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The crisis of management in the NHS - The absence of leadership

Abstract

The on-going changes in England and Wales health policy that aimed to promote competition, provide enhanced performance information and create small health organisations produce significant attention within management. As the organisation of health system has moved from what a 'loose-coupled' system to an integration control system, there is an issue regarding the roles of healthcare providers as professionals and mangers roles as leaders of healthcare organisations. It could be concluded that the financial challenge for staff and the institution besides the pressure of expectation influence the healthcare leadership. This resulted in involves them fully and without bias in this process whilst being pragmatic enough to develop ideas, theories and techniques despite pronounced resistance. Therefore to engage with these changes and the policy, which underpins it, this paper explore the behavioural aspect of leadership style and its effect on management practice. It also considers the management of change and the impact of leadership during the change process.

Key words: Health management; leadership

Introduction

The changing face of health policy in England and Wales is increasing controversially. However, it is part of a critical on-going organisational process. Major structural, policy, financial and managerial reforms have been continually put in place to promote competition, provide enhanced performance information, and create small health organisations. The New Labour government's policies and it's endorsement of a quasi-market system that encouraged co-operation, diversity and choice. (Barr & Dowding, 2012) These changes have created tension within management, especially with relation to performances concerning performance. Contentiously these changes informed professional autonomy and transformed accountability within the health sector (Northouse, 2007).

The fundamental change in the organisation of health system has moved from what a 'loose-coupled' system to an integration control system (French, Rayner, Rees & Rumbles, 2011). Traditionally, administration in healthcare was the management of structures and processes around instruction not the management of instruction istelf. Thery argued that the administrative superstructure tended to buffer the weak technical core of healthcare provision from exterrnal scrutiny. This has raised fundamental questions about the roles of healthcare providers as

professionals and mangers roles as leaders of healthcare organisations. The 'loose coupled' system proposed that because healthcare providers were competent professionals they should be sole custodians of the profession with limited to no interference. Mangers had limited involvement in improving instructional effectiveness but were focussed on healthcare management (Gopee, & Galloway, 2009). These reform stressed performance management at both instructional and at an administrative level and raised questions as to whether the collective goals, the needs of patients and healthcare organisatons was being met. Equally, healthcare being a need presents leadership within these organisations with a unique set of challenges.

This has produced a drive towards inspection which has helped to reform standards, also performance management has also led to accountability and significant changes in leadership and management styles to give effect to policies. Therefore to engage with these changes and the policy which underpins it this paper will explore the behavioural aspect of leadership style and its effect on management practice. It will also consider the management of change and the impact of leadership during the change process.

Methodology

The methodology applied is a critical review of the relevant literature in leadership and healthcare management. The literature search focused on the use of secondary literature. The first step was to define the search parameters and a thorough review on literature that was relevant on the subject. The publications found were too broad. To help to define the subject matter and refine the search, keywords were generated. These keywords were applied to construct a relevance tree that posed the question "Can leadership transform healthcare management?" This relevance tree led to the research of two main concepts – leadership and service quality – and those two concepts were further refined to other associated research terms, like stakeholder theory, corporate governance, business ethics, microfinance and strategic policy. These research terms were further deconstructed in other relevant search terms. To ensure that the searches were objective and consistent, the terms were catalogued relatively to their eligibility on the research questions based on a predetermined set of criteria. The criteria applied to the research included the date of publication, theory relevance, and reference in other publications, the position of support or contradiction to the central theme of research, bias and methodological omissions.

The second search with the applied criteria was refined in the secondary literature that addressed directly the topic in question. The methodology follows McIntosh & Voyer (2012) systematic approach into examining healthcare management literature. Initially, the search parameters were

defined broadly as literature on leadership and healthcare managment. These three concepts were used to search abstracts Proquest searches of academic journals generated articles as follows – leadership (6,612) and healthcare management (15,661). To refine the search, keywords and concepts were searched together. When these three concepts were searched together only seven abstracts were generated. The analytical coding categories from data were in the first instance categorised within certain leadership pillars (e.g., leadership in the workplace and in the community). In the second instance, the material was categorised in relation to leadership (e.g., strategy and service quality) and in the third instance, sustainability and psychology. To ensure that the searches were objective and consistent, the terms were catalogued relative to their eligibility on the research areas based on a predetermined set of criteria. The criteria applied to the research included the date of publication, theory relevance, and reference in other publications, the position of support or contradiction to the central theme of research, bias and methodological omissions (Saunders *et al.,* 2007). Several cases studies were discussed from this material. The limitation of this paper is through the lack of primary data collected to determine the hypothesis posed. The validity of this paper is limited to a purely theoretical approach that needs to be further investigated with primary data collection

Leadership Approaches

Jeremy Hunt's healthcare reform places a premium on the relationship between leadership, healthcare improvement, and service provision. Hunt does not believe that strategic healthcare leadership is the driver for change the actor for change in this narrative is the patient. This has presented research from diverse countries has confirmed the role of leadership in securing development and change and hence influences the effectiveness of the healthcare settings and the provision provided, but argues that that contemporary leadership models are limited in explaining basic level change. Medical professionals are seen as leaders in the healthcare organisations.

However, there were difficulties with this position - leadership in healthcare settings was informed by the resources of the organisations they lead. While being further limited by the focus towards orthodoxy in leadership that is concerned by the capabilities of an individual as opposed to a transformational leader who is the conduit to increased performance (Sinha, 2010). This concept posits the practitioner as the facilitator of change and transformation through empowerment. The differentiation between leaders and managers links practitioners into the transformational model which identifies different sets of behaviours and characteristics. Transformational versus transactional leadership required in situations of organisational

transformation organisational stability. Transactional leadership is more closely aligned with scientific management theory based on contingent reward and management by exception, when a delegated task or function is failing to meet expectations. The emphasis is on the notion of contrasting free will relationships with followers versus contracts with subordinates. This links into the tradition of the hierarchal and authoritarian features of healthcare tradition that links into formal organisational structures and processes such as line management, roles and job descriptions (Reeve, 2009).

Healthcare is therefore in a state of flux given the ongoing reform process. Transformational leadership is inspired by a common vision, purpose, and mission that is underpinned by intellectual stimulation and individualised concern for feelings, aspirations, and personal development. The reality of a ready supply of strong leaders with vision, that are capable of transforming failing hospitals, whilst dealing with day to day routines is not present. Senior Management are expected to master skills and knowledge ranging from leadership and political expertise to deal with community demands, to instructional roles to managers dealing with finance, contracts, and operations. Commitment to organisational vision can be achieved by a strategy of distributed leadership through a network of interacting individuals engaged in concerted action to create an organisational culture based on trust rather than regulation, in which leadership is based on knowledge and not position.

Distributed leadership

Armstrong and Laschinger (2006) describe three different types of distributed leadership being collaborative, collective, and co-ordinated distribution. Collaborative distribution occurs where leaders work together to carry out a specific leadership function that develops into shared practice. Collective distribution occurs or two or more leaders work separately but interdependently towards a common goal that creates shed practice. Coordinated distribution occurs when different leadership tasks are performed in a particular sequence for the execution of a leadership function. Each type involves more people in leadership roles in a healthcare setting that can lead to new ideas and solutions whilst creating a strong team approach. This can potentially shift the traditional norm of staff isolation into a shared vision and implementation of shared strategies in terms of the transformational model.

The practice of distributed leadership is entrenched within leadership development Frameworks it does not challenge the notion of leader and follower but rather suggests that the focus is on how leadership practice is distributed in a "de-centred" leadership environment where healthcare

professionals develop expertise by working collaboratively. It suggests that leadership is distributed across formal and informal leaders, and represents the glue holding together a common vision necessary in a knowledge intensive organisation Reiling (2005) argues leader behaviour and style is central to effectiveness. Autocratic or authoritarian style is linked to transactional management where the focus of the power is the manager who is solely responsible for decision making, policy, procedures for achieving goals and work task relationships. Chang, Multz, and Hall (2005) argue that transforming autocrats who are focussed ensure that decisional power is retained under their control. However, a laissez-faire style occurs when a manager consciously makes a decision to pass the focus of power to a group and allows them freedom of action without interference.

Alimo-Metcalfe and Alban-Metcalfe (2001) focuses on the relationship between the situational or context of leaders' work and their actions, goals, and behaviours argues that effective leaders draw on a repertoire of styles and that particular styles were dependent on both the leadership task and the context. For example, a task-oriented style is more effective when followers have limited experience and competence (i.e., 'immature' followers), a blend of task and relationship-oriented styles work best with more mature groups, and a delegating style of leadership appears most effective when working with very mature groups (Mullins, 2000). Apekey *et al.,* (2011) defines taxonomies of styles including 'closed' (authoritarian, inaccessible, inflexible, non-supportive), "control-oriented" (manipulative, self-serving, focused on eliciting compliance), and "open" (facilitative, democratic and accessible.)

Avolio and Gardner (2005) suggest that the particular context of hospitals influences the adoption of leadership style. They carried out research into hospital facing challenging circumstances which confirmed that authoritarian forms of leadership are most prevalent in a failing hospital context where special measures and immediate action is required. They state that Senior Management adopt leadership styles that match the stage of a hospital's development. Their research indicated that the senior management tended to adopt an autocratic style of leadership at critical times but acknowledged that this approach was least likely to lead to sustained development Their study indicated that a form of democratic leadership that empowered others and distributed activity across the sector that created the climate for moving forward. Successful Senior Management adopted highly creative approaches to tackling complex change processes working at a team and individual level to manage change. Staff shared in decision processes with an emphasis on collaborative decision making. A major leadership success factor in following a democratic style was professional and personal values that placed human needs ahead of the organisation whilst maintaining a firm and sometimes ruthless stance

in terms of standards. The research does not distinguish between transformational and democratic leadership and describes a democratic leadership style notionally interchangeable with that of distributed leadership.

However, Woods and Gosling (2003) argue that a distributed perspective on leadership focuses on leadership practice. They state that shared leadership, team leadership, and democratic leadership are not synonyms for distributed leadership. They suggest that a team leadership approach does not involve subscribing to a distributed perspective in which leadership practice is viewed as the interaction of leaders, followers, and situation. Their view is that a distributed perspective allows for leadership that can be democratic or autocratic. From a distributed perspective, leadership thus can be stretched over leaders in healthcare settings, in a manner than is not necessarily democratic.

This presents a limiting condition between the dichotomy between distributed leadership and managerial power. Policy is not predicated on the successful application of transformational leadership by senior management through distributed leadership, but rather through a range of regulatory and performance management mechanisms to ensure compliance. There has presented a notional reduction in central control replaced by an ambiguity of intent which entrenches positional power. At the very time that education demands are intensifying, distributed practices appear to be becoming the accepted norm. Government policy instruments are increasing accountability measures that bear little connection with distributed practice and are likely to exacerbate intensification of pressure on leaders. Heightened performance expectations have influenced practitioners who are uncertain about the future direction of their careers with additional grounds for disengaging and abstaining from becoming leaders. The separation of power and leadership can be effected when leadership is exercised by a body of professionals in a healthcare environment through a non-hierarchal network of collaborative learning, alongside, and separate from a hierarchal power structure. The promotion of distributed leadership is essential to mediate Government policy. It is only the effective devolution of power to practitioner level, which will create an effective distributed leadership strategy, and hence practitioner led reform. Is raises the question where does that lead us?

Leadership and change

An organisation can only perform effectively through interaction with the broader environment of which it is part. The underlying objectives of change are therefore modifying the behavioural

patterns of members of an organisation and improving the ability of the organisation to comply with changes in its environment.

Strategic leadership is required to effect meaningful sustainable change through effective management of the change process. Change management is similar in description to transformational leadership and is considered the art of influencing people and organisations in a desired direction to achieve an agreed future state to the benefit of that organisation and its stakeholders. This description has elements of vision in terms of a desired future state, and supports the notion of transformational leadership (Woods & West, 2014). Graetz (2000) suggests that distributed leadership offers a positive channel for change but requires change agents to carry forward the transformational through a 'guiding coalition' with 'boundary spanning' managers as change agents capable of translating a leader's vision by means of language and material artefacts in a meaningful form. Lewin's three step change management process of unfreeze-move-refreeze supported by force field analysis is similar to Graetz's findings on an effective change process; i.e. the creation of capacity for change, setting a vision, ensuring leadership commitment reinforcement of messages and the institutionalisation of new behaviours. Lewin's process suggests a tendency of an organisation to homeostasis or the tendency of an organisation to maintain it's equilibrium in response to disruptive change. Lewin's force field analysis is a useful tool to understand the driving and resisting forces in a change situation as a basis for change management. This technique identifies forces that might work for the change process, and forces that are against the change. Lewin's model suggests that once these conflicting forces are identified, it becomes easier to build on forces that work for the change and reduce forces that are against the change through visionary leadership and the use of change agents to effect change. Unfreezing: means collaboratively defining the current situation at healthcare setting, surfacing the driving and resisting forces that maintain that status, and creating a desired vision of the future for it. Communication and consensus is essential because movement will only occur if affected staff feels a need to do so. The second step is about moving to the new state through participation and involvement using techniques such as brain storming. The third step is refreezing and stabilising the new state by setting policy, rewarding success, and establishing new standards.

Given that change is reciprocal and affects both managers and staff's lives and careers, the difficulty is the assessment of strength or duration of a force, particularly when the human dimension is considered in terms of resistance to change. Woods and West (2014) suggest that politically driven change heightens resistance in a transactional management environment typical

of the traditional authoritarian style healthcare leadership paradigm. He suggests that in these circumstances, change occurs through the application of coercive power of the management, but staff passively resist the change and the system reverts to homeostasis. The shift from an autocratic style of management through a hierarchal structure in a loose coupled environment to that of a distributed leadership model operating through a flatter structure is therefore particularly susceptible to resistance especially since it interferes with professional autonomy.

The revolutionary nature of reform requires rapid change given the historical factors where the established way of doing things is entrenched in the system. An autocratic style of leadership is best suited for revolutionary whilst transformational change requires time to realign and adapt to the new paradigm. This contradiction in terms of healthcare reform processes, suggests that transformational leadership through a distributed leadership strategy without an appropriate time-frame is likely to create stressors at the individual level because the change management process is paradoxical in message. Resistance to change can take many forms and it is often difficult to pinpoint the exact reasons for resistance. Key factors include ignoring the needs and expectations of professionals, providing insufficient information, and conditions where practitioners don't accept or perceive the need for change. Fears include deskilling of job content, loss of job satisfaction, changes to social structures, loss of individual control over work and greater management control. Healthcare professionals' own interpretation of the drivers of change present a unique perspective which can translate into selective perception and a biased view of reality thus responding to change in an established and accustomed manner. Habit serves as a means of comfort and security and as a guide for decision making. Proposed changes to established habits will cause resistance unless there is a clear perceived advantage. Changes to education, especially in the area of performance management have meant an inconvenience and loss of freedom which together with the economic implications of increased workload without pay adjustment, and threat to job security could lead to increasing resistance. The traditional healthcare structures have provided security and any tendency for a return to the well established comfortable procedures of the past means that a vigorous change management process is essential (Mullins, 2000)

Yukl (2013) argues that emphasising non-monetary benefits of change, communication programmes focussing on fears and concerns, and eliciting spousal and significant other support are critical success factors for movement to a transformational model. By implication, shared knowledge of learning outcomes, standards, and shared practice together professional development plans and a peer evaluation program can reduce resistance and lead to improved

service provision and instructional outcomes. At an organisational level, (ie the level of application of a distributed leadership strategy), resistance is influenced by the culture of the NHS and the maintenance of predictability and stability. The traditional model has relied on organisational structure and mechanistic rules, procedures and policies. Voyer and McIntosh (2005) argues that the decisive issue in movement from autocratic to distributed leadership is the question of ultimate strategic power. Distributed leadership approaches or a watered down democratic leadership style, is a function of the exercising of power by a dominated hierarchy. They argue that many in authority see a transformational leadership approach and the practice of distributed leadership as a means of mediating government policy through their own value systems. The contradiction remains that the senior management remains accountable in a target based culture and hence limits the practice of distributed leadership to a minority of senior staff. This then reduces the risk of a challenge to changing policy that would be allowed in a participatory or democratic leadership environment. McIntosh, Voyer, & Shenoy (2013) consider that the distributed leadership ideal cannot be achieved within government driven policy. The change process and impact on staff presents an irreconcilable resistor to authentic distributed leadership and in so doing, reinforcing the leader-follower model of transformational in its theoretical form.

Potential translation of the current transactional model of leadership enacted through autocratic leadership styles that are entrenched in a bureaucratic hierarchy, into the distributed leadership model is not a theoretical, academic ideal, but rather a function of a change in government policy and a real commitment to the ideal of devolved power to the lowest unit of leadership.

Discussion

Leadership approaches in healthcare delivery and structures are cyclical. Healthcare leadership has moved from approaches as varied as the autocratic through to 'New Managerialism'. As a task-orientated discipline there had been long held aspirations to attain greater flexibility these aspirations were in part achieved due to a combination of changes necessitated by demographic developments and political factors. They resulted in a transition from a prescriptive to a proscribed education system. This has had serious implications for those seeking to exercise independent judgement. Two conflicting aspects emerged, the requirement of 'New Managerialism' for practitioners to give account for their practice decisions and the contrasting requirement, for staff to act as practitioners in accordance with managerial directives. For autonomy to be operational there must be a culture within the working environment that will

allow it. However, there is an underlying assumption of an incompatibility of the autonomy of practitioners and managerial requirement to control rising costs.

As 'New Managerialism' was in essence economically driven with its "managers" focused on the allocation of resources. Change has incrementally lead to a progressively systematised form of delivery which reduces professional autonomy and transforms the practitioner into a highly skilled practitioner who follows pre-determined procedures. This evidence supports the perception, in a post-Fordism context, of an increasing reliance on a core of functionally flexible, re-skilled workers, who perform an increasingly diverse range of tasks, surrounded by a periphery of less skilled, numerically flexible workers, namely, healthcare assistants. Against the background of economic constraints and an increasing emphasis on "customer satisfaction" within a more market-driven approach to health care, some managerial functions are also being devolved downwards. Healthcare Management is being transmuted both unintentionally and unwillingly into a form of management devoid of leadership. These developments only increase the tension between professional autonomy and change with a consequent danger of an erosion of the principles of professional beneficence independence.

It is evident that there is a conceptual confusion among healthcare professionals. The use of one way rhetoric has been striking, with managerial concepts and language imposed upon the profession has exposed the nature of change driven by several coinciding factors. Firstly, that the healthcare hierarchy have the aspiration and are not unduly concerned about the basis on which it is established. Secondly, that it has arisen out of political necessity, to address devolutionary changes that have affected the profession. Professionalism certainly has been seen as a way of appealing to a wider candidature. Thirdly, change in its self is a hegemonic imposition to exert control by distorting the use and meaning of terms, in order to manipulate a group of staff by encouraging them to believe they have one status, whilst exerting control by another means. The resulting confusion can render staff very vulnerable to suggestion and direction.

Conclusion

There are two distinct and separate challenges facing healthcare, the first is financial both for staff and the institution. Secondly, there is an equal and opposite pressure of expectation. This presents a unique and pressing challenge in relation to leadership; however how this response is framed is a challenge within its self. The challenge facing healthcare leadership involve them fully and without bias in this process whilst being pragmatic enough to develop ideas, theories and techniques despite pronounced resistance. This development has been described as a new form

of revisionism, replacing the benign revision of 'New Labour' and arguably resulting in a reduction of autonomy within the sector.

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