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# Leadership in Health Care: A Summary of The Evidence Base

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# Evidence and implications

The Faculty of Medical Leadership and Management (FMLM), The King's Fund and the Center for Creative Leadership (CCL) collectively initiated a review of the evidence for leadership by a team including clinicians, managers, psychologists, practitioners and project managers. This review was published with a full list of references as *Leadership and Leadership Development in Health Care: The Evidence Base* (February 2015) and is available on the **FMLM** and **The King's Fund** websites.

This document summarises the evidence emerging from that review and outlines the main implications for leadership, as follows:

- Leadership of NHS organisations is required to ensure direction, alignment and commitment to the core task of ensuring cultures that deliver continually improving, high quality and compassionate patient care.
- Leadership is required to develop inspiring visions operationalised at every level by leaders; clear aligned objectives for all teams, departments and individual staff; supportive and enabling people management; high levels of staff engagement; learning, innovation and quality improvement in the practice of all staff; and effective team working.
- Leadership is required to embody support for staff, honesty, kindness, altruism, fairness, accountability and optimism.
- Leadership is required to ensure cultures that are not preoccupied with target setting, rules, regulations and status hierarchies.
- Leadership is most effective when all staff accept responsibility for their leadership roles, especially doctors, nurses and other clinicians.
- Leadership requires leaders to work together, spanning organisational boundaries both within and between organisations, prioritising overall patient care rather than the success of their components, and working collectively to build a cooperative, integrative leadership culture - in effect collective leadership.
- Developing such collective leadership for an organisation depends crucially on local contexts and is likely to be best done 'in house' with expert support, integrating both Organisation Development and Leader Development.
- Evidence-based approaches to leadership development in health care are needed to ensure a return on the huge investments made.
- Experience in leadership is the most valuable factor in enabling leaders to develop their skills, especially when they have appropriate guidance and support. Focusing on how to enhance leaders' learning from experience should be a priority.
- National level leadership is required that embodies developmental, appreciative and sustained approaches, with health service organisations seen as partners to be supported.
- National level leadership is required to ensure the overarching national organisations (Monitor, CQC, NHS England, NHS Trust Development Authority) exemplify models of collective leadership, positive cultures and have a core orientation of compassion towards the entire health service.

## The influence of leadership

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

## The leadership task

The leadership task is to ensure direction, alignment and commitment within teams and organisations. 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 on their individual or immediate team's success in isolation.

## Methodology and research evidence

The project team conducted a literature review across a large number of databases. The search was structured (details of the search terms are available from the authors) and limited to peer-reviewed articles published in English in the last 10 years. A separate review was conducted which looked at the grey literature and trade press.

Despite thousands of publications on the topic of leadership in health care, our review (consistent with others) 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.

# Leaders in health care

In reviewing the evidence, greater attention has been given to the medical and nursing professions than to other clinical and non-clinical leadership roles in health care. However, the research does cover leadership at team and organisational levels.

## 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 two-way partnership of medical leaders and general managers was perceived to be more important. There were variations both between, and within organisations in the extent to which doctors felt engaged in the work of their organisations. Those organisations 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 or 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 the percentage of clinicians on governing boards was low compared with international rates, but 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.

## Nurse leaders

Nurses prefer managers who are participative, facilitative and emotionally intelligent and such styles are in turn linked to team cohesion, lower stress, and higher empowerment and self-efficacy. Effective nurse leaders are 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 and staff levels of well-being, burnout and turnover intention. In their literature review [Wong, Cummings, and Ducharme \(2013\)](#) also note a relationship between nurses' relational leadership styles and lower levels of mortality rates and medication errors.

[Katrinli, Arabay, Gunay and Guneri \(2008\)](#) examined the quality of nurse managers' relationships with their staff, 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. The evidence clearly suggests the value of transformational and authentic leadership as a predictor of quality outcomes in health care settings. Such styles are characterised by leaders offering good role models consistent with values and vision for health care, individualised consideration of staff, inspirational motivation and stimulation of creativity and innovation among staff. Authentic leadership is characterised by honesty, altruism, kindness, fairness, accountability, and optimism; authenticity implies consistency with values of providing high quality and compassionate patient care.

## Team leaders in health care

Effective team working is essential for organisational success and is frequently cited in the grey literature. The largest study to date used team member ratings of leadership in an NHS sample of 3,447 respondents from 98 primary health care teams, 113 community mental health teams, and 72 breast cancer care teams. The results revealed leadership clarity was associated with clear team objectives, high levels of participation, commitment to quality of care, 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 meta-analyses of research consistently indicate that, across sectors, shared leadership in teams predicts team effectiveness (eg [D'Innocenzo, Mathieu & Kukenberger, 2014](#); [Wang, Waldman & Zhang, 2014](#)). These findings are not inconsistent. Having a clearly designated team leader may be associated with less conflict over leadership and contribute to team members smoothly assuming 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 NHS 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. 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 top management team leadership predicted the performance of hospitals in both studies: in the first, it was strongly and positively associated with clinical governance review ratings, and significantly lower levels of patient complaints; in the second, it was linked to high hospital star ratings as well as high clinical governance review ratings. This is one of the few studies examining leadership and organisational outcomes in health service settings.

# Leadership, culture and climate in health care<sup>1</sup>

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*”. Meterko, Mohr & Young (2004) assessed organisational culture from 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. 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. In all studies of culture in health care, dominant hierarchical cultures, characterised by a preoccupation with target setting, rules, regulations and status hierarchies never predict good performance. Instead, they potentially inhibit a positive climate for safety due to fear of negative outcomes and blame for reporting safety-related problems.

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; 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. The noteworthy finding was that the best performing hospitals had high staff engagement in decision-making and widely distributed leadership.

The largest study of culture in the NHS (Dixon-Woods, Baker, Charles, Dawson, Jerzembek, Martin, McCarthy, McKee, Minion, Ozieranski, Willars, Wilkie, West, 2014) reached similar conclusions. It involved 299 interviews with key stakeholders; over 650 hours of ethnographic observations; 715 survey responses from patient and carer organisations; team performance data from 651 clinical teams; and archival analysis of 793 sets of minutes from 71 Boards for 18 months. The researchers concluded that six key elements were necessary for sustaining cultures that ensure high quality, compassionate care for patients: inspiring visions operationalised at every level by leaders; leaders ensuring clear aligned objectives for all teams, departments and individual staff; supportive and enabling people management; high levels of staff engagement; leaders focused on ensuring learning, innovation and quality improvement in the practice of all staff; and effective team working.

Organisational 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*”. A number of studies have shown first line supervisors play an important role in influencing climate and determining the performance of health care organisations. In a longitudinal study of 52 acute hospitals in the UK, 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 remained after controlling for prior mortality levels in the hospitals and a variety of potential influencing factors (eg number of doctors per 100 beds, number of public health care facilities

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<sup>1</sup> 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.

per 100,000 population). So, 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. 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 longitudinal study, involving 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 and 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. The data from this large NHS study were collected over time (eight years) and many of the analyses are longitudinal with careful controls for potential confounds. So, 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.

## Leader and leadership development

Leader and leadership development are vital for health care, but use considerable resources from budgets under great pressure. NHS England has invested 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.

One approach relies on the definition of leadership competencies. Numerous competency frameworks, libraries and assessments are available off-the-shelf and organisations have been using them for years to map the leadership competencies required for the success of their organisations. The NHS competency orientation derives from the multiple, overlapping competency frameworks and career structures developed over recent years. 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). Varied instruments are used to underpin these competency frameworks with the majority having, at best, poor psychometric properties and unclear theoretical underpinnings. Consequently, there is little evidence that the use of these competency frameworks translates into improved leader effectiveness or evidence about which framework is most appropriate. The research literature on leadership generally does not yet show that competency frameworks are potent in enabling leaders to improve their effectiveness.

Evidence of the effectiveness of leader development in health care mainly derives from research with medical and other clinical leaders. One-off programmes generally do not provide the sustained support and continual improvement in leadership training to ensure impact on key outcomes, such as quality of care. There are examples of successful programmes from within the NHS such as the Royal College of Nursing Clinical Leadership Programme (CLP), which has been offered since 1995 and has been shown to improve 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 not in terms of patient care or other organisational outcomes. 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 after the programme. Doctors report multiple barriers in their hospital settings upon completion of leadership programmes, including a lack of appreciation for their new skill set. A review of the Health Foundation's portfolio of leader development courses suggests they were helpful in enabling organisational improvement in health care. In a review of nine studies of nurse leader development, all suggested a positive impact of such training on nurses' leadership behaviour and competencies. However, demonstrated links to patient outcomes are difficult to discern from the existing research literature.

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 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 power is 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.

The need for leadership cooperation across boundaries is not only intra-organisational. Health and social care services must be integrated in order to meet the needs of patients, service users and communities both efficiently and effectively. Health care has to be delivered by an interdependent network of organisations which requires leaders to work together, spanning organisational boundaries both within and between organisations, prioritising overall patient care rather than the success of their component of it. This means leaders working collectively and building a cooperative, integrative leadership culture - in effect collective leadership at the system level.

The current focus in the NHS on empowering clinicians and other front-line staff in terms of their decision-making competencies also emphasises the need for collective leadership that includes a broader practice of leadership, 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. 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. 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 house' with expert support, highlighting the important contribution of Organisation Development and not just Leader Development. Overall, the evidence for the effectiveness of specific leadership development programmes within the NHS is highly variable. 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.

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 such learning from experience should also be a priority.

### National level leadership

National level leadership plays a major role in influencing the cultures of NHS organisations. Many reports have called for the 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.

## 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.



# Acknowledgements

The authors would like to thank the following people for their support and involvement in this work:

Deena Maggs, Beatrice Brooke and Kirsty Morrison (The King's Fund)

Anna Topakas (University of Sheffield)

Wouter Keijser (TeamSHOPP Netherlands)

Elise Anderson (Center for Creative Leadership)

Peter Lees (Faculty of Medical Leadership and Management)

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This summary is taken from West, M.A., Armit, K., Loewenthal, L., Eckert, R., West, T., and Lee, A. (2015) Leadership and Leadership Development in Health Care: The Evidence Base. London, FMLM/The King's Fund/CCL.

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