

Effective medical leadership development for a complex NHS

The NHS Leadership Academy in England is investing £46 million in a standardized model of development, with academic qualifications becoming essential in future NHS leadership roles. This represents a cul-de-sac for medical leaders because it is based on a series of misplaced assumptions about health-care leadership and its development.

Since the 1960s the NHS has spent millions of pounds on developing managers, although the exact amount is unknown (Goodwin, 2000). Evaluation of these programmes has been largely anecdotal. A decade ago a major review of the literature on leadership in health care concluded that only 4.4% of the 6628 articles reviewed were based on evidence; the largest proportion of research (41.4%) was purely descriptive of demographic characteristics or personality traits of leaders and only 15.2% included any correlation of qualities or styles of leadership with measurable outcomes for patients or positive changes in organizations (Vance and Larson, 2002).

Over 10 years on, it seems very little has changed. Leadership development works as much through 'generative' causation – creating the conditions where things can emerge, change and move on to destinations as yet unknown – as through 'successionist' causation – achieving predictable and pre-known outcomes through direct linkages between means and ends (Pawson and Tilley, 1997), so it is not easy to measure. Nonetheless, the didactic, course-based qualification route has increasingly become the conventional wisdom for leadership development in health care in the UK, despite emerging evidence of the problematic nature of this direction.

The most recent summary of research on leadership in the NHS (Health Services and Delivery Research, 2013) identified that:

- Traditional 'heroic' leadership models were still dominant, although in practice responsibilities were more distributed and leadership styles more diverse. What leaders did in practice consisted of relationship-building, negotiating complex inter-boundary activity and exercising political skills
- Engaging leadership styles were more predictive of improved organizational performance than leadership based on traits and competences or qualifications which were divorced from the complex realities and context of working lives
- Leaders placed the greatest emphasis on learning from personal experience and that of colleagues in their own community of practice.

So how has this intelligence shaped medical leadership development?

Medical leadership development Unitarist vs pluralist approaches to leadership in health

The leadership programmes mentioned above are firmly grounded in a set of unitarist assumptions (Fox, 1985), which emphasize a single source and locus of organizational control (health-care management), a single identity and loyalty focus (the employing health-care organization) and adherence to a single set of common objectives. Conflict is seen as a rare and transient phenomenon, typically attributed to the activities of troublemakers and deviants. The managerial prerogative is emphasized and this perspective exemplifies the command-and-control approach to running organizations, defined as:

'...regulation by management, with its battery of computer and other informational aids... where decision-making is distant from the work and based on abstracted measures.' (Caulkin, 2007)

The command-and-control approach sees organizations as top-down hierarchies where work is designed in functions, managers make decisions and workers do the work (Seddon and O'Donovan, 2007), and is founded on the metaphor of an organization as a machine (Morgan, 1986).

An alternative pluralist view seems closer to the actual practice of leadership in health care and recognizes diverse interests, seeing health-care organizations as loose coalitions, where some degree of conflict is inherent and ineradicable (and may be positive and functional) (Blackler and Kennedy, 2006). From this perspective a health-care organization is a diverse plurality of power-holders drawing their power from different sources. Effective leaders recognize that sustainable change comes from debate, challenge, persuasion and negotiation – a model of adaptation.

The tyranny of competences

The best example of how such a technical-rational view (Fish and Coles, 1998) predominates is the competence-based approach to leadership (and medical leadership) in

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health care. This has been true since the early 2000 Hay Group consultancy for the NHS in England which led to the Leadership Qualities Framework, then the Medical Leadership Competency Framework, the Clinical Leadership Competency Framework, back to a single NHS Leadership Framework in 2011 and finally a Healthcare Leadership Model in 2013 (Edmonstone, 2011).

This plethora of initiatives and bodies involved embodies a tension between, on the one hand, uniformity, and on the other diversity (a more local, contextual and clinically-based approach). They can also be interpreted as an attempt by senior health-care organizational leaders to exercise and reassert clarity and control – to ‘hold things together’ in the face of the volatile and virtual environments of health-care organizations in the 21st century.

The competency approach contains some very fundamental flaws – it supports and reinforces ‘personality trait’ views of leadership, diminishes leadership to a reductionist set of fragmented skills, focuses on past or current performance and hence has little predictive value, and struggles to take account of situational or complex organizational factors (Swanwick and McKimm, 2011). The notion of a single one-size-fits-all leadership framework applicable to everyone, no matter what their discipline or in what part of the service they operate, has been labelled as ‘ridiculous’, especially when applied to such a large and complex organizational context as the NHS (Vince, 2012).

The current conventional wisdom simply reinforces the unitary model of organizational working and the technical-rational view alone of professional practice.

The nature of clinical leadership

Hartley and Allison (2000) conceptualize leadership from three perspectives – those of person, position and process. ‘Person’ and ‘position’ perspectives focus on the personality and behavioural characteristics of leaders, as well as the formal authority and status conveyed to them by virtue of the role they occupy within an organizational hierarchy. Leadership as a process assumes that leadership is not just about individuals but also about collectives (teams and groups). The emphasis is on social capital – the quantity and quality of the connections and relationships in a system – the active connections between people, where trust, mutual understanding, shared values and behaviours link people, making cooperative action possible (Prusak and Cohen, 2001).

It is also concerned with the cultivation of political ‘nous’ – the ability to scan and read situations, identify patterns, build alignments and alliances, and balance the interests of key stakeholders. The importance of developing such political astuteness is increasingly recognized as a vital skill for individuals and groups in the public sector in general and health care in particular (Centre for Innovation in Health Management, 2006; Manzie and Hartley, 2013).

Clinical leadership has had a strong emphasis on the patient and clinical specialty and is largely based on a combination of ‘personal power’ (credibility, respect, trust, abil-

ity to influence, persuade, debate and negotiate) and ‘expert power’ (knowledge of the clinical condition). Managerial leadership, by contrast, always takes the corporate or organizational viewpoint and is largely based upon ‘position power’ or place in the managerial hierarchy (Malby et al, 2011). These are, in effect, competing ideologies which operate in a degree of tension with each other. Within medicine there is also an interesting distinction between professionalization (through which members guard knowledge and work boundaries) and professionalism (a set of core characteristics which shape how work is done in a professional service). Professionalization is essentially an expert (doing-to) model, while professionalism sees the clinician as a leader of collective effort or doing-with fellow clinical professionals, managers and service users.

Learning the leadership task

Wicked vs tame

The leadership task in the NHS is focused on wicked problems (Rittel and Webber, 1973) not tame (or benign) problems (characterized by predictability, certainty, clarity of the end point). By contrast, wicked problems (or ‘messes’) (Ackoff, 1974) interact with other problems and are part of a set of inter-related problems which cannot be addressed in isolation. They sit outside single professional or occupational hierarchies and across organizational systems. Typically incomplete and contradictory they have none of the clarity of a tame problem. They cannot be removed from their environment, solved and returned without affecting that environment, so are context-specific. Where some form of resolution is possible it may, in turn, even create another problem – so the problem changes over time.

Grint (2010) suggests that in health care there is a tendency for problems to be defined as either critical (a matter of life and death) or tame (a simple repeat of a similar problem), ignoring the wicked problems, or oversimplifying them and inevitably failing.

‘Our learnt instinct is to troubleshoot and fix things – in essence to break down the ambiguity, resolve any paradox, achieve more certainty and agreement and move into the simple system zone.’ (Plsek and Greenhalgh, 2001).

What type of learning for wicked problems?

If learning is closely associated with problem-solving, research has identified four distinct modes in terms of the way in which learning is used (Eraut, 1994) (Table 1).

Addressing wicked problems (increasingly those which health care faces) requires asking appropriate and pertinent questions and engaging in collaborative working with others. In doing so all four modes of learning usage (replicative, applicative, interpretive and associative) are needed and both technical (or explicit) and practical (or tacit) knowledge needs to be used (Polanyi, 1966). The difficulty with the conventional wisdom – competence-based leadership and management qualifications – is that it simply does not foster the kind of learning needed.

Exiting the cul-de-sac

The conventional wisdom is that health care will improve and develop by strengthening the unitarist and hierarchical system further by focusing, through individual-focused and competence-based approaches, on technical-rational matters entirely, recognizing only explicit knowledge and using only replicative and applicative learning. All problems are either crises or tame problems or can be reduced to such and can 'solved'. An alternative view recognizes that health care represents a pluralist system with many differing interests and that to effect improvement involves embracing the professional-artistry approach as well as the technical-rational one – in other words, using both explicit and tacit knowledge and accessing all four learning modes. Rather than competence, it is concerned with developing adaptability – the continuing ability to cope with changing future circumstances, adapting to such changes, generating new knowledge and improving performance. Rather than focussing on the individual, the focus is on the group or team as a means of addressing wicked problems through questioning and dialogue (see *Case study*).

Medical leadership programmes should be wary of the complex dressed up as simple, of the individual *vs* collective approach, and of competences as the solution. Programmes that take real issues and use knowledge and inquiry will lead to more effective medical leadership in the NHS. **BJHM**

Conflict of interest: none.

- Ackoff R (1974) *Redesigning The Future: A Systems Approach to Societal Problems*. John Wiley, London
- Blackler F, Kennedy A (2006) The design and evaluation of a leadership programme for experienced chief executives from the health sector. In: Rigg C, Richards S, eds. *Action Learning, Leadership and Organisational Development in Public Services*. Routledge, Abingdon: 79–100
- Caulkin S (2007) Command, control ... and you ultimately fail. *The Observer* 12 December (www.theguardian.com/business/2007/dec/16/2 accessed 29 July 2014)
- Centre for Innovation in Health Management (2006) *What really works: an exploration of what a sustainable, high-performing healthcare organisation looks like*. Centre for Innovation in Health Management, University of Leeds, Leeds
- Edmonstone J (2011) The challenge of capability in leadership development. *Br J Healthcare Management* 17(12): 541–7
- Eraut M (1994) *Developing Professional Knowledge and Competence*. Falmer Press, London
- Fish D, Coles C (1998) *Developing Professional Judgement in Health Care: Learning Through the Critical Appreciation of Practice*. Butterworth-Heinemann, Oxford

- Fox A (1985) *Man Mismanagement*. Hutchinson, London
- Goodwin N (2000) The national leadership centre and the national plan. *Br J Healthcare Management* 6(9): 399–401
- Grint K (2010) The cuckoo clock syndrome: addicted to command, allergic to leadership. *European Management Journal* 28(4): 306–13 (doi: 10.1016/j.emj.2010.05.002)
- Hartley J, Allison M (2000) The role of leadership in modernisation and improvement of public services. *Public Money and Management* 20(2): 35–40
- Health Services and Delivery Research (2013) *New evidence on management and leadership*. Health Services and Delivery Research Programme, National Institute for Health Research, University of Southampton, Southampton
- Malby R, Edmonstone J, Ross D, Wolfenden N (2011) Clinical leadership: the challenge of making the most of doctors in management. *Br J Hosp Med* 72(6): 341–5
- Manzie S, Hartley J (2013) *Dancing on ice: leadership with political astuteness by senior public servants in the UK*. Open University Business School, Milton Keynes
- Morgan G (1986) *Images of Organisation*. Sage, London
- Pawson R, Tilley N (1997) *Realistic Evaluation*. Sage, London
- Plsek P, Greenhalgh T (2001) The challenge of complexity in health care. *Br Med J* 323(7313): 625–8
- Polanyi M (1966) *The Tacit Dimension*. Routledge and Kegan Paul, London
- Prusak L, Cohen D (2001) How to invest in social capital. *Harv Bus Rev* 79: 86–93
- Rittel H, Webber M (1973) Dilemmas in a general theory of planning. *Policy Sci* 4: 155–69
- Seddon J, O'Donovan B (2007) Why aren't we all working for learning organisations? *Organisations and People* 17(2): 18–23
- Swanwick T, McKimm J (2011) What is clinical leadership... and why is it important? *Clin Teach* 8: 22–6 (doi: 10.1111/j.1743-498X.2010.00423.x)
- Vance C, Larson E (2002) Leadership research in business and healthcare. *J Nurs Scholarsh* 34(2): 165–71 (doi: 10.1111/j.1547-5069.2002.00165.x)
- Vince R (2012) The contradictions of impact: action learning and power in organisations. *Action Learning: Research and Practice* 9(3): 209–18 (doi: 10.1080/14767333.2012.722356)

Case Study: The Leeds Medical Senate

Recognizing the problems stated above and the need for medical leaders to learn to do the difficult work of leading together across organizations to work on complex problems, the Leeds Medical Senate Development Programme was established funded by the NHS and provided by the Centre for Innovation in Health Management at the University of Leeds. The programme for the 26 most senior medical leaders in the city developed a real understanding of the context based on the medical leaders' multiple viewpoints, used current issues and problems as the currency of learning, generated through ideas and experience a shared approach to change, and has led to the establishment of the Leeds Institute for Quality Healthcare to re-balance the health system in Leeds from the technical-rational model of performance management, compliance and regulation to a more adaptive professional model of change and innovation through evidence and peer review.

KEY POINTS

- Medical leadership programmes should draw on a pluralist model of leadership, developing adaptive leadership capability through the use of current issues facing medical leaders in health systems.
- The competency model will not deliver effective medical leadership.
- Medical leaders should not be seduced into reducing complex issues into simple predictable solutions that are amenable to reductionist models of management.
- Professional leadership requires inquiry and tacit knowledge.

Table 1. Modes of learning use

Replicative	For use in situations which are routine and which call for little use of any personal discretion
Applicative	Where the emphasis is on translating learning into particular prescriptions for action in a range of different situations and occasions
Interpretative	Comprising both understanding and judgement
Associative	Learning in a semi-conscious and intuitive way and involving the use of metaphors and images