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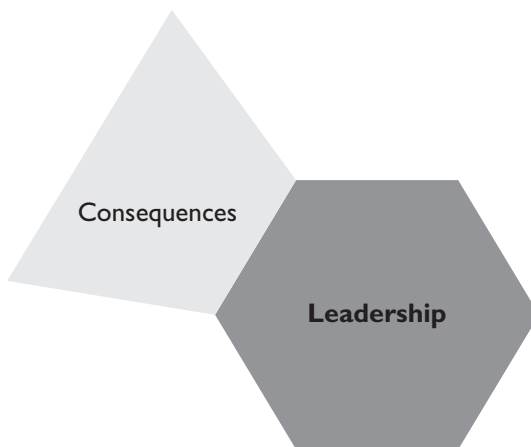
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Consequences of leadership

In this chapter:

The ideas and the evidence about how leadership has (or is thought to have) impacts on other people and on organisational and health outcomes is examined. It is widely asserted that leadership is critical for organisational performance whether in the public, private or voluntary sectors. But what is the evidence? We examine the problems of establishing the impact: lack of data; lack of clear causation; and attribution errors. The chapter then looks at two frameworks that may help to tease out the impacts, or consequences, of leadership. Yukl's framework focuses on three organisational impacts: efficiency and process reliability; human resources and relations; and innovation and adaptation. The chapter then takes a broader view of consequences by using a public value perspective to look at outcomes and impact. Evidence from healthcare is then examined in relation to this framework, focusing on inputs, activities, partnership/network working and co-production, user satisfaction, outputs and outcomes.

Figure 7.1: The consequences of leadership



Establishing causes and effects

There are any number of texts that assert that leadership is critical for organisational performance, whether in the private, public or voluntary public sectors. In the public sector in the UK, there has been a particular emphasis on leadership as one of the means by which improvements in services and/or service transformation is achieved. Leadership was signalled as central to the reform of UK public services, with the Cabinet Office's Performance and Innovation Unit document *Strengthening leadership in the public sector* (PIU, 2000). There was no escape from the prevalence of leadership in public service reform under the Labour Government from 1997 onwards. Health is no exception to this, and the Darzi report (DH, 2008) pays particular attention to the need to develop leaders, both clinical and non-clinical, in order to improve healthcare.

However, while the impact of leadership on performance is often asserted, the evidence is more fragile, ambiguous or incomplete. There are problems on several fronts in relation to evidence. First, there is more writing about leadership in general descriptive terms than there is detailed research evidence. Some of this is 'the romance of leadership' (Meindl and Ehrlich, 1987). So, it is sometimes claimed that particular qualities, behaviours or practices are relevant for 'effective' leadership but no data are given. This leaves the field open to broad principles and vague generalisations that are not supported by evidence. Second, some writing is vague about how 'effectiveness' is defined – what is the outcome that influential leadership is expected to produce? What concrete indicators and/or measures of performance are associated with effective leadership?

Third, leadership is often assumed to result in improved outcomes, implying that there is a causal link from leadership to outcomes. However, many studies are cross-sectional in nature and while leadership may be associated with the outcomes, such research designs are unable to establish that leadership causes the effects or to rule out alternative explanations.

Furthermore, attribution errors or processes can play a part. For example, it is possible to have cases where group members assume or believe that leadership is effective because there are positive outcomes, or they assume the existence of leadership because of positive outcomes. These are illustrations of reverse thinking in terms of causation – a type of attributional misinterpretation (Cha and Edmondson, 2006; Martinko et al, 2007).

The idea of charismatic leadership hints at attributional error, because ‘followers’ may project extraordinary or exceptional qualities onto the leader when they have positive experiences. There are also situations where the attribution is the opposite – where ‘followers’ attribute negative qualities to the leader when a situation does not meet expectations (Bion, 1961; Cha and Edmondson, 2006). Thus, attribution can lead to disenchantment with the leader despite the leader’s best intentions. Psychodynamic theories also emphasise leadership-performance attribution in terms of the internal psychological processes of the ‘followers’ and the unconscious processes of the group (for example, Bion, 1961; Hirschhorn, 1997; Kets de Vries, 2006).

Finally, there may also be situations where the leadership is so subtle or so participative that commentators are not aware of the full extent of the leader’s role in achieving outcomes. The saying of the Chinese master, Lao-Tzu, is a reminder of this: “But of a good leader who talks little when his work is done, his aim fulfilled, [the people] will say: We did it ourselves” (Lao-Tzu, translated by Bynner, 1944, sentence 3).

As we explored in Chapter 6, there can be different attributions about leadership effectiveness depending on whether the leader is male or female (Ford, 2005; Sinclair, 2005; Parry and Bryman, 2006). This is not about whether women *are* different as leaders but whether they are *seen to be* different and judged accordingly by those they come into contact with and try to influence.

How people construct meanings from leadership acts, roles, contexts and experiences affects whether and how leadership is seen to be effective. Leadership and leadership effectiveness is socially constructed, not simply read off from actions and behaviours. The quality of the relationship between the leader and the people being influenced, and the organisational, cultural and policy context, may all shape whether leadership is viewed as effective. This also means that the evaluation of leadership and leadership development is not straightforward.

With these caveats in mind, we now turn to consider two frameworks that may help to think systematically about potential impacts of leadership.

A framework linking leadership and organisational performance

Yukl (2006) unpacks the potential impact of leadership on organisational performance, setting out three major strands, or meta-categories, of the potential impact of leadership and these are shown in Table 7.1.

Table 7.1: Management systems, programmes and structural forms for improving performance

Efficiency and process reliability
Performance management and goal setting initiatives (for example, management by objectives, target setting, zero defects)
Process and quality improvement initiatives (for example, lean management, six sigma, the productive ward, quality circles)
Cost reduction initiatives (downsizing, outsourcing, budget restructuring)
Structural design (reorganisations, commissioning arrangements, service reconfiguration)
Appraisal and rewards linked to efficiencies and process reliability
Human resources and relations
Quality of work–life initiatives (flexitime, job-sharing, child care, fitness centre)
Employee benefits (terms and conditions, sabbaticals, study leave)
Socialisation and team-building (induction, ceremonies, social events and celebrations)
Staff development (continuing professional development, education, training, 360 degree feedback)
Human resource planning (succession planning, recruitment initiatives)
Empowerment initiatives (self-managed teams and collaboratives)
Appraisal and reward linked to service, skill or skill acquisition
Innovation and adaptation
Needs analysis initiatives and environmental scanning (for example, health needs in particular populations and subgroups, policy analysis)
Market analysis (intelligence to inform commissioning, benchmarking; competitor products and processes; international comparisons of healthcare services and processes)
Innovation initiatives (creativity development, entrepreneurship, piloting and testing)
Knowledge acquisition (ideas from a range of sources, promising practice ideas, evidence-based practice)
Organisational learning (knowledge management systems, seminars and workshops; debriefing, learning from near-misses in clinical practice; developing models of learning, use of organisation development managers and leads)
Temporary structural forms for implementing change (for example, steering committee, task force, diagonal slice of staff)
Growth and diversification initiatives (preparing for Foundation Trust status, building clinical specialities, strategic commissioning, joint ventures)
Appraisal and rewards linked to innovation and patient satisfaction

Source: Adapted from Yukl (2006, p 371) to incorporate examples of current initiatives in the NHS

Yukl elaborates on each strand by looking at the activities that can be used by leaders to develop organisational (or team or service) performance. Impacts may occur not only through direct interaction with colleagues but also indirectly through having an impact on organisational systems, which themselves may shape individual, team and organisational performance. The table is valuable for being one of the few accounts that systematically maps the range of possible impacts. It suggests how a leader can judge their own impact or that of others in leadership positions.

A public value perspective

The Yukl framework is valuable when considering consequences of leadership for organisational performance. But a public value perspective (Moore, 1995; Benington and Moore, 2010) may be helpful in thinking about the consequences of leadership beyond organisations, and upon citizens and communities, and society as a whole. Public value is a theory of particular relevance to public service organisations such as healthcare, where the impacts may be much broader than the individual or the specific organisation and that may benefit – or detract from – the wider community and society. For example, reducing the risk of diseases in the community, preventing climate change, building public trust and confidence in the healthcare system are all outcomes that contribute benefits to the public sphere. In addition, some public organisations also have a role to play in establishing collective rules and purposes (Marquand, 2004).

Applying these ideas to healthcare, it is possible to think about the value created not only by activities and services to treat illness and disease, but also the contributions that healthcare can make to illness prevention, and to a societal culture in which people take responsibility for many aspects of their health through their lifestyle choices. A public value perspective becomes increasingly important as the UK health service aims to shift more into ‘predict and prevent’ rather than just ‘treat’, and into the promotion of well-being (Tritter, 2010).

Benington (2010) defines public value as having two elements: “what the public values” and “what adds value to the public sphere”. The first part of the definition means taking account of the expressed needs and aspirations of users of services, their advocates, and citizens and taxpayers and complementing this with the judgements of the producers. This is an argument to take into account the views of the public, in its myriad forms, but goes beyond what the public ‘wants’ and focuses more questioningly on what the public most ‘values’. This

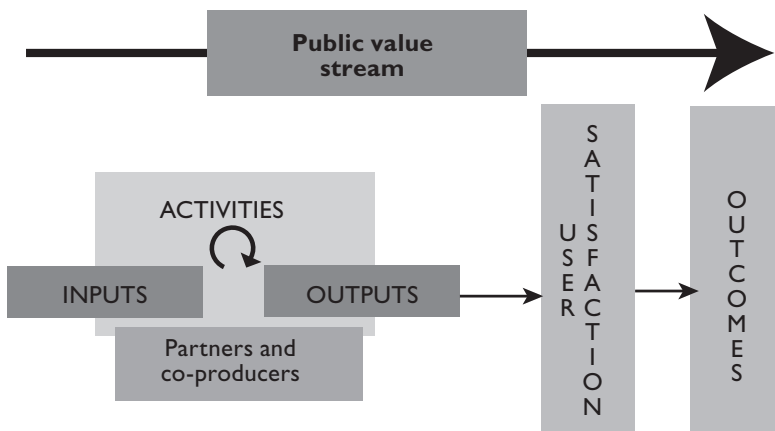
involves the making of trade-offs and choices between competing priorities. The second element of the public value definition is “what adds value to the public sphere”:

This counterbalances the first part of the definition (“what the public values”) by focusing attention not just on individual interests but also on the wider public interest, and not just on the needs of current users but also on the longer term public good, including the needs of generations to come. (Benington, 2010)

Public value is one approach to conceptualising the consequences and outcomes of public services. The concept originates from Mark Moore in the US (Moore, 1995) but is now being further developed by Benington and several other academics in the UK, Europe and Australia (for example, Alford and O’Flynn, 2009; Benington and Moore, 2010). Ideas about public value have been applied in the UK to the BBC, to further education, to policing and to the health service (Benington et al, forthcoming).

The consequences of leadership can be conceptualised by using a model of the public value stream, shown in Figure 7.2. This examines all the processes through which value is added via the various stages of inputs, activities and processes, outputs, user satisfaction and outcomes. The attraction of value stream analysis is that it enables the added value of a public service such as healthcare to be assessed at each stage, identifying those processes that add value, those that subtract value and

Figure 7.2: The public value stream



Source: Diagram from Benington and Moore (2010)

those where public value is stagnant. A key question for leadership is whether and how leadership can contribute to the public value stream and generate added value for the public sphere.

Examining healthcare from this perspective, leadership could potentially contribute at a number of points, as follows:

- **Inputs:** How leadership (and leadership reputation) might influence recruitment and selection of staff, financial resources available to the organisation, equipment and technological resources, other inputs.
- **Activities:**
 - How leadership impacts on the activities that take place within the healthcare organisation, for example, systems and procedures, team-working, improvement and innovation initiatives, organisational and cultural change, organisational capacity and adaptability.
 - How leadership has an impact on the attitudes and practices of staff within the organisation.
 - How leadership contributes to organisational capability and capacity (including the ‘leadership engine’ mentioned in Chapter 5).
 - How leadership can have an impact on the co-production of health working with patients, families, partner organisations and communities. Part of the leadership role may be to help patients to understand where they can contribute to their own health outcomes rather than just relying on health professionals (for example, medicine compliance, following health advice, thinking about preventative health actions through lifestyle).
- **Outputs:** How leadership shapes the outputs of the organisation, for example, the number of operations undertaken, the quality of healthcare advice, the proportion of the population screened or immunised and so on.
- **User satisfaction:** How leadership influences patient and public satisfaction, and the satisfaction of those who are carers for patients (for example, families, relatives, health advocates).
- **Outcomes:** How leadership has an impact on health outcomes more broadly, for example, prevention of future illness, trust and confidence in medical practitioners among the population and so on.

Public value outcomes may be examined from a number of stakeholder perspectives – both internal (for example, doctors, nurses, managers) and in terms of external stakeholders such as the government, the local authority health scrutiny panel, advocacy and patient groups and so

on. They may not always agree on some elements of impact. Public value outcomes are inevitably contested and are subject to continuous debate and challenge, through formal political channels, the media and in teams, organisations and communities.

Evidence of the impact of leadership on organisational performance and on health outcomes

It is often asserted that leadership has an impact on the group being influenced and on organisational performance but it is important to turn to the evidence to know:

- whether a causal, correlative or no relationship exists between the leadership and the performance outcome;
- what specific aspects of leadership contribute to the impact;
- how the impact is thought to happen;
- whether the impact is direct (for example, immediate impact) or indirect (through other variables);
- what contingencies or features of the organisational or wider context affect whether leadership is effective or not.

We will explore the empirical evidence using the public value stream framework.

Inputs

There are few studies about the impact of leadership on organisational inputs. Anecdotally, there is a view that inspiring or effective leaders attract good staff to work with them, but more robust evidence is hard to find.

An interim report by Bailey and Burr (2005), based on consultation with chief executives, found that these leaders estimated that about 20% of leadership success in acute trusts was due to ‘legacy’ – that organisational performance was partly due to the organisation’s history rather than the current situation. Part of this legacy might be presumed to be the previous leadership. Recent work about senior management in the university sector (Goodall, 2009) suggests that the choice of leader is affected by the type of previous incumbent – for example, there is evidence of a pendulum swing between the appointment of academic and managerial types of vice-chancellor. Both pieces of research are a reminder that leadership rarely starts with a blank canvas, but must take into account recent organisational history, current organisational culture as well as size and other organisational factors.

Activities

This section examines the impact of leadership on staff attitudes to work, attitudes to work practices, attitudes to improvement and innovation, and the use of scientific evidence in health professional practices.

The idea that leaders have an impact on the attitudes and behaviours of the staff they directly supervise has been established since leadership studies began. In relation to the health service, a number of studies have examined leadership approach and job attitudes among nurses. For example, Morrison and colleagues (1997), in a survey of US nurses, found that both transformational and transactional leadership styles correlated with job satisfaction but that transformational leadership had a greater impact on empowerment (as the theory would predict). Other studies have reported that transformational leadership is associated with higher levels of self-reported job satisfaction, satisfaction with the leader, organisational commitment, work effort and reduced intention to leave the job (Taunton et al, 1997; Vandenberghe et al, 2002; Borrill et al, 2003). Other work in health has found that transformational leadership is associated with lower levels of burnout, specifically emotional exhaustion, among nurses, but also that some aspects of transactional leadership are associated with positive outcomes including assigning tasks, specifying procedures and clarifying expectations (Stordeur et al, 2001). In fact, at the unit level, transactional leadership more than transformational leadership was associated with perceived unit effectiveness (Vandenberghe et al, 2002). These findings reinforce the view, examined in the capabilities chapter (Chapter 6), that both transformational and transactional leadership are important. This also underlines the need for good management as well as good leadership in many organisational settings.

An unpublished paper by Borrill et al (2003) reported a large study that involved over 23,000 staff across 134 UK trusts (acute, specialist, primary care, mental health and ambulance). They found that both top management leadership and direct leadership (immediate supervision) were associated with staff well-being (as measured by overall job satisfaction and low intention to leave the trust). However, the relationship was much stronger with direct leadership, suggesting that it has a particular impact on staff attitudes towards their work. This may be a reminder of the value to staff of daily and direct engagement with, and influence by, leaders.

All of the studies reported are based on cross-sectional data (data collected at the same time) and so it is not possible to say that leadership

causes staff attitudes to work. However, work outside health has suggested that there may be a causal relationship, based on research conducted over time (Arnold et al, 2007; Nielson et al, 2008; Barling et al, 2009).

Having examined work attitudes, what is the impact of leadership on work practices? These include behaviours related to improvement and innovation in the workplace, and also the use of evidence-based practices in healthcare.

Two studies (Laschinger et al, 1999; Manojilovich, 2005) found that leadership that encouraged empowerment and self-efficacy (belief in one's ability to be effective) among nurses was also associated with a higher level of professional practice. Research with mental health providers (Aarons, 2006) found a relationship between transformational leadership and the willingness of staff to voluntarily adopt evidence-based practice. However, willingness to adopt was also influenced by aspects of the internal organisational context such as policies and procedures. There were also individual differences related to education and experience.

A large study by West and colleagues (2003) about leadership, team processes and innovation in healthcare found that leadership had an impact on innovation but that the relationships varied by type of team and organisational context. The study examined healthcare teams made up of a range of different professionals (for example, GPs, nurses, administrative and managerial staff, specialist doctors and nurses, medical consultants and so on). Leadership had the potential to influence four key team processes: clarifying objectives; encouraging participation; enhancing commitment to quality; and support for innovation. Leadership clarity was associated with better team processes, and with actual innovation – and ambiguity about leadership was associated with low levels of innovation. This supports the role of leadership in helping to create a compelling direction and ensuring participation of team members in decision-making. However, interestingly, leadership clarity was associated with innovation for community mental health teams and breast cancer teams, but not for primary care teams. Given that the latter are more often varied in team composition, with less clear team boundaries and roles, there may be an effect of group composition, type of task and degree of clarity about leadership, so it is not only about the leadership approach.

A key review of the impact of leadership on quality and safety improvement was undertaken by Øvretveit (2005a, 2005b). He notes that “although most literature emphasises the importance of committed leadership for successful quality and safety improvement,

research evidence supporting this is scarce and often scientifically limited” (2005a, p 413). However, from the evidence that is available he concludes that senior leadership is critical for improvement, so long as those senior leaders have a strong commitment to quality improvement and demonstrate this through their behaviour. Examples of demonstrating commitment include taking stock of quality improvement programmes and being flexible about how they are introduced on the basis of encouraging learning from their introduction on the ground. Other studies have reported a lack of leadership as being critical to poor attitudes to quality improvement. Involvement of the board and of doctors by senior managers is also important (Weiner et al, 1997).

Other roles are also important in improvement – including middle managers, doctors and other health professionals, and also ‘opinion leaders’, that is, those whose opinion is influential with colleagues: “Engaging doctors is essential to quality improvement” (Øvretveit, 2005a, p 422). The variety of roles involved in improvement suggests that creating organisational systems and a climate that supports improvement is valuable.

Øvretveit argues for the need to consider the impact not just of individual leaders but of a system of leadership for improvement that includes “all formal and informal leaders, teams and groups which support improvement as part of the everyday work of the organization”, where leaders for improvement are “any people who influence others to spend time on making the service better for patients” (Øvretveit, 2005a, p 423). This requires thinking about organisational capacity and organisational processes.

Finally, Barrett and colleagues (2005) argue, from their study of regional health authorities in Canada, that in complex organisations there is a need to see leadership as one of the important foundations for organisational learning, and for leadership to promote practices that support and enhance organisational learning. They found a clear relationship between leadership and such capacity-building.

Partnerships and co-production

There is relatively little evidence about the role of leadership in partnership working (in terms of working across organisations and in networks). There is some anecdotal evidence and some suggested frameworks for evaluating partnership, or collaborative advantage, in healthcare (for example, Lasker et al, 2001; Dickinson, 2009; Glasby

and Dickinson, 2009), but less actual evidence at this stage about the impact on either organisational practices or outcomes.

Co-production is the idea that some (not all) services are created by the interaction of ‘producers’ (for example, in the case of health, doctors, pharmacists) and ‘consumers’ or clients (for example, in the case of health, patients, carers) (Alford, 2009). The service cannot be effective in terms of health outcomes unless there is a willing, capable and attentive patient or patient advocate. So the impact of leadership on encouraging the recruitment and engagement of patients, community representatives and others in the co-design and delivery of healthcare could be important. There are examples of trust leadership encouraging, for example, the involvement of newly arrived refugees in supporting the health activities of others in their own language and cultural communities. Public and patient involvement is one element of co-production. Experience-based design is starting to gain ground in healthcare (Bate and Robert, 2007) and shows the impact of leadership on designing and achieving change.

Patient satisfaction

Evidence of the impact of leadership on patient satisfaction and patient outcomes is hard to come by, perhaps in part because the impact of leadership is likely to be indirect (mediated through the actions of staff and the quality of systems of healthcare). In addition, patient satisfaction can be influenced by expectations and other factors, so is not always a reliable or valid indicator of quality services.

A study of managerial leadership in just over 200 US hospitals found that senior management is more strongly linked with process quality than with clinical quality: “hospital management has more influence on process design, improvement and execution than on clinical quality, which is predominantly the doctors’ domain” (Marley et al, 2004, p 362). On the other hand, Goodwin (2006) comments that poor leadership has a greater impact on patients than on staff, although he does not provide research evidence to support this conclusion.

Work by Shipton et al (2008), however, provides some hard performance data, including patient complaints as a percentage of treatments, trust star ratings (the former national rating system for trusts) and Commission for Healthcare Improvement (CHI) clinical governance review ratings. The sample included over 17,000 staff and 86 trusts. The research found that staff ratings showed that better senior leadership was associated with fewer patient complaints.

Outputs

Outputs can be examined both directly (for example, tests and operations performed) and indirectly (through external audit and inspection regimes). Some research shows that the impact of leaders on overall organisational performance is through shaping or influencing the culture (and some of the subcultures) of the organisation or the climate for quality care. Mannion and colleagues (2005) used a research design of two high- and four low-performing hospital trusts in the UK (based on star performance ratings in the national rating system) and then carried out case studies of their functioning, including leadership and management orientation. Their analysis suggested that high and low performance environments may be very different environments in which to work, suggesting considerable cultural divergence. Interestingly, they found that the leadership in high performance trusts tended to be characterised by top-down 'command and control' styles, with strong directional leadership from the centre and a 'top-down' approach to performance and organisational change. In contrast, the four trusts deemed to be low performing (with new turnaround management teams brought in because of the trusts' 'underperformance') had leaders who were widely seen to be charismatic. But they were seen to lack the transactional leadership skills needed to create and maintain effective performance management systems.

Additionally, in the low performers, the use of emotional engagement through charisma meant that loyalty to the senior management team was highly valued – but that the organisations seemed to have a monoculture with insufficient questioning and exploration as a result, and with an 'emasculated' middle level of management. There was a focus on internal functioning but insufficient attention to the demands from the external environment, and an over-dominance of clinical interests in decision-making. This is a small but detailed case study project, which raises important issues about the relationship of leadership style to the task in hand, and the influence of the external context on the leadership challenges (see also Scott et al, 2003). Research by Shipton et al (2008) found that senior leadership was associated with a strong emphasis on quality healthcare (which they called 'the healthcare climate') and this was related to the performance of the trust as measured by the star ratings used at the time.

Buchanan (2003) argues that, when designing leadership development, it is important to consider organisational effectiveness from a number of different angles, in order to avoid being trapped in a particular leadership style. He suggests that the balanced scorecard by Kaplan and Norton

(1996) is one way to try to ensure a rounded view of performance and could be applied both to individual organisations and to those that promote and provide leadership development.

Outcomes

Evidence on the relationship between leadership inputs and healthcare outcomes at the societal level is hard to find. The need to think about the wider purposes of healthcare organisations in terms of public value outcomes should help to create a valuable agenda for future research. The leadership of large, complex but effective healthcare organisations is not just about the number of patients treated, but is also about how to contribute to happy, healthy communities and societies.

A contingency view of consequences

This chapter has reviewed the ‘consequences’ of leadership, while also noting that attributions affect what is perceived as leadership and its consequences. There is less hard evidence than there are claims about the impacts of leadership upon performance at team, service, staff and patient, and organisational levels. Nevertheless there is some evidence that leadership can have an impact on these elements, although there is a need for much more information about how and why leadership has these impacts.

There is also a need to understand more about the contingencies of effective leadership. What are the environmental contexts or organisational conditions that promote or inhibit the relationship between leadership influence and practical outcomes? This chapter has shown that some aspects of leadership are associated with positive outcomes in some settings and some tasks. Certain types of leadership (for example, direct or indirect, technical or adaptive, with or without authority) are more closely associated with certain types of outcomes than others.

The evaluation of leadership impact therefore needs to be based on ‘what works for whom, when, how and why’ rather than on universalistic principles. It was noted earlier that a key skill of leadership is ‘reading’ and analysing the context and this may be crucial for thinking about how best to create positive consequences for staff, patients, the organisation and for wider public value.

Policy and practice implications:

- The idea of causal consequences of leadership is provisional in that there is relatively little in the way of longitudinal evidence of its impact.
- In addition, perceptions of leadership effectiveness and leadership impact are shaped by attributions (how people explain what is cause and what is effect). These may not be accurate but can be firmly held. This can underestimate the impact of leadership by women (and probably minority ethnic leadership too).
- Effective leadership may not be noticed or commented on – a consolation for the leader who has worked hard but who does not receive appreciation!
- In terms of organisational performance, strategic and operational leaders may wish to reflect on how far they are able to have an impact on efficiency and process reliability, on human resources and human relations, and on innovation and adaptation.
- A wider public value perspective also considers the impact of the healthcare organisation on the public sphere.
- The public value chain is one useful way to conceptualise the potential impact of leadership on healthcare: through the impact on inputs, activities, partnerships and co-production; on patient and carer satisfaction; on outputs; and on outcomes.
- Different stakeholders may not agree on elements of public value that are created. The impact of leadership is not an exact science.
- There is a fair degree of evidence that leadership can have an impact on staff attitudes. Both transformational and transactional leadership can contribute to job satisfaction but transformational leadership seems to have a greater impact on a sense of empowerment.
- Direct leadership is particularly significant for staff attitudes.
- The impact of leadership is also affected by organisational context, including type of task, type of team, organisational culture and roles.
- Leadership has a substantial role to play in creating organisational climates that support patient safety and a commitment to quality improvement.
- More effective senior management is associated with fewer patient complaints.
- While there has been a strong fashion for transformational leadership, research on leadership style and trust ratings suggests that transactional leadership can be important for creating and maintaining effective performance management systems.
- There are arguments for adopting a multifaceted approach to measuring the impact of leadership. The public value chain is one approach, the balanced scorecard is another.

