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### Leadership in Healthcare: A Review of the Evidence



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The delivery of clinical care is based on careful research to determine the most effective way of providing care for patients. At the same time the UK National Health Service (NHS) spends huge amounts on leadership development without a clear understanding of what kind of leadership and leadership development has most impact on patient outcomes.

#### **The Leadership Task**

The leadership task is to ensure direction, alignment and commitment within teams and organisations (Drath et al. 2008). Direction ensures agreement among people in relation to the organisation's vision, values and strategy. Alignment refers to effective coordination 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.

#### **Research Evidence**

Despite thousands of publications on the topic of leadership in healthcare, a recent review (West et al. 2015) reveals relatively little research conducted to a high academic standard. In addition, much of what is written about leadership and much effort on leadership development in the NHS is based on fads and fashions rather than theory-driven evidence. Moreover, successive government reviews often fail to draw on the evidence base, only adding confusion via strong opinion to the vast body of writing on what constitutes good leadership in healthcare. The evidence is clear though: leadership at every level - from frontline leadership in wards, primary care and community mental health teams, to board leadership in trusts, to national leadership in overseeing bodies - is influential in determining organisational performance. The evidence points towards the need for what we call collective leadership. Collective leadership is characterised by shared leadership, where there is still a formal hierarchy, but power is more dependent on who has the expertise at each moment. Leadership is most effective when all staff, especially doctors, nurses and other clinicians, accept responsibility for their leadership roles. Collective leadership is characterised by leaders working together to nurture a shared culture, adopting leadership styles that are consistent across the organisation, and cooperating and supporting each other across boundaries within the organisation to deliver continually improving, high quality and compassionate patient care.

We conducted a literature review across a large number of databases, including Business Source Complete (EBSCO), Web of Science, British Nursing Index (BNI), CINAHL (Cumulative Index to Nursing and Allied Health Literature), and JSTOR. We limited our search terms to articles published in the last 10 years, in English, and peer-reviewed. A separate review was conducted, which looked at the grey literature and trade press. Below, we briefly summarise some of the evidence we found from our review, in relation to key leadership groups.

## **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 et al. (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 wellbeing, burnout and turnover intention. In their literature review Wong et al. (2013) also note a relationship between nurses' relational leadership styles and lower levels of mortality rates and medication errors.

Katrinli et al. (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. 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.

## **Medical Leaders**

In a large scale review of medical leadership models Dickinson et al. (2013) found that medical or clinical leadership varied across the case study sites they assessed. There were reported 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 medical engagement performed better on available measures of organisational performance than others. In an earlier study Hamilton et al. (2008) found that in high-performing trusts, interviewees consistently identified higher levels of medical engagement. Additionally, Veronesi et al. (2013) examined strategic governance in NHS hospital trusts, and found that the greater the percentage of clinicians on governing boards the better the performance, patient satisfaction and morbidity rates (inversely) were.

## **Team Leaders in Healthcare**

Effective team working is an essential factor for organisational success, 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. The results revealed that leadership clarity was associated with clear team objectives, high levels of participation, commitment to quality of care and support for innovation. Where there was conflict about leadership within the team, team processes and outcomes were poor. However, more recent metaanalyses of research consistently indicate that, across sectors, shared leadership in teams predicts team effectiveness (eg D'Innocenzo et al. 2014; Wang et al. 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**

In one of the few studies examining the relationship between leadership and organisational outcomes in healthcare, Shipton et al. (2008) investigated the impact of leadership and climate for high quality care on hospital performance. The research revealed that top management team leadership predicted the performance of hospitals. Specifically, top management team leadership was strongly and positively associated with clinical governance review ratings, hospital 'star' ratings, and significantly lower levels of patient complaints.

## **Leadership, Culture and Climate in Healthcare**

In the largest study of culture in the English National Health Service (NHS), Dixon-Woods et al. (2014) 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.

Another large scale, longitudinal study, involving all 390 NHS organisations in England, identified a link between aspects of climate (eg working in wellstructured team environments, support from immediate managers, opportunities for contributing toward improvements at work) and a variety of indicators of healthcare organisation performance (West et al. 2011). Climate scores were linked to outcomes such as patient mortality, patient satisfaction, staff absenteeism, turnover intentions, quality of patient care and financial performance. The results revealed (among many other relevant relationships) 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.

## **Leader and Leadership Development**

Leader and leadership development are vital for healthcare, with considerable resources dedicated from budgets always under great pressure. In the UK, 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 percent 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, 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. The UK NHS competency orientation derives from the multiple and overlapping

competency frameworks and career structures developed over recent years. A wide range of programmes based on these competency models have been delivered, and 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 healthcare 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 likely to be necessary to ensure impact on key outcomes, such as quality of care. However, there are examples of more successful programmes from within the NHS such as the Royal College of Nursing Clinical Leadership Programme (CLP), which has been offered since 1995, and which has been shown as successful in improving nurses' transformational leadership competencies. There is no evidence of benefits to patient care, however.

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, as previously noted 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. 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 healthcare.

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. Healthcare 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 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.

Evidence-based approaches to leadership development in healthcare 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. The challenges that face healthcare

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 healthcare. Healthcare 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 healthcare needs of the populations they serve.

### **Key Points**

- Leadership in NHS organisations needs to ensure direction, alignment and commitment to the core task of developing cultures that deliver continually improving, high-quality and compassionate patient care.
- Leaders need to work together, spanning boundaries within and between organisations, prioritising overall patient care rather than the success of individual components, and to build a cooperative, integrative leadership culture – in effect collective leadership.
- Developing collective leadership for an organisation depends crucially on local contexts and is likely to be done best ‘in house’ with expert support, integrating both organisational development and leadership development.
- Evidence-based approaches to leadership development in healthcare are needed to ensure a return on the huge investments made.

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