Leadership and management are complex nursing essay

Introduction

Leadership and management are complex, inter-related concepts, and are essential for health services delivery, reform and administration. Both can be viewed as activities within organisation rather than as functions of specific job roles (Story, 2004; Mullins, 2007). A manager is a member of a specific professional group who manages resources and activities, establishing rules and procedures; and usually has clearly defined subordinates (Northhouse, 2010). A leader is someone, irrespective of professional background and level within an organisation, who build teams and coalitions, and has influence over other people (Rocchiccoli and Tilbury, 1998; Northhouse, 2010). Within the National Health Service (NHS) management require influence rather than giving orders, hence there is a need for effective leaders (Bristol Royal Infirmary Inquiry, 1991; IIes and Sutherland, 2001; Jones, 2007)). Effective leaders are those who possess the ability to influence motivate and enable others to contribute toward the effectiveness and success of the organisation of which they are members (Mullins, 2007; Chism, 2010; Northhouse, 2010). The role of leaders in the NHS is to improve patients' care, treatment and experience; promote a healthier population; and enhance the NHS's reputation as a well-managed and accountable organisation as well as motivate and develop staff (Hartley and Benington, 2010). Poor leadership styles, with an increased pressure at work, and enforced change, creates dissatisfaction and low morale among staff, which may lead to crisis (Reed, 1995; Oliver, 2007; Mullins, 2007). It is the intention of this essay to highlight the importance of leadership and change management theories to understand and solve contemporary management

issues. It will present and critically analysing in the light of theory the management crisis that stroke Mid Staffordshire Foundation Trust between 2005 and 2008, as reported by Alberti (2009) and Thomé (2009).

The Mid Staffordshire Foundation Trust Case

The Mid Staffordshire Foundation Trust (MSFT) is a small to medium-sized trust that serves a semi-rural population (Alberti, 2009). During the summer and autumn of 2007, while analysing mortality in England, the Healthcare Commission became aware of consistently higher rates of mortality for specific conditions at the Trust (Healthcare Commission, 2009). When carrying out detailed examination, the Commission found that, mortality appeared to be concentrated on those admitted as emergencies. The reasons for the failing at the Trust, as explained by the Commission are the existences of deficiencies at virtually every stage of the pathway of emergency care (Healthcare Commission, 2009). The overall mortality rate had indeed been comparatively high for several years as shown by Dr Foster's Hospital Guide (Alberti, 2009). As a result, the government appointed Professor Sir George Albert and Doctor David Colin Thomé, to investigate the problem and suggest solutions. It can be said that, the MSFT has suffered from many leadership and management issues, which eventually affect the quality of care provided to patients. The reports by Alberti (2009) and Thomé (2009) identified many issues that escalate the situation at MSFT and offer recommendations on how to manage them. These include the lack of effective clinical leadership; poor use of data and information evident in the lack of action from the concerned Strategic Health Authority (SHA) and Primary Care Trust (PCT) in relation to the increased

mortality rate at the hospital, as reported during 2007 by the Hospital Standardized Mortality Rate (HSMR) data; and poor governance and clarity of accountability of all the different organisation in the system. The MSFT crisis is used here as a case study, because I have no work based experience; and for the purpose of this analysis, the above mentioned issues will be examined in relation to leadership and change management theories, with brief highlight of inter-organisation collaboration approach..

Leadership and change management theories

Hellriegel et al. (1998) suggest that behaviour within an organization may be explained by viewing the organization as an iceberg. Their assumption is " What sinks ships isn't always what sailors can see but what they can't see". Similarly, what cause problem for organizations is not what managers can see, but what they cannot see. The organisation Iceberg is based on the assumption that most of the internal factors affecting an organization are invisible, refer to as (covert) but affect the behavioural of individuals involved, such as attitudes, communication patterns, informal team processes, personality, conflict and political behaviour. While formal aspects refers to as (Overt) can be observed from all level, that include physical facilities, rules and regulations, customers and organisation designs The iceberg model relates directly to Paton (2000) who describe organisations are made of complex components that all influence the overall system. In relation to MSFT this model describe the relationship between the PCT's, SHA's and MSFT and how they work together. The Organisation Iceberg highlights that there are many factors within an organisation service that cannot always be seen and cause many problems in reality, which in the

case of MSFT could be the shortage of staff, which affects the communication between employees; and lack of time to complete routine duties effectively.

Change is inevitable in both organisational and social life, it is a pervasive influence and everyone is subject to continual change in one form or another (Mullins, 2007). Within organisations change is seen as a constant feature, and the ability to manage it, is seen as a core competence of successful organisations (Burnes, 2004). Paton and McCalman (2000) describes an organisation as a system of organised assembly of components, which are related in a way that the behaviour of any individual component will influence the overall status of the system. Organisational change can be initiated deliberately by managers or it can be evolve slowly (Mullins, 2007). In both situation, change can occur because of many reasons, sometimes refers to as ' triggers', which can be internal or external. Triggers can be due to an increased patient and public expectations, changing technologies, government legislation, competitor, supply change activities, an acquisition or merger (Paton and McCalman, 2000). In the case of the MSFT, the triggers have been external, and involve the need to response to government legislation, social pressure and the inquiry. Nevertheless, change can be planned, implemented and seen; approaches to change management include: Lewin's Force Field Model, Group Dynamic, Action Research and Three-Step model

The Force Field Model – (Lewin, 1951 cited by Iles and Sutherland, 2001), describe factors that can encourage change and the forces that can create resistance, during the transition state. Lewin's theory can be related the MSFT as there were driven forces such as economic reasons and the need to

increase customer care that lead to the establishment of the PCT and SHA. Yet there are resisting forces such as poor communication during the transition periods of PCT and SHA, and the lack of professional responsibility from the clinicians and other members of the hospitals' staff. Alberti (2009) illustrated in his report that, the trust application for Foundation Trust status led to major saving being required. This financial savings was one of the driving forces that encouraged change. This in turn led to a major fall in clinical staffing, which suggested to be a resisting forces that lead to the deterioration of patient care. As suggested by Lucas and Lloyd (2005) change may bring the about resistance, even though the change can be positive. Change is not a straight forward process, whenever an organisation imposes new things on people, there will be difficulties. Thus, participation involvement and open, early, full communication are essential factors (www. bussinessballs. com). Lewin described an organisation as systems that are held in a steady state or equilibrium by equal forces (King and Anderson, 2002). These forces are the ' driving forces' and the ' resisting force'. When change is proposed it is important to minimise those resisting force first; any premature increase in driving forces for a change will be met with an equal opposite increase in resisting forces (King and Anderson, 2002). It is therefore necessary to reduce the resisting forces through consultation and participation in the change process. Once the resisting forces have been minimised the driving forces can be increased, shifting the equilibrium to the desire state . Within the MSFT, tackling resistance to change should have been a priority, given the circumstances and events that occurred. Resistance to change can be in many forms, these can be at an individual level or organisational level, and often difficult to pinpoint the causes. Mullins

(2007) suggested that individual resistance may be due to habit, inconvenient or loss of freedom, security in the past and economic implication. Similarly, King and Anderson (2002) argued that individuals may resist simply because change represents a more move into the unknown. Examples of security in the past causing resistance can be seen at MSFT and the surgical words, in the past surgical patients were admitted to the emergency accident unit (EAU), this was found to be of unsatisfactory level leading to opening of a temporary small surgical assessment unit. This unit was found to be successful; however has no been closed, despite its success. Resistance to change and the feeling of security in the past admission procedures allowed a successful change to be closed.

Group Dynamic – is another a approach to change, Lewin was the first psychologist to write about group ' Group Dynamic' and the importance of the group in shaping the behaviour of its all members (Burnes, 2009). Lewin developed of this concept by addressing two questions. First, what is about the nature and characteristics of particular group that cause it to respond, as it does to the forces which trench on it? Second, how these forces be changed in order to elicit a more desirable form of behaviour? Group Dynamic stresses that, group behaviour, rather than that of individuals, should be the main focus of change (Hayes, 2007; Burnes, 2009). Lewin maintain that it is fruitless to concentrate on changing the behaviour of individuals because the individual in isolation is constrained by group pressure to conform. Consequently the focus of change, must be at the group level and should concentrate on factors such as group norms, roles, interactions and socialization processes to create disequilibrium and change

(Hayes, 2007) Lewin recognized that, there is need to study and understanding the internal dynamics of groups, such as the different roles people play and how groups need to change over time. However, for him this understanding was not sufficient by itself to bring about change (Burnes, 2009). Lewin also recognized the need to provide a process whereby group members could be engaged in and committed to changing their behaviour. This led Lewin to develop Action Research and the Three-Step model.

Action Research – Lewin conceived of Action Research as a two-pronged process which would allow groups to address these three questions. Firstly, it emphasizes that change require actions, and is directed at achieving this. Secondly, it recognizes that successful action is based on analyzing the situation correctly, identifying all the possible alternative solutions and choosing the one most appropriate to the situation at hand (Hayes, 2007). To be successful, though, there has also to be a ' felt-need'. Felt need is an individuals inner realization that change is necessary. If felt-need is low in the group or organisation, introducing change becomes a problematic (Burnes, 2009)

Three-Step model – is programme of planned change and improved performance, this model is developed by Lewin, to assist with change. It involves the management of a three-stage process of behavior modification: unfreezing, movement and refreezing (Mullins, 2007). Unfreezing by reduce those forces which keep behavior in its current form, recognition of the need for change and improvement to take place. Lewin believed that the stability of human behaviour was based on a quasi-stationary equilibrium supported by a complex field of driving and resisting forces, thus the equilibrium needs

to be destabilized before old behaviour can be discarded and new behaviour successfully adopted (Burnes, 2009). Movement, this step shifts the behavior of organisation to a new level; it involves the development of new attitudes or behavior and the implementation of change, Lewin recognized that, without reinforcement, change could be short-lift (Hayes, 2007; Burnes, 2009). Refreezing, this step stabilizing the organisation at new state of equilibrium, it is frequently accomplish through the use of supporting mechanism, for examples polices, structure or norms (Mullins, 2007). The main point about refreezing is that new behaviour must be, to some degree, congruent with the rest of the behaviour, personality and environment of the learner or it will simply lead to a new round of disconfirmation (Burnes, 2009).

Clinical Leadership

Effective, accountable clinical leadership at all levels of the NHS from where patients are treated and cared for right up to the board of an organisation, is another essential pre-requisite of a safe, high quality and effective service (IIes and Sutherland, 2001). In Mid Staffordshire hospital trust, this was lacking. It could also have been more effective in the PCTs and SHAs.

Thomé (2009) suggested that clinical leadership had a major role in the deterioration of patient care at MSFT. He described the visible clinical leadership as lacking in MSFT as well as in SHA and PCT. The poor leadership was observed at all levels, with clinicians failing to raise concerns about patients quality of care, and management failing to improve staff level that would have a big impact on patient quality of care. Clinical leadership may be defined as ' an expert clinician involved in providing direct clinical care,

which influences others to improve the care they provide continuously' (Cook, 1999, p. 306). Cook and Leatherhard (2004) describe five characteristics of an effective leader that can be adopted into the clinical environment to produce the best care for the patients. These include creativity by understand the situation and seeking new possibilities; highlighting through identifying new ways of care delivery; influencing by help others see and understand situations from different perspectives; respecting through well develop perceptual ability of others; and finally supporting by supporting others through change. The effective leader characteristics are link to the Trait Theory (Lord et al, 1986) which suggests that leaders have physical traits and abilities that are individual and distinguish them from others. The Trait Theory based on early studies which claim that leaders are born not made, and key characteristics and skills are inherited (Mullins, 2007). The benefit of trait approach is the ability to focus on the individual who is the leader, rather than the task of leading. This allows for analysis of the leader and their individual leadership traits, in term of effectiveness and efficiency and highlights their strength and weakness, which in turn can lead to the improvement of leadership capabilities. Being an ineffective leader in NHS can have severe consequences on the staff in the workplace, as well as patient by having psychological impacts that cause deterioration in patient acre and result in stressed staff. Alberti (2009) and Thomé (2009) . It is clear that there was a distinct lack of Cook and Leathard's (2004) five characteristics, that need to influence staff, implement change and be creative. According to Alberti (2009) and Thomé (2009) reports, leaders of MSFT were very focused on a financial change and lacked creativity in many other aspects of the organisation, such as

implementing change management at an individual care staff level. They show disrespect for their staff, by failing to support them and provide adequate training. Alberti (2009) and Thomé (2009) suggest that they could provided training that would enable staff to adapt to changes in the organisation. Also, there could have been changes to the staff levels, to provide departments with the sufficient staffing, to maintain appropriate care levels. This in turn inhibit the introduction of any new care plans that could potentially improved the care. There was also a lack of influential staff; Thomé (2009) commented on the lack of responsibility shown by general parishioners in the hospital, who fail to report poor quality of care , that they often observed in the clinical settings. According to Palfrey (2000) within the NHS management decisions often relate to resources or the allocation of resources, and that managing budgets and managing people require two very different functions. It is clear that the financial component of MSFT system was a priority, and the leaders in charge missed the opportunity to manage their staff and individuals well, by focusing too much on the budgets and resources (Alberti, 2009; and Thomé, 2009).

Inter -organisational collaboration

Alberti (2009) review of MSFT, found that there are highly committed, acute surgeons working at the Trust but too few in each of the surgical specialties. He therefore recommended that a system of networking with neighbouring trusts to be created. Similarly, a network or board should be established for urgent and emergency care including all partners, such as the PCT, the ambulance trust, social services, the voluntary sector, pharmacies, patients and the public as well as the MSFT. In his view this could and should greatly

facilitate delivery of care by the most appropriate person in the most appropriate setting in timely fashion. Partnership means learning together and works together; it is a good way of making things happen (Davies and Foley, 2007). The need to bring together, different inter-linked professionals skills has increasingly arisen in response to the complexity of health and welfare services; the expansion of knowledge and the subsequent increase in specialisation resources; for lessening duplication and provide a more effective, integrated and supportive services for both users and professionals (Naidoo and Wills, 2001).

According to Leathard (1994) one striking feature about inter-professional work in Britain is that there has been a generally held belief that collaboration is good thing and inter-professionals teams have increasingly gained favour in recent years. However, threes has been little evidence to substantiate the view that collaboration leads to an increase in the quality of care. Similarly, Hudson et al (1999) have argued that interagency collaboration in the public sector remains very difficult, yet governments committed to it. Adams (2007) mentioned that partnership have number of strengths. First, they reassure people that cooperation and collaboration between diverse groups and organisations are possible. Second, they enable people as individuals and in groups to join forces to achieve shared goals. Finally, they are means by which agencies can work together to solve problems they cold not tackle alone. McGrath (1991) noted three advantages of inter-professionals teams working in the field of community mental handicap. Firstly, more efficient use of staff, for example enabling specialist staff to concentrate on specialist skills and maximising the potential of a

qualified staff. Secondly, effective service provision, for instance, encouraging overall service planning and goal orientation. Thirdly, creating a more satisfying, work environment, again by promoting a more relevant and supportive services.

Inter-agency and inter-professionals coordination and collaboration, are not however, readily in practice (Sands et al, 1990). Inter-professionals pitfalls included conflicting professional and organisational boundaries, inequality in status and pay, and time consuming consultation (McGrath, 1991). Sweeney et al (2000) concluded that, the three reasons for failures in collaboration drawn from research are cited as being differing professional perspectives on problems; different occupational cultures and confusions over professional roles. Confidentiality and sharing information within and between agencies are other issues. It is clear that PCT, SHA and Monitor at MSFT were unsure about their involvement and responsibilities once the hospital has been awarded the Foundation Trust status, which result in neglecting patient care (Alberti, 2009; Thomé, 2009). Adams (2007) pointed out that it is difficult for organisation with diverse cultures and ways of working to work together. Successful partnerships and effective joint work between different agencies and professionals, depend on a number of conditions being fulfilled These include a willingness to share tasks, high trust between different professionals and openness and good communication. Likewise Hudson et al (1999) have developed a conceptual framework setting out some main issues that need to be considered when planning collaborative services. These include assessment of collaborative capacity, identification of a legitimate basis for collaboration, ensuring wide organisational ownership

and nurturing fragile relationship. Close culture and lack of data sharing, were among the issues that caused the situation to deteriorate at MSFT; a Good understanding of multi-organisational networking, alliance and partnership principles, would have improve the communication at the trust. This in turn can improve patient flow through the hospital and ensure greater networking with neighbouring trusts.

Conclusion

Within the NHS management systems, a manager requires need to influence other rather than giving orders, thus they need to be an effective leaders. The Mid Staffordshire Foundation Trust (MSFT) crisis was a result of poor leadership and management of staff and services (Alberti, 2009; Thomé, 2009). The lack of smooth organisational change management, as described by the Organisational Iceberg, affected many components of the trust. The reconfiguration of PCT and SHA was to improve the quality of care at the trust. However unstable transition and transformation of change that was caused mainly by inadequate leadership capabilities prevent a successful case of change management in this organisation. As a result the poor standard of care continued to be performed in the hospital, without any attention or plan to change. Change is a common feature s in both organisation and social life, and can be planned, implemented and seen. Lewin's Force Field Model, Group Dynamic, Action Research and Three-Step models of change forming un integrated approach to analyzing, understanding and brining about change at group, organisational and societal level (Burnes, 2009). Clinical leadership in particular played important in the deterioration of patient care at the MSFT. Effective clinical

leadership required creativity, highlighting, influencing, respecting and supporting (Cook and Leatherhard, 2004). Inter-professionals and partnership approach in public sectors aims to enable people to work together to achieve shared gaols. However, these approach, hindered by problems such as the conflicting professional and organisational boundaries and loyalties. Successful partnerships depend on a number of conditions being fulfilled these include a willingness to share tasks, high trust between different professionals and openness and good communication (Adams, 2007).