ABC of Clinical Leadership

SECOND EDITION

Edited by Tim Swanwick and Judy McKimm

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Clinical Leadership

Second Edition

EDITED BY

Tim Swanwick
Senior Clinical Adviser and Postgraduate Dean, Health Education, England
Visiting Professor in Medical Education and Leadership, University of Bedfordshire
Honorary Senior Lecturer, Queen Mary University of London and Imperial College, London, UK

Judy McKimm
Director of Strategic Educational Development, Swansea University UK
Visiting Professor, Princess Nourah bint Abdulrahman University, Riyadh, Kingdom of Saudi Arabia
Guest Professor, Huazhong University of Science and Technology, Wuhan, China
Contributors

Stuart Anderson
Associate Dean of Studies, London School of Hygiene and Tropical Medicine, London, UK

Deborah Bowman
Professor of Ethics and Law, St George’s, University of London, London, UK

Judy Butler
Senior Consultant, Coalescence Consulting Ltd, Bath, UK

Jonathan Gardner
Cancer Programme Director, University College London Hospitals NHS Foundation Trust, UK

Valerie Iles
Honorary Professor, London School of Hygiene and Tropical Medicine, London, UK

Tracie Jolliff
Head of Inclusion and Systems Leadership, NHS Leadership Academy, Leeds, UK

Sarah Jonas
Consultant Child and Adolescent Psychiatrist, Sussex Partnership NHS Trust, UK

Sir Bruce Keogh
Medical Director, NHS England, London, UK

David Kernick
General Practitioner, St Thomas Medical Group, NICE Fellow, Exeter, UK

Jennifer King
Managing Director, Edgecumbe Consulting Group Ltd, Bristol, UK

Chris Lake
Head of Professional Development, NHS Leadership Academy, Leeds, UK

Andrew Long
Consultant Paediatrician, Great Ormond Street Hospital for Children, London, UK

Hester Mannion
Final Year Medical Student, Swansea University, UK

Lynn Markiewicz
Managing Director, Aston Organisation Development Ltd, Farnham, UK

Layla McCay
International Researcher, Department of Global Health Entrepreneurship, University of Tokyo, Japan and Director of Centre for Urban Design and Mental Health

Judy McKimm
Director of Strategic Educational Development, Swansea University, UK
Visiting Professor, Princess Nourah bint Abdulrahman University, Riyadh, Kingdom of Saudi Arabia
Guest Professor, Huazhong University of Science and Technology, Wuhan, China

**Fiona Moss**
Dean, Royal Society of Medicine, London, UK

**Tim Swanwick**
Senior Clinical Adviser and Postgraduate Dean, Health Education, England Visiting Professor in Medical Education and Leadership, University of Bedfordshire Honorary Senior Lecturer, Queen Mary University of London and Imperial College, London, UK

**Celia Taylor**
Associate Professor, Warwick Medical School, University of Warwick, UK

**Michael West**
Head of Thought Leadership, The King’s Fund, London, UK
Professor of Organizational Psychology, Lancaster University Management School, Lancaster, UK
CoDirector, Aston Organisation Development Ltd, Farnham, UK
Welcome to the second edition of *ABC of Clinical Leadership*. Since the first edition, theories and concepts, research and the practice of clinical leadership have shifted considerably. Reflecting this, our book has been extensively revised with a wealth of new material, including two completely new chapters. Everything has been brought up to date and in the course of preparing this edition, several new authors have joined the team.

*ABC of Clinical Leadership* is designed for clinicians new to leadership and management as well as for experienced leaders. It will be relevant to doctors, dentists, nurses and other healthcare professionals at various levels, as well as to health service managers and support staff. The book is particularly appropriate for guiding doctors in training and their supervisors and trainers.

*ABC of Clinical Leadership* has been written in the context of an increasing awareness that effective leadership is vitally important to patient care and health outcomes. Patient care is delivered by clinicians working in systems, not by individual practitioners working in isolation. To deliver healthcare effectively requires not only an understanding of those systems but also an appreciation of how to influence and improve them for the benefit of patients. This in turn requires the active participation of clinicians in leading change and improvement at all levels, from the clinical team to the department, the whole organisation and out into the wider community.

This book aims to inform and encourage those engaged in improving clinical care, and we have been fortunate in attracting a team of authors with huge expertise and knowledge about leadership in the clinical environment. We thank them all for their contributions. What we have aimed to do is provide an introduction to some key leadership and organisational concepts as they relate to clinical practice, linking these to real-life examples and contemporary health systems. Each chapter is freestanding, although reading the whole book will provide a good grounding in clinical and healthcare leadership theory and practice. Along the way, we have provided pointers to additional resources for those who want to find out more or explore additional aspects of leadership.

The book begins with an introduction to clinical leadership, through contextualising this in key policy drivers and leadership, management and followership theory. We move on to consider key aspects of leadership: leading teams, change, projects, organisations and complex environments. Then we look at the specific contexts of leading clinical services and education. The later chapters consider the broad contexts of collaboration and partnership working, how gender, culture and ethical issues influence leadership, and finally how leadership development may best be carried out. We hope that you enjoy the book, and that it stimulates you to reflect on and develop your own leadership practice and that of others.

Tim Swanwick
CHAPTER 1
The Importance of Clinical Leadership

Sarah Jonas¹, Layla McCay² and Sir Bruce Keogh³

¹ Sussex Partnership NHS Trust, UK
² University of Tokyo, Japan
³ NHS England, UK

OVERVIEW

- Clinical leadership is vital to the success of healthcare organisations.
- Strong clinical leadership is associated with high quality and cost-effective care.
- Clinical leadership means healthcare professionals engaging in setting direction and implementing change.
- Effective clinical leadership is collaborative and multidisciplinary
- Clinical leadership is needed at every level.

Healthcare is a huge, important and inherently complex business; every person in the world needs it, every country spends substantial proportions of their gross domestic product (GDP) on it, governments are judged by it, populations are determined by it and almost everyone has a personal interest in how it is delivered. The USA spent 17% and the UK 9% of its GDP on healthcare in 2013. Healthcare organisations also provide employment for a substantial sector of the population; for instance, the UK’s National Health Service (NHS) employs 1.4 million people, making it the third largest civilian organisation in the world.

To enable organisations of such magnitude to deliver high quality healthcare, high quality leadership and management are vital at every level, from the national to the local, all the way down to the orchestration of individual interactions between patients and healthcare professionals. To be truly effective, this leadership must come not just from professional managers, but from across the clinical professions (Figure 1.1).
What is clinical leadership?

The terms ‘leadership’ and ‘management’ are often used synonymously or as overlapping concepts. But as Chapter 2 describes, they are two distinct but interdependent ways in which organisations, groups or individuals set about creating change while maintaining stability. Leadership involves creating a vision, setting strategic direction and establishing organisational values. Management is more focused on directing people and resources to deliver the strategic aims established and propagated by leadership. A lack of either – leadership or management – makes it difficult for an organisation to effect change or bring about improvement.

Clinical leadership refers to the concept of healthcare professionals, as opposed to professional managers, undertaking the leadership task: setting, inspiring and promoting values and vision, and using their clinical experience and skills to ensure the needs of the patient are the central focus in their organisation’s aims and delivery. Clinical leadership is key in both promoting high quality care and transforming services to meet evolving population needs. And there is a role for clinical leadership at every level in healthcare organisations and systems; leadership is a process, not a position.
Why is clinical leadership important?

Globally, healthcare organisations must balance the need for financial sustainability and competitiveness with the need to deliver safe and effective care. There is mounting international evidence that good clinical engagement is associated with high organisational performance, and that strong clinical leadership leads to care of higher quality (Box 1.1). Effective leadership in healthcare occurs at distinct levels: the strategic, the organisational and the frontline. And just as multidisciplinary approaches benefit faceto-face patient care, drawing on diverse experience and skills can also help achieve high quality healthcare at these various levels.

**Box 1.1 Evidence for an association between clinical leadership and quality of care.**

- High performing organisations are more likely to have clinicians on the governing board (but the direction of this association is not clear).
- Organisations with high levels of clinical engagement tend to perform better against a range of quality metrics.
- There is an association between distributed leadership and quality of care.
- Teams with low levels of conflict and shared leadership function better and deliver better care.

Despite the strong face validity of a link between clinical leadership and quality of care, a broad evidence base in this field has been slow to develop. This is largely due to the variability of how clinical leadership is defined and the complexity of healthcare organisations. However, some conclusions can be drawn.

At the organisational level, promising correlations between medical leadership and hospital rankings have emerged in the US (Goodall, 2011), while in the UK, a large scale review of medical leadership models (Dickinson et al., 2013) found that organisations with high levels of engagement between doctors and managers performed comparatively better than other organisations on available measures of organisational performance. Another UK study examined annual reports, performance statistics, patient outcomes, mortality rates and national patient survey data and showed that higher proportions of clinicians sitting on a hospital’s strategic governance board were associated with better performance, patient satisfaction and morbidity rate (Veronesi et al., 2012). Across the world, studies of organisational culture find strong links between high levels of clinical engagement, the distribution of leadership perceived by clinicians working in an organisation and the quality of care achieved by that organisation.
International evidence also shows that clinical leadership is also a key variable in the effectiveness of healthcare development and change implementation in an organisation (Greenhalgh et al., 2005). Of particular importance is the presence of clinical champions who are willing to lead by example (Soo et al., 2009).

At the level of clinical and nursing teams, metaanalyses of research consistently indicate that across sectors, shared leadership and participative management in teams predict team effectiveness, including empowerment and selfefficacy, whereas team conflict is, not surprisingly, connected with poor performance (d’Innocenzo et al., 2014; Wang et al., 2014).

The development of clinical leadership practice

Historically, healthcare management has been described as ‘management by consensus’, where administrative, medical and nursing hierarchies coexisted but had no power over one other. Administrators made administrative decisions, doctors made medical decisions, nurses made nursing decisions and central funding bodies, including government, made funding decisions. More recently, increases in costs and the complexity of healthcare have made this model difficult to maintain.

Globally, countries have taken different approaches to the leadership and management of healthcare, with many countries employing doctors (or, less frequently, other health professionals) in senior leadership roles. In the UK, however, the governmentcommissioned Griffiths Report (1983) led to the introduction of general management in the NHS. This involved formalising management arrangements, creating boards and appointing clinical and medical directors to manage particular service areas with the intention of aligning clinicians with the objectives of the organisation; however, this was not always achieved. Throughout the 1990s, there was a growing recognition that clinicians needed to be actively engaged in the leadership and management of health services in order that change might proceed unimpeded. By the next decade, it had become apparent that clinical engagement was not only necessary to prevent the derailing of managerial initiatives, but a vital prerequisite for effective direction setting and change management. The prevailing view today is that highperforming healthcare organisations tend to be clinically led, with strong partnerships between clinicians and professional managers, and a shared commitment to clinical quality.

Leadership and healthcare professionals

Health organisations have always experienced an inherent tension between central control and clinical autonomy. Mintzberg (1992) describes healthcare organisations as ‘professional bureaucracies’, where significant organisational decisions are made at the periphery by individuals with a relatively free rein – as opposed to a ‘machine bureaucracy’, such as a government department or a factory, where organisational decisions are made centrally, directed by a middle tier of management and enacted by a large group of workers operating under instruction.
An essential feature of the professional bureaucracy is the need for leadership to come from within in order to engage that group in enacting the vision for change. A lack of effective leadership can lead to anarchy as significant decisions involving the whole organisation can be made at the frontline without regard for overall organisational strategy, while such strategies may not be ‘heard’, paid attention to or implemented on the frontline. However, activated successfully, the professional bureaucracy can drive excellence in a way that a machine bureaucracy cannot. Embedding clinical leadership at every level is important to ensuring that the multitude of decisions made at the frontline in large healthcare systems on a daily basis add up to concerted action aligned with the organisation’s goals.

Today’s growing interest in a joined up strategic approach in healthcare organisations, incorporating clinical leadership at every level, derives from a number of success stories from around the world where clinicians are already actively engaged in the running of health services to achieve significant quality improvement (Box 1.2).

**Box 1.2 Case studies: Clinical leadership in action.**

**Kaiser Permanente, USA**

Clinical leadership is central to the structure and function of Kaiser Permanente, a US health management organisation. Its doctors are essentially partners in the business, transcending the traditional barriers between clinicians and managers, and closely aligning priorities and strategies to create a joint mission. Clinicians are actively encouraged to take on senior management roles, and quality improvement projects are seen as internally generated rather than externally imposed.

**Veterans Association, USA**

The Veterans Association (VA) is a public sector healthcare provider for US military personnel. In the 1990s, its reputation for quality care was low; it has since transformed itself into an organisation esteemed worldwide for the success of its quality improvement initiatives. These changes were led by a medical chief executive and included clinical leadership as a central premise. Today, the VA is a leader in clinical quality and has shown that clinical leadership is associated with high quality care, and with lower cost care.

**Orygen, Australia**

Orygen, based in Melbourne Australia, is a clinically led, not for profit centre of excellence for youth mental health. Offering a combination of clinical services, research and policy analysis with strong clinical leadership, Orygen has been a global leader in generating interest in early intervention in psychosis.
Clinical leadership – the policy response

Perhaps the most systematic interest in clinical leadership from a national perspective has taken place in England. Government policy, detailed in *High Quality Care for All* (Darzi, 2008), placed quality improvement at the heart of the NHS and, importantly, highlighted clinical leadership as a key factor to achieve this. A number of national leadership competency frameworks followed, articulating the detail of what was required of clinical leadership (Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement, 2008; General Medical Council, 2012). A Faculty of Medical Leadership and Management was founded in 2011, followed by an NHS Leadership Academy in 2012. Subsequently, serial public inquiries, reports and reviews of service failures in England have continued to emphasise the importance of clinical leadership in the delivery of highquality care, and have embedded clinical leadership as a principle for healthcare delivery. The evolving thinking about the role of clinical leadership in healthcare is summarised in an excellent series of internationally relevant publications by the UK health policy thinktank, the King’s Fund (Fig 1.2).
Clinicians have often been deterred from taking up leadership roles due to a lack of remuneration, professional recognition and respect, formal training or career pathways for these roles. In particular, a culture of antimanagerialism has arisen in some organisations, where clinicians may unhelpfully refer to their colleagues who participate in clinical leadership as ‘going over to the dark side’. Leadership can also be perceived as a somewhat nebulous concept, and in a world of evidence-based practice, the study of leadership can be seen as nonrigorous and unscientific. It is up to clinicians to further develop the study of this vital discipline and recognise and reward the true importance and power of clinical leadership.
Throughout the world, healthcare systems are increasingly expensive and complex, and the imperative to continuously improve care quality has taken centre stage. The impetus for clinical leadership to align forthcoming healthcare reforms with the needs of the patient has never been greater. The task for clinicians will be to grasp the opportunity and help lead future change through effective clinical leadership.

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Further resources


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CHAPTER 2
Leadership and Management

Andrew Long
Great Ormond Street Hospital for Children, London, UK

OVERVIEW

- Management and leadership are interrelated, complementary activities, both essential for organisational success.
- Complex organisations require both wise leadership and consistent management.
- Management helps provide order and consistency; leadership is about change and movement.
- Many healthcare organisations are overmanaged and underled.
- Both leadership and management skills can be learned.

Introduction

Until fairly recently, intense debate raged about the difference between managers and leaders, or indeed whether a difference existed at all. Bennis and Nanus (1985), for instance, suggested that ‘managers are people who do things right and leaders are people who do the right thing’ (p.21). A more contemporary view is that categorising individuals as either a leader or a manager is unhelpful as in daytoday life, most people carry out both sets of activities and even very senior leaders do a lot of ‘management’. There is some consensus, though, that management activities are those that provide order and consistency, whilst leadership tasks produce change and movement (Northouse, 2015). Think of a ship setting out on a journey; while it is vital to set direction and motivate the sailors to cope with challenging conditions (the leadership aspects), the ship will not reach its destination if it is not watertight and doesn’t have enough fuel, provisions or people to sail it (the management activities) (Table 2.1).
### Examples of general and clinical management and leadership activities.

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Management activities</th>
<th>Leadership activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working with people</td>
<td>Recruitment, selection, performance monitoring and review, disciplinary procedures</td>
<td>Motivating, inspiring, supporting, collaborating, building networks</td>
</tr>
<tr>
<td>Physical resources and facilities</td>
<td>Planning and maintenance, remediation of deficiencies</td>
<td>Scanning the horizon to see what is possible, seeking opportunities</td>
</tr>
<tr>
<td>Financial aspects</td>
<td>Budget management, making efficiency savings as needed</td>
<td>Seeking new sources of funding, frugal innovation</td>
</tr>
<tr>
<td>Projects</td>
<td>Ensuring project is planned, stays within budget, meets milestones and deliverables</td>
<td>Being a project champion, networking, communicating, sharing the vision</td>
</tr>
<tr>
<td>Meetings</td>
<td>Producing and sticking to agenda, time management, followup actions done</td>
<td>Encouraging contributions, managing disruption, understanding and ensuring communication flows</td>
</tr>
<tr>
<td>The organisation</td>
<td>Understanding of how formal structures, processes, roles and responsibilities work</td>
<td>Understanding of power bases, the ‘shadow organisation’, the culture, the narratives</td>
</tr>
<tr>
<td>Working in clinical teams</td>
<td>Keeping to time, attention to detail, followup actions, appropriate delegation</td>
<td>Ensuring shared understanding of goals, facilitating communication between all involved, being inclusive</td>
</tr>
</tbody>
</table>

This more integrated way of viewing leadership and management helps overcome earlier analyses which tended to denigrate management and managers (and indeed followership and followers) as somehow boring, unsatisfying and less important than leadership and leaders. Leadership, followership and management activities coexist and the successful leader, who may be in a managerial position (for example, a hospital medical director or the partner responsible for quality improvement in a group family practice) or not, can select the right behaviours and skills for the situation. Most recent work takes the view that leadership is not invested in a single person but requires a multidirectional influence relationship between leaders and followers, and may therefore be seen as a collaborative endeavour (see Chapters 4 and 12). This is perhaps less true of management, where there are clearer lines of accountability, power relationships and control of funding and other resources.

The current view, then, is very much a reconciliatory one. Leading and managing are distinct but complementary activities and both are important for success (Box 2.1). Indeed, the separation of the two functions – management without leadership and leadership without management – has even been argued to be harmful (Box 2.2, Figure 2.1).
Leadership, followership and management are both necessary for success.

Leading and managing are distinct, but both are important. Organisations which are overmanaged but underled eventually lose any sense of spirit or purpose. Poorly managed organisations with strong charismatic leaders may soar temporarily only to crash shortly thereafter. The challenge of modern organisations requires the objective perspective of the manager as well as the brilliant flashes of vision and commitment wise leadership provides.

Source: Bolman and Deal (1997).
Box 2.2 The separation of management from leadership is dangerous.

[T]he separation of management from leadership is dangerous. Just as management without leadership encourages an uninspired style, which deadens activities, leadership without management encourages a disconnected style, which promotes hubris. And we all know the destructive power of hubris in organisations …

Source: Gosling and Mintzberg (2003).

Clinicians in management

Health services across the world are in a period of rapid change, needing to respond (often with dwindling resources) to increasing patient expectation, an ageing demographic and an explosion in longterm conditions and comorbidity. Such challenges have led to governmental drives for greater efficiency and effectiveness. Responding to these challenges requires strong leadership and there is increasing expectation that clinicians need to take on significant leadership roles.

Within the UK, the past decades have seen major changes in health service structures, accountability and control. An initial increase in management capacity has been followed by a ‘streamlining’ of arrangements to ensure that as much of the health budget as possible is spent on patient care. Experiments with total quality management, business process reengineering and the development and diffusion of innovation during the latter part of the twentieth century highlighted the paralysing effect of reform on disengaged healthcare professionals; very often ‘loose coalitions of clinicians engaged in incremental development of their own service largely on their own terms’ (McNulty and Ferlie, 2002). This brought about a growing recognition that clinical engagement within organisations needed to be strengthened through the incorporation of clinical leadership within the ‘top management team’.

Changes in the role and function of doctors who took on managerial roles brought with them an inherent suspicion; any clinician who professed an interest in taking on a ‘managerial’ role was said to have moved to ‘the dark side’. It was perceived, usually unjustly, that there was an inherent conflict of interests, balancing patient care within a finite budget. Furthermore, senior clinical professionals have a tendency to resist restrictions on their autonomy through vehicles such as line management relationships, quality linked remuneration and performance review.

The importance of engaging clinicians in management is now internationally recognised (CollinsNakai, 2006) and not limited to the medical profession – although doctors are particularly powerful members of their healthcare communities. Clinicians in senior management play a vital role in coordinating and improving care delivery within the organisation, ensuring greater clinical ownership of the quality of services and ensuring that
budgets are managed effectively. Organisations with clinicians in senior management roles have been shown to perform better on a range of outcome measures than those with lower levels of clinician participation (FordEikoff et al., 2011; Molinari, 1995).

In the last few years, a highly influential investigation into the failings at one hospital, the Francis Report (Box 2.3), has seen the reestablishment, in the UK, of the patient at the heart of care, with a new focus on service transformation centred on patient needs. The clash of cultures highlighted in the report brought into sharp focus the historical divisions between medicine and management and again highlighted the need for increased clinical involvement in how services are run. The important issue here, though, is that it has been recognised that to align clinicians behind such reforms requires not only a cultural change but also a fresh understanding of what is meant by clinical leadership.
Box 2.3 Case study: Learning from Mid Staffordshire.

In 2008, the UK healthcare regulator launched a review into standards of care at Stafford Hospital, part of the Mid Staffordshire NHS Foundation Trust, prompted by concerns about the Trust’s high hospital standardised mortality ratio, and in response to complaints from patients and their relatives. In March 2009, the regulator published its report, which revealed serious failures in care over the period from 2005 to 2008.

As a result, the UK government set up an independent inquiry led by Sir Robert Francis QC. The Mid Staffordshire NHS Foundation Trust Public Inquiry focused on how the wider system responded to failings in one hospital, but insisted that the whole health and care system needs to listen, reflect and act to tackle the key challenges of hostile culture and adverse behaviour that the report highlighted.

The report of the Inquiry makes disturbing reading. At every level, individuals and organisations let down the patients and families they were there to protect. A toxic culture was allowed to develop unchecked which fostered the normalisation of cruelty and victimisation of those brave enough to speak up… ‘This was a systematic failure of the most shocking kind and a betrayal of the core values of the health service as set out in the NHS Constitution’.

The analysis of what went wrong shows that Mid Staffordshire NHS Foundation Trust’s leadership and board focused on the wrong things – ‘hitting the target and missing the point’ – and a wider system where warning signs were dismissed or unheeded and crucial information was not shared.

The essential diagnosis from the Inquiry is of a health service that had veered or was pushed too far from its core humanitarian values and in too many places had its priorities wrong. Targets and performance management in places overwhelmed quality and compassion. Topdown management instructions drowned out patient voices.

Source: Department of Health (2013).

Managers in healthcare

In healthcare, the emergence of the ‘manager’ as a recognised occupation is relatively recent, and there has been a drive to attain management qualifications, such as a Masters in Business Administration (MBA), as a means of professionalising the role. Increasingly, generic management skills are developed and honed independent of the organisation in which the work takes place, meaning that individuals can move between private and public sector roles depending on market influences. This can be positive in that fresh eyes are brought to bear on
entrenched issues or situations but the downside is that it may result in insensitivity to context and a lack of ‘organisational memory’, both of which are acquired through experiential learning.

Charles Handy, former Professor at the London Business School, asserts that the manager is the first person to be given problems that require solutions or decisions. There is then a requirement to carry out four basic activities: identification of the symptoms, diagnosis of the origin of the problem, decision on the most appropriate management and commencement of the remedial process. It was his observation that often managers failed to address one of these stages, which meant that the underlying issues were not addressed and the problems returned.

It is generally accepted that the old ‘command and control’ culture, still present within many healthcare organisations, is no longer acceptable. It is important that leaders aiming to develop the right organisational culture have a skill set that includes an emotional awareness of the needs of their employees and an understanding of both the skills required for modern communication and the importance of work/life balance. Leaders also need to develop shared responsibility and accountability within their organisations, are responsible for the actions of managers working with them and should encourage followers to ask critical questions of the organisational activities in which they are engaged.

An inherent tension therefore exists between management and leadership activities. Management responsibilities include maintaining control and predictability, getting things done on time and within budget. This means that the focus on ‘people’, change and innovation can become secondary to meeting performance targets and can lead to perceived detachment, risk averse behaviour, avoidance of conflict and a more transactional style of working. The ‘modern’ clinical leader/manager should have an awareness of the needs of the healthcare workforce and actively promote individual and departmental development as well as an understanding of the nature of small group behaviour, role definition and the negative impact of individual stress and interdepartmental conflict. They should be adept at change management and have some understanding of organisational learning. They should also acquire management skills such as finance and human resource management, system understanding and time management. Once these dual skill sets are developed, the differences between leadership and management are less marked and individuals can utilise both in a range of situations and contexts.

Leadership and management – a fine balance

As far back as the 1970s, John Kotter, Professor of Leadership at the Harvard Business School, identified the need for two ‘distinct and complementary’ systems of action, leadership and management, to cope with increasingly complex organisations. Kotter insisted that leadership is a learnable skill that is complementary to management. His view of the US business sector at that time was that it was overmanaged and underled. In his opinion, management is focused on preventing chaos and maintaining order, whereas leadership is about producing change. All organisations, large or small, should have the capacity to adapt.
Effective leadership involves setting new directions, challenging assumptions and beliefs and having a broader vision.

In the light of this, keeping the clinical leadership and professional management of health services in balance is important, not only for the benefit of patients, services and the healthcare workforce but also in order to maintain public confidence. Demands for healthcare are unpredictable and turbulent. External influences, changing populations and the nature of disease together with technological advances mean that future health needs are, at best, uncertain. If health services are to provide the best care possible in the face of these challenges, all those responsible for care need to undertake appropriate leadership and management activities and move away from the traditional view of management activities being less important than leadership – both are essential.

References


Further resources


CHAPTER 3
Leadership Theories and Concepts

Tim Swanwick
Health Education England, London, UK

OVERVIEW

- Leadership is a social process of influence towards the attainment of a common goal.
- The leadership task is to achieve direction, alignment and commitment.
- No one unifying theory or framework of leadership exists.
- Leadership theory can be viewed as a historical progression from the attributes of the ‘great man’ to considerations of leadership as a collective and collaborative activity.

‘Leadership’, wrote Warren Bennis and Burt Nanus, ‘is like the abominable snowman whose footprints are everywhere but who is nowhere to be seen’ (Bennis and Nanus, 1985). But, like the abominable snowman, that hasn’t stopped us trying to describe it. In this chapter, we will examine the different ways in which leadership has been thought about during the course of the last century, and the relevance of those ideas to the clinical setting. We will also look at recent attempts to entrap this elusive creature within the confines of a 21st century professional phenomenon – the competency framework.

In Chapter 2, we considered leadership and its relationship to management. Although the nature of leadership is hotly debated, when we look through its vast literature, three common themes emerge. Leadership is a process of *influence*, relating to the attainment of some sort of *goal* – which may be generally or specifically defined, such as improved partnership with patients or reducing accident and emergency department waiting times to under four hours – and it occurs in the context of a social *group*. The leadership task, then, is to ensure direction, alignment and commitment. Beyond that, however, it starts to get a little tricky.

A number of variables affect the way that leadership is conceived. These may be the *preoccupations of the time*, the *sociopolitical system* in which leadership is exercised and differences in *cultural norms and values*. To expand. Particular ways of thinking about leadership have been favoured at certain times in history: Winston Churchill was famously successful during the Second World War, only to fail as Prime Minister soon afterwards. The systems in which we work affect our thinking about leadership: favoured models in a communist or socialist state may differ from those prevalent in a free market economy. And cultural differences influence the way that leadership is played out: individualism versus collectivism, masculinity versus femininity, whether leadership is seen as a faraway or nearby process, the degree to which uncertainty is tolerated and cultural orientation to the short or long term. Such cultural differences are important to bear in mind when working in a
multiethnic, multiracial and multifaith environment – as characterises many health systems across the world – and we address this in more depth in Chapter 14.

Leadership theory and the way leadership is conceptualised have developed over time. The following sections trace a broadly chronological evolution of leadership thinking and practice with specific reference to the clinical context. This is not an exhaustive list. Many other leadership models exist that we do not have the space to touch on here; however, some of these (including an increased attention on followership) are discussed in subsequent chapters.

**Trait theory**

The first half of the twentieth century saw the emergence of the idea of the ‘born leader’. Trait, or ‘great man’, theory proposed that leaders had a number of personal qualities. You either had these qualities or you didn’t and almost invariably, they seemed to be linked to a Y chromosome, perhaps reflecting the position of women in society at the time. A stroll through the foyers and committee rooms of many medical royal colleges and medical schools (with the occasional notable exception) reveals portraits and photographs of the ‘great man’. But studies in the second half of the century began to throw doubt on whether there really was a set of personal attributes that set leaders apart from the rest of the crowd, although some weakly associated generalisations – namely ability, sociability and motivation – were found. Our fascination with leadership as a set of personal attributes is enduring. Daniel Goleman’s theories of emotional intelligence (Goleman, 1996) have been highly influential and ‘personal qualities’ can be found at the heart of most leadership frameworks. Box 3.1 lists the capabilities of emotional intelligence and their corresponding competences.
Perhaps the most compelling evidence that personality is important to leadership comes from work on the ‘big five’ personality factors – that is the degree to which individuals exhibit
extroversion, neuroticism, openness to new experience, conscientiousness and agreeableness. A review of the literature from across a range of sectors and contexts (Judge et al., 2002) found weak but significant positive correlations with extroversion, openness to new experience and conscientiousness. Leaders then tend to have personalities that lead them to do their thinking in public, that make them eager to explore new ideas and to work hard. The review also found a weak but negative correlation with neuroticism – that is, it helps not to be too anxious – but no link between leadership ability and agreeableness, suggesting that leaders may have to be willing to upset people sometimes.

**Leadership styles**

In the 1940s and 1950s, an alternative approach was suggested relating to leadership styles. These democratising ways of thinking about leadership focused on what the leader actually does, rather than who they were. Leadership styles theory tends to group around two issues: how decisions are made and where the focus of attention lies. A number of taxonomies of decisionmaking styles have appeared over the years, perhaps the most famous being that of Tannenbaum and Schmidt (1958), who describe a spectrum from the autocratic (‘do as I say’) to the abdicatory (‘do what you like’) (Figure 3.1).
Style also relates to the extent to which leadership is focused on results or the people in the organisation. Blake and Mouton’s (1964) managerial grid illustrates this well with the aim being, of course, concern for both the task in hand and your staff, what they refer to as ‘team management’ (Figure 3.2).
Adair (1973) took this a step further in his ‘three circles’ model, propounding that effective leadership requires a balance of attention not only to task and the individual but also to the team (Figure 3.3). It may be interesting to observe next time you are in the operating theatre, clinic or a practice or departmental meeting to what extent these three areas are being looked after by those in leadership positions and what the consequences are if they are not.
More recently, Goleman (2000) described six styles of leadership resulting from research on over 3500 US executives and their impact on the climate of an organisation – and that could equally be a hospital, ward or primary care organisation (Table 3.1). A recent analysis of leadership in the UK NHS (King’s Fund, 2012) identified an overreliance on pacesetting whereas an authoritative (or visionary) style, mobilising people empathetically towards a vision, is most strongly correlated with performance.
**Table 3.1** Leadership styles and their effect on organisational climate.

Source: After Goleman (2000).

<table>
<thead>
<tr>
<th>Style</th>
<th>Aim</th>
<th>Leaders say</th>
<th>Effect on climate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directive</td>
<td>Compliance</td>
<td><em>Do as I say…or else</em></td>
<td>−</td>
</tr>
<tr>
<td>Visionary</td>
<td>Alignment</td>
<td><em>I have a dream</em></td>
<td>++</td>
</tr>
<tr>
<td>Affiliative</td>
<td>Harmony</td>
<td><em>Why don’t we all just get along?</em></td>
<td>+</td>
</tr>
<tr>
<td>Participative</td>
<td>Consensus</td>
<td><em>Is that all right with everyone else?</em></td>
<td>+</td>
</tr>
<tr>
<td>Pacesetting</td>
<td>Achievement</td>
<td><em>If I can do it, you can</em></td>
<td>−</td>
</tr>
<tr>
<td>Coaching</td>
<td>Development</td>
<td><em>How can I help you achieve your potential?</em></td>
<td>+</td>
</tr>
</tbody>
</table>

**Contingency theories**

While leadership styles introduced the notion that leadership could be construed as a set of behaviours, they gave little indication as to what sort of behaviours worked best in which circumstances. This was addressed most popularly by Hersey and Blanchard (1988), whose *One Minute Manager* series was a business bookstore hit. The idea that managers (or leaders) should adapt their style to the competence and commitment of their staff (or followers) is appealing and the four styles of directing, coaching, supporting and delegating can be brought into play for different people at different stages of their engagement (*Figure 3.4*). So a trainee new to your practice or a nurse newly appointed to the department may require *directing* to begin with, *coaching* as their initial enthusiasm wears off, *supporting* as they develop in competence and eventually can be *delegated to* once they have developed both high ‘skill’ and high ‘will’. Quite often in the health service, we forget that the first three steps are important and after a brief induction, junior colleagues are simply ‘left to get on with it’ and we are then (perhaps unreasonably) disappointed when they struggle or fail.
Transformational leadership

It became apparent in the 1980s that none of the leadership approaches to date offered advice on how to cope in environments of continual change. Models described so far were effectively transactional and leadercentric in focus; followers were rewarded (or otherwise) for their efforts and the dynamic between leader and follower was not considered. Such approaches may help plan, order and organise at times of stability but, it could be argued, are inadequate for describing how people or organisations may be led through periods of significant change. A new paradigm emerged, that of *transformational leadership*, a concept best summarised under the four ‘i’s of Bass and Avolio (1994), namely of leaders exercising:

- idealised influence
- inspirational motivation
- intellectual stimulation
• individual consideration.

In the transformational model, leaders act to release human potential through the empowerment and development of followers. They paint a picture of the future and develop in followers a real sense that they want to move towards that envisioned future. Martin Luther King’s ‘dream’ speech of 1963 is a consummate example. Transformational leadership has proved a pervasive model and has been incorporated into many public sector frameworks. Its influence can be clearly seen in ‘inspiring shared purpose’, ‘engaging the team’ and ‘sharing the vision’ of the UK’s NHS Healthcare Leadership Model (Figure 3.5).

![Figure 3.5 The nine dimensions of the NHS Healthcare Leadership Model.](image)


**Charismatic leadership**

One of the natural sequela of a transformational approach is the veneration of the individual leader. And in the 1980s and 1990s, charismatic leaders were flown in to turn around failing organisations and high-profile captains of industry brought in to save health services. The charismatic leader combines a dominant personality with the self-confidence to influence others, strong role modelling and high expectations, and articulates ideological goals with strong moral overtones. Many senior medical leaders have favoured this form of leadership, the problem being that it may cultivate excessive pride, arrogance and selfobsession. The flipside of charisma is narcissism.

**Servant leadership**
Robert Greenleaf’s (1977) idea of servant leadership provides an antidote to the bright lights of the ‘podium leadership’ described above. Popular in the ministry and public sector, the servant leader is said to act as a steward, appointed to serve the needs of the community which they lead, to facilitate growth and development, to persuade rather than coerce, and to listen and act with empathy. Interestingly, the model also seems to translate across into the cut and thrust of a business environment, and Jim Collins’ classic study of highly successful US companies *Good to Great* found that the, largely lowprofile, leaders at the helm of some of the most successful US companies combined a ‘paradoxical blend of personal humility and professional will’ (Collins, 2001).

**Authentic leadership**

In order to engender trust and gain the commitment of followers, it is important for leaders to build a legitimate authority through open, honest and ethical relationships with followers, valuing and respecting their contributions. Living one’s values is a vitally important aspect of authenticity, particularly so when leading health services that aspire to be person centred. Positive correlations have been found between authentic leadership, trust in management, staff satisfaction and patient outcomes. In Chapter 16 we explore values-based leadership in relation to healthcare in more detail.

**Distributed, shared and collaborative leadership**

Some of the most recent theories of leadership are highly relevant to healthcare organisations in that they shift the focus from the individual qualities of leaders to the process of leadership within a team or organisation. In contrast to the models discussed so far, distributed leadership is considered not to reside in one individual; it is an informal, social process where expertise is acknowledged to be distributed, boundaries to leadership are open and leadership emerges from connections within the organisation. This embedded idea of leadership shifts the focus from the individual qualities of leaders to the process of leadership within an organisation. Collective or shared leadership sees the distribution and allocation of leadership power to wherever expertise, capability and motivation reside. And collaborative leadership recognises that leadership teams are more important than isolated ‘heroic’ leaders, and that the leadership task requires the input of multiple individuals who may be located across professional and organisational boundaries. All three models are now seen as vital to the effectiveness of largescale complex healthcare systems.

Leadership development (see Chapter 17) then becomes not just an issue of creating more leaders but developing systems that allow leadership to be taken on by a diverse range of groups and individuals. The possibilities that open up if leadership is understood as everyone’s responsibility are both exciting and enabling (Box 3.2).
Box 3.2 Where’s the evidence for approaches to leadership in healthcare?

Recent reviews cite the paucity of high quality research into leadership in healthcare although a number of themes are emerging.

- A *transformational* approach improves staff and patient experience and patient outcomes.
- Similar findings have been found for *authentic* leadership.
- Effective nurse leaders are *engaging*, *collaborative* and *empowering*.
- High performing healthcare providers have high levels of medical engagement and *strong representation of clinicians* on governing boards.
- *Shared* leadership in teams predicts team effectiveness but clarity over team leadership is also required.
- A *team leadership* approach at the top of healthcare organisations is correlated with improved organisational performance.
- *Longevity in senior management* roles in healthcare is positively correlated with performance.


References


**Further resources**


OVERVIEW

- Consideration of followership is essential to an understanding of leadership behaviour and practice; the one cannot exist without the other.
- Leadercentric approaches undervalue the influence and creative force of an engaged followership.
- Social identity and culture in the health professions directly impact individual attitudes towards followership and teamworking.
- ‘Ingroup’ and ‘outgroup’ thinking is closely associated with group identity and loyalty of followers to leaders.

Introduction

While literature on leadership abounds, relatively little attention has been afforded to theories of ‘followership’ and still less to their particular relevance in the context of health provision. In Western and medical cultures, personal success and career progression are often highly prized and associated with individualism and leadership. ‘Following’, like management, is often seen as secondrate, perhaps even considered in a derogatory fashion. Despite this, it is clearly the case that leaders do not lead all the time. It is also true that one leader alone cannot be responsible for a revolution (Figure 4.1). Understanding how, and why, people follow gives us an understanding of how, and why, leaders are chosen and allowed to lead. It also extends our appreciation that in healthcare, most successes are team successes.
What is followership?

The concept of followership has largely been attributed to Robert Kelley who published his paper ‘In praise of followers’ in the *Harvard Business Review* in 1988. Over the last 30 years, the conversation about the importance and application of followership theory has developed to include frameworks that aim to understand organisations, group dynamics, power and processes in a world that is still leadercentric in its outlook. This is especially true in the clinical environment where teamwork is espoused but traditional thinking about leading from the front is still the cultural norm.

The study of followership considers the influence of followers on their leaders, how the different follower types influence leadership decisions, how the personal, professional and social identity of followers directly affects whether leaders are embraced or rejected, and the profound impact followership attitude has on team cohesiveness and effectiveness.

The way followers operate within a team is predictably complex, influenced by a great many factors including team dynamics, social and professional identity, personal motivation and personality. Kelley (2008) groups followers into five main types (Box 4.1). If the team dynamic is supportive and the leader–follower relationship is open and flexible, highly trained
and motivated professionals in the clinical environment have the potential to fulfil the role of ‘star followers’. But it takes more than drive, motivation and independence to nurture star followers; as individuals, followers need to feel stimulated and valued, that they are part of a community.

**Box 4.1 Types of followers.**

**Sheep**
- Passive
- Need external motivation

**Yespeople**
- Positive and will always agree with leader
- Need directing but will enthusiastically carry out tasks
- Consider themselves to be ‘doers’ rather than ‘thinkers’

**Alienated**
- Think independently, stifle progress, a lot of negative energy
- See themselves as mavericks who ‘stand up to the boss’

**Pragmatics**
- Fence sitters
- They preserve the status quo, sit it out and survive

**Star followers**
- Think for themselves, are very active
- Independently evaluate leadership decisions.
- They will challenge leaders if they feel it necessary and offer constructive alternatives

Source: Kelley (2008).

Kellerman (2008) also categorises followers ([Figure 4.2](#)), placing them on a scale of increasing engagement and participation, from ‘isolates’, who work in a detached and disinterested way, to the ‘diehards’ who show complete devotion and loyalty to their organisation or business. These methods of categorisation can be useful in deciphering group behaviour with a view to promoting engagement and improving group functionality,
productivity and morale.

**Figure 4.2** A spectrum of followership.

Source: Kellerman (2008).

### Why does followership matter?

‘Our understanding of leadership is incomplete without an understanding of followership.’

(UhlBien *et al.*, 2014)

So why is an understanding of followership as important, arguably more important, than an understanding of leadership? All leaders have experienced being part of a followership, and their ideas of good leadership are shaped by their own experiences of being led. Even those who predominantly lead in their professional life do not lead all the time and will find themselves functioning in a followership role in different contexts. Not only are followers as important as leaders, Kellerman argues that ‘Followers are more important to leaders than leaders are to followers’ (Kellerman, 2008). Followers can and do more than simply influence leadership behaviour; in many cases, they play a role in creation and construction of a particular leadership style (UhlBien *et al.*, 2014) (Box 4.2).
Box 4.2 Why does followership matter?

- An understanding of leadership is not possible without an understanding of followership.
- Leaders need followers more than followers need leaders.
- Leaders gain their understanding of good leadership by participating in followership.
- No one leads all the time.
- Followers don’t just influence leaders, they cocreate and can change leadership behaviour.

Theoretical perspectives

Leadercentric research continues to dominate the field, arguably at the expense of a true understanding of the complex interplay between leaders and their followers. This approach describes a largely oneway arrangement where leaders use their influence to affect change and stimulate growth and progress. Charismatic and transformational theories continue to be central in leadercentric thinking (Bass and Riggio, 2006), emphasising personality, style and appearance, with a focus on inspirational personal qualities. Followers in the leadercentric literature are subordinates; they are there to be won over and then directed. The role of a follower is not an aspirational one. Relational leadership models go some way to redress this imbalance, placing emphasis on the dynamic between individuals and the importance of a highquality exchange between leader and follower to ensure positive outcomes (Graen and UhlBien, 1995). The followercentric approach seeks to uncover how followers create, construct and deconstruct leaders. It looks at how leaders are, knowingly or unknowingly, influenced by their followership, how they are inspired and changed by it, and acknowledges the reality that leaders will choose to lead in certain contexts and follow in others (Figure 4.3).
Followers cocreate and can change leadership behaviour.

Consistent undervaluing of the influence and importance of followership can result in the failure to nurture followers who would otherwise prove engaged and productive; it also fails to take into account the ways in which followers’ perceptions of their leader actively create the resultant leadership style. A disproportionate focus on the importance of leadership can lead to romantic notions that simplify the leadership/followership relationship and may give a leader unrealistic heroic status (Bligh et al., 2004; Meindl, 1985). This makes it more difficult for leaders to fail and then recover; it also fails to take into account the multifactorial nature of a success or failure.

**Followership in the clinical environment**

Most health professions’ professional and regulatory bodies emphasise the importance of teamwork and leadership in both professional practice and the development of future generations of health professionals (e.g. General Medical Council, 2015). This rhetoric does not always match the hierarchical nature of professions. In medicine, for example, competition, selfpromotion and aspiration to leadership roles are implicitly encouraged in the reward systems for students and doctors in training. In addition, the role of a doctor brings a great deal more than professional identity to the individual; it conveys a social and community status that is associated with leadership qualities. Although team goals are important to many doctors, the
pressure of assuring career progression and demonstrating leadership potential can be at odds with this. It is possible that doctors struggle to work effectively in teams because they do not necessarily share the same goals as their team. Commitment and career drive should not be confused with the enthusiasm and motivation associated with effective followership; Kelley clearly states that his ‘star followers’ are not simply disguised leaders or ‘leaders in waiting’ (Boxes 4.3 and 4.4).

Box 4.3 Case study: Leaders who follow and followers who lead.

Aaliyah is a medical student attending a morning ward round in a large general hospital. She is part of a group of eight comprising the consultant specialist, two registrars (or senior residents), a number of other doctors in training and the nurse looking after the bay. She trails around at the back of this crowd, straining to hear the consultant’s conversations with each patient and to keep up with discussion about management plans. Occasionally, one of the trainee doctors sends her off to collect request and referral forms as the morning’s tasks accumulate.

The team approach one patient who appears very confused and whom they suspect has suffered an acute stroke. The man does not appear to be able to communicate in English and repeats the same phrase in Arabic repeatedly. Aaliyah steps towards the bed from the back of the group and addresses him in fluent Arabic, explaining that the doctors have come to assess him. The dynamic on the round instantly changes – not only does the consultant communicate with the patient through Aaliyah but appreciates that she is the only person present who is able to assess his dysphasia before a family member is located. The history that Aaliyah is able to obtain and her assessment of his function are central to the consultant’s decisions about management.
Box 4.4 Star followers are not leaders in disguise.

‘Star followers think for themselves, are highly active, and have very positive energy. They do not accept the leader’s decision without their own independent evaluation of its soundness. If they agree with the leader, they give full support. If they disagree, they challenge the leader, offering constructive alternatives that will help the leader and organization get where they want to go. Some people view these people as really “leaders in disguise”, but this is basically because those people have a hard time accepting that followers can display such independence and positive behaviour.’

Source: Kelley (2008).

Professional cultures within medicine and nursing currently divide people into leaders and followers but the rigidity of this approach may stifle innovation and distract from a common goal of excellent service provision. It may be more productive to consider how individuals and groups move seamlessly between leader and follower roles whilst delivering a shared task or activity, for example managing a cardiac arrest. Doctors who feel liberated to aspire to good followership might use their motivation, flexibility and charisma to achieve team and organisational successes with the skills to take up a leadership role when the situation demands. Conversely, while nurses have a stronger group identity than doctors, and possibly a better teamworking culture, Croft et al.’s (2015) study exposed identity difficulties for nurses transitioning to leadership roles.

Group identity in healthcare

Ingroups and outgroups

Group identity in the clinical environment is defined by shared clinical expertise and knowledge. Not only is a group likely to turn against internal members whose behaviour is countercultural or significantly dissimilar, evidence suggests that identification of an outgroup reinforces salient group identity and support for their leader (Tee et al., 2013). Clinical leadership is set apart from management in health service organisations primarily by clinical training and expertise and as a result, nonclinical management may easily be identified as the outgroup and is still often viewed negatively within health. While identification of an ingroup and an outgroup might improve home team cohesiveness, this becomes problematic in large organisations where multidisciplinary teamworking and good communication between clinical and nonclinical staff are essential. With many teams existing in name only (West and Lyubovnikova, 2013), preconceived ideas about who leads and who follows who can impede service provision and stifle innovation.

Prototypicality
Implicit leadership theories (Burnette et al., 2010) describe how followers use complex preconceived ideas about ‘good’ and ‘bad’ leadership to judge leadership quality. These judgements are influenced by personal and professional experiences, social norms propagated through media and some deepseated cultural convictions. The concept of ‘prototypicality’ refers to how closely leaders are considered representative of the group (Tee et al., 2013). In healthcare environments, this helps to explain why it is important for clinical leaders not only to maintain a level of clinical work but also to be an excellent practitioner. Although practising as an excellent health professional does not necessarily equate with good leadership skills, in the clinical environment this is of paramount importance in the eyes of the followership. However, being prototypical as a leader is not in itself sufficient – fair attribution of team success is also essential in maintaining followership loyalty.

Followership at a systems level

In large and complex health organisations or systems, people are the most important components. Even the best designed, tried and tested systems require engaged and thoughtful practitioners for full functionality. Investment in the ‘social capital’ (AlimoMetcalfe et al., 2007) of good relationships, professional confidence and trust is therefore vital for the effective running of services, as is an understanding of the value of both leadership and followership. Followers who are engaged in policy creation, who challenge and innovate when they witness failings and understand causality are in the best position to bring about change. Extending the interdependency of the leader/follower relationship further, Stacey (2001) offers a theory of ‘complex response processes’ in which leaders engage in a public conversation in which an everchanging coherence of meaning emerges continuously through an ongoing and iterative interaction with those around them. At the intricate and complex systems level, then, it is via the many hands of the followership that the organisation is refined and made truly fit for purpose.

References


**Further resource**

CHAPTER 5
Leading Groups and Teams

Lynn Markiewicz1, Michael West2 and Judy McKimm3

1 Aston Organisation Development Ltd, Farnham, UK
2 King’s Fund, London, UK
3 Swansea University, UK

OVERVIEW

• Wellfunctioning multidisciplinary teams are essential to the provision of high quality healthcare.
• Effective team leaders ensure that their teams have a clear vision, objectives and effective group processes.
• Effective team members report high levels of role clarity, trust, safety and support.
• Not all groups are teams – ‘pseudoteams’ have low levels of interdependence, shared objectives and reflectivity.
• Teams do not work in isolation – effective interteam relationships are as important as good intrateam relationships.
• Clarity around team leadership is important to success.

The evidence for teambased working

A large body of research evidence identifies teamworking as a key predictor of success in healthcare organisations. In terms of the delivery of care, teams have been reported to reduce hospitalisation time and costs, improve service provision, enhance patient satisfaction and reduce patient mortality. In terms of staff wellbeing, teamworking is related to increased job satisfaction, reduced levels of harmful stress and increased involvement (Box 5.1). There is also evidence (World Health Organization, 2009) that effective multidisciplinary or interprofessional clinical teamworking is related to improved patient safety and highquality care (Figure 5.1).
Healthcare team innovation. Professionally diverse teams have been found to be more innovative than unidisciplinary teams. Innovations introduced by such teams were also found to be more radical and to have significantly more impact on patient care.

Source: Borrill et al. (2000).
Box 5.1 Benefits of teambased working: the research evidence.

- Reduced hospitalisation and associated costs
- Improved efficiency
- Improved levels of innovation in patient care
- Increased staff motivation and mental wellbeing – associated with reduced sickness absence and turnover
- Reduced error rates
- Reduced violence and aggression
- Lower patient mortality

Why is the link so strong?

In complex organisations, where it is essential for the skills and knowledge of different professional groups to come together to produce high quality services, multidisciplinary teams are the vehicles for translating individual effort and skill into valued outcomes. Successful teams develop real synergy, through the contribution of all available knowledge, skills and experience to ensure the best possible decisions and outcomes. Achieving this level of teamworking takes time and effort but the benefits are measurable and valuable.

What is a team?

Teams come in many shapes and sizes and it is often a challenge to clearly define the boundaries of healthcare teams, which can seem to stretch into other services and include different professionals who spend relatively more or less time in the team. A practical definition of a team is: a group of people who have clear shared objectives, who need to work interdependently to achieve these objectives and who are able to regularly take time to review the way in which the team is working to achieve those objectives.

It is rare that individuals work in only one team. This can lead to confusion over individual priorities and objectives so it is essential that all team members have a clear understanding of their role in each of the teams in which they work. One of these will usually be what could be regarded as their ‘home team’; that is, the team whose objectives influence the way they work in all the other teams in which they are involved. In complex organisations, the ability to identify individual teams is important, but equally important is the need to map ‘team communities’. Teams do not exist in isolation; they can only succeed when they work
effectively with other relevant teams, for example the teams that make up a patient pathway (Figure 5.2).

**Figure 5.2** Team communities bring together a number of individual teams which rely on each other to deliver higher level outcomes.

Not all groups are teams, however. West and Lyubovnikova (2013) identify ‘pseudoteams’ which have low levels of reflectivity, shared objectives and interdependence. Their detrimental effect is compounded because health workers work in multiple teams in different contexts and times. Teamworking therefore requires ‘an adaptive mix of flexibility, credibility and authenticity, and leaders need also to be able to effect communication and manage activities (within and) between teams’ (O’Sullivan et al., 2015).

**Key dimensions of effective clinical teams**
Effective clinical teams demonstrate a number of key features, including clarity of identity, team objectives and role, effective team and interteam processes and clear and visible leadership (Box 5.2).

**Box 5.2 Characteristics of effective teams.**

- Clear team identity
- Clear team objectives
- Role clarity
- Effective team processes:
  - decisionmaking
  - communication
  - constructive debate
  - creative conflict
- Effective interteam working
- Clear leadership

**Team identity**

Team identity is important for a number of reasons.

- Humans are social beings who need to relate to those around them. Strong team identity provides feelings of belonging, safety and support that enable individuals to do their best work.
- Team identity provides clarity of purpose and direction for the work of team members.
- Team identity enables organisations to order work in ways that reduce duplication of effort and enhance synergy.
- Task identity has been found to contribute to satisfaction of intrinsic individual needs and therefore influences a variety of useful outcomes, such as reduced absenteeism, increased work motivation and high-quality work performance.

A key task for team leaders is to enable the development of a clear team identity which is aligned with the organisation’s purpose, objectives and culture.

**Team objectives**

The reason why people are organised to work in teams is to pursue a common goal or purpose
that will be achieved more successfully if they work together rather than individually. This notion of shared purpose is a defining feature of teams at work. Research shows that clarity of objectives is closely related to levels of individual job satisfaction, intention to quit and to task and contextual performance (Figure 5.3).

**Figure 5.3** Clarity of objectives has a number of positive effects.

Source: Aston OD (www.astonod.com). Data from 61 acute trusts in England.

Effective team objectives describe the specific outcomes by which success will be measured,
that is the results, consequences, products or impacts of actions taken by team members. These objectives also need to:

- have an obvious fit with the organisation’s purpose and objectives
- be few enough to provide focus on what is most important (the most effective teams have been found to have between six and eight objectives)
- have the committed support of the next level of management and of other teams which can influence the achievement of the team’s objectives.

**Role clarity**

Teams are created to enable people with different knowledge, skills and experience to come together to create synergy. All too often, however, lack of role clarity leads to the duplication of effort or gaps in communication and service provision. Such difficulties increase levels of distrust, decrease respect between team colleagues and increase levels of harmful conflict.

Role clarity and mutual understanding of roles amongst team members are essential for the creation of synergy. There is evidence also that role clarity increases team member confidence and job satisfaction.

**Effective team processes**

**Decision making**

One of the principles underlying teambased working as a way of structuring and managing organisations is that teams make better decisions than individuals do. In wellfunctioning teams, individuals who have relevant knowledge and experience are able to influence decisions and willingly do so. This does not mean that everyone is included in all decisions, but that team members are clear about who is involved in what type of decision and agree with the criteria for involvement. Effective teams regularly review involvement in different types of decisions to ensure that all relevant team members are involved.

Team leaders also need to be aware of the social processes which can undermine the effectiveness of team decision making and to structure discussions in ways that ensure that all available knowledge and experience are utilised (Box 5.3).
Box 5.3 Factors which undermine effective decision making.

- **Personality factors** – e.g. knowledgeable team members may not contribute because of shyness
- **Social conformity** – individuals may withhold opinions or information which appear to be contrary to the majority view
- **Skills** – those who are highly articulate may unduly influence others in the team
- **Individual dominance** – ‘air time’ and expertise are correlated in highperforming teams and uncorrelated in poorly performing teams
- **Status and hierarchy** – more senior members of the team may have an undue influence and may inhibit others from contributing their views
- **Leader/follower relations** – if not managed well, can lead to ‘in and outgroups’

**Communication**

Effective communication takes place when each team member receives all the information they require to carry out their job role and has access to information that will challenge them to think about and adapt their role and ways of working. It is vital for patient safety as many errors or near misses arise because of poor or miscommunication. Effective team communication requires a climate of participative safety, sufficient team member interaction and effective information exchange.

**Participative safety**

In effective teams every team member feels safe to express her/his views, ask for help or advice and is confident to put forward new ideas and suggestions about changes to the way the team is working. This will enable individuals to take appropriate risks, which are necessary for the development of creativity and innovation. Trust takes time to develop and needs to be continually nurtured. Effective, inclusive leaders model appropriate behaviours and put in place processes which enable trust and respect between team members to develop (Box 5.4).
Box 5.4 How to develop trust in teams.

- Provide opportunities for team members to discuss values and aspirations.
- Highlight interdependency of outcomes.
- Ensure role clarity and good information flow.
- Encourage team members to take appropriate risks.
- Talk positively about team members and others outside the team.
- If conflict arises, deal with it sensitively.
- Keep promises.

Interaction

Teams that have regular meetings also report higher levels of innovation. In primary healthcare teams, regular meetings are associated with greater levels of innovation; teams which had at least one meeting a week were judged by external raters to have introduced a greater number of innovations, and innovations which were of a greater magnitude (Borrill et al., 2000). It is therefore necessary to have regular, well-managed, whole-team meetings. This can be a challenge, particularly in busy and/or geographically dispersed teams where team members may see each other very infrequently. However, the potential costs of not meeting often enough are high. Leaders therefore need to explore different ways (such as using technology) of ensuring sufficient team member interaction.

Information sharing

Information is not only crucial to the effective achievement of team tasks, it is also a source of power. Distrust within teams often arises because people feel that information has been withheld or used in a manipulative way. It is essential for teams to regularly check that all members feel they are receiving the information they need and that it is easily accessible. Such a review will usually allay fears about lack of access to information. Box 5.5 lists some specific tools that can help members of clinical teams communicate with one another, particularly at busy times of transition (such as handover or handoff) or out of hours when junior or new members in particular may feel pressured or reluctant to challenge or bother a senior.
Box 5.5 Tools to help team members communicate or challenge.

- **SBAR** – Situation, Background, Assessment, Recommendation
- **I PASS THE BATON** – Introduction, Patient, Assessment, Situation, Safety concerns, Background, Actions, Timing, Ownership, Next
- **Callout or Checkback** – repeating what you have heard to ensure you’ve heard it correctly
- **Twochallenge rule** – voicing and relating concerns at least twice
- **CUS** – I am Concerned, I am Uncomfortable, this is a Safety issue
- **DESC** – Describe the specific situation/behaviour/issue, Express how the situation makes you feel, Suggest other alternatives, state the Consequence (good for conflict resolution)
- **AAA** – Awareness (of the issue), Acceptance (that I can and need to do something about it), Action (what I will do about it)

**Constructive debate**

Constructive debate and ‘fierce conversations’ are necessary in teams to ensure high-quality outcomes and to prompt a constant flow of innovation in care or service development and in ways of working. They also foster independent thinking and professional development amongst team members and encourage the creation of strong team identity and team member attachment. This is the very opposite of the consequences of interpersonal conflict in teams. Where there are high levels of interpersonal conflict, there are often low levels of achievement, high levels of employee stress and very little innovation or personal development. Effective team leaders establish and maintain a climate of constructive debate in the team and with other relevant teams (Boxes 5.6 and 5.7).
Box 5.6 Team climate for constructive debate.

- Openness to and exploration of opposing opinions
- Concern for quality and innovation
- An inclusive leadership style
- Valuing diversity of members and perspectives
- Mutual respect for opposing views
- Concern for the integration of ideas

Box 5.7 Case study: Effective team leadership.

Jane is newly appointed to lead the community dementia service team. After three months, many team members are complaining about her ‘dictatorial’ approach. They say that decisions are made without consultation, they are emailed about ‘rules’ and feel that they are not being treated or consulted as expert health professionals with a wealth of experience in the field. Two members of the team go off sick; others feel as if they want to leave. This comes to a head when two members of the team approach the senior management about their concerns.

Jane’s line manager talks with both Jane and the team and attends two team meetings as an observer. As a result, a coach is appointed to work with Jane to help her develop a more constructive team climate. Regular team meetings are established, information is shared more openly and Jane is reminded to speak with people on the telephone or face to face as well as through emails. Key objectives are agreed and developed through a new service plan and different team members are invited to lead on specific initiatives. After six months, the team reports working in a much more collegial, trustful and functional way and Jane herself is feeling much more in control through having the support of the team.

Interteam working

The ability of teams to form effective cooperative relationships with other teams is as important to success as the ability of team colleagues to work effectively together. Team leaders need to be ‘boundary crossers’ and help their colleagues to identify relevant partner or interteam relationships and to ensure that these flourish through:

- acknowledged mutual benefit
• partner role clarity
• understanding about and respect for different ways of working
• shared commitment to highquality outcomes
• interprofessional trust and respect.

**Clarity of leadership**

In healthcare organisations there can often be a lack of clarity about team leadership and yet research shows that clear leadership is positively correlated with effective teamworking, reduced levels of stress amongst team members and levels of team innovation (West *et al.*, 2015) ([Figure 5.4](#)).
Leadership clarity is associated with improved team effectiveness.

*Source: West et al. (2003).*

It is important, then, for team leaders to regularly discuss and review the nature of their leadership role with team members. This will include discussion about responsibilities for:

- decision making
- managing team processes
- supporting team and team member development.

The role of clinical team leadership is often challenging, but teams simply cannot achieve their
full potential without clear and effective leadership. Part of this is ensuring that all team members understand who the team leader is and what exactly that role entails in a specific team.

References


Further resources


A range of research papers and diagnostic and development materials relating to teambased working can be found at www.astonod.com.
CHAPTER 6
Leading and Managing Change
Valerie Iles
London School of Hygiene and Tropical Medicine, London, UK

OVERVIEW

- Change may be described as planned, emergent or spontaneous.
- Approaches to leading and managing change need to suit the context, organisation or system.
- Contexts for change can be viewed as four domains: the known, the knowable, the complex and the chaotic, each of which requires a different approach.
- Behaviour is as important as techniques when managing change.
- Effective leadership behaviours for managing change involve caring, conversations, respect and authenticity.

Introduction

There is no single ‘best’ way of delivering change. The approach you choose should depend on the nature of the change, the people and professions involved and the context. In this chapter we focus on some fundamental principles of leading and managing change.

Thinking about change

One way of thinking about change is to consider whether it is planned, emergent or spontaneous.

Planned change

In planned change, an initial analysis leads to a change agenda, an action plan and an implementation programme. On completion, the change is subject to review or evaluation. The planned, ‘linear’ model of change dominates even in contexts where it is the least useful. This tendency is difficult to counter and change leaders need to be able to use the language of the planned alongside other approaches to shift the thinking of those who are unfamiliar or uncomfortable with less certain approaches.

John Kotter (1995) developed a widely used model for planning organisational change (Box 6.1). This model assists with planned change through eight iterative steps, i.e. previous steps
may need to be revisited along the way. It is also a useful checklist to examine why and where change projects may be going wrong.

**Box 6.1 Eight steps in leading change.**

1. Establish a sense of urgency – this provides momentum for the change.
2. Create the guiding coalition – team includes stakeholders with power to lead the change.
3. Developing a vision and strategy – helps direct the change effort.
4. Communicating the change vision – as widely as possible; change leaders need to model the change.
5. Empowering broadbased action – getting rid of obstacles, changing systems and structures, encouraging those involved.
6. Generating shortterm wins – quick visible wins with recognition for those who made these possible.
7. Consolidating gains and producing more change – may need more people to implement the change.
8. Anchoring new approaches in the culture – the change is no longer a project but ‘the way we do things round here’.


**Emergent change**

Here, change leaders work with people who have ‘authenticity’ and ‘intuition’ which they use to understand and view the organisation. Patterns of behaviour that indicate the direction of change already under way are identified and encouraged. Whereas planned change works entirely with explicit knowledge, emergent change also involves tacit knowledge.

**Spontaneous change**

Where systems are largely selforganising, interventions from the outside often lead to unintended consequences or are defeated by the reemergence of existing dynamics. Here change leaders concentrate on the relationships between elements within the system (for example, people), focusing on behaviours rather than analysis or narrative.

**Different contexts for change**

The context for change provides insight into which approach might be used. Snowden and
Boone (2007) (see also Chapter 8) suggest that we can engage with innovation and change in four different domains:

- the known
- the knowable
- the complex
- the chaotic.

**The known**

Here, there are clear cause and effect relationships: A causes B. If we want to achieve B then we can do A, and we can undertake research to check that A is better than X or Y at achieving B. In the domain of the known, leaders need to ensure effective ways of sensing incoming data, categorising it and responding with predictive models in accordance with best practice (Figure 6.1). In this approach to change, there’s one best way of doing things which, once identified, is what everyone must do (Box 6.2).

![Figure 6.1 Planned change.](image)
The hospital’s clinical lead for diabetic care is asked to consider trialling a new drug designed to modulate peaks and troughs in blood sugar levels in patients using a particular insulin regime. She agrees to be involved in a randomised controlled trial to explore whether the new drug is better than the previous regime at keeping the patients’ diabetes stable.

The knowable

Cause and effect relationships also exist here but are less clear, perhaps because there is some distance between them in time or place. The relationships may only be known to a few experts. Research methods include experiment, fact finding and scenario planning, aiming to elucidate the cause and effect relationships more clearly. Leadership here is ‘oligarchic’, held by the small number of informed individuals who understand the challenges (Box 6.3).

A recent audit highlights an increase in admissions to the special care baby unit (SCBU). The quality and safety team are asked to look into these concerns and identify that an increasing number of women are choosing to have home births through the new community midwife led service. While the team supports a woman’s right to choose the place of birth, they wonder if there is a link between this trend and the increase in SCBU admissions. They decide to carry out research with the medical and health professionals involved in both services, including interviews and data analysis of maternal admission rates and SCBU admissions.

The complex

In this domain, although there are cause and effect relationships, the number of agents and the frequency, richness and unpredictability of their interactions mean that patterns can be perceived but not easily categorised or predicted. Using research methods relevant to the knowable and known domains is inappropriate and can be misleading, suggesting causality where there is none. A wide range of (possibly innovative and less conventional) research methods need to be used. The most effective leadership style is ‘emergent’ which combines effective administrative procedures and safe governance with an enabling and adaptive approach (Box 6.4). In many cases, it involves helping people to grasp the factors contributing to the complexity, and supporting them in their own attempts to make very local changes.
Following a series of complaints about the professional attitudes and behaviour of staff, the hospital medical director decides professionalism needs to be addressed within the organisation. A trustwide series of meetings is established to focus on the issue to explore what staff understand about their professional roles, responsibilities and relationships. There is no sense as to what may emerge from the process but, over a period of a year, complaints begin to fall and there is a noticeable change in the culture of the organisation.

Box 6.4 Case study: Engaging with the ‘complex’.

The chaotic

In this domain there are no perceivable relationships. The system is too turbulent and time to investigate change is not available. Here, a leader needs to be able to act through a hierarchy where decisions can be relayed quickly and acted upon without question. Authority is required to ‘control’ the space so as to move it into the knowable, the known or the complex (Box 6.5).

Box 6.5 Case study: Managing chaos.

The accident and emergency department at the largest hospital in the area has a plan for dealing with major incidents. A train derails two miles from the hospital with over 200 people killed or injured. Emergency staff are initially overwhelmed by the scale of the disaster. However, rapid and collaborative action by hospital managers, senior clinicians and the ambulance service in accordance with the plan leads to mobilisation of key staff to the scene. The injured are rapidly triaged and taken to the most appropriate centres in the area; only the most seriously injured are brought to the major hospital. Prompt and assertive action quickly brings the ‘chaotic’ into the ‘knowable and the ‘known’.

Approaches to leading change

Where a change is wholly ‘known’ in nature (i.e. it is clear that an alternative way of working yields better outcomes), a planned approach is appropriate. Where the nature of the change is knowable, the emergent approach may be better, and with complex change the spontaneous approach should be chosen. Major changes in health services and organisations are complex and do not fall neatly into one of these domains, especially that of the ‘known’. Change leaders need to use all three approaches to change simultaneously and not rely primarily on explicit planned change methods such as those shown in Figure 6.1. Chapter 8 discusses complexity in more detail.
Table 6.1 provides a matrix of approaches to managing planned, emergent or spontaneous change. Leading change effectively requires the rigorous, competent and creative use of all boxes in the matrix. In practice, however, it is often the case that:

- individual change leaders prefer one approach and undervalue the others. A conversation that unearths assumptions and judgements can allow a team of people with different preferences to work together more effectively
- instead of creative competence in each of the ‘boxes’, an unaware combination is used. Clear thinking about each of the boxes in turn can prevent this
- reflection is usually forgotten, so very little experiential learning takes place about how to lead change effectively. Although time for reflection is difficult to find, it is a very worthwhile investment, as long as it is conducted with the aim of understanding rather than seeking to apportion blame.

**Table 6.1** Approaches to change.

<table>
<thead>
<tr>
<th>Overall approach</th>
<th>Planned change</th>
<th>Emergent change</th>
<th>Spontaneous change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before</strong></td>
<td>Undertake a rigorous analysis that leads to a list of critical issues that need to be addressed, and develop an implementation programme</td>
<td>Work with the people with ‘tacit knowledge’, authentic and intuitive understanding of the organisation. Experiment with different ideas and look for patterns in the experience of the organisation</td>
<td>Engage with a wide range of people, encouraging them to contribute their perspective and to take responsibility for playing their part in shaping the analysis and the design</td>
</tr>
<tr>
<td><strong>During</strong></td>
<td>Manage the programme or project, using sound, proven methods for monitoring progress</td>
<td>Make all your usual everyday decisions that appear to have little connection with the implementation plan. Take opportunities as they arise, fostering and crafting choices to make the best of each unforeseen situation</td>
<td>Keep in mind, and articulate for others, the spirit of the programme of change; help others to behave in the spirit of this plan</td>
</tr>
<tr>
<td><strong>Overall approach</strong></td>
<td>Analyse, plan and implement</td>
<td>Foster, craft, discover and detect patterns</td>
<td>Observe events, actions and behaviours as they develop spontaneously from interactions in a complex adaptive system</td>
</tr>
<tr>
<td><strong>Key skills</strong></td>
<td>Key skills: analytical and computational</td>
<td>Key skills: spotting patterns, identifying authenticity</td>
<td>Attributes needed include attentiveness, flexibility, dynamic poise and responsiveness</td>
</tr>
<tr>
<td>plans, performance management</td>
<td>as well as explicit, and bring meaning to events as they unfurl</td>
<td>Try to understand what actually happened and how, by considering the events and processes, behaviours and relationships that emerged as time went on. This gives a better understanding of the dynamics of the system and enables the design of development programmes that will influence the way people respond in the future</td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>After</strong></td>
<td>Compare actual events and outcomes with those of the plan, and with the analysis that led to the plan. In practice, this can have a developmental intent (enabling better analysis and planning in the future) or a judgemental one (performance management)</td>
<td>Tell stories. Help people make sense of what has happened by selecting some events and decisions and not others. Stories woven here are not accurate pictures of reality but simplified, coherent versions of reality that can be told to multiple stakeholders. This engenders a sense of meaning and of belonging to a longer narrative, which can become part of the history of the service or organisation</td>
<td></td>
</tr>
</tbody>
</table>

### Useful behaviours when leading change

The effective change leader requires a toolkit of appropriate actions, analyses and competences; however, they also need leadership behaviours and values that are appropriate for healthcare.

### The need to care

If we are to effect beneficial change in patients and in organisations, we are more likely to do so if we care, i.e. if we engage in acts of work and courage. When leading change, we often need to care about the growth and development of others. Here acts of work can include gathering data, finding out about the interests, enthusiasms and personalities of staff involved and meeting with them all. Acts of courage could involve discussing the change with people who see little need for it, finding out the views of others about existing problems and being prepared to challenge and change your own solutions and approaches. In any situation, it is therefore useful to ask:

- Did I care enough here?
- Did I do as much work as was needed?
- Was I sufficiently courageous?

### Concentrating on the ‘simple hard’

Imagine that we banned the term ‘communication’ and did not think about a ‘communication strategy’. We would be forced instead to think about the following.
• Who needs to hear what, and from whom?
• Who needs to say what, and to whom?
• Who needs to ask what, and of whom?
• Who needs to discuss what, and with whom?

This calls upon different kinds of action and energy from that of ‘developing and implementing a communication strategy’. This is an example of focusing on the simple hard instead of the complicated easy.

The simple requires clear but straightforward thinking about what needs to be done, some careful thought about how to do it and courage to carry it out. The complicated, like writing that communication strategy, calls upon much more of our intellect but little else. While the complicated often involves an analysis or a computation that can be considered to yield a ‘right’ answer, the simple is indeed hard, and, although we will never get it right, we will get less bad at it with practice. We can take pleasure in learning and growing as we do. While some complicated stuff is needed, it is the simple that determines success. And often, that comes down simply to ‘conversation’.

**Conversation as a vehicle for change**

Simple, empathic, purposeful, ongoing conversations are the essence of good management. They may be opportunistic and informal or planned and formal. The important thing is to bring together people’s needs, enthusiasms and aspirations with the needs and ambitions of the organisation. The outcome comprises three rules of good management:

• a set of shared expectations about what will be done and how
• a mutual confidence that there are the skills and resources to achieve it
• ongoing feedback on how things are going.

Change arises as a result of multiple, authentic conversations and storytelling over time, most of which will be unrehearsed and emergent.

**Respectful uncertainty**

Perhaps the most valuable stance to take when considering change is that of respectful uncertainty: constantly looking at a system with a degree of creative suspicion. Not challenging for the sake of it, yet not leaving things as they are because of assurances from those involved that all is well. Being respectful of the people involved, because their intentions and the practices they have developed are vital. However, at the same time, a change leader needs to gently challenge any certainty that these are the best or only ways, and demonstrate confidence in people’s ability and willingness to consider other options.

**Bringing choices into awareness**

We all develop routines to help us deal with the world; we could not function if conscious
choices had to be made about all the options open to us every moment of the day. Many choices therefore operate on a subconscious level. Change may require people to do differently things that they are currently doing on autopilot and all change (for example, starting a new job) involves a sense of loss, even if the change is positive and welcome. Awareness of people’s emotional responses to change (Figure 6.2) can help a change leader to respond and support people appropriately. If change leaders use a heavyhanded, coercive approach, motivation and good will can be damaged. A lighter, supportive touch, involving gentle querying about activities and refreshing ambitions, can remind people of certain decisions and promote openness to change.
Speaking to what matters to others

Above all, when engaging with others, we must speak to what matters to them. If we treat the healthcare context as a marketplace and simply advocate efficient transactions, we may achieve a valuable amount of systematisation and reduce undue variation in practice and in outcomes. But we will also alienate people who see healthcare as something more: something with elements of the ‘gift economy’ in which there is a covenant between care giver and care receiver. Effective change leaders will encourage and demonstrate both sets of care.

**Figure 6.2** Emotional responses to change.

*Source: Adapted from Hay (1996).*
behaviours (Box 6.6).

### Box 6.6 Transactional care and the ‘gift economy’.

<table>
<thead>
<tr>
<th>Care as a set of marketplace transactions</th>
<th>Care with elements of the gift economy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient or service cared ‘for’</td>
<td>Patient or service cared ‘about’</td>
</tr>
<tr>
<td>Focus on objectivity, activities that can</td>
<td>Acceptance of the importance of subjective</td>
</tr>
<tr>
<td>be measured and counted</td>
<td>judgement, wisdom and silence</td>
</tr>
<tr>
<td>Healthcare professionals and services</td>
<td>The meaning of an encounter for both</td>
</tr>
<tr>
<td>seen as depersonalised units of production</td>
<td>patient and healthcare professional is</td>
</tr>
<tr>
<td></td>
<td>seen as important</td>
</tr>
</tbody>
</table>

### Behaving like you

When leading change, integrity is more important than heroism. So, while change leaders may want to move outside their comfort zones to develop new skills, they must always feel in harmony with others. In particular:

- find gentle ways of saying hard things, then you will say them
- divide tasks into doable chunks
- look for allies, people who will support and challenge you.

### Conclusion

Leading change involves a range of skills and behaviours, many of which can be learned. In this chapter, we have looked at the management of change through two lenses: change as planned, emergent or spontaneous, and change in terms of contexts for innovation. Most importantly, we have emphasised that an effective change leader needs to lead by example, through appropriate, authentic behaviours, always making the link between care and change. So, only lead change when you care, and when you do care, find ways of leading change.

### References


Snowden DJ and Boone ME. (2007) A leader’s framework for decision making. *Harvard*
Further resources


OVERVIEW

• Key tasks for clinical leaders include providing vision and setting strategy.
• Leadership is crucial in shaping an organisation’s culture.
• Assessing organisational climate is a necessary prerequisite to changing culture.
• Clinical leaders need to recognise the ambiguities and challenges created by multiple perspectives on healthcare organisations.
• Reframing is a powerful tool for leaders of organisations.
• System leadership across complex interdependent care systems is a new and demanding role for clinical leaders.

The organisational landscape in healthcare

Healthcare is delivered by organisations which vary greatly in size, purpose and funding. Indeed, healthcare is increasingly provided not by a single organisation but by groups of organisations working together. In order to meet the population health needs of the twenty first century, it is widely believed that providers of healthcare need to form local integrated care systems, with leadership provided by the most experienced managers and clinicians. This chapter provides an introduction to the issues, approaches taken and challenges faced by clinical leaders in leading both healthcare organisations and the systems of which they are part.

Multiple perspectives exist on what constitutes an organisation and clinical leaders need to recognise the ambiguities that these create. Healthcare is delivered in a variety of settings by a range of providers: in family medicine, in the community, in hospitals and by public, private and voluntary organisations. New forms of social and economic organisation have emerged, which possess varying degrees of political and economic authority. They lie at different points along a spectrum of ‘publicness’ between hierarchies and markets (Anderson, 2012). Such organisational forms have been given a variety of labels, including strategic alliances, dynamic networks and valueadding partnerships.

Vision, mission and strategy
One of the functions of clinical leadership is to provide direction and establish a culture that enables the organisation to thrive and perform. Those articulating the vision need to ensure that it is consistent with both the organisation’s mission, and the strategies in place to deliver it. Mission, strategy and vision address different organisational questions and operate over different time periods (Table 7.1).

Table 7.1 Mission, strategy and vision.

<table>
<thead>
<tr>
<th>Concept</th>
<th>Question addressed</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mission</td>
<td>Why does this organisation exist?</td>
<td>A mission statement provides a brief account of the organisation’s present purpose</td>
</tr>
<tr>
<td>Strategy</td>
<td>How will this organisation deliver its mission?</td>
<td>Usually looks ahead over the next 3–5 years, developed iteratively and taking into account external environmental factors and influences</td>
</tr>
<tr>
<td>Vision</td>
<td>Where does this organisation see itself in the future?</td>
<td>Focuses on a more distant future, gives an indication of where the organisation would like to be, the direction in which it needs to travel, or the challenges to be addressed</td>
</tr>
</tbody>
</table>

Those aspects of the social, political, economic and technological landscape that have an impact on organisational performance are referred to as the external environment. This covers everything from political priorities and changes in legislation to economic constraints and health scares reported in the media. Clinical leaders have little control over the external environment, but they can sometimes anticipate it, making sure that available resources are used efficiently and effectively and by creating a supportive and responsive culture.

**Organisational culture**

There are many definitions of organisational culture. It has been variously described as ‘how things are done around here’, ‘the social and normative glue that holds an organisation together’ or ‘a set of meanings, ideas and symbols that are shared by members of a collective and have evolved over time’. Culture manifests itself through human behaviours and social systems. These can be illustrated by means of the cultural web (Johnson et al., 2010) at the core of which is ‘the paradigm’, defined as ‘the taken-for-granted assumptions and beliefs which are the collective experience applied to a situation to make sense of it and inform a likely course of action’ (Figure 7.1). Key elements of the cultural web are summarised in Box 7.1.
Figure 7.1 The cultural web.

Source: Johnson et al. (2010).
Box 7.1 Elements of the cultural web.

**Routines:** describe ‘the way we do things around here’ on a daytoday basis. They often have a long history and may be common across organisations. They can help to keep the organisation running smoothly, but they can be taken for granted and be difficult to change.

**Rituals:** activities or events that emphasise, highlight or reinforce what is especially important in the culture. Examples include interview panels, promotion and assessment procedures and training programmes. Rituals can also be informal activities such as drinks in the pub after work.

**Stories:** told by members of an organisation to each other, to outsiders and to new recruits, both in person and increasingly using social media. They typically concern successes and failures, and heroes and villains. They can be a way of letting people know what is important in an organisation.

**Symbols:** can be objects, events, acts or people that create, convey or maintain meaning over and above their functional purpose. Examples include offices and office layout, cars and titles, all of which have a functional purpose but are also signals about status and hierarchy.

**Power structures:** powerful groupings within an organisation are likely to be closely associated with its core assumptions and beliefs. In organisations that experience strategic drift, senior managers are often found to have long associations with oldestablished ways of doing things.

**Organisational structures:** usually reflect power and show key roles and relationships. Hierarchical structures tend to emphasise that strategy is the province of top managers and others follow orders. Devolved or flatter structures may signify that collaboration is more important than competition.

**Control systems:** measurements and reward systems emphasise what the organisation feels is important to monitor. Public organisations may feel pressured to be more concerned with stewardship of funds than with quality of service. This is reflected in the focus of procedures.

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**Power, authority and influence**

Clinical leaders exert considerable power, authority and influence, but to be effective they need to understand the differences between them and the nature and source of each.

*Power* concerns the extent to which one individual has control over another within a certain social system. A has power over B to the extent that they can get B to do something that B
would not otherwise do, and whether they want to or not. Power in an organisation may reside in unexpected places, for example the rota coordinator or switchboard operator.

**Authority** is the power granted to individuals, groups or institutions through active or passive consent. Weber (1958) identified three sources of such legitimate authority: legal rational (for example a director of nursing), traditional (for example, a president of a royal college) and charismatic (for example, a talented and extravert colleague).

**Influence** is an outcome of the exertion of both power and authority, but also describes an informal process, either tacit or overt, whereby the behaviour or worldview of another person is affected.

It is particularly helpful for leaders to recognise when, and where, they can exercise power, how power flows within a particular organisational setting and the different kinds of power being exercised by others. This may take many forms, such as the *hierarchical* power exercised by consultants over junior staff, and *status* power exercised by different medical and surgical subspecialties, or between doctors and other health professionals. Effective clinical leaders manage tensions between those with different sources of power, such as doctors and administrators or finance officers. But they may also be unaware of just how much authority or influence they have over the behaviours and beliefs of others both by their actions and inactions.

**Organisational structure**

Organisational structure refers to ‘the formal division of work and labour, and the formal pattern of relationships that coordinate and control organisational activities’ (Bratton 2015). Structure is most commonly displayed in the form of an organisational chart and may encompass a number of aspects of organisations, including complexity, formalisation and centralisation ([Box 7.2](#)).
Box 7.2 Complexity, formalisation and centralisation.

**Complexity:** the degree of differentiation in the organisation. This gives an indication of the division of labour and the extent of specialisation within the organisation, but also its configuration such as the number of levels in the hierarchy (for example, pyramidal or flat).

**Formalisation:** the degree of standardisation of work and jobs in the organisation. This is the extent to which work is controlled by fixed rules and procedures. Where staff have a high level of freedom to use their discretion, the degree of formalisation is low. This can vary widely both within and between organisations.

**Centralisation:** the degree to which decision making is concentrated at a single point in the organisation. It identifies the level in the organisation at which decisions are made. The greater the autonomy of people lower down the hierarchy, the greater the degree of decentralisation.


An understanding of organisational structure is important for clinical leaders as its consequences are often farreaching. Overspecialisation may lead to inefficiency, while too little formalisation may mean that essential tasks are not undertaken rigorously enough, and the degree of centralisation may have a major impact on levels of motivation, job satisfaction and working relationships.

The organisational theories of Mintzberg (1979) suggest that healthcare organisations function as ‘professional bureaucracies’ in which a skilled and knowledgeable body of staff exercise a high degree of degree of control over the delivery of services. In a professional bureaucracy, workers are regulated by external professional bodies with their work normalised across networks of peers. This contrasts with a ‘machine bureaucracy’ where the organisation enforces procedures and processes through strong, topdown, line management structures. Professional bureaucracies have a decentralised and inverted power structure, where frontline staff have greater influence over daily decision making than those who, through formal positions of authority, are responsible for managing the service. In such a system, the ability of service managers to influence is constrained, highlighting the need for clinicians at all levels to be engaged in the leadership task.

**Climate**

People working in an organisation will perceive it in different ways. Perceptions of the work environment are referred to as the organisational climate (Patterson et al., 2005) and are best understood as intervening variables between organisational context and behaviour concerning
employees’ shared perceptions of organisational events, practices and procedures. At the individual level of analysis (known as psychological climate), perceptions indicate how work environments are appraised and meaning attached by individual employees. While culture addresses the question ‘How are things done around here?’, climate asks ‘How is it for you?’.

Climate has a number of dimensions originally developed by Litwin and Stringer (1968) and modified slightly over the years. These are summarised in Table 7.2. A positive organisational climate is strongly correlated with performance. The effect of various leadership ‘styles’ on organisational climate is discussed in Chapter 3.

**Table 7.2** The dimensions of organisational climate.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>In an organisation with a positive climate…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexibility</td>
<td>There are no unnecessary rules, policies or procedures and new ideas are readily accepted</td>
</tr>
<tr>
<td>Responsibility</td>
<td>Employees are given the authority to accomplish tasks without seeking permission</td>
</tr>
<tr>
<td>Standards</td>
<td>Challenging but attainable goals are set for employees and the organisation</td>
</tr>
<tr>
<td>Rewards</td>
<td>Staff are recognised and rewarded for good performance</td>
</tr>
<tr>
<td>Clarity</td>
<td>Everyone knows what is expected of them</td>
</tr>
<tr>
<td>Team commitment</td>
<td>People are proud to be a part of the organisation</td>
</tr>
</tbody>
</table>

Leaders can gain real insights into the culture of their organisation by carrying out an audit of climate (Box 7.3). Typically, staff are asked to judge a range of statements from definitely false to definitely true. Examples include ‘Management let people make their own decisions much of the time’, ‘People are suspicious of other departments’ and ‘New ideas are readily accepted here’.
Box 7.3 Case study: Using climate to change culture.

A newly appointed clinical leader was assured by her colleagues that the hospital where she had recently taken up post had an open, transparent culture where collaboration between departments was effective, where information was widely shared and where people were constantly searching for new ways of solving problems.

However, after a week or so of visiting departments and talking to staff, she began to realise that there was a wide gap between the views of senior managers about the hospital’s culture and those of its staff. She arranged to survey the perceptions of all staff using an organisational climate measure. This established that in fact, many people were suspicious of other departments, that there were often breakdowns in communication and that most managers were not really interested in trying out new ideas. She drew the attention of her senior managers to the findings of the survey. They were asked to implement a range of measures designed to bring the culture of the hospital more into line with what many of them believed it to be in the first place.

Reframing organisations

We all have a particular view of the world based on our background, training and experience. Bolman and Deal (2008) point out that a central mistake for leaders is to lock into limited and flawed views of their world as their colleagues are likely to frame a situation differently, each focusing on a different but vital piece of the larger picture. Leaders often miss significant elements in decoding the situations and opportunities they face. The risk is that they focus on selected cues and fit what they see into a familiar pattern, even if it isn’t quite right.

A key response to this is ‘reframing’, defined as ‘the deliberate process of looking at a situation carefully and from multiple perspectives, choosing to be more mindful about the sensemaking process by examining alternative views and explanations’. Bolman and Deal suggest that organisations can be viewed through four different lenses or frames, described as the structural, human resource, political and symbolic (Box 7.4). Effective leaders are able to be flexible about how they view organisations, and switch frames when one perspective isn’t working for them.
Box 7.4 Reframing organisations and the leadership task.

**Structural frame:** build an appropriate organisational structure with a coherent set of rules, roles, policies and procedures.

**Human resource frame:** address the complexity of human nature and create work environments that facilitate creativity, satisfaction and productivity.

**Political frame:** manage conflict resulting from the enduring differences of all kinds which lead to incompatible priorities and power struggles.

**Symbolic frame:** create a culture that aligns the purposes and values of the organisation and provides the symbolic glue that coordinates the activities of many.

Source: Bolman and Deal (2008).

**Leading healthcare systems**

A sustainable future for healthcare is seen as dependent on greater collaboration between healthcare organisations and also between health and social care, the third and private sectors and other services. The term ‘integrated care’ is used to describe joinedup, high value services centred on the needs of patients (Shaw et al., 2011). Providing leadership across such complex systems is a new role for clinical leaders, one that usually has to be undertaken alongside that of leading the individual component institutions (Fillingham and Weir, 2014). One of the challenges here is that a hierarchical style of leadership, based on direction or regulation from above (currently predominant in healthcare), is not what is needed for leading these complex integrated networks. System leadership is shared, collaborative and engaging and requires a new set of skills, knowledge and behaviours. System leadership is also flexible and may reside within or outside a particular organisation, and at any level. Most importantly, it is purposeful, values based and has the patient at its heart (Box 7.5).
Box 7.5 Observations on system leadership.

- System leadership is not easy.
- It requires both constancy of purpose and flexibility.
- It takes time to achieve results.
- It starts with a coalition of the willing.
- A stable core leadership team is important.
- Patients and carers are crucial in helping design changes.
- System leadership needs to have an evidence base for change.
- To achieve the most, you have to give away ownership.
- Financial stringency has not yet led to acceptance of system working.
- Not enough is being done to develop system leaders.


References


Litwin GH and Stringer RA. (1968) Motivation and Organizational Climate, Division of Research, Graduate School of Business Administration, Harvard University, Boston.


**Further resources**


CHAPTER 8  
Leading in Complex Environments

_David Kernick¹ and Tim Swanwick²_

¹ St Thomas Medical Group, Exeter, UK  
² Health Education England, London, UK

OVERVIEW

- Insights from complexity theory offer a useful alternative framework for leaders when operating in environments of ambiguity and paradox, such as healthcare systems.
- Detailed planning and topdown direction of complex systems may prove futile.
- Complex systems are nonlinear, and although emergence is certain, there is no certainty of what will emerge.
- A range of interventions are available to leaders of complex systems.
- Systems leadership requires both technical skills and adaptive behaviours.
- The behaviour of complex systems may be profoundly influenced through attention to shortrange social processes.

Introduction

Dynamic human systems, such as a hospital or a health service, have an innate tendency towards stability whilst, at the same time, their constituent members relentlessly pursue their own agendas and experiment with new ways of adapting to an ever changing environment. At one extreme of this spectrum is order, at the other, chaos. For most of the time, we operate somewhere in the middle, in a zone of complexity. Stacey (2001) describes this zone as arising when there are significant levels of uncertainty about the future and a lack of agreement about the way forward.

Stacey’s ‘certaintyagreement’ matrix (Figure 8.1) describes four domains: simple, complicated, complex and chaotic. If leaders want to make rational changes or decisions, they will need a reasonable degree of agreement about the way forward, and certainty about what is likely to happen as a result. Adaptive leaders are comfortable in the zone of complexity, perturbing the ‘edge of chaos’ to stimulate change; they don’t know what the change will be exactly but know that something will emerge. Alongside many others, Stacey suggests that when working in this zone (which we are, most of the time), a unique set of operating principles apply, and organisations are therefore helpfully viewed as ‘complex systems’.
Snowden and Boone (2007) also developed a model around these four zones to inform how leaders and managers can make decisions and solve problems – the ‘Cynefin’ framework (Figure 8.2). In the simple zone (the known), systems are in place, people agree what should be done and how. The complicated zone depicts the ‘knowable’ where you can find out how best to do things if you ask around, but the complex zone is where you can only look for patterns and ask questions. The chaotic zone is where completely unique problems lie, with often unique solutions. This is not an area in which healthcare organisations can operate safely and the best strategy for leaders here is to act fast to try to stabilise the situation, which
hopefully will move rapidly to become ‘complex’. Chapter 6 explores these approaches further in relation to change.

**Figure 8.2** Different contexts require different approaches.

**What is a complex system?**

A complex system is a network of elements that exchange information in such a way that change in the context of one element changes the context for all others (Figure 8.3). Negative
(damping/stable) and positive (amplifying/unstable) feedback operating reiteratively give rise to nonlinearity. This means that small changes in one area (for example setting a four hour wait target for all patients in emergency departments) can have large effects across the whole system (the butterfly effect) or, conversely, large impacts can have little effect. Complex systems cannot be analysed by reducing them to their component parts or their future predicted or controlled with certainty. This is in contrast with a complicated system, whose action can be determined by an analysis of its component parts and where behaviour is linear and predictable.

Figure 8.3 Complex systems: changes in one element alters the context for all the others.

A number of theoretical approaches to complex systems exist depending on their context and configuration. Human organisations are often viewed as ‘complex adaptive systems’ – the processing of information by elements changes with time as they learn and adapt in response to other elements or their environment. Some important features of complex systems are shown in Box 8.1.
Box 8.1 Features of complex systems.

- Complex systems consist of a large number of elements that interact. The richness of network connections means that communications will pass through the system but will be modified on the way.

- It is difficult to determine the boundaries of a complex system. The boundary is often related to the observer’s needs and prejudices rather than any intrinsic property of the system itself.

- History is important in complex systems and can determine future behaviour.

- The system is different from the sum of its parts. In attempting to understand a system by reducing it to its component parts, the analytical method destroys what it seeks to understand.

- The behaviour of complex systems evolves from the interaction of agents at a local level without external direction or the presence of internal control. This property is known as emergence.

- Emergence is a pattern of system behaviour that could not have been predicted by an analysis of the component parts and gives systems the flexibility to adapt and self organise in response to external challenge.

- Complex systems exhibit repetitive patterns into which they settle, known as attractors.

Viewing health services as complex systems is helpful because the nature of the final product, health, is contested and there is an often tenuous relationship between healthcare and health. Consumers of healthcare have imperfect knowledge about the product that they receive and managers have an imperfect knowledge of the system they oversee. Unpredictability arises because clinical professionals have a high degree of agency and autonomy and there are unique features of the relationship between the healthcare professional and the patient, including advocacy, trust and empathy.

How can a ‘complexity’ perspective help clinical leaders?

A complexity perspective leads us to a new view of organisations. Box 8.2 summarises some of these fundamental differences.
**Box 8.2 Traditional and complexity organisational perspectives.**

<table>
<thead>
<tr>
<th>Traditional perspective</th>
<th>Complexity perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decisions made by logical, analytical processes with an emphasis on managers controlling and driving strategy. The generation of new ideas is the province of experts</td>
<td>Decisions made by exploratory and experimental processes. Intuition and reasoning by analogy encouraged. New ideas can emerge from anyone</td>
</tr>
<tr>
<td>Focus on experts and leaders</td>
<td>Focus on the creation of favourable conditions for learning and development</td>
</tr>
<tr>
<td>Centrality of goalsetting strategic plans with the replication of processes that have worked well elsewhere</td>
<td>Emphasis on the here and now. Local structures, processes and patterns are seen as important</td>
</tr>
<tr>
<td>Organisation understood through the analysis of its component parts</td>
<td>Holistic perspective. The organisation is different from the sum of its parts</td>
</tr>
<tr>
<td>Emphasis on measurement and system quantification</td>
<td>Qualitative aspects of measurement important. The importance of process factors is emphasised as part of a learning process</td>
</tr>
<tr>
<td>Attempt to rationalise decision making even when problems are ‘messy’, reducing uncertainty and ambiguity</td>
<td>Recognising the creative potential of ambiguity and the importance of resolution through dialogue</td>
</tr>
<tr>
<td>Teams are permanent and part of a hierarchical reporting structure. Managers decide who participates and where the boundaries lie</td>
<td>Teams are informal, spontaneous and temporary. Participants decide who takes part and what the bounds of their activities are. The focus is on self organising networks with an appreciation of the importance of both cooperation and competition</td>
</tr>
<tr>
<td>Organisation based on strong shared culture</td>
<td>Organisation provoked and constrained by culture</td>
</tr>
</tbody>
</table>

Source: Adapted from Kernick (2004).

Recent thinking about healthcare (Timmins, 2015) urges leaders to take a systems approach, i.e. thinking about a whole system and not just the separate parts. Indeed, once we start to consider a system as dynamic and evolving, then this becomes an intervention in itself. With
complex systems, forms of influence cover a spectrum relating to the perceived ability of leaders to stand outside the system and manipulate it towards a predefined objective. Broadly speaking, these approaches range from the manipulative to the descriptive (Figure 8.4).

**Figure 8.4** Ways of leading in complex systems.

*Systems thinking* (Checkland, 1981) places leaders and managers outside the system. From here, they are able to dispassionately analyse and model how the system functions. They can then select an appropriate intervention that they hope will engineer the system towards a desired objective within the context of a largely predictable future. They then stand back, observe the effect and apply the next intervention. Government policy in health, and other areas, can often be seen to be operating in this way.

*Complexity engineering* sees the leader merging systems theory and complexity insights to manipulate the system in a required direction. The focus is on identifying and changing the simple rules, modulating system attractors or identifying organisational tipping points where a small input can change the trajectory of the system. Axelrod and Cohen (2000) suggest paying attention to internal processes, particularly those that foster variation, encourage interaction of system agents and apply selection pressures.

*Cultural paradigm*. Culture is defined as ‘the values and beliefs that characterise organisations as transmitted through the socialisation experiences newcomers have, the decisions made by management, and the stories and myths people tell and retell about their organisations’ (Schneider and Barbera, 2014). In the cultural paradigm, the behaviours of system agents are aligned through the development of an organisational culture in which more or less the right thing happens, more or less all of the time, because ‘that’s the way we do things around here’. The current focus in healthcare on ‘values’ and ‘the St Elsewhere’s way’ is illustrative of this approach.

*Complex responsive processes* (Stacey, 2001). At the far end of the scale are a collection of approaches united by a focus on local interaction and the unpredictability of the future. Here the emphasis is on the essentially responsive and participative nature of the human processes of relating and the radical unpredictability of its evolution as we interact with each other in the coevolution of a jointly constructed reality. The focus is on ‘going on together’. What constitutes the organisation or system emerges as a result of communication between individuals at a local level. We are always participants and can never step outside the system to shape it. Leadership is distributed, emergent and without boundaries.
A leadership approach particularly suited to working in complex systems is adaptive leadership, deciding whether challenges are technical and can be solved with known expertise or are adaptive problems where new learning and behaviours are required (Heifetz et al., 2009). The leader’s work here is to mobilise and enable people to solve challenges while keeping the picture of the whole system in mind. The adaptive leader asks difficult (‘wicked’) questions that enable conflicts and sensitive issues to be surfaced and addressed. Rather than telling people how to manage the problem, they help them by facilitating discussion and providing the information they need to know to enable them to make decisions (Box 8.3).

**Box 8.3 Case study: Leading change in a complex system.**

The clinical lead for quality in a large teaching hospital wants to encourage the participation of doctors in training in quality and safety improvement. She recognises that there are multiple stakeholders and is aware of a number of tensions and drivers within the system, including demands on training time, financial cuts and a drive towards ‘metrics driven’ improvement. Despite reluctance from her medical colleagues, she includes other healthcare professionals and arranges a series of meetings for colleagues offering only a broad outline of her vision and encouraging discussion about how they would approach the issue. She supports and encourages departmental initiatives that emerge even though at times they seem to be at odds with each other. She also facilitates interaction between those involved, particularly across professions, inviting expert external input to support promising ideas and challenge the status quo. She sets up a space on the hospital intranet to enable the sharing of good practice and promotes the use of a common set of terms and language. She is supportive when a couple of junior trainees start a hospital newsletter and suggest a series of prizes and awards for projects and departments that he instigates.

Things don’t seem to be moving forward particularly quickly until at the end of the first year, a serious safety issue cuts across a number of departments. This seems to galvanise the hospital and after two years, the project has taken on a life of its own and quality improvement has becomes a strategic priority owned by the entire Board and senior leadership team.

**What does this mean in practice?**

Zimmerman et al. (1998) suggest a number of principles developed from a complexity perspective for leaders in healthcare systems.

- **Develop a ‘good enough’ vision.** Build a good enough vision of the future rather than plan out every little detail. In a nonlinear system the future is, in practice, unpredictable and
detailed planning is futile.

- **Tune the system to the ‘edge of chaos’**. Foster the right degree of information flow, diversity and difference, connections inside and outside the organisation, power differential and anxiety. Uncover and work with paradoxes rather than shying away from them as if they were unnatural. Encourage both cooperation and competition. Let innovation emerge from a creative balanced tension as the system adapts to the configuration that is best suited for the constraints placed upon it.

- **Grow complex systems by ‘chunking’**. Allow them to emerge out of links amongst simple systems that work well and are capable of operating independently.

- **Listen to the organisational shadow side**. Informal relationships, gossip and rumour contribute significantly to actions. It is in the shadow system that the ‘simple rules’ of the system are articulated.

- **Work with ‘simple rules’**. This concept is perhaps the most widely used application of complexity insights. The contention is that organisational characteristics emerge from the recursive application of simple rules or guiding principles at a local level (more specifically ‘rules of thumb’ rather than rules that must be adhered to). Here, the key questions for the leader are: what are the existing and often implicit rules that underpin the existing system; how can they be identified and modified; how can new simple rules be disseminated and introduced? Three types of simple rules for human systems have been proposed: general direction pointing; system prohibition, i.e. setting boundaries; and resource or permission providing. To be accepted, simple rules must have a clear advantage compared with current ways of doing things, be compatible with current system and values, easy to implement and test before making full commitment and the change and its impact must be observable. An example where detailed system specification was replaced by simple rules is shown in Box 8.4.
Box 8.4 Case study: Some simple rules for thrombolysis where a heart attack is suspected and their classification.

- Ensure patient receives thrombolysis within 60 minutes of chest pain (direction pointing).
- Administration can occur in any environment by a properly trained individual (direction pointing, boundary setting).
- Remain within the overall project budget (boundary setting).
- Emergency departments and ambulance authorities can draw funding from a pooled budget that has been established to support this change in practice (resource providing).

Source: Adapted from Plsek and Wilson (2001).

Conclusion

Complexity insights can offer the leader a useful alternative framework when operating in environments of ambiguity and paradox where the focus is on patterns of relationships within organisations, how they are sustained, how they selforganise and how outcomes emerge. If it only sensitises us to the interplay of patterns that perpetually transforms healthcare organisations, it can ameliorate the anxiety of being in command but not in control and help us muddle on together with a little more confidence. The versatile leader will use both linear and nonlinear approaches, depending on the context of the task at hand but, ultimately, complexity theory alerts us to the fact that there are no quick fixes or any easy way to integrate analytical techniques to leadership processes.

References


**Further resources**


CHAPTER 9
Leading and Improving Clinical Services

Fiona Moss
Dean, Royal Society of Medicine, London, UK

OVERVIEW

- High quality care requires good clinical leadership.
- Building capacity for quality and safety improvement is a fundamental leadership task.
- The clinical team is at the heart of quality improvement.
- Measurement is a prerequisite for improvement.
- Quality improvement requires clinicians and managers to work collaboratively.
- Clinical leaders need to challenge the status quo, articulate clear and ambitious goals and set a culture of improvement.

Introduction

Delivering high quality care is the undoubted aim of all health professionals; no one sets out to deliver poor care. But in all health systems, it is known that a proportion of the care received is in some way less than optimal, unsafe or not what the patient wanted. Poor quality care takes many forms and includes inappropriate use of effective interventions, underuse of effective interventions, lack of concern for patient dignity, inappropriate delays for procedures or appointments or the number of ‘never events’ (for example, wrong site surgery) reported. Mostly, problems with the quality of care reflect endemic problems with the organisation of healthcare delivery rather than failures of individual healthcare professionals.

Occasionally, a significant failure in healthcare results in a public inquiry designed to understand the root causes of the failure and to ‘learn lessons’ in order to prevent such a thing happening again. An analysis of 59 such inquiries in the UK into a range of healthcare failures over 28 years identified a number of common themes underpinning these events (Walshe and Higgins, 2002). Inadequate leadership was found to be one of the top five antecedents to significant healthcare failings (Box 9.1). High quality care is dependent on the quality of leadership throughout an organisation.


Box 9.1 Themes common to inquiries into NHS errors.

- **Organisational or geographical isolation**: inhibiting transfer of innovation and hindering peer review and constructive critical exchange.
- **Inadequate leadership**: lacking vision and unwilling to tackle known problems.
- **System and process failure**: in which organisational systems are either not present or not working properly.
- **Poor communication**: both within the NHS and between it and patients or clients, which means that problems are not picked up.
- **Disempowerment of staff and patients**: where those who might have raised concerns were discouraged or prevented from doing so.


Developing clinical leaders with the skills to bring about improvement is essential, not just for the prevention of ‘big impact’ failures but for the daytoday functioning of healthcare organisations sensitive to the needs of patients with the flexibility and capability to make, continuously, the sort of changes that lead to better care. Such organisations are made up of wellled, highfunctioning, competent teams committed to quality improvement who understand the relationship between wellworking clinical and organisational systems and the quality of care provided to individuals.

**Skills for quality improvement**

Building capacity for quality improvement within organisations is an important leadership task. Following another highprofile inquiry into the failings of care at one NHS hospital (see Chapter 2, Box 2.3), Don Berwick, former president of the US Institute for Healthcare Improvement, was commissioned to report on improving the safety of patients in England (Berwick, 2013). Two of his 10 recommendations were about training and capacity building namely that ‘Mastery of quality and safety sciences and practices should be part of initial preparation and lifelong learning of all healthcare professionals and managers’ and that ‘The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale’.

Training for most healthcare professionals is focused on the care of individual patients with little emphasis or formal training in organisational skills such as teamworking and leadership or the importance of working collaboratively both within and between organisations. And yet, improvements in the quality of care invariably require organisational change and alterations to the way people work together. Twenty years previously, Berwick set out the skills needed for
quality improvement (Box 9.2). These skills – that reflect the complexities within healthcare – include managing teams, the ability to understand work both as a process and as a series of interdependencies, and being able to lead change across internal and external boundaries (Berwick et al., 1992).

Clinical leaders tasked with managing and supporting their colleagues have a specific role in defining what it means to be a professional in a particular organisational context. Such leaders need to be able to persuade other clinicians of the relationship between effective organisational functioning and the quality of care for individual patients. They will also need to help colleagues acquire the skills described as part of their continuing professional development. Otherwise, it is unlikely that organisations will develop the necessary capacity for the distributed leadership and team development that are crucial for continual quality improvement (Box 9.2).

**Box 9.2 Skills needed for quality improvement.**

- Ability to perceive and work in interdependencies
- Ability to work in teams
- Ability to understand work as a process
- Skills in collection, aggregation and analysis of outcome data
- Skills in ‘designing’ healthcare practices
- Skills in collaborative exchange with patients and with lay managers

Source: Berwick et al. (1992).

Managing people and supporting the development of the workforce are recognised leadership functions. Performance management frameworks that link an individual’s goals to those of the organisation are potentially useful tools for supporting staff development but may be difficult to use in circumstances where individual staff members belong to several different teams. Furthermore, line management may follow professional hierarchies more closely than organisational ones. Professional and personal development for some staff, in particular doctors and other clinical professionals, may be linked to their specialty and to outside bodies rather than to the immediate needs of the organisation. The ambiguities which can arise from professionals’ different sets of loyalties and identities may have benefits to the organisation, but need to be recognised and acknowledged – and managed and balanced – against the importance of functional multiprofessional teams loyal to the organisation and its aims. Understanding and resolving such conflicts are some of the tougher challenges of clinical leadership.

Measurement is at the heart of quality improvement. Those leading improvement can be overawed by the magnitude of the whole task and distracted by calls for more ‘scoping’ work
or data collection. One approach is to initiate small pilot projects and set up small plan–do–study–act (PDSA) cycles (Langley et al., 1992) (Figure 9.1). However, although the PDSA cycle may seem simple, it is perhaps deceptively so and in practice may be difficult to sustain (Taylor et al., 2014). Quality improvement often requires small iterative steps, an approach to discovery and change that may not be familiar to clinicians more used to the traditional world of clinical research. Working with people to help them appreciate small changes, to work through the complexities of quality improvement, to understand the need for and difficulties of even small changes in practice, and to keep a team focus on continuous improvement are all part of the role of the clinical leader.

Figure 9.1 A model for improvement.
Source: Langley et al. (1992).

Teamworking and the quality of care

Teams that work well, and whose members experience low stress levels, deliver better quality care than poorly functioning teams. Ensuring good teamworking is an essential task for clinical leaders and central to quality improvement. In the complex environment of healthcare, this may
not be straightforward. Some teams are ‘real’ but many are virtual. For example, routine investigation of a patient found to have a shadow on a chest radiograph may touch the work of over 20 people, some of whom may not know each other; some will not have seen the patient and yet all must work well together to provide high-quality safe care for this and other patients (Figure 9.2).

**Figure 9.2** Good teamworking is essential for quality improvement.

Problems with poor care are unlikely to be resolved by individuals simply working harder, as the quality of clinical care is the function of how well people work together. Good teamworking and employee engagement are both linked to better outcomes for patients, including lower mortality, lower infection rates and better patient satisfaction; poorly structured teams are associated with poor outcomes. There is a strong relationship between the quality of staff management and the quality of care: staff working in well-functioning teams are more likely to feel supported than those in poorly functioning teams. Functional teams do not happen sporadically or simply by chance but are the product of good leadership and a culture that allows them to flourish. Moreover, good staff engagement is also associated with lower absenteeism and staff turnover. Ensuring staff wellbeing, their engagement with their work and fostering good team functioning are all part of the role of leaders – at all levels in an organisation – determined to improve the quality of care (West and Dawson, 2012; West *et al.*, 2014). More on teams and team leadership can be found in Chapter 5.
Leading for improvement

Leading improvement requires the courage to challenge the status quo and to set ambitious goals. Such ‘stretch goals’ serve to highlight the inadequacies of the current system and the need for improvement. Another of the key tasks of leadership is to engender a culture of quality improvement and support clinical teams as they ‘translate’ such aims into achievable objectives relevant to their daily work. Attention to the quality of care should be within everyone’s remit and not simply a response to poor quality care. Routine vigilance by all clinical staff of the quality of care they deliver, with an organisational responsiveness and flexibility that ensure a culture of continual improvement, requires skilful, sustained and distributed leadership.

Leaders of improvement have a particular responsibility to understand both clinical and managerial pressures and to bring these together through the development of a shared aspiration. Cooperation and understanding between clinicians and ‘lay’ managers are essential for quality improvement as sustained improvements in the quality of clinical care require changes in the organisation and delivery of care. For healthcare professionals trained in the care of individual patients, becoming a leader requires an ability to translate concern for individuals into an appreciation of how the whole system of care contributes to the well being and care of all patients. Clinical leaders also need to be aware that some interventions or improvements may need to be ‘upstream’ of health services (for example, improving health through improving housing or alleviating poverty).

Professional autonomy and clinical freedom are highly valued commodities within healthcare and clinical leaders must be sensitive to how these play out within the organisational context. Clinical leaders need to support colleagues to appreciate the balance between autonomous clinical practice and the benefits to patients of being cared for within a safe and effective organisation.

Leading for innovation

Finally, leaders of improvement need to understand the role of innovation in responding to the emerging futures of healthcare. This involves anticipating and planning for change and being prepared to experiment with new and sometimes gamechanging ‘disruptive’ technologies (Christensen et al., 2000) (Figure 9.3). But there is no simple recipe for success when it comes to introducing and embedding innovation as the interaction between the intervention and the context of its introduction is complex, and healthcare systems are inherently change averse. Leaders of improvement thus need to be comfortable with risk and learn how to tolerate failure. Some may also need reminding from time to time that the aim is not to innovate the most but to bring about the greatest improvement.
Figure 9.3 Tablets and smartphones: disruptive innovations in healthcare?

The impact of leadership on the quality of care

To appreciate the effect of good, sustained leadership on the quality of care and the links between organisational cohesion and care quality, it is useful to look at places where there is evidence that leadership has made a significant difference. Boxes 9.3 and 9.4 provide two such case studies. Both illustrate the importance of leadership at all levels, from the top of the organisation to the leadership of small clinical teams. And both highlight the centrality of a culture for improvement and the congruence of goals.
In 2002, Salford Hospital in the UK received ‘zero stars’ – the bottom rank – in the Health Commission’s rating system but now has a reputation for outstanding healthcare and is demonstrably one of England’s top performing hospitals. Salford performs extremely well across a range of healthcare measures, standardised mortality is in the top 10% nationally and hospital acquired infections have plummeted. Both staff and patients view the hospital highly and it consistently tops national staff surveys and achieves highly positive patient ratings.

This significant turnaround, followed by sustained improvement, is the product of good leadership and a persistent concern about the quality of clinical care. Explicit focus on quality improvement starts at ‘the top’ but here it is clearly distributed throughout the organisation. On the hospital website, there is the clear, unmissable, unambiguous declaration that ‘Salford Royal NHS Foundation Trust aims to be the safest organisation in the NHS through providing safe, clean and personal care to every patient, every time’ (www.srft.nhs.uk/). The involvement of all staff, and an acknowledgement of the importance of leadership at all levels within the hospital, is also seen in Salford’s Quality Improvement Strategy (www.srft.nhs.uk/aboutus/quality). This well-written, accessible document is not only available to all (including patients) but explicitly links quality improvement to service development and other local initiatives. It is clear that at Salford, quality improvement is embedded throughout the organisation.
Box 9.4 Case study: Cincinnati Children’s Hospital Medical Center.

Cincinnati Children’s Hospital Medical Center, a large specialist hospital in the US, illustrates the impact of a sustained organisational commitment to quality improvement, and the transformation that is possible when a whole organisation works to the same goals. Cincinnati Children’s states that its vision is to be ‘the leader in improving child health’ and has maintained a ‘significant focus on improving evidence based and family centred care since the 1990s’. Inspired by the Institute of Medicine’s report To Err is Human: Building a Safer Health System (Institute of Medicine, 2000), the hospital’s strategic plans are linked to quality improvement. Executive leaders provide clear direction but transformation and quality improvement are part of the work done by 19 crossfunctional teams. Integration between research and the design of the system of delivery of care and participation of patients and families are just some of the important factors in their success. Outcomes in many different areas are measured and published and reasons for any gaps between performance and goals are searched for and used to improve the processes of care. Senior leadership is clearly pivotal but the focus on quality is spread throughout the organisation and quality improvement sustained by distributed leadership at many levels. At Cincinnati Children’s, the whole organisation is explicitly ‘Dedicated to Collaboration, Transparency and Improving Outcomes’ (www.cincinnatichildrens.org/about/qualitymeasures/default/).

Conclusion

Continuous quality improvement is the product of sustained organisational leadership combined with effective and dispersed clinical leadership within highfunctioning teams. When this happens, clinicians are able to reflect on the care they give, understand the importance of collaborating with others and empowered to make changes that result in improvement.

Improving the quality of care should be the main focus for all clinical leaders. To achieve this aim requires a range of personal skills, an understanding of the importance of staff engagement and cohesiveness, and the need to work with all clinical colleagues, to ensure that they too have the skills for quality improvement and understand the relationship between good organisational functioning and the quality of care delivered to individual patients. Supporting staff through building trust, creating a positive working climate and ensuring highquality training and education are essential tasks for clinical leaders determined to improve the quality of care.
References


Further reading


Institute of Healthcare Improvement Open School provides a wide range of online training and tools to help teams deliver excellent, safe care. www.ihi.org/education/ihiopenschool


willperms
CHAPTER 10
Leading Projects
Jonathan Gardner
University College London Hospitals NHS Foundation Trust, London, UK

OVERVIEW

- The key to a successful project is to define it carefully at the outset.
- Emphasise the benefits at every opportunity.
- Good governance and senior sponsorship are essential for success.
- Organise yourself – there are lots of tools to help you do this.
- An effective project manager is first and foremost a good leader.

So, you have come up with a good idea to transform patient care. But no doubt, like many clinicians, you have seen countless great ideas either never move beyond that first eureka moment or else start well only to fade after a few weeks or months. So, the question is, how to turn your good idea into reality? How can you get people engaged enough to keep going through the difficult times, progress fast enough to make a difference, secure the financial resources you need and get a great quality outcome? Well, that is what project management is about.

Starting a project

The key to a good project is a good start, which means making sure that you have defined the project clearly. This is often done through writing a project initiation document (PID). These can be very lengthy when often a single page that answers the following questions is enough.

- What is the problem?
- What is causing the problem?
- Can you describe the vision of the future?
- What are you going to do about it and by when?
- What resources do you need?
- Who can help you?
- How will you measure success?

The advantage of this approach is that it helps ensure that the scope of your project remains the same throughout and you avoid ‘scope creep’ where additional, often unrealistic, aims are
added part way through or even when you think you’ve finished. The nature of a project is that it is a temporary endeavour with a clear start and finish point, very different, say, from large scale cultural change. The template in Figure 10.1 provides a simple example of how all those questions can be answered on a single sheet of paper and suggests some additional tools that may be helpful in addressing the questions.

### Figure 10.1 Project planning template.

At the outset, it is important to be absolutely clear why your project is looking at this issue and what is driving (and resisting) the change. It helps to try and encapsulate this in an ‘elevator pitch’ – if you had to describe the problem to a colleague in another clinical department, what would you say?

Sometimes, it is necessary to describe how a particular process works, such as how a patient gets a slot on a theatre list. This can be done through ‘process mapping’. Figures 10.2 and 10.3 show that these can be fairly straightforward to construct, or really quite complex. Process maps can also be useful in defining an intended ‘future state’.
A number of tools are available that can help get to the bottom of a problem or issue, sometimes called ‘root cause analysis’. The simplest of these is the ‘five whys’, a process in which you keep asking the same question until you get to the real cause of the problem. See Figure 10.4 for how this can be applied to the problem ‘theatre lists don’t start on time’.
Problem: Theatre lists don’t start on time

Why? Because the surgeon isn’t there on time.
Why? Because he/she is doing other things.
Why? Because the patient usually isn’t ready anyway.
Why? Because the anaesthetist hasn’t prepped the patient yet.
Why? Because the patient didn’t turn up on time.
Why? Because the letter sent to the patient said the wrong time.
Why? Because the surgeon changed the list order and forgot to tell the administrative staff.

Figure 10.4 Five ‘whys’.

Another commonly used tool is the fishbone, or Ishikawa diagram. This is a way of exploring the question ‘why is this happening’ under a number of headings or categories. Figure 10.5 applies this approach to the same theatre list problem.
The next step is to define the intended outcome of the project, its vision, aims and goals. Again, try and do this as succinctly as possible and where possible, align these with the overall aims of the organisation and the policy context. Goals or objectives should be expressed in a ‘SMART’ format (Box 10.1).

**Box 10.1 SMART objectives.**

**SMART objectives are:**

- Specific – clearly defined with completion criteria
- Measurable – you will know when they have been achieved
- Achievable – within the available resources
- Realistic
- Timebound.

Example:

*From 1st January, routine operating lists in theatres 1 and 2 will start (‘knife to skin’) by 8.30am Monday–Friday.*
The project template shown in Figure 10.1 then requires that you state the solutions that will be put in place and the actions that will be required. It is also important at this stage to identify any key risks and mitigating actions that will need to be taken. Perhaps most importantly, the benefits of your project should be spelled out at this point. What positive developments will arise as a result from its implementation? And who will benefit from these?

**Getting the right support in place**

As you use the template in Figure 10.1 to start defining your project, you will need to pinpoint your key decision makers. Who will decide if you can have resources? Who could stop this project? Who will be a champion and help you break through blockages if there are problems? Which senior executive has the most to gain or lose with the success of this project? This person needs to be the project’s Senior Responsible Owner (SRO) and agree to your initiation document. An early meeting with them to get their opinion and support is crucial. You can’t reach too high for your SRO, and even a small project will have far more chance of success if the SRO is an executive director of the organisation.

**Stakeholder engagement**

Next, you need to identify who will be affected by your project and what their view is on what you are proposing. One way to do this is to use the twobytwo ‘stakeholder map’ shown in Figure 10.6. Draw it on a flipchart and spend an hour or so with colleagues, filling the boxes with Postit notes. As you do this, it is important that you remember all staff types, including administrative and support functions, and don’t forget the patients!
The next question is, how do you make sure the right decisions are made through your project and that they ‘stick’? This is what ‘governance’ is all about. Together with your SRO, and based on your stakeholder mapping, you need to decide: Who will make decisions? Will you need a ‘project board’ and what will its terms of reference be? How often will you meet? Do you need subgroups? What will be the frequency of their meetings and what delegated authority will they have? What is the best balance between having representatives from all affected parties and the ability to make decisions? Meetings with more than 10 people are rarely effective.
It is worth drawing this structure in a single slide. The structure should be clear about the relationship of any subgroups to the project board and each other, and how the project board reports through to any executive.

It is also helpful to create a regular reporting function to keep people informed and to highlight risks and mitigations. The report template in Figure 10.7 is an example. Project risks are often scored on a scale of 1–5 for ‘likelihood’ and ‘impact’, with the two scores multiplied to provide an overall risk score (Figure 10.8). Other tools you may find helpful are a separate ‘Risk Register, Action Plan, Issues Log, Dependencies log’ (RAID).

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<th>Board name</th>
<th>Project name</th>
<th>SRO name</th>
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**Figure 10.7** Example of a project reporting tool.

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<th>Work Stream</th>
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<th>Proposed Mitigation</th>
<th>Impact (Time/Cost/Quality/Scope)</th>
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<th>Issues that Require Escalation / Decision</th>
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**Figure 10.8** A typical risk matrix.

**Communications and managing the politics**
Projects only work if key people ‘buy into’ the change. There are many ways to do this, but a few that work well in the healthcare environment include the following.

- **Champions** – these are individuals you have nominated to take the lead and convince others. They should have influence amongst their peers, but that doesn’t necessarily mean that they are the most senior people – often they’re not.

- **Patients** – using articulate patients to help convince clinicians of the needed change.

- **Data** – clinicians like to be persuaded through data. Don’t be put off by their requests for more and more information.

- **Coalitions and alliances** – influence behind the scenes, and persuade key people to go and do the same with their colleagues.

Above all, ‘sell the benefits’ of your project at every opportunity.

As you go about the above, remember that there is no such thing as too much communication. You need a clear channel through which you will regularly communicate with the teams affected. A short weekly email is a good start but think creatively about how to engage your audience; could social media, websites, notice boards and team meetings be more appropriate and effective? Be as inclusive as possible, try not to leave anyone out, and provide an easy way for communication to come back to you. Finally, even when little progress is being made, keep those communications going as this is when rumour begins to take over.

**Financial business case**

If you need investment upfront or you need another member of staff as part of your plans, then you will need to build a business case to persuade the financial director to invest in your scheme. Ask your finance colleagues if your organisation has a template and ask if they can support you in filling it in. If you don’t have one, here is a helpful list of headings.

- **Strategic context** – how does your project fit with organisational priorities?

- **Case for change** – what is the problem and what will you do?

- **Project summary** – what are the project’s objectives and scope?

- **Options** – usually ‘do nothing’, ‘do preferred’ and ‘do something else’.

- **Requirement for investment** – what do you want and why?

- **Cost and benefits** – include all costs and all benefits, quality and financial.

- **Risk assessment of options**.

- **Postproject evaluation method**.

The finance team will be asking: How will your project (a) bring in more income for the same cost, (b) cost less to bring in the same income or (c) cost the same to improve quality? If you are suggesting that your organisation will carry out more work, you may need to check that
funders will be willing to pay for it. If you are improving quality at increased cost, you will need to argue that the risk to patients is too great for the trust not to invest in this project. A financial summary analysis might look like Table 10.1. If your project does not add activity but rather changes the way things are done, you may be able to have two columns to show the variation between ‘as is’ and ‘after project implementation’ to demonstrate efficiencies.

**Table 10.1** Example financial summary.

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<th><strong>Income from activity</strong></th>
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<td>How many pieces of activity (outpatient appointments, episodes of care etc) x the unit income of that activity per year</td>
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**Total Income**

**Pay**

How many people x their salary per year

**Recurrent nonpay**

How much will consumables cost per patient x number patients per year

**Nonrecurrent nonpay**

Any oneoff equipment or capital investment?

**Overheads**

Usually around 10–20% of income to cover facilities and support functions (e.g. human resources, finance etc)

**Total Expenditure**

**Gross margin**

Total expenditure minus total cost

**Minus depreciation and interest**

This will be something for your financial colleagues to calculate and relates to any large equipment (capital) you may need.

**Net margin**

**First year net contribution to the organization**

**Keeping the project on track**

In order to ensure that your project doesn't fall behind, and to highlight when it does, you will need to create a project tracker, to be used on a weekly basis. You can use ‘off the shelf’ project planners if you wish, but often the easiest way to keep a project on track is to use a
spreadsheet program to create a simple ‘Gantt chart’ to track your actions along a timeline (Figure 10.9).

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<td>Milestone</td>
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Figure 10.9 A simple Gantt chart created in a spreadsheet program.

Your project plan should visually answer these questions.

- What key actions are required?
- Who is responsible for doing them?
- How long will they take?
- When must they be completed by to ensure the project ends on time?
- Which actions are dependent on other actions being completed first?

This creates a ‘critical path’ of key actions that must happen in time for success.

As part of your project plan, you should have a list of ‘dependencies’, i.e. things that your project depends upon or that are affected by your project. For example, if you change cancer surgery, then pathology services may be affected and you might need theatres to change. So, it will be important to list these, and then to ensure that key stakeholders from these dependencies are involved in the project plans.

**Measuring and celebrating success**

Remember that PID? To keep yourself on track, it will be important to both keep returning to it and also to work out how you will measure success a weekly, monthly or quarterly. If you have
put financial benefits in the business case, then these should be tracked along with quality gains. Then, as the teams hit key milestones (‘visible wins’) or deliver the expected improvements, it is important to celebrate success. This can be as simple as a pat on the back or a thank you, but often the engagement of the SRO at this stage is really valuable, and asking them to pop down to the ward, clinic or other setting to say a personal thank you goes a long way (Box 10.2). Other options could include getting your project recognised in the organisation newsletter or website.

Box 10.2 Case study: Understanding what matters to people.

When I was involved in a project to centralise cancer surgery at one of a group of hospitals, the first thing I did was to contact all the key players and meet them individually for coffee. These initial informal meetings proved to be crucial to the success of the project, as they helped me to understand both who was influential and who would be supportive. Particularly crucially, they also helped me to understand the motivations, politics and fears of staff who would be affected, and this mattered because one of the biggest problems I was going to later encounter was the fear amongst staff that not only would their jobs change, but that what they had been doing throughout their entire career was suddenly being devalued. As a result, it was important that they knew that I understood the issues, and cared for them as people. One way I achieved this was to sit next to a surgeon in theatre for four hours during an operation, allowing him to tell me what excited him. Then, over time, he opened up about his concerns. I didn’t have the answers then, but for the rest of the project I was seen not as an enemy, but as an ally.

Why projects go wrong

Projects go wrong in three main areas.

Engagement

If people are not engaged in your project, don’t understand the value or don’t see why they should invest their time to support you, the project will slow down or even stop. People have conflicting priorities and often projects are seen as ‘nicetohave’ additional benefits that ‘get in the way’ of the daytoday work and firefighting pressures. Some people simply don’t want the project to succeed and put blockages in place.

Resources

A lack of sufficient senior executive time for support, financial funding or operational teams support can all affect the success of a project.
Distractions

In a busy clinical environment, lots of other issues compete for attention. A lack of focus on the project will impede progress.

Tips for success

Finally, here are a few tips for a successful project.

- Provide consistency and continuity of vision.
- Be a constant source of optimism and problem solving.
- Understand the motivations of different people, help them to understand how your project will solve their problem, improve their lives or that of their patients.
- Connect people together. You sit at the centre of a network.
- Support teams emotionally through the difficult times.
- Respond quickly to questions and difficulties. Silence breeds rumours and further concerns.
- Engage constantly, face to face. Don’t hide behind email or meetings. The best way to get things done is to go and meet people. One to one, people are more likely to feel listened to, and see your vision.
- Use your governance wisely. Meetings can be a good way to ensure you can hold people to account in a group setting. Do not hesitate to use the SRO to smooth your path and keep them informed before a problem escalates.
- Manage expectations. Everyone will have different expectations of your project, so you need to ensure that you set expectations, meet those expectations and modify them as the project develops.
- Communicate, communicate, communicate.

Above all, think of your role as being not simply a project manager, but a project leader.

Reference


Further reading


OVERVIEW

- Clinical education is a ‘crowded stage’ involving ‘players’ from health, university and other public service sectors.
- In health professions education, leadership occurs at all levels, from one-to-one supervision or mentoring, through to leading complex educational organisations.
- To be effective, educational leaders require a good understanding of health service delivery, higher education management, quality assurance and funding mechanisms.
- Traditional professional roles and boundaries are being challenged by patient needs.
- Effective educational leadership is essential to ensure the quality and safety of patient care, today and tomorrow.

Introduction

Clinical educators carry the double burden of managing and leading teams and institutions in a rapidly changing educational environment, while working in close collaboration with a range of healthcare professionals to deliver safe and high quality patient care. In this chapter, we consider the context for healthcare education, discuss current educational systems and structures and consider leadership roles in medical and other health professionals’ education. Challenges for educational leaders are discussed which include leading across boundaries, controlling funding and resources, interprofessional education, the evolution of professional roles, the impact of learning technologies, widening participation and diversity.

The education policy context

Clinical education straddles higher education and health services, both arenas of rapid change. Responding to a never ending stream of new policy and strategic initiatives (summarised in Box 11.1) poses huge challenges.
Box 11.1 Policy and service drivers in clinical education.

- Widening access and increasing diversity of learners
- Selection for values
- Increasing student numbers
- Internationalisation – global communities of learners
- Modularisation of programmes
- Increased access to flexible education and training
- Technological advances, e.g. elearning, simulation
- Accountability for educational quality
- Patient safety and quality improvement
- Changing profile of service delivery:
  - shift to community settings
  - integrated services
  - ageing patient population
  - increase of longterm conditions, comorbidity
  - faster throughput with reduced patient access
  - new fields of practice, e.g. genomics
  - personcentred approaches to care
- Changing workforce planning, funding and commissioning
- Professionalisation of clinical education; ‘training the trainers’
- Redefinition of professional roles
- Migration and global workforce challenges
- Financial constraint

Higher education and wider policy agendas such as lifelong learning, inclusivity, widening participation and internationalisation have resulted in a larger and more diverse learner population. Technological advances, such as simulation, elearning and mlearning (mobile learning), have provided impetus for the development of new modes of educational delivery. Elearning and the use of mobile devices offer solutions for managing increased student
numbers in diverse geographical and clinical locations (Figure 11.1). But clinical education is also profoundly affected by health service changes. Workforce planning and commissioning arrangements are increasingly complex and demand new skills from clinical education leaders as they engage with a range of different bodies, including service leads, regulators and patient groups. Furthermore, provider reconfiguration, the development of integrated services and the devolution of services to local communities means that where and how learners learn is changing. Different types of health workers are needed (such as physician’s associates) and traditional healthcare roles are being challenged (for example, by extending scopes of practice).

Figure 11.1 Inclusivity, widening participation and internationalisation – just some of the many drivers in clinical education.

*Photo:* Swansea University and University of the Gambia partnership in action. Permission granted by Dr Jon Morris, Swansea University.

Crucially, increased student numbers and service changes have resulted in a reduction of learner access to patients and direct clinical experience. Although simulated environments such as clinical and communication skills laboratories provide alternatives, planning and delivering the workplace based clinical education required by professional bodies, and
Indeed patients, is increasingly difficult, requiring ever more creative solutions and ‘agile’ curricula.

**Structures in clinical education**

Educational leadership is played out across three sectors: undergraduate (preregistration), postgraduate (postregistration) and continuing professional development. Although each healthcare profession has its own unique set of educational structures and processes, there are similarities across the disciplines. Broadly speaking, six key functional areas can be identified which may be carried out by different organisations depending on context and culture:

- funding
- commissioning
- provision
- regulation of programmes
- standard setting
- licensing.

To illustrate this, Table 11.1 gives examples of the typical bodies responsible for these functions in health professions’ education internationally.
### Table 11.1 Examples of structures and functions in health professions’ education.

<table>
<thead>
<tr>
<th>Sector Function</th>
<th>Undergraduate</th>
<th>Postgraduate</th>
<th>Continuing professional development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
<td>Individual students, governments, sponsoring bodies</td>
<td>Government, employers, individuals, sponsoring bodies</td>
<td>Individual or employer</td>
</tr>
<tr>
<td>Commissioning</td>
<td>National, regional or local government</td>
<td>National, regional or local government</td>
<td>Individual or employer</td>
</tr>
<tr>
<td>Provision</td>
<td>Universities (direct) and service providers (clinical placements)</td>
<td>Government (usually devolved at regional or local level), universities (academic teaching) and service providers (clinical placements)</td>
<td>Various including independent providers, universities, Royal Colleges, professional associations, employers</td>
</tr>
<tr>
<td>Programme regulation</td>
<td>Regulatory professional councils and university quality assurance agencies</td>
<td>Professions’ councils</td>
<td>Professions’ councils, employers, government</td>
</tr>
<tr>
<td>Standardsetting</td>
<td>Councils with universities</td>
<td>Councils with other professional bodies, e.g. Royal Colleges</td>
<td>Councils, Colleges, government</td>
</tr>
<tr>
<td>Licensing and relicensing</td>
<td>In many countries students aren’t licensed, in some countries they are licensed and regulated by Councils</td>
<td>Councils, professional bodies</td>
<td>Councils, professional bodies</td>
</tr>
</tbody>
</table>

The formal leadership of healthcare education may be exercised from a number of organisations or agencies, such as professional bodies, Colleges, universities, government bodies and health service providers. Increasingly, we see collaboration between institutions and authorities developing as a way of achieving ‘buy in’ to strategic initiatives. The development, in Canada, of the CanMeds (2015) curriculum framework, widely adopted internationally, is a good example.

On the ground, clinical educators all need to engage with leadership tasks, although in practice this activity tends to be aligned with particular job roles, such as college or undergraduate tutor, training programme director, associate dean, university lecturer, professor or head of department or school. Increasing numbers of clinicians are trained in teaching and learning but a persisting concern is that leaders in clinical education are often promoted to positions of
influence without formal educational qualifications and, more often than not, without any managerial or leadership experience.

Integration of education with service delivery

One of the major challenges for leaders of clinical education is the integration of service and educational delivery. Workbased learning has considerable educational validity, and is essential for preparing students and doctors in training for the real world of independent clinical practice.

This raises a number of important issues. Workplacebased teaching and learning creates strains on services already struggling to cope with a targetdriven agenda, patient safety is a concern and there are implications for staffing and resources. Truly integrating education with service relies on clinicians to deliver education, a task that is not their primary role and for which they may be ill prepared. Leaders of clinical education need to understand and work across the education-service interface, and boundaries between organisations, professions, subject disciplines and professions, to influence, enable and set the conditions to make work based learning possible.

Developing the future workforce within today’s resources

One of the tricks that the educational leader must bring off is to maintain a focus on the development of a workforce for the future, not the needs of the present. The postschool education and training required to produce a consultant specialist, for instance, may take 15–20 years. But will that ‘output’ be what future populations require? And if not, do resources need to be diverted into producing a different kind of doctor, such as a communitybased generalist, or another type of healthcare professional, say an advanced practice nurse. Moving resources around to meet future patient need is a particular challenge in postgraduate medical education where training posts are tied up in the delivery of today’s service, and where largescale disinvestment and reinvestment to build more futureresponsive training pathways may destabilise current provision.

Changes in professional roles and responsibilities

In response to service changes, traditional professional roles are being questioned and redesigned. In the past, health professions’ training was carried out uniprofessionally with a relatively clear understanding on what the future role of those professionals might entail. But this situation is changing. Although most undergraduate programmes are still fairly traditional, designed to produce, for example, doctors, nurses or pharmacists, programmes aimed at producing new health and social care workers are being introduced, such as practitioners dually qualified and registered as social workers and mental health nurses. The number of
health and related ‘professions’ has correspondingly increased as roles such as paramedic, operating department practitioner and physician’s associate are professionalised through degree level education and nationally regulated training programmes.

At postqualification level, two additional changes are occurring as traditional roles and responsibilities of qualified practitioners are extended through the creation of advanced practitioners such as nurse consultants and prescribing pharmacists, alongside increasingly distributed and team based approaches to patient care. The wider impact of these workforce changes on service, education and the identity and requirements of traditional professions are profound, and educational leaders need to be attentive to the tensions posed by the continual reshaping of professional roles and boundaries.

**Interprofessional education**

Although educational trends come and go, interprofessional education, where learners from different groups ‘learn with, from and about one another’ (Centre for the Advancement of Interprofessional Education, 2011), is persistent, and provides a perpetual challenge for the educational leader.

Interprofessional education reflects the working and communication patterns in real clinical practice and so gives opportunities for learners to practise skills and develop these relationships in a relatively safe environment. However, delivering interprofessional education in a busy service context where learners still tend to be taught by members of their own profession is not easy (Freeth, 2014). Box 11.2 summarises the benefits of interprofessional education and barriers to its delivery and Box 11.3 describes how some of these barriers can be overcome.
Box 11.2 Interprofessional education: benefits and barriers.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Barriers</th>
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<tr>
<td>Encourages learners to learn about different healthcare roles and responsibilities</td>
<td>Logistics can be difficult with competing timetables and clinical placements</td>
</tr>
<tr>
<td>Develops respect for other professional attributes and roles</td>
<td>Uniprofessional training programmes tend to maintain working in professional ‘silos’</td>
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<tr>
<td>Develops professional identity in relation to other health professionals</td>
<td>Needs good facilitation from a range of different health professionals</td>
</tr>
<tr>
<td>Develops skills in team working and collaboration</td>
<td>Can lead to increased stereotyping if not well facilitated</td>
</tr>
<tr>
<td>Improves patient care and health outcomes</td>
<td>Some students (and teachers) do not see the benefit</td>
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</table>

Box 11.3 Case study: Leading interprofessional education.

A health sciences faculty in a large university has three separate programmes for medical, nursing and pharmacy students. The Dean of Education wishes to introduce interprofessional education because she feels that students would be advantaged in learning to work with and from other health professional students at an early stage. After reading the literature and considering the barriers and constraints, she decides to involve key stakeholders from all departments and students in a group to plan how interprofessional education might be introduced. After some considerable negotiation, the group is persuaded to introduce a brand new initiative for all health professional students in the first week of their study at the university. The ‘freshers’ week’ initiative includes formal education social events and an introduction to studying at the university. The initiative is very successful and paves the way for further events linked to common learning outcomes which run throughout the curricula of all three programmes.
‘The teacher, like the artist, the philosopher and the man of letters, can only perform his work adequately if he feels himself to be an individual directed by an inner creative impulse, not dominated and fettered by an outside authority.’

(Russell, 2009)

Bertrand Russell’s observation encapsulates a key dilemma for the leader of clinical education who has to tread a fine line between accountability and autonomy: working responsively but creatively with policy, monitoring and maintaining standards, while allowing clinical teachers the freedom they need to innovate and work imaginatively with learners. In fact, this balancing act is systemic throughout higher and professional education as curricula and standards have become increasingly centralised and responsibility for interpretation and delivery is pushed out to the periphery. Examples of centrally determined curricula or frameworks which place an obligation on providers for their delivery include the General Medical Council’s recommendations on undergraduate medical education, Outcomes for Graduates (2015) and standards for medical education and training Promoting Excellence (2016).

Resource management

A key activity and challenge for clinical leaders is identifying and managing the human and physical resources required to deliver education when learning opportunities with patients are increasingly restricted. In clinical education, funding (where it exists) comes from a range of sources within and external to the organisation, department or service. Leaders need to be aware of the opportunities that exist for providing effective (‘it works’) and efficient (‘within budget’) clinical education. The complexity of resource management should not be underestimated, particularly when the clinical setting includes learners from different professional groups and at different levels, all of whom may well be funded from different sources. Problems of educational delivery can usually be solved by collaboration, imagination, willingness to work in different ways and understanding both of where funding may be obtained and how educational methods (such as elearning) can be used creatively and flexibly. Involving different professional groups and sponsors or collaborating with other organisations can also help to optimise the development and utilisation of major teaching facilities such as clinical skills centres or simulation suites.

Leading professional colleagues

Leading professional colleagues is never easy – ‘herding cats’ is a commonly deployed description – and professional organisations themselves tend to be sluggish to respond to change. In Henry Mintzberg’s (1992) comparative anatomy of organisations, Structure in Fives, he points out that in a ‘professional bureaucracy’, changes in the behaviour of professionals within the organisation’s ‘operating core’ result from a slow and gradual shift in norms and values brought about by interactions between members, or more usually by new blood coming into the organisation (Figure 11.2). Unlike other organisational forms such as those found in industrial or commercial companies, the standards for professionals are
normally set outside the organisation by, for instance, medical colleges or professional associations, and professionals work to these standards, exercising a high degree of autonomy. As a result, strategy in a professional organisation tends to represent an accumulation of projects or initiatives that individual members are able to convince it to undertake. The message here for those who attempt to lead change and improvement in clinical education is that ‘command and control’ is an ineffective leadership style and topdown direction rarely results in lasting and deeprooted change.

Figure 11.2 The professional bureaucracy.

Challenges for leaders of clinical education

A summary of some of the key challenges identified for leaders of clinical education is presented in Box 11.4 (McKimm, 2004). Being aware of these challenges and seeking ways to address them at individual, team and organisational levels will provide leaders of education with a checklist and framework for action. The students of today are the practitioners of
tomorrow, and so there is a professional obligation on all clinicians to be involved with teaching, supervision and training activities. The current focus on embedding leadership ‘at all levels’ emphasises the need for everyone to take some sort of educational leadership role. Despite the challenges, leading clinical education activities and initiatives (at whatever level) is not only a core component of professional life but can often be one of the most rewarding. Support is provided to extend teaching knowledge and skills from universities, postgraduate centres and postgraduate deaneries, which can also assist health service leaders in gaining an understanding of the principles and practice of clinical education. Coupled with a wider awareness of education structures and management systems, an understanding of leadership and management roles and a willingness to collaborate to meet learners’ needs should result in the provision of high quality learning opportunities, delivered in accordance with the needs of health services, students and peers.

Box 11.4 Challenges for leaders of clinical education.

Personal issues
- Maintaining an appropriate work/life balance.
- Culture of senior management practice impacts on career progression for those with domestic responsibilities.
- For women, career breaks, career progression and the ‘glass ceiling’.
- Difficult to manage clinical and senior educational commitments.
- Decisions over leaving clinical practice tied in with maintaining credibility.
- Educational role often undervalued by organisations.

Organisational and cultural issues
- Need to understand the history and anthropology of their own organisation, organisational strengths and function.
- Managing and leading people, ensuring they are in the right roles and positions.
- Work/life balance issues, culture and work ethos.
- Hierarchical and centrally controlled structures can impede change management.
- Some clinicians find it difficult to reduce clinical workloads and make the shift into educational roles.

Balancing competing agendas
- Working with the rapid and complex changes affecting the service: difficult to make longterm decisions or contracts.
• Dual demands of working in university education, which is very accountable, and service prone to rapid change which puts greater strain on healthcare education leaders than in other sectors of university education.

• Conflict between the core values and demands of the service (patient led, service driven) and those of university education (student and research led).

• Management styles differ between universities and the service. University staff can resent overmanagement and seek autonomy, whereas clinical staff are more used to working in formal hierarchies with vertical management styles.

• A ‘crowded stage’ with multiple task masters; leaders have to predict and meet the needs of the service and universities, enabling staff to work through partnership and collaboration.

• Healthcare education leaders have to deal with the needs of professional and statutory, quality assurance and funding bodies.

• Difficult to motivate clinicians with heavy clinical workloads, and academics who are being pushed into generating research output.

The wider agenda

• Healthcare education leaders have an influential role in changing and improving healthcare systems and structures through partnership and education.

• Awareness of wider educational agendas helps leaders to drive and address issues such as interprofessional learning, diversity and innovation in learning strategies.


References


McKimm J. (2004) Case Studies in Leadership in Medical and Healthcare Education: Special Report 5, Higher Education Academy Subject Centre for Medicine, Dentistry and Veterinary Medicine, NewcastleuponTyne.


**Further reading**


CHAPTER 12
Collaborative Leadership and Partnership Working

Judy McKimm
Swansea University, UK

OVERVIEW

- Integrated health and social care services require new ways of working and new forms of leadership.
- Collaboration and partnership working are related but different concepts.
- Collaborative practice improves health outcomes and patient experience.
- Collaborative leadership involves working across complex organisational, functional and professional boundaries.
- Collaborative leadership requires a specific approach and way of working.

Introduction

In today’s integrated health and social care services, widely dispersed networks of service providers, complex funding arrangements and multiple accountabilities are the norm. This requires a collaborative approach to leadership. Collaborative leadership entails working with others not only across a range of health and social care organisations but also with service users, carers and ‘third sector’ voluntary agencies. The move towards more joined up working brings opportunities and challenges for clinicians in leadership, requiring a broad based understanding of systems, organisations, people and communities coupled with a willingness to work and lead in new ways.

Collaboration and partnership

The terms ‘collaboration’ and ‘partnership’ are often used interchangeably, but they are defined differently. Collaboration is a process involving ‘a philosophical and cultural commitment to the principles and practice of partnership working in the shared interest of better outcomes for the end user and the whole community’ (McKimm et al., 2008). Outcomes are enabled through:

- joint decision making among interdependent parties
- joint ownership of decisions
- collective responsibility for outcomes
• working across professional, functional, organisation and system boundaries
• establishing supporting factors such as resources, systems and processes.

Partnership describes the relationships that need to be achieved, maintained and reviewed, often through formalised, legal agreements.

**Collaborative practice**

Collaborative practice is when multiple health and care workers from different professional backgrounds work together with patients, families, carers and communities to deliver high quality and comprehensive care services. The World Health Organization (WHO) endorses that collaborative practice improves health outcomes and strengthens health systems (World Health Organization, 2007). A strong, flexible and collaborative workforce is essential to address major health challenges such as ageing populations and management of longterm conditions, with crossdisciplinary teamworking, cocreation of knowledge and shared practice all playing major parts. The global system shift from individual healthcare providers to a collective approach embeds collaboration in leadership frameworks, working practices and research endeavours. **Box 12.1** describes how the WHO defines interdependent components of complex health systems.
Box 12.1 The six building blocks of a health system.

Good health services are those which deliver effective, safe, quality personal and non personal health interventions to those that need them, when and where needed, with minimum waste of resources.

A wellperforming health workforce is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).

A wellfunctioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.

A wellfunctioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and costeffectiveness, and their scientifically sound and costeffective use.

A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.

Leadership and governance involve ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system design and accountability.


Benefits of collaboration

The benefits of collaborative practice in acute, primary and community settings are well evidenced and summarised here in Box 12.2. Such benefits are recognised by governments and other agencies, and healthcare policy and funding streams are increasingly geared towards stimulating collaboration and partnership working in order to support much needed service improvement and innovation.

The risks to patient care when health professionals don’t (won’t or can’t) collaborate are both serious and widereaching. Improved health outcomes often depend on health and nonhealth workers collaborating in achieving broader upstream health determinants such as better housing, clean water, food, security, education and a violencefree society. Collaborative clinical leaders need to be ‘system aware’, ‘collaborative practice ready’ and think outside the confines of health and health systems.
**Box 12.2 Benefits of collaborative practice.**

Improved patient care:
- higher levels of satisfaction
- better acceptance of care
- improved health outcomes.

Improved access to and coordination of health services.

More appropriate use of specialist clinical resources and of scarce resources.

Increase in safety and reduction of clinical errors.

Decrease in:
- total patient complications
- length of hospital stay and duration of treatment
- hospital admissions
- outpatient and clinic visits
- mortality rates
- staff turnover
- overall cost of care.


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**New organisational forms and new ways of working**

'Truly adept leaders know not only how to identify the context they’re working in, but also how to change their behaviour to match.'

(Snowden and Boone, 2007)

As health and social care provision becomes ever more complex, new systems are replacing traditional organisational forms, relying less on formal structures and status and more on relationships formed through informal interdependency. These include:

- **Networks and meshworks** – loosely coupled collections of people and systems, relying on relationships forged through ‘interactions’ around shared values, visions, ideas and projects, for example, clinical networks, special interest research groups, etc.

- **Alliances** – unions of interests that have similar character, structure or outlook.

- **Coalitions** – temporary alliance of parties for some specific purpose.
• Consortia – association, a group of similar interests.
• Communities of practice – a model of collaborative, situational working where members work towards a common goal defined in terms of knowledge, rather than task (Wenger Trayner and WengerTrayner, 2015).

Effective service delivery needs to combine good operational management (getting things done in a timely and efficient way), strategic thinking and effective coordination. And service coordinators need to be able to collaborate with others, develop and use networks, gain trust and respect, handle conflict, share control and power and build effective relationships (Archer and Cameron, 2013). Within these new organisational forms, a great deal of activity occurs in the ‘spaces between’ organisations, professions, departments and functions. In order to enable systems to collaborate effectively, develop unanimity of vision and deal with shared problems, new types of leadership roles are needed at all levels, requiring individuals who are comfortable working in these spaces, brokering agreements and bridging across boundaries (Long et al., 2013) (Figure 12.1).

**Figure 12.1** Bridging, brokering and boundary spanning: key roles for effective collaboration.
Collaborative leadership

Collaborative leadership sits within a group of ‘new paradigm’ approaches which include transformational, situational (or contingent), dispersed or distributed, and valueled leadership (see Chapter 3). It is a model that reflects Greenleaf’s (1977) ‘servant leadership’, in which serving the organisation, profession or sector takes precedence over the urge to lead, and ‘collective leadership’, which focuses on creating cultures of compassionate care, leadership power sharing and allocation of responsibility at all levels of the organisation (West et al., 2014). Traditional views of leadership are being challenged and, although there is no coherent or consistent view on what might replace them, Simkins (2004) and others have identified some of these key shifts (Box 12.3).

Box 12.3 Traditional and contemporary perceptions of leadership.

<table>
<thead>
<tr>
<th>The traditional view</th>
<th>The contemporary view</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership resides in individuals</td>
<td>Leadership is a property of social systems</td>
</tr>
<tr>
<td>Leadership is hierarchically based, linked to position</td>
<td>Leadership can occur anywhere, ‘at all levels’</td>
</tr>
<tr>
<td>Leadership occurs when leaders do things to followers</td>
<td>Leadership is a complex process of mutual influence</td>
</tr>
<tr>
<td>Leadership is different from and more important than management</td>
<td>The leadership/management distinction is not important; they are activities which can be carried out by the same individual</td>
</tr>
<tr>
<td>Leaders are different and have certain personal qualities</td>
<td>Anyone can be a leader</td>
</tr>
<tr>
<td>Leaders are born</td>
<td>Leadership can be learned</td>
</tr>
<tr>
<td>Leaders make a crucial difference to organisational performance</td>
<td>Leadership is one of many factors that influence organisational performance</td>
</tr>
<tr>
<td>Effective leadership is generalisable</td>
<td>The context of leadership is crucial</td>
</tr>
<tr>
<td>Leaders hold power</td>
<td>Power is dispersed and allocated across the organisation or system</td>
</tr>
</tbody>
</table>

Source: Adapted from Simkins (2004).
A growing consensus would also suggest that a collaborative approach is particularly relevant when dealing with complex, ‘wicked’ problems where change is emergent, the organisational context is ambiguous and multiple perspectives on everything are essential for collective solution finding (see Chapter 8).

**Personal qualities for collaborative leadership**

Collaborative leaders may need to draw on personal qualities rather than positional power, particularly when working in situations where their organisational role or professional qualification may not be relevant, such as working across organisational, sector or professional boundaries (Box 12.4). Working in interprofessional teams (see Chapter 5) requires different leadership approaches and active followership. And establishing credibility among people or groups with very different values and ways of working takes time, effort and emotional labour.

**Box 12.4 Skills required for effective collaboration.**

- Building trust and credibility.
- Finding the common ground and defining a mutual intent to inspire action.
- Asking questions and seeking examples that illustrate what is meant.
- Active listening and ‘walking in the shoes’ of your collaborator.
- Advocating your point of view without harming your collaborator’s feelings.
- Being clear, avoiding ambiguity and duplication of effort.
- Spotting when a conversation gets emotional and then making it safe again to continue meaningful dialogue.
- Telling and eliciting stories, conversation and dialogue.
- Being able to get things done, so you have something to show (‘visible wins’).
- Networking, being a ‘connector’ across people and systems.
- Showing that you are willing to learn and don’t know everything.
- Being able to live with outcomes that may not be what you anticipated as long as they improve patient care or outcomes.
- Being resilient and able to handle conflict.
- Showing humility and being able to apologise.

Crucially, collaborative leaders also lead by example through demonstrating commitment to the
process and outcomes of the collaboration and supporting others in collaborative initiatives, system developments or service improvements.

Power, authority and influence

Collaborative approaches to leadership raise a number of issues in relation to power and authority. Many people feel that power is somehow a dirty word, but collaborative leaders need to be comfortable with the acquisition and deployment of power, while being alert to its potential misuse. Partnerships or collaborations usually involve an imbalance of power, relating to financial or other resources, formal leadership of the initiative (bestowed, legitimate power), individual or organisational track record or status (referent power), professional knowledge (expert power) or accountability arrangements (for example, for funding).

Effective leadership requires credibility to be established, often with individuals and groups with different goals, values or histories. Personal maturity and a new notion of power which does not fear loss of control enable power sharing. The power of a collaboration established through a collective approach to leadership is stronger than the sum of its parts (Figure 12.2). Notably, power can also be ‘gained through giving’ by giving people important work to do, discretion and autonomy, visibility and recognition and by building relationships (Kanter, 1982).
Different players in healthcare teams may have very different expectations of leadership roles and behaviours. Medical leadership in particular has traditionally been ‘top down’ and hierarchical, focused on individuals with positional authority. While senior doctors frequently have ultimate clinical accountability for patients and manage resources, the shift towards more integrated care services led and managed by other (not necessarily health) professionals means that the responsibility for healthcare and outcomes is often shared. Sticking with traditional leadership approaches may mean that some clinicians find themselves out of step with the way in which flatter, interprofessional and collaborative teams need to work (Figure 12.3).
Collaborative strategies

Leaders using collaborative approaches ensure that all people affected by a decision (the stakeholders) are part of the change process. This is also known as inclusive leadership. Collaborative initiatives, such as coproduction of services, require the early identification of all stakeholders so that opportunity can be provided for input, influence and the exchange of ideas through establishing communication systems and building in time for discussion, responses and change. This is where the ‘philosophical commitment’ to collaboration and meaningful consultation is most challenging, especially when there is pressure from funders or more senior managers for quick changes and early completion.

Even when support for collaboration and partnership working is strong, shared initiatives are often imposed in a contractual and legalistic fashion. This can cause resistance. Understanding organisational and interpersonal barriers to collaboration and using knowledge and skills from both leadership and management will facilitate crossboundary and collaborative working. Activities might include:
• raising awareness of organisations’ and professionals’ responsibilities and powers
• learning the systems, processes and ways of working to identify and overcome structural and societal obstacles to collaboration
• developing an organisational culture that supports collaboration through teasing out and challenging existing work practices
• thinking of how funding mechanisms can be used across collaborations by aligning, pooling or disaggregating funds
• stimulating crossfunctional and organisational working through becoming involved in new projects or health innovations
• using a project management approach to achieve a strong collaboration through a ‘guiding coalition’, stakeholder involvement, defining vision, mutual benefit (collaborative advantage) and visible wins
• mapping systems and your connections with others to help identify networks through which change can be effected.

Collaborative clinical leaders need to work hard to identify and develop shared values between organisations, professions and communities. Above all, their leadership is not about personal glory, but about making a real and lasting difference to health care delivery for the benefit of the people and communities whom they serve. (Table 12.1, Box 12.5).
**Table 12.1** Shared and collaborative leadership.

Source: Adapted from LeeDavis *et al.* (2007).

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Heroic leadership</th>
<th>Shared and collaborative leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Is found:</strong></td>
<td>At the top of organisations</td>
<td>Throughout and across organisations</td>
</tr>
<tr>
<td><strong>Decision and strategy is crafted by:</strong></td>
<td>The top</td>
<td>Cadre of people who solve problems, relationship building</td>
</tr>
<tr>
<td><strong>Impact:</strong></td>
<td>Holds and retains power</td>
<td>Helps others achieve their potential, power sharing</td>
</tr>
<tr>
<td><strong>Motivating others is based on:</strong></td>
<td>Myth/mystique, charismatic authority and positional power</td>
<td>Collaborative engagement</td>
</tr>
<tr>
<td><strong>Trust is found in:</strong></td>
<td>Processes</td>
<td>Relationships, values and the way that conflict is handled</td>
</tr>
<tr>
<td><strong>Change is:</strong></td>
<td>Initiated by the top and resisted by those below</td>
<td>Initiated through development and innovation</td>
</tr>
<tr>
<td><strong>Rewards mostly go to:</strong></td>
<td>Shareholders, leaders and senior managers</td>
<td>All who help the organisation achieve improvements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All stakeholders affected by the organisation’s actions</td>
</tr>
</tbody>
</table>
Box 12.5 Case study: Collaborative leadership and coproduction.

A group of senior leaders from universities and health and social care organisations had been meeting informally with service users to discuss ideas for a regional collaboration around improving mental health services. The group took advantage of key drivers, including a policy paper on simulation, the need for all organisations to demonstrate efficiency in practice placements, the quality improvement agenda, community mental health legislation and a willingness to collaborate. Working in the spirit of co-production, the group established a formal collaborative, devised a project bid, applied for funding and initiated an educational programme for health and social care professionals to work collaboratively with service users in a simulated environment around clinical and professional decision making for people with mental health issues.

Programmes were developed for undergraduate students, postgraduate students and continuing professional development for experienced practitioners. The impact on patient care through these interprofessional collaborations was measurable and influential, leading to the establishment of a national training programme for health and social care professionals using this simulation.

References


Further reading


Fillingham D and Weir B. (2014) System Leadership Lessons and Learning from AQaA’s Integrated Care Discovery Communities, King’s Fund, London.


CHAPTER 13
Understanding Yourself as Leader

Chris Lake¹ and Jennifer King²
¹ NHS Leadership Academy, Leeds, UK
² Edgecumbe Consulting Group Ltd, Bristol, UK

OVERVIEW

- Who we are is how we lead.
- Personality has a significant influence on leadership effectiveness.
- Clinicians need to understand how traits that make them good clinicians may not always serve them well as leaders – and vice versa.
- Selfesteem and selfawareness are key drivers of leadership development.
- Leaders need to use their strengths to the full but guard against overplaying their strengths, which may lead to ‘derailment’.
- Selfdoubt is normal in all walks of life, including leadership.
- Leaders can develop and become more effective through reflection, feedback and coaching.

Personality, attitude, behaviour and leadership

‘Are leaders born, or made?’ It’s an ageold question to which the answer is ‘both’. Some people may have an inbuilt propensity to engage and inspire people, but everyone can develop the insight and skills required to be an effective leader. This means looking into oneself, growing an awareness of one’s strengths and limitations and appreciating how these affect those you lead. The research is clear: who you are is how you lead. Indeed, when it comes to leadership effectiveness, ‘... the most important element ... comes from a combination of emotional expressiveness, selfconfidence, selfdetermination, and freedom from internal conflict’ (Bass, 1992).

But personality alone does not make a clinician a good or bad leader. Rather, it sets up predispositions for leaders to behave in certain ways – and these behaviours will either help or hinder. Furthermore, traits and behaviours that make clinicians good at the technical aspects of patient care may serve them less well as clinical leaders. Additionally, whereas the development of clinical skill is often founded upon the acquisition of knowledge (especially from the natural sciences), the development of leadership skill is underpinned by introspection and (human) connection.
Understanding yourself goes beyond personality. Personal introspection demands understanding of our attitudes (how our values show up in our actions), our emotions and our self-esteem. All these things, and the context in which we find ourselves, affect our behaviours and our ability to marshal ourselves in service of skilful clinical leadership.

The psychological levels model (Deering et al., 2002) provides a useful framework for understanding the layers of oneself as a clinical leader and how this ‘self’ interacts with the world (Figure 13.1).

![Psychological levels of self](image)

**Figure 13.1** Psychological levels of self.

The model encourages clinical leaders:

- to be aware of the *environment* within which you work, and reminds you that what might work well in one context might fail in another
- to be aware of your *behaviour* and so have in mind the fundamental question of leadership: ‘What’s it like to be on the receiving end of me?’
- to practise and actively develop the *skills and capabilities* of clinical leadership that go beyond preference
- to explore your *beliefs and values*, especially how your actions show what you truly value (rather than what you might like to think you value)
- to explore your *selfidentity*. Who do you really see yourself as? A clinician? A leader?
Something else? And to bolster your self-esteem (see more on selfdoubt below)

- to locate yourself and your work in reference to your spirit; your connection to the wider world and the meaning you find in and from it.

### Personality

Countless studies of leadership traits have sought to identify the ‘perfect’ leader profile. Indeed, as we touched on in Chapter 3, the study of leadership itself started with scrutiny of ‘great men’ (at the time, leadership was considered a genderspecific quality!) and then extended to supposed leadership ‘personality traits’. Today, while we recognise that leadership is much more than personality, it’s still a people business, and so understanding personality, especially our own, is vital.

Personality research, especially occupational psychology, over the last three decades has coalesced around the identification of five key factors, known as the ‘Big Five’ dimensions of personality (Barrick and Mount, 1991) (Box 13.1).

#### Box 13.1 The ‘Big Five’ dimensions of personality.

<table>
<thead>
<tr>
<th>Personality Dimension</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuroticism</td>
<td>Need for stability, emotional reactivity</td>
</tr>
<tr>
<td>Extroversion</td>
<td>Sociability, enthusiasm and activity</td>
</tr>
<tr>
<td>Openness</td>
<td>Originality, openness to new experience</td>
</tr>
<tr>
<td>Agreeableness</td>
<td>Adaptability and cooperation</td>
</tr>
<tr>
<td>Conscientiousness</td>
<td>Will to achieve, focus, organise</td>
</tr>
</tbody>
</table>


The constellation of personality traits that correlates with some success as a leader appears to be as follows: emotional stability (resilience to stress and setbacks), extroversion (sociable, assertive and energetic), openness to experience (intellectually curious, adaptable to change and empathic) and conscientiousness (focused, organised and dutiful) (Judge et al., 2002).

As well as possessing certain personality traits, effective leaders need to be able to do five tasks: inspire people, focus their efforts, enable them to do their job, reinforce their efforts (managing both good and poor performance) and help them to learn. Personality may affect the extent to which a leader can or cannot carry out these tasks effectively. For example, highly conscientious leaders are likely to be better at focusing than leaders who are themselves unfocused or disorganised. Leaders who are agreeable are likely to be better at enabling, engaging and rewarding but less good at tackling poor performance.

Leadership can present a particular challenge for clinicians. Most healthcare professionals are
motivated by a strong desire to care for patients. They are often, by nature, highly agreeable. This trait is more likely to make a good clinician but not necessarily a good leader. Leaders need to challenge and provoke, to encourage others to change. They may have to tackle conflict or push hard for resources. Therefore, many clinicians who seek to lead may find themselves confronted by their own natural, altruistic traits, and so must learn ways to be more single minded about delivering improvements. This may at times bring them into conflict with their own values and personal disposition. Whilst this may not always be avoided, understanding when and why such conflicts occur can prove valuable in seeking strategies to manage them.

**Personality ‘type’ and leadership**

Each leader has a unique set of gifts that may help them in some situations and hinder them in others. This is the premise of the well-known MyersBriggs Type Indicator (MBTI) (Kirby, 1997). Rather than identifying the type of characteristics that make a good leader, MBTI highlights differences in preference across four fairly core aspects of human experience: how people tend to become energised, how they like to find out about things, how they prefer to make decisions, and how they tend to orientate themselves to the external world (Box 13.2).
**Box 13.2 The dimensions of the MyersBriggs Type Indicator.**

<table>
<thead>
<tr>
<th>Where do you prefer to get your energy from?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Extraverts (E)</strong> tend to be energised by the outer world and especially people; prefer to talk their way through thoughts</td>
<td><strong>Introverts (I)</strong> tend to be energised by their inner world, especially thoughts and ideas; prefer time for reflection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How do you prefer to find out about things?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sensors (S)</strong> prefer to focus on realities, data, facts and the present; tend to approach things sequentially</td>
<td><strong>Intuitives (N)</strong> prefer to see the big picture, working broadbrush with ‘gut feel’ and the future; tends towards possibilities and connections</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How do you prefer to make decisions?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Thinkers (T)</strong> prefer to make objective decisions based on dispassionate, criteriabased logic</td>
<td><strong>Feelers (F)</strong> prefer to make subjective decisions based on personal feelingsbased priorities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How do you prefer to orientate yourself to the world?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Judgers (J)</strong> are often driven to seek closure so prefer to plan, be organised and structured; reach a conclusion</td>
<td><strong>Perceivers (P)</strong> are often driven to avoid closure so prefer keeping options open; flexible, spontaneous, adaptable</td>
</tr>
</tbody>
</table>

It’s perfectly possible for any personality type to lead; the MBTI is about *preference* and not *ability*. However, knowing your own preferences and propensities can be very helpful as a clinical leader. Such understanding can give a leader choices: to do what comes naturally, which may or may not be the best leadership intervention, or to transcend your preferences and make an informed intervention that’s more likely to benefit patient care.
Case study: Personality type.

Fara was a public health doctor in training and, in Myers Briggs terms, had clear preferences for extraversion, sensing, thinking and judging (ESTJ). As an outgoing extravert (E), she found it easy to connect with people in the early days of a new placement – this helped her quickly build networks. Her logical thinking (T) style and her data rich (S) and structured (J) approach to project management won her a good deal of admiration from colleagues. Her personality preferences were supporting her leadership practice in this regard.

However, at times, and especially when rushed or stressed, Fara would espouse her opinions with a little too much force, as if they were incontrovertible fact rather than merely thoughts or ideas. Her communication would land with others as somewhat overwhelming and occasionally even bossy. The same preferences that were working in her favour before were now acting as the other side of a double edged sword.

In our example (Box 13.3), becoming familiar with her own personality ‘preferences’ helped Fara marshal her innate strengths and dampen or counteract her weaknesses. Being predisposed to a certain personality type does not prevent leaders from leading in certain ways, but it does mean they need to put effort into managing themselves, their development and their behaviour. For example, a leader who prefers introversion may be neither gregarious nor communicative by nature, yet they can learn ways to communicate and spend time with their team that will pay dividends in terms of engagement, buyin and followership. However, such development takes time and effort. In addition to working on oneself, a good leader will recognise and accept where changes can be made and where it may be more productive to call on others in the team with complementary preferences.

The emotionally intelligent leader

As the psychological level model above suggests, effective leadership is more than simply knowing yourself. It also requires being aware of, and managing, the impact that you have on others.

There is proven correlation between good leadership in healthcare, and positive culture, organisational performance (both quality and financial), staff engagement, patient safety, experience, outcomes, morbidity and mortality (West et al., 2014). Many clinical leaders are intelligent and effective in their technical field, but may be less ‘emotionally intelligent’ (Goleman, 1996). Emotional intelligence, known as EI (or EQ), is the habitual practice of thinking about feeling and feeling about thinking to guide behaviour (Sparrow and Knight, 2006). Since leadership is clearly about one’s impact on others, EI has been argued to be a core component of leadership effectiveness. Box 13.4 lists 16 dimensions of emotional
intelligence described by Maddocks (2014). This model, unlike some theories of emotional intelligence, presupposes that:

- self-esteem or self-regard is at the core of emotional intelligence. The most powerful way to develop one’s emotional intelligence is to invest in your own sense of worth
- self-awareness – paying attention to your own body, its feeling, sensations and state – is a prerequisite to both your self-management and your awareness of others
- regulating your impulses and actions (self-management) is multifaceted and a prerequisite to managing relationships with colleagues
- the route to developing emotional intelligence, in addition to the natural (yet slow) process of maturing, is critical reflective practice.

### Box 13.4 Sixteen dimensions of emotional intelligence.

#### Regard and awareness

| 1 Selfregard | Degree to which I accept and value myself. Am I ‘OK’? |
| 2 Regard for others | Degree to which I accept and value others (as distinct from liking/approving of what they do). Are you ‘OK’? |
| 3 Self awareness | Degree to which I am in touch with my body, feelings and intuitions |
| 4 Awareness of others | Degree to which I am in touch with the feelings and states of others |

#### Intrapersonal emotional intelligence (self-management)

| 5 Emotional resilience | Degree to which I can pick myself up and bounce back from life’s inevitable knocks |
| 6 Personal power | Degree to which I believe I am in charge of, and take responsibility for, my outcomes in life |
| 7 Goal directedness | Degree to which my behaviour is related to (in service of achieving) my longerterm goals |
| 8 Flexibility | Degree to which I am able to adapt my thinking and behaviour to match changing situations |
| 9 Connecting with others | Extent and ease with which I am able to make significant connections with people by sharing myself with them (being open) |
| 10 Authenticity | Degree to which I invite the trust of others by being principled, reliable, consistent, knowable |

#### Interpersonal emotional intelligence (relationship management)
<table>
<thead>
<tr>
<th>11 Trust</th>
<th>Tendency to trust others</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 Balance outlook</td>
<td>How well I balance optimism with realism</td>
</tr>
<tr>
<td>13 Emotional expression and control</td>
<td>Degree to which I am emotionally controlled or expressive</td>
</tr>
<tr>
<td>14 Conflict handling</td>
<td>How well I handle conflict, how assertively I deal with disagreement</td>
</tr>
<tr>
<td>15 Interdependence</td>
<td>How well I balance meeting my own needs and taking others into account as I work with others</td>
</tr>
<tr>
<td><strong>Emotional intelligence development</strong></td>
<td></td>
</tr>
<tr>
<td>16 Reflective learning</td>
<td>Degree to which I enhance my EI by reflecting on what I and others feel, think and do, noticing the outcomes these produce, and altering my patterns as most appropriate</td>
</tr>
</tbody>
</table>

Source: Maddocks (2014).

### Leadership ‘derailers’

The attributes for which many leaders are valued are invariably the same characteristics that may cause their downfall. When leaders are exposed to intense or prolonged stress – for example, the transition to a new role, heavy workloads, fatigue, anxiety or other source of pressure – they may overplay natural strengths to the point of becoming counterproductive. Thus strengths (built on positive traits) become weaknesses (drawn from negative attributes of the trait) which can ultimately lead to dysfunctional behaviour (often referred to as the ‘dark side’ of the personality trait).

Hogan and Hogan (2001) identified 11 such personality derailers (Box 13.5). Clinical leaders must learn to recognise and manage their own particular ‘dark side’ characteristics, so that they can continue to exercise their strengths without allowing these to derail their leadership.

### Box 13.5 Leadership derailers.

<table>
<thead>
<tr>
<th>Positive trait</th>
<th>Negative attribute</th>
<th>Dark side</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Excitable</strong> leaders have a tendency to take things personally, and can become hard to work with if they seem temperamental, unpredictable or hard to please</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Enthusiastic</strong> Changeable</td>
<td>Volatile</td>
<td></td>
</tr>
<tr>
<td><strong>Sceptical</strong> leaders are in danger of seeming suspicious and will become hard to work</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
with if they are always questioning the motives and true intentions of others

<table>
<thead>
<tr>
<th>Astute</th>
<th>Suspicious</th>
<th>Mistrustful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cautious leaders can be overly concerned about making mistakes or being criticised, and can become hard to work with if they are perceived to be reluctant to stand up for the valid needs of their team or to fight their corner</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Safe</th>
<th>Risk averse</th>
<th>Overcareful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reserved leaders may come across as aloof, uncommunicative and lacking interest in or awareness of the feelings of others</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Selfsufficient</th>
<th>Aloof</th>
<th>Detached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leisurely leaders may seem reluctant to work to anyone else’s agenda. Such people may be considered set in their ways and determined to work to their own methods, reluctant to be hurried, ignoring people’s requests and becoming irritable if they persist</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cooperative</th>
<th>Resistant</th>
<th>Passive aggressive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bold leaders can be too strident in their views and opinions, sometimes coming across as having strong feelings of entitlements and as overestimating their talents. They are at risk of being considered overbearing, unwilling to admit mistakes or listen to advice</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Confident</th>
<th>Overconfident</th>
<th>Arrogant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mischievous leaders may at times use their talent for charm manipulatively. They may also seem to enjoy taking risks and testing the limits, are easily bored and have a craving for excitement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Charming</th>
<th>Exploiting</th>
<th>Manipulative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colourful leaders take pleasure in being the centre of attention, and this can become an end in itself. Such people can become unable to turn it off, or allow themselves to appear selfindulgent, attention seeking or shallow</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lively</th>
<th>Sensational</th>
<th>Dramatic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imaginative leaders may have too many ideas which can be counterproductive. Such people can be uncomfortable to work with if they misjudge the impact of unconventional ways of thinking and behaving</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Creative</th>
<th>Eccentric</th>
<th>Peculiar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diligent leaders risk applying uniformly high standards indiscriminately in tasks where a more approximate approach would have been appropriate. They can become both overcritical of the performance of others and reluctant to delegate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assiduous</th>
<th>Perfectionist</th>
<th>Pedantic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dutiful leaders may appear so eager to please everybody that this may raise doubts about their ability to make decisions and their capacity to take independent action</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Loyal</th>
<th>Pleaser</th>
<th>Dependent</th>
</tr>
</thead>
</table>
Derailment can be prevented through timely feedback that alerts the leader when his or her behaviour is crossing the acceptable line. As such behaviour is, in effect, a response to stress, effective stress management and the maintenance of an effective work/life balance can also help prevent becoming ‘derailed’.

**Selfdoubt and the imposter syndrome**

Another source of derailment is selfdoubt. Do you ever feel secretly inadequate, a deep seated and yet suppressed feeling that you’re not up to the job? This feeling is called the imposter syndrome – and it’s completely normal. Assuming you’re one of the majority of leaders who experience (or suffer) the imposter syndrome, what can you do?

- Believe that it’s normal. Take a look around at those you admire, and know they experience it too.
- Ask for feedback. Since the imposter syndrome is really a denial of the realities of your own worth (Figure 13.2), seek out others who can give you a more dispassionate view. They’ll probably tell you you’re not perfect – but that you deserve the success you’ve earned.
- Save up positive feedback – and use it when you need it, be it a patient’s ‘thank you’, a colleague’s ‘well done’, a manager’s recognition or a good appraisal. Some people keep a ‘my plaudits’ file on their computer offering a mine of restorative nuggets to be excavated in times of need.

![Figure 13.2](image)

*Figure 13.2* The imposter syndrome – and overcoming it.
Developing as a clinical leader

No leader, indeed no person, can be ‘complete’; no one has a ‘perfect’ personality profile. However, can leaders change their personality? Some experts stress that personality remains relatively stable over time and there may be little that a leader can do to change their underlying character. However, becoming increasingly aware of your traits, preferences, habits and patterns means it’s perfectly possible to deploy your personality to greater leadership effect.

Equally, others believe that describing personality as fixed is unhelpful and, indeed, untrue, and that selfdevelopment is perfectly possible. Such commentators build on Piaget’s (1952) theories of child development. Piaget argued that selfdevelopment has two ongoing processes: assimilation and accommodation. Assimilation occurs when we grow in a way that is consistent with our existing selves – an example would be the acquisition of knowledge. Accommodation occurs, however, when we are confronted by realisations that do not fit who we know ourselves to be, and importantly we allow ourselves to be modified rather than rejecting the learning offered. The two processes are described in Figure 13.3.

**Figure 13.3** Assimilation and accommodation.

A particular challenge for clinical leaders is that the majority of their training reinforces and
rewards the skilful use of assimilation as clinicians become increasingly adept at acquiring knowledge and skills. Successful development as a clinical leader is, though, a task of accommodation, in which an ongoing process of critical reflection is key to learning to lead, a journey of personal transformation. Chapter 17 discusses how best that journey can be supported.

References


Further reading


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CHAPTER 14
Leading in Culturally Diverse Health Services

Tracie Jolliff\(^1\), Tim Swanwick\(^2\) and Judy McKimm\(^3\)
\(^1\) NHS Leadership Academy, Leeds, UK
\(^2\) Health Education England, London, UK
\(^3\) Swansea University, UK

OVERVIEW

- Healthcare workforces and patient populations are increasingly culturally diverse.
- Addressing diversity and equality is key to ensuring effective healthcare delivery.
- Effective clinical leaders demonstrate cultural intelligence.
- Addressing cultural factors can help reduce clinical errors and improve patient safety and health outcomes.
- An understanding of the legal framework underpinning diversity and equality is essential for safe and effective practice.

Introduction

Around the world, populations are rapidly becoming more diverse, so a key consideration for clinicians is how to lead in a culturally diverse health service. However, it is not possible to lead a culturally diverse service without having a genuine appreciation of what it means to lead a racially diverse one (Chettih, 2012). So in this chapter we will focus predominantly on diversity issues in healthcare that arise in relation to race and ethnicity (Box 14.1). Issues of gender are addressed in Chapter 15. As demographic and legal contexts are nation specific, we will provide examples from the UK NHS, although the generic messages of this chapter are applicable to other health systems.
Box 14.1 Race, ethnicity and culture.

Race
The term ‘race’ refers to the concept of dividing people into groups on the basis of various sets of physical characteristics resulting from their putative ancestry. However, there is no genetic basis for mutually exclusive racial categories because such features and characteristics sit along a continuous distribution. Many sociologists would argue that no clearcut races exist, only assorted physical and genetic variations across human individuals and groups. The concept of race is therefore socially constructed, as is racism, a prejudice based on socially significant physical features.

Ethnicity
An ethnic group or ethnicity is usually considered to be a population group whose members identify with each other on the basis of common nationality or shared cultural traditions. The most common characteristics distinguishing various ethnic groups are a sense of history, language, religion and forms of dress. Ethnic differences are not inherited, they are learned. But ‘ethnicity is far from a static concept’ and ‘globalization, intermarriage, the changing nature of migration and the massive shift in travel and transportation are challenges to the things that preserve and protect ethnicity’ (Office for National Statistics, 2000).

Culture
‘Culture’ is another slippery concept but has been defined as ‘integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups’ (US Department of Health and Human Services Office of Minority Health, 2000). Culture in the context of health behaviour has been defined as ‘unique shared values, beliefs, and practices that are directly associated with a healthrelated behavior, indirectly associated with a behavior, or influence acceptance and adoption of the health education message’ (Pasick et al., 1994).

Diversity and equality
Diversity is concerned with recognising individual and group differences and valuing the contributions of everyone in society. Jehn et al. (1999) describe three types of diversity:

- social category – concerned with demographic differences
- informational – concerned with knowledge, education, experience
• value – personality and attitudes.

The diversity agenda covers issues such as personality, social class, job or professional background, educational attainment, gender, disability, sexual orientation, age and ethnicity.

Equality, on the other hand, is about:

‘… ensuring that every individual has an equal opportunity to make the most of their lives and talents, and believing that no one should have poorer life chances because of where, what or to whom they were born, what they believe, or whether they have a disability. Equality recognises that historically, certain groups of people with particular characteristics e.g. race, disability, sex and sexuality, have experienced discrimination.’

(Equality and Human Rights Commission, 2015)

An equalities approach identifies patterns of experience based on group identity and the processes that limit an individual’s health and life chances. For example, people from black and minority ethnic (BME) groups comprise 16.7% of the overall NHS workforce, but the percentage of BME leaders represented at board level nationally is less than 7.4% (Kline, 2014) (Figure 14.1). These statistics do not reflect the ability of BME staff to progress but rather have been shown to indicate a lack of commitment from senior leaders to address the issues pertaining to race equality, and a corresponding feeling amongst BME staff that they are undervalued members of the workforce (Kline, 2014). When inequality is deeply embedded in organisations or systems, this is known as ‘institutional racism’.

![Figure 14.1](https://www.nhsemployers.org)

**Figure 14.1** Diversity in the NHS (England) workforce.


The case for a culturally diverse workforce

It is now generally accepted that a prerequisite for health systems that aim to provide high quality care, and that also provide for diverse populations, is a workforce which reflects the diversity of the people that it serves. This is thought necessary for a number of reasons.
First is the need, in an increasingly complex world, for creative and diverse ways of thinking about problems and issues. The importance of this for leaders is highlighted by Weisbord and Janoff (2010) who describe a historical trend in the leadership of improvement culminating in ‘everybody’ being involved in whole system reform (Figure 14.2) – this is inclusive leadership and it is shown to be highly effective, in business terms as well as improving the culture and organisational climate.

**Figure 14.2** Historical trends in leadership and management.

Diversity is needed within a system to allow for evolution and development. A diverse workforce will bring considerable intellectual capital to bear on a problem or issue. But not everyone has an equal opportunity to get involved, owing to a range of factors, including the impact of cultural background and the perceptions of others.

A lack of racial representation within the workforce can not only impede innovation (Hewlett et al., 2013), but can adversely affect decision making by providers, who are more likely to fail to meet the needs of deprived communities where there is significant minority ethnic representation (Salway et al., 2013). Conversely, there is a correlation between increasing the numbers of underrepresented minorities in the health professions and improved health outcomes for some of the most vulnerable populations (Betancourt et al., 2003).

A culturally diverse workforce can also raise awareness and increase acceptance of difference within the workforce itself, helping to prevent discrimination. Discrimination is harmful to those who are targeted by it, making staff sick and contributing to a variety of health problems (Williams and Mohammed, 2009). The effects of discrimination can be a vicious circle, contributing to a disengaged workforce and a lowering of staff morale, curbing the likelihood
of collective and individual discretionary effort and consequently creating a poor working culture and climate. This in turn impacts negatively upon patient care raising stress levels across the organisation (West and Dawson, 2012) (Figure 14.3).

Figure 14.3 Impact of discrimination within health systems.

So an increasing body of evidence suggests that a lack of racial and cultural diversity of staff at all levels leads to poorer outcomes for patients and plays an important role in the maintenance of health inequalities, as well as being damaging for the wider economy (Ayanian, 2015).
Cultural competence

Cultural competence is defined as an ability to respond to ‘people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each’ (National Association of Social Workers, 2001).

The inclusive leader displays high cultural competence and intelligence rooted in respect, validation and openness toward differences among people. This begins with an awareness of one’s own cultural beliefs and practices, biases and prejudices, and the recognition that others believe in different truths and realities from one’s own. It implies that there is more than one ‘right’ way of doing the same thing.

In order to develop a culturally competent clinical practice, one needs to be aware of the cultural and religious attitudes and values that patients bring to the process of decision making (Chettih, 2012). Alongside this, there is a need to appreciate the impact of the dominant culture in which these relationships are operating, and to be aware of relevant differences in perceptions and values (Panos and Panos, 2000). As healthcare systems become more tailored to the specific needs of individual patients, it is also essential that clinicians understand key areas of cultural difference where targeted action is needed. Box 14.2 illustrates some common situations that require different approaches to healthcare delivery for people from different cultures.

Clinical leaders also need to appreciate the norms and values of different cultures and understand how they perceive leadership and its associated behaviours. Such understanding will enable more effective leadership (and followership) practices and, as a result, the delivery of more appropriate, and more culturally sensitive, patient care.

An understanding of the impact of cultural difference within clinical teams is also vital for patient safety. We can turn to the aviation industry for an example. Research findings reveal that behind many air safety incidents lie failures of communication, including those stemming from the relationship between the captain and copilots (Helmreich and Merritt, 2000). Where more junior staff feel that the leader is above them in the social hierarchy, their deference and unwillingness to challenge authority can lead to disaster. Such discomfort can lead to teams sticking with procedure where a more flexible approach to uncertainty may help avoid risk.

In the clinical context, Bleakley’s (2006) and Lingard et al.’s (2004) research on social identity in the operating theatre and intensive care unit indicates that communication failures (including failure to engage in briefings or to speak out when something is wrong) and assumptions and behaviours based on cultural background put patient safety at risk and increase clinical errors. The expectations followers have of their leaders (and vice versa) varies greatly between cultures and greater attention to developing good, clear, open communication between teams and professional groups is a key aim of culturally competent leaders. The failure of clinical leaders to acknowledge and incorporate diverse cultural values in relation to their practice is always at the expense of the patient (Chettih, 2012). Cultural
competence is an essential leadership skill.

**Box 14.2 Common healthcare situations requiring acknowledgement of cultural diversity.**

- Illness behaviour
- Attitudes to nudity
- Birth rituals
- Birth control
- Blood transfusions
- Involvement of carer or family in decision making
- Clothing and dress norms
- Concepts of sickness, healing and care
- Disability and rehabilitation
- Language and translation requirements
- Palliative care, preparation for death, dying and death rituals
- Preferences for practitioner gender or culture

**Cultural safety**

The concept of ‘cultural safety’ describes a safe environment where there is ‘no assault, challenge or denial of a person’s identity of who they are and what they need’ (Ramsden, 1992). The people most able or equipped to provide a culturally safe atmosphere are people from the same culture. The concepts of cultural competence and safety provide a basis for embedding culturally appropriate health, employment and education practices, enhancing personal empowerment and improving service delivery. The World Health Organization and United Nations declarations on the right to health encompass the right to a culturally appropriate healthcare system. This includes the right to access different forms of treatment (such as traditional medicine or healing practices) and the right to self-determination. Inequalities in healthcare resulting from cultural factors may then need to be addressed at many levels: societal, organisational, professional and interpersonal.

**Race, ethnicity and healthcare leadership**

Returning to our examples of the UK NHS, given the diversity of the workforce, it should be
expected that diversity representation is reflected and distributed throughout the various leadership tiers of the service. The true picture, though is very different. Figure 14.4 illustrates the way in which black and minority ethnic (BME) representation diminishes throughout the recruitment process.

**Figure 14.4** Racial discrimination in the recruitment process.
*Source: NHS Providers (2014).*

Kline (2014, p.4) points out that ‘the proportion of senior and very senior managers who are BME has not increased since 2008 and has fallen slightly in the last three years. The likelihood of white staff in London being senior or very senior managers is three times higher than it is for black and minority ethnic staff’ (Figure 14.5). Furthermore, he identifies an overrepresentation of NHS BME staff in relation to negative employment indicators such as disciplinary procedures, dismissals and discrimination (Figure 14.6).
**Figure 14.5** Black and minority ethnic representation in the boardroom.

Figure 14.6 Black and minority ethnic and white staff experiences of discrimination.


The significant underrepresentation of a racially and culturally diverse staff at senior levels paints a picture of a workforce that is increasingly ‘out of sync’ with the diversity of the population it seeks to serve. It is difficult to conceive that a health system which does not treat its workforce fairly could demonstrate, and practise, culturally intelligent and inclusive clinical leadership for the benefit of its patients.

A range of educational and service interventions can be established to train and attract staff from underrepresented groups. These may include positive action programmes around widening access to medical school entry or recruitment of staff from a specific ethnic group. Positive action (Box 14.3) is being promoted at all levels in UK health services, including the identification of future BME leaders, as evidenced by the NHS Leadership Academy ‘Ready Now’ programme (www.leadershipacademy.nhs.uk/programmes/thereadynow programme/).
Box 14.3 Positive action.

‘Positive action’ means the steps that an employer can take to encourage people from groups with different needs or with a past track record of disadvantage or low participation to apply for jobs.

An employer can use positive action where they reasonably think (in other words, on the basis of some evidence) that:

- people who share a protected characteristic suffer a disadvantage connected to that characteristic
- people who share a protected characteristic have needs that are different from the needs of people who do not share it, or
- participation in an activity by people who share a protected characteristic is disproportionately low.

Sometimes the reasons for taking action will overlap. For example, people sharing a protected characteristic may be at a disadvantage and that disadvantage may also give rise to a different need or may be reflected in their low level of participation in particular activities.

To deal with the three situations, an employer can take proportionate action to:

- enable or encourage people to overcome or minimise disadvantage
- meet different needs, or
- enable or encourage participation.


Such interventions have led not only to quality improvements and the reduction of racial/ethnic disparities but also to more productive health services (Betancourt et al., 2003). However, another key leadership challenge for those managing health services is that migration patterns resulting from increased employment mobility and shifting political and economic landscapes mean that many health workforces are not only increasingly culturally diverse but are also more transient, with all the problems of assimilation and access that that brings.

Legislative frameworks

Clinical leaders and managers need to understand the legal basis for equality and diversity and be able to apply this in practice. In the UK, legislation has two main elements enshrined in the Equality Act of 2010: an antidiscriminatory framework, which gives individuals a route to raise complaints of discrimination around employment and service delivery, and the General
Equality Duty, a proactive obligation on organisations to address institutional discrimination. The Equality Act was introduced in 2010 and replaced over 100 pieces of previous antidiscrimination legislation and regulations to make UK law simpler and more consistent.

*Discrimination* is described as where someone is treated less favourably than someone else because of their ‘protected characteristic(s)’. The Equality Act makes it unlawful to discriminate against people on the basis of:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation.

The Act also sets out the different ways in which it is unlawful to treat someone, such as direct and indirect discrimination, harassment, victimisation and failing to make a reasonable adjustment for a disabled person.

The proactive *Public Sector Equality Duty* obliges the NHS to:

- eliminate unlawful discrimination, harassment and victimisation
- advance equality of opportunity between different groups
- foster good relations between different groups.

The intention is to prevent discrimination occurring in the first instance rather than retrospectively addressing the detrimental consequences of discriminatory acts.

**Cultural competence and the clinical leader**

At the interpersonal level, culturally competent leadership involves a similar skill set as culturally competent patient care. Many of the issues are the same and relate to understanding, empathy, sense making and motivation coupled with shared respect, meaning, knowledge and experience, of learning together with dignity, and truly listening.

As well as demonstrating respect and empathy, leaders need to be able to challenge discrimination or unlawful practice. This requires an understanding of the legal framework and the rights of different groups as well as the personal courage and capacity to challenge poor practice at individual, organisational and systems levels.
Culturally competent clinical leaders need to understand the communities they serve, the sociocultural influences on individuals’ health practices and beliefs and the elements of health and social care systems that prevent certain groups from receiving quality healthcare. They need to devise strategies to reduce and monitor barriers to employment, education and training and healthcare that need to be adopted at the organisational level, the systemic level and in the clinical context. Effective strategies include positive action programmes to encourage leaders from underrepresented groups into senior posts and involving communities in decisions and policy making, providing language support and training students and staff in crosscultural communication (Box 14.4).

Box 14.4 Case study: Leading for diversity.

Abra is the lead community midwife working in a primary care trust with a large Muslim population. It is a community of women with a poor obstetric record characterised by late presentations and antenatal complications, and is a source of frequent cultural and linguistic misunderstandings. She decides to address this by assembling an ‘expert panel’ of women from the local community. The panel meets with the community team in a workshop format to discuss their ideas, concerns and expectations in relation to pregnancy, childbirth and child rearing. As a result, the team feels more empowered in supporting this group through their experiences of childbirth and later reports much more effective relationships and antenatal care. The women are pleased to have been consulted and keen to continue to be involved in the ongoing education of healthcare professionals. The panel becomes an established feature of the healthcare landscape and is subsequently asked for its input on a number of service redesign issues relating to local maternity and children’s services.

What is encouraging in the UK health sector is a growing recognition of the need to value and respond to diversity issues and one important example of this is the Workforce Race Equality Standard (www.england.nhs.uk/ourwork/gov/equalityhub/equalitystandard/) which aims to ensure that BME staff are treated fairly in the workplace and have equal access to career opportunities. For the first time, the standard requires organisations employing most of the 1.4 million NHS workforce to show progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of BME Board representation.

High quality patient care requires increased diversity in our healthcare leadership pipeline, with leaders reflecting the workforce and the communities they serve – notably people from black and minority ethnic backgrounds, with disabilities and women. And it is today’s healthcare leaders who are charged with turning the rhetoric into reality.

References


**Further reading**


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Synthetic Cultures, Nicholas Brealey Publishing, Yarmouth.


CHAPTER 15
Gender and Clinical Leadership

Celia Taylor¹ and Judy McKimm²
¹ University of Warwick, UK
² Swansea University, UK

OVERVIEW

- Evidence and theoretical perspectives suggest that women make good clinical leaders.
- Women are underrepresented as clinical leaders due to a number of individual and societal factors.
- Interventions to redress the imbalance include education, structural change, positive action and a reframing of leadership to accept a more ‘feminine’ approach.

Introduction

‘The mental model of a typical leader remains tenaciously male, especially in traditionally maledominated fields, such as academic medicine.’

(Burgess et al., 2012)

The assertion that clinical practice needs more female leaders is not only based on a belief in social equality, or the need for leadership to be representative of its workforce, but also because gender profoundly influences the way leaders interact with followers, and how followers interact with them. The differing dynamics that occur as a result impact on an organisation’s performance. This is not to argue, of course, that all leaders should be female, but highperforming organisations tend to adopt an inclusive ‘feminine’ leadership style where diversity is promoted, welcomed and supported.

‘Inclusive leaders get the best out of all their people, helping their organisations to succeed in today’s complex, diverse and global environment. Through their skills in adaptability, building relationships and developing talent, inclusive leaders are able to increase performance and innovation.’

(Hewlett et al., 2013)

A crossnational study covering the UK, USA and India reported high financial benefits of gender diversity at Board level for publicly traded companies (Grant Thornton, 2015) and another study identified that genderheterogeneous working groups tend to produce higher quality science (Campbell et al., 2013), It is reasonable to assume that similar benefits of diverse leadership would accrue to healthcare organisations.
This chapter considers how theory and empirical research have started to recognise the importance of female leaders – and feminine leadership – in clinical practice but also highlights the persistence of barriers that mean the level of participation of women in leadership remains suboptimal (Box 15.1).

**Box 15.1 Sex and gender: what’s the difference?**

The terms ‘sex’ and ‘gender’ are closely connected, but they do not mean the same thing. **Sex** is generally used to refer to the biological and physiological characteristics that define men (male) and women (female). **Gender**, on the other hand, relates to a set of attitudes, behaviours and cultural practices, and the way a society encourages the two sexes to behave in different ways through socialisation. Viewing gender (masculine or feminine) as a socially constructed phenomenon means that gender, as opposed to sex, varies between and within societies and can change over time.

For the purposes of this chapter, then, it is perfectly possible for someone of the male sex to have a feminine leadership style, and vice versa.

**Theoretical perspectives**

‘A profession that loses its male dominance tends to lose some of its power.’

(Dame Carol Black, quoted in Hall, 2004)

Ideas relating to who makes a (good) leader have historically been male centred, such as the **great man** theory, which espoused heroic, top-down leadership in which traditionally masculine traits were seen as critical for success. Such ideas have been predominant in healthcare. For example, the ‘doctor–nurse game’ (Stein, 1968), reflecting a postwar patriarchal society, was traditionally played out between male (hero leader) doctors and female (subservient follower) nurses. Women who strived for leadership positions, stepping out of their gender expectations by ‘acting male’, were seen as aggressive, pushy, challenging and threatening and so were in a loselose situation. And while the majority of nurses are still female, more women than men are now in medicine (at least at entry point) in many countries. A study exploring contemporary aspects of the ‘doctor–nurse game’ in a New Zealand context found that:

‘… erroneous assumptions in healthcare delivery about who might lead and who might follow, of when they might do so and what forms such leadership and followership may take may result in overt conflict, tacit followership or subversion, leading to negative impacts on patient care’

(Barrow et al., 2010).
This raises some important points about interprofessional working and gender dynamics in healthcare teams.

The emergence of *contingency theories* of leadership, that different styles of leadership were more or less effective in different contexts, helped raise the profile of alternative, less authoritative styles that were seen as more suited to women. In particular, by focusing on leadership styles rather than inherent traits, the idea that leadership could be learned emerged and is predominant in the majority of leadership development programmes (see [Chapter 17](#)).

More recently, service-led demands, such as the need for teamwork in preventing and learning from patient safety incidents, and concerns that compassionate care was falling by the wayside, have seen a further shift from the reliance on heroic leadership in healthcare and the recognition that traditionally feminine capabilities are important for successful leadership. Leadership that is engaging and collaborative requires emotional intelligence and the ability of a leader to motivate and empower their followers to produce their best. In an era of austerity, leadership of change through collaboration rather than by *command and control* is essential to ensure that standards of care are maintained while cost savings are found. This requires all staff to be ‘on board’ (or *engaged*) to prevent care compromising crises of low morale and burnout ([Box 15.2](#) and [Figure 15.1](#)).
**Figure 15.1** A model of ‘engaging’ leadership.

Box 15.2 Evidence for a more gender-inclusive leadership style.

Heroic models of leadership were based largely on focusing on ‘distant’, very senior, male leaders in US commercial organisations. But to understand the nature of leadership that increases staff engagement in healthcare organisations, research methodologies must focus on gathering data on leaders of various quality, and data based on the experiences of staff across the organisation with whom these leaders have worked. Any model must also be based on a truly inclusive sample of staff, i.e. by gender, level, ethnic background, age, occupational group, etc.

One example of a model of engaging leadership emerged from a three-year study conducted in the NHS, involving a sample of over 2000 staff, and later extended and validated across the wider public, and private, sectors. The model comprises 14 dimensions of leadership behaviour, described in four clusters.

- Personal qualities and values
- Engaging individuals;
- Engaging teams/the organisation
- Working in partnership with a range of different stakeholders (see Figure 15.1)

This model of engaging leadership is essentially feminine, and resembles notions of ‘servant leadership’ with its emphasis on selfless actions that recognise and appreciate the contributions of others, and empower them to use their initiative and by so doing become more effective as leaders in their own right. It focuses on strengthening relations with others, including members of one’s own team and those being served, such as patients, carers, colleagues and partners in other organisations. It encourages questioning the status quo and judicious experimentation and innovation, and focuses on building shared visions and values and working in partnership, coowning and codesigning the means by which change will be implemented. This reflects contemporary approaches to health service design such as coproduction and experience-based codesign.


Figure 15.2 illustrates how the demands for different types of leader in healthcare have shifted in response to changes in the environment in which care is delivered and how these relate to leadership theories (Gabriel, 2015).
Recent developments in the leadership required by healthcare organisations.

**The benefits of female leaders**

The benefits of female clinical leadership may be demonstrated in two ways. The ‘indirect’ route is to show that women tend to have more of the traits now associated with leadership effectiveness than males, such as cooperation and collaboration. The ‘direct’ way is to evidence that having women in leadership roles improves organisational performance. Direct evidence provides stronger proof of a cause-and-effect relationship, but indirect evidence helps us to explain why, such that both are important (**Figure 15.3**). Both approaches can also provide evidence relating to *intervening variables*, which propose a mechanism through which successful leadership leads to improved performance and outcomes. Such variables (for example, job satisfaction) are shown in the middle layer of **Figure 15.3**.
Perhaps due to the lack of women in senior clinical roles, there is a paucity of direct evidence linking the presence of female leaders to organisational performance in healthcare. However, a good example of ‘indirect’ evidence is a systematic review of leadership styles and outcome patterns in nursing by Cummings et al. (2010). Nurses’ job satisfaction was positively influenced by use of leadership styles such as transformational leadership that focused on people and relationships – those generally identified as feminine – and negatively influenced by use of styles that focused on tasks – those generally identified as masculine (Figure 15.4).
Feminine leadership improves staff morale, job satisfaction and performance.

**Underrepresentation of female leaders**

The proportion of women entering most clinical professions has been increasing globally since the 1970s, yet even accounting for the need to ‘catch up’, women are still underrepresented in positions of leadership. In UK medicine, for example, women will soon be the majority of qualified doctors. However, they are overrepresented in lower roles and comprise only 24% of Board members and medical directors, 33% of hospital consultants and 41% of GP partners, with large variation between specialties (Newman, 2015). This picture of underrepresentation is echoed around the world.

As illustrated in Figure 15.5, the continued underrepresentation of women in clinical leadership has explanations from both the demand side, i.e. whether women are able to obtain positions of leadership, and the supply side, women’s decisions as to whether to pursue positions of leadership. Central to the lack of demand for female leaders are two tacit processes, which have become known as the ‘glass ceiling’ and the ‘glass cliff’ (Box 15.3). Potential explanatory mechanisms for these two phenomena are outlined in Box 15.4 and illustrate the difficulty of bringing about change even when the benefits of female leaders are well known.
Figure 15.5 Explanations for the continued underrepresentation of women in clinical leadership.

Box 15.3 The glass ceiling and the glass cliff.

Glass ceiling

The glass ceiling is an invisible barrier to women advancing into leadership positions and:

- is not explained by other jobrelevant characteristics of the employee
- is greater at higher levels of the organisation than at lower levels
- affects chances of advancement to higher levels
- increases over the course of a career (Cotter et al., 2001).

In medicine, some evidence exists for the glass ceiling at Board level and other senior leadership positions in many countries.

Glass cliff

Women are overrepresented in leadership roles with a high risk of failure, making them more likely to fail. For example, in medicine, female medical school deans in the US have shorter tenures than their male counterparts – tenure, in this case, providing a proxy for the ‘riskiness’ of the deanship role.
Box 15.4 Potential explanations for the glass ceiling and the glass cliff.

- Lack of suitability qualified women – the cohort or catchup effect.
- Traditional gender schema (the way gender is culturally portrayed and experienced) combined with controllable roles (jobs which are structured around regular and predictable hours such as family medicine, anaesthetics). Noncontrollable specialties include surgery and obstetricsgynaecology.
- Women lack the attributes necessary for successful leadership (deficiency theory) or suffer from stereotype threat – the belief that they do not have traditionally masculine traits makes them likely to underperform.
- Lack of incentive to change the status quo and equalise gendered distribution of careerenhancing resources such as outreach, training, mentoring and sponsorship (exacerbated by a lack of a ‘critical mass’ of women in leadership).
- Lack of monitoring of the proportion of women in different types of leadership roles.
- Unintentional and institutional sexism such as networkbased recruitment.
- Lack of acceptance that the glass ceiling and cliff exist or matter.

Source: Jackson and O’Callaghan (2009). Reproduced with permission of Springer.

Interventions to redress the imbalance

The individual explanations for the continued underrepresentation of women in clinical leadership do not operate in isolation, but synergistically (Reed and BuddebergFischer, 2001). Interventions to redress the imbalance cannot then be tokenistic and must engage both men and women at all levels of an organisation. Positive examples of such interventions include a multifaceted intervention at Stanford University which has been successful in fostering the career development of female academic physicians (Valantine et al., 2014) and a range of mentoring and coaching initiatives to support existing and aspiring women leaders in the UK NHS (Newman, 2015). However, two drivers for change in the UK do not inspire confidence that all such interventions will be inclusive, meaningful and implemented with the required credence. First, it has taken critical events, such as the exposé of poor quality and uncompassionate care at Mid Staffordshire NHS Trust, to accelerate the notion that ‘feminine’ leadership traits (such as ‘caring’ and ‘compassion’) are valuable in clinical environments. Second, voluntarily implemented interventions have had to be supplemented with toptdown directives to invoke change; for example, UK medical schools cannot apply for funding to develop research centres and units unless they have achieved the Athena SWAN Silver Award, which requires evidence of policies and practices that support and promote women in
Conclusion

The lag in the expected rate of progression of women into clinical leadership can be partially explained by a general notion of think leader – think male, which is exacerbated by the ephemeral description of the traits required of successful leaders as masculine or feminine rather than androgynous. Of course, another plausible explanation is that women do not have the same aspirations of leadership as men and it is their true, rather than constrained, preferences that limit the number of women seeking leadership roles. However, this cannot explain factors such as differential success rates when applications for leadership roles are made. Addressing the imbalance will require structural change in order to make leadership roles more attractive to women, as well as interventions to develop women’s leadership skills, to promulgate the benefits associated with diverse leadership teams and to reduce people like me unconscious bias. The benefits of such changes and interventions should help to reduce the need for women to make a choice between career and family, and also improve the way in which healthcare is delivered and experienced.

Acknowledgement

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**Further reading**


CHAPTER 16
Values Based, Authentic and Ethical Leadership

Deborah Bowman and Tim Swanwick
1 St George’s, University of London, London, UK
2 Health Education England, London, UK

OVERVIEW

- A values based approach to clinical leadership ensures that patients remain at the centre of healthcare.
- Valuesled leaders retain a constancy of purpose in challenging circumstances.
- Authenticity is essential in building trust and commitment.
- Ethical leadership is informed by both external guidance and an internal commitment to its practice.
- The notion of the ‘virtuous leader’ provides a way of thinking about ethical leadership that focuses on consistent and positive ways of working, irrespective of the context.

Introduction

‘Management is doing things right, leadership is doing the right things.’

This widely quoted comment of management guru Peter Drucker is appealing in its simplicity. But just how do leaders know what the ‘right’ things are, and when is the ‘right’ time to do them? Indeed, the ‘right’ thing may not immediately be apparent in a complex dynamic human system such as healthcare, where leaders can struggle to define the problem, let alone the decision to be made. Maintaining constancy of purpose, remembering what we are leading for and remaining true to oneself are not easy tasks for those in leadership roles, but they are essential for sustained effectiveness and, in healthcare specifically, are fundamental for safe, high quality and compassionate care. In this chapter we explore three perspectives on how, in challenging circumstances and over long periods of time, leaders can continue to ‘do the right thing’: values based, authentic and ethical leadership.

Values based leadership

Values based leadership requires leaders and organisations to reflect on the normative values which shape their work. These values underpin behaviours exhibited, actions taken and decisions made. Most healthcare organisations will own a set of value statements, usually
developed in collaboration with staff and patients. Figure 16.1 provides an example of how such organisational values are often expressed. They provide a visible and constant reminder of who and what the organisation is about, and can be a touchstone for those in leadership roles, guiding choices where the way forward is not immediately apparent. An explicit set of organisational values can also be useful as a cultural tool, establishing a shared understanding of organisational norms and giving people permission to challenge behaviours that are inconsistent with expectations. Values-led leaders are willing to challenge others and to address conflict whilst advocating for better healthcare or improved patient safety (Shale, 2008).

Figure 16.1 Organisational values: visible, clear and owned by all.

Source: Siaya District Hospital, Kenya.

The particular relevance of a values-based approach in healthcare has been highlighted by a number of high-profile failings in care at the beginning of the twenty-first century (see Chapter 2) where in a drive to meet targets and financial challenges, the patient was somehow lost. Rediscovering personal and organisational values such as ‘compassion’ has been an important part of putting this right.
‘Caring and compassion, as core values and behaviours, must be central to [healthcare] organisations – “the way we do things around here” – not just in relation to patients but in all interactions, including those between staff.’

(King’s Fund, 2013)

Such is the perceived importance of a values-based approach, the NHS in England has developed a set of systemwide values (Box 16.1) which sit at the heart of its Constitution. These are now in regular and widespread use as the foundation for values-based recruitment not just of leaders but of all healthcare staff and students (NHS Employers, 2016) (Figure 16.2).

Figure 16.2 Caring and compassion: core values for all healthcare organisations.
A particular strength of values-based leadership is that it leads to a consistency of approach so that followers know the sort of response they can expect from leaders. Such consistency of thought and deed is important in establishing trust – an essential prerequisite for followership – but this will not be possible unless a leader’s espoused values are internally consistent with their personal beliefs and behaviours. This leads us to considerations of authenticity and integrity.

**Authentic leadership**

‘The best measure of a man’s honesty isn’t his income tax return. It’s the zero adjust on his bathroom scale.’

(Arthur C. Clarke)

As a reaction to the fraudulent exploitation of customers and staff by the leaders of many large corporations – and more recently banks – the first two decades of the twenty-first century have seen an explosion of interest in authentic leadership. As Copeland (2014) highlights, authenticity, or being true to oneself, is a construct that dates back to ancient Greece, but practitioners and scholars have increasingly emphasised the need for leaders who demonstrate ‘self-awareness, openness, transparency, and consistency’, as well as being motivated by positive end values and concern for others (Brown et al., 2005, p.599).

Such an approach has its roots in Greenleaf’s servant leadership (see Chapter 3) which focuses on what it means to serve, to be in a position of stewardship and to hold the trust of those whom one serves. Key ingredients in such an approach are altruism, care, selflessness, honesty and probity.

Explicit statements of values and consistent processes are integral to a values-based,
approach to leadership. However, authentic role models that are visible within, and provide leadership of, an organisation are the most powerful tool in ensuring that ethical leadership is valued, enacted and maintained. As Albert Einstein is said to have observed, ‘Setting an example is not the main way of influencing another, it is the only way’.

Authenticity is closely linked with the concept of ‘integrity’, a quality that refers to something sound, coherent, consistent and unified. But there is an alternative meaning to the word, one that refers to honesty and the ownership of strong moral principles. Integrity is about doing the right thing, even when no one is looking.

**Ethical leadership**

*Morals* are those personal principles on which we base judgements of right and wrong. This contrasts with *ethics*, shared social principles of right conduct in relation to a particular context or culture. Ethical leadership is guided by external sources and internal choices, each of which is considered below. Whatever the context, the practice of ethical leadership always depends on a particular set of attributes or, to use the language of ethics, *virtues*.

There is a bewildering array of material available for those seeking to understand leadership, with authors variably engaging with the notion of an ethical approach (see Chapter 3). Leadership approaches focusing on followers (for example, servant, transformational) contrast with more functional approaches concerned with maximising the best outcome for groups or populations, for example staff, clients, patients or other interested parties. The ethical principle here is utilitarianism, in which moral decisions are made according to which choice is likely to produce the greatest good for the greatest number.

Aside from the theoretical, what guidance exists for the individual who wants to ensure that their leadership is ethical? The NHS Healthcare Leadership Framework (NHS Leadership Academy, 2013) is a relevant and accessible analysis of clinical leadership and its practice and ethical dimensions of leadership can be found throughout the framework (see Figure 3.5).

Whilst leadership can be learned, truly ethical leadership requires internal reflection and personal commitment to a coherent set of core values. Being a virtuous leader depends on an individual’s willingness to become self-aware, emotionally intelligent and reflective. Whilst theoretical models and development programmes can be helpful, without a genuine commitment to, and belief in, the ethical dimensions of leadership, credible and authentic leadership is unlikely (Gilbert, 2005). Without internal commitment to the virtues of ethical leadership, behaviour is likely to be dissonant, inconsistent or unpredictable, leading to inequity, unreliability or unfairness. The virtuous leader is not a return to ‘trait’ based leadership, where individual characteristics are identified as more or less suitable for leadership. Rather, it is an approach that assumes everyone has the ability to become self aware, to reflect critically, to adapt and develop their strengths and weaknesses, but acknowledges that such a process is lengthy, challenging and requires a commitment by those who are serious about becoming and remaining ethical leaders (Oakley and Cocking, 2008).
Discussion: the virtuous leader in practice

So what does an authentic, ethical and values led approach look like? Box 16.2 presents a short case study. This is followed by a discussion that considers what it means to be a virtuous leader in practice.

Box 16.2 Case study: Mr Holmes and the anesthetists.

Mr Holmes is the clinical lead for surgery and anaesthetics in a large tertiary referral centre. For some time, the anaesthetists have been concerned about staffing levels, especially as ambitious plans to develop two specialist surgical centres within a wide catchment area are in progress. The anaesthetists expressed their concerns informally to Mr Holmes, who was sympathetic and offered to discuss the situation with the Medical Director. The Medical Director listened carefully to the concerns but said he could offer no more staff or resources to the department. One Monday morning, Dr Mayes, a newly appointed consultant anaesthetist, comes to see Mr Holmes and tells him that a patient died on the table over the weekend. She believes that, although the patient was very sick, low staffing was also a factor. She explains that she was covering three theatres and in the end had to ring her specialist trainee to ask if he would come in ‘as a favour’ and help because she was so pressured. She asks Mr Holmes what he is going to do about this ‘completely untenable situation’.

Prioritise patient safety and interests

The anaesthetists believe that patient care is compromised. Even if there is not a causative relationship between the patient death and staffing provision, Dr Mayes is seeking a response from Mr Holmes. There is, at the very least, a question about patient safety to be addressed. Information is crucial if progress is to be made: what are the actual effects of the levels of staffing? Mr Holmes spoke to the Medical Director previously, but there is an imperative to seek further detailed information about staffing in anaesthetics and its impact on service commitments. Information must be represented honestly to the Medical Director. If the Medical Director disagrees that patient safety is an issue, comprehensive and clear information will allow Mr Holmes to ask questions about the risks of current anaesthetic staffing in the context of plans for specialist surgical services. Using a carefully drawn account of the issue(s) makes the moral problem explicit and allows Mr Holmes to discuss specifically how existing provision and proposed change influence a shared commitment to patient safety.

Respect for, and support of, others

Mr Holmes should inform staff what he is doing and why (which, of course, requires Mr
Holmes himself to examine his own motivations). He needs to support his team but avoid being seduced into false promises. If Mr Holmes makes a commitment, it must be met. Simple actions such as setting a timescale for making progress and informing the team of any meetings or decisions reflect a genuine respect for, and support of, others.

Similarly, Mr Holmes should act respectfully towards the Medical Director and listen to his perspective, engaging in constructive discussion rather than obdurate advocacy for ‘his’ team and patients. It is likely that everyone will, to some extent, have an emotional response, which must be acknowledged but not allowed to distort how the issue is addressed. Dr Mayes may be feeling angry, frightened, guilty and anxious following her experience and Mr Holmes should enable her to express her emotion and be supportive even as he is determining the next steps.

Everyone in an organisation has different roles and perceptions and there can be multiple versions of the ‘truth’ about a situation. Using the information he acquires as he investigates further, Mr Holmes should seek to influence with integrity and respect those who may see the situation differently, trying to understand difference where it occurs and using new information to revisit core issues.

**Awareness of self and impact on others**

Mr Holmes may have an intuitive response to Dr Mayes. It may be sympathy, a sense of solidarity, shared frustration, guilt that the experience happened to one of ‘his’ team, irritation (‘another problem’) or defensiveness. The history and hierarchy of their relationship are relevant too. It is essential that ethical leaders are aware of their own reactions to others; the colleague whom one finds ‘difficult’ or who has a ‘reputation’ must be treated as fairly as the colleague with whom one trained.

By being aware of the effect of relationships on his responses and taking time to reflect critically on what is revealed by an initial response, Mr Holmes is acting ethically. His is a considered, selfaware response that acknowledges human interaction and its inevitable effects on leadership.

**Honesty and integrity**

Honesty and integrity are essential to trust and credibility; there is much more at stake here than the specific question of staffing. Honesty and integrity require Mr Holmes to keep both Dr Mayes and the Medical Director informed. He must be open about what he is going to do and meet commitments. Exaggerated promises, omitted details and premature reassurance will compromise not only the resolution of this specific situation but also Mr Holmes’s reputation and credibility, weakening him as a leader, perhaps irrevocably.

**Accountability and conscientiousness**

Mr Holmes should make himself available to Dr Mayes. If there are competing priorities, Mr Holmes should explain when and how he expects to investigate Dr Mayes’s concerns. Patient safety has been raised as a concern and a prompt response is indicated. At each stage, Mr
Holmes should be open about his actions and the rationale for his proposals, and be prepared to respond professionally to challenge. Leadership requires effort, application and patience. An ethical leader understands the importance of adhering scrupulously to proper processes. Mr Holmes must see events through. However brilliant a leader may be in a crisis, routine or difficult situations must be addressed through to their conclusion. An ethical leader is accountable and conscientious even when exciting new challenges beckon.

Teamworking and collaboration

Leaders depend on their teams and must work collaboratively across an organisation. Regrettably, situations can quickly degenerate into quasiterritorial disputes in which adversarial positions are assumed and unhealthy alliances dominate. Mr Holmes may be part of several teams (e.g. clinical teams, management teams, educational teams). He brings to each team a genuine commitment to collaboration in which imaginative solutions are sought, individual interests are seen as dependent on collective outcomes and quiet empowerment is preferred to charismatic direction. These actions will enable Mr Holmes to retain the support of his team long after the particular staffing issue is resolved.

Commitment to service

The concept of service encapsulates the essence of ethical leadership, namely that committed, respectful, inclusive, personcentred practice is its primary function. Yet individualism is still often actively encouraged and promoted in medicine and it can feel challenging to subjugate personal interests to those of others, even when to do so is a professional obligation. Feelings of frustration, irritation or even resentment may emerge. Indeed, one could argue that to deny such feelings is misleading and ultimately unhelpful in seeking to develop and maintain leadership. The key is to acknowledge the human variables, biases, intuitions, assumptions and values that all leaders have, while simultaneously understanding that such feelings must not influence behaviour and diminish the integrity of leadership (Pendleton and King, 2002).

Mr Holmes may reflect on the core purpose of healthcare and his role to elucidate what it means to serve. It is a simple but powerful step in articulating what is often assumed and throws into sharp relief the ‘bottom line’ of an individual’s obligations. Merely by asking ‘What does it mean to serve in this situation?’ and ‘What do we actually mean by patient safety?’, Mr Holmes is beginning to demonstrate his commitment to service.

Conclusion

Clinical leaders are often required to make decisions where there are no clear or ‘right’ answers, when, because of limited resources or other issues, the best that can be achieved is a compromise. Indeed, the fact that there is no clear way forward almost certainly means that this is a significant problem worthy of attention. Inevitably, such situations will result in conflicts between what our ‘moral compass’ would suggest and what is actually possible in the given circumstance. This is where the real challenges for valuesbased leadership lie, but the more
clinical leaders understand themselves, their motivations and the ethical basis for their decisions, the more often they may choose consistently to ‘do the right thing’, and by their actions persuade those around them to follow.

References


Further reading


CHAPTER 17
Developing Leadership at All Levels

Tim Swanwick1 and Judy Butler2
1 Health Education England, London, UK
2 Coalescence Consulting Ltd, Bath, UK

OVERVIEW

- Effective healthcare organisations require leadership at all levels.
- Leadership development and organisational development should be linked activities.
- Leaders can learn to lead.
- The timing of leadership development is critically important.
- Development programmes should be practical and work focused, link theory to practice, support individual development and build networks.

Health systems across the world require clinicians who understand the leadership task (and themselves), have a well-developed set of technical and social skills and are prepared to take on managerial positions and responsibilities. The challenge is in providing timely and appropriate development opportunities for these individuals so that when the circumstances demand – and given the appropriate context – they may contribute effectively to the performance of their clinical teams and organisations.

The growing consensus that healthcare professionals should embrace leadership in order to better effect change and improvement has been accompanied by the widespread provision of leadership development programmes for clinicians, from inhouse on-the-job training to courses supplied by external providers (including universities), to national programmes delivered by health service organisations such as, in England, the NHS Leadership Academy.

Is there any evidence to support the effectiveness of such leadership development? The short answer is ‘not much’. There is little good evidence in healthcare settings that relates any particular developmental approach to improved patient outcomes (West et al., 2015). This paucity of research is perhaps surprising when we consider the huge investment made in leadership development – both within and outside healthcare – but evaluation of effectiveness is challenging, the interventions and context diverse, and those providing programmes of varying levels of experience and skill. In the meantime, a body of thinking on what is considered to be ‘best practice’ in leadership development is emerging.

Leadership development: for whom?
If we ascribe to the view (reiterated throughout this book) that in healthcare, leadership is everyone’s responsibility, then leadership development should be provided at all levels of an organisation and throughout the career of every clinician. Successful organisations are ‘leaderfull’ rather than simply well led, and it is therefore equally important that the nurturing of future leaders is tied in with the development of their organisations. All the leadership development in the world won’t improve organisational or team effectiveness if there are fundamental misalignments in strategy or structure. Aspiring leaders need to be identified, trained and assessed, through both formal development programmes and a supportive, enabling organisational culture (Figure 17.1).

![Figure 17.1](image-url)

**Figure 17.1** Leadership development, capability and organisational performance.

Indeed, leadership development and organisational development can be seen as part of the same process, that of ‘increasing the capacity of organisations and the people within them to better achieve their purpose’ (Bolden 2010, p.117). This takes us beyond a historical but pervasive approach to leadership development that focuses on training individuals to one that emphasises the building of leadership capacity across whole systems.

**Leadership development: what?**

At the heart of the leadership development debate is the question ‘Can leadership be learned?’. As discussed in earlier chapters, there probably are some inbuilt personal attributes that affect the type of leadership practised, but the majority of necessary competencies can be acquired. The knowledge, skills and behaviours required are often couched in the form of a ‘competency framework’. There are a growing number of national leadership frameworks in
healthcare, but organisations may also articulate their own sets of competencies, describing leadership in a language that reflects their particular culture. Typically, these contribute to an annual appraisal or performance review cycle, but can also be used to support recruitment and ongoing development.

The primary aim of a development framework is to clarify the areas of ability required either for a specific role or situation. Each area is broken down into clearly defined skills, knowledge and behaviours in order that they can be more readily observed, assessed and developed. Competency statements are usually written to reflect different levels of ability. This allows individuals to understand how to operate more successfully in increasingly complex situations and roles. Quite often, the behaviours that limit an individual’s capability are also included as these can support a discussion with an individual about why they are not being as effective as expected. Table 17.1 provides a worked example for a leadership competency, described here as ‘Impact and influence’.
Table 17.1 Sample extract from a leadership competency framework.

<table>
<thead>
<tr>
<th>Competency area</th>
<th>Impact and influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>Persuades, convinces and gains the respect and agreement of others</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level</th>
<th>Definition</th>
<th>Positive indicators may include</th>
<th>Negative indicators may include</th>
</tr>
</thead>
</table>
| Level 1 | Confidently explains own views when questioned and refers to, or quickly accesses, relevant factual information | • When questioned can refer to, or quickly access, relevant factual information  
• Gives an accurate picture of the situation | • Lacks confidence and withdraws from discussions when questioned |
| Level 2 | Tailors own approach, taking account of the audience and their requirements | • Adapts the content, style and tone of presentations/discussions to appeal to others’ interests  
• Anticipates and prepares for others’ reactions and plans how to tackle objections | • Does not understand the needs/interest of the audience and therefore is unable to gain buyin |
| Level 3 | Uses own personal network across departments to enable him/her to keep up to date with views and feelings to obtain a range of perspectives on organisational issues | • Successfully influences at all levels to strengthen own case  
• Builds trust with clinical partners, colleagues, peers  
• Confronts areas of non performance for mutual benefit | • Takes a lowkey approach and is not perceived by others as having presence |

Used well, competency frameworks provide helpful insights into the behaviours and approaches that are valued. They support the feedback process by encouraging a conversation around key areas, inform personal development plans and clarify routes to different roles and levels. However, some notes of caution should be sounded; it is difficult to write simple, unambiguous statements of behaviour that reflect the overall capability sought, and the resulting
lists of skills and personal attributes may appear overwhelming and unachievable. Finally, competency frameworks should certainly not be seen as a ‘tick list’ as leadership development is as much a journey of self-discovery and personal transformation as it is about the acquisition of specific competencies.

## Leadership development: where?

Mintzberg’s jibe that ‘using the classroom to help develop people already practising management is a fine idea, but pretending to create managers out of people who have never managed, is a sham’ (Mintzberg 2004, p.5) accords with a growing consensus that leadership development should be both drawn from and embedded in work-based activities. A useful rule of thumb is that in effective leadership development programmes, 70% should be work or project based, 20% should occur through personal development as a result of, for example, working and interacting with others, multisource feedback and coaching, and 10% can be provided through formal training programmes such as attendance at courses (cited in Lombardo and Eichinger, 2000) ([Figure 17.2](#)).

![Figure 17.2](#) The 70:20:10 rule of leadership development.

## Leadership development: when?

In many health organisations, the opportunities to develop the abilities of an effective leader are not consistently introduced until the point at which a leadership role, such as service line head or clinical director, is taken on. Until then, learning tends to be focused on the development of clinical expertise. [Figure 17.3](#) compares a desirable path (green) with that usually experienced by clinicians (blue). Timely development is not just a question of starting
earlier. As with any new learning, it is about ensuring that individuals take a cumulative approach to development, considering basic concepts early on and having the opportunity to put them into practice at that time.

One way in which organisations seek to be more proactive about development is through ‘talent management’. The talent management matrix (Figure 17.4), commonly referred to as ‘the nine box grid’, is a simple yet effective tool used to assess future leadership potential within organisations. The grid enables an assessment of individuals in two dimensions: past performance and future potential. The aim of the tool is provide a structure around which can
be had an open, honest and constructive conversation between manager and staff member exploring where they are now, where they want to be and how they are going to get there. The talent management ‘conversation’ seeks to identify and maximise how the individual is currently performing, and explores the developmental opportunities that would be most useful in order to move them towards a future leadership role.

![Talent management matrix](image)

**Figure 17.4** Talent management matrix.

**Leadership development: how?**

As with any educational programme, at the outset it is essential to clearly define the needs of the learners and the aims and outcomes required, and to select which of the vast array of theories and models will best underpin the activities and intended learning. Different approaches and emphases will be taken depending on underlying assumptions made about the nature of leadership, the trainers’ background and experience and the needs of individuals and organisations. No two leadership development programmes will be the same but broadly, the aim is to create a personalised ‘programme’ rooted in realworld experience.

Within this framework, a number of potential interventions are in common use (**Figure 17.5**).
Courses, seminars and workshops – courses and formal learning opportunities provide a group of participants with a sense of community and unity of purpose; they also provide participants with time out for reflection and a new shared language to think about and discuss relevant issues. Through the introduction of new ideas and exposure to those in leadership positions, new ways of thinking about familiar situations are encouraged.

Action learning – in an action learning set, individuals engage in real life problems with a small group of peers, where a combination of reflection, support and challenge and a commitment to act create a powerful environment for change and development.

Multisource feedback – also known as 360 degree appraisal, multisource feedback is now a familiar feature of the health professions’ education and training. As with all such tools, care must be taken in how feedback is provided and how sensitively the, often highly personal, learning is incorporated into the overall development programme.

Coaching and mentoring – coaching and mentoring sit on a spectrum of learning relationships that enable individuals to take charge of their own development. Each activity is built around a conversation which aims to release the potential of the ‘client’ and to help them achieve results which they themselves value. Coaching tends to focus on the short term achievement of specific objectives and mentoring on the longer term advancement or development of an individual within a particular organisational context.

Simulation – simulation is a particularly useful vehicle for the rehearsal of leadership behaviours in the team context. Simulated exercises may range from practising one-to-one communication skills, such as how to give feedback to a colleague, through to full immersion situations involving whole teams or organisations. A key issue, though, as with clinical simulation, is how the skills rehearsed then ‘transfer’ to the workplace setting.

Psychometric tools – selection for leadership roles and leadership development programmes often uses a range of psychometric tests ranging from simple feedback tools to high-reliability psychological assessments. As with multisource feedback, psychometrics are best used as a starting point for discussion rather than being seen as offering some ‘absolute truth’.

Elearning – despite the convenience of online learning, and the fact that courses and interventions can be made available to large numbers of learners, the use of elearning in the development of social processes, such as leadership, is limited and attrition rates tend to be high. However, the rise of social media (Facebook, Twitter), coupled with mobile technologies, now provides a powerful vehicle for networking and support, with global communities of practice coming together with relative ease.

Workbased initiatives – shadowing, project work, internships and fellowships (Box 17.1) are all essential vehicles for getting ‘under the bonnet’ of organisations. Coupled with coaching or action learning, the learning that results through such participation in realworld experiences can be extremely powerful.
Commonly used leadership development interventions.

<table>
<thead>
<tr>
<th>Courses, seminars, workshops</th>
<th>Action learning</th>
<th>Multi-source feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simulation</td>
<td>Psychometric tools</td>
<td>Structured workplace experiences</td>
</tr>
<tr>
<td>E-learning</td>
<td>Coaching and mentoring</td>
<td>Project work</td>
</tr>
</tbody>
</table>

**Box 17.1 Case study: Fellowships in clinical leadership.**

An example of a programmatic, workbased approach to clinical leadership development is provided by London’s ‘Darzi’ Fellowships in Clinical Leadership. This innovative programme, named after an influential surgeon and former health minister, provides a multiprofessional cohort of doctors in training and healthcare professionals in their early career with a unique opportunity to develop the organisational and leadership capabilities necessary for their future roles as clinical leaders. Fellows are appointed from primary, acute, foundation and mental health services. The posts comprise 12 months ‘out of programme’ from specialty training, during which time Fellows work on a number of projects covering service change, quality and safety improvement and leadership capacity building, under the guidance of a nominated clinical director. The Fellows are supported throughout by a leadership development programme, including coaching, project consultancy and taught sessions, leading to the acquisition of a postgraduate certificate.

Whilst the development activities described above can be delivered on an *ad hoc* basis, perhaps more important is how they are assembled programmatically. Building on the literature describing best practice, Swanwick and McKimm (2014) have proposed five principles for the design of leadership development programmes (*Figure 17.6*), namely that effective programmes should:

- be *practical* – through the incorporation of the development of key skills such as coaching, change management and negotiation
- be work oriented – by including project work as a key component supported by action learning sets
- be supportive of individual development – through multisource feedback, coaching and mentoring
- link theory to practice – through the provision of selected leadership and management literature relevant to the educational context
- build networks – through action learning, coaching and social networking.

**Figure 17.6** Characteristics of an effective leadership development programme.

Petrie (2014) builds on these ideas in his description of two types of leadership development: horizontal and vertical. Horizontal development entails the acquiring of competencies through engagement in experiential activities, courses and programmes to add knowledge to existing perspectives and ways of thinking. Vertical development is a longitudinal process in which learners’ evolving sense of the world becomes ever more complex, systemic and inclusive, vital in a world that is volatile, uncertain, complex and ambiguous. Petrie suggests that vertical leadership is achieved through exposure to and reflection on three interlinked sets of activities:
• ‘heat experiences’ (the what) – opportunities that disrupt usual ways of thinking which stretch people beyond their comfort zone and into new more advanced models of thinking

• ‘colliding perspectives’ (the who) – occur within heat experiences by exposing people to people with different views, backgrounds and ways of thinking

• ‘elevated sensemaking’ (the how) – incorporating time for reflection, conversation, feedback, coaching or mentoring. This allows for greater sense making and major shifts in ways of thinking and behaving.

In a similar way that clinicians learn to manage clinical problems over time and with experience, the most effective leadership development activities expose individuals safely to dealing with ever more complex problems that may require a shift in approach or perspective. This can be achieved through a range of learning and teaching methods supported by the means to reflect and learn from significant events and experiences.

References


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*High Quality Care for All* (Darzi, 2008)

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- Griffiths Report (1983, UK)
  - traditional model

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