



**Institute of Governance
& Public Management
(IGPM)**

**LEADERSHIP
IN HEALTHCARE**

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

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EXECUTIVE SUMMARY

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

The work has **two key objectives**:

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

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

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

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

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

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

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

A FASHION FOR LEADERSHIP?

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

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

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

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

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

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

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

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

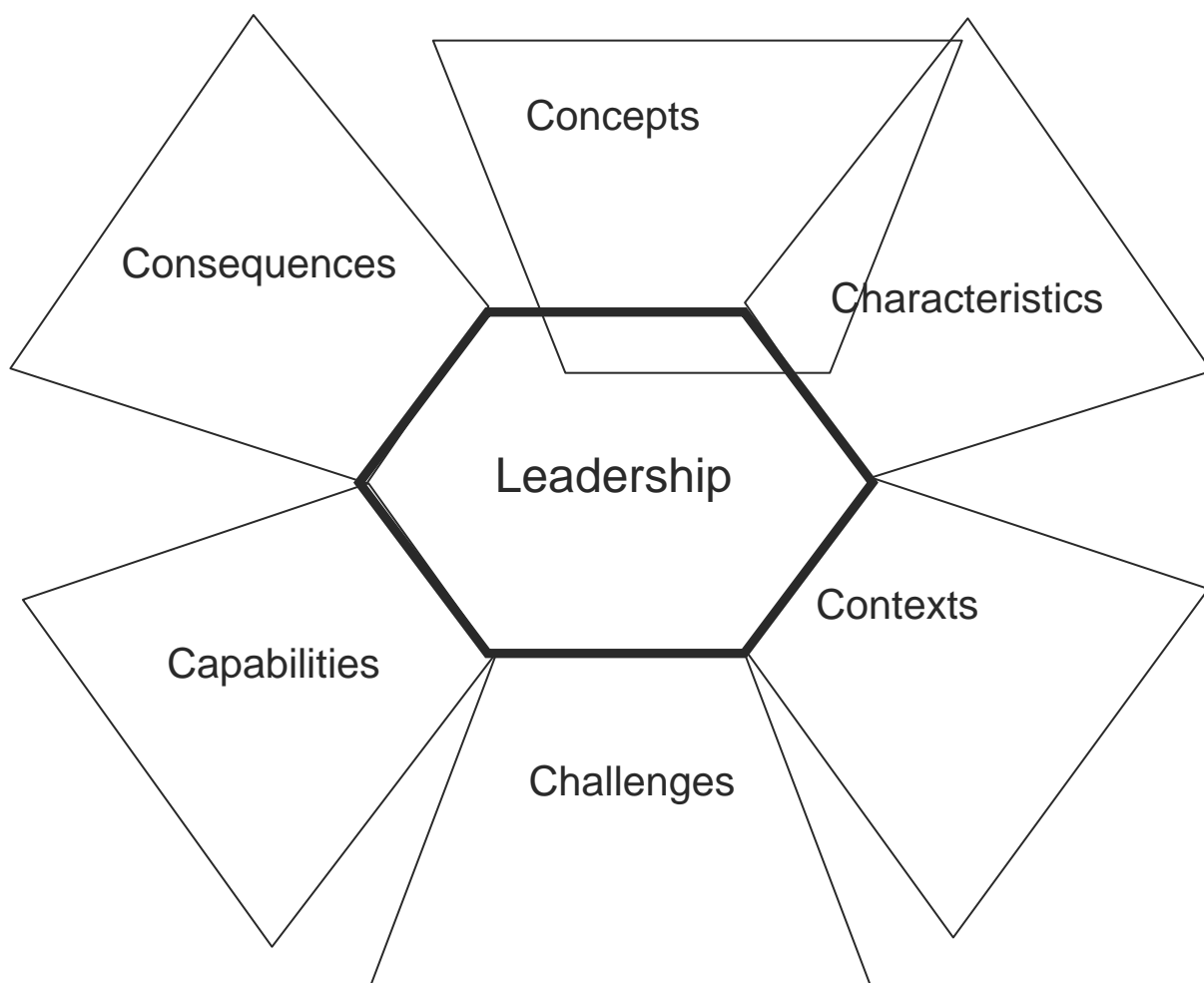
A FRAMEWORK FOR THINKING ABOUT LEADERSHIP

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

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

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

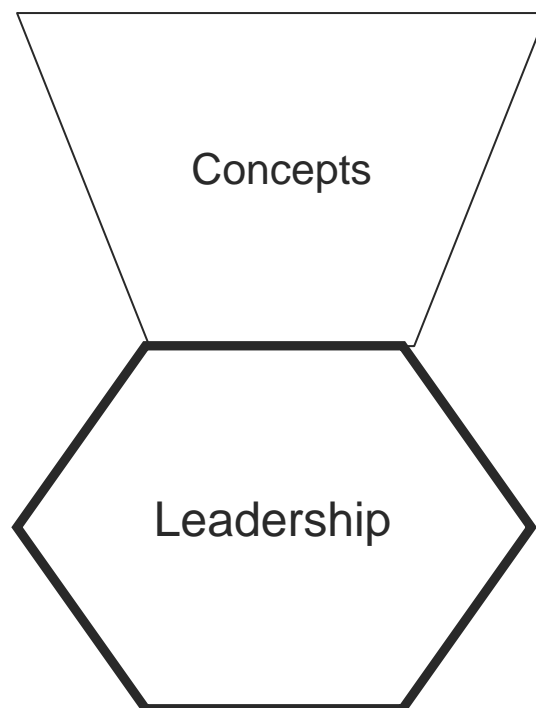
Figure 1: The Warwick road map for thinking about leadership



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

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

THE CONCEPTS OF LEADERSHIP



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

An early definition of leadership is still helpful:

“Leadership may be considered as the process (act) of influencing the activities of an organized group in its efforts towards goal setting and goal achievement”

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

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

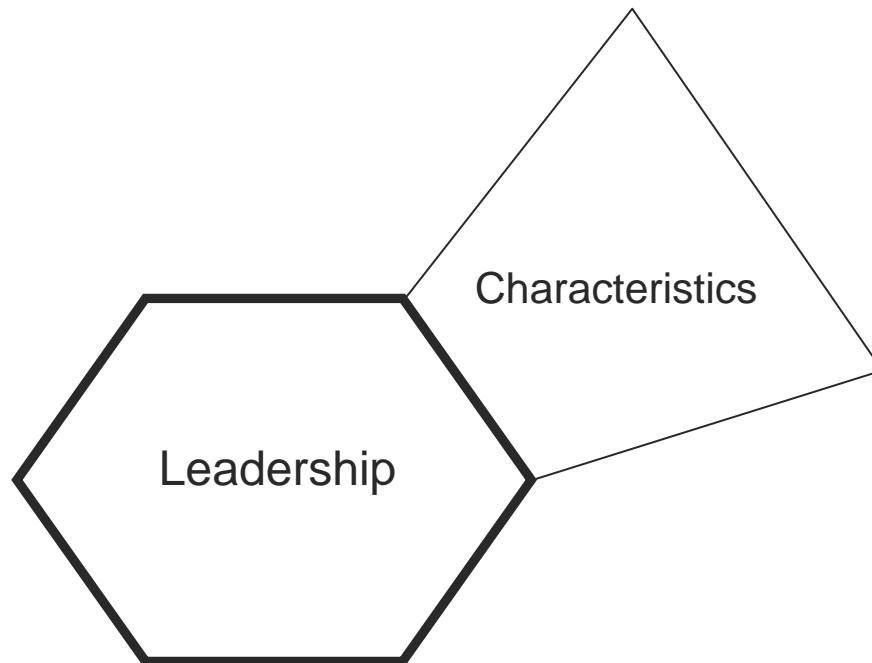
These have also been called the person, position and process approaches to leadership.

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

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

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

CHARACTERISTICS OF LEADERSHIP



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

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

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

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

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

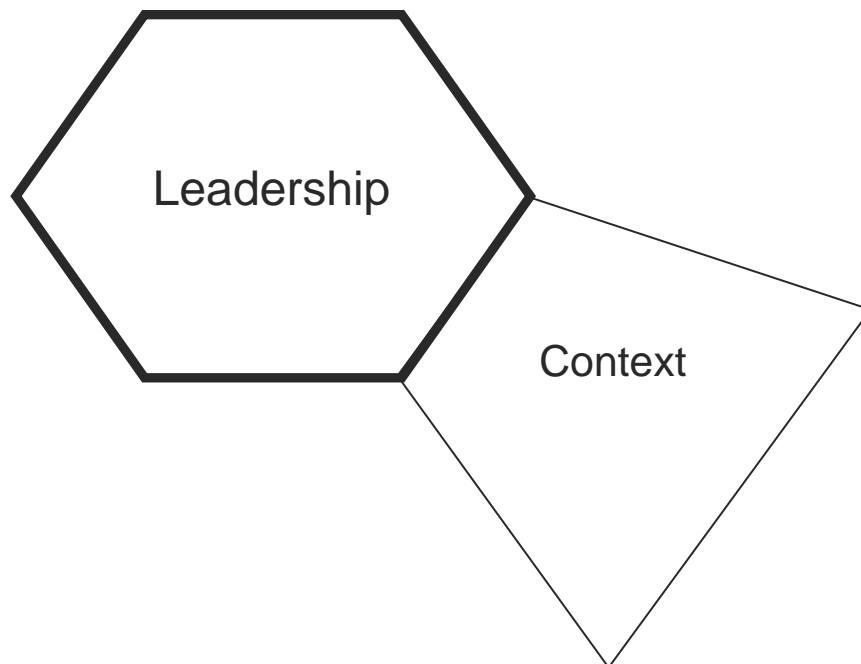
make decisions on behalf of the various stakeholders who elected them (and future generations).

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

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

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

THE CONTEXTS OF LEADERSHIP



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

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

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

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

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

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

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

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

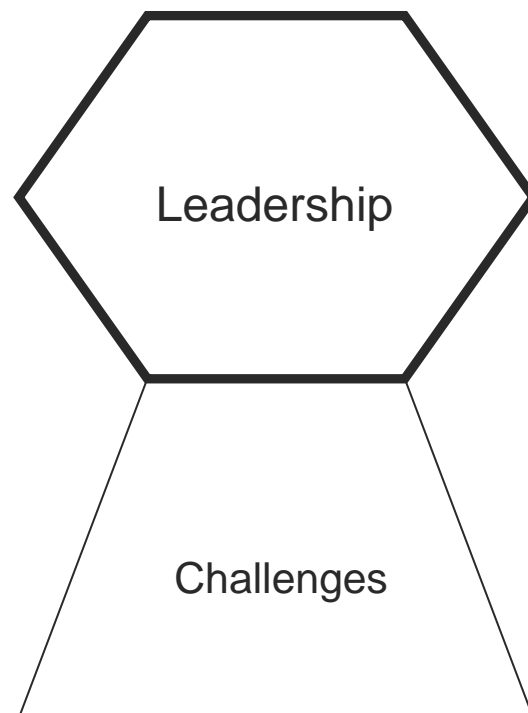
A further layer of context is that of the regional or local health-care system. 'Reading the context' at this layer has two key elements. One is about reading the context of complex inter-relationships at the regional/local level and the second is working out how to lead effectively in this context,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

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

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

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

THE CHALLENGES OF LEADERSHIP



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

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

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

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

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

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

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

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

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

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

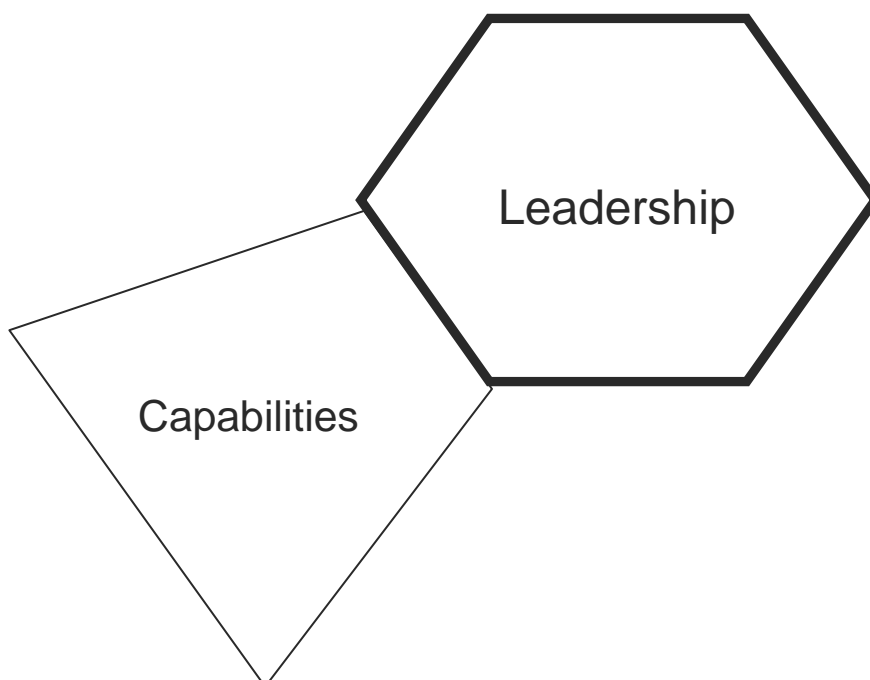
The leadership challenge is to prevent internal rivalry, dislocation from the focal organization and lack of adaptation to environmental needs.

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

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

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

THE CAPABILITIES OF LEADERSHIP



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

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

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

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

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

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

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

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

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

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

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

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

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

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

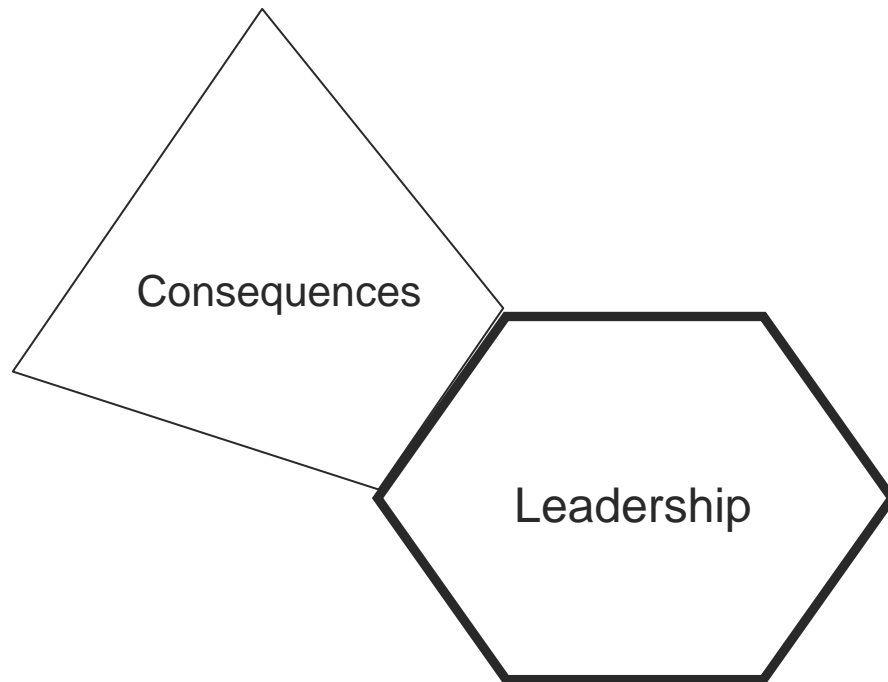
Transformational leadership has been very fashionable, and the view is sometimes heard that transformational leadership is ‘better’ than transactional leadership because it rises above a kind of pragmatic, cost-benefit analysis and exchange (transactional leadership) to engage followers emotionally in

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

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

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

THE CONSEQUENCES OF LEADERSHIP



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

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

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

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

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

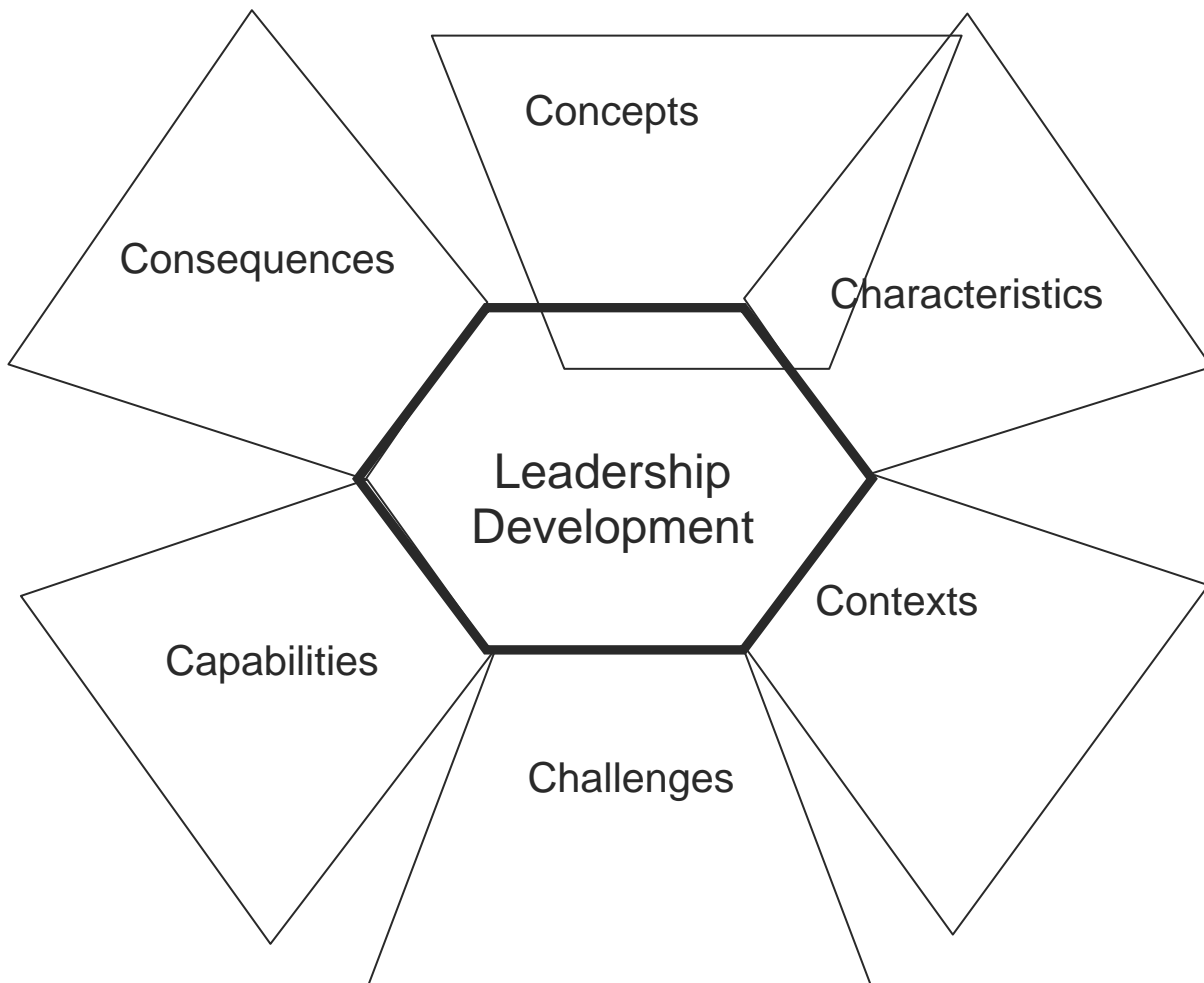
Public value can be conceptualised using the value chain. The attraction of the value chain is that it enables the added value of a public service such as healthcare to be assessed at each stage. A key question is whether and how leadership can contribute to the public value chain. Using the public value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

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

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

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

FROM LEADERSHIP TO LEADERSHIP DEVELOPMENT



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

factors such as performance pressure and expectations). The subjective elements come from the perceptions and mental models which individuals and groups hold about leadership and leadership development.

The contingent nature of leadership (that it is affected and affects the contexts, the challenges, the characteristics and the capabilities) means that leadership development is likely to also be contingent, and this suggests searching for leadership development impacts using a realist perspective based on *what works, for whom, when, in what circumstances and why*¹ rather than seeking universal principles.

CHAPTER 1

INTRODUCING LEADERSHIP

In this chapter:

We set out the aims of the book and explain how it may be useful to practicing leaders and managers in the health service as well as to policy-makers and health researchers.

We explain that this is a review of the burgeoning literature on leadership and is both rigorous and relevant, clear and contemporary, which examines the evidence about the nature and impact of leadership in healthcare.

We question whether leadership is simply a faddish fashion for the health service and conclude that the changing demands on and nature of healthcare in the twenty-first century means that new patterns of leadership are increasingly important, in order to address the new context and challenges of healthcare.

We set out a framework for analysing leadership which provides a “road map” for both thinking and practice. It addresses:

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

Later chapters take each of these aspects of leadership in turn and examine them in detail.

AIMS OF THIS BOOK

This book has been commissioned by the National Institute for Health Research Service Delivery and Organization Programme. The NIHR SDO commissions research and produces research evidence that improve practice in relation to the organisation and delivery of health care. It also aims to build capacity to carry out research amongst those who manage, organise and deliver services and improve their understanding of research literature and how to use research evidence.

The research has been carried out by researchers at the Institute of Governance and Public Management (IGPM), at Warwick Business School, University of Warwick.

The aim is to produce a clear, rigorous and accessible book about leadership in healthcare which is of value to practising leaders and managers in health care as well as to policy-makers and advisors and for health researchers.

The work has **two key objectives**:

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

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

- Reviewed the literature on leadership and leadership development, mainly but not exclusively in healthcare. This included a focused systematic literature review of the academic and policy literature of leadership in healthcare in the last 10 years. It also included relevant reports and papers from the former NHS Leadership Centre and the current NHS Institute of Innovation and Improvement.

- Drew on wider literature about leadership and leadership development where it was felt to have direct relevance to healthcare.
- Tested the draft chapters with academics and practitioners in order to ensure that the book is clear, convincing and has practical applications.
- Ensured that the review is contemporary by contacting key UK and international researchers in the field of leadership and healthcare leadership in order to be able to review papers which were accepted for publication but which are not yet published.

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

This book will be of interest to anyone who exercises leadership in relation to healthcare. This will include those who have a formal leadership position in a healthcare organization (e.g. chief executive, clinical director, doctor, nurse manager) or those whose leadership is through influencing opinions and actions relevant to healthcare (e.g. local government elected members and officers, patient groups). It is directed more to those in formal positions, but also has wider relevance.

At the strategic level this book will be of interest to Board members, clinical directors, finance directors, senior managers and human resource (HR) professionals - and health scrutiny members and officers in local government.

At the operational level, the book will be of interest to health professionals, such as doctors, nurses, pharmacists, and other professions, in leading and influencing health care and improvements in healthcare.

The framework and the research evidence will also be of interest to policy-makers and policy advisors, and to health researchers, particularly those concerned with service delivery and organization, with leadership and the evaluation of leadership development.

This book aims to explore the degree to which there is an evidence base for ideas and practices about leadership and to apply rigorous thinking to how such ideas can be applied. “Evidence-based” medicine has gained considerable ground over recent years, and there is a growing interest in evidence-based management as well². Of course, being located in social science not medical science means that the evidence base for leadership will always be more ambiguous and open to varied interpretations than medical science. However, having a clear sense of which leadership ideas and practices are rooted in theory and evidence, and which are more speculative, can be very helpful for healthcare leaders surrounded by conflicting advice, or being urged to behave in particular ways because it is fashionable. Having a clear “road map” of the terrain of leadership will help to avoid at least some of the pitfalls, fallacies and fantasies about leadership.

How you can use this book:

- Read the summary at the head of each chapter to get an overview of the main themes to be covered in the chapter.
- Read the main text to explore key arguments and evidence about leadership and its relevance for healthcare
- Turn to the endnotes for more detailed evidence to follow up particular ideas if you wish. The endnotes are numbered in the text itself, so you can follow up in more detail by turning to the end of the book for more information.
- Consider the implications for policy and practice at the end of each chapter
- Researchers can also think about the implications for further research at the end of each chapter.
- Each chapter also gives three or four suggested books or articles to read if you want to follow up the themes of the chapter in more detail.
- At the end of the book is the full list of all references used, in alphabetical order.

Thus, the book can be used at different levels:

- Read the main text to gain insight into key themes and ideas for policy and practice
- Access the evidence base for those who wish to follow up detailed points.

The methodology of the literature review, and the sources of papers analysed are given in detail in Appendix 1. The methodology was systematic and extensive. It ensured that key papers about leadership in healthcare were examined and used where relevant, and that contemporary articles were accessed through contacting leadership researchers. More than 150 papers or books were examined.

A FASHION FOR LEADERSHIP?

Leadership is currently quite a trendy topic.³ This is true across the private, public and voluntary sectors, with new books and articles being published by the day. The interest in leadership is very evident in the public sector. There has been a series of policy-papers asserting the importance of leadership in public service improvement, stemming from the influential Performance and Innovation Unit report of the Cabinet Office in 2001⁴. In the last decade, a number of dedicated leadership centres have been set up for particular public service sectors including central government, local government, schools and police amongst others.

Health is no exception to this interest, where leadership is seen as central to improving the quality of health care and the improvement of organizational processes. The NHS Plan⁵, produced in 2000, argued for more attention to be paid to leadership and the development of leaders and this is one of the functions of the NHS Institute for Innovation and Improvement. More recently and very prominently, the Darzi report (*High Quality Care for All*)⁶ places considerable emphasis on healthcare leadership, especially but not exclusively by clinicians as the NHS tackles new challenges to improve health quality and care. From the opposite end of the argument, some of

the high profile media cases of lapses in professional care have, in part, been attributed to leadership problems, as in the Bristol Royal Infirmary case, and the Victoria Climbié case.⁷

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

- There are new challenges in healthcare - the kinds of illnesses are changing. For example, the major post-war curable diseases, such as measles and diphtheria are largely conquered but instead chronic and multiple diseases associated with a larger elderly population, and chronic diseases due to lifestyle choices (such as obesity and smoking) are becoming more important⁸. How can leadership be used to anticipate rather than just react to changes in demographic and disease profiles?
- There are new health goals. Partly due to the changing nature of illness but also to address longer-term pressures on budgets, “predict and prevent” become more important goals alongside “treatment”. Health not just sickness is of concern. Healthcare in the community not just in hospitals and clinics is important. Public health may be moving to the centre of health policy - and working with partner organizations becomes increasingly important⁹. How can leadership be deployed to shape these new goals, and to ensure that there is a close link between ideas and practice on the front-line and between different partners?
- The expectations of patients, carers and communities are shifting, with more widespread knowledge about health available via the internet, less deference for professional authority, and higher expectations of personalised and flexible care. What are the implications for healthcare organizations and their staff and how can

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

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

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

A FRAMEWORK FOR THINKING ABOUT LEADERSHIP

“Leadership research has a narrow focus, and there has been little integration of findings from different approaches.” (Yukl)¹⁰. , 2006, p.445).

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

leadership. Indeed, the illustrations of leadership qualities and behaviours are often derived from heroic personalities – arctic explorers, political leaders in war or crisis, business leaders turning around major companies on the brink of bankruptcy. Such heroic approaches may be particularly appealing to healthcare leaders, where the heroic consultant or doctor, (and their sibling the heroic manager) have been admired for their qualities of leadership as individuals. In such narratives (and they are often stories), the focus is generally on the leader as an individual.

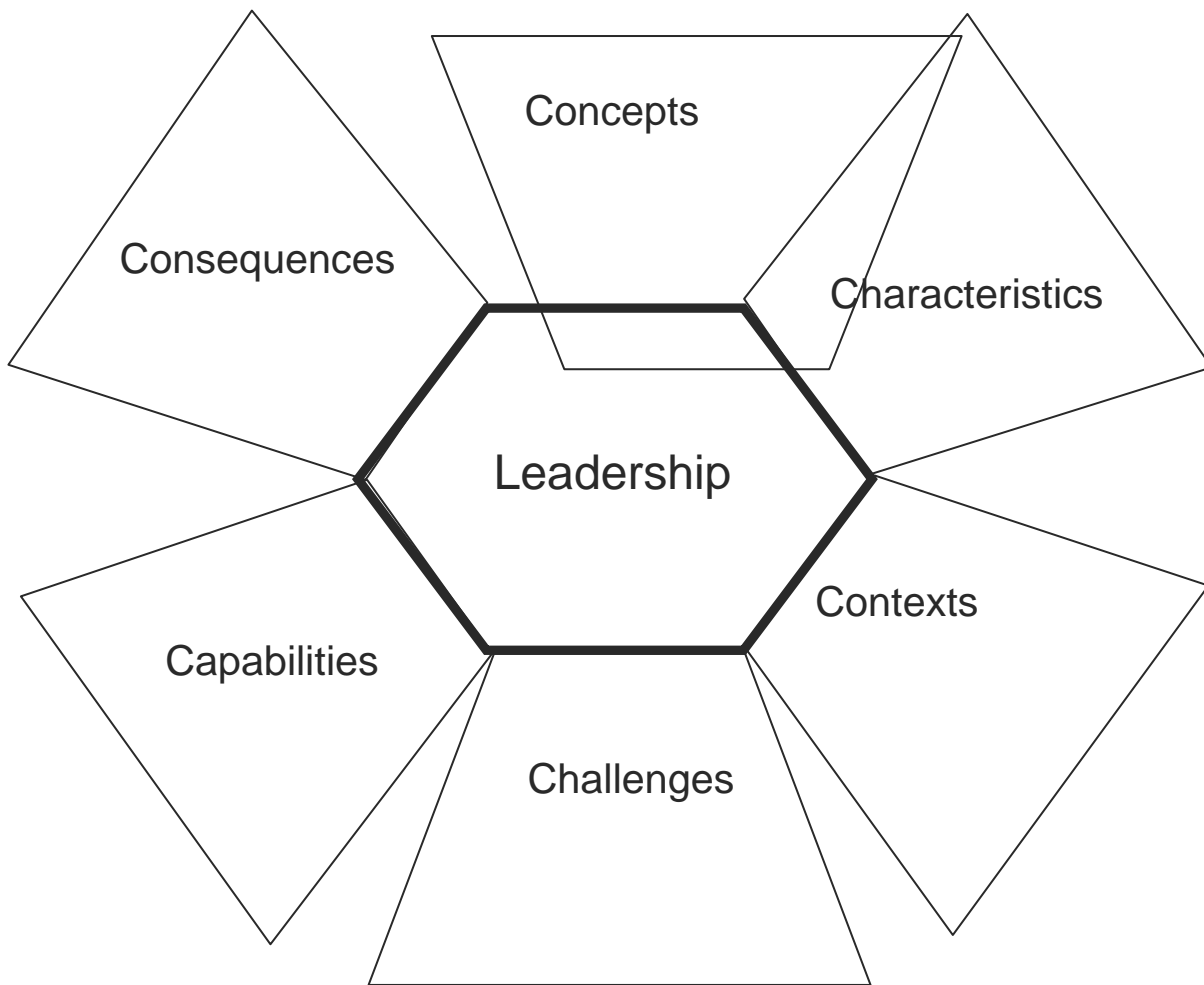
The individualistic focus of much leadership writing means that there are relatively few frameworks for taking a more holistic or system-wide view of leadership. Such frameworks are few and far between, but they are very important if leaders and potential leaders are to take an overview of the field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

Storey¹¹ presents a leadership framework based on an interlocking set of factors: the impact of context on leadership, the perceived need for leadership, behavioural requirements and leadership development methods (this last is actually about how to improve leadership rather than being about leadership itself). His framework also includes a consideration of outcomes in terms of unit performance, and evaluations by a range of stakeholders. This is one attempt to create an overarching framework.

Yukl¹² presents an ‘integrating conceptual framework’ but it is based on predicting the behaviour of the individual leader from their traits and power resources and those of ‘followers’. There is little sense of an organizational context to understanding leadership.

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

Figure 1: The Warwick road map for thinking about leadership



First, this book examines the different **concepts** which are used to define and explain leadership, noting that the definition of leadership influences the ways in which leadership behaviours, processes and outcomes are viewed. The different approaches to leadership taken by different authors have an impact on the questions and the use of evidence about leadership.

Second, themes and questions about **context** are identified, because the context (e.g. political and economic context, policy context, organizational context) both places constraints on action and is also a source of action for leaders.¹³ In particular, healthcare raises critical questions about the importance of the political, economic, policy and institutional context, which has perhaps been underplayed in many analyses of leadership¹⁴, and raises questions as to how far the sectoral/industry, institutional or organizational context has been sufficiently examined in accounts of leadership more generally. In addition, there is more work to be done to understand how leaders 'read' context and scan, interpret and articulate the wider environment for the group, organization or network. Context is critical to understanding the processes and consequences of leadership.

Third, the **characteristics** of leadership are examined, with questions about how far informal and formal leadership roles and processes are similar or different; and whether 'near' and 'distant' leadership¹⁵ are distinctive. The characteristics of leadership are also shaped by the organizational and inter-organizational conditions which may support, enhance or limit leadership. How far do particular organizational forms, systems and processes have an impact on leadership activities and outcomes? In addition, how far is leadership of inter-organizational networks similar to, or different from, the leadership of discrete organizations?

Fourth, and crucially, the **challenges** of leadership concern the principal purposes, goals or aims which leaders and leadership attempt to address. It can be argued that the task of leadership is central to understanding leadership effectiveness though not all leadership studies address this question of purpose. The interest in 'new leadership'¹⁶ brought back to the fore an interest in leadership as providing 'vision' yet the purposes of leadership often go beyond vision into the goals, values and aims of leadership. How are purposes formulated, articulated and debated? The complex context of healthcare makes this a particularly fertile site for the exploration of purposes and the contestation of purposes by different stakeholders. In particular, for public services such as healthcare, there is also the question of assessing whether or not the leadership purposes contribute to, or detract from, the creation of the wider public good, or public value.¹⁷

Fifth, the literature review examines **capabilities**, sometimes called competencies, examining the varied frameworks which have been developed to consider the qualities of the leader in terms of skills and abilities.

Sixth, the review examines the **consequences** of leadership, rigorously questioning the extent to which the claims of a link between leadership and performance is justified, and also examining the literature about the attributional processes of leadership, where causal links may be reversed in people's everyday explanations of leadership and performance.

Each of these issues will be explored further in the following chapters.

Policy and practice implications:

- Understanding leadership is an increasingly important task for healthcare policy-makers and managers as the goals and context of healthcare in the UK become more complex
- Leadership is a very fashionable topic in the public sector, so there are grounds for some scepticism. But leadership is not just a passing fad, and it is worth considering whether and how it can contribute to healthcare improvement.
- Much leadership literature focuses on heroic individuals but there is a need to go beyond that to consider a wider range of influences on leadership as part of a complex system, including characteristics, contexts, challenges, capabilities and consequences.
- Using the Warwick framework (Figure 1) will help to analyse leadership in a more rounded way, increasing the opportunity to be effective in healthcare settings.

Research implications

- Too much literature is anecdotal and based on fantasies about heroes rather than critical and evidence-based analysis. Researchers need to be aware of evidence base for assertions about leadership.
- Researchers should put more emphasis on developing and testing clear conceptual frameworks and models for leadership.
- The healthcare sector provides fertile ground for research into leadership because of the changes in the context and the complexity of the goals of healthcare.

Want to know more? Further reading

For general introductions to leadership ideas, try the following:

Grint, K. (2005). *Leadership: Limits and possibilities* London: Palgrave.

Storey, J. (2003). *Leadership in organizations: Current issues and key trends*.
London, Routledge.

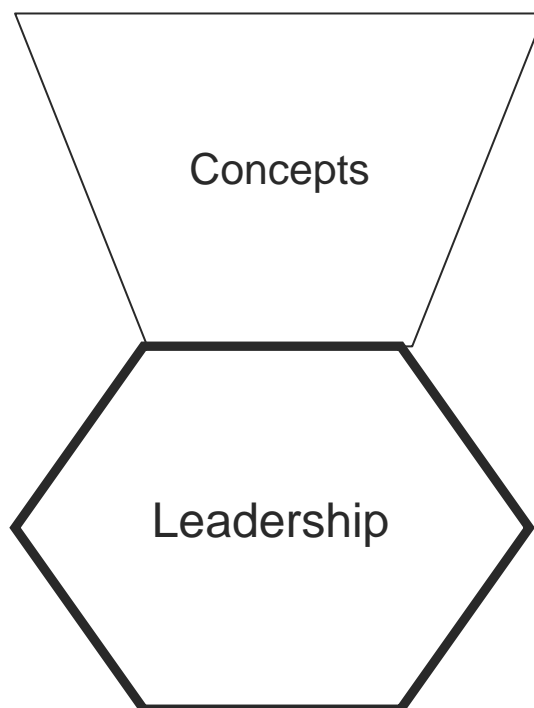
Yukl G (2006). *Leadership in organizations (6th edition)*. Upper Saddle River
NJ: Pearson Prentice Hall.

CHAPTER 2

THE CONCEPTS OF LEADERSHIP

In this chapter:

We note that there are many and varied ideas about what leadership is and how it can be defined. First, we examine whether and in what ways leadership is different from management. Then, the chapter examines some of the key approaches to defining leadership, focusing particularly on the person, the position, the process, and the performance as different ways to conceptualise leadership. It is valuable to be aware of these different concepts of leadership in reading, and talking with others about leadership. Each emphasise different facets of leadership and may be incomplete on their own.



This chapter examines the first segment of the framework given in Chapter 1. Here we examine the concepts of leadership. Why use the plural (concepts) rather than the singular (concept)? There are very many definitions of leadership and in everyday speech and in academic writing there are myriad ways in which the term is used. Grint¹⁸ argues that the term is 'multi-faceted'. Many writers avoid the complexity entirely and fail to indicate what they mean by leadership!

Unless there is awareness of the different ways in which the word leadership is used, there are likely to be grounds for confusion because people will mean different things, or will emphasise different aspects or elements.

What do we mean by leadership?

An early definition of leadership is still helpful:

*"Leadership may be considered as the process (act) of influencing the activities of an organized group in its efforts towards goal setting and goal achievement".*¹⁹

This has a number of elements – it views leadership as a process (of influencing) occurring within a group (so it is not just about individual leaders, there is a need to think about social dynamics as well) and concerned with purposes (goal setting and/or goal achievement). This suggests that the work that the group aims to do together is central to the definition, and that leadership is about influencing others, in other words it is relational. This definition is not based on a person but on a process (influence).

Other definitions emphasise, to a greater or lesser degree, these features.

For example:

*"the process of inducing others to take action towards a common goal"*²⁰

*"mobilising people to tackle tough problems"*²¹

*"the ability of an individual to influence, motivate and enable others to contribute to the effectiveness and success of the organization"*²²

*“leadership is realized in the process whereby one or more individuals succeed in attempting to frame and define the reality of others”*²³

*“leadership is exercised when persons... mobilise...institutional, political, psychological and other resources so as to arouse, engage and satisfy the motives of followers”*²⁴

These definitions vary substantially – whether the focus is on influence broadly, or on defining the reality of others; whether the definition focuses on the purpose or goal, or whether it focuses on the social dynamics; whether the focus is the group, the organization or the social system; whether the intention is to satisfy followers or to engage them in difficult problem-solving (tough problems).

In the health field, Goodwin argues for a definition of leadership based on a systems-wide view:

“Leadership is a dynamic process of pursuing a vision for change in which the leader is supported by two main groups: followers within the leader’s own organization, and influential players and other organizations in the leader’s wider, external environment”.²⁵

Leadership or management?

It’s not so long since policy papers and academics were arguing that ‘management’ was the answer to improving organizations, so why is there now a focus on leadership?

There are varied views about whether ‘management’ and ‘leadership’ are different or basically the same, as activities within organizations. For example, Kotter²⁶ argues that organizations need both leadership and management but that they are different: leadership is concerned with setting a direction for change, developing a vision for the future, while management consists of implementing those goals through planning, budgeting, staffing and so on²⁷. Kotter comments that most organizations are over-managed and under-led.²⁸ The table below gives some commonly understood

(though perhaps slightly caricatured) views of leaders versus managers, and it is worth considering this because many people use these distinctions (though others, as we shall see, do not):

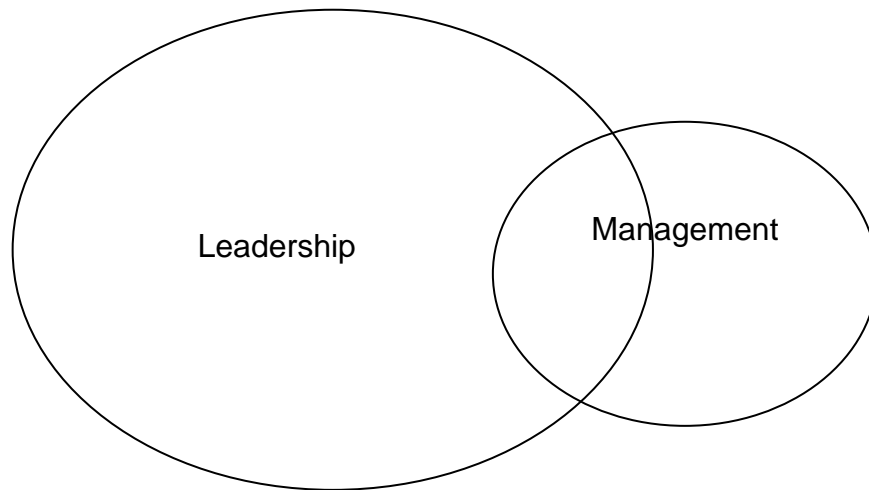
<i>Managers</i>	<i>Leaders</i>
Are transactional	Are transformative
Seek to operate and maintain current systems	Seek to challenge and change systems
Accept given objectives and meanings	Create new visions and meanings
Control and monitor	Empower
Trade on exchange relationships	Seek to inspire and transcend
Have a short-term focus	Have a long-term focus
Focus on detail and procedure	Focus on the strategic big picture

Source: Storey²⁹

However, there is an alternative view which is also strongly held. Many studies of leadership have been based on managers in any case so clearly some managers can be assumed to be leaders (though being a manager does not per se make one a leader). Mintzberg³⁰ described leadership as a key managerial role. Yukl argues that defining leadership and management as distinct roles, processes or relationships may obscure more than it reveals: “*Most scholars seem to agree that success as a manager or an administrator in modern organizations necessarily involves leading*”.³¹

So managers are potentially leaders but they are not the only ones. Leadership is broader than management because it involves influence processes with a range of people, not just those who are in an authority relationship. It involves change but also can involve the routine; the transactional as well as the transformative.

The overlap, for many writers, between leadership and management is illustrated in Figure 2 below.



In addition, the debate about the relationship between management and leadership may be in part be driven by the disciplinary interest of management theory, and the dominance of business schools in research and writing about leadership. Leadership analyses from different perspectives would pay as much attention to a variety of types of leadership in and around organizations. It is notable that the literature from healthcare specifically pays attention to medical leadership, clinical leadership, nurse leadership as well as to managerial leadership³².

Anyone who influences others can be seen as a leader and therefore leadership is not just the top managers or consultants in a hospital or surgery or Primary Care Trust. Nurses, occupational therapists, ward sisters and many others may at particular times and in particular contexts work in ways which show leadership. Clinical leadership and professional leadership are as important as managerial leadership in healthcare settings.

Leadership is multi-faceted. Understanding leadership requires an understanding of the relationship between the behaviours of individuals in leadership positions and those they seek to influence.

Perspectives on the concept of leadership

In this chapter we use a three-fold typology of conceptual approaches to leadership to reflect the relative emphases placed on:

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

Hartley and Allison have conceptualised leadership as; ‘person, position and process’.³³

These conceptual approaches are shown in Table 1 below.

Table 1: Conceptual perspectives on leadership

Conceptual approach	Definitions/models	Features
Personal qualities of the leader	Defined in terms of personality and behaviours of individual leaders	Individual behaviours and attitudes Personality traits Learned skills and capabilities Concerned with standards of personal effectiveness
Organisational positions	Defined in terms of formal organisational leadership roles, position, authority and/or professional status eg line management, expertise, reflected in both hierarchical and distributed or dispersed forms of leadership	Status and/or profession Organisational and personal authority Often associated with seniority and/or supervisory Linked to organisational effectiveness
Leadership as social interaction	Defined in terms of social interaction with ‘followers’ with an emphasis on	Relational Influencing/motivational skills

	communication, empathy for others, empowerment and coaching of others.	Effects on followers
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Personal qualities of the leader

Research on the person as leader, including personal characteristics of leaders abounds³⁴. Early work tried to find the personality types or personality characteristics (traits) which were associated with leadership, but this work largely foundered through lack of evidence. Personality, by and large, is not associated with leadership and this suggests that leaders are not born but are largely made (and developed).

The literature more recently has focused on the skills and abilities of leaders, and here there is a large literature which examines the behaviours, the skills and abilities of leadership, which will be examined further in a later chapter (on the capabilities of leadership).

Other work has considered the idea that individual leaders may vary their style according to the task and/or the context³⁵, gender differences³⁶ and the behaviours³⁷ of individual leaders. Bennis and Thomas for example, suggest that leaders are people with particular qualities or traits who are shaped by the formative experience of leadership.³⁸

The role of individuals with their personal qualities in shaping events and circumstances at certain times is clear. The disadvantage of such approaches is that they can lionise particular individuals and assume that they have pre-eminent capacity and power, which ignores “followers” and organizational and community constraints, and places too much emphasis on personal development at the expense of leadership development as collective capacity. In fact, Bryman³⁹ argues that effective leadership by individuals is an interaction of the individual with their context. Sinclair⁴⁰ argues that the lack of women in senior leadership positions is better explained by how society defines leadership than the qualities of women as leaders. Despite the limitations of taking a solely person-based perspective, however, Alimo-

Metcalfe and Lawler note that a number of organizations are still taking a “strong leader” approach to their leadership development, with this focus on the individual and his/her personality.⁴¹

Leadership as organisational position

Leadership can also be conceptualised in terms of organizational position. This is particularly relevant for complex healthcare systems where there are different types and sizes of organizational structures and cultures, including clinical teams, small clinical practices, multi-agency organizations, independent specialist providers and large hospitals.

As Hartley and Hinksman⁴² suggest, position within an organization is one key indicator of leadership. A formal position within an organization, such as chief executive or team leader or consultant, brings with it the authority and legitimacy to lead others. In terms of social relationships, those in formal positions of authority are most likely to be regarded by staff as being in a leadership role as a result of the power and influence connected to the role they exercise in the working environment.

In healthcare organizations, leadership is reinforced by the status or prestige of the formal role within the formal hierarchy. For example, the chief executive, director or chair of the board is accorded prestige because of their senior position, and as a consequence of this position has the opportunity to exert greater influence than someone further down the pecking order.

However, leadership is not solely about position, because there are many examples of ineffective leadership within particular roles – as well as many examples of leadership taking place outside or beyond the formal role.

However, leadership is not only found at the top of the organization or in senior roles in teams. Writers have noted and commented on distributed or dispersed leadership in a variety of organizations including in health and in schools⁴³. For example, a team leader may operate with influence contributions from a range of people in the team. Indeed discussion and

debate about the efficacy of leadership in healthcare organizations is often concerned with questions about the site and practice of leadership across professional and managerial boundaries, both formal and informal, within single organisations and across organizational boundaries. We will explore this further in the following chapter – here we note particularly the idea (concept) of leadership being based in organizational position, role or power.

The extent to which, for example, chief executives are authoritative as leaders as well as managers is complicated both by their relationships with politicians who set the policy context and clinicians on whose professional expertise healthcare delivery relies. The capacity for both these groups within and outside the organization to affect the leadership of senior managers is significant. Nonetheless, the expectations on chief executives to achieve organizational change, improvement and innovation are high, reinforcing the view that relying on status or position as the authority base for leadership is insufficient. Indeed, charismatic ‘celebrity bosses’ who do achieve transformation by virtue of their position have been described as ‘dangerous leaders’ who may achieve much in the short term but leave their organisations destabilized.⁴⁴

Leadership as a social process

Leadership research in general has emphasised the importance of influence (it occurred in many of the definitions above) and so this requires thinking about leadership as a relationship between those trying to influence and those being influenced. Influence may occur at the team or group level, at the organizational level or at societal level.

Influence may involve authority and/or formal power or it may involve mobilising and engaging others, for example through vision, passion or the articulation of goals. As this view of leadership is about processes, we have to consider the relationships between ‘leaders’ and ‘followers’ – or processes of mutual influence as well.

Much of the work on leadership in healthcare has focused on leadership as a social process with the accent on how people in leadership positions transform organizations through influencing other people.

Bass and Avolio's work on transformational leadership has probably been the most influential⁴⁵, emphasizing the relational aspects of leadership skills as:

- Idealized influence (acting as a role model)
- Inspirational motivation (arousing team spirit)
- Intellectual stimulation (challenging assumptions)
- Individualized consideration (coaching and mentoring)

Acknowledging leadership as a social process suggests that effective leaders need to engage the hearts and minds of colleagues, staff and stakeholders to achieve leadership goals. This means taking care of relationships both internally and externally. Ferlie and Pettigrew have underlined the importance of external relationships as well as internal relationships in a network-based approach to leadership which is increasingly important in healthcare.⁴⁶ As an example of this, Goodwin helpfully summarises the network of external relationships for a trust chief executive, showing the need to establish relationships including with NHS providers, GPs, the private sector, local government, voluntary organizations, consumer groups, community groups, trade unions, local MPs, and the media.⁴⁷

The social interaction of leadership is also at the heart of another conceptual approaches: adaptive leadership⁴⁸, which will be explored further in the chapter on leadership challenges.

Studies of clinical leadership now recognize the importance of relationship management⁴⁹ and the need for emotional intelligence and coaching skills to achieve this⁵⁰ (we will return to these issues later). Paying attention to the inter-relational aspects of leadership is also reflected in the notion of 'communicative', 'democratic' or 'shared' leadership which highlights the importance of discussion and deliberation as a means of organizational development to empower staff.⁵¹ In their case study of nurse leaders in New

Zealand, Kan and Parry for example, acknowledge leadership as a social process arguing that it contributes through a better understanding of the group dynamics between nurse leaders, nurses and other professional groups, and highlighting the importance of networking, coalition building and persuasion.⁵² Similarly McDonagh points up the importance of the governing board as a site for deliberative processes which provide organizational leadership.⁵³

As we have indicated earlier, leadership is multi-faceted and can be conceptualized in a number of ways, with emphasis on the individual, on the social relationships of influence or on authority exercised within an organizational or inter-organizational setting.

Policy and practice implications

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

- The concept of leadership also shapes how leadership development is viewed. A focus on the individual will mean particular emphasis on selecting and developing individuals. A focus on organizational position may mean that only particular positions in the organization are given certain types of training and development in leadership skills. A focus on social processes will mean some development emphasis on working in groups and teams.
- 'Talent spotting' for people with leadership potential e.g. fast track trainees, clinical staff shifting into managerial roles and so on will be affected by the concept of leadership used.
- Confusion about leadership in discussions can be avoided by paying attention to how people understand and use the term leadership.

Research implications

- Too many studies fail to define what they mean by leadership. Creating an evidence base about leadership will be helped by clarity about how the researcher is using the term.
- Each of the perspectives has some merit and studies may need to consider how to combine them in studying leadership effectiveness
- The varied concepts of leadership have different implications for methodologies (e.g. focus on personal qualities will look at individuals, whereas a focus on social processes will need to look at relationships).
- Some studies have assumed that managers are leaders but this is not necessarily true. There is a need to be clear about the basis on which research informants are considered to be leaders.

Want to know more? Further reading

Western S (2008) *Leadership: A critical text* London: Sage.

Burke R and Cooper C L (2006) *Inspiring leaders*. London: Routledge.

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Storey, J. (2004). *Leadership in organizations: Current issues and key trends*. London, Routledge.

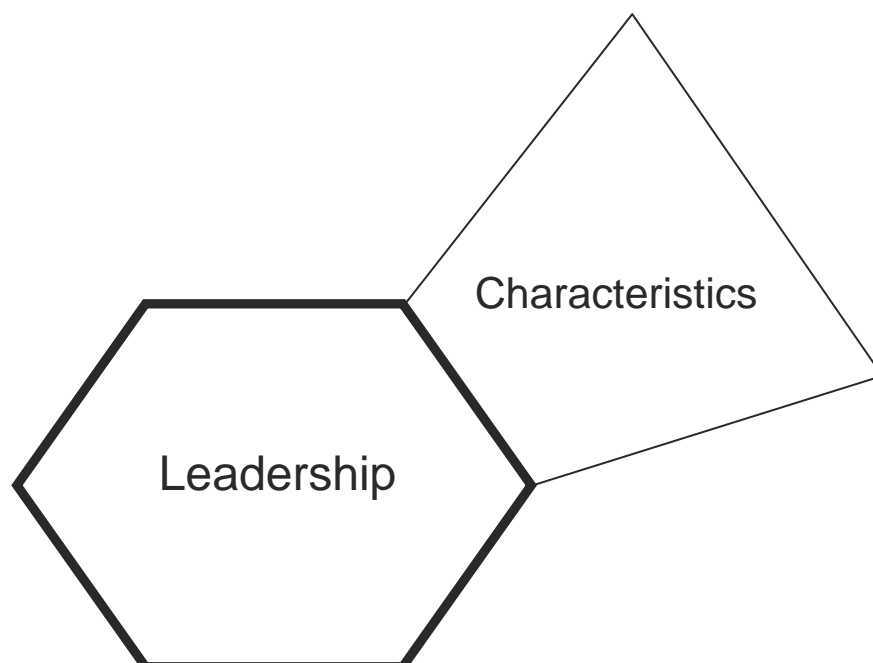
CHAPTER 3

CHARACTERISTICS OF LEADERSHIP

In this chapter:

Who are the key leaders in health? We examine those aspects of leadership which provide the sources of influence. This is about exploring the roles and resources of different types of leadership. It includes examining the different organizational and network roles, and also the sources of influence and power available to different types of leader. The chapter makes distinctions between formal and informal leadership, arguing that they each have particular sources of power and influence, as well as advantages and disadvantages as ways to influence others. The chapter then examines clinical and non-clinical leadership, and political and managerial leadership on the same basis, before looking at direct (local) and indirect (distant) leadership. The chapter also examines the sources of power and influence.

In examining the characteristics of leadership, we turn to the next segment in the leadership framework:



Who are the leaders in healthcare?

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

Formal and informal leadership

The work of the American former psychiatrist and now public management academic, Heifetz⁵⁴ is useful in first of all drawing the distinction between formal and informal leadership. Heifetz argues that the basis of authority provides different opportunities and constraints on exercising leadership.

Heifetz makes a crucial distinction between leadership *with* authority and leadership *without* authority. He argues that leadership research has made insufficient distinction between these, yet they affect the basis of leadership and the strategies of leading which are open to the person or group.

"I define authority as conferred power to perform a service. This definition will be useful to the practitioner of leadership as a reminder of two facts: First, authority is given and can be taken away. Second, authority is conferred as part of an exchange. Failure to meet the terms of the exchange means the risk of losing one's authority: it can be taken back or given to another who promises to fulfill the bargain." (p.57)

This can also be called positional power (power which derives from a position of authority). The conferring of power, in the quote above, emphasises that formal authority is given by other people, whether this occurs through election or appointment. Formal authority is an important form of leadership in healthcare (for example, the scope of authority implied in a job description, or the authority which is accepted and indeed expected from those in senior positions, whether clinical or managerial).

*“In our organizations and our politics, we look generally to our authorities for direction, protection and order.”*⁵⁵ There is a relationship between those in authority and those who accept (or resist or resent) authority. Authority is important in the analysis of leadership because the personal qualities of the individual is not the whole story, leadership may be a combination of personal qualities, authority, and the relationship(s) with the people who are being led or influenced.

Leadership without authority, or informal leadership, has a different base and therefore set of activities associated with it. These are individuals and groups who lead societies, communities, groups or particular issues (either inside or outside the organization) and influence others without formal authorisation. For example, a campaigning group or an expert whose views people take regard of even though that person is not in a formal position of authority.

A leader acting without authority may be less constrained by the roles and rules, and by the expectations of others (i.e. those who confer the authority) but there are also risks. Informal leaders, says Heifetz have two benefits. First, they have more latitude for creative deviance, for example they can dramatise for effect, or they can focus on a single issue, or they can press for action without having to look at the larger picture or balance competing priorities. They can campaign on issues with energy. Second, they may have close contact with the detailed experiences of some of the stakeholders and therefore have crucial information about the front-line in a way which can be much harder for those in authority positions to gain. For example, think of a health campaigner, compared with a chief executive to get a sense of the

different roles they have and the sources of influence that they use and have access to.

On the other hand, the strategies of informal leaders may be *“both more bold and more subtle”*. They can spark debate but can find it harder to orchestrate debate between stakeholders; they have depth of experience on the front-line but may be less aware of other aspects of the problem; they may get attacked for their views but have fewer resources to deflect the heat; and they have to think hard about where to direct their challenge to established authority because it is all too easy to challenge the authority figure rather than mobilise others to get things done.

There are all kinds of informal leaders in healthcare, whether these are influential clinicians, whose views are highly regarded, or front-line staff who are particularly persuasive or good at shaping the work of others. There are informal leaders outside the formal health structures, such as patient groups advocating particular types or levels of care, or journalists whose articles shape public opinion. In different ways, each of these can be considered to be informal leaders in healthcare in that they shape perceptions of and commitment to goals and outcomes in health, whether locally or nationally.

Some research has pointed to the importance of a particular category of informal leaders within healthcare, called opinion leaders. For example, Locock and others⁵⁶ evaluated the literature on programmes to implement evidence-based practice and found a strong role for opinion leaders. They emerged informally and their influence was based less on their formal role and more on their international research reputation, their commanding respect from others, and for their understanding of the realities of clinical practice. Locock et al found two types of opinion leader – those who were experts in their field, and those who were well regarded by their peers. They also found that these informal roles served different purposes at different stages of the implementation of evidence-based practice. At the early stage, the expert can have more influence, but in the implementation stage the peer has more influence.

Strong opinion leaders may lead in resisting change being proposed by others. Øvretveit (2005), in a review of the healthcare literature on leading quality and safety improvements, found that identifying and influencing the opinion leaders amongst doctors⁵⁷ was an important means of influencing improvements in healthcare quality and safety.

Direct and indirect leadership

A number of writers make a distinction between direct (also called near leadership or local leadership) and indirect leadership⁵⁸, (also called distant)⁵⁹. Direct leadership is face-to-face leadership, which often occurs at the front-line. This is where others in the team or group are used to seeing the leader daily or regularly in face-to-face working. Direct leaders are likely to be able to get to know those they work with and influence them on an interpersonal basis. They are likely to know all the members of the group that they are leading. They are able to develop members of their group on a one-on-one basis and they are close enough to see quite quickly when things are going well or badly. They have an important role in empowering staff⁶⁰. Yukl⁶¹ notes that most theories of leadership are based on the assumption that leaders are able to directly influence those they work with (because the majority of studies have been conducted on managers and their subordinates). In the context of healthcare, one can think of direct leadership as being embodied in the ward sister, or the consultant who is head of an operating team, or the leader of a cancer collaborative.

By contrast, indirect leadership is exercised, for example by chief executives, where the leader has an influence on others through the chain of command in the organization but where the relationship is too distant to be based on actual interaction. In other words, influence is indirect and takes place through, for example, through mass communication (e.g. newsletters, videos, large meetings) and through policies and procedures. It is not possible for indirect leaders to influence the group or organization through direct relationships and so part of their approach as leaders may be to try to create and communicate the overall goals, the values and the behaviours which are expected from

organizational members. This is one of the reasons why indirect leaders are concerned to shape the organizational climate and to communicate a compelling vision. Effective leaders are also aware of the value of symbolic acts in communicating culture or values⁶². When a chief executive spends time ‘on the shop-floor’ or working for a short period alongside front-line staff, then they both get a stronger sense of the front-line and also communicate symbolically the importance of a user focus.

Some indirect leaders may not work inside the organization at all, perhaps working in central government, on strategies and policies about healthcare. Policy-makers such as Ministers (e.g. the Secretary of State for Health) or policy advisors in the Department of Health aim to be significant healthcare leaders, though they will meet only a fraction of those whose work they are trying to influence.

The two types of leadership are not mutually exclusive. For example, a hospital chief executive will be a direct leader in relation to his/her own management team, but will be an indirect leader for the hospital staff overall, some of whom may rarely or never see this leader, though their work may well be shaped by their actions.

The distinction between direct and indirect leadership is valuable for considering how influence processes take place and the scale and scope of leadership. What works in a face-to-face daily situation may not work at all in a situation of indirect leadership (and vice versa).

Clinical and non-clinical leadership

Clinical leadership (whether by doctors, nurses or other medical professions) has both a different purpose or task (‘challenge’ in the language of this book) and a different influence base compared with non-clinical leadership. It has been suggested that the focus of clinical leadership is “*about facilitating evidence-based practice and improved patient outcomes through local care*”.⁶³ On the other hand, as occurs other organizations with high levels of professional staff, tribalism and empire-building and self-protection is also

sometimes evident. The influence base for clinical leadership has two sources. It is partly collective (the power and influence which comes through professional associations such as Royal Colleges, or the Royal Societies of each profession). The power base is also partly in of individual clinical expertise⁶⁴. Some research has also found that the relative power of doctors compared to managers is reinforced by the longer tenure in post of clinicians compared with NHS managers, which leaves the latter at a disadvantage in terms of the understanding of the organizational history, culture and practices and therefore sources of influence⁶⁵.

We found relatively little in the literature review about clinical leadership by doctors⁶⁶, with the exception of a recent review of the literature on this topic, which found that doctors play key leadership roles although there is potential for a greater degree of leadership involvement, that these roles and that dispersed and collective leadership amongst doctors is important. The review also noted a continuing influence of informal leaders and networks operating alongside formal structures⁶⁷. There is more about nurse leadership. Leadership by doctors would benefit from further research. The need to understand clinical leadership across a variety of health professions is given added impetus by the Darzi report⁶⁸, which sets out the importance of clinical leadership for the UK health service, and which sees the contribution of clinical leadership to clinical practice, to working in partnership (in health teams and with partners outside the health service such as social care) and to taking management posts to lead the organization in research, education and service delivery.

Political and organizational leadership

Health care across the world attracts considerable attention from national and local elected politicians⁶⁹, and the NHS is hotly contested amongst the public as well. Political leadership is relevant to healthcare particularly where politicians (e.g. the Secretary of State for Health) set policy and financial resource allocations for the health care organizations, and comment on the successes and failures of healthcare. They may become involved in controversial decisions by health organizations, for example over mergers or

closures of hospitals, or over drugs policy or patient safety policy. In addition, politicians are involved at the local level through the scrutiny of local policies and practices, for example, the Health Overview and Scrutiny body of the local authority in the area of a hospital or PCT)⁷⁰. The scope for discretion at local level by clinicians and managers is constrained, in the UK, by the political leadership exercised both in Parliament and through the Department of Health. Political leadership differs from organizational leadership because the basis for authority is different as politicians are elected not appointed and they have a responsibility to make decisions on behalf of the various stakeholders who elected them (and future generations)⁷¹. The basis of power for politicians lies in their support from the electorate and from their colleagues in their political party (or coalition), whether at local or national level. As a consequence they have to address complex goals which are sometimes in tension⁷². Governance roles, such as Board leadership, have to interact with the political world, and therefore political awareness, in terms of understanding the institutions and processes of government and the needs of diverse stakeholders can be important.⁷³.

Individual and shared/distributed leadership

"In academic medicine, we tend to think of leadership as being about a person in charge who wields power and stands apart. The word 'leader' may bring to mind vivid images: the gifted surgeon who pioneers a new procedure; the brilliant researcher who advances our understanding of a disease.....By and large, our view of leadership tends to centre around visible individuals and their talents, contributions and achievements. This view of leadership is not wrong, but it is no longer adequate." (Souba)⁷⁴

Some leadership roles are based on individuals and their contribution, often because they are in a role of formal authority or have to exercise leadership through the organizational hierarchy. However, it is recognised that it is increasingly difficult for a single person to accomplish the work of leadership, because of the pace and volatility of change in the external environment of organizations, (whether in the private or public sectors). So leaders have to

understand, lead, shape, manage and react to change with higher levels of uncertainty and risk than in the past. Knowledge needs to be shared across teams and across organizations in order to achieve quality outcomes. And if new ways of working are to be implemented effectively, then some leadership tasks may need to be shared. For example, in Primary Care Trusts, the collaborative leadership roles and relationships between the trust chair, chief executive and PEC chair/clinical lead is increasingly important. Other examples include cancer collaboratives, the productive ward, inter-organizational partnership working, which all require some degree of shared leadership. Shared leadership is particularly relevant to working in partnerships inside and outside the organization⁷⁵.

It has been noted that shared leadership is more complicated and time-consuming than vertical leadership⁷⁶ and for these reasons it is most effectively deployed where the tasks are:

- Highly interdependent
- Highly complex
- Require creativity⁷⁷

We can note that these are the conditions that Heifetz⁷⁸ describes as representing an adaptive challenge not a technical challenge (see chapter XX), and therefore this is where adaptive leadership comes into play, which involves engaging others in recognising that they have a role to play in solving the problem.

In some situations, there may be both vertical leadership (through lines of authority) combined with shared leadership, as for example, in teams which have an acknowledged head or formal leader in terms of accountability and responsibility but where a number of members in the team may contribute to the work of leadership.

In situations of organizational ambiguity and major change, then there may be a 'leadership constellation' whereby the leadership role informally passes

between different individuals and groups, with differing bases of expertise and legitimacy at different times⁷⁹. This may happen in complex change situations, for example in mergers or other major change.

A slightly different strand of the shared leadership approach is that of 'distributed leadership'. This signals a shift from heroic individual leaders towards collective or distributed leadership⁸⁰. It is part of the approach of seeing leadership as 'leading others to lead themselves'⁸¹. This approach is found in some empirical research studies⁸², though shared leadership is perhaps more talked about than researched. It is captured in the notion of transformational leadership which, among other things, argues that leadership includes strengthening the capacity of others to be empowered and to lead themselves. It has been argued that the greatest leadership challenge for leaders is to enable others to act and to build leadership capacity in the organization⁸³.

The notion of distributed leadership brings us close to considering leadership as a quality of the whole organization, network or system.

Dispersed or distributed leadership is based on the idea that leadership can be practiced at different levels of an organization and is not just the preserve of senior executives. Dispersed leadership challenges the traditional power structure of organizations where the assumption has been that leaders are superior to their followers⁸⁴. When leadership skills and responsibilities are decentralized there is a new focus on sharing knowledge and power as well as dispersing leadership. Distributed leadership presents a new way of thinking about the role of formal leadership at the top of the organization, acknowledging that the role of senior leaders is sometimes less to lead from the front than to enable others to lead. In so doing, the dependence (or sometimes over-dependence) of followers on formal leadership figures decreases and the whole group may become more empowered.⁸⁵

In healthcare organizations, particularly when innovation and change for improvement is required, dispersed leadership by change agents throughout

the organization may be particularly valuable. Denis et al⁸⁶ demonstrate this in their work in Canadian hospitals at a time of strategic change, Neath⁸⁷ reports on the significance of devolved leadership to strategic health authorities in their study of the National Booking Programme from 1998 to 2003. Williams⁸⁸ reports the importance of recognising the multi-layered nature of leadership throughout the organization in implementing change through information technology. Dopson, Fitzgerald and Gabbay⁸⁹ have also highlighted the role of 'opinion leaders' at all levels of the organization in blocking or encouraging healthcare reform, suggesting that their impact will be affected by their profile (for example as professional expert) and location within the organization.

Leading clinical teams can be described as a form of distributed organizational leadership, since it requires facilitation of processes of care delivery which includes the need to manage a range of relationships between professionals, managers and service users, particularly when working in a multi-disciplinary or multi-agency context.⁹⁰ Such forms of dispersed leadership rely on the professional and personal authority of leaders not just their location in the hierarchy of the organization. Studies of nurse leaders also reinforce the importance of organizations recognizing and supporting informal as well as formal leadership roles. It has been suggested that those in dispersed medical or nurse leadership roles will need to be recognized and supported as transformational leaders in order to effect sustainable organizational change and improvement⁹¹. Others acknowledge that there is an interplay between dispersed leadership and location in the hierarchy and that clinical staff leaders have unequal access to sources of power⁹².

Roles and sources of influence in organizational and network settings

This review of the various characteristics of leadership indicates the range of roles and the range of resources (authority, expertise, near or distant influence and so on) which have an impact on the ways in which leadership is exercised in organizational and societal settings. Each may shape the goals, the processes and the outcomes of healthcare, and there may be tensions between different leadership roles.

However, most of the leadership literature does not make clear what aspects of leadership are the focus of the work. For example, in a research study or in a piece of reflective writing, is the focus on near or distant leadership? Is it concerned with leadership based on formal authority or on informal leadership? (Most research has taken place within organizational settings and has not considered the distinction, leading to a confusion between leadership and formal authority). It is important to clarify what is the basis of the leadership which is being exercised, because the basis of influence and the behaviours which are possible, the types of relationships which can be established will vary according to the basis of leadership.

Leadership varies in its scope (near or distant), in its role (formal or informal authority, political or organizational; clinical or non-clinical) and in the types of influence which can be used depending both on the basis of authority (for example, expertise, election, appointment, reputation).

If leadership is an influence process with a group or groups of people, then leadership is not only about the behaviours of the leader but about the willingness or ability of others to accept or resist influence attempts. Yukl⁹³ summarised the research evidence⁹⁴ on different types of power used in influence attempts and distinguished between position power (derived from the person's position in the organization) and personal power (derived from attributes of the person and their relationship with those being influenced). This summary is shown in Table XX below.

Table XX: Different types of power

<i>Position power</i>	<i>Personal power</i>
<ul style="list-style-type: none"> • Legitimate power (formal authority) • Reward power (power to provide rewards) • Coercive power (power to provide 	<ul style="list-style-type: none"> • Referent power (desire of others to please the leader due to strong feelings of affection, admiration or loyalty, charisma is one type of referent power) • Expert power (task-relevant

<p>punishments or sanctions)</p> <ul style="list-style-type: none"> • Information power (access to and control over information) • Ecological power (control over the physical environment, technology, organization of work and organizational culture) 	<p>knowledge and skill)</p>
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Source: Adapted from Yukl

Power is not a ‘thing’ but a relationship. In common language we talk about some-one ‘having power’ but in fact they have power to the extent that this is accepted by others who are being influenced. For example, legitimate power (formal authority) is more of a source of influence for those who are loyal to the organization and who agree with the organizational goals and values, or who have internalised values about accepting authority. Expert power operates where others recognise the person as having expertise and does not derive from qualifications alone. Thus, power is a social process which depends on the qualities of both the leader and the people being influenced

Positional power and personal power interact in complex ways and it is sometimes hard to distinguish between them in any particular situation. The analysis of sources of power helps to tease out some of the different types of influence which derive from different roles and relationships. They help to explain why direct and indirect leadership may operate differently, or why clinical leadership has different characteristics from non-clinical leadership. It is possible to use this table to analyse the sources of influence for many different types of leader.

Policy and practice implications

- Too much mainstream writing on leadership has assumed a uniformity of leadership – as though it is simply a universal process of influencing others and that there is ‘one best approach’ to leadership. But this consideration of characteristics shows that the role and the resources (e.g. authority, information, reputation, resources, expertise) can vary

enormously. This explains why there are different types of leaders in and around healthcare organizations. It also explains why leadership cannot be considered solely from an individualistic perspective.

- This analysis also shows that leadership does not occur solely at the top of the organization (for example, in the Board or in the senior teams).
- Some leaders hold formal authority and are enabled to act with the legitimacy of the organization. But it is worth remembering that authority is conferred and accepted by others, so authority has to be used in ways which meet the needs of those who have conferred the authority.
- Informal leadership occurs in and around healthcare. Opinion leaders inside the organization and campaigning groups outside the organization are likely to be influential leaders but without formal authority. In thinking about leadership, it is worth taking account of who are the informal as well as the formal leaders who can have an impact on health outcomes.
- Clinical leadership is an increasingly important element of healthcare, where such leaders may be sources of influence directly as practitioners influencing others in their teams or departments, or else may be contributing to the wider management of the healthcare organization. The sources of clinical leadership lie in expertise but effective leadership also involves being able to see the wider strategic view about health care delivery and organization.
- Politicians are sometimes seen as an encumbrance to the efficient operations of healthcare, but this view does not take into account their different authority base, sources of legitimacy and goals to be achieved on behalf of the wider population, either locally or nationally.
- Leadership approaches will depend on whether the leader is a direct or an indirect leader. Much of the literature ignores this distinction but the sources of influence can be quite different. Indirect leadership requires influence through symbolic acts and through shaping the organizational goals, policies and practices.

- Shared, distributed or dispersed leadership is increasingly common and is particularly valuable for tasks which are complex, knowledge-intensive and where the outcomes are uncertain. Shared leadership requires a different set of skills from vertical leadership.
- Shared leadership will become particularly important to understand as community enterprise organizations are encouraged to provide healthcare.
- There are varied sources of power in leadership. The distinction between positional power (power derived from a formal position of authority) and power derived from personal qualities and/or the quality of relationships is useful in analysing the sources of influence to which both formal and informal leaders may use.
- There is not going to be 'one best way' to be a leader – the opportunities to influence will partly depend on the power resources available from the organization and from the individual.

Research implications

- Too much research discusses “leaders” but does not analyse their characteristics. Research needs to be clear about the roles and resources of leaders
- There is scope for more research which examines differences (and similarities) in the leadership behaviours and processes according to different leadership characteristics. For example, there is little detailed empirical research about clinical leaders across a range of professions (to the extent that it exists, most research is based on nurse leadership).
- As the policy context favours a greater engagement from clinicians in the running of healthcare organizations, there may be scope for researching the impact of clinicians as directors and chief executives. Are they different in their leadership and management from those who have come up through the management route?

- There is a need for more research on the impact of direct and indirect leadership on influence processes, on the quality of health care and on patient outcomes.
- Shared leadership deserves more research given that healthcare is increasingly being provided in complex teams, and in internal and external partnerships and networks.

Want to know more? Further reading

Yukl G (2006). *Leadership in organizations (6th edition)*. Upper Saddle River NJ: Pearson Prentice Hall. Chapter 6.

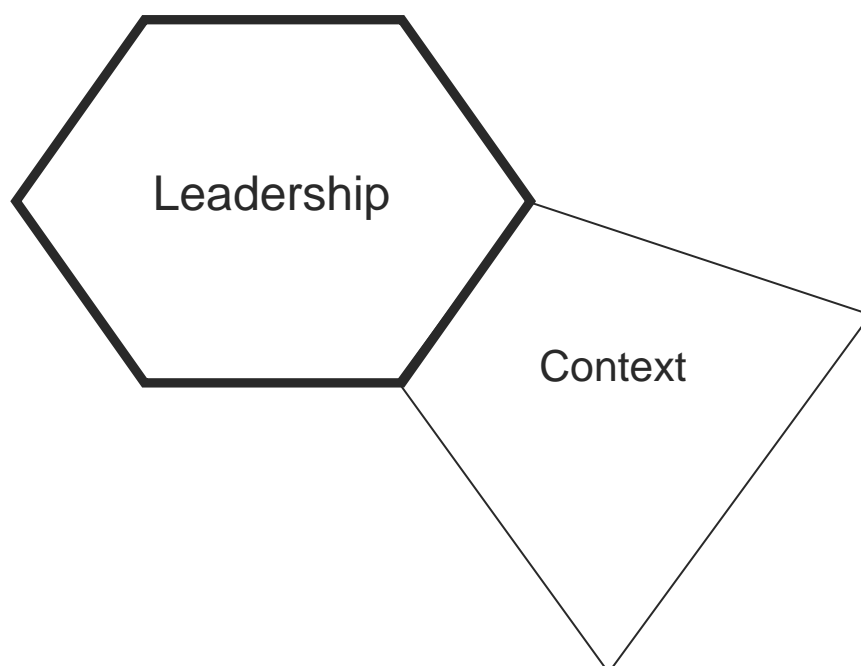
Heifetz, R. (1994). *Leadership without easy answers* Cambridge, MA, Belknap Press. Chapters 3 and 8.

CHAPTER 4

THE CONTEXTS OF LEADERSHIP

In this chapter:

What is 'context' and why is it important for leadership? We examine the interactions between context and leadership, in terms of three layers of context. The chapter looks at context in terms of three layers. First, the chapter addresses the public policy context of healthcare. Second, it looks at the local strategic context, including working in partnerships. Finally, the internal, organizational context is explored. Context is relevant for leaders in several ways. It provides the constraints on and opportunities for action and so a key skill for leaders is being able to 'read' the context. They also may shape the context (as far as possible) and also articulate and make sense of the context for others.



An important strand of thinking in leadership studies is the relationship between what leaders do and the context in which they do it. First, how does leadership vary according to the different circumstances or context? Second, how do leaders shape the context at any given time?

It is generally agreed that leadership is related to, or contingent on, context and that a key prerequisite of effective leadership is the need to understand the context in which it is being exercised. Theorists have looked at this from a number of perspectives, exploring both the influence of contextual factors on leadership and the influence of leadership in shaping context. However, there is much less work than might be expected on this crucial set of interactions between leadership and context. Porter and McLaughlin⁹⁵ review the theoretical and empirical knowledge about the organizational context and leadership (across all types of organization) and conclude that while leadership context is much discussed in fact there is much less research which takes this into account as an analytical factor, rather than part of the description of the location of a particular sample. They argue for much more rigorous and systematic attention to understanding the impact of context on leadership and vice versa. Grint⁹⁶ classifies theories about leadership according to the degree to which they pay attention to, or ignore, context, as an aspect of leadership.

Goodwin⁹⁷, writing about healthcare, observes that research has tended to focus on understanding leadership as a key determinant in shaping context rather than within a perspective which views organizational, economic, social and political contextual factors as factors which shape leadership. We commence with the impact of context on leadership and then turn to examine how leadership can shape or even construct the context.

Early work, in the 1970s, was influential in understanding how leadership varied by context, and the extent to which leadership was effectiveness by matching leadership style to context.⁹⁸ Different leadership styles are more effective depending upon the level of 'situational control', suggesting that a leader with a 'task-orientation' can be most effective in circumstances of

extremely high or low situational control while a leader with a 'people-orientation' would be most effective in circumstances of moderate situational control. In other words, the leader should modify their style according to how much control they had over the situation they are in.

This suggests that one key leadership skill is the ability to read different situations and respond appropriately⁹⁹. Situational analysis by the leader or leadership team/group is a key component in ensuring that the leadership strategy and style is in appropriate alignment to the context. (This includes the nature of the leadership challenge, or purpose, which is covered in the following chapter). Alignment might be achieved in two ways. One is by selecting particular leaders for particular contexts (in the challenges chapter we will examine how different leadership styles are useful in early compared with late stage of merger in healthcare). The second way is to encourage a leader to learn to be versatile, i.e. to adapt their style to the particular context.¹⁰⁰ Different situations will demand different leadership approaches and a leader who can adapt to changing contextual factors is more likely to be regarded as competent (and therefore effective) than one who has a rigid approach.¹⁰¹

In spite of legislative and organizational constraints for public service leaders, there is an interpretive space within which leadership capabilities come into play, interacting with context¹⁰². Reading context includes being able to take an overview of the external and internal conditions and opportunities, and also to be able to move between 'the balcony and the battlefield'¹⁰³, in other words to be able to link the small detail to the big picture. Skill lies in being able to sense the 'soft' points in the political, organizational or partnership culture where the leader's priorities can be taken forward without provoking stubborn opposition.

Any reading of contingent or situational leadership presents difficulties, since it acknowledges that leadership is carried out in an immense variety of dynamic situations with numerous contextual variables to take into account. In helping us to understand and explain effective leadership, theories of leadership

which suggest leadership is contingent on context are therefore only helpful up to a point. Yukl (2006) for example, suggests that '*...contingency theories do not provide sufficient guidance in the form of general principles to help managers recognize the underlying leadership requirements and choices in the myriad of fragmented activities and problems confronting them*'.¹⁰⁴

Grint goes a step further in the interaction between leadership and context to argue that effective leaders not only shape the softer elements of context but also work to constitute the context¹⁰⁵. This, 'constitutive' approach argues that leaders have a key role in making sense of the context for those they are trying to influence. So, how they define a situation and frame it for others is a key element of leadership¹⁰⁶. We will explore 'sense-making' as a crucial leadership challenge in more detail in the following chapter. Its relationship to the context is important.

Turning to the healthcare literature specifically, we found little which had been written on the impact of context on leadership¹⁰⁷. Reviews of the relationship between context and leadership hardly touched on the healthcare field¹⁰⁸. However, the idea that the interaction of leaders with their organizational and external context is a critical element in achieving leadership for change and improvement is increasingly recognised.

Layers of context

We suggest that leadership in healthcare can be thought of as being situated within three 'layers of context'. Of course, the boundaries between the layers are blurred and aspects of context may be evident at more than one layer. We outline this mapping of context in Table XX below.

Table XX: Layers of context in healthcare

<i>Context</i>	<i>Focus</i>
National political and public policy context	External political and policy environment
Strategic context	Intermediate NHS 'system' at the level of the regional/local health economy
Organizational context	Internal organizational structure, culture, history, size, geography and resources

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

Many writers on change management have argued that environmental or contextual volatility is a key factor to be understood and taken into account in leading successful organizations, acknowledging that the structures and practices appropriate in stable conditions are not suitable in more unpredictable times¹⁰⁹.

Within the UK NHS, whole systems thinking is helpful to understanding how these layers of context are part of an open system of complex networks rather than linear cause and effect relationships. In 'Organisational Change' Iles and Sutherland¹¹⁰ (2001) highlight the key points of understanding a system as:

- Made up of related and interdependent parts so that any open system must be viewed as a whole.
- Not considered in isolation from its environment
- In equilibrium which will only change if some type of energy is applied

- Comprising different players who will have different views of the system function and purpose
- In human activity systems, objectives are frequently multiple and often conflicting

It is helpful to take a wide systems view of the context of healthcare, with its myriad of influences on any particular healthcare organization and thus on the leadership in and of that organization.

The public policy context

National healthcare systems can be said to be 'context heavy'. They are necessarily affected by political, economic and social factors from the wider society, and in the introduction to this book we outlined some of the pressures of health change, public expectations and so on. The public policy environment tries to articulate those pressures and opportunities into priorities for healthcare. The public policy context has an impact on the national healthcare system and the leadership exercised within it. For example, increased consumer expectations alongside medical technological advances and an ageing population have put increasing pressure on scarce resources for healthcare. A growing acknowledgement of the importance of addressing public health issues through preventative care rather than continually expanding a health service which cures the sick is prompting new ways of thinking about healthcare provision and this is discussed in a range of White Papers, plans and reports. In the UK, political imperatives to meet increased demand and achieve value for money led to the a number of initiatives concerned with fostering innovation and improvement in healthcare to improve quality, safety, speed and efficiency in the provision of services. The role of central government in driving change through legislation, statutory guidance, financial control and performance measurement is thus a dominant contextual factor.

In England, the NHS Plan, created in 2000¹¹¹, set the framework for modernizing the NHS over a 10 year period and this has been followed up

with the Darzi review and report¹¹². These provide an ambitious and comprehensive national strategy with a vision for a healthcare designed around the needs of patients and with increased local responsibility and accountability for meeting nationally-set quality and performance standards. The leadership challenge is explicitly to transform in order to improve and to create step-change through innovation.

In this context of change and improvement, leaders in healthcare have to operate within a system in almost constant flux, including:

- The creation of independent Foundation Trust hospitals with public governors elected from the hospital membership.
- The drive to increase capacity within healthcare services through the voluntary sector, independent service providers and community enterprises
- Reconfiguration of primary care trusts resulting in a small number of PCTs generally aligned to local authority boundaries
- The introduction of local commissioning of services by PCT and GPs
- The introduction of increased patient choice of services e.g. the 'Choose and book' appointments system
- A stringent regime of changing national performance targets
- Greater local accountability to councillors of the local authority through new health overview and scrutiny committees

All of these factors result in a significantly changed and complex context for leadership. Understanding where and how leadership operates within such a complex context is an important prerequisite for success. In his study of NHS chief executives, Blackler (2006) records the pressures that health organization chief executives were subject to as *'conduits for the policies of the centre'* rather than being given scope to help lead the reform of the NHS.¹¹³ He starkly reports NHS chief executives *'having to function in an increasingly rigid hierarchy in which there was a lot of fear'*, suggesting that they *'needed to ignore uncertainties, were being forced to impose centrally determined priorities on their staff and were being held personally responsible*

for performance outcomes.’¹¹⁴ His conclusion that *‘the popular image of empowered, proactive leaders has little relevance to the work of the NHS chief executive’* underlines the central role of the state in shaping the context in which chief executives exercise leadership.

The Next Stage Review¹¹⁵ acknowledges the problems which have been engendered in earlier stages of recent changes in the NHS system, and aims to address this, in part by strengthening clinical and non-clinical leadership.

Goodwin (2000) acknowledges the impact of the wider political environment on leaders in the NHS, pointing out the importance of external relationships and inter-organisational networking to help balance local priorities against the *‘backcloth of national, government determined aims for public services’*¹¹⁶ and suggesting that future leaders, *‘... will have to be dependent not only upon establishing a successful partnership with politicians and professionals but also achieving greater inter-organisational collaboration by transcending traditional organizational boundaries ...’*¹¹⁷

These national policies and their local impacts have included an increased focus on the role of leadership to achieve sustainable and substantial change, and hence leadership development is an important issue across all levels and professions. This is a significant contextual framework for leadership in healthcare.

The strategic context - leadership for system redesign and development

A further layer of context is that of the regional or local health-care system. ‘Reading the context’ at this layer has two key elements. One is about reading the context of complex inter-relationships at the regional/local level and the second is working out how to lead effectively in this context, which currently uses partnership working as a major means of leading and managing in that context.

Inter-organisational collaboration is a key factor in the strategic context of an NHS system of healthcare. Public policy has resulted in almost continuous

system change in recent years with the introduction of different forms of organizational governance, merged organizations and an increased emphasis on inter-disciplinary and inter-organisational service delivery. Systems thinking is helpful in understanding how leaders interpret and respond to this strategic context of a network of organizations interrelating, collaborating and competing to provide healthcare. There is increasing awareness of and interest in how a systems approach is having an impact on the NHS and its network of other private, public and voluntary sector providers of health and social care¹¹⁸:

- An awareness of the multifactoral issues involved in healthcare which mean that complex health and social problems lie beyond the ability of any one practitioner, team or agency to address
- Interest in designing, planning and managing organizations as living, interdependent systems committed to providing 'seamless care' for patients
- Recognition of the need to develop shared values, purposes and practices within between organizations
- Use of large group interventions to bring together the perspectives of a wide range of stakeholders across the wider system

Leadership frameworks, by and large, have not yet caught up with the major changes which are taking place in the way that organizations operate – the increases in inter-relationships both through networking, joint ventures and strategic alliances and the greater impacts that a range of stakeholders such as lobby and campaigning groups may have on organizations in the private, public and voluntary sectors¹¹⁹. Selznick¹²⁰ argued that “the theory of leadership is dependent on the theory of organization” so that as organizations change, then theories of leadership need to change as well. Leadership which is able to influence not only colleagues and subordinates, but a range of stakeholders in the private, public and voluntary sectors is becoming increasingly important.

A number of commentators have noted the increasing use of networks and partnerships in the public service sector¹²¹, including in health¹²² for the achievement of service outcomes. However, as Goodwin¹²³ notes, while the value of networks in healthcare is discussed, the amount of research is actually very low. Some discussion is in adulatory terms, whereas those who have researched networks and partnerships in other contexts note that they are valuable for certain types of task but poor as a structure for other types of task.¹²⁴ Others have noted that as well as there being 'collaborative advantage'¹²⁵ there can also be collaborative disadvantage.

The analysis of networks suggests both that this is an important aspect of healthcare leadership, but also that there is still insufficient research both on the processes and outcomes of networks, let alone the implications for leadership and leadership skills.

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

Some research¹²⁶ suggests that approaches to management and leadership and change need to be different where the context is dynamic rather than a stable environment. So leaders may need to adapt their style to different contexts of system change and there is evidence that a 'transactional' leadership approach is likely to be less productive at a time when an organization faces complex new challenges which have not been encountered before. In addition, different styles may be more effective at different phases of a merger (further details in the chapter on challenge)¹²⁷ i.e. shifting the leadership approach according to the external and internal context

The organizational context

Leadership in healthcare takes place in organizations (such as hospitals, GPs practices; primary care trusts), in networks and partnerships, such as in regional delivery of services, or in the care of the elderly working with the local authority; or in whole systems, taking into account the local or the national health economy. Here we focus on the organizational context. From an organizational perspective, this is the internal context. For many in leadership positions, leading change in uncertain organizational situations is often the norm. Organizational context here refers to aspects of size, geographical location, structure, culture, staffing, skills and resources. The internal environment of the organization will represent strengths and weaknesses and as such is an important part of the context for the leader to 'read' and understand.

Brazier's review of the literature (2005) on the influence of organizational contextual factors on healthcare leadership focuses on understanding the influence of contextual factors on the power and influence of leaders and their capacity to encourage creativity and innovation. She concludes that bureaucratic organizations can be the most inhibiting for leadership, tending to exhibit transactional leadership approaches. Hierarchical structures, high staff turnover and lack of resources are most likely to stifle creativity and innovation. Organic structures (ones which are flexible and have a relatively flat hierarchy) facilitate a more transformational leadership approach¹²⁸.

In their study of the contribution of leadership to sustained organizational success in NHS Foundation Trusts, Bailey and Burr (2005) examine the extent to which organisational history and inherited organizational capabilities, what they termed 'legacy' are a significant factor. They define 'legacy' as the 'enduring influence of eight performance-critical organizational features'¹²⁹:

- The structure of the trust
- The prevailing culture
- Technological capability

- Operational capability
- Quality of staff
- Clinical reputation
- Strategic relationships
- Strategy

They suggest that effective leadership both builds on and works with the organizational legacy. In other words, leadership rarely starts from scratch but has to work with the existing internal context.

In a wider literature review by Scott et al,¹³⁰, inadequate or inappropriate leadership is highlighted as a key factor which may impede cultural change within healthcare organizations. These studies stress the importance of assessing the alignment between organizational culture and the wider environment, including acknowledgement of possible 'cultural lag' or 'strategic drift' in achieving alignment. Scott et al propose an integrated leadership style (both transactional and transformational) to achieve culture change. At a time of developing a patient-centred model of healthcare, they suggest that the leadership task is about radically redefining attitudes and behaviours, which can be deeply ingrained in the organization, through its culture.

Other studies point to the importance of understanding the organizational context, particularly culture for successfully leading change. Examining the role of senior leaders' actions in implementing quality and safety improvements in healthcare, Øvretveit (2005) concludes that their actions are important but that their influence as individuals is limited. He proposes a 'system of leadership for improvement' which takes account of where and how leadership can be enabled and demonstrated throughout the organization, especially by medical leaders. He suggests that senior leaders *'need to build a system of leadership for improvement which include all formal and informal leaders, teams and groups which support improvement as part of the everyday work of an organization.'*¹³¹ In order to do this effectively he argues that *'the first step in leading improvement is to understand the organisation's*

*stage of quality development, any internal experience with quality methods and assess 'readiness for change' ... (as well as) ... the current pressures which help and hinder improvement.'*¹³² . In other words, organizational diagnosis is an important element of the leadership of context.

The organizational performance context, and capacity for improvement and innovation is an importance consideration for leadership, not only in terms of the pressure to perform to centrally imposed targets but also the imperative of continuous improvement.

Policy and practice implications

- A key prerequisite for effective leadership is the need to understand the context in which leadership is exercised. Policy-makers, managers and professionals may find it helpful to think in terms of the three layers of context we have outlined here: the public policy context; the local strategic context, including partnerships, and the internal organizational context.
- These are not discrete but interact in complex ways. Systems thinking helps to reveal the interdependence between the elements and to remind us that outcomes may not be anticipated.
- Contingency approaches to context suggest that different leadership styles are effective in different contexts. Selecting leaders for particular contexts and/or helping leaders develop and deploy particular leadership styles according to context are both ways to address achieving some degree of match.
- 'Reading the context' is therefore a crucial skill. It includes being able to take an overview and link small detail with the big picture. Moving between 'the balcony and the battlefield' is one way to achieve this.
- Leadership is not only about shaping the context but also, in some situations, constituting the context. Leaders have a role in defining and articulating the key points of the context, framing it for others inside and outside the organization.

- The context for healthcare is changing, due to changing expectations, changing illness and disease profile and the greater emphasis on 'predict and prevent'. The leadership challenge is to transform to improve but this requires accurate and careful reading of the context.
- Reading the context of partnerships is a critical skill for healthcare leaders, particularly but not exclusively at senior levels.
- Partnerships may have collaborative advantage but also collaborative disadvantage, so reading the context and thinking through the challenges of partnership become crucial. Leadership needs to focus on system design and development, ensuring that partnerships contribute to strategic purpose.
- Reading the internal organizational context includes thinking about the strengths and weaknesses of a number of features, including size, location, structure, culture, skills, resources and reputation. Leadership has to work with the history of the organization and rarely starts from scratch. Organizational diagnosis is a key element of the internal context and the starting point for improvement and reform.
- Being aware of the informal as well as the formal leaders in the organization will enhance that diagnosis.

Research implications

- There is relatively little work on this crucial aspect of context and much more conceptual work and evidence-gathering could be undertaken. Some researchers have argued that context is central to understanding what happens in organizations and to understanding leadership
- In particular, more research is needed on how leadership shapes context
- How the reading of context links to the challenges of leadership is under-explored
- Research could explore whether some leaders are more effective at reading context than others, and how such skills can be enhanced.

- Research could explore which aspects of context are most susceptible to leadership influence.

Want to know more? Further reading

Grint, K. (2005a). *Leadership: Limits and possibilities* London: Palgrave.

Chapter XX

Grint, K. (2005b). Problems, problems, problems: The social construction of 'leadership'. *Human Relations*, 58, 1467 - 1494.

Goodwin N (2006) *Leadership in health care: A European perspective*.

London: Routledge. Chapter 3.

Hartley J, Fletcher C, Wilton P, Woodman P and Ungemach C (2007) *Leading with political awareness* London: Chartered Management Institute. Executive summary.

CHAPTER 5

THE CHALLENGES OF LEADERSHIP

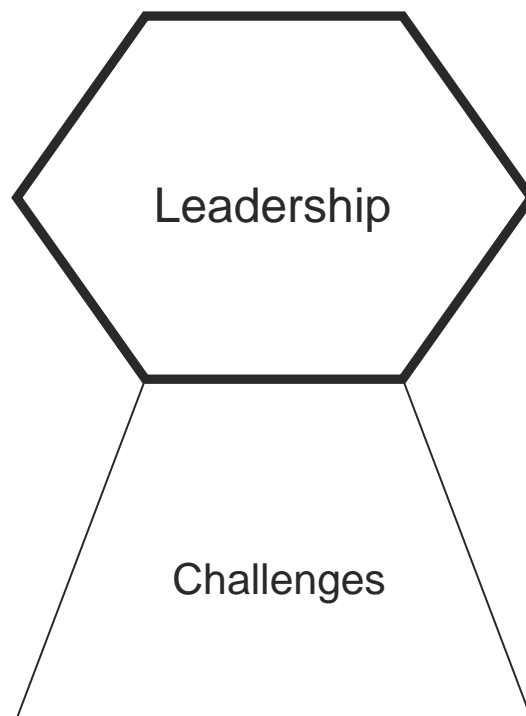
In this chapter:

We examine the purposes, or challenges, of leadership. What is the leadership in a particular situation for? In other words, what is it that leadership is trying to achieve for healthcare?

We examine this in several ways. First, we examine the challenge of sense-making – how do leaders make sense of the context and the purposes they are trying to achieve, and how do they communicate this to others to create a sense of common purpose? We examine ‘big picture sense-making’ and then turn to consider the different types of problems which leaders face, and therefore the degree of match between their leadership strategies and the problem, or challenge, to be addressed. In other words, how do leaders think about and orchestrate the work to be done? We examine tame and wicked problems, also called technical and adaptive problems and the types of leadership approaches which seem to be most effective.

The chapter then turns to examine five concrete leadership challenges for healthcare organizations. These are: the merger/acquisition challenge; leading partnerships and networks; leading turnaround; leading organizational change, innovation and improvement; and nurturing future leaders in the organization.

The chapter covers the next leadership segment as shown below.



This chapter focuses on the tasks of leadership. What are the goals or purposes that leadership is for, or that the leadership is aiming to achieve? We have called these tasks ‘challenges’ in line with an emerging literature which frames the leadership purposes in this way¹³³. Most definitions of leadership focus on some aspects of purpose such as influence towards a common goal, or mobilising others to tackle tough problems. The early definition of leadership (from Stogdill¹³⁴) is a reminder that the leader’s role may be to find or frame the purpose not just implement goals or communicate a vision to others.

Leadership as sense-making and as constituting challenges

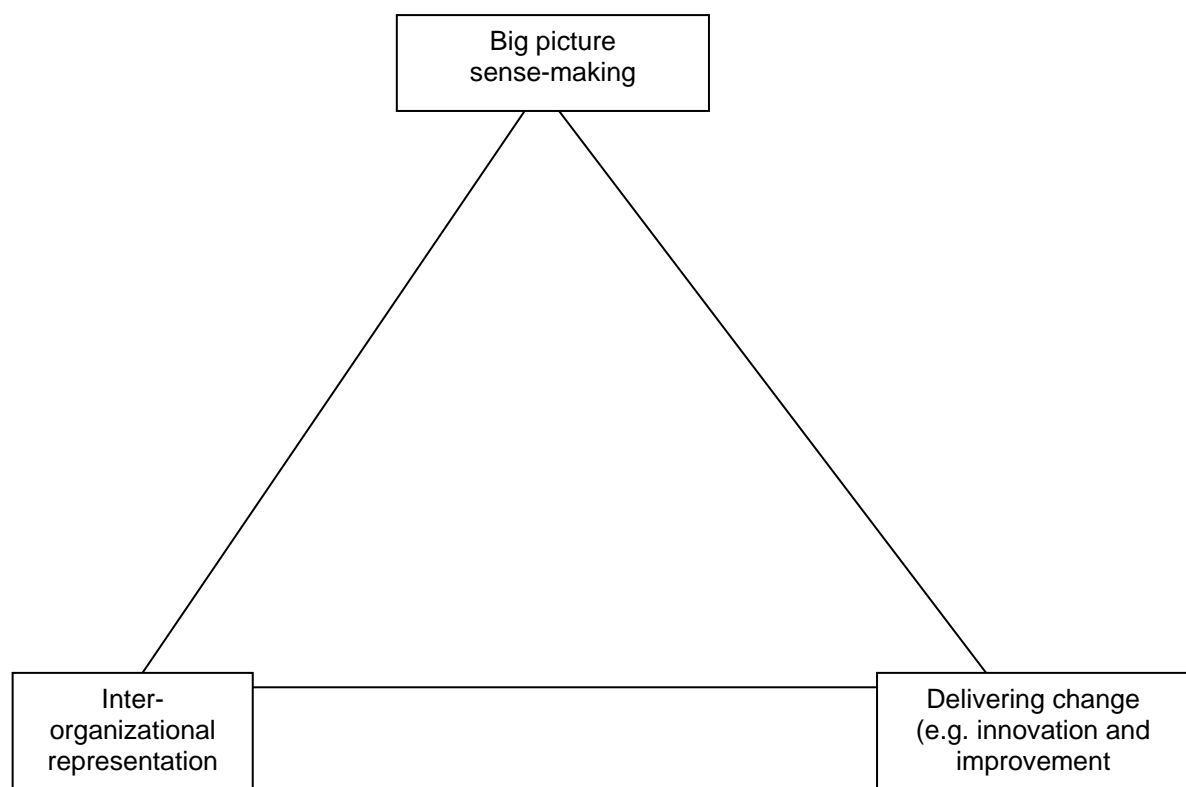
Leadership theory from the 1980s onwards¹³⁵ has revived the interest in leadership as providing ‘vision’ and a sense of clear purpose and direction for the organization. Yet vision is not a simple read-off from the context. Some have argued for a more constitutive approach which is based not only on rational analysis but also on the ‘reading’ of the various stakeholders and their interests. A constitutive approach is about the active framing of what is the problem as well as what is the solution (or perhaps rather range of ways of

addressing the problem)¹³⁶. How are purposes formulated, articulated and debated? The complex context of healthcare makes this a particularly fertile site for the exploration of purposes and the contestation of purposes by different stakeholders. In particular, for public services such as healthcare, there is also the question of assessing whether or not the leadership purposes contribute to, or detract from, the creation of public value.¹³⁷ i.e the wider public good (public value is covered in detail in Chapter XX).

Grint¹³⁸ notes that a key element of leadership is to define and make sense of context. However, the strategic leadership of change is not just about rational decision-making, however persuasive the *post hoc* rationalizations of leaders. Complex change in an uncertain world can only be partially predicted and planned for¹³⁹. Sense-making becomes important in organizational change under conditions of uncertainty or ambiguity (Weick, 1995¹⁴⁰). Sense-making captures the idea that people (individuals or groups) make sense of confusing or ambiguous events by constructing plausible (rather than necessarily accurate) interpretations of events through action and through reinterpretation of past events. The role of the leader, in a sense-making framework, may be less to be fully clear about the future and rational plans for shaping it (i.e. providing a 'clear vision'), and more about being able to provide a plausible narrative that helps people understand what may be happening and mobilises their support and activity towards addressing the problem. Pfeffer (1981) argues that a key role for leaders is to provide "*explanations, rationalizations and legitimations for activities undertaken in organizations*" (p. 4)¹⁴¹. In this sense, the view of leadership as sense-making for and with the organization is particularly valuable¹⁴².

Some writers have formulated purposes, or challenges, at a fairly high level of abstraction, which is helpful for broad orientation, though requires detailed working out in practice. Storey¹⁴³ sets out three key 'behavioural requirements' for leadership, which can be seen as part of the tasks of leadership. An adapted version of his approach is shown in the Figure XX below.

Big picture sense-making is about being able to scan and interpret the environment, particularly the external political and policy context (the context is covered in the previous chapter and here we examine how this has an impact on the purposes pursued by the leadership). It is also an important element of leadership to be able to communicate to others the vision, mission and strategy, and to help others to make sense of the experiences that they have¹⁴⁴. In the figure, inter-organizational representation is about exercising external influence and requires the ability to lead with influence rather than formal authority in many situations. The ability to deliver organizational and cultural change in healthcare organizations is also important, given the pace, scope and scale of change both as a response to demographic and social changes and as a response to governmental policy pressures and directives.



Source: Adapted from Storey, 2004

Also at the broad strategic level, Leach and Wilson¹⁴⁵ have formulated four key tasks for elected political leaders that have some resonance for

managerial or clinical leaders in healthcare. Leach and Wilson argue that elected politicians have to try to accomplish the following:

- Maintain political cohesion
- Develop strategic policy
- Exercise external influence
- Ensure task accomplishment

These tasks require some 'translation' into a managerial or clinical leadership setting, but the first task is concerned with building up a momentum of support for the proposed direction or purpose. It reminds us why 'ownership' of change is such a widely used concept when organizational and cultural change is embarked on, because if there is insufficient support then leadership will not achieve their goals¹⁴⁶. Many leaders will have to spend time on developing strategic policy (for example the board of a trust) or on shaping local policy to fit with national strategic policy. Exercising external influence through partnerships and networks is important for health professionals, managers and board members. And ensuring task accomplishment is about making sure the job gets done well once the vision or direction has been established – a key challenge for leadership. Leach and Wilson note that it is hard, if not impossible, to achieve all of these purposes to the same degree and there are inevitably trade-offs between these challenges.

In constituting challenges, an ever-present challenge for leadership in healthcare is the ability to create and chart the course for the achievement of organizational goals and objectives. From public policy performance targets, for example treatment waiting times, to local priorities, for example, GP prescribing policy, effective leadership requires a local strategy which takes account of the many contextual layers and mobilises resources for both acceptance of the approach and its implementation. This in itself will often require leaders to question the status quo, take thought-through risks and search for opportunities¹⁴⁷.

The nature of the challenge

A number of writers have distinguished different types of problem or challenge and argued that they call for different types of leadership. For example, Stewart¹⁴⁸ distinguishes between 'tame' and 'wicked'¹⁴⁹ problems in local government and Grint¹⁵⁰ draws on this distinction in his analysis of different types of leadership. Tame problems are ones which have been encountered before, for which known solutions already exist and which can be addressed by a particular unit, profession or service. Tame problems may be complicated but they are resolvable through existing practices. Wicked, or cross-cutting problems have no definitive formulation (different people may formulate the problem differently), are incomplete and have changing requirements. Solving a wicked problem may throw up other problems because the problems are inter-related. Often, large groups of people have to contribute to solving the problem, through changing their behaviours. An example of a tame (though complicated) problem is surgery. An example of a wicked problem is tackling the health issues of childhood obesity.

A similar distinction is made by Heifetz¹⁵¹ who distinguishes between 'technical' and 'adaptive' problems (equivalent to tame and wicked problems) faced by leaders. We examine these two approaches to distinguishing between problems, because they have major implications for leadership strategies, styles, processes and behaviours.

Grint's typology actually introduces a third type of problem – a critical problem where immediate and urgent action is needed (e.g. dealing with major road traffic injuries in the accident and emergency department).

Grint argues that there is a need for different types of leader in these three situations. Tame problems, where the parameters are known, can be dealt with through management (or Heifetz calls this technical leadership). It is the leadership required to bring together resources, people and schedules to deal with the challenge, often in a project-based way. Wicked problems require leadership (or Heifetz calls this adaptive leadership) in that the leader does not fully understand the problem or possible ways of addressing it and seeks

to orchestrate the help of a range of people to address it. Critical problems require a command and control type of leadership because the problem must be tackled urgently if it is not to be destructive. The distinction between the role of manager, leader and commander as different and relevant forms of authority to draw upon in relation to different types of problems which he describes as 'tame', 'wicked' and 'critical'. A definition of each of these types of problem and their type of authority is given in the table below.

Type or problem	Form of authority
<i>Tame problems :</i> Complicated but resolvable Likely to have occurred before Limited degree of uncertainty	<i>Manager:</i> Manager's role to provide the appropriate processes to solve the problem
<i>Wicked problems:</i> Complex and often intractable Novel with no apparent solution Often generates more problems No right or wrong answer just better or worse alternatives Huge degree of uncertainty	<i>Leader:</i> Leader's role is to ask the right questions rather than provide the right answers as answers may not be self-evident and require collaborative process
<i>Critical problems:</i> A crisis situation Urgent response needed with little time for decision-making and action No uncertainty about what needs to be done	<i>Commander:</i> Commander's role to decisively provide the answer to the problem

Source: Adapted from Grint 2005

Whilst this device is useful for leaders seeking to understand the nature of the problems or challenges they face, and how to employ different forms of authority to deal with them, Grint's analysis suggests that leaders in decision-making mode may be inclined to legitimize their actions '*on the basis of a persuasive account of the situation*' rather than concluding that correct decision-making lies in the correct analysis of the situation. In other words,

providing a narrative to others which helps to define the situation (as a crisis or not, as tame or not etc) is one element of leadership and reinforces the view of a challenge for leadership in both being able to read the context but also constitute it.

The work of Heifetz¹⁵² has become particularly relevant in the UK for thinking about the leadership of complex and difficult problems, where either the outcomes or the means are not clear or are not agreed upon. Benington and Turbitthave outlined succinctly the ways in which leaders can address complex or uncertain challenges (wicked problems or adaptive problems) using adaptive leadership. They tested this approach in a difficult policing situation in Northern Ireland.

“Heifetz’s theory of adaptive leadership (Heifetz 1994) argues that a distinction needs to be made between technical problems (where there is a general agreement about the diagnosis of the problem, and about the nature of the action required to solve it) and adaptive problems (where there is uncertainty, confusion or disagreement about the nature of the problem, and about the action required to tackle it). He argues that adaptive problems require a different kind of leadership from the tackling of technical problems – leadership which rejects the pressure from followers to provide magical solutions to complex problems, and instead works with stakeholders to take responsibility for grappling with these problems and for the changes in one’s own thinking and behaviour required.”¹⁵³

Heifetz suggests a framework of seven principles for adaptive leadership :

- Identify the adaptive challenge – the changes in thinking and behaviour (including one’s own) required to grapple with difficult issues
- Give the work back to the people faced by the problem – avoid the temptation to solve people’s problems for them; engage them in the adaptive work and in taking responsibility for the change process
- Regulate the distress necessary for adaptive work – creating and maintaining sufficient heat to keep things cooking, but not so much

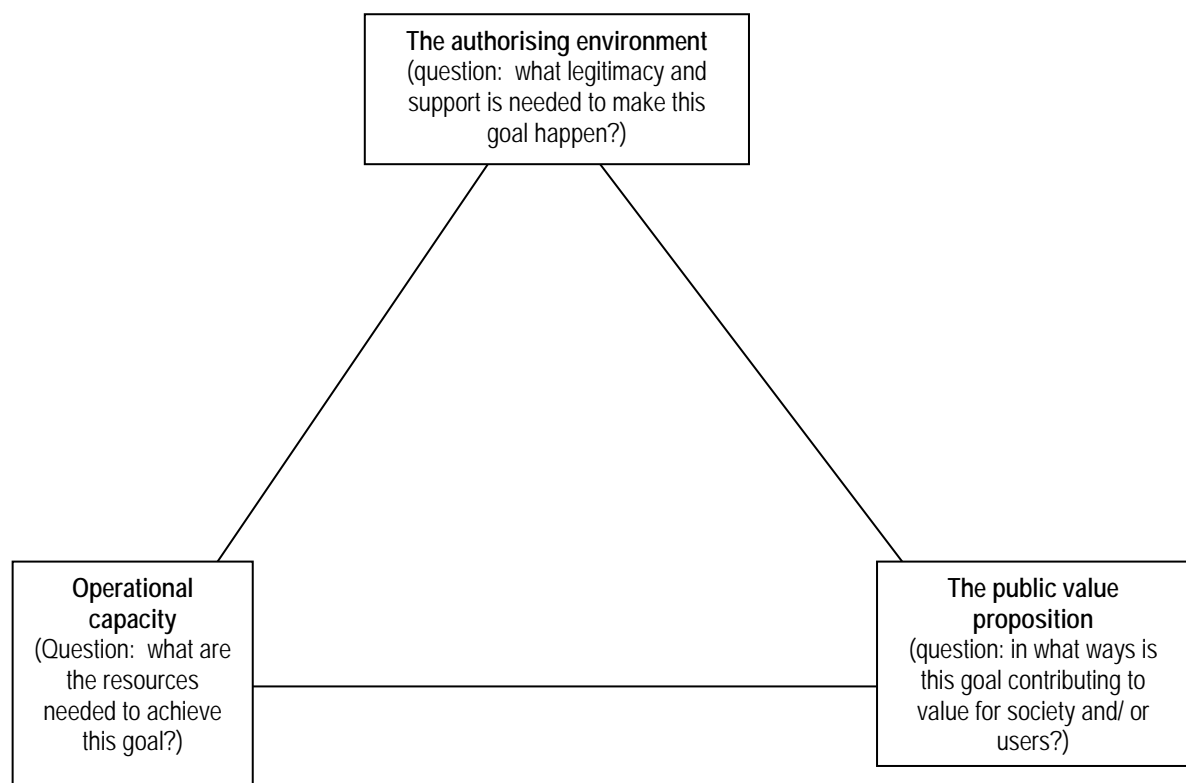
heat that everything boils over and spoils. Use conflict constructively

- Create a “holding environment” in which the painful adaptive work can be done effectively; this can be a physical and/or a psychological space, providing both safety and also stretch and challenge.
- Maintain disciplined attention – recognise the seductions of work avoidance and other displacement activity (e.g dependency; projection; fight/flight), and relentlessly bring the focus back on to the primary task.
- Protect the voices from below or outside – ensure that all perspectives and interests are considered, that minority viewpoints are taken into account, and that dominant views are questioned and challenged
- Move continuously between the balcony and the battlefield – in order to combine a helicopter overview of the whole situation and strategy, with an understanding of the changing situation at the front-line.

Not all problems are of the sort which require adaptive leadership and Heifetz recommends a different form of leadership (technical leadership) for problems which have familiar parameters (similar to Grint’s typology of management for tame problems). Heifetz’s work on leadership for adaptive problems is valuable because it is theory-based (considering group dynamics and the emotional aspects of group and community behaviour) and because he sees the tasks of leadership as partly about harnessing the resources of the group(s) which are needed to solve the problem.

In addressing any kind of leadership problem, Moore¹⁵⁴ describes the importance of public leaders and managers thinking carefully about three elements which are each needed for a successful strategy, which he calls ‘the strategic triangle’. The three elements of the triangle are public value (is there a value proposition in terms of the public sphere, i.e. is the proposed goal or

change defensible in terms of its contribution to public services); commitment from the 'authorising environment' (are the stakeholders who can provide or withhold legitimacy or approval supportive of the value proposition); and operational resources (is there sufficient money, people, skills or other resources to bring about the improvement sought)¹⁵⁵. This is shown in the figure below:



Moore: The strategic triangle for public service managers

There are a number of challenges to be juggled. At a formal, senior level, the leadership role of the chief executive as a non-medical manager responsible for managing an organization with multi-layered and multi-professional responsibilities is complex. According to Blackler and Kennedy¹⁵⁶:

'Chief Executives are responsible to government both for the finances and for the clinical performance of their organizations; they must enact national

priorities for healthcare and lead local change programmes; develop good working relations with the many professional groups working in their organizations; work with the chair of their board; build relationships with relevant local agencies to develop services for the public and generally foster public confidence in the NHS in line with governmental imperatives.'

Challenges at the organizational and inter-organizational level in healthcare

Having looked at how challenges are constituted and framed, we now turn to examine particular tasks/challenges in relation to healthcare improvement, innovation and change. For leaders in the NHS at every level perhaps the biggest challenge is the pace of organization and system change so here we examine particular organizational and cultural change challenges which are highly relevant in the healthcare field. These are:

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

The merger/acquisition challenge

The NHS has been through significant mergers of primary care trusts and strategic health authorities in order to achieve greater co-terminosity with the boundaries of local authorities and the government regions in England. Research by Dickinson et al¹⁵⁷ on private sector mergers and its applicability to healthcare, has suggested that the organizational transition at a time of merger requires particular types of leadership, as the leadership tasks are carried out. The authors suggest that these modes need to be employed in different phases of the transition period. These are shown in the table below. This research suggests that both transformational and transactional leadership needs to be employed at different stages of the merger transition

but that, on balance, a transactional style is the most crucial. (Transformational and transactional leadership types are covered in greater detail in the next chapter).

Table XX: Leadership type related to merger phase

Merger phase	Leadership type
Action pre-merger decision	Transactional: Assess/audit the culture of each of the merging organizations and use this knowledge as part of a careful strategy for highlighting and recognising the differences between the organizations.
Decision to merge	Transformational: Create and communicate a vision that sets out the purpose of the transition in an open and participatory manner
During merger process	Transactional: Provide resources to support the change process for staff. Manage the human resource and make this your main activity. Communicate the changes and latest developments relentlessly. Set up clear transitional structures incorporating senior people that enact the transition promptly. Attend to sense-making, help staff understand the implications of change.
Post merger	Transactional: Measure the impact of the transition both in relation to transition objectives and other measure – do this for at least three years.

Source: Adapted from Dickinson et al, 2006

There are, however, particular issues that leaders need to take account of in the merger of NHS organizations, which are in the public sector, which distinguish them from organizations in the private sector. The table below outlines these asymmetries.

Table XX: Asymmetries between the NHS and the private sector

Private sector	NHS
Acknowledged transition merger process	Merger regarded as closing one organisation and opening another
Potential merge organizations make a choice based on pre-merger assessment and planning	No choice of merger organisation
Possibility of de-merging	No possibility of de-merging
Organisational differences acknowledged and desirable	Organisational differences not acknowledged
Research shows that mergers do not achieve efficiencies	Belief that merged organizations achieve efficiencies
Focus on merging provider organisations	Focus on merging demand side organizations
Research shows it takes at least 3 years for performance to recover after a merger	Mergers tend to follow at about 3 year intervals
Empowered providers organize and carve up the system	Commissioning is a weak tool further weakened by reorganization
Merger processes led by the organisation's board and its directors	NHS merger processes led 'remotely' by politicians
Communication (especially with staff) acknowledged as key to successful merger	NHS poor at communication
Early indications which give 'psychological safety' to staff paramount	NHS human resource management processes lead to great uncertainty
The aims of mergers are rarely met	Mergers seen by politicians and policy-makers as a way of achieving policy goals
Mergers are a distraction with negative unanticipated consequences	Front line staff behaviour is rarely changed as a result of a merger

Source: Adapted from Dickinson et al, 2006

In a study of two hospital mergers in Quebec, Denis et al¹⁵⁸ highlight the challenges posed for leaders working in situations which have been imposed by government and which are often highly contested.

'The challenge of the mergers was not simply one of governance ... Each merger involved the rationalization of activities among the three sites, thus requiring 'micromergers' between myriad clinical services currently operating separately and demanding the fundamental transformation of the mission of some or all of the sites ... Thus, besides maintaining three operating

*institutions and learning to work collaboratively with former rivals, the leaders had to implement fundamental, [radical] change [which questioned the nature, existence and boundaries of the organization]”.*¹⁵⁹

They conclude that the formation of the ‘leadership constellation’ in the integrated board and leadership team for each merger situation needs to reflect the strengths and weaknesses of the historical ‘imprint’ of the merging organizations as well as take account of the climate within which the merger was taking place, for example the degree of political pressure and/or resistance within the internal and external environment. They also suggest that imposed merger situations require transactional leaders able to negotiate and make compromises between different interests and positions rather than transformational leadership which is more effective when leading a unified team.

The challenge of leading networked and partnership organizations

Denis et al¹⁶⁰ explore the strategic challenge for leaders in the ‘pluralistic’ contexts (where there are diverse interests and priorities within and between partners) and where leadership roles are shared, objectives are divergent and power is diffuse. Their analysis highlights four characteristics of strategic leadership in networks and partnerships, acknowledging that such leadership needs to be concerned with the network system as a whole.

Table XX: Characteristics of strategic leadership in networks and partnerships

Strategic leadership model	Elements
Collective	Strategic leadership requires contributions from more than a single individual Different individuals contribute in different ways to strategic leadership Recognition of diffuse power eg. professionals and external agencies Embodied in 'leadership role constellation' or 'top management team' Complementary roles to allow all to play in a concerted manner
Action/process oriented	Focus on the actions of people in leadership positions rather than on personality traits Significance of influencing/mobilizing others through tactical action
Dynamic	Leadership participants, roles and influences evolve over time Importance of construction, deconstruction and reconstruction of leadership roles Recognition of mutual influence of action and context Significance of the effects of leaders' actions on the organization, allocation of resources and distribution of power
Supraorganisational	Leadership roles and influences on them extend beyond organizational boundaries Consideration of external influences such as government funding, community, public and political pressures

Source: Denis et al, 2001

The researchers concluded that strategic leadership in pluralistic organizations is more likely to be established under unified collective leadership but that this is always fragile in the context of diffuse power. The leadership challenge here is to stabilise the collective leadership as much as possible to prevent it being shattered by internal rivalry (strategic uncoupling), dislocation from the focal organization (organizational uncoupling) or lack of

adaptation to environmental needs (environmental uncoupling). This is an issue which many 'managed clinical networks' are grappling with in the UK.

Alexander et al¹⁶¹ also address the issue of collaborative leadership in relation to community health partnerships. They conceptualise collaborative leadership in five mutually reinforcing themes:

- systems thinking: taking a population-based view of health focused on a 'wellness-based' social model and the structural drivers for good health at the community level e.g. housing; developing a sound working knowledge of how organizational systems at the community level interrelate and affect health, staying focused on the big picture.
- vision-based leadership: communicate a values-based envisioned future, mobilize resources and guide action towards long-term aims, particularly with key stakeholder groups.
- collateral leadership: broad-based leadership across the partnership with contributions from partnership staff, organizational representatives and advocates for particular community segments.
- power sharing: to set priorities, allocate resources and evaluate performance to foster a sense of joint ownership and collective responsibility.
- process-based leadership: translating substantive leadership into action through effective communication mechanisms and excellent inter-personal skills.

Their research identifies three challenges that may confront leaders in partnership situations because participation in their partnerships was voluntary and so entails cooperation rather than formal authority as the basis of leadership. They suggest possible approaches to leadership in terms of thinking about the constraints, trade-offs and conflicts which the partnerships face. These are set out in Table XX below.

Table XX: Challenges for collaborative leadership

Leadership challenge	Constraints, trade offs and conflicts
Continuity versus change	Striking the right balance between maintaining experienced leadership and infusing new leadership into the partnership
Leadership development	Identification of potential leaders, including those within the community but the need to expend considerable effort to orientate them towards the purposes of the partnership and to invite, coach and encourage them to be leaders
Power and participation	Power-sharing through 'neutral' leadership which fosters equal voice and representation among all partners and/or 'equity-based' leadership which reflects the financial contribution of partnership members

Source: Adapted from Alexander et al,

The challenge of turnaround and leading organizations out of failure

The recent emphasis national policy emphasis on improvement in public services in the UK, combined with easier and wider access to performance metrics, has made organizational failure more visible and more important. Given the league table mentality which has developed, it is perhaps surprising that more research has not been conducted in this area of challenge.

Leading organizations out of failure and creating turnaround is a particular leadership challenge for certain trusts. Jas and Skelcher¹⁶² analysed performance turnaround across local government (like health, subject to very public scrutiny of performance). They found that performance was cyclical (some of the organizations which were deemed by central government to have failed had had very high or very innovative performance in the past) but that where awareness of performance decline was absent and where there was low leadership capability then the organization failed to initiate its own recovery strategy and action, and this led to more authoritarian intervention. They also found that building or re-establishing leadership capability required

engaging with both political and managerial senior leaders in order to overcome the inertia of failure and to regenerate collective belief and action in the organization's ability to solve its problems. This suggests that leadership at all levels in the organization is critical to creating the rapid and major leap forward to arise from what is seen to be failure.

Valuable work has examined the choices of turnaround strategies by leaders including those of healthcare organizations, comparing them with the strategies available to the private sector ¹⁶³. Boyne found that turnaround from what had been deemed failing organizations in health, local government, schools, fire, police and prison services was influenced by pre-existing context (e.g. local deprivation) – but also by the ability of the organizational leadership to convince inspectors that the right activities had been undertaken and the right systems introduced to create rapid improvement, in other words legitimating actions (not always improvement actions)¹⁶⁴. The leadership challenge is both face inwards to the organization to build leadership capacity, but also outwards to manage the reputation of the organization with key stakeholders.

The challenges of leading change, innovation and improvement

The leadership challenge of improvement and innovation in healthcare delivery occurs at all levels of the system. Reform, service redesign, re-engineering, improving patient safety and quality, and innovation initiatives may focus on particular techniques and ways of building commitment to sustain cultural change. Nurse managers, doctors and other health professionals, and administrators, as well as senior managers, can all find themselves leading reform and redesign initiatives or aspects of these in projects or programmes of organizational and cultural change.

Research tracking the changing role and responsibilities of nurse leaders in 1993 and 1995 through the American Organisation of Nurse Executives network¹⁶⁵ suggested that organizational redesign had a substantial impact as the US healthcare system shifted from a service for the sick to a service to achieve health for the whole population and with a more client-centred,

market-responsive structure which required flexible clinical teams. This brought with it different and greater expectations of nurse leaders. The researchers reflect that service redesign usually has the following characteristics, suggesting a fundamental shift of priorities towards continuity and quality of health care, rather than simple cost-cutting exercises.

- Integration/coordination across departmental lines
- Critical path/protocol development
- Management restructuring
- Multiskilled worker development
- Patient-focused care implementation
- Case management implementation

Such changes resulted in nurse leaders focusing much more on team-building skills across departmental boundaries, deploying multiskilled workers, as clinical practice was improved. They found that nurse leaders have a critical role in redesign initiatives, with most respondents in the research reporting involvement in both initiation and implementation. Many nurse leaders also found themselves in different reporting relationships and with different formal titles, reflecting a broader role with responsibility for patient care. In most redesign situations, nurse leaders found themselves being required to lead new operational configurations, whilst reducing costs and maintaining or improving the quality of care. The challenge here was summarized as the need for nurse leaders to understand how to:

- Lead across cultural, functional and departmental boundaries
- Promote teamwork and build and maintain effective teams
- Manage personal growth by objectively challenging their own behaviours and beliefs
- Promote the continued development of the nursing profession in an integrated patient care environment
- Tolerate ambiguity and change

This research suggests a complex role for nurse leaders:

‘Leading clinical improvement across the continuum of care, facilitating integration of clinical services, working effectively with other clinical leaders and ensuring organizational success are just some of the challenges for current nurse leaders.’¹⁶⁶

However, other research carried out in New Zealand found that nurses were not reaching their potential as transformational leaders of organizational redesign due to cultural and social factors, linked to perceptions of traditional (and limited) conceptions of the nursing role which effectively repressed leadership in the new context.¹⁶⁷ Leadership interacts with the internal organizational context, including its culture, creating both opportunities but also constraints.

System re-engineering is one major means by which efficiency and improvement in healthcare delivery are striven for. Senior leaders clearly have a critical role to play and need to be equipped to face the challenge. Indeed, lack of effective leadership, including the accurate diagnosis of existing organizational conditions, has been cited as a primary cause for re-engineering failure in healthcare¹⁶⁸.

Guo¹⁶⁹ suggests that the role of the leader in healthcare re-engineering has four elements which are mutually reinforcing in a cyclical process (see below).

Table XX

Element	Key questions
Examination – of the healthcare organization and its environment	Timing for the re-engineering process Market challenges and opportunities Organizational strengths and weaknesses Purpose of the organization Future direction of the organization Outcomes of the organization
Establishment – of a long term strategic plan to determine the direction of the organization as it deals with the complexities in the environment	Quality Customer satisfaction Cost effectiveness Improved work environment for employees Realistic goals, timeline and budget Organizational culture and values
Execution – of the strategic plan	Allocation of resources (financial, human, capital) Redefinition of roles and responsibilities Managing conflict Education, training of managers and staff Communication and coordination of work efforts
Evaluation – of desired and unintended outcomes	Reach desired outcomes Effective change for the organization Continuous feedback to make adjustments Periodic review for more responsive organization Cooperation, integrated and empowered organisation

Source: Adapted from Guo, 2004.

Turning now to consider innovation, a number of writers have argued that, for both the public and the private sectors, innovation is a distinct concept from improvement. Innovation may or may not result in improvement, given that innovation is most usefully seen as a step-change rather than a continuous improvement approach¹⁷⁰. The leadership of innovation is likely to be different from the leadership of continuous improvement approaches because the scale and scope of change are different and therefore projects and people may need to be managed quite differently. The particular challenge to the leadership of innovation and change is the need to be creative and to encourage creativity in others in order to solve problems and generate the energy and enthusiasm needed to overcome inertia¹⁷¹. Leadership involves

acting as facilitators and educators for change, working to create an environment of 'psychological safety' that fosters risk taking and opportunism, and supports others to learn and adapt their behaviour. Adaptive leadership¹⁷² may be one approach to enable others to take ownership of and manage innovation successfully.

There are many elements of the leadership of organizational and cultural change. Given that change is an ongoing dynamic of organizations, it is an ongoing challenge, or purpose, of leadership at a number of levels in the organization. Some writers have noted that a key element of leadership for top organizational leaders is to shape organizational design, organizational culture and the distribution of resources¹⁷³. Such leaders, therefore, design the social architecture. *"They are responsible for the governing ideas underpinning the policies, strategies and structures which guide business decisions and actions and help build a shared vision"*¹⁷⁴. While this statement was written about the private sector, it is relevant for healthcare organizations.

As well as influencing structure, top leaders and direct leaders may also have a significant impact on organizational culture. This has been widely reported, from the seminal work of Schein¹⁷⁵ onwards, though writers vary in how far they see organizations as having a single integrated culture, how far they see a set of sub-cultures co-existing within the organization; and how far the sheer size and complexity of large, contemporary organizations means that it is hard to talk about managing or shaping culture in any meaningful way¹⁷⁶.

In supporting change and innovation, there is a task for leadership to create a climate, or culture, which encourages learning from failure. Often the ultimate challenge is for leaders to be able to acknowledge defeat as a result of evaluating change and innovation. In healthcare systems one major criticism has been the lack of learning from previous initiatives and the need for leadership to be reflective. Edmondson¹⁷⁷ suggests that hospitals do not learn from failure for two reasons. First, because the interpersonal climate at the frontline with patients (reinforced by the professional traditions of medicine) inhibits questioning and challenge and, second, because the work design

features of hospitals tend toward quick fix solutions to problems rather than root cause analysis and systematic problem solving. However, other research points to the value of learning from mistakes and unsuccessful attempts at change as well as learning from success¹⁷⁸.

There are many definitions of organizational culture but two useful ones are “the common set of shared meanings or understandings about the group/organization and its problems, goals, and practices” (Reichers and Schneider, 1990) or “the taken for granted and shared meanings that people assign to their social surroundings”(Wilkins, 1983). The concept of organizational culture is valuable because it reminds the leader that ‘message sent’ may not be the same as ‘message received’. Hatch cautions the leader: *“Do not think of trying to manage culture. Other people’s meanings and interpretations are highly unmanageable. Think instead of trying to culturally manage your organization, ie, manage your organization with cultural awareness of the multiplicity of meanings that will be made of you and your efforts.”*¹⁷⁹

The challenge of nurturing future leaders - the ‘leadership engine’

Some writers also remind us that a further challenge is not only the immediate purposes of goal accomplishment but also building up leadership capacity and capability by nurturing the next generation of leaders and creating a learning approach to leadership¹⁸⁰. It is about embedding leadership as an integral part of the organization¹⁸¹ and fostering the next generation of leaders, both individually through informal coaching and support and formally through leadership development initiatives. Some have called this building a ‘leadership engine’. This occurs where *‘leaders exist at all levels and leaders actively develop future generations of leaders’*.¹⁸² This is about conceptualising the organization as a system which produces leaders as part of its activities, thereby ensuring long-term capacity and adaptability for the organization. Many organizations pay insufficient attention to this, either formally through human resource systems or informally through fostering a climate of learning and development for potential leaders.

Policy and practice implications

- Challenges are partly made not given. A constitutive approach to thinking about the purposes of leadership in any particular context is about the active framing of what is the problem and how it might be addressed.
- Complex change in an uncertain world can only be partly predicted and planned for. Big picture sense-making is an important element of deciding how to address a challenge, or set of challenges. Also important are the challenges of delivering change, and representing the organization to other stakeholders.
- A key distinction has been made between 'tame' and 'wicked' problems, also phrased as technical or adaptive problems. The leadership of each requires different strategies, because in the first leadership is about bringing together the appropriate skills and resources to tackle a known or solvable problem, whereas the second involves a complex indeterminate problem, where the task of the leader is to orchestrate other people both to recognise and address ways of tackling the problem. This can be pressurising for the leader, where the group want the leader to solve the problem for them, but Heifetz's seven principles may help to keep the attention on the problem.
- The strategic triangle of Moore is one means by which healthcare leaders can frame their approach to adaptive problems, by thinking about what is the value to be created, who legitimates or supports that course of action, and what are the operational resources to achieve that end. This 'catechism' can be used in addressing any public service leadership challenge.
- Many of the challenges for healthcare leaders, at whatever level, are to do with bringing about change, whether through mergers, through service redesign, turnaround, or innovation and improvement. Thinking through what are the purposes which the leadership is pursuing is helpful.
- Styles or types of leadership may vary with the purposes being pursued at any phase of the organizational changes. For example, transaction

and transformational leadership styles are both relevant at different phases of merger/acquisition.

- Complex organizational change, such as mergers, may also be made more effective by relying on a 'leadership constellation' not just an individual leader.
- The leadership challenges of working in networks and partnerships are complex because leadership is generally fragile in conditions of diffuse power. The leadership challenge is to prevent internal rivalry, dislocation from the focal organization and lack of adaptation to environmental needs.
- Managing turnaround requires the building of leadership capacity and the use of legitimising actions (to reassure external stakeholders) as well as internal activity to overcome inertia and generate confidence to improve.
- Organizational change and improvement is the task of all kinds of formal and informal leaders in the workplace. Some may be constrained by role expectations and organizational culture, suggesting that such changes need to be whole system approaches.
- Innovation and improvement are different in scope and scale and may require different types of leadership. Innovation requires empowering others to be creative and creating an organizational climate with psychological safety.
- While there are useful comparisons and lessons from the private sector for example, in relation to mergers/acquisitions and turnaround), there are also differences which leadership needs to take account of (for example the need to engage with other external stakeholders such as national and local politicians, and audit and inspection organizations).
- A further job for leaders, and one easily squeezed out by other pressures but nevertheless very important, is nurturing future leadership talent so that leaders actively develop future generations of leaders.

Research implications

- Too little research has shown an interest in leadership purpose (focusing instead on leadership behaviours or leadership processes). How do leaders frame their challenges and how does this vary by context? There is a need for much more research in this area.
- The distinction between technical and adaptive problems has been made by a small number of researchers but to date there is still insufficient work applying this distinction to leadership challenges, and notably this is the case in relation to healthcare. There are plenty of adaptive problems in health so this could prove a fertile ground for further research and the testing of these ideas in practical application.
- There is still insufficient research into the leadership challenges of leading innovation in public services in general, and healthcare in particular.

Want to know more? Further reading

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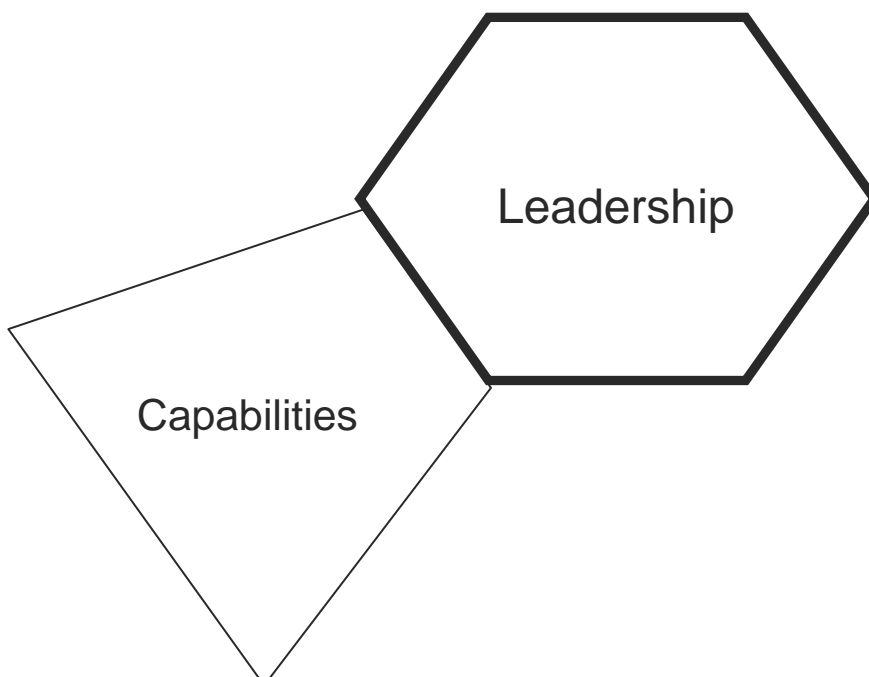
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CHAPTER 6

THE CAPABILITIES OF LEADERSHIP

In this chapter:

What are the attributes or qualities of leaders which are most closely associated with effective leadership? The chapter starts by looking at the individual leader and considering the evidence about qualities in terms of traits, behaviours and competency frameworks. The chapter includes a consideration of emotional intelligence and of political awareness as capabilities of leaders, along with the suggestion of 'meta-competencies'. The chapter then turns to looking at the behaviours and capabilities of teams (e.g. across a team, a board, an inter-organizational partnership). The chapter then focuses on capabilities in terms of processes of influence between the leader and those being influenced – so we look at transformational and transactional leadership –and post-transformational leadership. There is also a brief consideration of the question of gender – are women different or not in their approach to leadership and what are the implications for diversity more generally?



This chapter is based on the next segment of the framework about leadership. Some leadership writers would put capabilities right at the start of the book – so why have we not done this?

Thinking about individual qualities of leadership might seem a logical place to start (who are the leaders and what qualities do they possess). It would fit with the tendency which still exists across much of the literature to focus on ‘heroic’ leadership – the assumption that leaders are different from ‘followers’ in terms of some features of their intellect, motivation and/or personality. However, in this book we place this review of capabilities much later.

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

Traits

Early research (up to and into the 1940s) into leadership had focused on traits, such as personality, physique and cognitive style. These were assumed to be fixed and largely inherited¹⁸³. Large lists were generated of the traits which were associated with effective leadership (largely, at that stage, the leadership of small groups).

There were a number of problems with the trait approach to leadership. First, it assumed that leaders were largely born rather than made, because the traits were seen to be innate. Second, however, the list of traits grew and grew. Third, this approach did not take into account the different contexts within which leaders carried out their work, which was found to have an impact on

leader effectiveness. Fourth, contemporary understanding of personality is that many elements of it may not be fixed but can be developed over time, according to context, life experiences and self-awareness to develop. On the whole, research has moved on from seeking traits to looking at leadership styles and leadership behaviours.

Despite this, a limited number of personality characteristics have been found, in review studies, to be linked to specific leadership approaches. For example, Bass¹⁸⁴ (1998) found in empirical studies of transformational leadership that intelligence, ascendancy, optimism, humour, need for change, behavioural coping, nurturance, internal locus of control, self-acceptance, extraversion, hardiness and physical fitness were related to effectiveness. More succinctly, other research found that *“positive, adaptive, developmental and people-oriented traits form a distinct personality pattern that support’s transformational leadership’s social influence process”*¹⁸⁵. However, this is based on traits associated specifically with transformational leadership and so this may not be relevant to all situations. Overall, the view is that trait theory had very limited applicability to understanding the leadership qualities of effective leaders¹⁸⁶

Behaviours

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

Early work, such as the famous Ohio studies¹⁸⁷, found two key dimensions of effective leadership of small groups. These dimensions were labelled *consideration* and *initiating structure*. These reflected behaviours by the leader concerned with consideration for the social and emotional well-being of their subordinates or a focus on shaping and progressing the task. These twin themes of a focus on people and/or task have been echoed in other studies¹⁸⁸ and provide a powerful framework for thinking about leadership styles. These themes have also shaped thinking about leadership development, where a focus on improving personal and interpersonal skills to work with others, and on strategic vision and managerial competencies to address the task has been important. For example, a recent leadership development programme run by the Health Foundation focused on building the capability of multi-disciplinary teams both to work with each other and to reflect on the task of tackling diabetes care.

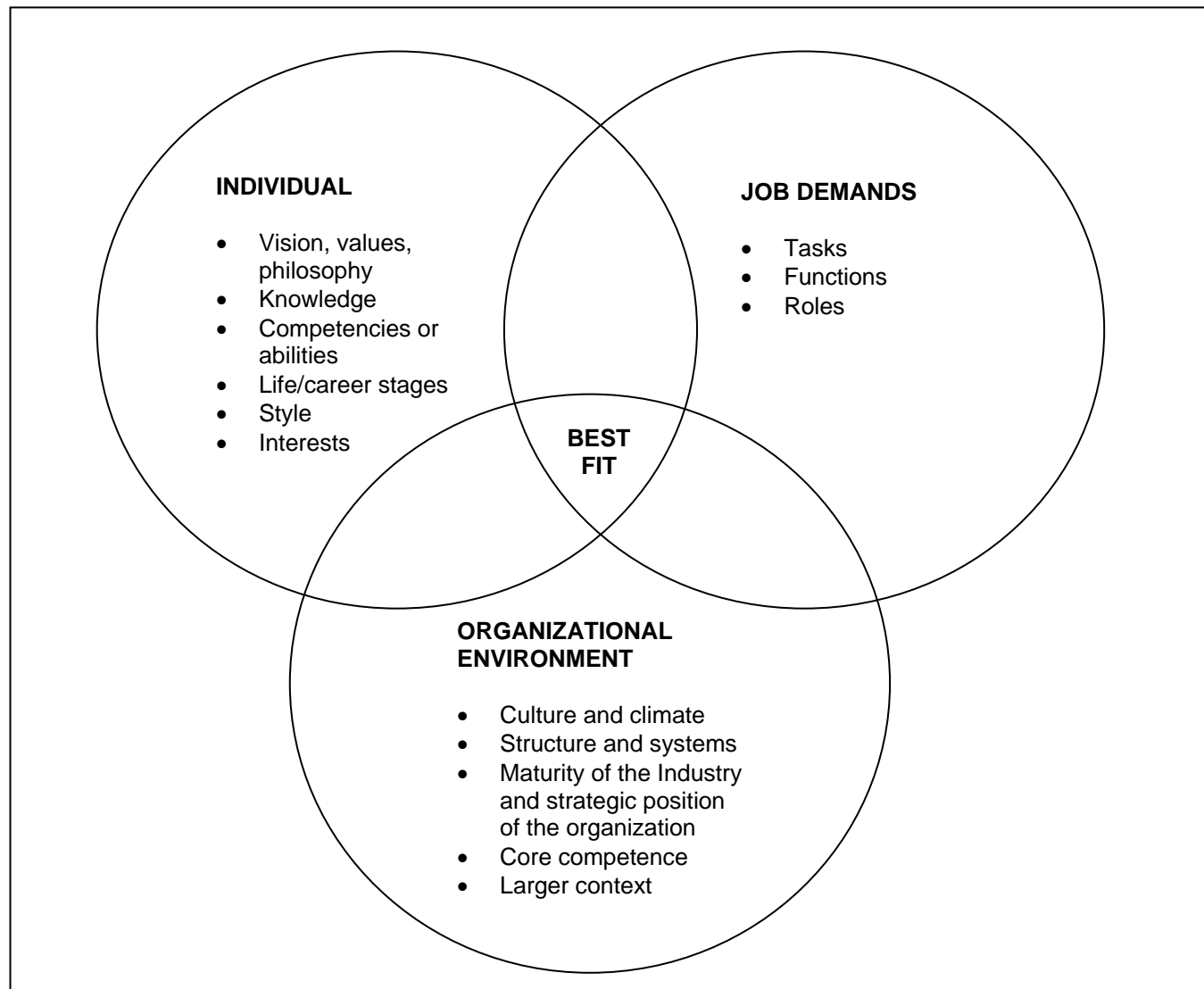
Competencies An important approach to understanding the behaviours of leadership has come from the competency frameworks, originally pioneered by Boyatzis¹⁸⁹ and widely used both to understand and to improve leadership qualities.

A competency has been defined by Boyatzis as an “*underlying characteristic of the person that leads to or causes effective or superior performance*”¹⁹⁰. More concretely, this has been described as “*the skills, knowledge,*

experience, attributes and behaviours that an individual needs to perform a job [or role] effectively' (Hirsh and Strebler 1995, p^{**})¹⁹¹. The crucial difference between a trait approach and a competency approach is that the competency approach focuses on qualities which are expressed in terms of behaviour. There is also an assumption that competencies may be acquired (e.g. through learning, practice, experience) rather than inherited as traits are assumed to be. Some writers have become rather wary of using the language of competency (as too rigid and focused on standards and qualifications) and instead use the language of capability. Other writers use the terms interchangeably. Each expresses skills of effective performance whether these are technical skills, interpersonal skills, cognitive skills, or broader mind-sets and values.

Competencies, or capabilities, are conceptualised as related to job (or role) performance. A competency approach recognises (or should recognise) the interaction between the context and the person. Boyatzis¹⁹² shows this in the following diagram:

Figure xx: Boyatzis' Theory of job action and performance



Source: Boyatzis 2006

The figure shows the interaction between person and their context expressed as the job demands and the organizational environment. This recognises that leadership performance is not simply a matter of a particular type of person. This is a contingency view of leadership, in that it is affected by the situation that the leader is in, and is not solely dependent on the qualities of the leader.

Competency frameworks have become a widely-used approach to thinking about the skills of leadership. For example, the NHS Leadership Qualities Framework has been widely used in healthcare in the UK and is shown in Figure XX (below)¹⁹³. It sets out the key skills or competencies for leaders in healthcare, across a range of settings.

FigureXX: The NHS Leadership Qualities Framework



Another example comes from the USA, where researchers developed a competency framework for those working in public health leadership¹⁹⁴. However, this was developed through focus groups and discussion rather than through the more rigorous methodology adopted by Boyatzis, and is based on the idea of a baseline set of competencies rather than the behaviours associated with superior performance as in the Boyatzis model. The public health approach identified four main areas of job demand (challenge) and clarified the competencies required for each of: transformation; legislation and politics; transorganization (inter-organizational partnerships and networks); and team and group dynamics

Some have argued that a competency approach to leadership is restrictive because it creates abstract qualities about leadership. While Boyatzis

emphasised the need to consider leadership competencies in their context, in practice some organizations have treated competencies as if they can be conceptualised and used on their own, as essential and primary ingredients of leadership¹⁹⁵. In this restricted use, the focus can become blinkered to concentrate solely on the person's individual behaviours, at the expense of understanding the context or the job demands, and their interaction with capability. This reduces learning about what leadership skills are appropriate to particular contexts. There is a danger that competencies are then used mechanistically for promotion, or job evaluation or development.

A further difficulty can be the accumulation of a list of competencies, which (like traits?) can grow in number. For example, the US public health framework has 79 competencies. This becomes unwieldy, and there is a consequent danger of developing an idealised skill set which only a superhuman could achieve. Also, there is a danger of competencies becoming a descriptive list rather than a theory about how such skills contribute to effective leadership performance.

Some competency frameworks are more evidence-based than others – a focus on behaviours helps to make explicit what are the practices which contribute to effective performance and help to anchor performance in real, observed practices. This is in preference to judgements about skill which are not evidence-based but which are prone to personal judgements which are affected by personal biases, attribution errors and halo effects.

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

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

Emotional intelligence

Emotional intelligence¹⁹⁶ is a concept which suggests that people vary in how far they are attuned to emotional, not just rational, aspects of life. In terms of leadership, emotional intelligence involves awareness of the feelings, moods and emotions of oneself and others and the ability to act in ways which contribute to goal formulation and goal achievement taking into account the emotions of those whom one is attempting to influence¹⁹⁷. The interest in emotional intelligence provides a counterweight to those theories which had primarily emphasised rational aspects of leadership (e.g. analytical ability) and where emotion in the workplace was seen as dysfunctional. Scholarly opinion is divided as to whether emotional intelligence is a distinct capability or whether it is an amalgam of other capabilities¹⁹⁸. It has certainly been useful in alerting leaders to think about and act in emotional terms, not just in rational terms, and to harness emotions constructively in the workplace. This may be particularly important in healthcare, where staff are working with a range of emotions on the part of patients and having to deal with the consequences of that in their own work¹⁹⁹. There is an accumulating body of evidence which suggests that emotional intelligence, measured by a variety of tools, does have either a direct impact on leadership effectiveness, or else an indirect effect (for example, a link between emotional intelligence and transformational leadership style, or the organizational commitment of 'followers'.)²⁰⁰

Goodwin has also suggested that leaders in the NHS would benefit from using emotional intelligence to manage the stress caused by organizational and wider health system change, including managing their own anxiety and pressure²⁰¹. He draws on the Goleman model of emotionally intelligent leadership, which requires personal skills:

- To know what you are feeling and be able to handle those feeling without them wholly dominating your interpersonal relationships and decision-making
- To be able to motivate yourself to achieve personal and group objectives , be innovative and creative and to perform at your peak
- To sense what your team and others in wider networks are feeling and handling interpersonal and inter-organisational relationships effectively

Leading with political awareness

Political awareness, political astuteness or political intelligence are all terms which cover the ability to analyse and act as a leader taking into account diverse groups which may sometimes compete and sometimes collaborate. The NHS Qualities Framework defined political astuteness as “*showing commitment and ability to understand diverse interest groups and power bases within organizations and the wider community, and the dynamic between them, so as to lead health services more effectively*” (p. 21)²⁰².

Recent work by Hartley et al (2007) has examined the key skills of political awareness amongst senior leaders in the private, public and voluntary sectors in a large, national survey²⁰³. The political awareness skills framework is based on the recognition that increasingly leaders have to influence a diverse range of individuals, groups and organizations not only inside the organization but outside as well, through networks and partnerships, and because of the increasing transparency of organizations due to information and communication technologies. Political awareness skills were found on five dimensions, of personal skills, interpersonal skills, reading people and situations, building alignment and alliances, and strategic direction and scanning.

Some UK writers²⁰⁴ have examined the capabilities for health leaders working in networks. Goodwin notes that a senior manager such as a chief executive will need to work with, and attempt to influence, a wide range of stakeholders. Ferlie and colleagues found that having strong interpersonal communication

skills, including listening skills; having an ability to persuade others, and having an ability to construct and maintain long-term relationships were critical to an effective approach to leading health networks.

Over-arching competencies

Finally, in this section, Fletcher undertook an analysis of the competency frameworks in use by Welsh public service organizations i.e. in use in the NHS Wales, in Welsh local government, and in the Welsh Assembly government²⁰⁵. He found that it was possible to summarise the main strands of competency in terms of 8 principal themes, but that there were two *meta-competencies* in addition. Meta-competencies are over-arching competencies in that they enable the acquisition of other competencies²⁰⁶. Increasingly, as leaders operate in a dynamic and uncertain world, the competencies which gave effective leadership performance in the past may no longer contribute or contribute as fully to future performance. Therefore, the ability to acquire new competencies becomes crucial. Two meta-competencies enable the acquisition of further competencies. These are:

- Identity -accurate self-assessment; acting on feedback; engaging in personal development activity; modifying one's self-perception as one's attributes change
- Adaptability – identifying qualities critical for future performance; eager to accept new challenges, exploration of new territory, comfort with turbulent change.

The capabilities of networks and teams

The increasing interest in distributed leadership²⁰⁷ means that capabilities shared across a team or a board, or across the leadership of a group of organizations involved in partnership working is becoming more important. There is still relatively little work on the capabilities of whole teams or governance groups, much less research within the health sector.

More broadly, networking has been increasingly recognised as a key skill of leaders. For example, some case study work on collaborative community

health partnerships in the USA²⁰⁸ suggests that leadership has a number of themes in practice:

- the need to think in whole systems terms;
- to be able to develop, communicate and work with a vision of what is to be achieved, consisting of a core ideology and an envisioned future;
- collateral leadership which is another way of saying distributed leadership;
- power sharing across the partnership in order to build a broad basis of support;
- process-based leadership, by which the authors mean a set of capabilities which involves the leaders paying attention to how the work gets done as well as what is done.

An overview of network leadership²⁰⁹ pointed out that network leadership is not only about interpersonal skills and the ability to build relationships between people but that leadership has to understand the structural power which pervades such networks, particularly for public service organizations such as health. Denis et al note that *“In organizations where power is diffuse, success or failure of the strategic process depends, among other things, on the capacity of leaders to constitute and maintain strong and durable networks”* (p. 453). This includes the ability to *“pull together a powerful alliance with diverse internal and external actors”* (p. 454) and with the capability to *“think simultaneously in terms of both the project and the networks of support they can engage. He or she will be drawn to consider the diverse meanings that various project definitions will have for others and how those meanings might be reconstructed either discursively or practically to render them more or less attractive”* (p.454). This ties in leadership as being about the management of meaning, and sense-making, as well as the achievement of goals.²¹⁰

It has been noted²¹¹ that bringing about major organizational change in complex healthcare systems is more likely to happen where there is a “leadership constellation” in which different individual leaders play different

roles or contribute different aspects of leadership at different phases of change, and where leadership roles are constructed and reconstructed as the change progresses. A leadership constellation may be particularly important in organizations with multiple professions, priorities and views (such as hospitals or universities) where a coalition to define, build support for and engage in leadership is critical.

There has been a small amount of work on the capabilities of whole boards, and the skills required by individuals and by the whole board for governance²¹². Some work has suggested that chief executives and chairs have a leadership role to play in ensuring that a focus on clinical care is linked to all trust developments, so that the 'business of care' is considered alongside financial performance²¹³. This is perhaps an area where further research and development would be helpful.

So far, the focus in this chapter has been on the personal qualities of leaders, whether acting as individuals or in a network or grouping. The emphasis is on the leader and their behaviours and practices and less about the impact on those whom they are trying to influence. The chapter turns now to examine leadership style in terms of theories and ideas which are based on the relationship between leaders and those they try to influence. It is not possible to cover all theories in this field so we have selected one which has particular prominence in healthcare leadership research and which is influential but sometimes misunderstood. This is the area of transformational and transactional leadership. We then turn to consider 'post-transformational' leadership.

Transformational and transactional leadership behaviours and styles

Theories of transformational leadership have become very popular in leadership research and practice in recent years. They are interesting on two counts. First, this approach takes into account not only the skills of leaders but also the impact of leader behaviour on so-called 'followers' (though these are often not the subordinates implied in the word follower but individuals, groups and organizations whom the leader aims to influence). Second, the

theory tries to take into account the situations in which leadership is exercised. Third, it has attracted considerable empirical research, which provides evidence to support many (though not all) of its conclusions. It is an approach which has attracted interest in the healthcare sector, where a number of studies have been conducted.

Transformational leadership theory has been developed, alongside its apparently contrasting cousin, transactional leadership, from initial research by Burns into political leadership²¹⁴. Transactional leadership is based on an exchange process between the leader and followers. The transaction is based on what the leader possesses or controls and what the 'follower' wants in return for providing their services. The exchange may be economic, political or psychological, and the relationship between leader and follower may involve negotiation as a core component.

Transformational leadership, on the other hand, is based on the leader engaging with their followers. The leader aims to engage followers in going beyond their self-interest because the leader seeks to win their trust, admiration and loyalty and so they are emotionally as well as rationally inclined to do more than they originally expected to do. The theory of leadership behaviours has been particularly developed by Bass and colleagues in the USA²¹⁵ and Alimo-Metcalfe in the UK²¹⁶. The latter developed much of the empirical measurement and research with managers in health and local government. Nadler and Tushman have described transformational leadership as 'envisioning, energizing and enabling'²¹⁷. In his later work, Bass²¹⁸ outlines four key elements of transformational leadership, which are shown in Table XX

Table XX: Transformational behaviours

- Idealised influence (behaviour that arouses strong follower emotions and identification with the leader)
- Intellectual stimulation (behaviour which increases follower awareness of problems, and influences followers to view problems from a new perspective)
- Individualised consideration (providing support, encouragement and coaching to followers)
- Inspirational motivation (communicating an appealing vision, using symbols to focus subordinate effort and modelling appropriate behaviours)

Source: adapted from Yukl, 2006, p. 263

Transformational leadership has been very fashionable, and the view is sometimes heard that transformational leadership is 'better' than transactional leadership because it rises above a kind of pragmatic, cost-benefit analysis and exchange (transactional leadership) to engage followers emotionally in higher aspirations and goals (transformational leadership). However, while Burns has perhaps implied that transforming leadership is superior, Bass is very clear that effective leaders may use both types of behaviour styles.

Furthermore, transactional leadership can sound rather basic, with its focus on exchange, but some have argued that this under-estimates the skills of transactional leadership. Being clear, focusing on expectations, giving feedback are all important leadership skills.

Table XX: Transactional leadership behaviours

- Clarifying what is expected of followers' performance
- Explaining how to meet such expectations
- Spelling out the criteria for the evaluation of this performance
- Providing feedback on whether the follower is meeting the objective
- Allocating rewards that are contingent on meeting those objectives

Source: Adapted from Tavanti (2008)

Transactional leadership can be particularly effective in hierarchical organizations where the followers are subordinates and where the group is focused on achieving clear task objectives. Transformational leadership may be valuable in dynamic, unstable environments²¹⁹ where there is an accepted need for change and where the organizational or partnership climate is such that leaders are encouraged and given powers to be more entrepreneurial in their approach to the task and their group. Mannion et al²²⁰ argue for contingent leadership in healthcare organizations: *"leadership that is able to express and embody corporate vision, but equally able to follow through with the transactional details"*. Other research has found both transformational and transactional leadership development to be important for the health service²²¹ and this also corroborates the earlier analysis of transformational and transactional styles in relation to the challenges of leading change (for example, different phases of merger/acquisition, see p. XX)

Transformational and transactional leadership have been measured in a variety of ways, particularly through the Multi-Factor Questionnaire (MLQ)²²². In the health field, numerous studies have been undertaken with nurse managers, but fewer studies have been undertaken with doctors, or with health service managers²²³. Transformational and transactional leadership have also been explored using a range of research methods, including case studies, interviews and even experimental studies (based on laboratory tasks).

Avolio et al studied 520 staff nurses in a large hospital in Singapore and found that transformational leaders foster higher levels of identification and commitment to the organization from employees.²²⁴ This study suggests that it is important for senior leaders to create a greater sense of empowerment amongst staff in order to have a more positive effect throughout the organization. This is echoed in a national study of 396 nurses across the United States, where higher levels of transformational leadership tended to occur in more participative organizations.²²⁵ Drawing on Bass's model, studies carried out in 54 mental health teams at the University of Chicago, report that transformational leadership generally seems to have an overall positive effect and is associated with positive views of the organization and low burnout amongst staff²²⁶.

Transformational leadership has been the 'spirit of the age' from the 1990s onwards, and there has been considerable work on its qualities, its impact on subordinates and colleagues and the need to consider both transformational and certain elements of transactional leadership. It is valuable as an approach to thinking about the qualities which are advantageous for leadership in health, whether from doctors, managers, nurses or others. It emphasises the need to inspire others with a strategic purpose and to engage with hearts as well as minds. It is a relational view of leadership i.e. it is based on how leaders interact with others, rather than on abstract qualities in isolation. The approach, by focusing on style, implies that many of the behaviours can be learnt, fostered and developed. The focus on empowering others through intellectual stimulation, individualised consideration and so on means that it can help organizations to think about the 'leadership pipeline' as well as existing leaders i.e. helping to foster the next generation of leaders.

However, there have been some criticisms, and some of these are particularly relevant to public service organizations such as those in healthcare. First, researchers have noted that different versions of transformational leadership appear to emphasise different clusters of behaviour and this is particularly true of transactional leadership. This might become problematic for healthcare leadership development if the leadership model is either not clearly specified

or not understood. Second, there has been little exploration of how the characteristics of leadership (role and resources) interact with leadership behaviours. It could be that different bases of authority may lead to different uses of transformational leadership – one could imagine this being the case for the leadership behaviours of medical consultants compared with chief executives, board members or nurses, or doctors compared with patient representatives.

Third, one element of transformational leadership is ‘idealised influence’ i.e. behaviour that arouses strong follower emotions and identification with the leader. This element derives from the interest in charisma as an element of leadership, which is based on the beliefs amongst followers that the leader has unusual and valuable gifts. Arousing strong emotion can be problematic on three counts, particularly in public service settings. Public services are provided under a political mandate from government so there are inevitably tensions around how far leadership is based on charisma. Second, the attribution of exceptional powers and abilities to the leader can undermine the group’s sense of their own empowerment and abilities, setting up unhealthy dependencies on the leader. This is one aspect of the ‘dark side’ of leadership theory²²⁷ and this has fostered interest in post-transformational leadership. Third, there can be problems with charismatic leaders especially in closed environments, such as psychiatric wards and children’s homes. Fourth, a concern with transformational leadership theory is that its fashionable status means that it may be held up in some quarters as “the answer” to leadership, although the research evidence is more contingent, as noted. Thus, for these reasons, while the theory of transformational leadership is promising, it also has some limitations.

Post-transformational leadership

There has recently been a shift away from the focus on transformational leadership²²⁸. The series of corporate scandals such as Enron showed the limits of transformational approaches. Storey²²⁹ notes that “*a common trait in the charismatic leaders studied was their willingness to deliberately fracture their organizations as a means to effect change*”. There has been a

recognition of some of the darker elements of transformational leadership in some situations, including narcissism and arrogance.

The theory of adaptive leadership by Heifetz²³⁰ is a valuable antidote to the view of the exceptional leader as charismatic, arguing that leaders need to be able to disappoint the expectations of their group that they will solve all problems for the group. Heifetz argues that adaptive leadership helps to group to recognise and address the issues it is responsible for, thereby rejecting inappropriate dependency on the leader. Fullan²³¹ argues for an approach to leadership which is based on supporting learning in others across the whole organization.

What about gender?

Debate continues to bubble about whether women are different in their leadership capabilities than men. Behind the debate are questions of evaluative judgement (better or worse). A recent authoritative review of the literature concluded that *“there is no consensus in the literature about gender differences in leadership styles”*²³². Women are only slightly more likely than men to use transformational leadership, for example²³³.

But people do hold stereotyped beliefs about ‘natural’ gender styles and these could influence how people behave at work. For example, it is often expected that women will be more nurturing and this could encourage women to place more attention on interpersonal relations at work. There is also evidence that the stereotype of the ‘heroic’ leader is closer to a typical male set of traits than a typical female set of traits, and this explanation has been used to explain why there are fewer women managers²³⁴ and fewer women leaders²³⁵ in the workplace. Thus, the views about the talents of women or men may be less to do with their inherent qualities and quite a lot to do with the way that society views leadership.

These findings are also relevant in relation to diversity more generally. For example, there is a noticeable lack of black and minority ethnic (BME) managers in senior positions in the NHS. Understanding how leadership is

socially constructed and may disadvantage particular groups in society is an important area.

Policy and practice implications

- Capabilities refers to a range of skills, knowledge, experience, mindsets, attributes and behaviours that are associated with superior performance.
- It is helpful to think not about universal qualities of leadership, but what works, in what kind of role and what kind of situation.
- The search for personality traits has turned out to be a dead end. It is more useful to think about leadership in terms of behaviours and styles (clusters of behaviours)
- The shift from traits to behaviour also implies that leadership capabilities can be developed. Leadership development comes to the fore as a way to create future leaders.
- Competency frameworks are most useful where they consider behaviours related to the job demands (the challenges of leadership) and what is needed in a particular organizational environment. Leadership performance is not simply a matter of a particular type of person.
- Emotional intelligence has captured the interest of policy-makers and practitioners, because it emphasises the need to understand one's own and others' emotional states and capacities. It counterbalances more rational approaches to leadership which have focused on analytical skills. Both may be important.
- Leadership with political awareness is emerging as an important set of skills, as leaders at a variety of levels have to understand and work with diverse stakeholders inside and outside the organization, both locally and nationally.
- There is increasing interest in the competencies which enable leaders to acquire new competencies! These meta-competencies include accurate self-assessment including modifying one's self-perception as

one's attributes change; and also being receptive to and comfortable with change and challenge.

- Thinking not only about the capabilities of individuals but also of teams, groups and boards becomes increasingly important in the context of more distributed leadership and more complex challenges.
- Although transformational leadership is popular, the research evidence shows that both transformation and transactional leadership make important contributions to leadership, and that each may be relevant to different situations or different phases of leadership.
- There is increasing caution about the charismatic element of transformational leadership (arousing strong follower emotions) in public service (and other) settings. There is interest in 'post-transformational' leadership which is focused on creating a climate of organizational learning.
- There is sometimes speculation that women make better (or worse) leaders than men. The research evidence on individual capabilities is very weak indeed, suggesting considerable variation in the leadership capabilities of men and women. So it is not helpful to assume that women (or men) have particular leadership styles. This is valuable for thinking about diversity more generally.
- There is evidence of gender stereotypes in relation to leadership, which may help to explain the fact that there are fewer women managers and leaders in top jobs.

Research implications

- Research into capabilities needs to be based on a contingent approach i.e. the capabilities which are related to superior performance in particular contexts or with particular challenges.
- Research has underpinned some competency frameworks but more research is needed into explaining why and how particular competencies are effective in leadership. In other words, research needs to move beyond the descriptive to the analytical and theoretical.

- New areas emerging for further research in healthcare settings includes leading with emotional intelligence and leading with political awareness.
- Most research has focused on capabilities at the individual level, but there is an increasing need to understand 'leadership constellations' and how these shift during complex leadership challenges, such as managing large-scale change.
- In particular, there is a need for further work at senior strategic levels, such as boards, to provide strong conceptual foundations and detailed empirical evidence to support a range of governance approaches.
- The work on gender could be extended to other aspects of diversity, including black and minority ethnic leadership.

Want to know more? Further reading

Burke R and Cooper C L (2006) *Inspiring leaders*. London: Routledge.

Chapter 6 by Richard Boyatzis.

Sinclair A (2005) *Doing leadership differently: Gender, power and sexuality in a changing business culture*. Melbourne: Melbourne University Press

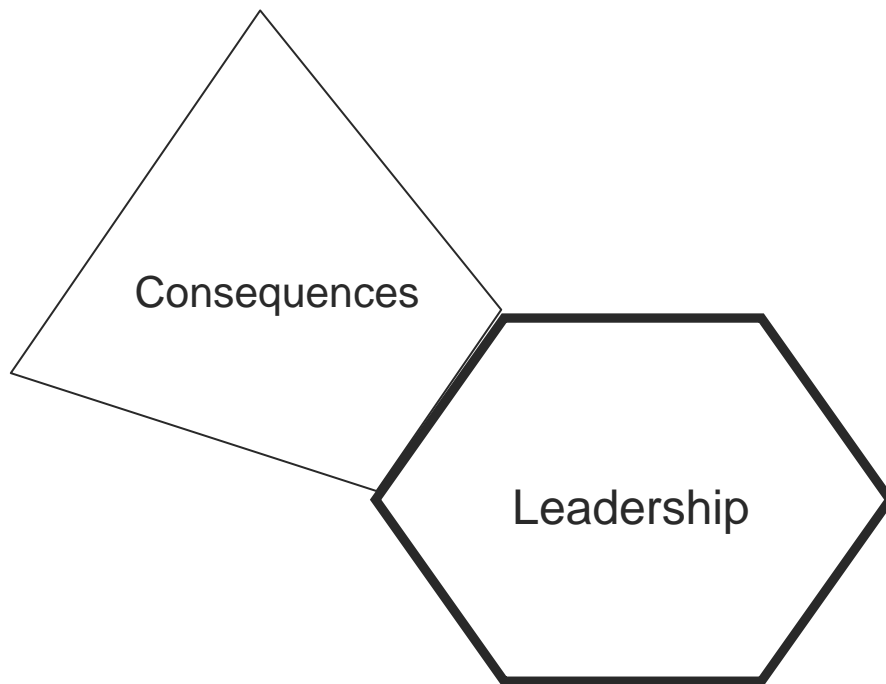
Storey, J. (2004). *Leadership in organizations: Current issues and key trends*. London, Routledge. Chapter 2

CHAPTER 7

CONSEQUENCES OF LEADERSHIP

In this chapter:

The ideas and the evidence about how leadership has (or is thought to have) impacts on other people and on organizational and health outcomes is examined. It is widely asserted that leadership is critical for organizational performance whether in the public or the private sectors. But what is the evidence? We examine the problems of establishing impact: lack of data; lack of clear causation; attribution errors which include assuming that because there is performance there must be leadership. The chapter then looks at two frameworks which may help to tease out impact, or consequences, of leadership. Yukl's framework focuses on three organizational impacts: efficiency and process reliability; human resources and relations; and innovation and adaptation. The chapter then takes a public value perspective on consequences by examining the public value chain of Moore. Evidence from healthcare is then examined in relation to this second framework, focusing on inputs, processes, partnership working and co-production; outputs, user satisfaction and outcomes.



There are any number of texts which assert that leadership is critical for organizational performance. In the public sector in the UK, there has been a particular emphasis on leadership as one of the means by which improvements in services and/or service transformation is achieved²³⁶. Health is no exception to this and the Darzi report²³⁷ pays particular attention to the need to develop leaders, both clinical and non-clinical, to improve healthcare.

However, while the impact of leadership on public services is often asserted, the evidence is more fragile or incomplete. There are problems on several fronts in relation to evidence. First, there is more writing about leadership in general descriptive terms than there is detailed research evidence. So, it is sometimes claimed that particular qualities, behaviours, or practices are relevant for “effective” leadership but no data are given. This leaves the field open to broad principles and vague generalisations which are not supported in evidence. Second, some writing is vague about what is the outcome that effective or influential leadership is expected to produce - what are the indicators and/or measures of performance as a result of, or associated with, leadership.

Third, the assumption is sometimes made that leadership results in improved outcomes implying a causal link from leadership to outcomes. However, it is also possible to have situations where group members believe that leadership is effective because there are positive outcomes! This is reverse thinking, a type of attributional misinterpretation²³⁸. The idea of charismatic leadership hints at this, where believers attribute extraordinary and exceptional qualities to the leader when they have positive experiences. There are also situations where the attribution is reversed but negative – where ‘followers’ attribute negative qualities to the leader where a situation does not meet expectations²³⁹. Thus, attribution can lead to disenchantment with the leader despite the leader’s best intentions.

Finally, there may also be situations where the leadership is so subtle or so participative that commentators are not aware of the full extent of the leader’s role in achieving outcomes. The aphorism of Lao-Tzu: *“But of a good leader who talks little when his work is done, his aim fulfilled, [the people] will say: We did it ourselves.”*

Attributional effects are found in relation to gender, as we explored in Chapter XX, where there can be different attributions about leadership effectiveness depending on whether the leader is male or female²⁴⁰. This is not about whether women are different as leaders but whether they are seen to be different and judged accordingly by those they come into contact with and try to influence.

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

With these caveats in mind, the chapter turns to consider two frameworks which may help to think systematically about potential impacts of leadership.

A framework of leadership and organizational performance

Yukl²⁴¹ unpacks the potential impact of leadership on organizational performance, setting out three major strands, or meta-categories, of the potential impact of leadership and these are shown in Table XX. He gives each strand some depth by looking at the initiatives which can be used by leaders to develop organizational (or team or service) performance. Impacts are not only through direct interaction with colleagues but also through having an impact on organizational systems which themselves shape individual, team and organizational performance.

Table XX: Management systems, programmes, and structural forms for improving performance (adapted from Yukl for healthcare).

Efficiency and process reliability

- Performance management and goal setting initiatives (e.g. management by objectives, target setting, zero defects)
- Process and quality improvement initiatives (e.g. lean management, six sigma, the productive ward, quality circles)
- Cost reduction initiatives (downsizing, outsourcing, budget restructuring)
- Structural design (reorganizations, commissioning arrangements; service reconfiguration)
- Appraisal and rewards linked to efficiencies and process reliability

Human resources and relations

- Quality of worklife initiatives (flexitime, job-sharing, child care, fitness centre)
- Employee benefits (terms and conditions, sabbaticals; study leave)
- Socialisation and team-building (induction, ceremonies, social events and celebrations)

- Staff development (continuing professional development, education, training, 360 degree feedback)
- Human resource planning (succession planning, recruitment initiatives)
- Empowerment initiatives (self-managed teams and collaboratives)
- Appraisal and reward linked to service, skill or skill acquisition

Innovation and adaptation

- Needs analysis initiatives and environmental scanning (e.g. health needs in particular populations and subgroups; policy analysis)
- Market analysis (intelligence to inform commissioning, benchmarking; competitor products and processes; international comparisons of healthcare services and processes)
- Innovation initiatives (creativity development, intrapreneurship, piloting and testing)
- Knowledge acquisition (ideas from a range of sources; promising practice ideas; evidence-based practice)
- Organizational learning (knowledge management systems, seminars and workshops; debriefing, learning from near-misses in clinical practice; developing models of learning, use of OD managers and leads)
- Temporary structural forms for implementing change (e.g. steering committee, task force, diagonal slice of staff)
- Growth and diversification initiatives (preparing for Foundation Trust status, building clinical specialities, strategic commissioning, joint ventures)
- Appraisal and rewards linked to innovation and patient satisfaction

This framework provides ideas about how a leader can judge their own impact or that of others in leadership positions.

A public value perspective

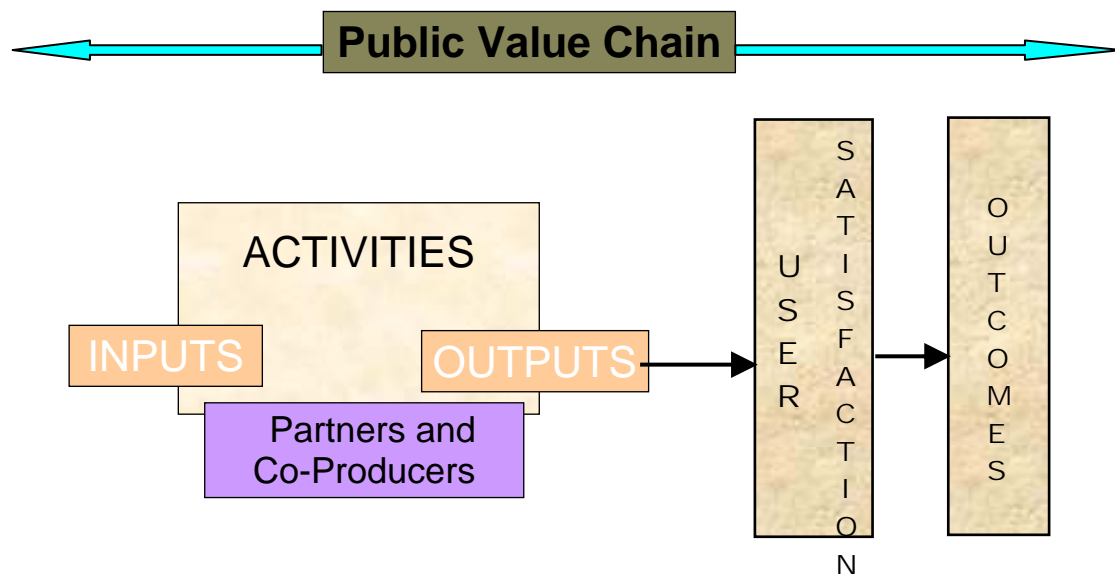
The Yukl framework is valuable when considering consequences in terms of organizational performance. But a wider view may also be valuable. One

feature of organizations providing goods and services for the benefit of the public (whether in the public, private or voluntary sectors) is that they are embedded in society, producing not only benefits (and obligations) for individuals but also providing goods and services which may benefit (or detract from) the wider community and society, for example, reducing the risk of diseases in the community, preventing climate change, building public trust and confidence in the healthcare system, establishing collective efficiency and collective rules and purposes²⁴². In terms of healthcare, it is possible to think about not only activities and services to treat illness and disease, but also the contributions which healthcare can make to illness prevention, and to a societal culture in which people take responsibility for many aspects of their health through their lifestyle choices. A public value perspective argues that healthcare can incorporate attention to promoting wellbeing (physical and mental) not just treating illness. A public value perspective also becomes increasingly important as the UK health service shifts more into 'predict and prevent' rather than just 'treat'.

Public value is one approach to conceptualising the activities, outputs and outcomes relevant to the public sphere. The concept derives from the USA²⁴³, but has also been developed in the UK context²⁴⁴. These ideas have been applied to the BBC, to further education – and are increasingly being applied to the health service.

Public value can be conceptualised using the value chain (see figure below), examining where value is added by inputs, activities and processes, outputs, user satisfaction and outcomes. The attraction of the value chain is that it enables the added value of a public service such as healthcare to be assessed at each stage. A key question for leadership is whether and how leadership can contribute to the public value chain.

Figure XX: The public value chain



Source: Adapted from Mark Moore.

Examining leadership in healthcare from this perspective, leadership might contribute as follows:

Inputs: How leadership (and leadership reputation) influences recruitment and selection of staff; financial resources available to the organization; technological resources; other inputs

Activities: How leadership has an impact on the activities which take place within the healthcare organization, for example systems and procedures, team-working, improvement and innovation initiatives, organizational and cultural change.

How leadership has an impact on the attitudes and practices of staff within the organization.

How leadership contributes to organizational capability and capacity (including the 'leadership engine' mentioned in Chapter XX).

Partnerships: How leadership has an impact on partnership (and network) strategies and activities, given that so many healthcare activities are undertaken through partnerships and networks.

How leadership has an impact on the co-production of health working with communities, the use of members of the community as health trainers and so on. Part of the leadership role may be about helping patients to understand where they can contribute to their own health outcomes rather than just relying on health professionals (e.g. medicine compliance, following health advice, thinking about preventative health actions through lifestyle).

Outputs: How leadership shapes the outputs, for example, the number of operations undertaken, the quality of health care advice, the proportion of the population screened or immunised etc.

User satisfaction: How leadership influences patient satisfaction, and the satisfaction of those who are carers for patients (e.g. families, relatives, health advocates).

Outcomes. How leadership has an impact on health outcomes more broadly e.g. trust and confidence in medical practitioners amongst the population; prevention of future illness, and so forth.

Public value may be examined from a number of stakeholder perspectives – both internal (e.g. doctors, nurses, managers) and in terms of external stakeholders such as the government, the local authority health scrutiny panel, advocacy and patient groups and so forth. They may not always agree on some elements of impact. Public services are inevitably contested, through formal political channels, the media and in teams, organizations and communities.

The evidence of the impact of leadership on organizational performance and on health outcomes

It is often asserted that leadership has an impact on the group being influenced, on organizational performance (which in the case of health might include quality of treatment or care or amount or efficiency of treatment or care) but it is important to turn to the evidence to know:

- Whether a relationship exists
- What aspects of leadership contribute to the impact (i.e. not just 'leadership as a broad concept')

- How the impact is thought to happen
- Whether the impact is direct (e.g. immediate impact) or indirect (through other variables).
- What contingencies or features of the organizational or wider context affect whether leadership is effective or not.

We will explore the empirical evidence using the public value chain framework.

Inputs

The literature review did not reveal any studies about the impact of leadership on inputs. Anecdotally, there is a view that inspiring or effective leaders attract good staff to work with them, but more robust evidence was not available. An interim report from consultation with chief executives in 2004²⁴⁵, found that they estimated that about 20% of leadership success in acute trusts was due to 'legacy' i.e. that organizational performance was partly due to the organization's history rather than current situation. Part of this legacy might be presumed to be the previous leadership. Recent work about senior management in the university sector²⁴⁶ suggests that the choice of leader is affected by the type of previous incumbent, such that there are signs of a pendulum swing between academic and managerial types of vice-chancellor. Both pieces of research are a reminder that leadership rarely starts with a blank canvas, but must take recent organizational history and current organizational culture into account in leadership activities.

Activities

It is possible to examine the impact of leadership on: staff attitudes to work, attitudes to work practices, attitudes to improvement and innovation, and the use of scientific evidence in health professional practices.

The idea that leaders have an impact on the attitudes and behaviours of the staff they directly supervise has been established since leadership studies began. In relation to health, a number of studies have examined leadership

approach and job attitudes among nurses. For example, Morrison and Jones²⁴⁷, in a US survey of nurses, found that both transformational and transactional leadership correlated with job satisfaction but that transformational leadership had a greater impact on empowerment (as the theory would predict). In a study of nurses in 17 Belgian hospitals, Vandenberghe and colleagues²⁴⁸ went further: they found that transformational leadership augments the effects of transactional leadership on self-reported job satisfaction, satisfaction with the leader, organizational commitment, work effort and reduced intention to leave the job²⁴⁹. Other work in health has found that transformational leadership is associated with lower levels of burnout, specifically emotional exhaustion, amongst nurses – along with some aspects of transactional leadership including assigning tasks, specifying procedures and clarifying expectations²⁵⁰. These findings appear to reinforce the view, examined in the capabilities chapter, that both transformational and transactional leadership are important.

At the unit level, transactional leadership was associated with perceived unit effectiveness more than transformational leadership²⁵¹. This underlines the need for good management as well as good leadership in many organizational settings.

The largest and most relevant study in the review involved over 23,000 staff across 134 UK trusts (acute, specialist, primary care, mental health and ambulance)²⁵². Both top management team leadership and immediate (direct supervisory) leadership was associated with staff well-being (overall job satisfaction and intention to leave the trust). However, the relationship was much stronger with the direct leadership, suggesting that it has a particular impact on staff attitudes towards their work.

All of the studies reported are based on cross-sectional data (data collected at the same time) and so it is not possible to say that leadership causes staff attitudes to work. However, work outside health has suggested that the relationship is causal, based on research conducted over time²⁵³.

Having reviewed job attitudes, attention now turns to consider the impact of leadership on work practices. These include behaviours related to improvement and innovation in the workplace, and also the use of evidence-based practices.

One study found that leadership which encouraged empowerment and self-efficacy (belief in one's ability to be effective) amongst nurses was also associated with a higher level of professional practices²⁵⁴. Research with mental health providers²⁵⁵ found a relationship between transformational leadership and the willingness of staff to voluntarily adopt evidence-based practice. However, willingness to adopt was also influenced by aspects of the internal organizational context such as policies and procedures. There were also individual differences related to education and experience.

A large study by West and colleagues²⁵⁶ about leadership, team processes and innovation in healthcare found that leadership had an impact on innovation but that the relationships varied by type of team and organizational context. The study examined healthcare teams made up of a variety of different professionals (e.g. GPs, nurses, administrative and managerial staff, specialist doctors and nurses, medical consultants etc. Leadership had the potential to influence four key team processes: clarifying objectives; encouraging participation; enhancing commitment to quality; and support for innovation. Leadership clarity was associated with better team processes, and with actual innovation – and ambiguity about leadership was associated with low levels of innovation. This supports the view of the role of leadership in helping to create compelling direction and ensure participation of team members in decision-making. However, leadership clarity was associated with innovation for community mental health teams and breast cancer teams, but not for primary care teams. Given that the latter are more varied in team composition, with less clear boundaries and roles, there may be an effect of group composition, type of task and degree of clarity about leadership not just the leadership approach.

A key review of the impact of leadership on quality and safety improvement was undertaken by Øvretveit²⁵⁷. He notes that *“although most literature emphasises the importance of committed leadership for successful quality and safety improvement, research evidence supporting this is scarce and often scientifically limited”*²⁵⁸. However, from the evidence available he concludes that senior leadership is critical for improvement, so long as those senior leaders have a strong commitment to quality improvement and show this through their behaviour. Examples of showing this include taking stock of quality improvement programmes and being flexible about their introduction based on what was being learnt on the ground. Other studies have reported a lack of leadership as being critical to poor attitudes to quality improvement. Involvement of the board and of doctors by senior managers was also important²⁵⁹.

Other roles are also important in improvement – including middle managers, doctors and other health professionals, and also ‘opinion leaders’ i.e. those whose opinion is influential with colleagues. *“Engaging’ doctors is essential to quality improvement”*²⁶⁰. The variety of roles involved in improvement suggests that creating organizational systems and a climate which supports improvement is valuable.

Øvretveit argues for the need to consider the impact not just of individual leaders but of ‘a system of leadership for improvement’ which *“are all formal and informal leaders, teams and groups which support improvement as part of the everyday work of the organization”*²⁶¹ where leaders for improvement are *“any people who influence others to spend time on making the service better for patients”*. This requires thinking about organizational capacity and organizational processes.

Finally, Barrett and colleagues²⁶² argue that in complex organizations (such as regional health authorities in Canada) there is a need to see leadership as one of the important foundation for organizational learning and for leadership to promote practices which support and enhance organizational learning. They found a relationship between leadership and such capacity-building.

Partnerships and co-production

The review did not find evidence, other than on an anecdotal level, relating to the impact of partnerships on either organizational practices or outcomes, though this is clearly an important area to evaluate.

Co-production is the idea that some (not all) services are created by the interaction of 'producer' (e.g. doctor, pharmacist) and 'consumer' (e.g. patient). The service cannot be effective in terms of health outcomes unless there is a willing, capable and attentive patient or patient advocate. So the impact of leadership on encouraging the recruitment and engagement of patients, community representatives and others in the design and delivery of healthcare could be important. There are examples of leadership encouraging, for example, the involvement of newly arrived refugees to support the health activities of others in their own language and cultural communities, or a variety of forms of public and patient involvement. This review did not find systematic evidence on the specific role of leadership, though the wider set of issues about building on experience-based design is starting to gain ground in healthcare²⁶³, though research in other fields suggests that it is important in service sectors²⁶⁴

Patient satisfaction

Evidence of the impact of leadership on patient satisfaction and patient outcomes is hard to come by, perhaps in part because the impact of leadership is indirect (mediated through the actions of staff and the quality of systems of healthcare). In fact, one study of managerial leadership in just over 200 US hospitals²⁶⁵ found that senior management leadership is more strongly linked with process quality than with clinical quality. *"...hospital management has more influence on process design, improvement and execution than on clinical quality, which is predominantly the doctors' domain."*²⁶⁶. Goodwin (2006) comments that poor leadership has a greater impact on patients than on staff though does not provide evidence to support this conclusion.

Work by Borrill and colleagues²⁶⁷ however, provides some hard performance data, including patient satisfaction, number of complaints as a percentage of treatments, trust star ratings (the former national rating system for trusts), and CHI clinical governance review ratings on a sample of over 130 trusts. The research found a clear relationship between leadership by the top management team and trust star ratings. Better senior leadership was associated with fewer patient complaints. Leadership effectiveness was also associated with overall clinical governance review ratings by staff.

However, there were differences between direct and indirect leadership. The study reported no relationship with patient complaints or patient satisfaction at the direct immediate level. This suggests that different types of leaders have different impacts on performance depending on their level or area of responsibility.

Outputs

Outputs can be examined both directly (e.g. tests and operations performed) and indirectly (through external audit and inspection regimes). Some research shows that the impact of leaders on overall organizational performance is through shaping or influencing the culture (and some of the sub-cultures) of the organization. Mannion and colleagues²⁶⁸ used a research design of 6 high and low performing hospital trusts in the UK (based on star performance ratings, with 2 high and 4 low performing trusts) and then carried out case studies of their functioning, including leadership and management orientation. Their analysis suggested that high and low performance environments may be very different environments in which to work, suggesting considerable cultural divergence. Interestingly, they found that the leadership in high performance trusts were characterised by top-down 'command and control' styles, with strong directional leadership from the centre and a 'top-down' approach to performance and organizational change. In contrast, the four trusts deemed to be low-performing, with new senior management teams because of the 'under-performance' were characterised by leaders who were widely seen to be charismatic. But they were seen to

lack the transactional leadership skills needed to create and maintain effective performance management systems.

Additionally, in this study, the use of emotional engagement through charisma also meant that loyalty to the senior management team was highly valued – and that the organizations seemed to have a rather mono-culture with insufficient questioning and exploration as a result, and with an ‘emasculated’ middle level of management. There was a focus on internal functioning but insufficient attention to the demands from the external environment and with an over-dominance of clinical interests in decision-making. This is a small but detailed case study project, which raises important issues about the relationship of leadership style to the task in hand, and the influence of the external context on the leadership challenges²⁶⁹.

Buchanan²⁷⁰ argues for the need when designing leadership development, to consider organizational effectiveness from a number of different angles, in order to avoid being trapped in a particular leadership style. He suggested that the balanced scorecard by Kaplan and Norton is one way to try to ensure a rounded view of performance and could be applied both to individual organizations and to those which promote and provide leadership development.

Outcomes

Evidence on the relationship between leadership and health care outcomes at the societal level have not been found in our review, but the need to think about the wider purposes of healthcare organizations in public value terms may be important for future research. Effective healthcare organizations – and therefore leadership of these large complex organizations – is not just about the number of patients treated, but is also about how to contribute to a happy, healthy (in all senses) society.

A contingency view of consequences

This chapter has reviewed the ‘consequences’ of leadership, though also noting that attributions affect what is perceived as leadership and as

consequences. The evidence is less than the assertions or claims about the importance of leadership in performance at team, service, staff and patient and organizational levels. Nevertheless there is some evidence that leadership can have an impact on these elements, though there is a need for much more information about how and why leadership has these impacts.

There is also a need to understand more about the contingencies of effective leadership. What are the environmental contexts or organizational conditions which promote or inhibit the relationship between leadership influence and outcomes? This chapter has shown that some aspects of leadership are associated with outcomes in some settings and some tasks. Certain types of leadership, for example, direct or indirect, are more closely associated with certain outcomes than others.

Therefore, the evaluation of leadership impact needs to be based on “what works for whom, when, how and why” rather than on universalistic principles. Earlier, it was noted that a key skill of leadership is “reading the context” and this may be crucial for thinking about how best to create consequences for staff, patients, the organization and the for wider public value.

Policy and practice implications

- Perceptions of leadership effectiveness and leadership impact are shaped by attributions (how people explain what is cause and what is effect). These may not be accurate but can be firmly held. This can have a prejudicial impact on leadership by women (and probably minority ethnic leadership too).
- Effective leadership may not be noticed or commented on. A consolation for the leader who has worked hard but who does not receive appreciation!
- In terms of organizational performance, strategic and operational leaders may wish to reflect on how far they are able to have an impact on efficiency and process reliability, on human resources and human relations; and on innovation and adaptation.

- A wider public value perspective also considers the impact of the healthcare organization on the public sphere.
- The public value chain is one useful way to conceptualise the potential impact of leadership on healthcare: through the impact on inputs, activities, partnerships and co-production; on patient and carer satisfaction, on outputs, and on outcomes.
- Different stakeholders may not agree on elements of public value which are created. The impact of leadership is not an exact science.
- There is a fair degree of evidence that leadership can have an impact on staff attitudes. Both transformational and transactional leadership can contribute to job satisfaction but transformational leadership seems to have a greater impact on a sense of empowerment.
- Direct leadership is particularly significant for staff attitudes.
- The impact of leadership is also affected by organizational context, including type of task, type of team, organizational culture and roles.
- Leadership has a substantial role to play in creating organizational climates which support patient safety and a commitment to quality improvement.
- More effective senior management is associated with fewer patient complaints
- While there has been a strong fashion for transformational leadership, research on leadership style and trust ratings suggests that transactional leadership can be important for creating and maintaining effective performance management systems.
- There are arguments for adopting a multi-faceted approach to measuring the impact of leadership. The public value chain is one approach, the balanced scorecard is another.

Research implications

- While the impact of leadership is often asserted, the evidence is thinner on the ground. The evaluation of impact is a high research priority.
- The public value chain framework provides a useful tool for considering not only what is known about leadership impact but also for identifying

where particular gaps are. There is less evidence on partnerships, on co-production, on patient satisfaction and on public value outcomes. (Most work has been on the impact on staff attitudes and staff clinical and other behaviours)

- Research needs to take into account the social attributions which are made about leadership. There is a need for further research into 'reverse causation' of the impact of leadership.
- The attributional issues also means that evaluation should use not only perceptions of leadership but also 'hard' measures where these can be collected.
- Evaluations of leadership sometimes start with the current state of the organization but leadership rarely operates on a blank canvas. Understanding the impact of organizational (and community) history may need to be part of the evaluation.
- There is negligible work on the role of leadership in fostering co-production (as well as the contribution of co-production to health outcomes). This is likely to be an area with a growing research agenda.
- Research evidence to date appears to be inconsistent with universal principles or styles of leadership. Instead, a realist evaluation framework may be more valuable, where researchers ask the questions: what works for whom, in what circumstances, when, how and why?

Want to know more? Further reading

Benington J (2005) From private choice to public value. *Public Management and Policy Association Review*, May, 6-10

Moore, M. (1995). *Creating Public Value*. Cambridge, MA: Harvard University Press

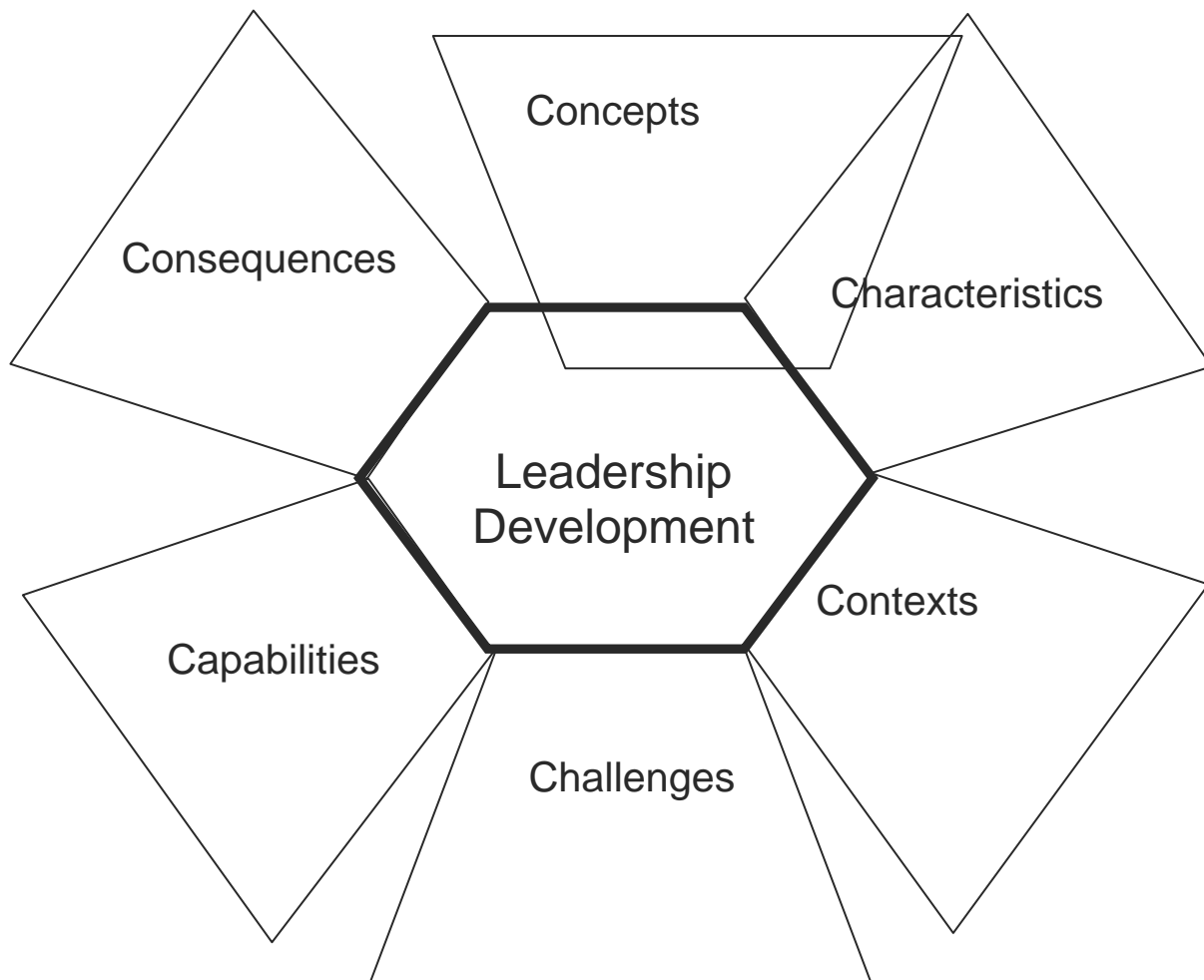
Øvretveit, J. (2005). The leaders' role in quality and safety improvement: A review of research and guidance. Stockholm: Karolinska Institute.

CHAPTER 8

FROM LEADERSHIP TO LEADERSHIP DEVELOPMENT

In this chapter:

We examine some of the implications of the review for how leaders and leadership are developed. We return to the “Warwick road map” about leadership, and use the ‘segments’ to inform thinking and practice about leadership development, drawing on understanding of concepts, characteristics, contexts, challenges, capabilities, and consequences and using these to critically think about and design leadership development practices. The chapter defines leadership development and presents a framework for thinking about how far leadership development is focused on individuals and how far it is focused on teams, groups or organizational capacity. The framework also shows a continuum of development from intentional development (e.g. education and training programmes, mentoring, and those experiences from which development is derived (e.g. job challenges and hardships). The implications for selecting staff for leadership development opportunities, for designing leadership development, and for evaluating leadership development are explored.



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

This book has reviewed some key literature about leadership – what, then, are the implications for leadership development? This is an important question because research shows that leadership development is often embarked on organizations with insufficient attention to the implicit or explicit model of leadership which is being used, either by leadership development commissioners or providers. There is sometimes an implicit belief that

leadership development is 'a good thing' without clear planning to ensure that it fits with the strategic direction and priorities of the organization, that it is supporting appropriate skills and values, that it is efficient in resource terms, and contributes not only to individual development but also to organizational change and improvement.

There is sometimes also a view that there is a 'right' or 'best' (universal) approach to leadership development, but a number of writers have dismissed this²⁷¹, arguing instead for the alignment of leadership development with organizational purpose, practices and people. This chapter aims to help ask appropriate questions for leadership development by using the roadmap about leadership presented in previous chapters.

What do we mean by leadership development?

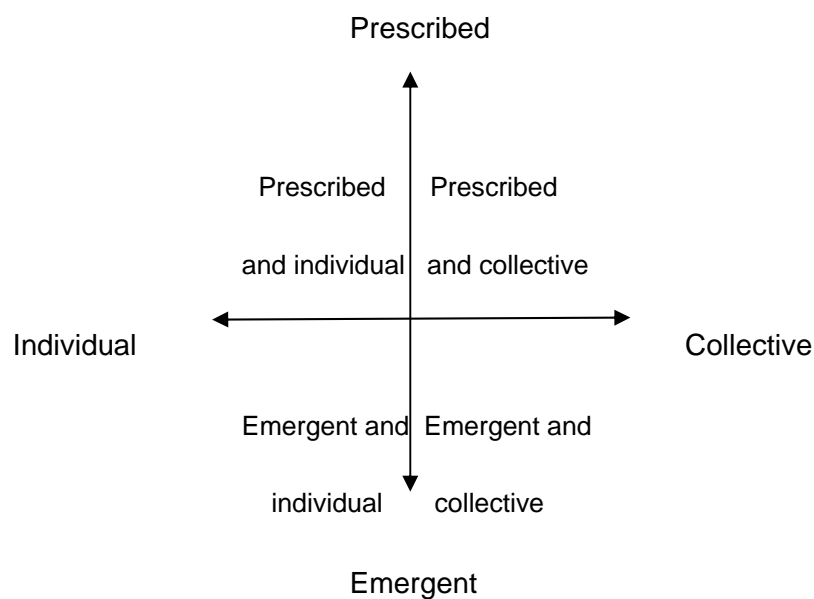
Leadership development concerns the activities which are used to enhance the quality of leadership and leadership potential in individuals and in groups and across the whole organization.

Until recently, the focus of leadership development has been on formal training and education programmes. While these are still important, there has been greater recognition a range of experiences, including informal and intended activities and experiences can be very formative in developing the skills of leadership²⁷².

Rodgers et al²⁷³ provide a typology for both leadership development and its evaluation in the public sector. They argue that there are two key dimensions when conceptualising leadership development. The first dimension is the extent to which leadership is conceptualised as about individuals or collectives (e.g. teams, distributed leadership, shared leadership). The second dimension is the extent to which leadership is prescriptive or emergent. By prescriptive is meant that it is possible to define the inputs (e.g. skills, competencies, traits etc) or the outputs (e.g. standards, performance) required for leadership (and therefore leadership development) in particular organizational settings. By contrast, emergent approaches to leadership and

leadership development see leadership as a dynamic process, with a set of interactions between leaders, followers, context etc and therefore that leadership has emergent properties (which cannot be predicted in advance). This leads to four quadrants of leadership development and leadership development evaluation, as shown in Figure XX.

Figure XX. A framework of leadership development (Rogers et al, 2003)



Source: Rodgers et al, 2003

This map is helpful in that it focuses both on individual and collective leadership, and also is a reminder that leadership development is not solely a set of training programmes or formal development activities.

In thinking about leadership development, it is useful to think of three elements: how people are selected for the leadership development activities; the design and use of leadership development activities; and the evaluation of leadership development activities. We will examine these using the Warwick roadmap outlined earlier.

The concept of leadership

The chapter on the concept of leadership earlier noted that leadership is often assumed rather than defined, and that there are a variety of ways of conceptualising leadership. A number of writers have warned of the difficulties which can arise if the model of leadership is not clear, or if the approach to leadership is based on fashion.

The literature shows that the approach to development is influenced by the model (explicit or implicit) of leadership being used. For example, Alimo-Metcalf and Lawler²⁷⁴ note that the concept of leadership was nebulous and ill-defined in the 30 organizations they studied and that this is problematic for leadership development for a number of reasons. Unless there is a clear and agreed approach to the concept of leadership and an agreed framework, then leadership development practices may be inappropriate for the kind of leaders which the organization is aiming for (e.g. developing transactional leaders when the organization needs transformational leaders) or old and out-dated practices may be relabelled as “leadership” to suit the current organizational rhetoric. In particular, if there is not a distinction made between management and leadership, then some leadership development may actually be traditional management development²⁷⁵. Alternatively, in the “rush to leadership”, courses may be designed to enhance a diffuse understanding of leadership where actually practical management is more appropriate.

It was noted in Chapter XX, that clarifying the distinction between leadership and management can be important, given the degree of confusion between the two concepts and the varied ways in which they are used. which exists between the two terms. Day²⁷⁶ suggests that:

“Leadership development is defined as expanding the collective capacity of the organizational members to engage effectively in leadership roles and processes...Leadership roles refer to those that come with and without formal authority, whereas management development focuses on performance in formal managerial roles. Leadership processes are those that generally enable groups of people to work together in meaningful

ways, whereas management processes are considered to be position- and organization-specific.” (p.582)

He notes an overlap between leadership development and management development, but suggests that management development tends to focus on enhancing task performance in management roles, whereas leadership development involves building the capacity of individuals to help staff learn new ways of doing things that could not have been predicted.

If the concept of leadership is a ‘heroic’ one i.e. the notion that leadership is about exceptional individuals, then there is a danger that leadership development will focus on personal development to the exclusion of, for example, context. It is also likely to focus more on selecting the ‘right’ people for development opportunities, rather than widening the opportunities for development across a group or organization.

If leadership is thought of as a set of influence processes between individuals, groups and organizations, then a different set of leadership development activities may be devised. But a focus on ‘process’ alone may create a rather lop-sided approach to leadership development, which under-emphasises context, roles or resources.

Thus, clarification of the specific concept of leadership being used in any given setting is an important pre-requisite for effective leadership development.

Characteristics of leadership

In Chapter XX, it was noted that leadership may vary according to the role (e.g. degree and type of authority, whether the people to be influenced are near or distant to the leader; the degree to which professional expertise is relevant to leadership). Leadership development activities need to be geared to the roles and resources of those in leadership positions. For example, where a leader is a ‘near’ leader, with daily interaction with those they

influence, then the focus may be particularly on interpersonal and social skills of influence. Where the leader is 'distant' then development may need to focus as well on how to influence people indirectly through strategy, communicating the vision, and thinking about how to have an impact on the organizational culture and systems. Different skills need to be developed as clinicians move from clinical practice to clinical leadership²⁷⁷.

The chapter also considered leadership as an aspect of an individual or where is shared or distributed in a team or group, or even whole organization. This may affect the approach to leadership development. Day²⁷⁸ makes the distinction between leadership development programmes which aim to build social capital and those which aim to build human capital:

"Leadership has been traditionally conceptualised as an individual-level skill. A good example of this is found in transformational leadership theory which proposes that transformational leaders engage in behaviours related to the dimensions of Charisma, Intellectual Stimulations, and Individualized Consideration....Within this tradition, development is thought to occur primarily through training individual, primarily intrapersonal, skills and abilities.These kinds of training approaches, however, ignore, almost 50 years of research showing leadership to be a complex interaction between the designated leader and the social and organizational environment...."

In addition to building leaders by training a set of skills or abilities, and assuming that leadership will result, a complementary perspective approaches leadership as a social process that engages everyone in the community...In this way, each person is considered a leader, and leadership is conceptualized as an effect rather than a cause. ...Leadership is therefore an emergent property of effective systems designLeadership development from this perspective consists of using social (i.e. relational systems) to help build commitments among members of a community of practice."

While the conceptual distinction between leader development and leadership development is useful one, both types of development are important, according to the given setting. The implications for leadership development are shown in the following table.

Table XX: Human capital and social capital approaches to leadership development

	<i>Development target</i>	
<i>Comparison dimension</i>	<i>Leader</i>	<i>Leadership</i>
Capital type	Human capital	Social capital
Leadership model	Individual Personal power Knowledge Trustworthiness	Relational Commitments Mutual respect Trust
Competence base	Intrapersonal	Interpersonal
Skills	Self-awareness Emotional awareness Self-confidence Accurate self-image Self-regulation Self-control Trustworthiness Personal responsibility Adaptability Self-motivation Initiative Commitment Optimism	Social awareness Empathy Service orientation Political awareness Social skills Building bonds Team orientation Change catalyst Conflict management

Source: Day, 2001

The increasing recognition of the importance of distributed leadership²⁷⁹ suggests that leadership development may be in part most appropriately effected through organization-wide initiatives, not just programmes for individuals. This suggests that if leadership is partly about organizational change, then situations of organizational change and development may help to foster leadership skills and the social capital of leadership.

This has been borne out in practice in some situations, where case study evidence shows that organization development can contribute to leadership

development. *“Hartley and Allison (2002) conducted case study research in four local authorities chosen as ones innovating in ways of leading their communities. Key findings included a leadership role for particular individuals in shaping visions of the future, but also frequently the empowerment of others to foster and promote change in the organization. The study concluded that innovation is nurtured rather than mandated.”*²⁸⁰ (quoted in Rodgers et al, 2003).

So, leadership development needs to think about who is to be developed, and what are their roles and resources for the organization. Different types of leaders use different sources and processes of influence, and it is helpful for leadership development to be designed appropriately. Some focus may be on individuals, some may be on a whole team, unit or organization. The exact balance will depend on any given setting, and will also relate to the contexts and the challenges, covered in later sections of this chapter.

The contexts of leadership

The growing recognition of the importance of context means that leadership development which helps leaders to understand and interpret existing context and potential future scenarios is particularly important and is stressed in certain types of leadership development, particularly though not exclusively through business schools²⁸¹.

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

Research²⁸² on ‘leading with political awareness’ notes the critical leadership skills for working with a range of stakeholders of being able to ‘read people

and contexts', 'build alignment and alliances' and undertake 'strategic direction and strategic scanning'. Political awareness skills have, until recently, been developed solely on an experiential basis, because there were no recognised development routes, though there are a number of actions which individuals, organizations and training organizations can take²⁸³.

The internal context, of the organizational structure and culture, size and history, are also important. The organizational context shapes how formal leadership development programmes are used, and also how informal and emergent experiences are drawn on. Leadership development can be considered in terms of formal programmes (e.g. training courses, development programmes, educational programmes) and in terms of informal activities which support leadership development (e.g. on-the-job experiences chosen to create "stretch" for the participant, mentoring etc). The organizational context may also influence whether the main focus is best located on the individual, the team or group, sets of roles (e.g. medical directors, aspiring chief executives; fast track programmes) or concerned with the whole organization (e.g. organization development). The organizational culture and procedures may also have an impact on who is seen as "leadership material" and who gets access to formal leadership development activities.

The organizational context may also affect how far there is a transfer of training back in to the organization after the leadership development programme. In part this may be due to difficulties in identifying how to apply ideas and practices back on the job, though the difficulties can also occur where more senior managers who have not been part of the leadership development programme, and/or working in an organizational culture which is not conducive to the new approaches²⁸⁴. A further difficulty is getting staff released to go on a training programme, either to get the time to go, or to have duties taken away in order to free up the time to go. As organizations become more team-based and decentralised, then being away from the office can create pressures for colleagues, leading to reluctance to go away even on short courses in leadership development²⁸⁵ (e.g. Hartley, 2002).

Organizational conditions (e.g. organizational structure, resources, culture, HR strategy) may also have an impact on how leadership potential is identified as well as developed²⁸⁶. An initial stage of any leadership development programme or set of activities is to identify (and then recruit) individuals or groups for leadership development. There are a number of ways in which this may occur in organizations and this is also often closely related to the (implicit) model of leadership – for example, whether the organization is making assumptions about strong (single, individual) leadership or distributed leadership. How far down or into the organization there is a search for leadership potential is a key strategic decision of organizations, though not always recognised as such.

Challenges of leadership

In Chapter XX, we examined two broad types of challenge (also called task or purpose). The first type of challenge, reflected in the work of Heifetz, and Grint, among others, focuses on what are called ‘wicked’ or ‘adaptive’ problems, and here the focus of leadership development is about how leaders learn to enhance their skills in defining problems and constructing meaningful explanations of the key purposes about which they to influence the thinking and behaviours of others. Deciding whether a problem is a ‘technical’ or an ‘adaptive’ problem and therefore whether it requires technical or adaptive leadership is an important skill, with enormous consequences for how the context and purpose is defined, and how the leader works with groups and individuals relevant to solving or addressing the problem, for example. Grint goes further and argues that effective leaders constitute or construct the definition of the problem as well as definitions about solutions. How can leadership development programmes focus on and help leaders to tackle these issues? A focus on problem-identification not just problem-solving is increasingly being thought of as a key skill for leaders and managers. Interpreting the type of challenge and the ways of leading responses is an important issue for leadership development.

A further type of challenge relates to managing organizational and cultural change through programmes of improvement and innovation. Such challenges partly require technical knowledge and skills (e.g. lean management, innovation project management skills) while also needing the skills for the leadership of change management. These are not inconsiderable skills. Knowing how to influence others to change accepted patterns and practices in the workplace, how to encourage innovation and the considered management of risk are important leadership skills. These may be a mix of 'adaptive' challenges and of 'technical' challenges.

Some challenges lie outside as well as inside the organization. There is more work to be done in understanding the leadership of partnerships, of working with local communities, and with working with elected politicians. How far are the current leadership development programmes in any given setting addressing these challenges? And what can be passed on from those who have led major challenges (mergers, reconfiguration, turnaround situations) to help those who have not yet been put in those testing situations? Job challenges are a significant means of developing leadership and fall in the emergent end of the dimension of leadership development. How far do organizations really capitalise on learning from job challenges. It has been suggested that the public sector has focused too much on prescribed rather than emergent leadership development²⁸⁷. Is the NHS making sufficient use of the potential for learning arising from job and organizational leadership challenges?

Capabilities of leadership

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

Many organizations have their own leadership capabilities framework, including the NHS and the police service. The models on which these are based will influence the approach to leadership development, including the dimensions which are sought in effective leaders. Kelloway and Barling²⁸⁸, for example, show how focusing on different dimensions of transformational leadership (the four elements of idealised influence, inspirational motivation, intellectual stimulation and individualised consideration) each provide different implications for the focus of leadership development.

Some have argued that the complexity of leadership in dynamic and changing organization, where partnerships and networks are important means that we need to consider post-transformational leadership development.²⁸⁹

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

Consequences of leadership

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

Unfortunately, evaluation is still quite rudimentary for a number of leadership development approaches. Problems range from an inadequate theory of leadership and leadership development such that evaluation is not possible,

to inadequate data collection (or the wrong type of data collection), to making inappropriate interpretations from the evidence collected.

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

There are a range of leadership development tools and techniques being used, though an explicit model of leadership and leadership development is not always articulated. Techniques include: 360 degree feedback, mentoring, coaching; networking; action learning, job challenges, secondments; formal programmes; fast track cohorts; organization development; and partnership working. Some of these are methods of identifying leadership potential as well as means of enhancing leadership for the organization²⁹⁰.

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

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

The research design for evaluation will also be influenced by their second dimension, - whether the focus is on the individual or the social group (team, organizational service unit, whole organization, critical mass of professionals).

Reviews of evaluation approaches²⁹¹, commissioned by the NHS Leadership Centre are valuable in setting out possible evaluation approaches and their strengths and weaknesses.

Evaluation of leadership development has both subjective and an objective elements. The objective elements may come from organizational performance measures (though these are themselves influenced by human factors such as performance pressure and expectations). The subjective elements come from the perceptions and mental models which individuals and groups hold about leadership and leadership development.

The contingent nature of leadership (that it is affected and affects the contexts, the challenges, the characteristics and the capabilities) means that leadership development is likely to also be contingent, and this suggests searching for leadership development impacts using a realist perspective based on *what works, for whom, when, in what circumstances and why*²⁹² rather than seeking universal principles.

Policy and practice implications

- Clear thinking about leadership development is essential. Using the analytical framework presented in this book will help to ask critical questions to ensure alignment between strategic purposes and leadership development practices.
- There is no one best way to achieve high quality leadership development. Clear planning is needed to ensure that leadership development fits with the strategic direction and priorities, that it supports appropriate skills and values, that it is resource-efficient, and that it contributes not only to individual development but also to organizational change and improvement.
- It is useful to think about how far the emphasis in any particular leadership development approach is focused on planned (e.g. formal training and programmes) or emergent (e.g. job challenges) features.

Also whether the focus is on individuals or groups (e.g. teams, units, cohorts).

- Planning leadership development needs to cover: how people are selected, the actual activities and how leadership development is evaluated.
- Clarifying the concept of leadership underlying the approach is essential, otherwise the approach may be inappropriate for the needs of the organization. How clear is the organization about its views of what constitutes leadership and what constitutes management? If the organization relies on a 'heroic' concept of individual leadership then it may miss opportunities to develop shared or distributed leadership.
- Thinking about characteristics focuses on the roles that people occupy and the sources and resources for influence are important so that the appropriate skills can be developed. Direct leaders may require different skills from indirect leaders. Clinical leaders need different skills if they are to move from clinical practice to clinical leadership. Thinking about shared leadership also has implications for the ways in which leadership development may be structured.
- The growing interest in contexts means that leadership development which helps leaders to understand and interpret existing contexts and potential future scenarios is important and is stressed in certain kinds of leadership development.
- If healthcare benefits from a 'whole systems' perspective, then leadership development might incorporate that view, with some development across services and across sectors.
- The organizational context has a large impact on the effectiveness of leadership development – who gets selected as leadership material, how transfer back to the workplace happens. Paying attention to pre- and post- leadership development activities is critical.
- More attention could be paid to using job challenges and hardships more effectively as an emergent approach to leadership development. But these require support for reflection from the experiences.

- The challenges of leadership emphasise the need to distinguish between technical and adaptive (tame and wicked) problems. Using leadership development to enhance not just problem-solving but problem identification is increasingly important. Interpreting the type of challenge and the ways of leading responses is an important issue for leadership development.
- The capabilities model being used will help to focus on what are seen as the key skills of leadership. But capabilities need to be seen in the context of job demands and organizational context. Developing universalistic models of capability may not be helpful.
- Cross-sector leadership development may be particularly important to help develop skills in emotional intelligence and leadership with political awareness.
- It is worth paying attention to the potential consequences of leadership right at the design stage of leadership development. What are the outcomes being sought?
- Organizational outcomes are important but so are the wider public value outcomes.
- Designing in evaluation at an early stage will help ensure that leadership development is focused and that it can be modified over time using systematic feedback.

Research implications

- Researching leadership development has mainly consisted of evaluating particular leadership development programmes, but there is a need to take a wider view of leadership development to understand how design and delivery are related to implicit or explicit models of leadership.
- Evaluation is still quite rudimentary for a number of leadership development techniques and approaches. Clear research design is needed and this should be related to the leadership development

approach (e.g. planned or emergent, focused on human or social capital)

- Methods will vary according to the type of leadership development activities. Where planned leadership development is used, then a 'scientific' approach specifying goals and outcomes and measuring these carefully may be used. In situations of emergent leadership development then a more qualitative evaluation approach may be needed.
- Evaluation of leadership development has both subjective and objective aspects and the research design and methods should reflect this.
- A critical realist framework is particularly valuable for evaluation studies of leadership development – what works for whom, in what circumstances, why and how.

Want to know more? Further reading

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APPENDIX: METHODOLOGY OF THE LITERATURE REVIEW

Systematic literature reviews in the social sciences

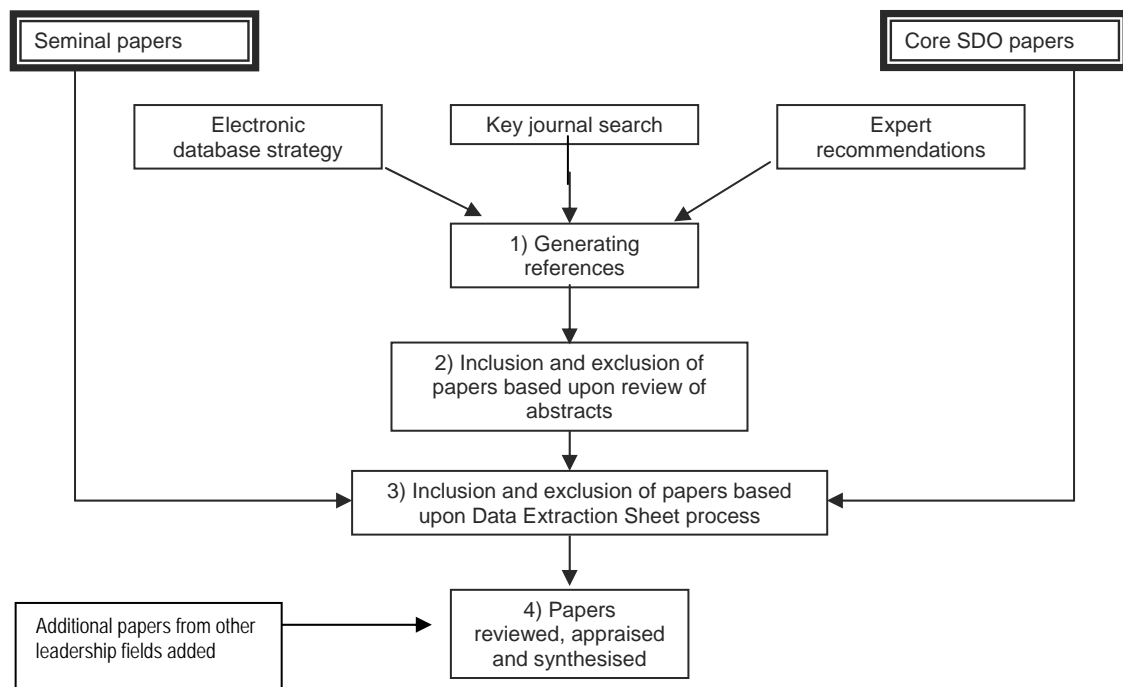
Systematic reviews were first developed in the medical sciences as part of the search for a better evidence base for policy-making and for clinical practice. Over recent years, systematic reviews have been used in a range of health, social care and educational fields in order to synthesise research in an orderly and transparent way so that the research evidence can be used by professionals to inform policy and practice.

It is difficult to apply the existing medicine-based systematic review methodology outside the “hard sciences”, where concepts may be operationalised less precisely and where different perspectives or theories underlie the use of particular concepts. In addition, concepts themselves may be more “fuzzy”, with a range of different meanings and interpretations of the same term, or the use of different terms to mean the same thing.

Using a systematic review methodology with a conceptual synthesis approach means that the review aims to provide an overview of the literature in a given field, including the main ideas, models and debates, with an emphasis on establishing the implications of these for evidence-based policy and practice. We treat the material gained from the systematic review not just as “data” but as a set of concepts, questions and issues which are of interest to academics, policy-makers and practitioners.

The search procedure for the review of leadership in healthcare

The following model depicts the search strategy undertaken for the review of leadership in healthcare:



Step 1 involved generating relevant references for the review and this was done in three main ways:

- Electronic search and database strategy. (Search period 1997-2005, using Web of Science) The database search focused on journal articles about leadership of healthcare organisations (not leadership of health policy); and leaders in a healthcare context. This search strategy resulted in an initial total of 1,177 articles.
- Key journal search. Searches were conducted across 21 key journals related to healthcare and/or leadership. These journals were identified by the research team as carrying articles on leadership in a healthcare context; general leadership; and management and organisation studies.
- Expert recommendations. The research team asked for recommendations for key articles, books and reports from 43 academics from the field of leadership and/ or healthcare. They were requested to send details of own recent unpublished or in press papers as well as their recommendations of key texts.

Step 2 involved inclusion and exclusion of papers based upon review of abstracts. Abstracts were included where they focused on Leadership for a purpose

- Leadership in a healthcare context
- Organisational leadership
- Facilitators of and/ or constraints to leadership.
- Features and characteristics of leadership
- Leadership capabilities.

Editorials, interviews, opinion leaders and briefing notes were excluded; as were exultant, prescriptive or exhortatory articles. Articles emphasising the following areas were also excluded:

- Purely descriptive papers
- Individual career development
- Community leadership
- Purely focused on governance/ policy issues
- Focused evaluations of particular training programmes outside the NHS
- Opinion leaders
- Student programmes
- Nurse education

Step 3: Use of data extraction sheets. These were designed as a template for the reading of full papers and cross-referencing between researchers. The data extraction sheets aided reading, analysis and synthesis and also provided an additional quality control stage. They included: publication details, keywords, type of paper (review, theoretical, empirical); research questions/focus; sector (public, private, voluntary etc); service area; organizational context; country of study; research design and methodology; participants and sample; existing theories drawn upon; models of leadership drawn upon; results and conclusions; relevance to the six themes (concept, characteristics etc); other themes; policy and practice implications; decision about inclusion of the paper in the review. Some papers were included in the data extraction sheet process, but were not included in the final review,

because the abstract had looked promising but the detailed reading disproved this. Papers went forward for the review on the criteria of:

- Quality (theory, concepts or empirical data)
- Interest
- Relevance to the review

NHS Leadership centre reports. 17 reports, previously commissioned by the NHS Leadership Centre, were also reviewed through the DES process.

Seminal papers. A set of 20 seminal, i.e. well-cited or prominent, sources in the field of leadership and leadership in healthcare was generated by the research team and these were also read with the aid of data extraction sheets in order to draw out the key themes.

Step 4: Papers reviewed, appraised and synthesised. The search and quality review process resulted in 95 papers being used for the review.

Step 5: Additional papers were added through the period of writing. In drafting, it became apparent where some of the gaps in the field lay, and where additional knowledge about leadership from other fields known to the researchers could be usefully added.

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Addendum

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