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**Leadership
and Leadership
Development
in Health Care:
The Evidence Base**

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Leadership and Leadership Development in Health Care: The Evidence Base

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Summary

The key challenge facing all NHS organisations is to nurture cultures that ensure the delivery of continuously improving high quality, safe and compassionate healthcare. Leadership is the most influential factor in shaping organisational culture and so ensuring the necessary leadership behaviours, strategies and qualities are developed is fundamental. What do we really know about leadership of health services?

The Faculty of Medical Leadership and Management (FMLM), The King's Fund and the Center for Creative Leadership (CCL) share a commitment to evidence-based approaches to developing leadership and collectively initiated a review of the evidence by a team including clinicians, managers, psychologists, practitioners and project managers. This document summarises the evidence emerging from that review.

The summary describes key messages from the review in relation to leadership at different levels of analysis: it includes a description of the leadership task and the most effective leadership behaviours at individual, team, board and national levels.

The leadership task

The leadership task is to ensure direction, alignment and commitment within teams and organisations (Drath, McCauley, Palus, Van Velsor, O'Connor, McGuire, 2008). Direction ensures agreement and pride among people in relation to what the organisation is trying to achieve, consistent with vision, values and strategy. Alignment refers to effective coordination and integration of the work. Commitment is manifested by everyone in the organisation taking responsibility and making it a personal priority to ensure the success of the organisation as a whole, rather than focusing only on their individual or immediate team's success in isolation.

Individual leadership in health services

Effective leaders in health services emphasise continually that safe, high quality, compassionate care is the top priority. They ensure that the voice of patients is consistently heard at every level; patient experience, concerns, needs and feedback (positive and negative) are consistently attended to.

They offer supportive, available, empathic, fair, respectful, compassionate and empowering leadership. They promote participation and involvement as their core leadership strategy. They ensure the staff 'voice' is encouraged, heard and acted on across the organisation and provide practical support for staff to innovate within safe boundaries.

They ensure everyone is clear about what they are required to do and give helpful, positive feedback on performance, including appreciation. They insist on transparency in relation to errors, serious incidents, complaints and problems and they regard mistakes as opportunities for learning. They act effectively to deal with poor performance and proactively address aggressive, inappropriate and unacceptable behaviours displayed by staff or patients/carers.

They promote continuous development of the knowledge, skills and abilities of staff in order to improve quality of patient care, safety, compassion and the patient experience. They consistently encourage, motivate and reward innovation and introduce new and improved ways of working.

Team leadership

Team leaders create a strong sense of team identity by ensuring: the team has articulated a clear and inspiring vision of the team's work; there is clarity about the team's membership; team members agree five or six clear, challenging, measurable team objectives; there is strong commitment to collaborative cross-team and cross-boundary working.

Team leaders ensure: there is shared leadership in teams and members are fully involved in appropriate decision making; responsibility for decisions is delegated to members appropriately; and there are constructive debates about how to provide and improve high quality patient care.

They also ensure the team regularly takes time out from its work to review its performance and how it can be improved, and there is a team climate of positivity, characterised by optimism, team efficacy, mutual supportiveness and good humour.

Leadership of organisations

Board leadership is most effective when boards enact the vision and values of their organisations through what they attend to, monitor, reprove or reward; when they listen to patient voices as the most important sources of feedback on organisational performance; and when they listen to staff voices to discover how they can best support and enable staff to provide high quality patient care.

Effective boards ensure a strategy is implemented for nurturing a positive culture; sense problems before they happen and improve organisational functioning; promote staff participation and proactivity; enable and encourage responsible innovation by staff; and engage external stakeholders effectively to develop cooperative relationships across boundaries.

National level leadership

National level leadership plays a major role in influencing the cultures of NHS organisations. Numerous reports have called for the various bodies that provide national leadership to develop a single integrated approach, characterised by a consistency of vision, values, processes and demands. The approach of national leadership bodies is most effective when it is supportive, developmental, appreciative and sustained; when health service organisations are seen as partners in developing health services; and when health service organisations are supported and enabled to deliver ever improving high quality patient care. The cultures of these national organisations should be collective models of leadership and compassion for the entire service.

Leader and leadership development

Overall, there is little robust evidence for the effectiveness of specific leadership development programmes. Undoubtedly some programmes work for some people some of the time, but evaluating their effectiveness empirically is challenging and demonstrating positive effects on patient outcomes is difficult. The interventions are diverse, participants face different work challenges and those providing the programmes have varying experience, knowledge and skill. More evidence-based approaches to leadership development in health care are needed to ensure a return on the huge investments made. Experience in leadership is demonstrably valuable in enabling leaders to develop their skills especially when they have appropriate guidance and support.

In comparison with the focus on leader development, leadership development - the development of the capacity of groups and organisations for leadership as a shared and collective process - is far less well explored and researched. However, much of the available evidence, particularly in the NHS, highlights the importance of collective leadership and advocates a balance between individual skill-enhancement and organisational capacity building. A collective leadership culture is characterised by shared leadership where there is still a formal hierarchy but the ebb and flow of power is situationally dependent on who has the expertise at each moment. Research evidence suggests this is valuable, particularly at team level.

There is also a clear, compelling and urgent need for leadership cooperation across boundaries (another key element of collective leadership) within and across organisations. Health care has to be delivered increasingly by an interdependent network of organisations. This requires that leaders work together, spanning organisational boundaries both within and between organisations, prioritising overall patient care rather than the success of their component of it. That means leaders working collectively and building a cooperative, integrative leadership culture - in effect collective leadership at the system level.

The current emphasis in the NHS on empowering clinicians and other front-line staff in terms of their decision-making competencies, also emphasises implicitly the need for collective leadership that includes a broader practice of leadership by clinicians and other front-line staff, rather than by designated managers alone. Such collective leadership is best achieved by a developmental focus on the collective, rather than on individual leaders alone. However, traditional leader-centric development programmes with tenuous links to organisational outcomes have continued to dominate.

The implication of this new understanding of leadership is that our approach to leader and leadership development is distorted by a preoccupation with individual leader development (important though it is), often provided by external providers in remote locations. Developing collective leadership for an organisation depends crucially on context and is likely to be best done 'in place', highlighting the important contribution of organisation development and not just leader development.

The leadership of organisations needs to be consistent in terms of leadership styles and behaviours; in developing shared leadership across the organisation; in embodying the vision and values of the organisation; in ensuring shared and consistent approaches to performance management; in practising compassion as a cultural value in all relationships within the organisation; in encouraging, facilitating and rewarding learning, quality improvement and innovation; and in developing team, inter-team and cross-boundary working within and across organisations in health and in social care. And leaders must work together and build cultures where the success of patient care overall is every leader's priority, not just the success of their individual areas of responsibility.

Leadership for cultures of high quality care

Commentators have argued that regulatory systems, increasing competition and setting targets are inadequate levers for bringing about the fundamental changes required to respond to the challenges (Ham, 2014). Instead, they argue that culture change within organisations is fundamental to health services that must adapt to be able to deliver continually improving, high quality and compassionate care. To respond to current and future challenges, organisational cultures in health care must be nurtured in parallel with changes in systems, processes and structures. The key influence on culture is the leadership of an organisation, the subject of this review. But in order to understand the leadership needed in health care, it is important to describe the cultures that we wish the leadership to create.

Cultures of high quality care

Drawing from research (Dixon-Woods, Baker, Charles, Dawson, Jerzembek, Martin, McCarthy, McKee, Minion, Ozieranski, Willars, Wilkie, West, 2014; Dawson, West, Admasachew, Topakas, 2011), we propose that five key cultural elements are necessary for sustaining cultures that ensure high quality, compassionate care for patients, these include:

- inspiring visions operationalised at every level
- clear, aligned objectives for all teams, departments and individual staff
- supportive and enabling people management and high levels of staff engagement
- learning, innovation and quality improvement embedded in the practice of all staff
- effective team working (West, Lyubovnikova, Eckert & Denis, 2014).

To ensure high quality care, there has to be direction, alignment and commitment to a shared, holistic view of care that includes commitment to improving linkages with other providers and to achieving system goals such as continuity of care. This in turn implies alignment across different parts of organisations, different providers and other groups. Ensuring the key cultural elements are in place also requires leadership that creates direction, alignment and commitment in relation to these cultural elements (Drath et al, 2008). These cultural elements are described below.

Compelling visions and strategic narrative

The research projects referenced above suggested that leaders in the best performing health care organisations prioritised a vision and developed a strategic narrative focused on high quality, compassionate care. In these organisations, all leaders (from the top to the front line) made it clear that high quality compassionate care was the core purpose and priority of the organisation (Dixon-Woods et al, 2014). There is evidence that such alignment has an important influence on reducing the effects of 'faultlines', defined as group and status differences that interfere with effective collaboration - a common problem in health care organisations (Bezrukova, Thatcher, Jehn, Spell 2012).

Visions must also be translated into leadership actions because the messages that leaders send about their priorities are communicated more powerfully through their actions than their words. Leadership authenticity is revealed by what leaders monitor, attend to, measure, reward and reinforce and this in turn regulates and shapes the efforts of staff (Avolio & Gardner, 2005).

Clear objectives

Staff in the NHS report often feeling overwhelmed by tasks and unclear about their priorities resulting in stress, inefficiency and poor quality care (Dixon-Woods et al, 2014). Creating cultures that are focused on high quality care requires leadership to ensure there are clear, aligned and challenging objectives at all levels in the organisation (West, 2013). This is not the same as the institution of target-driven cultures that are used by some governments and organisations to drive change in the system with, the evidence suggests, limited success (Ham, 2014).

People management and staff engagement

Where health service staff report they are well-led and have high levels of satisfaction with their immediate supervisors, patients report that they, in turn, are treated with respect, care and compassion (Dawson et al, 2011). Overall, the data suggest that when health care staff feel their work climate is positive and supportive, as evidenced by coherent, integrated and supportive people management practices, there are low and declining levels of patient mortality. These associations are consistent across all the domains of health care - acute, mental health, primary care and ambulance. Engagement also appears to be higher in health care organisations where leaders create a positive climate for staff so they feel involved and have the emotional capacity to care for others. (Dawson et al., 2011)

Learning, innovation and quality improvement

Following the failures in Mid Staffordshire NHS Trust, a report by Don Berwick in 2013 (Berwick, 2013) advocated culture changes in health care with a strong emphasis on embedding learning and quality improvement throughout health care organisations. The report recommended the NHS should 'continually and forever reduce patient harm' by adopting an ethic of learning. Moreover, the report recommended that the voice of the service user should be constantly heard by leaders establishing ways of ensuring that patients and their carers are represented at all levels of health care organisations. In effect, the report recommended that leadership must ensure all health services are delivered by 'learning organisations', with innovation a core part of all roles, and with a strong emphasis on transparency so all data on quality and safety is available to everyone involved in the services.

Team working

There is much evidence that team work is an important contributor to health care quality. Leaders must ensure that health care staff work together across professional boundaries to deliver high quality care, particularly as the complexity of health care increases and co-morbidity becomes more common (West & Lyubovnikova, 2012; West, 2012). The data from the national staff survey reveal that most NHS staff (91 per cent) report working in a team. Follow-up questions that are intended to test for the existence of basic elements of team work (team objectives, interdependent working, regular meetings) reveal only around 40 per cent of staff report working in teams (Lyubovnikova, West, Dawson, & Carter, in press). Analyses reveal that where staff report working in teams in organisations with those characteristics, the lower the level of errors, including staff injuries, harassment, bullying and violence against staff, staff absenteeism and (in the acute sector) patient mortality.

In conclusion, there are a number of relatively well-identified practical strategies that can be taken to develop cultures of high quality, safe and compassionate patient care. Leadership is the most influential factor in shaping organisational culture, so ensuring the necessary leadership strategies, behaviours and qualities are developed is fundamental to health service improvement. The key questions must focus on: what does the research evidence reveal about leaders' behaviours, leadership more generally and outcomes in health care. These are addressed in this review.

Review structure

The review has the following structure: we review leadership theory and research in general; focus on leadership theory and research in health care; examine the research on the links between leadership climate and culture in health care and outcomes, especially patient outcomes; explore the research on leadership development; and draw conclusions based on the review. The review methods are described in the Appendix.

Leadership theory and research¹

Some of the key conclusions from research into leadership over the last 80 years are described below; these locate our understanding of leadership in health care within the context of the considerable research and theory on leadership generally. Trait theory, research on leadership competencies, leadership behaviours, dyadic approaches and charismatic and transformational leadership theories are also briefly outlined.

Personality and leader effectiveness

The first major stream of research reflects a long standing fascination with the personality traits of those who become leaders. From this broader leadership research evidence we can identify core personality traits associated with leadership effectiveness, including (Yukl, 2013):

High energy level and stress tolerance - They have high levels of stamina and can work effectively over long periods. They are also less affected by conflicts, crisis events and pressure, maintaining equilibrium more than others. They are able to think relatively calmly in crisis situations and communicate that calmness and confidence to others.

Self-confidence - They believe they can be effective in difficult situations and give those they lead a sense of confidence and efficacy. They tend to be optimistic and confident in the face of difficulties. They are more likely to deal with difficult situations rather than deny or avoid them. However, excessive self-confidence or self-esteem can make leaders prone to making risky or wrong decisions.

Internal locus of control - They believe what happens around them is more under their control than the control of external forces and are motivated to take action to influence and control events. This is associated with a tendency to be proactive rather than passive. They also believe they can influence, persuade and motivate others and win their allegiance to courses of action.

Emotional maturity - They have emotional maturity and intelligence in the sense that they are less prone to moodiness, irritability and angry outbursts. They are positive and optimistic, communicating their positivity to others. They are aware of their own strengths, weaknesses and typical reactions to situations.

Personal integrity - Consistency between espoused values and behaviour is characteristic of those with high levels of personal integrity, along with honesty, transparency and trustworthiness. Such leaders also keep promises to staff and other stakeholder groups and tend not to use their leadership primarily out of self-interest.

Socialized power motivation - They seek power, but primarily in order to achieve organisational objectives and to support the growth, development and advancement of those they lead.

¹ This section draws particularly on the review of leadership in Chapter 12 of Woods, S. and West, M. A. (2014). *The Psychology of Work and Organisations*. (2nd ed). London: Cengage Publishing.

Achievement orientation - High achievement orientation is associated with leadership effectiveness but this is not a linear relationship. Managers with very high achievement orientation can become insensitive to the effects of their desires on those around them who feel driven by their leader's ambition.

Low needs for affiliation - This refers to the need to be liked and accepted by others, which effective leaders do not have. Those who did would be likely to put their need to be liked ahead of making good decisions in difficult situations or ahead of having to manage poor performance among their followers. Neither do they have extremely low affiliation needs, which would mean they were uncaring of others and their opinions.

Leadership competencies

Another body of research (Boyatzis, 1982) has focused on the competencies related to managerial effectiveness, including motives, skills, knowledge, self-image and some specific behaviours. The research suggests the following competencies are important for leaders:

- *Technical competence* wins the respect of followers. It includes knowledge about the organisation, its strategy, structure and processes; knowledge about health care services, treatments and technologies; and knowledge about the organisation's environment.
- *Conceptual skills* means having an understanding of the complex environments of organisations (both internal and external) to be able make sense of situations rather than deem them too complex to be comprehended or managed. The ability to analyse, plan and make decisions is central to organisational functioning, so leaders who have conceptual skills will increase the confidence of followers within the organisation.
- *Interpersonal skills* are vital: understanding the needs and feelings of followers, monitoring the effects of own behaviours and being aware of emotional reactions to others are essential.

These conclusions should be considered alongside caveats: only a few studies have rigorously tested the assumption that personality traits and competencies have a causal impact on leader effectiveness or emergence as a leader. For at least some personality traits and competencies, it is not clear which comes first, being in a leadership position or possessing the trait or competency in question. Implicit theories of leadership held by followers can facilitate leadership emergence (eg leaders 'should be' extravert) rather than leader traits predicting emergence. The trait approach provides little guidance concerning what advice or training to give current or aspiring soon-to-be leaders.

Other theoretical streams not covered here include literature on authentic leadership, servant leadership and emerging literature around shared, distributive and collective leadership (for more discussion of these topics, see West et al, 2014).

Leader behaviours

What does the literature indicate leaders are required to do? From extensive and repeated reviews of the research, Yukl (2013) argues for an integrative hierarchical framework of leader behaviours subsuming four broad categories:

- *Task oriented*: clarifying, planning, monitoring operations, problem solving
- *Relations oriented*: supporting, developing, recognising, empowering
- *Change oriented*: advocating change, envisioning change, encouraging innovation, facilitating collective learning
- *External networking*: external monitoring, representing

He has also distilled a statement of what constitutes the essence of effective leadership:

1. Helping to interpret the meaning of events. Effective leaders help their followers make sense of change, catastrophes, successes and the future. They provide a narrative which both makes sense to people and inspires them to give of their best and make a positive difference. Martin Luther King's 'dream' speech is an example.
2. Creating direction and alignment around strategies and objectives. Effective leaders clarify direction, strategy and the priorities for people's efforts. They help to create shared understanding and agreement about direction. They define the key priorities (few in number) and make clear what the team is not going to do rather than overwhelming people with inspirational priorities. They help to define clear, challenging, measureable objectives for all.
3. Nurture commitment and optimism. They encourage belief in the team or organisation about likely efficacy and a sense of the value of the work. They encourage positive attitudes and experiences rather than cynicism or defeatism and they do so with humour, belief and a sense of purpose which inspires others to be committed.
4. Encourage trust and cooperation. They emphasise the importance of people supporting each other, backing each other up and valuing each other's contributions to build trust and cohesion. They work to continually develop mutual respect trust and cooperation among followers. They help to resolve conflicts quickly and fairly. They continuously build a strong sense of community and supportiveness that ensures people act cooperatively and supportively with colleagues.
5. Create a sense of collective identity. They encourage a strong and positive vision of the value of the team's/organisation's work and a sense of pride in the efficacy of the group. They encourage a sense of identity for the group or organisation, such that people derive value from being part of that collective. They enable the group/organisation to see how their work makes a positive difference and they nurture a sense of the group's character, uniqueness and identity through rituals, celebrations, humour and narrative.
6. Organise and coordinate work efforts. They ensure people are clear about their roles and contributions and help them work together in a coordinated way towards success. They are practical and timely in dealing with systems difficulties and coordination problems so that the group/organisation can be successful.
7. Enable collective learning. They ensure followers engage in collective learning about errors, successes and means of ensuring continually improving quality. They ensure the group regularly takes time out to review objectives, strategies and processes so they collectively learn and improve.
8. Ensure necessary resources are available. They ensure the group or organisation has the resources (money, staff, IT support, time) necessary for them to get the job done and work actively and tirelessly to be certain these resources are in place. This may involve political acumen and risks in dealing with the wider organisation, customers and other stakeholders but they are consistent in working tirelessly to get the necessary resources for the group/organisation to be effective.
9. Develop and empower people. They focus on ensuring the continued growth and development of their followers; they provide high levels of autonomy and development opportunities to empower those they work with and ensure they continue to develop efficacy and confidence. They encourage followers to believe in their ability to respond successfully to greater challenges and responsibility while providing the necessary supports and resources to achieve this.

10. Promote social justice and morality. They emphasise fairness and honesty in their dealings with all, challenging unethical practices or social injustices on behalf of all, not just their followers. They set an outstanding example of ethical/moral behaviour, especially when it requires them to sacrifice their personal interests.

From this brief review of the wider literature on leadership, we now turn to examine the research on leadership in health care specifically.

Leadership theory and research in health care

Despite thousands of publications on the topic of leadership in health care, our review (consistent with others (eg Hartley, Martin, & Bennington, 2008); Kim & Newby-Bennett, 2012) reveals relatively little research conducted to a high academic standard. Nevertheless, there are some important findings to be drawn from the existing research which we summarise below.

Theories of leadership

Using theory to guide research into leadership in health care is vital to ensure the concepts and constructs the research seeks to address are both appropriate and the most relevant. Wong and Cummings (2007) and Wong, Cummings and Ducharme (2013) conducted two systematic literature reviews of nursing leadership and patient outcomes, which identified 20 articles of good methodological quality (research design, sampling, measurement, and statistical analysis). Of these, only nine were based on an explicit leadership theory. The search conducted for the review we report here produced similar results with few methodologically sound articles and few based on leadership theories.

Gilmartin and D'Aunno (2007) noted at the point they conducted their review, that leader member exchange (LMX) theory was not as well represented as it was in the wider leadership literature (we refer in more detail to this below). They suggested this reflected a reluctance to acknowledge that leaders in health care inadvertently create 'in-groups' and 'out-groups' which LMX theories reveal. They also note that emotional intelligence leadership theory (Goleman, 1995) is relatively neglected in the health care literature. Indeed, very few studies have considered theoretical perspectives other than transformational leadership (eg Akerjordet & Severinsson, 2010; Katrinli, Atabay, Gunay, Guneri, 2008; Wong and Giallonardo, 2013).

Transformational leadership theory is therefore the most influential theory guiding health care leadership research. In their review Wong et al (2013) found six out of the nine articles (from the 20 they selected) stating explicit leadership theories used transformational leadership theories (Bass & Avolio, 1994; Kouzes & Posner, 1995). Other theories identified in the current review of the literature included LMX theory (Katrinli et al 2008), authentic leadership (Wong & Giallonardo, 2013), and servant leadership theories (Nagel & Andenoro, 2012).

The focus on transformational (and transactional) leadership was also identified in a systematic review performed by Gilmartin and D'Aunno (2007) examining health care leadership research from 1989 to 2005. They concluded that studies in health care provide strong support for transformational leadership theory and identified links with staff satisfaction, unit or team performance, organisational climate and turnover intentions. They suggest these effects are stronger when assessed among more junior than senior staff. Positive effects of transformational leadership have also been demonstrated in relation to work-life balance, staff well-being, positive nursing outcomes, patient safety, openness about errors, and patient and staff satisfaction (Munir, Nielsen, Garde, Albertsen & Carneiro, 2012; Apekey, McSorley, Tilling & Siriwardena, 2011; Cummings et al., 2008; McFadden, Henagan, & Gowen, 2009; Kvist, Mantynen, Turunen, Partanen, Miettinen, Wolf & Vehvilaninen-Julkunen, 2013; Wong, Cummings &

Ducharme, 2013). Alimo-Metcalf and Alban Metcalf (2001) have offered an alternative nine-factor model for healthcare in the UK. However, the existing model does apply well in health care settings.

Authentic leadership is the focus of a small number of studies in health care. This approach emphasises the importance of building leader legitimacy through honest relationships with followers by valuing their contributions and behaving ethically and transparently. Trust then leads to engagement and improved individual and team performance. Wong, Laschinger, and Cummings (2010) found that nurses who reported higher levels of authentic leadership in their managers also reported a greater level of trust, work engagement and perceptions of quality of care. Wong and Giallonardo (2013) found positive relationships between authentic leadership and managerial trust, working life, and patient outcomes. Moreover, authentic leaders supported and encouraged nurse empowerment in their roles and this empowerment led to improvements in job performance.

In conclusion, the evidence clearly suggests the value of transformational and authentic leadership as a predictor of quality outcomes in health care settings. We now turn to examine research focused on specific leaders - nursing and medical staff and boards in more detail.

Nurse leaders

In their review of leadership in health care, Gilmartin and D'Aunno (2007) noted that the vast majority of research is focused on nurses and nurse managers. There were strong links between nurse managerial style and staff job satisfaction, turnover and retention. Nurses preferred managers who were participative, facilitative and emotionally intelligent and such styles were in turn linked to team cohesion, lower stress, and higher empowerment and self-efficacy. They also found that effective nurse leaders were characterised as flexible, collaborative, power sharing, and as using personal values to promote high quality performance.

Van Bogaert, Clarke, Roelant, Meulemans, and Van de Heyning (2010) examined the effects of nursing environments and burnout on job outcomes and quality of care. Nursing management was positively related to perceived quality of care and staff satisfaction in this study while other studies found relationships with medication errors (Van Bogaert, Timmermans, Weeks, van Heusden, Wouters & Franck, 2014) and staff levels of well-being, burnout and turnover intention (Weber, 2010; AbuAIRub & Alghamdi, 2012). In their review Wong, Cummings, and Ducharme (2013) also note a relationship between nurses' relational leadership styles and lower levels of mortality rates and medication errors.

Karilnli, Arabay, Gunay and Guneri (2008) examined the quality of nurse managers' relationships with their staff (using Leader Member Exchange theory), nurses' organisational identification, and whether job involvement mediated any relationship between these factors. When nurse leaders gave nurses opportunities for participation in decision making, nurses reported high levels of organisational identification and job performance as a consequence. Empowerment of nurses to bring about quality improvement emerges from the literature as a possible key factor. Wong and Laschinger (2013) describe how authentic leadership can influence job satisfaction and outcomes through empowerment. Leaders who understand and openly express their core values and who model ethical standards appear to communicate integrity and transparency to their followers.

Medical leaders

In a large scale review of medical leadership models, Dickinson, Ham, Snelling and Spurgeon (2013) found that medical or clinical leadership varied across the case study sites they assessed. Management triumvirates (medical, nursing and administrative leaders) existed on paper in most sites, but the partnership of medical leaders and general managers was perceived to be more important. There were reported variations both between, and within organisations in the extent to which doctors felt engaged in the work of their organisations. Those with high levels of engagement performed better on available measures of organisational performance than others. In an earlier study, Hamilton, Spurgeon, Clark, Dent, and Armit

(2008) found that in high-performing trusts, interviewees consistently identified higher levels of medical engagement. However, these cross sectional studies offer insufficiently robust data to confirm the likely direction of the relationship and causality.

Veronesi, Kirkpatrick, and Vallascas (2012) examined strategic governance in NHS hospital trusts by gathering data such as annual reports, trust performance statistics, patient outcomes, mortality rates and national patient survey data. They found that the percentage of clinicians on governing boards was low compared with international rates, but that higher representation appeared to be associated with better performance, patient satisfaction and morbidity rates. Goodall (2001) assessed the impact of clinical leadership on hospital rankings in the US, finding a strong relationship with the US News and World Report ranking. The authors caution that the research is correlational and may merely indicate top performing hospitals seek doctors as leaders.

Board leadership

There has been little detailed empirical research on board leadership. McFadden et al. (2009) found that CEO leadership style is linked to patient safety outcomes. Jiang, Lockee, Bass, and Fraser (2008) found that certain board practices were associated with better performance in terms of patient care and mortality. There is a vast grey literature but the quality of research is generally weak.

Team leaders in health care

Effective team working is an essential factor for organisational success, frequently cited in the grey literature (NHS Leadership Academy, 2013; Dickinson et al, 2013; Walmsley, & Miller 2008). Researchers have consistently pointed to the importance of leadership in determining the effectiveness of teams over the last ten years while suggesting that, particularly in health services, leadership is often poor (Øvretveit, Bate, Cleary, Cretin, Gustafson, McInnes, McLeod, Molfenter, Plsek, Robert, Shortell, & Wilson, 2002; Plsek and Wilson, 2001).

West, Borrill, Dawson, Brodbeck, Shapiro and Haward (2003) analysed ratings of leadership in a sample of 3,447 respondents from 98 primary health care teams, 113 community mental health teams, and 72 breast cancer care teams. This study examined the extent to which team members were clear about the leadership of the team, since there can be uncertainty about who occupies the leader role due to inter-professional boundary disputes and status incongruities. The results revealed that leadership clarity was associated with clear team objectives, high levels of participation, commitment to excellence, and support for innovation. These team processes consistently predicted team innovation across all three samples. Where there was conflict about leadership within the team, team processes and outcomes were poor.

However, more recent research consistently indicates that, across sectors, shared leadership in teams predicts team effectiveness (D'Innocenzo, Mathieu & Kukenberger, 2014; Wang, Waldman & Zhang, 2014). These findings are not inconsistent, because having a clearly designated team leader may be associated with less conflict over leadership and as a consequence the enhanced ability of team members to smoothly assume leadership roles and responsibilities when their expertise is relevant.

Organisational leaders

At the organisational level, Shipton, Armstrong, West and Dawson (2008) investigated the impact of leadership and climate for high quality care on hospital performance in two studies. In the first study, data were gathered on top management team and supervisor/manager leadership from 5,564 employees at 33 hospitals and linked with data on employee job satisfaction and intention to leave the hospital, hospital 'star rating' (an external audit body assessment of hospital performance) and patient complaints. Star ratings used in the analysis were calculated using five different methods:

breach (the number of times a hospital had failed to meet a given standard, for example, patients waiting longer than the maximum target time); pass/fail (whether the hospital had in place specified procedures); confidence interval indicators (whether the hospital performed above or below the 95 per cent confidence interval on, for example, admissions or deaths after a heart by-pass operation); percentile indicators (hospitals were ranked according to their original score on an indicator, for example readmission rates); and change indicators (that take account of the percentage change over time in the performance of hospitals on specific indicators, for example deaths from cancer, and thus control for random fluctuations and external factors). In the second study, data was collected on top management team leadership from 18,156 staff across 108 NHS hospitals, and linked with clinical governance review ratings (a similar external audit), hospital star ratings, patient complaints and patient satisfaction.

The research revealed that top management team leadership predicted the performance of hospitals in both studies. In the first study, top management team leadership was strongly and positively associated with clinical governance review ratings, and significantly lower levels of patient complaints. In the second study, effective top management team leadership was linked to high hospital star ratings as well as high clinical governance review ratings. Furthermore, positive staff ratings of both top leadership and supervisory leadership were associated with relatively high staff job satisfaction (study 1). The relationship was stronger for supervisory leadership than for top management team leadership. These studies also controlled for hospital size and budgets but were cross-sectional rather than longitudinal. Nevertheless they offer rare and therefore important evidence about the possible relationship between leadership and organisational performance in health care. This is one of the few studies examining leadership and organisational outcomes in health service settings.

In the grey literature, several papers provide evidence for the link between leadership and organisational performance. Chambers, Pryce, Li, and Poljsak (2011) undertook a review of 19 top NHS organisations and found consistent characteristics of high performing organisations, one of which was having a chief executive in post for more than four years. The authors suggest that the study “supports the view that longevity in senior management roles is an important factor for high performing trusts”.

What is typical of research into health care leadership is that methodological weaknesses abound. We briefly describe these below.

Methodological weaknesses

The preponderance of weak study designs in health care leadership research has been noted by others (eg Gilmartin and D’Aunno, 2007; Cummings, Lee, MacGregor, Paul, Stafford, Davey & Wong, 2008; Brady Germain & Cummings, 2010; Wong et al., 2013). Among the key problems are small sample sizes; lack of underpinning theory; survey instruments with inadequate reliability and validity; failure to measure important control variables; cross sectional designs; reliance on self-report (eg for measuring patient safety); and poor measurement of leadership (not systematic), all of which makes it difficult to draw more wide-ranging conclusions about the processes by which leadership affects key outcomes, in terms of moderators or mediators. Multilevel analysis could be used more effectively in this literature, as there seems to be an almost exclusive focus on the individual level rather than on teams or the organisational level (eg strategic leadership).

We now move on to consider how leadership might affect cultures and climates in health care.

Leadership, culture and climate in health care²

The research reviewed above focused largely on relationships at the individual level. Much research on team leadership (mostly outside of health care) has established how significant team leadership is for team effectiveness. The limited team research available within health care is consistent with this. There is also a good evidence base for positing a link between leadership and organisational outcomes in the general literature.

We begin with a consideration of organisational culture. Organisational culture is defined as “the values and beliefs that characterise organisations as transmitted by the socialisation experiences newcomers have, the decisions made by management, and the stories and myths people tell and re-tell about their organisations” (Schneider & Barbera, 2014). The most frequently employed approach to measuring culture in health care is the competing values framework (CVF) (Quinn & Rohrbaugh, 1983). We examine links between leadership and culture below, drawing particularly on research employing the CVF.

Organisational culture in health care

Meterko and colleagues (Meterko, Mohr & Young, 2004) assessed organisational culture using the CVF with a sample of 8,454 employees in 125 US hospitals. They found a positive association between ‘clan culture’ and inpatient satisfaction. Clan culture emphasises cohesiveness, participation, loyalty, tradition and morale. Hierarchical culture (bureaucracy, regulation, hierarchy) was negatively associated with inpatient satisfaction, while the other two types (adhocracy and market) had no significant relationship with outcomes across hospitals. The authors suggest the importance of a culture that promotes effective team working while cautioning against rules and regulations that can directly or indirectly negatively affect patient satisfaction. West and Anderson (1992) reached similar conclusions in an analysis of hospital board level innovations based on the CVF. In this instance, culture was assessed by examining in which domains board members were focusing their improvement efforts.

Gerowitz, Lemieux-Charles, Heginbothan and Johnson (1996) studied 265 hospitals in the UK, the US and Canada, using the CVF, assessing clan, adhocracy, hierarchy and market types. The performance indicators were employee loyalty, external stakeholder satisfaction, internal consistency, external resource acquisition, and overall adaptability. Their findings suggested a link between culture and performance for all but the hierarchical type of culture. The link was specific to relationships with performance indicators valued by the predominant culture of the management team. Thus, in hospitals where management teams pursued an open adhocracy culture (externally focused on stakeholders and opportunities for innovation) there was a link between this type of culture and stakeholder satisfaction.

Davies, Mannion, Jacobs, Powell and Marshall (2007) proposed that the cultural characteristics valued by leaders and managers will be associated with specific organisational outcomes. Using CVF data from 899 senior managers in 189 UK hospitals, they found that the ‘clan’ culture was dominant (54 per cent of hospitals) and was characterized by fewer patient complaints and higher staff morale. The opposite was true in ‘market’ cultures, the second most dominant type (29 per cent of hospitals). Such cultures had an external orientation and a focus on control and stability (competitive, with goal-oriented leadership and an emphasis on outputs and high achievement). ‘Adhocracy’ and ‘hierarchy’ types of cultures were less widespread (11 per cent and six per cent of hospitals respectively). The study revealed significant negative associations between organisation size and clan culture. Organisations with clan and market cultures tended to perform poorly on regulatory agency ratings, while those with adhocracy cultures did well. In general, dominant cultures had outcomes that were congruent with the central features of the

² This section draws particularly on West, M.A., Topakas, A., and Dawson, J.F. (2014). Climate and culture for health care performance. In B. Schneider and K. M. Barbera (eds.), *The Oxford Handbook of Organisational Climate and Culture*. (pp. 335-359). Oxford: Oxford University Press.

culture. Patients of hospitals with clan cultures rated dignity and respect highly; those with a dominant hierarchical culture had long waiting times and poor data quality.

Research on CVF culture types is indeterminate overall, suggesting that no culture type is ideally suited to health care organisations. The CVF originally proposed that cultures would be best described by the relative emphasis across all four types, so the simplistic strategy of seeking to identify a culture type from the four extremes that best predicts health care excellence may be misguided. It is worth noting that in all studies using the CVF, dominant hierarchical cultures, characterised by a preoccupation with target setting, rules, regulations and status hierarchies never predict good performance. Yet in many health care settings, command and control are the dominant values. Hartmann, Meterko, Rosen, Zhao, Shokeen, Singer and Gaba (2009) report that, when leaders create a strong entrepreneurial culture, initiative taking, group learning and innovative approaches to problem solving are all enhanced, which in turn informs action in dealing with patient safety issues. A strong emphasis on hierarchy, rules, policies and control, they argue, potentially inhibits a positive climate for safety due to fear of negative outcomes and blame for reporting safety-related problems.

Organisational climate in health care

Climate is *“the shared meaning employees attach to the policies, practices and procedures they experience and the behaviours they observe getting rewarded, supported and expected”* (Schneider and Barbera, 2014). A number of studies have shown that first line supervisors play an important role in influencing climate and determining the performance of health care organisations (eg McAlearney, Garman, Song, McHugh, Robbins, & Harrison, 2011; Preuss, 2003). In a longitudinal study of 52 acute hospitals in the UK, West and colleagues (West, Guthrie, Dawson, Borrill, Carter, 2006) demonstrated a link between a bundle of HR policies and practices (such as emphasis on training, participation and team working) and patient mortality. This association held even after controlling for prior mortality levels in the hospitals and a variety of potentially influencing factors (eg number of doctors per 100 beds, number of public health care facilities per 100,000 population). Thus, there is good evidence (as in other sectors) that leadership and people management, key climate factors, predict performance outcomes.

Aiken, Sloane, Clarke, Poghosyan, Cho, You, Finlayson, Kanai-Park, and Aunguroch, (2011) report on a cross-cultural study involving nearly 100,000 nurses across 1,406 hospitals in nine countries (USA, UK, Canada, Germany, South Korea, New Zealand, Japan, China and Thailand), examining work environment and nurse-reported hospital outcomes. The study used measures of nurse staffing (patients per nurse) and other aspects of the work environment including nurse manager ability and leadership; nurse-physician relationships; nurse participation in decision making; and nursing foundations for quality of care. Responses were first aggregated at the hospital level and then used to provide comparative country-level scores. The outcome measure, quality of care, was measured by nurses' assessments. The results revealed major country differences, high levels of nurse dissatisfaction across most countries and, not surprisingly given this was a common source study, strong associations between these work environment variables and perceived quality of care.

Another large scale, longitudinal study, incorporating all 390 NHS organisations in England, identified a link between aspects of climate (eg working in well-structured team environments, support from immediate managers, opportunities for contributing toward improvements at work) and a variety of indicators of health care organisation performance (West, Dawson, Admasachew & Topakas, 2011). Climate scores from 150,000 employees collected annually and aggregated to the organisational level, were linked to outcomes such as patient mortality, patient satisfaction, staff absenteeism, turnover intentions, quality of patient care and financial performance. The results revealed that patient satisfaction was highest in organisations that had clear goals, and whose staff saw their leaders in a positive light.

Staff satisfaction was directly related to subsequent patient satisfaction.

For example, staff reports of the supportiveness of immediate managers and their perceptions of the extent of positive feeling (communication, staff involvement, innovation, and patient care) in their trusts directly predicted patient satisfaction. Hospitals with high percentages of staff receiving job-relevant training, having helpful appraisals, and reporting good support from line managers had both low and decreasing levels of patient mortality at the same time as providing better quality care for patients generally. When staff had an annual appraisal meeting with their manager to agree clear, challenging objectives it helped them do their jobs better and left them feeling valued, respected and staff engagement was high.

Good training, learning and development opportunities for staff and support from immediate managers were also linked to lower patient mortality rates. It was particularly noteworthy that lower mortality occurred in those hospitals whose staff had opportunities to influence and contribute to improvements at work (mirroring the findings from the Aiken et al., study described above). What is significant about this large NHS study is that the data were collected over time (eight years) and many of the analyses are longitudinal with careful controls for potential confounds.

There is clear evidence from the more robust studies in the literature that supportive management and staff perceptions of having effective leaders creates a climate that is associated with health care excellence.

McKee, West, Flin, Grant, Johnston, Jones, and Yule (2010) used mixed methodologies (surveys, semi-structured interviews, observations of meetings, analysis of documents, and employee diaries) in an investigation of organisational factors, culture, leadership, staff well-being and patient safety in eight UK health care organisations. Among the key findings were the central role of senior management and CEO values (such as whether business goals predominated over patient safety) and attitudes in relation to patient safety and staff well-being; weak management at different levels; and the organisations' capacity for change, which was affected by the emphasis on organisational learning, and the extent to which staff felt empowered and involved in decision-making. Tenure and stability of leadership also affected the ability of the organisations to maintain a focus on patient safety. Leadership across organisational divisions and professional groups was also identified as important to enacting patient safety policies. Particularly noteworthy was the finding that, in the best performing hospitals, there was high staff engagement in decision-making and widely distributed leadership.

There is good evidence of links between leadership, culture, climate and outcomes in health care and a case to be made therefore for developing effective leadership. We now turn to a consideration of the leadership development literature.

Leader and leadership development

Leader and leadership development are vital for health care, with considerable resources dedicated from budgets always under great pressure. NHS England has invested many tens of millions of pounds through the NHS Leadership Academy in order to increase leadership capabilities across the NHS. Summative figures for local and regional investment are lacking, but estimates are between 20 and 29 per cent of an organisation's training and development budget is dedicated to leadership development (Rivera & Paradise, 2006; Training Industry Report, 2007; O'Leonard & Lamoureux, 2009). With so much money, and so much expected from leader development, an important question is 'to what extent is leader development effective?' Below we review evidence on the effectiveness of different types of interventions to promote leaders' effectiveness, including 360 degree feedback, assessment centres, developmental assignments, job rotation, action learning, mentoring and coaching.

Leader development interventions

Multi-Source (360 degree) Feedback via Questionnaire: This method of promoting leadership effectiveness involves the individual and several others with whom they work completing a questionnaire assessing the leader's behaviours and effectiveness. This is sometimes called 360-degree assessment because subordinates, peers and superiors are all asked to assess the individual. How effective is multi-source feedback? A number of studies have produced mixed results (Seifert, Yukl & MacDonald, 2003), some suggesting positive effects and others no effects. In a review that took in some 131 studies (not confined to leadership), Kluger and DeNisi (1996) found only a weak positive effect of multi-source feedback on performance. Indeed, in one third of studies the relationship was negative. It may be that, used in conjunction with training or other interventions this approach is useful, but there is no clear evidence for this. Many organisations use instruments with poor psychometric properties, inadequate theoretical grounding and unknown validity. Consultancy organisations are guilty of claiming more for the value of their leadership questionnaires than is justified by a careful examination of the supporting evidence. Within the NHS there is extensive use of such poor instruments at every level, having an undoubted impact on the efficacy of this intervention. Developing a list of those instruments that have demonstrated robust factor structures, based on sound theory and with good concurrent and predictive validity is desirable for the NHS.

Developmental Assessment Centres: Assessment centres, usually spread over two to three days, involve multi-source feedback, in-basket exercises, aptitude tests, interviews, group exercises, writing assignments and intensive reflection processes. There is evidence that such processes do have positive effects on subsequent leader performance (Engelbracht & Fischer, 1995). With such a mix of interventions, it is difficult to know which elements are potent in enabling leadership development and which are redundant. Although they appear to be effective, they are costly and therefore tend to be used only for the most senior executives.

Developmental Assignments: The best way to learn to lead, many argue, is through experience rather than through formal training, so giving potential leaders challenging assignments can be helpful (McCall, Lombardo & Morrison, 1988; McCauley & McCall, 2014). The research evidence and anecdotal reports indicate that much depends on the quality of the assignments and the size of the assignment challenge. The greater the variety of tasks, in general, the better the learning that people derive. Moreover, the better and more timely the feedback, the more effective learning from assignments is. The importance of providing support is clear - simply dropping people into deep water can be detrimental rather than helpful to leader development.

Job Rotation: Job rotation is a system of encouraging leadership development by assigning people to multiple jobs within the organisation in a short space of time. Managers are usually encouraged to work in up to five or six different jobs over periods usually up to two years. Overall, there is little research evidence to support the value of this method of encouraging leader development simply because there have been too few studies to provide a clear picture.

Action Learning: Action learning groups are formed of individuals who meet together regularly while working on a specific project in their work areas or organisations. They meet under the guidance of a facilitator to set objectives, review progress, problem solve and share experiences. By working in such a group, motivation is increased and there is a strong sense of mutual support. There is some evidence that this works best when a whole team works together. Very few published studies have evaluated outcomes, however. Prideaux and Ford (1988a,b) reported positive outcomes, but these were based only on retrospective self-reported benefits. Much depends on how the groups are set up, the training of the facilitator and the development of appropriate group processes to support learning. All of these tend to be highly variable.

Mentoring: Mentoring refers to situations where an experienced manager works with a less experienced individual to support their leadership development. The evidence suggests that mentoring is useful, but there is little to suggest it leads to increased leadership effectiveness. It is notable that women tend to experience more difficulty in finding a suitable mentor within organisations than men.

Executive Coaching: It is mainly senior leaders and managers in organisations whose development needs are provided by executive coaches. The coach is usually a high-level (often retired) manager or specialist (such as an occupational psychologist). The purpose of coaching is to help the individual learn new skills, handle difficult problems, manage conflicts or learn to work effectively across boundaries. There has been only limited research so far examining the effectiveness of coaching, but what there is has been favourable (De Haan & Duckworth, 2013). Hall, Otazo and Hollenbeck (1999) reported on a study of 75 people from six companies for whom executive coaching was helpful. However, this study was based on self-reports and was retrospective, limiting confidence in the findings. Olivero, Bane and Kopelman (1997) assessed outcomes associated with a three-day training workshop, augmented by eight weeks of executive coaching focused on individual action projects. The results suggested the managers were more productive as a result of the training and these effects were augmented by the coaching; indeed coaching had the stronger effects of the two interventions. A study by Bowles, Cunningham, De La Rosa and Picano (2007) produced similarly positive results. A careful review suggests that there are clear benefits from coaching but most studies are flawed so solid evidence for effectiveness in predicting team and organisational performance outcomes is still lacking (De Haan and Duckworth, 2013). Again, much depends on the quality of coach training, clarity of structure and processes of coaching, the underlying theoretical model, supervision of coaches and clarity about overall purpose. Huge amounts of NHS money are spent on coaching but we have little evidence to indicate the return on this investment.

Above we have presented some evidence on the value of specific interventions to improve leader effectiveness in health care, whether or not they are delivered as part of multi-faceted programmes. We now go on to consider leader and leadership development in general in health care integrating both the academic and grey literatures in this review.

Leader development in health care

Broadly, the research literature shows that there is no best way to develop leaders; good leader development is context sensitive (Hartley, Martin, & Benington, 2008). Most frequently, this development is based on an analysis of the development needs of an individual leader, linked to a formal or informal gap analysis between desired capacity to lead, and the leader's actual capacity to do so.

One approach relies on the definition of leadership competencies. Numerous competency frameworks, competency libraries and assessments are available off-the-shelf and organisations have been using them for many years to map the leadership competencies required for the success of their organisations (Gentry & Leslie, 2007). Leadership competencies can be seen as the result of a leader's experience, wisdom and ability to perform effectively on leadership tasks that are presented to them in an organisational context, and which have cognitive, behavioural, emotional, and meta-level components (McClelland, 1973). The NHS competency orientation derives from the multiple and overlapping competency frameworks and career structures developed over recent years (British Association of Medical Managers, 2004; NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2010; NHS Leadership Academy, 2011 and 2013). A wide range of programmes based on these competency models have been delivered (including those offered by the NHS Leadership Centre between 2001 and 2006; the NHS Institute for Innovation and Improvement from 2007 to 2012; and currently the NHS Leadership Academy).

This national focus on leadership in the NHS has led to the development of a number of frameworks to support individual leadership development in the NHS and thereby team and organisational development. Their variety is a cause of some confusion. They include the NHS Leadership Framework (NHS Leadership Academy, 2011), which is for all staff in the NHS; the Medical Leadership Competency Framework (NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges 2010), the Clinical Leadership Competency Framework (NHS Leadership Academy 2011) and the Healthcare Leadership Model (NHS Leadership Academy, 2013). Varied instruments are used to underpin them that have, at best, poor psychometric properties and unclear theoretical underpinnings. Consequently, there is little evidence that their use translates into improved leader effectiveness or evidence about which framework is most appropriate or effective. As we saw above, the research literature does not show that using competency frameworks is demonstrably helpful in enabling leaders to improve their effectiveness.

Evidence of the effectiveness of leader development in healthcare mainly derives from research with medical and other clinical leaders. These populations, due to their non-managerial background and strong technical expertise, are often reluctant or ill-prepared to take up leadership positions and thus require high levels of support compared with leaders in other organisations (Curtis, de Vries & Sheerin, 2011; Heller, Denkart, Esposito-Heer, Romano, Tom, Valentine, 2004; Levenson, Atkinson & Shepherd, 2010; McKimm, Rankin, Poole, Swanwick, Barrow, 2009). One-off programmes do not provide the sustained support and continual improvement in leadership training likely to be necessary to ensure impact on key outcomes, such as quality of care.

Examples of more successful programmes from within the NHS include the Royal College of Nursing Clinical Leadership Programme (CLP), which has been offered since 1995 and exported as a toolkit to other countries (including Belgium, Australia, Singapore and Switzerland). Large, Macleod, Cunningham and Kitson (2005) and Martin, McCormack, Fitzsimons and Spirig (2012) found that the CLP in England and in Switzerland was successful in improving nurses' transformational leadership competencies. There is no evidence of benefits to patient care, however.

Several studies in the grey literature have identified the benefits of leadership development for individuals but again not in terms of patient care or other organisational outcomes. Stoll and Foster-Turner (2010) found that those participating in the NHS London 'Darzi' Fellowships in Clinical Leadership Programme, reported a 'mind-shift in their self-understanding, confidence and knowledge of leadership'. The Health Foundation programmes led to self-reported benefits for participants and a review noted the importance of supportive environments for transferring and applying skills both while on and after the programme (Walmsley & Miller, 2008). This theme was echoed in a study by Bagnall (2012) who interviewed 27 junior doctors pursuing leadership roles in health care. The doctors reported multiple barriers in their hospital settings upon completion of their leadership programme, including a lack of appreciation for their new skill set. A later review of The Health Foundation's portfolio of leader development courses suggested

that leadership development is helpful in enabling organisational improvement in healthcare (Hardacre, Cragg, Shapiro, Spurgeon & Flanagan, 2011).

In a review of nine studies of nurse leader development, all suggested a positive impact of such training on nurses' leadership behaviour and competencies (Cummings et al, 2008). Similarly, Janes (2008) and Williamson (2009) report qualitative evidence for the impact of a nurse leadership programme in changing behaviours and attitudes. However, not all such training is successful. An evaluation of a Canadian nurse leader programme showed no improvement in self-perceptions; only data from the nurses' (untrained) peers and supervisors endorsed the training's effectiveness (Tourangeau, Lemonde, Luba, Dakers, Alksnis, 2003). Similarly, the portfolio of standardised programmes offered by the NHS Leadership Centre, which trained more than 65,000 people, did not always achieve the goals intended (Hewison & Griffiths, 2004).

Other training programmes involve multiple professional groups working together, encouraging a multi-disciplinary perspective on leadership in the NHS, such as the Leadership Challenge programme (Department of Health, 2011). NHS South Central's Lead and Be Led programme provided a foundation of leadership training for all junior managers within the region, increasing participants' understanding of the NHS and how to navigate it successfully, as well as providing a basis for cross-disciplinary and cross-departmental collaboration and support. More than half of participants also reported organisational impact, such as raised cost-awareness, realisation of cost savings, and improved patient care (Eckert, Champion, Caza & Hoole, 2011).

Benefits of leader development can, however, go beyond the individual level and apply to organisations and patients, if participants can transfer their learning into their workplace and improve quality and efficiency in healthcare. Qualitative evidence from semi-structured interviews with 200 healthcare professionals revealed that leader development was seen as increasing workforce capabilities, enhancing efficiency in education and development, reducing turnover and related costs, and focusing organisational attention on strategic priorities (McAlearney, 2008). Further evidence for this is provided by an evaluation of the NHS Lanarkshire Clinical Leadership programme, which showed that participants reported cognitive learning, changed attitudes and better leadership behaviour (Sutherland and Dodd, 2008). However, most of this research is methodologically weak, largely based on self-reports, cross-sectional and does not control for likely third variable influences.

The patchy nature of the evidence suggests important moderating factors that affect whether and how leadership development interventions lead to improvements in health care team or organisational performance. Among the moderators are the design of programmes, knowledge and skills of facilitators, motivation of trainees, supports in the workplace and processes to facilitate the transfer of training. The following are characteristics of successful programme design (Yukl, 2013):

- Clear learning objectives - a limited number of clear objectives to ensure appropriate focus
- Clear, meaningful content - meaningful in relation to the objectives of training; periodic summaries of content and models that are simple enough for people to understand, remember and apply
- Appropriate sequencing of content - models should be presented before people are exposed to techniques derived from them; material should progress from the simple to the more complex; intervals in training to allow people to practice techniques and digest learning between training sessions
- Appropriate mix of training methods - formal lectures, practice sessions, role plays, coaching and experiential exercises can all be used as appropriate to the capacities of learners and the particular skills being taught
- Opportunity for active practice - trainees should be asked to restate the principles, try them out in a safe way and then put them into practice in the workplace with an opportunity to review effectiveness

- Relevant timely feedback - about the success or otherwise of leadership behaviours during the training process
- Promoting the self-confidence of trainees - reassurance, praise; by beginning with simple tasks, trainees can experience success before moving onto more complex tasks (eg dealing with poor performance or aggressive behaviours)
- Follow-up activities - specific tasks back in organisations with reviews of success and problems (see also Woods & West, 2014).

Leadership development in health care

In comparison with the focus on leader development, leadership development - the development of the capacity of groups and organisations for leadership as a shared and collective process - is far less well explored and researched. However, much of the available evidence, particularly in the NHS, highlights the importance of collective leadership (Dickinson et al, 2013; West, Eckert, Steward & Pasmore, 2014) and advocates a balance between individual skill-enhancement and organisational capacity building (Edmondstone, 2011). A collective leadership culture is characterised by shared leadership - by a constantly swirling mix of changes in leadership and followership, dependent on the task at hand or the unfolding situational challenges. Of course, there is still a formal hierarchy with dedicated positions but the ebb and flow of power is situationally dependent on who has the expertise at each moment. Research evidence suggests the value of this, particularly at team level: meta-analyses demonstrate that shared leadership in teams predicts team effectiveness, particularly but not exclusively within health care (Aime, Humphrey, DeRue & Paul, 2014; Carson, Tesluk & Marrone, 2007; D'Innocenzo et al, 2014; Wang et al, 2014).

The need for leadership cooperation across boundaries is not only intra-organisational. Governments, practitioners and policy makers are increasingly agreed that health and social care services must be integrated in order to meet the needs of patients, service users and communities both efficiently and effectively (Ferlie, McGivern, De Moraes, 2010; Huerta, Casebeer & VanderPlaat, 2006; Lemieux-Charles, Cockerill, Chambers, Jaglal, Brazil, Cohen, LeClair, Dalziel & Schulman, 2005; NHS England, 2014). Health care has to be delivered increasingly by an interdependent network of organisations. This requires that leaders work together, spanning organisational boundaries both within and between organisations, prioritising overall patient care rather than the success of their component of it. That means leaders working collectively and building a cooperative, integrative leadership culture - in effect collective leadership at the system level.

While academic traditions have focused on leadership in terms of entities - leaders, followers and shared goals (Bennis, 2007) - the changing nature of health care organisations and increased ambiguity and interconnectedness among organisations require a broader focus. This requires a new orientation to leadership based on collectives, not defined by individual leaders but by the three key leadership outcomes: (1) direction: widespread agreement in a collective (team or organisation) on overall goals, aims, and mission; (2) alignment: the organisation and coordination of knowledge and work in a collective; and (3) commitment: the willingness of members of a collective to subsume their own interests and benefits within the collective interest and benefit (Drath et al, 2008). Viewing leadership in such terms means that the practice of leadership would not only involve leaders, followers and their shared goals but would include the production of direction, alignment, and commitment). Likewise, leadership development would focus on developing direction, alignment and commitment in an organisation or team. This may involve the development of leaders, followers and shared goals, but is not confined to such entities and focuses more on the processes between those entities rather than the entities themselves.

The current emphases in the NHS on empowering clinicians and other front-line staff in terms of their decision-making competencies, also emphasises implicitly the need for collective leadership

that includes a broader practice of leadership by clinicians and other front-line staff, rather than by designated managers alone. The NHS Leadership Framework reflects the basic assumption that acts of leadership can and should come from anybody, not only those in formal positions of authority. Service-line management as advocated by Monitor is an example of leadership becoming more patient-centric and therefore more distributed amongst members of the service-line (Dickinson et al, 2013). Such collective leadership is best achieved by a developmental focus on the collective, rather than on individual leaders alone (because this focus would imply that others in the organisation are designated as non-leaders; a role-designation that runs contrary to the idea of collective leadership). Collective leadership development is often demanded explicitly or implicitly by best-practice recommendations, for example for public services (Northern Leadership Academy, 2007). Organisational leadership development, tailored to the organisation's needs and combining learning activities with practice activities, has been recommended for the NHS over the last decade (eg Bullivant, 2010; Degeling and Carr, 2004; Wood & Gosling., 2003; Hewison & Griffiths, 2004; Willcocks, 2005) and has been the focus implicitly of many development initiatives (Hardacre et al, 2011). However, traditional leader-centric development programmes with tenuous links to organisational outcomes have continued to dominate.

Evaluations of first attempts to introduce collaborative leadership development are relatively small scale, but show the positive impact such programmes can have for individuals to recognise interdependence and opportunities for cross-functional and cross-organisational collaboration (Rouse, 2013). So a priority for further research is to identify practical examples of collective leadership development within the NHS (such as development initiatives aiding an organisation's implementation of service line management) and to evaluate rigorously the outcomes of such interventions not only for the participating managers, but for the organisation as a whole and particularly for patient outcomes.

The implication of this new understanding of leadership is that our approach to leader and leadership development is distorted by a preoccupation with individual leader development (important though it is), often provided by external providers in remote locations. Developing collective leadership for an organisation depends crucially on context and is likely to be best done 'in house', highlighting the important contribution of Organisation Development and not just Leader Development. The leadership of organisations needs to be consistent in terms of leadership styles and behaviours; in developing shared leadership across the organisation; in embodying the vision and values of the organisation; in ensuring shared and consistent approaches to performance management; in practising compassion as a cultural value in all relationships within the organisation; in encouraging, facilitating and rewarding learning, quality improvement and innovation; and in developing team, inter-team and cross-boundary working within and across organisations in health and in social care. In addition, leaders must work together and build cultures where the success of patient care overall is every leader's priority, not just the success of their individual areas of responsibility.

National level leadership

National level leadership plays a major role in influencing the cultures of NHS organisations. Numerous reports have called for the various bodies that provide national leadership to develop a single integrated approach, characterised by a consistency of vision, values, processes and demands. The approach of national

leadership bodies is most effective when it is supportive, developmental, appreciative and sustained; when health service organisations are seen as partners in developing health services; and when health service organisations are supported and enabled to deliver ever improving high quality patient care. The cultures of these national organisations should be collective models of leadership and compassion for the entire service.

Reflections on leader and leadership development in health care

Overall, the evidence for the effectiveness of specific leadership development programmes within the NHS is highly variable and little robust evidence has been accumulated, despite the vast sums spent. Undoubtedly some programmes work for some people some of the time and the need to ensure effective leadership is clear, but evaluating their effectiveness empirically is challenging and demonstrating positive effects on patient outcomes has proved elusive. Leadership interventions in the NHS are diverse: participants face different work challenges and those providing the programmes have varying experience, knowledge and skill. Changes in the surrounding environment produce reactive responses from those providing programmes and often the content of programmes is not theoretically grounded. Health care interventions rely on evidence but leadership interventions in the NHS are often not evidence-based, reflecting more the providers' particular ideological enthusiasms. Evidence-based approaches to leadership development in health care are needed to ensure a return on the huge investments made. It remains true that experience in leadership is demonstrably the most valuable factor in enabling leaders to develop their skills especially when they have appropriate guidance and support. Focusing on how to enhance the learning from experience should be a priority (Day, 2000; Day & Harrison, 2007; McCauley & McCall, 2014).

Conclusions

The key challenge facing all NHS organisations is to nurture cultures that ensure the delivery of continuously improving high quality, safe and compassionate care. Leadership is the most influential factor in shaping organisational culture so ensuring the necessary leadership behaviours, strategies and qualities are developed is fundamental. There is clear evidence of the link between leadership and a range of important outcomes within health services, including patient satisfaction, patient mortality, organisational financial performance, staff well-being, engagement, turnover and absenteeism, and overall quality of care.

The challenges that face health care organisations are too great and too many for leadership to be left to chance, to fads and fashions or to piecemeal approaches. This review suggests that approaches to developing leaders, leadership and leadership strategy can and should be based on robust theory with strong empirical support and evidence of what works in health care. Health care organisations can confidently face the future and deliver the high quality, compassionate care that is their mission by developing and implementing leadership strategies that will deliver the cultures they require to meet the health care needs of the populations they serve.

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Appendix: Review methods

Previous reviews of research into leadership in health care have been limited in the knowledge they have offered, due to the poor quality of much research on leadership in health care. Compared to the broader literature on leadership in organisations, the huge volume of publications on health care leadership research offers little added knowledge. Often, this is because the research has not been theoretically based and research designs tend to be of poor quality. Applied research is based on very small sample sizes or specific settings. Consequently, the generalisable knowledge that can be gleaned from leadership research in health care is limited and reviews have reflected this. Here we proposed to review research into leadership in health care in the context of the wider leadership research literature. By and large, we suggest, the wider research literature is highly relevant to health care and we should draw on it to advance our understanding of leadership in health care specifically.

A literature review was conducted across a large number of databases: Business Source Complete (EBSCO), ABI/INFORM Complete (Proquest), Web of Science, Cochrane Library, PsycArticles (via Proquest), Scopus, JSTOR, PubMed, British Nursing Index (BNI), CINAHL (Cumulative Index to Nursing and Allied Health Literature), Health Business Elite, and HMIC. The search terms were limited to articles published in the last 10 years, in English, and peer-reviewed and the search was structured (details of the search terms are available from the authors). A separate review was conducted which looked at the grey literature and trade press. The databases used for this search were PubMed, British Nursing Index (BNI), CINAHL (Cumulative Index to Nursing and Allied Health Literature), Health Business Elite, and HMIC. This search was done from 2003 to 2013. Further details of process, coding and filtering are available from the authors.

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