

Bristol University Press
Policy Press

Chapter Title: The capabilities of leadership

Book Title: Leadership for healthcare

Book Author(s): Jean Hartley and John Benington

Published by: Bristol University Press, Policy Press. (2010)

Stable URL: <https://www.jstor.org/stable/j.ctt9qgmjk.10>

JSTOR is a not-for-profit service that helps scholars, researchers, and students discover, use, and build upon a wide range of content in a trusted digital archive. We use information technology and tools to increase productivity and facilitate new forms of scholarship. For more information about JSTOR, please contact support@jstor.org.

Your use of the JSTOR archive indicates your acceptance of the Terms & Conditions of Use, available at <https://about.jstor.org/terms>



JSTOR

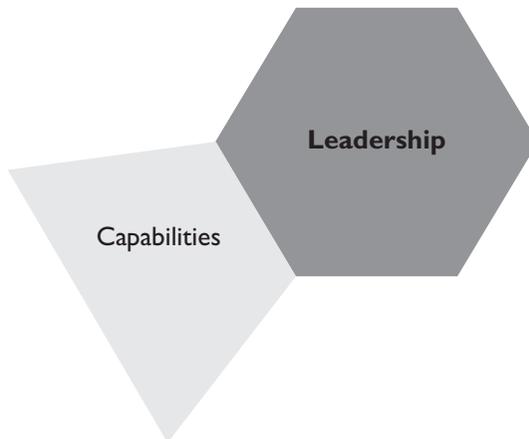
Bristol University Press, Policy Press are collaborating with JSTOR to digitize, preserve and extend access to *Leadership for healthcare*

The capabilities of leadership

In this chapter:

What are the capabilities (attributes or qualities) of leaders that are most closely associated with effective leadership? The chapter starts by looking at the individual leader and considering the evidence about qualities in terms of traits, behaviours, practices and competency frameworks. The chapter includes a consideration of emotional intelligence and of political awareness as key capabilities for leadership, along with the idea of 'meta-competencies'. The chapter then turns to looking at the behaviours and capabilities of teams (for example across a team, a board or an inter-organisational partnership). The chapter then focuses on capabilities in terms of processes of influence between the leader and those being influenced, and, therefore, looks at transformational and transactional leadership, and post-transformational leadership. There is also a brief consideration of the question of gender and the social construction of leadership. This analysis has implications for diversity more generally.

Figure 6.1: The capabilities of leadership



Some leadership writers would put capabilities right at the start of the analysis in this book – so why have we not done this? The individual qualities of leadership might seem a logical place to start (‘Who are the leaders and what qualities do they possess?’). It would fit with the tendency that still exists across much of the literature to focus on ‘heroic’ leadership – the assumption that leaders are different from ‘followers’ in terms of their special intellect, motivation and/or personality.

However, this book is based on an alternative analytical framework, which argues that the context and the challenges shape the kinds of leaders who will emerge in particular situations, or who will put themselves forward, intentionally or not, as sources of influence. So, this approach is a contingent one, which suggests that the kinds of skills and abilities that an effective leader needs to exhibit will depend on the situation they are in, and the kinds of goals they are trying to formulate or accomplish. We turn now to the evidence about capabilities, within this framework.

Traits

Early research into leadership (up to and into the 1940s) had focused on traits, such as personality, physique and cognitive style. These were assumed to be fixed and largely inherited (Stogdill, 1974). Large lists were generated of the traits that were associated with effective leadership (largely, at that stage, the leadership of small groups).

There were a number of problems with the trait approach to leadership. First, it assumed that leaders were largely born rather than made, because the traits were seen to be innate. Second, however, the list of traits grew longer and longer. Third, this approach did not take into account the different contexts within which leaders carried out their work, which was found to have an impact on leader effectiveness. Fourth, contemporary understanding of personality is that many elements of it may not be fixed but can be developed over time, according to context, life experiences and self-awareness to develop. On the whole, research has moved on from seeking leadership traits to looking at leadership styles and leadership behaviours.

Despite this, a limited number of personality characteristics have been found, in review studies, to be linked to specific leadership approaches. For example, Bass (1998) found in empirical studies of transformational leadership that intelligence, ascendancy, optimism, humour, need for change, behavioural coping, nurturance, internal locus of control, self-acceptance, extroversion, hardiness and physical fitness were related to effectiveness. More succinctly, other research found that “positive,

adaptive, developmental and people-oriented traits form a distinct personality pattern that supports transformational leadership's social influence process" (Sosik, 2006, p 41). However, this is based on traits associated specifically with transformational leadership and so may not be relevant to all leadership situations. Overall, the view is that trait theory had very limited applicability to understanding the leadership qualities of effective leaders (Parry and Bryman, 2006; Yukl, 2006; Jackson and Parry, 2008).

Behaviours

Disappointment with trait theory led to a greater interest in the behaviours exhibited by leaders from the mid-20th century onwards. This meant that there was a focus on what leaders do rather than on who they are (in the sense of personality or background). This is also called the style approach, in that it examines clusters of behaviours commonly used by leaders. Here, the focus is still on the individual leader, but examines what can be explicitly seen or sensed through behaviour. It also assumes that behaviours can be acquired, so there is a shift from a dominant interest in selection, to a focus on leadership development.

Early work, such as the famous Ohio studies (for example, Halpin and Winer, 1957), found two key dimensions of effective leadership of small groups. These dimensions were labelled 'consideration' and 'initiating structure'. These reflected behaviours by the leader concerned with consideration for the social and emotional well-being of their subordinates or a focus on shaping and progressing the task. These twin themes of a focus on people and/or task have been echoed in other studies (Marturano and Gosling, 2008) and provide a valuable and recurring framework for thinking about leadership behaviours and styles. These themes have also shaped thinking about leadership development, where a focus on improving personal and interpersonal skills to work with others, and on strategic vision and managerial competencies to address the task, has been important.

Competencies

An important approach to understanding the behaviours of leadership has come from the competency frameworks originally pioneered by Boyatzis (1982, 2006) and widely used both to understand and to improve leadership qualities, though not without critics (for example, Hollenbeck et al, 2009).

A competency has been defined by Boyatzis (1982) as an underlying characteristic of the person that leads to or causes effective or superior performance in a job. More concretely, this has been described as the skills, knowledge, experience, attributes and behaviours that an individual needs to perform a job (or role) effectively (Hirsh and Strebler, 1995). The crucial difference between a trait approach and a competency approach is that the competency approach focuses on qualities that are expressed in terms of behaviour. There is also an assumption that competencies may be acquired (for example, through learning, practice, experience) rather than inherited, as traits are sometimes assumed to be.

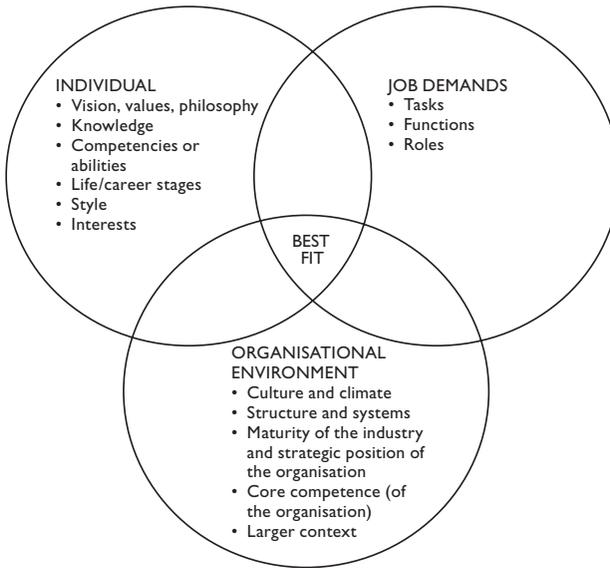
Some writers have become rather wary of using the language of competency (as they see it as too rigid and focused on standards and qualifications) and instead use the language of capability. Other writers use the terms interchangeably. Each expresses skills of effective performance whether these are technical skills, interpersonal skills, cognitive skills or broader mindsets and values. (The word 'skill' is often used as a shorthand to cover the range of knowledge, experience, attributes, behaviours and mindsets that make up the qualities that competency covers, rather than the narrower sense of skill as learned behaviours to achieve predetermined outcomes.) Fletcher (2008) notes that a more restricted view of competency is as an observable skill or ability to complete a managerial task successfully. Our focus here is on individual-level competencies not on organisational competencies.

Competencies, or capabilities, are conceptualised as related to job (or role) performance. A competency approach recognises (or should recognise) the interaction between the context and the person. Boyatzis (2006) shows this in a diagram, reproduced as Figure 6.2.

The figure shows the interaction between person and their context, expressed in terms of the job demands and the organisational environment. This recognises that leadership performance is not simply a matter of a particular type of person. This is a contingency view of leadership, in that it is affected by the situation that the leader is in, and is not solely dependent on the qualities of the leader. Boyatzis describes best fit as the "area of maximum stimulation, challenge and performance" (2006, p 122).

Competency frameworks have become a widely used approach in thinking about the qualities for effective leadership. For example, the NHS Leadership Qualities Framework has been widely used in healthcare in the UK and is shown in Figure 6.3. It sets out the key skills or competencies for leaders in healthcare, across a range of settings.

Figure 6.2: Boyatzis's theory of job action and performance



Source: Adapted from Boyatzis (2006, p 122)

Figure 6.3: The NHS Leadership Qualities Framework



Source: NHS Institute for Innovation and Improvement (2005), www.nhsleadershipqualities.nhs.uk

Another health example of a competency framework comes from the US, where researchers developed one for those working in public health leadership (Wright et al, 2000). However, this was developed through focus groups and discussion rather than through the more rigorous methodology adopted by Boyatzis, and is based on the idea of a baseline set of competencies rather than the behaviours associated with superior performance as in the Boyatzis model. The public health approach identified four main areas of job demand (challenge) and clarified the competencies required for each of: transformation; legislation and politics; trans-organisation (inter-organisational partnerships and networks); and team and group dynamics.

Some have argued that a competency approach to leadership is restrictive because it creates abstract qualities about leadership (Bolden and Gosling, 2006) and that this applies to the NHS Leadership Qualities Framework specifically (Bolden et al, 2006). On the other hand, Boyatzis emphasised the need to consider leadership competencies in their context, and so it seems that the practice in some organisations is problematic where competencies have been treated as if they can be conceptualised and used on their own, as essential and primary ingredients of leadership (Bolden and Gosling, 2006). In this restricted use, the focus can become blinkered to concentrate solely on the person's individual behaviours, at the expense of understanding the context or the job demands, and their interaction with the organisational purposes and environment. There is a danger that competencies are then used mechanistically for job promotion, job evaluation or development. This can obliterate a situational view of leadership, where effective leadership is seen to be related to particular contexts.

A further difficulty can be the accumulation of a list of competencies, which (like traits?) can grow in number. For example, the US public health framework has 79 competencies (Wright et al, 2000). This becomes unwieldy, and there is a consequent danger of developing an idealised skill set that only a superhuman could achieve. Also, there is a danger of competencies becoming a descriptive list rather than a theory about how such skills contribute to effective leadership performance.

Some competency frameworks are more evidence-based than others – a focus on behaviours helps to make explicit what the practices are that contribute to effective performance and help to anchor performance in real, observed practices. This is in preference to judgements about skill that are not evidence-based but are prone to personal judgements, which are affected by personal biases, attribution errors and halo effects.

Most competency frameworks cover a range of personal, social and cognitive, or conceptual skills. For example, personal skills may include self-awareness, confidence, integrity, resilience in the face of adversity. Social skills might include the ability to empathise with others, to communicate clearly and persuasively, maintaining cooperative relationships. Conceptual skills might include analytical ability, creativity, having foresight, making sense of complexity.

Some elements of leadership capability have received particular attention recently. It is not within the scope of this book to cover them all, but here we look at three specific clusters of capabilities: emotional intelligence, political awareness and meta-competencies.

Emotional intelligence

Emotional intelligence (Mayer and Salovey, 1993; Goleman, 1995) is a concept that suggests that people vary in how far they are attuned to emotional, not just rational, aspects of life. In terms of leadership, emotional intelligence involves awareness of the feelings, moods and emotions of oneself and others, and the ability to act in ways that contribute to goal formulation and goal achievement, taking into account the emotions of those whom one is attempting to influence (Goleman, 1995; Goleman et al, 2002; Dulewicz and Higgs, 2004; Cherniss, 2006). The interest in emotional intelligence provides a counterweight to those theories that had primarily emphasised rational aspects of leadership (for example, analytical ability) and where emotion in the workplace was seen as dysfunctional. Scholarly opinion is divided as to whether emotional intelligence is a distinct capability or whether it is an amalgam of other capabilities (Matthews et al, 2002). It has certainly been useful in alerting leaders to think about and act in emotional terms, not just in rational terms, and to harness emotions constructively in the workplace (Dulewicz et al, 2005). This may be particularly important in healthcare, where staff are working with a range of emotions from patients, carers and others, with their own emotions, and with the consequences of emotion on their own work (Menzies Lyth, 1988; Hoggett, 2006). There is an accumulating body of evidence (for example, Cherniss, 2006), which suggests that emotional intelligence, in a variety of conceptualisations and measured by a variety of tools, does have either a direct impact on leadership effectiveness, or else an indirect effect (for example, a link between emotional intelligence and transformational leadership style, or the organisational commitment of 'followers').

Goodwin (2006) has also suggested that leaders in the NHS would benefit from using emotional intelligence to manage the stress caused by organisational and wider health system change, including managing their own anxiety and pressure. He draws on the Goleman model of emotionally intelligent leadership, which requires personal skills:

- To know what you are feeling and be able to handle those feelings without them wholly dominating your interpersonal relationships and decision-making.
- To be able to motivate yourself to achieve personal and group objectives, to be innovative and creative and to perform at your peak.
- To sense what your team and others in wider networks are feeling and thereby handle interpersonal and inter-organisational relationships effectively.

Leadership with political awareness

Political awareness, political astuteness, political acuity and political intelligence are all terms that cover the ability to analyse and act as a leader taking into account diverse groups that may sometimes compete and sometimes collaborate. The NHS Qualities Framework defined political astuteness as “showing commitment and ability to understand diverse interest groups and power bases within organizations and the wider community, and the dynamic between them, so as to lead health services more effectively” (NHS, nd, p 21).

Recent work by Hartley et al (2007) and Hartley and Fletcher (2008) has examined the key skills of political awareness among senior leaders in the private, public and voluntary sectors in a large, national survey, based on 1,500 managers across the private, public and voluntary sectors, and including a substantial number of managers from healthcare. The political awareness skills framework is based on the recognition that increasingly leaders have to influence a diverse range of individuals, groups and organisations, not only inside the organisation but outside as well, through networks and partnerships, and because of the increasing connectivity and transparency of organisations through information and communication technologies. Leadership with political awareness was found by Hartley et al (2007) to operate on five dimensions: personal skills; interpersonal skills; reading people and situations; building alignment and alliances; and strategic direction and scanning. They found that senior and middle managers reported using political awareness skills in a wide range of contexts, reflecting both ‘small p’ and ‘big p’ politics, with managers having to be Janus-faced, that

is, facing into and outside the organisation, in order to lead diverse, and sometimes competing, interests among a variety of stakeholders. They also found that managers reported acquiring their political awareness skills through a variety of somewhat haphazard routes, with 88% reporting making mistakes as a valuable or very valuable way of gaining these skills. The research makes recommendations about making development more systematic and less painful, through actions by individuals, organisations and development providers.

One context where political awareness is particularly needed (as found in the research) is in working in networks and partnerships, where both collaboration and competition may coexist (Hartley and Fletcher, 2008). Some UK writers have examined the capabilities for health leaders working in networks. Goodwin (1998) notes that a senior manager such as a chief executive will need to work with, and attempt to influence, a wide range of stakeholders. Ferlie and Pettigrew (1996) found that having strong interpersonal communication skills (including listening skills), having an ability to persuade others, and having an ability to construct and maintain long-term relationships were critical to an effective approach to leading health networks.

Overarching competencies

Finally, in this section, Fletcher (2004) undertook an analysis of the leadership competency frameworks in use by Welsh public service organisations, that is, in use in the NHS Wales, in Welsh local government and in the Welsh Assembly government, as part of a larger analysis of leadership development for the whole public service system in Wales (Benington, 2004). Fletcher found that it was possible to summarise the main strands of competency in terms of eight principal themes, but that there were, in addition, two 'meta-competencies', as identified by Briscoe and Hall (1999). Meta-competencies are overarching competencies in that they enable the acquisition of other competencies. As leaders operate in a dynamic and uncertain world, the competencies that gave effective leadership performance in the past may no longer contribute or contribute as fully to future performance. Therefore, the ability to acquire new competencies becomes crucial. The eight competencies and two meta-competencies that enable the acquisition of further competencies are shown in Table 6.1.

Table 6.1: Analysis of competencies and meta-competencies in Welsh public leadership

The eight core capabilities include skills in:
Motivating, empowering and developing staff, by establishing and communicating high expectations and high standards.
Inspiring, promoting and facilitating change, encouraging new ways of working, influencing perceptions of change – making it achievable and exhilarating.
Providing purpose and vision, translating the vision into practical goals, and ensuring that the longer-term perspective informs and inspires thinking and action.
Establishing credibility and integrity, transparency and consistency, honesty and courage, respect and responsibility.
Influencing and persuading based upon evidence and argument, analysing opposing viewpoints, negotiating, finding common ground, building networks.
Building teamwork and partnerships, encouraging cross-boundary working, seeking diverse viewpoints, empowering stakeholders in decision-making.
Focusing on customers and delivery, identifying customer needs and tailoring the service to meet them, continuously improving performance and outcomes.
Commitment to learning and self-awareness, awareness of one's own strengths and limitations, applying learning from own and other experience.
The two 'meta-competencies' or 'learning competencies', which affect the ability to acquire other competencies, focus on:
Identity – accurate self-assessment; seeking, hearing and acting on feedback; being able to modify self-perceptions as attributes change.
Adaptability – comfort with turbulent change; ability to identify the qualities needed for future performance; and flexibility to make the changes needed.

Source: Clive Fletcher, in Benington (2004)

The capabilities of leading networks and teams

The increasing interest in distributed leadership (Gronn, 2002; Spillane, 2005) means that capabilities shared or distributed across a team or a board, or across the leadership of a group of organisations, is becoming more important. There is still relatively little work on the leadership qualities of whole teams or governance groups, much less research specifically within the health sector.

More broadly, networking has been increasingly recognised as a key skill of leaders. For example, some case study work on collaborative community health partnerships in the US (Alexander et al, 2001) suggests that leadership has a number of requirements in practice:

- the need to think in terms of whole systems;

- to be able to develop, communicate and work with a vision of what is to be achieved, consisting of a core ideology and an envisioned future;
- collateral leadership (which is another way of saying distributed leadership);
- power sharing across a partnership in order to build a broad basis of support;
- process-based leadership, by which the authors mean a set of capabilities that involves the leaders paying attention to how the work gets done as well as what is done.

Denis et al (2005) and Peck and Dickinson (2008) point out that network leadership is not only about interpersonal skills and the ability to build relationships between people, but also about the ability to understand the structural power that pervades such networks, particularly for public service organisations such as health. Denis et al (2005, p 453) note that “In organizations where power is diffuse, success or failure of the strategic process depends, among other things, on the capacity of leaders to constitute and maintain strong and durable networks”. This includes the ability to “pull together a powerful alliance with diverse internal and external actors” (p 454) and with the capability to:

think simultaneously in terms of both the project and the networks of support they can engage. He or she will be drawn to consider the diverse meanings that various project definitions will have for others and how those meanings might be reconstructed either discursively or practically to render them more or less attractive. (p 454)

This ties in with leadership as the management of meaning, and sense-making, as well as the achievement of goals (Smircich and Morgan, 1982; Weick, 1995; Pye, 2005).

It has been noted (Denis et al, 2001, forthcoming) that major organisational change in complex healthcare systems is more likely to happen where there is a ‘leadership constellation’ in which different individual leaders play different roles or contribute different aspects of leadership at different phases of change, and where leadership roles are constructed and reconstructed as the change progresses. A leadership constellation may be particularly important in organisations with multiple professions, priorities and views (such as hospitals or

universities) where a coalition to define, build support for and engage in leadership is critical.

There has been a small amount of work on the capabilities of whole boards, and therefore the competencies required both by individuals and by the whole board for healthcare governance (McDonagh, 2006; Endacott et al, 2008). Some work has suggested that chief executives and chairs have a leadership role to play in ensuring that a focus on clinical care is linked to all trust developments, so that the ‘business of care’ is considered alongside financial performance (Burdett Trust for Nursing, 2006). This is perhaps an area where further research and development would be helpful.

So far, the focus in this chapter has been on the personal qualities of leaders, whether acting as individuals or in a network or group. The emphasis is on the leader and their behaviours and practices and less about the impact on those whom they are trying to influence. The chapter turns now to examine leadership style in terms of the relationship between leaders and those they try to influence. It is not possible to cover all theories in this field so we have selected for detailed analysis one that has particular prominence in healthcare leadership research, and that is influential but sometimes misunderstood. This is the area of transformational and transactional leadership. We then turn to consider ‘post-transformational’ leadership as a reaction to this work.

Transformational and transactional leadership behaviours and styles

Theories based on the idea of transformational leadership have become very popular in leadership research and practice in recent years. Transformational leadership is interesting on several counts. First, this approach takes into account not only the skills of leaders but also the impact of leader behaviour on so-called ‘followers’ (although these are often not the subordinates implied in the word follower, but individuals, groups and organisations whom the leader aims to influence). Second, the theory tries to take into account the situations in which leadership is exercised. Third, it has attracted considerable empirical research, which provides evidence to support many (though not all) of its conclusions. It is an approach that has attracted interest in the healthcare sector, where a number of studies have been conducted. Transformational leadership is part of a cluster of theories linked with charismatic leadership (for example, Conger and Kanungo, 1987; Bryman, 1992), and visionary leadership (Westley and Mintzberg, 1989) based on creating strong links between leaders and ‘followers’.

Transformational leadership theory has been developed, alongside its apparently contrasting cousin, transactional leadership, from initial research by Burns into political leadership (1978). Transactional leadership is based on an exchange process between the leader and ‘followers’. The transaction is based on what the leader possesses or controls and what the ‘follower’ wants in return for providing their services. The exchange may be economic, political or psychological, and the relationship between leader and follower may involve negotiation as a core component.

Transformational leadership, on the other hand, is based on the leader inducing positive feelings in their followers, which then motivate loyal and committed performance. The leader aims to engage followers in going beyond their self-interest because the leader seeks to win their trust, admiration and loyalty and so they are emotionally as well as rationally inclined to do more than they originally expected to do. The theory of leadership behaviours and competencies has been particularly developed by Bass and colleagues in the US (Bass, 1985; Bass and Avolio, 1990; Avolio, 1999) and Alimo-Metcalfe in the UK (Alimo-Metcalfe and Alban-Metcalfe, 2004, 2005). The latter developed much of the empirical measurement and research with managers in UK health and local government. Nadler and Tushman (1980) have described transformational leadership as ‘envisioning, energising and enabling’. In his later work, Bass (1999) outlines four key elements of transformational leadership, which are summarised by Yukl (2006) and shown in Table 6.2.

Table 6.2: Transformational leadership behaviours

Transformational behaviours:
Idealised influence – behaviour that arouses strong follower emotions and identification with the leader.
Intellectual stimulation – behaviour that increases follower awareness of problems, and influences followers to view problems from a new perspective.
Individualised consideration – providing support, encouragement and coaching to followers.
Inspirational motivation – communicating an appealing vision, using symbols to focus subordinate effort and modelling appropriate behaviours.

Source: Adapted from Yukl (2006, p 263), based on the work of Bass (1999)

Transformational leadership has been very fashionable, and it is sometimes assumed that transformational leadership is ‘better’ than transactional leadership because it rises above a kind of pragmatic,

cost–benefit analysis and exchange (transactional leadership) to engage followers emotionally in higher aspirations and goals (transformational leadership). However, while Burns has perhaps implied that transformational leadership is superior, Bass is very clear that effective leaders in practice use both types of behaviour styles. The evidence from research studies shows that the approach varies by context and challenge.

Transactional leadership can sound rather basic, with its focus on exchange, but some have argued that this underestimates the skills of transactional leadership. Being clear, focusing on expectations, giving feedback are all important leadership skills. These are shown in Table 6.3.

Table 6.3: Transactional leadership behaviours

Transactional leadership behaviours:
Clarifying what is expected of followers' performance.
Explaining how to meet such expectations.
Spelling out the criteria for the evaluation of this performance.
Providing feedback on whether the follower is meeting the objective.
Allocating rewards that are contingent on meeting those objectives.

Source: Summarised from Tavanti (2008), which draws on the work of Bass (1985)

Transactional leadership can be particularly effective in hierarchical organisations where the followers are subordinates and where the group is focused on achieving clear task objectives. Transformational leadership may be valuable in dynamic, unstable environments (Yukl, 2006) where there is an accepted need for change and where the organisational or partnership climate is such that leaders are encouraged and given powers to be more entrepreneurial in their approach to the task and their group. Mannion et al (2005) argue for contingent leadership in healthcare organisations: “leadership that is able to express and embody corporate vision, but equally able to follow through with the transactional details” (p 438). Other research has found both transformational and transactional leadership development to be important for the health service (Edmonstone and Western, 2002; Peck et al, 2006). This also corroborates the earlier analysis of transformational and transactional styles in relation to the challenges of leading change (for example, different phases of merger/acquisition, see Chapter 5).

Transformational and transactional leadership have been measured in a variety of ways, particularly through the Multi-Factor Leadership Questionnaire (MLQ) designed by Avolio et al (1990). In the health field, numerous studies have been undertaken with nurse managers,

but fewer studies have been undertaken with doctors, or with health service managers (Morrison et al, 1997; Corrigan et al, 2000, 2002; Stordeur et al, 2001; Vandenberghe et al, 2002; Leach, 2005; Aarons, 2006). Transformational and transactional leadership have also been explored using a range of research methods, including case studies, interviews and even experimental studies (based on laboratory tasks), as reviewed by Yukl (2006).

Avolio et al (2004) studied 520 staff nurses in a large hospital in Singapore and found that transformational leaders foster higher levels of identification and commitment to the organisation from employees. This study suggests that where senior leaders create a greater sense of empowerment among staff this can have a positive effect throughout the organisation. This is echoed in a national study of 396 nurses across the US, where higher levels of transformational leadership tended to occur in more participative organisations (Dunham-Taylor, 2000). In addition, drawing on Bass's model, studies carried out on 54 mental health teams at the University of Chicago (Corrigan et al, 2002; Garman et al, 2003) found that transformational leadership seems to be associated with a generalised positive effect on staff, positive views by staff about the organisation and low burnout among staff.

Transformational leadership has been the 'spirit of the age' from the 1990s onwards, and there has been considerable work on its qualities and its impact on subordinates and colleagues. It is valuable as an approach to thinking about the qualities that are advantageous for leadership in health, whether from doctors, managers, nurses or others. It emphasises the need to inspire others with a strategic purpose and to engage with hearts as well as minds. It is a relational view of leadership, that is, it is based on how leaders interact with others, rather than on abstract qualities of the leader in isolation. The approach, by focusing on style, implies that many of the behaviours can be learned, fostered and developed. The focus on empowering others through intellectual stimulation, individualised consideration and so on means that it can help organisations to think about the 'leadership pipeline' as well as existing leaders, that is, helping to foster the next generation of leaders.

However, there have been some criticisms, and some of these are particularly relevant to public service organisations such as those in healthcare. First, researchers have noted that different versions of transformational leadership appear to emphasise different clusters of behaviour and this is particularly true of transactional leadership (Yukl, 2006). Second, Kelloway et al (2005) note that transformational and transactional leadership are not discrete categories and that any leader may display some behaviours from each approach. Both of these issues

might be problematic for healthcare leadership development if the leadership model is either not understood or not clearly specified. Third, there has been little exploration of how the characteristics of leadership, which were explored in Chapter 3 (roles, sources of authority, and power and resources), interact with leadership behaviours. It could be that different sources of authority may lead to different uses of transformational leadership – one could imagine this being the case for the leadership behaviours of medical consultants compared with chief executives, board members or nurses, or doctors compared with patient representatives. Fourth, transformational leadership theory is so fashionable that it may be held up in some quarters as ‘the answer’ to all problems and situations, although the research evidence is more contingent, favouring both transformational and transactional leadership according to context and purpose (as noted earlier in this chapter and in Chapter 5).

Fifth, one element of transformational leadership is ‘idealised influence’, that is, behaviour that arouses strong follower emotions and identification with the leader. This element derives from the interest in charisma as an element of leadership, which is based on the belief among followers that the leader has unusual and valuable gifts. Arousing strong emotions can be problematic on several counts, particularly in public service settings. Public services are provided under a political mandate from government so there are inevitably tensions around how far leadership can or should be based on charisma rather than policies. In addition, the attribution of exceptional powers and abilities to the leader can undermine a group’s sense of its own empowerment and abilities, setting up unhealthy dependencies on the leader. This is one aspect of the ‘dark side’ of leadership theory (Buchanan, 2003; Burke, 2006b) and this has fostered interest in post-transformational leadership. Furthermore, there can be problems with charismatic leaders especially in closed environments, such as psychiatric wards and children’s homes, where power asymmetries can become abuses of power. For these reasons, while the theory of transformational leadership is promising, it also has some limitations.

Post-transformational leadership

There has recently been a shift away from the focus on transformational leadership (Parry and Bryman, 2006). The series of corporate scandals such as at Enron showed the limits of transformational approaches. Storey (2004, p 32) notes that “a common trait in the charismatic leaders studied was their willingness to deliberately fracture their organizations

as a means to effect change". There has been recognition of some of the darker elements of transformational leadership in some situations, including narcissism and arrogance.

The theory of adaptive leadership by Heifetz (1994) is a valuable antidote to the view of the exceptional leader as charismatic, because he argues that leaders often have to be able to disappoint the expectations of their 'followers' that the leader will solve all problems for the group. Heifetz argues that adaptive leadership is based on enabling the group to accept and address the issues it is responsible for, thereby rejecting inappropriate dependency on the leader. Fullan (2001) argues for an approach to leadership that is based on supporting learning in others across the whole organisation rather than taking on heroic problem-solving.

What about gender?

Debate continues to bubble about whether women are different from men in their leadership capabilities (eg Alimo-Metcalf, 1999). Behind the debate are questions of evaluative judgement (better or worse). A recent review of the literature concluded that "there is no consensus in the literature about gender differences in leadership styles" (Parry and Bryman, 2006, p 461). Women are only slightly more likely than men to use transformational leadership (see, for example, Eagly et al, 2003), despite the common assumption that women are more relationship-oriented than men.

However, people do hold stereotyped beliefs about 'natural' gender styles and these could influence how people behave at work. For example, it is often expected that women will be more nurturing, and this could encourage women to place more attention on interpersonal relations at work. There is also evidence that the stereotype of the 'heroic' leader is closer to a typical male set of traits than a typical female set of traits, and this explanation has been used to explain why there are fewer women managers (Schein et al, 1996) and fewer women leaders (Sinclair, 2005) in the workplace. Thus, the views about the talents of women or men may be less to do with their inherent qualities and quite a lot to do with the way that society views leadership.

These findings are also relevant in relation to diversity more generally. For example, there is a significant under-representation of black and minority ethnic (BME) managers in senior positions in the NHS. Understanding how leadership is socially constructed and may disadvantage particular groups in society is an important area but one that appears to be under-studied.

Policy and practice implications:

- Capabilities refers to a range of skills, knowledge, experience, mindsets, attributes and behaviours that are associated with superior performance.
- It is helpful to think not about universal qualities of leadership, but what works, in what kind of role and in what kind of situation.
- The search for personality traits has turned out to be limited beyond a few features. It is more useful to think about leadership in terms of behaviours and styles (clusters of behaviours).
- The shift from traits to behaviour also implies that leadership capabilities can be developed. Leadership development comes to the fore as a way to create future leaders.
- Competency frameworks are most useful where they consider behaviours related to the job demands (the challenges of leadership) and what is needed in a particular organisational environment. Leadership performance is not simply a matter of a particular set of competencies.
- Emotional intelligence has captured the interest of policy-makers and practitioners because it emphasises the need to understand one's own and others' emotional states and capacities. It counterbalances more rational approaches to leadership that have focused on analytical skills. Both may be important.
- Leadership with political awareness is emerging as an important set of skills, as leaders at a variety of levels have to understand and work with diverse stakeholders inside and outside the organisation, both locally and nationally.
- There is increasing interest in the competencies that enable leaders to acquire new competencies. These meta-competencies or learning competencies include accurate self-assessment and being comfortable with change and challenge.
- Thinking not only about the capabilities of individuals but also of teams, groups and boards becomes increasingly important in the context of more distributed leadership and more complex challenges.
- Although transformational leadership is popular, the research evidence shows that both transformational and transactional leadership make important contributions to leadership, and that each may be relevant to different situations or different phases of leadership.
- There is increasing caution about the charismatic element of transformational leadership (arousing strong follower emotions) in public service (and other) settings. There is interest in 'post-transformational' leadership, which is focused on creating a climate of organisational learning.
- There is sometimes speculation that women make better (or worse) leaders than men. The research evidence on gender differences is very weak. So it is

not helpful to assume that women (or men) have particular leadership styles. This is valuable for thinking about diversity more generally.

- There is evidence of gender stereotypes in relation to leadership, which may help to explain the fact that there are fewer women managers and leaders in top jobs.

