Chapter Title: The contexts of leadership

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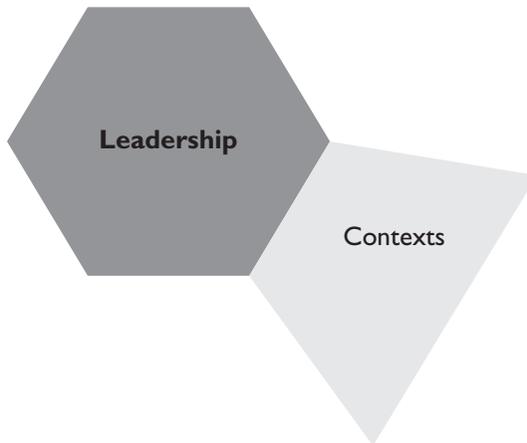
The contexts of leadership

In this chapter:

What is 'context' and why is it important for leadership? This chapter examines the interactions between context and leadership, in terms of three layers: the public policy context of healthcare; the local strategic context (including working in partnerships); and the internal, organisational context. Context is relevant for leaders in several ways. It provides the constraints on and opportunities for action, and so a key skill for leaders is being able to 'read' the context. They also may shape the context in some situations and articulate and make sense of the context for other people.

An important strand of thinking in leadership studies is the relationship between what leaders do and the context in which they do it. First, how does leadership vary according to different contexts? Second, how can and do leaders shape the context in which they operate?

It is widely agreed that leadership is related to, or contingent on, context and that a key prerequisite of effective leadership is the ability

Figure 4.1: The contexts of leadership

to understand that context. Theorists have looked at this from a number of perspectives, exploring both the influence of contextual factors on leadership, and the influence of leadership in shaping context. However, there is much less work than might be expected on this crucial set of interactions between leadership and context. Porter and McLaughlin (2006) review the theoretical and empirical knowledge about leadership and the organisational context (across all types of organisation) and conclude that there is little research that takes context into account as an analytical factor, rather than simply as part of the description of the location of a particular leadership case or situation. They argue for much more rigorous and systematic attention to understanding the impact of context on leadership and vice versa (see also Osborn et al, 2002). Grint (2000) thinks this issue of context is so important that he classifies theories about leadership according to the degree to which they pay attention to, or ignore, context as an aspect of leadership.

Goodwin (2006), writing about healthcare, observes that research has tended to focus on leadership as a determinant in shaping context, rather than vice versa – on political, economic, social and organisational context as determinants of leadership choices and styles.

Early work on leadership was influential in understanding how leadership varied by context, and the extent to which leadership was effective in its matching of leadership style to context (Fiedler, 1967; House and Dessler, 1974). Fiedler's work suggested that different leadership styles are more effective depending upon the level of control that a leader has in a situation. A leader with a 'task-orientation' can be most effective in circumstances of extremely high or low situational control, while a leader with a 'people-orientation' would be most effective in circumstances of moderate situational control. In other words, the leader should modify their style according to how much control they have over the situation they and the group are in.

This suggests that one key leadership skill is the ability to read different contexts and respond appropriately (Hartley et al, 2007; Hartley and Fletcher, 2008). Situational analysis by the leader or leadership team/ group is a key component in ensuring that the leadership strategy and style are aligned to the context. (This includes the nature of the leadership challenge, or purpose, which is covered in Chapter 5.) Alignment might be achieved in two ways. The first is by selecting particular leaders for particular contexts (for example, in Chapter 5 we examine how different leadership styles are useful in early stages compared with late stages of merger in healthcare). The second way is to encourage a leader to learn to be versatile, that is to adapt their style to the particular context. Different situations demand different leadership

approaches, and a leader who can adapt to changing contextual factors is more likely to be regarded as competent (and therefore effective) than one who has a rigid, inflexible approach (Buchanan, 2003).

Reading the context includes being able to take an overview of the external and internal conditions and opportunities, and also being able to move between "the balcony and the battlefield" (Benington and Turbitt, 2007, p 384). This involves the ability to link the strategic big picture with the operational detail. Part of the skill lies in being able to sense the 'soft' points in the political, organisational or partnership context where the leader's priorities can be taken forward without provoking stubborn opposition (Leach et al, 2005).

Contingent or situational leadership perspectives acknowledge that leadership is carried out in a variety of dynamic situations with numerous contextual variables to take into account. In helping us to understand and explain effective leadership, theories which suggest that leadership is contingent on context are therefore only helpful up to a point. Yukl (2006) for example, suggests that "contingency theories do not provide sufficient guidance in the form of general principles to help managers recognize the underlying leadership requirements and choices in the myriad of fragmented activities and problems confronting them" (p 240).

Grint (2005b) goes a step further in discussing the interaction between leadership and context to argue that effective leaders not only shape the softer elements of context but also work to constitute the context. This 'constitutive' approach to leadership argues that leaders have a key role in making sense of the context and defining reality for those they are trying to influence. So, how they define a situation and frame it for others is a key element of leadership (see also Hartley, 2002a; Leach et al, 2005). We explore this 'sense-making' aspect of leadership as a crucial challenge in more detail in Chapter 5. Its relationship to the context is important.

Turning to the healthcare literature specifically, we found little on the impact of context on leadership. Reviews of the relationship between context and leadership hardly touched on the healthcare field (Porter and McLaughlin, 2006). However, the idea that the interaction of leaders with their organisational and external context is a critical element in achieving effective change and improvement is increasingly recognised.

Layers of context

We suggest that leadership in healthcare can be thought of as being situated within three 'layers of context'. Of course, the boundaries

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between the layers are blurred, and some aspects of context may be evident at more than one layer. We outline this mapping of context in Table 4.1.

Table 4.1: Layers of context in healthcare

Context	Focus
National political and public policy context	External political and policy environment
Regional and local context	Intermediate NHS 'system' at the level of the regional/local health economy
Internal organisational context	Internal organisational structure, culture, history, size, geography and resources

Layers of context are likely to be dynamic and changing. Leadership within healthcare organisations does not operate within a static context but rather needs to take account of fluctuations in public policy, political change and the organisation's performance level (and capacity for improvement).

Many writers on change management have argued that environmental or contextual volatility is a key factor to be taken into account in leading successful organisations, acknowledging that the structures and practices appropriate in stable conditions are not always fit for purpose in more unpredictable times (Dunphy and Stace, 1993; Greenwood and Hinings, 1996; Scott, 2001).

Whole-systems thinking is helpful to understand how these layers of context are part of an interconnected system of complex networks rather than mechanical and linear cause–and–effect relationships. Iles and Sutherland (2001) highlight the key points of understanding a complex and open system as:

- being made up of related and interdependent parts so that any system must be viewed as a whole;
- a system that should not be considered in isolation from its environment;
- being in equilibrium, which will only change if some type of energy is applied;
- comprising different players who will have different views of the system function and purpose.

In addition, they note that human activity systems are characterised by frequently multiple and often conflicting objectives.

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It is helpful to take a systems view of the context of healthcare, with its myriad influences on any particular healthcare organisation and thus on the leadership in and of that organisation. Leadership theory is increasingly taking account of whole-systems thinking and analysis (for example, Wheatley, 1992; Marion and Uhl-Bien, 2001; Benington and Hartley, 2009; Uhl-Bien and Marion, 2009).

The national public policy context

National healthcare systems can be said to be 'context heavy'. They are necessarily affected by political, economic and social factors from the wider society. Chapter 1 outlined some of the pressures on health organisations and health economies of changes in health needs, public expectations, financial provision and so on. For example, increased consumer expectations alongside medical-technological advances and an ageing population have put increasing pressure on scarce resources for healthcare. The importance of preventative strategies and the promotion of health rather than expanding remedial responses to sickness is prompting new ways of thinking about healthcare provision in the UK. Political imperatives to meet increased demand and also achieve value for money and promote efficiencies have led to measures to foster innovation and improvement in healthcare (for example, to improve quality, safety, speed and efficiency in the provision of services). The role of central government in driving change through legislation, statutory guidance, financial control and performance measurement is a dominant contextual factor.

In England, *The NHS Plan* (DH, 2000) set the framework for modernising the NHS over a 10-year period and this has been followed up with the Darzi review and report (DH, 2008). These documents provide an ambitious national strategy, with a vision for healthcare designed around the needs of patients and with increased local responsibility and accountability for meeting nationally set quality and performance standards. The leadership challenge is explicitly to transform services in order to improve, and create step-change through innovation. The financial crisis and predictions of reduced public expenditure from 2011 onwards create further challenges to 'do more with less' while maintaining quality and safety.

Leaders in healthcare thus have to operate within a context and a system in almost constant flux, including:

- the creation of independent Foundation Trust hospitals with governors elected from the hospital membership;

- the drive to increase capacity within healthcare services through the voluntary sector, independent service providers and community enterprises;
- the reconfiguration of Primary Care Trusts (PCTs), resulting in a smaller number of PCTs generally aligned to local authority boundaries;
- the local commissioning of services by PCTs and GPs;
- the introduction of increased patient choice of services, for example, the 'choose and book' appointments system;
- a stringent regime of national performance targets, with central government intervention for underperforming organisations;
- a greater emphasis on innovation and continuous improvement in healthcare and in healthcare management;
- greater local accountability to councillors of the local authority through new health overview and scrutiny committees;
- increasing financial pressures after an extended period of growth in healthcare funding.

All these factors result, or will result, in a significantly changed context for leadership in healthcare. Understanding where and how leadership operates within such a complex context is an important prerequisite for success. In his study of NHS chief executives, Blackler (2006) records the pressures that health service chief executives were subject to as "conduits for the policies of the centre" (p 5) rather than providing the scope to help lead the reform of the NHS. He reports NHS chief executives "having to function in an increasingly rigid hierarchy in which there was a lot of fear", suggesting that they "needed to ignore uncertainties, were being forced to impose centrally determined priorities on their staff and were being held personally responsible for performance outcomes". His conclusion that "the popular image of empowered, proactive leaders has little relevance to the work of the NHS chief executive" (p 15) underlines the central role of national government in shaping the context in which chief executives exercise leadership.

Goodwin (2000) acknowledges the impact of the wider political environment on leaders in the NHS, pointing out the importance of external relationships and inter-organisational networking in helping to counterbalance local priorities against the "backcloth of national, government determined aims for public services" (p 56) and suggesting that future leaders "will have to be dependent not only upon establishing a successful partnership with politicians and professionals

but also achieving greater inter-organisational collaboration by transcending traditional organizational boundaries" (p 58).

These national policies and their local impacts increase the challenge facing leadership to achieve sustainable and substantial change. This is a significant element of the context for leadership in healthcare. The *Next stage review* (DH, 2008) acknowledges the problems that have been engendered in earlier stages of recent restructurings and other changes in the NHS system, and aims to address this, in part by strengthening clinical and non-clinical leadership.

The regional and local context

A further layer of context is that of the regional or local healthcare system. 'Reading the context' at this level involves two key elements. The first is how to interpret the complex interrelationships at the regional/local level, and the second is how to lead effectively in this context.

Public policy has been in almost continuous system change over recent years with the introduction of different forms of organisational governance, merged organisations and an increased emphasis on interdisciplinary and inter-organisational service delivery. Systems thinking is helpful in understanding how to lead in this context of complex networks of organisations interrelating, collaborating and competing to provide healthcare. There is increasing interest in how a systems approach may be helpful in understanding the NHS and its network of other private, public and voluntary sector providers of health and social care (Iles and Sutherland, 2001). A systems approach for healthcare involves:

- an awareness of the multifactoral issues involved in healthcare, which mean that complex health and social problems lie beyond the ability of any one practitioner, team or agency to address;
- interest in designing, planning and managing organisations as dynamic, interdependent systems committed to providing 'seamless care' for patients;
- recognition of the need to develop shared values, purposes and practices within and between organisations;
- use of large group interventions to bring together the perspectives of a wide range of stakeholders across the whole healthcare system.

Leadership frameworks need to take account of the increases in the interrelationships between organisations, through networking, joint

ventures and strategic alliances, and the greater impacts that stakeholders such as lobby and campaigning groups may have on organisations in the private, public and voluntary sectors (Hartley and Fletcher, 2008). Selznick (1957, p 23) argued that "the theory of leadership is dependent on the theory of organization". This means that as theories of organisations change, then theories of leadership need to change as well. Leadership that is able to influence not only colleagues and subordinates, but also a range of stakeholders and networks in the private, public and voluntary sectors is becoming increasingly important.

A number of commentators have noted the increasing use of inter-professional and inter-organisational networks and partnerships in the public service sector for the achievement of service outcomes (Benington, 2000, 2001; Stoker, 2006). However, as Goodwin (2006) notes, while the value of networks in healthcare is discussed, the amount of research is actually very low. Some discussion is in adulatory terms, but Benington (2001) has argued that while networks and partnerships have the advantages of flexibility and adaptability, they also have disadvantages in terms of 'steering' and accountability. Others have noted that as well as there being 'collaborative advantage' there can also be collaborative disadvantage (Huxham and Vangen, 2000).

The analysis of networks suggests that this is an important aspect of healthcare leadership, but that there is still insufficient research both on the processes and outcomes of networks, let alone the implications for leadership and leadership skills.

The context at this intermediate regional and local level is one of interrelationships between a complex network of commissioners, providers, regulators, opinion-formers and advocacy groups. The network may also include those organisations whose activities have an impact on public health and on community healthcare, such as the local authority, the police and the voluntary sector. There is a need for leadership to focus on system design and also on organisational and inter-organisational development. This becomes particularly relevant in the newer context of 'world-class commissioning'.

Some research (Mintzberg, 1978; McDaniel, 1997; Salaroo and Burnes, 1998) suggests that approaches to leadership and management need to be different where the context is a dynamic rather than stable environment. So leaders may need to adapt their style to different contexts of system change and also to the different kinds of challenges that are encountered. For example, different leadership styles may be more effective at different phases of a merger (further details in Chapter 5 on the challenges of leadership), that is, shifting the leadership

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approach according to the external or internal context during the change process (Dickinson et al, 2006).

The internal organisational context

Leadership in healthcare also takes place, of course, within discrete organisations (such as hospitals, GP practices, PCTs). From an organisational perspective, this is the internal context. Organisational context here refers to aspects of geographical location, history, size, structure, culture, staffing, skills and resources. The internal environment of the organisation will offer both strengths and weaknesses in relation to the leadership challenges, and as such is an important part of the context for the leader to 'read' and understand.

Brazier's (2005) review of the literature on the influence of organisational contextual factors on healthcare leadership focuses on the power and influence of leaders and their capacity to encourage creativity and innovation. She concludes that bureaucratic organisations can be the most inhibiting for innovation, tending to foster transactional leadership approaches. Hierarchical structures, high staff turnover and tightly controlled resources are most likely to stifle creativity and innovation. On the other hand, she found that organic structures (that is, with high levels of lateral communications, a relatively flat hierarchy, with work teams brought together flexibly to deal with tasks and with decentralisation of decision-making – Burns and Stalker, 1994) facilitate a more transformational leadership approach.

In a study of the contribution of leadership to sustained organisational success in NHS Foundation Trusts, Bailey and Burr (2005) examined the extent to which organisational history and inherited organisational capabilities (which they termed 'legacy') are a significant factor. They define 'legacy' as the long-term impact of eight performance-critical organisational elements:

* the structure of the trust
* the prevailing culture
* technological capability
* operational capability
* quality of staff
* clinical reputation
* strategic relationships
* strategy.

They suggest that effective leadership both builds on and works with the organisational legacy. In other words, leadership rarely starts from scratch but has to work with the existing internal context.

Scott et al (2003) and Mannion et al (2005) highlighted inadequate or inappropriate leadership as a key factor that may impede cultural change within healthcare organisations. These studies stress the importance for leadership of assessing the alignment between organisational culture and the wider environment, including possible 'cultural lag' or 'strategic drift' in achieving alignment. Scott et al (2003) propose an integrated leadership style (both transactional and transformational) to achieve culture change. They suggest that, in developing a patient-centred model of healthcare, the leadership task is about substantially reshaping attitudes and behaviours that can be deeply ingrained in the organisation, through its culture.

Several studies point to the importance of understanding the organisational context, particularly organisational culture, for successfully leading change. Examining the role of senior leaders in implementing quality and safety improvements in healthcare, Øvretveit (2005a) concludes that leaders' actions are important but that their influence as individuals is limited. He proposes a 'system of leadership for improvement', which takes account of where and how leadership can be enabled and demonstrated throughout the organisation, especially by medical leaders. He suggests that senior leaders "need to build a system of leadership for improvement which includes all formal and informal leaders, teams and groups which support improvement as part of the everyday work of an organization" (p 423). In order to do this effectively he argues that "the first step in leading improvement is to understand the organisation's stage of quality development, any internal experience with quality methods and assess 'readiness for change … [as well as] the current pressures which help and hinder improvement" (p 424). In other words, organisational diagnosis is an important aspect of leadership context.

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Policy and practice implications:

- A key prerequisite for effective leadership is the need to understand the contexts in which leadership is exercised. Policy-makers, managers and professionals may find it helpful to think in terms of the three layers of context that are outlined here: the national public policy context; the regional and local strategic context, including partnerships; and the internal organisational context.

- These are not discrete levels but interact with each other in complex ways. Systems thinking helps to reveal the interdependence between the elements and to act as a reminder that outcomes may not always be predictable.

- Contingency approaches suggest that different leadership styles are effective in different contexts. Selecting leaders to match particular contexts, and/or helping leaders to develop and deploy particular leadership styles according to the particular context are both important skills to develop.

- 'Reading the context' is therefore a crucial skill. It includes being able to take an overview and link the big picture with the fine-grain detail. Moving between 'the balcony and the battlefield' is one way to achieve this.

- Leadership may involve not only shaping the context but also, in some situations, constituting the context. Leaders have a role in defining and articulating the key points of the context, framing it for others inside and outside the organisation.

- The context for healthcare is changing, due to rising expectations, new illness and disease profiles and the greater emphasis on 'predict and prevent' rather than react and ameliorate. The leadership challenge is to transform and improve, but this requires accurate and careful reading of the context.

- Reading the context of partnerships and inter-professional and inter-organisational networks is a critical skill for healthcare leaders, particularly but not exclusively at senior levels.

- Partnerships may have collaborative advantage but also collaborative disadvantage, so reading the context accurately and thinking through the challenges of partnership working become crucial. Leadership in this context needs to focus on whole-system design and development, to ensure that partnerships contribute to strategic purpose.

- Reading the internal organisational context includes thinking about the strengths and weaknesses of geographical location, history, size, structure, culture, skills, resources and reputation. Leadership has to work with the history of the organisation and its culture and rarely starts from scratch with a blank sheet. Organisational diagnosis is a key element of leadership and the starting point for improvement and reform.