Leadership in a changing environment nhs management essay

Spending on the NHS has risen from £447m a year to £96bn over the last 60 years (Ham 1997), nearly a 10-fold increase after adjustment for inflation (Hawe 2008). In 2000 the Labour government initiated a programme of investment of 7% budget increases for 7 years that was unprecedented for any healthcare system (Department of Health 2000). However, Andrew Lansley the new health secretary, recently announced that the NHS budget would continue to rise above inflation in the coming years, but signalled that the NHS may need to make more savings than the previously announced £20bn in efficiency cuts, a move health experts described as “ extremely ambitious” and unions warned could have a “ devastating impact” on hospitals (The Guardian, 2010).

The government say it is necessary to make savings on such a scale because of the squeeze in public spending. So the NHS, with a budget of £100bn – amounting to a fifth of total public spending – will have to do “ more with less”.

The individuals charged with steering the NHS through this period of relative famine will no doubt be required to display all the qualities of ‘ good leadership’ in order to meet the demanding financial and strategic challenges that face the organisation. But what are those qualities? How are they being developed within the NHS, and are they even the right qualities needed to produce effective leadership in an organisation as complex and demanding as the NHS?

This paper firstly takes a critical look at what might constitute good healthcare leadership with reference to the current NHS Leadership Qualities

Framework (NHS Institute of Innovation and Improvement, 2005) and presents an alternative to the individualistic approach of seeing leadership as a set of distinct personal qualities, capabilities and/or behaviours. Some of the theoretical and methodological weaknesses of the individualistic approach are exposed in an attempt to challenge the established formula for good leadership, and argue that in the increasingly tough economic climate that the NHS has to operate in, a new style of leadership is required to meet the challenge of delivering high quality healthcare whilst balancing the books.

Secondly we look at the role of organisational change in facilitating this new approach to leadership. Established models of culture change are summarised and analysed to see if they might fit within this new approach to leadership.

Finally the author discusses his own personal style of leadership in light of the findings and attempts to apply theory to practice within his own working environment.

Leadership in the context of the NHS

The NHS employs more than 1. 3 million people spread across hundreds of organisations. Leaders of NHS organisations need to provide strong, strategic leadership for their organisation while being held to account by local Primary Care Trusts (PCTs), Strategic Health Authorities (SHAs) and other regulatory bodies for nationally and locally set objectives. The performance of these organisations is dependant on the performance of clinicians who are often

leaders in their own right, and due to the nature of their profession are expected to work under a great deal of autonomy.

This is a problem that the NHS has been struggling with over its entire history. In 1983 the Conservative government of the time commissioned the Griffiths Report, which was a key trigger to the development of management and leadership in the NHS. In the report, Roy Griffiths famously said, ‘ If Florence Nightingale were carrying her lamp through the NHS today she would be searching for the people in charge.’ (Griffiths, 1983). The report is best known for recommending that general managers be introduced into the NHS.

During the 1980s, hospitals began to integrate the medical profession into the management structure. In the early 1990s, however, with the introduction of the internal market, managers and leaders were tasked very clearly with balancing the books. This resulted in managers becoming stereotyped as ‘ bean counters’, a popular viewpoint still held by many (Kings fund, 2009). It was important then that the publication of Lord Darzi’s NHS Next Stage Review in 2008 (Doh, 2008) shifted the focus from general management onto the need for more clinical leadership. Clinicians are being asked to have increasing involvement with the management agenda and take responsibility for the delivery of services locally.

As a result of this increased recognition of a need for high quality leadership to deliver the NHS Plan (Doh, 2000) in 2009 the Chief Executive of the NHS, David Nicholson, established, and currently chairs the National Leadership Council (NLC). The Council has five main work streams: Top Leaders,

Emerging Leaders, Board Development, Inclusion, and Clinical Leadership. This development represents a switch from where people were left to work out their career options for themselves, to a more nurturing environment, with a greater focus on support to both individuals and organisations.

The Leadership Qualities Framework

The document that underpins the development of leaders through the (NLC) is the Leadership Qualities Framework which has a number of applications and builds on the increasing emphasis in management recruitment, development and education on nurturing individual character traits in leaders, with the sole purpose of producing a set of abilities and transferable skills that can be applied in a variety of situations and contexts. Through this approach, NHS organisations hope to produce adaptable leaders, able to work across a multitude of complex environments and systems typical of a healthcare organisation. The term ‘ leadership’ is applied then to those who seemingly possess the abilities deemed necessary to lead, such as communication, people management, decision making and problem-solving. This dominant approach focuses on individual personal qualities for leadership development and is the latest in a long line of competency frameworks that have emerged in the last 50 years.

The history of competency frameworks

Leadership thinking has developed substantially over the last 50 years. The idea of individual character traits that started with Stogdill (1950) soon expanded into other schools of thought with McGregor pioneering the behavioural approach (1960) and Fiedler the contingency school (1967). These ideas were added to by Hersey & Blanchard (1977) with situational

leadership and Burns with transformational leadership (1978). All these approaches focus on leadership as a set of qualities embedded in the individual and can be thought of as competency approaches. There focus is on leaders who impress others; inspire people; push through transformations; get the job done; have compelling, even gripping visions; stir enthusiasm; and have personal magnetism (Maccoby, 2000).

The NHS Leadership Qualities Framework is the latest such tool that adopts the individualistic approach with a focus on 15 core personal characteristics such as self-belief, empowering others, intellectual flexibility, political astuteness and integrity. These personal qualities are undoubtedly important but do not probably tell the whole story of what makes a good leader. Sanderson (2002) makes the point that management is more likely a consequence of complex contextually-situated interrelations, thoughts reiterated by Mintzberg in 2004 who suggests that our view of leadership is more likely to be an over-simplification of a vast pool of environmental data compressed into a few key people. So what are the major criticisms of competency models such as the LQF, and how might such a model have to adapt to ensure that the National Leadership Council produces the right kind of leaders needed for the future?

Weaknesses of competency approaches to leadership

There are at least five areas where the competency approach could be seen to be flawed (Bolden et al, 2006). Firstly it can be seen to be reductionist in the sense that it reduces the management role to its constituent parts rather than seeing it as a whole (Lester, 1994 & Ecclestone, 1997). Secondly, the competencies that are listed as prerequisites for good leadership are often

generic with no accounting of the nature of the task or situation (Swales & Roodhouse, 2003). Thirdly, that focusing on personal traits may reinforce stereotypes about leadership rather than challenge them (Cullen, 1992). Fourthly, that not enough attention is given to the subtle qualities such as the moral and emotional elements of leadership that are difficult to quantify and measure (Bell et al. 2002). The fifth and final main criticism of competency frameworks is that their content forms part of an approach to education that aims to train individuals to improve their performance at work rather than develop more general cognitive abilities (Grugulis, 1997).

If we accept the above weakness as legitimate, then it does cast doubt over the validity of competency frameworks such as the LQF to actually select and develop leaders. Salaman (2004) suggests that these frameworks may actually be confusing the issue when he states that

‘ The problems it promised to resolve are not capable of resolution and its promise consisted largely of a sleight of hand whereby organizational problems were simply restated as management responsibilities’

Weaknesses specific to the LQF include the fact that the initial research on which it was built was taken from interviews with Directors and Chief Executives rather than observation of good leadership in practice (NHS Leadership centre 2005). Also the qualities being promoted such as awareness, self-belief and integrity may be admiral in their own right but do not necessarily automatically lead to effective leadership. Bolden et al (2006) lists the characteristics as (a) a somewhat persecutory list of ‘ oughts’, and (b) suggest that the characteristics still do little to get effective

leadership done. ‘ One may be visionary, communicative and honest – and still find leadership to be elusive’. This then is the great paradox found within the competency approaches; that while they aim to highlight the skills that may be needed in certain situations, it is highly unlikely that people will encounter the exact same set of circumstances in their own practice because of the inherent complex nature of working life. Also, that while providing prescriptive solutions to problems may increase consistency, they may stifle any original though in the leader wanting to apply their own reasoning to the problem.

The characteristics of the LQF seem then to be then a description of the qualities found in people in the top jobs rather than the prerequisites for leadership. The difference in viewing these traits as descriptive rather than prescriptive cannot be underestimated. Such descriptions however tend to oversimplify and may prove to be of limited, practical value within the climate of complexity, interdependence and fragmentation that arguably characterizes multi-disciplinary organizations such as the NHS (Blackler et al., 1999). Additionally, individuals are likely to try and define themselves according to the corporate language found within competency frameworks to legitimise their role rather than seek new ways of working and improving their practice (Holman & Hall, 1997).

Going back to Sanderson’s earlier point that management is more likely a consequence of complex contextually-situated interrelations, we can see how in a medical setting such as in a busy outpatient department the desired outcomes can only be achieved as a consequence of multiple staffing/patient/organisational/medical factors working in synergy. Successful

leadership in this sort of environment is not likely to be the result of any one individual, but a result of all the characters competently playing their respective parts. Marx (1973) suggests that we should not focus on a few key individuals when trying to explain leadership in an organisation, because if we do so there is the danger that individuals become pigeonholed as either ‘ leader/follower’ and the nuances of the group interactions as a whole become lost. He ultimately describes the leadership focus on a few key people as an illusion. Using the earlier example of a trip to the outpatient department there is no point looking for a leader throughout the care process, as responsibility passes between various individuals, especially if you include the initial referral from the GP and follow up staff such as home help after the visit.

Beyond individual competencies

So if traditional competency frameworks, including the Qualities Leadership Framework are flawed, how can a view of leadership based on contextual factors better steer the future of leadership development within the NHS?

Building on the initial thoughts of Marx in 1973, Bolden et al (2006) develop the argument that leadership is an organic process that is an ongoing, ever developing situation that individuals find themselves in whilst interacting with others. Leadership can come and go depending on the relationships that people have with each other and is inextricably linked to the particular environment of the time. Like power, leadership is an internal relation, constantly ‘ in-tension’ and subject to a myriad of ‘ meanings, values, ideals and discourse processes’ (Alvesson, 1996). One of the implications of

reclassifying leadership in this way is that ‘ good’ and ‘ effective’ leadership cannot now be taught, only experienced by others.

Sandberg (2000) interviewed assembly line workers and concluded that finding purpose at work led to appropriate competencies arising naturally. He proposes that by engaging in dialogue to clarify a workers purpose leads to better outcomes compared to presenting them with a list of competencies to achieve. Within the outpatient department example it is likely that the unified sense of purpose will bind the individual players, creating an environment that facilitates the emergence of positive behaviours when required.

In light of the increasing economic constraints that health organisations have to operate within, it would be wise to promote leadership as potentially accessible to all by placing more emphasis on personal autonomy. Perhaps then this re-conceptualisation would encourage a shift not only in how leadership is researched, but also in how it is recognised, rewarded and developed within the NHS. Practically speaking the NHS needs to ‘ cast its net a bit wider’ when trying to define good leadership. It means opening up leadership from multiple angles, searching its ‘ small details, minor shifts and subtle contours’ (Dreyfuss & Rabinow, 1982) to see it in the context of its environment.

Bringing about organisational change

In light of our proposal that it would be wise to promote leadership as potentially accessible to all by placing more emphasis on personal autonomy, there needs to be a way that leaders can disseminate this culture

within their organisations. As many health organisations are built on strict hierarchical chains of command it is inevitable then that many organisation will have to go through some form of culture change to embrace new ideas and practices. Many people working in health organisations will be familiar with organisational change of some sort. But most would associate organisational change with shifts in management structures or indeed the creation/removal of whole new organisations. When structural change is implemented it is usually with the intention of bringing about change to meet wider goals such as introducing stronger leadership, achieving financial balance or addressing a previously unmet service need. There is however an alternative, the option of attempting to change the culture within the organisation to meet these same goals.

There are a vast range of models for understanding organisational culture change which were reviewed by Brown in 1995. His extensive review of the literature identified five main models detailed in Box 1.

Lundberg's model, based on earlier learning-cycle models of organisational change; emphasises external environmental factors as well as internal characteristics of organisations.

Dyer's model, posits that the perception of crisis in conjunction with a leadership change are required for culture change to occur.

Schein's model, based on a simple life-cycle framework; posits that different culture change mechanisms are associated with different stages in an organisation's development.

Gagliardi's model, suggests that only incremental culture change can properly be described as a form of organisational change.

A composite model, based on the ideas of Lewin, Beyer and Trice, and Isabella; provides some insights into the microprocesses of culture.

Box 1: Five Models of Organisational Culture Change (Scott et al., 2003, adapted and derived from Brown 1995).

No model is comprehensive enough to be said to be the definitive blueprint for change processes, but the merits and weaknesses of each are briefly listed in turn:

Lundberg's model

Figure 1 Lundberg's organisational learning cycle of culture change (Lundberg, 1985) and reproduced in Brown (1995).

Lundberg's model (1985) recognises the presence of multiple subcultures that operate within organisations, and at each stage there are various

internal and external conditions that need to be met in order to move round the cycle and for change to occur. It is not possible to go into all the detail that surrounds this model, but Lundberg describes the numerous precipitating events that can spark change (otherwise known as the trigger events) before describing the types of strategies employed by leaders and the different forms of action planning required to bring about change.

Critics (Scott, 2003) suggest that the model is rather mechanistic, failing to fully acknowledge the dynamism and uncertainty between cause and effect in organisational life. It also fails to address the political forces (doctor-managerial tensions) within organisations, or recognise the influence of key individuals and groups in facilitating and resisting culture change (Mannion, 2010).

Dyer's cycle of cultural evolution

Figure 2 The cycle of cultural evolution in organisations (Dyer 1985) and reproduced in Brown, (1995).

Dyer's model (1985) suggests that a crisis paves the way for a culture breakdown within an organisation, which in turn leads to the emergence of new leadership. A power struggle ensues whereby the new leadership has to assert their dominance over the old leadership by being seen to resolve the conflict between to two parties. To aid with this transition the new leadership introduce new values, symbols and artefacts into the organisation to banish the old organisational history. New people are recruited who support the new values and so the new culture is sustained.

One advantage of Dyer's model over many other theoretical models is that its two essential conditions for cultural transformation – crisis and new leadership – are relatively easy to identify and test in organisational settings. There is also a particular focus on leadership in organisational culture and change. However Scott (2003) again criticises the model for oversimplifying the change process, pointing out that the roles of the majority of individuals in an organisational culture are de-emphasised in favour of a focus on innovative leadership. Mannion (2010) mentions that Dyer's model also fails to ask a crucial and rather obvious question about the causes of crises in organisations.

Schein's Life Cycle Model

Figure 3 Growth stages, functions of culture, and mechanisms of change. Reproduced from Schein (1985) and reproduced in Brown, (1995)

Schein's life-cycle model of organisational culture change (1985) suggests that organisations undergo the three distinct stages of birth and early growth, organisational midlife, and organisational maturity.

In the early birth and growth stages the organisation battles with its identity, characterised by revolutionary change and possible challenges to the leadership from individuals from the old culture.

The midlife phase is characterised by deeply embedded values that need be brought to the surface through organisational development to bring about change. Other factors that can precipitate change during this stage however are new technology, scandals (such as the Bristol heart surgery

tragedy/Harold Shipman) and the gradual drip feeding of new ideas by the leadership described by Quinn as Incrementalism (1978).

The final mature stage implies that change would come easily to this type of organisation. In fact the opposite is true, and companies may have to go through large turnaround projects to detour from their well established courses. Leaders are also more likely to need to use coercive strategies for change when more subtle approaches have failed to produce results.

Gagliardi's model

Figure 4 Gagliardi's model: Cultural change as an incremental process (Brown 1995)

Gagliardi (1986) agues that rather than seeing old cultures as totally replaced by new ones, the old ones are merely built upon to incorporate the new values. Leaders will ascribe success to the new ways of doing things despite the fact that the new process might have no connection to that particular outcome.

This model of cultural change is interesting because it embraces the fact that gradual change can happen over time, and that the way that this happens can often be as a result of the way that successful leaders attribute the reasons behind the organisations success to previous decision making, even though those decisions would have made little or no effect on the result.

The Composite model of Lewin, Beyer and Trice, and Isabella

Figure 5 Understanding organisation culture change: three related domains (reproduced from Roberts and Brown (1992)

The final model of organisational change discussed by Brown (1995) is a compilation model based on the ideas of Lewin (1951) as modified by Schein (1964), Beyer and Trice (1988) and Isabella (1990). Essentially the model describes the three stages of learning as freezing- clinging to what one knows, unfreezing – exploring ideas, issues and approaches and refreezing – identifying, utilising and integrating values, attitudes and skills with those previously held and currently desired.

The framework is very general and applicable to any type of organisation and to any level within an organisation. However the model (much like Lundberg's in model 1) paints a very mechanistic picture of change, and it does not recognise the often painful transitions that can to take place moving between the three stages.

This type of planned change model is not without its critics, and Garvin (1994) argues that change cannot occur from one stable state to another in the turbulent business environment that exists today. Bamford and Forrester (2003) suggest that the planned approach assumes that all parties are in agreement on their goals and direction and this is rarely the case. Hayes (2002) highlights that some organisations may have to change initially for environmental reasons but have no desire to define the end state. It serves

then as a fairly limited descriptive tool, and does not attempt to inform as to whether any change programme has been successful or not.

In contrast to planned change, emergent approaches see change as less reliant on the manager (Wilson 1992) and less prescriptive and more analytical in nature (Dawson 1994). Dawson claims that change must be linked to developments in markets, work organisation, systems of management control and the shifting nature of the organisational boundaries and relationships. There is therefore more emphasis on ‘ bottom-up’ action rather than ‘ top-down’ control in commencing and implementing organisational change. Given the need for NHS managers to harness the cooperation of professional staff and work across complex organisational boundaries, emergent approaches are often well suited to achieving change because the role of senior management shifts from a controller to a facilitator.

Personal responses to leadership

In having to reflect on my own leadership style I am immediately presented with a dilemma. The objective of this paper was to deconstruct the established models of leadership (including the NHS Leadership Qualities Framework) and adopt a new approach to leadership that incorporates the situational context and other social factors. I refer back to Dreyfuss & Rabinow, (1982) who encourage us to open up leadership from multiple angles, searching its ‘ small details, minor shifts and subtle contours’ to see it in the context of its environment.

There are at least five major weaknesses to this individualistic approach which have been discussed at length already, so I will not repeat myself here. But essentially by subjecting myself to these established competency frameworks I would undoubtedly be shoehorning myself into a set of constructs that would probably do little to help me establish how best to operate in my individual working environment. To take this thought one step further I would say that the best leaders are therefore the individuals most able to analyse their environment, adapt their interactions and self actualize within that environment appropriately.

In light of the fact that NHS organisations are moving from large highly structured institutions to smaller stakeholder organisations with multiple players, the skills most required to lead will most probably be relational and persuasive. Perhaps then ones ability to interact with others according to model of relational proximity best describes the leaders of the future. This model lists the values needed for effective relationships such as focusing on the quality of the communication process, maintaining relationships, breadth of knowledge, use and abuse of power and valuing similarity and difference. I am again however again inclined to see this model as too prescriptive, and as Bolden mentions earlier lists the characteristics as (a) a somewhat persecutory list of ‘ oughts’, and (b) suggest that the characteristics still do little to get effective leadership done.

As a manager working in a Primary Care Trust I am able to see first hand how the general move towards decentralisation with greater autonomy does seem to be creating a paradox within the organisation. The combined effects of commissioning organisations splitting away from their provider arms and

an increasing move towards an open market has created a more mechanistic approach towards commissioning and providing services. This seems to pull against the other central directive of remaining flexible to meet local need.

Effective leadership for me then and I suspect all working a healthcare environment is to somehow ‘ thread the needle’ by employing on the one hand a mechanistic approach that satisfies the performance management demands from monitoring bodies, while at the same time remaining flexible enough to respond to the changing healthcare marketplace.

Concluding remarks

This paper has set out to demonstrate that the existing emphasis on developing leadership through competency based models such as the Leadership Qualities Framework is a flawed. Less emphasis needs to be placed on individual leaders and more attention paid to the environmental and situational factors that encourage leadership to thrive. The NHS is an organisation dependent on responsible shared leadership. It would not be accurate to attribute its successes and failures to the few as that viewpoint is likely to be an over-simplification of a vast pool of environmental data compressed into a few key people.

Organisational culture change was discussed as a vehicle for introducing new approaches to leadership and the five main models of organisational change as reviewed by Brown in 1995 were summarised and discussed. None of these models were found to comprehensively describe the change process and most could be accused of being rather mechanistic, failing to fully

acknowledge the dynamism and uncertainty between cause and effect in organisational life (Scott, 2003).

The mixed messages distributed by policy makers centrally add to the confusion within healthcare, requesting that workers are both centrally accountable and at the same time expected to work flexibly and autonomously. The argument being then, that it is not possible (or even preferable) to maintain one leadership style in this context.

Further research it seems is required to deepen our understanding of ideal environmental factors that allow leadership to blossom through ‘ bottom-up’ emergent processes as opposed to imposed ‘ top-down’ structural changes and rigid concepts of what constitutes good leadership.