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The challenges of leadership

In this chapter:

We examine the challenges, or purposes, of leadership. What is it that leadership is trying to achieve?

First, we examine the challenge of 'sense-making' – how do leaders make sense of the context and the purposes they are trying to achieve, and how do they communicate this to others to create a clear sense of common purpose? We examine 'big picture sense-making' and then turn to consider the different types of problems that leaders may face, and the degree of match between their leadership strategies and the problem, or challenge, to be addressed. How do leaders think about and orchestrate the work to be done? We distinguish between technical and adaptive challenges (sometimes called tame and wicked problems) and the leadership approaches that seem to be most effective in tackling each of these two types of problem.

We then turn to examine five concrete leadership challenges for healthcare organisations. These are: the merger/acquisition challenge; leading partnerships and networks; leading organisational turnaround; leading organisational change, innovation and improvement; and nurturing future leaders in the organisation.

This chapter focuses on the challenges and purposes of leadership (see Figure 5.1). What are the goals or outcomes that leadership is aiming to achieve? We have called these tasks 'challenges' in line with an emerging literature that frames leadership purposes in this way (Heifetz, 1994; Heifetz and Laurie, 1997; Burgoyne et al, 2005; Morrell and Hartley, 2006). Most definitions of leadership focus on purpose in some way – for example, leadership as being influence towards a common goal, or mobilising others to tackle tough problems. The definitions of leadership from Stogdill (1974) or Smircich and Morgan (1982) are a reminder that the leader's role may also be to find or frame the purpose not just to implement agreed goals, or communicate a vision to others.

Figure 5.1: The challenges of leadership



Leadership as sense-making and as constituting challenges

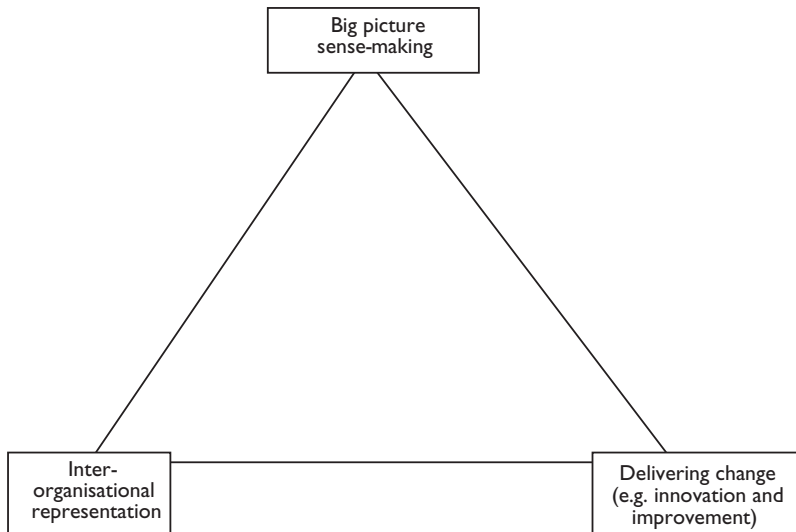
Leadership theory from the 1980s onwards has revived interest in leadership as providing ‘vision’ and a sense of clear purpose and direction for an organisation or group of followers (for example, Conger and Kanungo, 1987; Nadler and Tushman, 1990; Bryman, 1992). Yet vision is not a simple read-off from the context. Some have argued for a more constitutive approach that is based not only on rational analysis but also on an analysis of the various stakeholders and their interests and an attempt to negotiate a coalition and common purpose. A constitutive approach is about the active framing of what the problem is as well as what the solution is (or rather, perhaps, the range of ways of addressing the problem) (Parry and Bryman, 2006; Heifetz et al, 2009). DuPree (1998, p 130) argues that “The first responsibility of a leader is to define reality. The last is to say thank you”. How are purposes formulated, articulated and debated? The complex context of healthcare makes this a particularly fertile site for the exploration of purposes and the contestation of purposes by different stakeholders. In particular, for public services such as healthcare, there is also the question of assessing whether or not the leadership purposes contribute to, or detract from, the creation of ‘public value’ (Moore, 1995; Benington and Moore, 2010), that is, the wider public good. (Public value is discussed in detail in Chapter 7.)

Grint (2005b) notes that a key element of leadership is to define and make sense of context. The strategic leadership of change is not just a matter of rational decision-making (however persuasive the post hoc rationalisations of leaders may be). Complex change in an uncertain world can only be partially predicted and planned for by the leadership (Hartley, 2000). ‘Sense-making’ becomes important in organisational change, particularly under conditions of uncertainty or ambiguity (Weick, 1995). Sense-making captures the idea that people (individuals or groups) make sense of confusing or ambiguous events by constructing plausible (rather than necessarily accurate) interpretations of events through action and through reinterpretation of past events. The role of the leader, in a sense-making framework, may be less about being fully clear about the future and rational plans for shaping it (that is, providing a ‘clear vision’), and more about providing a plausible narrative that helps people understand what may be happening and mobilises their support and activity to address the problem. Pfeffer (1981, p 4) argues that a key role for leaders is to provide “explanations, rationalizations and legitimations for activities undertaken in organizations”. In this sense, the view of leadership as sense-making for and with the organisation is particularly valuable (Smircich and Morgan, 1982; Hartley, 2002b), and this has been noted in relation to healthcare (Weick et al, 2002).

Some writers have formulated purposes, or challenges, at a fairly high level of abstraction, which is helpful for broad orientation but requires more detailed working out in practice. Storey (2004) sets out three key ‘behavioural requirements’ or meta-capabilities for leadership, which can be seen as part of the key challenges for leadership. An adapted version of his approach is shown in Figure 5.2.

Big picture sense-making aims to scan and interpret the environment, particularly the external political and policy context (analysing context is discussed in Chapter 4 and here we examine how this has an impact on the purposes pursued by the leadership). Another important element of leadership is the ability to communicate the vision, mission and strategy to others, and to help them to make sense of the experiences they have (Hackett and Spurgeon, 1996). In Figure 5.2, inter-organisational representation requires the ability to lead with influence rather than formal authority. The ability to foster organisational and cultural change is the third element of the triangle. This is particularly important in healthcare organisations, given the pace, scope and scale of change both as a response to demographic and social changes and as a response to governmental policy pressures and directives.

Figure 5.2: Three key challenges for leadership



Source: Adapted from Storey (2004)

A different but relevant framework for considering the challenges of leadership comes from Leach and Wilson (2000, 2002). While their work is based on the challenges for local political leaders, it also has resonance for those tasked with strategic management and corporate leadership. Leach and Wilson have formulated four key tasks for elected political leaders:

- maintain political cohesion
- develop strategic policy
- exercise external influence
- ensure task accomplishment.

They note that it is hard, if not impossible, to achieve all of these purposes to the same degree and there are inevitably trade-offs between these challenges.

This framework requires some ‘translation’ into a managerial or clinical leadership setting, but the first task is recognisable in both settings as building up, consolidating and maintaining a sufficiently strong coalition of support for the proposed policy, direction or purpose. It reminds us why ‘ownership’ of change is such a widely used concept when organisational and cultural change is embarked on, because if there is insufficient support then the leadership will not achieve its

goals (Iles and Sutherland, 2001; Burnes, 2004). Increasingly, support needs to be mobilised outside as well as inside the organisation (Hartley et al, 2007).

Senior leaders will have to spend time in developing strategy, or will be involved in shaping local policy to fit with national policy. Reyatt (2008, p 154) notes that strategic visioning, as a key element of developing policy, involves at its core “imagining what is not present and what should be”. Other elements of strategy involve creating concrete plans and actions from that imagination and vision. Westley and Mintzberg (1989) argue that central to strategic leadership is the ability to take account of context but also to work with vision. Kaplan (2006) warns against lopsidedness: the need to link strategy with operations and not just be concerned with strategic ideas.

Exercising external (inter-organisational) influence through partnerships and networks is increasingly important for all types of organisations across all sectors and a key challenge for health professionals, managers and board members. This challenge is covered in more detail later in this chapter.

Task accomplishment is the fourth challenge in Leach and Wilson’s framework, and involves making sure the job gets done well once the vision or direction has been established. Strategic leaders have to ensure that this happens, mainly by working through others, rather than through micromanagement.

An ever-present challenge for leadership in healthcare is to create and chart the course for the achievement of organisational goals and objectives. From national performance targets (for example, treatment waiting times), to local priorities (for example, GP prescribing policy), effective leadership has to take account of the many contextual layers and mobilise support for both the approach and its implementation. This in itself will often require leaders to question the status quo, take thought-through risks and search for opportunities (Kouzes and Posner, 1995).

The nature of the challenges

A number of writers have distinguished different types of problem or challenge and argued that they call for different types of leadership. For example, Stewart (2001) distinguishes between ‘tame’ and ‘wicked’ problems (Rittel and Webber, 1973) in local government, and Grint (2005b) also draws on this distinction in his analysis of different types of leadership appropriate for different problems. ‘Tame’ problems include those that have been encountered before, for which known solutions

already exist, and which can be addressed by a particular organisation, profession or service. Tame problems may be complicated but they are potentially resolvable through existing practices. The leadership challenge is to make it happen. One example of a tame problem in the health service is the need to wash hands to prevent the spread of infection within hospitals. Everyone knows and agrees what needs to be done – the challenge is to make it happen in practice. By contrast, ‘wicked’ problems have no agreed diagnosis (different people may formulate the problem in different ways), the solutions are not fully known or agreed, yet there is pressure to resolve the problem in some way. Solving a wicked problem may throw up other challenges because the problems are cross-cutting and interrelated. Often, large groups of people have to contribute to solving the problem, through changing their behaviours. An example of a wicked problem is tackling the health issues of childhood obesity.

A similar distinction is made by Heifetz (1994, 2004), who distinguishes between ‘technical’ and ‘adaptive’ problems (equivalent to tame and wicked problems) faced by leaders. We examine these two approaches to challenges because they have major implications for leadership strategies, styles, processes and behaviours.

Grint’s typology introduces a third type of problem – a critical problem where immediate and urgent action is needed (for example, dealing with major road traffic injuries in the accident and emergency [A&E] department) and where the people involved in the crisis accept a command and control style of leadership in order to take urgent action, in a way which they would not if there were not a crisis.

Heifetz (1994) argues that technical problems, where the problem or task has been encountered before and the parameters are known, can be dealt with through technical leadership (Grint calls this management). It is the leadership required to bring together resources, people and schedules to deal with the challenge, sometimes in a project-based way. By contrast, adaptive problems (Grint calls these wicked problems) require a different kind of leadership in which the leader must refuse to collude with the fantasy that he or she has magic solutions to the problem and instead must persuade ‘followers’ that they may need to be involved in addressing the problem and may indeed be part of the problem as well as part of the solution. The leadership challenge in these circumstances is to confront the complexity of the problem and seek to orchestrate the work of a range of people to address it. The idea that different types of challenge may require different types of leadership is captured in Table 5.1.

Table 5.1: Types of problem and forms of authority

| Type of problem | Form of authority |
|--|---|
| <i>Tame problems (technical challenges):</i> Complicated but resolvable Likely to have occurred before Limited degree of uncertainty | <i>Manager:</i> Manager's role to provide the appropriate processes and resources to solve the problem |
| <i>Wicked problems (adaptive challenges):</i> Complex and often intractable Novel with no apparent solution Often generate more problems No right or wrong answer, just better or worse alternatives Huge degree of uncertainty | <i>Leader:</i> Leader's role to ask the right questions rather than provide the right answers, because answers may not be self-evident and are likely to require collaborative processes |
| <i>Critical problems:</i> A crisis situation Urgent response needed with little time for decision-making and action No uncertainty about what needs to be done | <i>Commander:</i> Commander's role to decisively provide the answer to the problem |

Source: Adapted from Grint (2005b)

While this framework is useful for leaders seeking to understand the nature of the problems or challenges they face, and how to employ different forms of authority to deal with them, Grint's (2005b) analysis suggests that leaders in decision-making mode may be inclined to legitimise their actions "on the basis of a persuasive account of the situation" (p 1475) rather than concluding that effective decision-making necessarily lies in the correct analysis of the situation. Providing a narrative to others that helps to define the situation (as a crisis or not, as tame or not and so on) is one element of leadership, and reinforces a challenge for leadership in both being able to read the context and also to constitute the context. This is not leadership responding to contingency, but leadership framing the reality as seen by others.

The constitutive and perceptual nature of the problem is also captured in the idea that a problem may be seen differently by different stakeholders. What is a crisis to a patient arriving at A&E may be a technical problem to the emergency team who have dealt with this kind of situation many times before. Part of the skill of leadership is in understanding how others frame the situation and then taking that framing into account.

The work of Heifetz (1994) is particularly relevant for thinking about the leadership of complex and cross-cutting problems, where neither the means nor the outcomes are clear or agreed upon. His

work is valuable not only in terms of framing and addressing the challenge, but also in terms of challenging the ways of working with various stakeholders involved in the problem – identifying the adaptive challenge; creating a safe but challenging holding environment; regulating the distress; maintaining disciplined attention; protecting the voices of leadership from below; moving continuously between the balcony and the battlefield – see later for detailed discussion of these. Benington and Turbitt (2007) have tested ways in which leaders can address complex or uncertain challenges using adaptive leadership in a very complex policing situation in Northern Ireland – the Drumcree demonstrations:

Heifetz's theory of adaptive leadership (Heifetz 1994) argues that a distinction needs to be made between technical problems (where there is a general agreement about the diagnosis of the problem, and about the nature of the action required to solve it) and adaptive problems (where there is uncertainty, confusion or disagreement about the nature of the problem, and about the action required to tackle it). He argues that adaptive problems require a different kind of leadership from the tackling of technical problems – leadership which rejects the pressure from followers to provide magical solutions to complex problems, and instead works with stakeholders to take responsibility for grappling with these problems and for the changes in one's own thinking and behaviour that are required. (pp 383–4)

Heifetz outlines a framework of seven principles for adaptive leadership:

- Identify the adaptive challenge – the leader needs to think hard about what the real underlying challenges are (which may not be the same as the presenting problem) and also whether the issues can be dealt with by technical or adaptive leadership. Adaptive leadership is indicated where changes in thinking and behaviour (including one's own) are required to grapple with difficult issues.
- Give the work back to the people faced by the problem – avoid the temptation to solve people's problems for them; engage them in the adaptive work and in their taking responsibility for their contribution to the problem and to the change process.
- Regulate the distress necessary for adaptive work. Heifetz notes that where levels of personal or social distress are very high, a society may reach for extreme or repressive measures to try to restore a sense of

order and control, although for an adaptive challenge this may not solve the problem. So authoritative action is likely to reduce distress while inaction will increase it. A wise leader will keep the level of distress in a range in which people can function effectively, paying attention to the issues but not getting overwhelmed – creating and maintaining sufficient heat to keep things cooking, but not so much heat that everything boils over and spoils. This may involve ‘cooking the conflict constructively’.

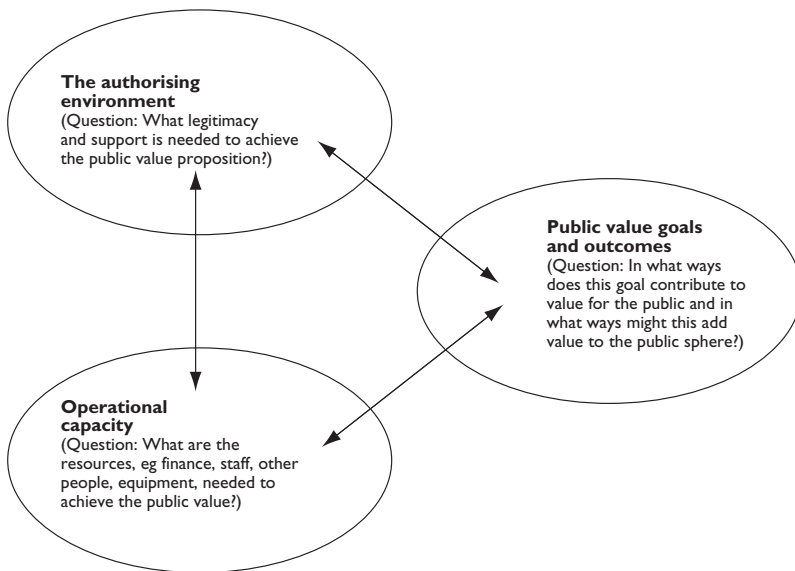
- Create a ‘holding environment’ in which the painful adaptive work can be done effectively; this can be a physical and/or a psychological space, providing both safety and also stretch and challenge. Heifetz (1994) defines the holding environment as “any relationship in which one party has the power to hold the attention of another party and facilitate adaptive work” (p 105). An adaptive leader needs to think carefully about the physical and psychological space in which adaptive work gets done.
- Maintain disciplined attention to the issues – recognise the seductions of work avoidance and other displacement activity (for example, dependency, projection, fight/flight), and relentlessly bring the focus back on to the primary task, which is the adaptive challenge.
- Protect the voices from below or outside – ensure that all perspectives and interests are considered, that minority viewpoints are taken into account, and that dominant views are questioned and challenged.
- Move continuously between the balcony and the dancefloor (or battlefield in Benington and Turbitt’s [2007] term) – in order to combine a helicopter overview of the whole situation and strategy with an understanding of the changing operational situation at the front-line. The balcony view enables the leader to see all the players on the battlefield and also to look out to the horizon to see longer-term issues. The front-line battlefield perspective gives a strong sense of what issues are like on the ground, and what they feel like for the players, which enables the leader to have greater empathy and understanding in order to regulate the distress and lead the adaptive challenge. It also enables the necessary linking of strategy and operations.

Not all problems require adaptive leadership and Heifetz recommends a different form of leadership (technical leadership) for problems that have familiar parameters (similar to Grint’s typology of tame problems). Heifetz’s work on leadership for adaptive problems is valuable because it is theory-based (working within a Tavistock-type ‘open-systems framework’) and because he sees the tasks of leadership as including

harnessing the commitment and work of the group(s) that are needed to solve the problem.

Moore (1995) describes the importance of public leaders and managers thinking carefully about and aligning three elements that are needed for a successful strategy to create public value outcomes. The three elements of his strategic triangle are public value goals and outcomes (what is the value proposition in terms of adding value to the public sphere; and what does the public most value?); commitment from the 'authorising environment' (have the stakeholders who are necessary to provide or withhold legitimacy and/or support of the public value proposition been mobilised?); and operational resources (are the necessary resources of money, people, skills, technology and equipment aligned behind the public value outcomes?). This is shown in Figure 5.3.

Figure 5.3: The strategic triangle for public managers



Source: Adapted from Moore (1995)

There are therefore a number of difficult challenges to be juggled by senior healthcare leaders. At a formal, senior level, the leadership role of the chief executive as a non-medical manager responsible for managing an organisation with multilayered and multi-professional responsibilities is complex. According to Blackler and Kennedy (2004):

[Chief executives] are responsible to government both for the finances and for the clinical performance of their organizations; they must enact national priorities for healthcare and lead local change programmes; develop good working relations with the many professional groups working in their organizations; work with the chair of their board; build relationships with relevant local agencies to develop services for the public and generally foster public confidence in the NHS in line with governmental imperatives. (p 182)

These tasks can be reformulated, in Moore's terms, as being about framing the public value proposition, gaining sufficient legitimacy and support for the approach, and mobilising operational resources (from both within and outside the organisation, through partnerships and networks).

Challenges at the organisational and inter-organisational levels in healthcare

Having looked at how challenges are constituted and framed, we now turn to examine particular tasks/challenges in relation to healthcare improvement, innovation and change. For leaders at every level in the NHS perhaps the biggest challenge is the pace of systemic and organisational change, so here we examine several challenges of organisational and cultural change that are highly relevant in the healthcare field:

- organisational mergers and acquisitions;
- networked or partnership organisational arrangements;
- leading organisations out of failure;
- organisational change, innovation and improvement;
- nurturing future leaders.

The merger/acquisition challenge

The NHS has been through significant mergers (for example, Primary Care Trusts and Strategic Health Authorities) in order to gain claimed efficiencies and to achieve coterminosity with the boundaries of local authorities and the Government Offices of the Regions in England. Research by Dickinson et al (2006) on private sector mergers and their applicability to healthcare has suggested that organisational transition

at a time of merger requires particular types of leadership in different phases of the transition period. These are shown in Table 5.2.

Table 5.2: Leadership type related to merger phase

| Merger phase | Leadership type |
|----------------------------|--|
| Action pre-merger decision | Transactional: Assess/audit the culture of each of the merging organisations and use this knowledge as part of a careful strategy for highlighting and recognising the differences between the organisations |
| Decision to merge | Transformational: Create and communicate a vision that sets out the purpose of the transition in an open and participatory manner |
| During merger process | Transactional: Provide resources to support the change process for staff Manage the human resource and make this your main activity Communicate the changes and latest developments relentlessly Set up clear transitional structures incorporating senior people that enact the transition promptly Attend to sense-making, help staff understand the implications of change |
| Post-merger | Transactional: Measure the impact of the transition both in relation to transition objectives and other measures – do this for at least three years |

Source: Adapted from Dickinson et al (2006)

This research suggests that both transformational leadership (inspiring, transforming) and transactional leadership (practical, operational) need to be used at different stages of the merger transition but that, on balance and perhaps counter-intuitively, a transactional style is the most crucial. (Transformational and transactional leadership types are covered in greater detail in Chapter 6.)

There are, however, particular issues that leaders need to take account of in the merger of NHS organisations that distinguish them from organisations in the private sector. Table 5.3 outlines some of these differences.

In a study of two hospital mergers in Quebec, Denis et al (2001) highlight the challenges posed for leaders in change situations that have been imposed by government and that are often highly contested. They note that:

the challenge of the mergers was not simply one of governance.... Each merger involved the rationalization of activities among the three sites, thus requiring ‘micromergers’ between myriad clinical services currently operating separately and demanding the fundamental transformation of the mission of some or all of the sites.... Thus, besides maintaining three operating institutions and learning to work collaboratively with former rivals, the leaders had to implement fundamental, [radical] change [which questioned the nature, existence and boundaries of the organization]. (p 828)

Table 5.3: Merger asymmetries between the NHS and the private sector

| Private sector | NHS |
|--|--|
| Acknowledged transition merger process | Merger regarded as closing one organisation and opening another |
| Potential merger organisations make a choice based on pre-merger assessment and planning | No choice of merger organisation |
| Possibility of demerging | No possibility of demerging |
| Organisational differences acknowledged and desirable | Organisational differences not acknowledged |
| Research shows that mergers do not achieve efficiencies | Belief that merged organisations achieve efficiencies |
| Focus on merging provider organisations | Focus on merging demand-side organisations |
| Research shows it takes at least three years for performance to recover after a merger | Mergers tend to follow at about three-year intervals |
| Empowered providers organise and carve up the system | Commissioning is a weak tool further weakened by reorganisation |
| Merger processes led by the organisation’s board and its directors | NHS merger processes led ‘remotely’ by politicians |
| Communication (especially with staff) acknowledged as key to successful merger | NHS poor at communication |
| Early indications from human resource management that give ‘psychological safety’ to staff paramount | NHS human resource management processes lead to great uncertainty |
| The aims of mergers are rarely met | Mergers seen by politicians and policy-makers as a way of achieving policy goals |
| Mergers are a distraction with negative unanticipated consequences | Front-line staff behaviour is rarely changed as a result of a merger |

Source: Adapted from Dickinson et al (2006)

Denis et al conclude that the 'leadership constellation' formed by the integrated board and leadership team for each merger situation needs to reflect the strengths and weaknesses of the historical legacy and 'imprint' of the merging organisations as well as take account of the climate within which the merger is taking place (for example, the degree of political pressure in the external environment and/or opposition to change within the internal organisation). They also suggest that imposed merger situations require transactional leaders able to negotiate and make compromises between different interests and positions rather than the transformational leadership that may be more effective when leading a unified team.

The challenge of leading networked and partnership organisations

Denis et al (2001) explore the strategic challenge for healthcare leaders in 'pluralistic' contexts, where there are diverse interests and priorities within and between partners, and where leadership roles are shared, objectives are divergent and power is diffuse. Their analysis highlights four aspects of strategic leadership in networks and partnerships, emphasising that such leadership needs to be concerned with the network system as a whole. These are shown in Table 5.4.

The researchers concluded that strategic leadership in pluralistic organisations is more likely to be established under unified collective leadership but that this is always fragile in the context of diffuse power. The leadership challenge here is to stabilise the collective leadership as much as possible to prevent it being shattered by internal rivalry (strategic uncoupling), dislocation from the focal organisation (organisational uncoupling) or lack of adaptation to environmental needs (environmental uncoupling). This is an issue that many 'managed clinical networks' are grappling with in the UK.

Alexander et al (2001) also address the issue of collaborative leadership in relation to community health partnerships. They conceptualise collaborative leadership around five mutually reinforcing themes:

- Systems thinking: developing a sound working knowledge of how organisational systems interrelate and affect health at the community level, while also taking into account the big picture.
- Vision-based leadership: communicating a values-based envisioned future, mobilising resources and guiding action towards long-term aims, particularly with key stakeholder groups.

- Collateral leadership: broad-based leadership across the partnership with contributions from partnership staff, organisational representatives and advocates for particular community segments.
- Power sharing: to set priorities, allocate resources and evaluate performance in order to foster a sense of joint ownership and collective responsibility.
- Process-based leadership: translating substantive leadership into action through effective communication mechanisms and good interpersonal skills.

Table 5.4: Aspects of strategic leadership in networks and partnerships

| Strategic leadership model | Elements |
|----------------------------|--|
| Collective | Strategic leadership requires contributions from more than a single individual Different individuals contribute in different ways to strategic leadership Recognition of diffuse power, for example, professionals and external agencies Embodied in 'leadership role constellation' or 'top management team' Complementary roles to allow all to contribute in a concerted manner |
| Action/process oriented | Focus on the actions of people in leadership positions rather than on personality traits Significance of influencing/mobilising others through tactical action |
| Dynamic | Leadership participants, roles and influences evolve over time Importance of construction, deconstruction and reconstruction of leadership roles Recognition of mutual influence of action and context Significance of the effects of leaders' actions on the organisation, allocation of resources and distribution of power |
| Supra-organisational | Leadership roles and influences on them extend beyond organisational boundaries Consideration of external influences such as government funding, community, public and political pressures |

Source: Denis et al (2001)

Alexander et al's research identifies three challenges that may confront leaders in partnership situations where participation is voluntary. These are set out in Table 5. 5.

Table 5.5: Challenges for collaborative leadership

| Leadership challenge | Constraints, trade-offs and conflicts |
|--------------------------|--|
| Continuity versus change | Striking the right balance between maintaining experienced leadership and infusing new leadership into the partnership |
| Leadership development | Identification of potential leaders, including those within the community but the need to expend considerable effort to orientate them towards the purposes of the partnership and to invite, coach and encourage them to be leaders |
| Power and participation | Power sharing through 'neutral' leadership that fosters equal voice and representation among all partners and/or 'equity-based' leadership that reflects the financial contribution of partnership members |

Source: Adapted from Alexander et al (2001)

The challenge of turnaround and leading organisations out of failure

The UK government's emphasis on performance improvement in public services in the UK, combined with easier and wider access to performance metrics, has made organisational failure both more important and more visible.

Leading organisations out of failure and creating turnaround is a distinctive leadership challenge. Jas and Skelcher (2005) analysed performance turnaround across local government. Like the health service, local government is subject to very public scrutiny of its performance. They found that performance was cyclical (some of the organisations that were deemed by central government to have failed had had very high or very innovative performance in the past). Where awareness of performance decline was absent and where there was low leadership capability, the organisation failed to initiate its own recovery strategy and action, and this led to more authoritarian intervention from central government and its agencies. They also found that building or re-establishing leadership capability required both political and managerial senior leaders to overcome the inertia of failure and to regenerate collective belief across the organisation in

its ability to solve its own problems. This suggests that leadership at all levels in the organisation is critical to creating the rapid and major leap forward from what is seen to be failure.

Other authors have examined the choices of turnaround strategies by leaders of healthcare and other organisations, comparing them with the strategies available to the private sector (Boyne, 2004, 2008; Walshe et al, 2004). Boyne (2008) found that turnaround from what had been deemed as failing organisations in health, local government, schools, fire, police and prison services was influenced by the pre-existing context (for example, local deprivation), but also by the ability of the organisational leadership to convince inspectors that appropriate activities had been undertaken and the 'right' systems introduced to create rapid improvement (in other words legitimisation in addition to improvement). The leadership challenge is both to face inwards to the organisation to build leadership capacity, and also outwards to manage the reputation of the organisation with key stakeholders.

The challenge of leading change, innovation and improvement

The leadership challenge of developing and sustaining innovation and improvement in healthcare delivery occurs at all levels of the system. Reform, service redesign, re-engineering, improving patient safety and quality, and innovation initiatives may focus on particular techniques and ways of building commitment to sustain cultural change. Nurse managers, doctors and other health professionals, and administrators, as well as senior managers, can all find themselves leading reform and redesign initiatives or aspects of these in projects or programmes of organisational and cultural change.

Research tracking the changing role and responsibilities of nurse leaders in 1993 and 1995, through the American Organization of Nurse Executives network (Gelinas and Manthey, 1997), suggested that organisational redesign had a substantial impact as the US healthcare system shifted from a service for the sick to a service to achieve health, and with a more client-centred, market-responsive structure that required flexible clinical teams. This brought with it different and greater expectations of nurse leaders. The researchers reflect that service redesign often had the following characteristics, suggesting a shift of priorities towards continuity and quality of healthcare, rather than simple cost-cutting exercises:

- integration/coordination across departmental lines;
- critical path/care-protocol development;

- management restructuring;
- multiskilled worker development;
- patient-focused care implementation;
- case management implementation.

Such changes resulted in nurse leaders focusing much more on team-building skills across departmental boundaries, deploying multiskilled workers, as clinical practice was consciously improved. The researchers found that nurse leaders have a critical role in redesign initiatives, with most respondents in the research reporting involvement in both initiation and implementation (although it can be noted that this was as self-reported). Many nurse leaders also found themselves in different reporting relationships and with different formal titles, reflecting a broader role with responsibility for patient care. In most redesign situations, nurse leaders found themselves being required to lead new operational configurations, while reducing costs and also maintaining or improving the quality of care. The challenge here was summarised as the need for nurse leaders to understand how to:

- lead across cultural, functional and departmental boundaries;
- promote teamwork and build and maintain effective teams;
- manage personal growth by objectively challenging their own behaviours and beliefs;
- promote the continued development of the nursing profession in an integrated patient care environment;
- tolerate ambiguity and change.

This research suggests a complex role for nurse leaders:

Leading clinical improvement across the continuum of care, facilitating integration of clinical services, working effectively with other clinical leaders and ensuring organizational success, are just some of the challenges for current nurse leaders. (Gelinis and Manthey, 1997, p 42)

However, other research carried out in New Zealand found that nurses were not reaching their potential as transformational leaders of organisational redesign due to cultural and social factors in the organisation, linked to traditional, rather limited, conceptions of the nursing role that effectively limited or repressed leadership in the new context (Kan and Parry, 2004). Leadership interacts with the internal

organisational context, including its culture, creating both opportunities and constraints.

Systems re-engineering is one major means by which efficiency and improvement in healthcare delivery are striven for. Senior leaders clearly have a critical role to play and need to be equipped to face the challenge. Indeed, lack of effective leadership, including the accurate diagnosis of existing organisational conditions and cultural support for change, has been cited as a primary cause for failure of re-engineering in healthcare (McNulty and Ferlie, 2004).

Guo (2004) suggests that the role of the leader in healthcare re-engineering has four elements that are mutually reinforcing in a cyclical process, as shown in Table 5.6.

Table 5.6: The role of leadership in healthcare re-engineering

| Element | Key questions |
|---|--|
| Examination – of the healthcare organisation and its environment | <ul style="list-style-type: none"> Timing for the re-engineering process Market challenges and opportunities Organisational strengths and weaknesses Purpose of the organisation Future direction of the organisation Outcomes of the organisation |
| Establishment – of a long-term strategic plan to determine the direction of the organisation as it deals with the complexities in the environment | <ul style="list-style-type: none"> Quality Customer satisfaction Cost-effectiveness Improved work environment for employees Realistic goals, timeline and budget Organisational culture and values |
| Execution – of the strategic plan | <ul style="list-style-type: none"> Allocation of resources (financial, human, capital) Redefinition of roles and responsibilities Managing conflict Education, training of managers and staff Communication and coordination of work efforts |
| Evaluation – of desired and unintended outcomes | <ul style="list-style-type: none"> Reach desired outcomes Effective change for the organisation Continuous feedback to make adjustments Periodic review for more responsive organisation Cooperation, integrated and empowered organisation |

Source: Adapted from Guo (2004)

Turning now to consider innovation, a number of writers have argued that, for both the public and the private sectors, innovation is distinct from continuous improvement as a strategy to achieve performance improvement. Innovation may or may not result in performance improvement. Innovation is most usefully seen as a step-change rather than as continuous improvement (Albury, 2005; Hartley, 2005; Osborne and Brown, 2005). The leadership of innovation is likely to be different from the leadership of continuous improvement because the scale and scope of change are different and therefore projects and people may need to be led and managed quite differently.

The particular challenge of the leadership of innovation is the need to be creative and to encourage creativity in others in order to solve problems and generate the energy and enthusiasm needed to overcome inertia (Isaksen and Tidd, 2006). Leadership involves acting as facilitators and educators for change, working to create an environment of 'psychological safety' that fosters risk taking and opportunism, and supports others to learn and adapt their behaviour. Adaptive leadership (Heifetz, 1994) may be one approach to enable others to take ownership of and successfully manage innovation.

The diffusion of innovation is particularly relevant to public service organisations, because many of the benefits of innovation are accrued in terms of policy change at the institutional or sectoral level, in addition to the individual organisational level (Hartley, 2008, 2010c). If a local innovation improves healthcare, there is value in spreading that practice across healthcare organisations rather than the originating organisation protecting its intellectual property. So leadership to support the spread of good or promising practices, through the diffusion of innovation and broader change, is highly relevant to healthcare organisations (Kimberly and de Pouvourville, 1993; Buchanan et al, 2007; Hartley and Rashman, 2007). Such leadership is necessary at both corporate level and at service or team level.

There are many elements in the leadership of organisational and cultural change. Given that change is an ongoing dynamic in organisations, it is an ongoing challenge, or purpose, for leadership at a number of levels in the organisation. Some writers have noted that a key challenge for top organisational leaders is to shape organisational design, organisational culture and the distribution of resources (Senge, 1994; Schein, 2004; Goodwin, 2006). Such leaders, therefore, design the social architecture: "They are responsible for the governing ideas underpinning the policies, strategies and structures which guide business decisions and actions and help build a shared vision" (Munshi

et al, 2005, p 12). While this statement was written about the private sector, it is equally relevant for healthcare organisations.

As well as influencing structure, leaders may also have a significant impact on organisational culture. This has been widely reported from the seminal work of Schein (2004) onwards. However, writers vary in how far they see organisations as having a single integrated culture; how far they see a set of subcultures coexisting or competing within the organisation; and how far the sheer size and complexity of large, contemporary organisations means that it is hard to talk about managing or shaping culture in any meaningful way (Parry and Bryman, 2006).

There are many definitions of organisational culture. A useful one is from Schein (1992, p 12):

A pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems.

The concept of organisational culture is valuable because it reminds the leader that ‘message sent’ may not be the same as ‘message received’. Hatch cautions the leader:

Do not think of trying to manage culture. Other people’s meanings and interpretations are highly unmanageable. Think instead of trying to culturally manage your organization, i.e., manage your organization with cultural awareness of the multiplicity of meanings that will be made of you and your efforts. (Hatch, 1997, p 234)

In supporting change and innovation, there is a task for leadership to create a climate, or culture, which encourages learning from failure as well as from success. Often the ultimate challenge is for leaders to be able to acknowledge defeat in achieving change and innovation! In healthcare systems, one major criticism has been the lack of learning from previous initiatives and the need for leadership to be more reflective. Edmondson (2004) suggests that hospitals do not learn from failure for two reasons. First, because the interpersonal climate at the front-line with patients (reinforced by the professional traditions of medicine) may inhibit questioning and challenge; and, second, because the work design features of hospitals tend towards quick-fix solutions

to problems rather than root cause analysis and systematic problem-solving. Other research points to the value of learning from mistakes and unsuccessful attempts at change, as well as learning from successes (Bate and Robert, 2002; Rashman and Hartley, 2002).

The challenge of nurturing future leaders

Some writers also remind us that a further challenge is not only the immediate purpose of goal accomplishment but also building up leadership capacity and capability by nurturing the next generation of leaders and creating a learning approach to leadership (for example, Fullan, 2001; Burke, 2006a). It is about embedding leadership as an integral part of the organisation (Huff and Moeslein, 2004) and fostering the next generation of leaders, both individually through informal coaching and support and formally through leadership development initiatives. Some have called this building a 'leadership engine' (Tichy and Cohen, 1997). This occurs where leaders are seen to occur at all levels of the organisation and where a key role of leadership is actively to develop future generations of leaders, according to Tichy and Cohen (1997). This is about conceptualising the organisation as a system that produces leaders as part of its activities, thereby ensuring long-term capacity and adaptability for the organisation. Many organisations pay insufficient attention to this, either formally through human resource systems or informally through fostering a climate of learning and development for potential leaders.

Policy and practice implications:

- Challenges are partly made not given. A constitutive approach to thinking about the purposes of leadership in any particular context is about the active framing of what the problem is and how it might be addressed.
- Complex change in an uncertain world can only be partly predicted and planned for. Big picture sense-making is an important element of deciding how to address a challenge, or set of challenges. Also important are the challenges of delivering change, and representing the organisation to other stakeholders.
- A key distinction has been made between 'tame' and 'wicked' problems, also described as technical or adaptive problems. The leadership of each type of problem requires different strategies. In the first case, leadership is about bringing together the appropriate skills and resources to tackle a known or solvable problem. The second case involves a complex problem, where neither

the causes nor the solutions to the problem are known or agreed. The task of the leader in this case is to orchestrate other people both to recognise their part in the problem and to address ways of tackling the problem together. This can be pressurising for the leader, where the group may want the leader to solve the problem for them, but Heifetz's seven principles (see pp 58-9 above) may help to keep the attention on the problem and promote necessary adaptations in thinking and behaviour.

- Mark Moore's strategic triangle is one means by which healthcare leaders can frame their approach to adaptive problems, by thinking about what is the public value to be created, who can be mobilised to legitimate or support that course of action and how to align operational resources of finance, staff and equipment behind these goals.
- Many of the challenges for healthcare leaders, at whatever level, are to do with bringing about change, whether through mergers, through service redesign, turnaround, or innovation and improvement. Thinking through what the purposes and outcomes are that the leadership is pursuing is helpful.
- Styles or types of leadership will need to vary with the purposes being pursued at any phase of the organisational change. For example, transactional and transformational leadership styles are both relevant at different phases of merger/acquisition.
- Complex organisational change may also be made more effective by relying on a 'leadership constellation' not just an individual leader.
- The leadership challenges of working in networks and partnerships are complex because leadership is generally fragile in conditions of diffuse power. The leadership challenge is to prevent internal rivalry, dislocation from the focal organisation and lack of adaptation to environmental needs.
- Managing turnaround requires the building of leadership capacity and the use of legitimising actions (to maintain the support of external stakeholders) as well as internal activity to overcome inertia and generate confidence to improve.
- Organisational change and improvement is the task of all kinds of formal and informal leaders in the workplace. Some may be constrained by role expectations and organisational culture, suggesting that such changes need to be whole-system approaches.
- Innovation and improvement are different in scope and scale and may require different types of leadership. Innovation requires leaders to empower others to be creative and they have a key role in creating an organisational climate with psychological safety.
- A further challenge for leaders (and one easily squeezed out by other pressures but nevertheless very important) is nurturing future leadership talent so that leaders actively develop future generations of leaders.

