Change management in the NHS - Distributed leadership
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Abstract

The on-going changes in UK health policies, such as NHS 2000, Health and Social Care Act (2012), NHS Act (2014), Five Year Forward View and now the NHS Long Term Plan (2019) have aimed to promote competition, provide enhanced performance and deliver better quality care to patients. However, the financial constraints have presented unique challenges for healthcare leaders. To engage with these ongoing changes and the repetition of policy, which underpins it, the service has had to become even more adaptive. This article explores the opportunity to apply distributed leadership across the healthcare environment.

Key words: Healthcare management; Healthcare leadership; distributed leadership; health policy

Introduction

The changing face of health policy in the UK is profound. Major restructure, policy, financial and managerial reforms have been continually put in place to promote competition, provide enhanced performance information and create various sizes of health organisations. Governments of all complexions have endorsement various levels a quasi-market system with notional choice. These changes have created tension within management, both within organisations and across partnerships, especially in relation to performance and finance. These changes have informed professional autonomy of healthcare organisations and transformed accountability within the health sector (Barr and Dowding, 2012).

The NHS is located within an integration control system, and traditionally the administrators in healthcare were the management which abided with policy instruction (Layland, 2018). The administrative superstructure tended to buffer the weak technical core of healthcare provision from exterrnal scrutiny. Historically managers, had limited involvement in improving practice effectiveness as they were focussed on healthcare management (Gopee and Galloway, 2009). Changes introduced since 1997 have produced a drive towards inspection and regulation

which has helped to reform standards and performance management, with accountability being central to leadership and management approaches. However, there have been failures of leadership and subsequently performance and finance, none more so than reported by Francis (2013). This article will explore the behavioural aspect of leadership style and its effect on management practice.

Methodology

A critical review of the relevant literature in leadership and healthcare management was undertaken to establish an original view point on the subject of distributed leadership in healthcare. The literature search focused on the use of secondary literature only from a number of databases. The first step taken was to define the search parameters and undertake a systematic review on literature that was relevant on the subject. To help to define the subject matter and refine the search, keywords were generated; change management, NHS transformation and distributed leadership. A systematic review excluded duplications and where full-texts were unavailable. This research identified of two main concepts – leadership and service quality – and those two concepts were further refined to provide a focus on the themes to other associated research terms like: stakeholder theory, corporate governance, business ethics, microfinance and strategic policy. The criteria applied to the research included the date of publication, theory relevance, and reference in other publications, the position of support or contradiction to the central theme of research, bias and methodological omissions. This resulted in a small volume of suitable literature for this article.

Leadership Approaches

Jeremy Hunt the former health secretary from 2012 to 2018 applied healthcare reforms which placed a premium on the relationship between leadership, healthcare improvement and service provision. Strategic healthcare leadership was an unmentioned driving force behind the policies created across the country. However, there are difficulties with this position as leadership in healthcare settings are informed by resources, of which we know there is a huge deficit of. This practitioner is the facilitator of change and transformation through empowerment, but the NHS is intrinsically centralised and transactional by nature. Transformational versus transactional leadership is required in situations of organisational transformation and

organisational stability (Northouse, 2018). Paradoxically, while the NHS has been viewed as structurally stable, it has always experienced organisational change even from its inception (Layland, 2018). Healthcare management is in a constant state of flux given the ongoing reform process and competing pressures being enforced by regulators and national bodies (Barr and Dowding, 2012).

The reality of a readily supply of suitable leaders with vision, that are capable of transforming failing healthcare organisations, while dealing with day to day routines is not present (Rose, 2015). Senior management are expected to master skills and knowledge ranging from leadership and political expertise to deal with community demands, to instructional roles to managers dealing with finance, contracts and operations. Multiple frameworks and models have been developed in an attempt to achieve this, however, seldom is this used consistently across organisations. Models such as the Clinical Leadership Competence Framework (2011), Healthcare Leadership Model (2013) and Developing People - Improving Care (2016) are all available but rarely commented upon in healthcare management literature. We argue that a commitment to organisational vision and culture can be achieved by adopting a strategy of distributed leadership through a network of interacting individuals engaged in concerted action to create an organisational or system culture based on trust rather than regulation, in which leadership is based on knowledge and not position. However, this theoretical position has been difficult to achieve practically.

Distributed leadership

Armstrong and Laschinger (2006) describe three different types of distributed leadership: collaborative, collective and co-ordinated distribution. They point out that collaborative distribution occurs when leaders work together to carry out a specific leadership function that develops into shared practice. Collective distribution occurs when two or more leaders work separately, but interdependently, towards a common goal that creates shared practice. Coordinated distribution occurs when different leadership tasks are performed in a particular sequence for the execution of a leadership function. Each of these types of distributed leadership require more people in leadership roles within a healthcare setting which we would state leads to new ideas and solutions, whilst creating a strong team approach. This can potentially shift the traditional norm of staff isolation into a shared vision (NHS Leadership

Academy 2013) and we suggest that this then can lead to implementation of shared strategies, in terms of the transformational model.

The essence of distributed leadership is indicated within multiple leadership development frameworks. However, it does not challenge the notion of leader and follower relationships but rather suggests that the focus is on how leadership practice is distributed in a 'de-centred' environment whereby healthcare professionals develop expertise by working collaboratively. A format which is not distributed leadership but inter-professional practice. Leadership which is distributed across formal and informal leaders can represent the 'glue' holding together the common vision and culture necessary in a knowledge intensive organisation. Reiling (2005) argues leader behaviour and style is central to effectiveness. He considered that a shared leadership, team leadership and democratic leadership are not synonymous for distributed leadership. In fact, whilst these are related, there are individual characteristics that differentiate this theory (Layland, 2019).

We believe that this presents a limiting condition between the dichotomy of distributed leadership and managerial power. Policy is not predicated on the successful application of transformational leadership by senior management through distributed leadership, but rather through a range of regulatory and performance management mechanisms to ensure compliance, which is highly considered to be transactional methods (Northouse, 2018). This has presented a notional reduction in central control replaced by ambiguity of intent which entrenches positional power. At the very time that health demands are intensifying, distributed practices appear to be becoming the accepted norm. Government policy instruments are increasing accountability measures that bear little connection with distributed practices and are likely to exacerbate and intensify pressure on healthcare leaders. We have recognised that heightened performance expectations have influenced people who are uncertain about the future direction of their careers with additional grounds for disengaging and abstaining from becoming leaders. This is reflective in the current senior level vacancies across the health service. We therefore argue that the separation of power (Benwell and Gay, 2011) and leadership can be affected when leadership is exercised by a body of professionals in a healthcare environment through a non-hierarchal network of collaborative learning, alongside and separate

from a hierarchal power structure. The promotion of distributed leadership is essential to mediate Government policy and internal cultures within healthcare organisations. We believe that it is only the effective devolution of power to practitioner level which will create an effective distributed leadership strategy and hence, practitioner led reform.

Leadership and change

An organisation can only perform effectively through interaction with the broader environment of which it is part (Senge, 2006). The underlying objectives of change are therefore modifying the behavioural patterns of members of an organisation and improving the ability of the organisation to comply with changes in its environment.

Strategic leadership is required to effect meaningful sustainable change through effective management of the change process (Senge, 2006). Change management is similar in description to transformational leadership and is considered the art of influencing people and organisations in a desired direction to achieve an agreed future state to the benefit of that organisation and its stakeholders (Kotter, 1996). This description has elements of vision in terms of a desired future state and supports the notion of transformational leadership. Distributed leadership offers a positive channel for change but requires change agents to carry forward the transformation through a 'guiding coalition' with 'boundary spanning' managers as change agents who are capable of translating a leader's vision by means of language and material artefacts in a meaningful form.

Given that change is reciprocal and affects both managers, staffs lives and careers, the difficulty is the assessment of strength or duration of a force, particularly when the human dimension is considered in terms of resistance to change. Woods and West (2014) suggest that politically driven change heightens resistance in a transactional management environment typical of the traditional authoritarian style healthcare leadership paradigm. He suggests that in these circumstances, change occurs through the application of coercive power of the management (French and Raven, 1960), but staff passively resist the change and the system reverts to 'the way it always is'. We can therefore determine that the shift from an autocratic style of management through a hierarchal structure in a loose coupled environment to that of

a distributed leadership model operating through a flatter structure is therefore particularly susceptible to resistance especially since it interferes with professional autonomy.

The nature of reform ==in healthcare== requires rapid change. Given the historical factors, where the established way of doing things is entrenched in the system, an autocratic style of leadership is best suited for revolutionary change (Northouse, 2018), while transformational change requires time to realign and adapt to the new paradigm. This contradiction in terms of healthcare reform processes suggests that transformational leadership through a distributed leadership strategy without an appropriate time-frame is likely to create stressors at the individual level because the change management process is paradoxical in message. Resistance to change can take many forms and it is often difficult to pinpoint the exact reasons for resistance. Key factors include ignoring the needs and expectations of professionals, providing insufficient information, and conditions where practitioners do not accept or perceive the need for change. Fears include deskilling of job content, loss of job satisfaction, changes to social structures, loss of individual control over work and greater management control. Healthcare professionals' own interpretation of the drivers of change present a unique perspective which can translate into selective perception and a biased view of reality, thus responding to change in an established and accustomed manner. Habit serves as a means of comfort and security and as a guide for decision making. Proposed changes to established habits will cause resistance unless there is a clear perceived advantage. Changes to education, especially in the area of performance management have meant an inconvenience and loss of freedom which together with the economic implications of increased workload without pay adjustment, and threat to job security could lead to increasing resistance. ==What is the problem with the term 'performance management' though? This fear of terminology and== traditional healthcare structures have provided security with any tendency for a return to the well-established comfortable procedures of the past means that a vigorous change management process is difficult to implement (Mullins, 2000).

Emphasising non-monetary benefits of change, communication programmes focussing on fears and concerns, and eliciting spousal and significant other support

are critical success factors for movement to a transformational model. By implication, shared knowledge of learning outcomes, standards and shared practice, together with professional development plans and a peer evaluation program can reduce resistance and lead to improved service provision and instructional outcomes. The NHS Leadership Academy (2013) calls this 'shared purpose'. At an organisational level, (i.e. the level of application of a distributed leadership strategy), resistance is influenced by the culture of the NHS and the maintenance of predictability and stability. The traditional model has relied on organisational structure and mechanistic rules, procedures and policies. Voyer and McIntosh (2015) argues that the decisive issue in movement from autocratic to distributed leadership is the question of ultimate strategic power. Distributed leadership approaches or a watered-down democratic leadership style, is a function of the exercising of power by a dominated hierarchy. They argue that many in authority see a transformational leadership approach and the practice of distributed leadership as a means of mediating government policy through their own value systems. The contradiction rmeans that the senior management remains accountable in a target-based culture and hence limits the practice of distributed leadership to a minority of senior staff. This then reduces the risk of a challenge to changing policy that would be allowed in a participatory or democratic leadership environment. McIntosh, Voyer, and Shenoy (2013) consider that the distributed leadership ideal cannot be achieved within government driven policy. The change process and impact on staff presents an irreconcilable resistor to authentic distributed leadership and in so doing, reinforcing the leader-follower model of transformational in its theoretical form.

Potential translation of the current transactional model of leadership enacted through autocratic leadership styles that are entrenched in a bureaucratic hierarchy, into the distributed leadership model is not a theoretical academic ideal, but rather a function of a change in government policy and a real commitment to the ideal of devolved power to the lowest unit of leadership.

Discussion

Leadership approaches in healthcare delivery and structures are cyclical. As a task-orientated discipline there had been long held aspirations to attain greater flexibility. These aspirations were in part achieved due to a combination of changes

necessitated by demographic developments and political factors. They resulted in a transition from a prescriptive to a proscribed education system. This has had serious implications for those seeking to exercise independent judgement. Two conflicting aspects emerged, the requirement for practitioners to give account for their practice decisions and the contrasting requirement for staff to act as practitioners in accordance with managerial directives. For autonomy to be operational, there must be a culture within the working environment that will allow it. However, there is an underlying assumption of an incompatibility with autonomy of practitioners and managerial requirement to control rising costs. When considering cost pressures, leaders should devolve their power through distributed leadership and ask their staff to consider what does and does not add value to the patient journey. If it does not add value then serious questions must be asked about its necessity.

Change has incrementally led to a progressively systematised form of delivery which reduces professional autonomy and transforms the practitioner into a highly skilled practitioner who just follows pre-determined procedures. This is not autonomy. This evidence supports the perception, in a post-Fordism context, of an increasing reliance on a core of functionally flexible, re-skilled workers who perform an increasingly diverse range of tasks, surrounded by a periphery of less skilled, numerically flexible workers, namely, healthcare assistants. Against the background of economic constraints and an increasing emphasis on 'customer satisfaction' within a more market-driven approach to healthcare, some managerial functions are also being devolved downwards. Healthcare Management is being transmuted both unintentionally and unwillingly into a form of management devoid of leadership. These developments only increase the tension between professional autonomy and change with a consequent danger of an erosion of the principles of professional beneficence independence.

It is evident that there is a conceptual confusion among healthcare professionals. The use of one-way rhetoric has been striking, with managerial concepts and language imposed upon the profession exposing the nature of change driven by several coinciding factors. Firstly, that the healthcare hierarchy have the aspiration and are not unduly concerned about the basis on which it is established. Secondly, that it has arisen out of political necessity, to address devolutionary changes that

have affected the profession. Professionalism certainly has been seen as a way of appealing to a wider candidature. Thirdly, change in itself is a hegemonic imposition to exert control by distorting the use and meaning of terms in order to manipulate a group of staff by encouraging them to believe they have one status, while exerting control by another means. The resulting confusion can render staff very vulnerable to suggestion and direction.

Conclusion

There are three distinct and separate challenges facing healthcare. The first is financial both for staff and the institution. Secondly, there is an equal and opposite pressure of expectations from staff and the public. Thirdly, there are considerable workforce shortages which question how distributed leadership could play its part in supporting future workforces. Overall, these present a unique and pressing challenge in relation to leadership. However, how this response is framed is a challenge within itself and requires cultural changes to embed better leadership across healthcare.

We believe that distributed leadership is the only way to encourage systems to work together, to know the various intricacies of the system and to determine how change may affect areas. These are vital skills of leaders across healthcare. However, while facing the triple-threat and having policies that restrict distributed leadership, there are limited practical steps to be taken which can improve healthcare for patients, but more importantly improve the leadership of those who work in healthcare, which in turn can have major positive effects.

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