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Exploring a shared leadership perspective for NHS doctors

The UK government, like those in other countries, has introduced changes to the structure and functioning of the NHS with an emphasis on involving doctors with new planning and commissioning organisations, and ensuring their continued involvement with hospital services, (DOH, 2010). Their involvement with leadership and decision making within these organisations will be critical to the success of the changes. This paper looks at the policy background to involving doctors in leadership, definitions of leadership, including clinical leadership, and current approaches to leadership theory and practice in the NHS. In particular, it will focus on shared leadership, and the implications for practice. The focus is the UK NHS, and doctors, although this should have some relevance to other disciplines in healthcare.

Policy background

Historically, the involvement of doctors with leadership in hospitals can be traced back to the 1980s, with the development of directorate structures based on the model developed at Guys hospital, London, in the UK, and the Johns Hopkins hospital, Baltimore, in the USA. In the 1990s, NHS hospital trusts were established, along with the roles of clinical director and medical director and further development of the clinical directorate structure. The latter introduced a 'hybrid' leadership model, combining clinical and management responsibilities, (O'Riordan and McDermott, 2012, p622). This has become the established way of involving doctors in leadership in hospitals in the UK.

Leadership or management has received less attention in primary care where doctors have not generally occupied such roles outside their practices, (O'Riordan and McDermott, 2012, p622). GPs have enjoyed autonomy as independent contractors, but this has been threatened by contractual changes. More recently, policy initiatives have encouraged GPs to become involved with leadership, (DOH, 2010). GPs are now involved with leadership in the organisations created by these initiatives, in particular CCGs (clinical commissioning groups), which are meant to be clinically-led, but also Clinical Senates, which provide clinical advice and support to CCGs, Clinical Networks, which have been set up to provide advice on specific conditions such as cancer, or cardiovascular disease, or Health and Well Being Boards which are local government bodies set up to assess local health needs and devise health and wellbeing strategies, (Ham, et al, 2015, Kings Fund).

More generally, it has been noted that there has been a shift in policy and use of terminology from administration, to management, to a focus on leadership; and also a shift towards involving a wider range of stakeholders in leadership, regardless of formal position in the organisation, (Martin and Learmonth, 2010, p285). The involvement of doctors with leadership is part of this shift and is now generally accepted, particularly given the perceived link between leadership and quality, (Bekas, 2014, p31).). The latter places a much stronger emphasis on medical leaders improving quality in healthcare, (Dickinson, *et al.*, 2013, p 18).

One of the first policy drivers suggesting a link with quality was the review of the NHS, 'High Quality Care for All', (DOH, 2008). This was reiterated more recently by the Public Inquiry into the Mid Staffordshire NHS Foundation Trust, (Francis, 2013), and by the Keogh Review (2013), and Berwick Report (2013), (Keogh, 2013, Berwick, 2013). The Public Inquiry is significant in that, having identified failures of care at the Mid Staffordshire Trust, it raised questions about: "a dangerous culture and weak leadership", (Kings Fund, 2013, pp 1-3). The Inquiry advocated the need to change the culture of

the NHS, and ensure a culture of patient safety and quality. While cultural change is not easy, the Inquiry argued that “leadership is crucial and responsibility for leadership needs to be shared at all levels, from the board to the ward”, (Kings Fund, 2013, p 5).

Defining leadership

Defining leadership generally is difficult, given the diversity of contexts , and this has inevitably led to the development of different approaches, models and frameworks, and continuing controversy (Cragg and Spurgeon, in Chambers, *et al.*, 2007, Howieson and Thiagarajah, 2011, p7). Indeed: “almost everyone who studies or writes about leadership interprets it differently”, (Howieson and Thiagarajah, 2011 p8). Definitions are difficult because leadership theory itself is fragmented, with theory covering a variety of different aspects of leadership, (Barr and Dowding, 2012, p46). It has been suggested that there is a lack of integrating theories of leadership, (Hartley and Benington, 2010, p7).

Hartley and Allison believe it is possible to coalesce different definitions or approaches around three overarching perspectives: person; position; and process. The first two are about the individual leader, for example, personal qualities or skills, or formal position in the organisation. The third is about the process of social interaction and group dynamics, (Hartley and Allison, 2000, cited in Malby, *et al.*, 2011, p341). Definitions of leadership have tended to shift from the individualistic, to the latter - distributed, or shared, definitions of leadership with an emphasis on process, (Carr, *et al.*, 2009, Bolden, 2011). This shift away from individualistic interpretations is discernible in public sector organisations where shared or distributed leadership is said to fit with or complement a corresponding shift towards network organisations, (Currie *et al.*, 2011, p244).

A specific definition of leadership in healthcare, distinguishing it from generic definitions, is to focus on the link with patients, or quality, and define it as ‘clinical’ leadership, (Willcocks, Milne and Milne, 2013, p183). Clinical leadership is widely accepted, although some observers are sceptical about the ‘almost magical powers ascribed to’ it, (Checkland, 2014, p254). One definition of clinical leadership is that it is about facilitating evidence - based practice and delivering patient outcomes, (Barr and Dowding, 2012, p7). Similarly, clinical leadership is said to be about leading the process of service improvement with a view to delivering excellent patient care, (Howieson and Thiagarajah, 2011, p10). In this view, doctors have a significant role in changing clinical practice, and improving quality of care or service.

Definitions of clinical leadership, as opposed to leadership generally, point out that it is ‘exercised’ near the patient. A recent paper by the Kings Fund has argued that: “nowhere is [clinical] leadership more crucial to improving care quality than on the front line... [and] best performed by clinicians”, (Kings Fund, 2013, p13).

Defining clinical leadership as a front line activity focuses attention on a doctors’ combination of personal qualities, expert power, based on medical expertise, and the use of persuasion, as opposed to hierarchical power, distinguishing it from managerial conceptualisations, (Malby, *et al.*, 2011, p 342). A recent paper by the BMA reports that expert power is a crucial feature of clinical leadership; it is important for clinical leaders to have extensive clinical experience and to remain in practice to be credible, (BMA, 2012, P8).

Approaches to leadership theory and practice in the NHS

The approach to leadership theory and practice in healthcare has varied but in essence, it has focused on individualistic, charismatic, and 'heroic' approaches or conceptualisations of leadership, (Fulop, 2012, p579; Edmonstone, 2011, p8; Willcocks, Milne and Milne, 2013, p182). However, these have been the subject of criticism; for instance, Shapiro believes traditional individualistic models of leadership are becoming increasingly outdated, (Shapiro, 2011, p2). Other observers have claimed that heroic leadership focuses too much on the individual leader, and neglects both leader-follower relations, and the context, or situation, (Alimo-Metcalfe and Alban-Metcalfe, 2011; Bolden and Gosling, and Bolden, cited in Howieson and Thiagarajah, 2011, p10; and Grzeda, 2005, p530). Another criticism is that there is a 'dark side' to charismatic and heroic models with concern about leaders' exhibiting arrogance, narcissistic, and manipulative behaviours, (Alimo-Metcalfe and Alban-Metcalfe, 2011 p7).

Yet, an individualistic focus is still evident in current approaches to leadership in the NHS, (fig 1). For example, the 'Leadership Qualities Framework' and 'transformational leadership' are both centred on developing individual competencies, (Fulop and Day, 2010, P347). The transformational leadership model, which has a focus on the top leader in the US version, has been influential in the NHS. Indeed, it has been suggested that models and competency frameworks in both private and public sectors tend to be based loosely on transformational leadership, and identify individual qualities, such as cognitive, affective and inter-personal qualities, (Bolden, *et al.*, 2003, p37). The recent 'healthcare leadership model' is also essentially individualistic, in that it identifies individual leadership behaviours or competencies.

Leadership programmes for doctors are no exception in that they tend to be individualistic and prescriptive, (Bekas, 2014, p34). However, the Medical Leadership Competency Framework in fig. 1 is a change from other approaches to leadership in the NHS in that it emphasises the distribution of leadership across the medical team. It says 'shared leadership' is integrated into the doctors' role, (Academy of Medical Royal Colleges 2010, p 1). According to the Medical Leadership Competency Framework, leadership focuses on the dynamic relational process and the interaction within groups, (Academy of Medical Royal Colleges 2010, p1). Even so, the Framework is contradictory in its espoused support of shared leadership, and at the same time, its focus is on developing individual competences, (Bekas, 2014, p34).

Leadership Qualities Framework (LQF-2006) - general framework aimed at all staff

Medical Leadership Competency Framework (2010) - specific framework aimed at doctors

Clinical Leadership Competency Framework (2011) - framework aimed at all clinical staff

The Leadership Framework, (DOH, 2011) - general framework

Healthcare Leadership Model, (Leadership Academy, 2014) - most recent general framework, based on nine dimensions of leadership behaviour

Fig 1-Current approaches to leadership in the NHS

Current leadership theory and practice suggests that shared or collective leadership might be the way forward. The Kings Fund, for example, concludes that leadership in the NHS should be “collective and distributed rather than left to a few individuals at the top of these organisations”, (cited in Ham, 2014, p44). Similarly, West et al believe that a collective approach to leadership is vital in delivering the overall aim of high quality patient care, and transforming the culture of the NHS: “collective [shared] leadership creates the culture in which high quality, compassionate care can be delivered”, (West et al, 2014, p7). Storey and Holti argue that the competence of individual leaders is only one part of an organisation’s improvement mechanism. Also important is leadership as a relational process that is enacted by multiple constituencies, (Storey and Holti, 2013, p16). As noted, a policy shift is already underway from hierarchical management and representation to a position of greater medical engagement and to a system of shared leadership, (Clark, 2012, p1, Baker and Denis, 2011, p357-8). This shift in approach is part of a general trend in theoretical development from transformational leadership to distributed or shared leadership, (Currie and Lockett, 2011, p288).

Shared leadership in the NHS?

It has been noted that “the boundaries of the concept... [shared leadership] have been somewhat blurred by the range of different terms employed to describe leadership that extends beyond the individual”, (Currie and Lockett, 2011, p288). However, definitions of shared leadership tend to centre on the significance of the relationship process. For example, shared leadership is: “a collective social process emerging through the interactions of multiple actors”, (Bolden, 2011, p251). Similarly, shared leadership is defined as a social process, involving dynamic relationships between leaders and followers, and situated in a specific context, (Edmonstone, 2011, p10). Likewise, it is defined: “more in terms of social interaction and group dynamics in which greater emphasis is attached to followers and context...”. (Wirrmann and Carlson, 2005, cited in Malby, *et al*, 2011, p341).

Defining shared leadership as part of the relationship process, involving group dynamics and social interaction, is particularly apposite when applied to the healthcare context. The latter is characterised in terms of professional cultures where team working, autonomy, and devolved authority tend to be emphasised. Historically, such professional cultures feature a large amount of professional autonomy and control, and an emphasis on the informal influence process, (Dickinson and Ham, 2008, p4). Shared or distributed leadership may be seen as a characteristic of such cultures, known as professional bureaucracies, where leaders’ may be from a professional background and not necessarily occupying positions of formal power and authority, (Dickinson and Ham, 2008, p2).

One of the perceived benefits of shared leadership is that it involves an inclusive decision making process and an emphasis on participative styles of leadership. Such features are compatible with clinical leadership and decision making in healthcare organisations, for example, in multi-disciplinary clinical teams, or directorate and divisional structures in NHS Trusts, (Fulop and Day, 2010, p348). They may also enhance doctors’ engagement with the decision making process, and contribute to the development of more cost effective systems of delivery. The latter is important in the current financial climate in the NHS, particularly given the need to ensure front line staff are supportive of ways of dealing with the financial challenges. Similarly, in CCGs, a participative and collegial decision making process, involving GPs, might improve the quality of decision making and the commissioning

process. CCGs are likely to be important drivers in the process of implementing policy reforms at local level such as redesigning services and shifting resources from acute to primary care.

It can also be argued that shared leadership has a role in nurturing and supporting change, for example, developing “new practices and innovations” in healthcare, (Turnbull James, 2011, p4). Innovation at clinical level is emphasised in the current reforms. Shared leadership may facilitate change in clinical practice, and importantly, generate commitment for such change, and promote innovative delivery and patient- centred care. A specific example of this may be the role of shared leadership in facilitating change in service delivery such as in the shift in service provision from secondary to primary care. Another example is the way shared leadership might support new models of service delivery. Hunter and Goodwin make the point that collaborative (shared) leadership might be a way to encourage: “others to influence and bring about intra and inter-organisational change”, (Hunter and Goodwin, 2014, 2).

Shared leadership may also play a part in the building of relationships and encourage collaborative working across organisational or professional boundaries, (Turnbull James, 2011, p6). Collaborative working remains important across local partnership organisations in providing integration of services. Examples include Health and Well-Being Boards, as well as other local organisations such as CCGs, and area teams of NHS England. A specific example is where doctors are involved with the leadership of clinical networks and clinical senates, providing collegial expert advice to providers and commissioners. Similarly, collaborative working in public health networks is important, particularly sharing leadership with other staff in developing and delivering a public health strategy.

More generally, it has been suggested that a culture of shared leadership may be conducive to improving the quality of care: “collective [shared] leadership cultures are characterised by all staff focusing on continual learning and through this, on the improvement of patient care”, (West et al, 2014, p4). The reforms currently being implemented emphasis improvements in quality and patient care. Improvement of patient care requires active involvement of all clinical leaders, (Malby, et al, 2011, p 341). This involvement is also important in terms of the implementation of new delivery models and new ways of delivering quality in service delivery. Shared leadership provides a collaborative approach, underpinned by continuous learning, (Smith *et al.*, 2013, cited in Ham, 2014, p30).

Given the above features, it can be argued that shared leadership will have a positive impact on healthcare organisations and on partner organisations and organisations in other health or social care systems, such as local government agencies, independent healthcare organisations and voluntary organisations. It can be noted however that this view of shared leadership has been challenged, indeed, it has been said that policies proposing shared or clinical leadership are ‘relentlessly positive’, (Checkland, 2014, p 254). Checkland suggests that “ rather than turning all NHS staff into leaders [ie shared or distributed leadership] we should perhaps tone down the level of our rhetoric and instead emphasize the need for a service full of good followers who will remain a relentless focus on care, quality and efficiency”, (Checkland, 2014, p253). From a more critical perspective, Martin and Learmonth question whether shared or distributed leadership is really a rhetorical device or discourse to ensure that clinicians are engaged and committed to a political project, ie healthcare reforms and policy change, (Martin and Learmonth, 2010, p286).

Implications for practice?

There is a growing recognition that more needs to be done to develop the leadership potential of doctors. Indeed, the Royal College of Physicians argue that leadership should be incorporated into medical training, (Storey and Holti, 2013, p27). Ham, et al, 2011 point out that: “doctors who become [clinical leaders] are self-styled ‘keen amateurs’ and there is a need to provide more structured support to enable them to become skilled professionals”, (Ham, et al., 2011, p113). One may point out, however, that there are reservations about whether leadership can, in fact, be learnt, (Checkland, 2014, p255).

Traditional approaches to development are ‘leader’ centred, aimed at developing individual competencies, such as style or traits, a popular example of which is transformational leadership, (Fulop and Day, 2010, p344). These have been questioned as a way of developing leadership. West et al, for example, suggest that traditional approaches focus on developing individual capacity and neglect the need to develop collective capability, (West et al., 2014, p4). Ross and Baker say that leadership development that only centres on developing individual competencies is likely to have limited impact, (Ross Baker and Denis, 2011. P360). Similarly, Turnbull James notes that: “while competent leaders are important, development that is focused on leader attributes alone will be insufficient to bring about desired organisational change”, (Turnbull James, 2011, p4).

The challenge will be to avoid over reliance on individualistic approaches to leadership, by emphasising collective leadership development, although there are financial and resource implications in developing a wider pool of leadership. Current leadership development programmes in the NHS need to give more emphasis to the distributed or shared nature of leadership, with less attention to developing individual skills and competencies. They should generate an understanding about leadership and culture that is consistent with shared leadership, prioritise collective attributes and competencies, and focus on relational processes and the social and team dynamics that underpin leadership, (Fulop and Day, 2010, p345).

To deliver these changes, education and training needs to make greater use of group based approaches, action learning sets and team based learning interventions. Education and training will need to focus on key features of shared leadership such as developing relationships, and supporting collaborative and collegial working within and across organisations. This is important in healthcare organisations which are based on developing collaborative relationships across primary and secondary care. It is also important, given recent proposals to create new models of care such as multi-specialty community providers and vertically integrated primary and acute care systems, (NHS England, 2014). These organisations will require new approaches to leadership and decision making, at the same time as requiring the continuing engagement of doctors with medical leadership.

One of the drawbacks, however, in developing shared leadership is that it may be perceived as a challenge to traditional approaches, derived from the pre-existing hierarchical culture in the NHS, associated with top down ‘command and control’ styles of leadership. More cynically, it has been suggested that shared leadership is partly designed to ‘mitigate the tension’ between a decentralised NHS and the reality of a centralised service, (Martin and Learmonth, 2010 p286). Implementing shared leadership may be a challenge in large complex organisations such as those in healthcare, although it has been identified as important by the Public Inquiry into the Mid Staffordshire NHS Foundation Trust, (Francis, 2013) The Inquiry has called for cultural change as an essential pre requisite for improving the NHS. This is potentially a major challenge and involves

creating the right cultural environments in different settings which are likely to be supportive of new and innovative approaches to leadership. Such environments will need to be nurtured and supported, particularly in clinical settings, ensuring that due attention is paid to the involvement of all doctors.

Introducing the changes requires more than just new methods for education and training. Shifting the focus to shared leadership may require wider systemic changes, given that leadership is embedded in, and determined by, the collective challenges in the context, (Turnbull James, 2011, p4). It has been suggested that leadership development should be supported by organisation - wide change in both culture and structure to facilitate the nurturing of a philosophy of shared as opposed to individual leadership, (Bekas, 2014, p34). Shared leadership requires policy makers to ensure that the right resources are available, such as financial, and educational and training resources, but perhaps more significant for the future is the need to facilitate a shift in the cultural, social, and political context underpinning the new approach to shared leadership. The former represent practical challenges in developing shared leadership, and requires the support of policy makers and senior management. The latter is less easy to achieve and requires significant change in the culture of the NHS. It requires a wider systemic approach to change and a strategy requiring the involvement of all staff.

Conclusion

While there is no 'one right way' in terms of leadership approach for doctors, it is equally the case that any approach taken should be compatible with both culture and policy context. Culture has been highlighted in the Francis Inquiry as of crucial importance in transforming the NHS. Shared leadership may be the way forward, in terms of facilitating cultural change, subject to various preconditions.

One may argue that the benefits in developing shared leadership are likely to outweigh the costs in the healthcare context. Shared leadership is a way of encouraging a more inclusive and democratic culture in healthcare organisations at a time when these organisations need to be mutually supportive in the face of constraint and financial uncertainty. However, one has to be cautious about the espoused benefits of shared leadership, taking cognisance of the fact shared leadership may be interpreted more critically as a discourse or rhetorical device designed to commit front line staff to policy reform in the NHS, (Martin and Learmonth, 2010).

This paper suggests that shared leadership approach for doctors has potential given the nature of clinical practice, the inherently collaborative nature of healthcare, and the demands and challenges faced by new healthcare organisations. The latter are derived from various factors, not least the specific context in the NHS. There is a need to conduct research focusing specifically on the shared leadership approach in different national contexts. This may take the form of case study research into the impact of shared leadership on traditional power structures, different cultural contexts, and the effect of this on decision making, engagement, motivation, and on outcomes such as the quality of care, and other performance criteria. Also, research may be undertaken exploring how to introduce shared leadership, identifying how to create supportive and receptive environments for shared leadership, and developing innovative education and training methods. Health policy reform generally will mean that all doctors need to be engaged with leadership, albeit, perhaps, at different levels, and with different degrees of formality. Leadership will remain an important precondition for

the success of the reforms. This is likely to be the case for other countries involved in healthcare reform.

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