Leadership in learning organizations: a strategy for improvement

The learning organization is a potential framework for managing transformational culture change and delivering high quality health care. It helps to shift the focus from the development of individuals as leaders to one which takes a 'whole organization' approach.

Developing the leadership capabilities, skills and appropriate behaviours of the whole health workforce is vital (NHS Leadership Academy, 2013). However, the gap between the skills possessed by leaders and the skills required is hampering current service delivery (Leslie, 2015). There is a deficit in leaders' ability to manage strategic change, lead employees and establish their organizations as part of a 'learning organisation' (Senge, 1990). Without rectifying this deficit, NHS services and their leaders will continue to face overwhelming challenges to the provision of sustainable high quality health care. Embedding a culture of collective leadership is deemed to be vital for the future of health-care organizations (West et al, 2014).

All organizations are potentially vulnerable. Particularly because of its size, complexity, fragmentation and the stakes at play, being aware of and mitigating these vulnerabilities are of paramount importance within the NHS. Over the last few years, a number of factors have been repeatedly identified through inquiries, reports and in the media. In a number of health-care settings major failings in care have been identified despite hardworking, uncomplaining and dedicated staff (e.g. Francis, 2013; Keogh, 2013; Andrews and Butler, 2014; Kirkup, 2015; Mazars, 2015). Levy suggests that when 'good teams go wrong' the Nut Island effect occurs with a disconnect between a dedicated cohesive team and a distracted cohort of senior managers and executives (Levy, 2001; McKimm et al, 2015). He concludes:

> **'when good people are put in a situation in which they inexorably do the wrong things, it is not normal or unavoidable. It is tragic. It is a cruel waste of human passion and energy, and a deep-seated threat to an organisation's mission and bottom line' (Levy, 2001).**

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In the current political and economic climate, the NHS faces a real and unprecedented danger of progressing rapidly beyond its current deficit towards a toxic environment steeped in resentment and distrust. Avoiding this scenario and rectifying relationships between health professionals and others is paramount, and the NHS requires a comprehensive and systemic approach to the development of value-based leaders who can rejuvenate organizational culture. Revisiting Senge's (1990) concept of the learning organization provides a potential framework for managing transformational culture change and delivering high quality health care, and helps shift the focus from the development of individuals as leaders to one which takes a 'whole organization' approach.

What is a learning organization?

Learning organizations (Senge, 1990) are designed and managed to promote effective learning through a systems-based, highly connective approach. From this perspective, incidents result from a complex array of interconnected and interdependent components and relationships rather than being isolated chains of linear, cause-and-effect relationships (Senge, 1990; Iles and Sutherland, 2001). While a system-based approach is becoming more widespread in the NHS, it is often limited to individual micro-environments rather than at a macro-organizational level where the whole organization is constructed in such a way to facilitate this style of learning and adaptability.

Indeed, a 2016 report into the sudden closure of an English psychiatric hospital noted that the 'current organisation of the NHS is a factor…, relationships between the various groupings are both complex and fragmented …, all the agencies involved focussed on their particular role without sufficient attention to the big picture'. This was summarized as a 'lack of strategic grip' (Ransford, 2016).

In order to ensure safe, high quality and sustainable integrated social and health care within budgetary constraints and constant structural change, leaders should aim to instil a culture of organizational learning. This begins internally, through developing the three core levels of learning that can occur within an organization (*Table 1*) (Argyris and Schön, 1978) and then looking outwards for fresh perspectives, applying these to the 'five pillars' of a learning organization.

The five pillars of a learning organization

Personal mastery

> **'the discipline of continually clarifying and deepening personal vision, of focusing energies, of developing patience, and of seeing reality objectively' (Iles and Sutherland, 2001).**

Sound technical knowledge of both the industry and leadership is required to effect organizational change. However, developing personal mastery to lead effectively often expands beyond theory and is more about the leader's internal 'action logic' and the application of this, supplemented by regular feedback, reflection, and greater awareness of themselves and the wider world (Rooke and Torbert, 2005; Warner, 2015). Rooke and Torbet (2005) identify 'seven transformations of leadership' reflecting different action logics:

1. Opportunist
2. Diplomat
3. Expert
4. Achiever
5. Individualist
6. Strategist
7. Alchemist.

Progressing through these stages can be accelerated by activities such as promotion to more senior roles, structured developmental interventions, seeking new perspectives, and developing new relationships with those at a more advanced stage (Rooke and Torbert, 2005).

Progressing beyond different action logic stages requires different approaches to development and practice which echo that of 'vertical leadership', whereby personal mastery is attained through advances in more interdependent styles of complex, systemic and strategic thought (Petrie, 2014; Till et al, 2016). Development in vertical leadership involves three key components: heat seeking 'stretch' experiences, exposure to colliding perspectives and elevated 'reflective' sense-making opportunities. Engagement outside the organization and context is important, not just to acquire new skills and knowledge but also to explore possibilities for the breakthroughs required for organizational learning. This requires new ways of thinking and exposure to different mental models.

Mental models

> **'the discipline of working with mental models allows individuals to unearth the assumptions and generalisations that influence their understanding of the world and shape how action is taken' (Iles and Sutherland, 2001).**

This is critical within modern health and social care and, according to the Institute for Healthcare Improvement, the delivery of value-based health care relies on four particular models to promote innovative practice:

1. Individuals and families should be partners in their care
2. Organizations should compete on value and continually strive to reduce operating costs
3. Services should be reorganized and aligned with payment systems
4. Everyone should be valued and developed as an improver (Swensen et al, 2013).

Modern health-care leaders are trying to navigate their service through the volatile, uncertain, complex and ambiguous challenges that the NHS faces and shape organizational cultures to reflect these mental models. If mental models and assumptions are not challenged, organizations will carry on as they always have. Such deeply held assumptions and ways of seeing the world are great barriers to effecting change, but if corrected, are one of the areas of organizational learning which can make the most significant impact (Magzan, 2012). For good leaders, personal commitment to these new models should not be challenging. However, sharing and instilling these throughout the leaders' organizations requires a considered strategy, and central to this will be the leader's ability to hold reflective conversations, reframe assumptions, embody these mental models through his/her own behaviour and actions, and build a shared vision.

Table 1. Levels of organizational learning

Single-loop	Incremental change, through adaptive learning, improves the status quo by narrowing the gap between desired and actual conditions. In these situations, the fundamental objectives and processes rarely change, with attention focused on error detection and correction. In clinical practice this might be through completed audit cycles
Double-loop	Transformational change, through generative learning, changes the status quo by challenging existing assumptions and conditions. In these situations, the fundamental objectives and processes are often redefined. In health service delivery this is would apply to service innovation and redesign
Deutero-learning	Change, through meta-learning, is a third distinct process directed towards the learning process itself. In clinical practice this is rarely observed, but where present, involves sharing the lessons learned from one service throughout the organization to improve both single- and double-loop learning

From Argyris and Schön (1978)

Building shared vision

> **'the discipline of unearthing "shared pictures of the future" that foster genuine commitment and enrolment rather than compliance, encouraging people to excel and learn' (Iles and Sutherland, 2001).**

The delivery of high quality health care depends on the skills, commitment and compassion of empowered staff who should be guided to develop appropriate mental models and provided the opportunity to influence the future of their organizations through continual quality improvement (Department of Health, 2010; Ham, 2014).

KEY POINTS

- A 'learning organization' minimizes traditional hierarchies, helps to deliver high quality health care and prevents well-intentioned individuals producing adverse events.
- The NHS requires a comprehensive and systemic approach to the development of value-based leaders with a systems perspective.
- Focused on personal qualities rather than technical skills leaders must be fostered, harnessed and developed at an organizational level.

Integral to achieving this is unearthing a collective vision for the organization. An example of this is the Listening into Action initiative which helps to engage and support staff to address their own service challenges rather than imposing solutions on them. Embracing the mental model that everyone should be valued and developed as an improver, a groundswell of engagement and staff-led change for the benefit of patients and themselves begins (Forbes, 2012). Rolled out to over 100 NHS organizations, Listening into Action engages staff in a big conversation, with large-scale executive-led events to discuss barriers to effective service provision, existing areas of excellence, and priority areas for improvement. With executive support, staff-led teams then prioritize feedback and lead change.

Listening into Action fundamentally shifts the way in which organizations work and lead. It helps establish two-way communication between the board and frontline service providers in such a way that fosters genuine commitment and a shared vision for the organization. If organizations are the 'jungle gyms of learning opportunities' (Warner, 2015) then Listening into Action is one approach to create an appetite where people want to 'play'.

Team learning

> **'the discipline that builds the capacity of team members to suspend assumptions and enter into a genuine thinking together. It also involves learning how to recognise patterns of interaction in teams, such as defensiveness, that undermine learning' (Iles and Sutherland, 2001).**

Recognizing the importance of harnessing and combining the ability of teams to navigate a successful outcome, the aviation industry has pioneered safety improvements for several years. Designated mandatory programmes for pilots and crew, such as crew resource management, focus on 'non-technical skills', including situational awareness, decision making, communication, team-work, personal resource and leadership, to improve team working (Flin et al, 2002). Based on the latest evidence and adverse events, crew resource management uses 'double-loop' learning and specifically provides personal, social and cognitive training to improve and minimize negative effects of the organizational climate on team performance (Flin et al, 2002). Training in these non-technical skills is becoming widespread in other high-reliability environments, including clinical medicine (Yule et al, 2006).

Careful consideration should be given to extending its more formal integration into organizations and clinical medicine as a whole (Kemper et al, 2016; McCulloch, 2016) as such team-based training and learning, when combined with quality improvement science, and the remaining pillars of a learning organization, can also help underpin major organizational change.

Systems thinking

> **'the fifth discipline that integrates the other four, fusing them into a coherent body of theory and practice' (Iles and Sutherland, 2001).**

Appreciating the complexity of individual components and their multitude of interactions is vital within many industries, but particularly within 'safety-critical industries' such as the NHS where failure can lead to the loss of life. To safely deliver high quality health care there must be wider appreciation that underlying systems errors should be identified and rectified to reduce errors and develop organizational learning; it should no longer be a case of identifying who is to blame, but why it happened at all and how to make sure that it never happens again (Darzi, 2015).

Leaders with first-hand knowledge of the reality of the system, at both a national and frontline level, are needed to evoke cultural change whereby a continual ethic of learning and quality improvement science are adopted:

> **'The most powerful foundation for advancing patient safety in the NHS lies in its potential to be a learning organisation…. collaborative learning through safety and quality improvement networks can be extremely effective… and the best are those that are owned by their members, who determine priorities for their own learning' (Berwick, 2013).**

Developing future leaders

Continuing professional development is well established in health care and, for doctors, has undoubtedly been strengthened through the introduction of revalidation (General Medical Council, 2012). However, to implement the five pillars of a learning organization, leaders must ensure that learning is expanded beyond individuals and is fostered, harnessed and developed at an organizational level. This enables learning organizations to maximize, mobilize and retain this learning potential for substantial quality improvements (Davies and Nutley, 2000).

When looking to develop the next generation of health-care leaders we must recognize that technical mastery, while once considered one of a leader's most important competencies, is no longer prioritized to the same degree (Van Velsor and Wright, 2015). Personal qualities are now considered the most important element with even the most junior employees being capable of finding themselves to be 'exemplary leaders' (NHS Leadership Academy, 2013).

Leaders must themselves understand, embody and model the core leadership behaviours expected (NHS Leadership Academy, 2013) with the appropriate openness, risk taking and reflection necessary for learning (Iles and Sutherland, 2001). This leadership approach actively nurtures a strong collective leadership culture of open innovation throughout organizations which, as far as possible, should operate within flattened structural hierarchies (West et al, 2015). Minimizing traditional hierarchical limitations facilitates engagement and team working as employees feel more empowered to network across organizational boundaries, to take risks, innovate and learn from their mistakes. Supported with appropriate guidance, and real time information systems to support the implementation of quality improvement science, leaders will enable their employees to become the creators and users of organizational learning as they acquire and share new knowledge and skills (Iles and Sutherland, 2001).

Conclusions

Personal qualities, rather than technical skills, are increasingly valued for high quality leadership within health care. They play a central role within learning organizations, which themselves must be enhanced, to help prevent well-intentioned individuals producing adverse events, and perverse operational and commercial results (Davies and Nutley, 2000; Levy, 2001). To deliver sustainable, high quality health care, within economic and political restraints, we must not focus solely on developing talent for the individual's own benefit, but for the wider progression of the organization to which they belong and the health and social care system as a whole. **BJHM**

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