Leadership in systems, organizations and cultures

This article reviews the complex nature of health systems, organizations and cultures, and suggests that a nuanced understanding of these is important to thinking about leadership and change.

This article reviews some of the principal debates surrounding the ideas of organizational culture, leadership and change as they relate to the NHS, to make explicit the complex and contested nature of these ideas. As austerity impacts upon the NHS, the variations between devolved authorities and between clinical commissioning groups make it increasingly difficult to talk about a single and uniform NHS (Klein, 2007, 2013; National Audit Office, 2012), let alone prescribe a model of change or of leadership appropriate to the whole organization. Instead, the authors argue that all health-care practitioners have a responsibility for the future of the NHS. In our actions and inactions, we shape the institutions in which we work. Recognizing the importance of individual agency and responsibilities is as much about innovation and leadership as it is a response to the Francis Inquiry (2013).

The authors first review the complex environment in which health-care practitioners work before questioning the idea of top-down understandings of policy and organizational change. Studies of implementation problems in other public services emphasize the unintended consequences of change. Austerity adds a further level of complexity in the different responses to the financial pressures that are to be found in public service agencies. In this context, of increasing variation and complexity, the article then explores the impact of the Francis Inquiry and argues that a greater emphasis on thinking about change and about leadership should be placed upon the individual and his/her scope to influence and to act. Far from there being an implementation science, the authors suggest that health-care practitioners all need to take responsibility for shaping the NHS of the future.

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On complexity in systems

Changes in the NHS over the past 30 years can be interpreted from a number of different perspectives. There are arguments about efficiency and about improving quality, but there is also a clear succession of efforts to change the ways in which professionals make decisions.

Griffiths (1983) sought to constrain discretion by introducing management to hospitals. The 1989 reforms (Department of Health, 1989) sought to strengthen management and, at the same time, extend the influence of primary care in decision making. Many of the reforms of the New Labour era may be understood in a similar light, with the idea of commissioning emerging as its clearest expression (Klein, 2006). The days of the hospital administrator, as caricatured in *Yes Minister*, are long gone. However, with freedoms and managerial autonomy have come central concerns with quality and standards.

In one sense, the lingering presence of bureaucratic thinking can be felt in Performance Assessment Frameworks and other forms of monitoring and audit (Power, 1994; Department of Health, 2000). This tendency, to speak of freedom to make decisions, of choice and, more recently, of personalized medicine, is overlaid with a heavy coating of scrutiny and evaluation that, in practice, can stifle precisely these ideas. Policy innovations have begun to emerge in the devolved administrations. Variations in long-term care, in priorities and in the role of the private sector offer the potential for policy learning and transfer. In practice, variation has become politicised, perhaps particularly in Wales, as any variation in standards that arise as a consequence are scrutinized.

These differences, in outcomes and in systems, find echoes in the many different responses to austerity and to changing pressures and priorities in regions and localities across England. Consequently, it is difficult to argue that the NHS is a single national service. Rather, it is a complex web of institutions and relationships, shaped by local forces and people responding to external policy stimuli in very different ways (Klein, 2006; National Audit Office, 2012).

In this confused context, *Equity and Excellence: Liberating the NHS* (Department of Health, 2010) established clinical commissioning groups with responsibility for the health care of communities and 80% of the NHS England budget (Barr, 2014). This is in marked contrast to Northern Ireland, Wales and Scotland, where care is provided through regional health boards and where primary and secondary care is integrated at a local level (National Audit Office, 2012). Although political and operational responsibility for health care lies with four national executives, regulatory bodies such as the General Medical Council and the Nursing and Midwifery Council remain organized on a UK-wide basis, as are the professional bodies, aggravating the complexities of structures and systems that health-care professionals work within.

On unintended consequences

However, throughout the past 30 years, and in contrast to the first 30 years of the NHS, one thread that has remained consistent has been change. Organizational forms and boundaries have changed at a bewildering rate. Scarcely has one change been launched than the next is announced. For all the language of evidence, of evaluation and of learning, one obvious message all too often escapes those in positions of power. Policy rarely, if ever, achieves the intended outcome. In studies of policy implementation, this is well understood (Hogwood and Gunn, 1984;

Hill and Hupe, 2012). Indeed, the problem is well expressed in the extended title of Pressman and Wildavsky's (1973) classic text on the subject. Beyond the sense of disappointment this title expresses, it misses the unintended consequences of change and, in particular, of changes overlaid upon changes. Indeed, one might see the NHS not so much as a system but as the outcome of a concatenation of unintended consequences (Klein, 2006; Timmins, 2012).

And austerity

These complexities are compounded by external drivers, especially economic ones. In an effort to address health inequalities, real term spending on the NHS increased significantly during the Blair government (Barr, 2014). For many managers in the NHS, as in all other public services, this experience of growing budgets and investment is all they have known. This growth concealed some of the pressures that were emerging, pressures associated with an ageing population and rising demand. (Grant et al, 2012). But how to manage these pressures with a declining budget? How to maintain services and innovate with less? These are the key questions that austerity is asking of managers and leaders in the NHS today.

We can begin to identify a number of different ways in which organizations are responding to the crisis that straitened financial times provokes. These responses echo those observed during the 1970s, particularly in American cities, and research into those experiences proves instructive in analysing the situation in different NHS institutions (Behn, 1980). Aside from the obvious pressures on organizations, cuts produced unanticipated consequences across organizational and service boundaries as withdrawal of one service exerted pressure elsewhere. Flexibility and the ability to cope with these pressures were constrained just as they were most needed, always affecting the poorest most severely. Just as innovation becomes essential to meet these challenges, those ideas that emerged were starved of resources in overcommitted organizations (Biller, 1980).

As well as innovation, it became fashionable to talk of leadership at this time. Glassberg (1978) identified three types. The first, the 'cut the fat tough guy', will be familiar to many today. He/she is focused on the financial demands, changing services and reaching decisions using accounting technologies, treating individuals, whether staff or patients, as numbers to be balanced. The second leader, the 'receiver in bankruptcy', seeks to scale down the organization smoothly, upsetting nobody and avoiding difficult choices, a balancing act that can feel like aimless drifting with the only hope being an external change, whether economic or political. It is the third, the 'revitalising entrepreneur', that government ministers and senior officials visualize as they talk of developing leaders in the NHS. These are the leaders who exploit the situation to drive through ideas that, in easier times, seemed unnecessary or ones that could be introduced at leisure.

More recently, Boyne (2004, 2006) has drawn lessons on organizational turnarounds from the private sector. Three strategies are:

- Retrenchment: withdrawal from some markets or contraction by reducing activity or selling assets
- Repositioning: becoming more dominant in existing markets or by diversifying into new ones
- Reorganization: planning, (de)centralisation, human resource or cultural change initiatives.

After 30 years of public service reform that has emphasized competition, these responses will also be familiar to many in the NHS. But, despite leadership frameworks and the like, there is no single direction or sense of purpose. Rather, there is divergence and confusion.

And on cultures

The Francis Inquiry report (Francis, 2013) throws some of these tensions and dilemmas into sharp focus. The management of a trust had become much like the management of other organizations. Decisions were made remotely, on the basis of reports and of numerical data. Presenting these data to external audiences in the best light, partly in order to achieve foundation trust status, was a central concern for the senior team.

In theory, their ambition to develop the trust was built upon an organization that was performing well, with an emphasis on process as opposed to patient outcome (Barr, 2014). But, beneath the abstract data, standards of care were not what they should have been. Pressures and priorities that were abstract at a senior level were very real on wards and in specialist teams. Indeed, one might interpret aspects of the report as indicating that, because the internal language of decision-making was largely about data and information, the patient had long since ceased to be a focus of concern, but was a unit to be processed in a way that could be presented numerically to external audiences. That is to say, a culture developed that is alien to most people's understandings of the NHS. And while it is atypical, it is not a unique case. Indeed, Boyne (2004, 2006) would recognize the familiar strategies he observed in private organizations.

We can sometimes speak about culture as if it is homogenous. Francis illustrates very clearly that there is no one NHS culture. Indeed, the report also illustrates, along with the work of others (e.g. Schein, 1996), that there are different cultures within hospitals and other organizations. Practitioners will recognize these differences in their encounters with staff as they go about their daily duties. Some units and teams are open and helpful where others, performing similar duties, are obstructive. Different professions tend to exhibit different behaviours, developing professional silos and tribes (Francis, 2013). If we add into the mix the impact that austerity is having, it becomes clearer that to speak of culture is to miss the many cultures and micro-climates to be found in large organizations, such as hospitals.

On agency

However, this places the emphasis on structure. Yes, the professions are different. Performance targets do affect our behaviours. We are constrained by institutional systems and processes. But we need also to recognize the scope for our own agency, together with others around us. Research consistently demonstrates the degree to which individuals talk of their lack of choice and of the constraints they experience while exercising discretion routinely (Lipsky, 1980; Schon, 1983). The emphasis on structure tends to suggest that individuals are powerless to

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affect the nature and the quality of the service they provide. Observations in public service and other institutions demonstrate the degree to which they actually define the service received in the way they exercise their discretion (Maynard-Moody and Musheno, 2000; Lea, 2008; Watkins-Hayes, 2009; Dubois, 2010; Evans, 2010). We even encounter programmes that are officially bound by rules and structures which, on closer inspection, are the product of local custom and practice rather than any externally imposed requirements (Rowe, 2002).

We should acknowledge not just that we do make decisions and exercise discretion. We must also recognize that it is our actions that make structures. Organizational structures are not embodied in buildings but in the behaviours of people. The Francis Report (2013) criticized health-care professionals' failure to deliver appropriate care and called for the re-establishment of professional behaviours, values and attitudes conducive to a caring environment. Likewise, the report calls for a culture in which the public and patients will both expect and receive transparency and candour. Higher education institutions are now being directed towards the integration of core values including care and compassion within undergraduate health-care curricula.

On the science of improvement

It is in this environment of opacity and confusion that government reform efforts seek to impose order. Indeed, government policy assumes there is an order in the first instance and that it can be altered. Manifestations of this sense that change from above can be engineered are to be found in some of the ideas emerging from the Behavioural Insights Team at the Cabinet Office (see, for example: Behavioural Insights Team, 2012) and, in health, in the work around the ideas of improvement science (e.g. Shojania and Grimshaw, 2005; Berwick, 2008; Lobb and Colditz, 2013; Nilsen et al, 2013).

These differing approaches to understanding and seeking to influence change share a common strand: the sense that, if only the right mechanisms, incentives or combination of pressures could be discovered, then we might hope to see improvements. At the heart of their frustration are the professionals and public servants who, despite the evidence, stubbornly continue to do the wrong things. If only they could be changed.

Conclusions

The authors would rather turn to the idea of the 'revitalising entrepreneur' as a leader in the current climate, in contrast to this technocratic vision of change or more conventional styles of leadership. The authors believe that the Francis Inquiry report underlines the need for leadership at all levels and in all professions in the complex worlds of NHS institutions. This echoes the conclusions of Lord Darzi (Department of Health, 2008) who advocated for a model of distributed leadership, based on inclusivity and with the patient at the centre of decision-making processes.

The dilemma for a large scale bureaucratic organization like the NHS is the culture shift required at every level of the organization. Whether challenging poor practice, responding to emerging policy agendas or commissioning in new and more imaginative ways, the actions of many thousands will constitute the NHS that emerges in the coming years. Making those actions conscious and reflective ones, choices to act in particular ways, will be an innovation in itself, and one from which change will emerge. The need here is for leaders, throughout the many organizations and cultures that constitute the NHS, who will actively engage in the process and be prepared to give their 'emotional labour' (McKimm and O'Sullivan, 2013). It also requires an expansive structure in which leadership is encouraged within the many complex and adaptive systems in which health-care professionals work (Fraser and Greenhalgh, 2001). **BJHM**

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KEY POINTS

- Leadership in large and complex systems, such as the NHS, needs to come from the top, bottom and middle.
- Health-care practitioners need to be alive to the enablers, opportunities, points of resistance, structures and cultures in which they operate.
- Culture often operates as a barrier to change.
- In every crisis, there are also opportunities to review current practices and to make changes that, in easier times, would not be considered.

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