Vertical leadership in highly complex and unpredictable health systems

This article explores how the concept of vertical leadership development might help health organizations cope with and thrive within highly complex and unpredictable health systems, looking at concepts of VUCA (volatility, uncertainty, complexity and ambiguity) and RUPT (rapid, unpredictable, paradoxical and tangled).

Leadership development continues to be increasingly recognized as being of vital importance for the future of health care (General Medical Council, 2012; Rose, 2015). Over recent years, various strategies have been employed at national and local level to increase and improve medical leadership; however, the most effective means to do so continues to be debated. Great progress has been made in recognizing that, rather than individual heroic leadership, systems thinking is required in which leadership is considered to be a process, not vested in individuals. However, considerable evidence suggests that poor leadership still exists which contributes to poor quality care (The King's Fund, 2011; Care Quality Commission, 2015). The numerous incidences of failings (sometimes even in basic health care) indicate that many existing strategies are less than adequate, and in some cases they are failing service users and health workers (Francis, 2013; Keogh, 2013; Mazars LLP, 2015). In this context, it is timely to explore different approaches to developing medical and clinical leaders who are operating in an increasingly complex and unpredictable environment.

A VUCA and RUPT world

Meeting the demands of modern health care requires leaders capable of understanding and overcoming volatility, uncertainty, complexity and ambiguity (VUCA). VUCA is a military acronym that has been increasingly adopted within numerous settings, including health care. It describes and suggests strategies for addressing the environmental challenges that leaders face. These concepts are introduced here to provide a simpler framework for action than that of (for example) complex adaptive leadership (McKimm and Till, 2015).

The term VUCA comprises four distinct characteristics – volatility, uncertainty, complexity and ambiguity – which must be considered each with their own unique leadership approach (Bennett and Lemoine, 2014) (*Table 1*).

In a VUCA world, which health care, and particularly the NHS operates within, leaders must be developed who are capable of understanding these challenges and adopting these approaches.

Progressing from the concept of a complex VUCA world, in order to more readily connect the current environment with the leadership required, the Centre for Creative Leadership has introduced the concept of a RUPT environment, one that is rapid, unpredictable, paradoxical and tangled (Magellan Horth, 2016a).

- Rapid: leaders face overlapping challenges, in multiple domains, which occur and should be overcome at pace
- Unpredictable: leaders face unexpected challenges, which despite thorough strategies and governance, can rapidly challenge assumptions and cause us to reframe our thinking
- Paradoxical: leaders face challenges in polarity. Rather than providing one solution, challenges should be embraced as polarities to be leveraged both in the short and long term
- Tangled: leaders face interdependent challenges across and beyond the boundaries of their system.

Within this often chaotic environment, rapid and unpredictable paradoxes are embedded in tangled multi-causal relationships. In order to work effectively in these contexts, leaders must develop (within themselves and their organizations) 'learning agility', where the majority of learning occurs within developmental experiences designed around real-life RUPT challenges. Learning agility is the single best predictor of long-term leadership success and without this leadership either freezes or becomes derailed from its strategy through subjective reactionary responses to the challenges faced (De Meuse et al, 2010; Magellan Horth, 2016b). This approach echoes aspects of adaptive leadership (Heifetz, 2009), resilience and Senge's 'learning organisation' (Senge, 1990).

Developing effective leadership within this VUCA and RUPT world is one of the greatest challenges that modern health care faces. One way of addressing this is by adapting the current approach to developing leadership

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Table 1. VUCA characteristics and approaches

	Characteristics	Approach
Volatility	Leaders face challenges that, while not necessarily hard to understand, may be unstable, unexpected or last for an unknown duration	Leaders should prepare supplementary resources and mitigation in all domains, financial performance, intangible performance and leadership, according to the extent of registered risk
Uncertainty	Leaders face challenges where the basic cause and effect are known but the lack of supplementary information shrouds the change management process	Leaders should invest in information systems and predictive analytics to collect, interpret and share information to reduce uncertainty
Complexity	Leaders face challenges with a multitude of interdependent variables across and beyond the boundaries of their system	Leaders should optimize and develop resources with the structure and specialism to address the complexity
Ambiguity	Leaders face challenges of 'unknown unknowns' where there are unclear relationships between cause and effect	Leaders should firmly embed systems of quality improvement throughout the organization to test hypotheses, learn and spread sustainable change according to strategic objectives

adapted from Bennett and Lemoine (2014)

talent. A way forward may be through a combination of vertical leadership development, considering the role of followership and promoting collective and transformational leadership, as discussed next.

Vertical leadership

The concept

Conceptualized through the analogy of a cup filled with water, Nick Petrie (2014) at the Centre for Creative Leadership introduced the concept of 'horizontal' and 'vertical' leadership development, considering 'the cup' as a leader's mind, and 'the water' as his/her knowledge.

Petrie argues that existing leadership development is flawed as it primarily concentrates on pouring more water into the cup, i.e. more knowledge into an existing mind. This is horizontal leadership development. In health care and the clinical environment, this predominantly occurs through ill-defined osmosis or completion of standalone programmes designed to introduce new models, tools and techniques. When these occur in isolation and in an uncoordinated manner, such strategies struggle to develop adaptive and sustainable leadership within the VUCA world.

Taking the metaphor further, while we must not cut off the water supply, in order to develop the strength and quality of leadership that we require, leadership development must not focus solely on imparting knowledge and skills. In addition to providing systematic and focussed horizontal development, vertical leadership development should also be introduced. This involves leaders undergoing a more in-depth and complex developmental journey to expand the size of their individual 'cup' or leadership capacity and capabilities. Petrie suggests that through vertical development, leaders will develop their minds to a higher cognitive level, which will enable them to adapt and think in more complex, systemic, strategic and interdependent ways.

The process

During the process of vertical leadership development, rather than a singular event, similar to a child's early developmental years, a leader's habitual routines and thinking styles are tested, refined and solidified. With three primary conditions – 'heat experiences', 'colliding perspectives', and 'elevated sense making', interwoven in a longitudinal balanced process – leaders of any stage can reach their next developmental level to fulfil their potential (Petrie, 2015).

Heat experiences

Heat experiences are opportunities that disrupt a leader's habitual thinking and should be designed, within the leader's competency levels, to stretch the leader beyond his/her comfort zone and into new, more advanced models of thinking. Examples of heat experiences might be leading a difficult meeting, taking on a challenging or new project, or working with a very diverse multidisciplinary team. The heat experience is a situation that leaders put themselves in to provide a way of developing new skills and understanding.

Colliding perspectives

Colliding perspectives occur within heat experiences to develop the leader's thinking further. Ideally, these should focus on exposure to professionals and others with different views, backgrounds and thinking. This is vital within health care where leaders often interact with wide-ranging multidisciplinary teams across organizational boundaries. As in inclusive leadership which celebrates and welcomes diversity, it is important for the leader to be willing to listen to others' views and opinions, to be challenged, to take on board ideas that differ from his/her own and to be willing to adapt and change. Such an approach requires emotional intelligence, in particular

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self-insight and self-regulation (Goleman, 1995), and an understanding of unconscious or cognitive biases.

Elevated sense making

Elevated sense making should incorporate time for reflection, coaching, mentoring and professional conversations. This allows for greater development and integration of the learning from heat experiences and understanding gained from colliding perspectives. Used effectively this develops a wider and more in-depth view of people, organizations and systems. This part of the process is all about the ‘so what?’ component of reflective practice, it requires the leader to make meaning and sense of his/her own role within the more complex system. Ideally this should lead to identification of learning needs including further heat experiences, knowledge and skills.

The outcome

Similar to that of the NHS Healthcare Leadership Model, rather than leadership pertaining to meeting competencies with increasingly senior hierarchical positions, vertical leadership expects individuals to grow at different rates, with some expressing exemplary skills and behaviours earlier than others (NHS Leadership Academy, 2013; Petrie, 2015). If the three primary elements of vertical leadership can be embedded early and systemically into training alongside appropriate horizontal leadership, health-care professionals and organizations should be able to develop tailored personal, professional and collective strategies for improvement.

But what about followers?

Following behaviours are recognized as ‘behaviour that helps co-construct leadership’ and that without this, ‘there is no leadership’ (Uhl-Bien et al, 2014).

The concept of vertical leadership development focuses predominantly on intrinsic development. While there are clear attributes that would benefit the generation of followers and perpetuate following behaviour, such as the concept of eliciting colliding perspectives, this is not fully explored within Petrie’s work which remains ‘leader-centric’ (Bass, 2008; Mannion et al, 2015).

From a ‘constructionist’ approach to leadership, rather than being viewed as subordinates, followers are firmly established as active participants and hold equal importance to that of the leader (Meindl, 1995). As a leader, to encourage this and stimulate followership, the leader’s ability to adopt a transformational leadership style, whereby the leader encourages the ‘four I’s’ (Idealised influence, Inspirational motivation, Individualised consideration and Intellectual stimulation), is integral to produce performances beyond expectations and meet the ever-increasing demands of contemporary health care (Bass and Riggio, 2006). More than this though, individuals at all levels should have the skills and insight to know when to take on leadership, followership and management roles and activities: the ‘leadership triad’ (Till and McKimm, 2016). People will need to be supported and developed to appreciate, understand and accept this approach. However, this alone will not be sufficient. The flattening of hierarchies needed to eradicate the traditional autocratic leadership that has dominated health care to date must be reinforced by a positive organizational culture which is exemplified by the concept of collective leadership (West et al, 2014).

Collective leadership

Collective leadership distributes and allocates leadership power to wherever expertise, capability and motivation sits within organizations. Introducing fluidity into the recognition of leadership and followership roles dependent on situational requirements builds the capability of staff to accept responsibility for the overall effectiveness of the organization. However, for this to be effective, ‘all staff must be focussed on good followership, regardless of their seniority in the organisation’ (West et al, 2014).

While individual leadership development is crucial, it is not the only way forward as the context within which leadership occurs is a vital factor to be considered. For collective leadership to thrive, organizations require a supportive culture with leadership development occurring ‘in place’ within teams and organizations (West et al, 2015). Currently, the predominant focus of collective leadership is internal but organizations need to recognize the complexity of the increasingly integrated health and social care system, and attend to building interdependent organizational networks across this system (West et al, 2014). In order to survive and thrive within an increasingly VUCA world, working across boundaries and appropriately risk-assessing the wider political, economic, social, technological, legal and environmental (PESTLE) factors is crucial.

A future strategy

NHS leadership is ‘in crisis’ and the organization as a whole cannot continue wasting leadership talent (*Health Service Journal*, 2015; Till and McKimm, 2016). To harness the latent potential of health-care professionals, greater attention towards leadership development is needed earlier in their careers (Till et al, 2016). While a vast quantity of leadership literature exists, its presence and practical application in health-care settings is limited (West et al, 2015). It is clear that while a systematic

approach to the development of leadership talent should be implemented (Till, 2015) no one model or theoretical construct is sufficient. Innovative leaders should explore new models from wide sources of evidence and literature and adapt them to create a bespoke yet systematic approach to leadership development that will suit their own organizational system. One example of this approach is the National Medical Director's Clinical Fellow Scheme (Faculty of Medical Leadership and Management, 2016), which could be adapted within individual organizations to accelerate the pace and scope of leadership development within the NHS.

As discussed in this article, a combination of horizontal, vertical, transformational and collective leadership and followership development may provide a blueprint against which to develop strong leadership within organizations. Vertical leadership helps refine and balance an individual's own personal developmental journey to maximize his/her leadership potential. Transformational leadership helps guide the leadership style that an individual might adopt along his/her journey to maximize the potential of his/her followers. Followership helps individuals step up and back in different situations while collective leadership helps organizations to establish a positive culture whereby leadership can flourish to maximize clinical effectiveness.

Health care in general, and particularly within the NHS, faces unprecedented challenges as it aims to adapt and survive in the increasingly tortuous VUCA and RUPT world it operates within. While new models of care are required, so are new attitudes and approaches to leadership whereby excellence in leadership is valued as strongly as excellence in care. **BJHM**

Conflict of interest: Dr A Till and Dr N Dutta have been accepted onto the National Medical Director's Clinical Fellow Scheme 2016–17; Professor J McKimm: none.

KEY POINTS

- Leadership development must be afforded greater attention to meet the demands of highly complex and unpredictable health systems.
- Integrated systemically within postgraduate medical training, the three primary conditions of vertical leadership development can develop leadership talent at the earliest stages of their careers.
- Flattening traditional medical hierarchies is integral to developing a culture where medical leadership can flourish, it introduces and facilitates a fluidity between the roles encompassing the 'leadership triad'.
- The NHS must harness latent leadership talent and use multiple theoretical constructs to develop the existing evidence base.
- Leadership and high quality care are inexplicably linked: excellence in leadership must be valued as strongly as excellence in care.

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