CRANFIELD UNIVERSITY

NAMSHAN ALI ALGARNI

# A FRAMEWORK TO FACILITATE THE LEADERSHIP PERFORMANCE IMPROVEMENT IN THE HEALTHCARE SECTOR: THE CASE OF THE KINGDOM OF SAUDI ARABIA

THE SCHOOL OF AEROSPACE, TRANSPORT AND MANUFACTURING

PhD THESIS
Academic Year: 2014 - 2018

Supervisor: Dr Patrick McLaughlin

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This thesis is submitted in partial fulfilment of the requirements for the degree of PhD

# ABSTRACT

In order to improve leadership performance and enhance effective leadership in the healthcare sector organisations in general and the Kingdom of Saudi Arabia (KSA) in particular, this study proposes a theoretical framework to address the ways in which leadership competency strengthens the relationship between leaders and followers. The research is based on a single case as a longitudinal study to allow for in-depth investigation. The research applies a constructive-interpretivism approach – inductive to gain a deep understanding and clear explanation of the leadership performance and practices in the organisational setting. The data were collected using triangulated methods—semi-structured interviews, focus groups and observation. This research applies a qualitative strategy to achieve its objectives. This approach, is most appropriate for this research, which is exploratory and interpretive in nature.

This study targets participants who are experts in the phenomena of the field study. The participants represented several levels of the organisations studied. Data were collected in three stages, using issue focus in-depth interviews. The saturation level was reached after 33 interviews. A number of elements emerged as important in shaping the leadership performance in the field study, in the areas of culture, values and context. The present study suggested a framework to facilitate a culture of leadership performance improvement in the healthcare organisations. This framework was developed based on the main emerged themes of the study

This study is expected to contribute to the existing literature on leadership competencies, the process of change management and social identity by providing empirical data on the significance of leadership competency in improving performance in the healthcare sector in general, especially in the KSA and the Gulf Cooperation Council (GCC countries).



Keywords: Saudi Arabia, leadership, competencies, healthcare sector, culture, change management

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# List of publications:

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1- Namshan Algarni, Dr Patrick McLaughlin, Dr Ahmed Al Ashabb 'Developing a framework to improve leadership performance in healthcare organisations: The case of the Kingdom of Saudi Arabia' – An abstract published in the "BMJ publications- journal of BMJ leader". BMJ Leader Oct 2017, 1 (Suppl 1) A2-A3; DOI: 10.1136/leader-2017-FMLM.4.

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3- Namshan Algarni, Dr Patrick McLaughlin, Dr Ahmed Al Ashabb, 'A Framework to facilitate a culture of change in the healthcare organisations to improve the leadership performance: The case of the KSA' – Journal paper- Submitted in February 2018 to be published in the journal of "The international journal of Humane Resources Management" – The current statues: Under review.

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## Conferences papers:

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**Posters:**

1- Namshan Algarni, Dr Patrick McLaughlin, Dr Ahmed Al Ashabb, 'Factors influencing leadership performance in Saudi's public health sector'. "Poster presented at the conference by: Leaders in Healthcare – Liverpool 31st October 2016.

2- Namshan Algarni, Dr Patrick McLaughlin, and Dr Ahmed Al Ashabb "Developing a competency framework to improve leadership performance in the healthcare organizations" poster presented at the conference of FMLM Scotland Regional Conference Promoting Resilience – Edinburgh 14 March 2017.

3- Namshan Algarni, Dr Patrick McLaughlin, Dr Ahmed Al Ashabb 'A proposed framework of interventions to facilitate a culture of leadership performance development in healthcare organisations: the case of Saudi Arabia'. "Poster presented at the conference by: Leaders in Healthcare – Liverpool 31st October 2017.

4- Namshan Algarni, Dr Patrick McLaughlin, Dr Ahmed Al Ashabb 'Developing a competency framework to improve leadership performance in healthcare organizations' – Manufacturing Doctoral Community – Cranfield University 07 September 2017.

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- UK Health Show – London 28 September 2016.
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- UK Health Show – London 29 September - 2017.
- Leaders in Healthcare – Liverpool 30 Oct – 1 Nov 2017
- 30th IBIMA Conference _ Madrid, Spain 8-9 November 2017

# TABLE OF CONTENTS

# LIST OF FIGURES

# LIST OF TABLES

# LIST OF ABBREVIATIONS

| | |
|---|---|
| KSA | Kingdom of Saudi Arabia |
| GCC | Gulf Cooperation Council Countries |
| HNG | Health Affairs of the Ministry of the National Guard in KSA |
| NG | Ministry of the National Guard in KSA |
| GT | Ground Theory Approach |
| PI | Performance Improvement |
| SME | Small and Medium Enterprises |
| CATS | Changing as three steps |
| NTP | National Transformation Program |
| MOH | Ministry of Health |
| IWE | Islamic Work Ethic |
| JS | job satisfaction |
| OC | Organizational Commitment |
| LPD | Leadership Performance Development |

# 1 INTRODUCTION

## 1.1 Background and Motivation

Leadership is a major area of interest within the field of healthcare performance development ( West *et al.*, 2015; Long and Javidi, 2016; Almgren, 2017) and delivering improvements in the quality and safety of healthcare remains an international challenge ( Taylor *et al.*, 2014; Turner, 2017). According to McAlearney (2006, p. 969), “Leadership development practices are defined as educational processes designed to improve the leadership capabilities of individuals”. The history of leadership research has demonstrated that organisational success highly depends on leaders’ leadership style and performance ( Wang *et al.*, 2011; Turner, 2017).

In addition, Turner, (2017); Liu *et al.*,( 2017) indicate to the similar challenges that Walston et al. (2008, p. 243), mentioned “Many countries across the world are struggling to improve healthcare quality, contain or control costs, and provide access to healthcare for their citizens [and] much has been written about United States’ and European struggles to balance quality, cost, and access to healthcare”. This in line with Carlström and Ekman (2012) who outlined various of critical challenges facing healthcare organisations throughout the world. These are complex and costly care and treatment needs of the growing population of persons with long-term illnesses (Eric D. Carlström and Ekman, 2012). However, recent studies outlines clear evidence of the link between management practice including leadership and a range of important outcomes in health services, including patient satisfaction, patient mortality, organisational financial performance, staff well-being, engagement, turnover and absenteeism, and overall quality of care (WHO, 2013; Armit *et al*., 2015; Turner, 2017).

However, it is important to understanding the difference between management and leadership. According to Kotter (2008) “Management is a set of processes that keep an organisation functioning”. These processes are about planning, budgeting, staffing, clarifying jobs, measuring performance, and problem-solving when results did not go to plan. On the other hand, leadership is very different "It is about aligning people to the vision, that means buy-in and communication, motivation and inspiration" (Kotter, 2008).

Similarly, the current situation in the healthcare sector has created challenges to its leadership and management practices performance because of the shortage of local health workers and the increase of demand for healthcare (Liu *et al.*, 2017; Maurer, 2015). Further challenges are its ways of financing and expenditure, the accessibility of healthcare services, the privatisation of public hospitals, the use of electronic health (e-health) strategies and the development of a national system for health information (Almalki et al., 2011 Maeda et al., 2014; Maurer, 2015, Alsulame et al., 2016). In a recent study Alsulame et al., (2016, p. 205) defined (e-health) as "all forms of electronic healthcare delivered via information and communication technology channels, ranging from informational, educational, and commercial, to direct services offered by healthcare organizations, professionals, and consumers themselves".

Additionally, Walston et al. (2008) indicate other factors affecting the service of this sector: the large percentage of foreign workers and the high proportion of young people in the population. These factors and challenges affect the level of service, may leading so far, to the failure of the government's plan to sustain the development of this important sector this can discredit the government and disappoints patients.

However, in the Kingdom of Saudi Arabia, the healthcare sector also has a comprehensive development and modernisation plan for improving its performance and delivering a better service (Albejaidi, 2010; Saleh and Otaibi, 2017). Furthermore, the government of Saudi Arabia has given its healthcare services high priority (Albejaidi, 2010; Alkhamis, 2012). According to Almalki et al. (2011, p. 792) "The national strategy for healthcare services is to be implemented by the Ministry of Health in cooperation with other healthcare providers and it will be supervised by the Council of Health Services". The planned time frame for this strategy is 20 years (Almalki et al., 2011). Moreover, the Ministry of Health (MOH) is seeking to launch several health initiatives related to the National Transformation Program (NTP) 2020 and the Saudi Vision 2030 (The Minsitry of Saudi Health, 2017).

Significantly, the Kingdom's SR 270 billion healthcare plan under Vision 2030 will set Saudi Arabia on a fast trajectory to growth in the sector, projected to be a SR 92.6 billion market by 2020 (Saudi Embassy in the USA, 2017; The Saudi Gazette 2017). Hence, Saudi Vision 2030 presents certain challenges to the healthcare sector in terms of achieving Saudization targets and reducing dependence on foreign workers

(Al-Bosaily *et al.*, 2017). Expatriates currently make up the majority of the professional workforce, such as doctors, but Saudi Vision 2030 requires increased employment of Saudi nationals in these positions. This will mean that education standards in the Kingdom, including those for medical and nursing degrees, will need to be raised to facilitate the achievement of that vision (Healthcare in the Kingdom of Saudi Arabia — An Overview 2016).

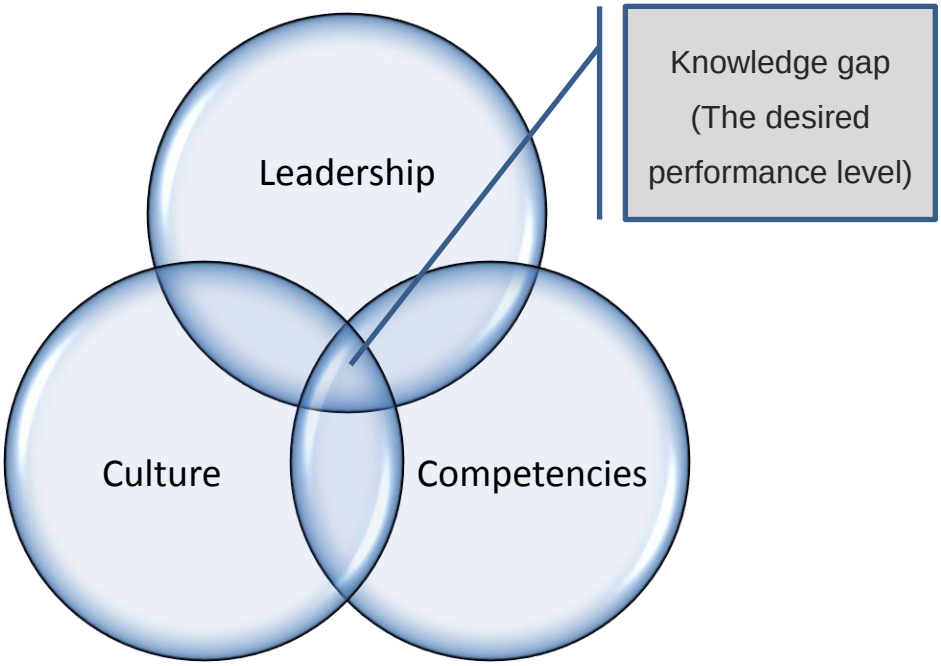


**Figure 1-1 Knowledge gap**

The Gulf Cooperation Council (GCC) consists of six countries, Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates (UAE), as member states. According to Khoja *et al.*, (2017) these countries are currently experiencing an increased demand for healthcare services due to an immense population growth and increasing life expectancy. This suggests that the healthcare sector in Saudi Arabia and GCC countries would benefit from research to develop a framework that would make this critical sector more efficient (Alkhamis *et al.*, 2017). Importantly, such frameworks would need to be modified to suit the KSA and other GCC countries' cultural settings and needs.

The present study thus seeks to understand the current situation of leadership skills and management performance in the healthcare sector of the KSA. There are,

however, obstacles and challenges deriving from the current situation regarding the performance of the leadership in this sector (Almalki et al., 2011; Alkhamis *et al.*, 2017). These tend to negatively affect the service level and reduce the pace of development in this sector.

According to Hollenbeck et al., (2006, p.23), “effective leadership has a broad range of competencies, accurately reads the difference between situations, and uses the appropriate competencies that will lead to successful outcomes”.

## 1.2 Significance of this Research

Identify managerial problems in healthcare organisations is vital task in terms of management development. The healthcare sector is an important priority of politicians, economists, academics and many others because of its fundamental role in every country (Turner, 2017; Papanicolas and Smith, 2013). The main issues affecting this sector seem to involved funding, governance, education and research, and most studies of the sector, from a range of disciplines, are interested in these issues (Collins, 2017).

With McAlearney's concerns (2006, p. 969) above, a recent study by McDonald (2014, p. 228) notes leadership development programmes “lack a theoretical base and a sense of how they fit with individual or organizational goals” in the healthcare sector. Significantly, the literature on leadership generally does not yet show that competency frameworks have any power to enable leaders to improve their effectiveness (Armit et al., 2015).

Furthermore, in their recent study Khoja *et al.*, (2017) state that there is a need for development and implementation of new approaches in tackling the emerging healthcare challenges in GCC states. According to a report published recently by the Saudi Embassy in the USA (2017), the government of Saudi Arabia places a high priority on healthcare with the understanding that people are the country’s most valuable asset. According to recent international statistics, in 2030, the population of the Kingdom of Saudi Arabia will reach 39.1 million, an increase of 24.1 per cent from 2015 (Euromonitor International, 2016). Therefore, this research can contribute to facilitating the government plans to develop this vital sector.

## 1.3 Research Problem

Surprisingly, the literature has still not yet closely examined the impact of leadership competencies on the effectiveness of leadership performance improvement (Boyatzis and Boyatzis, 2008; Priest and Gass, 2017). Hence, this study aims to investigate the impact of applying competency frameworks to improve leadership performance in healthcare organisations.

## 1.4 Aim, Objectives and the Research Questions

The aim of this study was to develop a framework to facilitate a culture of leadership performance improvement in the healthcare organisations. The purpose is to understand this relatively new area of leadership research by building a theory based on data, rather than allowing the extant literature to lead and determine the findings of this research.

This study addresses the following questions:

1. What leadership competencies lead to improved leadership performance in the healthcare sector?
2. How can these leadership competencies be applied to improve the performance and management practices of healthcare organisations?

This will be accomplished by carrying out the following tasks:

1. To identify best practices and key leadership competencies that can improve leadership performance, via an extensive literature review.
2. To investigate, via field study, the leadership characteristics that encourage or inhibit the improvement of organisational performance.
3. To develop a competency framework that can be used to improve the performance of organisation leaders in the healthcare sector.
4. To validate the developed framework via expert evaluations.

## 1.5 Demographic and Economic Patterns of Saudi Arabia

Saudi Arabia is a country in Western Asia covering an area of approximately 2,250,000 square kilometres (868,730 square miles) between the Arabian Gulf on the east and the Red Sea on the west (Alexander, 2011; Al-Rabeeah, 2003; Hamdan, 2005). In 2017, its population was approximately 32,552,336 million people, of which the population of Saudi nationals was 20.8 million people (66.9% of the total population)

with a 1.62% annual population growth, and a foreign population of 10.25 million, (33.1% of the total population) as shown in Table 1-1 (The Saudi General Authority For Statistics, 2017). The gender ratio of the Saudi population is 104 males/100 females. This means in Saudi Arabia the number of male citizens is close to the number of female citizens (The Saudi General Authority For Statistics, 2017).

The generation of Saudis born in the 1930s lived a traditional, tribal existence, as the state was just beginning to develop national institutions and identity (Al-Bakr *et al.*, 2017). The country was established in 1932 by King AbdulAziz ibn AbdulRahman Al Saud (Mellahi, 2007; Alexander, 2011). Arabic is the official language and Islam is the official religion (Alexander, 2011). According to Mellahi, (2007, p. 88) “Saudi Arabia is governed by an Islamic monarchy in which Islam makes up the civil, cultural, economic, legal, political and social fabric of the country”.

The role of Islam as the first tenet of Saudi culture is largely established on the basis of the Qur'an (the holy book) and the Sunna (the sayings and practices of the prophet Mohammed, peace be upon him) (Tønnessen, 2016; Aldraehim *et al.*, 2012). These two sources unify the Islamic world and Saudis through Sharia’a law, which affects both the morality and the practice of employees in the workplace.

The Kingdom of Saudi Arabia has religious importance as the birthplace of Islam and the home to two of the holiest Muslim sites, the holy Mosque in Makkah and the Prophet Mohammad Mosque in Madinah (Dirani et al., 2017). This has made the country the primary otherworldly middle for Muslims the world over, with millions of travellers visiting Saudi Arabia each year (Abdulwahab, 2015). As a matter of fact, as a result of a Wahabi translation of the Qur’an, sexual orientation isolation characterises the broader Saudi Middle Eastern society, including instruction, work, and the open society (Baki, 2004).

Similarly, gender segregation is the other widespread practice in Saudi Arabia significantly hindering women’s ability to exercise their rights and participate fully in public life (Al-Bakr *et al.*, 2017). ‘Khulwa’, the mixing of unrelated men and women, is forbidden (Berger, 2013; Tønnessen, 2016). The Saudi system of gender segregation is unique among Muslim-majority countries and ensures gender segregation in all public places, including schools, universities, restaurants, government offices, and private businesses (Berger, 2013; Tønnessen, 2016). As a result, all facilities must be

duplicated: women have their own schools, university campuses and banks, and government buildings have separate entrances (Al-Bakr *et al.*, 2017).

In term of economics, the Kingdom of Saudi Arabia has the largest global oil reserves, containing 25% of the world's resources (Saleh and Otaibi, 2017; Aljaidi, 2010). The KSA represents one of the most significant markets in the region for both domestic and international investors (Al-Bosaily *et al.*, 2017).

It estimated that the population of Saudi Arabia will reach 39.8 million by 2025, and 54.7 million by 2050 (United Nations, 2003). This expected growth of the population will mean an increased demand for essential services and facilities, such as healthcare services (Alkhamis *et al.*, 2017). This is in line with the new vision of the country. The momentum and pace of economic and social reforms have been fuelled by the Kingdom's Vision 2030 and its strategic goals (PWC - Middle East - Hala Kudwah, 2017).

The new vision of the country 'Vision 2030' outlines 24 specific goals for the Kingdom to be achieved in its economic, political and societal development (Saudi Embassy in the USA, 2017). To achieve these planned goals, Vision 2030 further articulates 18 commitments with specific initiatives in numerous sectors. These are renewable energy, manufacturing, education, e-governance, entertainment and culture (Saudi Embassy in the USA, 2017). Similarly, according to Al-Bosaily *et al.* (2017, p. 2) "Vision 2030 seeks to reshape Saudi Arabia and boost what is the Arab world's largest economy". However, Vision 2030 is built on three pillars—a vibrant society, a thriving economy, and an ambitious nation—that require the full power of the country to be harnessed (PWC - Middle East - Hala Kudwah, 2017).

Finally, Vision 2030 outlines specific goals, including raising the private sector contribution to GDP growth from 40% to 65% (Al-Bosaily *et al.*, 2017), raising the SME sector contribution to GDP from 20% to 35%, and seeing female participation in the workforce increase from 22% to 30%. All of this requires the activation of female Saudi talent within the workforce (PWC - Middle East - Hala Kudwah, 2017).

**Table 1-1 Population by Age Group and Gender and Nationality (Saudi/Non-Saudi)** (The Saudi General Authority For Statistics, 2017)

| | Saudi | | | Non-Saudi | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| | MALE | FEMALE | Total | MALE | FEMALE | Total | MALE | FEMALE | Total |
| 0 – 4 | 1,088,294 | 1,047,398 | 2,135,692 | 275,515 | 260,851 | 536,366 | 1,363,809 | 1,308,249 | 2,672,058 |
| 5 – 9 | 1,062,238 | 1,024,877 | 2,087,115 | 348,658 | 331,935 | 680,593 | 1,410,896 | 1,356,812 | 2,767,708 |
| 14 - | 947,971 | 919,891 | 1,867,862 | 286,895 | 270,662 | 557,557 | 1,234,866 | 1,190,553 | 2,425,419 |
| 19 - | 895,691 | 863,860 | 1,759,551 | 235,442 | 218,567 | 454,009 | 1,131,133 | 1,082,427 | 2,213,560 |
| 24 - | 1,036,957 | 949,752 | 1,986,709 | 277,658 | 204,875 | 482,533 | 1,314,615 | 1,154,627 | 2,469,242 |
| 29 - | 963,845 | 942,320 | 1,906,165 | 706,028 | 415,850 | 1,121,878 | 1,669,873 | 1,358,170 | 3,028,043 |
| 34 - | 867,938 | 853,785 | 1,721,723 | 924,102 | 412,159 | 1,336,261 | 1,792,040 | 1,265,944 | 3,057,984 |
| 39 - | 762,425 | 743,680 | 1,506,105 | 1,357,183 | 530,960 | 1,888,143 | 2,119,608 | 1,274,640 | 3,394,248 |
| 44 - | 643,653 | 620,187 | 1,263,840 | 1,283,392 | 485,115 | 1,768,507 | 1,927,045 | 1,105,302 | 3,032,347 |
| 49 - | 541,375 | 512,317 | 1,053,692 | 943,251 | 260,089 | 1,203,340 | 1,484,626 | 772,406 | 2,257,032 |
| 54 - | 431,365 | 407,210 | 838,575 | 642,806 | 98,260 | 741,066 | 1,074,171 | 505,470 | 1,579,641 |
| 59 - | 336,096 | 308,710 | 644,806 | 384,846 | 64,120 | 448,966 | 720,942 | 372,830 | 1,093,772 |
| 64 - | 243,534 | 227,683 | 471,217 | 206,011 | 46,320 | 252,331 | 449,545 | 274,003 | 723,548 |
| 69 - | 167,366 | 164,141 | 331,507 | 81,117 | 25,267 | 106,384 | 248,483 | 189,408 | 437,891 |
| 74 - | 111,894 | 120,097 | 231,991 | 27,029 | 14,879 | 41,908 | 138,923 | 134,976 | 273,899 |
| 79 - | 68,605 | 70,596 | 139,201 | 11,732 | 8,560 | 20,292 | 80,337 | 79,156 | 159,493 |
| + 80 | 62,117 | 73,714 | 135,831 | 11,690 | 9,174 | 20,864 | 73,807 | 82,888 | 156,695 |
| Total | 10231364 | 9850218 | 20081582 | 8003355 | 3657643 | 11660998 | 18234719 | 13507861 | 32,552,336 |

**Table 1-2 Saudi Arabia Population History** (World Population Review, 2017)

| Year | Population | % Male | % Female | Density (kmÂ²) | Population Rank | Growth Rate |
|---|---|---|---|---|---|---|
| **2017** | 32938.21 | 0.5707023 | 0.429297606 | 15.32 | 41 | 0.021647722 |
| **2015** | 31557.14 | 0.5669934 | 0.433006136 | 14.68 | 41 | 0.028461574 |
| **2010** | 27425.68 | 0.5615411 | 0.438459493 | 12.76 | 45 | 0.027853792 |
| **2005** | 23905.65 | 0.5565615 | 0.443438611 | 11.12 | 46 | 0.028576545 |
| **2000** | 20764.31 | 0.5446471 | 0.455352722 | 9.66 | 48 | 0.020772287 |
| **1995** | 18735.84 | 0.5548153 | 0.445184927 | 8.72 | 48 | 0.027908232 |
| **1990** | 16326.82 | 0.5601189 | 0.439880773 | 7.59 | 51 | 0.043607432 |
| **1985** | 13189.12 | 0.5490265 | 0.450973397 | 6.14 | 52 | 0.062492806 |
| **1980** | 9740.599 | 0.5364089 | 0.463590484 | 4.53 | 61 | 0.055685445 |
| **1975** | 7428.703 | 0.5202308 | 0.479769214 | 3.46 | 72 | 0.049430671 |
| **1970** | 5836.389 | 0.5091475 | 0.490852306 | 2.71 | 76 | 0.037993334 |
| **1965** | 4843.635 | 0.5046297 | 0.495369697 | 2.25 | 78 | 0.034577793 |
| **1960** | 4086.539 | 0.5021841 | 0.497814654 | 1.9 | 83 | 0.028078216 |

| Year | Population | % Male | % Female | Density (kmÂ²) | Population Rank | Growth Rate |
|---|---|---|---|---|---|---|
| **1955** | 3558.155 | 0.5043735 | 0.495629336 | 1.66 | 84 | 0.02654241 |
| **1950** | 3121.335 | 0.5075367 | 0.492464923 | 1.45 | 85 | 0 |

## 1.6 The Saudi healthcare system

The initial health service infrastructure began to develop in 1925 when the first Public Health Department was established in Makkah in 1925 following a Royal decree from King Abdulaziz (Khaliq, 2012; Al-Rabeeah, 2003; Alharthi et al., 1999). This department was responsible for sponsoring and monitoring free healthcare for the population and pilgrims and establishing a number of hospitals and dispensaries (Almalki et al., 2011; Saleh and Otaibi, 2017). According to Khaliq (2012, p. 53) "the origins of the Saudi healthcare system can be traced to 1926, with the establishment of a Health Directorate in Jeddah and the opening of Ajyad hospital in Mecca and Bab Shareef hospital in Jeddah". In 1951, the Saudi Ministry of Health was created (Khaliq, 2012).

From 1983 to 2009, there was significant progress in the key health indicators of the KSA (Al-Borie and Abdullah, 2013). Significantly, the Ministry of Health (2009) reported life expectancy increased from 66 years to 73.5. This is consistent with the new Saudi Vision 2030 that aims to increase life expectancy to age 80 by 2030 (Saudi Embassy in the USA, 2017).

The hospital bed capacity in the KSA in 2015 was 69,394; more than half of this (58.7%) was under the Ministry of Health; other state agencies controlled 20.2 per cent; and 21.0 per cent was in the private sector (Saudi General Authority Statistics, 2016). According to a recent report produced by the Saudi Embassy in the USA (2017), Saudi Arabia is considered the largest market for medical equipment and healthcare products in the Middle East. This includes medical education, research, facilities, provision, and the healthcare value chain.

Healthcare in Saudi Arabia is currently provided free of charge to all Saudi citizens and to expatriates working in the public sector, primarily through the Ministry of Health and augmented by other governmental health facilities (Walston et al. 2008; Al-Yousuf et al., 2002). KSA has a national healthcare system that provides health services through a number of governmental agencies: The Ministry of Health, the Ministry of National Guard, the Ministry of Defence and Aviation, and the Ministry of the Interior (Khaliq, 2012; Alsulame et al., 2016). Figure 1-2 below shows the structure of the Saudi healthcare sector.

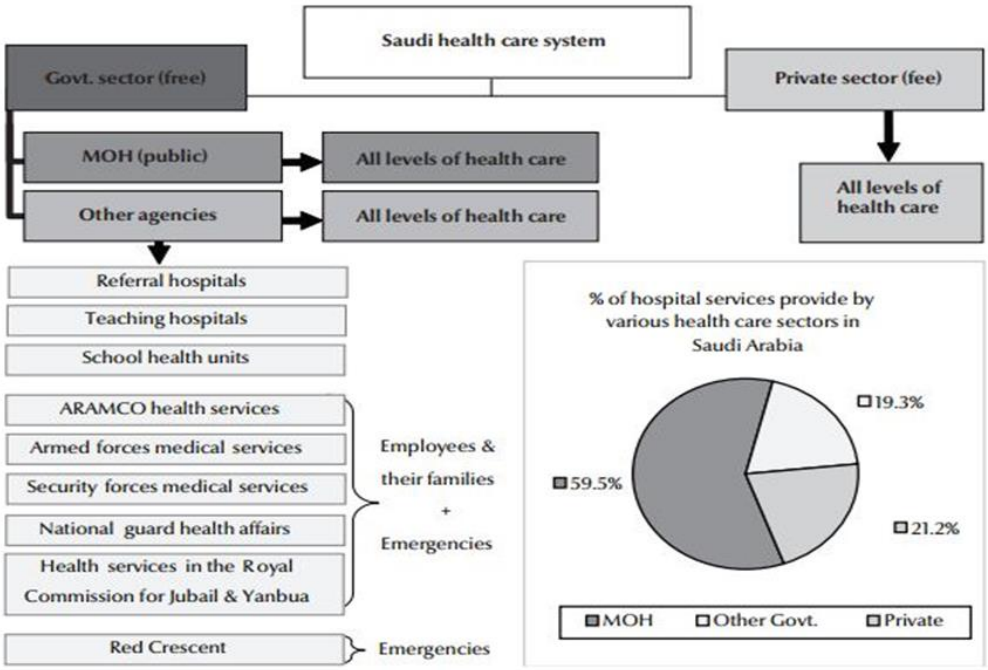


**Figure 1-2 Structure of the Saudi healthcare sectors** (Almalki et al., 2011)

There is also a growing participation in the provision of healthcare (HC) services by the private sector (Alkhamis *et al.*, 2017). There are total of 244 hospitals with 33,277 beds and 2,037 primary healthcare providers (Yusuf, 2014) in the private sector. These hospitals make up 60 per cent of the total healthcare services in Saudi Arabia. The government operates 115 hospitals, which have a capacity of 10,822 beds. The private sector offers healthcare services in cities and large towns with 125 hospitals (11,833 beds) and 2,218 clinics and dispensaries (Yusuf, 2014).

According to Albejaidi (2010) the Ministry of Health (MOH) is the major government agency entrusted with the provision of preventive, curative and rehabilitative HC services for Saudi citizens. It also supervises all the HC-related activities undertaken by the private sector (Almalki *et al*., 2011). In the past few decades, health and health services have improved significantly in terms of quantity and quality (Saleh and Otaibi, 2017).

As shown in Table 1-3 below, the number of hospitals and beds in the healthcare sectors of the KSA has gradually increased.

**Table 1-3 Total Hospitals and Beds in the Saudi healthcare** (Saudi General Authority Statistics, 2016)

| | Total Hospitals and Beds in the Kingdom by agency 2011-2015 . | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Table 4-17 | | | | | | | | | |
| | 2015 | | 2014 | | 2013 | | 2012 | | 2011 | |
| | Beds | Hospitals | Beds | Hospitals | Beds | Hospitals | Beds | Hospitals | Beds | Hospitals |
| MOH | 41297 | 274 | 40300 | 270 | 38970 | 268 | 35828 | 259 | 34450 | 251 |
| Other governmental sectors | 11449 | 43 | 12032 | 42 | 11414 | 41 | 11043 | 39 | 10948 | 39 |
| private sector | 16648 | 145 | 15665 | 141 | 14310 | 136 | 14165 | 137 | 13298 | 130 |
| Total | 69394 | 462 | 67997 | 453 | 64694 | 445 | 61036 | 435 | 58696 | 420 |
| | Source: MOH | | | | | | | | | |

In 2006, the Saudi health services ranked 26$^{th}$ out of 190 of the world's health systems (Alkhamis *et al.*, 2017; WHO 2000).

According to Almalki *et al*.(2011, p. 792) “The national strategy for healthcare services is to be implemented by the ministry of health in cooperation with other healthcare providers and it will be supervised by the Council of Health Services”. The time frame for this strategy is planned to be 20 years (Almalki et al., 2011).

Yusuf (2014, p. 117), however, pointed out some challenges to the Saudi government saying, “the increasing population and health expenditures are forcing the government to come up with considerable changes in the healthcare system”. Additionally, it is estimated that by 2020, the total number of people aged 60 and above will be over 2.5 million (Yusuf, 2014; Alkhamis *et al.*, 2017). This aging of the population will increase the demand for and expenditure on healthcare.

**Table 1-4 General statistics about KSA** (World Health Organisation, 2016)

| | |
|---|---|
| **Total population (2015)** | **31,540,000** |
| **Gross national income per capita (PPP international $, 2013)** | 53 |
| **Life expectancy at birth m/f (years, 2015)** | 73/76 |
| **Probability of dying under five (per 1 000 live births, 0)** | not available |
| **Probability of dying between 15 and 60 years m/f (per 1 000 population, 2013)** | 89/67 |
| **Total expenditure on health per capita (Intl $, 2014)** | 2,466 |
| **Total expenditure on health as % of GDP (2014)** | 4.7 |

Health expenditure in the Kingdom has more than doubled in the past decade in the Kingdom's 400 hospitals, 2,075 primary health centres, and 850 private clinics (Saudi Embassy in the USA, 2017; Alkhamis *et al.*, 2017; Saleh and Otaibi, 2017). According to the Saudi transformation plans for the coming five years, the government intends to proceed with the construction of 56 new and 51 replacement hospitals and 750 primary health centres (Saudi Embassy in the USA, 2017).

Significantly, Al-Borie and Abdullah (2013) maintain that one of the challenges that healthcare in the KSA must combat is the current state of planning and development initiatives, which are top-down (imposed) and not bottom-up (agreed). They also emphasise that healthcare in the KSA must continually develop the professional skills of its workers so that they can deal with challenges they may encounter in the reforms.

## 1.7 Structure of the thesis

This section introduces the structure of this thesis, which comprises seven chapters, including the current chapter. Chapter One serves as an introduction, describing the background to the problem in question, and the purpose and significance of the study. Chapter Two contains a systematic review of the relevant literature on leadership development and support, discussing existing definitions, leadership theories, leadership and competencies, the organisational culture and change management models and practices and the healthcare system, demographics and economic patterns of Saudi Arabia. Chapter Three describes in detail the methodology utilised in this study is. Chapter Four presents in detailed the data collection and analysis process stages with its findings. Chapter Five presents the framework development process with the proposed interventions and the framework validation feedback. Chapter Six presents a discussion of the overall findings of the research. The final chapter comprises the conclusion, the summary, contributions, limitations and further research. References and appendices are included at the end of the thesis.

# 2 LITERATURE REVIEW

In this chapter, the literature associated with the context and research areas related to this study are reviewed to reveal any research gaps and develop a better understanding of the area under investigation. The chapter is divided into six main parts.

Part one focuses on exploring the concept of leadership, including definitions of leadership and the main leadership theories. The second part of the chapter reviews the concept of leadership in the Islamic approach. The third part is devoted to investigating the concept of competencies and their impact on performance, as well as the current situation of the culture in the KSA and it impacts on leadership practices. The fourth part discusses the link between leadership performance and organisational culture and the relationship between leadership and culture. This section discussed the concept of culture in depth by discussing its definition, levels, nature and cultural dimension models. The fifth part discusses the change management theories and process to deliver successful change. Finally, a section aimed to investigating the relationship between leadership functions and healthcare practices.

## 2.1 Overview of Leadership

A considerable amount of literature has been published on the topic of leadership. Similarly, the concept of leadership has long captured the interest of practitioners and academics (Silverthorne, 2001; Bolden, 2004). Dulewicz and Malcolm (2003) and Higgs (2003) claim that leadership is the most studied aspect of human behaviour.

According to Joseph (1993), over 221 definitions of leadership were featured in books and articles between 1900 and 1990. With such abundance, it may be valuable to classify these concepts into broader categories. From the various definitions, Hackman and Johnson (2013) identify four principal areas of leadership:

A. Leadership has to do with the personality of the leader. This is one of the traditional ways to conceptualise leadership. It focuses on the nature and identification of traits belonging to those who nominate themselves for leadership posts.

B. Leadership has to do with a person's capacity for action and ways of dealing with circumstances. This definition focuses on the way in which leaders use their power. A leader can also be defined as someone who influences others.

C. Leadership has to do with the leader's decisive actions. The part played by leaders is highlighted in practical applications, rather than in any theoretical definition

D. Leadership has to do with the leader's relationships with others. From this point of view, success is a collaborative effort between leaders and their followers, who create common objectives and then work together to achieve them.

Zalenznik (1977) began the trend of contrasting leadership and management by presenting an image of the leader as an artist who uses creativity and intuition to navigate his/her way through chaos (Zaleznik, 1992; Bolden and Gosling, 2006).

Leadership is currently one of the most talked about issues in business and organisations (Carlton *et al.*, 2015; Bolden, 2004). Authors have suggested several different definitions and analyses of leadership, as shown below in Table 2-1.

**Table 2-1 Leadership definitions**

| | |
|---|---|
| Lussier and Achua (2007) | The influencing process of leader and follower to achieve organisational objectives through change. |
| Yukl (2002) | Leadership includes influencing task objectives and strategies, influencing group maintenance and identification and the culture of an organisation. |
| Marshall and Hooley, (2006) | The ability to guide others, whether they are colleagues, peers, clients, or patients toward desired outcomes. |
| Gold (2003) | Leading people towards the achievement of a common goal. |
| Northouse (2004) | Characteristics or talents that differentiate the individuals who have them from others. |
| Doyle and Smith (2001) | A clear idea, as leader of what one wants to achieve and why. |

In sum, leadership can be defined as the ability to guide others towards the achievement of certain desired objectives by individuals who have learned, or are endowed with, special distinguishing characteristics. This definition captures a number of the important features of leadership presented in the literature. The definition of leadership has undergone many gradual changes (see Table 2-1). “Whilst early theories tend to focus upon the characteristics and behaviours of successful leaders, later theories begin to consider the role of followers and the contextual nature of leadership” (Bolden *et al.,* 2003). It is also important to refer to the quality of the relationship between a leader and the members of the team because this plays a crucial role in the success or failure of any organisation (Flin *et al.*, 2003).

This section reviews the leadership literature giving an overview of the subject, including its key characteristics, definition and benefits as well as the subsequent development of leadership.

### 2.1.1 Leadership Theories

This research broadly considers the extensive literature that has been published on the subject, from “Great Man” and “Trait” theories to “Transformational” leadership. One of the first ideas about leadership was the Great Man theory, which evolved in the 1840s (Ghasabeh *et al.*, 2015). The Great Man theory assumes that the traits of leadership are intrinsic (Dulewicz and Malcolm, 2003). This simply means that great leaders are born leaders (Garrick, 2006). The main assumption of this theory is to assume that certain people possess congenital qualities and characteristics that make them superior and therefore natural leaders (Vroom and Jago, 2007). This conclusion is first mentioned by the Scottish writer Thomas Carlyle in his 1841book *On Heroes, Hero-Worship and the Heroic in History*.

The Great Man theory holds that during human history there have been extraordinary people (heroes) who display personal traits, character and superior qualities that give them influence over the masses (Garrick, 2006). However, this theory has received a number of criticisms, such as the absence of evidence-based research to support it, and the argument that it is society and circumstances that make individuals great, and so heroes are made, not born (Organ, 1996; Mhatre and Riggio, 2014). It has been assumed that, in order to understand the nuances of various leadership styles, a basic knowledge of leadership theory is needed (Northouse, 2017).

Bolden *et al.*, (2003) claim that the importance of leadership emerged after the Industrial Revolution, when the foundation of the economy moved from agriculture to manufacturing. However, leadership theory can be classified into four broad areas: trait-based, transformational, situational, and path-goal oriented (Peter G. Northouse, 2017). The literature on leadership provides many options and approaches, some extolling the virtues of certain attributes in leaders, such as specific leadership traits, skills or styles. In addition, other studies detail the situations that leaders find themselves in, the benefits and shortcomings of being a leader, or when to exercise leadership.

There are several important areas of the literature that discuss the relationship between leaders and teams, looking at power relationships between leaders and followers alongside the notion of servant leadership. Power and context are important issues in this regard. For instance, Crawford, (2014, p. 4) claims, "Three different aspects of leadership—the person, the place and the policy context--make up a narrative that is woven together over time". Therefore, context is a key issue for leaders because it is closely related to the culture and structure of a firm; with this in mind, leaders can deal with individuals and policy (Schein, 2004; Priest and Gass, 2017). Power is also linked to context; it partly concerns what people believe and how some people influence others (Morgeson *et al.*, 2010; Hodges, 2016). This section reviews some theories related to traits, charisma, transformation, situation, contingency and path-goals.

#### 2.1.1.1 Traits and Charisma in Leadership Theories

Initial attempts at formulating leadership theory focused on the traits or personal characteristics of leaders, essentially looking at certain inborn attributes that made good leaders (Tejeda *et al.*, 2001; Dulewicz and Malcolm, 2003; Antonakis and Day, 2017). These so-called Great Man theories viewed traits such as intelligence, self-confidence, determination, integrity and sociability as the means of leading effectively (Bernard and Ruth, 2008; Northouse, 2017). One of the major weaknesses of this early form of thinking was that it focused solely on the leaders; it has since been understood that followers—and their characteristics—have a significant impact on leadership (Higgs, 2003; Hosking, 2007; Antonakis and Day, 2017).

Modern researchers looking into charismatic leadership, however, take a similar view as researchers investigating trait leadership, albeit with a more specific characteristic in mind. Bass and Riggio, (2006) suggest, for example, that "charismatic and inspirational leaders instil faith in a better future for the followers in terms of their self-expression, self-evaluation, and self-consistency." Proponents of charismatic leadership place a high value on the charisma of individuals who, by a mix of charm and sociability, can induce a strong sense of loyalty and camaraderie in their followers (Burns, 1978; Dulewicz and Malcolm,

2003; Antonakis and Day, 2017). This can make for incredibly effective leadership (Conger and Kanungo, 1988; Holt *et al.*, 2003; Northouse, 2017).

#### 2.1.1.2 Transformational and Instructional Leadership

Much of the literature on leadership styles focuses on the two main scopes of leadership, i.e. transactional and transformational leadership (Zareen *et al*., 2015). Transformational leadership theory has developed into a hot topic in management research (Ndiga *et al.*, 2014; Mhatre and Riggio, 2014). According to Laohavichien and Fredendall (2009), adopting either transformational or transactional leadership behaviour can help in the success of an organisation.

Transformational leadership focuses on the capacity of deeply-held beliefs of leaders, with the application of certain values, to create effective leadership; these include such virtues as justice and integrity (Burns, 1978; Dulewicz and Malcolm, 2003; Jyoti and Bhau, 2015). Transformational leadership theory was first proposed by Burns (Bass, 1985), and then advanced by Bass (Burns, 2010), who made an outstanding contribution to the development of the theory (Jyoti and Bhau, 2015).

Transformational leadership is defined by Bass (1985, p. 11) as “moving the follower beyond immediate self-interests through idealised influence (charisma), inspiration, intellectual stimulation, or individualised consideration”. In another point of view, (Posner and Kouzes, 1993; Yukl, 2002) argue that transformational leadership is a set of observable and learnable practices employed to influence employee attitudes and assumptions and to build employees’ commitment to the organization’s mission (Jaskyte, 2004).

However, four key tenets of transformational leadership have been identified: idealised influence (charisma), inspirational motivation (vision and purpose), individualised consideration, and intellectual stimulation (Hackman and Johnson, 2013; Charkhabi and Naami, 2014). These four ideals, when displayed in a leader, have a significant impact on followers, and when combined, can result in extremely effective leadership (Bass and Avolio, 1994; Hayati, 2014).

Transformational leaders are able to recognise and articulate a vision for an organisation, support a culture of intellectual stimulation and provide support and a chance for development to individual staff members (Sun and Leithwood, 2012; Morgeson *et al.*, 2010). This is because transformational leadership is more directly related to the leader-subordinate relationship and employee emotions (Jyoti and Bhau, 2015). For these reasons, transformational leaders tend to propose a bottom-up approach (Jyoti and Bhau, 2015). Similarly, according to Jyoti and Bhau (2015, p. 2), "A transformational leader transforms the followers thinking in such a way that they adopt the vision of the organization as if sustainability of that vision was their own". This change spurs representatives to overcome their personal interests and endeavour toward the collective objectives (Bass and Riggio, 2006).

Additionally, transformational leadership was viewed as the type of leadership needed to create radical change and transactional leadership was viewed as the type of leadership used to produce incremental change (Bass and Avolio, 1994).

In contrast, instructional leaders propose a top-down approach (Hallinger, 2003); this recalls the Saudi context. Instructional leaders also aim to assist staff members in achieving a predetermined set of goals, but not necessarily to create a common vision among staff. Transactional leadership is an exchange process. The leader rewards or punishes based on the degree to which the followers comply with their requests and/or achieve organizational goals (for example, Yukl 1999; Tejeda *et al*., 2001).

Significantly, Hartog *et al.* (1997) point out that transitional leadership is fundamental, since it clarifies objectives and the ways to fulfil these objectives. For instance, path-goal leadership theory (House, 1971) is a type of transactional leadership theory. The path-goal model is a theory based on specifying a leader's style or behaviour that best fits the employee and work environment in order to achieve a goal (House, *et al.*, 1974; Northouse, 2017). However, both transformational leadership and transactional leadership help in predicting subordinates' satisfaction with their leaders (Bennett, 2009; Girma, 2016).

#### 2.1.1.3 Situational, Contingency and Path-Goal theories

Situational leadership theory examines how a leader deals with social events and happenings in the day-to-day running of an entity (Northouse, 2015; Dugan, 2017). According to Day (2011), effective leaders should be seen as part of the system itself, defining the best ways to lead as the situation demands and developing strong interdependency between themselves and their followers. This can allows a situational leader to control the events of their own making and those of others (Northouse, 2015 ; Kotter, 1995).

In earlier study, Fiedler's (1967) pointed out that contingency theory of leadership is a popular branch of situational theory. The theory posits that a leader's impact on performance depends not only on the leader's orientation, but also on certain contingency factors: leader-member relations, task-structure clarification, and the power position of the leader (Miner, 2015; Villoria, 2016). A flaw in the theory, however, lies in its assumption that a leader's manner of leadership is inflexible (Miner, 2015).

With regard to the path-goal theory, one of the key roles of a leader is creating goals and paths that team members can easily follow and understand (Yukl, 2008; Northouse, 2017). The path-goal theory focuses on this part of leadership and isolates four distinct kinds of behaviour that leaders should adopt for various situations: directive (leader commands followers), supportive (leader attends to the needs of followers), participative (leader includes followers in the decision-making process), and achievement-oriented (leader sets high expectations for followers to meet) (G. Yukl, 2002). This theory demonstrates the importance of structuring the relationship between effective leaders and their colleagues or team members.

The path-goal theory can best be thought of as a process in which leaders select specific behaviours that are best suited to the employees' needs and the working environment so that they may best guide the employees through their path in obtaining their daily work activities goals (Northouse, 2015)

Northouse (2015) described leadership theory from two standpoints: trait and process (see Figure 2-1), which illustrates the nature of the relationship between leaders and followers in these aspects.

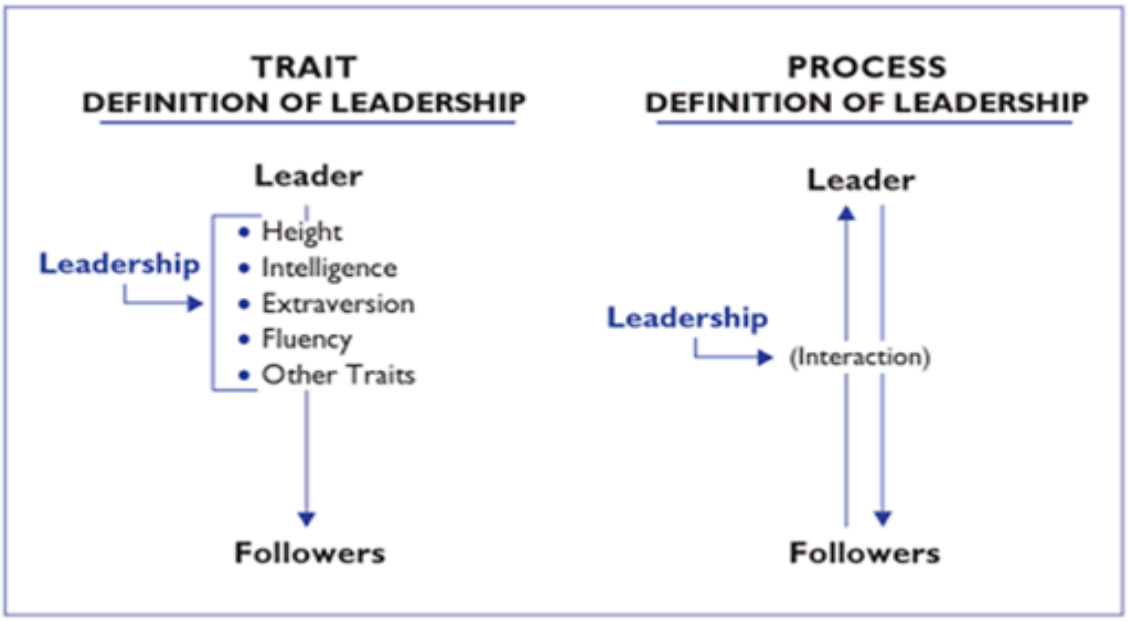


**Figure 2-1 Trait and process of leadership approach** (Northouse, 2012)

This theory shapes the relationship between leaders and their followers as shown in Figure 2-1 above. In a study investigating the different models and theories of leadership, Sharma and Jain (2013, p. 310) state that "leadership is a process by which a person influences others to accomplish an objective and directs the organization in a way that makes it more cohesive and coherent". This definition is linked with Northouse (2012, p. 5) who claimed that "leadership is a process whereby an individual influences a group of individuals to achieve a common goal".

Sanghi (2016) argued that contingency theories and contingency-situational theories of leadership were developed to demonstrate that the style to be used is contingent upon such factors as the situation, the people, the task, the organisation, and other environmental variables (Bolden *et al.*, 2003). These factors have attracted two main bodies of theory (Bolden *et al.*, 2003):

- Fiedler's Contingency Model: this model assumes that there is no ‘better way’ for managers to lead; leadership style is created in response to the situation and requirements for a manager.
- The Hersey-Blanchard Model of Leadership: This model sees leadership from the situational side and suggests that the developmental levels of a leader's subordinates play the greatest role in determining which leadership styles (leader behaviours) are the most appropriate.

Gosling *et al*. (2003) adds that the main effect on a leader's views about effective leadership strategies, in McGregor's thesis, comes from human nature (see Table 5).

Commentators divide behaviours into task-oriented and relationship-oriented categories, as standard. In addition, some texts address newer leadership concepts such as transformational leadership, team leadership, and strategic leadership (Thach and Thompson, 2007a).

To conclude this section, the literature has identified the various leadership definitions and has reviewed the subsequent development of leadership theories.

### 2.1.2 Leadership in the Islamic culture

The concept of the Islamic work ethic (IWE) has two main sources: the Qur’an and the sayings of the Prophet Mohammed. Yousef ( 2001) points out that the IWE ethic has a strong influence on both commitment to an organisation and satisfaction with one’s job. Additionally, Ali (1987) indicates Islam in his study as one of the most influential factors shaping Arab value systems.

According to Ather and Sobhani (2007), under Islam, the leader is associated with a team which has abundant confidence in its religion and is expected to perform in a pattern consistent with it; leaders are expected to add influence in developing and achieving moral goals and objectives. It is argued that the most appropriate way to measure the success of a leader is the way the team is encouraged (Faris and Parry, 2011). Naturally, Arabs in various countries share many values and traits (Rice, 2003). Bass and Avolio (1994) point to the close

relationship between culture and leadership and claim that “the culture affects leadership as much as leadership affects culture”.

Throughout the Islamic cultural realm, it is the actions and words of the prophet Mohammed that still, crucially, set the main standards and directions for Muslims in their decisions and their lives (Faris and Parry, 2011).

Beekun and Badawi (1999) describe leadership from an Islamic perspective as having two primary roles: of a servant-leader and a guardian-leader. Importantly, Faris and Parry (2011) state, “Within a Western context, one of the problems in Islamic leadership is to balance the deep moral and religious characteristics derived from the religion of Islam with the practical aspects of leadership that Western scholarship has already established”. The Prophet Mohammed said that the leader of a Jamaah (organisation/community/nation) is its servant. A leader should be in the business of serving and helping others get ahead (Faris and Parry, 2011). Furthermore, they indicate the importance of trust and responsibility and are aware of the influence of how these qualities influence leadership performance in Islam.

## 2.2 Competencies

Reviewing the literature demonstrates that competency modelling has become a major area of interest to students of performance assessment and organisational development (Bolden and Gosling, 2006; Priest and Gass, 2017). According to Boyatzis and Boyatzis (2008, p. 5), “The concept of competency-based human resources has gone from a new technique to a common practice in the 35 years since David McClelland (1973) first proposed them as a critical differentiator of performance”. According to Bueno and Tubbs (2012), competency originated from a Latin word that signifies ‘suitable’ (80). Various attempts in the literature have been made to define leadership competencies. For instance, Boyatzis (2008) defines competencies as “capabilities or ability.” In addition, Spencer (2008) adds that a competency is a group of characteristics related to effective performance in a work situation. In another point of view, Bratton and Gold, (2012,

p. 339) stated that “competencies are considered as descriptions of the behaviours, attributes and skills that people need to perform work effectively”.

Additionally, recent studies claim that the expectations of the new generation of employees differ from older generations’ expectations, and therefore, the future workforce requires a novel managerial approach (Stanley, 2010; Piper, 2012; Coulter and Faulkner, 2014). According to Goldberg *et al.* (1992, p. 115), “competency frameworks not only provide a solid foundation for talent management, but also are well suited for culture change initiatives”.

Over the past decade, most researches of competencies have emphasised the use of such sources as the knowledge, skills, abilities and behaviours of individuals (Hollenbeck *et al.*, 2006b; Priest and Gass, 2017) to define competencies. Bartram (2005) defines competencies as specific behaviours that can help to achieve targeted outcomes. Similarly, although some individuals are less able to learn than others, outlining competencies can guide strategic human resource management practices, such as recruitment and succession planning (Tubbs and Schulz, 2006; Brown *et al.*, 2016) .

Deist and Winterton (2005) discuss the difference between ‘competence’ and ‘competency’: whilst competence is shown in functional tasks, competency considers behavioural aspects. Salaman and Taylor (2002) argued that competencies can be used to define leadership and management performance, requiring leaders and managers to align themselves with a particular way of behaving. Similarly, Spencer and Spencer (1993) indicated that competencies are important for a variety of purposes, including selection quality, performance management, compensation, and succession planning. This in line with Priest and Gass (2017), who stress the key role of competencies features all these tasks.

In his book, *The Handbook of Competency Mapping*, Sanghi (2007, p. 164) states, “The competencies within the dictionary have been grouped into the following four clusters: Thinking Capabilities, Leadership Effectiveness, Self-

management and Social Awareness. Each cluster covers a broad range of behaviours and provides an overall picture of focus of different behaviours".

However, in a study investigating the impact of competencies on performance, Gruban (2003) indicates the importance of competency as the ability to use knowledge and other essential capabilities for successful and efficient achievement of an appointed task, transaction at work, goal realisation, or performance of a certain task in the business process. In addition, Hollenbeck *et al.* (2006a) claim that situational factors and individuals have a significant influence on a leader's effectiveness. Similarly, they find that developing leadership skills within competency models may help individuals and organisations at the same time.

However, to develop useful competencies for individuals, these writers (2006b) also propose four main ways in which models can help individuals to create useful competencies:

- Summarising the experience and insight of seasoned leaders.
- Specifying a range of useful leader behaviours.
- Providing a tool that individuals can use in their self-development.
- Outlining a leadership framework that can be used to help select, develop, and understand leadership effectiveness.

To help organisations to achieve their goals, Hollenbeck *et al.* (2006b) and Priest and Gass (2017) suggest that a competency framework needs to focus on the following main tasks:

- Openly communicating which leader behaviours are important.
- Helping to discriminate the performance of individuals.
- Linking leader behaviours to the strategic directions and goals of the business.

- Providing an integrative model of leadership that is relevant across many positions and leadership situations.

Furthermore, in a study investigating the relationship between the main dimensions within organisations, Boyatzis (2008) argued that the "theory of performance is the basis for the concept of competency". As shown in Figure 2-2, it is argued that the highest performance, or "best fit", can be achieved when the leader's capability is consistent with the job requirements and the organisational environment (McClelland and Boyatzis, 1982).

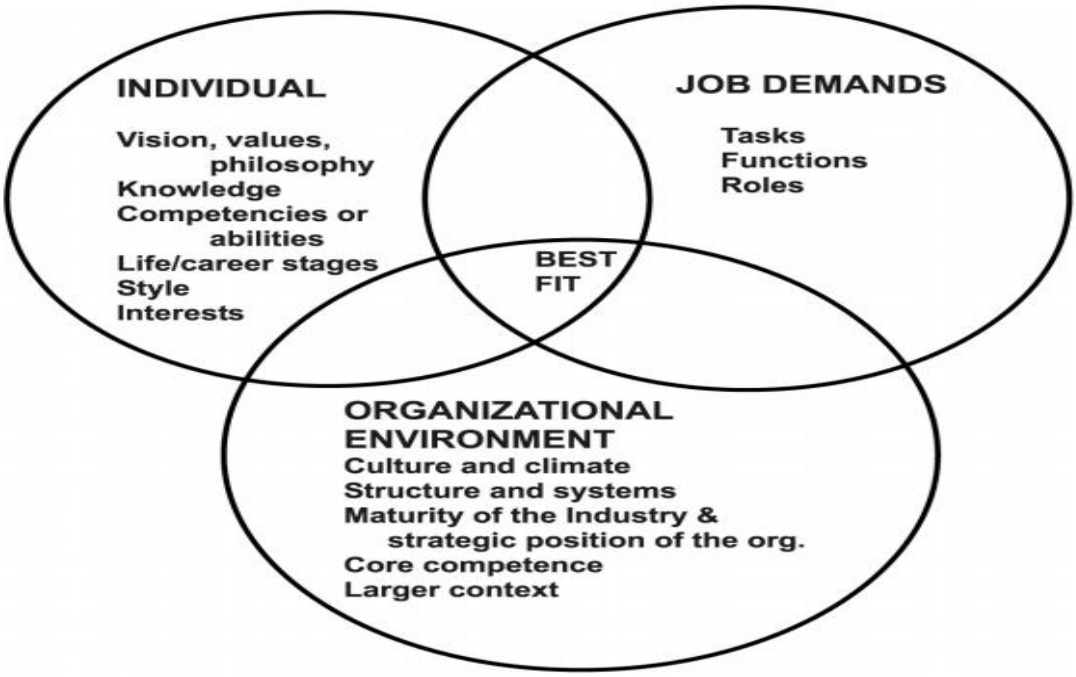


**Figure 2-2 - A theory of action and job performance: best fit** (Boyatzis and Boyatzis, 2008)

This view is supported by Boyatzis and Boyatzis, (2008) who write that if the leader's capability or talent is matched with the job needs and the workplace environment, there is a significant opportunity to achieve high productivity in the outcome, as shown in Figure 2-2 above. Similarly, organisational leadership development can be tailored to the organisation's needs and learning activities can be combined with practice activities (Armit *et al.*, 2015; Hodges, 2016).

In other words, improving performance within organisations requires a leader with the essential knowledge. Meanwhile, achieving useful results needs a specific pattern of skills (Bolden and Gosling, 2006; Peter G. Northouse, 2017). This pattern can be created from competencies that are cognitive, functional, or involving public abilities and skills (Czabanowska *et al.*, 2014; Priest and Gass, 2017). In addition, successful competencies should be attainable by all individuals and may be used to perform diverse tasks in various areas (Pagon *et al.*, 2008; Mathieu *et al.*, 2015).

Redick *et al.*, (2014) suggested a model of effective leadership competency based on four main elements (see Figure 2-3):


**Figure 2-3 Four-Part Model for project leadership competency** (Redick *et al.*, 2014)

This model is built on four main clusters, as demonstrated above in Figure 2-3. These are self-leadership, leading others, a desirable environment and psychology aspects. What is interesting in this model is the dynamic interactions that link the model's dimensions. This is the bedrock of the function of

competencies in improving performance within the workplace (Sanghi, 2016; Priest and Gass, 2017). Similarly, in an earlier study, Bennis (1987) emphasised that effective leadership performance needs a cluster of competencies covering vision and goals, interpersonal skills, self-knowledge and technical skills.

According to Robinson and Heron (1997, p. 3), “the competency framework (or list of competencies) is the tool by which competencies are expressed, assessed and measured”. Similarly, Hollenbeck *et al.* (2006, p. 26) state that “competency models are not a prescription for effective leadership, but represent an attempt to capture the experience, lessons learned, and knowledge of seasoned leaders to provide a guiding framework for the benefit of others and the organization”.

Numerous competency frameworks and assessments tools have been used by organisations for years to map the leadership competencies required for the success of their organisations’ activities (Armit *et al.*, 2015). However, this study offers the following two samples of competency models as examples of developed competencies models in different sectors.

This framework is composed of six competencies that match the behavioural attributes:

Senior Civil Service Competency Framework in the UK Figure 2-4:

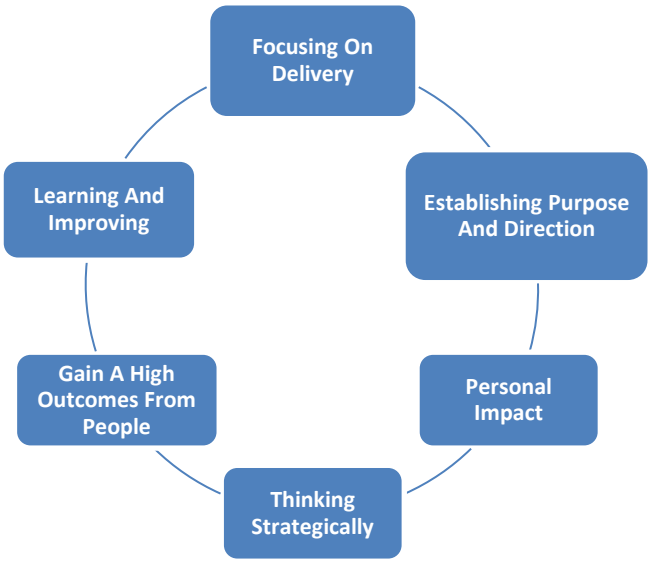


**Figure 2-4 Senior civil competency framework in the UK** (Bolden *et al.*, 2003)

Ministry of Defence Model in the United Kingdom

This framework offers three components that can ultimately help to achieve the organisation's purpose (Bolden *et al.*, 2003).

These elements are:

• **Leading and working together.**

• **Being personally effective.**

• **Delivering results.**

On the other hand, much of the current literature on leadership competencies pays further attention to such new areas as emotional intelligence and social/environmental responsibility (Thach and Thompson, 2007b). Furthermore, other factors, depending on the culture of the organisation, are considered essential, including entertainment and innovation (Sanghi, 2016; Guggenheimer and Szulc, 1998).

In addition, Hollenbeck *et al*. (2006b) suggest that “competencies should also reflect the leadership skills that are needed to accomplish the organization's strategic objectives. For example, an operations-driven company might emphasise a different set of leadership competencies than a marketing-driven company”. From this point of view, most current competency patterns do not clarify the crucial interaction between competencies and the various situations that may arise at work, although recently, some organizations are setting up their models with more situational factors (Conger and Ready, 2004; Priest and Gass, 2017).

With a critical point of view, Buckingham and Vosburgh (2001) argue that at an individual level, leadership competency encourages conformity rather than diversity. In addition, Bolden and Gosling (2006) claim that by hiding certain important factors the competency framework presents leadership as a concept rather than dealing with it as a reality issue and go on to say that “another danger

of using competencies to drive a wide range of organisational practices is that they may become used for purposes for which they were not designed" (p. 150).

In a previous study aimed to define the usage of competencies in the US, the UK, France and Germany, Le Deist and Winterton (2005) found various definitions. For instance, functional competences and cognitive aspects are increasingly being linked to behavioural competencies in the US; whilst in the UK, cognitive and behavioural competences are linked to the occupational functional competence model (Le Deist and Winterton, 2005).

According to Thach and Thompson (2007), who evaluated several models, there are no main differences between non-profit and for-profit leadership competency models. Non-profit models, however, tend to concentrate on new competencies, such as governance effectiveness, boardroom contribution and service to the community (Chait *et al*., 2011), whereas for-profit organisations tend to focus on financial responsibility and accountability more than their counterparts. In general, the literature suggests that there is a set of common leadership competencies that is appropriate for any type of organisation, whether for-profit, non-profit or governmental (Thach and Thompson, 2007).

However, in order to be useful, a competency model should take account of particular behaviours together with the predicted outcomes and benefits provided by the competency (Wright *et al.*, 2000; Thach and Thompson, 2007; Sanghi, 2016). According to Goldberg *et al.* (1992, p. 115) "using a competency framework is the best way to generate a number of stories that exemplify the best aspects of the organisation and, in the process, to effectively change the culture for the better".

According to Bennis (1987), to determine the effects of leadership competencies, effective leadership performance needs a cluster of competencies covering vision and goals, interpersonal skills, self-knowledge and technical skills (Higgs and Dulewicz, 2016). Similarly, Robinson and Heron (1997) claim that competencies are required to provide adequate support to individuals in implementing them

successfully. They also indicated three main factors that organisations need to consider when adopting and implementing such an approach.

These are, according to Robinson and Heron (1997):

- Using competencies to discuss career development.
- Using competencies to define job requirements.
- Training their managers to use competencies.

In the final analysis of their study, Robinson and Heron (1997) suggest two essential interventions to facilitate gaining the desirable value of adopting competencies:

- Firstly, using competencies to define job requirements that can benefit the organisations.
- Secondly, training staff in the use of competencies to avoid any wasted costs from failures in using them. (Robinson and Heron, 1997).

Importantly, Strebler and Bevan (1996) raised their concern about the growing use of competencies: that it can bring potential conflicts to organisations if they fail to give clear messages about the purpose using the competencies. To overcome this conflict, Sanghi (2016) underlines that an organisation needs to deliver a clear message of what competencies are proper and how these agreed-upon competencies will be implemented. This can help to gain the desired outcomes of a change.

## 2.3 Culture and leadership

The literature focusing on describing the relationship between organisational culture and leadership performance is rich and diverse. In his book, *Managing Change,* Burnes (2009, p. 214) stated that “leadership is just one aspect of culture”. Similarly, in a study aimed to provide empirical evidence of the links between different types of organisational culture, Ogbonna and Harris (2000) stress that that organisational culture and leadership are clearly linked. Similarly,

the actions of leaders and responses of followers reflect the cultural values, attitudes and behaviours of each (Dickson *et al.*, 2012).

However, culture may be defined in a number of different ways, for instance, Armit *et al*. (2015, p. 16) defined the organisational culture as "the values and beliefs that characterise organisations as transmitted by the socialisation experiences newcomers have, the decisions made by management, and the stories and myths people tell and re-tell about their organisations". In another point of view, Cummins (1989) defines organisation culture as the drive that recognises the efforts and contributions of the organisational members and provides holistic understanding of what and how to be achieved, how goals are interrelated, and how each employee could attain goals. Similarly, Hofstede (1981, p. 260) defined culture somewhat more colloquially, as ''the collective programming of the human mind that distinguishes the members of one human group from those of another.''

According to Schein (1996), culture can be seen as a set of shared, taken-for-granted implicit assumptions that members of an organisation hold and that determines how they perceive, think about and react to things. In other words, it is 'the way we do things around here'. Similarly, in a recent study on the medical field, West *et al.*, (2014, p. 5) emphasise that "every interaction in an organisation both reveals and shapes its culture—for instance, how staff talk to or about patients, and how they talk to each other". Put another way, culture reflects what an organisation values: quality, safety, productivity, survival, power, secrecy, justice, humanity and so on. If there are strong values of compassion and safety, new staff learn the importance of caring and safe practice (Edgell *et al*., 2015; West *et al.*, 2014).

There have been researches studies to explore the effect of organisational culture on various human resource development programmes of an organisation. For example, scholars (including Hofstede, 1980; Ouchi, 1981; Hofstede and Bond, 1988; Kotter and Heskett, 1992; Magee, 2002) claim that organisational culture helps to provide opportunity and broad structure for the development of human resources' technical and behavioural skills in an organisation.

In another conversational theory that studied the crucial role of culture, Schein (2004) argues that culture is a pattern of underlying assumptions that have been evolved, discovered or developed by a given group as it learns to cope with its problems of external adaptation and internal integration. Figures 2-5 and 2-6 below illustrate Schein's model of organisational culture.

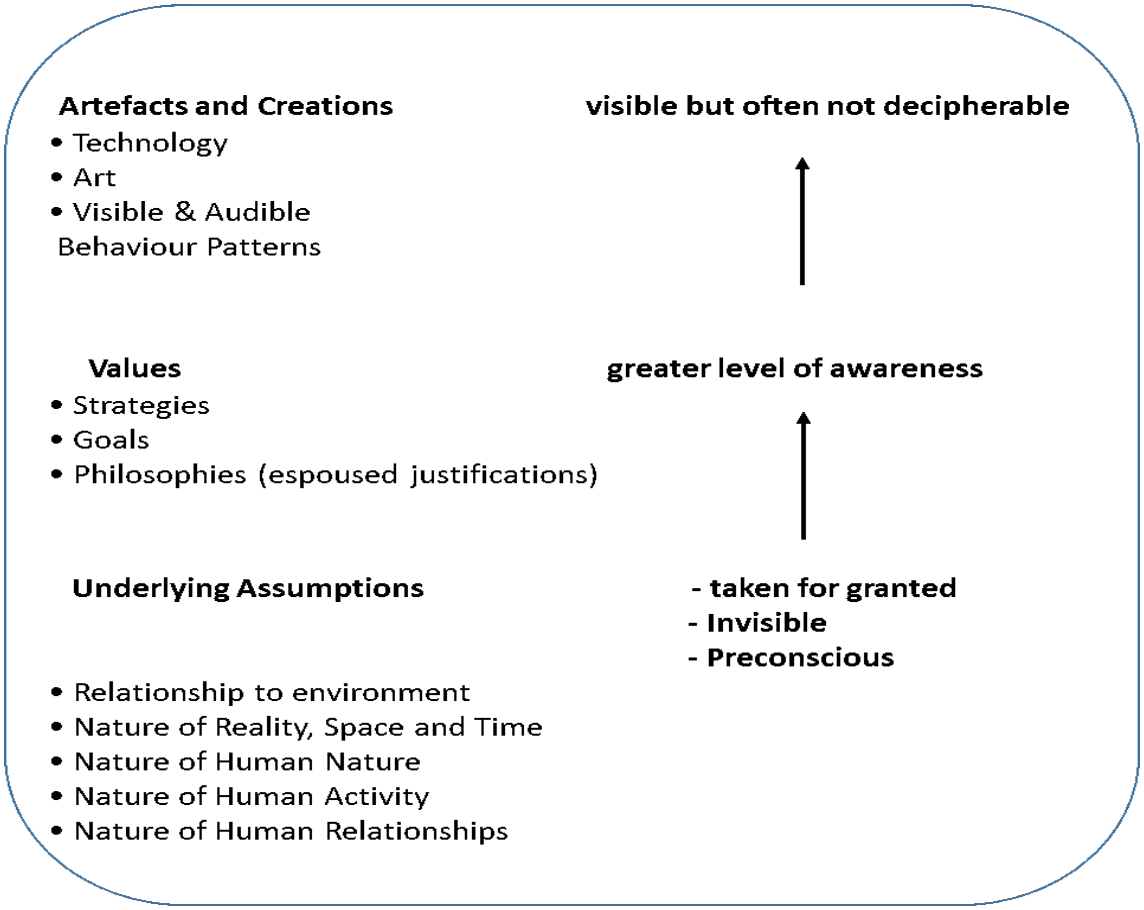


**Figure 2-5 Schein's model (1992)**

The bedrock of Schein's model reinforces the notion that before any attempt is planned to change an organisation's culture, it is first necessary to understand the nature of the existing culture and how this is sustained (Kritsonis, 2005). According to Schein, this can be achieved by analysing the values that govern behaviour and uncovering the underlying and often unconscious assumptions that determine how those in the organisation think, feel and react (Burnes, 2009). Schein's approach is to treat the development of culture as an adaptive and tangible learning process (Kritsonis, 2005). To explain the dynamic interaction

between this model's levels, Burnes (2009, p. 229) mentioned that, “it illustrates how assumptions are translated into values and how values influence behaviour”. The main idea of this model of culture is understanding current instruments used to shaped culture and how new values and behaviours are learnt (Schein, 2004).

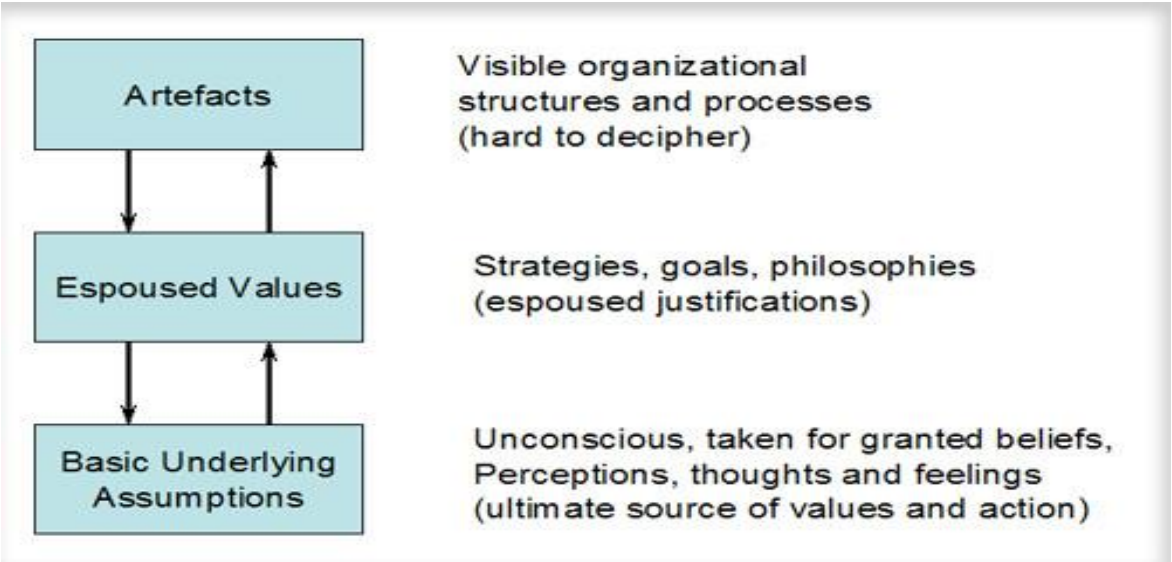


**Figure 2-6 Three levels of culture in Schein's model (Schein, 1996)**

‘Artefacts’, above, refers to the visible structures and processes of an organisation based on Schein’s theory. They include written and spoken language, the physical space and layout of the organisation and the overt behaviour of the individuals (Martin, 1992). The second level is concerned with behaviour, including organisational rituals. The third and deepest level is the basic underlying assumptions shared by group and which are historically established structures used to direct their relationship with the environment, with reality and with other human beings (Kong, 2003). This level is concerned with organisational anecdotes, stories and myths, and organisational heroes and villains. Values are the social principles, goals and standards held that have intrinsic worth in a culture (Schein, 2004). They define what the members of the organisation care about. They are unwritten rules that allow members of a culture to know what is expected of them (Schein, 1996).

It is commonly said that the organisational culture reflects the values of its employees (Engelbrecht *et al.*, 2014). According to Hodges (2016), employees

use their values to make decisions when they tackle problems, address issues and seek solutions. Underlying assumptions are the least visible aspect of the model. To understand a group's culture it is necessary to get at its shared underlying assumptions (Schein, 1996). These assumptions, however, as Schein (2004) argues, are beliefs and habits of perception, thoughts and feelings that are taken for granted and are rarely made explicit. When a solution to a problem works repeatedly it becomes taken for granted. These assumptions become learned responses that guide behaviour and determine how members think, act and feel (McLaughlin *et al.*, 2005). In Schein's model, artefacts may be easy to observe but difficult to decipher and values may only reflect rationalisations or aspirations (Skar *et al.*, 2014).

Similarly, O'Reilly (1989) states it is possible to change or manage a culture by choosing the attitudes and behaviours that are required, identifying the norms or expectations that promote or impede them, and then taking action to create the desired effect. Therefore, there is a body of opinion that sees culture as something that can be managed and changed (Adeyoyin, 2006; Hodges, 2016).

In a previous study that examined the significance of the concept of culture for organisational analyses, Smircich (1983) discussed two approaches to the study of the cultural phenomenon in organisations. In his point of view, if culture is an organisational variable, then culture is something that can be manipulated, as shown in Figure 2-7.


**Figure 2-7 Smircich concepts of culture and organisational analysis** (Smircich, 1983)

Hence, various aspects such as the nature, direction, and impact of such manipulation are dependent on the skills and abilities of the leader (Ogbonna and Harris, 2000). Additionally, based on an analysis of the different definitions of culture, Cummings and Huse (1989) produced a composite model of culture, comprising four major elements existing at different levels of awareness. Four major layers of culture have been defined below by Cummings and Huse (1989).

1. Basic assumptions – At the deepest level of cultural awareness are unconscious, taken-for-granted assumptions about how organisational problems should be solved.
2. Values – The next higher level of awareness includes values about what ought to be in organisations.
3. Norms – Just below the surface of cultural awareness are norms guiding how members should behave in particular situations.
4. Artefacts – At the highest level of cultural awareness are the artefacts and creations that are visible manifestations of the other levels of cultural elements (Schein, 2016). These include observable behaviours of

members, as well as the structures, systems, procedures, rules, and physical aspects of the organisation.

The literature review revealed that there are some factors that can play important roles in changing and influencing the organisational culture. For instance, in an earlier study, Morgan (1986, p. 139) explained that “managers can influence the evolution of culture by being aware of the symbolic consequences of their actions and by attempting to foster desired values, but they can never control culture in the way that many management writers advocate.” Hence, it is important for an organisation, before employing plans to change its culture to ensure they are applicable with the new systems design. This can help it to avoid the employees’ resistance, which, if encountered, can lead to an unsuccessful implementation (Korbi, 2015; Parmelli *et al.*, 2011). Therefore, it is obvious that the speed of leadership development, change and reform in different contexts are based on the characteristics of culture, values, traditions and history.

Finally, because this study focuses on the reasons behind making a change within an organisation and the process of this change, it is important to pay attention to the role of the organisational culture and the leadership role (Kotter, 2012).

### 2.3.1 Cultural Dimensions Models

This section describes a number of organizational culture models that aim to provide tools to understand the effects of culture on organizations performance. For instance, the Kluckhohn and Strodtbeck (1961) model is considered to be one of the earliest comprehensive models that tries to explain cultural differences (Dickson *et al.*, 2012). In their 1960s book *Variations in Value Orientations*, the authors focused on complementing the anthropological study of culture by studying variance within cultures. They believed that this approach would help researchers understand cultural change and complexity at a different level (Bryman and Bell, 2015).

However, it had some limitations; for example, Hofstede points out that it comprises “classification of all kinds of social comparisons, without concern for

their geographic limitations, without considering the effect of levels of aggregation, and without empirical support" (2011, p.4). In addition, its value orientations and variations are not precisely defined (Pantelic and Pinter, 2016; Bhagat and Steers, 2009).

Hofstede (1998) developed a four- layered hierarchical model of culture which ranges from values at the deepest level through rituals, heroes and, at the surface level, symbols. Figure 2-8 below illustrates these levels of the Hofstede model of culture (Burnes, 2009).

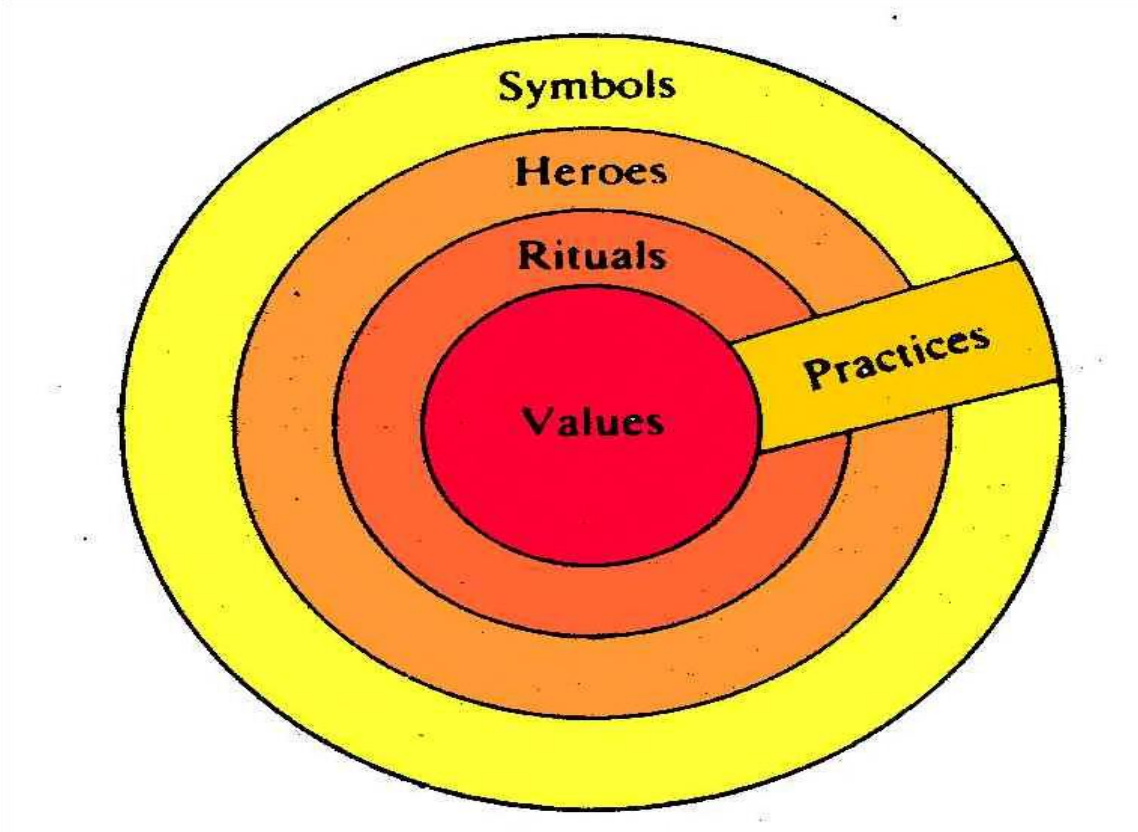


**Figure 2-8 Hofstede Model of Culture** (Hofstede, 1998)

In this context, Hofstede (1998) who studied organisational culture in depth, stated that organisational cultures can be influenced by both external factors (i.e., environmental factors) and internal factors (i.e., organisational factors). There are some external elements that can partly predetermine the organisational culture, such as nationality, market, industry, and task (Kotter, 2012). Also, organisational variables, such as control systems and structure, will partly relate to the

organisational culture (Hofstede *et al.*, 2010). In addition, Hofstede (2001) showed the importance of the leaders' values and how they influence the organisational culture of an organisation. Similarly, Bass and Avolio (1993), Hayes (2014) agreed that the values of key leaders feature the organisational culture, which, in turn, affects the members' practices.

Hofstede's (1980) well-known model of cultural dimensions is known to be based on data from the multinational company IBM, which employed people from fifty different countries. At first, he identified four cultural dimensions and then added a fifth dimension based on research by Chinese scholars. Yet another dimension was added in 2010 based World Value Survey items (Hofstede, 2011). Hofstede's seven dimensions are:

**- Power distance**, which is the degree of inequality of power between people (Wrong, 2017).

**- Uncertainty avoidance,** which alludes to how cultures deal with questionable circumstances; individualism and collectivism, or how people see themselves in society (Hofstede, 2011);

**- Individualism** versus its opposite, **collectivism**, as a societal, not an individual, characteristic meaning the degree to which people in a society are integrated into groups (Hofstede, 2011).

**- Masculinity and femininity***,* which measures the degree to which cultures support one sex over the other (Smith *et al*., 1996)

**- Long or short-term orientation**, which is how cultures deal with past, present and future in their life choices; in the business setting this measurement is called "(brief term) regulating versus (long term) down to business " (Jones, 2007).

**- Indulgence versus restraint**, which is the degree that a culture appreciates the satisfaction of needs and wants, such as, the desire to have fun and appreciation of life (Kottler, 2017).

Hofstede's (1980) model is the most influential cultural framework in cross-culture studies (Chang *et al.*, 2015). It is also popular because it is easily understandable (Tung and Verbeke, 2010).

However, the Hofstede model has been criticised by many scholars such as Schwartz (2012), who argued that Hofstede's samples of countries did not correctly reflect the full scale of national cultures. Additionally, for example, Baskerville (2003), in his paper *Hofstede Never Studied Culture*, identifies a number of limitations and argues that Hofstede's work has been rejected by both anthropology and sociology scholars who believe that there is no link between culture and nationality, a point on which Hofstede relies heavily.

## 2.4 Culture and Leadership in Saudi Arabia

The purpose of this section is to present contextual factors affecting leadership practices and development in the KSA. The kingdom of Saudi Arabia is considered the heart of the Islam world since it is facilitates the holiest mosques of Muslims individuals at Mecca and Medina (Dirani *et al.*, 2017). In a previous study investigating the history of the country, Obaid (1999) said that the nation had a solid foundation based on the relationship between Al Saud and the relatives of Sheik Muhammad ibn 'Abd al-Wahhab (1703-1792). He also stated that "this cooperative and consensual relationship has provided the kingdom with one of the most stable societies in the region and has allowed it to avoid the war and revolution that has wracked nearly every one of its neighbours" (1999, p. 51). Similarly, Al-Bakr *et al.* (2017) in their study, indicated that the KSA was created out of an course of action between religion and political control that rose in the mid-eighteenth century.

According to Al-Bakr *et al.* (2017) as an implication of preservation, Saudi Arabia has mainly adopted the Qur'an and the Prophet's Hadith (written record of Muhammad's declarations) as its Essential Law of Government. It is based on equality in accordance with the Islamic Shari'a, or Islamic law (Al-Bakr *et al.*, 2017). This clearly affects most of the leadership practices and life aspects in general of the country. This is aligned with Hofstede (2013), who argues that Arab

countries, including Saudi Arabia, are high in power-distance and uncertainty-avoidance, and are collectivist cultures where masculinity is higher than the world average. Be that as it may, the nation is experiencing quick changes: its mature administration is ceding control to a unused era, and its society, which is ruled by youthful individuals, is anxious (Dirani *et al*., 2017).

However, Aseri (2015) argues that although globalisation is influencing culture and behaviour, especially that of the younger generation, the Saudi Arabian people remain very connected to their religion, families and tribal identities.

Indeed, a new study in Saudi Arabia has shown employers are increasingly realising the benefits of investing in an inclusive culture and workforce (PM editorial, 2017). Two organisations, Glowork and AccountAbility, launched a joint study on female leadership and management in the Kingdom, with a focus on what happens once women are employed (PM editorial, 2017). “We strongly believe in the positive and sustainable value that can be created with diversity in management and leadership,” said the report’s foreword by David Pritchett, global head of research at AccountAbility and Khalid Alkhudair, founder and CEO of Glowork (PM editorial, 2017).

## 2.5 Change management

A review of the literature shows that there are many different definitions of change management. The simple definitions tend to stress the process of planning, controlling, and managing company change; whereas the more elaborate definitions detail the various culture and structural elements of change as well as the need to overcome forces of resistance. The term is commonly used to refer to the process of managing a shift from some current state of operation toward some future state. For instance, in a previous study, Moran and Brightman (2000, p. 66) described change management as “the process of continually renewing an organisation’s direction, structure and capabilities to serve the ever-changing needs of external and internal customers”. Similarly, Kotter (2012), in his book *Leading Change*, defines change management as an approach to transitioning individuals, teams, and organisations to a desired future state. In other words,

Eric D Carlström and Ekman (2012), Elwing (2005) shown, for example, that a communicative culture and the feeling of belonging to a community had a favourable effect on readiness for change. What interesting about these definitions it that it clearly links change process with culture and well-structured communication within organisations.

According to Ferlie and Shortell (2001, p. 287), “the importance of the organisation as a lever of change to improve quality lies in the organisation’s ability to provide an overall climate and culture for change through its various decision-making systems, operating system, and human resources practices”.

Change management is a systematic approach to dealing with change, both from the perspective of an organisation and on the individual level (Connor and Kilmann, 1986; Alvesson and Sveningsson, 2015). Additionally, it is argued that change management has at least three different aspects, including: adapting to change, controlling change, and effecting change (Moran and Brightman, 2000). A proactive approach to dealing with change is at the core of all three aspects. For an organisation, change management means defining and implementing procedures and/or technologies to deal with changes in the business environment and to profit from changing opportunities (Green, 2007).

According a recent study by Burke (2017), the more effectively one deals with change, the more likely the effort will lead to the desired change. Hence, Green (2007) claim that adaptation might involve establishing a structured methodology for responding to changes in the business environment like fluctuation in the economy or a threat from a competitor or establishing coping mechanisms for responding to changes in the workplace like new policies or technologies. In his book *Organization Change: Theory and Practice*, Burke (2017) argues that change management is the control and coordination of process to move to new structures of working process of actions and ways of working. Hence, in managing change, there is an intention to orchestrate or steer processes toward some preferred or predefined outcome (Burnes, 2009).

### 2.5.1 Change Management Models

The change management process is the sequence of steps or activities that a change management team or project leader follows to apply change management to a project or situation (NHS Improvement, 2011; Cameron and Green, 2015). This process will appear more like a modern science through a business-oriented approach, referred to as a change management framework (Heracleous and Marshak, 2004; Cummings *et al.*, 2016; Rothwell *et al*., 2016).

There exists in the literature a number of change models to guide and instruct the implementation of change in organisations. For example, Kurt Lewin, widely considered the founding father of change management, introduced his "changing as three steps' (CATS) model as shown in Figure 2-9 (Cummings *et al.* , 2016). According to Fullan (2001, p. 116) CATS has subsequently "dominated almost all western theories of change over the past fifty years".


**Figure 2-9 Kurt Lewin's changing as three steps (CATS) model**

Lewin's model introduced the three-step change; unfreezing the old behaviour; moving to a new level of behaviour; and refreezing the behaviour at the new desired level (Green, 2007; Cummings *et al.,* 2016). In this explanation (of why something works or happens the way it does), the third step is extremely important because it reinforces new patterns and make a behaviour acceptable through formal and informal (machines/methods/ways), including policies and procedures (Robbins, 2003). In a study discussing several change theories and assumptions about the nature of change, Kritsonis (2005, p. 6) argued that "Lewin's model is very rational, goal- and plan-oriented". From the negative side,

a change may look proper on paper, because it makes rational sense, but when implemented, the lack of consideration for human feelings and experiences can have negative consequences (Kritsonis, 2005). The main idea of this model is that the culture when changed would then remain constant until the next change came along (Goldberg *et al.*, 1992).

One of the most popular model for transforming organisations is Kotter's (1995) strategic eight-steps model (Mento et al., 2002). He developed this model for changing after conducting a study of over 100 organisations varying in size and industry nature. The main aim of this study was to learning and find answers to the question “Why Transformation efforts fail” (Kotter, 1995). However, Mento et al., (2002) indicated to two key lessons Kotter learned from the model that are the change process goes through a series of phases, each lasting a considerable amount of time, and that critical mistakes in any of the phases can have a devastating impact on the momentum of the change process (p. 46).

In his pioneering book ‘Leading Change’ Kotter (1996) stresses that successful transformations often begin, and begin well when an organization has a new and good leadership that sees the need for serious change.

Figure 2-10 below shows the strategic eight-steps model of Kotter.

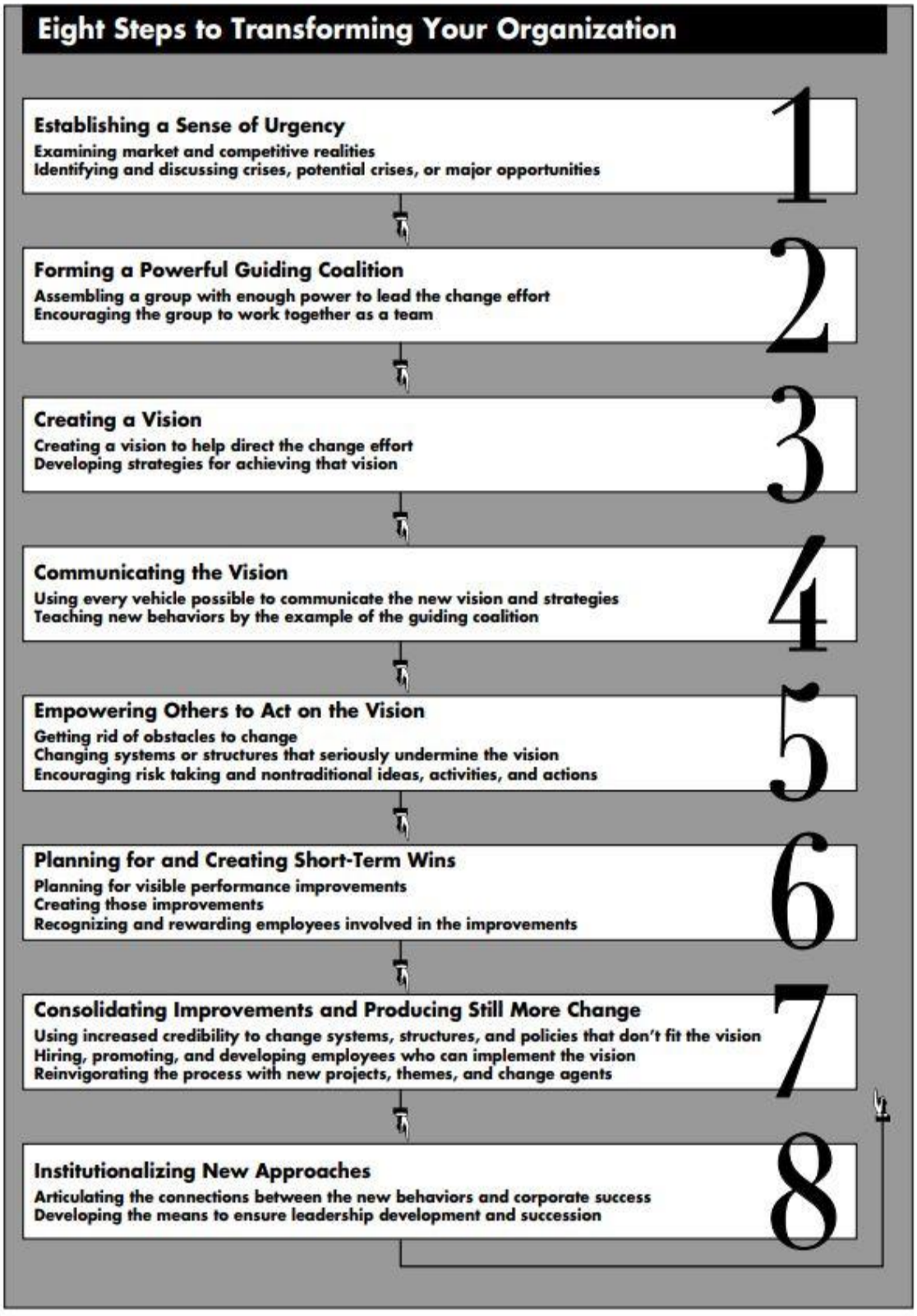


**Figure 2-10 Kotter's model of change** (Kotter, 1995)

According to Kotter (1996), following are the eight steps to transform an organization (Appelbaum *et al.*, 2012):

1- Build up an awareness of urgency about the necessity to accomplish change – it is very difficult for the people to change unless they don't realize the need to do so;
2- develop a guiding coalition – bring together a group with energy, power and organizational influence to lead the advancement;
3- establish a vision and strategy – build up a vision about the change, inform people about the necessity of change and how it will be attained;
4- convey the change vision – inform people in any feasible way and at every possibility, about the what, how and why of the changes;
5- encourage broad-based action – instead of pondering why people don't like the changes and how to change their perception, motivate people to involve in the change effort and how to attain it;
6- create short-term wins – since it is difficult to recognise the changes happening and monitor the work being executed by people to achieve the change, generating the short-term achievements will be useful;
7- build up gains and consolidate changes – establish momentum for change on the basis of successes achieved, stimulate people through the changes, develop people as change agents; and
8- support new methodologies in the corporate culture – it is difficult for long-term success and regulate the changes. Failure to do so may mean that all the hard work and effort done to achieve the success are in vain with people's tendency to return back to the traditional and simple ways of doing things (p. 766).

On the other hand, Appelbaum *et al.,* (2012), Sidorko (2008), Penrod and Harbor (1998) criticized the work of Kotter because of the difficulties in implementing all the eight steps and long-time duration to follow up the change project. In addition to that, this model fails to provide sufficient assistance for critical aspects viz. commitment and resistance to change (Jaros, 2010; Appelbaum *et al.*, 2012). In spite of this, Kotter's model remains very popular (Appelbaum *et al.*, 2012)

In another approach of applied change, Prosci's approach to change is considered one of the most effective and commonly applied change management models (Hiatt and Creasey, 2003). According to this approach, most change management processes contain the following three phases:

Phase 1 - Preparation, assessment and strategy development

Phase 2 - Detailed planning and change management implementation

Phase 3 - Data gathering, corrective action and recognition

These phases result in the following approach as shown below in Figure 2-11.

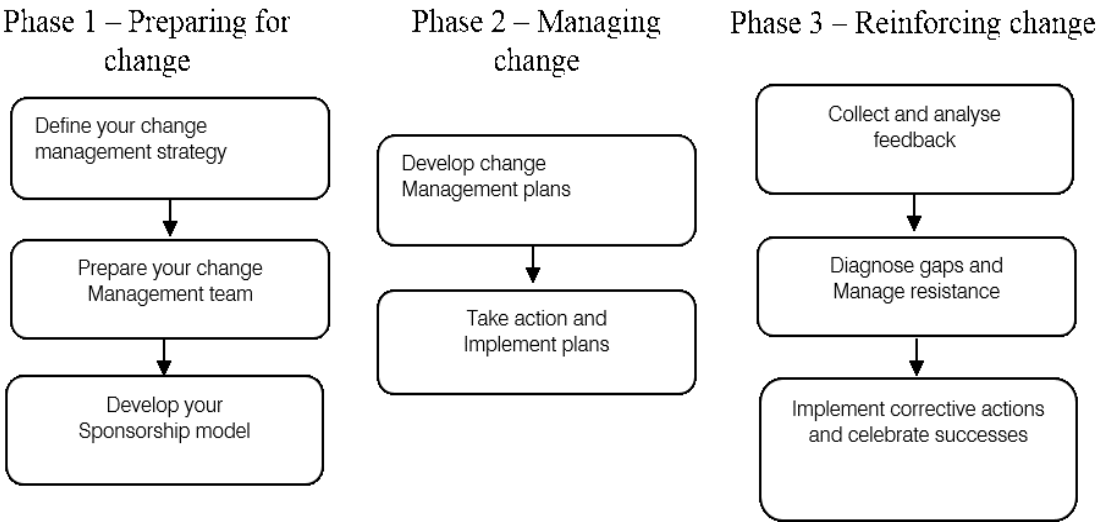


**Figure 2-11 Change management process - Prosci's approach**

The key role of the change management processes is to deal with or speak to the people and organisational factors that provide a helping force in making changes in the organisation (NHS Improvement, 2011). Thus, scanty or unclear communication when change is expected or needed can ruin attempts at change (Weber and Joshi, 2000, p. 392).

Similarly, Hassard and Sharifi (1989) suggested a similar approach but instead stress how crucial aspects of culture change. They reinforce that senior managers must understand the implications of a new system for their own behaviour: and senior management must be involved in all the main stages

preceding change (Burnes, 2009). In other words, in change programmes, special attention must be given to the company's 'opinion leaders' (Hassard and Sharifi, 1989).

In addition, Cummings and Huse (1989) identified crucial steps to cultural change implementation as shown below in Figure 2-12 . In this an action research model, Cummings and House suggest that a change plan should focus on planned changes as a cyclical process involving joint activities. They also emphasise that, in practice, a change model needs to involve multiple steps that overlap and interact. Finally, this model emphasises data gathering and diagnosis prior to action planning and implementation and making an assessment of results after implementation (Cummings and Huse, 1989).


**Figure 2-12 Steps to successful cultural change (Cummings and Huse, 1989)**

Importantly, establishing a clear vision about the direction of the change process is another key element for assuring successful change (Goldberg *et al.*, 1992; Klunk, 1997). Furthermore, measuring and monitoring outcomes of the change

process plays a crucial role in recognising whether or not the change process has fulfilled its purpose (Leatt *et al.*, 1997; Connor and Kilmann, 1986).

On the other hand, there are various of challenges to organisations to achieve its desired change. For instance, Smith (2005) highlights how elements such as people, the human resources of organisations, are both an essential factor in organisational change and, at times, the biggest obstacles to achieving change (p. 408). This in line with (Appelbaum *et al.*, 2012) who indicate to the key role of resistance to change and commitment to change which can hinder the change project.

## 2.6 Leadership in the healthcare sector

Today, leadership considered as vital topic in healthcare organisations that are keen to develop their services (Long and Javidi, 2016). Recently, investigators have examined the effects of successful leadership practices on the productivity of healthcare organisations (Holden *et al.*, 2015). According to McDonald (2014, p. 227), “There is a trend in health systems around the world to place great emphasis on and faith in improving leadership”.

Significantly, there is growing evidence in the literature that improving leadership practices in healthcare organisations results in improved safety and health levels and also leads to improving employee productivity (Long and Javidi, 2016; Kelloway and Barling, 2010).

Furthermore, leadership development is increasingly recognised as fundamental to efficient, high-quality healthcare (King’s Fund, 2011; West *et al.,* 2014). It is a key strategy for building cultures that value patient and staff experiences, learning and safety, (Francis, 2013), quality (King’s Fund, 2011; (Berwick *et al*., 2008), effectiveness and knowledge translation (Kitson *et al.*, 2008). Cultures that provide high-quality care are characterised by shared values translated into agreed ways of working that embrace care, compassion and support and are developed through leadership recognised as a collective endeavour rather than as command and control (West *et al*., 2014; Washington *et al.*, 2016).

Attempts to develop healthcare managers and leaders have been described as inadequate and contradictory (McCallin and Frankson, 2010; Townsend *et al.*, 2012). Importantly, healthcare organisations seeking to invest in their leaders should align organisational needs, system-wide leadership capability and individual leader development (C.Leadership, 2010).

The NHS Leadership Academy described leadership within the context of health and care, saying "… leadership is not restricted to people who hold designated management and traditional leader roles, but in fact is most successful wherever there is a shared responsibility for the success of the organisation, services or care being delivered." (NHS Leadership Academy, 2011, p. 6).

The nature of current global challenges and changes in healthcare is promoting a fundamental shift in the type of managers and leaders needed by organisations in this sector (Armit *et al*., 2015b). In addition, the literature suggests that both clinical and organisational aspects of healthcare organisations face significant challenges to the development of leadership at all levels (McAlearney, 2006).

Reviewing the literature reveals various factors found to influence healthcare services which have been explored in several studies. For instance, Armit *et al.* (2015) argue that health and social care services must be integrated in order to meet the needs of patients, service users and communities efficiently and effectively. In addition, healthcare has to be delivered by an interdependent network of organisations; this requires leaders to work together, spanning organisational boundaries both within and between organisations, prioritising overall patient care rather than the success of each component (Armit *et al.*, 2015).

Moreover, McAlearney (2006, p. 968) argued that "complexity in the healthcare industry undoubtedly creates special challenges for leadership and leadership development, stemming from a combination of both environmental and organisational factors". Recent studies in the literature provide clear evidence of the link between leadership and a range of important outcomes in health services. For Instance, patient satisfaction, patient mortality, organisational financial

performance, staff well-being, engagement, turnover and absenteeism, and overall quality of care (Armit *et al*., 2015).

Results from earlier studies demonstrate a strong and consistent association between some aspects within workplaces to facilitate improvement. For instance, Fottler (1981) discusses how the different constraints that are characteristic of each sector are likely to impact the carrying out of managerial functions (planning, organising, leading, and controlling).

Previous studies have also reported some of the characteristics that leaders in healthcare can embody to stimulate enthusiasm in others include a positive vision, inspiring core values, emotional intelligence, courage, and an engaging and inclusive leadership style (Bilimoria *et al.*, 2005). In particular, theories of charismatic (House, 1996) transformational (Bass and Riggio, 2006) and visionary leadership (Sashkin, 1988) have inspired volumes of research and numerous training programs for business managers (Thach and Thompson, 2007c).

However, recent several developed competency frameworks have emerged particularly to help the healthcare sector to improve its performance. For instance, Bolden *et al.* (2003) offer several public sectors frameworks, such as:

1- NHS Leadership Qualities Framework, Bolden *et al*., (2003):

This framework is based on 15 different competencies that relate to personal qualities, setting directions and delivering services, as follows.

- **Personal qualities**: Self-belief, Self-awareness, Self-management, Drive for improvement, Personal integrity.
- **Setting Directions**: Seizing the future, Intellectual flexibility, Broad scanning, Political astuteness, Drive for results.
- **Delivering services**: Leading change through people, Holding to account, Empowering others, Effective and strategic influencing, Collaborative working.

In a recent study aimed to exploring a shared leadership perspective for NHS doctors Willcocks and Wibberley (2015) indicate that leadership or management has received less attention in healthcare sector where doctors have not generally occupied such roles outside their practices (O'Riordan and McDermott, 2012).

In a study aiming to fill the gap in leadership performance in the healthcare sector, C.Leadership (2010) argued that healthcare organisations seeking to invest in their leaders should align organisational needs, system-wide leadership capability and individual leader development. In the same study, three elements have been emerged as the key findings of the research. It emphasises that (C.Leadership 2010);

- The top priority for leadership development in the healthcare sector is to improve the ability to lead employees and work in teams.
- Healthcare organisations also need to create strategies to provide current and future leaders broad, cross-organisational experiences and learning.
- The ability to adapt to change and to meet business objectives are strong points for healthcare leaders.

In a recent study investigated the future of leadership in healthcare, B.E.Smith, (2018) emphasize that successful leadership has always been important for healthcare organizations improvement, but in today's competitive environment it is critical. This founded that leaders in healthcare not only need to represent clinical knowledge on the management team, but also need to be improved in different areas. For instance, it essential to them to build required soft skills in strategic planning to in order to enable them to be integrated in the leadership structure (B.E.Smith, 2018).

## 2.7 Research Gap

Significantly, a review of the literature indicates that there is a lack of research that investigates the impact of leadership practices and organisational culture on organisations' productivity in the healthcare sector in Saudi Arabia (Aseri, 2015; Khan and Varshney, 2013; Saleh and Otaibi, 2017). Additionally, much uncertainty still exists about the relationship between the effectiveness of

competencies and leadership performance. For instance, Boyatzis and Boyatzis (2008) find only a limited number of published studies on the relationship between competencies and performance, as seen in Figure 1. Furthermore, in her book, Still Moving, Rowland (2017) emphasises that leadership competency frameworks and engagement processes rarely embrace the importance of the influence of culture and the behaviours of leaders in the decision process.

In addition, McAlearney (2006, p. 969) indicates the importance of management practices in healthcare organisations, stating, “In healthcare settings, there is often little attention given to how to improve management practice, increasing the likelihood that previous mistakes will be repeated”. In the same study, McAlearney, (2006) states that few organisations in the healthcare sector have made a clear investment in developing leaders and talent management. This is consistent with Turner (2017), Liu et al.; (2016) who recently emphasises the key role of management practices development in delivery of good services by healthcare organisations. Taken together, these studies support the notion that developments such as these frameworks may be beneficial to fill this noticeable gap as shown above in Figure 1-1. Similarly, in a recent study aimed to investigate the effects of leadership competency frameworks on leadership development in healthcare, Czabanowska et al., (2014) stated that:

“Although considerable work has been done in the development of leadership competencies in the field of health worldwide, these frameworks seem very generic and none of them was specifically developed to support the educational curriculum for public health professionals” (p. 851).

In a recent study, McDonald (2014, p. 228) noticed that “a recent review of leadership development programmes in healthcare notes organisational goals”. Significantly, the research literature on leadership in general does not show that competency frameworks are yet capable of allowing leaders to improve their effectiveness (Armit et al., 2015).

However, a further review of the literature also shows that the topic of leadership competencies in Saudi health organisations has not received enough academic

attention. For instance, Al-Borie and Abdullah (2013) indicated the limitation of social research towards organisational and structural reforms in the services of the healthcare sector. There is also a small amount of empirical evidence about the value of leadership practices in shaping the healthcare effectiveness in the Gulf Cooperation Council (GCC) countries and particularly, in the Kingdom of Saudi Arabia (KSA) (Khoja *et al.*, 2017; Alkhamis *et al.*, 2017).

## 2.8 Chapter Summary

In summary, this chapter has critically reviewed and discussed the literature surrounding four theoretical dimensions of culture, leadership, competencies and change management approaches. As a result of this wide literature review a research gap has been identified as Figure 1.1 shows.

The research gap lies in the intersection of the dimensions and can be expressed as exploring a culture of performance improvement in the context of leadership in the healthcare sector organisations.

# 3 RESEARCH METHODOLOGY AND DESIGN

## 3.1 Introduction

It will be useful first to define how research and methodology are interpreted and understood in this study. In attempting to define the research concept Gorman and Clayton (2005) claimed that research is an inquiry process that has clearly defined parameters and has as its aim the discovery or creation of knowledge, or theory building; teasing, confirmation, revision, refutation of knowledge and theory; and/or investigation of problems for local decision making (p. 2).

Methodology, on the other hand, is what determines the research framework that will be used in practice (Johnson and Onwuegbuzie, 2004). According to Wellington (2000), methodology is the "activity or business of choosing, reflecting upon, evaluating and justifying the methods you use" (p.22). The term 'methodology' as used in the social sciences refers to the principles on which the implementation of a study is based. Therefore, it can be considered as a framework for all the stages that form part of any particular study. The design of the research is also crucial in determining which methodology should be applied. The methodology is therefore selected on the basis of its suitability in helping to answer particular research questions (Eriksson and Kovalainen, 2015).

This chapter discusses the philosophical assumptions and will be explained by identifying the ontological and epistemological standpoints assumed also the design strategies underpinning this research study. The chapter explains and justifies the methodology and methods that this study has undertaken. It starts with the justifications behind choosing this study's paradigm. The final part discusses the research methods of this study. It sets out the methods conducted to collect and analyse the data; and procedures to ensure validity and reliability and the way in which triangulation was employed as a research process in this study will be illustrated.

## 3.2 Research Philosophy

Understanding the philosophical position underlying the research is important foundation for researchers choosing the research design that is most appropriate to their research project (Broad, 2014; Collins, 2017). This position explains the relationship between data and theory and helps to structure the research design (Easterby-Smith *et al*., 2012; Giacobbi *et al*., 2005). Moreover, Mills *et al*. (2006, p. 26) state, "to ensure a strong research design, researchers must choose a research paradigm that is congruent with their beliefs about the nature of reality".

### 3.2.1 Research Paradigm

The social science literature illustrates many definitions of 'paradigm' in research, but they all set boundaries for work of this kind. For example, Bogdan and Biklen (1998) define a paradigm as "a loose collection of logically related assumptions, concepts, or propositions that orient thinking and research". Schwandt (1997), however, argues that a research paradigm is a set of beliefs and values that are shared between the researchers in the same program. Before him, Lincoln and Guba, (1989, p. 105) claimed that 'paradigm' means "the basic belief system or world view that guides the investigator, not only in choices of method, but in ontologically and epistemologically fundamental ways". Significantly, Mackenzie and Knipe (2006, p. 194) stress that "without nominating a paradigm as the first step, there is no basis for subsequent choices regarding methodology, methods, literature or research design". The three main components that can help researchers to define the term appropriately are their beliefs about the nature of knowledge; the methodology that their research requires; and their criteria of validity (Mackenzie and Knipe, 2006; Collins, 2017). The two particular areas of philosophy, moreover, that shape the way of thinking about reality and beliefs about the world are ontology and epistemology (Burrell, 1979; Broad, 2014).

#### 3.2.1.1 Ontology

Ontology refers to the nature of the world, or what people see as 'reality', which, of course, contributes to their understanding of what 'knowledge' is; essentially, it discusses objectivism and constructivism. Greener's view (2008, P.33) is that

“objectivism states that social entities have an existence, which is separate from the people in them”.

In a study investigating research methods, Mackenzie and Knipe (2006) stated that at the opposite extreme, constructivism claims that social phenomena and their meanings cannot be understood separately from the social factors currently in play. Furthermore, a constructivist approach attempts to clear a pathway toward the possibility of attaining knowledge by assuming that “it is constructed in the minds of those who think about it” (Greener, 2008. p. 33). In their study, Mills *et al.* (2006a) argue, “Constructivism is a research paradigm that denies the existence of an objective reality”. In addition, Golafshani, (2003) states that constructivism values the multiple realities that people have in their minds. Furthermore, Crotty, (1998, p. 42) also defines constructivism from a social perspective as "the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context. In addition, constructivists take a subjective view of the world and attempt to understand the processes through which reality is produced (Crowther, Lancaster and Lancaster, 2012).

#### 3.2.1.2 Epistemology

Epistemology deals with the nature of what we can know or reveal as “true,” but taking account of the nature of social entities, such as organisations (Greener, 2008b; Padgett and Deborah, 2016). In addition, this approach is concerned with how we know reality and within the relationship between the researcher and what is known (Klenke, 2016).

It does so because at its heart it is concerned with the study of knowledge. It asks how knowing works, and how to clear the route towards it (Lincoln and Denzin, 1994). In this regard, positivists assume that one reality exists and it is the duty of the researcher to discover it (Klenke, 2016; Mertens, 2014a). Data already exist in the world; the researcher notes them and ‘discovers’ theory from them. Furthermore, positivism, the epistemological position that views the world as

objective, measurable, value-free, generalisable and replicable (Scott and Usher, 1996; Basit, 2010; Collis and Hussey, 2013). Similarly, Hjorth et al., (2015, p. 252) argue that “positivists believe that knowledge is objective, and is acquired by examining empirical evidence and testing hypotheses to uncover general or fundamental laws”.

On the other hand, Interpretivists, however, consider that there are multiple realities (Lincoln and Denzin, 2003). The interpretive view is the opposite of the positivist view in that it accepts that the observer makes a difference to the observed and that reality is a human construct (Alvesson and Sköldberg, 2017). Thus, the study of a social phenomenon can only be understood from the point of view of the individuals who are directly involved in the activities to be studied (Burrell and Morgan, 1994) (Hjorth et al., 2015).

Further paradigm is realism or critical realism which focuses mainly on the reality and beliefs which already exist independently of the perceiving mind, i.e. the reality existing in the environment (Willis, 2007). There are two types of this paradigm. Direct realism which argues that what we experience with our senses is the accurate reality while critical realism holds that sensory experience is not true reality (Crowther and Lancaster, 2012; Collins, 2017)

Table 3-1 below describes these different philosophical paradigms.

**Table 3-1 Research philosophy paradigm** (Fontana *et al.*, 1998; Merriam, 2014)

| | Positivism | Post-positivism | Realism | Constructivism |
|---|---|---|---|---|
| Ontology | Objective point of view | The findings are probably objectively true | Both subjective and objective points of view | Subjective point of view |
| Epistemology | Reality is objective and apprehendable` | Reality is objective, but only imperfectly knowable | Reality is merely virtual and is shaped by social, political, cultural and economic values | 'Reality' is constructed from local, specific, constructed values |

However, it is important to choose the most appropriate methods for what is being investigated (Collins, 2017; Anderson, 2010). A constructive-interpretive philosophical approach, applying a qualitative strategy, is the most appropriate for the present research, since it is exploratory and interpretive in nature. According to Sekaran and Bougie (2010, p. 120), "an exploratory study is undertaken when not much is known about the situation at hand, or when no information is available on how similar problems or research issues have been solved in the past". Similarly, Pidgeon and Henwood (1997) state that a constructive-interpretive philosophy is likely to contribute most to understanding the subjective interrelationship between researchers and their participants, as well as the construction of meaning.

Adopting this ontological position to discuss the challenging questions underlying the theories and models in the present study and to better understand the ontological status of the world will help in addressing the research problems (Lincoln and Denzin, 1994; Broad, 2014).

### 3.2.2 Research Approach

The appropriate approach depends, as we have seen, on the nature of the research. In the study of Mackenzie and Knipe (2006, p. 194) "the most common

definitions suggest that methodology is the overall approach to research linked to the paradigm or theoretical framework, whilst the method refers to systematic modes, procedures or tools used for collection and analysis of data".

According to Johnson et al., (2007) there are three major "research paradigms" (quantitative research, qualitative research, and mixed methods research) (p. 112). In other words, several authors indicate these three major research approaches in studying leadership and management, (Gorman and Clayton, 2005; Briggs et al., 2012; Hibberts & Jonson, 2012). Both the quantitative and the qualitative paradigm have received wide-ranging criticism. Whether the researcher chooses a quantitative or a qualitative paradigm depends on the research question to be answered (Bryman and Bell, 2015; O'Dwyer and Bernauer, 2013). Therefore, the decision as to which one to choose depends mainly on the philosophical assumptions which underpin the aims of the study. In next sections all these approaches have been discussed.

#### 3.2.2.1 Quantitative Research

Wide range of literature attempted to explore the nature of this approach of research. For instance, O'Dwyer and Bernauer (2013), Robson and McCartan (2016) claim that quantitative research relies on the collection of numerical data. In addition, Creswell (2003) defined quantitative research as research "in which the investigator primarily uses post-positivist claims for developing knowledge" (p.18). in addition, Creswell (2015) describes quantitative research as "an approach for testing objective theories by examining the relationship between variables" (p. 55). These variables, in turn, can be measured, typically on instruments, so that numbered data can be analysed using statistical procedures". In other words, quantitative research uses quantified data (numbers) to explain phenomena by applying numerical analysis (statistical methods) (Aliaga and Gunderson, 2005). This type of research focuses on human behaviour, transfers data into numbers, analyses data through statistical techniques, and results in objectivity between researcher and participants (Creswell, 2015).

In a previous study, Sale et al., (2002) characterised quantitative research as being numerical in nature and based on positivism; the empirical data are the main feature of the paradigm. Furthermore, quantitative research is concerned with existing variables and their measurement tools (Silverman, 2015).
The nature of quantitative research is therefore positivistic, and it is applied in naturalistic settings by examining a phenomenon scientifically, isolating it from its context (Somekh and Lewin, 2005; Sale et al, 2002) . In the social sciences, any type of quantitative research, whatever its assumptions, can be employed in researching human phenomena by using standardised measurements and examining relationships between dependent and independent variables. According to Creswell (2003), quantitative research can be divided into two main types: experiment and survey.

However, the main criticism of quantitative research is that it does not provide a deep understanding of the phenomenon under study and may not apply to particular local contexts or to particular individuals and circumstances (Sale et al, 2002). It might overlook some important phenomena and the presentation of findings may be too general (Johnson & Onwuegbuzie, 2004) and may fail to reflect the whole picture of the phenomenon under study.

#### 3.2.2.2 Mixed Methods Research

Mixed methods research is still a relatively young methodological paradigm in social science and educational research (Mayoh and Onwuegbuzie, 2015). The term, ‘mixed methods’, refers to the use of qualitative and quantitative data in a single research study. According to Johnson et al., (2007) mixed methods research is one of the three major “research paradigms” (quantitative research, qualitative research, and mixed methods research).

Various studies attempted to describe this approach of research. For instance, Johnson et al. (2007) gave a recent definition of mixed methods research as “Mixed methods research is an intellectual and practical synthesis based on qualitative and quantitative research; it is the third methodological or research paradigm (along with qualitative and quantitative research)” (p. 129).

In their recent study, Teddlie and Tashakkori (2012) argue that mixed methods researchers must be competent in the full spectrum of research methods and approaches to select the best paths for answering their research questions (p. 777). There are, however, challenges associated with adopting a mixed methods approach. One such challenge is the difficulty of determining at which stage interpretation should take place, given the lack of practical guides as to how to accomplish a genuine integration of the findings derived from both methods (Gummesson, 2000). Similarly, one of the key criticisms of mixed methods research is that it is often adopted uncritically by researchers, who pay little attention to the paradigmatic differences between methodological approaches (Sale et al., 2002).

#### 3.2.2.3 Qualitative Research

Qualitative studies deal with information that is not numeric in nature. (Charmaz and Belgrave, 2002) Groman and Clayton (2005) define qualitative research as: A process of enquiry that draws data from the context in which events occur, in an attempt to describe these occurrences, as a means of determining the process in which events are embedded and the perspective of those participating in the event, using introduction to derive possible explanations based on observed phenomena (p.3).

Qualitative research is formed by the nature of the inquiry and its assumptions, which rely on interpretivism and constructivism (Holloway and Galvin, 2016). In addition, qualitative research focuses on human experiences and interactions within a particular context, and how people cooperate (Creswell *et al.*, 2003).

According to O'Leary (2017), qualitative data is represented through words, pictures or icons and analysed using thematic exploration; quantitative data is represented through numbers and analysed using statistics. Given that the present research into social phenomena is exploratory and interpretative in nature, qualitative methods are, as stated above, the most appropriate for it (O'Leary, 2017; Denzin and Lincoln, 2017; Alvesson and Sköldberg, 2017).

To gain a sufficient understanding of the participants' thinking and their views about leadership, qualitative research is often effective and efficient (Lincoln and Denzin, 1994; Bryman and Bell, 2015). Furthermore, Cassell and Symon (1994), Alvesson and Sköldberg, (2017) also suggest that the qualitative method is particularly useful if the research question is related to organisational processes.

Therefore, this research is intended to study social phenomena that will reveal something about leadership competencies and how they may help to improve the performance of leadership organisations in healthcare sector. In addition, as this study aims to understanding how leadership performance in the healthcare sector can be influenced by organisational culture and other possible factors, the answers to these questions can be obtained through participants' interpretations. The meaning of their stories can be explored and interpreted. Therefore, qualitative methods are called for in this research; they can help the researcher to gather sufficient data from which to construct a theory (Alvesson and Sköldberg, 2017; Bryman and Bell, 2015).

Qualitative research, broadly defined, means "any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification" (Strauss and Corbin, 1990, p. 17), but instead is the kind of research that produces findings arrived at from real-world settings where the "phenomena of interest unfold naturally" (Patton, 2002, p. 39). Furthermore, Cassell and Symon (1994), (Gorman and Clayton, 2005) argue that the qualitative method is more powerful if the research question is related to organisational processes. Additionally, O'Leary (2004) emphasises that qualitative data are represented through words, pictures, or icons and analysed using thematic exploration, whilst the quantitative approach is represented through numbers and analysed using statistics. It has been suggested that in order to gain sufficient understanding of the participants' thinking and their views about the leadership, the qualitative method can offer an effective and efficient way to acquire that knowledge (Lincoln and Denzin, 1994).

Hence, qualitative methods are useful for identifying and characterising the desirable outcomes of studies like this one. It is widely accepted that

interpretivist/constructivist approaches to research set out to understand “the world of human experience” (Bryman and Bell, 2015; Cohen and Manion, 1994). In line with this, Greener (2008b) claimed that “a qualitative approach to research is likely to be associated with an inductive approach to generate theory”. Moreover, in another study Murphy *et al.*, (1998) reinforce that much contemporary qualitative work stresses its inductive character, whilst quantitative work tends to stress its deductive character. Hence, an interpretivist model can facilitates constructing knowledge rather than seeking to find it in reality (Greener, 2008; Padgett and Deborah K., 2016). Table 3-2 outlines the paradigms with their primary methods and tools.

**Table 3-2 Paradigms, methods and tools (Mackenzie and Knipe, 2006)**

| Paradigm | Methods primarily employed | Data collection tools |
|---|---|---|
| Positivist/ Post-positivist | Quantitative: “Although qualitative methods can be used within this paradigm, quantitative methods tend to be predominant" (Mertens, 2014b) | Experiments<br>Quasi-experiments<br>Tests<br>Scales |
| Interpretivist/ Constructivist | Qualitative methods predominate, although quantitative methods may accompany them. | Interviews<br>Observations<br>Document reviews<br>Visual data analysis |
| Pragmatic | Qualitative and/or quantitative methods may be employed. Methods are matched to the specific questions and purpose of the research. | May include tools from both positivist and interpretivist paradigms: Interviews, observations, testing and experiments. |

### 3.2.3 Research Methods

The research methods are the sources and tools that the researcher uses to collect the required data (Denzin and Lincoln, 2017; Collins, 2017). Qualitative data collection methods emerged as soon as researchers admitted that traditional quantitative data collection methods could not capture human feelings and emotions (Broad, 2014; Crabtree and Miller, 1999). Designing and analysing qualitative research involves greater subjectivity than quantitative data may allow ( Denzin and Lincoln, 2017; Jick, 1979; Bryman and Bell, 2015).

Hence, a grounded theory (GT) approach was taken in the present work to elicit the perceptions of the participants from the organisation (Glaser, Strauss and Strutzel, 1968). The interpretive paradigm and GT were found to be useful for this research in enabling the researcher to use individuals' perceptions and meanings in order to explore, explain and describe what is going on; they enabled the researcher to construct a theory that was grounded in the data collected (Corbin and Strauss, 2014). GT attempts to generate theory inductively from data as it emerges rather than verifying prior theories on the basis of the collected data (Locke, 2001 ; Greener, 2008; Corbin and Strauss, 2014).

#### 3.2.3.1 Grounded Theory Approach

Grounded theory was introduced by two American sociologists, Glaser and Strauss, in 1967, in their seminal publication (Holton, 2008). They introduced the GT approach after they undertook research in an area that had not been previously investigated and they were unable to identify an appropriate research framework (Glaser and Strauss, 1967). In order to clearly understand the emergence of GT, one should review the backgrounds of the two founders of GT. Glaser graduated from the University of Columbia, a quantitative and empirical research-based institution, (Holton, 2008; Tillmann, 2003). Strauss, on the other hand, studied at the University of Chicago where he had been influenced by scholars of symbolic interactionism (Holton, 2008;Ullah, 2012). Symbolic interactionism claims that people react to their situations based on the meanings they attach to them (Corbin and Strauss, 1990).

Based on the above backgrounds, it can be noted that Glaser was behind the continuum comparisons of data in GT (Corbin and Strauss, 1990), whilst Strauss encouraged the focus on respondents' views and values to generate concepts and theories. According to Holton (2008), the well-documented schism in the collaboration between Glaser and Strauss occurred with the publication of *Basics of Qualitative Research* (Strauss and Corbin, 1990).

GT facilitates the understanding of social reality, and lets the data tell their story (Glaser and Strauss, 1967). The concepts of GT are discussed in greater depth below. GT is expected to reflect reality and give a clear understanding of the phenomenon to clarify the gap between theory and practice by providing a meaningful guide to action (Glaser*et al.,* 1968, Corbin and Strauss, 2014).

The main difference between GT and other methodologies is its focus on data rather than having a preconceived theoretical framework (Fischer, 2005; Bryman and Bell, 2015). This focus is meant to enhance the reflection of what is going on, and to have theorised data that have direct contact with a complex social world (Charmaz *et al.*, 2015; Strauss, 1987). Therefore, GT gives a better understanding of the phenomenon and consequently closes the gap between theory and practice.

There are different sources of data that can be used for qualitative research as shown in Table 3-3 below.

**Table 3-3 The main sources and procedures in this study, related to most popular qualitative methods (Yamagata-Lynch, 2010)**

| Methodology | Sources | Procedure |
|---|---|---|
| *Document analysis* | Reports, Future plans, publications | Read all materials and documents related to the research subject |
| *Interviews* | Primary participants, Secondary participants | Tape recorded semi-structured interviews, then transcribed the interviews for the participants to review |
| *Observations* | Observed participants' interactions | Took notes |

The tools depend mainly on their availability and their suitability for the research and the research questions (Corbin and Strauss, 2014; Willig and Rogers, 2008).

This study has utilised interviews, informal chats, field notes, journals/magazines, observation to collect the data required. According to Padgett and Deborah (2016), in qualitative research, the potential data come from different sources, such as formal and informal interviews, participant observation and document analysis. Adopting any of these sources will significantly help the researcher, using an inductive approach, to understand the stories people tell, built up from their experiences (Mills *et al.,* 2006b; Denzin and Lincoln, 2017).

The appropriate method that was found to elicit the aspects that control performance in the fieldwork was to use a particular issue as a focus (Sackmann, 1991). This encourages participants to focus their attention on a specific action. According to Sackmann (1991, p. 299), "An issue focus enables both the surfacing of tacit components of culture and comparisons across individuals and research settings". Furthermore, an issue focus method introduces a specific context that forces participants to draw on their existing knowledge (McLaughlin, Bessant and Smart, 2005). This method helped the researcher to understand the aspects that influence the culture of the organisation.

Moreover, capturing the specific aspects that play key roles in the field study was essential for carrying out the remainder of the research process.

An issue focus is hence crucial for ensuring that the stories from the respondents reflect the same cultural aspects within the organisation (Sackmann, 1991). Adopting an issue focus enabled the present researcher to understand the tacit components that were shaping the values of the culture and gain some perception of the factors influencing the performance of the organisation through its members. An issue focus was used to determine the factors that affect performance within the field study.

A case-study approach was chosen to conduct this exploratory field study as shown in Table 3-4. Robson (2002) defines the case study as "a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon". It also provides the researcher to study the system, process, and functions of both the organ8isation and the individual (Creswell, 2015).

**Table 3-4 Research Methodology**

| **Paradigm** | **Interpretivist** | | |
|---|---|---|---|
| Research Approach | **Field Study** | | |
| Research Strategy | **Qualitative** | | |
| Research Methods | **Interviews - Issue focus** | **Observation** | **Focus Groups** |
| Analytic Framework | **(Open Coding, Selective Coding, and Axial Coding) - Textual analysis** | | |

### 3.2.4 Research Process

To achieve the aim and objectives of this research, the following phases, shown in Figure 3-1, have been identified. A diagram is provided to show the research journey.

**Phase One: Exploring the Literature Review**

**Tasks:**

Conduct a comprehensive review of the literature in order to understand the various aspects of the research and to establish a comprehensive understanding of the field of research topic, as well as other related areas. This includes covering the related concepts, definitions, models and frameworks.

**Methods:**

Conduct a literature review of articles and documents. Attend conferences; meet and discuss the topic with experts and colleagues. This phase is to identify key aspects, main authors and writers, as well as specialised journals and organisations.

**Phase Two: Carrying Out Pilot Studies**

**Tasks**:

To determines in detail the main research problem in the field study that will be investigated in this research. Also, explore the existing enablers and inhibitors that influences on leadership performance in the healthcare sector of the KSA and its characteristics. First, the researcher conducted a pilot study between June and July 2015.

**Methods:**

The fieldwork of the first stage of the study consisted of nine semi-structured interviews with participants from different job/position levels to elicit their beliefs and experiences. The questions aimed to identify the factors that relate to performance level, as encouragers or inhibitors of performance improvement.

Before the fieldwork began, ethical clearance was obtained from Cranfield University. The face-to-face interviews of the pilot study each lasted between 45 and 92 minutes. In an attempt to make each interviewee feel as comfortable as possible, the interviewer tried to build a good relationship with participants prior to each interview.

At the start of data collection, the participants received a description of the purpose of the study. All of the participants agreed to the audiotaping and transcription of the interviews, which produced a total of 515 minutes of speech and over 187 pages of transcripts. The interviews were first conducted in Arabic, and then the interviews were transcribed and translated into English. The study aimed to investigate what aspects in particular of the field under study and its culture ultimately affect the performance of its top-ranking officers. The data were collected and then triangulated – semi-structured interviews were checked against a document review and the findings from a focus group discussion and direct observation.

Jick (1979) explains the term ‘triangulation’ as the use of multiple techniques for data collection and analysis to investigate the same phenomenon from different viewpoints. Verbatim quotations representative of the data were selected (McAlearney, 2006). However, the researcher allowed the data to tell their own story, not spinning it to cover any specific topic. The researcher immediately wrote notes about every interview as soon as it ended.

After the first phase of interviews had finished, the researcher began to analyse the data to discern the main themes, phenomena and problems in the field in order to focus upon, explore and better understand them in the succeeding phases. After transcribing the recorded interviews and collecting the relevant documents, the researcher re-read the data several times to ensure an in-depth understanding of the case study. Following this, he coded them and compared them with each other (theoretical sampling). These codes/concepts were then categorised and the categories in turn were compared and verified. The data were read again to enrich and/or confirm the categories.

The researcher designed and conducted a pilot study in the KSA as an initial step in order to help in clarifying the research problem issues and key elements. This study used interviews (issue focus) with selected interviewees among the health affairs of the Ministry of Saudi National Guard.

**Phase Three: Collecting Data for the Main Study**

**Tasks:**

This phase represents the main body of research conducted in the health affairs of the National Guard of Saudi Arabia; large amounts of data were gathered from various resources. This phase validated the themes that emerged from the analysis of data. Moreover, it helped further identify leadership competencies that are needed, as well as enablers and inhibitors that influence leadership performance, to improve performance in the healthcare sector.

**Methods:**

A set of interviews included executive managers, senior managers and general staff of the health sector of the National Guard of Saudi Arabia in order to ensure objectivity in the data analysis of the result. Other qualitative methods, such as a focus group and observations, were considered essential in this task in order to improve the validity of findings.

During the second stage of the study, a second series of personal interviews was held between December 2015 and January 2016. The interviewees were asked to take part in refining the factors that emerged. Sixteen interviews were conducted with participants of different ranks than those in the first series. Semi-structured interviews (issue focus) were retained and the interviews were preceded, as before, by a description of the purpose of the study. The researcher also took field notes during the interviews to record any new ideas. Before this new data collection, the participants agreed to have their interviews audio recorded and transcribed, producing approximately 832 minutes of speech and over 293 pages of transcripts. The interviews were conducted in Arabic and then

were transcribed and translated into English. A qualitative data analysis tool, NVivo, was used to facilitate the data reduction and coding procedures.

Constant comparisons with the literature and the collected data as well as the iterative steps of data collecting from the participants was carried out (Goulding, 2009).

**Phase Four: Emergence of the main themes**

**Tasks:**

The aim of this stage of data collection was to refine the emerged aspects, aggregate the codes into significantly fewer second-order concepts and then divide them into categories (main themes).

**Methods:**

Rosch's definition (1978) guided the field study engagement and the grouping of categories into main themes using a collaborative workshop, which offers another advantage of data collection. It was decided that the best method to adopt for this investigation was open discussion in one place.

A selected group of the research participants was invited to a workshop with the aim to gather feedback to refine the factors that had emerged from the analysis of the first data collection phase. This was in June 2016. The purpose of this workshop was to aggregate the aspects into main themes. Table 3-5 shows the details of the participants in this workshop.

**Table 3-5 Participants demographics**

| Gender | Position | Age | Experience in years | Qualification |
|---|---|---|---|---|
| Male | Executive Director | 53 | 25 | Master's degree |
| Male | Executive level | 54 | 29 | Master's degree |
| Female | Operational Manager | 42 | 12 | Master's degree |
| Male | Manager | 39 | 9 | Bachelor's degree |
| Female | Administrative coordinator | 24 | 2 | Bachelor's degree |
| Male | Operation Services | 38 | 14 | Bachelor's degree |

**Phase Five: Self-assessment against the ideal position of the emerged themes**

**Task**

The aim of this assessment was to identify the themes that were farthest from the ideal position and use them as opening points for group discussions about mediations that might revolutionise the culture toward improved performance.

**Methods**

Descriptive formations of leadership performance culture were developed for each of the themes. A series of short statements relating to each of the seven themes was developed to demonstrate an ideal position in the culture of leadership performance improvement. Fifty-two individuals of out of 65 returned the questionnaires.

**Phase Six: Framework Design and Validation**

This is the stage that concludes the research and in which the researcher presents the developed framework designed to improve leadership performance and enhance effective leadership in healthcare sector organisations in the GCC countries in general and the KSA in particular.

The framework includes specific suggestions and interventions to improve the leadership performance in the healthcare organisations. This phase demonstrates the achievement of the research aim and objectives.

Subsequently, validation is conducted to ensure the usefulness of this framework. The last task of this research is to validate the developed framework via expert evaluations.

**Final Phase: Conclusion and Recommendations**

This phase represents the final results and findings from the data collected. Figure 3-1 graphically presents the research process.

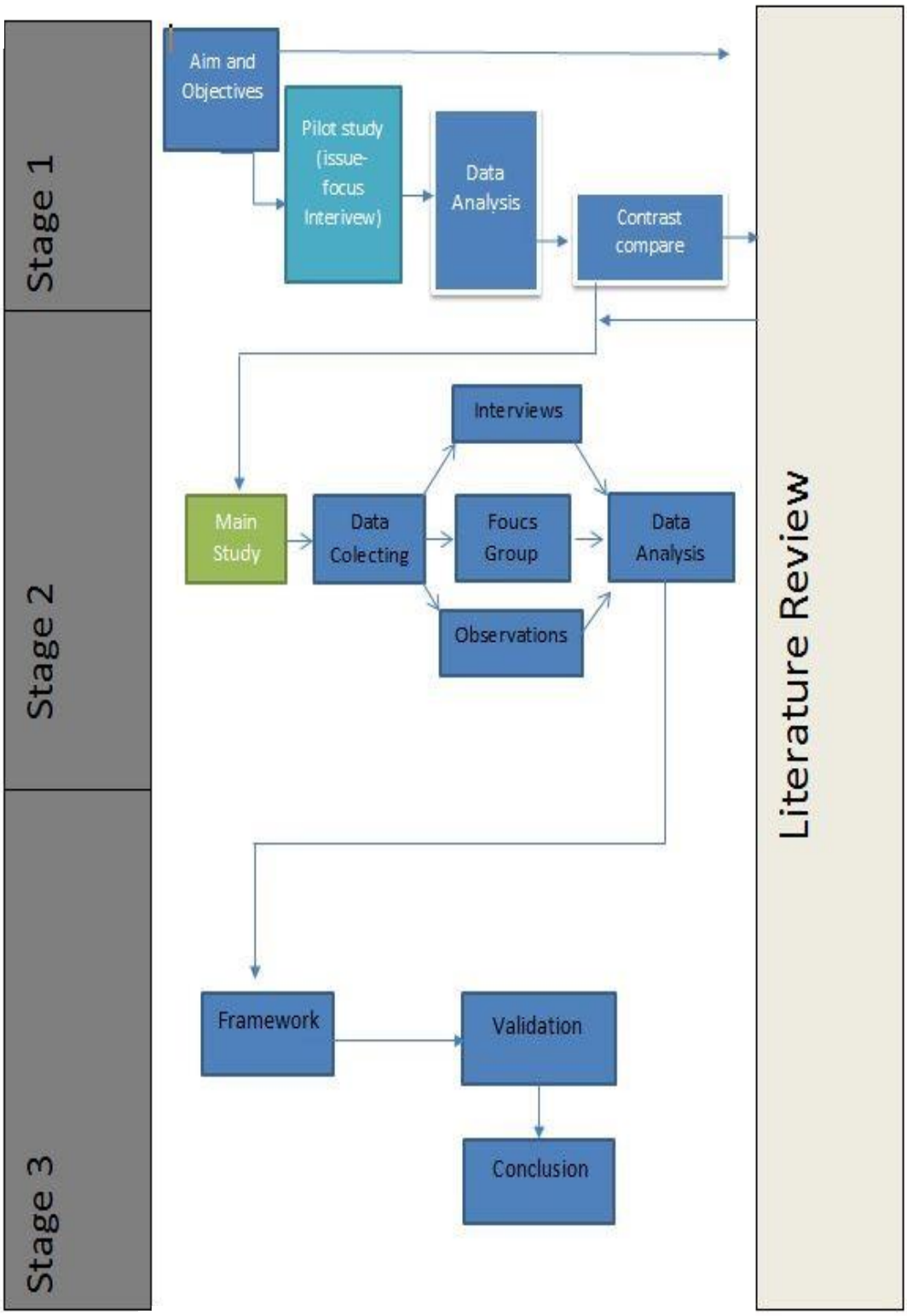


**Figure 3-1 Research Process**

## 3.3 Sampling

The sample of the study is the health affairs of the Ministry of the National Guard in KSA. The healthcare service is provided through several governmental agencies as shown in Figure 1-2: The Ministry of Health, the Ministry of National Guard, the Ministry of Defence and Aviation, and the Ministry of the Interior (Mazrou, *et al.*, 1990).

The National Guard Health Affairs (NGHA) is one of the largest health organisations in the Kingdom, providing modern medical care to the employees of the National Guard and their families, as well as to Saudi nationals with tertiary health problems (Geneva Health International Limited, 2016). Under the umbrella of NGHA, KSA has five hospitals and sixty primary and secondary health centres (Ministry of National Guard/Health Affairs, 2016). NGHA has also become well known internationally, especially with regard to the successful separation of conjoined twins; this is just one example of many high level services that have put NGHA at the heart of medicine in its own land (Geneva Health International Limited, 2016).

According to one of the top executive levels of the participants in this research, historically the NGHA has passed through different stages:

“The health sector in the Saudi kingdom had passed through and experienced many phases, especially the health sectors like the National Guard, Defence and Ministry of Health. Ways vary from one facility to another because of the Operational Management and the strategic plans of the facility. We, in the National Guard, have experienced many phases. In the first phase: the company was British, so that all the practices and works were related to the British works, but it was under the Saudi labour and the civil service law”. Additionally, he explained how NGHA moved to the current situation:

“The second phase was translated, and the sector was under LMI, an American company. The British system depended on documents, applications, rules and regulations strictly, whilst the American one depended on innovation and creative

visions more than the British system. Then, we moved to the self-operation program".

He added an interesting point that, according to the self-operation program, the budget then fell under the operational management of health affairs, which manages the budget according to what each organisation needs. The functional organisational chart of the SNGHA is illustrated in the appendices.

Finally, the participant explained the self-operation system that is employed currently, saying:

"In the self-operation system, there are many advantages and disadvantages, too. That system depends on the leader completely, whoever he is, and the dependence of British and American systems on the leadership was less than the self-operation system. They were based on decisions set by the high-level management, and these decisions were implemented in the long, medium or short term. The operation management plans and implements policies so it knows what is going on and spends money on what is needed".

**Table 3-6 Saudi National Guard hospitals**

| | |
|---|---|
| ➢ **National Guard Health Affairs - Riyadh** | This hospital, which has a 1025-bed capacity, is based in the Central Region of Saudi Arabia. |
| ➢ **National Guard Health Affairs - Jeddah** | This is a 531-bed hospital located in the Western Region of Saudi Arabia. |
| ➢ **National Guard Health Affairs - Al Ahsa** | The hospital is a 312-bed facility and provides primary and secondary care to National Guard personnel. |
| ➢ **National Guard Health Affairs - Dammam** | This hospital, like Al Ahsa, is based in the Eastern region of Saudi Arabia and has 146-bed capacity |

| | |
|---|---|
| ➢ **National Guard Health Affairs- Al Madinah** | This is the fifth National Guard Hospital in the Kingdom after Riyadh, Jeddah, Dammam and Al Ahsa. It is a full-service facility with a 320-bed capacity and located in the city of Al Madinah. |

Geneva Health International Limited, (2016) and Ministry of National Guard/Health Affairs (2016)

## 3.4 Rigour in the research

Rigour in action research generally refers to the ability to apply the appropriate research tool or method to meet a stated research objective. Contextually, it implies the way in which data are generated, aggregated, explored and assessed and procedures and scenarios are examined and interpreted in a cycle of multiple research actions. Showing rigour in action research has been considered key to demonstrating research quality (Coghlan and Brannick, 2001). Typically, the core of every piece of research should be characterized by a story of the events and activities that brought about certain conclusions. Thus, in line with the suggested requirements by Coghlan and Brannick, 2001), the following procedures were adopted at this stage of the research:

- **Action Research Learning Cycles**

Action research learning cycles were demonstrated in the recurrent refinements that were initiated and completed after the data were gathered. Throughout all the stages of the research project, the participants' contributions were sought.

The results from each group session were developed and discussed at subsequent sessions. Participants' discussions were initiated at every stage of the research and their input noted. After appropriate analysis, the results at the active stage were yet again fed back to participants and further responses solicited, which were transmitted and used to build the succeeding stage of the process.

- **Resolving Inconsistent Interpretations**

The aggregated data from the interviews formed one source: essentially, the primary source of data. Observations and reflections made from the critical literature reviews of research journals and articles provided a second source which corroborated the data from the interviews.

- **Testing interpretations against the literature**

Themes were evaluated against the views in the relevant literature, showing that the literature was generally supportive of the outcomes expressed in the themes. However, a refutation from literature is observed in the aspect of articulating 'clear objectives'. During the interview process, recorded remarks attributed to the participants indicated a consensus that it was desirable to have a clear and fixed project specification. However, previous writers specified only well-defined objectives at an objective level or in an overview, but were less emphatic about the need for it in depth.

Leadership development in the healthcare sector is such that in-depth specifications may well have to change in response to eventual dynamics in the understanding and awareness of possible solutions. The desire to produce clear specification was considered by the researcher and other organisation members who were not in the research participatory team; it suggests a strong repugnance to taking ownership for a defined product specification.

## 3.5 Conclusion

To summarise, this chapter has briefly discussed the main philosophical paradigms in social science and the adopted paradigm for this study, which is social constructivism. The research design has also been explained, including the sampling, data collection method and data analysis. The next chapter presents the data collection and analysis stages as well as the findings of this research and develops a discussion of the finding in the extant of literature.

# 4 DATA COLLECTION AND ANALYSIS

## 4.1 Conceptual Framework

To be useful, a theoretical model must be both adequately described and fit for its purpose (Collins, 2017). A conceptual framework is a structure that organises the currents of thought that provide focus and direction to an inquiry. Similarly, it is argued that a theoretical framework, as distinct from a theory, is sometimes referred to as a paradigm (Mertens, 2014; Bogdan and Biklen, 2007; Collins, 2017).

According to Rallis and Rossman (2012, p. 89), “It is the organisation of ideas—the central concepts from theory, key findings from research, policy statements, and professional wisdom—that will guide the project”. The framework emerges from wide and intensive reading of relevant literature and links a project to on-going conversations in the field, thereby establishing parameters: what the researcher’s focus is, and what it is not (Rallis and Rossman, 2012). It also provides direction for the research questions, the design decisions and the preliminary analytic strategies (Collins, 2017; Agee, 2009).

This research employs Schein’s model of organisational culture. Referring back to the literature review section, Schein’s model (1984) provides a valuable framework for understanding the improvement of a culture. The author views culture as the insight or empowerment acquired by a group over a period whilst resolving issues or problems concerned with its survival and relevance. Schein argues that culture is a perceptual structure of underlying assumptions that have been discovered, developed, or improved by a given group as the group learns to cope with its challenges of external adaptation and internal integration (Schein, 2010).

Furthermore, culture has been defined to imply a set of shared, taken-for-granted implicit assumptions held by the members of an organisation, which determine the way that they perceive, think about and respond to things (Schein, 2016). Culture is thus reflected in what Schein terms ‘artefacts’, which point to visible organisational structures and processes. Artefacts include: written and spoken

language, the physical space, organisational layout and the overt behaviours of organisational individuals (Goldberg *et al.*, 1992).

The physical space category relates to tangible artefacts used to identify an organisation. It may include organisational logos, motifs, insignia, trademarks, etc. The behavioural categories relate to defined or adopted organisational rituals, procedures and modus operandi. The third level is concerned with organisational anecdotes, stories, myths and histories relating to organisational high-fliers, protagonists and villains (Schein, 2016).

All three categories of artefacts are usually tied to or reflect organisational values (Goldberg *et al.*, 1992). Such values outline the social principles, goals, standards and/or ideals believed to be highly valued by a group (Katan, 2014). These values are usually characterised by high emotional investment which is inherently useful by being knitted to the group's culture, defining the attributes and thresholds that are highly esteemed by an organisation and/or its members (Katan, 2014). They are sometimes written and sometimes implicit and they enable members of a culture to know what is expected of them (Hofstede and Minkov, 2010).

According to Schein (2010), an organisation's culture should essentially mirror the values of its employees, such that by appealing to the values, organisational members are empowered to make decisions about the order in which to tackle emergent problems and issues and to develop solutions. The underlying assumptions are at the most impalpable level of the model (Schein, 2016).

These assumptions are usually handled with presumed beliefs, perceptual sensitivities, judgements and behaviours and are rarely made plain (Pakdil and Leonard, 2015). A recurrent, effective solution to a problem is habitually taken for granted. Assumptions evolve into absorbed responses that guide behaviour and influence the way members reason, act and feel (Schein, 2016).

According to Schein's model (Schein, 2010), deciphering a culture can be carried out using the following pattern:

1. Visit and observe

2. Identify artefacts and processes that puzzle you.
3. Ask insiders why things are done that way.
4. Identify espoused values that appear to you and ask how they are implemented.
5. Look for inconsistencies and ask about them.
6. Figure out from the above the deeper assumptions that determine the observed behaviour.

### 4.1.1 Data Collection and Analysis Stages

A three-stage analytical process was undertaken in this project. Theoretical saturation was reached after 33 interviews. Figure 4-1 illustrates the following characteristics among the participants.

**Figure 4-1 Participants' demographics**

| Gender of Participants: | | Levels Position of Participants: | |
|---|---|---|---|
| Male | 21 | Executives level | 5 |
| Female | 8 | Managers | 14 |
| | | Employees | 10 |

Data, collected over several months, were gathered from multiple sources at various time points during the research process. Throughout the iterative steps in data collection, theoretical sampling was followed to determine a certain level of saturation, as shown in Figure 4-2. Following guidelines from Binder and Edwards, (2010, p. 241), the researcher continued to recruit and interview participants until the point at which no new data was produced that added new information or insights for constructing the theory. Figure 4-2 depicts graphically the overall data collection process.

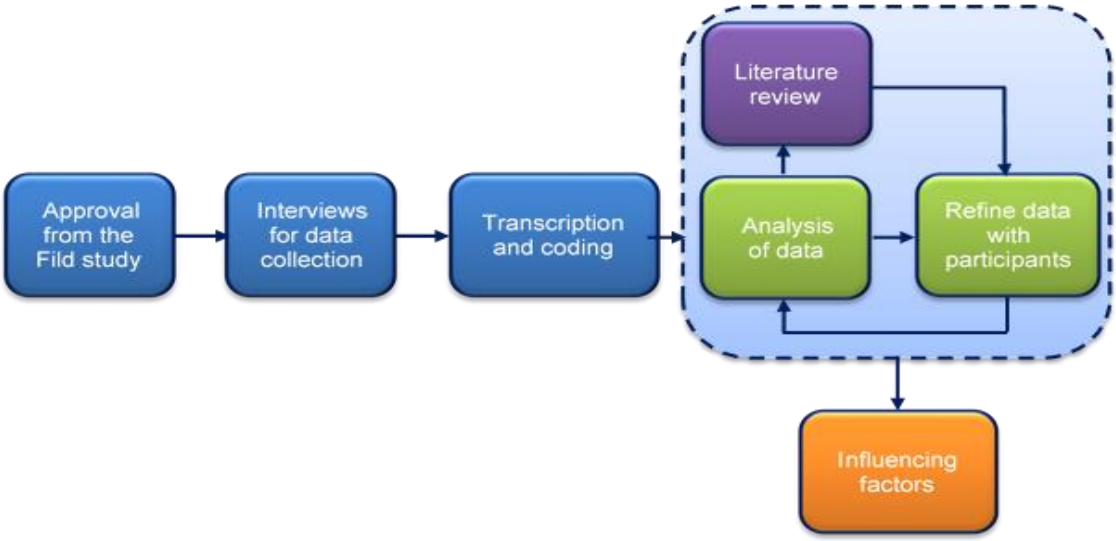


**Figure 4-2 Data collection and analysis process**

The major advantage of using semi-structured (face to face) interviewing according to Fontana *et al.*, (1998) is that it provides a suitable channel for collaborating with participants, whilst letting them reveal their opinions about an issue. In addition, it was chosen for this study because it allows a better understanding of the factors that the participants believe play a key role in shaping the current situation. According to Klein (1996, p. 33) “one of the chief advantages of face-to-face communication is the ability of the participants to pick up non-verbal cues as the interaction unfolds”. This adds richness to the interpretation of the message as well as communicating the emotional aspects which otherwise might be hidden (Gioia and Sims, 1989).

Importantly, the data were recorded on digital audio before being transcribed. The researcher also took field notes during interviews to record initial ideas. The data management and analysis tool selected was NVivo software. This qualitative data analysis package was used for the initial stages of coding and facilitated the coding and analytical processes (Yin, 1989). Given the innovations in software technology, electronic techniques of data coding are being employed more often to obtain rigor in dealing with such data (Saleh and Alabri, 2013). In addition, NVivo, a Qualitative Data Analysis (QDA) computer software package produced by QSR International, has many advantages and may significantly improve the

quality of research (Saleh and Alabri, 2013). According to Bazeley and Jackson (2013) this software (NVivo) can provides advantage in managing collected data and ideas, querying data, modelling visually and reporting.

To ensure the trustworthiness of the findings and the accuracy of the coding, every response made, whether positive or negative, was considered. In GT, data are analysed qualitatively, line by line or even word by word, in order to reach the saturation stage of building a theory (Corbin and Strauss, 1994; Marshall and Rossman, 2006).

#### 4.1.1.1 First Stage of Data Collection and Findings

This level of data collection aimed to build an initial understanding of the context of the project and hence, address the critical factors and aspects that might influence leadership performance improvement in the healthcare sector in Saudi Arabia. As a first step, the study asked what factors encourage or inhibit performance improvement in general.

Table 4-1 below displays the aspects that were obtained from the analysis and description of the data. The findings show the factors that influence the behaviour of leaders in the healthcare sector of the KSA and also play a fundamental role in inhibiting and encouraging the development of leadership performance in this sector.

**Table 4-1 Aspects that influence leadership performance**

| Aspect | Description |
|---|---|
| 1- An assessment period for employing a new candidate | A short probationary period for evaluating and discerning the proficiency of candidates before confirming their employment positions. |
| 2- Avoiding favouritism/ tribalism | Avoiding selective employee preferences based on ethnic, racial, or religious affiliations, which can cause cooperation to break down. |
| 3- Appreciation | Acknowledging and according value to employee attributes and/or outputs. |
| 4- Applying pressure | Placing stressful requirements on employees in a second attempt to solve problems can sometimes bring about good results. |
| 5- Blocks to development | Performance declines and stalled organisational improvement due to the extended absence of developmental initiatives. |
| 6- Centralisation | Consolidating process and decision control under one central influence or authority. |
| 7- Challenge | Extending demanding tasks to employees, typically beyond their known capacities, with a view to unveiling or discovering inherent, hidden, unused skills and potentials to bring about positive change. |

| Aspect | Description |
|---|---|
| 8- Close supervision | Undertaking rigorously attentive management oversight on the performance or operation of employees or situations. |
| 9- Collaboration | Joint work by leaders and employees for unified organisational goal(s). |
| 10- Combining a human aspect with regulation | Perceived concurrent application of both social (human) and rules-based approaches for better employee output. |
| 11- Communication | Organisations should have well-defined channels for conveying and exchanging information at all levels among employees. |
| 12- Complaints | Complaints within organisations are inherent and critical and should be speedily followed up upon in every work environment. |
| 13- Conflict resolution | Leaders should be quick to bring peaceful solutions to disagreeing parties and interests within the workplace in the interest of continuity and performance of the organisation |
| 14- Confronting mistakes | Timely response to employee inaccuracies to forestall possible deviations from the targeted organisational goals. |
| 15- Constant observation | Continuous and ceaseless monitoring by workplace leaders to drive productivity and performance improvement. |

| Aspect | Description |
|---|---|
| 16- Creating an appropriate working environment | A successful organisation keen to target goals should create a suitable work environment for employees that will drive work perception, motivation and inputs to targeted goals. |
| 17- Creating work teams that work cooperatively | Basing leadership on teamwork and encouraging cooperation and team spirit among employees. |
| 18- Empowerment and delegation | Boosting employee commitment, loyalty and confidence by delegating leadership and authority. |
| 19- Enhancing knowledge | Continually updating and improving upon existing knowledge in all aspects, to sustain relevance, headship and firmness. |
| 20- External training courses | Subscribing to and undertaking external, standard and globally accepted professional training courses. |
| 21- Exchanging experiences | Improving performance through creating interactive platforms and facilitating the exchange of know-how between leaders and employees in the organisation. |
| 22- Evaluating the employee mind-set | Ascertaining employees' willingness to work, or desire for self-development through the continual delegation of tasks and observance of reactions. |

| Aspect | Description |
|---|---|
| 23- Fairness and equality | Ensuring impartial, or non-selective management of employees, but rather conforming to laid down organisational rules and policies. |
| 24- Flexibility and breaks | Giving a more flexible working structure through the institution of structured breaks and time-out periods for employees after extended periods of work. |
| 25- Human interpersonal relationships | Improving performance through building good human interpersonal relationships among employees for a more friendly and motivated workplace. |
| 26- Humility | The quality of being modest in interactions with other employees. An attitude that leaders desire from employees. |
| 27- Improving capacity | Improving employee capacity through training and education for knowledge and skills. |
| 28- Individualising employee motivations | Being able to tie motivating factors to individual, as different people can have quite different motivators, e.g., money, recognition, time off, promotions, etc. |
| 29- Indirect leadership and guidance | Using other employees or third parties to correct employee inaccuracies in the organisation. |

| Aspect | Description |
|---|---|
| 30- Innovation | The use of, or support of new ideas or concepts from employees. |
| 31- Involvement in solutions | Being part of the effort to solve (potential) problems in the workplace. |
| 32- Interaction between leaders and employees | Mutual relations and interfacing between leaders and their subordinates in the organisation. |
| 33- Integrity | The quality of being honest, upright and reliable. Having strong moral principles. |
| 34- Interpersonal skills | Leadership's personal ability to relate easily and liberally, which helps them manage their work whilst building relationships with employees. |
| 35- Interpersonal loyalty that can benefit the organisation | A decent interpersonal relationship/ employee allegiance in the workforce that fosters organisational benefits. |
| 36- Intuition | Engaging instinctive knowledge in the discovery and constructive exploitation of subtle employee capability for organisational gain. |
| 37- Lack of administrative skills and experience | Managerial skills and practice deficiencies in leadership, amounting to incompetence in duty and a loss of employee confidence. |
| 38- Lack of incentives | Lack of appropriate incentives to support and motivate employees to boost outputs. |

| Aspect | Description |
|---|---|
| 39-Leadership by example | Good leadership gains respect and admiration by exemplifying and portraying what is expected of employees in all aspects emphasising commitment to the organisation in order to gain their respect. |
| 40-Leading by rhetoric | Boosting employee self-esteem by leadership, using supportive language and expressions to drive loyalty and improvements in performance. |
| 41-Make changes | Leaders need to engage in gradual positive changes in the work environment to build and sustain employee interests and productivity. |
| 42-Make employee feels responsible | Boost employee devotion, confidence and sense of duty through the delegation of responsibilities and reporting. |
| 43-Morals | Leadership's depiction of good character and behaviour when dealing with subordinates. |
| 44-Morality criteria for employment | Part of the criteria for employment should include the human aspect of sound moral values, in balance with other requirements. |
| 45-Mutual trust | A relationship built on reciprocated trust between leadership and employees and the degree to which that is expressed in the workplace. |

| Aspect | Description |
|---|---|
| 46- Mutual respect | Reciprocated esteem or regard to a person, or his/her views with regard to needs, space, friendship, etc. |
| 47- National culture | Specific aspects of national culture which potentially affect performance improvement in an organisation |
| 48- Observation with evaluation indicators | Process of monitoring employees' performance and basing evaluations on clearly defined performance indicators |
| 49- Openly communicating | Making the direct and unrestricted exchange of messages or information between leaders and followers possible in an organisational structure. |
| 50- Personal relations with employees to support their personal issues | Some employees are keen on building personal relations with leaders as a strategy to attain self-gains (promotions, external training and other incentives) in the organisation. |
| 51- Personal relationship | Building good interpersonal relationships with and among employees is key to improving performance and achieving a conducive working environment. |
| 52- Personifying the work environment | Preventing the kind of conflict that may arise between leaders and their employees as a result of discussing mistakes related to the workplace. |

| Aspect | Description |
|---|---|
| 53-Rewards | Rewarding hard work and excellence in deserving employees to motivate and persuade others in the organisation, e.g. awards for employee of the month/year. |
| 54-Responsiveness to change | Being receptive and supportive to new and positive employee ideas for changes and improvements. |
| 55-Recognition | Granting acknowledgment and appreciation to employees for their achievements and efforts. |
| 56-Religious values (Islamic) | Religious values and beliefs that influence leadership thoughts and employee relationships in an organisation. |
| 57-Routine | A sequence of habitual organisational procedures, an adherence of which is capable of hampering creativity in the workplace. |
| 58-Setting fair evaluation criteria | Establishing well-defined policies and criteria for employee evaluation, appraisal, benefits and promotion and unconditionally ensuring strict adherence. |
| 59-Self-awareness | Having a clear consciousness and understanding of self; thought pattern, behaviour, and responsiveness to others. This self-ability helps better structuring of personal and professional relationships. |

| Aspect | Description |
|---|---|
| 60- Sharing in decision making | Leadership style that supports mutual contributions to decision making by both leaders and employees in an organisation. |
| 61- Situational approach decisions | Making leadership decisions that depend on situation and personal dispositions. |
| 62- Speed and punctuality | Keenness on earning achievements promptly through driving punctuality from employees |
| 63- Strategic thinking | Adopting a structured approach to thinking, assessment, organisation and the establishment of capacities, goals and policy requirements |
| 64- Supervising the relationship between managers and employees in the workplace | A formal approved duty of a designated department in the organisation, which involves observing, assessing and managing the relationship between these two sides to avoid relational frictions capable of affecting normal work. |
| 65- Supporting initiatives | Leadership and organisational support and encouragement for employee creative suggestions and propositions for work improvements. |
| 66- Tolerance | Broad-mindedness towards employees' mistakes, misbehaviours and criticisms, allowing for gradual learning and improvements. |

| Aspect | Description |
|---|---|
| 67-Training | Setting up courses and activities for employees to build their knowledge, skills and competence for undertaking organisational roles and responsibilities. |
| 68-Understanding the vision and mission of an organisation | Understanding the organisation's mission, or its purpose for existence. A mission often reflects the values and beliefs of top managers in the organisation. |
| 69-Undervaluing employees' status | Underrating and failing to appreciate the importance of employees in an organisation is likely to yield negative performance and outputs |
| 70-Using different skills in different situations | Leadership is expected to apply varied skills for dealing with varied employee personalities, behaviours and situations in relation to organisational objectives and requirements. |
| 71-Unclear tasks and information | Unclear articulation of tasks, duties, targets and timelines by leaders to their employees. |

What is interesting about the data in Table 4-1 is that the overall trends it discloses indicate that most of the emerging factors show the characteristics of transformational leadership. Transformational leadership focuses on the deeply-held beliefs of leaders, with the application of certain values in areas such as justice and integrity to create effective leadership (Burns, 1978).

Burns (1978) interprets transforming leadership as a relationship of mutual stimulation and elevation that converts followers into leaders and may convert leaders into moral agents. Moreover, he suggests that transforming leadership is

found when one or more persons engage with others in such a way that leaders and followers raise one another to higher levels of motivation and morality (Bolden, 2004). According to Bolden (2004), this style of leadership emphasises the leader's ability to motivate and empower his/her followers and also the moral aspect of leadership. In a previous study, Franco *et al*. (2002) indicated the key role of transformational leadership and its ability both to shape the organisational culture and to inspire loyalty to the organisation.

However, these aspects tend to employ different behaviours and aspects of a leader's cognitive, interpersonal qualities. All these qualities play a key role in a leader's abilities either to inhibit or encourage the performance of the organisation to improve. The dominance of factors, such as fairness and equality, the national culture and Islamic values seems to most affect leaders' decisions. It also determines their relationships with subordinates as well as their commitment to the organisation, as shown in Figure 4-3. Furthermore, the collected data indicated aspects that are essential in shaping the relationship between leaders and their employees. These aspects are collaboration, arrangement, communication skills and appreciation.

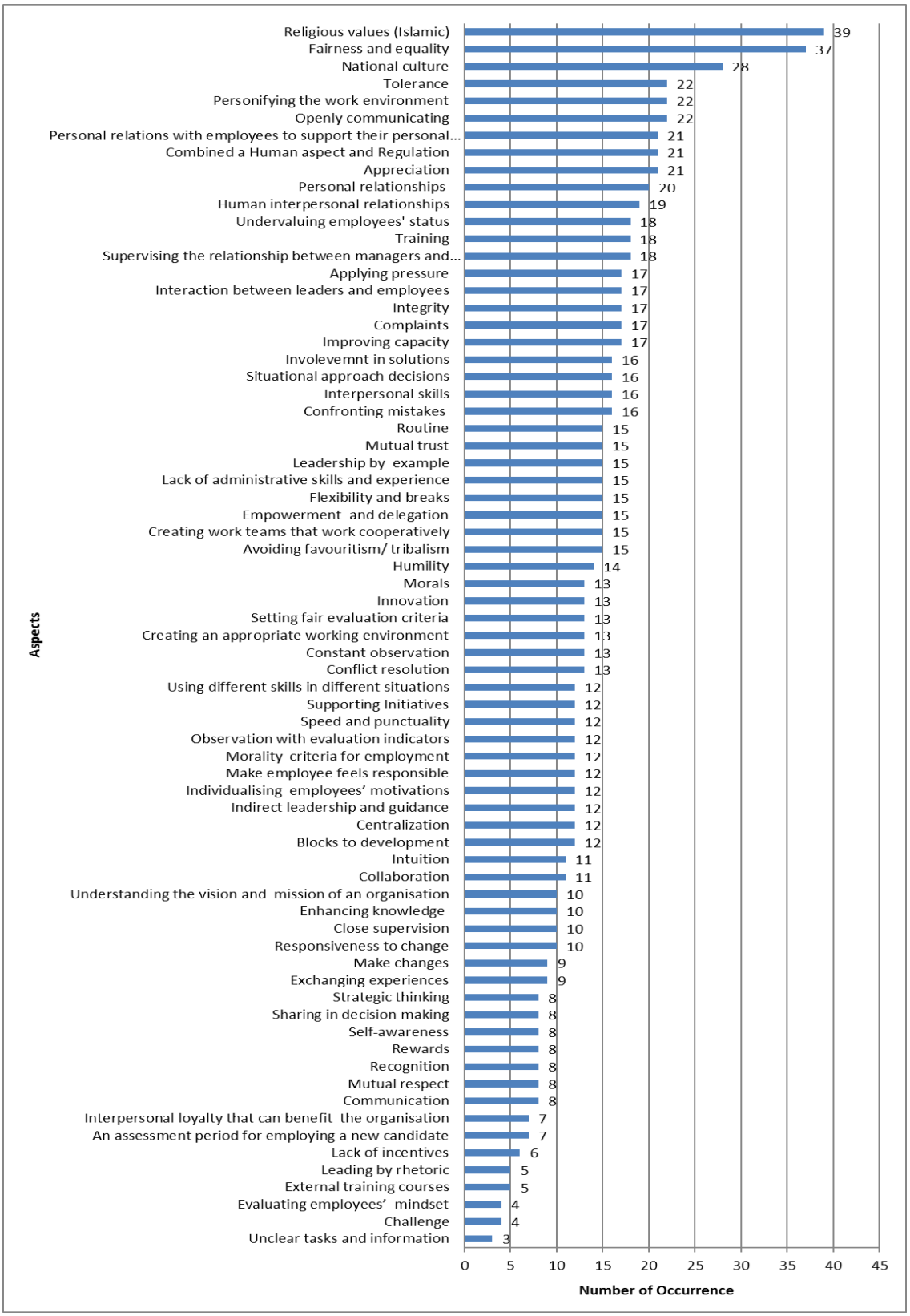


**Figure 4-3 Distribution of the emerged aspects**

The pilot study provided an opportunity to advance understanding of the influences in this field study and assess how far they dominate current performance. Seventy-one open codes emerged from the data, as shown in Table 4-1. The interviewees indicated that these aspects influence the behaviours of leaders in the healthcare sector of the KSA. They play a fundamental role in inhibiting and encouraging the development of leadership performance in the health sector in question.

The overall trends observed in the data indicate that 'transformational leadership' characteristics appear most often among the list of emerging factors. These factors tend to be seen in the behaviours and aspects of the cognitive and interpersonal qualities of leaders. The pilot study clearly indicates that there is a relationship between current leadership practices and culture aspects. For instance, the initial study found that a number of elements emerged as essential for shaping aspects of a leader's performance, such as regard for Islamic values and the national culture and fairness and equality.

The findings show that the aspect called 'Islamic values' is the most influential element in the performance of leaders and employees in the organisations surveyed, with a high frequency of 39, as shown in Figure 4-3. In this regard, one interviewee said,

> *"A lot of things [happen] in the work environment. If we apply the teachings of Islam in our work, we will find ourselves the greatest nation on earth, but sadly, we don't. If you think of it right, Islam says: "Allah will be pleased with those who do their work perfectly".*

In addition, the current data highlight the fact that Islamic values affect the relationship between leaders and their subordinates and also their relationship with their organisation's environment. For example, one interviewee said,

> *"Well, first it was a religious duty… no matter what our ranks are, I should observe him as a brother or a son because he is a part of this society and if I can fix things for him, it will lead to more positive results".*

The second most influential factor that appeared in these data was ‘fairness and equality’, with a frequency of 37. An example of this frequent perception comes from one interviewee:

> *“For me, the features of leadership are fairness and equality...along with brotherly treatment. Such things—I believe—are essential for leadership”. He added, “Of course the most significant thing I wish all leaders would have is … fairness. [It] is very important…it is the basis of judgment, once it is applied and handled in the best way between leaders and their followers…I find this crucial point to be essential with a very positive effect on the leader’s role, work and responsibilities”.*

Furthermore, one of the participants mentioned that:

> “the major inhibitor is the lack of justice”.

Similarly, one of the interviewees indicated nepotism as an example of the lack of justice that can negatively affected the process of choosing the appropriate people. In this she said,

> *“I mean, there is nepotism and bias. Some people do not deserve to be managers. [Filling] these positions must follow certain criteria like proposing a committee to determine the qualified people”.*

The results of this study clearly point to the impact of the ‘national culture’ on leadership performance and the organisational culture and their effects on employees’ job satisfaction and commitment. The frequency of this aspect was 28, as shown in Figure 4-3. Furthermore, the study indicates that the participants, on the whole, demonstrated that emotional intelligence, such as being human and showing honesty, initiative, cognitive skill and eagerness to develop also play a crucial part in the performance of the organisation. Surprisingly, only a minority of participants indicated the importance of factors such as strategic thinking and sharing in decision-making.

The main common factors among the findings were ‘Combining human aspects with regulation’, ‘Fairness of the evaluation criteria’, ‘National culture difficulties’,

‘Openly communicating’, ‘Personal relationships’, ‘Personifying the work environment’ and ‘Tolerance’. The effects of these factors on performance, as shown in Figure 4-3, were different in intensity, scoring between 21 and 37. Other findings show how the relations between leaders and their employees can be affected negatively as a result of a decision taken by a leader that affects subordinates. In this regard, an interviewee said:

> *“I then asked him why he took it personally…he answered that he didn’t and that, even though he had done wrong, my punishment was cruel…though I only applied what the system says. So sometimes, when you treat your followers well, they treat you well… But if they repeat a mistake and you have tried many times to correct them with no hope of change…when you apply the regulation and penalty, they take it personally. This behaviour has been seen many times, but after all…regulations and policies should be applied to all of us”.*

‘Appreciation’ emerges significantly often in this study (21 appearances) as an essential factor for motivating employees. About this, an interviewee said:

> *“Appreciation is so important. One of the motivators that you must use (and this one I'm not really good at) is having a good memory for names”. He added: “When you pass by an employee and you don't even know who he is, he will give you a strange look, but if you approach him and call him by name and ask him "How are you today? …”. In line with this, one of the participants pointed out, “Motivating words like "thank you" and "I appreciate your efforts" can affect a lot. I insist on the importance of appreciation and motivation, which makes a positive energy”.*

The findings of this initial study suggest that the relations between leaders and their followers need to be under the official supervision of the highest tiers of management. As a number of interviewees suggested, this can provide a clear security system for both leaders and employees and protect their rights in the organisation. As one interviewee said,

*"Certainly, there should be something to protect and defend the employee if [he] is right. There should be an agency to investigate a case in which an employee's evaluation is 99% and s/he does not get promoted".*

Interestingly, one of the more noticeable findings to emerge from this study is the power of several factors that particularly affect leadership performance in the healthcare sector of KSA; for example, help for employees who have personal problems, individualising employees' motivation, having moral criteria for employment, observing according to evaluation indicators, supervising the relations between managers and employees in the workplace and evaluating employees' mind-sets.

#### 4.1.1.1.1 Comparison with the Literature

As noted above, both the findings and the literature indicate that the characteristics of 'transformational leadership' are emerging factors. These factors tend to be found in the behaviours and aspects of the cognitive and interpersonal qualities of leaders (see Table 4-2). They all play a key role in a leader's (in) ability to improve. According to Bolden *et al*. (2003, p. 6) "Whilst early theories tend to focus upon the characteristics and behaviours of successful leaders, later theories begin to consider the role of followers and the contextual nature of leadership".

**Table 4-2 Comparison with the literature**

| Aspects | Authors |
|---|---|
| 1. Religious values (Islamic) | (Rees and Althakhri, 2008), (Mellahi, 2007), (Ali, 1987), (Faris and Parry, 2011), (Bartram, 2005), |
| 2. Fairness and equality | (Bass and Riggio, 2006), (Thach and Thompson, 2007), (Boyatzis and Boyatzis, 2008), (Ruge, 2010), (Sanghi, 2007) |

| Aspects | Authors |
|---|---|
| 3. National culture | (Yousef, 2001), (Hunt and At-Twaijri, 1996),(B. Bass and Avolio, 1994), (Abdeh, D., 2006), (Rees and Althakhri, 2008) |
| 4. Tolerance (Humility) | (Boyatzis and Boyatzis, 2008), (Bolden *et al.*, 2003), |
| 5. Personifying the work environment (relationship between a leader and the member of their team-work) | (Bass and Riggio, 2006), (Flin *et al.*, 2003), (G. Yukl, 2002), (Redick *et al.*, 2014), (Boyatzis and Boyatzis, 2008). |
| 6. Openly communicating | (Hollenbeck, McCall and Silzer, 2006), (Bass and Riggio, 2006), (Boyatzis and Boyatzis, 2008), (G. Yukl, 2002), (Sanghi, 2007) |
| 7. Personal relations with employees to help support their personal issues (promotion, training) | (Sanghi, 2007) |
| 8. Combining a human aspect with regulation | (Bass, 1985), (Bass and Riggio, 2006), (Boyatzis and Boyatzis, 2008), (Bolden and Gosling, 2006). |
| 9. Appreciation (recognition) | (Yukl, 2002), (Chapman, 2013) |
| 10. Personal relationships | (Hollenbeck, McCall and Silzer, 2006), (G. Yukl, 2002), (Guggenheimer and Szulc, 1998) (Rice, 2003), (Sanghi, 2007) |

| Aspects | Authors |
|---|---|
| 11. Human interpersonal relationships | (Hunt and At-Twaijri, 1996), (Redick *et al.*, 2014), (Burns, 1978), (Redick *et al.*, 2014), (Bass and Riggio, 2006). |
| 12. Undervaluing employees' status | (Atambo, Kabare and Munene, 2012), (Altman *et al*. 2013) |
| 13. Training | (G. Yukl, 2002), (Thach and Thompson, 2007), (Boyatzis and Boyatzis, 2008), (Sanghi, 2007), (Bratton and Gold, 2012) |
| 14. Supervising the relationship between managers and employees in the workplace | (Bratton and Gold, 2017), (Mor Barak, 2016). |
| 15. Applying pressure | |
| 16. Interaction between leaders and employees | (Hollenbeck *et al.*, 2006), (Trottier *et al.*, 2008), (Burns, 1978), (McShane and Glinow, 2014) |
| 17. Integrity | (Bolden *et al.*, 2003), (Bass and Riggio, 2006), (Guggenheimer and Szulc, 1998), ( Ruge, 2010). |
| 18. Complaints | (Thach and Thompson, 2007), (Aycan *et al.*, 2000), (G. Yukl, 2002). |
| 19. Improving capacity | (Boyatzis and Boyatzis, 2008), (Thach and Thompson, 2007), (Hollenbeck *et al.*, 2006), (Faris and Parry, 2011) |

| Aspects | Authors |
|---|---|
| 20. Solutions involvement | (G. Yukl, 2002), (Thach and Thompson, 2007), |
| 21. Situational approach decisions | (Hollenbeck *et al.*, 2006), (Thach and Thompson, 2007) |
| 22. Interpersonal skills | (Bass and Riggio, 2006), (Hollenbeck *et al.,* 2006), (G. Yukl, 2002), (Guggenheimer and Szulc, 1998) |
| 23. Morality criteria for employment in health sector | (Sanghi, 2007) |
| 24. Evaluating the employees' mind-set | (Mohammadrezaei *et al.*, 2016), (Sanghi, 2007) |

A number of authors indicate a variety of factors that can help to build successful leadership. Boyatzis and Boyatzis (2008) argue that performance is best when a leader's qualities, such as his/her values, vision and knowledge, are consistent with the job requirements and organisational environment. The study findings correspond with the findings in Bolden and Gosling (2006), who propose that leadership benefits by sets of components, such as the traits, qualities, skills and behaviours which encourage the teamwork, development and commitment of others in an organisational environment. Bass and Riggio (2006) bring up the importance of 'fairness and equality' in the environment of successful organisations. This is in line with Armit *et al*., (2015), who state that leaders should emphasise fairness and honesty in their dealings with all, challenging unethical practices or social injustices on behalf of all, not only their followers. Similarly, more recent studies outline the importance of fairness and justice in workplace. For instance, Sanghi (2016) stresses that fairness and equality aspects should be given a high priority by leaders in the workplace. Similarly, Harbi et al., (2016) claim that to achieve justice or fairness in the workplace more attention should be given to the employees' perspectives (p. 6).

Significantly, the national culture plays an important role in shaping an individual's work ethic (Yousef, 2001). Moreover, culture not only influences how leaders emerge, develop and are chosen, but also affects the success of organisations (Dickson *et al.,* 2012). Specifically, Idris (2007) investigated the influence of cultural barriers on the organisational performance in Saudi Arabia (p. 36) "Executives and managers in Saudi Arabia face great challenges in their endeavour to improve the performance of their organisations". These challenges, particularly, are cultural issues and work practices that limit employee performance levels compared to those in developed international companies (Idris, 2007). In line with this, Hunt and At-Twaijri (1996) claim that further aspects such as friendships and personal views are given more attention by Saudi managers than performance and organisational objectives. According to McLaughlin *et al.* (2005), "The organisational culture reflects the values of its employees". Similarly, Bass and Avolio (1994) indicate the strong relationship between culture and leadership and claim that "the culture affects leadership as a much as leadership affects culture". This view is supported by Rees and Althakhri (2008) who write that "Saudi Arabian culture is strongly affected by Islamic and tribalism systems". Similarly, it is believed that there are two main strands that shape Saudi Arabian culture; firstly, tribal traditions, customs and values, and secondly, Islamic culture. Saudi culture is therefore a blend of both (AlGhamdi, 2012). In support of this view, Rice (2003) argues that in many Arab organisations, the appointment of a family or tribal member is natural because this means that the hired person is someone of trust. Similarly, the concept of the Islamic work ethic (IWE) has its basis in the doctrines of the Qur'an and the sayings of the Prophet Mohammed. Additionally, Ali (1987) indicates Islam as one of the most influential factors that has shaped the Arab value systems. In line with this, one participant commented:

> *"our prophet Mohammed said (in near meaning of his word): does the adulterer commit adultery whilst he believes in God? He said yes, and does a man steal whilst he is a believer? He said yes, but when he was asked about the liar, he said no".*

Whilst the data show that only two of the participants believed in the effect of 'strategic thinking' on their performance, authors like Bass and Avolio (1994) indicate the important role of this factor and argue that "strategic thinking helps to create and build the vision of an agency's future". Similarly, Sanghi (2016) reinforces that behavioural strategic thinking should involve a course of action to accomplish a long-term goal and shares with others one's personal view of the desirable future state of the organisation.

The literature also indicated certain major aspects that do not appeared in the field study. These factors include: having public abilities and skills, matching job needs with employees' capabilities, having talent and technical competence (Boyatzis and Boyatzis, 2008; Yukl, 2006; Hollenbeck, *et al.*, 2006; Bass, 1990; Riggo, 2006; Sanghi, 2016). Importantly, there are several factors in the findings of the present study that demonstrate effects on leadership performance that are not shown to be important in the literature. Among them are helping employees with support in personal problems, individualising their motivation, having moral criteria for employment, supervising the relationship between managers and employees in the workplace and evaluating the employees' mind-set. This presents an important issue for future research.

Communication within the organisation appeared as one of the aspects that heavily influences organisation performance and shapes the relationship between its members, as shown in Table 4.1. In line with this finding, Bratton and Gold (2012) stress that the effectiveness of communication can be affected by various organisational characteristics, such as organisation hierarchy, power relations and the abilities and biases of managers and non-mangers across the organisation's departments and levels (Bratton and Gold, 2012). According to Sanghi (2016), to build an effective competency guideline, the communication should be both formal and informal between leaders and their staffs.

### 4.1.2 Conclusion of the first stage of the project

The identified factors that affect leadership performance in the Saudi healthcare sector tend to be those in the behaviours and aspects of cognitive or interpersonal

qualities of leaders. A number of elements emerged as important in shaping leadership performance development, such as fairness and equality, Islamic values and the national culture. All of these aspects play a key role in a leader's abilities either to inhibit or encourage performance improvement. The most obvious findings to emerge from this study heavily influence the leadership performance in the field study. Whilst a minority of interviewees indicated factors such as strategic thinking and sharing in decision making, all agreed that other factors such as combining a human aspect with regulation, using fair evaluation criteria, difficulties from the national culture, openly communicating, personal relationships, personifying the work environment and tolerance, play a key role. Taken together, these results suggest that there is broad agreement between the study findings and the literature in the vast majority of factors. However, one of the more significant findings to emerge from this study is that a number of factors that particularly affect leadership performance in the healthcare sector of KSA are dominant. Examples include personal relations with some employees as a form of personal support, individualising employees' motivation, having moral criteria for employment, observing using evaluation indicators, supervising the relationship between managers and employees in the workplace and evaluating employees' mind-set. Reviewing the literature did not show the importance of any of these factors for leadership competency and still less for leadership performance as a whole.

### 4.1.3 Reliability and validity of the findings

Although the terms reliability and validity traditionally have been associated with quantitative research, increasingly they are being seen as important concepts in qualitative research as well (Murphy *et al.*, 1998b). in his study Anderson, (2010a), argues that examining the data for reliability and validity assesses both the objectivity and credibility of the research. According to Anderson, (2010, p. 140), "Validity relates to the honesty and genuineness of the research data, whilst reliability relates to the reproducibility and stability of the data".

However, some researchers have argued that validity and reliability are not relevant and not applicable to qualitative research because these criteria

originate in the positivistic tradition and should not be adopted elsewhere (Ahrens and Mollona, 2007; Golafshani, 2003).

The purpose of the grounded theory approach is to only code and describe data enough to be able to generate and suggest theory, not to deduce anything from it statistically (Corbin and Strauss, 1990). Similarly, Saldaña (2015, p. 3) claimed, “A code in qualitative inquiry is most often a word or short phrase symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data”.

However, grounded theory looks for theory through a structured method of investigating what is said or written (inductive) and produces categories of ideas, which can then be used to characterise, develop or change organisations (Greener, 2008b). Strauss and Corbin (1998, p. 58) emphasises that “analysis is not a structured, static, or rigid process, rather it is a free-flowing and creative one in which analysts move quickly back and forth”. Finally, the result of a grounded theory study is not the reporting of facts but the generation of probability statements about the relationships between concepts – a set of conceptual hypotheses developed from empirical data (Glaser, 1998, p. 3)

However, in this study, a number of techniques were employed to assess the validity and reliability in the present study. Multiple data sources were used: interviews, focus groups and observations, as shown in Figure 4-4.

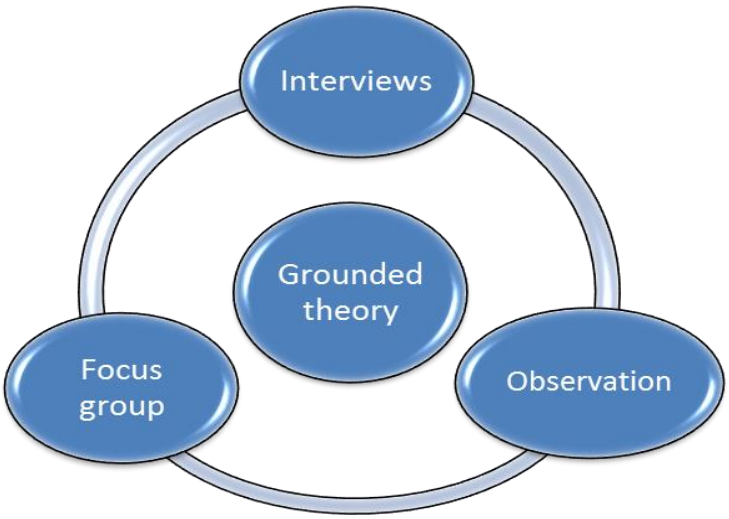


**Figure 4-4 Data collection methods adopted**

Using triangulation in data collection helps researchers "to eliminate bias and increase the researcher's truthfulness of a proposition about some social phenomenon," which in turn improves the validity and reliability of a study (Golafshani, 2003, p. 604). According to Golafshani (2003, p. 604), "To improve the analysis and understanding of a construction by others, triangulation is a step taken by researchers to involve several investigators or peer researchers' interpretation of the data at a different time or location". Furthermore, Creswell and Miller, (2000, p. 126) define triangulation as "a validity procedure where researchers search for convergence among multiple and different sources of information to form themes or categories in a study". In addition, triangulation is needed to ensure trustworthiness (Lincoln and Guba, 1989) of a study and to identify potential alternate explanations. Triangulation includes protocols (data, investigators, or theories) that confirm accuracy and look for alternative explanations (Murphy *et al.*, 1998a). This approach enabled the data collected to be triangulated across methods.

The coding and descriptions of the translated data were carried out in English. Two techniques were employed to increase the reliability of the coding of the interviews and their analysis. First, a number of interview transcripts which represented the codes were used and were back-translated from English to Arabic by a bilingual peer (Binder and Edwards, 2010; Neuman, 2006). The

results were compared and led to minor changes in the translation until reconciled. Second, an inter-rater scoring method was used to check the reliability and validity of the collected data (Rashid *et al.*, 2010). Twenty-one per cent of the transcripts were coded by different coders (R1 – R7), selected academics, as shown in Table 4-3. This helped the researcher to refine or add codes in order to produce an agreed-upon coding between the different coders (Binder and Edwards, 2010).

**Table 4-3 Reliability and Validity of the emerged aspects**

| Aspects | R1 | R2 | R3 | R4 | R5 | R6 | R7 | T. | P.A. (%) |
|---|---|---|---|---|---|---|---|---|---|
| 1. An assessment period for employing a new candidate | √ | | | | √ | √ | | 3 | 42.86 |
| 2. Avoiding favouritism/ tribalism | √ | √ | √ | √ | √ | | √ | 6 | 85.71 |
| 3. Appreciation | √ | | √ | √ | | √ | √ | 5 | 71.43 |
| 4. Applying pressure | √ | √ | | | √ | | | | 42.86 |
| 5. Blocks to development | √ | | √ | | | √ | | 3 | 42.86 |
| 6. Centralisation | √ | | √ | | | | | 2 | 28.57 |
| 7. Challenge | √ | | | √ | √ | √ | √ | 5 | 71.43 |
| 8. Close supervision | √ | | | √ | √ | √ | √ | 5 | 71.43 |
| 9. Collaboration | √ | √ | √ | | | √ | | 4 | 57.14 |
| 10. Combining a human aspect and regulation | √ | | √ | √ | | √ | √ | 5 | 71.43 |
| 11. Communication | √ | | | | √ | √ | | 3 | 42.86 |
| 12. Complaints | | √ | | | √ | √ | √ | 4 | 57.14 |
| 13. Conflict resolution | √ | | | √ | √ | √ | √ | 5 | 71.43 |

| Aspects | R1 | R2 | R3 | R4 | R5 | R6 | R7 | T. | P.A. (%) |
|---|---|---|---|---|---|---|---|---|---|
| 14. Confronting mistakes | √ | | √ | √ | √ | √ | √ | 6 | 85.71 |
| 15. Constant observation | √ | | | √ | √ | √ | √ | 5 | 71.43 |
| 16. Creating an appropriate working environment | √ | | | √ | √ | √ | √ | 5 | 71.43 |
| 17. Creating work teams that work cooperatively | | | √ | √ | √ | | √ | 4 | 57.14 |
| 18. Empowerment and delegation | | | √ | √ | √ | | √ | 4 | 57.14 |
| 19. Enhancing knowledge | √ | √ | √ | | | √ | | 4 | 57.14 |
| 20. External training courses | √ | | | | | √ | | 2 | 28.57 |
| 21. Exchanging experiences | | √ | | √ | √ | √ | √ | 5 | 71.43 |
| 22. Evaluating the employee mind-set | √ | √ | √ | √ | √ | √ | | 6 | 85.71 |
| 23. Fairness and equality | | √ | √ | √ | | √ | | 4 | 57.14 |
| 24. Flexibility and breaks | | | | √ | | | √ | 2 | 28.57 |
| 25. Human interpersonal relationships | √ | √ | | √ | | √ | √ | 5 | 71.43 |
| 26. Humility | √ | √ | √ | √ | √ | | √ | 6 | 85.71 |
| 27. Improving capacity | √ | √ | | √ | | | | 3 | 42.86 |

| Aspects | R1 | R2 | R3 | R4 | R5 | R6 | R7 | T. | P.A. (%) |
|---|---|---|---|---|---|---|---|---|---|
| 28. Individualising employee motivations | √ | | √ | | | | √ | 3 | 42.86 |
| 29. Indirect leadership and guidance | √ | | √ | | | | | 2 | 28.57 |
| 30. Innovation | √ | √ | √ | √ | √ | | √ | 6 | 85.71 |
| 31. Involvement in solutions | | | √ | | | √ | | 2 | 28.57 |
| 32. Interaction between leaders and employees | √ | √ | | | √ | | | 3 | 42.86 |
| 33. Integrity | | √ | | | √ | | | 2 | 28.57 |
| 34. Interpersonal skills | √ | | √ | √ | √ | √ | √ | 6 | 85.71 |
| 35. Interpersonal loyalty that can be of benefit to the organisation | √ | | | | √ | √ | | 3 | 42.86 |
| 36. Intuition | √ | | | | | √ | | 2 | 28.57 |
| 37. Lack of administrative skills and experience | | | | √ | | | √ | 2 | 28.57 |
| 38. Lack of incentives | √ | | | √ | √ | √ | | 4 | 57.14 |
| 39. Leadership by example | | | √ | √ | | | √ | 3 | 42.86 |
| 40. Leading by rhetoric | √ | | | | | √ | | 2 | 28.57 |
| 41. Make changes | | √ | | √ | √ | √ | √ | 5 | 71.43 |
| 42. Make employee feels responsible | | | √ | √ | | | √ | 3 | 42.86 |
| 43. Morals | √ | √ | √ | √ | √ | | √ | 6 | 85.71 |

| Aspects | R1 | R2 | R3 | R4 | R5 | R6 | R7 | T. | P.A. (%) |
|---|---|---|---|---|---|---|---|---|---|
| 44. Morality criteria for employment | | | | √ | | | √ | 2 | 28.57 |
| 45. Mutual trust | √ | | √ | √ | √ | √ | √ | 6 | 85.71 |
| 46. Mutual respect | √ | | | | √ | √ | | 3 | 42.86 |
| 47. National culture | | √ | √ | √ | | √ | | 4 | 57.14 |
| 48. Observation with evaluation indicators | | | | √ | | | √ | 2 | 28.57 |
| 49. Openly communicating | | √ | √ | √ | | √ | √ | 5 | 71.43 |
| 50. Personal relations with employee to support their personal issues | | √ | √ | √ | | √ | √ | 5 | 71.43 |
| 51. Personal relationships | √ | | | √ | | | √ | 3 | 42.86 |
| 52. Personifying the work environment | | √ | √ | √ | | √ | √ | 5 | 71.43 |
| 53. Rewards | | | √ | | | √ | | 1 | 28.57 |
| 54. Responsiveness to change | √ | √ | | √ | √ | √ | √ | 6 | 85.71 |
| 55. Recognition | √ | | | | | √ | | 2 | 28.57 |
| 56. Religious values (Islamic) | | √ | √ | √ | | √ | | 4 | 57.14 |
| 57. Routine | √ | | √ | √ | √ | √ | √ | 6 | 85.71 |
| 58. Setting fair evaluation criteria | | | | √ | √ | √ | √ | 4 | 57.14 |
| 59. Self-awareness | | | | √ | √ | √ | | 3 | 42.86 |
| 60. Sharing in decision making | | √ | | √ | √ | √ | √ | 5 | 71.43 |

| Aspects | R1 | R2 | R3 | R4 | R5 | R6 | R7 | T. | P.A. (%) |
|---|---|---|---|---|---|---|---|---|---|
| 61. Situational approach decisions | | | √ | √ | | | √ | 3 | 42.86 |
| 62. Speed and punctuality | √ | | √ | √ | | | √ | 4 | 57.14 |
| 63. Strategic thinking | | √ | | √ | √ | √ | √ | 5 | 71.43 |
| 64. Supervising the relationship between managers and employees in the workplace | √ | √ | | | √ | | | 3 | 42.86 |
| 65. Supporting initiatives | √ | | √ | √ | √ | | √ | 5 | 71.43 |
| 66. Tolerance | | √ | √ | √ | | √ | √ | 5 | 71.43 |
| 67. Training | √ | √ | | | √ | | | 3 | 42.86 |
| 68. Understanding the vision and mission of an organisation | √ | √ | √ | | | √ | | 4 | 57.14 |
| 69. Undervaluing employees' status | √ | √ | | | √ | | | 3 | 42.86 |
| 70. Using different skills in different situations | √ | | | √ | √ | √ | √ | 5 | 71.43 |
| 71. Unclear instructions | √ | √ | √ | √ | √ | | | 5 | 71.43 |
| Total | 45 | 30 | 35 | 47 | 38 | 44 | 41 | | |
| Percentage | 63.38 | 42.25 | 49.3 | 66.2 | 53.52 | 61.97 | 57.7 | | |

## 4.2 SECONED STAGE OF THE PROJECT

### 4.2.1 Emergence of the themes influencing performance

Generally, an iterative data collection approach allows for the exploration of new ideas that eventually emerge from subsequent feedback aggregation methods such as interviews. To help this process, it was decided to further validate and refine the various classifications of the coding structure into higher-level codes.

The aim of this stage of data collection was to refine the emerged aspects and aggregate the codes into significantly fewer second-order concepts and then divide them into categories (main themes) as shown in Table 4-4. This helped the researcher to build an initial understanding of the relationship between each of the properties and discover the similarities and differences between them (Glaser, Strauss and Strutzel, 1968). In his study, Rosch (1978) defines categories as cognitive classifications which group objects, events and the like with similar perceived attributes. Table 4-4 below, illustrates the categorisation of the features that emerged.

Analysis generated seven themes fundamental to successful implementation of goals of leadership performance development in the healthcare sector. The themes that emerged from these data sources ultimately led to the creation of a clear path to answering the research question (Mills *et al*., 2006b).

The full list of developed themes and associated aspects obtained from all the interview data is shown in Table 4-4.

**Table 4-4 Themes developed and the emerged aspects of each**

| Themes | Aspects |
|---|---|
| Setting direction and culture | - National culture<br>- Creating an appropriate working environment<br>- Make changes<br>- Understanding the vision and mission of an organisation<br>- Collaborating<br>- Openly communication |

| Themes | Aspects |
|---|---|
| | - Responsiveness to change<br>- Indirect leadership and guidance<br>- Routine<br>- Supervising the relationship between managers and employees in the workplace<br>- Sharing in decision making |
| Thinking strategically | - Improving capacity<br>- Supporting Initiatives<br>- Strategic thinking<br>- Communication<br>- Innovation<br>- Creating an appropriate working environment<br>- Using different skills in different situations<br>- Intuition<br>- Flexibility and breaks |
| Leading people | - Indirect leadership and guidance<br>- Unclear instructions<br>- Interaction between leaders and employees<br>- Interpersonal loyalty that can be of benefit to the organisation<br>- Combining a human aspect and regulation<br>- Personal relations with employee to support their personal issues<br>- Mutual trust<br>- Evaluating employees' mind-set<br>- Creating work teams that work cooperatively<br>- Rewards<br>- Confronting mistakes<br>- Setting fair evaluation criteria<br>- Complaints<br>- Fairness and equality |

| Themes | Aspects |
|---|---|
| Developing and empowering people | - Empowerment and delegation<br>- Enhancing knowledge<br>- Recognition<br>- Make employee feels responsible<br>- Blocks to development<br>- External training courses<br>- Training<br>- Lack of incentives |
| Demonstrating Interpersonal traits | - Personal relationships<br>- Lack of administrative skills and experience<br>- Religious values (Islamic)<br>- Avoiding favouritism/tribalism<br>- Tolerance<br>- Leadership by example<br>- Human interpersonal relationships<br>- Humility<br>- Integrity<br>- Leadership by rhetoric (enthusiasm)<br>- Centralisation<br>- Personifying work environment<br>- Morals<br>- Undervaluing employees' status<br>- Self-awareness<br>- Interpersonal skills |
| Managing resources to deliver services | - Conflict resolution<br>- Individualising employees' motivation<br>- Constant observation<br>- Challenge<br>- An assessment period for employing a new candidate<br>- Applying pressure<br>- Morality criteria for employment<br>- Exchanging experiences/knowledge<br>- Close supervision |
| Managing activities and quality | - Situational approach to decisions<br>- Observing with evaluation indicators<br>- Finding solutions<br>- Involvement in solutions<br>- Speed and punctuality |

Figure 4-5 below illustrates the percentages distribution of the influences aspects within the main emerged themes.

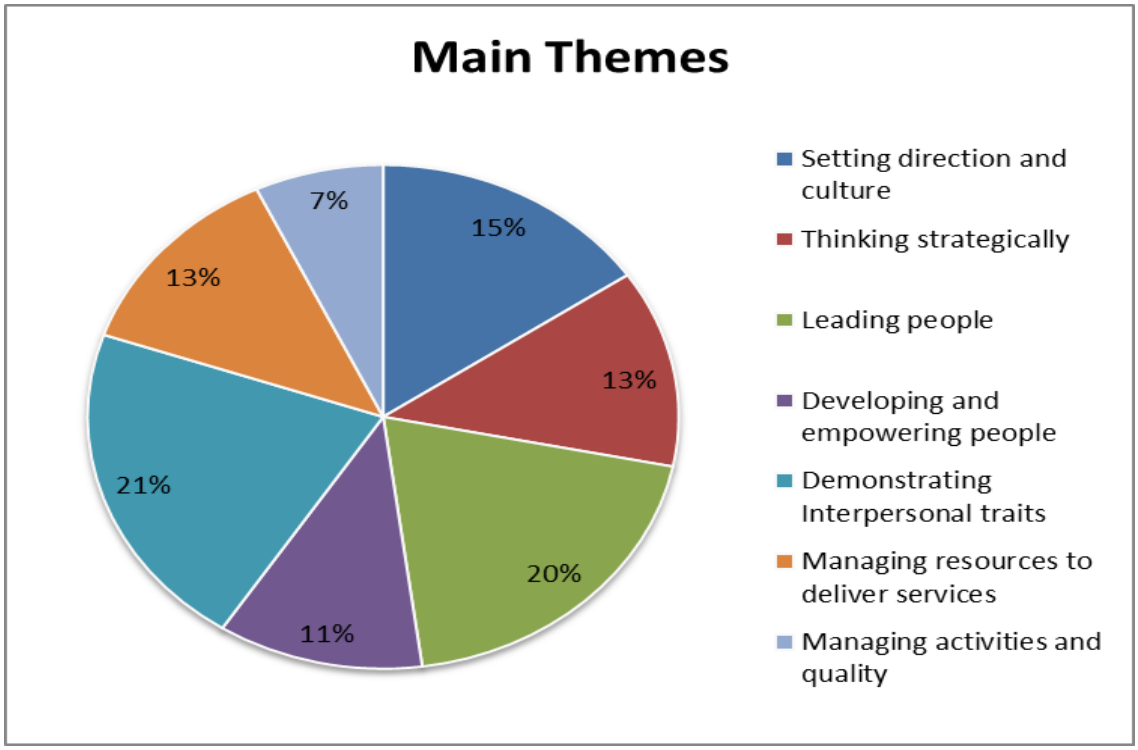


**Figure 4-5 The distribution of the emerged aspects within the main themes.**

### 4.2.2 Themes development


**Figure 4-6 The main emerged themes of the study**

The themes identified in these responses are presented in Figure 4-6 above. These themes can help to facilitates a culture of performance improvement of leadership in the healthcare sector. This section discusses these themes in detail and the impact of each on the leadership performance in healthcare organisations.

#### 4.2.2.1 Setting Direction and Culture

One of the main tasks of leaders in organisations is to establish direction and a suitable culture. These are the organisation's purpose, planed objectives and its priorities (Scholtes, 1999). However, in the context studied, *direction* refers to a course or target agreed upon by people in an organisation, effectively reaching a unanimous understanding of the desired collective achievement (organisational purpose) (Rother, 2010). According to Sanghi (2007, p. 208) it refers to "how a common vision/mission will be implemented and aligning all the involved parties

to reach the same goals and objectives". It encompasses goals and objectives in relation to desirable attributes such as care, quality and safety.

Avolio and Gardner (2005) state that visions must also be transformed into leadership accomplishments. This relates to the organisational vision, mission and values, emphasising such characteristics as empathy, transparency, engagement, single-mindedness and patience.

Setting direction in an organisational setting involves the clear and concise outline of a desired future state, the resolving of critical issues, such as how specific processes should function, and the defining of future organisational directions (Rother, 2010; Kotter, 1995). Freeman (2010, p. 90), however, finds "direction setting" to be intrinsically tied to understanding the endorsement or support of corporation's managers and employees. Similarly, the main aim of a leadership task is to provide a clear direction, alignment and commitment within teams delivering healthcare services (Khoja *et al.*, 2013). In line with this, Dulewicz and Higgs (2005) argue that one of the most important and influential leadership role competencies is the ability to recognise and characterise a clear future picture that affects the way in which people exert their effort and employ their skills. It also involves learning and relating to individuals in their own contexts and capacities and improving their power to contribute by giving them a better grasp of the organisational vision (Drath *et al.*, 2008).

Setting a clear direction can empower an organisation and boost its ability to envision and delineate a clear image of its future (Kotter, 2012; Khoja *et al.*, 2017). This of course has the capacity to motivate or direct people's use and deployment of skill and effort. Furthermore, the organisation's strategic focus is widely seen as encompassing the determination of a vision and the setting of directions (De Zulueta, 2016).

It has been argued that having a target condition is significant; it causes efficient process improvement and management, such that an organisation will typically not venture into improvements or progressions without clearly articulating such a condition (Rother, 2010. p. 77). Essentially, individuals must envision a

meaningful goal before they can engage and collaborate in change processes (Weber and Joshi, 2000, p. 392).

The second crucial factor that also chiefly influences the shaping of organisational values is the organisational culture. Culture, however, is often used to refer to both the values and the beliefs expressed through systems and structures and the scale of acceptance and adherence by the actors (Edgell *et al*., 2015; McLaughlin *et al.* , 2005).

Previous studies in this context confirm that the significant impact of organisational culture on worker motivation and organisational performance is widely acknowledged (Franco *et al.*, 2002; Edgell *et al*., 2015; Parmelli *et al.*, 2011b). Organisational culture has been defined as 'a shared set of norms and behavioural expectations characterising a corporate identity' (Grindle, 1997).

Alternatively, it has also been described as involving and delineating all the patterns of thoughts, sensitivities and actions shared by the members of a society or other bounded social group (Schwartz, 1997). Cultural physiognomies influence organisational structure, decision-making processes and acceptable levels of autonomy (Franco *et al*., 2002).

According to West *et al.*, (2014) members of top management are responsible for ensuring their organisation develops a coherent, effective and forward-looking collective leadership strategy for the organisation and assuring that it is implemented. This strategy comes from purposefully describing the leadership culture desired for the organisation (Appelbaum *et al.*, 2012; West *et al.*, 2014). Effective boards promote staff participation and proactivity encourage and inspire trustworthy innovations in the staff and effectively engage external stakeholders to develop collaborative relationships across boundaries (Armit *et al.*, 2015).

Hence, leadership is a key influencing factor in modelling organisational culture; thus, the necessary leadership behaviours, strategies and qualities must be fostered (Schein, 2004). Leaders should work collectively and build cultures where leaders' inclusive priority is good patient care, regardless of individualised responsibilities and success requirements (Armit *et al.*, 2015; Akhtar *et al.*, 2016).

Leadership that creates direction, alignment and commitment is required if the essential cultural elements are to inhabit an organisation; the leadership must relate to the targeted cultural elements (Kotter, 1995; Drath *et al.*, 2008).

Interestingly, one of the top-level participants in this study suggest that;

> *'First, as a leader, you should be convinced with the change and aware of all its positives and also aware of its negatives if it has any.*
>
> *Number two, you have to educate your staff. Education is the only way. And you explain for them the advantages and the pros of this policy or the new system or the new change or…etc.*
>
> *Number three, you have to get along with any system because you have to submit your subordinates even if you don't see that this system will serve people. There definitely are people who made committees for studying this system and they definitely have a foresight regarding this subject. They know that on the long run, there will be benefits'.*

In a recent study, West *et al*. (2014) suggest that healthcare organisations that are good places to work and receive compassionate, high-quality care need cultures that sustain high-quality care at all levels;

<u>These cultures do the following:</u>

• Focus above all on the delivery of high-quality, safe healthcare.

• Enable staff to do their jobs effectively.

• Value, support and nurture 'the front line'.

• Ensure that there is a strong connection to the shared purpose, whatever one's role or position in the system.

• Ensure collaboration across professional, role and organisational boundaries.

• Achieve high staff engagement at all levels.

• Encourage and support patient and service-user involvement.

• Ensure transparency, openness and candour.

• Encourage people to accept responsibility for outcomes and welcome learning and innovation from errors or failures.

• Promote and value clinical leadership.

• Support, value and recognise staff.

• Foster leaders who create opportunities for others to lead and an overriding commitment to learning, improvement and innovation can be found in all services at all levels ( West *et al.*, 2014b).

#### 4.2.2.2 Thinking Strategically

Effective organisations require both tactical and strategic thinking as well as culture building by its leaders. Strategic thinking helps to create and build the vision of an agency's future (B. Bass and Avolio, 1994). In a recent study, Sanghi, (2016, p. 166) stated that “strategic orientation is the ability to link long-range visions and concepts to daily work. It includes an understanding of the capabilities, nature and potential of the department and the organisation”.

According to Bass and Avolio (2013), Kotter (1995) strategic thinking helps to create and build the vision of an organisation's future. The vision can emerge and move forward as the leader constructs a culture that is dedicated to supporting that vision (Bass and Avolio, 1994). Sanghi (2016, p. 157) explained that a strategic planner “sets goals and objectives based on a clear vision of the future and works towards their achievement, while ensuring that short-term goals are met”. This is consistent with the step two of Kotter’s model of change (1995).

However, in healthcare organisations a focus on the broader issues and their implications can empower the organisations to improve their services by giving them more opportunities to develop and amplify their capabilities to in keeping with leadership roles (Armit *et al.*, 2015).

Other ranges of strength are the investigation of a wide range of connections, keeping short-term and long-term consideration in mind, the ability to see the

effect of one's activities and choices over the association, recognisable proof of opportunities and dangers, the ability to understand stakeholders' needs and the suggestions of outside variables on choices and activities (Dulewicz and Higgs, 2005). These ideas were articulated in Scholtes (1999) in a similar range of aspects affecting the nature of competencies, among which were the definition of a clear vision, direction and focus throughout an organisation. One of the participants in the present research corroborates the crucial function of having a clear vision and corresponding strategic plans:

> *'Without a strategy…when I say strategy, some understand it as just a plan! It is a plan that includes everything. It should have a financial aspect, a strategic aspect; it should include all departments—a manpower aspect. All these requirements should be taken into account alongside setting an achievable plan with clear objectives. Without a strategy, you cannot follow a plan and the relationship between areas that are financial [and] human resources'.*

Another interviewee implicitly endorsed this view:

> *'We have the financial resources, manpower and educated, qualified people, but we lack the proper strategies'.*

Effective boards of directors ensure the implementation of strategies aimed at nurturing a positive culture (Garg *et al*., 2011). These boards sense issues well before their emergence and proactively improve organisational functions. The leaders in the best performing healthcare organisations notably prioritise their visions and establish a strategic narrative that centres on high quality beneficial care (Khoja *et al.*, 2017). In these organisations, all leaders (from the highest to the lowest positions) set high quality compassionate care as the foremost purpose and priority of the organisation (Hoffmann *et al.*, 2014).

This is evidenced by the research outcomes that demonstrate the highest patient satisfaction is found in organisations that have clear and articulate goals and where staff esteem their leaders positively (C.Leadership, 2010). In another point of view, staff satisfaction tends to be proportionate to consequent patient

satisfaction (Armit *et al.*, 2015). This In line with what one of the participants believed as he said:

> *"But as a leader, the most important thing that you as a director of management teams and all the managers of this team are keen to do is to ensure that goals are working to achieve…staff satisfaction and customer satisfaction".*

A significant analysis and discussion on the subject was presented by Sanghi (2007, p. 166) "strategic orientation should involves taking calculated risks based on an awareness of socio-economic and political issues as they impact the strategic direction of the department and the organisation".

#### 4.2.2.3 Leading people

The concept of leading people hinges on the view that some people have a potential to take on more demanding tasks and roles and should be encouraged to do so (West *et al.,* 2014a). This concept ensures direct and adequate support for the development of competencies and for the investment of valuable time, effort and resources in the coaching of individuals so they can make meaningful contributions, whilst improving themselves (Kelloway *et al.,* 2017).

According to C.Leadership (2010, P. 15) "the ability to lead employees is a highly variable skill, requiring strong self-awareness and interpersonal savvy". This function also furthers the identification of new tasks and roles to be allocated to others and does not undermine the value of critical feedback and challenges (Carlton *et al.,* 2015). All these aspects are imperative for leaders to work efficiently with others (Dulewicz and Higgs, 2005).

Other vital capacities include working with people to build their aptitudes and help them to work out the contributions that they see themselves making (Rees and French, 2016). It also requires being open to serious dialogue, especially with those involved in the organisation and encouraging free, honest unbiased and constructive debates on all issues at every organisation level (Akhtar *et al.*, 2016). In addition, creating a functional team work environment is also essential when leading other workers (West *et al.*, 2014a; Turner, 2017).

In an attempt to justify this position further, messages communicated by leaders about their priorities must be conveyed more strongly by their actions than their words (Drath *et al.*, 2008). The authenticity of leadership is demonstrated by what leaders monitor, attend to, measure, reward and reinforce—which in turn regulates and models the efforts of staff (Boyraz *et al*., 2014). In line with this, Sanghi (2016, p. 170) indicated the required attributes that leaders need to successfully handle their daily tasks: “It may include providing leadership, direction and inspiration to others by making difficult decisions and taking actions that may not be popular, but are in the best interests of the organisation and its clients”.

Importantly, greater engagement seems to abound in healthcare organisations where leaders create an unbeatable atmosphere that supports inclusiveness for staff, thereby boosting their emotional capacity to care for others (West and Dawson, 2012). It is a leadership responsibility to ensure cooperation to provide high quality nursing and nurturing among healthcare staff across professional boundaries, chiefly because of the increasing complexity of healthcare needs amidst widespread ill-health (West and Dawson, 2012; West and Lyubovnikova, 2013).

Significantly, the advancement of social justice and morality is a general characteristic desirable in leaders, especially in healthcare organisations (Almgren, 2017). To be successful in their responsibilities, leaders should emphasise and practice fairness and honesty with their followers (Wong and Laschinger, 2013). They must set exceptional examples of ethical/moral behaviour, especially when it comes to the sacrifice of personal interests (Armit *et al.,* 2015). In line with this, one of the participants offers:

> *“The leader should understand the abilities, feelings and mentality of the employees, not just to put forth a plan and achieve a goal—the leader should put the right man in the right place. For example, it is not good to ask an employee who does not like calculation to work with numbers and calculations. Distribution of the works is the leader's mission and it should*

*be done according to the mentality, qualifications and desires of the employees in order to get the best of his staff".*

#### 4.2.2.4 Develop and Empower People

Developing and empowering people in the workplace is deemed a vital duty of leaders (Dulewicz and Higgs, 2005). Thus, it is quite pertinent for leaders to focus their efforts on guaranteeing the continuous growth and development of their followers. Leaders need to avail themselves of high levels of self-governance and advancement opportunities to empower those who work with and under them and ensure they continue to foster efficiency and self-reliance (Drath *et al.*, 2008). One of the most essential roles of leaders is to inspire followers to believe in their ability to effectively meet greater responsibilities and challenges whilst affording the necessary support and resources that their staff need (Wong and Laschinger, 2013). Such leaders are usually not as particular about directing the activities of the enterprise as about building in others the capacity for achievement (Dulewicz and Higgs, 2005; Appelbaum *et al.*, 2012).

According to Sanghi (2007, p. 167) "Development of people involves taking actions to develop people's contribution and potential [and] involves a genuine intent to foster the long-term learning or development of others, including direct reports, peers, team members or other staff".

Framing aims to identify the power relationship behind communication and the level of performance between top managers and followers in terms of the level of support the latter receive. Crawford (2014) agrees with Bernstein's (1996) theory, claiming: "without the ability to span boundaries, leadership and management can be insular, unproductive and static" (p. 110). This is because treating boundaries as obstacles might lead the organisation into difficulties and dilemmas causing the leaders to miss crucial issues inside or outside the organisation (Crawford, 2014). Similarly, the key role of empowerment is to enhancing employees' participation, productivity, satisfaction and commitment (Conger and Kanungo 1988; Lok and Crawford 2004; Malone, 1997; Singh, 2002).

Naturally, the role of leaders is crucial in these areas and leaders must become personally involved in preparatory and development programmes in order to increase overall potential for the development of workers (Amrstrong, 2012). Similarly, Sanghi (2016) stresses that the major role of leaders is to develop their subordinates' capabilities by planning effective experiences related to current and future jobs, in the light of individual motivations, interests and current work situations. Additionally, Franco *et al.* (2002, p. 1257) claim that "health worker motivation exists when there is alignment between individual and organisational goals and when workers perceive that they can carry out tasks". In similar with that one of the participants argues that;

> *'From the motivating things that we see, that definitely there are achievements. For instance, annual award for the best employee. There is always a best employee and they put…And the COO, who is the Chief Operating Officer, comes several times and motivates people and distributes presents by the end of the year. These are motivating things'*

In another point of view one participant indicate to important for collecting the right people within the workplace;

> *'I don't select anyone, I bring them, I ask them to volunteer for two or three weeks, I study their behavior, I don't study their knowledge, I don't care about their knowledge. They can acquire the knowledge later. But it's about the behavior. I ask about them and their previous work, I ask their previous employee then I hire good people. It happens that whatever you do, there might be some conflict'.*

#### 4.2.2.5 Demonstrating Interpersonal Skills

Interpersonal skills are essential; understanding the needs and feelings of followers, closely monitoring the effects of one's own behaviours and being aware of emotional reactions of others are all important characteristics (Armit *et al*., 2015). This touches on leaders' expression of their characters (Armit *et al.,* 2015).

Essentially, the behavioural attributes of leaders should be those that spur others to align themselves with the organisational direction and the means of reaching

its goals (Akhtar *et al.*, 2016). Above, it has been noted that leaders ought to be more concerned with building up in others the capacity to achieve, rather than ensuring the close direction of the enterprise (Dulewicz and Higgs, 2005), although no one would disagree with the view that human behaviour is a highly complex process that is never completely comprehensible (Scholtes,1999, p. 706), leaders' interpersonal skills and qualities are characterised by some understanding of their followers' needs and feelings.

Similarly, one participant reinforces on the key role of interpersonal skills of the leaders;

> *'The environment and the motivators. The environment, there should be a healthy environment especially that we have a policy that is called professional of contact which means that the way that you deal with others is very important. Your relationship with others, what they call the interpersonal skills. This is very essential. These are motivating things in our environment. Our relationships with each other are very good and this reflects on the work environment and finally reflects on the employee's performance'.*

It is essential to monitor the effects of individual behaviours and not be oblivious to the emotional responses of and impacts on others (Armit *et al.*, 2015). In supporting this point of view, one participant claimed,

> "*In healthcare administration, one of the components that I lived with…is interpersonal skill. I mean, how to develop interpersonal skills between you and other people. I mean, be a standard professional. Therefore, I think I have benefited a lot from this. I have special relationships in the hospital. All of them, you know, because you work in quality…the hospital police, they call them sometimes, to absorb people and engage them with you in the program that you developed"*.

He also added that;

*'In healthcare administration, one of the components that I lived in there is interpersonal skills. I mean how to develop interpersonal skills between you and other people. I mean, be standard professionals. So, I think I have benefited a lot from this. I have special relationships in the hospital. All of them, you know, because you work in quality, you know to…the hospital police, they call them sometimes to absorb people and engage them with you in the program that you developed. It's different than forcing them to do something that they don't believe in. You have to educate and educate and educate them then you engage them, not force them. And I think that interpersonal skills are very important to any leader. It is one of the things that we always use in the hospital with my colleagues and with my other relations here, work relations'.*

Although a far-reaching understanding of people's feelings and how they are expressed is hardly feasible, a reasonable measure can be derived and acted upon appropriately (Schank and Abelson, 1977). In another point of view, experience in leadership is apparently the most valuable characteristic for enabling leaders to grow their skills—especially with the appropriate guidance and support (Kanter *et al.,* 1992). Learning from experience should be of the utmost importance and take priority (Day, 2000; Day and Harrison, 2007; McCauley and McCall, 2014).

However, core personality traits have been linked to leadership efficiency, emphasising such traits as a high energy level and stress tolerance, self-confidence, emotional maturity, personal integrity and socialised power motivation (Kelloway *et al.*, 2017). Conversely, traits such as achievement orientation are liable to make leaders highly insensitive to the effects of their aspirations on those around them. The latter often feel exploited in order to further leadership ambitions (Yukl, 2012). Most appropriately, a collective leadership strategy should be advanced that focuses on the skills and behaviours brought in by leaders for the purpose of shaping the desired culture (Akhtar *et al.*, 2016; West *et al.*, 2014a). In an organisation, employees with good interpersonal skills are likely to be more productive than those with poor interpersonal skills because

of their propensity to project a positive attitude and look for solutions to problems. In line with this one interviewee put it:

> *"Unfortunately, some managers are just good at giving orders, without considering the employees' opinions. That affects productivity because the employee prefers promoting his ideas and sharing his opinions. The successful boss should be friendly. Cooperation, transparency, sharing ideas and communication skills are the important factors". Demonstrating personal skills plays key role in a leader's behaviour".*

He also proposed a three-month experimental period to evaluate the abilities of managers and said,

> *"It may be an evaluation after the experimental period. This method may help to reduce the problems that happen because of unsuccessful leadership".*

Similarly, one of the participants suggested leadership skills, problem solving, control and communication skills are essential things to look at when choosing the manager. (see Edmonstone, 2011b). Regarding this she said,

> *"I mean there are nepotism and bias. Some people do not deserve to be managers. These positions must follow certain criteria like proposing a committee to determine the qualified people".*

This in line with Sanghi (2007) who argued that organisations should employ measures for performance required to meet organisation's goals. As a result, this can help any organisation to ensure effective leaders selection.

#### 4.2.2.6 Managing sources for delivering services

Delivering the desired services involves planning well ahead, organising all resources and harmonising them efficiently ( Armit *et al*., 2015; James, 2011). However, it must start by establishing clear objectives and converting long-term goals into action plans. Ensuring the availability of needed resources is a key duty of leaders in healthcare organisations. Leaders in this area must ensure that their group or organisation has the resources (money, staff, IT support, time)

necessary for the job to be done and actively assure the accessibility of the available resources if and when needed (Armit *et al.,* 2015; Turner, 2017).

The leaders must be seen to maintain consistent and tireless efforts to assemble the necessary resources to support the group/organisation's operational effectiveness (Armit *et al.*, 2015). A sensed or observed lack of control, resources or time can set back or derail plausible change endeavours (Weber and Joshi, 2000, p. 392). In a previous study, Seema (2007, p. 170) stressed that leadership should "make decisions that allocate limited resources (time, people, budgets, etc.) to meet programme delivery and/or policy objectives". Similarly, one of the participants highlights that;

> *'the management is like puzzles; it consists of many parts. Financial, operational and service and support service. It is important to not neglect any part of this puzzle and manage them equally. For example, we always consider the practical things'.*

He also added that;

> *'I am always reminding them about the effort that they are exerting, not just because they are employees, that also impacts the patients' and the safety. We are not working in engineering or in factory, we are working with patients, and affecting the patients' safety. Whatever effort you do, it will sure eventually affect the patient and the patient's safety'.*

These authors further suggest that environments that support open and free access to information, resources, guidance and equal learning and development opportunities will empower leaders and their associates to accomplish their work more effectively (Swayne *et al.*, 2008). It suffices that, for leaders and followers to be efficient, leaders must promote an inclusive organisational atmosphere that encourages continual learning and development for all (Avolio and Gardner, 2005; Lussier and Achua, 2007).

#### 4.2.2.7 Managing Activates and Qualities

Board leadership is most successful when boards imprint the vision and values of their organisations through their attributes of focus, observation, rebuke and reward ( Bratton and Gold, 2012; Carlton *et al*., 2015). This is demonstrated when leaders listen to patients and regard patients' feedback as the most important source of opinion on organisational performance (Blumenthal *et al.*, 2012). It is also found when leaders listen to staff to learn how the leadership can best support and empower staff to provide high quality patient care (Armit et al., 2015). Activity and quality management also involves the regular monitoring and evaluation of staff work and the tolerance of their sensitive, honest and constructive feedback ( James, 2011; Lofthouse *et al.*, 2010).

Pocklington and Weindling (1996) believe that mentoring and evaluation benefits the mentors themselves, opening ample capacities that range from providing opportunities to discover alternative methods, to reflecting on their own methods, forming connections with colleagues in the organisation and offering consultations for assistance on impending or emergent issues. Structured mentoring is helpful for organisational unification—bringing all members of all levels of the organisation together (West *et al.*, 2014). Similarly, Freeman (2010) highlights that continuous evaluations and monitoring are vital activities in an overall strategic plan that includes a monitoring aspect. In the author's terms, "controlling strategy is equally important as formulating and implementing strategy" (p. 171).

Moreover, mentoring takes place at significant career events such as induction programmes (Lofthouse *et al.*, 2010). Mentoring is essentially the process of building rapport and offering work-related advice. Freeman (2010) sees constant evaluating and monitoring as a vital task of strategic planning to ensure the plans and strategies are being developed.

One of the participants indicates to the importance of mentoring;

> *'yes, you can measure the productivity using many methods without the direct supervision. There are reports submitted to determine the quality of*

*work and they are as indicators. So, you, as a leader, must have quality tools to be a strong leader. I use fishbone tools and diagrams tools. I make statistics for the employees show the percentage of the employee's contribution; 80% or 90%. So, I encourage the employee by choosing the perfect employee every month and putting his/her picture with motivating words under it'.*

### 4.2.3 Themes located on Schein's model

The presented themes do not exist in isolation, but rather are correlated representations of aspects of existing performance cultures as the participants see them. These themes reflect the views of the field study participants and were developed through participatory assessment with the workshop team members. It is argued that the focus on figurative trends that rest on organisational behaviour, stories, myths, logos, heroes and other mixes of verbal or physical artefacts concentrates and articulates the obvious, whereas it is impossible to display the core of informative systems that lends coherence to a culture (Barley, 1991).

In the model by Schein (1992), it is easy to note the artefacts, but reasonably complex to interpret them. The values may reflect only the rationalisations or aspirations of the group. Thus, grasping a group's culture clearly requires making sense of the group to reach its shared motivational notions and beliefs (Schein, 1992). A cultural assessment may offer a significant initial way into evaluating an organisation's effective readiness for change. Cultural assessment tools that are exclusive to healthcare can assist change agents in answering such questions as, 'What is the existing culture?' 'What is the desired culture?' and 'What gaps exist and how can these gaps be closed?' (Weber and Joshi, 2000, p. 393). Nevertheless, it is not certain that beliefs that are intuitively taken for granted, behavioural perceptions, and thoughts and feelings that form fundamental assumptions can be fully grasped and made plain to cultural outsiders (Schein, 1991). Consequently, the themes as facets of the culture for performance improvement using Schein's model are only presented at the level of either noticeable indexes (artefacts) or as sensed values as shown in Figure 4-7. The

primary assumptions are the ultimate source of these artefacts and values (Schein, 1992).

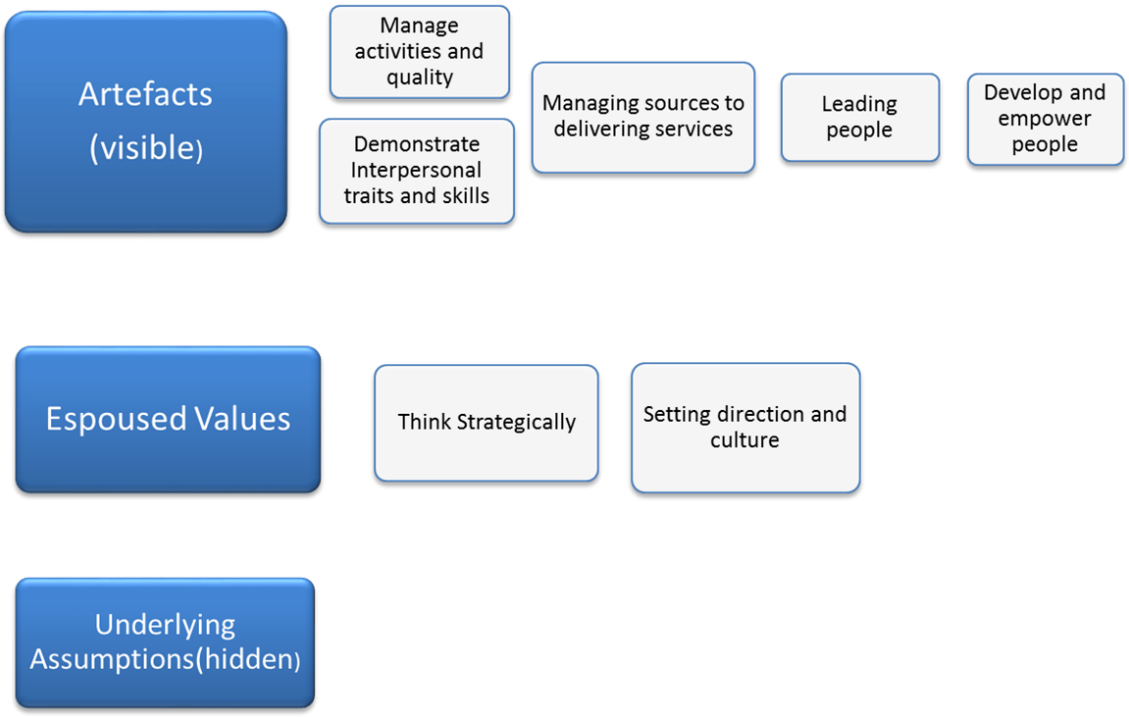


**Figure 4-7 Representation of themes as internal/external and visible/perceived**

### 4.2.4 Self-assessment against the proposed ideal positions

In order to precisely evaluate the positive changes in the culture of improving leadership performance in the healthcare sector, an assessment tool that is centred on the performance culture archetype is described in Table 4-5. This tool was developed from a harmonisation of the literature and the acquired data. Descriptive configurations of leadership performance culture were developed for each of the themes. A series of short statements relating to each of the seven themes demonstrates an ideal position in the culture of leadership performance improvement. The statements were then assembled to form seven theme-based descriptions of leadership performance development in healthcare organisations. The statements adopted for each theme's proximity evaluations are shown below, in Table 4-5.

**Table 4-5 The proposed ideal position of themes**

| Theme | Ideal position |
|---|---|
| Setting the direction and culture | Direction refers to a course agreed by the people in an organisation, effectively reaching consensus on their desirable achievements (i.e., the organisational purpose) (Kotter, 1995; Armit *et al.*, 2015). It should encompass goals, objectives in relation to such desirable attributes as care, quality and safety (Cummings and Huse, 1989; Rother, 2010). The culture is characterised by an unwavering focus and adherence of all staff to systemic and organisational structures, capped by the continual learning of measures and approaches to improve patient care (Turner, 2017; West *et al.*, 2014). |
| Thinking strategically | Thinking strategically refers to improving an organisation's ability to produce a decided, decisive or desired outcome (Lovrien and Peterson, 2013). This demands prudent planning, relentless devotion and an unvarying focus on fostering leadership and culture (Hoffmann *et al.*, 2014), (Rother, 2010). The role of leader should be to act as the organisational lead member, working strategically and ensuring that people are a priority and work is set against the organisation's strategic direction (Aguinis, 2009; O'Boyle, 2015; Kotter, 2012). |
| Leading people | Leaders should have the authority to reward and rebuke (Bratton and Gold, 2012; Rees and French, 2016). They manage information and resources and when necessary, make informed choices about structure (Aguinis, 2009; Slipicevic and Masic, 2012). |

| Theme | Ideal position |
|---|---|
| | Leaders also contribute to either the healthy or unhealthy modelling of followers' and colleagues' lives at work. To be successful in their responsibilities, leaders should emphasise and practice fairness and honesty with their followers (Almgren, 2017; Armit *et al.*, 2015; (Engelbrecht *et al.*, 2014; James, 2011; ). |
| Demonstrating interpersonal skills | Leadership conduct and attributes should always focus on supporting others to follow the organisational direction and providing the means for attaining the prescribed goals (Allen *et al.*, 2016; C.Leadership, 2010). Empathising with the needs and feelings of followers, monitoring the effects of individual behaviours and being mindful of emotional reactions of others are all essential (Aguinis, 2009; Riggio and Reichard, 2008). In an organisation, employees with good interpersonal skills are likely to be more productive than those with poor interpersonal skills, because of their propensity to project a positive attitude and look for solutions to problems ( Turnbull James, 2011; Turner, 2017). |
| Developing and empowering people | Leadership responsibilities should usually include ensuring the sustained growth and development of followers (Allen *et al.*, 2016; Bratton and Gold, 2012). Leaders are required to provide high levels of self-sufficiency and development opportunities to empower fellow workers, especially subordinates, and ensure a continuous build-up of efficiency and confidence (Akhtar *et al.*, 2016; Allen *et al.*, 2016). They should inspire followers to rise to their own capacity to |

| Theme | Ideal position |
|---|---|
| | respond effectively to seemingly bigger challenges, whilst affording the necessary support and resources to manage the challenges (Rees and French, 2016; Turnbull James, 2011). Health worker motivation exists when the individual and organisational goals are aligned, and workers perceive that they can carry out tasks (Allen *et al.*, 2016; Franco *et al.,* 2002; Turner, 2017) |
| Managing sources to deliver services | Leaders in this area must ensure that the group or organisation has the resources (money, staff, IT support, time) necessary to do their work and should actively ensure the accessibility of the available resources if and when needed (Armit *et al.*, 2015; Turner, 2017) |
| Managing activities and quality | Leadership should always seek to resolve systemic problems, monitor shared leadership processes and encourage a mutual leadership learning atmosphere (Druckman *et al*., 1997; Edmonstone, 2011a). Responsible leadership supports high level dialogues, debates and constructive discussions to share the understanding of problems and solutions ( Garg *et al*., 2011; Hayati *et al.*, 2014). Activity and quality management also involves the regular monitoring and evaluation of staff work and sensitive, honest and constructive feedback (Armit *et al*., 2015; Turnbull James, 2011). |

The objective of this assessment was to identify the themes that were farthest from the ideal position and use them as opening points for group discussions about mediations that might revolutionise the culture of improved performance.

Having declared the ideal positions, points of reference could then be established for the participants as targets for intervention. The participants in this assessment were asked whether they believed their current situations close or far from these proposed ideal positions of the emerged themes. The participants evaluated their perceptions of the performance improvement culture by judging their proximity to each of the theme statements that signified an ideal position in the performance improvement culture. The overall response to this assessment was very positive. Fifty-two individuals of 65 returned the questionnaires. Twenty-two of the participants were female as shown in Table 4-6.

**Table 4-6 Participates' demographic in the self-assessment**

| Male | Female | Executive levels | Manager | Employees |
|---|---|---|---|---|
| 30 | 22 | 6 | 18 | 28 |

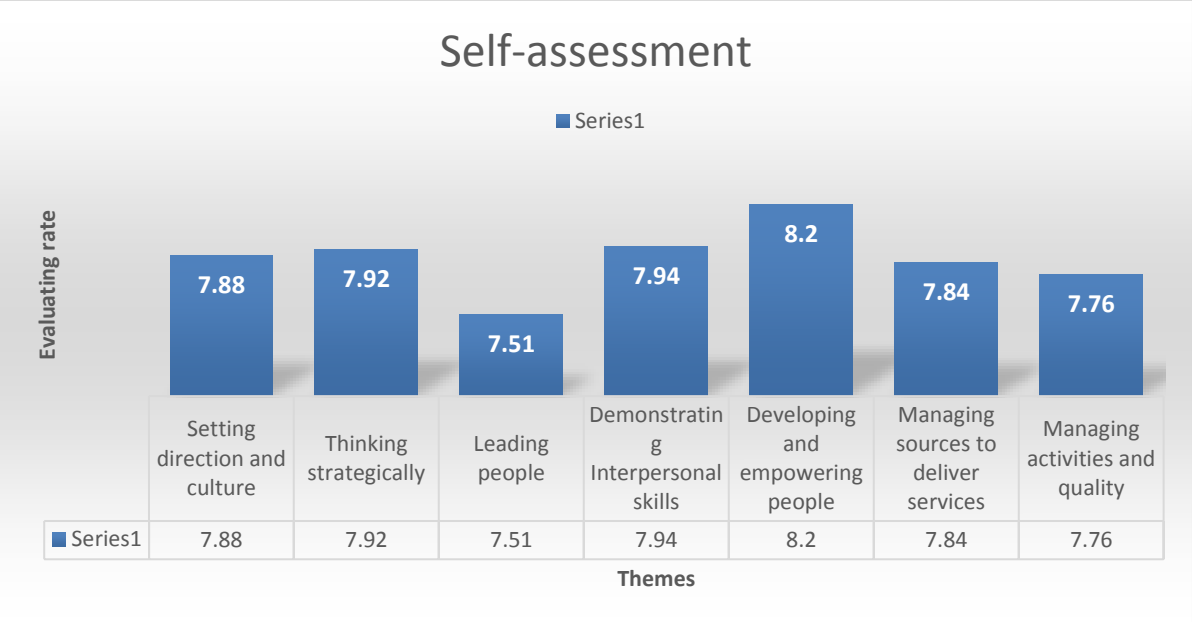


**Figure 4-8 Self-assessment of respondents based on major themes**

From the chart above, it can be seen that the theme farthest from the ideal position is 'leading people' with a score of 7.51 out of 10. This result indicates that the participants felt of all the attributes, their way of leading was farthest from

the ideal way to lead. What is interesting in this assessment is the similarity of the scores given to the majority of themes (all scoring around 7.8), except for the theme ‘develop and empower people’, which was assessed a score of 8.2 as shown in Figure 4-8 above. ‘Demonstrating interpersonal skills was given the next highest score of 7.94, followed by thinking strategically (7.92) setting direction and culture (7.88) managing sources to deliver services (7.84) and managing activities and quality (7.76). These results may reflect differences in the position level of the participants, their education, gender and the length of experience.

Figure 4-9 shows participants' outcomes in the assessment by gender.

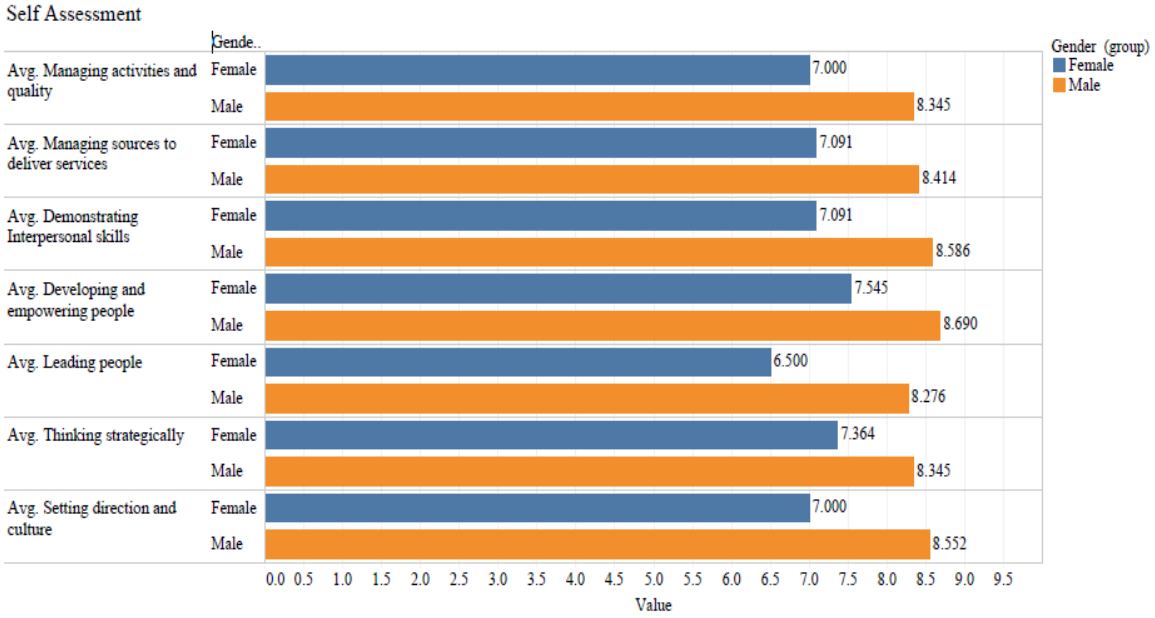


**Figure 4-9 Self-assessment outcomes by gender**

There was, in contrast, a variation between both genders in this assessment results. As shown above in Figure 4-9, there are clear differences in the outcomes level of the assessment by gender. In every theme, the women rated themselves lower than the men. This was seen across all themes between the male and female point of view. This difference this may reflect the influences of culture and religious aspects related to the female position in the KSA. However, this will be discussed in more detail in the chapter of discussion.

Finally, the output from this set of instruments indicates the extant position against an ideal type for a performance improvement culture. It also indicates areas where there are perceived inhibitors to developing the leadership performance improvement culture in healthcare organisations. This provides a starting point for a participative evaluation of the assessments and developing a plan of integrated interventions to facilitate a leadership performance improvement culture in the healthcare sector.

## 4.3 Summary

The aim of this chapter of data collection was to refine the emerged aspects, aggregate the codes into significantly fewer second-order concepts and then divide them into categories (main themes). These themes reflect the views of the field study participants and were developed through participatory assessment with the workshop team members.

# 5 FRAMEWORK DEVELOPMENT

## 5.1 Introduction

This chapter is designed to identify appropriate mediations that could encourage a culture of improvement in leadership performance. Hence, workshops with participants from the fieldwork were conducted to attempt to determine their opinions about potential interventions that could build the relationship between these identified themes in the proposed framework. A constant comparison with the literature and collected data was carried out to understand the relationship between the emerged themes (Goulding, 2009). This helped the researcher to gain greater perception about the required interventions that support the linking between these themes in order to develop the framework of this research.

A literature search in this regard revealed a few mediations applicable to developments in the leadership performance culture in the healthcare organisations. These guided the model interventions adopted, the implementation approach and the conceived impact of transforming the performance improvement culture. In this research, interventions are used to denote precise actions that have or could be applied to a group with the goal of fostering aspects of a culture of leadership performance improvement.

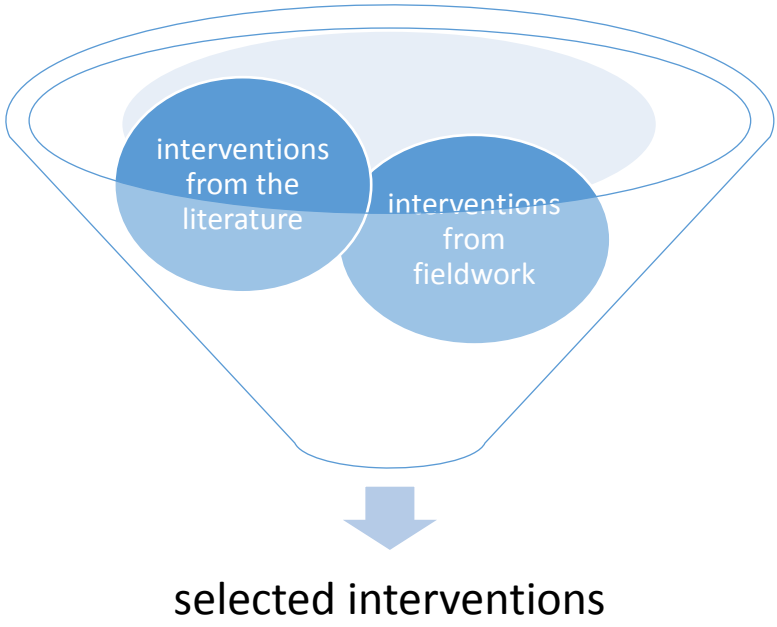


**Figure 5-1 Sources of interventions**

### 5.1.1 Interventions from the fieldwork

A workshop-oriented brainstorming session was organised for a group of the research participants for aggregating ideas on developing a performance improvement culture. This was aimed at eliciting recommendations that could encourage an effective and improved leadership performance culture. The aggregated views were subjected to debate and subsequently refined in an iterative process to obtain promising interventions that could encourage aspects of a culture of improved leadership performance. Each intervention measure was feasibly described in contexts that specified an end-point and the corresponding group of people responsible for making the intervention. The discussion yielded a list of eleven suggested interventions, which were considered practicable for organisational members and the related levels of management. This was to help these stakeholders create a realistic set of intents and the capacity to grow an ideal type of performance improvement culture in line with their expectations. The suggested interventions from the collected data are shown in Table 5-1.

**Table 5-1 Interventions from the fieldwork**

| | Interventions from the fieldwork |
|---|---|
| 1 | Encourage education, continuing training and on-the-job training for employees during their regular working hours in the same work setting, to share experiences and develop their interpersonal skills. |
| 2 | Schedule a weekly meeting for all the organisation's departments to facilitate the cooperation between all its leaders that would enable them to work together to attain the goals set by/for the organisation. Support a shared leadership that aims to encourage better connections, the sharing of learning and collaboration between all staff to foster continuous and sustainable improvement. This would require leaders to work collectively and build a cooperative, integrative leadership culture – in effect, a collective leadership at the system level. |
| 3 | Engage all staff in dialogue and in decision-making processes and gain their support in taking innovations forward. This could help to engage all staff in any plans for change and development and thus facilitate change implementation in the workplace, avoid resistance and enhance commitment and loyalty. |
| 4 | Guarantee core competencies related to effective leadership including communication, meeting facilitation, negotiation and networking to enhancing working as a team. Leaders in healthcare organisations must ensure that all staff work together across all levels to deliver high quality care. Develop people and empower them. |
| 5 | Give clear strategic work process with direct communication across all levels and apply mentoring alongside evaluating the outcomes constantly. This will eventually require the engagement of all key stakeholders and leaders throughout the organisation. The strategy must also design systems and processes that impel leaders to work together effectively to nurture and sustain the desired culture via leadership teams. |

| | Interventions from the fieldwork |
|---|---|
| 6 | Recruit the best existing global practices and models in healthcare. This can be done by creating a direct cooperative relationship or “partnership” with developed healthcare organisations, especially those in the developed countries, to gain more experience and adopt successful practices that can facilitate a developed and enhanced leadership role in healthcare. The process involves seeking out, sensing, adopting and adapting good practice wherever it is found. |
| 7 | Give more attention to the perspectives of external and internal stakeholders. Leadership is assumed to apply to a wide group of stakeholders, with the result that, to some extent, all staff, not only those in senior management roles, are viewed as leaders and patients’ enquiries and perspectives are considered. |
| 8 | Offer a feedback form for assessing every leader’s behaviours and effectiveness. This would enable all staff and subordinates to evaluate their leaders. |

Following the development of these suggested interventions, interventions from the literature were used to develop the culture of performance improvement of leadership in healthcare organisations.

### 5.1.2 Interventions from the literature

The literature was reviewed for interventions made to improve leadership capability and performance development in the healthcare sector. Table 5-2 below illustrates the interventions captured by the literature.

**Table 5-2 Interventions from the literature**

| | Intervention | Supporting literature |
|---|---|---|
| 1 | A coaching programme for leaders “Executive Coaching”. Coaching develops the leader in “real time” within the context of their current job, whilst allowing them to maintain their day-to-day responsibilities. | (Armit, 2015), (Bratton and Gold, 2012), (De Haan and Duckworth, 2013), (Otazo and Hollenbeck, 1999), (West *et al.*, 2014). |
| 2 | Systematically plan for and create a “short-term win.” Whilst keeping an eye on the long-term vision, try to establish smaller-scale tactical objectives for the team to meet within a reasonably short period of time. | (Bratton and Gold, 2012), (Weber and Joshi, 2000), (Kotter, 2012), (Kotter, 1995). |
| 3 | Documentation and on-going feedback on progress by gathering and using "data as an energizer. | (Bratton and Gold, 2012), (Hogan and Murphey, 2002), (Tsai Roussos and Fawcett, 2000). |
| 4 | Team development for newly formed teams or those facing challenges. | (West *et al.*, 2014) |
| 5 | A focus on driving integration to achieve collective leadership culture.<br>The collective leadership strategy focuses on the skills and behaviours that leaders will bring and develop to | (Armit *et al.*, 2015), (Raelin, 2016), (Turnbull James 2011), (Weber and Joshi, 2000), (West *et al*., 2014); |

| | Intervention | Supporting literature |
|---|---|---|
| | shape the desired culture. Collective leadership means the distribution and allocation of leadership power to wherever expertise, capability and motivation lie within organisations | |
| 6 | A value-based program of induction for new medical consultants to support them in adjusting to a leadership role. | (West *et al*., 2014) |
| 7 | Multiple forums, including meetings, memos, newsletters, and hallway conversations will be necessary to adequately communicate any planned change. | (Weber and Joshi, 2000) |
| 8 | Appropriate mix of training methods - formal lectures, practice sessions, role plays, coaching and real-life exercises can all be used, as appropriate to the abilities of learners and the clearly stated/particular skills being taught. | (Armit *et al.*, 2015), (Bratton and Gold, 2012), (West *et al.*, 2014). |
| 9 | Action Learning.<br><br>Groups are formed of people who meet regularly whilst working on a particular project in their work areas or organisations. Action learning is a practical and energetic way to learn, reflect and bring about personal and | (Armit *et al.*, 2015), (Bourner *et al.,* 2002) (Hale and Saville, 2014), (Leonard and Marquardt, 2010), O'Hara *et al.,* 2004), (Pedler, 2008), (Ronald Laing, 1989), (Tsai Roussos and Fawcett, 2000) |

| | Intervention | Supporting literature |
|---|---|---|
| | organisational change with the support of others facing almost the same challenges. | |
| 10 | Mentoring and evaluation. Mentoring refers to situations where an experienced manager works with a less-experienced individual to support leadership development. | (Armit *et al.*, 2015), (Bratton and Gold, 2012), (West *et al.*, 2014), |
| 11 | Multi-Source (360 degree) Feedback via Questionnaire. This method of promoting leadership effectiveness involves the individual and several subordinates completing a questionnaire assessing the leader's behaviours and effectiveness. | (Armit *et al*., 2015), (Akhtar *et al*., 2016), (Kluger and DeNisi (1996), (Seifert, Yukl and MacDonald, 2003). |
| 12 | Developmental Assessment Centres. An evaluation centre is a multi-method approach to selection by which a candidate will complete several different tests that are specifically designed to evaluate the key capabilities for the role for which they are applying.<br><br>Evaluation centres, usually spread over two to three days, involve multi-source responses to in-basket exercises, tests that measure how well people are likely to do things in the future, interviews, group | (Armit *et al*., 2015), (Appelbaum *et al.* (1989), (Engelbracht and Fischer, 1995), (Sanghi, 2016). |

| | Intervention | Supporting literature |
|---|---|---|
| | exercises, writing assignments and intensive reflection processes. | |
| 13 | Job Rotation.<br><br>Job rotation is a system of encouraging leadership development by assigning people to many jobs within the organisation in a short period of time. | (Armit *et al*., 2015), (Carlton et al., 2015). |
| 14 | An annual appraisal meeting for staff with the manager to agree on and clear challenging objectives. | (Armit *et al.,* 2015), (Bratton and Gold, 2012), (Kettley, 1997), (West *et al.*, 2014). |
| 15 | 'Post-heroic' model of leadership.<br><br>Involves many actors who take up leadership roles both formally and informally and importantly share leadership by working in a cooperative way. | (Raelin, 2016), (James, 2011). |
| 16 | 'Pioneer Teams' programme. Teams are encouraged to come together for 15 minutes daily to figure out what things that are the most important, provide updates and deal with problems, and to recognise and appreciate successes. They record their progress visually at a central point to keep the whole team updated | (Raelin, 2016), (James, 2011), (West *et al.*, 2014). |

### 5.1.3 Developing the interventions

As can be seen from Table 5-3 below, some intersecting coherence or overlap of interventions emerged between the intervention outlines derived from the data collected and from reviewing the literature. These interventions have been proposed to facilitate a culture of leadership performance improvement in the healthcare sector.

There were eleven intervention overlaps. These interventions were used as the foundation for developing precise mediations intended and structured to yield the conditions for a preferable culture that improves and enhances leadership performance in the healthcare sector. Table 5-3 below presents the outcomes and impact of the eleven interventions chosen to yield the preferred aspects of a culture of performance improvement by leaders in the healthcare sector. The recommended interventions interact to form a set of ways to positively create a culture that can enable developing leadership performance in healthcare organisations, such as interventions that might encourage a “do things differently” approach to problem solving. The peak of the interventions involves the selection and development of a leadership project in this vital sector. The interventions themselves are less important than the hidden beliefs and values being developed and embedded. It is these underlying beliefs and values that spread the desired behaviours connected with a development culture that can help to make this framework more workable.

**Table 5-3 Ideal positions of themes and the interventions to facilitate improvement**

| Ideal position of theme | Intervention from Literature | Intervention from the data | Proposed intervention |
|---|---|---|---|
| - Setting direction and culture<br>Direction refers to a course agreed by the people in an organisation, effectively reaching consensus on their desirable achievements (i.e., the organisational purpose) It should encompasses goals, objectives in relation to such desirable attributes as care, quality and safety. The culture is characterised by the unwavering focus and adherence of all staff to systemic and organisational structures, capped by the continual learning of measures and | - Encourage collaborative leadership in the organisation to achieve collective leadership culture (Armit et al., 2015), (Weber and Joshi, 2000), (West et al., 2014).<br><br>- Encourage people to come together for 15 minutes daily 'Pioneer Teams' programme. (West et al., 2014).<br><br>- Develop a fast track planning system (Killian and Pretty, 2008)(Killian and Pretty, 2008), (Sanghi, 2016) | - Schedule a weekly meeting for all the organisation's departments to facilitate cooperation between all its leaders.<br><br>-Engage all staff in dialogue and in decision-making processes and gain their support in taking innovations forward.<br><br>- Engage all staff in any change plans and development process.<br><br>- Create a suitable culture and work environment for | - Encourage teams to come together daily or weekly to determine priorities, provide updates and address problems, and to recognise and appreciate successes.<br><br>- Give clear strategic work process with common goals.<br><br>- Create short term plans with wins (yearly operational plan) to monitor and evaluate |

| Ideal position of theme | Intervention from Literature | Intervention from the data | Proposed intervention |
|---|---|---|---|
| approaches to improve patient care. | - Weekly team meetings (Frahm and Brown, 2007).<br>- Short-term wins (Bratton and Gold, 2012), (Kotter, 1995) (Weber and Joshi, 2000), (Reichers et al., 1997; Marks, 2007).<br>- Creating a guiding coalition within change plan (Kotter 1996). | the employee to do his work comfortably. | the on-going strategic plans. |
| - Thinking strategically is referring to improving an organization's ability to produce a decided, decisive or desired outcome. This demands prudent planning, relentless devotion and an | - Design a systematic plan for and create a "short-term win." (Bratton and Gold, 2012), (Kotter, 1995) (Weber and Joshi, 2000), (Reichers et al., 1997; Marks, 2007). | - Recruit the best existing global practices and models in healthcare.<br>- Give clear strategic work process with a direct | - Encourage teams to come together daily or weekly to determine priorities, provide updates and address problems, and to |

| Ideal position of theme | Intervention from Literature | Intervention from the data | Proposed intervention |
|---|---|---|---|
| unvarying focus on fostering leadership and culture. | -Encourage teams to come together daily or weekly to determine priorities ('Pioneer Teams' programme) (West et al., 2014), (Frahm and Brown, 2007).<br><br>- Enable all the organisation's staff to focus and collaboratively act on priorities (Bratton and Gold, 2012).<br><br>- Action learning program (Armit et al., 2015), (Volz-Peacock et al., 2016), (Walia and Maran, 2014),<br><br>- Developmental Assessment Centres. (Armit et al., 2015), | communication across all levels and apply mentoring alongside evaluating the outcomes constantly<br><br>- Monitoring and evaluating in the process of development. | recognise and appreciate successes.<br><br>- Give clear strategic work process with common goals.<br><br>- Create short term plans with wins (yearly operational plan) to monitor and evaluate the on-going strategic plans.<br><br>- Action learning |

| Ideal position of theme | Intervention from Literature | Intervention from the data | Proposed intervention |
|---|---|---|---|
| | (Engelbracht and Fischer1995), (Sanghi, 2016). | | |
| - <u>Leading people</u><br><br>Leaders have the authority to reward and rebuke. They manage information and resources and when necessary, make informed choices about structure. Leaders also contribute to either the healthy or unhealthy modelling of followers and colleagues' lives at work. To be successful in their responsibilities, leaders should emphasise and practice fairness and honesty with their followers within the workplace. | - Mentoring an evaluation (Bratton and Gold, 2012).<br><br>- Developmental Assessment Centres. (Armit et al., 2015). (Engelbracht and Fischer, 1995), (Sanghi, 2016).<br><br>- create short term wins (Reichers et al., 1997; Marks, 2007), (Kotter, 1996).<br><br>- Adopt and Implement an evaluation system such as "An annual appraisal meeting" for staff with their manager. (J Bratton and Gold, 2012), (Kettley, 1997). | - Give clear strategic work processes with direct communication across all levels and apply mentoring alongside evaluating the outcomes constantly.<br><br>- Guarantee core competencies related to effective leadership including communication, meeting facilitation, negotiation and networking to enhancing teamwork.<br><br>- Create a suitable work environment for the | - Clear strategic work process with common goals.<br><br>- Action learning.<br><br>- Building in an on-going customer service training programme.<br>- Implement Assessment Centres. (Bratton and Gold, 2012) |

| Ideal position of theme | Intervention from Literature | Intervention from the data | Proposed intervention |
|---|---|---|---|
| | - Implement Assessment Centres (Bratton and Gold, 2012)<br><br>- Coaching (Chiaburu and Tekleab, 2005), (Schilling and Kluge, 2009), (Bratton and Gold, 2012).<br><br>- Appraisal | employee to do his work comfortably. | |
| - <u>Develop and empower</u><br>Leadership's conduct and attributes should always focus on supporting others to follow the organisational direction and providing the means for attaining the prescribed goals. Empathising with the needs and feelings of followers, monitoring the effects of | -Design and Implement appropriate mix of training methods – formal lectures, practice sessions, role plays, coaching and experiential exercises given to employees during their regular working hours in the same work setting. (Chiaburu and | - Encourage education, continuing training and on-the-job training for employees during their regular working hours in their work setting. | - Develop a program for developing leaders and managers.<br><br>- Develop Feedback tools.<br><br>- Implement a learning method such as "action learning ". |

| Ideal position of theme | Intervention from Literature | Intervention from the data | Proposed intervention |
|---|---|---|---|
| individual behaviours and being mindful of emotional reactions of others are all essential. In an organisation, employees with good interpersonal skills are likely be more productive than those with poor interpersonal skills, because of their propensity to project a positive attitude and look for solutions to problems. These skills should include leadership attributes, direction and inspiration to others by making difficult decisions and taking actions that may not be popular, but are in the best interests of the organization and its clients. | Tekleab, 2005), (Schilling and Kluge, 2009).<br><br>- Develop and use a Feedback Questionnaire. (Bratton and Gold, 2012), (Holton et al. 2007).<br><br>- Action learning program (Armit et al., 2015), (Volz-Peacock et al., 2016), (Walia and Maran, 2014).<br><br>- Developmental Assessment Centres. (Armit et al., 2015), (Engelbracht and Fischer, 1995), (Sanghi, 2016).<br><br>- Coaching (Stober, 2008), (Bratton and Gold, 2017). | | - “Job rotation”.<br><br>- Implement Assessment Centres.<br><br>- Team development for newly formed teams or those facing challenges. |

| Ideal position of theme | Intervention from Literature | Intervention from the data | Proposed intervention |
|---|---|---|---|
| - <u>Demonstrating personal skills</u><br><br>Leadership responsibilities should usually include ensuring the sustained growth and development of followers. Leaders are required to provide high levels of self-sufficiency and development opportunities to empower fellow workers, especially subordinates, and ensure a continuous build-up of efficiency and confidence. They should inspire followers to rise to their own capacity to respond effectively to seemingly bigger challenges, whilst affording the necessary support and resources to manage the challenges. Health worker motivation exists when the | - Design and Implement appropriate mix of training methods. (Chiaburu and Tekleab, 2005), (Schilling and Kluge, 2009).<br><br>- Adopt and Implement an evaluation system such as “An annual appraisal meeting” for staff with their manager. (J Bratton and Gold, 2012), (Kettley, 1997).<br><br>- Encourage teams to come together daily or weekly to determine priorities (‘Pioneer Teams’ programme) (West et al., 2014), (Frahm and Brown, 2007). | - Encourage education, continuing training and on-the-job training for employees during their regular working hours in the same work setting.<br><br>- Engage all staff in dialogue and in decision-making processes and gain their support in taking innovations forward. | - Develop a program for developing leaders and managers.<br><br>- Implement a learning method such as "learning by action".<br><br>- “An annual appraisal meeting<br><br>- Building in an on-going customer-service training programme.<br><br>- “On-the- job training” for employees during their regular working hours in the same work setting. |

| Ideal position of theme | Intervention from Literature | Intervention from the data | Proposed intervention |
|---|---|---|---|
| individual and organisational goals are aligned and workers perceive that they can carry out tasks. | - Adopt and Implement an evaluation system such as "An annual appraisal meeting" for staff with their manager. (J Bratton and Gold, 2012), (Kettley, 1997).<br><br>-Coaching | | |
| -<u>Managing to deliver services</u><br><br>Leaders in this area must ensure that the group or organisation has the resources (money, staff, IT support, and time) necessary to do their work and should actively ensure the accessibility of the available resources if and when needed in order to deliver a better | - Adopt and implement an evaluation system such as "An annual appraisal meeting" for staff with their manager to agree clear, challenging objectives or Self-appraisal. (Bratton and Gold, 2012), (Kettley, 1997).<br><br>- Encourage teams to come together daily or weekly to | - Assign commissioning teams.<br><br>- Give clear strategic work processes with direct communication across all levels and apply mentoring alongside evaluating the outcomes constantly. | - Build an on-going customer-service training programme.<br>- Create short term plans (yearly operational plan). |

| Ideal position of theme | Intervention from Literature | Intervention from the data | Proposed intervention |
|---|---|---|---|
| and more effective service to customers. | determine priorities ('Pioneer Teams' programme) (West et al., 2014), (Frahm and Brown, 2007).<br><br>- Creating a guiding coalition within change plan (Kotter 1996). | | - Assigned commissioning teams.<br>- Team development for newly formed teams or those facing challenges. |
| - <u>Managing activities and quality</u><br>Leadership should always seek to resolve systemic problems, monitor shared leadership processes and encourage a mutual learning atmosphere. Responsible leadership supports high level dialogues, debates and constructive discussions to share the understanding of problems and solutions. Activity and quality | - Mentoring and evaluation (Armit et al., 2015), (Bratton and Gold, 2012), (Freeman, 2010), (Pocklington and Weindling ,1996).<br>- Documentation and ongoing feedback on progress. (Hogan and Murphey, 2002), (Tsai Roussos and Fawcett, 2000). | - Get on-going feedback<br>- Give clear strategic work process with a direct communication across all levels and apply mentoring alongside evaluating the outcomes constantly.<br><br>- Monitor and evaluate in the process of development. | - Clear strategic work process with common goals.<br>- Implement a learning method "learning by action".<br><br>- Build an on-going customer service training programme. |

| Ideal position of theme | Intervention from Literature | Intervention from the data | Proposed intervention |
|---|---|---|---|
| management also involves the regular monitoring and evaluation of staff work and sensitive, honest and constructive feedback. | - Facilitating leadership development by assigning people to multiple jobs in the organisation in a short space of time “job rotation”. (Armit et al., 2015).<br>- Encourage teams to come together daily or weekly to determine priorities (‘Pioneer Teams’ programme) (West et al., 2014), (Frahm and Brown, 2007).<br>- Action learning program (Armit et al., 2015), (Volz-Peacock et al., 2016), (Walia and Maran, 2014) | - Encourage teams to come together daily to determine priorities, provide updates and address problems, and to recognise and appreciate successes. | - Assigned commissioning teams.<br>- Encourage teams to come together daily or weekly to determine priorities, provide updates and address problems, and to recognise and appreciate successes. |

**Table 5-4 Relationship between identified interventions**

| List of interventions | Intervention from literature | Intervention from data |
|---|---|---|
| **A coaching programme for leaders "Executive Coaching".** | √ | |
| **'Pioneer Teams' programmes.** | √ | |
| **Assigned commissioning teams** | √ | √ |
| **A 'post-heroic' model of leadership.** | √ | |
| **An annual appraisal meeting for staff with their manager to agree on clear, challenging objectives.** | √ | √ |
| **Job rotation.** | √ | |
| **Building an on-going customer service training programme.** | √ | √ |
| **Recruiting the best existing global practices and models in healthcare.** | | √ |
| **A questionnaire assessing the leader's behaviours and effectiveness.** | √ | √ |

| List of interventions | Intervention from literature | Intervention from data |
|---|---|---|
| **"On-the- job training" for employees during their regular working hours in the same work setting.** | √ | √ |
| **Giving clear strategic assignments with direct communication across all levels.** | √ | √ |
| **Giving more attention to external and internal stakeholders' perspectives.** | √ | √ |
| **Focusing on driving integration to achieve a collective leadership culture.** | √ | |
| **Team development for newly formed teams or those facing challenges.** | √ | |
| **Documentation and on-going feedback on progress.** | √ | √ |
| **Engaging all staff in dialogue and in decision-making processes and gaining their support in** | √ | √ |

| List of interventions | Intervention from literature | Intervention from data |
|---|---|---|
| **taking forward innovations.** | | |
| **Encourage teams to come together daily or weekly to determine priorities, provide updates and address problems, and to recognise and appreciate successes.** | √ | √ |
| **Action Learning.** | √ | |
| **Multi-Source (360 degree) Feedback via Questionnaire.** | √ | |
| **Core competencies related to effective leadership including communication, meeting facilitation, negotiation and networking to enhance teamwork.** | √ | √ |
| **Mentoring, where an experienced manager works with a less-experienced individual to support leadership development.** | √ | √ |

| List of interventions | Intervention from literature | Intervention from data |
|---|---|---|
| **Appropriately mixing methods of training – formal lectures, practice sessions, role plays, coaching and experiential exercises.** | √ | |

Table 5-5 below describes the proposed interventions and its desired effects.

**Table 5-5 Proposed interventions and its desired effects**

| | Proposed Interventions | Desired effect |
|---|---|---|
| 1 | Design and Implement appropriate mix of training methods – formal lectures, practice sessions, role plays, coaching and experiential exercises given to employees during their regular working hours in the same work setting. | Support learning and sustain training and other necessary capabilities (knowledge, interpersonal skills, and experience) in decision makers for effective handling of varied aspects and situations that may abound. It can provide a culture of learning and a support from leaders, for a direct effect on staff's motivation for learning and training (Chiaburu and Tekleab, 2005a), (Schilling and Kluge, 2009a). |
| 2 | Implement a developmental programme such as "Executive Coaching" (someone outside the organisation provides such this service) for leaders to develop them in "real time" in the context | Help the individual learn new skills, handle difficult problems, manage conflicts and learn to work effectively across boundaries and to help leaders resolve interpersonal conflicts among employees. |

| | Proposed Interventions | Desired effect |
|---|---|---|
| | of their current job whilst allowing them to maintain their day-to-day responsibilities. It is usually spread over two to three days, involving multi-source feedback, in-basket exercises, aptitude tests, interviews, group exercises, writing assignments and intensive reflection processes. | Enhanced executive learning, gains in corporate performance, enhanced relationships, increased leadership effectiveness and personal and organisational improvements. Benefits to the organisation include enhanced individual and organisational performance that positively affect organisational culture (Bratton and Gold, 2012). This kind of coaching can lead to the formation of more specific goals, more effort to make improvements and better ratings from staff (Smither *et al.*, 2003). |
| 3 | Facilitating leadership development by assigning people to multiple jobs in the organisation in a short space of time, or "job rotation". | To foster good and high-quality leadership development, managers are advised, as a rule, to work in up to five or six varied jobs/roles for up to two years (Thomson and Mabey, 1994). |
| 4 | Encourage teams to come together daily or weekly to determine priorities, provide updates and address problems, and to recognise and appreciate successes. | Foster mutual learning whilst undertaking routine assignments. Participants reap the substantial benefits of concerted working and retain clear roles to exhibit and sustain collaborative work development in their own organisations (James, 2011). It can allow employees to be trusting and open (Frahm and Brown, 2007). |

| | | |
|---|---|---|
| 5 | Assigned commissioning teams. | The collaboration between leaders and skilled managers can help leadership to be dispersed from the top of an organisation to lower levels (James, 2011). As a result, the role of leadership can be distributed to many levels as well as the top of an organisation (Northouse, 2017). |
| 6 | Implement a learning method such as "learning by action". This method forms groups of individuals who meet together regularly in their normal routine. They are guided by a facilitator to set objectives, review progress, solve problems and share experiences. | This method reportedly raised productivity by over 30% ( Bowerman and Hale, 2016). The approach assists organisations to better explore the inherent abilities of their staff. It also supports individuals in mutual learning through shared discussions of the inherent challenges affecting individual members of the 'action learning' set whilst resolving critical organisation issues (West *et al.*, 2015). The process of action learning can help people, teams and the organisation to deal with change plans and innovation (Elliott and Pedler, 2017). |
| 7 | Develop feedback tools to enable all employees to see how others conceive of their inputs and performance in all areas that relate to the employee's job. | The objective of feedback is to enable an employee to see without bias how others conceive of his or her inputs and performance in areas such as leadership, teamwork, interpersonal communication and interaction, management, contribution, work habits, accountability, vision, etc., as related to the employee's job. The aim remains to afford the |

| | | |
|---|---|---|
| | | employee crucial and pertinent perceptions without overwhelming him or her with excessive data to process (Bratton and Gold, 2012), (Holton and Swanson, 2014). |
| 8 | Adopt and implement an evaluation system such as "an annual appraisal meeting" for staff with their manager to agree on clear, challenging objectives or self-appraisal. Appraisal is an on-going process, composed of regular supervision meetings and an annual review. | This aims to support organisational staff in improving their ways of attaining their roles without feelings of disdain or scorn (James, 2011). Rather, it leaves them with a greater sense of being prized, appreciated and fully engaged. It helps to clarify expectations and reduce ambiguity related to performance, determining rewards, improving communication, selecting people for promotion, setting goals and targets and identifying training and development opportunities (Bratton and Gold, 2012). Moreover, self-appraisal can provide a positive experience and encourage all staff to share their thoughts and experience with others (Kettley, 1997), (Peng *et al.*, 2016). |
| 9 | Create short term wins (yearly operational plan) to monitor and evaluate the on-going strategic plans. | To demonstrate the effectiveness of change processes or mechanisms. For instance, it showcases early positive outcomes that show the workability of the intended changes. These have the potential to disarm cynicism, keep the main participants involved and amplify the drive towards change (Haines, 2000), |

| | | |
|---|---|---|
| | | (Kotter, 2012). Developing a systematic plan for a "short-term" wins can provide some early positive outcomes to show the change is working as planned. Drtina *et al.*, (1996) highlight the important role of this approach as it can help organizations to remove any obstacles to change process. This tool also can provide people and management reassurance that their plans are on the correct Track (Reichers et al., 1997; Marks, 2007) |
| 10 | Documentation and on-going feedback on progress. Systems that are more centred on transitional outcomes boost effective partnership by aiding the identification and provision of feedback on what is (and is not) working. | When groups work at this process, they measure, communicate and use early indicators of progress to evaluate and improve an effort to begin doing something, rather than waiting until the situation is over to evaluate what has changed (Akhtar *et al*., 2016), (Hanson, 2010) |
| 11 | Building an on-going customer service training programme. This can be facilitated by designing and implementing an appropriate mix of training methods – formal lectures, practice sessions, role plays, coaching and experiential exercises given to employees during their regular working hours in the same work setting. | Good training enables employees to feel confident and competent, leading to increased morale and productivity. Effective training enables employees to resolve any problems quickly and professionally. Such a programme can help a team develop important listening and problem-solving skills which empower them to deliver a great service (Participation, 2015), (Jerome and Harold, 1997) |

Finally, Table 5-6 below shows the chosen interventions linked with the emerged themes.

**Table 5-6 Chosen interventions**

| Themes | Intervention |
|---|---|
| **Setting direction and culture** | - Encourage people to come together daily or weekly to determine priorities, provide updates and address problems and to recognise and appreciate successes.<br>- Systematically plan for and create a “short-term wins.”<br>- Give clear strategic work process with common goals. |
| **Thinking strategically** | - Systematically plan for and create a “short-term wins.”<br>- Encourage education, continuing training, on-the-job training” for employees during their regular working hours in the same work setting.<br>- Give clear strategic work process with common goals.<br>- Set up a coaching programme for leaders; give “Executive Coaching”.<br>- Documentation and on-going feedback on progress. |
| **Leading people** | - Design and Implement appropriate mixes of training methods – formal lectures, practice sessions, role plays, coaching and experiential exercises for employees during their regular working hours in the same work setting.<br>- Systematically plan for and create a “short-term wins.”<br>- Set up an annual appraisal meeting for staff with their manager to agree clear, challenging objectives.<br>- Action Learning. |

| Themes | Intervention |
|---|---|
| | - Encourage people to come together daily or weekly to determine priorities, provide updates and address problems and to recognise and appreciate successes. |
| **Develop and empower people** | - Design and Implement appropriate mixes of training methods – formal lectures, practice sessions, role plays, coaching and experiential exercises for employees during their regular working hours in the same work setting.<br>- Set up an annual appraisal meeting for staff with their manager to agree clear, challenging objectives.<br>- Action Learning.<br>- Encourage people to come together daily to determine priorities, provide updates and address problems and to recognise and appreciate successes. |
| **Demonstrating personal skills** | - Documentation and on-going feedback on progress.<br>- Action Learning.<br>- Job Rotation.<br>- Design and Implement appropriate mixes of training methods – formal lectures, practice sessions, role plays, coaching and experiential exercises for employees during their regular working hours in the same work setting. |
| **Managing to deliver services** | - Multiple forums, including meetings, memos, newsletters and hallway conversations to adequately communicate the change.<br>- An annual appraisal meeting for staff with their manager to agree on clear, challenging objectives.<br>- Documentation and on-going feedback on progress. |
| | - Multiple forums, including meetings, memos, newsletters and hallway conversations will be necessary to adequately communicate the change. |

| Themes | Intervention |
|---|---|
| **Managing activities and quality** | - Documentation and on-going feedback on progress.<br>- Set up an annual appraisal meeting for staff with their manager to agree clear, challenging objectives<br>- Action Learning.<br>- Encourage people to come together daily or weekly to determine priorities, provide updates and address problems and to recognise and appreciate successes. |

Using Schein's model of culture as a guide the interventions that influence the behaviours and can lead to adoption of values and underlying beliefs, the "way things are done" can be changed to behaviours that are in line with a performance improvement culture.

A series of interventions to facilitate change rather than a diffusion from one type to another is suggested as a method of moving towards a performance improvement culture. If these interventions are perceived as actions taken at the artefact and value level in Schein's model of culture, then transition between types is possible by embedding new values and underlying assumptions through implementation of artefact examples for the group.

As the value relating to the artefact created by the intervention is developed, it in turn leads to a behaviour and as that behaviour begins to solve the problem which driven it, the value is slowly changed into an underlying assumption about how things really are. As the assumption is increasingly taken for granted, it drops out of awareness, thus creating a shift in the organizational culture. This shift facilitates the transition towards a Type of performance improvement culture within the organisation.

The support, encouragement and involvement of top levels in organisation toward the development of performance process and activities sends a clear signal that performance improvement is part of the "way we do things round here". Top management can interweave this a trend into the business strategy such that it becomes an integral part of the day-to-day activities of the business (Kotter,

1995). This can only be achieved if there is visible support and encouragement for the type of such behaviours (Katan, 2014). This in line with Goldberg *et al.* (1992) who suggested that; Change comes more readily to the organization that has:

• A clear mission and strategy that guides and informs the goals of teams and individuals.

• Supportive leaders at every level who effectively engage, motivate, and communicate with their teams.

• Employees who are engaged, informed, and involved.

Similarly, efforts can and should be made at both the individual level and at the organizational level to understand how to improve and foster leadership development in areas where a gap or limitation is identified (C.Leadership, 2010; Cummings and Huse, 1989). In addition, Goldberg *et al.* (1992, p. 125) emphasizes that “a transition is far more likely to achieve success when the leadership style, work climate, and environment are already receptive to change”.

## 5.2 Experts Judgment Validation

The last task of this research was to validate the developed framework via expert evaluations. According to (Noble and Smith, 2015) evaluating the quality of research is essential if findings are to be utilised in practice and incorporated into care delivery.

Therefore, the proposed framework was discussed with selected experts and academics as shown in Table 5-7. This process was to help the researcher to gain potential helpful feedback and opinions to give the findings of the research more credibility and reliability (Anderson, 2010b). One of the strengths of qualitative research is the research framework and direction can be quickly revised as new information emerges as a result of validation tasks (Anderson, 2010b). Hence, prior to the validation task of the framework, the researcher considered the potential to modify or seek new data that may be needed at this stage.

**Table 5-7 shows the details of the participants in this evaluation**

| Educational level | Years of experience | Position level |
|---|---|---|
| **Professor** | 27 | Executive |
| **Master** | 26 | Executive |
| **PhD** | 21 | Med- level Management |

The developed framework of this study was shared with various experts in the healthcare sector as explained in the following section.

### 5.2.1 Expert 1

The researcher met the expert 1, who was a Deputy Chief Executive of one the National Institutes for Health and Care Excellence in the UK.

After that meeting, a copy of the framework was sent to the expert to request feedback. The feedback evaluation was received with a short comment. Her statement was;

> "You've obviously given it lots of thought and, without giving it a thorough review, it looks like a very helpful framework".

### 5.2.2 Expert 2

A further expert who participated in the judgment was a Chief Medical Officer in one of the International organisations in the UK. The researcher had a meeting with the expert at the Leaders in Healthcare 2017 conference in Liverpool. During this meeting, a brief of the project was given to the participants in the event, including this expert. He received a copy of the framework with details to seek his evaluation and he participated in several exchanges with the researcher. After a week, his feedback was collected with various suggestions. For instance, he pointed out:

> "*I wondered, 'how will you know if what is proposed has worked?' You may wish to think about a feedback loop within the framework so that any effect can be captured – that may be qualitative, but you are proposing an*

*improvement cycle in leadership and as with any such cycle, thinking how to measure if the desired effect has been achieved will be important*".

Hence, the suggestion of setting up a way to measure the outcomes of the framework implementation is essential. Cyclical measurement and the concept of iterative tests of a change are central to many performance improvement approaches (Taylor *et al.*, 2014). Therefore, employing such a tool can provide a structured experimental learning approach to testing and measuring the desired changes (Ogrinc, 2014). The purpose of such a method lies in learning as quickly as possible whether an intervention works in a particular setting and making adjustments accordingly to increase the chances of delivering and sustaining the desired improvement (Ogrinc, 2014).

### 5.2.3 Expert 3

To gain feedback from an expert from the fieldwork that may feature the current situation, the framework was discussed in depth with one of the participants at the executive level in the healthcare field. He suggested implementing a yearly operational plan into the process of the framework that can measure short-term gains. This suggestion has been added as one of the proposed interventions, as illustrated in Table 20. In addition, he mentioned various other positives points in his feedback. For instance, he said.

> "Your thesis of *Leadership Performance Development in Healthcare Organisations is actually the core of development concept in the healthcare sector, and it is expected to be a vital torch that enlightens the way to a professional future of healthcare enhancement".*

He also added another statement, which is:

> *"We have got that sort of self-satisfaction and relief believing that such developed studies and such professional resources will definitely contribute significantly and add a huge enhancement to healthcare perceptions, approaches and performances in the Kingdom of Saudi Arabia and lead its professionals to a bright future fulfilling our high expectations in this regard".*

Finally, to facilitate the proposed change of this project he suggested a "leadership style" for managing this targeted change. He called it 'the journey of success'. This suggested change cycle process consists of five main sequences steps as shown in Figure 5.2.

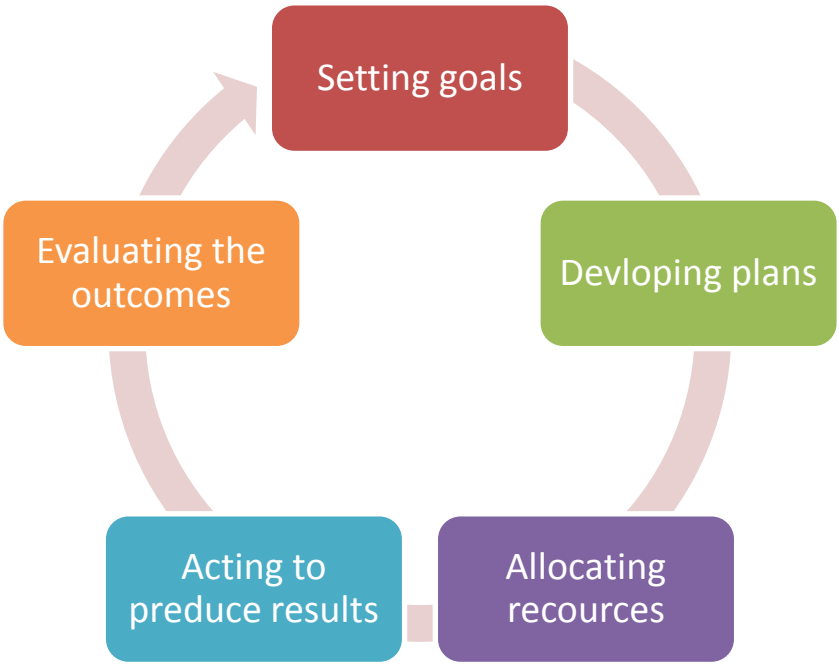


**Figure 5-2 An expert 3 leadership style for managing change**

The expert argues that: 'such this style can provide tools for the evaluating and continuous learning and correct to go again and again. Then leaders can step back to a look at the global challenges that confront them as leaders now and in the future'.

## 5.3 Summary

This chapter is designed to identify the appropriate mediations that could encourage a culture of improvement in leadership performance. The suggested interventions to create a culture of improvement discussed in this chapter, and how its desired effect could be achieved explained. Moreover, experts' judgment validation discussed in this chapter.

# 6 DISCUSSION

## 6.1 Introduction

In this chapter, the findings are discussed. In the previous five chapters, the context of the study was described, the relevant literature was reviewed to provide a background and rationale for the study, and the conceptual and methodological frameworks of the study and the research findings were presented. This chapter is divided into three main sections, each of which presents the results relating to one of the research questions.

A case study approach was chosen to conduct this exploratory study. According to Yin (2013, p. 14) a “distinctive need for case study research arises out of the desire to understand complex social phenomena”. In addition,

The interpretive paradigm was useful for this research as it enables the researcher to explore, explain and describe “what is going on” based mainly on individuals’ perceptions and meanings, and offer the ability to construct a theory that is grounded in the data collected (Corbin and Strauss, 1994). Hence, this study used a constructive-interpretive philosophical approach, applying a qualitative strategy to answer its questions and achieve the objectives of the research. Qualitative analysis was employed in this the study to gain insights into the aspects that dominate the field study practices. Qualitative methods can be more useful for identifying and characterising the real situation of phenomena.

## 6.2 Discussion of Research Results

This section provides the discussions of the findings of this research. This research was intended to study social phenomena that aimed to reveal something about leadership competencies and how they may help to facilitate a culture of leadership performance development in the healthcare organisations. This an exploratory study was designed to determine the effect of leadership style and practices on the job performance of leaders in Saudi Arabia’s healthcare sector. The research questions were as follows. Firstly, what are the leadership competencies that will lead to improved leadership performance in the healthcare

sector? Secondly, how can these leadership competencies be applied to improve leadership performance in healthcare organisations?

However, reviewing the related literature showed that there is a need for research that investigates the impact of leadership practices and organisational culture on organisations' productivity in the healthcare sector.

This section is subdivided into two sections. Section one highlights the key influences aspects that emerged from the initial stage of this study. Section two presents the findings of the research, focusing on the seven main themes that emerged from the study and discuss also the potential effects of the suggested interventions.

### 6.2.1 The Influences Aspects

An initial stage of the project was to identify participants' perceptions in terms of enablers and inhibitors of performance improvement and their influences on the leadership practices. However, as discussed earlier in (Chapter 2), a number of authors argue that it is essential investigate and understanding the current assumptions that affect the organization artefacts level and shapes its values and dominates the current practice. This was a pivotal step before proposing any solutions in this study (Schein, 2010;Cummings and Huse, 1989). Hence, pilot interviews were initially conducted to identify factors that relate to the level of performance, including enablers and inhibitors of performance improvement. This helped the author build an initial understanding of the context of the project and to address the critical aspects that may influence improvements in leadership performance in the public health sector in Saudi Arabia. The main question in this initial study sought to determine the aspects that promote and inhibit performance improvement culture.

The study participants openly shared their views about the way in which culture affects their performance and discussed how aspects such as Islamic values influence Saudi perceptions of leadership practices. The findings of this initial study found that different aspects influence the level of leadership performance as illustrated in Table 4.1. Significantly, culture aspects issues founded heavily

play a key role in that situation. As mentioned in the literature review in (Chapter 2), culture is a pattern of underlying assumptions that have been evolved, discovered or developed by a given group as it learns to cope with its problems of external adaptation and internal integration (Schein 2004). Figures 2-5 and 2-6 illustrates Schein's model of organisational culture.

According to the research participants, both the positive and negative behaviours of leaders and executives in top management affect the performance of employees and shape the organisational culture. In general, the results did not show any differences between leaders and followers in this regard, which is in line with the findings of Schein (2010), who argued that culture in general is created by shared experience in organisations, and that the leaders initiate this process by acting according to their beliefs and values. Similarly, Hardman *et al.* (2007) proposed that the cultural characteristics valued by leaders and managers will be associated with specific organisational outcomes. Moreover, Rice (2003, p. 471) states in this regard that "Arabs value the person and the relationship more than the task". This view is supported by Rees and Althakhri (2008, p. 124), who write that the "Saudi Arabian culture is strongly affected by Islamic and tribalism systems". This result is in line with Alkhamis *et al.* (2017) and Smith *et al.* (1996) who indicated the key role of national culture in shaping the value of organisational employees.

As matter of fact, one of the most interesting findings of the study is that 'Islamic values' appeared as the most influential element in shaping the performance of leaders and employees in a KSA healthcare organisation. The findings of the current study are consistent with the literature that indicates individuals are highly committed to Islamic work values is consistent with previous research (Ali, 1987; Alkhamis *et al.*, 2017; Mellahi, 2007; Rees and Althakhri, 2008; Yousef, 2000 and 2001). Associating the findings of this study with those of other studies (Al-Bakr *et al.*, 2017; Hunt and At-Twaijri, 1996) indicates that the Islamic work ethic plays a fundamental role in the commitment of Saudi leaders to their organisational tasks and their subordinates, as Yousef, (2001 p.18), would confirm.

Similarly, in a recent study investigates the impact of IWE on organisational commitment, job satisfaction, Athar *et al.*, (2016) found that the there is an important effect of IWE on the JS and OC (p. 129). Different Islamic researchers such as Al-Kazemi and Ali, (2002) described that Islamic work ethics are important and play crucial role for the success and development of the Muslim regions and their organizations.

Importantly, according to Yousef (2001), “Despite its importance, little research has been devoted to an in-depth study of the Islamic work ethic and its impacts on job-related outcomes such as organisational commitment, job satisfaction, job performance and the like”. This statement suggests that it would be interesting in future studies to investigate extensively the influence of this factor on leadership style and performance.

This initial study found that the factors of fairness and equality appeared dominant among the factors that most affect leaders' decisions; they also determine leaders’ relations with subordinates as well as their commitment to the organisation. This result is in line with Bass and Avolio (1994) who indicated that ‘transformational leadership’, applying certain values to create effective leadership, is one of the deeply held beliefs of leaders. The values include areas such as justice and integrity (Yukl, 2002). Such factors tend to be seen from the behaviours and aspects of the cognitive, interpersonal qualities of leaders. These factors play a key role in a leader’s ability to inhibit or encourage her/his own performance improvements and those of the workforce.

The findings of this study indicate the positive impact of leadership openness and honesty on the organisational workplace environment. The research participants, overall, believed that emotional intelligence, such as “being human”, having honesty, and showing initiative” are essential. This result is in line with Bennis and Nanus (2003) who emphasise the importance of these aspects in the function of leadership approach. Moreover, it plays a crucial role in leading people within the workplace ( Hoffmann, 2007; Kotter, 2012).

Furthermore, setting a good example as a leader is one of the influential aspects that appeared in this study. This is in line with Sanghi (2016) who argued that

leaders must set a good example by personally modelling desired behaviour and establishing norms for group behaviour. Similarly, Allen (2003) reinforces that if leaders present themselves as good examples, it ultimately creates good followers within the workplace.

Another interesting finding from this study is that 'having moral criteria for employment' is considered one of the main requirements in healthcare workforce recruitment. This is consistent with Piper (2012, p. 16) who stated that "the common traits that define or are associated with generation workers are often regarded as barriers, yet provide healthcare leaders with a clear guide to understanding these employees and draw out their best qualities and performance".

However, the pilot study provided an opportunity to advance understanding of the influences in this field study and assess how far they dominate current performance. Seventy-one open codes emerged from the data, as shown in Table 4-1. The author compared these emerged aspects with the related areas in the literature to find any a potential gap in the knowledge as explained in (section 4.1.1.1.1). The interviewees indicated that these aspects influence the behaviours of leaders in the healthcare sector of the KSA. They play a fundamental role in inhibiting and encouraging the development of leadership performance in the health sector in question.

Importantly, there are several factors in the present findings that demonstrate factors in leadership performance, which are perhaps, have not been shown to be as important in the literature. For example, supporting employees with personal needs can improve employee productivity and raise their loyalty towards the organisation, as shown in Table 4-2 Furthermore, aspects such as individualising employees' motivation, having moral criteria for employment, observing using evaluation indicators, supervising the relationship between managers and employees in the workplace and evaluating the employees' mind-set have appeared as important in this study.

This results also suggests that organisations in the healthcare sector could benefit by giving more attention to these aspects in the future. Personifying the

work environment is another finding revealed by this study; this shows how relations between leaders and their employees can be affected negatively as a result of a poor decision on the part of a leader that affects subordinates. Organisations should take the impact of this factor into account because it can seriously affect the service level of this essential sector.

### 6.2.2 The dimensions of the proposed framework component

To gain a deeper understanding of the competencies that healthcare organisations need most, this research turned directly to the people who work in the sector. Thus, this study produced the participants' seven dimensions that built the main emerged themes of the proposed framework. The present study suggested a framework to facilitate a culture of leadership performance improvement in the healthcare organisations. This framework was developed based on the main emerged themes of the study. As shown in the Figure 4-6, these themes were developed in a participative work with the research participants as explained in (section 4.2.2). These essential themes illustrate various of functions that play main role to enable leaders in this sector to implement change plans process within workplace. These emerged themes were discussed in the (chapter 2.2).

From the previous discussion, it can be seen that the research participants believe that a lack or absence of clear 'strategic thinking' plans with clear regulations and standards can lead to undesirable outcomes. This, however, can negatively affect their performance based on the collected data. This result is in line with Bass and Avolio (1994) who indicated the important role of this factor and argue that "strategic thinking can helps to create and build the vision of an agency's future". Similarly, in a recent study, Sanghi (2016) states that strategic orientation plays the key role in linking long-range visions and concepts to daily work. This includes an understanding of the workforces' capabilities and the potential of the department and the organisation (Sanghi, 2016).

Thus, this research stresses the importance of having a clear and agreed-upon vision and mission statements, which provide a directional path for staff. These must be translated into clear, aligned, agreed-upon and challenging objectives at

all levels of the organisation, from the board, to frontline teams, to individuals (Locke and Latham, 2013). According to West *et al.*, (2014, p. 14) “Agreeing on clear objectives is the most important element of effective appraisals for staff in terms of performance”. From their point of view, this must be matched by timely, helpful and formative feedback for those delivering care if they are to continually improve the quality of care (West *et al.*, 2014). Similarly, the step three of Kotter’s model of transformation, also references the pivotal point of formulate a clear and sensible vision for the change process. (Kotter, 1996).

One of the most significant findings drawn from the study is to emphasise the importance role of creating a suitable culture and work environment to do daily work more comfortably. Talking about this issue an interviewee said:

> *‘The most important thing that a manager should be occupied with is how to create a suitable work environment [for the employee] to feel that his manager or director is supporting him and not to feel that his manager is always a threat to him or taking actions against him’. One of the participants commented, “I totally believe that you can change the culture in a department, in the environment. You can put the objectives for it and don’t make these objectives requirements from the department but a nature of the department, a culture for that department to work in this way”.*

This is consistent with Franco *et al*. (2002) who argued that cultural characteristics can influence the organisational structure decision-making processes within organisations. Similarly, it is argued that cultural aspects pose a particular challenge to the performance improvement in Saudi Arabia (Assad, 2002; Idris, 2007). Moreover, Khoja *et al.*, (2017) indicated that healthcare organisations face challenges to promote a culture that continuously improves the quality of services, patient safety and compassion in healthcare. This result is similar with Sanghi (2016), who stated that organisations need to establish and foster a suitable culture that can enable to them to build strong working relationships within the workplace. This can be achieved through aspects such as working closely with the team and ensuring that needs are considered, issues

are addressed and situations are managed in a collaborative, consultative, creative and flexible manner (Sanghi, 2016; Willcocks and Wibberley, 2015).

Another remarkable finding revealed diverse aspects of challenges that affect the Saudi healthcare system as shown in (Table 4-1, in Chapter 4). For instance, the lack of strategic thinking in organisations' activities appeared as one the main challenges that needs more attention. One interviewee said:

> *"Without a clear strategy…when I say strategy, some understand it as just a plan! It's a plan that includes everything. It should have a financial aspect, a strategic aspect...it should include all departments, the manpower aspect. All these things must be put in an achievable plan and you have to have objectives".*

Thus, the findings of this study emphasise that strategic thinking needs to give real attention within the developed framework. Moreover, the results of this study are in line with others who stress that direct communication across all levels as well as mentoring along with constantly evaluating the outcomes can positively enhance the organisation's position and improve its productivity (Armit *et al.,* 2015; Bratton and Gold, 2012; West *et al.*, 2014).

However, the developed framework of this study, as shown in Table 5-3, explains suggested interventions that can provide solutions to enable healthcare organisations in general and in KSA and GCC countries, particularly, to overcome its current challenges. These challenges as outlined in Chapter 4, (see Table 4-1) are related to cultural aspects, planning methods, leadership practices, personal skills and required capabilities that leaders behaviourally need in this vital sector. These are aspects that leaders in the healthcare sector need to meet the future needs of service, develop their own potential, and learn from both success and failure (NHS Leadership Academy, 2013).

Hence, the framework aims to guide leaders at every level of an organisation to develop a critical set of leadership and improvement capabilities linking the staff and themselves. These capabilities can relate to knowledge, experience, and personal skills that can help leaders to deal with any situation with compassion.

This means paying close attention to all one's staff, understanding the situations they face, responding empathetically and taking thoughtful and appropriate action to help. As indicated earlier in (Chapter 2), effective leadership performance needs a cluster of competencies covering vision and goals, interpersonal skills, self-knowledge and technical skills (Bennis, 1987).

Therefore, this study aimed to present a framework of competencies linked with proposed interventions that can help to provide a culture of change in order to improve leadership performance in the healthcare sector, as shown below in Table 5-3.

The developed framework of this study indicates the important role of building a stable workplace environment. It also claims that implementing a clear strategic work process with common agreed goals contributes toward the development of the performance of organisations in this vital sector.

In order to enable healthcare organisations to monitor and evaluate the on-going strategic plans, the study reinforces the creation of short term plans, such as a yearly operational plan, that can facilitate the plan, as shown below in Table 5-3. This result supports previous researchers work that argue the organisational management structure and processes can influence the clarity of vision and the attainment of goals in the organisation (Franco *et al.,* 2002). For instance, Weber and Joshi, (2000) argued that in their study, developing a systematic plan for a "short-term" wins can provide some early positive outcomes to show the change is working as planned. This result is in line with Sanghi (2016), who shown that organisations should establishes a course of action to accomplish a long-term goal and leaders should share with others their personal views of the desirable future state of the organisation. Similarly, Kotter (1995) emphasize that in the step six in his model of change "without short-term wins, too many people give up or actively join the ranks of those people who have been resisting change" (p. 65). This supported by Reichers et al.,(1997), Lee Marks (2007) who indicate the good effect of rewarding opportunities and celebrating small wins.

In addition, these authors highlight that such this tool can provides people and management reassurance that their plans are on the correct Track (Reichers et

al., 1997; Marks, 2007). Moreover, short-term wins approach can also provide a number of benefits for the healthcare organizations. For instance, Drtina *et al.*, (1996) highlight the important role of this approach as it can help organizations to remove any obstacles to change process. Similarly, Kotter (2012) in his well-known model of transformation state that short-term wins can enable organizations to find opportunities to celebrate and reward those working for the change process.

From the perspective of the workforce requirements, this study stress that real attention should be given to required aspects to improve performance. These include encouraging education, continuing training and offering on-the-job training for employees during their regular working hours in the same work setting. In accordance with the results, previous studies have demonstrated that it can facilitate the performance development of healthcare organisations and support its sustainability (Chiaburu and Tekleab, 2005; Schilling and Kluge, 2009). Additionally, understanding and identifying a training or developmental need and establishes new programmes or materials to meet it are necessary (Sanghi, 2016). In line with this, one participant commented:

> *'So, in the way you manage, you have to be up-to-date with the development that takes place in the health sector worldwide which is very dynamic and changeable. So, to be on top of this, you have to know what has changed and what has developed and what are the new things that came up in this field. Another thing is that a leader in the health sector should be knowledgeable. Not like any…I mean knowledgeable on daily basis. Currently, we always attend conferences, attend courses because the health sector is dynamic'.*

These results also reflected those of Schilling and Kluge (2009) who indicated various sources of development programmes, as shown in Table 5-3. These programmes design and implement appropriate mixes of training methods—formal lectures, practice sessions, role plays, coaching and experiential exercises given to employees during their regular working hours in the same work setting. In addition, support for learning, sustained training and enhancing necessary

capabilities (knowledge, interpersonal skills, and experience) in decision makers for effective handling situations that may arise is very important (Chiaburu and Tekleab, 2005b). similarly, one of the participants argues that;

> *'If we are speaking about managers and leaders, the first thing is that there should be a real development program. So that there becomes a common language in the world, I mean if you are talking about KPIs which are the Key Performance Indicators, everybody talks about them, from the mechanic in a respectful workshop to the biggest factory or hospital, however, when you talk to the leaders, they are not aware of such a thing! That's because of the circumstances under which they have been hired whether according to experience or through an intermediary, or so. So, it's necessary that if there was…. there should be, let's say rehabilitation'*.

He also added that;

> *'They start to join it then they filter the people who have real skills. The people who have good behavior, the ones who have the leadership potential and who can lead the health institution or the factory or whatever. So, I think that we need such a program and at the same time, we need education, like courses and so. I mean really structural. I mean that to reach a certain position, not only must you have years of experience, but you also have to finish some courses, certain credit hours and so on'*

Hence, this study reinforces that building in an on-going customer service training programme (internal training) can provide a learning environment that helps to develop workforces, as shown in Table 5-3. As a result, things such this this intervention can enable healthcare organisations to deliver better services to ultimately achieve customer satisfaction.

This result is in line with Volz-Peacock *et al.* (2016, p. 319) who wrote, "Foremost is the fact that organisations worldwide are faced with the growing challenge of increasing the capabilities of their leaders with less time and fewer financial resources". Thus, organisations have to be able to develop their leaders whilst at the same time get "real" work done (Volz-Peacock *et al.,* 2016). Hence, the

findings of this study assume that developing a program for developing leaders and managers can help to improve their capabilities and skills, as illustrated in Table 5-3. This can be achieved within a programme of an appropriate mix of training methods— formal lectures, practice sessions, role plays, coaching and experiential exercises during employees' regular working hours in the same work setting. In line with this, one of the managers level of the participants in the research suggest that;

> *'I think the most important recommendation that should come out of the research is that regarding the leader in the Middle East and precisely in KSA, we have to have a developmental program for the leader. A leadership developmental program for the leaders. A man should not be hired as hospital manager while he doesn't understand what those papers are, what memos are. He should be introduced to this program for two years then he should be hired. A curriculum related to leadership related to…there are many things but let's say that it is as if you are teaching him a Diploma or master's degree in healthcare administration'.*

However, according to Bratton and Gold (2012) coaching can brings number of desired benefits for organisations. For instance, managers who coached are more likely to improve performance and can learn about their staff and improve their capabilities in order to improve their productivity (Bratton and Gold, 2017). This support the work of Stober (2008) who argues that coaching can contribute to the organisational change effort. Similarly, Hunt and Weintraub (2016) highlight that coaching mainly used as an individual growth and improvement process with organisations, particularly at the leadership level.

As a result, this can this can help leaders and managers in organisations in the healthcare sector to enable people to improve their interpersonal skills and successfully lead people in the workplace. Thus, these training programmes can also play important role to facilitate change process (Kotter, 1995).

This study produced results that corroborate the findings of a great deal of the previous work on the importance of the role of collaborative leadership in enabling healthcare organisations to achieve planned objectives, as illustrated in Table 5-

3. To facilitate this, this result supports the work of Armit et al., (2015b), Frahm and Brown (2007) who suggests interventions such as weekly or daily meeting including all department leaders within an organisation. Thus, during the process of these meetings an appropriate environment of cooperative work can be built. This can encourage teams to come together daily to determine priorities, provide updates and address problems, and to recognise and appreciate successes. One participant explained the potential outcome of such intervention, saying,

> *"That would enable them to work together to attain the goals set by/for the organisation".*

Similarly, one participants added that;

> *'It needs a workshop where thinkers are introduced to put practical strategies to the way of hiring managers and how leaders should work and who leaders are and how to create the program. There must be a workshop, a series of workshops should be held where experienced people should be invited and specialized people from management institutes. They start creating that program and create the How to and even change the requirements and the job description'*

Various studies have investigated the impact of collaborative leadership on organisations' productivity. For example, Bratton and Gold in their book *Human Resources Management - Theory and Practices"* (2012, p. 435) argue that "information exchange and transmission of meaning are the very essence of organisational life". Additionally, encouraging collaborative leadership and knowledge exchanging in the workplace can build a collective leadership culture within the workplace, that can ultimately make the desirable objectives more achievable (Armit et al 2015, Weber and Joshi 2000, West *et al.,* 2014). Similarly, it is argued that cultures that provide high-quality care are characterised by shared values translated into agreed ways of working that demonstrate care, kindness and support, and are developed through a collective effort, rather than through command and control (Stodd, 2016; West *et al.,* 2014).

To provide a culture of mutual learning whilst undertaking routine assignments, an intervention such as a 'Pioneer Teams' approach can be effective. This approach encourages people to come together for 15 minutes daily to determine priorities, provide updates, address problems and to recognise and appreciate successes programmes (West et al., 2014; Frahm and Brown, 2007). Similarly, participants reap the substantial benefits of concerted working and retain clear roles in exhibiting and sustaining collaborative work development in their own organisations (Vroom and Jago, 2007; West *et al*., 2014).

From the perspective of engagement and involvement, to facilitate the improvement and change process in a workplace, the results of this study emphasise the important role of engaging all staff in change plans and development processes. This result is in line with Hoyle (2009, p. 11) who points out that "people at all levels are the essence of an organisation and their full involvement enables their abilities to be used for the organisation's benefit". This is consistence with Kotter, (1995) who indicates that in his strategic eight-steps model, the main aim of a change management initiative is to ensure that every individual in the organisation is ready and willing to transition to a new role in the proposed environment.

Therefore, during the organisational goal setting and planning, management should pay special attention to making people part of this process. Whilst this can help healthcare organisations to facilitate change management in the workplace, it also can raise staff's commitment and loyalty toward their organisations. Organisational commitment and loyalty are crucial to building sustainable success (Daft, 2015).

However, Faisal and Al-Esmael (2014) defined organisational commitment as an employee's psychological attachment to the organisation. In another point of view, organisational commitment is a combination of three distinct aspects: employee acceptance and belief in the organisation's goals and values, employee willingness to work hard for the organisation and employee desire to be retained by the organisation (Grusky, 1966).

Similarly, an interesting idea was mentioned by one interviewee, who indicated that:

> *"This could help to engage all staff in any plans for change and development and thus facilitate change implementation in the workplace, avoid resistance and enhance commitment and loyalty".*

In addition, one of the participants also added:

> *"I found that when the person is convinced and feels that he is part of that change and that he wants it, he will be more productive and there will be success".*

Hence, this study suggested that adopt and implementing an evaluation system such as "an annual appraisal meeting" for staff with their manager can facilitate agreement on clear, challenging objectives or self-appraisal as shown in Table 5.3. In line with this result, Peretz and Fried (2012) claim that performance appraisal is a key human resource activity in organisations. "Appraisal" can be defined as an on-going process, composed of regular supervision meetings and an annual review (Bratton and Gold, 2012; Kettley, 1997; Sanghi, 2016). Similarly, in his book, *Performance Appraisal on the Line*, DeVries (1981) defined performance appraisal as the process that allows firms to measure and determine the quality of an employee's accomplishments and behaviour over a certain period of time.

Furthermore, Choudhary and Puranik (2014) state that a performance appraisal is more likely to be accepted in healthcare environments. This is in line with Dupree at al., (2011), who claimed that the performance appraisal process can provide effective tools that can facilitate performance improvement in healthcare organisations. In their a comprehensive book HRM theory and practices, Bratton and Gold (2012) indicate number of desired benefits for appraisal. For instance, improving motivation and moral, determining a route of rewards, facilitate a communication within the workplace, and appraisal interviews can also help leaders in setting goals and targets (JBratton and Gold, 2012). They also argue

that appraisal can play an important role in identifying the required training programmes and development opportunities.

Another important finding of the research indicated the key role of the feedback process within the organisation structure. This result is in line with others whose emphasise that feedback enables employees to see without bias how others conceive of their inputs and performance in areas such as leadership, teamwork, interpersonal communication and interaction, management, contributions, work habits, accountability and vision (Bratton and Gold, 2012; Holton *et al.,* 2007).

The results of the study revealed one of the inhibitors that is causing a certain problem in the Saudi healthcare system. This problem is "unclear tasks and information" such as daily assignments from the top levels of organisations to their staff as outlined in Figure 4-3. This result, as mentioned in Chapter 4, is in line with Al-Borie and Abdullah (2013) who indicated that the current adopted style of planning and development initiatives in healthcare in KSA is top-down and not bottom-up and the KSA needs to correct the direction in its health reforms. Talking about this issue, an interviewee said,

> *"When you give unclear guidelines to an employee, that will be disappointing for him/her. Some of them will ask you what you meant, whilst others may feel shy or afraid to ask. Your responsibility, as a leader, is to communicate clearly''.*

To enable this sector to overcome challenges such as these, the study suggests that having clear communication channels within the workplace can facilitate and foster a culture of leadership performance development in healthcare organisations. As a result, this can help to improve services that are delivered to patients. Similarly, the literature indicates that communication of goals to the organisation's members is one of the most important steps in the change process (Weber and Joshi, 2000). This is consistence with Kotter (1996, p. 90) who argues that "two-way communication is always more powerful than one-way communication".

However, there are various of tools that can facilitates this communication. for instance, Weber and Joshi (2000) suggest different tools such as having multiple forums, including meetings, memos, newsletters, and conversations to facilitate this. In addition, Appelbaum *et al.* (2012) also indicate to the key role of communication in the change process. However, the lack of information regarding the change plans may lead to a lack of involvement in the change process, ultimate this may cause frustration among employees towards this change (Appelbaum *et al.*, 2012). Similarly, in a previous study conducted to evaluate the uncertainty during organisational change, Bordia *et al.*, (2004) found that communication is plying importance role during the change process as it reduce uncertainty. Organizational communication is defined by Daft (1997, p. 560) as "the process by which information is exchanged and understood by two or more people, usually with the intent to motivate or influence behaviour".

One key finding of this study is that the research participants believed that assigned commissioning teams can help to minimise potential obstacles and difficulties that organisations may face, enabling them to successfully implement their targeted plans. For instance, one interviewee said,

> *"So when I build a hospital or add wards…let me give you an example, the oncology wards: from the beginning, we had specified what equipment is needed, the manpower, and how many nurses are needed, and how many doctors; a commissioning team studies all the issues related to this development so that when the construction is done, and the equipment is ready, the preplanning is ready, even, the jobs are ready"*.

This in line with the second step of the Kotter's model of transformation (1996). In this step, Kotter states that creating a guiding coalition within change plan is crucial to formulate a vision for change effort and ensure that it is communicated through the organisation. According to Kotter (2012) this guiding coalition should made up with people have essential characterises; people with enough key position power, expertise with the relevant needed points of view to facilitate decision making, credibility of members, and required leadership skills so leaders can drive change process.

In the perspective of how to help leaders in organisations in the healthcare sector to develop their skills and capabilities, the study discusses the potential impact of adopting learning methods such as “learning by action" as shown in Table 5-3. There is much in the literature about action learning in general, and action learning within leadership training programmes, in particular. For instance, Volz-Peacock *et al*. (2016, p. 319) defined this program as “a cost-effective approach that enables leaders to develop capabilities whilst working to solve urgent organisational or social problems”. In addition, this method forms groups of individuals who meet together regularly in their normal routine (Edmonstone, 2011a). They are guided by a facilitator to set objectives, review progress, solve problems and share experiences (Armit *et al*., 2015). Furthermore, action learning is an educational process that involves an group of people working together on real issues, taking action, and learning as individuals, as a team, and as an organization (Walia and Marks-Maran, 2014).

It is argued that this is an efficient method to solve real problems that involve acting and reflecting upon the results, which helps improve the problem-solving process, as well as the solutions developed by the team (Edmonstone, 2011a). Similarly, in another point of view, this intervention was designed to enable leaders to learn whilst working (Walia and Maran, 2014). Volz-Peacock *et al.*, (2016) investigated the impact of action learning practices on leadership skills development and how these skills are embodied and consequently transferred in the workplace. The most significant conclusion drawn from the study argues that every leadership skill can be developed in an action learning session as people are working with a group of people on a problem for which there is no known solution (Volz-Peacock *et al*., 2016).

Additionally, another study investigated the potential effects of adopting an intervention such as action learning on the performance outcome level. Pedler (2008) argued that the process of action learning helps individuals, teams and organisations to deal with changes and innovation. Professor Reginald Revans is the originator of action learning. He proposed and developed this method in the United Kingdom in the 1940s (The World Institute for Action Learning (WIAL)).

He encouraged managers to meet together in small groups to share their experiences and ask each other questions about what they saw and heard. The approach increased productivity by over 30% (Altounyan 2003). Additionally, as McGill and Brockbank (2004) stated, “action learning is a continuous process of learning and reflection that happens with the support of a group or set of colleagues, working on real issues, with the intention of getting things done.” (p. 21).

Importantly, the main function of a coach here is to facilitate the process of action learning successfully (Bratton and Gold, 2012). The responsibilities of a coach include setting the tone, developing competencies, improving team performance, ensuring reflection, managing time, and identifying learning (WIAL, 2014). Moreover, according to Volz-Peacock *et al.* (2016, p. 322) “the coaching role enables a team to build a learning climate; create openness, trust, and critical thinking; encourage teamwork; enhance listening, questioning, and reflection; and stress the importance of actions to support the team and the three levels of learning making certified coach-facilitated action learning more effective for the development of leadership skills”.

The findings of this study also indicated the importance of monitoring and evaluating in the process of the performance development culture. Regarding this, one of the interviewees said,”

> *“I see the evaluation as a person’s mirror from where he knows his weaknesses and his strengths. The second thing is that evaluation is a chance for developing the employee. I stand with the management that says: I have that employee who has low communication skills; as an organisation, I have to provide a training course for him to correct this weakness. I shouldn’t just look at it as a point of weakness that he has without trying as an organisation to develop the employee”*.

Similarly, Bratton and Gold (2012) indicated the important role of mentoring and evaluation in assessing people’s performance continually, as shown in Table 5-3. Hence, the assessment centre is one of the most helpful techniques that can help organisations to assess their people earlier, as shown in Table 5-3.

According to Sanghi (2016, p. 128), “the assessment centre is a method or an approach that is used to make decisions about people—to choose them, promote them or to put them on a ‘fast-track’ scheme”. This method was designed to obtain the best possible indication of people’s current or potential competence to perform at the target job or job level (Sanghi, 2007). It is argued that the process of the assessment should be controlled by a collected team of assessors (Sanghi, 2007). Significantly, the assessment centre should be designed to be a part of the HR strategy which, in turn, needs to be linked to the organisations’ strategy, as illustrated in Table 5-3 (Bratton and Gold, 2012). This aims to ensure that the organization has capable people (James, 2011)

This study produced similar findings to those of Sanghi (2016) who claims that successful organisations need to adopt a flexible organisational structure and improve communication to implement change effectively. Similarly, Yukl (2002) also finds that attention should be paid to delegating authority to staff and improving communication channels between managers and staff.

Previous studies also indicate the key role of empowerment by management in enhancing employees’ participation, productivity, satisfaction and commitment (Conger and Kanungo 1988; Lok and Crawford 2004; Malone, 1997).

In investigating the nature of the relationship between leaders and their followers within the workplace, most participants significantly believed in the importance of building a strong relationship between leaders and their followers through clear and dynamic communication channels. Hence, the findings of the study claim that there are clearly links between designing flexible communication channels and successful change implementation in the workplace. To support this result, one of the participants said:

> *“During the stages of change, in my personal opinion which is based on experience, there should be feedback and information going up and down. I mean you have to give information to the employees and receive a reaction from them so that you maintain and ensure that you’re on the right track”*.

This result is in line with Yukl (2012) who stated that in his book, “Leadership in Organisations”, divided charismatic leadership in two types of behaviour. One focuses on the tasks or performance of the firm, such as planning, clearly stating the vision or goals for the organisation, monitoring subordinate activities, and providing necessary support, equipment and technical help. The other focuses on relationships with workers, including being supportive of and helpful to assistants, showing trust and confidence in staffs, being friendly and thoughtful, trying to understand subordinates' problems, showing appreciation for a subordinate's thoughts and providing recognition for subordinates' contributions and activities ( Wang *et al.*, 2011; Yukl, 2012).

The findings of the research also, indicate the impact of designing clear communication channels within an organisation to facilitate change and make desirable changes more acceptable and achievable. In regard to this, one interviewee said:

> *“Many people resist change, so the leader's role is to present a new instruction and explain the advantages of the new laws to benefit the citizens. The leader should hold a meeting to discuss the advantages of the new change and obstacles that may face the employee to implement the change*”.

This finding broadly supports the work of other previous studies in this area that link communication with performance improvement and facilitating planned change. For example, Weber and Joshi (2000) indicate the key role of communication and how the lack of understanding the need for change or unclear expectations can negatively affect the attempts at change within organisations (Raelin, 2016).

Furthermore, the traditional view of change management in an organisation is the implementation of change as a top-down process (Boonstra, 2004). According to Weber and Joshi, (2000, p. 392) “a growing body of literature emphasises that change must occur within the organisation at the individual level”. This is consistent with Cummings and Huse (1989) who argue that change plans should involve all organisational members.

#### 6.2.2.1 Women's Situation as Leaders in Saudi Arabia

Another interesting finding of this study was the variation in the outcomes of the self-assessment between males and females across all themes. An assessment was conducted, as explained in Figure 4-9 (Section 4.2.4) to measure the current situation of several themes against the ideal proposed position based on the best practices in the literature. It has commonly been assumed that, this difference may reflect the influences of culture and religious aspects related to the female position in the KSA as the findings of the present study. For instance, the results of this study illustrated that a few women are allocate leaders' positions in the fieldwork. To support this finding one of the participants said,

> "Particularly for the female here, if you achieved a leadership position and start to manage both genders (male and female) people around you will not be confident in a female leader, this is as you know in general is a result of the of the national culture aspects here".

This result is in line with a recent study by Metin Mitchell & Company (2017) that investigated the role of women as a leaders in Saudi Arabia. This study showed that "there are still cultural challenges to achieving more women in leadership positions" (Metin Mitchell & Company, 2017).

This is also consistent with Al-Bakr *et al.* (2017, p. 53) who argue that "A review of the relevant literature provides insight and context for the current situation of women in Saudi Arabia, which is heavily influenced by strict Islamic beliefs". This may as a result of that the KSA developed out of a strong relationship between religion and political power that emerged in the mid-eighteenth century (Al-Bakr *et al.* 2017). Similarly, Baki (2004) argued that through the Wahabi interpretation of the Qur'an, gender segregation forms the Saudi society, including education, employment, and the public sphere.

In a study investigating the challenges facing women as in the workforce in the KSA, Al-Ahmadi (2011) indicated several difficulties in this issue, such as structural issues, including centralised decision-making and lack of participation in strategic plan formulation (Al-Ahmadi, 2011). In addition, Saudi women as

leaders perceived various of reasons that may cause this situation. These are, for instance, a lack of support for professional growth, including an absence of training programmes, limited opportunities to gain diverse experience and skill sets and a lack of networking and mentoring programs (Al-Ahmadi, 2011; Al-Bakr *et al.*, 2017).

Additionally, Al-Ahmadi (2011, p. 149) found in her study that "evidence suggests that women in leadership positions are facing a different reality from their male counterparts due to organisational, personal and cultural challenges that impede their effectiveness as leaders". Similarly, women are permitted to work in KSA in accordance with cultural and religious guidelines that require that female employees are separated from male colleagues in the workplace, with separate facilities, work stations and work place entrance (Khoja, 2016).

In a recent study aimed to investigate the obstacles to women's development in the KSA, Hodges (2017) reveals similar findings, that such social, religious, cultural and organisational challenges represent the main obstacles faced by professional women in the KSA. This is consistent with Al-Rasheed (2013) who states cultural and social factors do indeed play a role in the position of women; however, researchers point out that religion is also very influential in seeking to preserve women's status and confirm their position as subordinate members of society.

However, according to Al-Ahmadi (2011, p. 149) "Saudi Arabia [is moving] towards an even greater role for women in public life and into top leadership positions in public domains". Moreover, evidence endorses that women in authority in KSA are confronting a diverse reality from their male partners due to organisational, individual and social challenges that obstruct their adequacy as leaders (Al-Ahmadi, 2011). Similarly, according to Al-Bakr *et al.* (2017) despite the Saudi culture difficulties, not only have some women managed to enter the labour market, they have risen to senior positions as well.

According PWC - Middle East - Hala Kudwah (2017), one of the main goals of the Kingdom's Vision 2030 is to increase the female involvement in the workforce from 22% to 30%. Interestingly, based on statistics published in the first quarter

of 2017, of the one million Saudi jobseekers identified at the time, over 800,000 were women (PWC - Middle East - Hala Kudwah, 2017). In addition, the Saudi Vision 2030 aims to strengthen the future of women and increase their contribution to the development of the society and economy and ultimately to increase women's participation in the workforce to 30% by 2030 (David and AlKhudair, 2017; The Saudi Vision 2030).

To support the achievement of this vision, there are several recent important changes particularly relating to the women in the KSA. For instance, in a recent remarkable event, on 26 September 2017, a Saudi Royal Decree enabled women to drive for the first time in Saudi Arabia, marking a significant milestone in the empowerment of Saudi women—a journey that started 58 years ago with the introduction of female education (PWC - Middle East - Hala Kudwah, 2017). This is consistent with Sara Khoja (2016) who states that the Ministry of Saudi Labour has long aimed at increasing the rate of KSA female participation in the workforce.

According to the current announced transformation plans of the government, the economic need for KSA women to participate in the workplace is growing and they are a key contribution to the development of the Kingdom (Sara Khoja, 2016). This is in line with Haifa Al-Lail (2017) who states that later advancements in the Kingdom demonstrate that there is presently a clear procedure on the part of policymakers to permit women to prosper professionally and to expect more noteworthy and more capable positions in the public sphere. Similarly, in a recent study investigating women in Management and Leadership in the KSA, David and AlKhudair (2017, P. 10) stated, "We also found evidence that Saudi employers understand the business value and benefits of hiring women and promoting a diverse workplace. Our findings suggest that the Kingdom is set up to make solid advancements towards a more gender-inclusive workforce".

For these reasons, Haifa Al-Lail (2017) emphasises that the current revelation create a unique opportunities for women now in the KSA; the role of a women in leadership must always include a serious determination to confront all challenges with an aim of expanding her influence and inspiring others—women, in

particular, but men, as well. Another findings of a report presented by the Saudi Embassy in the USA, supports this (2017, p. 30), “Since 2010, the number of Saudi women in the workforce has increased 48 per cent”. Hence, this is an indication to illustrate the real desire of the government of Saudi Arabia to make a new power of women in its new plans. Similarly, one of the executive participants level in this study stated that;

> *‘yes, there is a Saudi female employee. She is great, and she had worked as an admin assistant and secretary. Now, she is the corporation coordinator. She has the leadership elements, and she is the example of the hard-working Saudi woman. Finally, I hope that the Saudi woman gets her opportunity in real leadership’.*

A recently published article by Hodges (2017) suggests employing a programme on leadership development for women across Saudi Arabia. Regarding this, he said, “this would be of benefit, because having trainers from a variety of cultures outside of the Middle East, would help to break down stereotypes and ensure that women gain exposure to a range of people and ideas from varying cultures” (p.44). Thus, the proposed framework of this study may provide solutions to overcome such these obstacles.

### 6.2.3 Framework implementation

Generally speaking, the research results offer a relatively clear answer to the part of the first research question related to identifying the leadership competencies that will lead to improved leadership performance in the healthcare sector and how these competencies can be applied as explained in Table 5-3.

This framework intends to facilitate a culture of leadership performance improvement in the healthcare sector as explained in Table 5-3). These themes, as shown in Figure 4-6, include required competencies that organisations in healthcare sector need to develop its leaders’ knowledge and improve their skills (West *et al.*, 2014). The findings of this study are linked with others in the literature. For instance, C.Leadership (2010, P. 14) in a research study, investigated how to address the leadership gap in healthcare stating, “Leaders

can benefit from further development of the interpersonal and leadership skills needed to create direction, alignment and commitment within the organization". Moreover, this development involves skills such as coaching employees, delegating effectively, hiring talented people and implementing change through others (Leadership, 2010; Turner, 2017).

In a study reviewed different approaches of change management, Adeyoyin (2006), argued that the work of Schein (1985), Schwartz and Davis (1981), Cummings and Huse (1989) and Dobson (1989) provide organizations with the guidelines and methods for evaluating the need for and undertaking cultural change. Schein's work, for instance shows how an organization's existing culture can be revealed. While Schwartz and Davis' shows how the need for cultural change can be evaluated and the necessary changes identified, Cummings and Huse (1989) and Dobson (1989) on the other hand shows how cultural change can be and is implemented.

However, the intended output of this framework, as explained in Chapter 5, is to build on-going learning and informed action. Hence, successful application of the proposed methodology may enable users to achieve their performance development goals more efficiently and to reach goals they would otherwise not have achieved.

According to Reed and Card (2016), in moving from planning to implementing a change in practice, it crucial to provides a structure for experimental learning to determine whether a change has worked or not, and to learn and act upon any new information as a result. This in line with Cummings and Huse (1989), who suggest this in their change model of culture, as explained in Chapter 5. They emphasise that change plans should focus on planned changes as a cyclical process involving joint activities with the organisation's members.

Similarly, in a previous study discussing how to manage change management in the healthcare sector, C.Leadership (2010) emphasises the use of effective strategies to facilitate organisational change initiatives and overcome resistance to change.

This in link with the feedback of the ‘Expert 2’ who participated in the evaluation task of the framework. As illustrated earlier in the section of the expert’s judgment, he suggested to employ a cyclical change process in parallel with the framework implementation. He also claims that such this cycle process can provide a measurement tool in a leadership improvement cycle, as with any cyclical process, can help to measure if the desired effect has been achieved.

This in link with the ‘Expert 3’ who suggested a leadership style with sequences steps that can facilitate this a proposed change as shown in Figure 5.2. Similarly, this idea places attention on the root of change, the translation of ideas and intentions into action and ultimately, the adaptation to change (Cummings and Huse, 1989). In addition, to facilitate the successful implementation of new learning in the change model process, C.Leadership (2010, p. 4) suggests that “organizations and individual leaders also need a clear picture of how leadership skills match up with organizational priorities and needs”.

This should begin with identifying and understanding leadership strengths and weak spots, then defining how well individual strengths match up with organisational needs (C.Leadership, 2010). Significant discrepancies between areas of strength and areas of need indicate leadership gaps—and help to focus development and learning (Akhtar *et al.*, 2016). If problems are identified with the original plan, then the theory can be reviewed building on new learning. A follow-up experiment can see if the problem is resolved and identify if any further problems also need to be discussed (Ogrinc, 2014). According to Ogrinc (2014, p. 6), “in the complex social systems of healthcare, flexibility and adaptability of these methods are important features that support the adaption of interventions to work in local settings”.

Impotently, the resistance to change is one of the main challenges that negatively can affect organisations plans to change implementations (Oakland and Tanner, 2007). In a previous study, Piderit (2000) argues that the individuals’ resistance to alter is a multidimensional concept comprising emotional, cognitive and behavioural spaces. Similarly, Oreg (2003) identified four sources of resistance

to change. These are routine seeking, emotional reaction to imposed change, and cognitive rigidity.

The findings of the research also, indicate the impact of designing clear communication channels within an organisation to facilitate change and make desirable changes more acceptable and achievable. In regard to this, one interviewee said:

> *"Many people resist change, so the leader's role is to present a new instruction and explain the advantages of the new laws to benefit the citizens. The leader should hold a meeting to discuss the advantages of the new change and obstacles that may face the employee to implement the change*".

This finding broadly supports the work of other previous studies in this area that link communication with performance improvement and facilitating planned change. For example, Weber and Joshi (2000) indicate the key role of communication and how the lack of understanding the need for change or unclear expectations can negatively affect the attempts at change within organisations (Raelin, 2016).

Furthermore, the traditional view of change management in an organisation is the implementation of change as a top-down process (Boonstra, 2004). According to Weber and Joshi, (2000, p. 392) "a growing body of literature emphasises that change must occur within the organisation at the individual level". This is consistent with Cummings and Huse (1989) who argue that change plans should involve all organisational members.

Significantly, the current adopted style of planning and development initiatives in healthcare in KSA as discussed in the Chapter 1 is directed top-down and not bottom-up; therefore, the KSA needs to correct the direction of its healthcare reforms (Al-Borie and Abdullah 2013). To change this style of leadership to new organisation dynamics, leaders need capabilities to handle it (James *et al.*, 2007). However, such change is not simple (James, 2011). Hence, this proposed

framework can offer a means to identify the required competencies to facilitate such this required change as shown in Table 5-3.

In previous studies, Beer et al.,(1993), Beer et al., (2009) pointed out a number of reasons that cause the most change management initiatives fail. For instance, while the change direction may be misguided in some cases, it is the failure to communicate with, engage and change the behaviour of staff that underpins such failure (Barratt-Pugh, 2013). To overcome such these difficulties Smith (2005) suggest that by creating change readiness before attempts at organisational renewal begin the need for later action to cope with resistance may be largely avoided (p. 408). This can help leaders to avoid spending time and energy dealing with any potential resistance to change (Smith, 2005).

However, it has been argued that HR function is playing a key role during organisational culture change (Bratton and Gold, 2012). Similarly, pugh, and Gakere (2015, p. 750) emphasises that "The relationship between HR and organisational change reflects the increasing focus on human resources as a source of strategic advantage rather than a peripheral component of production". In a study discussed the critical role of people in organisational change Smith (2005) stated that "The people in organisations can be either the key to achieving effective change, or the biggest obstacles to success" (p. 411).

This is consistence with one of the participants in the research who said:

> *"the person who can deal with…any changes…I believe that in order for changes to be successful in any department, I have to involve everybody in the department. They have to be involved in the change and contribute with their ideas".*

Nevertheless, to enable the implementation of the suggested framework of this study, the very important eight steps of Kotters' model (1996) (as mentioned before in section 2.5.1.) has been recommended. Kotter's model is still accepted as one of the most comprehensive strategies to facilitate organisations to implement change (Appelbaum *et al.*, 2012).

In his useful model, Kotter (1995) demonstrates that successful change efforts must initiate with individuals and groups assessing the market position, financial performance, technological trends and competitive situation of the organisation. He claims that leaders should find different approaches to transfer this information “broadly and dramatically” (p. 65). He also argues that the first step is very important as the beginning of organizational changes need strong collaboration of many individuals (Appelbaum *et al.*, 2012). Essentially, the necessity for change must be understood; if not, the change agents will not have sufficient “power and credibility to initiate the required change program” (Kotter, 1997). Moreover, Kotter highlight that company should have enough proven leaders to be able to manage the change process adequately (Kotter 2012). In line with this, Oakland and Tanner (2007) emphasize that leadership function plays a key role in setting the directions, motivating the change all over the organization and verifying that change is successfully implemented.

The basic aim of a change management initiative is to make sure that everybody in the organisation is prepared and ready to transition to a new role in the proposed environment (Kotter, 1990). To enable this, Smith (2005) claims that one of the important steps in change process is to communicate the change message and confirming participation and involvement of every individual. Similarly, this study produced similar findings to those of Sanghi (2016) who argues that successful organisations need to adopt a flexible organisational structure and improve communication to implement change successfully. This is also similar to the findings of Lewis and Seibold (1998) who described how communication affects the successful implementation process, and they further emphasize that communication is essential to anticipate the outcomes of planned change.

Importantly, the author indicates a well-conducted application of this framework may promise learning. But in contrast it does not, and cannot, promise that users will achieve the desired affects outlined in Table 5-5. However, the process of change rarely progresses in simple, linear steps (Ogrinc G, 2014). To deal with that, Kotter (1996, p. 44) recommends the use of consultants as a tactic for

creating a sense of urgency and challenge the status quo. This is consistent with the work of (Armenakis et al., (1993) who support the idea of recruitment of sources outside the organization, as they can reinforce the change agent's message.

To facilitate this desired change, Smith (2005) indicates to the key role of creating an appropriate environment for the change. These are staff training and development, team building, and role modelling from the top of the organization are all powerful tools in the process of achieving a shift to a change-ready organizational culture and philosophy (p. 411).

A summary of the main findings and of the principal issues and suggestions which have arisen in this discussion are provided in the next chapter.

## 6.3 Summary

This chapter discussed all the findings of this research and the framework dimensions. Furthermore, the steps of framework implementation explained.

# 7 CONCLUSION, SUMMARY, CONTRIBUTION, LIMITATION AND FURTHER RESEARCH

## 7.1 Introduction

This chapter consolidates the background, summary and contributions of this study. The first part offers an introduction of this research, a description of how this research was conducted, and an explanation of the methodology and findings of this study. The second part summarises the finding of this research. The third section states the academic and practitioner contributions, followed by the research limitations and suggestions for further studies.

## 7.2 Background of the Research

The general objective of this study was to understand the status of the current leadership practices in the healthcare sector in a developing country such as Saudi Arabia; and consequently, to construct a theoretical framework that tells us: 1) what leadership is; 2) how it is applied; 3) the reason for its current status, and 4) what has happened to change it.

This research has been conducted in one of the largest governmental healthcare providers in Saudi Arabia. The selected healthcare organisation is one of the leading and large in Saudi Arabia. The reason for selecting one organisation as a single case study is that the majority of healthcare organisations in Saudi Arabia, as discussed previously, are applying the same healthcare practices related to leadership and management practices, and have the same operating rules, making them more or less similar in terms of performance.

Consequently, the researcher believed that having one case study would enable him to undertake a more in-depth investigation and acquire a much greater understanding of the situation. Therefore, the researcher intensively studied the status of leadership performance in the selected organisation by collecting data from different sources and various people in the organisation's different hospitals.

The interpretivism approach was adopted in this study, because it allows the data to 'speak' with less influence from preconceived theories and models. This

approach is a helpful methodological approach when the research is about a less researched area (Padgett and Deborah, 2016). Using the data from the case study, a theory of leadership competencies modelling the healthcare sector was built, and a framework was also developed after comparing and integrating the theory of this study with the extant literature in order to make the theory more relevant and general to the healthcare sector and the study of competencies.

## 7.3 Revisiting the Research Aim, Objectives and Questions

This section explains how the study answers the research questions. The main research questions were as follows: firstly, what are leadership competencies that will lead to improved leadership performance in the healthcare sector; secondly, how can these leadership competencies be applied to improve leadership performance in healthcare organisations? Thus, this study set out to determine the perspective of leadership in the Saudi healthcare system. The research objectives are identified as follows:

1. To identify best practices and key leadership competencies that can improve leadership performance, via an extensive literature review.
2. To investigate, via a field study, the leadership characteristics that encourage or inhibit the improvement of organisational performance.
3. To develop a competency framework that can be used to improve the performance of organisation leaders in the healthcare sector.
4. To validate the developed framework via expert evaluations.

To address the above research questions, social constructivism was chosen as the research paradigm of the study, as discussed in Chapter 3, since it helped the researcher to explore the phenomenon of leadership and to answer the research questions from the perspective of Saudi leaders and followers in healthcare sector.

## 7.4 Contribution of the Research

This section describes the academic and practical implications contributed by this study. The first section highlights the academic contributions of this study, while

the second section explains the empirical (practitioner) contributions of the research.

### 7.4.1 Academic contribution

This research contributes to the body of knowledge from an academic perspective in several ways. Firstly, it addresses a significant gap in the literature by enhancing the understanding of the connection between performance improvement and the role of leadership competencies and how to create a culture to facilitate this linking. Hence, this research on leadership development in healthcare which is an area of study that has, to the present day, been given little attention. For academics, this research contributes to knowledge relating to aspects of organisational culture that facilitate performance development in healthcare organisations.

Additionally, this research fulfils an identified need to study how culture can influence workforce practices in healthcare organisations and to what extent that can affect the quality of services delivered to patients.

Furthermore, this study has contributed to the area of leadership knowledge in the healthcare sector by developing a framework that includes proposed interventions for improvement. This framework was developed to improve the current understanding of leadership competencies role in improving leadership performance in healthcare organisations. As described in (section 1.1), in healthcare settings, there is often little attention given to how management practices can be improved or to organisational and structural reforms. This research to some extent contributes to these areas of knowledge.

Moreover, the present study has also provided an additional evidence with respect to challenges and obstacles hinder women as workforce in Saudi Arabia, particularly in leadership positions. Although, there is still a need to explore further the issues that serve as obstacles to women's advancement in the country. However, this research improves the understanding of different challenges relevant to various aspects such as a social, religious, cultural and organizational level.

### 7.4.2 Empirical (Practitioner) contributions

The present study is considered the only empirical investigation on understanding the impact of a competency framework toward the improvement of leadership performance in the Saudi healthcare sector. The key research contribution is the development of a competency framework to facilitate a culture of leadership performance improvement in healthcare organisations in GCC countries in general and in the KSA, in particular. Efficient leadership models are vital in this context and can contribute greatly to improvements (Armit *et al*., 2015).

This research aimed to achieve an in-depth understanding of the existing practises of leadership in healthcare organisations. The interventions suggested as part of the research are designed to develop a culture supporting LPD. These interventions are based on empirical examples and address the reduction of the gap between the extant and ideal position of the culture. For practitioners, the contribution is therefore, in what a leadership development culture “looks like” and “how to get there” (Hargadon, 2003). It is likely that the situation will improve in long term. In addition, in the case of this field study, the participants were engaged in the process; they understood that change was required, and they wanted to develop some of the leadership practices to satisfy their patients and improve their organisations.

The study developed a GT that reflects the current practise in the field. The theory explores and explains how a there is an absence of a competency framework absence, and it found multiple characteristics of leadership improvement were absent from current models. In addition, it explained, in detail, how the players in healthcare organisations must learn what is desirable leadership performance in this sector. This research proposed various solutions to enable healthcare organisations, in general, and particularly in KSA and GCC countries to overcome their challenges. These challenges are related to the cultural aspects, planning methods, leadership skills and required capabilities that leaders need in this sector as showed in Table 4-1.

Finally, consequences of the lack of leadership development programmes and strategies are described by empirical data.

The developed framework of this research has been constructed based on empirical data that were collected from a variety of participants. The researcher interviewed a wide range of players that have an influence on performance in healthcare organisations, particularly those of dominant power, such as the middle- and top-level managers. It also collected data from different departments, such as administrative staff. In a study aimed to investigate the linking between organisational cultures and the employee's resistance to change, Carlström and Ekman (2012) argued that earlier studies of organisational culture and its impact on the performance of healthcare organisations have often investigated culture at the highest level of the organisation (p. 157).

The researcher ensured that there were variations between interviewees from the same background. Such variations disclosed different attitudes towards the existing leadership performance and enriched and strengthened the theory. The developed framework of this study suggests various competencies and interventions. All organisations have individuals in leadership roles, but few researchers consider leadership training as an effective intervention (Kelloway *et al.,* 2017). Hence, this framework aims to enable organisations in the healthcare sector to overcome obstacles like those identified from the collected data, as illustrated in Table 4-1. These obstacles include, for example, lack of training programmes, cultural aspects, lack of fairness and equality, unclear communication channels in the workplace, lack of clarity in tasks given to employees, and unclear job requirements.

## 7.5 Limitation

The discipline of leadership has very limited studies on understanding the relationship between performance improvement and competencies in general; particularly in the case of healthcare practices. One of the main difficulties with this line of reasoning is that studies on leadership management in the healthcare sector are still very limited. In healthcare settings, there is often little attention given to how to improve management practice (McAlearney 2008). This weak background did not give the researcher a solid foundation for a preconceived understanding of the relationship between competencies and performance

development before conducting the study. Few published studies have investigated this topic (Boyatzis and Boyatzis 2008; Turner, 2017).

In addition, because of the chosen research approach of this study, the research result may lack generalisability. Therefore, researchers are encouraged to further test the proposed propositions. The researcher suggests that more GT studies on similar cases would strengthen and confirm the GT of this study; and believes that there is more to be discovered in studying leadership in the healthcare sector.

## 7.6 Further Research

The main opportunity for further research is in observing the impact of the planned interventions implemented over time on the development of a performance culture. The results of the interventions should be evaluated latter after implementation. The culture also needs to be re-assessed using the same assessment tools that were used in section 4.2.4 and the changes will be identified.

This would provide an opportunity for participative research in which the researcher, as practitioner, plays a central role in developing a performance improvement culture appropriate for leadership development. Significantly, Sanghi (2016) indicated that organisations should consider how present policies, processes and methods might be affected by future developments and trends.

Two opportunities for further research are in evaluating interventions suitable for a broader range of organisations and in developing interventions specifically focused on creating a particular type of belief. This form of research is likely to be more academic in nature; the practitioner setting of this research precluded taking such an approach.

The ultimate outcome for this developed framework is not the suggested list of interventions from the research, but in the creation of a culture of leadership performance improvement that facilitates a stream of new developed services.

Although the research is based on a single organisation, it allowed for a deep evaluation of the aspects influencing leadership performance improvement. The

research strategy focused on understanding the dynamics present within a single setting.

A study of this type produces large volumes of rich data. The forced comparisons created new categories and concepts (Eisenhardt, 1989). Overlapping this study with similar studies in other mature organisations in the healthcare sector would add a wider range of data and allow more comparisons to be drawn. Overall, this study strengthens interesting topics for future cross-cultural research.

### 7.6.1 Summary

This chapter has restated the background of this research and how the research was developed. A summary of the findings was presented, and academic and practitioner contributions were stated. Academic contributions were made toward leadership development in the healthcare sector, in general, and toward some phenomena in competencies and leadership, in particular. Finally, this chapter has acknowledged the limitations of this research, and made suggestions for future research.

1- Academic contribution:

- Enhancing the understanding of the connection between performance improvement and the role of leadership.
- Aspects of organisational culture that facilitate performance development.

2- Empirical (Practitioner) contributions:

- Framework to improve leadership performance in healthcare sector organizations.
- How to improve management practices in healthcare sector.

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# APPENDICES

# Appendix A: Research Proposal Application Form

**KING ABDULLAH INTERNATIONAL MEDICAL RESEARCH CENTER**
**KING SAUD BIN ABDULAZIZ UNIVERSITY FOR HEALTH SCIENCES**

**National Guard Health Affairs**

**RESEARCH PROPOSAL APPLICATION FORM**

| **Date of Receipt**<br><br>**7.6.1.1.1.1** | **Protocol Number** |
|---|---|

**1. Title of Proposal:**
**Developing a competency framework to improve leadership skills in the public health sector organizations of the Kingdom of Saudi Arabia**

**2. Type of Project:** (Please check all applicable options)

| | | | |
|---|---|---|---|
| Chart Review ☐ | Diagnostic ☐ | PhD Project ☐ | Qualitative Research ☐ |
| Human ☐ | Laboratory ☐ | Msc Project ☐ | Quantitative Research ☐ |
| Therapeutic ☐ | Basic Science ☐ | Other ☐ | _____ |

| **3. Starting Date:** | **4. Duration:** | **5. Total Fund Requested (SR):** |
|---|---|---|
| 01/11/2015 | 90 days | |

| | | |
|---|---|---|
| | | _____ ____ |

**6. Principal Investigator (PI):**

Name: Namshan Ali Algarni_____ Tel. No.(W): _____ Mobile No.: 0555586822

Affiliation & Address: King Khalid military academy – Ministry of National Guard

Title/Position: PhD researcher_____ E-mail: n.a. Algarni@cranfield.ac.uk

**7. Name of co- Investigators:** (instructions: there is no limit to the number of co-investigators and their expertise should cover the different research areas. )

| Co-Investigators | Title/Position | Department | Signature |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**8. Principal Investigator's Assurance:**

The undersigned agrees to accept responsibility for the scientific and technical conduct of the proposed research and submission of progress reports if this application is approved.

Namshan Ali Alagarni_____ _____ _____

Name of Principal Investigator Signature Date

**DEPARTMENT APPROVAL:**

_____ _____ _____

Name of Chairman Signature Date

## Appendix B: Approval of Conducting Current Research

بسم الله الرحمن الرحيم

Kingdom of Saudi Arabia
**National Guard**
Health Affairs
Al Imam Abdulrahman Bin
Faisal Hospital, Dammam

المملكة العربية السعودية
رئاسة الحرس الوطني
الشؤون الصحية
مستشفى الامام عبدالرحمن بن فيصل
بالدمام

**Training & Development Department**

*Office of the Director-Eastern Region - Dammam*


019 ☎ 03-8532555 x 32260 Fax #: Ext. 32255 E-Mail: Train&DevD@ngha.med.sa


# MEMORANDUM

*Ref no:* T&D/Dam/123/15 *Date:* (G) 8 October 2015
(H) 25 Dhu alhijja 1436

**TO:** DR. PATRICH MCLAUGHLIN
*Senior Lecturer, SATEM , Canfield University*

**FROM:** GEN. ABDULLAH AL SUNAIDI
*Director, Training & Development – Eastern Region*

**SUBJECT:** **Approval for PhD student Mr. Namshan Ali Al Garni**

---

Referring to your memorandum regarding the above mentioned student, we would like to inform you that your request has been approved to collect specific data for the research titled: (***Developing a competency framework to improve leadership performance in the public health sector organization in the KSA***) at Imam Abdulrahman Bin Faisal Hospital - Dammam

For coordination and inquire please do not hesitate to contact Mrs. Maryam Al Quraish on Tel# 0138532555, Ext: 32260 or E-mail: Quraishm@ngha.med.sa.

Thank you and best regards

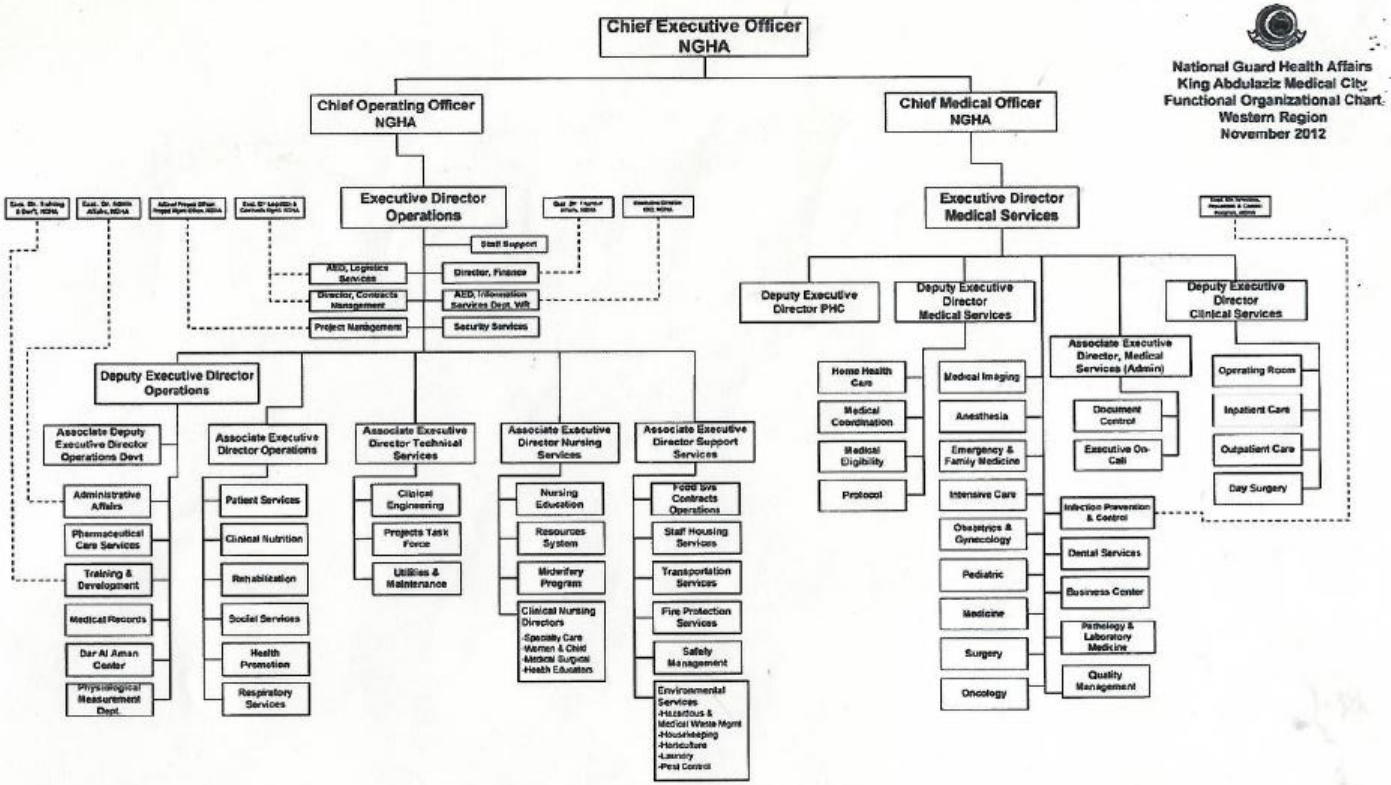
Cc: File


P.O. Box: 4616
DAMMAM 31412
KINGDOM OF SAUDI ARABIA
(ORACLE 112356)

ص.ب. ٤٦١٦
الدمام ٣١٤١٢
المملكة العربية السعودية

## Appendix C: Structure of Saudi NG Health Affairs

National Guard Health Affairs
King Abdulaziz Medical City
Functional Organizational Chart
Western Region
November 2012




| Recommended By: | Recommended By: | Reviewed By: | Endorsed By: | Endorsed By: | Approved By: |
|---|---|---|---|---|---|
| Brig. Gen. Engr. Khalid Bakulka<br>Executive Director, Operations – WR | Executive Director, Medical Services – WR | 18 NOV 2012<br>Mr. Abdulmonsen Al Ashry<br>Executive Director, Internal Audit & Organizational Development, NGHA | Chief Operating Officer, NGHA | Dr. Saad Abdulaziz Al Mohaij<br>Chief Medical Officer, NGHA | Dr. Bandar Al Knawy<br>Chief Executive Officer, NGHA |

# Appendix D: Ethical Form

**Algarni, Namshan**

**From:** SEREC
**Sent:** 10 June 2015 11:12
**To:** Algarni, Namshan
**Subject:** RE: SEREC 051-2015

Dear Namshan

Your proposed research activity "SEREC 051-2015" has been reviewed by SEREC and confirmed as posing a low risk in terms of research ethics. Before you commence with your research activities the reviewer has asked for a minor amendment.

Amendment
*The consent form should be updated to state that the interviews will be recorded, unless the interviewee prefers otherwise. Namshan should also be mindful of how the recordings are stored – I.e. Make sure the files are kept securely and that the file name doesn't identify the individual (use the participant number ideally).*

We do not need to see the amendments but would be grateful if you could acknowledge that you will follow the request above.

You can now proceed with the research activities you have sought approval for and we wish you a successful project.

Please remember that SEREC occasionally conducts audits of low risk projects and we may therefore contact you during or following execution of your fieldwork to verify that you are following good practice.

Guidance on good practice in research ethics is available at
https://intranet.cranfield.ac.uk/researchethics/Pages/SEREC.aspx

With best regards,

Michelle Everitt
Project Co-ordinator, Research and Innovation Office, Conway House
E: M.Everitt@cranfield.ac.uk
T: +44 (0)1234 758029

---

**From:** Algarni, Namshan
**Sent:** 09 June 2015 12:28
**To:** SEREC
**Subject:** RE: SEREC 051-2015

Dear Michelle,

Thanks lot for your email and a valuable comment that you have added, I would just like to answer your queries:

1- The results will be kept in a highly confidential situation and just be for Cranfield.
2- The leadership of the SNG will not know who's been interviewed as well as the other interviewees will not know who's been interviewed.
3- The interviews will be recorded (and they will be informed before starting any interview) and all of these interviews will be destroyed at the and of the research.

Hope this information is a sufficient to answering all your queries.

1

**Algarni, Namshan**

**From:** Algarni, Namshan
**Sent:** 06 November 2015 12:29
**To:** SEREC
**Subject:** Re: SEREC 051-2015

Dear Michelle,

Thank you for your email and your usual support. I confirm that all details of the original application are the same and that the only issue is the data gathering date I originally advised of August 2015.

Best regards.

Yours sincerely,
Namshan Algarni

Sent from my iPhone

On Nov 6, 2015, at 12:51, SEREC <serec@cranfield.ac.uk> wrote:

> Dear Namshan
>
> Thank you for your email. Can you confirm if all details of the original application are the same and that the only issue is the data gathering date you originally advised of August 2015?
>
> Thanks
>
> Michelle
>
> ---
>
> **From:** Algarni, Namshan
> **Sent:** 06 October 2015 13:39
> **To:** SEREC
> **Subject:** RE: SEREC 051-2015
>
> Dear Michelle,
>
> Hope this finds you well.
>
> I'm writing to ask your urgent help. I have already obtained the ethics approval and conducted data gathering from a pilot study. Currently, I am planning to commence additional data gathering in November 2015, however, I just realised that the intended end date of fieldwork of the ethics approval form is "August 2015", I was supposed to indicate a date later than August 2015; to accommodate my next data gathering. The August 2015 date was an unforeseen mistake, and so I need your kind help in resolving this issue, as I do not have sufficient time to process a new ethics approval.
>
> I look forward to hearing from you soon.
>
> Best regards.

1

## Appendix E: Participant Consent Form

Participant number: _____

Date: _____

I, _____ (please print your name in block capitals) confirm that I agreed to participate in the *PhD* project, which has been described to me by Namshan Algarni as:

1. To identify best practices and key leadership competencies that improve the leadership performance via extensive literature review.
2. To investigate, via field study, the leadership characteristics that enable / inhibit performance improvement.
3. To develop a competency framework to improve the leadership performance as a change-mechanism for development.
4. To validate the framework in order to ensure that this has both practical and research value.

I understand that all personal information that I provide will be treated with the strictest confidence and I have been provided with a participant number to ensure that all raw data remains anonymous.

I understand that although the information I provide will be used by Cranfield University for research purposes, it will not be possible to identify any specific individual from the data reported as a result of this research.

I understand that the data collected will only be used for research purposes as part of the *PhD* project (Developing a competency framework to improve leadership performance in the public sector of the Kingdom of Saudi Arabia).The results will be written up as *[a PhD thesis]* I further understand that my raw data will be accessible only to the researcher and the supervising staff at Cranfield University. All data collected will be stored in accordance with the UK Data Protection Act (1998).

I understand that I am free to withdraw from this project at any stage during the session simply by informing a member of the research team, for whom contact details have been provided. I also understand that I can also withdraw my data for a period of up to 7 days from today, as after this time it will not be possible to identify my individual data from the aggregated results.

**I confirm I have read and completely and fully understand the information provided on this form and therefore give my consent to taking part in this research.**

Signature: _____ Date: _____

Full name: _____ Contact number:

Address: _____ Email address:

## Appendix F: Participant Consent Form

| # | Description of 'Leadership performance development in healthcare organizations' | Ddisagreed very strongly | Disagree strongly | Generally Disagree | Disagree somewhat | Disagree a little | Agree a little | Agree somewhat | Generally Agree | Agree strongly | Agree, very strongly |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1. | Direction refers to a course agreed by the people in an organisation, effectively reaching consensus on their desirable achievements (i.e., the organisational purpose). It encompasses goals, objectives in relation to such desirable attributes as care, quality and safety. The culture is characterised by the unwavering focus and adherence of all staff to systemic and organisational structures, capped by the continual learning of measures and approaches to improve patient care. | | | | | | | | | | |
| 2. | Leaders need to ensure the adoption of leadership functions by all staff in the workplace and their personal commitment to the delivery of safe, effective, high quality and beneficial care for patients and other service users. This demands prudent planning, relentless devotion and an unvarying focus on fostering leadership and culture. | | | | | | | | | | |
| 3. | In leading people, leaders should have the power to reward and punish. Effective leaders help their followers make sense of change, catastrophes, successes and the future. They provide a narrative which both makes sense to people and inspires them to give of their best and make a positive difference. | | | | | | | | | | |
| 4. | Understanding the needs and feelings of followers, monitoring the effects of own behaviours and being aware of emotional reactions to others are essential. Leader behaviors and traits should focused on facilitating others in achieving both nature of the direction and means of achieving the necessary goals. They emphasise fairness and honesty in their dealings with all, challenging unethical practices or social injustices on behalf of all, not just their followers. They set an outstanding example of ethical/moral behaviour, especially when it requires them to sacrifice their personal interests. | | | | | | | | | | |
| 5. | Leadership responsibilities should usually include ensuring the sustained growth and development of followers. Leaders are required to provide high levels of self-sufficiency and development opportunities to empower fellow workers, especially subordinates, and ensure a continuous build-up of efficiency and confidence. They should inspire followers to assent to their own capacity to respond effectively to seemingly bigger challenges, while affording the necessary support and resources to manage the challenges. Health worker motivation exists when the individual and organisational goals are aligned and workers perceive that they can carry out tasks. | | | | | | | | | | |
| 6. | Leaders in this area must ensure that the group or organisation has the resources (money, staff, IT support, time) necessary to do their work and should actively ensure the accessibility of the available resources if and when needed. | | | | | | | | | | |

## Appendix E: Interviews Questions

1- What the aspects that enabler and inhibitor leadership performance?
2- How could these aspects affect leader's performance?
3- What solutions may have required to improve the current performance?