bit of bad press sometimes, I think people get agitated with him, but I think it's because he tries to manage things, and he tries to be very fair, and he tries to solve problems that have been with us for a long time, so again, I think he is a good leader, he is trying to do the right thing for the Trust in the long term. He is erm ... sometimes it's difficult for him to carry people with him, but I think that will pay off in the long run. And I think he's thinking of a long term plan, he's prepared to take a bit of short term flack...but I think it will work out in the end. I think he's going about doing stuff in the right way, he's being fair and he's trying

to be consistent, he's making sure he's got an evidence base for doing things, it's not just a random decision, he's collecting information, and that kind of thing...I think there are a lot of people in this organisation at this point who would say they didn't think he was a good leader, but I think time will tell the story there.

This extract from the interview, while consistent with Gerald's descriptions of his own behaviour, proposes an evaluation of his style which indicates he is likely to be successful in the longer term because he is 'trying to do the right thing for the Trust'. However also she identifies quite clearly that his leadership is failing to take many of the people who matter along with him, she positions herself as sharing his vision for the longer term benefit of the Trust which may reflect her *a priori* engagement with NHS management rather than with a clinical profession as she does not have a clinical background herself. It also seems to reflect collusion with his narcissistic style because she seems to mirror his version of himself. This participant continues:

Sometimes they're [other senior staff particularly doctors] quite quick to criticise without really understanding what the problem is that needs to be solved, and what some of the rules are we can't ignore. Some of the national directives, that we just have to do, there's no point fighting against them, we've got to find a way of implementing them, and I think sometimes he gets a really raw deal...but he's said, he's consistent, he will communicate to people, write to people and speak to people very quickly the minute they raise a problem, and he definitely shows that he is not shying away from difficult problems...I think that's a very strong characteristic.

Her description of the other staff appears to chime with Bion's theory of a fight/flight basic assumption group based on unconscious emotional ties of the group involved which (mostly) represents an anti-task resistance to the leader (Bion, 1961). *This extract above reinforces the possibility that Gerald is emotionally disengaged from his followers* and perceives his Trust to be in line with and in favour of NHS 'national directives'. The participant here who in a way is 'damning' Gerald with *strong* praise may be looking to Gerald as a potential mentor by making it clear that she will support his particular efforts. However when the researcher asked her about her *own* leadership she said:

.... because one of my strengths is pulling people together, one of my strengths is building teams, so I think from that point of view then yes, but then sometimes I look at people like [Gerald and her immediate boss] and I think 'Oh my God'. I've got so much respect for the way they deal with

the very difficult issues. Sometimes I wonder if I really put my neck out enough to say 'Ok, Ok, this is what we all need to be passionately aiming for.' Even if not everybody is quite wanting to do the same thing. I think sometimes I sit back a bit more and wait to see what the general feedback is, rather than stick my neck out and say 'Ok, this is the direction we've got to go in.' And I think as a leader you have to...well, in fact you probably have to do a bit of both.

This participant, it seems, is somehow subjugating her own skills and strengths to those whose skills and strengths do not correspond with what she believes in makes her a good leader and seems to be putting herself down for the skills she has got and does seem to value. Alternatively, she might have realised that her strengths might complement Gerald's and through his own narcissistic valency he may position her as someone to promote.

Finally, in relation to Gerald, whose example she insists on returning to, having described other more emotional and successful clinical leaders in the Trust:

.... And they [other senior staff] make it very evident that they don't support him [Gerald] in his role, and not only do they make it very evident, but they do a lot of stirring behind the scenes, to get up a bit of a frenzy against him And I think there's some very clever leadership involved in that process, and there's a lot of learning, gathering people in, getting them on board and uniting them in a common purpose, and this and that and the other, but it's not constructive.

7.2.2 'Kerry'

Kerry is Gerald's immediate boss (the CEO) and evidence from the interviews, shadowing and observations in both cases indicates they do not always work effectively together³³. Kerry herself has met with similar difficulties which seem to be the outcome of her attempts to encourage distributed leadership in that:

Kerry: Erm, erm, well we set up a process to...we re-wrote the discharge policy here. I chaired the group. I wanted to know what the problem was about discharges, and I was told we needed to rewrite the discharge policy,

³³ Regardless of personal authority in the cases of both Kerry and Gerald, it is clear that the organisation has had its own very particular problems which are *endemic in the system* (see Chapter Six for a more systemic analysis of leadership).

and we'd just done it. People looked at me, and I just said, well I've spent...I've chaired five meetings myself, where we put all the information forward, and all these arrangements in place and nobody's done anything about it. I think that's poor leadership.

Q: So erm...poor leadership on whose part? Because presumably you had people who you delegated this to?

Kerry: So the consultants, the nurse managers, the matrons...all the people that were on the working group really. And they just didn't implement it. Beyond belief really.

This extract reveals several levels of emotion and authority and (as with Gerald's narrative) there is an 'I' who takes action and the 'they' who are against her. Kerry had identified a problem with discharges but had to ask 'them' what it was and was told that 'we' needed to rewrite the policy. She took up the role of chairing five meetings, the group/'we' put the information forward and the arrangements in place (presumably to take action) but 'no-one' did anything. It is not known how she handled this 'failure' of leadership on 'their' part. Kerry appears to be a micro-manager (in that she herself was involved in the meetings). Reflecting on this interview, and reading the text, one of us reported back to the research team that she had misunderstood Kerry, thinking that Kerry had been talking about her *own* case of poor leadership. Perhaps it was as unclear in the action as it was in the telling (thus perhaps on an unconscious level the lack of clarity was communicated in the meetings). Why did Kerry, as the leader, not pick up the group's dependence (or *resistance*) (Bovey & Hede, 2001; Hughes, 2005)? This suggests that she herself had resisted emotional attachment to her 'followers' and failed to engage them on an emotional level during the meetings. One approach that helps to understand the example above of *resistance*, specifically in the context of the five reported meetings, is the idea of 'fight/flight' from the work of Wilfred Bion (1961/1983). He suggested that a 'group mentality' (or group culture) emerges from the development of a group over time as it continues to meet, because individual contributions conform to this mentality. In brief, the formed 'group culture' unconsciously constrains individual members (see also Sherwood, 1964).

So, in this case it may have been that despite the seniority of the staff involved in rewriting the discharge procedure, the culture that had developed over the course of the five meetings (and possibly prior to this as 'they' had suggested the need to re-write the discharge policy) had *prevented/resisted distributed leadership*. This could have led to the group not making sense of the leader's expectations and reverting to the comfortable pattern of being that had not been challenged possibly (again) because of the leader failing to manage her own emotions or engage with those of her team.

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Bion (1961/86) suggests, that the group mentality exists on both at a conscious and unconscious level so that the team were probably not deliberately, or consciously, going against the leader. It seemed from the leader's description that the team had been almost 'sleep walking' – not recognising that they had already done what they later ignored and suggested needed doing. Dependency, according to Bion, meant dependency on the leader or "... *when all individuals in the group look to myself as a person with whom each has an exclusive relationship*" (Bion, 1961/86: 119). Within this mode there is little connection between the members themselves and there is a '*mass inertia*' (op cit). This links to Klein's depressive position (Gould, 1997). It also raises questions of who is depressed here - Kerry, the group, or the group in Kerry's fantasy? The unconscious resistance and frustration experienced by the leader here demonstrates the fluidity of power and potentially the influence of gender (Fletcher, 2004; Nicolson, 1996; Vince, 2001)

Kerry, however, did claim success in turning around previously identified failings in patient care targets. How did she manage this?

Well I ... I... I mean it requires a great deal of focus, which hasn't been succeeded by other individuals, so...and it's required the organisation to understand its importance, and that it is possible to do. So it's been trying to talk to people about 'OK it's a target, but it's a quality... a patient quality target, so don't look at it in a sort of derogatory manner'.And ((3)) ...so it's a bit of culture about are you being bullied, as a member of staff to achieve the target and if you're not being bullied well then why is important and then well it's important because its patient quality ((1))...and then I suppose, something about... I mean one of the turning points for me is about our reputation as well, which is...well everyone else is achieving it, and we're not, 'why do you want to be in the bottom 20% of the country?'

Resisting her own emotional attachment here she talks in the third person. Rather than saying that as a new senior manager she had managed to engage the staff, which to a point she seems to have accomplished, she states that successfully addressing targets has 'required the organisation to understand its importance'. She clearly perceives senior staff as taking a negative position in relation to government targets and has attempted to persuade people that such targets are about good quality patient care. Another feature of the discourse slips in here – is her style of leadership perceived to be a bullying one? It may be that a group mentality, which takes resistance and dependency to be part of its culture, perceives a leader with a vision, or at least with determination (and 'focus' to quote Kerry) to be bullying them out of their emotional safety. This is a problem for any organisation that suggests to its staff that successful change and development is solely about strong leadership. We have to turn again and again to the clear message emerging from the data that without an

emotional attachment and the ability to manage their own emotions leaders and followers are not going to achieve goals related to patient care.

7.2.3 'Quentin'

Unlike Gerald, Quentin feels that he is succeeding in bringing about change and unlike Kerry he is mostly positive about the impact he is having upon the staff groups. He told two stories, one of which was when his leadership worked, and another where he continues to experience problems although he emphasised (to support his authority) that the latter was not a great a worry to him. In his interview he focused very much on the importance of personal authority: *"I'm still playing the trick of getting people to do things by example"*. He tries to back up his personal authority through making personal contact as much as he can:

You know my job could be answering my e-mails and I'm desperately trying not to. I've made a pact with myself that I will not explain myself in e-mail. If it needs to be explained I will go and explain it [personally].

He distinguished between the roles of the CEO and medical director, which in his opinion were *manager* roles, and that of clinical director which was a *leadership* role.

Quentin moves between the position where:

...people need constantly to be reminded of what they need to achieve ... [in relation to patient care] ...I use the word good care because [they] have the tendency to lapse into what is acceptable or even worse, what they can get away with.

To the position that:

And I think there is some requirement to continually challenge the organisation about what it is providing and sort of have a re-education process. And I guess we all need that – because I need that as well you know and it is one of my roles to keep reminding everybody why they are doing what they are doing.

Quentin sees himself as needing space to reflect upon the aims of the service provision and recognises that he is just as able to lose track of the organisation's main purpose as his colleagues/followers are, given the daily round of work. While Quentin gives an interesting example of how he and the team succeeded in meeting a target for patient waiting times in Accident & Emergency (which involved him engaging personally with the staff in an emergency meeting):

... which was all about persuading your senior contemporaries and peers. It's about the juniors, the people who are actually delivering the services. It's about making a reasoned argument. It's about being visible. It's about being honest and it's about delivering it.

The success, he believes, was about the personal contact and his own visible attachment in trying to change things alongside his colleagues and being very clear that " *...this needs to be achieved at all costs - which was quite liberating*". The rhetoric here is very different from that used by both Gerald and Kerry, who feel their colleagues are letting them down; possibly they are 'splitting' the 'bad' and projecting it into recalcitrant colleagues in order to feel reasonably good about their own positions (Klein 1987, 1983). Quentin is talking about success and success through *taking an emotional risk*. Saying that a change needed to be achieved at all costs (which he described as liberating) could be interpreted as Quentin making an emotional commitment to engage with his followers about something identified by the government, the NHS and his Trust as important. This stands in direct contrast to the experiences and rhetoric of both Gerald and Kerry who express the frustrations at what the 'others' are failing to do. However with what Quentin called a "*slightly different problem*". He has had great difficulty dealing with a doctor who is "*just a very difficult person to manage ... and I need to say to him 'this is crap and needs to be done in a completely different way'. I don't quite know why I haven't done that*". Once again Quentin was expressing an emotion – anger but without pushing/projecting blame on to the other, but being clear what the other person was doing and reflecting on his own sense of why, how and when he might take this issue up with the protagonist.

While Quentin operates with a quiet assurance and takes up his formal authority, and the power that accompanies it, from a classic Kleinian 'depressive position' (Klein, 1975; Segal, 1973), both Gerald and Kerry, despite their formal authority, fail to engage with their followers which leads to their powerlessness and a sense of rage and frustration.

7.3 Conclusion

The interconnections between power, authority and emotion play a complex part in understanding what leadership means to all those involved and in each organisational context. Leadership cannot be understood as something that can be observed and/or measured 'objectively', it is not an essential 'quality' which resides in an individual but is socially constructed, meaning different things to different people at different times. Following Ford (2010) a more contemporary, appropriate and critical approach to the study of leadership "*pays attention to situations, events, institutions, ideas, social practices and processes that may be seen as creating additional repression or discursive disclosure*" (Ford, 2010, p. 51)

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To be specific Rioch (Rioch, 1975), and others had made the point that *"Leader' is a word which implies a relationship So the word 'leader' does not have any sense without a word like 'follower' implied in it".* (p. 159).

The relationship between leaders and followers might be more or less successful and in order to be a follower a person needs (even on a very temporary basis) to 'give over' something of themselves (i.e. make themselves emotionally open) to the leader for the relationship to have meaning. Being a follower may be both (or either) passive or active and there is the potential for the follower to engage and support, or subvert leadership (Bondi, 1997; Halton, 2007; O'Brien, 1994). Consequently, in order to analyse what it means to 'lead' in an organisation, understanding the practice(s) of emotional management alongside an analysis of power relations is fundamental (Grint, 2005; Schilling, 2009). For Foucault (Burrell, 1988; Foucault, 1982) power *"exists only when it is put into action, even if, of course, it is integrated into a disparate field of possibilities brought to bear upon permanent structures."* (1982, p. 788) Thus, while organisations give formal power to relatively few leaders (including in a distributed model of leadership) consent is still required for the power to be maintained. Furthermore, 'the other' that is the one over whom power is exercised, needs to be *"recognised and maintained to the very end as a person who acts"* (Foucault, 1982, p. 789).

The leaders we have described above all admit falling into traps where their authority has been challenged/resisted and they have been (potentially) made powerless. Quentin alone demonstrated awareness that he was working *with* people rather than treating them as resources. This meant that despite experiencing some frustrations, he managed to continue to *feel* and *think*, and with his colleagues/followers on board, *implement* changes. Kerry and Gerald, while attempting to take up their 'legitimate' power and lead change, both squander their authority through failing to manage and/or engage with their own and their followers' emotions. This is evidenced by their displays of frustration, impatience and anger with those who fail *to do what they are expected/commanded to do*.

Gerald held a classic authoritarian view of power, indicating that whether he takes people with him or not, he intends to get to the *'goals that I like'*. He also sees the resistant followers as stupid. He defines leadership accordingly, in that the leader should *'direct [the] team'* and not be afraid to *'face up to a fight'*.

Kerry sees herself somewhat differently even though she experiences anger and frustration when followers fail to do what she wants and expects. In attempting to empower her subordinates and set up the 'processes' to distribute empowerment (such as the meetings described above) she was left feeling disempowered following an (apparent) breakdown of

communication between herself and the senior team she tried to work with. That one of the interviewers also had to clarify: "*poor leadership on whose part?*" suggested that Kerry possibly re-experienced the rage and frustration she felt at the time of her encounter with the followers in her story when she told it. This rage obscured clear communication both then and in the telling. It might be that the overwhelming need to prevent the Trust from being '*in the bottom 20% of the country*' was a source of anxiety for her and the importance of achieving these specific sets of goals contributed to her impoverished emotional literacy.

Distributed leadership (Gronn, 2002; Mehra et al., 2006b), as a response to 'postmodern' organisations (Tierney, 1996) sets out the changing nature of authority/power. In combination with ideas from the emotional/social intelligence literature, distributed leadership suggests a more relational model of leader/follower relations whereby leadership decisions may represent both outcomes and inputs (Ashkanasy et al., 2003; Wolff, Pescosolido, & Druskat, 2002). A warning note, however, reminds us of the persistence of the patriarchal version of 'the' leader (Ford, 2010; Ford & Harding, 2008) which occupies the dominant discourse within which the notion of 'effectiveness' neglects (if not ignores) the importance of the management of emotions in the leader and followers.

Through the use of innovative research methods and data analysis, which take account of both conscious and unconscious processes through which leadership is socially constructed and exercised, the intrinsic complex connections between authority, power, emotion and leadership in the context of health care can begin to be disentangled.

Leadership that 'works' for an organisation such as the NHS is a multifaceted, emotional *process* in which leaders manoeuvre to manage their own and their followers' emotions and behaviours on both intellectual and emotional levels. To be effective in, what are now seen to be, postmodern organisational contexts, leaders also need to reflect upon themselves in their role and to understand the structural, cultural and emotional expressions of their authority and the authority and power of their followers. The legitimization of emotionally engaged leaders' authority supports effective service delivery across the different levels of the organisation through undermining conscious and unconscious resistance(s) as described in the examples above. Power as a coercive violence (see Foucault, 1982) has been exposed and undermined in such organisations and 'replaced' by concepts of 'distributed' leadership where the persistent claim to power is by definition and necessity more fluid.

8 Gender and Leadership

8.1 Introduction

Gender and leadership is an area that has attracted interest among policy makers and researchers, because the styles of leadership that are currently perceived to be the most effective, such as transformational and distributed, are believed to 'fit' more closely to 'feminine' styles of leadership. Fletcher (2004) notes that traditional 'heroic' leadership is usually associated with masculine traits (rather than men and women *per se*) such as individualism, control, assertiveness advocacy and domination, while 'post heroic leadership traits (such as empathy, community vulnerability, collaboration) are more associated with feminine traits. Ford (Ford, 2010) reconsiders the concept of *effective* leadership which is in fact a patriarchal model perpetuating an exclusionary and privileged view of the leader (metaphorically the 'father' figure).

Traditional research into gender, organisations power and leadership suggests that there are particular 'masculine' and 'feminine' leadership traits that are generally believed to characterise men and women's leadership styles (Rosener, 1990; Collinson and Hearn, 1994; Nicolson, 1996; Carless, 1998). Because women are widely believed to adopt a more democratic leadership style and men believed to adopt a more autocratic one, distributed leadership and concerted action in networked organisations may potentially be more conducive to those (women or men) who can adopt a more traditionally feminine relational style of leadership. Furthermore, feminine styles are more akin to displaying social and/or emotional intelligence (Guy & Newman, 2004; Leon, 2005).

In reality, both men and women display a variety of 'masculine' and 'feminine' leadership styles, depending upon their individual personality, age, position and the situation involved (Cross & Bagilhole, 2002; McDowell, 2001). However, gender *expectations* influence perceptions and beliefs and research suggests that subordinates are often more satisfied with leaders who behave in gender-typical ways than those who go against gender-type (Porter, 1992; Rosener, 1990; Williams, 1993).

Indeed, women in explicit leadership roles often tend to be viewed less positively than men, in the belief that 'masculine' traits (competition, authority, lack of emotion) conform more to expectations of how a 'leader' should behave but not how a woman should (cf. the work of Broverman et al. 1970). The 'paradox' it seems persists in contemporary organisations so that some women leaders feel they have to behave in a 'masculine' way which frequently makes them appear rather heavy-handed and/or as a 'bullying' because these behaviours do not fit with ideas about women (Eagly & Carli, 2003).

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Most of the women and (some) of the men we spoke to during the study, made a point of denying that gender was an issue in today's NHS, indicating that they believed that women and men were treated equally, with an equal chance of success. However, several participants also mentioned gender differences in the negotiation of power and identities describing how either women or men were likely to gain advantage through use of their gender-typed styles (Lewis, 2000; Schnurr, 2008; West, 1984).

Gender and leadership it seems remains a contradiction in people's minds but gender is a fundamental component of the discourses surrounding leadership in the NHS because of the demographic issues in clinical management and leadership (Evans, 1997; Gardiner & Tiggerman, 1999) and as we have shown in Chapters Four to Seven, role models and styles of leader/follower engagement have a major part to play in the transmission and exercise of leadership (Gill, Mills, Franzway, & Sharp, 2008; Greener, 2007).

We want to note here, partly in passing, although an example below (in the interview with 'Jeff')³⁴ demonstrates its importance - that the *researchers'* gender and physical appearance (age, ethnicity, attractiveness) also played an important role in the research process.

8.1.1 Senior women managers: 'we're all the same now'

Women in senior managerial and/or professional positions either deny that being a woman is an issue for them or for their organisation or that they know what they had to do to prevent being seen as a senior '*woman*', rather than a senior leader.

Denying the impact of your own gender on how you are seen and how you manage and lead is not an easy position to maintain and we observed some senior women working hard not to be seen as women even though at the same time they were arguing that *this behaviour was not necessary* because of the way 'things have changed'.

The researcher's observation of a senior female manager (Catherine) indicated that she thought that Catherine was trying to avoid being 'feminine' in her interactions. When the two interviewers were waiting to begin the interview, Catherine's PA came into the room with an important message but was shouted at in front of them. Thus in her notes one researcher judged that Catherine wanted:

....to indicate lack of interest and assume a position of superiority. Catherine was transgressing the boundaries of polite professional behaviour and attempting to define 'her' territory of the hospital. Answers to the

³⁴ Not his real name.

questions were also defensive, perhaps indicating a lack of self-assurance. Despite the tough exterior she obviously felt a need to stamp her authority on people in order to maintain control of the situation. This may partially be related to her gender and need to appear 'more masculine than the men' in a competitive environment.

The researcher following on from her observational notes with comments following the interview suggested that *"whilst she [Catherine] initially denied gender to be a relevant issue [for senior managers in the NHS], she then went on to make reference to 'testosterone' and 'the emotions of females' as problems in managing in her senior role".*

The relevant part of the interview transcript is below:

Q: Ok, so are men a problem? Are women a problem? Are there gender politics? Or am I just old fashioned there?

A: I don't think there are anymore, I think there were. I mean when I was appointed, I could have been one of [only] four [senior] women, so the whole senior management was very ... very 'suitish'. I don't think, no, I don't think it is a problem anymore. No, I think it is, if you talk to people in the north of England, they will say it's still a problem, and I think its a bit more of a problem to get females into acute trusts, big acute trusts, it's a bit of a climate difference. I think there's a lot less testosterone around now, there's a sort of slightly...erm I mean I've got quite a young male management team.

Q: Right

A: I find the testosterone and sort of challenges a bit much from time to time So I mean from that point of view, it is quite interesting, it does manifest itself. As do emotions of females really.

Catherine's somewhat aggressive, or at least uncompromising, behaviour witnessed by the researcher tended to soften after that and she added:

A; So I do think the answer to the question is that there are differences, but I don't think they're... they don't fundamentally affect how you do the job.

Vicki, a senior geriatrician, discussed the question of gender openly and at some length with the researcher who suggested that she had seen both Vicki and Mandy, another senior female consultant geriatrician, being very 'gentle' in their approach to patients and the researcher wanted to know how far this was linked to the fact they were women. Vicki thought though that their approach was not about gender but:

You know it could be a geriatrician thing, I don't know, ((1)) you know you'd automatically say 'it's oh because we're women', but I think it's only when you start following a few men around as well who are doing the specialty as we are, because the thing that attracts us to elderly care rather

than any other specialties in the first place, and that could simply be what you're observing.

It seemed important to Vicki that she was not stereotyped as a woman leader although she was keenly aware that as more women took up medicine and were arriving in senior positions that this demographic change would in some way impact on leadership.

So maybe that's where you've got to go as well as men in geriatrics you actually need to look at women in other specialties and follow them on a ward round and see what they do and that may be a good idea as well for the gender thing. But it's quite important for your study because at the end of the day we're training over 50% of women as doctors and in the future they think that almost all GPs will be women so that will affect the leadership and sort of, that you see in patient care.

So Vicki, while seeing feminine *characteristics* as more important in her clinical specialism than gender *per se*, still believes women doctors (e.g. GPs) will make different kinds of leaders from men.

During her shadowing of Mandy, the researcher noted what she identified as gender-typical behaviour:

Mandy also implements a mothering aspect to her leadership role (also noticed in Vicki) as she is always thoughtful and considerate to her followers, making sure they are comfortable and happy with decisions made and that they are up to speed with their medical knowledge. This mothering role also seeps into the delivery of patient care. Mandy is also a leader that appreciates the help of her followers and always thanks them for their input and help.

While keeping in mind that the researcher herself is making assumptions about what is a 'mothering' style and also recalling Vicki's assertion that it may be more to do with the kind of people who are attracted to geriatrics than gender itself, it is important to note that the researcher spent several days shadowing and observing female *and* male geriatricians. Further, she discussed reflexively what she saw and how she interpreted it with the research team to check out her observations.

8.1.2 Men: the 'natural' leaders?

The researcher who interviewed and observed Catherine also interviewed and observed Jeff (another non-clinical manager) and contrasted their styles of interaction with other people in the organisation, and with her, during the interview. At first Jeff seemed more approachable, relaxed and generally more amenable than Catherine had been:

Jeff was a newly appointed male senior manager. From the outset he displayed supreme confidence in his own authority and power as a 'leader'

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and obviously did not regard a young female researcher as a threat. He was very friendly and personable and happy to open up the space of the hospital for us, answering his own emails rather than through a secretary, coming to collect me personally from the main reception and chatting and joking all the way back to his office. Throughout the interview he showed confidence in his own opinions and was happy to talk in detail about both his own and others' leadership. This confidence may be a result of several factors such as position, age, class, gender or personality. He freely admitted that he did not mind appearing 'hard' or unpopular if it was necessary to get the job done, however he felt that his main asset was his own 'charm' and 'charisma'.

Thus Jeff firmly claimed his place within the (masculine) 'heroic' leadership tradition.

While Catherine was perceived as guarding her territory and demonstrating her power, Jeff appeared to be relaxed, being more approachable and particularly not hiding behind his PA. In fact, his account of himself in the interview was somewhat disarming.

Q And do you see yourself as a leader?

*A: Oh yes certainly. I can remember the time when I realised that I should be in management. I was working in a **** clinic in [a Trust] and it was so inefficiently run and I said as much to the manager. She said 'if you think you can do it better then why don't you manage?' So I said 'OK I will!' And I think I'm pretty damn good at it. I don't play by the rules, I don't have any formal qualifications, but I can get things done. I'm not perfect – I shout, I swear and mostly I'm just very, very cheeky, but I'm good with people and that's what you need in this job. You have to be tough too, take knock-backs and step on people to reach your targets. But mostly I care passionately about the patients. I would never ever chase a target if I didn't think it would improve patient care. So that's why I went into management, and I suppose the other thing is I discovered, I surprised myself actually about, I was going to say how easy it was, it wasn't easy, erm I had a natural aptitude to do it, you know it was something that I was successful in so you know yeah?*

Jeff wanted it made clear that the 'inefficient' manager was a woman and that he himself is 'good' with people (and on the surface the researcher acknowledged this). However, he also valued the tough, target-driven 'stepping on people' (masculine) qualities of his leadership which he believed were important in delivering patient care.

Jeff put his confidence and self-identified ability partly down to personality, but also to his gender and upbringing, adding that certain class backgrounds seem to 'breed' leaders:

I do think that great leaders are kind of born, but my background was that I was at all male public boarding school for 10 years. As my father said 'the biggest waste of money' given my academic erm qualifications at the end of it, erm and there was something there about you know that sort of environment. I mean does it grow leaders? You would think so, you look at the number of public schoolboys that end up as MPs, that's probably not a good analogy

Q:((Laughs))

A: But there is something about that kind of white middle class upper class upbringing that you have, and although I wasn't from that background before I went to the school, erm you learn survival among your peers, you learn I think to survive, you know if you think at the age of eight you are sent away you have to survive you haven't got your infrastructure.

It seems that Jeff is suggesting that leaders are either 'bred' or 'grown' but either way the influence that makes them a leader comes early in their lives. In the example he gives here, 'growing' takes place in a male-only context reinforced by social class, possibly wealth and a general sense of entitlement. This model does not echo the efforts and ambitions of the NHS in everyday practice nor would it appear to be in any way appropriate to the model proposed by the NHS (see Chapter One) which is focused on the type of leadership appropriate to managing and leading 'diversity' and 'difference'.

8.1.3 Gender wars?

Being motherly (like Vicki and Mandy) is not equivalent to being weak or compliant as perhaps some gender stereotypes might describe women (see for example Bem, 1993; Nicolson, 1996). During an observation of Mandy, the researcher identified what she considered to be a 'battle of the sexes':

Gender issues were brought into consideration during the interaction between Mandy, a female consultant and a male consultant. During this interaction a battle of the sexes and power occurred with the two consultants struggling for power in very different ways. The male consultant tried to assert his power through attempting to ignore Mandy's presence, never looking directly at her, but was raising his voice and being rude. On the other hand Mandy was always very polite, looked directly at him, spoke very softly and smiled a lot, although it was quite obvious that behind the soft smile was a vicious bite.

Perhaps this isn't so much a battle of the sexes but an example of how men and women might behave differently towards each other in the course of a power struggle. The detailed observation notes show the encounter move by move:

There are some territory issues with Patient 9 and Mandy is angry that there is a patient on her ward that is being treated by another doctor. She asks why the doctor has continued his care now that the patient has moved ward and suggests that if the doctor feels that he needs to continue with the patient's care then the patient should be kept on one of his wards rather than blocking a bed that could be used for one of her patients. She asks "why can't we look after this patient? We are not supposed to have any outliers on this ward!" Mandy's registrar Melvyn can not, or does not want to answer her questions and simply shakes his head and shrugs. Mandy says she needs to speak with the consultant and asks Melvyn who the patient is under. Melvyn gives the name and admits that he has seen him arrive on the ward a couple of minutes ago, so he should still be there.

Who is Melvyn afraid of here? Or is Melvyn simply not wanting to witness a battle over territory and patient care?

Mandy walks round the other side of the nurse's station to find the [male] consultant with three other doctors/medical students standing some distance away and his registrar to whom he is speaking. Mandy and 'our' group move over to his location and the junior doctors from both groups greet each other and share whispered conversations. Mandy stands patiently at the side of the registrar waiting to speak with the consultant. Although Mandy continues to smile pleasantly I think that she is angry or frustrated on two levels. First because the consultant is on her ward and hasn't come to speak to her and second, because he doesn't seem to have the manners to even acknowledge she is waiting. After the conversation between the consultant and registrar has finished the consultant turns his attention to his paper work and the registrar moves to be with the other doctors (some distance away) Mandy lifts her eyebrows up to Melvyn (clearly annoyed with the male consultant's behaviour) and then asks if she can speak to him about Patient 9. Mandy explains politely that they do not have outliers on this ward and therefore asks whether the patient could be moved to another ward or if this cannot be arranged she take over the care for the patient. While she speaks the consultant doesn't look at her and continues to write, his body language and behaviour are both arrogant and rude. The consultant says that the patient is his and he will not be passing the patient over as she has problems not solely aligned with geriatric care and that she needs a specialist. Although this was clearly a statement to undermine Mandy's capabilities she continues to smile and tell him that the patient will be moved before the weekend so that a patient needing specialist geriatric care can have a bed.

Moving through this detailed account the gender issue becomes obscured by the fact of Mandy's skill as a clinician, a leader, her concern to give appropriate care within a context of limited resources and her ability to handle herself in the face of rudeness and arrogance. These are skills that ensure she will shine through as a leader in any context but particularly one

which is still a man's world. In a socially or emotionally intelligent context where concerted action is seen as important, patience, politeness and clarity of purposes will eventually win out over arrogance and bluster. As we see in the next extract Mandy's 'opponent' does not possess these attributes.

The male consultant becomes angry and raises his voice to Mandy and says there is nowhere else for the patient to go. Mandy lowers her voice and says that the patient must have been on one of his wards before she was moved so she can move back. The other consultant looks swiftly at the group of doctors who are stood behind him (both his own and Mandy's) and then eyes me suspiciously before turning back to Mandy and speaking in a lowered voice. The conversation moves back and forth between Mandy and the other consultant and it is clear that despite his outbursts and undermining statements to Mandy that she has the upper hand and although she continues to smile, she is very forceful and strong in her argument and objectives. To conclude the whispered conversation Mandy raises her voice and tells the group that the patient will be transferred on Friday and that she will be getting a transfer set up straight away. She then thanks the other consultant for understanding and walks back round to the group with a smile on her face and asks Melvyn to set the transfer up.

This is a consummate example of patience, calm and the ability to lead doing what she considers to be the best for her patients, her team and her department. Her skills in continuing to be quiet, calm and smiling have 'seen off' the male consultant in the meantime but reading this it would be surprising if the humiliated man does not try to take revenge. Although there is very little evidence that this is anything other than a 'normal' power struggle it is the case that Mandy is in fact a woman and has played, what is mostly recognized to be, a feminine role.

Returning to male expressions of power it is important to be aware that blatant attacks, such as the one in the encounter above, are not necessarily the only ways of demonstrating confrontational masculinity.

It appeared from the interview with Jeff (discussed above) that he believed he did not need to defend himself in the face of gender stereotyping. He had strong opinions on women's leadership and also on women's 'availability' with no qualms about voicing these which contrasts strongly with women's accounts where they try to underplay gender, that is that many senior women take the view (overtly) that gender is irrelevant.

The researcher's notes about the meeting with Jeff continue describing a dramatic example:

Jeff's supreme confidence meant that whilst he came across well in an interview situation, he crossed boundaries of professionalism in other ways, telling unsuitable stories about staff and inviting me (researcher) out for a drink after the interview, invading my personal space. In the extract below

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he accuses a female colleague of not only being attracted to him, but trying to use her sexuality (unsuccessfully) to get ahead at work, whilst simultaneously flattering me that I am his 'type' by subsequently asking me to meet him for a drink.

And in the interview:

Q: And could you give me some examples of bad leadership that you've seen?

A: Well, Melanie Willson³⁵, have you met her?

Q: No I was meant to but she cancelled the interview three times...

A: Exactly, she probably thought she was too important to talk to you. Now I can tell you an interesting story about her. She's a good looking woman, stunning, very intelligent too. But there's something not quite right, I don't know what it is... really cold. She's got no soul. I appointed her as divisional manager and at first she was doing really well, but then she ran into some problems. She was failing in her job. And that's when she started to flirt outrageously with me. It was like she couldn't beat me intellectually so she was going to do it another way. But, well... she's not my type. And she was really jealous when I got this job, I had Lucy (PA) go and announce it at the morning meeting and you should have seen her face. Anyway I hear she's got a promotion now so she must be doing something right.

Melanie Willson clearly perplexed Jeff – 'stunning' but no 'soul'; 'flirting' to avoid being faced with 'failing' in her job; unable to beat Jeff 'intellectually' and resorting to using her sexual attractiveness. After stating that she was not his type (indicating that the flirting also failed) he then made another woman humiliate Melanie in a public context. The implication of her subsequent promotion being based on something other than ability was also a powerful 'aside'.

Discriminatory comments against women though are perhaps not that commonplace. Jeff's sense of 'entitlement' may be a dying one across most NHS organisations and it is certainly against all stated mores. Discrimination on the basis of gender is more opaque. The researcher interviewed Helen, a senior female consultant, and talked about gender and arrogance of male consultants. The researcher suggested:

... this was possibly seeing me as an ally as a young female professional. In addition to the immediately obvious behavioural differences between women and men she also mentioned unseen discrimination in the form of merit awards at senior levels and problems of combining work and family commitments which may mean female staff are less likely to achieve these.

³⁵ Not her real name.

In the interview Helen responded:

Q: Do you think there are any gender differences in leadership that you have noticed?

A: Yeah, yeah I think, I think so, erm you know the men are more well, can I, the men are less inclusive of a group and they have ((1)) already formed an opinion sometimes and before listening, erm, ((1)) err ((1)) yeah.

Q: Yeah ((laughs))

A: Need I say more ((laughs))? But I think there is a difference ...Competitive, that's what I was saying, there's that competition, yeah competitive, exactly ...Of course not but the insight is very, very small, and then those meetings go on and on and on and it's people trying to get one up on another so... I just want to leave. It's handy having a beep you know you can say 'oh, I've got to be off (laughs)'.

The suggestion here is that men are apt to waste time on each other and power struggles and that for them competition is central to their 'nature'.

8.2 Conclusions

Despite the increased numbers of women who have reached senior leadership positions in the NHS, both as senior managers (clinical and non-clinical) and as senior clinicians *per se*, there were nonetheless some interesting differences between women and men's self-descriptions and perceptions of others as leaders, sometimes made on the basis of gender alone (Gill et al., 2008). Descriptions given of leaders and leadership for members of the 'other' sex were also frequently gender-typed.

It may be that despite valiant and frequently effective attempts to change the culture of NHS Trusts that a 'traditional' view of leadership remains at least in the organisational 'memory'. This might go some way to explaining why women who are clearly powerful and influential are reluctant to identify themselves as taking up these more 'feminine' styles even though they may in fact use the skills associated with these qualities. Eagly and Carli (2003) make a case for women as having a leadership 'advantage' in contemporary organisations where the type of leadership required has changed. However, they argue that in many cases women have to battle against the inherent prejudices in male dominated organisations. Although there is still a reference to gender stereotypes when discussing gender in organisations and gender and leadership as we have seen from the extracts above in this chapter, as Rosener (1990) stated: "*Women managers who have broken the glass ceiling in medium-sized, non-traditional organisations have proven that effective leaders don't come from one mould*" (p. 119).

In Chapter Five the OCS revealed that women across all professions scored lower than men on 'recognition' in that they perceived their managers as

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not recognising their particular attributes as clinicians or managers and they also perceived that the organisational climate was one in which 'recognition' was more likely to be given to men than women. That men did not see this as a problem for them reinforces the view that regardless of trying to establish gender equality across NHS organisations it is still not embedded in the management culture.

As we have seen and has been well documented in the literature, it remains difficult for women to exercise leadership without their behaviours being construed as either 'weak' or 'aggressive'. The paradox is that leadership requiring more 'feminine' characteristics is at least explicitly more desirable in the contemporary NHS.

9 Patient Care, Leadership and Service Delivery

9.1 Introduction

The NHS has a history of reform/modernisation aimed at making patient choice and care more cost and clinically effective by improving the organisational structures through which care is delivered (Bate & Robert, 2002; Becher & Chassin, 2001; Darzi, 2008; Wilson, 2009) .

The NHS remains committed to its original aims of providing a cost and clinically effective patient care (Doherty, 2009; Phillips, 2005), at least partially through the NHS's organisational structures, including the gate keeping function of primary care, while providing a universal service free at the point of delivery. Since the 1990s patient choice has been added to the longer term commitment to efficiency (Bhandari & Naudeer, 2008; Bojke, Gravelle, Hassell, & Whittington, 2004; Bryan, Gill, Greenfield, Gutridge, & Marshall, 2006). And at the same time there has been an explosion in new diagnostic and therapeutic technologies accompanied by a public awareness of the availability, or lack of availability, of those technologies (Aberbach & Christensen, 2005; Greener & Powell, 2003; Mueller, Sillince, Harvey, & Howorth, 2004a).

In this chapter we particularly address:

- what respondents (staff and patients) say about patient care and service delivery based on the interviews and focus groups;

- what we *observed* about service delivery and patient care and particularly the *interactions* between clinical staff and patients *observed* and *described* during the shadowing.

As in Chapter Six the Trusts are conceptualised as open systems whereby high quality patient care (the input) corresponds with effective service delivery (the output) with the primary task defined as caring for sick patients (or those who are giving birth).

9.2 Defining patient care and service delivery

The thematic analysis highlights similarities across all grades, statuses and disciplines of the staff and the patients involved in the study. The themes that emerged consistently from the data that were about good patient care were:

1. Putting the patient first:

...of course patients do come first but actually really, on everything that you do, I mean everything you do you think of the patients (service manager in acute medicine).

2. Thinking about what is good for the patient (all the time):

I still believe and I believe to this day that if you absolutely concentrate on what the patients' needs are, all other things take care of themselves. it's about really showing that you care. I mean genuinely showing that you care about your patients, erm there's a lot of talk about also looking after your staff and caring for your staff. I think that's important but I think the health service has got itself stuck far too many times concentrating on the needs of the staff and not the patients (Chief Operating Officer).

I think that's what you have to make sure is that everyday you are thinking to yourself, 'am I doing this for the good for the patient?' 'is it the right way to do it?' so I think when you get eleven years down the line, one of the things is that you can loose sight of is that, very easily (Matron).

3. Awareness of the diversity in the patient's world (culture, family, age, home and work environments):

..it would be making sure older patients have high quality of care during their surgical admission (senior consultant Geriatrician).

you need to support your staff ... you know and you have to have an awareness of the different culture of the patients (administrator).

4. Making sure the patient received the care that staff would expect for themselves and their relatives:

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I would define patient care that of - if it was one of my relatives who were ill (senior manager).

5. Talking to patients about what has happened, their medical history and their clinical condition:

....if they talk to you one-on-one and you know where you're at (patient).

6. Safety and empowerment of patients:

They [the multidisciplinary care of the elderly team] believe that good patient care sits around ideas of timely discharges, safety, making sure the patient understands their condition and their treatment, empowering patients by allowing them to make their own decisions about their care (to a point), providing the appropriate treatment and care, being responsible for the patient. Examples of bad patient care are viewed as delayed discharges, poor decision making and discontinuous care. (Notes from an observation of a team meeting).

From the descriptions it is clear (and perhaps no surprise) that senior managers, clinicians and patients all hold slightly different perceptions which inform their judgements to give 'patient care' a specific meaning. Some of the judgements are related to their particular clinical specialty or organisational responsibility although generally respondents reiterated that patients need to be at the centre of daily practices. Patients in all cases wanted more than anything to be kept informed about their care, and if possible this should be done by the clinician in charge.

At a more complex level the definitions above reveal a 'vision' of good patient care which links the 'practical', 'professional' and 'political' elements of NHS life. It also links to the 'human' elements associated with the tasks of caring. For example, the Matron (quoted above) shows a revealing insight that the routine *organisational* tasks might take over as a perceived priority from what a person initially knew to be their primary task (i.e. patient care). As she says, several years down the line you might lose sight of what you are really there to do.

9.3 How is good patient care achieved?

9.3.1 Managers

Managers each have different levels of responsibility for delivering good patient care which may differ from priorities expressed by patients and clinicians:

Erm, that's the bit about lifting your eyes up off of the horizon, and lifting the eyes up above the horizon is about looking at the totality because the

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medical, again, the medical management model is very much that you should do what you need to do when the patient is in front of you. The management model, the pure management model is about doing the right thing for the 450,000 patients who were looked after last year, so some of that will be about compromising, and offering the best care to the widest group that you can (CEO).

Immediately this respondent exposes the potential for conflict at senior level in that he/she³⁶ positions the 'medical management model' differently from the 'pure management model'. In the former the patient is a particular individual with a health care problem – the patient 'in front of you'. However for senior management there are many thousands of patients that require good patient care which means (maybe) compromising to provide the best possible care to the greatest number. Despite this, another senior manager had a different 'take' upon good patient care and in answering the question focuses on what they themselves would expect evoking a more individualised model:

I would want good consultant input into my care ((1)) as soon as it was appropriate in the pathway that I was on. I would want to be able to have a conversation about what was wrong with me and what treatments and options there were, ((1)) erm ((1)). I would want the assurances of the people that deliver the care know what they are doing. ((1)) I would want the care to be provided in an environment that was clean and in an ideal world I would want a single ensuite room, err and I would like to choose my own food and all that jazz. ((1)) erm and the erm, ((2)) so really you want the environment to be correct and you want to have the confidence in the clinicians giving care and you want to have had input into what your care should have been (Senior Manager.)

This manager has a very clear model of their 'ideal type' which positions the relationship between the patient and clinician, the skills/expertise of the clinician and the physical space and environment as central to good care. There is awareness here that planning and teamwork are also part of the process of care but particularly important is the knowledge of how to deliver the appropriate care and information in order to facilitate joint decision-making.

³⁶ We do not want to risk identification of any individual participant.

9.3.2 Clinicians

Good quality patient care for most doctors interviewed was:

... making sure that erm the patient achieves the outcome that you would wish them to as a result of either their outpatient visit or their inpatient stay erm and that outcome is kind of on a objective kind of medical measure, erm but it's also in terms of the quality of the care that they've received and whether they are satisfied with the care that they've received. (Senior consultant)

Another senior consultant who is also on the senior management team of the Trust took the concept of patient care further:

... it should be delivered well I think is the answer ((laughs)). I think on the whole we do deliver it well, we have the lowest mortality rate in the country, ((1)) or one of them. I think we do actually and we ((1)) I'm very proud of the care and I think there are two things to be proud of and one is the basic care and ... we do emergency work I am very proud of. Then the other bit of care we're proud of is that ... I think there is a real culture of innovation and I'm trying to do something new up here, and I think that's actually really important in terms of leadership. My job is being able to see a clinician with an idea and then work out of him or her how to turn that idea into a self service innovation. I think that we have created over the last few years a much stronger patient safety culture.

This respondent clearly links leadership and patient care stressing both the relationship between supporting other clinicians in innovations that improve care (particularly attending to safety) while also being proud of the culture across the Trust for low mortality, innovation, and supporting staff. Crucially there is a pride and energy about this account. The culture puts patients first but the staff gain satisfaction and a sense of professional pride from the performance of the Trust as a whole [T3].

The clinician manager below takes up the relationship between staff empowerment (and support which links clearly to the outcomes reported in Chapter Five) and returns us to the focus on staff training and skills, indicating here that if the managers train and empower staff – services to patients will improve.

... it's about working together as a team so we can try and improve things for patients. Now we've provided them with an awful lot of training in the past erm, especially the admin and clerical staff, because they're the frontline reception staff and they are the first thing that patients experience when they come into the department. So what we did is, we worked with training and development and we came up with a specific programme that was aimed at empowering them to improve their service area etc. etc. and

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also provided them with some skill sets that they probably didn't have prior to that. (Senior Manager, Therapies)

While from a similar perspective the nurse quoted below stresses that team work and morale mark the path towards good patient care and you need to look after *staff* in order to deliver a good service to patients.

... And I think it is also, sort of, taking into account the people they work with, the team members and boost the morale, and that can make a lot of difference to, you know, to have people at work and sort of take the stress levels off and I think, you know, it would sort of, quality certainly would happen, sort of energise them, able to care for the patient. (Nurse, focus group)

9.3.3 Patients

For patients overall it was clear that most of all direct communication and consistency of staff was experienced to be good care:

A: ... I've been transferred here from [another Trust] and there it's a bit more, not one-to-one but you see a lot of different doctors here whilst there [the other Trust] you have only one doctor, your one midwife and your one consultant. Here you see a lot of different people.

Q: And which one do you prefer?

A: I'd say probably just to see the one 'cause lots people tell you different things.

Q: Okay, so it can be a bit confusing?

A: Yeah, sometimes it can be, yeah.

The patient quoted below reinforces the need for clear patient/clinician contact and communication.

For another woman:

Now whilst I'm here my care has been very good especially with the [specialist] who first saw erm, who first flagged up the problem. Erm yep it's been good it's been good since I've been in. It's just the initial communication as an outpatient to an inpatient I should have really - you know that should have been. I don't know where the fault lies but there should have been some communication there between the appropriate people (Maternity patient on postnatal ward).

9.4 Delivering patient care

9.4.1 Doctor-patient interactions

We look firstly at three consultants' (Cameron, Kenneth and Henry) styles across two different Trusts as they interact with patients to explore the importance (or otherwise) of good communication and engagement. What emerges, perhaps unsurprisingly, is that different consultants have different styles of engaging. The style adopted though feeds through to the 'ethos' of the clinical team, relates to, and impacts upon, the culture of the Unit thus affecting the doctor-patient interactions as part of an evolutionary cycle.

9.4.2 Empathy and Communication

9.4.2.1 'Cameron'

From the researcher's notes we gain an impression of Cameron who deals mostly with stroke patients for whom verbal and non-verbal communication may be very restricted:

Cameron offers a very personal and individualised style of patient care to his patients. He is often very tactile often rubbing the tops of their hands, arms and heads to encourage them or to show support when he is discussing difficult problems with them such as their inability to go home, the definition of a stroke and the future impacts of them having a stroke. He also speaks to the patients in a very friendly and informal way and sometimes draws on their mother tongue to say a few phrases to make them feel welcome and at ease.

In his interactions with his patients he is very positive and upbeat, often speaking loudly to encourage and motivate his patients. He also tries to share a few jokes with them and breaks down doctor/patient power relationships by crouching down in front of his patients or sitting on a chair or their bed so that he is always the same height or lower.

This description alone demonstrates how Cameron's *behaviour* relates to several of the descriptions above which identify good patient care in that he:

- communicates (verbally and physically)
- takes care to acknowledge their humanity through recognition of their cultural (linguistic) heritages the fact that they have a life outside the hospital
- attempts to empower them within the relationship (at least via discussion and physical presence and to an extent with knowledge of their condition).

Below is a detailed example of Cameron (and his team's) encounter with an elderly stroke patient (Mrs. D) which is part of the evidence the researcher has employed for her assessment of the processes engaged by Cameron in his provision of patient care:

"Hello Mrs. D? (Patient nods head and smiles) do you have a headache? (Patient nods head) Do you know why? (patient shakes her head staring wide eyed at B). "OK, I'll tell you..." Cameron sits on the edge of the patient's bed and explains that she has had a stroke and she has a headache because sometimes patients who have had strokes will have suffered from headaches due to pressures on the brain. The patient stares and nods her head occasionally as Cameron explains. "Mrs. D, do you understand what I have just told you?" (patient nods her head and then croaks "yes") on this speech Cameron sounds surprised and encourages her to speak again "Oh wow Mrs. D, that sounded good, can you say something else for me?...well done". The patient looks up at the doctor and smiles croaking again "I don't have anything to say doctor", "well never mind Mrs. D, I am sure I can get something out you a bit later!...excellent, your voice seems to be coming back...isn't that good?. We will have you singing in no time!" (Mrs. D. smiles and shakes her head "can't sing" Cameron smiles and laughs.

Despite the clear power differentials, doctor/patient and healthy/unhealthy, in this relationship Cameron is doing what he can to encourage and communicate effectively with the patient. Not only does he literally get down to her level by sitting on the bed but he explains the condition, how it happened and communicates the indicators for (potential) recovery. He is respectful and careful although the intellectual/cultural difference between the patient, Cameron and the care team is exposed by the encounters below.

"Now Mrs. D. can I examine you?" (Patient nods her head) Cameron takes the patients hand and she flinches "cold!" Cameron smiles and apologies saying it that "it is the alcohol" (alcohol gel he had just rubbed into his hand). The patient eyes Cameron suspiciously "have you been drinking?" the group laugh and Cameron explains that it is the hand-wash and she nods slowly and looks at each member of the team for what seems confirmation that this is the truth. Cameron then begins testing the patient's strength. He checks her arms and then her legs with simple strength tests calling out numbers between 1-5 for the SHO to write in the notes. As he instructs the patient with her tests he speaks very slowly and loudly and the instructions are very simple and clear and he often demonstrated his instructions, especially for those patients that have cognition problems. As the patient does the task Cameron is very encouraging shouting words such as "good", "excellent" or "well done after

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each task". After the strength tests Cameron checks the patient's reflexes with a small hammer. Again he shouts out numbers and makes comments about the reflexes that the SHO writes down in the notes. Following the reflexes Cameron checks the patient's facial muscles by asking the patient to smile, grit their teeth, stick out their tongues and move them about. He then checks her speech by asking her to repeat phrases or noises after him. The first phrases or groups of words were given as words that would be familiar to the patient such as the patient's name or names of simple objects such as pens. As the patient is able to say these words he moves on to more complex words such as "hippopotamus" which the patient struggles with. Cameron then checks the patient's ability to co-ordinate by getting the patient to touch her nose and then his finger with her index finger. The patient clearly struggles with this and is very slow and inaccurate.

For a brief moment after the tests Cameron has a quick discussion with L [another doctor] asking him what he thought about the tests and what they would expect to see on the CT scan. Cameron then turns to the patient and says "sorry Mrs. D, just discussing your test results with my colleague, we think that you are progressing very well...there has been much improvement hasn't there?" the patient stares blankly at Cameron for a brief moment before shaking her head "no, you don't think so? Now what about your speech, when you first arrived you couldn't say a word, now listen to you, don't you think you have improved?" patient shrugs her shoulders and looks down at the bed. "Well Mrs. D, we all think you are improving...so well done..." patient looks up and smiles sadly.

The style of meetings between clinical staff and patients was as much a feature of *Unit and team culture* as of a particular clinician's practices. Thus, while Cameron above was engaging with the patient in what appeared to be a *genuinely caring* manner, his colleagues were attentive, while in the background.

9.4.2.2 'Kenneth' and 'Henry'

In what follows two consultants worked together and while Kenneth was the more senior and experienced clinically, Henry held a senior managerial role (as well as being a senior consultant). Kenneth was described by the researcher as:

... a very warm and caring man ... he is very sweet, kind and caring to his patients and makes them feel comfortable and less vulnerable by empathising with them and drawing on his own personal experiences as a patient.

As with Cameron above, Kenneth was also described as 'tactile' and that he took the time to explain things to patients. Kenneth empathised with patients by sharing a joke (as did Cameron):

For example one lady was embarrassed because she had fallen down in her flat and sustained injuries and did not really want to explain how she had fallen over or what she had hurt [to the whole team]. Kenneth then told the patient that he had slipped over in the hospital and in the M&S food section. This meant that she no longer kept quiet through embarrassment and told Kenneth after that exactly what had happened.

However, during the two day shadowing of Kenneth the researcher was particularly:

...struck by how intimidating this group of doctors must be to the patient, especially an elderly or vulnerable patient as a large group of faces arrive at their bedside and close the curtains around them making the space feel incredibly claustrophobic and that the patient's space felt 'invaded'.

While shadowing Kenneth, the researcher was in a position to observe Henry (who was also shadowed for two days on a different occasion). The researcher's notes here, which describe a joint ward round with Kenneth and Henry, state:

I was struck by how impersonal Henry was towards the patients [in direct contrast to Kenneth]. He did not greet them or introduce himself. [In one case] Instead of asking the patient how she was getting on with the oxygen machine Henry asks the SHO how she thought the patient was getting on with the machine. When the patient tried to give reasons they seemed irrelevant to Henry who just told her she must use her oxygen machine every day or she will not get better.

The researcher goes on to describe how Kenneth (the senior clinical consultant although Henry has a senior leadership role) stands quietly behind the junior doctors on the round with Henry at the front of the group talking to the patient. Henry stands up. Kenneth stands at the back of the group with his hands folded behind his back and Henry every so often asks Kenneth if he agrees with Henry's thoughts on the patient's health status and treatment. While Henry is taking the lead in this way the researcher notes:

Not one of the doctors explains to the patients what will be happening to them that day or beyond nor do any of them say goodbye.

One patient on Henry's round is in the bathroom as the team arrive at her bed.

Henry knocks on the door of the bathroom and says "Mrs. X, it's Dr. Henry we are all here to see you". He then asks a nurse if she can hurry the patient along as he is very busy. It seemed strange [to the researcher] that Henry could not have just visited another patient until this patient had finished rather than rushing her. Before the nurse can enter the bathroom another nurse pokes her head out from behind the door and says that she is washing the patient. Henry asks whether this could be finished after he has seen her. The nurse, who looks frustrated, says she will be a minute. The nurse then helps the elderly lady to shuffle to her chair and helps her sit down. Without greeting the patient Henry begins talking over the patient's bed about her X-ray that was taken yesterday and then asks the nurse about the patient's progress.

In the examples above describing both Cameron and Kenneth's interactions with patients there is evidence that the patients were given a chance to explain to their consultant how they felt and either to tell the doctor what had happened to them or to hear the doctor's explanation of why they felt like they did.

The patients were treated in both these examples as human beings and in doing so the doctors themselves positioned themselves in their *clinical role* but also as *people occupying that role*. By acknowledging mutual humanity (albeit in different styles) these doctors were able to *take authority* from their position as medical experts (see Chapter Seven above).

By contrast Henry also took authority but did this by silencing junior colleagues, Kenneth his fellow consultant and most importantly, the patients. While Kenneth and Henry were in the same Unit, the scenario described above suggests that Henry held more power and therefore exercised greater influence on junior colleagues (and this fed into the culture of the Trust).

In what follows we trace how these contrasting styles might link to the culture of the Units and the teams themselves and consider how this fits in with the definitions of good patient care and service delivery.

9.5 Clinical team work and service delivery

9.5.1 Giving patients care

Miller and Gwynne (1972) suggested that a 'warehousing' model of care operates for those who may be institutionalised in the medium to long term which they contrast with the possibility of a 'horticultural' model of care, akin to what might be identified today as a learning environment. Working in the care of the elderly takes its toll on the emotions of all the clinical staff

particularly in the 'horticultural'/learning setting, where efforts are made to ensure two-way communication and mutual understanding and development takes place. This can leave clinical staff open to experiencing directly the pain and distress experienced by their patients (see Menzies-Lyth, 1960 and the 'stories' below).

The following example demonstrates how engagement between clinicians and patients impacts emotionally upon even (and possibly especially) senior experienced staff. The researcher here, shadowing Mandy, a female senior consultant describes the following case:

Whilst cleaning up a suppurating wound an elderly male patient cried. It was a really touching and sad moment and Mandy was clearly distressed that she had hurt the man. On first seeing him cry Mandy appeared to have a moment of shock/panic where she looked amongst her team to find out whether this was normal behaviour for this patient. On hearing the answer was 'no' Mandy tried to soothe the patient and seemed genuinely sorry for hurting him. The nurse who arrived at the scene also appears to be genuinely concerned about the patient and goes over to help Mandy and prevent the patient from crying. This scene was particularly sad because in today's society and especially in the patient's generation it is thought that men don't cry or show emotion. For the man to cry he must have been in severe pain and must have been struggling with himself to prevent the tears. Mandy's genuine empathy and somewhat guilt might have reflected that.

Mandy and the nurse in this context are using emotional intelligence (see Chapter One) in a relevant situation. Mandy also engages in conjoint action with the nurse rather than take action in an autocratic fashion without consultation. Mandy notes the patient's crying with a start (according to the description) and instead of continuing with the work on the wound (which many doctors might well do because it was necessary for a positive health outcome) she immediately appears to take in the context as a whole – thinking about her patient's behaviour and reactions. The nurse in this case mirrors the behaviour of the consultant. This is an important issue for discussions of leadership and patient care in that teams tend to reflect the beliefs and actions of their leaders.

9.5.2 Discussing patient care

In a shadowing the researcher at the start of the observation describes in detail the way two doctors discussed the patients before embarking on the ward round. This is another case of concerted action:

09:00 Breakfast meeting with Cameron [T3]

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Once they have consumed their breakfast Cameron and Mandy turn to business. Cameron begins by asking Mandy's opinion on one of the patients that they had seen on the ward round that morning. They chat for a couple of minutes about the patient before both getting a patient list out and going through the names systematically and discussing their care plan for each patient. Several patients will need to be discussed in a patient case meeting as they have complex discharge problems, others will need to be referred to the CCP so that a greater social package will be considered. Mandy says that she will go and see a few of the patients herself later and occasionally delegates tasks to do for Cameron, but mostly he is autonomous and says what he needs to do for a patient and what he will organise on behalf of the patient.

This is a quiet and supportive meeting between Mandy the senior consultant and Cameron the more junior member of the team. However, the researcher notes the systematic discussion of the patients and their care along with a plan about who Mandy will see and how Cameron's tasks are designated.

A similar atmosphere of calm and authority are evoked by the description of a case meeting with Cameron's team at the start of the first day of shadowing:

I approach the nurse's station and look around to see if I can see Cameron. I spot him at the far end of the ward sat at a computer with a mixed group of staff (doctors, nurses) surrounding him. I approach the group and stand amongst them. Cameron is facing the computer screen and discusses a CT scan with his registrar [L].I notice that as these two doctors discuss the scan a SHO writes notes in the patient's file occasionally craning his neck to look at the scan at certain parts of the discussion. A few nurses also crane their necks at various points but most just stand patiently in silence waiting to visit the patient. Once the discussion draws to a close Cameron turns his head from the computer and asks the team if they have anything to add. ...[later on in the same meeting the researcher listens to a telephone conversation] ...Cameron has rung the wife of a patient to update her on her husband's health. He is very honest with the wife saying that her husband has had a second stroke during the night at that he is now in worse health. Despite the bad news Cameron is very friendly and pleasant with the relative and is very sympathetic to her questions and on several occasions empathises with her. Coming off the phone Cameron returns to the team and gives a brief update to L regarding the conversation with the patient's wife. The SHO writes this summary in the notes. Cameron takes a short sharp breath before asking "shall we go and visit the patient?" Cameron turns quickly on his heels and enters the ward.

The observation here reveals the high workload and 'multi-tasking' undertaken by the team (looking at the computer, discussing scans, taking notes, calling relatives and so on). But there seems to be focused attention on patient care and individual patients. At the end of this extract it also seems that Cameron himself takes the ward rounds very seriously – gathering his mind together and possibly seeking the emotional strength to move from the clinical team and considering evidence from notes and colleagues to imparting and collecting information from the patients.

The same researcher who has shadowed both Kenneth and Henry at a different Trust from Cameron, gives examples of how some of Henry's patients are discussed. For example she describes a meeting to discuss patients chaired by Henry.

Henry criticises the way [Site B] is run and the management of beds and patients by that hospital. He praises the doctors for the current situation on [Site A] where they have spare beds stating that they have done so well in 'kicking them out'. Henry stated during [a previous meeting] that the patients needed to be removed or 'kicked out' of hospital as soon as possible. The rapid turnover of patients may on the surface appear that they are not receiving good care However getting patients home quickly reduces the risk of hospital acquired infections.

And is likely also to be what many patients would want.

As the researcher makes clear, it is important not to confuse the rhetoric with the quality of patient care, but rhetoric does determine and reflect a dominant ward or Unit culture.

9.6 Responsibility for patient care

Responsibility was a key element of the discussions of leadership particularly in Chapters Four and Five. Responsibility for individual patient care is in the hands of clinical teams led by the medical consultant but above that person is the clinical leadership/management (Clinical and Medical Directors) as well as the senior operational managers (CEO and COO and others).

Primary responsibilities for patient care however vary from *individual care* i.e. for both identifying care pathways and day-to-day care to responsibility overall for the care of all the patients. In Chapter Ten we review the findings from this study with some recent cases where responsibility has been mishandled to explore what lessons might be learnt.

In an interview with a consultant:

... we try to just have a really open forum where we can discuss that [specific patient care], just like open it up and letting people put their viewpoints first and then kind of trying to question where they're coming from with that in a positive kind of way but them also laying out where you feel that that might not be the right course of action. Erm and also at the end of that discussion making sure that everyone is happy with the outcome, and sometimes people aren't erm .. but it also realising that it is a consultant's responsibility at the end of the day and making sure that everyone knows that you're happy making that kind of decision and that you are happy to be made accountable for that decision.

9.6.1 Responsibility for emotion

It frequently falls on the clinical leader to cope with their own, the patient's and the relatives' emotional reactions and distress and also with those of the other members of the team. As the researcher noted:

One senior consultant, Tricia, made it clear that as the clinical lead she also took responsibility for talking to patients about DNR³⁷ forms and delivering 'bad news' to patients/ relatives. During the ward round Tricia removed the pressure from a junior member of the team who had been told by a relative that they didn't want their mother to be resuscitated. Being told this information had stressed out this junior member of the team as he was not yet ready for this type of responsibility. Tricia supports her junior colleague saying that he should have never been confronted with this situation.

One question here then is how do the clinical team handle such multi-layered emotional problems? How important is leadership in supporting (and developing) teams to cope?

9.6.2 Responsibility for teaching

Most clinicians in the study from all disciplines were interested in teaching the next generation, and their activities will influence patient care, provide role models for leadership and influence climate and culture of the organisation. The example below is chosen because Dr. Jenkins was very enthusiastic but also demonstrated compassion and courtesy when he was face to face with the patients. The researcher's notes describe this in detail:

Approaching the patient Dr. Jenkins shakes the patients hand and says "how are we doing today?...I see you were referred by your GP...you have a

³⁷ Do not resuscitate.

wonderful GP" (he comments on how wonderfully clear and precise the notes are). "That's not my GP, that's my missus's GP, mine's on holiday...I have Dr. U. U". "What a name! But looks like they have to wonderful GPs at your practice...the notes are seamless...you are lucky!" Jenkins then continues to ask the patient about his medical history. The patient is able to tell the doctor his entire medical in great detail including the drugs [more description from the researcher]. Dr. Jenkins stops the patient and asks the medical student to take a mental note of how a good GP leads to a well informed patient, which helps him (Jenkins) in his (patient's) treatment. He talks about 'aspects of professionalism' and the right ways of informing patients about their treatment and condition, he openly praises the patient for knowing so much about his patient history and tells the students that "medical history in patient care is so important". The patient begins talking about his treatment in the hospital and Dr. Jenkins states that "patient feedback is great, and they like to hear about it...we need to be more professional...primary care pathways are the key to patient care".

Dr. Jenkins behaves with humour towards the patients and the students and junior doctors but does so while continuing with his assessment of the patient, taking the relevant history and trying to impart good practice and professionalism. He manages to balance giving the students and junior a chance to gain hands-on experience while making sure he himself has all the information he needs for the care of the patient.

Dr. Jenkins then checks the patient's lungs and heart asking a SHO, Dr. Williams to check the cardiogram as he can hear an AF flutter. As Dr. Williams looks for the chart the patient tells him that his GP had thought the same and that is why he was thinking of changing his drugs. Dr. Jenkins looks at the students and says "wonderful isn't he?" he continues that the GP must have heard or felt it himself [the heart condition] and now they will need to see the chart to prove it then they can change the drugs as the GP had predicted. After looking at the chart Dr. Jenkins asks Dr. Williams to change the drugs and to get rid of one of the drugs he thinks are unnecessary. Dr Jenkins shakes the patients hand when he leaves and says that one of the juniors will be back later to sign off the new drugs.

Looking over the notes Dr Jenkins spends a lot of time teaching the [medical] students about various medical conditions and treatments that have arisen out of [a particular] patient and asks them to suggest other possible diagnosis and other treatments for his condition. Jenkins is a very enthusiastic teacher and the enthusiasm rubs off on the students who are all eager to share their knowledge and take stabs at questions they don't know. In the middle of the question and answer session he asks one of the students "what year are you in? I don't know how much you guys know already". The student base is a mixture from students from [different

schools] and he relishes the opportunity to teach the students some new medical knowledge. Whilst getting the students to look at the cardiogram he looks up and apologises to Irene [matron] for taking so long on his ward round "Sorry Irene, I will be here all day, this is such a pleasure to have students!" Concluding the teaching session he quotes someone for saying something about the health of gamblers and drinkers and then asks "now who said that?" the students look round each other and then he exclaims "me mother!" all the students laugh including the female registrar and Irene. He then ushers them onto the ward saying that he doesn't want to get in trouble with the matron.

9.6.3 Subverting responsibility

There are diverse ways that staff at both Trusts had for coping with emotional aspects of patient care and resisting authority (and thus taking responsibility for care into their own hands). One way that nurses (including senior nurses) operated was to *subvert* some of the doctors – particularly when the relevant doctors showed little interest. The shadowing of a senior nurse [Irene, the matron] during a ward round produced the case of Lola (described when shadowing Irene):

Irene tells me it is because many of the patients are elderly with complex cases and therefore they tend to stay for a long time. I note that one of the patients has been here for a long time and I ask whether due to the long length of stay on the wards whether she becomes attached to any of the patients, I point particularly to the patient who had been here for three months. Irene says, 'oh that's Lola, mmm has she been here 3 months?...let me check her notes'. Irene leaves the file that she is reading and picks up Lola's file and looks at the admissions page and then states (sounding surprised). That three months is correct. She then continues that she does find herself getting attached to her patients, especially if they have been here as long as Lola. She mentions that Lola should really have been moved to G Ward but she really doesn't want to move her 'she should be elsewhere, but she is ours' (highlighting emotional attachment and the sense of ownership over patients). She tells me that Lola is really sweet and all the nurses really like her and it would be quite strange if she was no longer on the ward as she is a returning patient and 'it is always nice to have her back'.

As we have suggested in Chapter One (and witnessed above), in order to protect one's self against anxiety clinical staff often 'split' patients into 'good' and 'bad'. Here the treatment of Lola indicates that the nurses may be using their care of her to defend themselves against some of the harsh treatment decisions made about other patients (by doctors and managers) particularly when there is pressure to discharge older patients due to bed

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shortages. This might lead them to consciously and unconsciously subvert these authorities when they can and there is a particular pleasure to be gained when they succeed in this 'subversion' with a 'good' patient such as Lola. What remains at stake is whether Lola's stay is actually benefitting her clinically (or even socially) and also whether it is preventing another patient receiving medical care.

9.6.4 Responsibility for end of life decisions

Responsibility for patient care resides not only with the clinical team but is sometimes shared between the team, the patient or the patient's closest relatives which is usually the case with end of life decisions. Sometimes the greatest emotional engagement is with the *relatives* of the patient rather than the patient themselves. This is particularly the case when the patient is likely to die which is particularly sensitive when it is a case of withdrawing life support. The following example of Cameron's Patient G and his daughter brings this into sharp focus.

The biggest emotional situation this day surrounded Patient G, a coma patient and his daughter. Cameron had to encourage the daughter to agree with his plan that her father's treatment should cease and palliative care take over. This is a very emotional situation especially due to the young girl's age but also because she was in 'denial' asserting that her father would get better and this caused her to present a whole range of emotions that Cameron had to deal with.

We enter the side room. The blinds are drawn causing the room to be quite dim. There is a young girl sat up right on a make-shift bed that she has made from four visitor chairs from the lounge. She has a blanket over her legs and is typing on her lap top her mobile phone ear phones in her ears and bags and other items are scattered around her chair. She looks up as we enter and pulls the ear phones from her ears. I am surprised at how young she is, I had expected a daughter of forty something not a teenager of 18 perhaps, but no more than twenty. She pulls the covers off her legs and places her lap top on the window sill. Cameron asks if she is ok and she nods and says she will leave him to it. Cameron says that he will bring her in once he has examined her father, she nods and opens the door pulling her jumper down over her leggings as she leaves. Cameron looks at me and comments (adding to what I was already thinking) "I think she is far too young to be dealing with this on her own....it is not fair".

He turns his attention to the patient and begins speaking loudly to him. He explains that he is a doctor in [Trust 3] hospital and that he wants to examine him. At each point of examination Cameron explains to the patient what he is going to do. Cameron is able to move the patient's limbs like he

is a doll. Each time the limbs are placed in a position they remain there. The patient doesn't respond to any pain stimulus as Cameron pinches the patient's skin and scratches the bottom of his feet with a stick. Cameron then checks the patient's eyes by pulling back the patients eye lids, the eye lids roll from side to side and Cameron explains that it is called a coma roll, which suggests that the patient is in a deep coma. Cameron teaches W by the patient's bedside and talks him through the patient's condition and talks about how the patient's recreational drug habits could probably have contributed to his stroke. Cameron and W engage in a small conversation about the problems of cannabis on the brain.

Cameron made the decision in consultation with his team to discuss with the daughter that they need to end the patient's treatment (and thus in all likelihood, his life). Cameron deals here not only with the daughter's distress but with the daughter's worry that she is involved in the decision to let her father die. Again a high degree of emotional intelligence and leadership as well as clinical knowledge operates in this communication.

While shadowing Owen [Trust 2] the researcher sees that while behaving perfectly correctly he puts emphasis on the clinical and health related aspects in an end of life situation above communication and empathy. He is not unkind but 'misses' the emotional level of communication. Here in the presence of a daughter and father the woman (mother/wife/patient) is clearly dying and being kept alive by the clinical team. Owen:

... talks directly to the daughter stating that her mother is coming to the natural end to her life and therefore she [the mother] is giving up - 'withdrawing from life' and tells the daughter that although they will feed her through a tube she [daughter] should prepare herself and her family for the inevitable. He also says that her mother will also start ripping the feeding tubes out to prevent herself from getting the right nourishment.

The image conjured by the 'withdrawing' from life and 'ripping' feeding tubes is dramatic and seems to give agency to the dying woman – almost indicating that somehow she is to blame as she will prevent herself getting the right nourishment. However, the researcher, as participant in this encounter, is bringing out a sense of the culture of this particular event. While Owen is probably protecting himself emotionally from the loss of life and the sense of clinical 'failure' he does not protect the daughter or the husband from the emotional onslaught of the woman's impending death.

The daughter says that she understands and turns to her father and says 'dad do you understand what the doctor is saying?' the husband paces up and down the side of his wife's bed looking lost and lonely. He looks up at Owen and says that his wife is giving up because someone at the nursing home said she was a burden. The daughter scolds the father for saying that

in front of her mother. She explains to Owen that although she [mother] doesn't say anything she listens to everything and the more her father says it the more she doesn't eat. Owen says he understands and asks how the family is coping.

The daughter here is also protecting Owen from the family's pain by scolding her father even though Owen asks how they are coping. However, although kind and polite, Owen does not seem to operate with emotional intelligence or engagement with others' pain.

The daughter says that her father is finding it very difficult because he is the main carer for her; she herself has taken time off work to care for her when she can to support her father. As she speaks about her father and how upset he is becoming she begins to become tearful. Owen listens to her as she speaks and occasionally asks further questions. The husband continues to potter around the room occasionally touching his wife's head and face. The daughter watches him.

Owen, while allowing the daughter to cry and not acting as if he is irritated or embarrassed, equally pays little heed as he continues to talk of the mother's deterioration.

Owen begins to talk about the deterioration of her mother and what they will be able to do for her. The daughter says that she knows what Owen wants to talk about 'you're talking about DNR aren't you?' Owen says yes he is and the daughter tells him that she knows about it because her friend's mother recently died and this was discussed with her. The daughter says that she knows what she would prefer but they will have to talk this through with her father. The daughter calls her father over and begins explaining DNR. He looks at his daughter, he looks lost and scared and she tells him that it is his decision but she thinks that the doctors should not resuscitate her mother because she will be resuscitated to the same state. Owen inputs that she will be 'worse' than how she is currently because she will be a lot weaker. The daughter says that she will have to talk through this with her father. Owen nods and leaves the room.

9.6.5 Stories of patient care

The following two stories show in detail the ways in which responsibility and power can shift between team members and highlight anxieties faced by doctors about caring for patients.

9.6.5.1 A story of system failure: Cancelled Clinic

The first story is told by a female registrar who describes a situation in which she felt disappointed with patient care due to cancelled clinics. In the

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following account, the narrative is broken down to four moments, and each is discussed to demonstrate how the doctor's anxiety is managed by being linked to a failure in 'the system' that climaxes in her interaction with patients.

Q: What about any time or incident that made you feel disappointed with patient care in this hospital?

A: Lots of times, particularly since we've not had a secretary. Every clinic, every single clinic I send somebody home because the notes aren't there at all. They are supposed to be coming to see the consultant [her immediate superior] and he's not there, and they've been put into my clinic and you look at the letter and it clearly says on the letter 'consultant only to see', and they turn up and he's in Italy, on holiday.

The registrar is expressing frustration. On the surface it is towards a recurring failure in patient care attributed to firstly not having a secretary and secondly because the consultant 'is not here'. The expression of the frustration however is confused; there is no secretary but the patients 'have been put' into her clinic. Furthermore, she sends someone home from each of her clinics because the notes are not there. The letter 'clearly says' the patient is to see the consultant who is not only not there but he's in Italy 'on holiday'. There is a feeling of being overwhelmed, and of rage and envy towards the consultant - and possibly the patients - emerging from this short paragraph (for discussions of workplace envy, see Vidaillet, 2007; Stein, 2000). There is also an expression of omnipotence in that she sends patients home. She has the 'legal' justification to do so because there are no notes and also because their letter says they have to see the consultant and the energy is directed towards this activity rather than getting patient appointments changed. The consultant is on holiday, presumably one to which he is entitled and one which has clear boundaries enabling them and the staff who make the appointments to re-arrange the patient dates.

There is clearly a high degree of frustration and anxiety present in this account; there are too many patients with 'needs' and not enough clinical or support staff backing the work in the way in which the doctor would feel comfortable with. As there is little opportunity either to express or assuage her anxiety so she becomes 'prey' to primitive phantasies and unconscious mechanisms to relieve the anxieties.

The story also sheds some light on doctors' anxieties about working in a multidisciplinary team. Medical education and postgraduate training provide a culture in which doctors believe they can rely on each other through which a sense of being an elite group and confirmation of professional omnipotence and responsibility - particularly of the consultant - arises. However the role of the consultant also brings about a sense of envy and

destructiveness in others which has its origins in the primitive defence mechanism of splitting off the painful parts of one self (e.g. the realisation that you are not omnipotent and that another has the ability to do what you cannot) and projecting them onto others in an envious attack (Klein, 1959).

...and you have to go out and say, 'I know you've waited three months for this appointment but I'm afraid the consultant is not here and he wants to see you personally, so thanks for coming but if you can just go away' and you can't even say to them 'you're getting an appointment for next week' because realistically they're getting an appointment in three months time, and I think that's really disappointing.

'Breaking bad news' is considered to be a difficult task for health professionals and one that is a constant cause of anxiety. In addition to having to find the appropriate means of communicating prospectively devastating prognosis and supporting patient through the immediate emotions, doctors must come to terms with possible changes in how the patients perceive them (Barnett, 2002). Even though the situation described here does not involve delivering bad news about an illness, it is a moment of disappointment for both the patient and the doctor. The patient's anticipation to receive treatment is rejected and the doctor has to acknowledge failure in service delivery. The patient's possible anger and anxiety is directed towards the messenger, who in this case, is unable to offer any practical solution. Instead of being the helpful, trustworthy saviour, the doctor transforms into an envoy of disappointment and will have to see to the patient's emotions as well as her own disappointment, to which there is no external consolation on offer. To alleviate the anxiety caused by the situation, the registrar clings on to a narrative regarding her workplace – she is disappointed in the system.

I feel very disappointed in the system, which, I know the system is a big, wide thing, but ... [it] lets people down from that point of view and, you know, we overbook theatre lists and they get cancelled and then again I feel disappointed.

By seeing the NHS as a faceless, bureaucratic, 'machine-like' (Elkind, 1998) entity, the registrar convinces herself that the situation is not her fault – it is not what she would want for the patients, or for herself. She feels anxiety for she cannot provide the care required, and as a consequence she projects this anxiety through blaming 'the system'; regardless of their individual efforts, doctors are powerless when the system fails. As this registrar said epigrammatically later on in the interview: 'I don't think the NHS works anymore' which at a conscious level represents the impact on her working life of a problematic bureaucracy while at an unconscious level it provides uncontainable stress. The doctor does not have the opportunity to delegate

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tasks to her superiors to reduce the 'heavy burden of responsibility' (Menzies, 1960, p. 118) thus feels that she is left to deal with the failure of 'the system', a system, which ironically is set to heal people, not cause them angst.

It's mostly because I'm thinking, how must that patient feel. You know, they've worked themselves up, they've told work they are gonna be off work for three weeks or four weeks or whatever and arranged cover and you go and tell them, sorry, you can't have your operation, you can go back to work tomorrow. That's really disappointing, to do that to people, very much so.

In the conclusion to her story, the doctor moves beyond expressing antagonism to the system to empathising with the patient. Thus, by failing, the system provides the doctor with a social defence mechanism but through empathizing with the victims of the failure, she fails to contain her anxiety.

9.6.5.2 A story of grace in adversity: Supporting the mother of a still-birth baby

The second story is told by a male registrar who describes how he provided good patient care by supporting a mother of a still-birth baby. Despite the plot, the story is not told as a tragic narrative but as a proud patient-care moment, a sequence of events that had thoroughly positive impact on the doctor's perception of himself. This narrative is also analysed in sections.

Q: Could you give an example where you felt that you have given good patient care?

A: I think that one of them was this lady who actually came to the labour ward and told me that she hasn't felt her baby move in the past one day and she had had some bleeding. Obviously there was some concerns on my behalf for the baby, because there could be a problem. This was a very wanted pregnancy because she was quite old and this was an IVF pregnancy. I examined her a little bit and on examining her I found that the baby did not have a heart beat, so she had lost the baby.

Describing the situation at first with the patient as an object helps the doctor to distance himself from the scenario and to do routine checks expected in this kind of situation. In a hospital setting instructions are given about the way each task should be performed and these rituals form a reassuring tool for staff (Menzies, 1960: 121).

I did explain everything to her, and obviously as a doctor responsible for her, I need to follow all the procedures that needed to be done and all the care that she needed to have, you know I explained it to her that, you know this by far something that words, you know cannot express, as you can imagine how

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difficult this situation would be, and if we could make it the slightest bit better, we would try everything in our power, you know, to make the situation a lot more comfortable. I ensured that she was given a quiet room, with a very good midwife looking after her at all times. Obviously I had my duties towards the rest of the labour ward as well. People visiting her room making sure she was ok, making sure the pain relief was ok, we had induced her because we did not want her to go home with a dead baby inside her. It was a very, very painful and stressful scenario, it really, really was, it was horrible, absolutely and it is very distressing, exceedingly, exceedingly distressing because, you know the woman is going through all that pain of labour.

Here, the doctor is empathising with the patient, feeling her emotional pain and in this case is mostly able to contain it through wanting to relieve the situation and then by offering extra care, by 'going an extra mile'. In this extract, there is a clear shift as the doctor uses strong emotional words to describe the crisis. In telling the story, he is projecting his own anxiety on the patient, living the distressing emotions with her and having to remind himself of his position as a medical professional - 'obviously I had my duties towards the rest of the labour ward as well'. By referring to 'all that pain of labour' the doctor enters a relationship with the pain. The phenomenon of pain and our relation to pain, whether someone else's or our own, is more immediate than that of reflective knowledge – we do not think about pain but react to it so the sensation is intersubjective. The person who is not experiencing the pain but affected by it is an 'interlocutor' in the situation (Crossley, 1996, p. 37).

...I tried to make it a point that I was present, present as much as I possibly, feasibly could during her emotional outbursts. I wanted her to have all the support that she needed... I did get attached to the patient, being around her, trying to get her care, even if I was out of hours, which means that when I was not meant to be in the hospital. Now I think that some people will argue that, that is a bit over the top, but I think that, I guess, I guess, that that is medicine for you, you know it is about lives, and sometimes you have to make that extra effort, to make that person feel that little bit more special.

In this excerpt the doctor starts to explain and justify his actions. Through self-reflection he has realised how he acted in a way not normally accepted in the hospital culture, that is, he went against the 'social defence system' to deliver patient care, but also to cope with his own anxiety. He dedicated extended time to his patient even though hospital doctor's time is considered to be 'fast and efficient'; 'doctors move quickly in the hospital wards. Their time is expensive. They cannot afford to linger too long in any one spot' (Mattingly, 1998, p. 21).

Menzies (1960) noted that while institutions have social defence systems, individuals may resort to their own defensive mechanisms, but a membership of an institution 'necessitates an adequate degree of matching

between individual and social defence system'. If the individual and the social defence systems are in disagreement, what follows is some degree of breakdown between them, for example, a doctor's work colleagues might reject them for behaving in an inconsistent or unprofessional way to the system. Consequently, the registrar providing patient care to the mother of the still-born baby is not only coping with anxieties created by that emotionally charged situation, but he also has to think about the culturally accepted limits of caring and possibly negotiate his way with other members of staff. On this occasion, the doctor keeps to his defences and spends extra hours with the patient, without being criticised by his peers.

Well you know that when things get worse, they get worse and they get worse and they get worse. Ultimately what happened with her was that we tried all the induction of labour, we tried everything possible to get that baby out, by induction. And in her case with the induction, it failed as well... and I can't tell you how dreadful that scenario was, that she needed a Caesarean section to have that baby out... I wanted to make sure that I was present at the Caesarean section, as well so that she would have a face that she knows. Once she delivered, you know obviously I was there with her, with the [dead] baby in her arms, and she was happy from the point of view.... and thanking me every now and then, which I said that she shouldn't because it was my job and one should do it. But she kept signalling the fact that not many people would do it the way that I had and I that was very special.

Much hospital work contains a 'constant sense of impending crisis' (Menzies, 1960, p. 26) which creates pressure and anxiety. The level of predictability in medical work is low and – as the registrar expresses it – 'when things get worse, they get worse'. The doctor explains that he attended the Caesarean section for the patient's sake, but this could also be interpreted as his coping mechanism – the need for a closure (Mattingly, 1996: 37). If you only see trauma and dramatic events without closure, the events will stay lingering and cause anxiety, stress and possibly depression. The doctor needed to be there and needed to have closure to be used as a coping mechanism against accumulating anxiety. So far the patient had been in a powerless position while the doctor had presumably been in control of the situation and emotions involved in it. Therefore, when the patient thanks the doctor, he gets confused. The patient had survived through the ordeal and suddenly has the power to relieve the doctor's anxiety, to nurse him (Menzies, 1960). The acute physical and emotional stress is released and the doctor can reflect back on his experiences.

And I think that is something very, very special and dear to my heart. And these are those situations when you sit back and you reflect on your life and

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say, "wow I have done something good, really, really something good and it is wonderful".... I saw her every single day on the post natal ward and obviously I made a point not to neglect her, or neglect her partner because people assume that the only person going through the trauma is the woman who has actually delivered, but they are a couple, and that needs to be understood so that was important as well. And he appreciated that quite a lot. They went home, two weeks later, I did receive a lovely letter, which kind of expressed a lot of gratitude, for what I had done for them.

The thanking letter provides closure for a difficult story, but maybe also goes beyond this. It hints at redemption – instead of a medical tragedy possibly compounded by failure in patient care, the story becomes one of a victory or at least grace under fire, a positive example of the doctor's powers even when he cannot actually perform miracles by restoring life. Anxiety is successfully overcome by the absolution from the patient and the doctor's 'priesthood' (Elkind, 1998) is restored. The letter from the patient acts as the final seal to exalt the extra efforts the doctor put in to solving the problem (Menzies, 1960, p. 31).

I know that I put in extra hours and I KNOW that I shouldn't have been there but no-one complained, because everyone knew that I was helping a situation. It is just an understanding that we have. It would be a terrible job if you were only allowed to work your set number of hours.

A narrative like this one permits people to attach themselves to 'desirable' ends, think well of themselves in moral terms', 'support their needs for autonomy and control', and 'promote feelings of self-worth' (see Baumeister, 1986 in Brown, Stacey & Nandhakumar, 2008, p. 1054). By telling this, not an easy or comfortable story, as a proud moment of good patient care, the registrar restores his professional and personal integrity. There is no 'system' in this story to blame on, no failure to confess, but despite the drama the story draws to a happily-ever-after ending. The story has entailed a narrative for the self (Brown et al., 2008) that has released the anxiety the event contained.

9.7 Conclusions

Patient care is a process and a social construction and as such means different things to different people. Norms and styles of patient care also change across time and differ site to site not only because of differences in beliefs, but also because there are different possibilities (technological advancement, different types and mixes of professional groupings) and different types of constraints on what might be offered. It is not always possible to put a clear value judgement on patient care and one example is to do with 'length of stay'.

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Managers, whose concern is to ensure that beds are not blocked, may or may not be holding in mind the image of an organisation that shares care with agencies and families in the community. They may simply be responding to government targets. They may have their mind fixed on those waiting for beds who have still not received treatment. Patients themselves may want to return home as soon as they can or become bewildered when they are discharged rapidly after treatment.

Working in multi-disciplinary teams with distributed leadership patterns may have improved practices for clinicians. Accountability for patient care still resides with the consultant and the hierarchy who manage the Trust. While senior managers are responsible for ensuring patient safety and preventing negligence to individual patients, they are also responsible for ensuring access to care for the community which involves managing scarce resources such as equipment, pharmaceuticals, beds and staffing.

Not all clinicians appreciated or respected these pressures as we saw particularly in Chapter Six. Nor do patients necessarily agree that good care is anything other than good and consistent communication with specific clinicians.

As demonstrated in Chapters Six and Seven managers are frequently frustrated by demands from staff who may try to subvert managerial targets (set by government and as such fundamental to resourcing of the Trust).

The quality of leadership is intimately linked to patient care. Good patient care relies on effective leadership of the kind that engages with staff and imparts to them the vision that (as far as humanly possible) the patient comes first. That in turn impacts upon the climate, culture and ethos of the Trust. When leadership fails, so does patient care.

10 Leadership and patient care: Assessing the past and thinking of the future

10.1 *Introduction*

Without effective leadership at all levels of the NHS and its various organisations patient care suffers. This knowledge has been evidenced in

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several key studies across recent years as reported above and elsewhere and consequently fed into the NHS Qualities Framework (see Chapter One).

In this report we have critically reviewed the relevant literature on leadership exploring as far as possible the relationship between leadership, followership and service delivery across five hospitals comprising three NHS Trusts (see Chapter Three). We employed different research methodologies (see Chapter Two) to capture data to investigate leadership qualities and their interaction with the climate and culture of the organisation and linked these to service delivery and patient care in different settings (ranging from obstetrics and gynaecology and cardiology to care of the elderly).

10.1.1 The organisational contexts

The organisational contexts of each Trust and each site or unit varied physically, structurally and in 'atmosphere' (the full details are provided in Chapter Three). We have been concerned in the report (and future papers) to steer a path between maintaining anonymity and confidentiality and thus not overtly identifying a Trust or site within a Trust, while also pointing to how the contexts impacted on the practices of leadership and service delivery.

Overall the Foundation Trust (3) in this study, which had not been experiencing mergers or threats of closures, where staff morale was high and where leadership practices were distributed across teams and clinical and management specialties, was clearly the one most conducive to effective communication and leader-follower engagement. There was an 'atmosphere' of connection and pride in belonging to the Trust as evidenced explicitly in Chapters Four and Nine in particular.

Trust 1 was applying for foundation status during the time of the investigation but also threatened by closure of some of its units, and with the senior managers possibly being transferred to the other site which was perceived by the participants as a threat to their status and possibly to resources for service delivery. This did not happen during the course of the investigation. The managers in Trust 1 were committed to their staff and to service delivery although there did appear to be some discontent with senior management from the medical staff. This may have been because most of the distributed leadership involved non-clinical managers and nurse managers with the medical teams appearing to take a more 'traditional' hierarchical stance. Most of the data from the OCS was derived from Trust 1 which demonstrated among other things the importance of management support for identifying good leadership and patient care practices.

In Trust 2 there appeared to be the greatest amount of conflict between groups of staff who sometimes seemed to be leading in different directions.

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Trust 2 was perhaps the 'victim' of a relatively recent merger between two large hospitals (and one or two other smaller units) which were some physical distance apart and had had a different history – one being a DGH and the other a teaching hospital. The DGH appeared at first to have a professionally diverse group of senior managers who distributed their leadership to effect, but one or two figures emerged during the course of the study who transgressed this approach with one person taking a back-seat while another was trying to drive through change in a somewhat cavalier manner. Furthermore in this particular Trust there were changes among the senior managers (some left, others moved to the other site during the course of this study). The CEO also indicated that it was difficult to recruit good middle-range managers and nurses in particular because both sites were away from the centre of the city where most people would look for a promoted post.

10.2 *Limitations of the study methods*

As with any large scale and complex study such as this one not all of our intentions were achievable although some were satisfied beyond our expectations.

We had difficulties capturing data from patients for two main reasons (fully detailed in Chapter Three).

Firstly, the 'gate-keeping' staff working on the Units on a day-to-day basis (as distinct from those who supported overall access to the Trust overall) obstructed data collection.

Secondly, it was also difficult gaining access to patients while they were in hospital because of ward procedures and in other cases the poor health of patients. So in the end we managed to conduct ten patient interviews but were unable to collect organisational climate survey data from patients at all³⁸. To overcome this we gained permission to observe clinicians' interactions with patients in their care and we believe we have managed to do more than compensate, making a contribution to knowledge with important new material to demonstrate patient care in different contexts and the processes involved in patient care and service delivery (see in particular Chapter Nine).

We also met with difficulties, with one Trust in particular, collecting *survey* data from staff although individual staff members proved more than willing

³⁸ These difficulties were reported to SDO in the interim reports and also separately when they arose.

to support the researchers by allowing them to interview, observe and shadow them during their working days. *This is all reported fully in Chapter Three.*

10.3 *Reviewing the findings*

In this final chapter then we draw together the findings from the study and make suggestions as to how they might contribute to policy and practice beyond the participating organisations.

This chapter is organised around the original study aims which were about leadership, organisational climate (culture and context) and how they impact on patient care. The overall plan was to identify the circumstances under which leadership can emerge and function as an effective *engine for change* in the organisation of health care, especially for both patient care and service delivery.

This research further sought to explore the following broad-based questions.

- First, how far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?
- Second, how do organisational climate and styles of leadership facilitate or hinder performance in the NHS?
- Finally, do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The specific aims and objectives are listed again below and we conflate these in what follows directing the reader to the relevant chapters.

- To understand how leadership in NHS health care organisations is exercised and experienced by those affected by it, from staff across all levels and disciplines, to patients;
- To gain a better understanding of the characteristics of leadership that facilitate or hinder service delivery and or performance;
- To explore how organisational climate and other features of the organisation facilitate or hinder service delivery and performance.
- To learn how service is defined by different stakeholders and what they see as determining its quality;
- To evaluate the extent to which a vision of patient care impacts service delivery;

- To learn how different stakeholders (specifically patients, nurses, members of professions allied to medicine, non-clinical managers, and senior managers) experience and attribute effectiveness to service delivery;
- To gain a better understanding of the different characteristics of service that facilitate or hinder the process of patient care;
- To identify how the need for change in service delivery is identified and what drives the need for change.

10.3.1 How far does the impetus towards high quality and effectiveness of patient care act as an *inspirational idea* within a health care organisation?

Throughout the participating Trusts there is evidence of the importance of high quality patient care. Chapter Nine in particular brings this together with quoted respondents emphasising that above all patient care matters to the aims of the organisation and those who work in it. Thus on a basic level, working for patient care is inspiring in itself and staff across the Trusts see good patient care as their *modus operandi*.

Our use of innovative ethnographic methods and story telling were particularly effective in providing the evidence of how patient-clinician relationships were practiced and how staff made sense of their own actions reflexively in the context of caring for patients³⁹.

Chapter Nine provided evidence of the ways in which care is practiced.

We begin here by summarising some of the evidence from the Foundation Trust in this study, which consistently appeared to demonstrate high levels of distributed leadership, emotional engagement and multi-disciplinary working across all levels. The data included several key examples of positive statements about the role and effectiveness of management. We saw, for example a senior clinical manager summarise the issue with reference to his

³⁹ For example, interviews opened with questions about leadership and patient care, and participants were then encouraged to tell 'stories and critical incidents illustrating their experiences'. The early parts of the interviews provided themes and indications of what the clinicians regarded as crucial to delivering good patient care, e.g. 'cleanliness', 'efficient administration', 'communication', 'empathy', 'sympathy', 'knowing the recent developments in your field' and 'everything behind the scenes the patients don't see'. However, it was the stories they relate to that provided us with insights into their core experiences of patient care (see Chapter Nine).

pride in working for the organisation drawing attention to its low mortality rates, and that the high quality staff and its reputation for patient care act to attract others at the top (or with the potential to be at the top) of their specialty.

By contrast, the CEO of one of the other Trusts had made the point in their interview that one of the difficulties they had was attracting high caliber nursing staff, partly because of their location (in the suburbs). In Chapter Four we identified the ways in which an organisation might be seen as a learning organisation as significant in supporting staff to develop their clinical and managerial skills and develop capacity for patient care. Where support for learning was apparent so was the enthusiasm and pride for the organisation and its goals.

What was striking was the way that all respondents who addressed this point were looking to see how patient care could be improved with aspirations that patients were satisfied with more than just the health outcome (although that is the bottom line) but also with the facilities and the atmosphere. In addition, several respondents made the point that they themselves were mindful of delivering (or at least aspiring to deliver) the type of care they themselves would want to receive.

That so many of the staff (clinical and non-clinical) worked long hours in which they were engaged in intensive work with either their clinical or management teams, or their caring for patients with the aim of delivering the best possible care, is yet further evidence of the ways in which patient care is inspirational.

What is most noticeable, however, is how some styles of clinical and managerial leadership appear wanting, when compared with the best. While some respondents are clearly excellent communicators who engage fully with their professional knowledge and with the patients and staff, others - equally expert and equally inspired to provide the best for their patients - seem to fall short in comparison. In Chapter Nine for instance, Cameron and Kenneth engage with their patients in human ways and there are examples in the chapter in which each clinician manages to gain important information from and for their patients by their hard work *and* their humanity. However, in Cameron's case he is supported by a team which has clearly been nourished and inspired by the organisational context (see references to Cameron's work in this report).

Kenneth, while equally able and empathic, from the ethnographic evidence reported in Chapter Nine, appears to be less able to transmit this or influence others to take up his brand of leadership and patient care. He remains slightly in the background while the younger and (it appears) more influential Henry sets the tone. The clinical team give the impression of

being business-like and impersonal and somewhat intimidating when they conduct their ward round. The culture being transmitted to the other clinical staff tends towards Henry's approach rather than Kenneth's. This raises questions about why this Trust and site is different from the FT in which Cameron and Mandy work. These matters were addressed in Chapters Six, Seven and Nine in particular and will be subjected to further analysis in subsequent publications. However the FT is established and settled. The Trust where Kenneth and Henry work was the product of a relatively recent merger and norms and values were still being 'negotiated' (see Chapter Seven and above in this chapter).

Subsequently we see Mandy working directly on a patient's wound not only acting humanely when she hurts the patient but working with the nurse to assess how they might best improve the patient's condition while caring for his mental state and self-esteem.

High quality care and inspiration come together through the ways in which clinicians and managers take responsibility for their work – for managing emotions (their own, their colleagues' and their patients'), teaching, making decisions about end of life care, communication with relatives and coping with everyday situations that raise anxiety levels for patients and staff. The story of the doctor in Trust 1 who cared for a woman with a still-born baby itself demonstrates how he went the extra mile (in his words) inspired by the possibility of providing care in a case where some might have tried to make minimal contact because a still-born baby might be seen as a clinical failure.

Overall emotional engagement with patients and followers leads to people working together in a human, humane and inspired way and impacts on the organisation itself which can become one with which people are proud to be associated.

10.3.2 How do organisational climate and styles of leadership facilitate or hinder performance in the NHS?

This question underpinned the entire study, but specifically we reviewed the relevant research literature on leadership and organisational climate (Chapter One) and discussed this in Chapters Four through to Eight. We began by reviewing the results from the story-telling interviews, focus groups and ethnographic methods (observations and shadowing). A range of potential practices and behaviours were reported to us which suggested where problems might lie in current leadership practices, as well as what many respondents held to be ideal types. What we summarise now represents a combination of what works and what does not although it needs to be noted (as identified in Chapter Nine in particular) that what

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patients see as good leadership (that they received clear and consistent information from one or two key staff) may not always intersect with what staff meant by good patient care or effective leadership and service delivery. The latter was usually seen as best delivered by a well-functioning multi-disciplinary team albeit frequently constrained by limited resources.

The following issues stand out as good practice that could feed into NHS (and local Trust) policy:

Leadership is a complex concept meaning different things to different people. Over recent years leadership in changing contexts such as the NHS has shifted from the 'heroic' model where leadership is hierarchical to a model that is more distributed across different levels and different parts of the organisations. The heroic and hierarchical (related) models frequently depended upon individual characteristics and where the senior managers were indeed heroic and charismatic, leadership might well have led to good patient care. However, this is unreliable and unpredictable and the NHS Qualities Framework which has identified leadership skills is more appropriate to the context (see Chapter One).

Our most important findings, however, make it clear that leadership which is emotionally engaging and distributed is the one which is most likely to lead and support service delivery successfully as well as drive necessary changes.

At the end of Chapter One we focused on contemporary studies of leadership which promoted the importance of *context* and of taking a more discursive stance in the analysis of leader-follower relations. We also drew attention to the revival (and reappraisal) of concepts from organisational studies from the 1960s to the 1990s which took psychodynamic ideas into account and related them to more 'popular' contemporary ideas about the significance of social and emotional intelligence in leader-follower relations. Thus, we explored the ways in which stakeholder accounts of the experiences and exercising of leadership demanded an attachment or engagement at an emotional level, which took account of the unconscious as well as conscious understanding of these experiences. There were several examples offered in the previous chapters of leadership practices that delivered the required services or changes through different types of concerted action and those that didn't. In some cases we were able to show that with the best will in the world if the leader, for whatever reason, was unable to *engage* and thus be supported by the followers, then their leadership failed to deliver.

Recent analyses of distributed leadership styles and organisational contexts show that if such leadership is to work then people need to act and work together and be prepared to both take up and relinquish authority for

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certain tasks and roles at the appropriate intervals. We saw in Chapters Six and Seven for instance that authority is hard to maintain if a leader loses touch with their staff and fails to hold their own organisation 'in mind'. We used the OCS survey results in combination with the data derived from the interviews, focus groups and ethnographies to demonstrate the importance to a positive organisational climate of good leadership. Satisfaction with a manager was predicted by the same variables that identified a positive organisational climate. For staff in the organisations surveyed it was important that managers were committed, responsible and supportive of their staff/followers.

But how were these characteristics demonstrated? Leaders who were experienced as effective, supportive and emotionally engaged with their followers were able to communicate their vision and dedication to improving the quality of care to patients, which in itself co-existed with good staff morale. Such leaders were also good listeners as well as being able to take staff with them when less palatable or unpopular changes were mooted by senior management or government. These effective leaders were closely connected to the way the organisation was structured (physically and emotionally). They were thus able to access the information they needed in order to lead. The evidence for this frequently came from the stories and accounts of staff and observations made by researchers – often of good leadership but perhaps more acutely when leadership was poor. Then there was a jarring effect or mismatch between (local) policy and the attempt to drive changes to meet improvement targets. There was also evidence on occasions of senior clinicians' behaviours being disengaged. Sometimes attempts were made to subvert the senior people when leadership went against the grain. There are examples in Chapters Seven and Nine in particular.

A final comment here is that despite the changes in gender demographics at the top of clinical specialties in medicine, nursing and related professions, as well as in senior management, gender has not 'gone away'. Indeed distributed forms of leadership have (perhaps stereotypically but with some evidence base) been associated with women's behaviours. The OCS (Chapter Five) suggested that women's perception of 'recognition' for their work and achievements was more negative than that of men. Men were either satisfied with the recognition they received or less in need of recognition from their managers within the organisation than were women. In the qualitative data (see Chapter Eight) it was also the case that while senior women were keen to deny the relevance of being female to their professional lives and their career progression per se, women used different strategies and perceived their roles slightly differently than did men, although the point was well made by some respondents that feminine and

masculine choices of specialty may have been more significant predictors of management styles than gender itself.

10.3.3 Do individual organisational approaches to patient care derive from one person's vision or are they co-created?

The contemporary NHS with its (mostly) distributed leadership practices at all levels tends to militate against the possibility of one person's vision being paramount. However, as suggested above in this chapter, there are nuanced influences of leadership style that (may) flow from one or two people's vision and/or style of leadership and patient care that influence organisational approaches.

In Chapter Seven, for example, we explored three senior people's visions and consequent behaviours to consider their authority and influence with the possibility that as opinion leaders they influenced organisational approaches to patient care. Quentin, for example, reflected his role as a senior clinical leader, and although there is no irrefutable evidence that his style was mirrored in the organisation itself, he does provide some evidence that in certain cases in relation to certain actions his vision had an impact on the overall organisational approach.

While the OCS (Chapter Five) captures data from a wider population, the ethnographic methods made a greater contribution to exploring how far an individual's vision influenced the organisations approach to patient care. Again in Chapter Seven we see Kerry battling against a resistant (and probably disillusioned for some reason) senior management team to improve discharge policy and meet government targets. She tries again and again (by her own account) to show her staff that they need to focus on targets because they will lead to improved care quality. She appears to fail (again according to her own standards) and expresses this by almost literally demonstrating that she is banging her head against a brick wall.

Differently with the same effect Gerald is introduced as having a clear vision for patient care in his Trust. However, his inability to take staff (at all levels of the organisation) with him in his vision is attributed in our analysis to his lack of emotional engagement and autocratic (verging on the authoritarian) style of management. His narcissism further ensures his inability to understand how his behaviour is impacting upon staff and he sees himself as having failed to win a 'fight'.

Chapter Six explores the organisation as an open system, and ways in which all stakeholders⁴⁰ hold a vision of the organisation in the mind at a

⁴⁰ Including patients but we cannot really speak definitively here due to lack of data.

conscious and an unconscious/emotional level acting accordingly. Thus, they have an image of the organisation (how well it is managed, how effectively it cares for patients), a sense of their own role and place within the organisation and how well the leadership understands the experiences of staff and patients. Recognition of the primary task, the roles and responsibilities of those who manage it and the (changing or threatened) boundaries of the organisation itself are critical concepts.

No doubt some members of the organisation have more personal and role/task related power and influence than others in the NHS Trust. Furthermore, the NHS as a system is fluid and dynamic, so that there is overall a group influence over the evolution of organisational context (climate and culture) which responds to visions from within and without (government, health care consumers) the wider system.

10.4 *What have we learnt from this study?*

10.4.1 How leadership relates to patient care

It is clear, from our empirical work and evidence from previous studies, that leadership is a process and set of practices which generally do not equate with the qualities residing in a particular individual regardless of their authority and formal role and status in the organisation. Leadership that 'works', as seen particularly (but not only) in the case studies in Chapter Seven, involves the person in the leadership role exercising social and emotional intelligence and engaging with their 'followers' (see Chapters One and Four) and offering staff recognition and support (Chapter Five). Moreover the role of leader is particularly effective when it is distributed among those who are best placed to exercise leadership towards the task in hand. So that in the context of an NHS hospital Trust, leadership might be exercised in relation to organising the administration for a unit, running an audit, or developing an innovatory clinical practice. Leadership in such contexts is time/project limited.

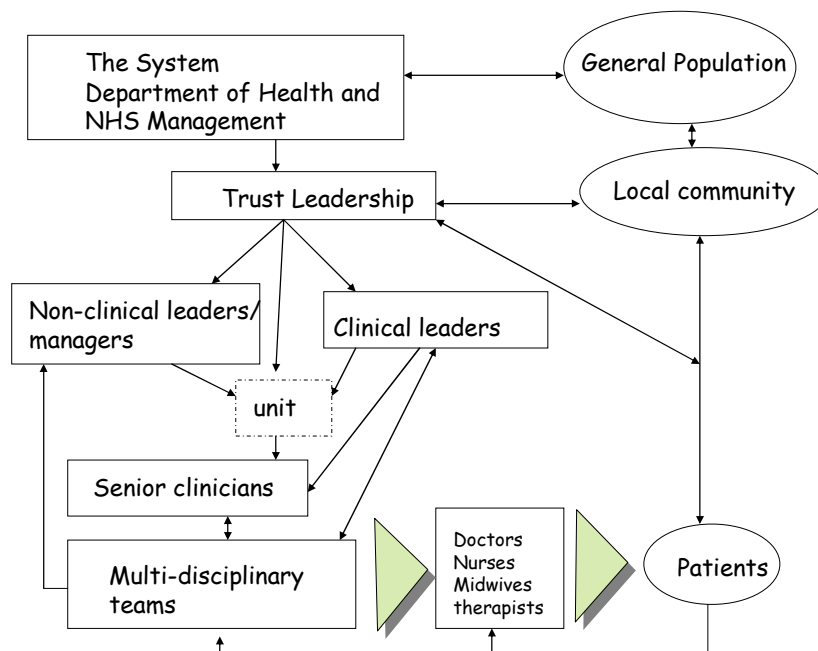
The primary task for NHS Trusts is to deliver a service to patients, as proposed in Chapter Six. All NHS Trusts operate as open systems with porous boundaries which enable change (planned and/or evolved). Leadership therefore can occur throughout the system at different levels including those of ward clerical and cleaning staff and the CEOs who 'manage upwards' and influence NHS/ Department of Health policy. Information of all kinds passes across the various boundaries not simply from the 'top' downwards.

Below in Figure 12 the relationship of the Trust leaders and patients within the NHS system is illustrated. It is also the case, as shown, that policy

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influences individual care, and the quality of that influence depends very much on the quality of leadership again across the system at all levels.

Figure 12. From the DoH to the Patient: An Open System



Patient care is represented here at three levels. The population who influence service delivery and patient care using their vote and/or lobbying through relevant patient groups, the local community who are served by a particular Trust and patients who are actively receiving medical treatment from individual clinical teams.

While on the whole it was the last group who were the main focus in this study some participants, particularly those in senior leadership/management roles, were concerned with service delivery at the local community and population levels. This sometimes meant that senior managers faced the dilemma of how to care for the community while attending to individuals and some individual clinicians were equally concerned about how their interactions with patients were influenced by some of the management dictates which derived from NHS policy that they

found difficult to understand (see Chapter Six and in 10.4.2. below for example).

10.4.2 Systemic dilemmas in patient care: Managing in the NHS

One participant had faced a 'dilemma' in wanting more face-to-face knowledge of patients in the community in order to be a more effective and informed leader, while also as his role required, attending to the demands of working within the wider system of the NHS:

As a chief exec in the NHS it was my privilege to make decisions. That was my privilege to go on and up the ladder. It was that I could go on and make faster and faster decisions. I get in the way I have always got in the way... the thing I would do is go out with the district nurse for the day, because I needed to be grounded in that. (Retired CEO)

Another manager who had previously had a military background advocated (along similar lines) that the best way to lead towards good patient care was to 'walk around' and support the leaders across the different parts of the organisation. In a seminar to clinical staff, which we attended and recorded, he drew participants' attention to the importance of *influencing* policy to achieving good patient care (at the population and community levels).

I hope some of you will find yourself in policy jobs at some point. Totally different, yes it still leads, but the actual process is so ... changing...both the chief executive and I spend a lot of time nurturing relationships which are partly to do with policy, but unless you get it right ... you communicate with them, it won't work.

In other words to be effective and to ensure the best for those in the Trust (staff and patients) a leader has to 'manage upwards' which gains influence. He continued by contrasting the experiences and perceptions of doctors with managers who lead at the macro level, drawing on the example of a recently qualified doctor. When the respondent quoted here asked this man about leadership in the NHS and how it impacts on patients he apparently answered:

'Oh I have got communication skills'. 'Blimey!' I said 'what do you know about the NHS?' And I asked him a couple of questions, nothing! But he hasn't been taught at an academic level about the context in which he is working. I think that is crucial and I know that is not how everyone does things. You know [doctors] keep people alive, but they really ought to have this basis of information about the context in which they are working.

While it is self-evident that the NHS is the context in which patient care is delivered, there is a tension between those who exercise leadership in that context and those who 'keep people alive'. In Chapter Seven, the frustration expressed by Kerry in trying to meet the demands of the government and community by improving the Trust's record of patient care, as well as motivate her senior staff to hold similar ideas, was palpable. From others' perspectives as shown in Chapter Six, there was evidence that 'management' was experienced negatively by several clinical staff when it tried to respond to Department of Health directives.

Managing the numbers

At another level of management good patient care was defined through achievement of returning satisfactory statistics, as this observational note of a meeting between capacity managers and clinicians suggests:

Patient care for the capacity managers appears to be a number crunching exercise. The need to get the patients in the right beds according to government targets meeting four hour waits and single sex bays. However because there is not a shortage of beds on this day, patient care moves from an exercise in numbers to thinking about patients in real human terms.

Sally (the capacity manager) talks about how better patient care can be delivered when there is less pressure on all the staff to meet their targets and get their job done. She talks about how [clinical] staff are then more able to talk to their patients and spend time with them. However, whilst reduced pressure means that for some, numbers translate into real people it is clear that in the capacity meeting that the role of the capacity manager is to think in terms of numbers and beds to deliver good patient care.

There is a potential conflict between the target driven service and the patient-clinician relationship which is about face-to-face contact. Perhaps this is well illustrated in Chapter Nine with the example of the 'grace in adversity' story, whereby the obstetrician spent extra time with a patient while his clinical colleagues turned a sympathetic blind-eye. The story of the patient 'Lola' also discussed in Chapter Nine who had been occupying a bed for three months with the tacit support of nursing staff would also have been anathema to staff responsible for managing targets about capacity.

10.4.3 Who judges what is good leadership and good patient care?

As shown above and throughout this report there is a tension throughout the system. The primary task of senior managers and leaders at and above the level of the Trust is to ensure the demands of the NHS and Department

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of Health leadership are met. These are policy driven with differing priorities at any particular time. The general population of (potential) patients has a keen influence on policy in different ways but particularly during local and general elections. For example the recent change from a Labour to the Coalition Government has raised questions about the role of 'targets' for future NHS priorities. Apart from other matters, finance makes a difference as to how priorities for service delivery are set.

Senior management at the Trust level is judged in a number of ways particularly related to how far the Trust meets the national priorities. However there is also pressure on CEOs and senior teams to get direct patient care and safety 'right'. This may be assessed through statistics as in the following example described by a senior midwifery manager:

Between 2002 and 2005 there were ten maternal deaths at [Trust], which exceeded the national figures. So the Healthcare Commission came in and reviewed a number of clinical organisational cultural governance issues, and then actually put the maternity services under special measures

There was a key number of issues then, and an action plan was developed, so actually I was newly appointed at that time, and there was a number of work streams that we had to work on, and it's never happened before, and I don't think its happened since in a maternity unit. So basically, even though that was a very sad event for all the families involved and very tragic for them, it was difficult for the staff, and obviously difficult for the Board in terms of reputation management. The whole action plan was implemented, the unit was turned around, and the special measures were lifted in 2006.

In this case there was a notable failure to deliver maternity care to the standards of safety prescribed by the NHS. Furthermore there was a failure of leadership perceived by this participant in terms of both 'culture' and 'governance' giving rise to the high proportion of maternal deaths and the consequent special measures. This participant also makes clear how much the staff themselves are influenced by events of this kind.

Another member of that staff team praised the changes at the top following these problems and combined the policy, context and face to face care in her assessment of the relationship of good leadership to good patient care:

.... the end goal for us, is ensuring the services we're providing.. the patients, are getting the best service from us on top of meeting all the Trust targets and the Trust strategy...for me really it's about ensuring that the patients are getting the best quality care, which, you know, I think they've got an improved quality of care here, with the team like mine who are here...and I think [leadership] is from the top down, so from Chief

Executive, right down to every level, to leaders in the ward, right down to our portering, to our domestics. Yeah, there certainly is, and we lead by example really don't we? and I think our chief exec, director of ops, deputy chief, they've all got good leadership skills.

Good leadership skills among senior managers can pay dividends in terms of reputation management. For example in August 2010 North Cumbria University Hospitals NHS Trust admitted a series of false positive diagnoses following breast cancer screening⁴¹. The CEO moved quickly to review the situation and apologise publicly. In other cases though, when there have been wrong diagnoses, neglect or medical errors over drug doses senior managers have been blamed for the failures - sometimes warranted and sometimes possibly not so (see below). Anecdotally it appears that leaders who are prepared to acknowledge problems as soon as they appear and deal with them in a transparent and effective way bring about improvements in service delivery and patient care in the ways perhaps that those who try to 'bury' problems might not achieve.

10.4.4 Leadership practices across the organisation

Leadership and patient care are intrinsically linked. Leadership is above all about taking responsibility but with changes in organisational structures, a growing emphasis on networks, open systems with porous boundaries, mergers and changes in the shape, structure and functions of Trusts, it is no longer tenable for leadership to be in the hands of a few. Leadership, then, is about a series of relationships and connections within and without specific organisational boundaries which have the potential for diffusing responsibility or sharing it, and therefore making leadership practices more co-operative.

It is important to focus, as we have done, on the many examples of good and excellent leadership we found within the three Trusts taking part in this study (each of which of course being hospital based and therefore not focused on the role of leadership in primary care). These sit in contrast to the examples of less effective and sometimes failures in leadership that we have cited. The differences crucially were about emotional attachment and engagement between leaders and followers. We did not meet any respondents who were disengaged with the aims of the NHS and none who were uncommitted to deliver the best patient care. But as evidenced above in the report and in this chapter, some leadership practices failed to take

⁴¹ <http://www.bbc.co.uk/news/uk-england-cumbria-10958423>

followers with them because of autocratic, insensitive behaviours and poor communication skills. Leaders need to be able to listen and engage – having a vision is not enough.

Leadership taking the importance of emotional engagement into account also needs to be transmitted across the organisation. This is best accomplished through making full use of individual skills. Clinical staff and managers can be effectively involved in specific change projects. These may be time-limited and/or specialism specific but collaborative concerted action is frequently the most significant way that a system might flourish with the staff taking responsibility and enhancing their sense of commitment.

10.4.5 When leadership fails patient care

The converse of good leadership is potentially catastrophic. The case of Beverly Allitt in the early 1990s, the nurse who murdered children in the Lincolnshire Hospital by injecting them with insulin, went relatively unchallenged because she was poorly supervised. Harold Shipman, a different case in that he was a GP in a sole practice, similarly was eventually thought to have committed over 200 murders of patients throughout his career. However, the report into his murders showed that doctors at Thameside hospital had failed to report suspicions about his prescribing⁴². The Alder Hey organs scandal involved the unauthorised removal, retention and disposal of human tissue, including children's organs during 1988 to 1995 and the Bristol Royal Infirmary inquiry about children's deaths during surgery resulted in doctors being struck off. All these cases represent a failure of leadership in which those who were responsible for patient care at all levels failed to identify and follow up on problems. More recently the independent inquiry into the Airedale NHS Trust, where the late Anne Grigg-Booth continued as night-nurse despite a high proportion of deaths of patients while under her care, identified 'a catalogue of systemic failures' whereby her dangerous behaviour was not spotted.

At the time of writing this report the Prime Minister David Cameron has ordered a full public inquiry into the events at Staffordshire hospital which have led to deaths of patients, it would appear in these cases, more due to negligence than intent. The Francis report which was published in 2009 found that patients were routinely neglected and there were systemic failings in patient care. Managers had been pre-occupied with cost cutting and meeting targets and unable to spot the build up of failures in patient care that were to cost several patients their lives. There were too few

⁴² These cases were subjected to inquiries which exposed a range of complexities which are not relevant here.

nurses, those who were employed were ill-trained, equipment was inadequate and experienced medical cover was not always available. It was a supreme failure of management and leadership. The Trust was poor at identifying when things went wrong and managing risk. Some serious errors happened more than once and there were higher levels of complaints compared with other trusts. Staffordshire was a foundation hospital that had managed to 'tick the boxes' although clearly there were a series of chasms between the clinical and managerial staff.

10.5 *Final thoughts*

By using innovative qualitative methodologies (described fully in Chapter Two) such as story telling, ethnographic observations and shadowing, to both supplement and augment data from interviews and focus groups, we have built up a picture of what happens in the daily lives of NHS staff working both with and as managers and in clinical teams. Using these methods provides opportunities to extend the scope of more traditional in-depth interviews and focus groups. The 'story', because it is chosen by the participant themselves, provides not only detail and depth but demonstrates the specific indices used by each interviewee to make sense of their own and others' behaviours within the organisational context.

The ethnographic observations, and the shadowing in particular, enabled the researchers to gain a sense of what 'a day in the life' of a member of the organisation *feels* like. They can 'experience' the interactions between staff, between staff and patients as well as the frustrations and pleasures of working in that Trust. No other method provides such acute insights. The subjective ingredients in this method enhance the process (i.e. as outlined in Chapter Two whereby the researcher themselves is the 'instrument' through which data is mediated). Moreover, and possibly conversely, the subjective elements are reconciled when the observation notes are discussed by other members of the research team, which again as discussed in Chapter Two is also a source of data (Czarniawska, 2008).

As a qualitative study, the success is proven by the richness of the data, showing the clear emotional connection participants had with the topics of both 'leadership' and 'patient care' (Lincoln & Denzin, 1994, p. 575). From this we were able to make sense of how leadership is experienced and exercised (see Chapters Four and then Six to Eight) and about the practices around patient care and service delivery that support patients to understand the relationship between their particular health-status, quality of life and the care and treatment they are receiving and/or expect (see Chapter Nine in particular).

The statistical analysis of the OCS⁴³ showed that, on the whole, the climate variables, 'support' and 'recognition' from managers and the system overall, predict 'satisfaction' with leadership and management. This reinforces the ideas expressed throughout the report that good practices by managers/leaders are about ongoing engagement with followers with concerted or conjoint leadership processes most likely to promote a sense of being supported and recognised (Roberts et al. 2005).

Thus we have not produced a list of 'good leader' qualities or a similar record of what constitutes 'good patient care', as these would fail to capture the crucial point that both leadership and patient care are experienced as a process. Thus this report aims to delegate *good practices* that were observed during the project, for the use and reflection of any staff member of the NHS – whether a leader, follower or patient.

10.6 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.

⁴³ As made clear above we were unable to capture corresponding data from patients.

- 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.

Appendix 1

Focus Group Questions

1. Leadership means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this hospital?

Prompts

1. Charismatic / Authoritative / Consultative / Directional / Varies – depends on situation/activity etc

2. Can you think of some incidents that sum up for you the way leadership is exercised in this hospital?

Follow-ups

1. Does this type of leadership operate throughout the hospital?

2. Could you give some examples of ways in which leadership is exercised in your team/the hospital

3. Patient care means different things to different people. What does it mean to you as a [clinical/nursing/administrative/other] member of staff in this organisation?

4. How important is patient care as a priority in the service that you and your colleagues provide?

5. What are your main priorities in ensuring a high level of patient care in this hospital?

6. Can you think of some incidents that sum up the way you and your colleagues try to deliver patient care?

7. To what extent is leadership reflected in the quality of patient care you and your colleagues provide?

8. Can you think of some incidents that sum up the way that leadership in this hospital approaches the issue of patient care?

9. Can you think of specific incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

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Follow-up

1. What would you suggest to improve this/these situations?
3. Stories and critical incidents
 - a) Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
 - b) Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
 - c) Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

Could you tell me about a time that made you feel disappointed with leadership in this hospital?

- In this unit?

Appendix 2 Interview Questions

Interview

*Introductions, background and experience in relation to patient care and leadership in the organisation

- The interviewees position/level
- Years at the hospital
- Role in the organisation

1. Leadership

'Leadership' means different things to different people.

- a. How would you define it?
 - Do you see that kind of leadership at this hospital? Why/not?
 - What about in this unit?
 - What makes someone a good leader/Qualities of a good leader? Can you give me an example?
 - Who here at work do you see as providing leadership to you personally? Why? Do you have a direct supervisor? Who? Do they have leadership qualities?
- b. Do you see yourself as someone who could be a leader?
 - Why/not?

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- Under what circumstances?
- c. Can you give me an example of leadership in this hospital?

2. Patient care

- a. Like leadership, 'patient care' means different things to different people.
 - How would you define it?
- b. Tell me about patient care in this hospital. How is it defined?
 - Are there differences between units? Tell me about them. Why do you think this is?
 - How would you improve patient care in the hospital?
 - How would you improve patient care in this unit?
- c. How do you [as a hospital worker, nurse, etc.] try to deliver good patient care?
- d. What do you think are some obstacles to delivering the sort of patient care you'd like to see? How could these obstacles be removed?
- e. Do you think leadership could improve patient care in this hospital?
 - Why/not?
 - Do you think that better leadership would improve patient care? Why/not?
 - How does good leadership influence patient care?
 - Has the leadership in this hospital improved patient care since you've been a member of staff? How so? Or why not?

3. Stories and critical incidents

- a. Could you tell me about a time that made you feel proud of patient care in this hospital?
 - In this unit?
- b. Could you tell me about a time that made you feel disappointed with patient care in this hospital?
 - In this unit?
- c. Could you tell me about a time that made you feel proud of the quality of leadership in this hospital?
 - In this unit?

- d. Could you tell me about a time that made you feel disappointed with leadership in this hospital?
- In this unit?

Appendix 3: Focus Group Questions: patients

1. Leadership means different things to different people. What does it mean to you as a patient of this hospital?
2. What is your opinion of the way leadership is exercised in this hospital?
3. Patient care means different things to different people. What does it mean to you as a patient of this hospital?
4. Can you think of some incidents that sum up the kind of patient care that staff in this hospital deliver?
5. Can you think of ways that leadership in this hospital could enhance the quality of patient care, as far as you are concerned?
6. Can you think of some incidents that sum up what else leadership could be doing?
7. Can you think of any other incidents that made you feel proud/anxious/angry/disappointed about the quality of patient care/leadership in this hospital?

Appendix 4: Staff Organisational Climate Survey

[attached separately]

Appendix 5: Participant Information Sheet

Leadership and Better patient Care: From Idea to Practice

Participant Information Sheet: Staff Interviews

You are being invited to take part in an interview study about leadership and patient care in three different hospital settings. Before you decide to participate in this study it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Contact me (see full contact information at the end of this sheet) if there is anything that is unclear or if you want to know more.

Take time to decide whether or not you wish to take part.

Thank you for reading this.

1. What is the purpose of the study?

The purpose of this study is to try to identify the circumstances under which leadership can be an effective engine for change in the organisation of health care, especially for patient care and service delivery. Although we suspect that leadership motivates workers and affects the climate or atmosphere of the places where people work, leadership can mean different things to different people. The same is true of patient care which can also mean different things to different people. In order to understand how leadership inspires health workers to provide better patient care, we want to learn how nurses, doctors, other medical professionals as well as managers and patients define and understand leadership and patient care. This includes exploring how their perceptions mesh or conflict with one another. It also includes listening to stories of important incidents that describe their experiences of leadership and patient care.

2. Why have I been chosen?

As part of the study we are interviewing staff (clinical, managerial and others) as well as patients to examine what leadership and

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patient care mean to them. You have been chosen as someone whose views represent the views of staff.

3. Do I have to take part?

No

4. What will happen to me if I do take part?

You will participate in a tape-recorded interview with a qualified researcher, which will last under an hour.

5. What do I have to do?

Arrange a mutually convenient time to have the interview.

6. What are the possible disadvantages and risks of taking part?

It is possible that the discussion may stir up distressing feelings you have regarding your organisation, its leadership and the patient care it provides. However, care will be taken to prevent this and you are free to leave the interview at any time. Apart from that, the only disadvantage is that you will be giving up some of your time.

7. What are the possible benefits of taking part?

This study may not directly help you but it is part of a serious initiative to improve the quality of leadership and patient care provided by the NHS.

8. Will my taking part in this study be kept confidential?

Yes. All data will be stored in locked filing cabinet in a locked office. It will be made anonymous and all names will be edited out of the transcripts. Only members of the research team will have access to the data.

9. What will happen to the results of the research study?

They will be published in a report to the funder and also presented in peer reviewed papers and conferences. A copy of the report will be provided for each participant who requests it.

10. Who is organising and funding the research?

The study is funded by the NHS Service Delivery and Organisation (SDO) Research and Development Programme of the National Institute for Health Research (NIHR) Programmes. The NIHR has been established as a part of the government's strategy Best Research for Best Health to provide the framework that will position, manage and maintain the research, research staff and infrastructure of the NHS in England. The study is conducted by a group of researchers from Royal Holloway University of London led by myself, which won the grant following a competitive bid.

11. What if I have any concerns?

If you have any concerns or other questions about this study or the way it has been carried out you should contact me (details below) or you may contact the hospital complaints department.

Contact for further information

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Appendix 5: Consent form (generic)

Title of Project: Leadership and Better Patient Care: From Idea to Practice

Name of Researchers: Emma Rowland Paula Lökman

Please initial each box

☐ I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

☐ I understand that some coded extracts from the interviews may be used for the purposes of the research report and academic articles.

☐ I give my consent for quotations to be used in the report and research papers on the understanding that I will not be able to be identified by the use of these in any way.

☐ I agree to take part in the above study.

Name of participant

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Date

Signature

Appendix 6: Patient Organisational Climate Survey

Thank you for agreeing to participate in this study which as you will know is part of a larger study on leadership and patient care in the NHS.

The following questions explore how NHS patients feel about the care they received and how things generally worked in the units where their care was managed.

The survey is anonymous, so please do not put your name on the survey.

If, however, you would like to receive the final results of the survey when the study is completed, please fill in the tear-out form on the questionnaire's last page and submit it to the researcher or the collection box.

It is important that you answer all the questions. This should take you approximately 10 minutes.

Your individual responses will be kept strictly confidential.

Researchers

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Please circle one number that best describes how you feel for each question in relation to the service provided by your NURSE.

1. I feel understood by my nurse.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

2. I am able to be open with my nurse at our meetings.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

3. My nurse has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

4. My nurse encourages me to ask questions.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

5. I trust my nurse.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

6. My nurse answers my questions fully and carefully.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

7. My nurse deals very well with my emotions.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

8. I feel that my nurse cares about me as a person.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

9. I don't feel very good about the way my nurse talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

10. My nurse tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

11. The way my nurse interacts with me influences my perception of quality care.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

12. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

Please circle one number that best describes how you feel for each question in relation to the service provided by your DOCTOR.

13. I feel understood by my doctor.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

14. I am able to be open with my doctor at our meetings.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

15. My doctor has made sure I really understand my condition and what I need to do.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

16. My doctor encourages me to ask questions.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

17. I trust my doctor.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

18. My doctor answers my questions fully and carefully.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

19. My doctor deals very well with my emotions.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

20. I feel that my doctor cares about me as a person.

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1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

21. I don't feel very good about the way my doctor talks to me.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

22. My doctor tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7	
strongly				neutral			strongly
disagree							agree

23. The way my doctor interacts with me influences my perception of quality care.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

strongly
disagree

neutral

strongly
agree

24. I feel that I have been provided with appropriate choices in relation to the care that I have received.

1 2 3 4 5 6 7
strongly
disagree

neutral

strongly
agree

25. What would improve the quality of care you receive at this hospital?

26. What services are you using within this hospital?

Demographic Information

27. In which year were you born?

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28. What is your marital or civil partnership status?

- ☐ Single
- ☐ Co-habiting
- ☐ Married
- ☐ Divorced

29. How many children do you have?

30. How would you describe your ethnic background?

31. What is your current salary?

- 1. Less than or around £20,000 per annum
- 2. Between £21,000 and 39,000 per annum
- 3. Between £40,000 and £59,000 per annum
- 4. Between £60,000 and £99,000 per annum
- 5. Above £99,000 per annum

Thank you again for your time. If you have any questions please speak with the researcher or alternatively you can contact Professor Nicolson.

I would like to receive the final results of the survey when the study is completed

Name:

Address:

Contact Telephone:

Please return this form to either the researcher or the collection box.

Appendix 7: Appendices for Chapter Five

[attached separately]

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⁷ There is a parallel ongoing debate as to whether university leaders should be drawn from outside academia.

Addendum:

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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.