

The competencies of leaders of innovative change in health service organisations: an exploratory study

George Stewart Boak

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Business School

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The candidate confirms that the work submitted is his own and that appropriate credit has been given where reference has been made to the work of others

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Abstract

This thesis contains an account of research into the competencies used by leaders of innovative change in health service organisations. A competency is defined as a capability that enables an individual to be effective in a task or a role. Leadership is defined as a process of influencing others to agree what needs to be done, and how it can be done, and assisting efforts to achieve the agreed aims. Innovative changes are changes that involve novelty to the organisation or group to which they are introduced.

A qualitative approach was taken to the research. Interviews were carried out with forty executives and clinicians in UK and Australian health service organisations, who had been identified as effective in leading change. The interviews followed a Behavioural Event approach, based on the critical incident method, and the recordings and transcripts were subjected to a grounded analysis to derive descriptions of behaviours and competencies.

Eleven competencies were identified from the interviews, including the ability to make sense of complex social systems, and the ability to work well in collaboration with others. The eleven competencies were used in combination in a range of leadership styles that were participative, collaborative, persuasive, transactional, pragmatic, personable and managerial. The majority of interviewees described bringing about effective change using styles that were not visionary – and therefore that did not employ what is often regarded as a central element of the leadership of change, and of transformational leadership, that of an appealing vision of the future. No significant differences in the competencies employed were found between UK and Australian interviewees in comparable roles.

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1. Introduction

This research asks: what capabilities do people need in order to bring about innovation and change in healthcare organisations, and what behaviours do they need to employ if they are to be successful leaders of change? These are relevant questions at a time when the effective provision of healthcare is so important to individual citizens and the organisation and delivery of healthcare in the UK consumes so much public money. Their relevance is increased by the pace of change, and the pressures to change, in healthcare organisations in the UK and elsewhere.

The period from 1997 to 2007 saw a series of policy-driven changes in UK healthcare organisations, systems and strategies. The sheer volume (and detail) of these central government policies, directives and targets may incline a detached observer to believe otherwise, but the success of these attempts to change healthcare organisations relies upon the actions of the members of those same organisations. The policies not only directed, restricted and constrained managers and professionals, but also required (and in some cases simply gave opportunities to) members of healthcare organisations to take on new roles, to take initiatives, to tackle problems in different ways, to innovate. Government-driven changes were the most obvious challenge (or opportunity) for the managers and professionals of healthcare organisations during this-period, but they were also facing changes in technology, demographics, and in the expectations of communities, patients and employees, that apply in particular forms to the business of healthcare. This research seeks to make a contribution to understanding how individuals can play an effective part in leading change in such organisations in such turbulent times.

In the course of the research, I interviewed 40 individuals who were identified as effective in leading change, 30 of them in the UK and ten, for purposes of comparison, in Australia. The interviews were recorded, transcribed, coded and analysed, in order to arrive at a framework of competencies and behaviours.

In addressing this issue I am aware that the behaviour of individuals is only one element influencing the success of attempts to bring about change. Salaman (2004)

argues that individual leadership is being called to account for organisational ills that may have structural or systemic causes, and in a similar vein Collins (2001:21) writes:

[The] "Leadership is the answer to everything" perspective is the modern equivalent of the "God is the answer to everything" perspective that held back our scientific understanding of the physical world in the Dark Ages

A dissatisfaction with the focus on individual leaders has led some writers to concentrate on leadership as a collective activity, but in this research I have sought to maintain a focus on the individual as they play or attempt to play a leadership role. Even if we accept it is useful to view leadership as a distributed or dispersed activity in modern organisations, it is still also useful to consider individual behaviours. If a person with formal authority accepts the value of dispersed leadership, then what should he/she do to encourage others to contribute? If organisations establish teams or other arrangements to support dispersed leadership, then how should the individual members behave?

I set off on this research with the aim of making some contribution to knowledge in this area, and also hoping that I could make some practical contribution to how people in healthcare systems *think* about leading change, and therefore to how they *actually go about* leading change in future. A description of relevant skills and behaviours seemed an appropriate way of presenting this contribution. Over the course of the research, I sometimes reconsidered my targets – would I seek to present a full framework (or even a set of frameworks)? Or would I concentrate on certain specific competencies (in the manner of Goffee and Jones 2000 or Skinner and Spurgeon 2005)? Given the controversy surrounding competencies and their current unpopularity in academic circles, should I seek to describe 'dimensions' or 'strategies' or 'elements' of leading change? However, throughout the research process I sought to produce a useful statement of what people did, what actions they undertook, in order to bring about change in their part of the healthcare system.

By including leadership, competencies and healthcare systems, the research contained much that was of personal interest to me. Locke (2001), Mason (2002) and others argue that the researcher's biography is relevant to qualitative research, and it is easy to see how certain aspects of my experience and career history inclined me towards this area of inquiry and towards the research methods I chose.

I have had a long-term interest in the practical application of theory about what managers do, particularly in the public sector. In 1983, as a lecturer at Newcastle Polytechnic, I began to develop and deliver short courses for practising managers and professionals on skills-based areas such as effective communication, prioritising, negotiation. In 1987 I joined the Northern Regional Management Centre (NRMC) an organisation established by the three then-Polytechnics in the North East, with a remit to design and pilot more flexible approaches to management development. NRMC won funding from the national Manpower Services Commission (the MSC - an organisation that was later re-absorbed within the Department of Employment) to develop qualifications programmes that used open learning approaches – including distance learning methods (which at that time consisted of printed, interactive materials) and negotiated agreements (called management learning contracts) about what a learner would do and how this could be assessed as part of a qualification (Boak 1998). My work at NRMC included:

- incorporating the managerial competency framework developed for the American Management Association (Boyatzis 1982) into an MBA programme
- leading one aspect of a large, UK-wide project, funded by the MSC, to identify the 'competences' of supervisory, first-line and middle managers, a project which led to the publication of the Management Standards by the Management Charter Initiative designing and delivering qualifications courses based on those Standards
- leading a small team in NRMC on a follow-on project for MCI to research behavioural competencies of senior managers, using a research approach based on the Boyatzis research
- incorporating this competency framework into an MBA programme

In 1995 I became self employed and continued to carry out projects funded by the Department for Education and Employment, later the Department for Education and Skills. These projects were mainly focused on encouraging activities on the edge of mainstream university business school work, supporting the development of flexible, work-based programmes, programmes for small businesses, or competency-based programmes. In this way I continued to be part of, and to witness, efforts to combine

academic inquiry into aspects of leadership, and academic delivery systems, with the immediate practical needs of individual managers in the workplace. As part of my self-employed portfolio I also developed other corporate competency frameworks for managers.

I was introduced to the final element of this current research in 1997, with the beginning of what has become a prolonged and extremely interesting exposure to the world of healthcare, and the business of trying to lead change within healthcare organisations, when I began working as a tutor on a part-time executive MA, which has recruited senior and middle managers mainly from the National Health Service, at what is now York St John University. I have also undertaken some consultancy activity in healthcare organisations, and, since 2002, I have helped to research and design competence frameworks, on national projects, for various clinical functions in healthcare, for Skills for Health, the Sector Skills Council for healthcare.

From the early 1990s, therefore, I was interested in leadership and leading change, and how to blend academic and practical concerns in those topics, and in the competencies of leaders and managers, and how they could be researched and then used to help individuals to develop. From the late 1990s and into this century I have had an opportunity to hear at second hand, observe at close hand, and indeed take part in, efforts to lead change in a healthcare environment. This is a context for leadership and management which can be intriguing in its complexity, offering unusual and varied barriers and opportunities, and where actions or inactions have potentially critical and personal consequences for customers, clients, communities and employees, where decisions can literally be matters of life or death, and issues of what it is to be human are raised every day.

I wished to research into the competencies of individuals who were leaders of change in healthcare, but I had no conscious pre-conceptions about what those competencies might be. I had had the good fortune to meet some excellent role models of leaders of change, and the opportunity also to observe ineffective attempts to bring about change, but I had not developed these observations into conclusions about competencies, much less worked them into a structured framework. And as I undertook the gathering and initial analysing of research data, I sought, as Glaser and

Strauss (1967:37) originally urged, to 'ignore the literature of theory and fact...in order to assure that the emergence of categories [would] not be contaminated by concepts more suited to different areas'. The chapters of this thesis are presented here in a conventional sequence of relevant literature followed by findings from the field work; in fact they were not written in this neat order but, in most cases, alongside each other.

The aims of this research were to derive, from interviews with individuals identified as effective leaders of change, a framework of competencies and behaviours that are of value in leading change in healthcare systems, and to link this framework to relevant literature on leadership and change in such systems.

This thesis sets out to:

Critically review, summarise and integrate literature on leadership and leading change

Present key characteristics of the public sector healthcare environment and their implications for leadership and leading change

Introduce and critically examine competency-based approaches to leadership and management

Explain and provide a critical evaluation of the research methodology I have used

Report on the findings of the research – the competencies and behaviours apparent in the leaders of change that I interviewed, and the ways in which these competencies and behaviours combined in styles of leadership

Relate these findings to the literature on leadership, leading change and leadership competencies

Identify a contribution to knowledge about the activities of leadership and leading change in healthcare systems, and suggest policy implications of these findings.

2. Leadership and leading change: literature review

There are almost as many definitions of leadership as there are persons who have attempted to define the concept

Stogdill 1974

This research is situated in the literatures of leadership and leading change, and the following chapter explores this literature. There are a number of different approaches to, and definitions of leadership, varying in tone and content. Notwithstanding Stogdill's observation, above, I have found that a useful, relatively neutral definition is provided by Yukl (2002:7):

Leadership is

the process of influencing others to understand and agree what needs to be done and how it can be done effectively, and

the process of facilitating individual and collective efforts to accomplish the shared objectives

The chapter is divided into three main parts. In the first part, common approaches to leadership are briefly discussed; these approaches are so well rehearsed I have called them 'mainstream' theories of leadership. This part of the chapter concentrates on the behaviours and styles theories that were dominant between the late 1940s and the mid 1980s, and the later 'new leadership' theories. Trait theory, which was popular up to the late 1940s, is linked to a competency approach to leadership, and it is briefly discussed in Chapter 4. Despite the dominance in the literature of 'new leadership' theories over almost the past 20 years, there remain some doubts, issues and ambiguities about their exact nature and application, and these are discussed. In the second part of the chapter, the literature on organisational change is reviewed for what it can contribute to the leadership of change. In the third part, leadership literature is selectively revisited for some ideas that are beyond the mainstream, but which potentially contribute to a rounded understanding of leadership and leading change. This is not intended to be a comprehensive survey of the literature: the very comprehensive review of leadership theory by Bass (1990) runs to over 900 pages; what follows will of necessity occupy much less space.

Mainstream theories of leadership

A convention has developed about how theories of leadership in organisations are described, following a broad chronology of schools of thought. Starting early in the 20th century with trait theory – the idea that certain personality traits provide a foundation for effective leadership – the conventional description also visits behavioural approaches to leadership, including style theories and contingency perspectives on leadership styles, before alighting on the new leadership theories, and transformational/charismatic theories of leadership in particular (eg Handy 1993; Bryman 1996; House and Aditya 1997; Kakabadse and Kakabadse 1999; Hunt 1999; Higgs 2003; Robbins and Coulter 2003; Schermerhorn 2005). This section will concentrate on the behaviours and styles approaches and the ideas concerning transformational leadership.

Leadership behaviours and styles

The early 20th century saw a number of attempts to identify traits of effective leaders, either through systematic observation, or simply by reflection on experience (Bass 1990; House and Aditya 1997). Contradictions and difficulties with this line of research, together with the emergence of seemingly more fruitful behavioural approaches, led to what Hunt calls a 'virtual shutdown' of trait research in studies of leadership (Hunt 1999: 132). There was, however, renewed interest, and a more systematic approach, from the 1970s onwards (House and Aditya 1997). The subject of leadership traits is one part of an interest in leadership attributes, which in addition to traits is also concerned with motives, skills and competencies, and I will return to this subject in Chapter 4.

The main interest in leadership behaviours has concerned the ways in which leaders can (or should) relate to their staff (or their followers). Most practising managers recognise a categorisation of leadership styles that range from autocratic (or directive, or commanding) to participative (or democratic, or involving a great deal of delegation of decisions to staff). Bass (1990) described a number of theorists who proposed variations of this continuum. Tannenbaum and Schmidt (1958), for example, name five styles, ranging from more autocratic to more participative. Theirs was a contingency theory, one that argued that the most effective style depended on certain

aspects of the situation. They argued that successful leaders would be flexible, and use the most appropriate style for each situation, depending on the team members and on the circumstances.

Earlier systematic studies on leadership behaviours, at the universities of Ohio State and Michigan, identified two factors that influenced leadership behaviour (Yukl 2002):

1. A concern for production, or for task achievement, called 'initiating structure' in the Ohio State studies
2. A concern for people, or for supportive behaviour, called 'consideration' at Ohio State

So leaders could have a high concern for task, or a high concern for relationships, or a high concern for both factors, or a low concern for both factors. These two factors were later developed into 2X2 grids of management styles by Blake and Mouton (1964) and by Hersey and Blanchard (1993). Blake and Mouton (1964) originally identified five styles of leadership, located at different points on the grid:

- a 9.1 style - high in task orientation and low in concern for people – representing a directive style
- a 1.9 style - high in concern for people and low in concern for production - what Blake and Mouton called a 'Country Club' style of leadership
- a 5.5 style was a compromise between concern for people and concern for task achievement. At times the leader may push the team to achieve task objectives: at other times he/she will let them take an easier pace
- a 1.1 style was an abdication of the leadership position, the called the Impoverished Style
- a 9.9 style makes progress towards task achievement, but also shows concern for people. This is a highly participative style of leadership, which fully involves the members of the team in achieving the task goals

Naturally, the 9.9 style was seen by Blake and Mouton as the ideal style. It presented a view that it was not always necessary to compromise between the concern for task achievement and the concern for people, and it was linked with emerging ideas about motivation at work, including those of Douglas McGregor, who argued that employees

could gain satisfaction and fulfillment from achievement of work goals (McGregor 1961).

A contingency approach to the leadership styles grid was produced by Hersey and Blanchard (1993) in the Situational Leadership Model. The four leadership styles were, as in the Blake and Mouton model, combinations of task-orientated, or directive, behaviour, and relationship-orientated, or supportive, behaviour. Hersey and Blanchard concentrated on the *ability* and *motivation* of the team as major factors that would indicate the most appropriate style of leadership. Other contingency models developed at this time included the work by Fiedler (1967), which proposed that the most appropriate style of leadership depended on the nature of the task, the extent to which the leader was able to control the situation and the relationship between leader and followers. The path-goal theory, first developed by House (1971), also concerns a consideration of the nature and context of the task, linked to the most appropriate/effective leadership style. In addition, the theory suggested mediating factors that will indicate the most suitable leadership style, concerning the expectations and motivations of the team members. The initial version of path-goal theory concentrated on two leadership styles, supportive and directive, which were expanded to four styles by House and Mitchell (1974) with the addition of a participative and an achievement-orientated style.

In addition to two-factor and continuum descriptions of leadership behaviours or styles, some multiple-style models have also been suggested. These are outside the mainstream of leadership research. For example, Quinn (1988), and Quinn et al (2003) presented a 'competing values' framework of eight leadership roles, or styles, linked to different orientations of organisations: there were the task-orientated, directive roles of producer and director; the people- and process-orientated roles of mentor and facilitator; the inventive, risk-taking roles of innovator and broker; and the conservative roles of monitor and coordinator.

In another framework, Goleman et al (2002) described six styles that leaders can use: the visionary style, the coaching style, the affiliative style, the democratic style, the pacesetter style and the commanding style. Effective leaders, according to Goleman et al, will employ a range of these styles – but may have a particular preference for

one or two of them. Each style is appropriate for certain circumstances, but will be ineffective in other situations, and Goleman et al (2002) therefore encourage leaders to develop proficiency in a range of styles. The work of Goleman et al (2002) is based on the importance of emotional intelligence, which can be defined as the ability to recognise and manage our own emotions and to recognise and work with the emotions of others. They note that four of the six leadership styles are resonant (ie they are likely to fit well with the emotions of others) and two are potentially dissonant (ie they may create tensions).

It is interesting to note that in both the Quinn (1988) and Goleman et al (2002) frameworks, the people-task styles of earlier taxonomies are represented, and also there are change-orientated styles (the innovator and the visionary style respectively). Revisiting behavioural theories of leadership, Yukl (2002) and Yukl et al (2002) proposed a three factor, or a three dimensional, model of behaviours, comprising task-orientated behaviours, people-orientated behaviours, and change-orientated behaviours, arguing that the relative importance of these would depend on the nature of the task and the environment, and that effective leaders would decide which types of behaviours would be most appropriate for particular situations (Yukl 2002: 65).

New models of leadership

The brief summary of theories about leadership in the previous section has not presented an entirely chronological account, skipping from early theories of styles and behaviours to later ones such as those of Quinn, Goleman et al and Yukl. A major change in thinking among mainstream leadership scholars occurred in the 1970s and 1980s, however, a change described as a paradigm shift by experienced leadership scholars such as Robert House and Jerry Hunt (House and Aditya 1997; Hunt 1999).

A conventional view of the relationship between leadership and management before 1980 was probably that the exercise of leadership was part of a manager's job - and that it related in particular to the manager leading his/her team: this involved motivating them, and directing and reviewing their actions (eg Mintzberg 1973; although note that this view persists in some contemporary management literature eg Robbins and Coulter 2003).

A fresh look at leadership and management was provided by Zaleznik (1977) who described leadership as setting new directions, initiating changes, and achieving change through 'changing the way people think about what is desirable and possible'. He described management as being about implementation, maintaining operations, keeping the machinery running, using rational and systematic methods. In the same year, House (1977) proposed a model of charismatic leadership in organisations, emphasising the role of the leader in providing vision and advocating change. This influenced subsequent developments of leadership theory (Conger 1999). A study of political leaders by James MacGregor Burns added to the development of new models of leadership. Burns (1978) highlighted the way in which some political leaders were able to inspire and influence those around them to set their sights on higher goals. Burns called this *transformational leadership*, and contrasted it with *transactional leadership*, where people are motivated to follow a leader by the expectation of some reward or exchange.

Bennis and Nanus (1985) were among those who built on the ideas of Zaleznik and Burns (also notably Bass 1985; Tichy and Devanna 1986; Kouzes and Posner 1987; Conger and Kanungo 1987; Kotter 1990). Bennis and Nanus (1985) argued that leadership concerned change and seeking new directions, whereas management concerned working within the status quo to achieve efficiencies. They summarised their view of leadership and management as:

Managers are people who do things right, but leaders are people who do the right things

John Kotter further developed these ideas, also distinguishing management from leadership (Kotter 1988). According to Kotter (1990) leadership involves:

- *Establishing direction:* developing a new vision of the future and creating strategies for achieving the vision
- *Aligning people:* communicating the vision, influencing others, and creating teams and coalitions to support the vision
- *Motivating and inspiring:* encouraging people to overcome major barriers to change

Whereas Kotter saw management as the traditional, rational functions of Planning, Budgeting, Organising and Staffing, Controlling and Problem Solving. Both leadership and management are needed for effective change (Kotter 1996:58) but they are different activities.

Zaleznik, Bennis and Nanus and Kotter expressed the view that many American corporations at that time were *over-managed* and *under-led* - in other words they were too concerned with efficiency and not sufficiently willing to seek changes in direction. By focusing on leadership and the differences between leadership and management, these writers hoped to encourage more leadership activity - and therefore more innovation - in organisations.

Bass was influenced by the ideas of Burns and House of transformational and charismatic leadership (Hunt 1999). He conceptualised a model of transformational leadership in organisations that has been a foundation stone for a great deal of subsequent research (Avolio and Yammarino 2002a; Antonakis et al 2003). Bass's (1985) model identified four components of transformational leadership:

- idealised influence – the leader serves as a role model for followers, provides vision and mission
- inspirational motivation – the leader behaves in ways that motivate and inspire followers
- intellectual stimulation – the leader encourages followers to be innovative and to try new approaches
- individualised consideration – the leader pays attention to each individual follower's needs for achievement and growth

Bass contrasted this with transactional leadership (which he identified as being the same as Zaleznik's description of 'management') and later also with laissez-faire leadership, establishing eight components of leadership that are the basis of his Multifactor Leadership Questionnaire (MLQ). Transactional leadership components are:

- contingent reward – the leader promises (and delivers) rewards to followers in exchange for carrying out a task

- management by exception (active) – the leader actively monitors mistakes, errors and deviances from standards and takes corrective action as necessary
- management by exception (passive) – the leader takes action if complaints about performance are received

Laissez-faire leadership provides the eighth component – it is defined as the 'avoidance or absence of leadership' (Bass and Riggio 2006: 8).

Bass (1985) argued that transactional leadership could be quite effective, but that transformational leadership was necessary to energise and mobilise followers to make significant changes. Like Burns (1978), Bass (1985) explicitly linked transformational leadership to Maslow's motivational model of the hierarchy of needs, and argued that the effect of transformational leaders was to increase the motivation of followers. In this early work, Bass appeared to include as transformational leaders

- those who were effective in bringing about radical change – including leaders who used a degree of coercion to bring about change, such as Henry Ford, Hitler, and Stalin
- those who exhibited the motivational influence and appeal that Burns would have recognised as transformational leaders, such as John F Kennedy, Martin Luther King, Franklin Roosevelt

Bass later changed his position to agree with Burns on the essential moral nature of 'true' transformational leadership (Bass and Steidlmeier 1999). Bass (1985) argued that individual leaders could be both transactional and transformational, as has Kent (2005), and Kakabadse and Kakabadse (1999: 49).

The idea of charismatic leadership was further developed from the 1980s to 2005 by Conger and Kanungo (1987), Howell and House (1992), Conger (1999), Shamir and Howell (1999), Howell and Shamir (2005). Howell and House (1992) distinguished between 'personalised' charismatic leadership, which is selfish and exploitative and 'socialised' charismatic leadership, which is collectively-orientated, employed for the benefit of the whole.

Almost all the literature on transformational leadership cited so far has been by US writers, but a UK model of transformational leadership has been promoted by Alimo-Metcalfe and Alban-Metcalfe (Alban-Metcalfe and Alimo-Metcalfe 2000a, 2000b; Alimo-Metcalfe and Alban-Metcalfe 2006, 2005, 2004, 2003, 2002, 2001, 2000). In survey-based research, initially in healthcare and local government in the UK, and later in the private sector, they developed a model of 14 dimensions of effective transformational leadership behaviour. They were influenced by, and incorporated into their research, Bass's ideas of the dimensions of transformational leadership. They found that the dimension of leadership most valued by staff was Bass's 'individualised consideration'. The charismatic, visionary component of Bass's model was seen as less important. The body of work by Alimo-Metcalfe and Alban-Metcalfe is particularly significant for the research I undertook, especially as it concerns 'dimensions' of leadership that are similar to competencies, and as much of their research took place in the UK National Health Service. I will return to it, therefore, in Chapter 4.

My experience as a lecturer is that the idea of transformational leadership is (at least initially) very appealing to students of management and leadership of all ages and backgrounds. However, certain conceptual problems and difficulties remain.

First, there are some common components in the models of transformational leadership, but there are also differences. The broad definition of a transformational leader is recognisable as someone who is able to inspire people to commit to a greater cause, and there is agreement that developing and communicating a vision is an important element of transformational leadership. After these similarities there are then a number of different approaches to describing the detail of transformational leadership, and explaining how transformational leaders may achieve their aims. The components of transformational leadership identified by Bass (1985) for example, were subtly different from those noted by Kouzes and Posner (1987), or by Bennis and Nanus (1985) and other contemporaries. Yukl (2002:271) argues that:

The term transformational has been broadly defined by many writers to include almost any type of effective leadership, regardless of the underlying influence processes. The label may refer to the transformation of individual followers or to the transformation of entire organizations

Bruce Avolio, a leading contributor to ideas about transformational leadership, in a co-written introduction to a new set of readings about the subject, argued that all views of transformational and charismatic have a common core, but 'there are nearly as many definitions of these notions as there are researchers in the field' (Avolio and Yammarino 2002b: xvii). Whilst Bass's model has been used as the basis of research, suggestions for modification and refinement continue (eg Rafferty and Griffin 2004; Hinkin and Tracey 2003; Antonakis and House 2002). For example, a concern with leadership integrity led Bass and others to argue that there is a difference – based on ethics and motivations - between 'authentic transformational leadership' and 'pseudo-transformational leadership' (Bass and Steidlmeier 1999; Avolio et al 2004; Price 2003).

Secondly, there is an uneasy relationship between ideas of transformational and charismatic and directive leadership, which has implications for transformational leadership and empowerment and participation. Bass (1985) included charisma as a component of transformational leadership (as part of idealised influence); he argued that charisma was an essential ingredient of transformational leadership – but that it alone was not sufficient to account for the transformational process (1985: 31). But other early writers found that the transformational leaders they studied were not charismatic (Bennis and Nanus 1985; Tichy and Devanna 1986; Kouzes and Posner 1987). However, charismatic and transformational leadership are taken to be similar by some writers (eg House and Shamir 1993; Hunt 1999) whereas others have argued they may be incompatible (eg Yukl 1999, 2005). 'Charisma can be as much a liability as an asset' writes Collins (2002:73), in research indicating that charismatic, high profile leaders are less effective than those who recruit a team, and work as a member of that team to bring about success for their organisations. Collins's research on successful chief executives emphasises their personal humility and their drive to succeed, and then incorporates the way they recruit and work well within a team.

Most writing on transformational leadership focuses on the individual leader, and it is easy to render a crude portrait of transformational leadership as one person initiating change to achieve their own vision through influencing others and, rather than empowering others, actually increasing their dependency on the leader (Kark et al 2003). A focus on the individual as an inspiring force can align transformational and

charismatic leadership, with all of the potentially *disempowering* effects of the charismatic leader on their followers. There is a difficult match between this picture and the notion that participative leadership styles can be more effective in winning commitment and releasing the energy of team members, and that leaders should seek to empower those they lead (eg Blake and Mouton 1985; Hersey and Blanchard 1993; Tannenbaum and Schmidt 1973; Senge 1990).

Bass (1985) argued that transformational leaders could be either directive or participative (also Bass and Riggio 2006). However, Yukl (1999: 290) argues that empowering and facilitating agreement should be included as part of transformational leadership, based on other theories and research on leadership effectiveness. Goleman et al (2002) emphasise that leaders should work with others in ways that create emotional resonance. Whilst Goleman et al praise 'great leadership' in terms that are familiar from transformational leadership literature (eg at 2002:3) and include 'Visionary Leadership' as a positive style of leading others, they also put forward three other emotionally positive styles that are all conspicuously people-orientated. Goleman et al offer two task-orientated (directive) styles, but only with the health warnings attached to them that they may create dissonance and damage. A number of other writers have developed perspectives on leadership that emphasise working with others. Most prominent of these is the notion of the leader as servant (Greenleaf 1977) taken up by Senge's (1990) idea of the leader as steward of his/her organisation, and supported by other writers as a model that explicitly values other people and encourages empowerment (eg Stone et al 2003; Attwood et al 2003; Russell 2001; Collins 2002). Servant leadership has recently been aligned by Alimo-Metcalfe and Alban-Metcalfe (2006) with their idea of a transformational leader for the UK environment.

A third conceptual difficulty is that transformational leadership has to some extent been defined by contrast with what it is not: such as transactional leadership (eg Burns 1978; Bass 1985) or management (eg Zaleznik 1977; Bennis and Nanus 1985; Kotter 1990). These two opposites are not (necessarily) the same: neither have the characteristics of transformational leadership, but they have been represented as having distinctive characteristics of their own. There are elements of McGregor's Theory X and Theory Y in the distinction usually made between transactional and

transformational leadership, whereas management, as described by Bennis and Nanus (1997) could be lower level team leadership or, as described by Kotter (1990), or House and Aditya (1997), could be complex administration. What is meant, exactly, by transactional leadership is also not entirely clear; its description in Bass's writings has been criticised as including 'a diverse collection of (mostly ineffective) leader behaviors that lack any clear common denominator' (Yukl 1999: 289). Although the characteristics of these contrasting (and inferior) types of leadership are therefore a little vague, it appears unnecessarily wasteful of useful ideas to overlook the differences between them and to conflate the two concepts into 'transactional management' as some writers do (eg Bass 1985, Burnes 2004a:521; Flanagan and Thompson 1993). Perhaps this links to Yukl's critique of the two factor theories that have been dominant in leadership research (Yukl 2002; Hunt 1999) – task-orientated and people-orientated leadership, and transformational and transactional leadership – that they over-simplify a complex set of distinctions.

A fourth problematic issue concerns a limitation of the idea of transformational/transactional leadership. From its origins in Burns's (1978) work, it has concentrated on the motivation of 'followers', leaving aside many of the tasks traditionally associated with leadership positions in organisations, in particular the tasks of creating and developing the necessary structures and systems (Yukl 1999: 290; Kets de Vries 1994; Boal and Hooijberg 2001; Pfeffer and Sutton 2006). Collins and Porras (2000) describe the key role of an organisational leader as 'building a clock, not telling the time'. Bryman et al (1999) found that a construct of 'instrumental leadership' (which they defined in terms of clarifying roles, organising, ensuring that sufficient resources are available) was rated highly by respondents in a piece of qualitative research.

A fifth issue concerns the extent to which transformational leadership is dependent on context for its emergence and its effect. This point has been raised by a number of writers (eg Pawar and Eastman 1997; Beyer 1999; Antonakis and House 2002; Avolio and Yammarino 2002c; Yukl 1999, 2002; Bass and Riggio 2006). Established as a form of leadership that is particularly appropriate for times when significant change is required, its effects may be contingent on the context in which it is exercised. However the concentration of so many positive attributes in transformational

leadership, in contrast to the lack of them in descriptions of transactional leadership or in management, may encourage its practice regardless of the context.

Transformational/charismatic leadership is not the only current model of leadership, but it casts a long shadow. In that shadow there remain issues concerning participation and direction, as discussed above, identified in older perspectives on leadership styles. Issues of transformation, participation and direction are also of concern in the literature on leading change, discussed in the following section.

Leading change

The literature on transformational leadership and the literature distinguishing leadership from management both emphasise the leader's role in bringing about change, but there is also an extensive literature on organisational change, which overlaps in places with that on leadership but has not been fully integrated with it (Eisenbach et al 1999) and, because the literature on change frequently contemplates large scale changes to organisations, it also overlaps with literature on strategy. In addition, from the outset of my research I was interested in what people did when leading *innovative* change, and there is a literature on innovation, too, overlapping with more mainstream change literature, but with distinctive concerns. Presenting a comprehensive summary of, and commentary on, all three of these areas of literature – change, strategy and innovation – is beyond the scope of this research, but some exploration is necessary. This part of this chapter is concerned with the extent to which the leadership of change is seen as similar to or different from leadership, as viewed by the mainstream leadership literature discussed in the previous section. To do this, I will first seek to define 'innovative change', and then consider ideas about different types of change, roles in the change process, and contributions from the change literature about what leaders need to do, in order to be effective in bringing about change.

Innovative change

The literature on innovation (thoroughly summarised recently by Greenhalgh et al 2004 in relation to innovation in healthcare) is characterised by a desire to understand

how organisations, and even nations, can encourage innovation in order to be more successful and competitive (eg Cabinet Office 2003; DTI 2003; Munshi et al 2005; Leadbeater 2006; Mulgan 2007).

An innovation has been defined as:

. . .the intentional introduction and application within a job, work team, or organization of ideas, processes, products, or procedures, which are new to that job, work team, or organization and which are designed to benefit the job, the work team, or the organization (West & Farr, 1990: 3)

Or, more simply as: '...the process of bringing any new, problem-solving idea into use.' (Kanter 1983: 20). Innovations are most commonly conceived of as technological developments – such as the introduction of a new product - but they may also be new processes, or new methods of working (King and Anderson 2002; Hamel 2006; Birkenshaw and Mol 2006).

In a book devoted to managing innovation, King and Anderson (2002) discuss definitional difficulties – particularly in relation to differentiating innovation from other types of organisational change – and come to the conclusion, after accepting the West and Farr definition, above, that the distinctions may be sought in matter such as aspects of emphasis and focus:

innovation research tends to be at least as much concerned with the origination and initiation of change as with their implementation, whilst organizational change research places its emphasis firmly on implementation (King and Anderson 2002: 4)

This is a point supported by Greenhalgh et al (2004), who perceive research on innovation to be a sub-set of research on organisational change. King and Anderson (2002) also suggest that 'routine change', such as the appointment of a new member of staff, would not count as an innovation – although the design of a new job would count as such. Innovation implies some novelty, but 'not necessarily absolute novelty' (West et al 2003). The key issue is that what is introduced is new to the environment in which it is being introduced, and is perceived as being new by the individual, group or organisation that is expected to adopt it (Van de Ven et al 1999: 9; Tushman and Nadler 1986).

West and Farr's definition also includes the requirement that the innovation should be designed to benefit the job, the work team, or the organisation. King and Anderson argue that this correctly rules out capricious changes, or malicious new practices, such as sabotage, from being counted as innovations, but in practice this issue of benefit may be contentious. If a new working practice, for example, is introduced into an organisation there may be members of the organisation who perceive themselves to be winners, but also other members who perceive themselves to be losers – most obviously so if the innovation leads to them losing their jobs. Or the new working practice may lead to benefit in some respects (say by reducing costs) but losses in other respects (such as reducing quality): what is the calculus of benefit here? Some changes may not easily fit under the heading of innovation at first sight – such as managing the closure of an organisation, or of a section of one. Arguably, however, this could also be an aspect of innovation seen from the viewpoint of the larger system (if the old organisation is being superceded by a new organisation, then the closure of the old organisation is itself part of the innovation process). In these three examples we can see that a broad view or 'benefit' is required to include it as part of the definition of innovation. However, as King and Anderson (2002: 3) note, the West and Farr (1990) definition 'has limitations, but as a pragmatic working definition it remains valuable.'

'Innovative change' therefore refers to changes that are intended to be of benefit to the system, the organisation or the group, and which involve novelty to the organisation or group to which they are introduced.

Types of change

A number of writers have sought to categorise different types of change, in the expectation that there are different consequences of, or methods that are effective for, the introduction of, the various types. A key concern has been to distinguish between different scales of change. Nadler and Tushman (1990), for example, differentiated between incremental changes and strategic (or revolutionary, or discontinuous) changes. They saw a typical pattern of change as one of incremental adjustments, punctuated by more radical changes. They also distinguished between those changes

that were anticipatory and those that were reactive, giving four different types of change:

- Tuning – incremental and anticipatory
- Adaptation – incremental and reactive
- Re-orientation – strategic and anticipatory
- Re-creation – strategic and reactive

Changes of different scale or scope have also been described in similar, but slightly different, terms by other writers, including Dunphy and Stace (1993), Buchanan and Boddy (1992), Balogun and Hope Hailey (2004 - followed by Johnson et al 2005), Iles and Sutherland (2001 – following Ackerman 1997).

These typologies all concern the scale or scope of the change. A different approach is taken by Paton and McCalman (2000) who propose a spectrum of types of changes from 'hard' to 'soft'. 'Hard' change projects are typically technical ones – tackling scientific or engineering problems, within a static environment, with clear objectives and constraints, and with few interactions with other people. 'Soft' change projects have a much higher people-orientation, with unclear or subjective performance measures, and with a much more volatile environment; they are more complex projects, with a higher degree of managerial and leadership challenge. Paton and McCalman's argument is that the intervention strategies required, and the appropriate style of leadership of the change, will be different for the different types of change.

A different typology is the contrast drawn by some writers between planned and emergent change (eg Hayes 2007; Burnes 2004a; Burnes 2004b; Balogun and Hope Hailey 2004; Weick 2000). Planned change is deliberate, intentional change, and may be associated with logical analysis (Hayes 2007) and/or with the movement from one state to another, known state (Burnes 2004a) and/or with strategic changes planned in detail by top management (Weick 2000). Emergent change is variously associated with natural incremental adjustments made by members throughout the organisation, which may in time add up to significant change (Weick 2000) and/or with changes arising from cultural or political factors in the organisation (Hayes 2007) and/or with ad hoc, small scale, decentralised changes (Burnes 2004b). The contrast between planned and emergent change is similar for most writers to the contrast between

deliberate and emergent strategy suggested by Mintzberg and Waters (1985). Beer and Nohria (2000) made an influential contribution to discussions of the planned-emergent typology by proposing a Theory E and a Theory O of change. Theory E is top-down strategic change, designed to maximise shareholder value; it focuses on structures and systems; change is planned and programmed. Theory O change aims to develop the organisation's members; it focuses on culture and learning; change is more participative and emergent. Beer and Nohria (2000) argue that organisations can use either Theory E or Theory O, or achieve better results by using both Theories sequentially - E followed by O - or, best of all, by synthesising E and O approaches. Balogun and Hope Hailey (2004) using similar language, argue that a common pattern for major change is 'reconstruction' (Type E change) followed by 'evolution' (Type O, a more gradual culture change).

Burnes (2004b) and Weick (2000) similarly acknowledge the value of both the planned and emergent approaches, used at different times, or together – Burnes explicitly explaining the need for some planned strategic change to tackle issues that would not be solved by emergent, incremental change, and Weick defending the efficacy of emergent change, but noting that 'If leaders take notice of emergent change and its effects...they can be more selective in their use of planned change' (2000: 237). Similarly, Senior (2002: 44) argues that fine tuning and incremental adjustment are associated with emergent change but that more radical change needs more deliberate action from senior management.

Leadership roles in organisational change

Several writers question the extent to which organisational change can be led or managed successfully. Hayes (2007: 37-38) identifies two views on this matter: a 'deterministic' view of change (following Wilson 1992) – that factors other than managerial actions, such as economic and environmental forces, determine the outcome of strategic changes, and a 'voluntaristic' view, that asserts that managers can make an important difference as agents of change. Hayes describes the deterministic view as 'an over-fatalistic perspective' (2007: 38) but implies that managers may sometimes not believe that they can make a difference, and that this can be problematic. Burnes (2004a) and Balogun and Hope Hailey (2004) also

consider the possibility that the success (or otherwise) of changes are determined by factors outside managerial/ leadership influence, and both texts agree that there is scope for influence. Burnes notes that 'managers do have significant scope for the exercise of choice' (2004a:194) and Balogun and Hope Hailey (2004: 6-7) 'take the view that the process of change can be facilitated if not controlled'. King and Anderson (2002), concentrating on innovation and change, argue that change can only be partially influenced by senior managers - but much of it may be beyond their control – they talk of the 'illusion of manageability' (2002:162) based on the idea that change to implement innovations is actually more complex than simple, linear models would suggest (also van de Ven et al 1999). In a classic text, Pettigrew and Whipp (1991) identified five factors that affected the outcome of attempts to change an organisation. The leadership of change was one of the factors. Pettigrew and Whipp argued that leadership was important as 'one key way of creating and redirecting energy within the change process' (1991:143). More recent studies by Gustafsen et al (2003) and Greenhalgh et al (2004: 272-73) have also identified multiple influences on the successful implementation of a change: both studies include effective leadership as a factor.

There is, therefore, a great deal of agreement that individuals and groups can influence change, but that other factors – some of them environmental and structural, some of them concerning the actions and reactions of other stakeholders in the change, some of them concerning the nature of the change itself – also exert an influence. Within this envelope of agreement, it is possible to identify different roles for leaders of change, often described in this literature as 'change agents'. The most obvious distinction is between more senior and less senior members of an organisation (eg Kanter et al 1992; Caldwell 2003b; Pappas et al 2004; Stewart and O'Donnell 2007).

Kanter (1983) emphasised the role of top management in encouraging innovation from lower levels, drawing attention to what this level of the organisation can do to support or to block innovation. Van de Ven et al (1999) identify the supportive senior manager roles of 'sponsor' and 'institutional leader' in addition to the 'corporate entrepreneur' role of the leader of a change project. Briner et al (1996), who focus on the leader of a change project, also distinguish between this role and that of the

project sponsor, and Buchanan and Storey (1997) suggested a four-fold typology of change agents that included a sponsor. Buchanan (2003) provides an extensive literature search on typologies of the roles of change agents; he notes several examples of sponsors or patrons or defenders of a change, as well as those who directly drive, implement or lead the change.

The relationship between top and middle managers in bringing about planned change is the subject of a study reported by Balogun (2003) and Balogun and Johnson (2004). In the course of a strategic change, initiated by senior managers, the middle managers were expected to act as implementers of the change, but the study found that the role could better be described as a 'change intermediary' because the managers were actively engaged in a process of interpreting and translating the senior management intent into implications for themselves and their teams (Balogun 2003: 75; also Balogun and Hope Hailey 2004: 213-14; also Currie 1999). This middle manager sensemaking occurred largely outside the control of senior management, as middle managers communicated with their peers, and had a significant effect on the outcome of the change (Balogun and Johnson 2004: 545). Balogun and Johnson argue that the study shows that middle managers are active change agents in influencing the process and outcomes of strategic change initiated by senior managers, and that senior change leaders should be sensitive to interpretations that the intended recipients may place on the intended change, and should carefully monitor the progress of changes to identify and tackle any design problems or 'black holes' that arise (2004: 546).

Kanter (2006) suggests a strategy for innovation that contains a mix of projects chosen by top managers with the opportunity for others to make proposals and have them heard (ie planned changes and allowing scope for emergent innovative changes). The approach includes providing some flexibility in planning and control systems to enable funding for new ideas, and building in systems to connect innovators and mainstream businesses. A similar view of the role of senior managers is taken by Johnson et al (2005:516) and also by Attwood et al (2003: 68), who observe that this means that leaders must find a balance between forthright expression of their views and listening to others, to give individuals the space to be motivated and innovative. Similarly Weick (2000) contrasts change agents who make

lower level, incremental changes, and top managers who should give latitude for others to make these changes, as well as taking responsibility for leading on strategic change (similarly Christensen et al 2006). Pascale and Sternin (2005) in their perspective on 'positive deviance' as means of bringing about innovative change, emphasise the facilitation role of top managers in enabling and supporting grass-roots change. As well as the organisation's managers, external consultants may also act as agents of innovation and change (eg Rogers 1995; Schein 1987; Caldwell 2003a).

Taken together, these publications on the roles of leaders of change indicate there may be a number of different leadership roles. For a strategic, planned change, for example, there may be a leadership role (or roles) at senior management level, and also roles that involve active leadership influence (involving shaping and directing the change, rather than simply implementing it) at lower levels in the organisation, or performed by external change agents. For changes that are, in terms of the organisation, more emergent, a key role is played by the change agent directly in charge of the change project, and there is also scope for a strong influence by more senior managers who may sponsor, support or promote the particular project, and who may also act to encourage suggestions for change and change initiatives, both by their personal actions and by the systems and structures they create.

Leaders of change, therefore, are unlikely to be effective in working alone. As Buchanan (2003: 5) concludes in his study of the roles of change agents:

it would appear from this review that several complementary contributions have to combine in some form to enable the work of the change agent, or more typically change agents, to proceed effectively

Similarly, Kotter (1996) in his work on bringing about transformational change in an organisation, emphasises the need to build a strong guiding coalition, a team of change leaders, and in an earlier work Kotter (1990), talked of multiple leadership roles in a change process. And Nadler and Tushman (1990), in a paper that begins with an emphasis on the power of a charismatic leader to change an organisation, end with the advice that such leaders need to develop the senior team and institutionalise the leadership of change in the organisation. Pettigrew et al (1992), Caldwell (2003a) and Johnson et al (2005) also note that the change agency may be a group or team rather than an individual.

In identifying different roles in leading change we have uncovered some ideas about what people need to do in order to lead change: a mixture of directly leading and also supporting the efforts of others to bring about change. It is, unsurprisingly, in the area of *how* to lead change, of what leaders of change actually do, that there is greatest overlap between the literature on leadership and the literature on change.

Unsurprisingly, in that the literature on transformational and charismatic leadership emphasises the leader's role in inspiring and bringing about change (eg Tichy and Devanna 1985; Kotter 1990; Conger and Kanungo 1987; Conger 1999). Eisenbach et al (1999) devoted an article to explicit links between change and transformational leadership, finding that successful leaders of change needed 'vision', 'intellectual stimulation' and 'individualized consideration' - dimensions of transformational leadership, as defined by Bass and his colleagues.

However, the literature on change also introduces some perspectives on the role of leadership that are different from the concerns of the mainstream leadership literature. I will focus on four areas in particular: the issue of leading a change through a series of defined stages; the task of 'overcoming resistance'; styles of leading change; and the concern with organisation politics.

Leading through a series of stages

A hot debate about how to lead change, discussed in the change literature, is the extent to which models of stages or steps of change are at all useful or accurate. An oft-cited stage model is that of John Kotter (1995, 1996), who claimed that organisations he had studied that failed to achieve transformational change did so because they made one or more of eight significant mistakes. He reversed these into a model of the eight steps leaders of change could make to bring about a successful transformation, and he emphasised that these steps should be undertaken in this order (see Box 2.1).

Box 2.1 A Strategy for Change: Eight Steps to Transforming Your Organisation

1. Establish a sense of urgency

examine the market situation. Identify and discuss crises or major opportunities

2. Form a powerful guiding coalition

assemble a group with enough power to lead the change exercise. help the group to work together as a team

3. Create a vision

this will help direct the change exercise

4. Communicate the vision

use every means possible to communicate the new vision and strategies. Teach new behaviours by example.

5. Empower others to act on the vision

change systems or structures that seriously impede the vision. Get rid of obstacles to change. Encourage risk taking and experimentation to achieve the vision

6. Create short term wins

plan and achieve visible improvements in performance. Recognise and reward people who achieve the improvements

7. Consolidate and build

use increased credibility to change systems, structures and policies that impede the change. Move employees into place who will implement the vision. Find new projects and themes to add energy to the process

8. Institutionalise the new approaches

establish and systematise the new approaches

From John Kotter (1995, 1996) and Kotter and Cohen (2002)

Described in Burnes (2004a: 308); Senior and Fleming (2006: 291); Johnson et al (2005: 540); Buchanan et al (2005: 194); Hayes (2007: 173-175); Carnall (2007: 70-71) Thompson and Martin incorporate Kotter's 8 stage model into a 12 stage model that includes more early analysis, before Kotter's stage 1 (2003: 827)

Probably the earliest stage model is Kurt Lewin's (1951) three stage Unfreezing-Shaping-Refreezing model, which emphasises the need to gain acceptance that change of some sort is needed - represented by the Unfreezing stage, before any shaping is possible - and that commitment, consolidation or institutionalisation are

needed – represented by the Refreezing stage - after Shaping has taken place. The model has been adopted and developed by some (eg Schein 1987) and criticised as outdated in a world of constant change by others (eg Kanter et al 1992). As a measure of its continuing influence Burnes (2004a) cites Hendry (1996): 'Scratch any account of creating and managing change and the idea that change is a three stage process which necessarily begins with a process of unfreezing will not be far below the surface' (also cited by Hayes 2007:81). Contrarily, Weick (2002), arguing that organisations are constantly in a state of change, suggests that the appropriate sequence is really: Freeze-Rebalance-Unfreeze, where to Freeze means to investigate, to make a sequence of activities visible and analyse patterns in what is happening; Rebalancing means reinterpreting, relabeling and resequencing activities; Unfreezing means allowing the emergent change to continue (2000: 236).

Beckhard and Harris (1987: 29) put forward a different three-stage model of the present state, managing the transition, and the future state. Kanter (1983: 217) offered a model of 'three waves of activity' for corporate entrepreneurs:

problem definition – the acquisition and application of information to shape a feasible, focused project...coalition building – the development of a network of backers who agree to provide resources and/or support...mobilization – the investment of the acquired resources, information, and support in the project itself...to bring the innovation from idea to use

Hayes (2007) offers a more detailed, more recent, series of stages:

1. Recognition – realising the need to change
2. Start of the change process – the need for change is translated into a desire for change. Key questions are: who to involve; what to make public; who should be responsible for the change
3. Diagnosis – review present state, identify the future state (may involve developing a vision, or may simply involve visioning the likely impact of the change)
4. Prepare and plan for implementation – technical and political factors need to be taken into account
5. Implement: two basic approaches – one where the end state is known – called a 'blueprint' change, where 'it is easier to view the management of change from the perspective of "planned change"' (p86) and one where it is not possible to specify the end point of change in advance of implementation – ie there is a broadly defined goal

and direction for change: in this case 'change needs to be viewed as a more open-ended and iterative process that emerges or evolves over time' (p86)

6. Review and consolidate

Hayes notes, however, that: 'At first glance this model suggests that change is a neat, rational and linear process. This is rarely the way that it unfolds and is experienced in practice.' (2007: 82). The diagram of the model shows several feedback loops, as the events in one stage may influence the preceding stages. Stage models are also provided by Beer et al (1990), Paton and McAlman (2000), Senior and Fleming (2006) and Carnall (2007).

This is one side of the debate. On the other side are commentators such as Dawson (2003) who question the accuracy and therefore the value of descriptions of such staged approaches. Buchanan and Storey (1997:127), for example, say that change processes are 'in reality messy and untidy, and... unfold in an iterative fashion with much backtracking and omission'. King and Anderson (2002: 161) argue that patterns of development of innovations vary: a stage-based model may be applicable to simpler innovations, but in fact innovations 'rarely progress in a clear and predictable sequence of clear stages'. Van de Ven et al (1999: 10) observe that rather than a simple sequence of steps an innovation 'process diverges into multiple, parallel, and interdependent paths of activities'. Balogun and Hope Hailey (2004: 6) strongly emphasise the effect of the particular context of any change, and argue that 'change cannot be reduced to prescriptive recipes and neat linear processes'. Pettigrew and Whipp (1991:105) in a similar fashion concentrate on context and reject the idea of staged approaches:

The main conclusion with regard to leading change is that there are no universal rules. The opposite is true. Leadership is acutely sensitive to context

However, the two sides to the debate may not always be so far apart as they are presented here. Just as Hayes notes that the suggestion of neatness and linearity implied by his model was not always experienced in practice, so Kotter (1995: 67) wrote: 'in reality, even successful change projects are messy and full of surprises'. And Kanter et al (1992) after presenting 'ten commandments' for executing change that, whilst they are not presented as stages as such, resemble a plausible time

sequence, exhort the reader to 'Respect – but challenge – the ten commandments and their applicability within your organisation' (1992: 386).

If some of the contributors on the prescriptive side of the debate, the identifiers of stages through which a change should be led, qualify the extent to which we can easily follow their planned sequence, so too do some of their 'change is messy, context is all' opponents. Clarke (1994), for example notes that it is difficult to come up with a simple stepped process of change 'because the change process is so messy' (1994: 185) but then provides a six stage model, because such a model can provide 'the basis for thinking through and planning for problems in advance' (p188). And having emphasised the importance of context, Balogun and Hope Hailey (2004) also present a model of six stages of a planned step change. Even King and Anderson (1992) talk about different phases of leading an innovation, describing them as: Initiation, Discussion, Implementation and Routinisation.

Attempting to make sense of these different viewpoints, it seems reasonable to conclude that

- commentators agree that change is messy and unpredictable, and that it is important to pay attention to the detail of context
- notwithstanding this, several commentators present models of stages through which a change – if it is to be successful – is likely to proceed, which indicate a broad sequence of activities that change agents need to undertake: many of these examples are much more detailed than the broad prescriptions from leadership theory of 'develop a vision and then communicate it'

An alternative approach to a stage model is to identify different types of activity that leaders of change need to undertake. For example, Buchanan and Boddy (1992: 70) bring together literature on traditional project management, and literature on participative styles of leadership, and add ideas about organisational politics to argue that there are three parallel sets of activities in leading a change:

- managing the content (ie engaging in technical expertise, and the subject matter of the change)

- managing control (ie traditional project management techniques, concerning planning and control)
- managing the process – this is split by Buchanan and Boddy into two areas, using participative leadership style to engage others in the change, and the ‘backstage’ (ie covert) activity of managing the organisational politics

They noted that the priority of each of these three elements may vary, depending on the particular change project.

Nadler (1993), Briner et al (1996) and Burnes (2004a) also put forward models of the change process that comprise three interlinked elements, Nadler (1993) observing, as did Buchanan and Boddy (1992) that different circumstances would determine which aspects would be more or less critical. Hayes (2007), whose staged model was described above, suggests that in addition there are a number of ‘people issues that are ongoing through the process’ (2007: 87), such as:

- power, politics and stakeholder management
- leadership
- communication
- training and development
- motivating others to change
- support for others to help them manage their personal transitions

These ‘people issues’ are in some respects similar to the ‘managing the process’ issues of Buchanan and Boddy (1992).

Overcoming resistance to change

A concern for many commentators on organisational change is how to manage resistance to change, and how to win support. Whereas mainstream leadership literature concentrates on motivation of followers, the change literature explicitly discusses the likelihood that leaders of change may encounter resistance and opposition. The typology of tactics for overcoming resistance first set out by Kotter and Schlesinger (1979) is frequently cited – Hayes (2007: 216-220); Thompson and

Martin (2005: 815); Robbins (2003: 562-63); Senior and Fleming (2006: 290); King and Anderson (2002: 201); Buchanan and Boddy (1992:18-19):

- Education and persuasion
- Participation and involvement
- Facilitation and support
- Negotiation and agreement
- Manipulation and cooption
- Direction and reliance on explicit and implicit coercion

As an alternative, Johnson et al (2005) use the rather mechanistic metaphor of 'levers' that can be used for managing strategic change, which include managing political mechanisms in the organisation; using the right amount of 'rich communication' for the complexity of the change; using issues of timing (eg building on an actual or perceived crisis; taking decisive action during windows of opportunity). Johnson et al argue that effective change agents will use these levers appropriately 'rather than following a set formula for managing strategic change' (2005: 537). Pfeffer and Sutton (2006) argue that change agents need to use four main elements, including clear communication and an acceptance that mistakes will be made as part of the change process. Complexity theorists Plsek and Wilson (2001) advocate a different approach again – talking of 'natural attractors' to the desired change in behaviour rather than considering a failure to change as 'resistance'.

Styles of leading change

Styles of leading change have also been widely discussed in the literature. Kotter and Schlesinger's tactics can be matched to styles of leadership, on a continuum from participative to directive. Senior and Fleming (2006: 285) follow Dunphy and Stace (1993) in describing the continuum of styles as: collaborative, consultative, directive, coercive. Christensen et al (2006) set out four types of 'cooperation tools' that managers can use – including 'leadership tools' (including charisma, vision, salesmanship) 'management tools' (measurement systems, training etc) 'power tools' (aspects of coercion) and 'culture tools' (including rituals and folklore) and argue that the optimal tools to use (in other words the style to adopt) will depend on the degree of consensus in the system on the need for change and how it can be achieved.

Pettigrew and Whipp (1991) emphasise the preparatory work that leaders carry out. The role of leadership in change 'would seem to lie in the ability to shape the process in the long term rather than direct it through a single episode' and 'the accumulation of more modest preparatory actions is all important' such as 'consideration of the political implications of a given strategy...through problem-sensing and climate-setting' (1991: 143)

The discussion about different roles played in the leadership of change, above, has implications for leadership styles. In arguing for some direction from senior management and some encouragement of initiative from more junior levels of the organisation, Kanter (2006), Weick (2000), Balogun and Johnson (2004) and others can be seen to argue for some directiveness and some participativeness of style. Kanter (1983: 236-40) found that the most successful corporate entrepreneurs adopted participative/collaborative styles. King and Anderson (1992: 101) argue that a democratic and participatory leadership style supports group and organisational innovativeness – but different styles may be needed over the course of introducing an innovation:

- a nurturing style, being supportive, encouraging ideas, at the beginning, followed by a
- 'developing style', to obtain opinions and evaluate proposals, agree implementation plans and push them forward, followed by a
- 'championing style' to sell the proposal, get commitment, ensure participation, followed by
- a 'validating/modifying style' to check the effectiveness of the innovation in action, to modify and improve

Connolly et al (2000), in a review of leadership in educational change, and Hartley and Allison (2006), in a review of case studies of change in local government, also note that leadership styles may successfully vary over the course of a change, and that different individuals and groups may take the lead at different stages.

In another view of leadership styles in change, Nadler and Tushman (1990) concentrated initially on the role of a charismatic leader in bringing about change, through 'envisioning, energising and enabling'. However, they soon argued that

effective leaders of change need to be more than charismatic: they need also to be 'instrumental'. Nadler and Tushman identified three elements of instrumental behaviour: structuring – building teams and creating structures; controlling – creating systems and processes for control; rewarding – contingent reward. Munshi et al (2005:12) also talk of the importance of 'structuralist leadership' for the leadership of innovation – ie the way that leaders in organisations 'undertake key administrative coordination tasks, such as organisation design, the integration of disparate activities, and the marshalling of resources'. These structuring activities can be regarded either as setting the organisational context for innovation and change (as in Kanter 1983) or carrying out key functions within the change project itself (as in Buchanan and Boddy 1992; Briner et al 1996). They may be activities that Kotter (1996) would regard as the contribution of management (as opposed to leadership) to the change project.

Organisational politics

Handling organisational politics is another concern of much of the literature of organisational change, as seen in the references in passing to this area above by Kanter (1983); Kotter (1996); Buchanan and Boddy (1992); Hayes (2007); Johnson et al (2005). Scholars including Pettigrew (1973), Nadler (1993), Dawson (1996), Briner et al (1996), Balogun and Hope Hailey (2004) and Senior and Fleming (2006) are also keenly interested in the role that politics plays in organisational change, while the central proposition of Buchanan and Badham's *Power, politics and organizational change* (1999) is that the 'change agent who is not politically skilled will fail' (1999:18).

Pettigrew, whose 1973 study of change in ICI emphasised the importance of political processes, argues in 2000 that:

All change processes are influence processes. All influence processes require awareness of, if not action in, the political processes of the organisation. Change and politics are inexorably linked. (2000: 249-50)

Burnes (2004a: 195) goes even further in saying that 'management in general, and the management of change in particular, is inherently a political process'. In a similar vein, Hartley and Branicki (2006: 5) have recently argued that all managers need to be able to act with 'political awareness'.

Organisational politics have less frequently been discussed in mainstream leadership literature (see Ammeter et al 2002; Treadway et al 2004) but have been examined more often in literature on organisational behaviour, strategy, and change management (eg Kakabadse et al 2004; Zivnuska et al 2004; Morgan 1996). Zaleznik (1977) related examples of political behaviour to 'managers' rather than to 'leaders'. The political perspective of organisations has been summarised by Morgan (1996): conflict in organisations is a natural feature of the social system. Different groups within organisations develop different goals, values, beliefs and interests, and are likely to compete for scarce resources and for influence over the overall direction of the organisation. Political behaviour is the working out of these differences and competitions. We can define organisational politics neutrally as the use of power and influence by individuals and groups in order to achieve their desired aims, but the subject arouses controversy: for example, Robbins (2003:375) defines political behaviour more selfishly as 'activities that are not required as part of one's formal role in the organization, but that influence, or attempt to influence, the distribution of advantages and disadvantages within the organization'. Mintzberg (1983: 172) regards organisational politics, as a negative, illegitimate, activity:

Politics refers to the individual or group behaviour that is informal, ostensibly parochial, typically divisive, and above all, in the technical sense, illegitimate – sanctioned neither by formal authority, accepted ideology, nor certified expertise

However, organisational politics has also become closely linked with innovation and changes that are of benefit to the organisation as a whole. Kanter (1983) and Kotter (1985) observed that innovators in organisations need to engage in politics to win support and resources for their projects, and to win cooperation of people over whom they have no direct authority. Both writers represented this engagement in organisational politics as a necessary activity for success, particularly in handling 'lateral relationships' (see also Sayles 1989). This 'positive' politics involves

campaigning, lobbying, bargaining, negotiating, caucusing, collaborating, and winning votes. That is, an idea must be sold, resources must be acquired or managed, and some variable numbers of other people must agree to changes in their own areas (Kanter 1983: 216)

This positive politics can be associated with proactively bringing about changes, rather than passively accepting problems, shortfalls or inflexibilities in the organisation (Hayes 1984). Kotter distinguishes this positive politics from the 'pathological aspects

of modern organizations: the bureaucratic infighting, parochial politics, destructive power struggles and the like' (1985:3). Tom Peters, whose writings encouraged organisations to embrace innovative change, went so far as to say: 'Anyone who loves accomplishing things must learn to love (yes, love) politics' (Peters 1994).

Sources of power for individuals in organisations, a key consideration for political activity, have variously been described by French and Raven (1959), Buchanan and Badham (1999), Bragg (1996), Yukl (2002) and Pfeffer (1992). French and Raven's description of the sources as reward power, coercive power, legitimate power, expert power and referent power has been influential. The possession of information and the support of others were highlighted by Kanter (1983) as two of the 'power tools' of a change agent, and Pfeffer (1992) noted that formal position, reputation and performance are all sources of power: 'the reputation for having power brings more power' (1992: 136) and 'in turn, effective performance in the job helps to build one's formal authority and reputation' (p142). Pfeffer (1992) and Bragg (1996) also argue that personal attributes can be sources of power.

Writers on politics and change have gone on to explore political tactics used by managers and change agents, including establishing credibility, identifying key stakeholders, networking (to acquire information, support and resources), coalition building and cooperation, using allies to argue your case, impression management, communication skills and the 'management of meaning', managing the timing of initiatives, persuasion, negotiation, bargaining, and manipulating organisational structures (from Kipnis et al 1980; Kotter 1982, 1985; Kanter 1983; Kanter et al 1992; Buchanan and Boddy 1992; Pfeffer 1992; Huczynski 1996; Bragg 1996; Kakabadse and Kakabadse 1999; Butcher and Atkinson 2001; Yukl 2002; Carnall 2003; Robbins 2003; Thompson and Martin 2003).

Leading change and leadership: complementary literatures

What does the literature on change and leading change contribute to the ideas of the mainstream literature on leadership? There are some obvious confirmations: vision is seen as important in new leadership theories and in much of the literature on leading change. Leadership styles – from more participative to more directive – are discussed

in both bodies of literature. The literature on leading change reviewed in the previous pages appears to add significantly to the mainstream leadership ideas in four areas.

First, the literature on leading change emphasises collective activity of leaders or change agents, rather than focusing on a single leader. Secondly, it provides more detail on the activities that leaders undertake, whether this follows a sequence of stages that some writers use to describe to describe the progress of a change, or sets out tools that leaders may use, or tactics they may employ. Thirdly, much of the change literature emphasises the importance of context, an understanding of context, and adjusting one's behaviour to act appropriately within the context. Finally, as leading change often means dealing with people of similar or even greater power, not just the 'followers' of much mainstream leadership literature, the change literature provides useful analysis and discussion of persuasiveness and organisational politics.

The next part of this chapter returns to literature on leadership and considers ideas, beyond the mainstream, that complement two of these areas.

Leadership: beyond the mainstream

In leadership literature the idea of transformational leadership, together with its visionary and charismatic siblings, and its transactional poor relation, casts a long shadow, but it is not the only current conceptualisation of leadership. This part of the chapter will consider ideas from the leadership literature that complement two of the four areas noted above as arising from the leading change literature: the importance of understanding context, and leadership as a collective activity.

Leadership and an understanding of context

In the section on leading change, above, we saw that a number of writers emphasised the importance of context, and therefore the need for an understanding of context in order to be effective as a change agent. In the review of mainstream leadership theory, above, the importance of context for the emergence of, and success of, a transformational style of leadership was also raised. It can also be said that an integral part of the operation of contingency/ situational models is for the individual to

employ an understanding of context (albeit a context represented by a quite limited set of factors) and to be able to adjust to it. The idea that a key part of a leader's task is to understand, interpret or make sense of the circumstances that surround them is the focus of a series of papers by leadership scholars including Mumford and Zaccaro. A common feature of their approach is to emphasise the organisational context of the leaders in whom they are interested, and to argue the importance of the individual's ability to solve complex problems in this social, organisational context. For example, Zaccaro et al (1991: 320) note:

organizational leaders need to be able to confront a variety of difficult problems and be able to fashion individual and organizational solutions in a complex and sometimes hostile environment

A good understanding of organisational context is thus of great importance (Mumford et al 2000: 27). This places a high premium on an ability to derive knowledge by analysing these difficult problems and to understand the 'complex and sometimes hostile environment' in which they occur – an ability variously described as social awareness or social judgement, or social intelligence (Zaccaro 1991; Mumford et al 2000; Zaccaro et al 2000; Boal and Hooijberg 2001) – skills that comprise an understanding not only of individual people, but also of social systems (Zaccaro et al 2000: 46) including the likelihood of acceptance and support of proposed solutions (Mumford and Connelly 1991). Mumford et al (2000: 26) argue that this approach to organisational leadership

is a distinctly cognitive model based on the proposition that leadership ultimately depends on one's capability to formulate and implement solutions to complex (ie novel, ill-defined) social problems

In an unrelated publication, leadership scholars Antonakis and House (2002) suggest adding an additional class of leader behaviour to the transformational/transactional dimensions, called 'instrumental leadership', which they propose would include environmental monitoring, strategy formulation and implementation – a wide range of categories of behaviour, of which the 'environmental monitoring' might overlap with the social awareness of Mumford, Zaccaro and colleagues. On a similar theme, Milner and Joyce (2005: 154-155) argue that a public sector leader needs a 'thorough knowledge of the business of the public service.... and [skills in] detailed planning and detailed checking on the execution of plans'. Of course, venturing outwith leadership theory briefly once more, Peter Senge's advocacy of the fifth discipline – systems

understanding (Senge 1990) - is another form of exploration of this area of making sense of complex systems, and Weick's (1995: 65-69) summary of sources demonstrates that the process of sensemaking in organisations has been a theme studied by a number of researchers throughout the 20th century. A complex systems perspective on leadership in organisations has an implication that leaders should cultivate an understanding of how the systems function (eg Marion and Uhl-Bien 2001; Attwood et al 2003).

Although Mumford et al protest the neglect of the complex problem-solving image of a leader, it is by no means a new angle from which to view leadership. Northouse (2004) presents the model of Mumford, Zaccaro and colleagues as a natural descendant of Katz's (1955) skills-based model of an effective administrator, with its emphasis on the importance of human and conceptual skills. However, it has lain in the shadow of other leadership activities. Goleman et al (2002), for example, concede that conceptual ability is important, whilst arguing for the primacy of emotional intelligence. Those who write of visionary leaders, such as Bennis and Nanus (1997), and Kotter (1996), talk of a process of analysing and understanding in order to develop the vision – but it is the vision that receives the emphasis, not the analysis and understanding. There is a question, therefore, about whether the transformational leadership models unwisely neglect this activity of analysing the social environment.

Leadership as a collective activity

Several of the writers on leading change decry the 'lone hero' image of the effective leader (eg Kanter et al 1992; Buchanan 2003). This was also discussed briefly above, as one of the problematic issues with transformational/charismatic leadership theories. A number of approaches have gone further, however, and specifically considered leadership as a collective activity. Dispersed, distributed and shared leadership are perspectives that move attention away from the individual leader and towards relationships and the contribution of a range of people (Drath and Palus 1994; Bryman 1996; Bennett et al 2003; Rodgers et al 2003; Ross et al 2004a, 2004b, 2005; Gronn 2002; Pearce and Conger 2003; Martin 2005; Mehra et al 2006).

Viewing leadership as a shared function is not new; Gronn (2002) traces 'distributed leadership' as a term back to Gibb (1954). In a review of social psychology perspectives on group working, Krech et al (1962) identified a number of process or management functions that are performed in groups, and observed that these may be performed by different group members. Bowers and Seashore (1966) suggested that leadership functions could be carried out by individuals other than the formal leader of a group. However, the increasing complexity of organisations has added impetus to viewing leadership as a shared process. Peter Senge's argument for the learning organisation was based on the view that the world had become too interconnected and complex for one person to lead an organisation from the top (Senge 1990: 4). Those who more recently take a complexity theory view of organisations are led towards a view of leadership as necessarily distributed across a number of actors in the complex system (eg Marion and Uhl-Bien 2001; Lichtenstein et al 2006). These perspectives naturally lead us to think more broadly than about the individual leader – some perspectives on shared leadership consider not only the individual, but also suitable mechanisms for sharing (eg Porter-O'Grady and Krueger Wilson 1995; Attwood et al 2003). Following this line of thought can lead to focusing on teams who share leadership functions (eg Seers et al 2003), or on networks of relationships, or on structural, systemic or other situational factors that enable or mediate leadership.

An alternative approach, which remains focused more clearly on the individual, would explore those behaviours he/she needs in order to work collaboratively with others, such as facilitation skills, networking and democratic leadership (Pedler et al 2003; Goleman et al 2002) working with groups and teams (Binney et al 2005; Attwood et al 2003; Collins 2002) asking questions to engage and collaborate with others (Heifetz 1994; Grint 2004; Heifetz and Linsky 2002; Scotts 2007) employing ways of opening up agendas to others (Huxham and Vangen 2005; Vangen and Huxham 2003). This takes what Ross et al (2004a, 2005), in their study of distributive leadership, describe as an approach of beginning with the 'distributing leader', and is congruent with the sentiment of Pedler et al (2004:7), for example, who write of leaders as 'connected individuals...creating a better world in good company'.

Summary

In this chapter I have reviewed mainstream theories of leadership, theories about the leadership of change, and two approaches to leadership that lie outside the mainstream. Of the mainstream theories, I have concentrated mainly on behavioural and style theories, and on the transformational-transactional perspective on leadership. Although this latter perspective has dominated leadership theory for almost 20 years, there are still unresolved issues and ambiguities concerning its precise nature and use.

Literature on leading change provides useful additions to leadership theory in four areas:

- it provides more detail on the activities that leaders undertake
- it provides a useful perspective on persuasiveness and organisational politics
- much of the literature emphasises the importance of context, and an understanding of context.
- there is an emphasis by some writers on leading change as a collective, rather than an individual activity

The final section of the chapter showed that some leadership scholars are interested in exploring the leader's ability to interpret or make sense of context, regarding this as a key skill, and some are concerned with leadership as a collective activity.

The approach I have taken in my primary research is not to seek to prove, or test, or disprove any particular hypotheses about the behaviour of people who attempt to lead change, but to carry out an analysis of behaviours that is grounded in individuals' accounts of change projects. However, this research takes place in the context of the knowledge of a range of theories about leadership and change, and at a certain stage in the analysis of the information from my interviews with change agents I will compare the emerging conclusions with the literature on leading change and leadership.

3. Leadership, change and healthcare

The previous chapter considered theories about leadership and change that are generic, or have been drawn from a variety of sources. This chapter considers whether there may be distinctive features of leadership and change in healthcare organisations.

I interviewed change agents in UK (mainly English) and in Australian healthcare systems, and so in the first section below the similarities between the English and Australian healthcare systems are summarised. This is followed by a consideration of whether the general literature on leadership and change described in the last chapter, much of it drawn from private sector contexts, may or may not be applicable to a public sector, and in particular a health sector, context. In the third section, a particular aspect of leadership in healthcare is pursued in more detail – the existence of different professional groups, and the tensions between the management group and the most prominent clinical group, the doctors. The fourth section very briefly reviews the programme of intense and radical reform that was being pursued in the English healthcare system at the time of this research, and the final section considers the extent to which – given this energetic, central programme of reform – it was considered possible for managers and clinical leaders to actually exercise leadership in healthcare organisations.

Healthcare organisations in England and Australia

My fieldwork was mainly carried out in the English healthcare system, with a smaller number of interviews with professionals and executives in Australian systems. In the UK, with devolution to the Scottish Parliament and the Welsh Assembly after 1997, the English National Health Service was separated to some extent from the Scottish and Welsh services. In Australia, the federal nature of the constitution means that the management of healthcare is the responsibility of the states, although the bulk of funding is provided from the federal government (AIHW 2004; Deeble 2002; Duckett 2002).

In both the UK and Australia, governments in the 1980s came to the conclusion that public sector organisations were in need of wholesale reform, and the Conservative government of Margaret Thatcher in the UK and the Labour government of Bob Hawke in Australia set about introducing measures to reduce spending and increase efficiency (Zifcak 1994:7). In both countries this entailed the application of management approaches more commonly used in the private sector, in order to manage and control resources - an international phenomenon, not unique to these two countries, that became known as New Public Management (Ferlie et al 1996; Barzelay 2002; Carroll and Steane, 2002; Podger 2004; Rowe et al 2004).

Fundamental factors that affected health services in developed economies between 1981 and 2005 were improvements in medical technology, changing demographics, and the increasing expectations of the public (Ham 2004:73; Wanless 2002). Improved technology means more forms of treatment can be offered to individuals who are ill; illnesses can also more easily be identified; people can live longer, despite chronic health conditions (albeit with increased medical support). Increasing expectations – allied with better access to information about possible treatment - mean that consumers are more demanding of healthcare organisations. These factors lead to increased costs of providing healthcare. Where healthcare is publicly-funded, these costs must largely be met from the public purse, and this becomes a political issue. This trade-off between cost and quality is not new: Webster (2002) notes that it has always been difficult to find the resources to adequately support the health service in the UK.

In both the UK and Australia, a distinction has traditionally been made between primary care and secondary care. Primary care is care provided in the community, most clearly symbolised by the General Practitioner (GP), the doctor who has traditionally been the first point of contact with someone who is ill (except in cases of emergency). Secondary care is most clearly symbolised by large hospitals, employing a range of healthcare staff, some of them specialists in particular diseases or types of trauma. Coordination between primary and secondary care organisations is essential to the provision of good quality care to many individuals – but it is not always achieved in the UK or in Australia (Leggat and Dwyer 2004; Mann 2005; Swerison 2002; Wilson et al 2003). In addition, coordination with other organisations providing

care to the individual – such as social care organisations – is important, but can be problematic. The literature indicates many similarities between health care in Australia and in the UK, including the pressure of the broad factors of technology, demographics, expectations, costs and public expenditure noted above (Farrell 2003; McLoughlin et al 2001; Zifcak 1994; Blendon et al 2004).

The introduction of competition and market-based structures came at a similar time in the Australian and UK public sectors, and the principles – of privatisation, focusing on regulation rather than public ownership, applying private sector management methods to public sector organisations, attempts to improve productivity and quality through competition or contestability – were similar in both countries (APSC 2003; Podger 2004). In the UK and Australia – and in other developed countries – from the 1980s onwards there was a process of systematising medical knowledge, developing means of measuring workloads, clinical protocols and guidelines and patient pathways (APSC 2003:146; AIHW 2004; Davies and Harrison 2003; Palmer and Reid 2001). Healthcare in both countries is substantially funded by the public purse, through general taxation in the UK, and through the Medicare health insurance scheme in Australia (see AIHW 2004). Arrangements for private health also exist in both countries, running alongside the public schemes, and take up of private health provision has increased since the 1980s. In Australia and in the UK, reforms from the 1980s onwards have meant restructuring of organisational units, such as hospitals (eg Braithwaite et al 2006; Dwyer and Leggat 2002); drawing clinicians into management and leadership roles (eg McKee et al 1999; Degeling et al 2001; Braithwaite 2004); and systems-based and process re-design approaches (Appleby 2005; Berwick 2003; Berwick 1996; Leigh 2003; Leigh et al 2004; Wilson et al 2003; Mortimer et al 2004; Iles and Sutherland 2001; Iles and Cranfield 2004; Modernisation Agency 2002a and 2002b; 2004a, 2004b 2004c; 2005).

Public and private leadership and management

There are questions about whether aspects of leadership are universal, or at least transferable, and the differences between leadership/management in the public and private sectors. Ferlie et al noted

a long-standing debate is apparent within management studies between those who argue that management roles and skills are generic across organizational settings...and contextualists who feel that they are specific either to an individual managerial job...or indeed to a sector (Ferlie et al 1996:20-21).

Boyne (2002:103) lists 13 hypotheses about the alleged differences between public and private management (see Box 3.1) – although his critical analysis of 34 empirical studies finds little to support them. Hurley et al (2004) argue that healthcare is more complex than the private sector: the rationale for change can be more difficult to articulate, and the shifting political context can have a marked impact.

Box 3.1 Alleged differences between public and private management

1. Public managers work in a more complex environment
2. Public organisations are more open to environmental influences
3. The environment of public agencies is less stable
4. Public managers face less intense competitive pressures
5. The goals of public organisations are distinctive
6. Public managers are required to pursue a larger number of goals
7. The goals of public agencies are more vague
8. Public organisations are more bureaucratic
9. More red tape is present in decision making by public bodies
10. Managers in public agencies have less autonomy from superiors
11. Public sector managers are less materialistic
12. Motivation to serve the public interest is higher in the public sector
13. Public managers have weaker organisational commitment

From: Boyne 2002:103

The application of New Public Management (NPM) measures to the public sectors in the UK (Ferlie et al 1996) and Australia (Podger 2004) assumed that private sector management systems, techniques and approaches were applicable to the public sector. New Public Management was first conceptualised by Hood (1991), and has been characterised more recently as a concern with directive leadership, measurement, efficiency and effectiveness (Ferlie et al 2003). Although Ferlie, Ashburner, Fitzgerald and Pettigrew (1996:10-15) proposed four different models of NPM, including a model that would include 'highly committed, bottom-up, product champions in stimulating innovation in public sector settings' (1996:13) in which 'deviants, heretics, and rockers of boats...can play a critical role in triggering off processes of strategic change' (1996:14), and a model that would be a 'fusion of private and public sector management ideas' (ibid), by 2003 Ferlie, Hartley and Martin considered the public sector to be in a 'post NPM era' in which the typical command

and control elements of NPM were proving uncomfortably resilient (Ferlie et al 2003: S10).

Iles and Sutherland (2001:80) say issues relating to the differences of leadership in the health sector include:

- *the complexities of leadership in large, multi-professional organisations...*
- *the role of leadership in complex settings, both within and across organisations, where interrelationships, interdependencies and awareness of different views of purpose are vital*
- *the role of 'new' leadership skills, such as the management of influence and networking, in addition to 'traditional' leadership attributes and skills.*

However, in their wide-ranging advice on managing change in the NHS, they draw on a variety of sources and ideas, both public and private, with some additional proffered advice on tailoring approaches slightly to the healthcare context. In a similar vein, Bevan (2005) discusses how to apply the (private sector) change model of Sirkin et al (2005), to the NHS, commenting that it 'is one of a number of predictive change tools currently available. I have seen them used effectively by many NHS change teams'. In the Australian context, Hurley et al (2004) uncritically use Kotter's (1995;1996) eight stage model of change to analyse an attempt to bring about significant change in healthcare provision.

If Hurley et al (2004) may be accused of making an assumption (that a model of change developed in the private sector will apply to healthcare) then Braithwaite's (2004) empirical analysis of the modes of operating, and the primary and secondary activities of a clinician manager, which include financial management, people management, data management etc, would not be out of place in a description of the role of a manager in engineering, or manufacturing - although Braithwaite acknowledges specific issues concerning influencing clinicians.

The NHS Leadership Qualities Framework (Modernisation Agency 2002) sets out a series of skills and characteristics for NHS chief executives and other managers that would not be out of place in a person specification for a senior role in a private sector organisation (with the frequent references to the health service context replaced with appropriate references to engineering, or banking, or manufacturing). The preamble to the model states that it was benchmarked externally with leadership models

developed for private sector organisations, and it is similar, although ‘a remarkable feature’ of the NHS model is the high requirement for skilful and subtle influencing, together with political astuteness. (We will look more closely at this framework in the next chapter.) Similarly, the contents of an Australian framework of competencies for leadership in public sector (APSC 1998), the Senior Executive Leadership Capability Framework could be embraced without any change by a private sector organisation (only the competency of ‘Demonstrates Public Service Professionalism and Probity’ stands out as an essentially public sector requirement). And a model of leadership behaviours published by Queensland Health (the public healthcare organisation for the State of Queensland, Australia) has little to distinguish it from a model that might apply to the private sector – only the words ‘hospital’ and ‘clinical environment’ give it away.

We have seen that models of transformational leadership have received much attention in the literature of leadership in general. Alimo-Metcalfe and Alban-Metcalfe (2000; 2001) argue that transformational leadership is needed in the health service; Xirasagar et al (2005) put forward the view that transformation leadership is needed for physician leaders in Australia; Millward and Bryan (2005:xvi) note that transformational leadership is the basis of the Leading and Empowered Organisation training programme, widely used in healthcare, and is advocated for professionals in healthcare who want to make a real clinical difference; Edmonstone and Western (2002) also put forward the view that transformational leadership – which they equate with ‘near’ leadership and shared leadership - is needed in healthcare, because of the high degree of complexity and the high levels of change (they note that transactional leaders are also needed – but much has already been done to develop them already). But Mannion et al (2005) found that in acute trusts that were judged to be high performing, there was a top down, command and control style of leadership, ‘a long tradition of strong directional leadership from the centre with the senior management team setting clear and explicit performance objectives for the organisation and establishing robust internal performance management and monitoring arrangements to meet those aims.’ (pp73-75) Whereas in low performing organisations, CEOs may be viewed as charismatic, they lacked the transactional skills, and many were described as being remote and disconnected. Middle management in low performing trusts was under-developed and without power.

To summarise: private sector techniques and ideas about management and leadership have been applied to the public sector, and to healthcare in Australia and the UK, with minor modifications. Ideas about what activities are performed by leaders and managers in healthcare – whether they need to apply transformational or transactional styles – and the kind of competencies they are said to require, are not significantly different from published ideas about leaders and managers in the private sector. As Dawson (1999:15) has said: the 'challenges for management and organisation in health are similar to those for managers in other complex businesses' – although, she adds, in health these challenges are particularly great (see also Dawson and Dargie 2002).

Dawson and others (eg Boyne et al 2006; Iles and Sutherland 2001; Edmonstone and Western 2002; Plsek and Wilson 2001) comment on the complexity of the systems within which health sector leaders and managers operate. The next section explores one aspect of this complexity, a recognised aspect of the landscape of leadership in healthcare: the existence of different groups of professionals, and the tensions between managers and clinicians.

Clinicians, managers and leadership

Leadership and management in the public sector is affected, according to Ferlie et al (1996) not only by a public sector ethos, but also by the highly professionalised nature of public sector organisations, where public service values combine professional values and standards to create 'a complex pattern of influences' (1996:165-6). The influence of professionals is often seen as particularly strong in healthcare, where there are profession-based sub-cultures with different values, interests and languages (Goodwin 1998; Dawson 1999; Degeling et al 2001; Glouberman and Mintzberg 2001; Dawson and Dargie 2002; Degeling and Carr 2004; Clinamen 2006).

Depending on your position within the 'complex pattern', this can enhance or limit your potential to bring about change. Ferlie et al (2005) and Currie and Suhomlinova (2006) concentrate on the effect of these sub-cultures on the acceptance and spread of innovation, and the sharing of knowledge.

Ferlie et al (2005) argue that professional communities of practice in healthcare spread innovation within their own community, but they are 'self-sealing groups'. Social and cognitive divides between different communities of practice will slow the spread of innovations – this applies whether to different segments within the same profession (such as acute and primary care doctors) or to different professions (such as obstetricians and midwives). 'Such differences can only be overcome through social interaction, trust, and motivation, and they are rarely surmounted where there is a history of distrust.' (2005:131). Similarly on tribalism and its restrictions: Currie and Suhomlinova (2006) note that organisational and professional boundaries present significant barriers to sharing knowledge (and therefore accepting other perspectives on issues). Currie and Suhomlinova (2006:2) argue that the increasing status of various categories of different professionals in the health care field in relation to the 'traditionally high-status hospital consultants' have contributed to the strengthening of normative pressures operating within those groups and therefore 'a further divergence in perspectives between them.' Denis et al (2002) also found that, whilst different professional groups draw on some representation of patients' interests in discussing potential innovations, their reactions to proposed changes were also affected by their perceptions of the impact of the change on the influence and status of their own professional grouping.

Similarly, on attempts to bring about change to improve quality, (Ovretreit 1998:119-120) cautions:

quality is political: ownership and leadership of quality is directly related to the power and autonomy of professions, including management, in the NHS. Raise questions about the quality of a service and practitioners automatically assume that their work will be scrutinised, criticised and controlled, probably by people who do not understand it

In healthcare, it is said that there are different and conflicting values and cultures held by managers and clinicians (Degeling et al 1998; Degeling et al 1999; Litwinenko and Cooper 1994; Pettigrew et al 1992:151; Courtney 2002; Farrell 2003) a core aspect of which is expressed in brief by one commentator as 'doctors think first about their individual patients, managers think first about organisations' (Smith 2003: 611). The dominant profession in healthcare has been the doctors: over the years there has been 'a measure of agreement about the dominance of the medical profession and its ability to fight off and reject unwanted changes' (Ferlie et al 1996:168; also Davies

and Harrison 2003; Dent 2003; Willcocks 1998). The existence of such an 'elite profession' is unusual in public sector organisations (Ferlie et al 2003: S3). There is a recognised need for leaders in healthcare to win support from professions, especially well-established medics (Degeling and Carr 2004: 409-410; Boyne et al 2003:71; Marshall et al 2003; Reinertson et al 2005).

Medics have much influence in health services, because of the tradition of professional autonomy. Traditionally, doctors decide what is best for their patients, including the type and length of assessment and treatment to be carried out: decisions which have implications for the use of resources. Therefore, as Ham (2004:177) observes 'A central issue in the implementation of health policy is therefore how to persuade doctors to organise their work in a way that is consistent with central and local policies.' The privileged position of the medics has shifted from that indicated by the British Medical Association's submission to the 1977 Royal Commission on the NHS (cited in Ovretreit 1998:21) 'We are not convinced of the need for further supervision of a qualified doctor's standard of care' - to a point where audits of quality of care are an accepted part of healthcare management, but the doctors are still highly influential.

In the UK, the Thatcher government reforms of 1983, in introducing a class of general managers and lines of responsibility similar to those found in the private sector, sought to limit the power of the doctors (Ashburner et al 1996; Poole 2000). Ferlie et al (1996), however, challenge the view that professionals simply lost out to managers: 'Closer scrutiny suggests that there has been a complex and interactive process of adaptation by both managers and professionals in some parts of the public sector.' (1996:167).

A change in responsibilities and structures in the 1980s also involved drawing clinicians into management positions in acute hospital trusts. In both the UK and Australia, clinical directorates were created to focus on particular disease areas, or particular treatments (Braithwaite et al 2006; Braithwaite 2004; McKee et al 1999; Corbridge 1995; Kitchener 2000). Clinical directorates have been described as

the health sector equivalent of strategic business units, given some delegated freedoms to meet objectives but also strongly accountable upwards to the corporate centre (McNulty and Ferlie 2004:1395)

Ferlie et al (1996) note that the clinical directorate structure led to 'potentially greater coherence, because the clinical professionals who are responsible for the key decisions on service and thus spending are part of the resource allocation process' (1996:99). The role of clinical director was (and is) often held by a clinician, supported by a business manager and a nursing manager. Although models of the clinical director role vary, common core activities include providing leadership, and being responsible for a team of consultants and junior medical staff in a directorate, taking overall responsibility for a budget and a business plan, and being involved in contracting discussions with purchasers (Harrison and Miller 1999:23).

Ferlie et al add that the 'new hybrid professional-manager roles represent an important bridge between the medical professions and general managers' (1996:104) and say that they can 'translate' between doctors and managers (Ferlie et al 1996:186; also Llewellyn 2001; Roddis 2005). There is an argument that clinical directors represent a re-professionalisation within healthcare, as individuals with clinical expertise also acquire management expertise (Thorne 2002) although it is argued that a tension remains in how to balance the needs of the individual patient with financial accountability (Shapiro and Mascie-Taylor 2005). The move of clinicians into management means that they are better positioned to tackle some issues that general management would not have dared to do, because of the tradition of clinical freedom, such as poor performance by clinician colleagues (Ferlie et al 1996:186) although relationships with medical colleagues may be difficult (Davies and Harrison 2003) and in managing clinical colleagues they may need to 'discuss, negotiate and persuade, rather than require, insist or demand in order to get things done' (Braithwaite 2004).

Whether they are in clinical director roles or not, there is an argument that every senior doctor has a management and leadership role: 'It's not something they necessarily choose to do; it's a component of their job' (Jenny Simpson - then Chief Executive of the British Association of Medical Managers - quoted in Coombes 2005)

To summarise, the implications of these patterns of influence and responsibility are that:

- the formal authority of a manager in a healthcare organisation – even a senior manager, such as a chief executive – is in practice likely to be limited by the influence of professions within his/her organisation
- changes involving more than one professional group are likely to face the additional difficulty of translating messages and seeking agreement across cultural and perceptual barriers between professions
- professionals have been drawn into management positions - a prime example of which is the role of clinical director - and they may be able to combine expertise from both clinical and management perspectives and act as a bridge between doctors and managers
- the position of these 'hybrid professional-managers' is different from that of pure managers or pure professionals, and it is not without potential problems and tensions

The changing environment for leadership: the UK experience

Most of my fieldwork was carried out in the UK, at a time of major changes to the whole National Health Service. These changes provide a context for the actions of the chief executives, clinical directors and others I interviewed, and this section will briefly set out the main features of this context.

Major changes had been asked of the health service by the Thatcher governments of 1979-1990. In addition to resource management methods, and outsourcing, designed to control the costs of the health service, the Conservative governments had also introduced general management to the health service (after the Griffiths Report of 1983) and introduced market mechanisms after 1989 in the hope that this would stimulate competition and lead to increased efficiencies. These were significant changes, which have been described as transformative and radical (Ferlie et al 1996; Ashburner et al 1996; Harrison and Miller 1999).

The Labour government elected in May 1997 continued to demand changes of the health service, leading one experienced commentator to note that 'the continuous revolution initiated by the Thatcher government was perpetuated under the Blair government which showed no wish to slow the process of change' (Ham 1999:61). A

White Paper, consultation documents, a comprehensive plan for the NHS, and an investigative report ensued (DoH 1997; DoH1998; DoH 2000; DoH 2001; Wanless Report 2002).

The new government replaced the market mechanism with improved performance measurement, backed by the threat of central intervention in the event of unsatisfactory performance. National Service Frameworks (NSFs), were produced, creating national strategies for dealing with particular diseases, or for working with particular groups (such as children). The National Institute for Clinical Excellence (NICE) was established in 1999, with a remit to investigate and publish advice on treatments (this advice was made mandatory guidance in 2002). The Commission for Health Improvement (CHI) started work in 2000, to oversee the governance arrangements of healthcare organisations. A Performance Assessment Framework was established – a series of targets that healthcare organisations were expected to meet. In opposition, Labour had focused on in-patient waiting times – in government this became a key target (Webster 2004:223). The Modernisation Agency, created under the NHS Plan 2000, brought together a number of teams working to bring about change in healthcare organisations. A favourite approach of the Modernisation Agency was to reengineer processes of delivering healthcare: this entailed examining how services could be delivered in different ways, (for example, see Edwards 2004a; Modernisation Agency 2002b and 2004b) including bunching tasks and functions in different ways, and creating different types of jobs. A Changing Workforce programme was announced by DoH 2001, designed to examine the potential of new staff roles in a variety of care group settings. In a variety of contexts, new job roles were created (see, for example, Edwards et al 2004)

Pressure was placed on healthcare organisations to meet performance targets. This particularly affected the acute sector, with poor performers exposed to public criticism, and subject to visits from Modernisation Agency teams to overhaul their systems and processes. Week-long inspection and audit visits from CHI teams to examine governance systems were prefaced by weeks of examination of the quality systems (Day and Klein 2004). The successor to CHI – the Healthcare Commission – was given a broader remit, to look at the quality of care, rather than clinical governance arrangements, and to inspect against standards. Complaints about the targets

themselves, and examples of perverse incentives and gaming behaviour, led to changes in what was measured. The ratings systems were comprehensively changed in 2005 (Lloyd 2005b) but monitoring by the centre remained a feature of how the service operated.

There were significant changes in organisational structures and systems in primary care over the period 1997-2005. Primary Care Groups (PCGs) were created, from 1998 onwards, to make decisions about commissioning healthcare services; after 2000 they were expected to amalgamate and to become legal entities, called Primary Care Trusts (PCTs), with their own boards of directors. Dissatisfaction with the performance and capability of these PCTs was voiced almost from the moment of their creation (eg Sheaff et al 2002:450; CHI 2004a and 2004b; Audit Commission 2004; Edwards 2004b; HSJ Editorial 2004; Goodwin and Smith 2002) and in 2005 a programme of significant mergers between them was announced, to create larger organisations. The old Health Authorities were dissolved when PCTs were created, and a smaller number of Strategic Health Authorities (SHAs) was formed in their place. The interdependent responsibilities of, and the power relationships between, PCTs and SHAs were ambiguous from the outset (see, for example, Leese 2002) and in some cases difficult. In theory, SHAs were supposed to facilitate and support the PCTs. In practice, the SHA chief executive could be held responsible by the DoH for performance in his/her area. A Health Service Journal survey in 2004 found that 75 (out of 100) PCT chief executives surveyed had experienced 'undue pressure' (ie to meet performance targets) from SHAs over the previous year (Clews 2004). When it was announced that PCTs would merge, in 2005, it was also announced that SHAs would merge to create fewer, larger organisations.

Financial pressures continued to affect the service. Investment below the rate of inflation in the preceding 25 years had left the service suffering 'problems of crumbling infrastructure, obsolete technical facilities, [and]...the melting away of the skilled workforce' (Webster 2002:215). Following the Wanless report (Wanless 2002) significant amounts of extra finance were provided, in a five year programme to increase funding by 7.4% a year in real terms. Schemes to enable greater patient choice of healthcare provider were introduced (Corrigan and Maynard 2005; Rosen

2005). There were concerns at this time within the service that private sector organisations would be able to compete with the National Health Service. (HSJ 2005).

A plan to introduce 'Foundation Hospitals' was announced in 2002: these would be a small number of larger acute health Trusts that, by proving they were able to meet the set targets, would be eligible to apply for more freedom from central control. The first ten Foundation Trusts were launched on 1 April 2004, amid confusion about the extent to which they would be able to exercise genuine independence - including being able to compete with other hospitals - and the extent to which they would be controlled or restricted, and expected to collaborate with the rest of the service (Smith 2004).

The reforms gave rise to greatly increased levels of job insecurity for chief executives: Cole (2002, cited in Blackler 2006) reported that in 2001, 20% of CEOs in the NHS in England had resigned or were sacked. The cumulative effect of these changes was, quite naturally, often to confuse, disillusion and dispirit staff at all levels in the health service. Common themes in a DoH survey were fears surrounding the constant pace of change; the development of a tick-box culture caused by all the targets; bad relationships between organisations; dissatisfaction with the level of political interference (Lloyd 2005a). One chief executive, quoted at the start of 2006, said:

The government has put too many changes in place at the same time without considering the impact on services. Targets are set nationally, locally we try and meet these and then get the blame when the targets and funding don't balance (HSJ 2006)

Another chief executive wrote of her experience in meeting groups of colleagues:

Stalwarts of the profession were admitting they could not remember a more challenging time....The national staff survey showed worrying levels of stress in all staff groups, but notably in senior managers. Policy changes seem to be constant and are coupled in several instances with uncertainty about whether they can be supported. Technical details that are needed to make the system work are often late or not provide at all. (Llewellyn 2005)

According to Burgoyne 'the average trust chief executive [in the NHS] lasts two and a half years....There's quite a lot of soft data that managers are actively managing their career to avoid being promoted to chief executive' (quote in Nolan and Carlisle 2006).

Webster (2002:142) categorised the reforms wrought by the Thatcher government as a sequence of changes 'in which the end result was not predictable at the beginning, and indeed the whole process of policy-making was akin to a journey through a minefield, advances being made in an erratic manner'. This description could apply equally well to the changes from 1997-2006.

The freedom to lead change

To what extent are managers and clinicians in healthcare able to lead change? In the UK, the rhetoric of leadership has been noticeable; for example, Lord Hunt, UK Health Minister in 2000:

We need leaders who are willing to embrace and drive through the radical transformation of services that the NHS requires. Leaders are people who make things happen in ways that command the confidence of local staff. They are people who lead clinical teams, people who lead service networks, people who lead partnerships, and people who lead organisations. (quoted in Hewison and Griffiths 2004:464)

Mike Dixon of the NHS Alliance, in 2005:

If you see no leaders, become the leaders. If you find no rules, make the rules. Where there are no plans or vision, this is your opportunity to create them. (quoted in Stevens 2005)

We have seen, above, writers such as Alimo-Metcalfe and Alban-Metcalfe commending transformational styles of leadership for healthcare, and the transformational themes of the Leadership Qualities Framework and the Australian SELC Framework. However, a number of observers have questioned the extent to which even senior managers in the English NHS are allowed the freedom to lead. For example, Hoque et al (2004:357, 370), noted that whilst successive UK governments have said they will devolve power and encourage enterprise in the healthcare system, since 1997 the Department of Health sought to set out exactly how managers were expected to perform, and on what they were expected to focus their efforts, with the result that they had little scope to determine their priorities. In a similar tone, Baggott notes (2004:182)

The command and control culture in the NHS is part and parcel of the new managerialism in Britain's public services, which involves the setting of central targets, regular and intrusive monitoring, and the identification of "failures" and their replacement by others, including the private sector.

He says that statements about decentralisation are met with considerable cynicism about whether they will translate into practice, 'given the high political stakes' (p183).

On the other hand, Ham (1999 and 2004) believes there is scope for leaders in the NHS to influence policy. Ham's interest lies in policy-making for healthcare, and he says that NHS bodies 'are semi-autonomous organisations who themselves engage in policy-making, and as such exercise a key influence over the implementation of central policies' (Ham 1999:160). In the post-2000 reforms, he notes that 'There was scope for NHS bodies to take the framework developed by the government and adapt it in the process of implementation' (Ham 2004:58). This is congruent with Klein's (2001:217) observation that 'Over the decades the NHS, a uniquely complex, heterogeneous and intractable organisation, had proved remarkably resistant to attempts to steer it from the centre.' McNulty adds (2003:S43) in a review of an application of Business Process Reengineering in the 1990s, that, despite the pursuit of control from the centre, 'professionals at a local level still have a major say in regulating the nature and pace of change'. In a study on perceptions of styles of strategy making, Collier et al (2002) found that the NHS was perceived (by employees) to be significantly more 'political' in its style of strategy making than other public sector organisations (ie strategies are developed through a process of negotiation and bargaining between stakeholders). Collier et al (2002:29) suggest that this may 'reflect the participation of strategy formulation in the NHS of a large number of active stakeholders (managers, clinicians, nurses, public funding bodies, trade unions).' (See also Currie 1999b)

But ultimately health care organisations are dependent on the Department of Health for almost all their income; and they are responsible to the Secretary of State, who is answerable to Parliament, so they must be prepared to account for even detailed issues to the Department of Health. As Dawson (1999:14) notes: 'the life and death issues which touch us all make health a highly politically sensitive issue'. Davies and Harrison (2003:647) argue that the effects of regulatory and inspection systems and the national performance framework are that senior managers are 'seen more as agents of government than as facilitators of professionally-driven agendas' (this point, of course, begs the question, seen by whom?) Blackler observes that chief executives in UK healthcare have 'become little more than the conduits of a highly centralised

management system' (Blackler 2006:14). He argues that any notions of distributed, shared leadership are inappropriate, given the degree of central demand for control, and that chief executives are being denied a leadership role: 'The constraints under which chief executives were working over the 2000-2002 period appear unsustainable and it is questionable whether they were leaders at all at that time.' (Blackler 2006:19). And Hewison and Griffiths (2004:470-471) argue that ideas of Bennis and Nanus – of leaders acting to 'choose purposes and visions that are based on key values of the workforce and create the social architecture that supports them' are not compatible with the need to 'comply with a complex Web of regulation, legislation and codes of conduct' – which discourages the risk taking and creative thought supposedly involved in such models of leadership. These writers are agreed that the extent of the control exercised over the UK health service by politicians and the Department of Health during this time severely limited the ability of senior managers to choose their own courses of action. Much time was spent in ensuring their organisations complied with the targets and expectations of the centre, to the extent that Blackler, above, doubts whether 'they were leaders at all' during one part of this time. However, to put the alternative case, observers such as Ham, Klein, McNulty, Collier et al indicate that there is still scope to lead, despite the directions from the centre.

A corollary of this is, as Longest (2004) writes, that strategic managers in healthcare need a good sense of not only current but also likely shifts in policy – or 'policy competences' as he calls them - to be able to anticipate challenges and opportunities. It is also likely to be the case, as shown by Cortvriend (2004), that leaders can make a difference to morale, motivation and performance by how they go about leading staff through radical changes imposed from outside.

At levels below chief executives, there is some evidence that there is scope for leadership, for example by innovating and spreading good practice, such as through 'beacon sites' (Baggott 2004:215-216); developing the basis of new organisational forms and practices which are later adopted as central policy (as described by Barnes 2002 in relation to NHS Direct and NHS Professionals); and providing leadership in developing local forms of umbrella strategies, such as Porte's (2002) account of

developing clinical governance arrangements in his own hospital. Dawson (1999:21) writes that

individuals in roles as leaders, mentors, change agents and consolidators can make a real difference to the way in which local managerial and organisational systems are created and sustained

In summary, despite the rhetoric of the importance of leaders and leadership, several observers argue that the scope for exercising leadership in healthcare organisations in the UK during this period was severely limited by the extent of reform and the number of initiatives imposed from the centre. Other writers and practitioners, whilst acknowledging that the actions of the centre substantially impacted upon individual leaders in health organisations, provide examples of leadership and change.

Summary

In this chapter we have seen that there are broad similarities between the healthcare systems in England and Australian. In both countries, healthcare organisations have strong public sector origins, and have over the past twenty years experienced the pressures of technological developments, changing demography, and increased demand. Solutions have been sought by governments in both countries to the rising cost of healthcare in the form of New Public Management-style reforms.

There are assumptions that much of the general literature on leadership and change is applicable, perhaps with some minor modifications, to a health sector context, with writers applying frameworks of change and models of leadership to explain events in healthcare. The existence of strong professional groupings is taken as a distinctive feature of healthcare organisations, however, and there have been tensions in particular between doctors and managers. A feature of healthcare organisation in both countries from the 1990s onward has been the emergence of a hybrid clinician-manager role. We have also seen that a programme of intense and radical reform was being undertaken in the English healthcare system at the time of the field research.

In relation to change agents in the UK healthcare systems, we have seen that there are competing views from commentators about the extent to which it is possible for

managers and clinicians to actually exercise leadership, in the context of a series of centrally-driven changes. The argument by a number of commentators that generic ideas about leadership can be applied to the healthcare setting (albeit that the context is more complex) will also be an interesting matter to take into account when evaluating the information gathered from the primary research. Neither of these points, however, will be formulated into hypotheses, to be tested during the research process. As noted in the previous chapter, the process of research will be to gather information from interviewees and to develop inductively ideas about the behaviours and skills of effective leaders of change, grounded in the data gathered from the field.

4. Competencies for leadership and leading change

Speculation about the characteristics and skills of effective leaders is an age-old pastime. In the early twentieth century this took the form of considering the traits of effective managers and leaders. Towards the end of that century, and during the beginning of this one, many researchers and consultants still sought to define the competencies – whether innate characteristics or learnable skills and behaviours – of effective performers of a wide variety of roles, from salespeople to dental technicians, from production directors to engineers, including leaders and managers in a variety of industries.

This chapter discusses relevant aspects of the literature on competencies of leaders, managers and change agents. It begins with a definition, and distinguishes between two different approaches to describing competencies. It provides a flavour of the range of competencies that leaders and leaders of change are said to need, drawing on the work of a wide range of writers. It then explains the systematic approach to developing competency frameworks, first developed by the McBer consultancy, and introduces two recent frameworks that are particularly relevant to this research: the Alimo-Metcalfe and Alban-Metcalfe framework of the 'dimensions' of transformational leadership, and the Modernisation Agency's Leadership Qualities Framework. Both of these descriptions of competencies have been developed through research in the NHS.

The definition of competencies and the use of competency frameworks has been an area of debate and controversy, particularly in the UK, and some choice criticisms of the competency are examined, weighed up, and to some extent countered.

What are competencies?

Competencies have been identified at organisational and at individual level as capabilities or distinctive strengths (eg Hamel and Prahalad 1990; Bergenhenegouwen 1996; Nordhaug 1998; Hoffman 1999; Horton 2000; Garavan and McGuire 2001; Hodgkinson and Sparrow 2002; Francis et al 2003; Ross et al 2004; Lodge and Hood 2005; Boxall and Gilbert 2007). At organisational level, 'core

competencies' give an organisation strategic competitive advantage (Hamel and Prahalad 1990; Murray 2003). An individual's competencies are most often represented as skills or other attributes of an individual, which may include knowledge, skills, attitudes, traits and motives (Boyatzis 1982; Higgs 2003; Klemp 2001; Guo and Anderson 2005; Hollenbeck et al 2005). These individual competencies – sometimes called 'behavioural competencies' (Rankin 2006) – may be described in a range of ways: in terms of specific skilled behaviours, such as 'use of oral presentations' (Boyatzis 1982), or motives, such as 'achievement orientation' (Spencer and Spencer 1993) or elements of personality, such as 'integrity' (Higgs 2003; Storr 2004) or as broad areas of activity, such as 'leadership' (Rankin 2006) 'transformational leadership' (Porter-O'Grady and Krueger Wilson 1995) 'people management' (Braithwaite 2004) 'managing change' (Quinn et al 2003) 'decision making' (Ross et al 2004).

In this research I am concerned with attempting to identify behavioural competencies that are used by individuals when they attempt to lead change. A useful definition of this type of competency is that it is 'an underlying characteristic of a person which enables them to deliver superior performance in a given job, role or situation' (Hay Group 2003: 2)

This approach to competency contrasts with quite a different method of defining competence (Boak 1990; Winterton and Winterton 1999) that has been sponsored by the British government since 1981 which, for clarity, I will briefly describe and distinguish. This alternative approach is based on specifying outcomes that a competent individual should be able to achieve, and thus aims to define generic standards of performance for job holders. The immediate origins of this approach are found in the publication of the New Training Initiative in 1981, which stated that the UK must 'develop training... to agreed standards...appropriate to the jobs available' (MSC 1981). Competence, taking this approach, has been defined as 'the ability to perform the activities within an occupational area to the levels of performance expected within employment' (Training Commission 1988).

The statements of competence produced as part of this ongoing project are developed through an approach known as Functional Analysis (Mansfield and Mitchell

1996; Mansfield 2004). Rather than trying to identify the skills or attributes that enable successful performance, which could be described as inputs to performance, Functional Analysis concentrates on the outcomes that effective job holders are expected to achieve. These outcomes might be tangible - an actual product, such as a sheet of glass, or a building - or intangible - a decision, a plan, a piece of advice or a sale (Mansfield 1993). Functional Analysis differs from a task analysis in that it seeks to focus on outcomes – what is achieved – rather than on *how* something is achieved (Mansfield and Mitchell 1996:97). Individual statements of this type of competence ('functional competences' as opposed to the 'behavioural competencies' that concern skills and other attributes – Rankin 2006) are set out in a format that usually includes:

- a statement of what the person is expected to be able to do (which serves as a title for the competence)
- statements of the standards of quality which a competent person should be able to achieve (these are called 'performance criteria')
- a statement about the range of circumstances in which the person may be expected to achieve the outcome (sometimes called the 'range statement', or 'scope')
- a statement of the knowledge and understanding that underpins the performance described in the rest of the competence

Functional competences have been developed extensively for various job roles within the UK health service by the Sector Skills Council for healthcare, Skills for Health (for examples see www.skillsforhealth.org.uk). This approach has contributed to a significant pay-restructuring exercise in the NHS, from 2004, called *Agenda for Change*, through the development of a template for individual competences – the NHS Knowledge and Skills Framework. Functional competences have also been developed by various other Sector Skills Councils for job roles in engineering, construction, TV and radio, purchasing and supply, marketing and selling, personnel, training and development, customer service, and manufacturing. Functional competences also form the basis of National Occupational Standards and National Vocational Qualifications (for a full list of current National Occupational Standards see www.ukstandards.org.uk).

Generic functional competences – or ‘standards’ - for managers were developed in the UK in series of projects, from 1988 to 2004. The management standards were first published in 1990, revised in 1997, and again in 2001-2004; the 2004 publication designated them as ‘Leadership and Management Competences’ (www.msc.org.uk). Standards for senior managers were first published in 1994. ‘Personal competency’ frameworks (ie behavioural competencies) for managers were also developed in 1990 and 1994.

The existence of these two types of description of competency or competence has given rise to some confusion (eg Lodge and Hood 2005; Mansfield 2004; Hoffman 1999; Strebler et al 1997; Johnson and Winterton 1999, paras 71-76; Winterton and Winterton 1999: 26-28). The confusion has led one leading American proponent of behavioural competencies to call them ‘capabilities’ in the UK to underline the difference between his approach and a standards-based description (Boyatzis and Adams 1999) and another proponent to talk of ‘dimensions/competencies’ (Byham and Wurstemann 2000). In practice, there are overlaps between the contents of the two types of framework, as both approaches to competency/competence include descriptions of behaviours. To the inexperienced reader, the format of the framework is the most obvious difference between the two approaches.

Although some writers describe the functional competences as ‘British’, in contrast to the ‘American’ behavioural competencies (eg Stuart and Lindsay 1997; Miller et al 1999; Garavan and McGuire 2001; Cheng et al 2002; Grzeda 2005) surveys indicate that behavioural competencies are actually more widely used in UK organisations than functional competences (Rankin 2005, 2006). Although characterised as Anglo-American, there are examples of competencies (and competences) being used in other countries, including Australia, countries in Western Europe and the Far East (Nyhan 1998; Valeavaara 1998; Miller et al 1999; Garavan and McGuire 2001; Dunoon 2002; Horton et al 2002; Moqvist 2002; Agut et al 2003; APSC 1998; Mansfield 2004; Page et al 2005; Hood and Lodge 2005; Brans and Hondeghem 2005; Chen et al 2005; van der Meer 2005; Australian National Training Authority 2005; Hay Group 2007a).

Both types of competencies/competences are used by organisations for training and development purposes, and for recruitment and appraisal, and the development of frameworks of competency/competence is usually intended to help individuals and/or organisations improve their performance (Boyatzis 1982; Goleman et al 2002; Conger and Ready 2004; Hay Group 2003). The most recent UK research to date indicates that the most common use of competencies by organisations is for training and development, followed by performance management/appraisal, followed by selection processes (Rankin 2006).

What competencies do leaders need?

Speculating about the attributes of effective leaders has been a time-honoured pursuit. Barnard (1948) for example, suggested effective leaders had five fundamental qualities:

- Vitality and Endurance
- Decisiveness
- Persuasiveness
- Responsibility
- Intellectual Capacity.

Research into the traits of effective leaders became less popular in the second half of the twentieth century, as studies produced no conclusive results, and researchers turned their attention to analysing leadership behaviours and styles. However, research into traits returned, in a more systematic form in the 1970s (Bass 1990). In a study of a number of groups, for example, Stogdill (1974) suggested that leaders tended to differ from followers in that they were more intelligent, dependable in exercising responsibility, original, and sociable. Research on personality and performance at work continues today, with meta-analysis of previous projects leading researchers to identify five main traits. Barrick et al (2001) argue that conscientiousness and emotional stability appear to be positively related to good work performance, but the other three main traits (extraversion, agreeableness and compliancy) show no such signs across the board. Nicholson (1998), however, carried out personality profiling of leaders and managers and suggested that, in comparison to the general population, they appeared to be more extravert, more

emotionally resilient, more conscientious, and less agreeable and compliant. Personality-based research tends to use self-assessment tests for its data, however, with the acknowledged difficulties of relying on individual self-perception (Barrick et al 2001).

Some frameworks of behavioural competencies concentrate on factors that are described in terms of aspects of personality (such as conscientiousness and extraversion) including motives, traits and values (Spencer and Spencer 1993); others define their competencies more in terms of skills and activities, such as, for example, building teams, developing people, focusing on the customer, influencing others. Klemp (2001) and Higgs (2003) suggest that frameworks may usefully include both attributes and skills, with Klemp picking out Integrity/Honesty/Ethics, and Achievement Drive as leadership attributes found in many competency frameworks (2001: 245) and Higgs suggesting that Authenticity, Integrity and Self-belief are among the personal characteristics required by leaders (2003: 278). Klemp and, to some extent, Higgs have specialised in examining competencies of leaders and managers, but writers in the broader fields of leadership and change have also speculated or drawn conclusions about the skills and attributes of effective practitioners.

Bennis and Nanus (1985), in their influential study of visionary leaders, talked of four broad 'areas of competency' or 'strategies' employed by the leaders they interviewed:

- developing a vision to focus attention
- communicating the vision
- maintaining trust through consistency
- self-knowledge and self-development

They described behaviours associated with each of these strategies, but they did not create a clear checklist.

As described in Chapter 2, Bass's (1985) work on defining transformational leadership suggested there are four key 'components' of an effective (transformational) leader:

- idealised influence

- inspirational motivation
- individualised concern
- intellectual stimulation

These 'components' or 'elements' (Bass and Riggio 2006) are described in more detail, and are not greatly dissimilar in form from what other writers have called competencies.

Conger and Kanungo (1994) developed a five factor assessment tool for their charismatic leadership model, which included:

- strategic vision and articulation
- sensitivity to the environment
- sensitivity to members' needs
- personal risk
- unconventional behaviour

Each of these factors was indicated by associated behaviours – 25 in the original 1994 publication, subsequently reduced to 20 (Conger et al 1997). Kouzes and Posner (2002) also present five factors – called 'leadership practices' – in their model of effective leadership.

Buchanan (2003) reviewed the literature on the roles and competencies of change agents, and uncovered a combined list of 'over 130 competencies, qualities, traits, "habits" and other attributes' (p22). These included a framework of 15 competencies of change agents that Buchanan had earlier helped to formulate (Buchanan and Boddy 1992: 92-108) where they argued that the competencies 'of the change agent can be identified and expressed in a relatively straightforward manner' (Buchanan and Boddy 1992: 109 – see Box 4.1). Balogun and Hope Hailey (2006) suggest that change agents need analytical skills, judgement skills, implementation skills and self awareness. They also note that the successful agents are often described as having other competencies, 'such as the ability to deal with complexity, and to be good at influencing those around them to sell change' (p 8). Later they note that

...some of the competencies typically identified for change agents include 'creativity, courage, perseverance/motivation, tolerance of ambiguity, flexibility, political judgement, common touch (to be able to deal with people

at all levels), visibility, persuasiveness, networking, team building, communication awareness (to be able to communicate the same message through many channels in many different ways) (2006: 212).

In a separate publication, Balogun et al (2005) identify five categories of 'boundary-shaking practices' (ie concerning making changes across intra-organisational boundaries) which, they argue, primarily concern the management of meaning – aligning agendas of different parties, engaging in 'stage management', and gathering information.

Carnall (2003) identified 22 different activities/skills of effective change agents, grouped under four competency headings:

- Decision making - includes: acquiring information, analysing and understanding it, synthesising it, 'cross cultural skills – empathy' (2003: 125)
- Coalition building – includes lining up supporters and bargaining
- Achieving action – includes handling opposition, motivating people, building self esteem
- Maintaining momentum and effort – includes team building, sharing information and problems, trust in the people to solve their own problems

Other writers have offered alternative competency frameworks, such as new models of leadership (eg van Maurik 1997, 2001, Kent et al 2001; Kent 2005) and competencies for specific leadership roles or contexts (eg Watson et al 2004; McCredie and Shackleton 2000; Boak and Coolican 2001; Dainty et al 2004, 2005; Wren and Dulewicz 2005; Young and Dulewicz 2005; Sternberg 2005) including leadership in healthcare (Porter-O'Grady and Krueger Wilson 1995; Modernisation Agency 2002a; Montgomery 2003; NCHL 2004; Guo and Anderson 2005; Healthcare Leadership Alliance 2005; Garman et al 2006; Garman and Johnson 2006) and the challenge of 'global' (ie international) leadership (eg Bueno and Tubbs 2004; Jokkinen 2005; Tubbs and Schulz 2006). Robie et al (2001) carried out large scale questionnaire assessments which asked managers to rate themselves and others against relatively undefined skill areas, such as 'establish plans', 'analyze issues' 'display organizational savvy'. Robie et al (2001) suggested that being able to solve complex problems and to learn quickly, and being persistent and hard working, were prerequisites for effective leadership in the US and in seven European countries. Palus and Horth (2002) suggested that, because of the complex challenges facing organisations, leaders need six 'complex challenge competencies' in addition to traditional management skills. The complex challenge competencies were described

as the sense-making abilities of: paying attention; personalising; imaging; serious play; collaborative inquiry; crafting.

Box 4.1 Competencies of a change agent
From Buchanan and Boddy 1992

Goals

1. **Sensitivity** to changes in key personnel, top management perceptions and market conditions, and to the way in which these impact the goals of the project in hand.
2. **Clarity** in specifying goals, in defining the achievable.
3. **Flexibility** in responding to changes outwith the control of the change agent, perhaps requiring major shifts in project goals and management style - and risk taking.

Roles

4. **Team building** capability, to bring together key stakeholders and establish effective working groups, and clearly to define and delegate respective responsibilities.
5. **Networking** skills, in establishing and maintaining appropriate contacts, within and outside the organization.
6. **Tolerance of ambiguity**, to be able to function comfortably, patiently and effectively in an uncertain and unpredictable environment.

Communication

7. **Communication skills**, to transmit effectively to colleagues and subordinates the need for changes in project goals and in individual tasks and responsibilities.
8. **Interpersonal skills** across the range, including selection, listening, collecting appropriate information, identifying the concerns of individuals, and managing meetings.
9. **Personal enthusiasm** in expressing plans and ideas.
10. **Stimulating motivation and commitment** in those involved in the change process.

Negotiation

11. **Selling** plans and ideas to others, by creating a desirable vision of the future.
12. **Negotiating** with key players for resources, or for changes in procedures, and resolving conflict.

Managing up

13. **Political awareness**, in identifying potential coalitions, and in balancing conflicting goals and perceptions.
14. **Influencing skills**, to gain commitment to change ideas and initiatives from potential sceptics and subversives.
15. **Helicopter perspective**, to stand back from the immediate project and take a broader view of priorities.

Porter-O'Grady and Krueger Wilson (1995) argued that leaders in US healthcare would need to work collaboratively with others and would need new competencies, which they clustered under four headings:

- conceptual competence
- interpersonal competence
- participation competence
- leadership competence

Following Porter-O'Grady and Krueger Wilson (1995), Guo and Anderson (2005) state that there are seven recognised 'leaders' competencies':

- drive
- leadership motivation
- integrity
- self-confidence
- intelligence
- knowledge of the business
- emotional intelligence

A number of writers argue for the importance of a particular competency, or competencies, without setting out a comprehensive framework. For example, Bonn (2001) makes the case that strategic thinking is a core competency needed by individuals; Halbesleben et al (2003) put forward 'understanding temporal complexity' as an important competency; Skinner and Spurgeon (2005) argue there is a relationship between empathy and leadership behaviour and effectiveness in healthcare organisations; Boutros and Joseph (2007) make a case for 'building, maintaining and recovering trust' as a core leadership competency for clinical leaders. Goffee and Jones (2000) claim there are four 'unexpected characteristics' of effective leaders.

Zaccaro and Mumford and colleagues, who presented a perspective on leadership that concentrates on complex problem solving in social settings, identified the skills that effective leaders need in terms of 'social perceptiveness' (an ability to understand the needs and goals of individuals and groups within organisations) combined with 'behavioural flexibility' (an ability to respond well to different situation demands)

(Zaccaro et al 1991: 321-322). Mumford, Zaccaro et al (2000) later recast these skills sets as

- complex creative problem-solving skills
- social judgment skills needed for working within a complex organizational setting
- social skills associated with motivating and directing others

A significant development in research into and use of competencies has concerned emotional intelligence (Mayer et al 2004). Emotional intelligence, conceptualised as subset of social intelligence, has been widely publicised by Daniel Goleman and colleagues (Goleman 1996, 1998; 2006; Goleman et al 2002). Goleman and colleagues have defined emotional intelligence as the ability to recognise and manage one's own emotions, and the ability to recognise and relate to the emotions of others. The competencies of emotional intelligence and their relationship to leadership and leading change have been explored by a number of writers (eg Dulewicz and Higgs 2000; Goleman et al 2002; Orme 2001; Dulewicz et al 2003; Higgs 2003; Higgs and Aitken 2003; Scott-Ladd and Chan 2004; Rosete and Ciarrochi 2004; Power 2004; Sy and Cote 2004; Boyatzis and McKee 2005; Skinner and Spurgeon 2005; Chrusciel 2006; Kellett et al 2006; Kerr et al 2006; Kupers and Weibler 2006; Groves 2006). Emotional intelligence competencies have been regarded either as additions to behavioural competency (eg Dulewicz and Higgs 2000; Orme 2001) or as a significant sub-set of behavioural competencies (eg Goleman 1998, Woodruffe 2001) or even as a way of structuring complete competency frameworks (Goleman et al 2002).

From the outset, the idea of 'competency' has been stretched to include not only skills but also attributes such as integrity and drive, and motives such as a concern for achievement. At later times, researchers and writers have also redefined the nature and boundaries of competency – such as by identifying 'meta-competencies', abilities which underpin or allow the development of competencies - (eg Brown 1993; Butcher et al 1997; Harvey and Butcher 1998). Writers have suggested attributes that people may need in addition to competency, such as motivation (Boyatzis 1993) disposition to act (Klemp and McClelland (1986) and 'key cognitive abilities' (Stamp 1997). Cheetham and Chivers (1998, 2001) attempted to re-draw the boundaries of

competency to include personal competency, ethical competency, cognitive competency, functional competency and meta-competency. This was followed by Winterton and Dodd (2001) who amended the model slightly by conflating ethical and personal competencies. Cheng et al (2002 and 2005) have also suggested how behavioural and functional competencies can be combined.

In addition to academic research, and practitioners who launch models into the public domain, many UK organisations have attempted to define the competencies (skills and other attributes, including knowledge and attitudes) that their employees require, evidently perceiving value in the process of exploring, discussing and amending their statements of competence as well as in the actual models they produce (Rankin 2005, 2006; Miller et al 2001; Lodge and Hood 2005; Horton 2005). These competencies can then be incorporated into job descriptions, appraisal systems, training programmes, recruitment and selection profiles and so forth. Such competencies might be expected to make a contribution to overall corporate performance by helping the organisation to ensure that its individual members have the skills, knowledge and attitudes that they need in order to be able to do their job effectively (Salaman 2004; Levenson et al 2006).

A brief review of published material indicates no overwhelming consensus about the competencies needed by effective leaders or change agents – although, as Buchanan (2003) notes, on closer examination the variety may be exaggerated, as some commentators may be found to be using different words to describe similar skills or attributes, or may be clustering skill sets in slightly different ways. A difference in emphasis in examining phenomena of change leadership may be explained by activities taking place in different contexts, or even by the pressure to produce a different solution for commercial or research record reasons (Hunt 1999). On the other hand the potency (or otherwise) of a competency framework may be in the detail of how these capabilities are described.

This section began by observing that speculation about the attributes of effective leaders has been a time-honoured pursuit. It has demonstrated that this speculation has continued to the present day, and has embraced competencies and skills (and 'dimensions' and 'elements') as well as attributes. Some of the competencies

discussed in this section have been the result of detailed research, others are the product of experience, or tacit knowledge, or debate and consensus, or perhaps guesswork. The next section is concerned with examples of systematic research into competencies.

Systematic research into competencies

A significant development in the design and use of frameworks of competencies was instigated by the American Management Association (AMA) in the late 1970s. The AMA commissioned the Boston consultancy of McBer and Company to research a model of generic management competencies. The research brought together the results of previous projects undertaken by McBer, which covered over 1000 managers in eight private sector companies and four public sector organisations. The researchers used a range of tests to try to distinguish differences between the abilities and attitudes of average, superior and poorly performing managers. The principal research method that successfully identified the competencies was the Behavioural Event Interview (BEI) (Boyatzis 1982). The BEI will be described in more detail in Chapter 5, below.

The McBer approach to competencies built directly on the work of David McClelland, one of the founders of McBer. McClelland, in the 1950s, sought to identify the different primary motivational drives of individuals (McClelland 1962, 1988). He distinguished the need for Achievement (nAch) the need for Power, and the need for Affiliation, and developed tests to measure the extent of these needs in individuals. His influential paper in 1973, 'Testing for competence rather than intelligence' signalled a shift in focus in his work from purely motivational factors to include other attributes.

In all, the McBer research in the 1970s identified 65 distinguishing behaviours. The 65 behaviours were grouped into twelve 'competencies' and seven 'threshold competencies'. The competencies were given names to indicate the common theme in the behaviours. The twelve 'competencies' showed significant differences between 'superior' and 'average' managers (in Spencer and Spencer 1993 and Hay Group 2003 these are called 'differentiating competencies'); the seven 'threshold

competencies' showed significant differences between 'average' and 'poor' managers (Boyatzis 1982). In this research a competency was defined by George Klemp (1980), an associate of McBer, as 'an underlying characteristic of a person which results in effective and/or superior performance in a job' (cited in Boyatzis 1982: note that the later definition from Hay Group 2003, quoted on the first page of this chapter, follows this tradition, but is less deterministic about the connection between the competency and the superior performance). One significant feature of the McBer research at the time was that it provided a framework of competencies that had roots in more than anecdote, speculation, or the tacit knowledge acquired from long experience. The statistical analysis of personal attributes, related to managerial performance, was unprecedented. This went beyond informed speculation. This looked like real science.

The McBer research also represented almost all of the competencies (including the threshold competencies) as being learnable skills – another respect in which it differed from early trait theories - which therefore made its findings more acceptable to the training and development industry.

The AMA research and Boyatzis's book had a considerable impact on ideas about competencies. Consultants had already been working on company-specific models: soon other models of this kind were being offered as generic, such as those of Klemp and McClelland (1986) Schroder (1989) and Cockerill (1989,1993) - for whilst the McBer research, and Boyatzis's publication and explanation of it in 1982, were in many ways revolutionary, the actual model was difficult to operationalise, many of the competencies had unusual names (such as the 'Use of Socialized Power') or even appeared potentially dangerous (such as 'Spontaneity').

Although Boyatzis's 1982 work *The Competent Manager* is frequently cited in articles on competency, a much more comprehensive description of competencies, their development and use was published in 1993 by other consultants from Hay-McBer, in the form of Spencer and Spencer's *Competence at Work*. This includes a dictionary of competencies, and shows that Hay-McBer had developed sophisticated scales for each competency, so that different degrees of competency can be described. This is intended to overcome a difficulty in operationalising the competency model. More up to date material is also available from the Hay Group website - www.haygroup.com.

Two specific pieces of systematic research merit further mention at this stage, both particularly related to healthcare organisations: that of Alimo-Metcalfe and Alban-Metcalfe, and research commissioned by the NHS Modernisation Agency.

First, Alimo-Metcalfe and Alban-Metcalfe (2000, 2002) identified a number of 'dimensions' of leadership (see Box 4.2) for line managers in the NHS and local government, which form the basis of a development tool – the Transformational Leadership Questionnaire (TLQ) they have created. The research drew on Bass's (1985) model of transformational leadership. One publication of these dimensions sets them in three clusters (Alimo-Metcalfe and Alban-Metcalfe 2005) those concerning direct leadership of others, underlying personal qualities (such as honesty, integrity, decisiveness) and those to do with leading the organisation. Although these are described as 'dimensions' of leadership, it is difficult to see any essential difference between them and what other writers would call competencies or capabilities – particularly with the 2005 grouping of some of the dimensions into 'personal qualities'. Hamlin's (2002) structured research into 'criteria of managerial effectiveness' of middle and front line staff provided support for some of the dimensions of the Alimo-Metcalfe and Alban-Metcalfe framework.

The Alimo-Metcalfe and Alban-Metcalfe research was first published after I had begun my own research, and I was naturally concerned that it would make my own efforts redundant. However, Alimo-Metcalfe and Alban-Metcalfe's research has proceeded thus far by asking employees what kind of leadership they like from their line managers, using large-scale survey research with questionnaires constructed from repertory grid interviews (Alban-Metcalfe and Alimo-Metcalfe 2000; Alimo-Metcalfe and Alban-Metcalfe 2000, 2007). The research has deliberately concentrated on 'near leadership', by asking staff about their line manager (Alimo-Metcalfe and Alban-Metcalfe 2001, 2004; Alban-Metcalfe and Alimo-Metcalfe 2000) and, in constructing their framework, on what staff *valued*, rather than what they regularly experienced (Alimo-Metcalfe and Alban-Metcalfe 2001) - the experience at times falling short of what is desired (Alimo-Metcalfe and Alban-Metcalfe 2003, 2006). My approach – the methodology will be fully described in the next chapter – has been to use a variation of the Behavioural Event Interview, as used by McBer, to talk to individuals about

what they have actually done. I have also concentrated on activities concerning leading change, rather than leading or managing staff more generally.

**Box 4.2 Dimensions of transformational leaders
From Alimo-Metcalfe and Alban-Metcalfe 2005**

Leading and developing others:

- Showing general concern. Genuine interest in staff as individuals; values their contributions; develops their strengths; has positive expectations of staff
- Enabling. Trusts staff to take decisions/initiatives on important matters
- Being accessible. Approachable and not status-conscious
- Encouraging change. Encourages questioning traditional approaches to the job; encourages new approaches and solutions to problems

Personal qualities:

- Being honest and consistent. Honest and consistent in behaviour
- Acting with integrity. Open to criticism and disagreement; consults and involves others; regards values as integral to the organisation
- Being decisive. Decisive when required; prepared to take difficult decisions
- Inspiring others. Inspires others to join them; infectious enthusiasm
- Resolving complex problems. Capacity to deal with a wide range of complex issues; creative in problem-solving

Leading the organisation:

- Networking and achieving. Communicates the vision of the organisation/service to a wide network of internal and external stakeholders; gains the confidence and support of various groups through sensitivity to needs, and by achieving organisational goals
- Focusing team effort. Clarifies objectives and boundaries; team-orientated to problem-solving and decision-making, and to identifying values
- Building shared vision. Has a clear vision and strategic direction, in which he/she engages various internal and external stakeholders
- Supporting a developmental culture. Supportive when mistakes are made; encourages critical feedback of him/herself and the service provided
- Facilitating change sensitively. Sensitive to the impact of change on different parts of the organisation; maintains a balance between change and stability

The second piece of research – also first published (Modernisation Agency 2002a) after I had begun this research – was commissioned by the NHS Modernisation Agency, who used the Hay Group consultancy to develop a framework of 'leadership qualities' (originally 'leadership competencies' – Modernisation Agency 2001). This

was based on interviews with 50 Chief Executives and Directors in NHS organisations, and provides a framework of 15 qualities (see Box 4.3).

The framework is made up of three clusters – personal qualities, setting direction qualities and delivering the service qualities. Although the framework was developed through research with only very senior NHS executives, it subsequently formed the basis of 360 degree assessment tools and was made available to all NHS leaders and managers. The assessment tools provide descriptors and grades by which individuals may be assessed against each quality. The accompanying documentation emphasises that, depending on your job role, some qualities may be more relevant than others – particularly in relation to your need for ‘setting direction’ qualities (more strategic) and ‘delivering the service’ qualities (more operational/ implementational).

Box 4.3 NHS Leadership Qualities Framework 2002
Modernisation Agency

Personal Qualities

Self belief
Self awareness
Self management
Personal integrity
Drive for improvement

Setting Direction Qualities

Seizing the future
Intellectual flexibility
Broad scanning
Political astuteness
Drive for results

Delivering the Service Qualities

Leading change through people
Holding to account
Empowering others
Effective and strategic influencing
Collaborative working

On the face of it, it appeared there was more likelihood of this framework overlapping with whatever competencies I discerned from my research, given the similarity of research methodology. However, the Modernisation Agency research a) concentrated on senior executives (whereas I interviewed both senior executives and individuals at different levels in the hierarchy) and b) did not concentrate on leading change (note in Box 4.3 that one of the qualities is called 'Leading change through people') so it appeared that there was possibly still scope for my research to add to these findings in some way.

Setting these two frameworks side by side it is far from obvious that they were derived from the same (albeit very large) organisation at roughly the same time. Perhaps the different research methodologies have given rise to some of the differences (Alimo-Metcalfe and Alban Metcalfe 2004: 178): a reasonably intelligent observer who was ignorant of the origins of the two frameworks would be able to identify quite quickly which of them had been developed by asking individuals what they would like from their immediate boss (see also Hamlin 2002 for differences in emphasis in multi-rater research). Davidson and Peck (2005) criticise both frameworks for failing to address the need to focus on outcomes for service users; this is a little unfair in respect of the LQF, which does frequently mention service users and patients in the detail below the qualities' titles. Alban-Metcalfe and Alimo-Metcalfe (2007) have recently published a version of their framework, slightly amended, appropriate to the private sector.

The full meaning of each quality/dimension in either framework is not always apparent from the title, making comparison between the frameworks more difficult than it might first appear. The LQF is particularly complex in this respect, with some qualities being described as mixtures of motives, skills and specifically-prescribed behaviours, and there are some interesting mixtures also in the Alimo-Metcalfe/Alban-Metcalfe framework, such as the dimension of 'Networking and achieving' which includes 'inspiring communication' of the leader's vision. Straightforward comparison of the elements of the two frameworks is therefore difficult, with a dimension from one having parallels with only parts of a quality from the other and vice versa (see Table 4.1). Davidson and Peck (2005) suggest that the LQF could be described as a 'top down' framework, whereas the Alimo-Metcalfe/Alban-Metcalfe framework is more 'bottom up', but in fact a more significant difference is one of tone and underlying

themes: the LQF, for example, contains themes of vocation, of public service improvement, of adding value for service users/patients, which are not present in the Alimo-Metcalfe/Alban-Metcalfe framework, whereas the latter, perhaps by virtue of the role played in its development by the assessments of a manager's direct reports, has more emphasis on supporting and caring for staff.

Table 4.1 Comparing two frameworks	
Alimo-Metcalfe/Alban-Metcalfe	LQF
<i>These dimensions overlap...</i>	<i>with these qualities</i>
Facilitating change sensitively Encouraging change	Leading change through people (sensitivity to others and encouraging others elements)
Networking and achieving (vision element)	Leading change (vision element)
Acting with integrity Being honest and consistent	Personal integrity (some aspects of)
Resolving complex problems	Intellectual flexibility
Focusing team effort	Leading change (team element)
Enabling Supporting a development culture	Empowering others
Networking and achieving Building shared vision	Effective and strategic influencing
Being decisive (confidence element)	Self belief
No equivalents of: Showing genuine concern Being accessible Inspiring others	No equivalents of: Seizing the future Collaborative working Broad scanning Holding to account Self awareness Self management

The result is that the two frameworks do not map closely against each other. Different elements of four dimensions from the Alimo-Metcalfe/Alban-Metcalfe framework overlap with one quality from the LQF, but there are six LQF qualities (out of 15) with no clear comparison dimension, and three dimensions (out of 14 – including the dimension that the authors consider most significant, that of Showing genuine concern) with no clear comparable quality. The lack of a close match between the frameworks indicated to me that there was still scope for a further exploration of competencies in healthcare, particularly as my focus was specifically on the competencies that were needed to lead change, which was only a component of these other two frameworks.

Criticisms of leadership and management competencies

Given the range of work indicated in this chapter so far, the definitions of a 'competency' and a 'competency framework' can be said to be fairly elastic, a point that not only supporters of competency approaches, but also their critics (and of course, those who are neutral, or at least as yet undecided) would do well to note.

For example, among the critics, Binney et al (2005) believe 'the competencies approach' is flawed, creates idealistic, unrealistic pictures of super-managers, and encourages deficit thinking (p81). 'There is no competency model that can be applied to build the perfect leader' they argue (pp10-11). The essence of their argument is that effective leaders draw on all their own life experiences to behave authentically towards others, and that leadership is so much shaped by context that what will be effective in one situation will not be effective in another. And yet, much of their writing concerns the behaviour of the effective leaders they studied (and this is turned into advice about what people might do if they wish to be effective leaders). For example:

The third requirement for effective leading is to know yourself. Can people learn how to be a better leader? You bet they can! However, leaders don't become more effective by trying to learn some formula. If, as we found, there is no one model or tool kit that says how to be a successful leader then the education needed is in self-awareness. The more aware leaders are of who they are, how others see them, what choices they are making and the consequences of those choices, the more effectively they can use themselves...(p16)

So Binney et al reject competencies in favour of 'requirements' – but 'accurate self assessment' was in fact one of the original McBer competencies (Boyatzis 1982) and overall it is difficult to distinguish between this and other 'requirements' that Binney et al identify for effective leaders (such as being 'authentic') and some versions of competency.

Pedler et al (2004) are also critical of the emphasis on competencies, arguing that this approach encourages 'an individualistic and one-size-fits-all approach to leadership' (p6). Pedler et al encourage an approach to development that takes account of the context of leadership action, and also addresses particular challenges that leaders may face. Twenty-one 'challenges' are identified in Pedler et al's publication, 14 of which concern specific activities that leaders may need to undertake, such as managing mergers, streamlining, improving working processes etc (Binney et al also concentrate part of their effort on tackling particular challenges, in keeping with their concern for the importance of context). For Pedler et al, seven of the challenges are core, inner challenges: they include 'leading yourself', 'asking challenging questions', and 'living with risk' - and the ways in which the challenges might be tackled are described as the 'Seven Core Practices'. It is difficult, however, to distinguish any significant difference between what Pedler et al describe as a 'core practice' and what others would describe as a 'competency'.

The two publications (of Binney et al and Pedler et al) both contain interesting and potentially useful insights, of value to individuals learning to be leaders and also to professionals engaged in helping people to develop. The rejection of 'competencies' (or the rejection of the emphasis on competencies) in both cases is almost a separate issue from the contribution that both publications make to thinking about the 'ingredients' and 'practices' (or capabilities) of effective leadership, and the challenges that effective leaders may need to be prepared to face. Perhaps these two publications illustrate the difficulty of providing some contribution to practical ideas about leadership without at some point setting out advice about what effective leaders have done and/or what they should do – which quickly becomes very similar to what other writers would call a description of leadership competencies.

Competencies designed for managers and leaders have attracted academic criticism in the UK from an early stage (eg Burgoyne 1989; Holmes and Joyce 1989; Townley 1994). In a survey of the literature, Bolden (2004) helpfully identifies five strands of this criticism:

1. competencies are overly reductionist, they fragment the managerial role rather than viewing it as an integrated whole
2. competencies frequently assume a common set of capabilities no matter what the nature of the situation, individuals or task
3. competencies may reinforce traditional ways of thinking about management, rather than offering a challenge
4. competencies tend to focus on measurable behaviours and outcomes to the exclusion of other factors, such as ethical concerns, situational factors, knowledge
5. competencies support a limited, mechanistic and training-based approach to education

From Bolden's list, I propose to leave aside point five, the impact of the incorporation of competencies into educational programmes, which lies outside the scope of this research, and appears to be related particularly to the narrow issue of the use of management standards in vocational qualifications. As for his third point, it must be accepted that some competency models will reinforce traditional ways of thinking about management – in this respect they are no different from any other piece of writing or reflection on management and leadership - but there is also the possibility that some competency frameworks will challenge traditional thinking, such as the emotional intelligence competencies did in the mid-1990s. This, therefore, is a criticism that may apply to some frameworks of competency and not to others. In a similar way, in relation to point four, the charge that competencies tend to focus on the observable and measurable may be true of some examples, but some competencies – such as the emotional intelligence suite, and the intellectual competencies defined by McBer, or the social intelligence skills of Zaccaro and Mumford – certainly do not. Once again, it is also a charge that may be laid against any piece of writing on management and leadership, not only those concerning competency frameworks.

It appears useful to address the remaining two criticisms in more detail: the issue of reductionism, and the question of generic competencies. The question of reductionism is arguably one aspect of a larger issue – that of causal links between competency and performance – and it will be incorporated in that discussion. The issue of generic competencies will be discussed separately.

Causal links and reductionism

Studies such as those undertaken by McBer are based on research into the skills of effective managers, and competency was defined in terms of a characteristic that 'leads to effective or superior performance', but Jubb and Robotham (1997) argue that there is 'no consensus among the academic community as to what exactly constitutes managerial excellence or effectiveness' and 'managerial effectiveness is in itself an ambiguous performance standard with no real measurable output'.

This raises difficult problems both at the conceptual and at the practical level, but despite Jubb and Robotham's argument, many organisations and individuals continue in their efforts to help managers and leaders to become more effective (however imperfectly we might measure this) rather than abandoning the project as impossible. This issue is discussed further in the following chapter, on methodology. However, there remains an additional issue that systematic, evidence-based research into competencies, such as that of McBer, studies the behaviours of leaders and managers who are currently considered to be effective, and it may be that such behaviours will not aid effectiveness in the future (Grzeda 2005).

Leaving this aside for a moment in order to pursue the argued link between competency and effectiveness, if we take 'effectiveness' as related in some way (however it is measured) to results achieved, or to performance, there are causal questions at a number of points:

- will improving the competencies of employees necessarily improve corporate performance?
- will improving the leadership competencies of an individual necessarily improve the performance of the group or team with whom he or she works?
- are competencies necessarily linked to individual performance?

- are individual behaviours necessarily linked to competencies?

Grzeda (2005) argues that, because of the highly complex nature of management it is 'virtually impossible' to establish a causal relationship between a competency and outcomes. At corporate level this is a reasonable argument. Individual competencies can only be one component of effectiveness. Other components can be identified in situational factors outwith the individual. In Chapter 2, we saw that Gustafson (2003) and Greenhalgh et al (2004) proposed lists of a series of factors (including leadership behaviours and skills) that would influence the implementation of change. The McKinsey 7S framework, for example, described key dimensions of an organisation's configuration as strategy, structure, systems, skills, (leadership) style, staff and shared values (Peters and Waterman 1982). In the 7S framework, individual competencies would be included as 'skills'. For example, in an industry where customer relations are held to give competitive advantage, it makes good sense for the organisation to encourage individual employees to develop the skills of focusing on customer needs – but the company should also make sure that systems, strategies, structures etc also help individuals to focus on customer needs. As another example, where an organisation is expected to deliver high quality specialist healthcare, it makes obvious sense to recruit people with the necessary competencies to deliver that healthcare – but the organisation must also ensure that the systems, structures etc enable the healthcare to be delivered. Clearly, a number of factors may influence corporate performance. Besides the internal configuration factors, we must also consider the impact of the actions of competitors, governments and other stakeholders outside the organisation, as well as the effect of luck (good and bad).

Proponents of competency-based approaches are often modest in their claims in this respect. For example, Schroder (1989: 6) wrote: 'Organizational effectiveness is neither the sole outcome of the characteristics of managers nor of the characteristics of the internal and external environment of the organization. It is an interaction between these two.' Boyatzis (1982: 242) also specified particular aspects of the organisational environment (including systems, processes, programmes and climate) which would affect managerial competencies. He suggested that, in order to improve corporate performance, members of an organisation should consider

- the impact of these elements
- the performance of managers in meeting basic job demands
- the degree of managerial competence, and
- the interaction between these three factors

Goleman (1998: 28) also regards competencies as 'necessary but not sufficient' arguing that an individual's motivation and the climate of the organisation will determine whether the competency leads to effective performance.

Whilst there is published, measurable data on corporate performance, studies from disinterested researchers have rarely shown clear causal connections between management competency and such corporate performance (but see Mabey 2002, 2005 on management development and corporate performance). Collins's (2002) research may prove one exception, but this includes not only an assessment of the competencies of the CEOs of the outstanding companies he researched, but also the effect of the particular types of strategies that they adopted. Goleman (1998: 38) claims to have identified links between strengths in a manager's emotional intelligence competencies and the financial performance of the division that he or she manages. The Hay Group claims that effective leaders increase productivity and bottom line performance by creating 'high performing, energizing climates' (Hay Group 2007b: 5; also Goleman et al 2002: 17-18).

Is there a clear causal link between the competencies of an individual and the performance of the group with whom they work? In other words, will improving the leadership competencies of an individual necessarily improve the performance of the group or team with whom he or she works? A logical answer is: no, not necessarily, although the efforts of a more skilled individual might be expected to yield better results from a group, all other things being equal, than those of a less skilled individual. The group or team may still be very difficult to influence, because of other factors affecting their perceptions of how they should behave - including their perception of how they should respond to the individual whose competencies we have tried to improve.

Silzer – a promoter of the use of competency frameworks - notes:

Supporters of leadership competency models would not argue that competency models are “the prescription” for effective leadership. They are simply an attempt to leverage the experience, lessons learned, and knowledge of seasoned leaders for the benefit of others and the organization (in Hollenbeck et al 2006: 403)

A related issue concerns whether, in investigating leadership, we should be particularly concerned with individual competencies at all. As noted in Chapter 2, some writers argue that leadership is better seen as a collective, shared, social activity (eg Drath and Palus 1994; Ross et al 2004a, 2004b; Pedler et al 2004). A further criticism of competency models by Bolden (2004, 2005) is that leadership is assumed to be a property of a leader – that it is individualistic and uni-directional.

However, even if we consider leadership to be a dispersed activity in an organisation, there is still a value in retaining a focus on the individual, and the competencies of the individual. Where leadership is shared or dispersed, the competencies that individuals require may be more about working cooperatively and participatively with others, than directing or controlling them. This may be reflected in common competencies. In fact, Miller et al (2001) analysed 40 competency frameworks and found that team orientation was the most common competency (found in 78% of models); Rankin (2005, 2006), in a survey of UK organisations that use competencies, found a similar result (team orientation, the most popular competency, found in 86% of models). This is hardly promoting individualistic, heroic leadership. The Hay Group has recently focused on collaborative leadership as a significant type of leadership role (Hay Group 2004; Scotts 2006) with distinctive competencies, and a Center for Creative Leadership survey found that organisations were increasingly viewing leadership as a collective process – with implications for the individual skills required: ‘participative management’ and ‘building and mending relationships’ were becoming viewed as more important, while the more individualistic ‘resourcefulness’, ‘decisiveness’ and ‘doing whatever it takes’ were becoming viewed as relatively less so (Martin 2005).

Retaining a focus on individual competencies makes pragmatic sense, too. Although it may be ideal to carry out development activities with workteams or workgroups, and thus explore how those groups and teams work together in patterns of mutual influence, the smallest common, practical focus of learning and development is the

individual, not the workgroup. Individuals often seek to develop themselves without the assistance or participation of their workteams.

Are competencies necessarily linked to individual performance? Bolden et al (2005:2) question this link: 'Whilst personal qualities are undoubtedly important, they are unlikely to be sufficient in themselves for the emergence and exercise of leadership'. Richard Boyatzis, one of the champions of a competency-based approach, agrees: he makes the case that 'A person's set of competencies reflect his or her capability. They are describing what he or she *can do*, not necessarily what he or she does, nor does all the time regardless of the situation and setting.' (Boyatzis 1982:23, italics in original). And quite apart from situations and settings, it may be the case that a person possesses a valuable leadership competency but is not inclined to use it (Boyatzis 1993).

Some writers caution against describing specific skills, for fear of losing a holistic perspective. For example, Jubb and Robotham (1997) similarly warn that by attempting to define competencies we may 'unacceptably simplify the complex realities of management behaviour'. However, every attempt to describe the complexities of social activity results in some simplification. To avoid simplifying, we must avoid describing at all, and this is generally of less value to companies and to individuals than providing descriptions which will provide reasonable guidance. Bolden et al (2005: 3) write that personal qualities and behaviours such as self-belief and personal integrity may not 'conjure up leadership'. Which begs the question what, exactly, *will* 'conjure up' leadership?

The analogy of the tool-kit or the set of golf clubs can be a useful one here. If the specified competencies identify a set of tools that a person needs, do they express enough about the whole person, who may need to be flexible in response to situations, and use the tools correctly? (Burgoyne 1989; Holmes and Joyce 1993). The distorting effects of reductionism can be increased if each competency is individually assessed, remote from the context in which it is needed for everyday performance. I may be proficient in playing an approach shot to the green with a seven iron, if I am told to demonstrate that skill in a training session. Will I still be able to deliver that same level of proficiency towards the end of a tight competition, on the

eighteenth fairway? Will I even realise that I need the seven iron, and not the six or the eight? Similarly, I may be able to demonstrate the competency of, say, 'relating to others with empathy' if that competency is assessed at one remove from everyday context, perhaps as part of an assessment centre exercise, or as a test of what I have learnt on a training programme. Will I still be able to apply that competency under pressure at work? Will I even recognise those occasions when I need to apply it? A holistic view is especially important when frameworks contain contradictory competencies (McKenna 2004) such as, say, an ability to consult and seek consensus, and also the ability to take decisive action.

This issue has obvious implications not only for the development and assessment of an individual's competencies, but also for the definition of competencies. For example, a project I undertook in 2002-2004 involved agreeing functional competences for healthcare practitioners who carry out screening for diabetic retinopathy. Part of this job entails taking digital photographs of the retina of a person's eye. Some of those involved in the project wanted to define the necessary technical competences (covering how to work the equipment) and also simply to specify that the job holders should be able to meet certain functional competences (which had already been published) around good communication with patients. Other people taking part in the project disagreed, arguing that a competent practitioner would be one who could apply both the technical and the communication competences *together at the same time*, and the best way to ensure this would be to combine them in the same units (statements) of competence. Fortunately, from the point of view of defining more integrated competences, this latter view prevailed.

Another definitional example is provided by the behavioural competency framework in use at Huntsman Petrochemicals (Warner 2004) which contains 16 key competencies. Not only is each competency defined, and linked to specific behavioural indicators, but signs of the over-use or under-use of each competency are also provided. For example, over-use of the competency called 'Achieving Valuable Results' (a type of achievement orientation, concerning setting targets, following through etc) may lead to the negative consequences (as defined by the company) of a lack of appropriate concern for people and ethics; a high turnover of staff due to pressure; a lack of team spirit. This approach to defining competencies

emphasises the need to understand and apply the competency behaviours in ways that are compatible with the context, and with the multiple goals that managers and professionals are expected to achieve (this approach is also seen in Quinn et al 2003). On a similar theme, research by the Center for Creative Leadership shows that competencies that may be appropriate at an early stage of an executive's career – such as a strong drive to achieve results - may lead to 'derailment' at a later stage when these competencies are not appropriate (Leslie and Van Velsor 1996).

Buchanan and Boddy (1992) use the 'tool-kit' analogy for their competency model, and argue that

the expertise of the change agent encompasses not only the tool-kit, but also the diagnostic, evaluative and judgemental capabilities required to use the tool-kit effectively....The effective change agent has to be able to bring to deploy sound understanding of context and process in order to bring the right tools to bear to achieve the desired results (Buchanan and Boddy 1992: 7).

Another issue concerning the link between competency and behaviour assumed more prominence as this research progressed, namely the evidence for particular competencies and the conclusions that could sensibly be drawn from that evidence. Klemp's definition of a competency as 'an underlying characteristic of a person which results in effective and/or superior performance in a job' (1980) asserts the existence of a component of an individual that can be observed only indirectly – through behavioural indicators. (In the same way, Barnard's Decisiveness, or his Vitality and Endurance, can only be observed indirectly.) What McBer and others called 'competencies' are conceptual constructs, just as the 'Big Five' personality factors are conceptual constructs, just as patience, consideration, personal drive, and hand-eye coordination are constructs. Whilst the notion of an underlying characteristic or capability is logical and useful, the definition of such characteristics is less straightforward – as is the question of their links to observed behaviour. The researcher who follows the approach that I have taken attempts to:

- identify significant behaviours in particular, specific examples of activity
- describe those behaviours in a more generalised way
- group these behaviours into clusters – called competencies, or attributes, or capabilities

The McBer researchers used factor analysis to group their 65 behaviours into nineteen attributes (Boyatzis 1982). In other projects, the grouping may be done on a less systematic, more intuitive, or more pragmatic basis. The connection between these constituent behaviours and their headline competency is not straightforward. So, suppose we observe behaviours X, Y and Z, and decide they are useful behaviours, linked to successful performance, and we should describe them, encourage others to understand them, learn how to adopt them. Do behaviours X, Y and Z all stem from the same underlying capability? Or do X and Y link to one capability, and Z another? Or do they each link to separate capabilities? Of course, these questions cannot be answered without an understanding of the particular values of X, Y and Z, and an appreciation of the alternative configurations they might occupy. This is an issue we will return to in the methodology and findings chapters of this thesis.

Generic leadership competencies

A related but separate issue to the questions about causality concerns whether it is possible to identify generic competencies for managers or leaders. This concern has obvious links with the points made in Chapter 2, above, about the relationship between transformational leadership and context. Management is a very volatile and context-specific occupation. Different jobs have different priorities - and much depends on the context of the job and the culture of the organisation. So a competency that is highly relevant in one company might not be relevant in another. Therefore there is doubt about whether generic management competencies (ie competencies that are valuable in a range of settings) can be identified (eg Ruth 2006; Grzeda 2005; McKenna 1999, 2004; Binney et al 2004; Cheng et al 2003; Jubb and Robotham 1997; Lindsay and Stuart 1997; Kilcourse 1994) or whether they represent no more than a return to discredited 'great man' trait theories (Hollenbeck and McCall in Hollenbeck et al 2006).

Research by Hayes et al (2000) into the applicability of detailed descriptions of competencies to senior managers working in four different work environments within one large organisation, for example, found that 'except at a very broad level of abstraction...different lists of detailed competencies were identified as important in

each of the [different] work environments' (2000: 98). However, Hayes et al suggested that there may be some relevant 'meta-competencies' – including the capacity for critical self-reflection - and there may also be some competencies common to a number of senior management roles.

Critics of generic competency frameworks also point out the differences between framework A and framework B and suggest that if A is right, then the competing framework B must be wrong, or that the lack of consensus casts doubt on both A and B (for example, Grzeda 2005; Mullins 1996:251). As some generic frameworks are based on extensive empirical research, whilst others are more creatively devised, it might seem an easy task to accept the one and discount the other - but there are contradictions between empirical frameworks also - and the details of the research methods are not always easily available for scrutiny. Even when the details are available, and appear thorough and convincing, the frameworks are open to the objections that a) they are limited to the people, or type of people, who were part of the research process and/or b) they may have expressed relevant competencies for that particular point in time, but they are of limited relevance to the present, or to the future (eg Grzeda 2005; Bolden 2005; Conger and Ready 2004; Cheng et al 2003; Hayes et al 2000; Bartlett and Ghoshal 1997:13).

As we saw at the start of this chapter, a focus on context was also put forward by Pedler et al (2004) who argue that situational factors are very significant, and most approaches to competency ignore this. Rather than constituting a compelling criticism of competencies, however, this three-part model is reminiscent of Boyatzis's (1982) helpful insight into seeing competencies in context (see Fig 4.1). Where competencies overlap with job demands and organisation requirements (ie context), according to Boyatzis, then they are valuable in achieving effective performance. Where competencies don't coincide with job demands and the company's required ways of working, then they will not lead to effective performance.

As Silzer argues

Leadership effectiveness is related to what competencies a person uses in different situations and how those competencies get balanced and integrated depending on the situational context. The action is in the interaction and balance of competencies, how the leader uses those competencies, and how

appropriate they are in a specific situation. Every situation is different in some ways so a leader needs to quickly read the situation and then utilize the appropriate competencies (Silzer in Hollenbeck et al 2006: 404)

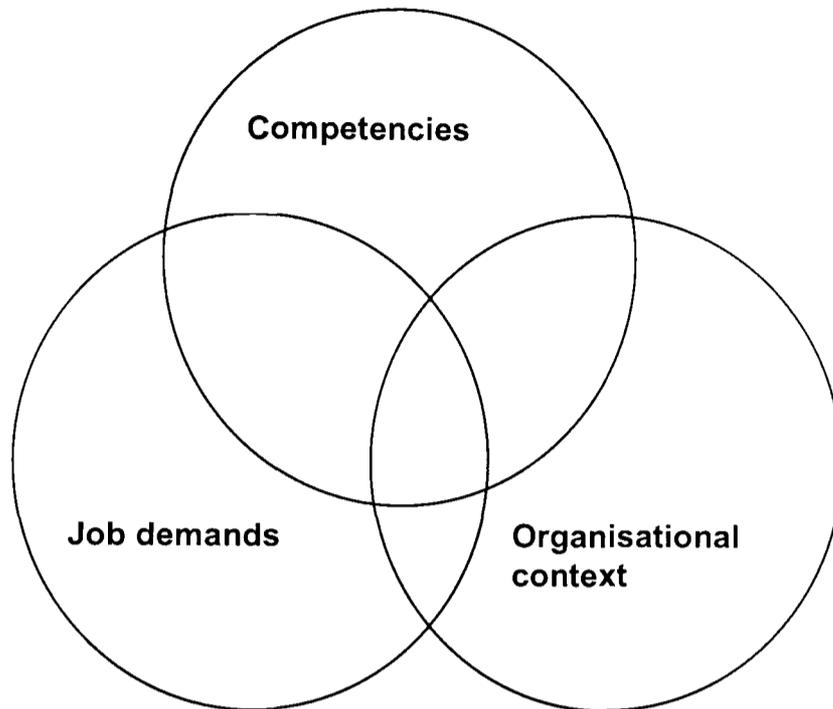


Fig 4:1 Competencies in context, from Boyatzis 1982

As Spencer and Spencer say of the generic competencies in their dictionary: 'The generic dictionary scales are applicable to all jobs - and none precisely' (1993:23).

An extension of this query of the possibility of generic competencies is an issue of whether all effective individuals need to possess all the identified competencies (cf Buchanan 2003: 2). The expectation that everyone must have all the competencies in a model gives rise to doubt among both practitioners and academics about the realism of the venture. Bolden and Gosling (2004:3) for example write: 'This almost iconographic notion of the leader as a multi-talented individual with diverse skills, personal qualities and a large social conscience, poses a number of difficulties'. It may be observed that a broad range of challenges face people in different managerial jobs, even within the same company, even within the same department. Logically, in any period of time, the competencies required of one manager may not be required at all of his or her colleague. This observation often fits with our experience that managers with quite different profiles of strengths may be effective -

in different ways - in similar jobs. If managers don't need all the competencies, then how many do they need? And which ones?

Once more, as with the issue of the causal connections between competencies and performance, the answer is rarely reached through some simple mechanical formula. Goleman (1998: 37) cites McClelland, who argues that there is a 'tipping point', when executives acquire a mix of competencies across the whole spectrum of emotional intelligence clusters, with top performers in one company possessing strengths in 'at least six competencies'. Such specificity in the literature is rare, however.

Returning to the generic-specific issue, one approach is to seek to define the leadership/ management competencies required for specific jobs (eg Boak and Coolican 2001; Kolb and Rothwell 2002; McCredie and Shackleton 2000; Dainty et al 2004, 2005; Watson et al 2004). Another approach has been to suggest suitable groupings of jobs, which might require similar competencies. For example, Bartlett and Ghoshal (1997) argued that managerial roles are significantly different at different levels of an organisation, and developed a set of differentiated competency profiles for managers at Operating, Senior and Top levels. (A point that is rarely repeated in the literature is that the McBer research of the 1970s found that some of their competencies were only linked with success at certain levels of the organisation, and not at others - Boyatzis 1982). More recently, in a Hay Group Working Paper (Hay Group 2004) it was argued that executive management roles could be categorised as one of three types – Operations, Collaborative or Advisory – and also according to the level of work required, from 'Enterprise Leadership' to 'Tactical Implementation', and it was suggested that different specific competencies would be particularly appropriate for each role and each level. This is a more explicit, more developed formula than that which Hay Group had earlier provided with the NHS Leadership Qualities Framework, where it was noted that the most relevant competencies for particular roles would depend on the requirements of the role, particularly whether it was more concerned with developing strategy or with delivering services.

Thompson et al (1997) building on Thorngate (1976) and Weick (1969) argue that there is an inevitable trade-off: competency frameworks can be any two of the following three:

- generalisable (ie generic) and simple *but* inaccurate, or
- simple and accurate *but* not generic, or
- generic and accurate, *but* so complex they are likely to be impractical

Competency frameworks can never achieve the ideal of simultaneously possessing all three characteristics, but Thompson et al (1997:50) note that in making this observation they do not intend to reject the use of competency frameworks, but rather seek to use them productively with an acknowledgement of 'real world constraints'.

A realistic claim for competencies

It is arguable that, in some respects, the issues discussed in the preceding pages, of causality and of the generic nature of competencies, arise from an overly-simplistic view of what research into competencies might achieve – a view which is not shared by many of the researchers who advocate the use of competencies. This overly-simplistic view may be held by some researchers, and by some users of competency models, and it may be inferred by critics of a focus on competencies, but it is more of a 'straw man' (Silzer in Hollenbech et al 2006) than a core element of the beliefs of many of those who believe in the value of competencies and competency frameworks. As we have seen, those proponents of competencies who support the notion of generic competencies argue for them to be used with some thought about their relevance in the manager's particular environment. Some advocates, such as Bartlett and Ghoshal, above, may even advise on the match between certain characteristics of the environment and certain competencies.

A modest but realistic claim for competencies is that they represent one contributing element to organisational performance. They provide one useful way of thinking about the behaviours of individuals. A well-designed competency framework may fail to express everything there is to know about being an effective manager or leader, but it can describe important dimensions of an individual's ability to perform. Van Aken (2005: 27) argues that those who regard management research as a design science aim to identify 'technological rules' that can be used to design a specific intervention

or achieve a desired outcome. A technological rule might be quite extensive – they ‘may fill an article, a report or even a whole book’. He writes:

the effective use of a technological rule needs considerable expertise: a thorough understanding of the rule with its indications and contra-indications, a thorough understanding of the local situation, [and] cognitive skills in translating the general to the specific.... (Academic doubts on the applicability of prescriptive knowledge in management are often based on the – usually implicit – idea that such knowledge should be applied as an instruction to be followed unquestioningly, instead of as a general basis for the design of specific management action...

A comment that could be applied to descriptions of leadership and management competencies.

Summary

The behavioural approach to defining competencies is a broad church, including frameworks that focus on broad activities, narrowly defined skills, and attributes such as Integrity and Authenticity. There have been numerous descriptions of the competencies that leaders and leaders of change need – Buchanan’s literature survey of 2003 found over 130 descriptions of the competencies of change agents. Many of the writers on leadership also provide descriptions of aspects of leadership that appear identical to competencies – although they are often termed ‘dimensions’ or ‘attributes’ or ‘elements’ or ‘practices’.

The systematic approach taken by the McBer consultancy (now part of the Hay Group) and first published in Boyatzis (1982) is undoubtedly responsible for the renewed interest in competencies (and the use of the term) during the 1980s and beyond, and remains an influence on competency development in the present day.

The use of leadership/management competencies has not been without critics, particularly in the UK, and this chapter has discussed some relevant criticisms of the approach. The chapter has explored in particular the criticisms that

- there is no proof that competencies lead to more effective performance at individual, team or corporate level, a criticism often linked with the accusation that the competency approach is overly reductionist/atomistic

- that so-called 'generic' competencies are of little value, given the influence of context on managerial/leadership behaviour

In both cases, the chapter argues that the critics of competency-based approaches have attributed a more extreme position to the advocates of the use of competencies than those advocates themselves adopt. Leading promoters of competency-based approaches, such as Goleman (1998), have stated that competencies are necessary but not sufficient for outstanding performance, and leading researchers such as Boyatzis (1982) agree with the importance of context. In proceeding with this research into competencies, I do so with the express qualification that the competencies of individual leaders of change are one factor – an important factor, but still one factor among others – in achieving success. The chapter also argued that a competency-based approach does not necessarily commit us to an individualistic, heroic model of leadership: many competencies concern collaborative work and team working (Rankin 2006).

Two frameworks of competency are particularly relevant to this thesis. Both of them were published after I had begun this research. Both of them are based on research in the UK health service. The Alimo-Metcalfe and Alban-Metcalfe framework of 14 'dimensions' of transformational leadership is based on questionnaire research into desired/valued behaviours of line managers. The Leadership Qualities Framework was developed by Hay Group researchers, using Behavioural Event Interviews with 50 senior executives in the NHS. Despite the fact that they were researched at a similar time, there is not a close match between the contents of these two frameworks, indicating that there is still ground to explore. In addition, neither of these frameworks have the same focus on the activities of leading change that I have pursued.

5 Research methodology

This chapter provides an explanation and critique of the methodology used in this research. The first section sets out a brief outline of the approach I took, which was based on gathering information from interviews with practitioners. The second section discusses the philosophy that underpinned this research approach. The following three sections examine the different components of selecting the interviewees, conducting the interviews, and analysing the material that I collected. In each of these sections a description of what I did is accompanied by a critique. In the final section I present a critical assessment of the Behavioural Event Interview, which was a principal tool in the research.

Outline

My approach to this study has been to attempt identify people who are effective in leading significant change in healthcare organisations, to interview them about what they have done on particular occasions when they sought to bring about change, and to attempt to identify themes in what they told me.

I interviewed 40 people. The interviews took place between autumn 2002 and autumn/winter 2005. Most of the interviewees were recommended to me by people who work in the healthcare sector and whose help I sought as referees. Since 1997 I have worked with managers and professionals in the health service as a tutor on an executive MA programme, and as a consultant and trainer, and I have developed good relationships with a number of people in the sector. I provided referees with a set of simple criteria for the kind of people I wanted to interview (see Box 5.1). My interview strategy was to seek accounts of specific examples of what people had done to bring about change on particular occasions. This approach was based on a type of interview, called the Behavioural Interview, or the Behavioural Event Interview (BEI), used extensively by McBer and Company and the Hay Group to develop models of competency. The interviews were recorded on audiotape or minidisk, and then professionally transcribed. Most of the interviews lasted between 50 and 65 minutes. In four cases my attempts to record the interview failed, and I made extensive notes immediately after the interviews, which were then transcribed. I also

made notes of my initial impressions of the interviewees, and noted any comments they made after the recording equipment was switched off. In the cases of three interviewees I also had the opportunity to hear them give guest lectures to groups of healthcare practitioners and managers about their experiences of leadership, and I made extensive notes of these presentations.

The recordings, transcripts and notes were then analysed for patterns and themes in the behaviours of the interviewee as they sought to bring about change. I approached the material without attempting to prove or disprove any specific ideas about particular behaviours or competencies, but with the aim of developing ideas from the materials I had gathered, carrying out a 'grounded analysis' (Easterby-Smith et al 2002) that included some elements of a grounded theory approach (Glaser and Strauss 1967; Charmaz 2006; Suddaby 2006). I sought to identify patterns of behaviour in the accounts provided by the interviewees, and to group them into competencies. As my analysis developed, I compared what was emerging with published material on competencies, leadership and leading change, and considered similarities and differences between ideas published elsewhere and the behaviours and competencies that were exercised by the interviewees.

Research philosophy

How do we know that competencies exist? How can we go about identifying them? How do we know that person A is an effective leader of change, while person B is not? These questions link to larger questions about the nature of reality and how we can apprehend it. My position in undertaking this research was that there is an external reality that is separate from our descriptions of it, but that certain aspects of it may be difficult to perceive, define or agree upon. How this position would be categorised varies from author to author, but it appears close to an epistemology of 'critical realism' (as described by Bryman 2004a) or 'social constructionism' (as described by Crotty 1998). This section discusses how I arrived at this conclusion.

Guba and Lincoln (1994:109) link different epistemological positions with different ontological beliefs, arguing that

- positivism is necessarily attached to 'naïve realism' which is 'apprehendable'
- 'postpositivism' is necessarily connected to 'critical realism' - wherein reality can only be 'imperfectly and probabilistically apprehended'
- constructivism is necessarily connected to an ontology of 'relativism – local and specific constructed realities'

In other words

- we can develop tests to identify effective leaders and to identify these real things called competencies which they possess (positivism and naïve realism)
- we can try to develop tests to identify effective leaders and to identify these real things called competencies which they possess – but we may not be entirely successful (post-positivism and critical realism)
- what constitutes an effective leader and what is a useful competency depends on your viewpoint (constructivism and relativism)

Not all writers would agree with these distinctions, however. Easterby-Smith et al (2002), for example, also distinguish between three epistemologies of social science:

- positivism, which in social science they link to an ontology of 'representationalism' (which is a type of realism)
- relativism, which is the name of an epistemology *and* an ontology
- social constructionism, which is connected to an ontology of nominalism, which assumes the descriptions and meanings we give to objects and events are crucial

There are some significant differences between these typologies, but also some similarities. Guba and Lincoln included 'critical realism' in their typology, and Easterby-Smith et al also note the development of critical realism as a 'recent variant' of relativism, which begins from a realist ontology, but incorporates an 'interpretist thread.' The critical realist Sayer (2004:6), however, rejects the connection between critical realism and relativism; he places critical realism as an alternative to 'the spurious scientificity of positivism' and to the 'idealist and relativist' positions he associates with 'extreme constructivism'. In the same publication, Fleetwood and

Ackroyd (2004:4) describe a fundamental tenet of critical realism in like terms to Guba and Lincoln, above: that there is a real world external to the researcher, but that gaining an understanding of this world is not straightforward.

Michael Crotty (1998) takes a different view again. From Crotty's perspective, the three-part distinction that Guba and Lincoln make is one of different epistemologies (or even of theoretical perspectives) not ontologies. Positivists and postpositivists, Crotty says, believe in a reality 'out there' – where they differ is in the extent to which we can come to know it, which is an epistemological issue. In contrast with Guba and Lincoln, and Easterby-Smith et al, Crotty argues that constructionists also believe in a reality 'out there' but expect individual subjects to interpret the reality in different ways. Crotty contrasts the epistemology of constructionism with 'objectivism' – which, he says, is the position that *meaningful* reality (as distinct from *some kind* of reality 'out there') exists independently of a conscious mind's attempt to understand it. For Crotty, positivism is a 'theoretical perspective' – a philosophical stance that is less fundamental than an epistemology. Another theoretical perspective (and one closely aligned with constructionism) is 'interpretivism'.

Social constructionism is described by Crotty as an epistemological standpoint that 'all knowledge, and therefore all meaningful reality as such [is] constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context' (1998:42). Constructionism is distinguished from pure subjectivism:

According to constructionism, we do not create meaning. We construct meaning. We have something to work with. What we have to work with is the world and objects in the world....The world and objects in the world may be in themselves meaningless; yet they are our partners in the generation of meaning and need to be taken seriously. (Crotty 1998:43-44)

Interpretations of these terms, and these positions, vary, as we have already seen. Burr (2003:7, 23) for example, approaching the subject from the standpoint of a psychologist, doubts whether social constructionism can be related to a realist philosophy (although she considers 'critical realist' positions can be adopted within social constructionism and notes that this is an area for debate). This debate aside, she argues that 'it is the analysis of language and other symbolic forms that is at the heart of social constructionist research methods' (2003:24). In other words, if I am

taking a social constructionist position in this research, I should be focusing on the meaning which people ascribe to their actions in the course of the interviews, and how they describe their behaviours, rather than trying to get a picture of what they actually did.

The arguments for the existence of a reality independent of the researcher are convincing, in that they fit with lived experience (at least with the lived experience of this researcher). These arguments are developed by the critical realist Sayer (2004), who distinguishes between what we might call the essential attributes of objects (what Sayer calls the 'necessity' of objects) and the contingent aspects of objects, including their context – those things that may differ with circumstances. In the context of this research we might say that an essential attribute of a leader of change is that they influence others to bring about changes in behaviour – but their methods of influencing, and the changes they seek to bring about, are contingent on the circumstances.

This distinction between the essential attributes and the contingent features of objects is central to a critical realist's perspective on change, according to Sayer (2004:11):

Causal powers are dependent on the nature of objects....However, it is contingent whether they are exercised at any particular time and place. Thus an organisation may have the power to fire workers, but for the most part may not need to exercise this power.

And if it does try to exercise this power, the results will depend on a number of contingent factors, such as the relevant legislation, the power of the workforce, etc. This position can be related closely to Boyatzis's (1982) statement that competencies will only produce effective performance if they fit with the contingencies of job demands and organisational environment.

What is the ontological position of competencies? A competency has been defined by George Klemp (1980) as '*an underlying characteristic of a person which results in effective and/or superior performance in a job*'. Boyatzis (1982:23) qualifies the causal connection between competency and effective performance by adding that a person's competencies describe his/her capability: they '*describe what he or she can do, not necessarily what he or she does all the time regardless of the situation and setting*'.

Most experienced observers of management and leadership would agree that there are certain skills, abilities, talents possessed by some people and not by others (or to a greater or lesser degree by different individuals) which enable those who possess them to behave in ways that those who lack them can not. We can, for example, observe two people attempting to lead decision-making meetings and agree that one is more adept at this task than the other, and therefore agree (if this superior performance is a regular occurrence) that A possesses skills or competencies that B lacks. We might need to define the competency quite clearly - A may be effective in drawing people out in consultative meetings, while B (it turns out) is actually better in negotiations. The outcome of the exercise of these skills, abilities, competencies is likely to depend on the contingencies, or context of the action. Where we may disagree is in how to describe or define these crucial skills, and the particular nature of the interaction between the skills and the individual's context. Following Crotty, this is a question of epistemology, not ontology: there are real competencies out there – although we may struggle to define them clearly, we may group them in different ways, and give them different names. As competencies are intangible, the essence of most (although not all) published research is interpretist in nature. Competencies are cognitive constructs.

The research strategy adopted by McBer and Company can arguably most easily be categorised as interpretist in nature, but it is clear that the McBer research does not unquestioningly accept the interpretations that *actors* place on their actions. In fact, Spencer and Spencer say that the 'basic principle of [our]...approach [to research] is that what people think or say about their motives or skills is not credible.' (1993:115). This, according to Spencer and Spencer is a) because most people don't know what their competencies are, and b) they may give 'socially desirable' replies to questions, telling researchers what they think the researchers want to hear. Although these interpretations are regarded as interesting information, the researchers seek more factual information about what people did and said on particular occasions, and then interpret these behaviours in terms of the competencies they may indicate. In fact, although the McBer research and a number of other attempts to define competency have obvious interpretist strands, they have adopted research methods that have strong associations with a positivist, or modernist epistemology (Mason 2002; Locke 2001). In their different ways, the McBer researchers, Alimo-Metcalfe and Alban-

Metcalfe, and others (such as Cockerill's 1993 validation work of Schroder's model) have sought to address what Schwandt has called 'the paradox of how to develop an objective interpretive science of subjective human experience' and have grappled with 'a synthesis of phenomenological subjectivity and scientific objectivity' (Schwandt 1994:119).

The core texts on competencies by Boyatzis and by Spencer and Spencer are not explicit about the epistemological standpoint underlying their research. Later work by Boyatzis (1998:xiii) aligns his method of analysing interview data with interpretism and social constructionism, while arguing that this form of analysis can form a 'conceptual bridge' between the interpretist and the positivist social scientist. In this light the positivist elements of the earlier studies can be seen as ways of avoiding subjectivity, of taking, as Crotty says, the world 'seriously', and avoiding the danger of projection of the researcher's own characteristics (Boyatzis 1998:13). The recasting and refining of competencies that Boyatzis carries out in the later book also indicates an interpretist standpoint (1998:103-108). The 'interrater reliability' – cited as evidence of research reliability by Boyatzis, Spencer and Spencer, and McClelland - was achieved through the development of an agreed set of behavioural indicators and competencies, which different raters learnt to apply: in other words, through the acceptance by different members of a research team of a shared set of meanings: *social constructionism* indeed.

It was not my intention, in exploring potential philosophical underpinnings of the research methodology I wanted to use in this study, to become the captive of one or another school of philosophy and to then be led to someplace else entirely by whatever logical imperatives inhabit that school, such as the political implications asserted by some critical realist theorists (eg Collier 1998: 57) or the focus on language and meaning assumed by writers such as Burr (2003) to be a necessary part of a social constructionist stance. Some elements of critical realism, however, have a resonance with thoughtful explorations of competency, as does Crotty's conception of social constructionism, and the possibility of the support of these philosophical approaches has helped me to reflect on the reasons for, and the strengths and weaknesses of, the actual methods I have used to explore the competencies of the people I have studied.

Selecting the interviewees

I wished to interview people who were effective practitioners, but the healthcare sector does not offer straightforward objective measures of ability (some writers, such as Jubb and Robotham 1997 would argue that this is the case for managers in any sector, as discussed in Chapter 4). At the time I carried out the interviews, UK health service organisations were assessed under a star system, where individual trusts were awarded between three and zero stars, so it could be argued that a measure of the ability of a chief executive of these organisations was reflected in the stars awarded. But that would be to over-simplify a range of situational and causal factors that impacted on the star system. In addition, not all of my interviewees were chief executives (and some of the chief executives I interviewed led organisations not subject to the star system). I was also interested not in people who were simply effective in leading organisations, but those who were effective in leading change in organisations, and objective measures of this ability are difficult to trace.

Instead I sought the recommendations of well-informed 'referees' who worked within the healthcare system, and who suggested potential interviewees to me based on their own knowledge and judgement. In all, fifteen people acted as referees, nominating potential interviewees. More people were nominated than I was eventually able to interview. Most people I approached agreed to be interviewed. One declined and a small number did not reply to my request. Some referees sought permission from the potential interviewees before forwarding contact details to me: at least one of these potential interviewees declined to be involved in the research. I also approached three interviewees because they had won awards for innovative work from the Health Service Journal, and I chose two other interviewees myself, who were people known to me: in one case I had worked with the person over two years on a change project, and they also had significant national recognition; in the other case I had known the person for several years, and they had achieved recognition for innovation in one organisation, and had then been appointed a chief executive in another organisation, and had undertaken considerable reform there. (I also knew three of the other interviewees from other contexts before I interviewed them, but they were recommended by referees.) Interviewees were identified, approached and interviewed on an ongoing basis throughout the period of the fieldwork. As well as

seeking people who met the criteria in Box 5.1, I sought to achieve a balance of male and female interviewees. For comparison purposes, I also sought to interview people from two different groups: a) chief executives and other director-level change agents and b) clinical directors and other senior clinicians (see Table 5.1 and Appendix 1). I did not select interviewees as part of a systematic 'theoretical sampling' – an approach advocated by Glaser and Strauss (1967) of deliberately seeking data that will enable the exploration of emerging categories in the analysis of research information, which is seen as a core element of grounded theory approaches (Suddaby 2006; Charmaz 2006; Easterby-Smith et al 2002).

Box 5.1 Interviewee criteria provide to all referees

Leading change in the health service

I am carrying out research into the skills and competencies of effective leaders of change in health and social care services, in the UK and in Australia.

As a key part of the fieldwork, I am seeking to interview people who are recognised as effective leaders of change in the sector.

I would like to interview people who:

- Have led a major change initiative (or initiatives), either within a single organisation, or across a number of organisations
- Have been effective and successful in leading this initiative (or initiatives)
- In this context, by a 'major change initiative' I mean an initiative which:
 - has a strategic impact on the organisation(s), or
 - is innovative and may lead to more widespread strategic change in future

George Boak

The majority of the UK interviewees were based in the northern part of England, partly because my network of contacts is largely located in that part of the country, and partly for convenience of access. Ten interviewees lived and worked in Australia; I arranged to interview them when I visited that country in 2003. They were recommended to me by a friend with long experience of, and a senior position in, Australian Healthcare and by the coordinator of the Clinical Support Systems

Program, a collaborative programme between the Australian Government Department of Health and the Royal Australasian College of Physicians (Sewell et al 2004). I was interested to see whether these interviewees behaved in very different or very similar ways to their UK counterparts.

Job roles of interviewees		Types of organisation	
Chief Executive (or equivalent)	12	Acute trusts/secondary care	26
Other executive director level	10	Primary care	6
Senior clinician (clinical director or senior consultant)	14	Strategic health authorities (UK - pre-2007)	3
Other clinician	2	Other	5
Other management	2		

Some organisations employed more than one of my interviewees – one large UK hospital supplied five interviewees, all working in different parts of the organisation. The total number of organisations in this research was 26.

All of the interviewees were recommended to me as people who met the criteria in Box 5.1 – that is, they were all effective in leading change. In this respect I did not follow the practice of the McBer research studies, where interviews with ‘superior’ performers are compared with interviews of ‘average’ performers. Boyatzis (1982:45-46) talks about ‘effective/superior’ performers compared with average or adequate compared with ‘poor’ performers. Spencer and Spencer (1993:96) talk of identifying a ‘clear group of superstars and a comparison group of average performers’, based on criterion-referenced measures of performance (1993: 13). McClelland (1998:332) talks of Outstanding and Typical performers. This is presented as central to the McBer approach to identifying competencies – for the competencies the researcher seeks are those that differentiate between ‘superior’ and ‘average’ performance – and therefore they are found in the behaviour of superior performers, but not in the behaviour of average ones (Spencer and Spencer 1993:137-142; Boyatzis 1982:53; McClelland 1998:332; Cheng et al 2003). This comparison between two groups of people who perform at different levels is missing from my study, and therefore it is not

possible for me to demonstrate that any capabilities I identify are typical of superior performers but not of average ones. They may be capabilities possessed both by superior and by average performers.

Two reasons led me to seek to interview only people who had been identified as effective. The first is a practical issue – the difficulty of asking referees to identify people who are ‘average’ at leading change. This was not a difficulty experienced only in my own research. Spencer and Spencer acknowledge that it is often difficult to get recommendations of people who are ‘only average’ and they suggest that if this problem arises, the researcher should press for the names of those who are particularly outstanding (the ‘superstars’, in fact) and assume that the others are, by default, average (although they also define superior quite specifically as ‘one standard deviation above average performance’ and contrast this with ‘effective’ performance, which ‘usually really means a “minimally acceptable” level of work’ – 1993: 13). Boyatzis (1982) was able to include the results of some ‘poor’ performers in his research – but only those working in public sector organisations: private sector employers refused to identify employees in this category, on the grounds that they were going to be shortly taking action to manage the performance problems of this group. The McBer experience had not changed much a decade later when Spencer and Spencer (1993) wrote: ‘In some organizations, it is politically impossible to get a sample of people doing a poor job’ because people are reluctant to identify them. McClelland (1998:332) introduces a little confusion around the scaling of ‘average’ or ‘typical’ when he writes that the ‘outstanding’ group are generally in the top 5-10% and the typical group is the next 11-25% of executives. This is not an ‘average’ (or even ‘typical’) in the normal senses of the word.

With referees I know well, however, a smaller number than those I actually used, I could probably have identified ineffective performers and sought to interview them. The second reason for not doing so was a certain discomfort on my part at the prospect of the deception that would be involved in interviewing people under these circumstances. As Athey and Orth (1999: 217) note in an article about developing competencies in more transparent ways: ‘The control group approach is often applied in a deceptive manner with participants often not told the truth about the group (high performer or average) to which they belong.’

The language of the introduction to the NHS Leadership Qualities Framework (research carried out by Hay Group) is interesting in this respect:

A detailed research study was conducted into the competencies demonstrated by a number of highly successful Chief Executives from the service. Some fifty in-depth structured interviews were carried out, comprising forty-six Chief Executives and four Directors, to collect rich data about what leaders actually said, did, thought and felt on specific occasions that led to successful outcomes. The transcripts from the interviews were analysed both thematically and statistically. This enabled the development of the leadership model and the pinpointing of what differentiated outstanding performance. This analysis added significant value to the prior research. It led to a more in-depth understanding of which competencies truly differentiate performance and a clearer picture of how particular competencies combine to predict success.

(Modernisation Agency 2001: emphases in the original)

The implication of the emphasis on differentiation is that some of these 50 interviewees were outstanding, but some were only average, or typical. On first reading the above, I wondered who was in which group – and were they told? A publication of answers to frequently asked questions about the framework (Modernisation Agency 2003) implies that nominations were indeed sought for ‘outstanding’ and merely ‘effective,’ but it notes that:

A balanced judgement was reached on the final sorting of evidence into “effective” and “outstanding”, taking into account:

- *Original nomination classification*
- *Evidence from the interview*
- *Judgement of the interviewer*
- *Judgement of the coder*
- *Judgement of two readers (per interview script)*
- *Judgement of full concept formation panel*

This process has stepped away from the distinct two-stages discussed by Boyatzis, or Spencer and Spencer of 1) selecting interviewees by independent criterion reference and 2) getting information from them about what makes them effective. Now the information-gathering from stage 2 is being used to decide whether a person is effective or not.

In short, in my research a combination of these practical difficulties and a certain unease about deceiving interviewees led me to seek only effective performers. In a later comment on the use of his approach, Boyatzis (1998:52) writes that where

comparison across two criterion-referenced sub-samples is not possible, 'the researcher needs to use his or her theories, or theories derived from prior research as a guide for the articulation of meaningful themes'.

In summary, the sample was quite a large one for qualitative interviewing, with interviewees, who had been identified as being effective in leading change, from a number of different healthcare organisations. These are positive points. What of the dangers? The main dangers in my approach to selecting interviewees concern my reliance on the judgement of my referees. My referees might nominate people without really being able to vouch for them, or they might (all) have had a bias towards particular styles of leading change. In these cases, the interviewees might either not be effective leaders of change, or they might all have a bias towards a particular way of leading change.

Why might referees nominate people without really being able to vouch for them?

Referees might conceivably do this because they wanted to help me and therefore they wished to be able to nominate *someone*. They might have chosen to nominate someone because of the person's position (chief executive, clinical director, project leader etc) or because of their reputation (one nominee was put forward because, in addition to being a chief executive, and having a national reputation, they were 'well regarded by their staff' – in the event, I did not pursue this nomination) or because the nominee had made an impact on the referee on a particular occasion.

The fact that the judgement of my referees was not universally shared was brought home by the (small number of) occasions when people other than my referees commented critically on the ability or behaviour of one of my interviewees (or someone who had been nominated as an interviewee). This led me to reflect on the extent to which the criticism could be supported by the material I had collected. For example, critical comments were made about two of my interviewees that they were overly directive, or too controlling. These comments were made by people who worked (indirectly) for my interviewees. I heard these comments after the interviews, as unsolicited opinions offered in the course of conversation. The people expressing the opinion were not aware that I had interviewed the person concerned. Reflecting

on these comments I could see that both interviewees had told me of actions they had taken that indicated a high regard for task achievement, getting the job done, holding other people to account, and I could understand that this might be experienced as *overly*-directive, or *too* controlling, but I retained a high degree of trust in my referees for these interviewees. My referees had not only experienced these interviewees in action at a closer hand than the people making critical comments, but my referees also had a wider experience of people working at this level (of chief executive) than the critics.

In another example, one of my interviewees was described as 'someone who can talk a good talk' by a critic who knew the interviewee had been included in my research. The essence of the criticism was that the interviewee was good at presenting themselves as an effective leader of change, but was not so good at actual performance. In this case, after reflection, I realised I was not sure of the extent of my referee's knowledge of this nominee, and decided to treat all of the interview material from this person with a little more caution than I might otherwise have done.

In the same way, it was pleasing to hear confirmation of the abilities of interviewees. I heard unsolicited praise for one interviewee, for example, from two other people (independent of one another) whose opinions I respected. Another interviewee was praised highly and repeatedly by someone who had worked with her and also by someone who had worked in her organisation. One interviewee was described in print as 'the most successful NHS manager of his generation' (Cowper 2005:20). The abilities of a number of other interviewees were also confirmed by people I encountered who worked in the sector. Contradictory information was the exception rather than the rule.

Why might my referees all have a similar bias about the styles of 'effective' leaders of change?

This possibility concerned me at an early stage in the research, when I was using only a small number of referees. These were people with whom I spend social and professional time, and the topic of our conversation may often concern change and how Mr X appears to have made a big mistake in organisation Y, but Ms Z has been

successful in changing hospital W. I wondered if we saw eye-to-eye so completely that their recommendations might all be of a kind. I became less concerned about this as more referees became engaged, and also as variety became apparent among the interviewees. Nonetheless it was interesting to compare the accounts of behaviours from interviewees who had been recommended by the same referee.

The interviews

The interview format was based on the Behavioural Event Interview (BEI), that has been at the heart of the McBer (and later the Hay Group) research, which in turn is based on Flanagan's Critical Incident Technique (Boyatzis 1982; Spencer and Spencer 1993; Motowidlo et al 1992; Flanagan 1954). I have been trained in the use of BEI in the UK, and in the USA, and have used the approach in developing competency models as a consultant. The use of this type of interview to gather information was one of my starting points for this research; from the outset I saw it as a natural part of the study, because it was a tool with which I was comfortable and familiar. Over the course of this research, however, I came to know it much more thoroughly than before, in the same way that you might get to know much better someone who has long been a casual friend, if you undertake a long and challenging journey with them. In a BEI, interviewees are asked to give examples of occasions when they have taken action, and requested to go into detail at times about exactly what they did, what they thought, how they felt.

Klemp and McClelland (1986: 36) write that the BEI tries to:

get a full report of a specific past occurrence, with a beginning, a middle and an end, and with characters who wanted certain things, thought in certain ways, and acted in certain ways. What the interviewer is trained to avoid is getting generalisations about what the person usually does in typical situations. The reason is that everyone has ideas about what he or she does, and when and why, but these ideas are based partly on theories about the job, so they do not tell much about the person's actual behaviour. By obtaining raw data on the person's behaviour, the behavioural interview [allows] us to get beneath the theories to the specific thoughts and actions that contribute to on-the-job success.

Spencer and Spencer (1993:104) write that

Done correctly, the BEI method gathers critical incident information equivalent to direct observation data, but much more efficiently. A 60 – 90-

minute interview can produce almost as much usable data as a week of intensive observation or a year of regular work activity

In advance of the interview, I prepared the interviewees by describing the purpose of my research, and explaining that my research methodology was qualitative, using interviews with people who had been identified as effective in bringing about change, and asking them to tell me what they did, and how they went about achieving the change. I said that in the interview 'I would simply like to talk about what you have done on particular occasions to bring about change'. Given this information in advance, some interviewees prepared for the conversation, and had thought about particular events they wanted to talk about. At the beginning of each interview, I repeated this information, adding that, because the difference between being effective and being, well, *less* effective, was often in the detail of what was said or done on particular occasions, from time to time I would want to ask questions about this detail.

The accounts of how McBer researchers have used BEI are prescriptive: the interviewee should ask for accounts of between five and six important events 'two or three "high points" or major successes and two or three "low points" or key failures' (Spencer and Spencer 1993:119; see also McClelland 1998; Boyatzis 1982:50; and Boyatzis 1998:102). However, I simply explained that I wanted to hear of occasions when the interviewee had been successful in bringing about change. Sometimes the interview was consumed by the account of a single project, sometimes two or more different events were covered. The accounts sometimes concerned difficulties or problems the person had to work to overcome. Sometimes interviewees offered examples of occasions when they had been unsuccessful. The choice of which change project(s) to discuss was generally left to the interviewees, although on four occasions I had approached interviewees in the context of a particularly successful change project they had led, and naturally we discussed that; and on eight other occasions the interviewee had been recommended to me by their referee in the context of particular projects, and these formed at least part of these interviews.

The theory behind BEI is that, by concentrating on details of particular events the researcher moves away from examining the theories that interviewees hold, or would like the interviewer to think they hold, about how they perform, and is able to focus on actual examples of activity (Spencer and Spencer 1993:115-116). This is similar to

the distinction between espoused theory (what people say they believe) and theory-in-use (what an examination of their behaviour would lead us to think they believe; Argyris and Schon 1996). According to practitioners of BEI, people are less likely to be able to convincingly misrepresent what they did, what they said, what their reasons were etc on specific occasions than they are to provide misleading generalisations (Klemp and McClelland 1986; Spencer and Spencer 1993). McClelland has claimed that BEI is much more effective than 'expert panels': 'experts only identify around 50% of the competencies you uncover in behavioural event interviews' (in Adams 1997). Klemp and McClelland talk about using the BEI as a means of 'obtaining raw data' on a person's behaviour. In a similar vein, Spencer and Spencer (1993:116-117) write that: 'by asking for an actual incident and very detailed example [sic] of real behaviour, the BEI method gets much closer to the truth'. More moderately, Boyatzis (1982:50) notes that a behavioural event interviewer 'attempts to get as accurate an account of the incident as possible'.

The notion that interviews may give us access to 'raw data' on a person's behaviour is more than a little problematic. Silverman (2000:36) notes that researchers must consider to what extent their interviews provide 'direct access to experience' and to what extent they are 'actively constructed narratives'. Constructionism seems a potential descriptive home for these interviews - as Crotty says (1998:64) social constructionism means that 'description and narration can no longer be seen as straightforwardly representational of reality' - but not if, as Silverman (2001) says, the main focus of the research then becomes the way in which meaning is constructed in the interviews. I think it is feasible to accept an interpretist/constructionist view of the interviews without then making the interview process itself the focus of the research.

I was able to reach a full evaluation of the strengths and the limitations of the BEI method in this research only after I had analysed the interview transcripts, and so I will set out this evaluation at the end of the chapter.

What were the alternatives to using the BEI method in this way? The interviews were a means of gathering qualitative information about what people did on particular occasions to attempt to bring about change. Different methods might have been used. For example, I could have sought to accompany people, or to 'shadow' them, over a

period of time (eg as in Binney et al 2005). Alternatively, or in addition, I could have sought to interview respondents on a number of occasions over the period of the study. Both of these alternatives would have required more time from each individual interviewee, which I judged would in most cases have been difficult to obtain. They would also have meant my spending more time with each individual, and therefore would probably have meant interviewing fewer people in total. My preference at the time was to interview more people.

Another additional method of gathering information would have been to seek information about the actions of the interviewee from other people in their work environment, to corroborate or to question the versions of events that were provided in the interview. This would have provided some triangulation in relation to the particular events they described. Of course, some confirmation of the *ability* of the interviewees was provided by the referees – and in some cases the interviewees were recommended because of *particular projects* they had undertaken successfully, which they described in the interviews. In the case of one interviewee, with whom I had worked on a change project, the interview covered aspects of the change project I had experienced, but from her perspective rather than mine. Detailed information from other sources would almost certainly have provided a richer picture of what took place on particular occasions, but it would have required more cooperation from my interviewees, and would, in my opinion, in most cases have been much more difficult to arrange than the approach I chose. An easier starting point for gathering information from multiple sources in this way would have been to begin with a defined change project and deliberately seek to gather views from a number of different actors in the project. If I had been able to gain permission to carry out research in this way, my limited resources would have meant I would have been able to study a smaller number of actual change projects than by following the strategy I chose.

Research into competencies has also been carried out by repertory grid methods and by questionnaires (eg Alimo-Metcalfe and Alban-Metcalfe 2001; Dulewicz and Higgs 1999). Repertory grid is a method of gathering information from individuals or groups about what they consider to be important (Easterby-Smith et al 2002). It can be used to help people to articulate their values, and therefore what they would *like* to experience, or what, out of what they have experienced, they liked (or disliked). It is

therefore possible to produce competency frameworks that have a high 'face validity' in that they are highly acceptable to users (Adams 2001), but because it does not necessarily focus on what has *actually happened* in particular situations, it is less effective than the Behavioural Event Interview in identifying actual behaviours that have been effective.

The use of questionnaires in the context of competencies can be used a) to check the acceptability of certain descriptions of competency (as in the Alban-Metcalfe and Alimo-Metcalfe 2000 research, and as in Dulewicz and Higgs 1999) or b) to apply a competency model to analyse particular situations (as in leadership research using the Multifactor Leadership Questionnaire – eg Antonakis et al 2003) or c) to assess importance of particular skills, using scales or measures that have already been developed (eg Treadway et al 2004). Any of these uses is logically best employed at a stage in a research process when a competency framework – even in draft form – has been derived by other methods of research. I did not want to evaluate a published competency framework. I wanted to start with a blank sheet of paper, and develop a framework from field data.

Jennifer Mason (1996:19) writes that your choice of research methodology is likely to reflect your own biography and the knowledge and training that your education has given you. My inclinations and experience led me to gather my information through interviews that were based on a BEI method, but I carried out this research with a critical eye on the methodology and, as described later in the chapter, I relaxed some of the standard rules of interviewing and coding, in the hope of glimpsing perhaps a little more than a pure BEI approach would capture.

Analysing the interviews

The information collected by the BEI is interpreted by the researcher by thematic analysis (Boyatzis 1998). Spencer and Spencer note that 'thematic analysis is the most difficult and creative part of the competency analysis process' (1993:135). My approach to analysing the interviews was based on grounded theory strategies (Glaser and Strauss 1967; Locke 2001; Charmaz 2006) in that initially I sought to develop descriptions of behaviours and competencies from the interview materials

themselves, without recourse to other competency frameworks, or to other theories about leadership or leading change. In this way, in a grounded theory tradition, I sought to derive ideas that were 'shaped from the data rather than from preconceived logically deduced theoretical frameworks' (Easterby-Smith et al 2002: 122-23) and to 'generate conceptual categories or their properties from the evidence' (Glaser and Strauss 1967: 23).

Locke (2001) elaborates and up-dates Glaser and Strauss's (1967) four stages of deriving meaning from the 'evidence' – coding (or naming) and comparing incidents in order to develop categories and properties; integrating categories and their properties; delimiting the theory by bounding it and bringing the analysis to a close; and writing up the research. Although the process of making sense of the information from interviewees was more complex, difficult and messier than this summary of four stages implies, they provide a reasonable overview of the activities involved.

I immersed myself in the interview material by reading the transcripts (which were typed professionally) in detail and listening to the recordings, sometimes in tandem with reading the transcripts. I coded the interviews over a period of months, assigning 'units of meaning' to the detail of the transcripts (Miles and Huberman 1994: 56). The process of coding has been described by Charmaz (2006:11) as the 'pivotal link between collecting data and developing an emergent theory to explain those data' and by Coffey and Atkinson (1996: 29) as 'allowing the data to be thought about in new and different ways'. In coding the interviews I was, of course, particularly interested in behaviours of the interviewees that appeared to contribute to their success in bringing about a change, and then in grouping these behaviours into meaningful clusters of competencies. As well as seeking common themes that might indicate common behavioural strategies, which may enable me to infer the existence of common competencies, I was concerned to compare differences between the behaviours evident in the accounts provided by interviewees, which might indicate logical boundaries between different competencies, or indicate particular strengths or weaknesses of the interviewee in this competency or that.

The mechanics of coding included making handwritten notes in the margins of transcripts (see Appendix 2), and/or reading transcripts on the screen and highlighting

sections of text. I tried the computer programme nVivo but preferred the manual approach to assessing meaning and allocating codes. At a later stage in the analysis I used a basic wordsearch on the transcripts to locate particular words that I thought might be significant, including 'vision', 'patients', 'culture', 'learning' and 'teaching' (see Appendix 3). I summarised themes derived from each interview on one or two sides of A4, and then sought to group themes from across interviews under category headings. Locke (2001) notes that an interest in processes has often led grounded theory researchers in management and organisational studies to produce stage or phase models of activity, and it was when I applied a stage description of change to explain behaviours of interviewees in some of the earliest transcripts to be coded that I felt that a meaningful set of categories was emerging (see Appendix 4). This interpretation was influenced by views, expressed by some interviewees, of change as a series of stages (details are described in the following chapter) rather than by the literature on stages in change described in Chapter 2, above. From this material I was able to develop categories (ie descriptions of competencies) and sub-categories of behaviours, or clusters of behaviours, within them. The framework of categories – of competencies and behaviours – was substantially developed from 16 of the transcripts and then applied to the remaining scripts, giving rise to revisions in descriptions and to changes to the borders between different competencies.

During the process of developing the framework I shared, at an early stage of the analysis, excerpts from two anonymised interviews with my research supervisors, and on three occasions used anonymised excerpts (of 2-4 pages) with Master's students, to enable them to practise qualitative analysis (on two occasions this group included other members of academic staff) – seeking their analyses of the scripts rather than presenting the details of my own (see Appendix 2) - and these exercises helped to confirm, in part, and shape, in part, my conclusions. As the framework began to take more robust form, I compared it in detail with other frameworks – beginning with the Leadership Qualities Framework and the Alimo-Metcalfe/Alban-Metcalfe frameworks described in Chapter 4 – to identify similarities and differences. As the framework neared its current shape, I offered a transcript (which they could choose at random from the 25 I had anonymised) to my supervisors and also to a colleague who had been trained in using the BEI approach to develop competency frameworks. The

colleague provided a detailed analysis that was in line with the analysis I had carried out on that script.

This was an exercise in grounded analysis, strictly speaking, rather than a grounded theory approach. Grounded theory approaches, according to Suddaby (2006), Charmaz (2006) and Locke (2001) include a constant analysis and comparison of the information gathered during the research, while information is still being gathered, and also the use of 'theoretical sampling' (Glaser and Strauss 1967: 45) to seek out further information, as the research progresses, to investigate particular categories. Whilst I reflected on the interviews throughout the research process, and the broad outlines of two of the competencies had emerged before half the interviews had taken place, the systematic and detailed analysis of the transcripts did not begin until all the interviews were complete. The use of more systematic constant analysis and comparison, and theoretical sampling, might have enabled me to provide a richer description of the competencies I describe in the following chapters. However, individuals who were interviewed later in this research volunteered information and accounts of leading change that were of great interest and of value in developing the framework. Using theoretical sampling might, given my limited resources, have excluded these interviewees from the research or, if including them, have led to me being more directive about the kind of issues I asked them to discuss. Nevertheless, the approach I took ensured that the findings were thoroughly grounded in the accounts provided by the interviewees.

The BEI method: a critical review

The BEI method has many strengths, but it also has limitations, and I came to an assessment of both in the course of this research. The strengths can be briefly summarised as: the interview focuses on accounts of actual events, and therefore examines behaviours of the interviewee (in this case about how they brought about changes) rather than accepting their generalisations, or their beliefs about how changes are brought about. The detail of behaviours can be gathered in this way, and then analysed, revealing a much richer picture than can be obtained from generalised rules about how an interviewee 'usually' behaves. Interviewees are less likely to provide what they consider to be 'socially desirable' answers to questions (Spencer

and Spencer 1993: 115). Information about behaviour can be gathered more completely, quickly and efficiently by a BEI than by 'shadowing' an individual over a period of time.

Spencer and Spencer (1993: 121-134) provide a useful list of problems that an interviewer might encounter when using the BEI method (such as the interviewee being 'vague' or unable to think of suitable examples) together with suggestions on interviewing techniques for overcoming these problems. The following evaluation of limitations of the BEI method go beyond simply noting these potential problems.

Spencer and Spencer (1993: 129) urge BEI users to encourage interviewees to re-create dialogues that took place in events, but in fact BEI appears more suited to some interviewees than others. In interviews, some people are able to remember and recount the details of how a certain decision was reached, and who said what to whom in a particular meeting; other people, perhaps with different cognitive preferences or learning styles, appear not to retain most of these details, and therefore are unable to recount them. In a BEI, they turn to summaries or to generalisations whenever possible, where they are more comfortable. When pressed for examples of, say, occasions when they have been more participative, they appear to have difficulty recalling specific events. When pressed further, they can often give examples but with less detail than would be ideal. This is a limitation of the BEI method (see Box 5.2). It is indeed possible that there are certain behavioural strategies, or competencies, that are used by those people who have difficulty in retaining the detail of specific events, which will be under-represented by research carried out with BEIs.

There was a related issue that some changes described by interviewees took place over an extended period of time (as indicated in Box 5.2) and that some of the activities that were undertaken were evidently of low-key preparatory nature: as Pettigrew and Whipp (1991: 143) observed, the leader's role in change may lie in shaping the change process in the longer term rather than in directing it 'through a single episode.' But a pure BEI approach is particularly suitable for capturing the detail of the single, perhaps dramatic, episode, such as a confrontation or a presentation, and is less suitable for gathering detail of the less memorable, more

mundane activities that may build up over a period of time into a successful change. In the course of coding the interviews I was conscious of the need to register the ongoing efforts of the interviewees in their attempts to bring about change, even if the detail they were able to provide about these efforts was less than ideal. Spencer and Spencer (1993: 99) note that by focusing on 'critical incidents' the BEI approach may 'miss less important but still relevant aspects of a job' – but the nature of Pettigrew and Whipp's observation, and the detail of some of the interviews, might raise questions about whether these aspects really are 'less important'.

Box 5.2 General, specific and over time examples

GB: Is there an example that you can bring to mind where there was something confrontational and how you handled it?

XY: Yes and I think, this was...it's not any one incident actually....It was a common theme that ran through a lot of the SHA events...

'I don't think there was one meeting where it all became apparent.'

'it happened by osmosis, I can't exactly remember how it happened...'

'I suspect I'm expressing myself more robustly in my recollection than I was at the time'

'Things get a bit hazy, I can't remember all the steps that I took'

'So there wasn't a particular episode, it was just constant wearing down and having to stand up against it.'

'it was a slow process of... almost to have a tailor-made plan for each colleague that would suit them and that would allow the overall picture to develop, and that took me some time to develop.'

GB: Before you come onto that JW, can you give me an example of how you tried to take people through those steps?

JW: Well I think that it happened really over time.

(From seven different interviews)

BEIs should get 'much closer to the truth' as Spencer and Spencer claim, but the extent to which an interviewee may mislead an interviewer in a BEI will also, logically, depend partly on what is at stake. In interviews where the outcome may be an offer of employment, a promotion or a pay rise, interviewees may be more highly motivated to

impress the interviewer, to the extent of departing from their honest memories of what they did on particular occasions. It is assumed that in the kind of research interviews I carried out for this study that an interviewee's motivation to exaggerate their own importance would not be so high that they would give an account of something they did that they knew to be false. At the same time, however, it would not be unnatural for interviewees to avoid talking in this context about actions they had taken that made them feel uncomfortable or regretful. Certain behaviours might therefore be under-represented in a BEI.

A further interesting issue was the re-told story. The importance of story telling for effective leaders and managers has been noted by a number of writers (eg Armstrong 1992; Morgan and Dennehy 1997; Denning 2005). As Boje (2003: 41) observes: 'We know that managers are storytellers and use stories to accomplish their everyday work.' Three interviewees were senior managers who, in addition to what they told me in the interviews, had also made presentations to groups of managers and professionals, which I had heard, where they had shared what appeared to be frank accounts of what they had done on particular occasions. My interviews took place after I had heard these presentations, and two of the subjects chose to talk about events that in some cases duplicated what I had already heard. There was no contradiction between the two accounts, although sometimes the interview touched on slightly different aspects of the event from the presentation (and vice versa), but it emphasised to me the fact that these were stories that the interviewees had told before. In some other cases, too, when senior managers recounted particular incidents from their careers I wondered how often this or that story had been told, and the extent to which it may have grown, or become more polished, in the telling. In presenting an event, one interviewee said:

I remember vividly the one of those [examples] that evoked the most response and [it's one] I've used constantly over the years in performance management discussions...

Logically, these accounts of particular events are still more likely to be honest representations of theory-in-use than if I had asked for generalisations or opinions about the skills that people felt were important for their success, but the effects of careful selection, re-telling and rehearsal of a story may move what is said some

distance from the relatively unmediated accounts of the subject's best memory of what was said and done, which were apparent in other instances.

In some cases interviewees were evidently deliberately selective: this was explicit, and represented as being helpful – for example to demonstrate different types of change which they had undertaken or to illustrate a variety of types of activity (see Box 5.3). Boyatzis (1982:50) acknowledges the potential weakness of selectivity, that 'only information that the respondent happens or chooses to remember is presented in the interview. This can result in self-serving biased information.'

The length of the interview in this research (most were between 50 and 65 minutes) necessarily meant that I was able to gain no more than a sample of the activities that the respondents had undertaken. Did this sample capture their particular strengths in leading change? It is not possible to say for sure. Longer interviews would have been helpful – simply because they would have enabled me to collect more examples of events from each person, but it was difficult in some cases to gain access to interviewees for even an hour. Boyatzis (1982:52) talks of an average length of interview of two hours in the early McBer studies, whilst Spencer and Spencer (1993:118) talk of a length of one-and-a-half to two hours. More recently Chris Dyson of Hay Group has said 'Our interviews typically last three to three-and-a-half hours' (in Adams 2001), Cheng et al (2003) write of BEIs of two to three hours, and David McClelland talks of a typical length of three hours (in Adams 1997) whilst acknowledging that the time and cost of interviews of this length has prevented them being more widely used. Boyatzis (1998:102) has used BEI as a 45-60 minute study when assessing people against an established competency model. I think it would have been difficult to gain permission for interviews of two and three hours with the range of respondents I engaged in this study, given that I was an independent researcher, approaching them from outside the organisation.

Where interviewees reflected on the deliberate selection of examples, exemplified in Box 5.3, it was usually accompanied by a statement or statements that indicated a desire to help me to learn about, or to illustrate different issues in leading change. These, and other, interviewees punctuated their descriptions of examples with expressions of lessons or rules – 'you need to do X or Y in leading change' or 'you

have to have support when you come up against opposition'. Statements of this type - expressions of rules of thumb or 'algorithms' - are identified by Boyatzis (1998) and Spencer and Spencer (1993) as providing insight into how the interviewee may use two or three competencies together or in sequence, although by themselves they are not, under formal protocols for coding BEI interviews, evidence of the interviewee having behaved or thought in that way at a particular point in time. The statements indicated that these interviewees saw themselves in the interview in an active role of imparting knowledge, even wisdom, rather than simply recounting examples of their experiences for someone else to analyse. This appears quite a natural stance to take – particularly for senior, experienced managers and professionals.

Box 5.3 Selection of examples

'Well I'll give you an example that L--- suggested to me the other day when I said, I've got no idea what I'm going to say [in this interview]. Because I think this is probably more typical of how I think I would probably tend to work'

'I think that there's so many [examples of change] but probably the ones...maybe if I could call upon two and we could maybe get pieces out of them that are useful to you.'

'...I've picked out three different incidents [to talk about] that show different approaches to change....'

'I'll try and give a completely different one [type of change] in that these were changes I didn't particularly want to see happening'

'I don't know whether this is going to be a useful approach or not but [I'd like to provide]... two or three different change triggers if you like...'

'I could give you all sorts of other examples, [but] that's probably the most outstanding one that would fit with your own ethos' [nb the basis on which the interviewee judged the researcher's 'ethos' it is not clear]

(From six different interviews)

Another feature of the interviews was that some interviewees were more forthcoming than others, happy to recount and explain particular incidents, and others were more reticent. Despite my assurances of confidentiality, some interviewees were cautious and it was difficult to persuade them to share detailed accounts of what they had done on specific recent occasions. This was particularly (although not exclusively) the case with some of the chief executives and directors, who may have experienced

challenging interviews with the press, and/or who felt they had a public position to maintain. (One particularly cagey chief executive told me that he had previously had a bad experience with an interviewer breaching confidentiality.) This was not a problem I experienced with people who evidently were prepared to trust me because of our previous acquaintance or because of our mutual relationships with the referee.

However, reticence might not only be related to caution about confidentiality. Collins (2002:12-13) notes that the outstanding leaders revealed by his research were 'self-effacing, quiet, reserved, even shy...a paradoxical blend of personal humility and professional will.' He adds:

During interviews with the good-to-great leaders, they'd talk about the company and the contributions of other executives as long as we'd like but would deflect discussion from their own contributions. (p27)

This effect was evident in some of my interviews, where the respondents recounted the actions that were taken by the organisation they led, or by their project group, in producing effective results, and their own personal actions became obscured by the operation of the team, the system, or the collective. Kanter (1989) in discussing the attributes of the 'new business athlete' – her name for the type of manager/leader who would be able to work effectively outside of the traditional organisation structures - talked of these people possessing a 'sprinkling of humility on their natural self confidence'. I found a small number of my interviewees so naturally reticent about their contributions, that on occasions I wished, to invert Kanter, they possessed a sprinkling of arrogance on their natural humility.

Collective and collaborative work was a feature of many of the accounts that interviewees provided. Raven (2001: 166) argues that BEI methods may mislead because, among other things, they may overlook the crucial performance of people other than the interviewee, people whose 'activities normally pass unnoticed, unmentioned, and invisible'. Hyperbole aside (it would indeed be very difficult to devise research methods to capture unnoticed and invisible activities) there may be a danger of overlooking activities that are not so easily captured by the BEI approach, such as the natural interplay of give and take that can be found in teams and collaboratives. Spencer and Spencer (1993: 126) urge interviewers to probe the use of the word 'we', so as to seek at all times what the individual interviewee actually did,

but in many interviews the outcomes (of successful change) seemed more closely linked to the performance of a group than the detail of the behaviours within the group of the interviewee, so that at times when interviewees talked about project teams, or how, together with a group of colleagues, they had tackled a particular problem, I listened to their accounts without repeatedly pushing for details of what they individually had contributed (indeed, it appeared that a key competency was the ability to work effectively in collaborations and partnerships with others).

A final, obvious limitation of using a BEI for researching competency models that may be used for self-development or for developing or recruiting people, is that BEIs ask for what people did at some point in the past – and there is a question about the extent to which that competency will be relevant in the future.

To summarise: the BEI method is a powerful research tool, but some limitations were revealed in this course of this research. Although BEIs are likely to yield rich information about the behaviour of interviewees, the accounts that they obtain may be distorted by memory and by their previous re-telling of the story of an event. Interviewees are also selective about which events and behaviours they describe (as acknowledged by Boyatzis 1982): in this research this selectivity was sometimes explicitly applied for the purposes of providing a variety of different examples and imparting lessons about leading change. The strict use of BEI interviewing and coding protocols may under-represent the behaviours and competencies of some interviewees, and under-represent some behaviours and competencies, such as those that are performed over time to achieve a successful change, those that may be judged to be less socially acceptable, and those concerning group or collective behaviours. The corollary is that a mechanistic application of interviewing and coding protocols may over-represent other behaviours and competencies, such as the dramatic, the confrontational or the otherwise memorable.

These limitations do not invalidate the research method, but they indicate that it is not a straightforward, simple tool to apply in gathering and making sense of data, that judgement must be exercised in its use, and that, at times, the results it obtains must be regarded with caution.

Summary

This chapter has set out the methodology that I have followed in carrying out this research, including the limitations of the BEI method and some of the possible alternative approaches I could have pursued.

The research methodology is such that I need at this stage to refine the definition of the competencies I am seeking to identify. The Hay Group definition, cited in Chapter 4 of 'an underlying characteristic of a person which enables them to deliver superior performance in a given job, role or situation' is no longer appropriate, as my methodology does not allow me to distinguish between 'superior' and (merely) 'effective'. Therefore my definition of a competency, as sought in this research, is 'a capability that enables an individual to be effective in a task or a role'.

How can the quality of this research be judged? Bryman (2004a) notes that issues of validity and reliability have been the subject of debate among qualitative researchers, some of whom believe that, given the potential existence of multiple accounts of social reality, the ideas of validity and reliability developed for quantitative research are inappropriate for qualitative studies. He cites Hammersley's (1992) reformulation of validity as meaning that the product of qualitative research 'must be plausible and credible and should take into account the amount and kind of evidence [it has] used' (Bryman 2004a: 276) and therefore the claims of a qualitative research should be judged on the adequacy of evidence offered to support them. The grounded theorists Locke (2001) and Charmaz (2006) are agreed that 'credibility' and 'pragmatic usefulness' are measures of the quality of the products of that approach to research (Charmaz also adds 'resonance' and 'originality'). Mason (2002: 40) seeks quality in research in a series of questions:

- Are my concepts meaningful?
- Are my methods appropriate?
- Have I designed and carried out the research carefully, accurately, well?
- Have I analysed my data carefully, accurately, well?
- Are my conclusions supported by my data analysis?
- Are they more widely applicable?

Despite any limitations in my methodology, as discussed above, I believe my concepts are meaningful, my methods are appropriate, and that I have designed and carried out the research, including the data analysis, carefully, honestly and well. As to Mason's final two questions, (are my conclusions supported by my data analysis? are they more widely applicable?) I will return to them in Chapters 8 and 9.

6. Findings: stages in the change process, and activities to win support

This chapter, and Chapter 7, describe and discuss information provided by the interviewees in respect of the changes they undertook to lead, the patterns of behaviours that were apparent as they did so, and the competencies that this appears to indicate they possessed and applied. As described in Chapter 5, I am defining a competency as 'a capability that enables an individual to be effective in a task or a role'. In this chapter a simple representation of the stages of a change process is introduced and is used to categorise behaviours and competencies that were apparent at different points in a change process. As well as these stage-specific behaviours, there were also some behaviours and competencies that appeared to be used at several points in the change process: one of these competencies – that of winning support and overcoming opposition – is described in this chapter, the others are described in Chapter 7.

As described in Chapter 4, there are numerous ways of grouping behaviours into competencies. This chapter and the next explain and illustrate the behaviours that I perceived in the interviews and propose how they might be grouped into a framework. The chief justification for grouping the behaviours in one way rather than another is, arguably, that the one way makes more sense to users and potential users of the framework than the other, that it is likely to make the framework more acceptable and accessible (Boak 2001; Rankin 2006) but this test has not yet been applied to this framework, and it is open to debate whether other ways of organising the behaviours would be more useful. At times in the following two chapters the possibilities of different groupings are raised and discussed.

Neither this chapter, nor Chapter 7, contains discussion of the relationship of these findings to appropriate published work on leadership, leading change or competencies, the central concern of this research: this is presented in Chapter 8. Some literature on how changes might be typified or described – issues peripheral to this research – is evoked in this chapter.

The interviewees have each been given a code simply based on the sequence of the interview, and the country in which the interview took place, from UK01 to UK30, and

AUS01 to AUS10, and these codes are used to indicate where examples of behaviours were provided, and to identify the origins of quotations. More information about the interviewees is set out in Appendix 1.

Changes

The choice of what changes to talk about was largely left to the interviewees themselves – although some of the clinicians, and one of the managers, had been recommended to me in the context of their involvement in a particular change, and they discussed this.

The changes the executives and managers described included: playing a role in organisational mergers; establishing new organisations; undertaking actions to change the culture and functioning of their organisations (or parts of their organisations) to improve performance; facilitating cross-organisational activities to influence, develop and deliver joint strategies; taking action to tackle performance problems – many of which, among UK executives and managers, related to meeting targets set for the organisation by government; analysing and carrying out changes to particular processes, systems and structures in order to improve services, and/or meet targets, and/or reduce expenditure. Some CEOs talked about establishing and implementing strategies for their organisations, or cross-organisational strategies, while interviewees at director level spoke about establishing and implementing strategies for their particular directorates. One executive talked about managing the closure of an organisation. Many of the changes interviewees described involved creating or amending structures, systems and responsibilities. Most of the executives and managers spoke of the need to work collaboratively with clinicians (particularly medics), to enlist their support.

Although these may sound like timeless changes, or at least changes that managers might be found carrying out at any time since the 1950s, the detail of them is arguably quite specific to the early 21st century and the context of: the application of systematic management methods and process analysis to the business of healthcare; changing attitudes among clinicians regarding process and job re-design; and changing attitudes regarding patient focus (or 'consumer' focus, as some of the Australian

interviewees described it). In the UK, important elements of context were also central government targets for performance, and structural upheaval in the National Health Service.

The changes the clinicians described included: making changes to systems, procedures, working practices, job roles and responsibilities in their area of clinical responsibility, to improve patient care, and/or hit targets; working across organisations to improve services to patients; personally developing new methods or approaches to delivering care to patients, and encouraging others to adopt them; building and growing their directorates; tackling performance problems by colleague clinicians; providing training for clinical staff; setting up education, training and research systems. One interviewee described work on developing a national training programme for a group of clinical staff; another spoke of leading a national project to support innovations in a specialist clinical area. In many of the examples described by the clinicians, there was a need to make a case for funding to support changes, either to hospital management, or to other health service organisations, or to central providers of funding. All of the clinicians were engaged, to a greater or lesser extent, in trying to persuade other people over whom they had no direct authority – clinicians or managers – to support them in their efforts. Many of the clinician-led changes, and some of the manager-led changes, involved specifying and seeking agreement on new protocols and standards for patient care, and then ensuring these were implemented.

The overwhelming majority of these changes involved innovation, as defined by West and Farr (1990) as the introduction and application of an idea, a process, a product, or a procedure which is new to the team, department or organisation, as discussed in Chapter 2, above. In a very small minority of cases, involving the closure of part of an organisation, and managing the process of redeployment or redundancy, innovation at the level of the team, department or organisation was difficult to preceive. (A more comprehensive list of the changes described by the interviewees is in Appendix 5.)

Many of the ways of classifying changes that have been suggested in the literature, as discussed in Chapter 2, concern the scale or scope of the change (eg Nadler and Tushman 1990; Dunphy and Stace 1993; Buchanan and Boddy 1992; Balogun and

Hope Hailey 2004; Iles and Sutherland 2001). Applying these conceptual frameworks to the types of change discussed in the interviews was not always a straightforward process. Some interviewees, for example, who described large-scale, organisation-wide changes – establishing new organisations, managing mergers, turning round failing organisations – were persuaded to give examples of details of particular elements of those changes: it was then interesting to deliberate whether the change to this procedure, or the introduction of that measure – incremental in themselves – were rendered transformational by virtue of being part of a larger change, that was evidently transformational. Working through these issues, however, it was possible and useful to make some distinctions about relative scales of change, and I developed a new categorisation of the change projects in terms of their scale and the degree of direction or influence over them provided by the interviewee (the change agent). The scale could be described as ranging from the:

- *narrow*, concerning changing personal practice, and/or changing the practices of a small number of people over whom the change agent had significant influence
- *medium*, involving a number of other people taking action, who must first agree on what to do, and perhaps working across departments
- *wide*, involving large numbers of relatively autonomous people, including cross-organisational or national activity

<i>High</i>	A	B	C
Influence of change agent	(J)	D	E
<i>Low</i>	(H)	G	F
	<i>Narrow</i>		<i>Wide</i>
	Scale		

Figure 6.1 Scope of change and contribution to leading change grid

The influence of the change agent was simply graded from high to low. So, for example, in two changes that could both be logged at point A, the change agents (clinicians) took the lead in small-scale changes, requiring cooperation from a small number of others, over whom the change agent had authority. Point B represents a case where the change agent took a leading role, exercising considerable influence, and the scope of the change could be described as medium, taking place within a single organisation, but affecting a significant number of people. Point C represents examples where the change agents took lead roles in bringing about changes involving a number of organisations. Examples of changes from the interviews with the chief executives of the Strategic Health Authorities fell into this category, as did several other examples from executives and managers, and from four of the clinicians. Point F, on the other hand, represents cases where the scope of the change was major, but the interviewee played a supporting role: for example, in one case the interviewee was one of a group of clinicians and managers seeking to bring about a change across a patient pathway, including primary and secondary care organisations. The interviewee took the lead on some activities (including drafting up protocols, making presentations) but did not appear to take a leading role in others. In another case that could be logged at point F, the interviewee, a director, played a supporting role in a hospital merger.

In the wide range of stories about changes, the forty interviewees provided examples of change that could be plotted on all points on this grid (except for the areas represented by H and J, which are the positions that might be occupied by people who are being led to change, rather than leaders). Different examples of change from the same interviewee could be plotted at different points on the grid; so, for example, a clinician whose first example of a change project was placed at point A subsequently went on to describe her role in a cross-organisational project that would be logged at point E (wide scope of change, but moderate influence). Conversely the clinician whose national project would be logged at point C later described a project in which he participated within his own hospital, which would best be logged at point D.

The precise points at which the change activities might be logged on this grid are open to debate in some cases, and not every single change activity has been logged.

However, the grid represents a useful way of thinking about one aspect of the type of change that was undertaken, and the role of the interviewee in its undertaking. Some changes that were described were more complex than others, with greater scale or width, some change agents were clearly significant drivers of the changes they described, others worked more in partnership with colleagues, as members of teams, (and not necessarily as the captains).

It should be noted that the complexity and scale of the change does not necessarily give a true guide to the degree of difficulty experienced by the change agent. Indeed, both the UK clinicians who led broad, inter-organisational, national changes, reflected that it was sometimes easier to do this than it was to bring about change in relation to colleagues in their own organisation, or in their local neighbouring organisations. As one of these interviewees said, comparing relationships with near and distant colleagues: 'they're the people down the road and you squabble with them, you don't squabble with the people 200 miles away.'

Another typology of changes discussed in the literature concerns whether a change is planned or emergent (eg Hayes 2007; Burnes 2004a; Balogun 2006) which can in some cases translate into whether it is top down or bottom up change – or a mixture of the two (eg Beer and Nohria 2000; Weick 2000). The changes described by interviewees could be regarded for the most part as mixtures of planned and emergent: plans were formed, intentions were pursued, but initial ideas were often revisited and revised as events confounded the change agent's plans.

Behaviours and competencies: a framework for leading change

Throughout the interviews, interviewees gave example of activities they undertook in order to bring about change, as well as opinions and evaluations of relevant activities, and their theories of change. As described in the previous chapter, this resulted in a large amount of information, and I made several attempts over a period of months to cluster and group it into a meaningful and useful code.

Because the interviewees were being asked to talk about occasions when they had brought about change, some of the things they described fell into patterns of

sequential activities. Some of the interviewees made explicit their view of the change process. For example:

[It's a process of] taking some time out, getting some data to actually back up what you want to do, producing a policy, consulting on that policy and being ensured that everyone says yeah, yeah, that will work, and then ensuring that the teams implement it according to that policy. (UK28)

So I suppose you had to achieve some sort of moral high ground really about the rightness of the thing you're doing and then once you've decided that that's it, there's something about toughing it out...and making sure that it's not just you toughing it out but that the strength of support for the idea, concept, plan, whatever is well grounded with everybody else... [You also need to] watch it, you can't do it and leave it... (UK12)

...you've got to be able to recognise the problem and you've got to be able to verbalise that problem in a way that other people can understand it. You've got to recognise that the way other people see that problem is not necessarily the way that you see it and you have to try and get them on board by getting them to see the problem in [your] light...(AUS04)

I think that you need to establish your vision and get a...cross-sectional group of people, influential people, people who are enthusiastic, people who are not enthusiastic, they all need to hear each other's views. You need to agree a line, you need to communicate that line and you need very quick wins and then you also then need to deal with the people who are against it, being negative, hopefully [you deal with them] in a positive way. And then get some more wins, keeping communicating it, be approachable, be enthusiastic and keep the whole thing moving forward at a pace and that way you move through the negativity... (UK04)

These quotations represent different conceptualisations of change as a staged process. We saw in Chapter 2 that descriptions of the stages of a change process vary (eg Hayes 2007; Thompson and Martin 2005; Kotter 1996; Balogun and Hope Hailey 2004; Kanter et al 1992) and that there are some commentators who argue that changes are so individual it is not possible to set out a standard series of stages (eg Dawson 2003). In the light of interviewees' comments, and bearing in mind published process models, I organised some of their descriptions of behaviours into an outline framework of:

Analysing the issue/the problem
Making decisions about the change

Winning support for change and overcoming opposition
Implementing change
Monitoring performance

As an awareness of which issues need to be examined and analysed often appeared to arise out of monitoring, the monitoring stage could lead into an analysis of an issue or problem, and so the stages are perhaps better seen as a cycle than a list:

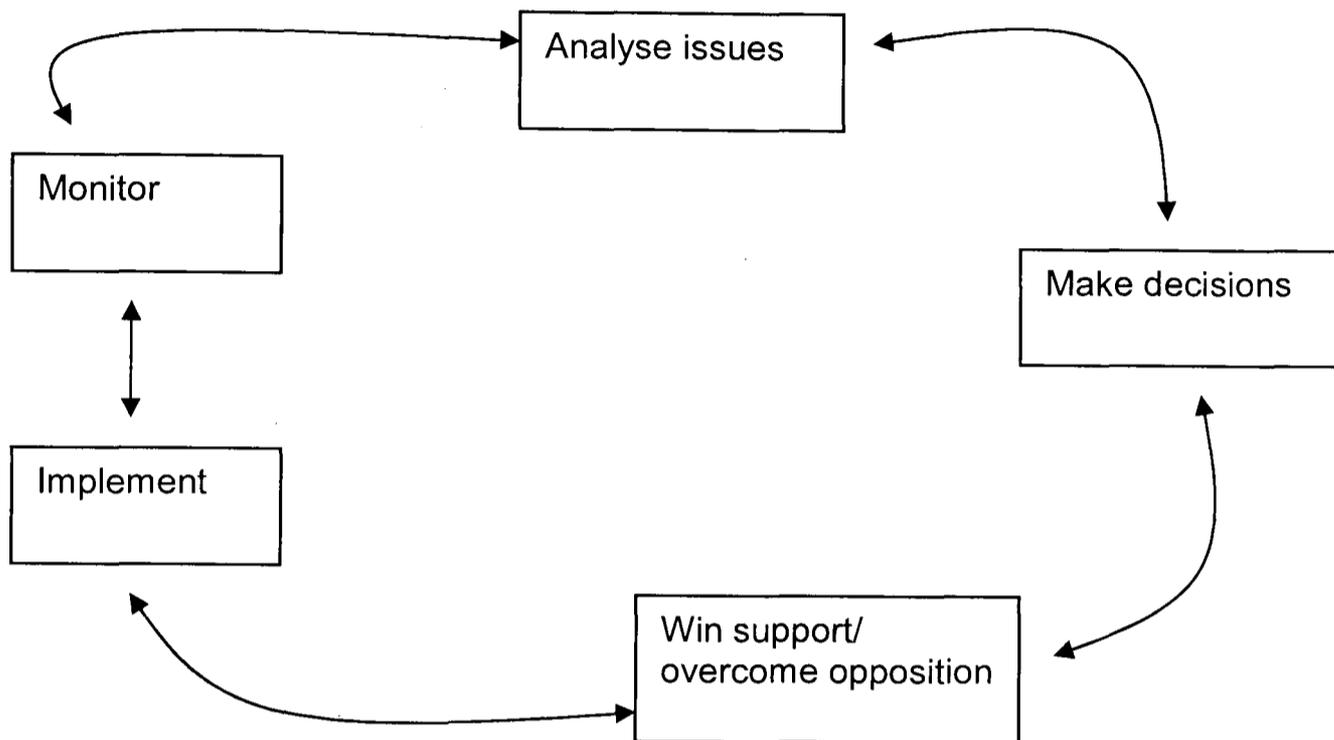


Figure 6.2 Cycle of change activities

Obviously, the diagram simplifies the reality of most changes: negotiations that take place during the winning support/overcoming opposition stage may lead to a revision of the initial decision. Monitoring often throws up issues that lead to adjustments in implementation. Some winning support/overcoming opposition activity may continue during the implementation and monitoring stages. Also, this is a picture of a simple single cycle, whereas the interviewees were often dealing with a number of changes simultaneously, or seeking to progress a large, strategic change through a number of initiatives, as implied by the quotation from UK04, above. Nevertheless, as Clarke (1994) says, an approximate model of the change process may be of more value than no model at all.

I found it was possible to code transcripts against these five broad stages, to organise many of the actions of the interviewees into one stage or another. However, certain activities and behaviours of interviewees appeared to take place at many stages of the change process – such as making assessments of the perceptions of other people. Therefore a first approximation of a description of the competencies that interviewees used was of activities undertaken specifically in each of the stages of the change process as a cycle (with a back-and-forth, two-way movement between the stages) and with other competencies, contributing to several of the stages, in the centre of the cycle (as in Figure 6.3).

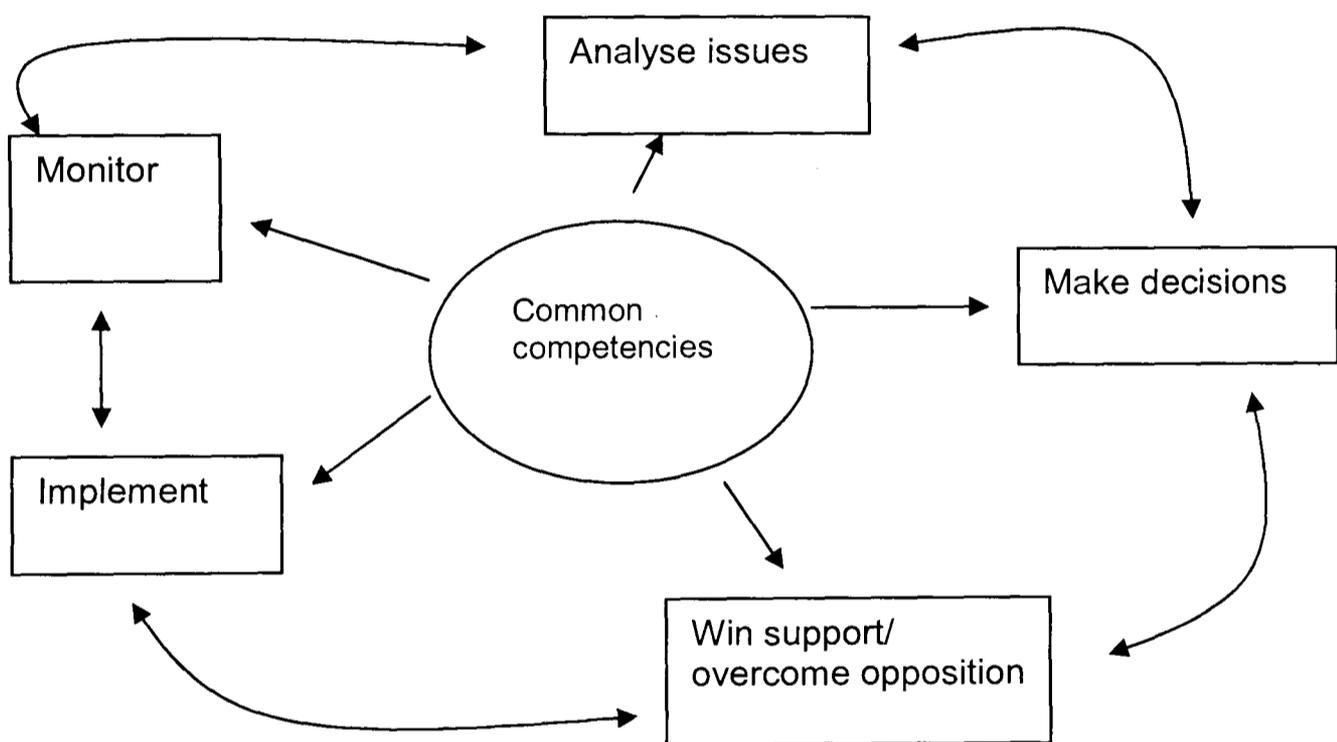


Figure 6.3 Cycle of change activities and common competencies

A feature of figure 6.3 is that it implies a particular stage when winning support/overcoming opposition is particularly important. In some examples, this indeed seemed to be the case: the change agent, alone, or with a small number of colleagues, analysed the issues and reached decisions about priorities and/or goals, and then sought broader support. The analysis, and the decisions that were taken, in most cases took into account the likely reactions of key stakeholders. Clear examples of this sequence of events included those cases where clinicians bid for funding to undertake change projects, and set out to address explicitly the criteria put forward by

the fundholders (eg UK16; UK18; UK23; AUS04; AUS08; AUS10). If they gained broader support, the change agent was able to move into an implementation phase. A common theme was that success in implementation led to more support for the scheme, and sometimes more general credibility for the change agent (eg UK18; UK19; UK21; AUS01; AUS02; AUS06; AUS08). Sometimes, however, this broader support was not forthcoming, in which case the interviewee either revised their decisions, or tried different ways of raising support, or attempted to continue in the face of opposition. However, some examples did not easily fit this pattern. A number of interviewees (particularly executives but including some clinicians) described occasions where the analysis of issues, and the decision making stages were much more collective activities than those just described. For example, in one case, a UK executive wished to apply lessons of good healthcare practices across a number of organisations in her region. A first stage in this was to establish benchmarks against which the organisations could assess themselves. This process (which could be described either as going about improving monitoring, or as 'examining the issues') was a sensitive one, in that stakeholders could perceive that the monitoring exercise might reveal their 'failure' to manage operations (cf Ovretit 1998 on quality being 'political' as noted above in Chapter 3). In a similar example, seeking to improve patient care in a number of hospitals in one specialist disease area, a clinician observed:

They've [the other clinicians] had a chance now to look at how we've actually calculated these indicators, they've looked at the data systems, they've had a chance to look at how rigorous we were in trying to make sure the data was as good as we could in terms of the way we did our abstractions, the way we did quality checks, etc, etc. So I think by the second round people had come around to thinking, well, these guys aren't going away (laughs). They're coming back to us with this information, the indicators are there, I guess we should try to do something about this, at least have a look.

In these examples, the major movements through the stages of the change process, the iteration of the change cycle that will lead to real change in the healthcare practices, are all social and collective. The change agent acts not as a single leader of change but as a facilitator of group processes. In these cases, the description of the cycle that places the majority of the 'winning support/overcoming opposition' activity into a single stage (albeit with interactions with the preceding and following stages) seems unrealistic. In both the UK and the Australian examples of collective action, the need to win support and overcome opposition was crucial from the earliest

stage, that of agreeing measures to monitor current practice, and agreeing the meaning of the results that emerged from monitoring.

An alternative to the conceptualisation of the cycle in Figure 6.3, therefore, is presented in Figure 6.4. Some changes may be best described by the more individualistic change cycle described in Figure 6.3, whereas others may best fit within the stages as described in Figure 6.4. It may even be that a change moves from one conceptualisation to the other, where, for example, an initial individual/small group cycle wins sufficient support to move on, but not simply to an implementation stage, but instead to a collective analysis of issues (eg AUS08). In some cases the movement could also be seen in the alternative direction, where collective deliberations and decisions then led to projects that were undertaken (at least initially) by an individual or small group, beginning with the analysis stage (eg UK17).

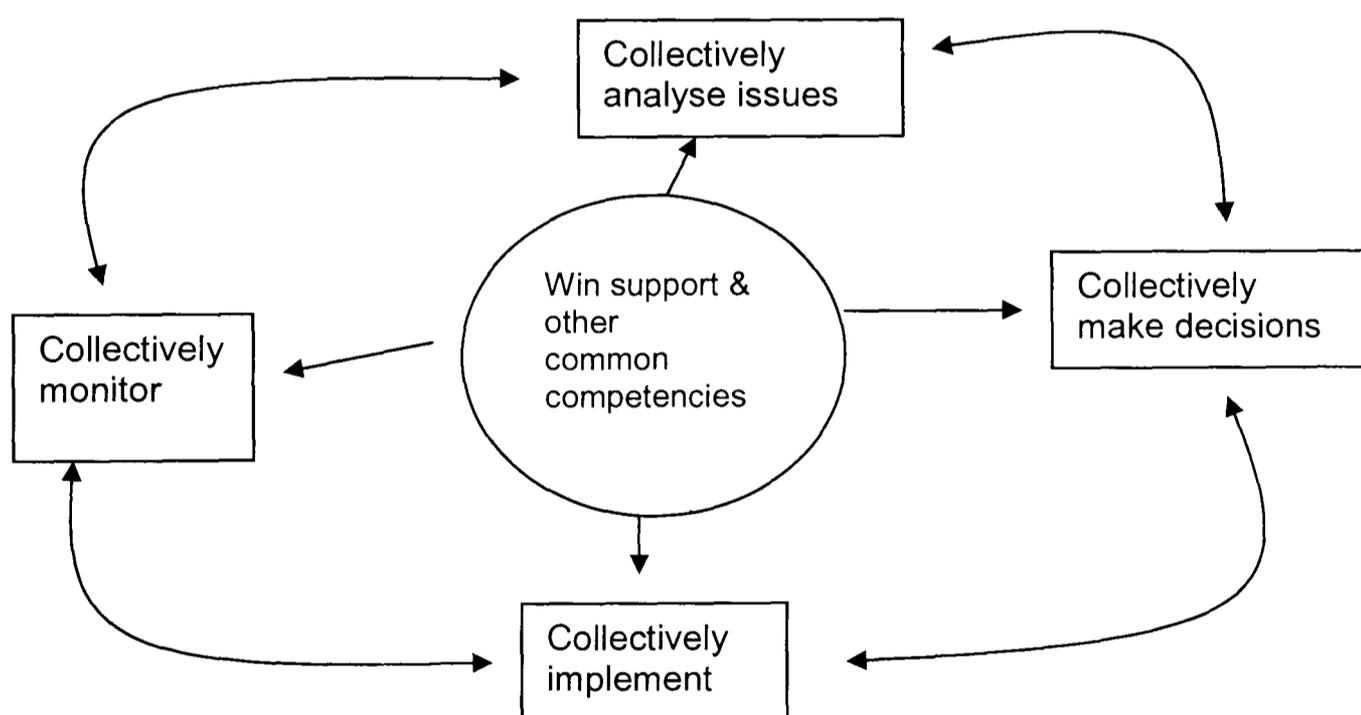


Figure 6.4: Collective change cycle

Although all the changes that interviewees described in the course of this research entailed working with other people, collective change cycles required much more social activity on the part of the change agent, to interact with others who are involved

in the change, and the activities of winning (and maintaining) support and overcoming opposition were more important throughout the whole cycle. The collective change cycle is more likely to be an appropriate description for changes that are wide in scope, such as those represented by points CEF on the scope and contribution to leading change grid in Figure 6.1. At point C (wide scope and major contribution) the individual change agent will take much responsibility for facilitating the collective processes (either personally or by ensuring their team members facilitate these processes). At point E (wide scope but moderate contribution) the change agent will take part in the collective processes, and may make some contribution to facilitating them. At point F, the change agent is one of the team, contributing to some element of the collective process.

The image of the cycle in figures 6.3 and 6.4 may be taken to imply a planned change: analysis leads to decision leads to action etc. This is partly justified by the information interviewees provided. Many of the changes they discussed were planned – to some extent – in that the individuals (sometimes acting alone, sometimes in company) started out with a concern to improve performance in some way, or with an awareness of a problem, or with a mandate to make changes in an area of activity. This starting point was itself a point in time, set in the context of what had gone before. Many of the interviewees talked of carrying on a project or a series of activities begun by someone else, or how they became involved in the project almost by accident rather than design (eg UK13; UK14; UK21; UK24; AUS08). Even those chief executives who talked about their efforts to change and shape their organisation when they came new into post, set their efforts in the context of the challenges they inherited, the results of activity (or inactivity) in previous months and years, and the interaction of those circumstances with their own ambitions for the organisation (eg UK06; UK10; AUS03).

At the outset of this particular cycle of change, the change agent, alone, or with a small number of colleagues, analysed the issues and reached decisions about priorities and/or goals, sought wider support, and agreed plans for implementation. However, it was clear that these attempts to analyse-decide-plan-implement in a structured way took place in the context of a complex and independently-changing environment, not in a calm or stable state where the only change in view was that

contemplated by the interviewee. A good example of this was the account given by one executive of how he and his team had carefully worked with a number of stakeholders across a range of organisations in order to introduce a coordinated electronic purchasing system. The executive was concerned not to try to proceed too quickly, despite the enthusiasm of his own staff, for fear of losing the interest and support of the different organisations, and (in terms of the stages of the cycle) the implementation stage was taking place slowly. He became aware, however, of the impending launch of a new government scheme, which also aimed to introduce electronic purchasing across a number of organisations, and which would cut across the scheme he was developing. He rapidly began a process of attempting to communicate with, and work with, the leaders of the new scheme in order to influence them. He was successful to the extent that the new scheme, as it developed, complemented and was influenced by his own scheme.

Other interviewees also gave examples when attempts to implement long-term proposals were threatened by independent events, or by changes elsewhere in their environment, such as policy changes, or the behaviour of a powerful stakeholder, and described how they worked to adjust, adapt or defend their original intentions – sometimes successfully, at other times not. Sometimes the independent events reduced the change agent to practising ‘damage control’ (in the UK, for example, the restructuring of the Modernisation Agency meant a sudden reduction in funding, which cut short a number of projects); sometimes the independent events enabled the change agent to extend their scheme (as in the purchasing example, above) or provided support for their scheme, which the change agent sought to take advantage of (eg UK16; AUS10). And on other occasions described by interviewees, an independent event arose that did not threaten the original intention but provided a beneficial opportunity for the change agent to extend their project, or expand or further develop it. If diagram 6.3 looks a little too planned, a little too controlled, a little too contained within its own stable space, perhaps it should be surrounded by jagged lines and arrows, or images of lightning bolts and hurricanes, to represent the changing environment in which many of these changes were attempted.

I considered applying alternative categorisations to the changes that interviewees described, for whilst some interviewees expressed a view of change as a staged

process, others contributed different (potentially complementary rather than competing) views of change. For example, one interviewee expressed the view that changes are different depending on whether they are 'enforced' (ie imposed) or whether they originate with your own wishes (a view not dissimilar to Nadler and Tushman's 1990 categories of reactive and anticipatory changes, described in Chapter 2). In the enforced change, she said, there are issues about whether you try to oppose it, or ameliorate its effects, and at what point you 'draw lines in the sand' – this kind of leadership of change is 'damage control' – 'you can make things better or hugely worse by the way you...approach it' (UK11). However, whilst the motive and the origin of the energy for change might be different in these two cases (and the motivational dynamics may also be very different) the cycle of these broad categories of activities is arguably the same. This interviewee had chosen the examples of change she wished to talk about in the interview to illustrate the difference that she described. Attempting to apply this categorisation to examples provided by other interviewees, however, it became apparent that, although some examples could be clearly shown to be enforced and some examples could be clearly shown to originate with the change agent's ideas, many fell into a middle ground, where attempts to enforce change were resisted, or diverted, or accommodated, and where change agents made proposals in the light of careful reading of the forces at work (or expected to soon be at work) on their organisations.

Others interviewees talked of incremental and step changes (eg UK08; AUS08) and momentum as a feature of change (eg UK07; UK 21; UK26; AUS06; AUS10). In the cases of momentum, there were examples of initial changes being well-received and this leading to a speedier adoption of the changes, or further development of the changes, in other parts of the system. These issues can be expressed in terms of the stages in the cycle either as:

- a) further adoption, development, or incremental changes are represented by further, complete change cycles, but they are likely to be achieved more quickly and easily than initial changes, or step changes, because they are of smaller scale
- b) further adoption, development, or incremental changes are represented by iterations between monitoring (assessing the effects of a change, or

assessing ongoing operations, and feeding back) and implementing (which includes making adjustments on the basis of experience)

The most appropriate way of expressing a particular change in terms of the cycle may depend on the scale of the change; a larger scale change might more appropriately be expressed by a new iteration of the whole cycle, a smaller one by an iteration between implementing and monitoring.

All successful change examples described by interviewees appeared to go through the cycle(s) described in Figures 6.3 and 6.4, whether individual, collective, or both. In some cases there were back-and-forth iterations within the cycle (as when unsuccessful first attempts to win support led to a reconsideration of the decision, or where monitoring led to revisions to implementation). Some unsuccessful examples stalled at particular points of the cycle. Some change projects were incomplete and ongoing at the time of the interview. Details of what the change agents did at each stage varied, depending on the context and their assessment of the most appropriate activities. The following sections describe the behaviours that the interviewees talked about, organised into the stages of the change cycle.

Analysing the issues

The analyses that interviewees described were sometimes prompted by changing policies, performance problems, financial constraints, and/or by the change agent's ambition to make changes in order to improve performance. In more than one case, the interviewee was prompted to carry out an analysis because of perceived inconsistencies in performance between staff, in order to identify good performance and areas for improvement (eg UK18; UK19). A collective analysis might also be brought about by the actions of the individual change agent in bringing people together to examine an issue.

Interviewees frequently described how they carried out detailed factual analyses of issues that appeared problematic, or appeared to offer opportunity. In some cases this entailed finding ways of measuring activities or outcomes that had not previously been measured - creating metrics and carrying out surveys to benchmark activities as

a basis for targeting improvement (eg UK30; AUS05). Process analysis was frequently used to come to an understanding of issues (eg UK04; UK18; UK19; UK21; UK23; UK24; UK25; UK28; AUS01; AUS04; AUS06; AUS08; AUS09). As one interviewee said: 'If it moves, we process map it.' In analysing processes and systems for patient care, it was common to find change agents examining details of times, costs, patient flows, outcomes, adherence to protocols, predicted workloads, percentage error rates etc (eg UK10; UK16; UK18; UK21; UK23; UK27; UK28; UK29; AUS04; AUS06; AUS08).

In a typical example of changes to processes, one clinician, who was aware of a problems in a process, wanted to analyse the process to see

whether we could streamline it, take apart the patient pathway, rebuild it and streamline it so that they [the patients] could get managed efficiently. So they get managed by the right person at the right place, at the right time (UK16).

(This desire to ensure activities were carried out by the right person, at the right place and the right time was expressed in identical terms by an Australian clinician, and similar skill mix decisions were described in different words by a number of other interviewees.) The UK clinician continued:

So we looked at the patient journey that was currently happening and we also looked at numbers and times, so we analysed a set of patient's records and we looked at the date of the referral letter from the GP, how long that took to get to us, how long it was taking us to have a look at it and prioritise it as urgent, soon or routine; how long it was then taking to get to the outpatients; how long it was taking from there to the operation; then the pathology results afterwards and the follow-up. So we mapped the patient pathway and the times it took on all those steps and then we thought, how can we redesign this to make it work better? And once we'd redesigned the thing it was a question of then implementing all those parts of the project.

The detailed analysis of issues sometimes included the collection of large amounts of data:

...[the process involved] trying to take masses and masses of information and findings and try and work this through to actually, what were the things that we could potentially change that might have an overall impact? (UK17)

The results of the detailed analysis were usually a heightened understanding of how a particular part of the system worked (or malfunctioned). Interestingly, senior managers and non-clinicians frequently showed a detailed understanding of medical/clinical issues under analysis and how particular parts of the system worked

(eg UK02; UK04; UK07; UK10; UK23; AUS03). One executive noted that it was important for him to get into detail with 'tricky clinical issues' in order to be able to 'talk with some credibility' (UK28). (In fact, some senior executives said that they had always enjoyed being close to the detail of action, but in order to carry out the other, more strategic aspects of their job, they had been forced to let much of this go – UK05; UK30; AUS05.) Detailed analysis often led to a good understanding of flows in the patient-management system: one manager in a hospital who achieved a detailed understanding of connections within systems along the patient pathway observed that 'discharge begins with pre-assessment' (ie the final discharge of the patient from the hospital is affected by activities that are undertaken prior to them being admitted). The collective analysis she facilitated meant that: 'over a period of time we got a picture of what the demand was, what the capacity was and what the activity was.'

The analyses were not only inward-looking, examining the organisation's activities and systems in detail, but often included seeking to learn from elsewhere: '[We thought] what are some of the innovative things coming from elsewhere that we might want to bring in?' (UK17; also UK01; UK03; UK08; UK19; UK20; UK24; UK26; AUS03; AUS05; AUS06; AUS07; AUS10). In two cases, for example, interviewees used information from national or state-wide audits to benchmark levels of prescribing (UK23; AUS07) and in a number of cases interviewees used clinical research evidence (and in the UK, NICE guidelines) and activities in other departments and other professional groups as part of their analysis (UK19; UK27; AUS08). Change agents also analysed potential policy changes and likely political and economic developments relevant to the change area, and the likely concerns of stakeholders (eg UK04; UK08; UK17; UK21; UK25; UK30; AUS05; AUS07).

In a small minority of cases, the analysis was limited, and changes were proposed based on past experience of the change agent in a different environment, together with a quick assessment of whether there were significant obstacles to these working practices being effective in the new environment (there were examples in the interviews with UK09; UK14; UK18). These were instances of relatively small-scale changes.

Depending on the scale of the problem and the circumstances, as noted above, the detailed analysis might be carried out by the individual alone, or might be the subject of a collective effort. The change agent might discuss the issue with their immediate team, or place an issue on the agenda of another group that was already constituted (eg UK05) or bring together a team of people in the organisation (eg UK01; UK23) in order to carry out a detailed analysis of a complex issue that would be acceptable to key stakeholders, or take part in such a group (eg UK27; UK29) or even create new cross-organisational groupings (eg UK07; UK17; AUS05; AUS07; AUS08). As well as analysing the issues, of course, these groups often then reached decisions. In some cases they continued to act as a project steering group, managing the implementation stage. One director developed a sophisticated collaborative system to achieve results, and set up structures and processes for clinicians to analyse needs and decide on service development (UK02; also UK11; AUS05; AUS07). One chief executive talked about how a major change process included getting influential people and people with diverse views involved in discussing and agreeing the strategy (UK04). Another executive described establishing steering groups, clinical groups, and user groups for consultation. The process was 'hugely inclusive of people, all groups of stakeholders in it. A massive infrastructure [was involved] in supporting that process and watching it, sheepdogging if you want....' (UK12). Managers also talked of how their teams discussed, analysed and decided on issues (eg UK04; UK05). Other clinicians talked of spending time developing group processes for coming to decisions on issues (UK17; UK26; AUS02). In many of these cases of collective analysis, the main role of the change agent was not as analyst, but of organiser and facilitator – and supporter and 'sheepdog'. The need to win cooperation (or support for the activity of analysing the issue) and to overcome opposition, was often an important element of the change agent's activity. One executive talked of working to ensure 'mutual benefit' for stakeholders (AUS07).

The issue of balancing the need to consult (and include) with the need to make progress was discussed by a number of interviewees. There were different perspectives on the ideal size of the group, from those who sought to be broad and inclusive from an early stage (eg UK11; UK12; AUS05; AUS07) and accepted the slower speed that could be achieved (eg UK13; UK27) and the mixture of degrees of commitment and motivation to change of the group they brought together (eg UK17;

AUS09) to those with a preference for a smaller group (eg UK07; UK18) who would prefer to work in the initial stages with 'zealots' (AUS08). One clinical director argued: 'You've got to keep I guess the management team, the people at the top who are actually pulling the levers, down to a fairly small number. Otherwise there's too many people pulling levers.'

On the way to reaching decisions, analysis might lead to new insights, including redefinition of categories of patients, of risks, of facilities, of activities that should be carried out, of priorities, of functions and or role boundaries (eg UK04; UK07; UK20; UK28; AUS04). In some cases, these new insights could be regarded as creative, unusual or original (eg UK15; UK18; UK19; UK21; UK29; AUS02; AUS07) but this was not an essential feature of an analysis that led to a successful change: as one interviewee said, of the outcome of one analysis, 'it was reasonably self evident' (UK16 also eg UK07; UK10; UK15). The analysis might also lead to decisions about the scope of the change. One clinician said that after a particular issue had been carefully analysed: '...it seemed to us... that [in order to address the problem] it would have to be a whole system change across primary care and secondary care.' (UK27)

The competencies that change agents demonstrated at this stage of the change process could be described as:

- the ability to analyse an issue thoroughly, or to contribute to a collective analysis of an issue, and to identify potential options for change
- this might include arriving at new insights, and new perspectives on elements of the issue

Change agents also demonstrated a desire to achieve improvement and change in how services are delivered, which led them to find ways of investing time and energy in analysing issues. This drive was evident at a number of stages in the change process, however, and was not confined to this initial stage. Other competencies that appeared to be relevant to a number of stages included:

- a broader conceptual ability than that employed to analyse the specific issue in question, which incorporated an ability to make good sense of how the surrounding social system operated: sometimes the process of analysing the issue appeared to teach the change agent more about the functioning of this

surrounding system (eg UK13; UK27) in other cases the analysis appeared to be a detailed and focused examination that took place in the context of a good understanding of how the overall system functioned. This ability is described in more detail in the next chapter under the heading of *Understanding complex social systems*

- the abilities required in order to bring people together to analyse issues and make decisions about possible change – including the ability to win the support and cooperation of others simply to take part in this analysis, and also the ability to work cooperatively – were evident in the more collective types of change project. Sometimes the ability to organise, set up groups, and establish systems for consultation or coordination was also evident at this stage. At a higher level of abstraction, these abilities – of winning support, working collaboratively, and setting up structures and systems, were also evident at other stages of the change process, and are discussed in more detail in the next chapter.

Making decisions about change

The decision-making stage followed on from, or flowed out of, the analysis stage. In some cases, the analysis appeared to lead directly to decision. One interviewee said: 'The reason I knew where we were going to go was because it was obvious' (UK21), and other interviewees argued that what they had done – and what they had decided to do - had been simple and straightforward, 'not rocket science' (eg UK02; UK07; UK10). However in some cases the interviewees said that the analysis did not lead to a clear plan of action, and they set off on a venture without knowing the solution to the problem. One interviewee described how a group set off on a project without knowing 'what we were getting into': it 'was clear the project was incredibly complicated because nobody had done the work before'; another admitted to not being sure that a proposed solution would work but said he was 'committed to giving it my best shot' (UK23 and UK29; also UK10; UK 12; AUS 04; AUS09). This lack of clarity led some executive interviewees to argue that it was best to move into an innovative area with a broad aim, as opposed to detailed planning, and proceed by experimentation and learning (eg UK06; UK08; UK20; UK21; UK28). As one executive said:

It's good to know where you might end up but you can't be too obsessed about that because you might have to change, things might change that destination.

But you've got to know where to go next and actually go there, and you take the next step (AUS10).

This willingness to take action in the absence of a clear direction is taken up in the next chapter, in the section on *Achieving results*.

In the decision-making stage, the first decision was sometimes one of what to address: in other words, the decisions might include some aspects of prioritising (we will tackle A but not B) or sequencing (we will tackle A this year and B at some future point). For example, one executive, in describing her work with an organisation with performance problems, talked about how she worked to achieve quality in a specific area of the organisation's activity where she 'decided, rightly or wrongly, that that was the area we were not going to screw up on, and people put huge effort into...getting it right' (UK11, also UK10; AUS07). Another manager, leading an under-resourced department, made the decision to prioritise, or focus, on certain activities, and cease to do others:

there were some things that... I decided really [weren't] adding value into the department and we stopped doing various things. And so we would concentrate on... doing things which hopefully added value to the service (UK21)

The decision making might be collective, or individual. Depending on the circumstances, however, the change agent might consult (and then make the decision themselves), or might need to negotiate with stakeholders of similar power, or might simply seek to facilitate the decision. The consultative approach might be informal and interpersonal (eg UK28; UK29); a more formal approach to get agreement on the way forward might be to write a paper that defined the issue, the options for tackling it, and the change agent's assessment of the preferred option, and then to seek comments, and amend the paper in the light of feedback (eg UK01; UK15; UK30; AUS03; AUS07; AUS10). Behaviours related to winning support and overcoming opposition, were evident in examples of collective decision making described by interviewees.

The language of rational decision-making is the language of objectives and criteria, and the objectives most frequently described by interviewees concerned the:

- quality of patient experience
- clinical outcomes

- ability to meet performance targets (such as waiting times)
- cost and resource factors
- sustainability
- alignment of practice with policy factors and clinical guidelines

Unsurprisingly, the most common tension was how to improve patient care within financial constraints (eg UK02; UK05; UK21; UK23; UK28; AUS01; AUS02; AUS06). One interviewee talked about the need to bring about improvements ‘on a shoestring’: she said, ‘we’re looking all the time at developing innovative systems that won’t actually cost us any money from the outside’ (UK23). In one project she described, this interviewee was considering projected costs and clinical evidence in making changes, and aiming to align practice with national clinical guidelines. Others worked to align the achievement of NSF objectives and financial constraints, and even to ‘...[combine] the policy imperative and the target requirement with people’s day to day function and what they themselves feel they need to do’ (UK28); or to achieve improved patient care in a cost neutral scheme (UK21) or with minimal financial support (eg UK16; UK17) or more generally to use patient outcomes and cost effectiveness as balanced objectives (eg UK02; AUS07; AUS08). Many of the clinician interviewees showed a very good grasp of the financial issues in the areas they had analysed, as did many of the managers, and both groups gave examples of occasions where they included financial arguments in their decision making and attempts to persuade (eg UK01; UK06; UK12; UK28; UK29; AUS01; AUS02). Interestingly, however, several of the executives downplayed the importance of finance as an objective or criterion in the decision making and persuasion processes (eg UK05; UK07; UK08; AUS03). One executive argued the best rule was: ‘Debate the issue and don’t get distorted by money. Look at the options. What’s the best business approach? We’ll look at the numbers later.’ (AUS05)

From the decision-making stage emerged ideas about goals and aims. We saw in Chapter 2 that many writers talk about the establishment of a ‘vision’ at this point, and indeed some interviewees described how they developed visions (eg UK06; UK07; UK08; UK09; UK17; UK21; AUS01) and how they devised ways of communicating them clearly and effectively to others (eg UK04; UK10). However, a majority of the interviewees did not use the word vision – of 40 interviewees only 17 used the word at

all, and as few as seven could be said to have used it as a description of what they sought to create at this stage, in order to inspire and guide. Of the 12 chief executives interviewed, only seven used the word at all. This is interesting, given the centrality of the notion of vision in writings about leadership and leading change. We will return to this point in Chapter 8.

Several of the behaviours noted in the previous paragraphs were also evident in other stages of the change process – such as seeking consensus, and negotiating, and aiming to improve services to patients. The main activities associated specifically with this stage could be described as:

- the change agent establishes priorities, goals and objectives in relation to the issue they seek to change, and a preferred way of achieving them

Implementing

At the implementing stage, change agents, acting alone but more usually with others, set targets, agreed protocols, clarified responsibilities, in some cases established new structures and systems, sometimes acted specifically to provide resources for implementation, sometimes provided training for staff (usually clinical staff) undertaking new duties, and, finally, held people to account for achieving results.

One of the executives described the early part of this stage as ‘the bureaucratic bit’ of seeking and achieving clear agreements on priorities and targets, translating visions into ‘real plans’ with targets and review points (UK25). This executive, and others, emphasised the need to set individualised, stretch targets to achieve continual improvement, and sought to agree targets that were stretching but realistic for the individual circumstances of the organisations (also UK07; AUS05; AUS06; AUS07). In some cases there was a concern for clarity: ‘I’ve got to ... make sure that all the i’s are dotted and the t’s are crossed... so people know exactly where they stand’ (UK26). Clear, specific protocols were also developed to shape clinical activities, and simple methods were used to communicate these protocols clearly (eg UK14; UK19; UK27; UK28; UK29). In some cases, interviewees described how they formalised procedures and decision rules to make it difficult for people to do what they didn’t want them to do – something they would personally reinforce in the early stages of

the implementation (eg UK11; UK18; UK28). These targets and protocols were not necessarily unchangeable in each case – there were examples of individuals experimenting with a new protocol and amending it when it did not work (eg UK23; UK24) and of piloting change in a limited area, and then monitoring, reviewing and amending in the light of experience, so the change ‘was very much an evolving process’ (UK21; also AUS07). Some interviewees described how they established systems (or sought to establish systems) that would provide incentives for people who cooperated with the change – such as schemes to reward individuals who took on extra work, or to reward organisations that committed to adopting different practices (eg UK07; UK17; UK18; AUS02; AUS03; AUS09).

Training and development activities were frequently mentioned in connection with change processes - 20 of the UK interviewees talked of this, as did six of the Australians. There is a logical connection: changes in processes for delivering care frequently required staff to learn new clinical skills and techniques, so that training became a key element of implementation (eg UK13; UK14; UK17; UK18; UK21; UK24; AUS06; AUS08; AUS10). In some of the larger scale changes there were examples of training and development in relation to management and leadership skills, in order to improve organisational capacity (eg UK05; UK08; UK10; UK11; UK12; UK22; UK30; AUS03; AUS05). Training was provided either on a personal basis by the change agent (eg UK14; UK15; UK18; UK24; UK30) and/or through establishing systems and training programmes (eg UK02; UK10; UK11; UK12; UK20; AUS05; AUS06; AUS10) depending on the scale of the training that was required. It was noticeable that some of those who established systems for training and development spoke very warmly of how the staff had developed, expressed positive views of what people can achieve, and provided and/or sought some recognition for their staff’s achievements (eg UK02; UK08; UK10; UK11; UK22; UK30; AUS05; AUS06).

Creating new structures, or amending structures, was sometimes an element of the change process, from setting up project groups ‘to start making these things concrete and happen’ (UK08) to formalising working groups and increasing their remit (eg UK17; AUS05; AUS07) – but these activities were also evident in examples of

collective analysis and decision-making at an earlier stage of the change process: they were not exclusively the province of the implementation stage.

Activities particularly associated with this stage could be described as:

- setting realistic targets, clarifying responsibilities for achieving the change
- setting up systems, procedures and protocols for guiding and monitoring performance, in some cases providing incentives or disincentives
- providing, or ensuring the provision, of any training that people need to achieve the change, and of any other required resource
- encouraging, motivating and requiring people to work towards the change

Monitoring performance

Although it is the last stage of the process to be described here, in some cases this was the first activity: a general monitoring of activities, or of the environment, that revealed an actual or impending problem, or a following up on problems or issues mentioned by more junior staff. Interviewees described how they monitored performance, and how monitoring revealed problems that required action, and led to the change agent investigating and seeking facts: gathering information from frontline staff, investigating the detail of issues when problems arose (eg UK02; UK10; UK14; UK28). Some interviewees gave examples of how they ensured regular monitoring of operations, and good communications about progress and performance (eg UK01; UK10; UK12; UK27; UK28; AUS03; AUS05; AUS06).

There were many examples of activity interviewees undertook to measure the results of the changes they had led, including establishing structured trials that led to hard, factual assessment of their initiatives – for example, in one case the change agent was able to say that the ‘Did Not Attend’ rate dropped to 5% (from 30%), and that changes improved waiting times from 52 weeks to 12 weeks (UK23). In another case, the interviewee was able to say: ‘we’ve actually halved the median time it takes from the decision to refer by the GP to the actual outpatient appointment’ and in another case to cite changes in error rates following training (UK16 also UK03; UK14; UK15; UK18; UK24; UK27; UK29; AUS06). This attention to detail and measurement mirrored that found in the analysis of problem issues. Both the scientific culture of

health services, and, in the NHS, the external monitoring of organisations against targets, which has led to more performance management in healthcare organisations, means that the emphasis on monitoring is perhaps unsurprising. The two different dimensions of this are exemplified by the clinician who monitored results in detail – partly in order to ‘show that it worked’ and the executive who used extensive monitoring systems for a change, who observed that it was important to ‘keep an eye on it [ie the change] and reinforce it occasionally’. Monitoring performance and implementation in this sense can form a loop of activities, where monitoring reveals a need to adjust the methods of implementation, perhaps by taking people to task: more than one interviewee described telling people to meet targets they had agreed to meet, focusing on the detail of results, and taking action where people failed to perform (eg UK10; UK12; UK28; UK30). On the other hand, recognition and reward were also spoken about explicitly by some interviewees, as an element of motivation and implementation (eg UK07; UK10; AUS03; AUS05).

Another aspect of monitoring was that results were often communicated formally to stakeholders in reports to inform and encourage them, and to communities in general, through papers, conferences and presentations (eg UK29; AUS06; AUS07; AUS08).

Activities particularly associated with this stage could be described as:

- monitoring the outcomes of a change against targets or expectations and/or
- monitoring performance of a service or a unit against targets or expectations and
- communicating the positive results to show progress
- initiating action where problems or shortfalls are indicated

Winning support and overcoming opposition

As has been said, in many of the changes described in the interviews there was a point at which decisions made by an individual or a small group were communicated to a larger group of stakeholders, and their support was sought. Where the change cycle was more collective, the activities of winning (and maintaining) support and overcoming opposition appeared to be present to some degree in all stages of the cycle. Consulting, communicating, and using influence in different ways are central

activities in achieving change, particularly in any kind of pluralistic system, where power is dispersed among different groups, and it is unsurprising that these activities were frequently described by interviewees. As noted above, the changes that interviewees described were of different scales of width, and differed in complexity, and the roles that the change agents played also differed in terms of the extent to which they exercised (or attempted to exercise) initiative and direction, as compared to contributing to a collective effort. Where the scale of the change was wide, the change was likely to be more complex and to involve more stakeholders and, particularly where the interviewee took on a leading role, the ability to win support and cooperation of other powerful actors was particularly important. Where the change was narrower, or the change agent occupied a more supporting role, the ability to use a range of means to win support was less important.

One UK executive in primary care talked about the importance of influencing in that sector as a regular way of life:

What they [people in secondary care] don't understand is you haven't got any power [here], you haven't got any control over these people, it's about influence, skills, cajoling, working the networks

This contrasted with one clinical director who, when asked how he had gained the support of his team to his idea for changes to how patients were managed, first replied: 'I'm the Clinical Director.... and I can determine what happens...' (his second reply, however, explained some of the benefits for his team, which made it more likely that they would go along with his ideas). An executive in secondary care also emphasised his perception of the need to communicate and consult with people, to get people to buy into change and accept it – otherwise 'they'll find ways to subvert it' (UK28). This executive used a range of methods of persuading people to change, including offering incentives, consulting, empathising, getting buy in, communicating with them in terms they understood, developing their understanding. Other interviewees described how they systematically identified the key stakeholders in a change and considered how they could be influenced (eg UK01; UK17; UK22; UK25; AUS05; AUS06; AUS07 – although only eight out of 40 interviewees used the word 'stakeholder'). An understanding of how the systems work, and therefore whose support is necessary, was in some examples an evident precondition for effective influencing.

It was not always easy for the change agents to win cooperation, and distrust and opposition were in some cases built into the situation in which they found themselves, by virtue of a history of antagonism between groups in the system, or mutual distrust (eg UK02; UK03; UK10; UK12; UK26; AUS05). One clinician noted: 'I spent a lot of time actually trying to soothe ruffled feathers' and 'it's taken a long time to actually get any sort of dialogue [with a neighbouring organisation] and get rid of the 'us' and 'them'" (UK26). And it was not always possible to win over all stakeholders - some interviewees described how they had to be prepared to work with a range of motivations of parties to the change, from fully committed to disengaged (eg UK17; UK27; AUS09; AUS10).

It was very common for change agents to seek resources, especially in relation to getting pilot funding for projects; many change agents described how they made business cases and sought funding for projects. In some exceptional circumstances, change agents described how they sought resources and support from a variety of sources to ensure continuation of projects (eg UK18; AUS06; AUS07; AUS08) cutting across usual organisational lines in two cases to seek support from a CEO (UK14; UK15), and persisting in seeking alternative sources of funding in order to keep a project alive (eg UK17). It was valuable to know where there may be money within the system that was not being used, which could be applied to give incentives or provide resources to improve services (eg UK23; AUS07). One interviewee used a metaphor of playing poker to win funding (ie bluff and game playing).

A number of different strategies were used by change agents to win support or overcome opposition. These categories of behaviours, described below, were developed from the interview data, without conscious or systematic reference to categories established in the literature, discussed in Chapter 2, such as in Kotter and Schlesinger (1979). Some comparison between these categories and those set out in other studies will be undertaken in Chapter 8. The interviewees did not all provide examples of behaviours in every category, but there were examples from each interviewee of behaviour from more than one category. It seemed likely that interviewees would seek to vary their strategies for winning support and overcoming opposition depending on their assessment of the situation they faced, but also that

certain interviewees would have preferences – slight or strong - for some strategies and perhaps aversions of varying strengths for others.

Consulting and seeking consensus

Seeking agreement on a way forward was a common element of winning support. One interviewee described how she aimed to achieve agreement through 'getting people together, building common ground and talking, sorting out differences, not taking a stand' (UK13). Another spoke of seeking to reach consensus by 'trying to ease people through, and talk to people, and trying to find routes that people can accept' (UK26). Frequently the proposed changes were consulted upon, in order to 'get people to buy into them' (UK28, also UK01; UK07; UK10; UK12; UK21; UK26; UK28; UK29; AUS02; AUS05; AUS06; AUS07). Consultation enabled change agents to acknowledge the concerns that others raised and in some cases address issues and objections (eg UK01; UK29; AUS05). As we saw, above, in the discussion of collective analysis, this consensus seeking activity was often a feature of the early stages of a change process. As one executive said, it was important to get the key stakeholders together to analyse the issue and to commit to a plan, so they each owned a stake in it and had a reason for seeing it achieved. He sought to create a 'community of interest' in order to bring about change (UK07, also AUS05). A feature of this consultation and consensus-seeking is that the change agent is likely to be prepared to compromise on, or concede on, or 'not take a stand on' certain issues – or that they are more concerned with 'finding routes people can accept' than with winning support for their preferred route. This tactic is, therefore, not necessarily one of gaining support for a particular proposal for change, but it could mean simply winning support for change of some sort, and jointly agreeing the nature of that change.

Communication and persuasion

Unsurprisingly, communication was a very common theme in the examples of change that interviewees described. An initial concern in some cases was simply 'raising the profile of an issue' (AUS10, also UK01; UK02; UK03). Change agents also sought to educate others, making cases for change based on the hard evidence they had

gathered during the analysis of the issue (eg UK03; UK13; UK14; UK29; AUS02; AUS06; AUS08). Some described repeated presentations to achieve their aim (eg UK10; UK29; AUS03) and making efforts to access different forums and meetings to 'tell the story' (UK06 also UK10; UK12; AUS03; AUS05; AUS07). Change agents arranged presentations and launch events to publicise schemes (eg UK15; UK22; UK27; AUS06; AUS09), some of which also served as two-way communications, where they could seek as well as disseminate information (eg UK30). Some change agents described using newsletters to communicate (UK08; AUS03; AUS09; AUS10). Others used multiple meetings to keep people informed, and to keep themselves informed about people's concerns and attitudes: as one said, during a disturbing change, 'people may not be getting all of the resources they need...but they will at least be getting all of the communication...they need' (UK11, also UK03; UK12; AUS09). Another interviewee shared her theory of communication: 'you probably need to have at least seven different mechanisms of communication, say the same message seven different times so they might actually [hear it and] do something about it'; another expressed a similar sentiment in talking of communicating frequently as 'gnawing away, getting them to understand' (AUS05 and AUS07).

Some interviewees expressed a concern for good, open honest communication with stakeholders, to avoid misunderstandings, or misrepresentations (eg UK10; UK14). One executive spoke of the importance of communicating in 'clear, simple and focused terms' (UK07, also UK03; AUS03); another chief executive took action to communicate her vision widely with staff, including by taking action to enable other managers to communicate the vision, and by conscious role modelling (UK10).

Interviewees described numerous ways in which they engaged in persuasion and communication, including ensuring they spoke to stakeholders individually outside of or in advance of group meetings (eg UK01; UK06; UK11; UK21; UK22; UK29; AUS02; AUS05; AUS06; AUS07; AUS10); and considering what language to use to convince particular individuals or groups (eg UK07; UK26; AUS02); shaping and directing arguments to the values and needs of particular groups and individuals (eg UK22; AUS02) including using figures and financial calculations to persuade, and presenting messages in different ways, based on what people value (eg UK25; UK26; UK28; UK29). In shorthand, making some assessment of 'which buttons to push',

which 'levers' to use to persuade people, or which 'carrots' will appeal (UK01; UK28; AUS09). As one interviewee said:

you do have to present different messages, or the same message in different ways to different audiences and that's legitimate... there's nothing wrong with emphasising the NSF compliance to Children's Services and the NSF group, and emphasising savings to the Director of Finance. Both wins get mentioned but the emphasis is a bit different

A range of benefits were invoked in persuasive argument, including policy compliance, improved patient care, and financial returns – as well as basic benefits for the individuals concerned - for example:

Although it's difficult to persuade people to change, if you demonstrate that it makes their lives easier then it's easy to do and even small changes can make big differences (UK16).

Demonstrating that a proposed project would align with wider strategies was an obvious tactic for winning support or funding from more senior managers or other agencies (eg UK16; UK17; UK23; AUS05; AUS07; AUS10). Of course, this persuasive activity requires a good understanding of what other people actually value and will perceive as a benefit: in some cases funding criteria are easily available, in other cases more insight is required, and effective use of persuasion depends on an ability to understand the perspectives of other people.

One interviewee sought to persuade everyone to focus on the gains:

what I haven't gone and done is gone and said, you're useless at this and it's not working well, you know, we've got to stop. What we've done instead is try and use every opportunity we can so that it's a gain/gain situation. I think that's important, that as soon as someone sees themselves as a loser in any particular situation then they dig their heels in and you're never ever going to move them

He sought to do this by getting people to take a different perspective on situations, to focus on the importance of improving practice, rather than considering themselves to be victimised. One executive, in a similar vein, talked of creating a 'different reality' in order to convince clinicians something was possible (UK07).

Timing was an issue in communication and persuasion. Some interviewees spoke of forewarning people, in order to get them ready for changes (eg UK02; UK21; UK26). This could at times be a long game: one interviewee said 'we've been working on

getting [a certain group] prepared for that, convinced that it's a good thing, in excess of a year' (AUS05). Others took opportunities to include new ideas on the back of an enforced change (eg UK11; UK21; UK28; UK29) or used problems that had arisen in order to get people to change (eg AUS03; AUS10).

Trading and negotiating

Trading and negotiation were also evident in some of the examples. As with persuasion, this required some understanding of what other parties valued. As one interviewee said 'if you are reducing a consultant's bed count, what can you give them?' (AUS01; also UK04). Another interviewee, trying to build a partnership with employee representatives, sought to make concessions, and provide financial support to aid the partnership, and to enable the representatives to show their members that they were succeeding (UK08). In other examples, cost-reduction benefits that a change project accrued were split between the partners (UK19; UK21; UK28; AUS02).

Providing resources

When managers exercise influence through an organisational hierarchy, a prime tool for influencing those below them is the provision (or withholding) of resources. I have included the actual provision of incentives (as opposed to promising them, or negotiating over them) in the competency of *Implementing change* but the provision of resources was also evident across organisations in a number of cases described by interviewees – providing funding for activities, for example, and/or providing staff who would carry out analyses, or 'do the leg work' (AUS09) or taking 'the burden of work off people' (AUS08, also AUS06; AUS07; UK05; UK25); or offering the use of facilities to other organisations as a way of building relationships – and improving patient care (eg UK19)

Developing and using alliances and partnerships

Collaborative working was mentioned very frequently by interviewees, including working in pairs, in teams, using networks, contacts and pre-existing relationships.

The ability to work collaboratively appeared to be a key competency, and is discussed in more detail in the next chapter.

In the context of winning support for change, some interviewees described using allies to provide support for their aims, and to help them win the support of others, by representation or by peer pressure (eg UK03; UK06; UK09; UK12; UK17; UK26; UK29; AUS06; AUS07; AUS09). Involving allies, making roles for them, and seeking active partnerships, was a theme in some examples of changes (eg UK30; AUS09). Some interviewees talked about how they worked to establish good relationships with others involved in a change process (eg UK01; UK10; UK13; UK19; UK26; AUS05; AUS10); knowing someone over a period of time could help (eg UK07; UK08; AUS05) and there were benefits of longevity in post: one executive said that she did not believe it was possible to achieve good relationships in six months (UK08, also UK07). However, one clinician who strongly demonstrated the ability to develop good relationships and ensuing trust and good communication with others emphasised the need to use facts to persuade them, not just emotional or relational appeals (UK13). More than one interviewee talked of working to include members of different health service clans – for example, ensuring nurses were able to talk to nurses about the project, doctors to doctors, pharmacists to pharmacists: as one interviewee said: 'I couldn't have got half the things done and implemented without having a nurse to go and sell it to the nurses' (AUS06; also UK04; UK17; UK26; AUS01). Chief executives talked of the need to find allies among their own staff, to help with the large-scale changes they had in mind (eg AUS03; UK06).

Impression management, reputation and credibility

A consideration for how others perceived the project, the change agent, the change agent's team, and the change agent's organisation, led to concerns for reputation and credibility, and also for appearances and impression management. In more than one case, for example, there was a strong concern to emphasise the appearance of partnership: '[it was] very important... that it came across that this was work across primary and secondary care, it wasn't the hospital telling the primary care what to do' (UK27, also UK30; AUS09). A concern for credibility, of oneself and also one's team (or even one's organisation) was also made explicit by a number of interviewees (eg

UK10; UK12; UK28; AUS01; AUS02; AUS03; AUS05; AUS06). As one interviewee said

[we tried to establish] how do we want to be seen, how do we want to be viewed, what's our reputation needing to look like? And I said... in the end we've got to be seen [to play things by the book, so that people will]... say, well they did do what they said...

As this interviewee said later in the interview: 'my reputation is more important to me than anything because you can't get it back once you've lost it can you?' Another spoke of reaching a 'critical mass of credibility' being crucial to the success of his projects. Credibility was enhanced in some cases of clinician change agents by outside recognition, by papers and awards (eg UK15; UK18; AUS06).

There were examples of change agents enrolling influential people to take part in events, to send messages about importance of the event (eg UK30; AUS09), and several of the senior interviewees were explicit about the symbolism of being seen personally to take part in events and to contribute personally to meetings (eg UK10; UK12; AUS05; AUS07). Leading by example, and consciously role modelling the behaviour they wished others to adopt were, were described by some interviewees (UK10; UK12; UK18; UK19; AUS07).

Demonstrating progress or success

A common aspect of winning support, described by a number of interviewees, was that the successful results of a change led to them winning more support (eg UK07; AUS02; AUS06; AUS08):

I thought this was going to happen, that we get a system working and working well in one ward or two wards and they would show it to the other wards. And they really were our ambassadors. They were telling people what we were doing, how good it was. (UK21)

that's what got everyone on board because they thought, well it works. (UK18)

they've come to accept it where they've seen the advantages of having people working like that (UK19)

A number of interviewees described how they had decided to proceed despite the doubts or opposition of others, and set themselves up to be judged by results, in the

expectation that success would eventually win them more support: 'they just look at me sometimes... but then you just go with the flow and when they see it all work out they'll be OK' (UK12); '[I said to them] you'll have to wait and see if I deliver' (UK10, also UK07; UK14).

Facing up to opposition

There was not always opposition to the change agents' proposals: the patient focus and evident benefit of a project described by one relatively junior clinician quickly won the support of the consultants to the extent that she said: 'we were... surprised at the resistance we didn't get'. However, others were not so lucky, and there was a common theme of change agents standing up to opposition, and in some cases proceeding with their course of action despite opposition (eg UK07; UK09; UK10; UK12; UK14; UK18; AUS07; AUS10). This was most obvious in the Implementing stage of the change process. The opposition ranged from negative comments from colleagues: 'a lot of people were saying "Why on earth do you want to do that?"' (UK19); to more open criticism and confrontation, even abuse and intimidation (eg UK03; UK09; UK10; UK15; UK18; UK26; UK30; AUS05; AUS07; AUS10). It was evident that a certain degree of determination was necessary to confront this opposition - it would often have been easier (at least in the short term) to avoid confrontation. Interviewees were often led to confront the opposition by a conviction that what they proposed was practically and in some cases morally right.

For example, one interviewee spoke out to resist proposals from more senior/more powerful actors where she did not believe they met the needs of the patient population, and she was prepared to confront people in this situation. This was an independent assessment of what was 'right', despite contrary perceptions of colleagues. There were other examples of people making clear, open statements of their position in a confrontation, and being successful in fending off the opposition, or even winning support (UK02; UK07; UK10; UK11; UK28; UK30). A good knowledge of the rules (including legal rights and responsibilities) was important in some examples (eg UK09; UK12). The stakes in the confrontation could be extreme. One interviewee talked about an occasion where she offered to quit her job if she was unsuccessful in a project, in order to win the cooperation of others; another offered to

resign if a more senior manager did not stop pressurising her to achieve short term results when she was engaged in a long term project; another said she would give up her job rather than compromise on patient care.

In some cases, the change agents were able to use their positional power to overcome opposition, particularly during the implementation stage, but there were also some examples of interviewees acting to overcome overt opposition at an earlier stage in the process. For instance, one interviewee described how she raised a problem directly with the person (a professional contractor) who had caused it and held him to account, with a 'very frank exchange of views about his future employment with us' – but sought a dialogue, to get the person to see her perspective, rather than just using the power of position to get rid of him: 'there was a need to confront the issue and not just say, "Well we're not going to use [this person] any more," but to actually have the conversation.' Another interviewee behaved firmly but reasonably to address problems when confrontation arose, seeking to impose what she felt was the right decision, but also seeking to address difficulties faced by the other party.

Summary

This chapter has set out some of the findings from the interviews. A range of different types of changes were described by the interviewees, from incremental changes of procedures and processes to major changes that included setting up new organisations, and taking radical action to improve the performance of whole organisations. The interviewees played different roles in the changes they described, and it was found to be useful to consider two dimensions of the change: the scale of the change, and the extent to which the change agent influenced decisions about the change. There were examples of high influence and wide scale, where the interviewees evidently exerted much influence over a major, cross-organisational change – a complex process, involving many stakeholders and different bases of power and influence. In other cases, interviewees exerted much influence, but on a much narrower, relatively less complex, scale. In other cases the change was major but the interviewee evidently played a more contributory role.

A simple description of the typical stages of a change process was used to organise the information provided by interviewees about how they sought to bring about change. In some cases the stages involved only a small number of people, in other changes – those that were broader in scope and often more complex – the stages involved more people, and the change agent's work was more facilitative, consultative, persuasive. From this description of the stages, the behaviours of the change agents could be organised into some competencies that were specific to particular stages of the change process, and some competencies that were applied at a number of different stages. The former can be described as the following competencies, with their associated behaviours:

Analysing the issues and making decisions about change

- analysing an issue thoroughly, or contributing to a collective analysis of an issue, and identifying potential options for change,
- this might include arriving at new insights, and new perspectives on elements of the issue
- establishing priorities, goals and objectives in relation to the issue they seek to change, and a preferred way of achieving them

Implementing change

- setting realistic targets, clarifying responsibilities for achieving the change
- setting up systems, procedures and protocols for guiding and monitoring performance, in some cases providing incentives or disincentives
- providing, or ensuring the provision, of any training that people need to achieve the change, and of any other required resource
- encouraging, motivating and requiring people to work towards the change

Monitoring performance

- monitoring the outcomes of a change against targets or expectations and/or
- monitoring performance of a service or a unit against targets or expectations
- communicating positive results to show progress
- initiating action where problems or shortfalls are indicated

Of the categories that could be applied to a number of the stages, only one was discussed in any detail in this chapter, and that was the competency of *Winning support and overcoming opposition*. Change agents described a range of approaches they used in different circumstances to achieve this aspect of leading change, and it seems likely that successful performance involves making a realistic assessment of what will be an effective set of tactics for a particular situation. The tactics were:

- consulting and seeking consensus
- communication and persuasion
- trading and negotiating
- providing resources
- developing and using alliances and partnerships
- impression management, reputation and credibility
- demonstrating progress or success
- facing up to opposition

Detailed discussion of the competencies in relation to other frameworks and literature on leadership and leading change will be presented in Chapter 8, but from what has been described in this chapter it is evident that there were more behaviours that could be described as 'managerial' (especially in the competencies of *Implementing* and *Monitoring*) than one might have expected, and much less evidence of visions being developed and communicated than the literature on leadership and change would lead one to expect.

The next chapter will describe the other competencies that appeared to be displayed in a number of the stages of the change process.

7. Findings: pervasive competencies

This chapter discusses other competencies that were discerned from the interviews, and the behaviours that were described by interviewees. These competencies were evident at several stages of the change process. The chapter describes each competency, how it is constituted, and how it appears to relate to other competencies. Finally, the chapter discusses similarities and differences in the profiles of groups of interviewees, as evidenced by the information they provided. As with the previous chapter, this chapter concentrates on material derived from the interviews; connections between this material and published ideas in this area will be explored in Chapter 8.

The seven competencies described in this chapter can be listed in brief as:

- Understanding complex social systems - the ability to understand the workings of the complex systems that make up health and social care
- Achieving results - a concern for achieving results, which translated into skilled actions to seek potential improvements and to make progress in bringing them about
- Working collaboratively – the willingness and ability to work well with others
- Understanding the perspectives and motivations of others - the ability to see things from another person's point of view
- Establishing systems and structures – the ability to establish or adapt systems and structures effectively
- Orchestrating the team – the ability to work interdependently with one's immediate team to tackle issues and problems
- Self belief and self management – the ability to remain self confident in the face of difficulties, and to take action to develop oneself

Understanding complex social systems

It was clear from an early stage in the research that many interviewees had gained and regularly employed a sophisticated understanding of the systems and situations within which they worked. They demonstrated this in the interviews as they explained how they assessed situations, and also as they provided explanations of how systems

operated, including the variety of influences at work on behaviours and outcomes. Interviewees based their actions on their understanding of the flows, the currents, the causal factors, the likely effects, of the complex systems in which they operated. This went beyond their detailed examination of issues or problems that was the initial, analysis stage of the change process. This capability, of being able to make sense of the complex systems around them, enabled change agents to decide which issues to tackle, what goals were possible, and what decisions they might take. This systems perspective went along, in many cases, with a desire to make coordinated changes to systems, and to find systems solutions to problems.

Demonstrations of this competency that were closely linked to the analysis phase of bringing about change were generally characterised by an ability to identify multiple factors that affected a situation, and to explain the interplay between them (eg UK07; UK16; UK19; UK23; UK29; AUS02; AUS04; AUS10). It was evidently possible, however, to carry out effective detailed analyses of specific issues without applying this broader sensemaking competency (there were two clear examples of clinicians who did this, and who achieved significant changes in their own areas of responsibility) but, without this broader system understanding, the extent of the changes that can be brought about are likely to be limited (both of these clinicians appeared to struggle to understand or to influence events outside their own area of responsibility).

This competency concerned understanding complex *social* systems and therefore required more than an understanding of predictable patterns and flows. For example, one interviewee used process mapping tools to understand flows of patients through a hospital (leading her to the observation, as described in the previous chapter, that 'discharge begins with pre-assessment' - ie the final exchange between the hospital and the patient, when they are discharged back into the community, begins with the very first exchange – pre-assessment – before they are admitted, because that first stage establishes expectations and begins plans). This executive also emphasised the importance of connectivity between different parts of the organisation: 'you can't just change one area, you have to understand what the implications are, and [the effect] runs through the whole organisation'. This is a relatively impersonal level of systems understanding. The same interviewee, however, also presented an

assessment of the rivalry between groups of physicians and surgeons that was based on a good understanding of their different roles, interests and perspectives as they worked within the hospital system, thus demonstrating a very social awareness, enabled by an understanding of different perceptions and values. Other demonstrations of this competency included: a systems analysis of problems faced by an interviewee's organisation, which took into account the perceptions of people in the organisation, the financial viability of various options, and the political influences at work; a complex assessment of factors affecting the organisation, including company needs, changing demographics, prevailing cultures in the local employment market, and the different motivations of staff; assessments of flows in the systems for caring for patients, including cross-organisational analyses; and the effects (including dysfunctional effects) of specific allocations and separations of authority (UK01; UK02; UK08; UK11; UK12; UK19; UK27; UK28; AUS 03; AUS 05; AUS07).

The use of this competency gave rise to an awareness of what one interviewee called the 'connectivity' – or natural linkages - between different initiatives, which led change agents to seek alignment and explicit connections, in some cases seeking to link what were apparently merely operational issues with a broader strategic movement, in other cases simply joining together, to good effect, initiatives that on the face of it appeared independent (eg UK01; UK11; UK14; UK16; UK23; UK24; AUS01; AUS05; AUS06; AUS07). Within a single organisation, an understanding of the connectivity between different services and functions could be significantly important (eg UK03; UK08; UK09; AUS01). The concern for connectivity was evident in those interviewees who looked across health and social care organisations for the causes of problems, and the nature of solutions (eg UK05; UK13; UK17; UK19; UK25; UK26; UK27; UK28; UK30; AUS05; AUS07; AUS08). An awareness of international developments in the delivery of healthcare, and an appreciation of their relevance, was also evident in several interviews (eg UK07; UK08; UK09; UK17; AUS01; AUS03; AUS05; AUS06; AUS08; AUS09)

Included in this understanding of complex social systems were assessments of the perspectives and motives of different groups and the actual or typical interchanges between them – such as civil servants and clinicians, finance people and clinical people, patients and clinicians, and clinicians from different professional disciplines

(eg UK02; UK07; UK13; UK17; UK26; UK30; AUS03; AUS05; AUS06; AUS09); readings of organisational and group cultures and their impact on other parts of the system (eg UK01; UK02; UK04; UK06; UK08; UK11; UK12; AUS 03); interpretations of political currents and patterns of influence (eg UK01; UK02; UK04; UK05; UK08; UK11; UK12; UK25; UK30; AUS03; AUS05); assessments of political and economic influences on the current and likely future operation of healthcare organisations (eg UK04; UK05; UK17; AUS05; AUS07).

This systems understanding was not a static, acquired property, and appeared to be neither effortlessly attained nor infallibly correct, but was the hard-won product of experience and enquiry. In some cases the conclusions reached were evidently reasoned guesswork, with the resultant action by the interviewee a gamble to a greater or lesser extent. Interviewees described how they continually made efforts to improve their understanding of events, systematically or opportunistically. For example, one clinician who played a major role in a national project recalled the early stages of her involvement: it was not easy to make sense of the new area: 'I went round and round in circles'; 'I still couldn't quite see where we were going with it, it took a while to work it out' (UK13). There were frequent examples of the interviewees' interpretations of the systems' performance, characteristics and needs being disputed by others (eg UK02; UK03; UK07; UK09; UK12; UK13; UK25; AUS05; AUS07; AUS08). There were also (as an illustration of the limits of the interviewees' understanding) examples of behaviours of business sub-systems – even effective behaviours - that defied explanation. For instance, one interviewee, who had introduced an effective system in his area of responsibility said:

I've been amazed at how this [new system] has sorted out our waiting list. I didn't think it was possible to do it and I still don't understand how it works but ... it somehow works itself out and your waiting list just melts away

The competency of understanding the wider social systems in which they acted was, on the whole, more strongly demonstrated by those interviewees who were executives and managers than by those who were clinicians - although it was strongly demonstrated by six clinicians who talked about cross-organisational examples of seeking to bring about change. It is likely that the work of the executives, which more often means they must take action across organisational, departmental and professional boundaries, simply requires this competency more often, and to a

greater degree. The examples of action that were provided by three of the four most senior executives of the whole group of interviewees were rich in detail of attempts to bring about changes that crossed multiple organisational boundaries, were reliant for success on persuasion, influence and consensus, and required frequent interpretations of causality and likely/possible consequences in very complex environments. In such circumstances, it appears essential to have strength in this competency in order to make sense of the numerous actual or potential influences on a situation and the variety of processes and decision-making systems that are in play.

This competency appeared to be associated in the interviews with effective action in bringing about change but it is not likely by itself to lead to effective performance. A person strong in this competency who lacked a desire to achieve results, for example, might be an effective and sophisticated commentator on events, without making much of a contribution to leading change. A person with this competency and a desire to achieve results might still be ineffective in particular situations, blocked by factors such as a lack of resources, by a lack of support, or by sudden changes in government policy: interviewees provided a number of examples of these blockages occurring. In these cases an ability to understand – or at least make some sense of – complex social systems appeared to enable the individual to draw some practical conclusions about what they could and could not influence, and to be philosophical when attempts to achieve change were derailed (eg UK02; UK04; UK12; UK17; UK22; AUS06).

The interviewees' understanding of the complex social systems in which they acted was supported and nurtured by their efforts to acquire information, and these information-seeking activities appeared to be such an integral part of the competency that they have been included as part of it. Information-seeking activities were obvious when a particular issue was being analysed, or progress was being monitored, but change agents also sought information as part of an ongoing sensing and inquiring into the system within which they worked. This often went beyond the activities that would normally be expected of any professional or manager of paying attention to the information presented to them, and included actively sharing and exchanging information on good practice with other organisations (eg UK01; UK08; UK13; UK16; UK17; UK18; UK20; UK21; UK23; UK24; AUS01; AUS05; AUS06) keeping abreast of

research and developments (eg UK09; UK14; UK15; UK27; AUS 05; AUS06; AUS07) and networking with professional or managerial colleagues elsewhere (eg UK04; UK09; UK13; UK17; UK30; AUS03; AUS05; AUS07). Executives described how they took steps to ensure that people lower down the hierarchy were able to communicate with them, and gave examples of useful information they received and acted on as a result of this (eg UK02; UK10; UK12; UK19; UK25; UK28; AUS03; AUS05) and medics spoke of how they relied on the network of nurses (among other sources) for information on how services were delivered (eg UK19; UK26). These activities required work on relationship-building to encourage useful communication. Executives and clinicians described how they spent time visiting, and in some cases working with, front line staff in order to gather useful information, develop relationships, and encourage communication (eg UK01; UK08; UK09; UK10; UK12; UK14; AUS07). Moving into a position of responsibility in a new organisation required extra effort to seek information and to develop relationships: for example, one chief executive said that he spent much time simply talking and listening to people in his new organisation to find out what people saw as the problems and opportunities: 'it took me six weeks, I suppose, to get around and talk to as many people as possible' (AUS 03; also evident in UK06; UK10).

This competency was closely linked with the competency of *Understanding the perspectives of others*. Indeed, these two clusters of behaviours might be regarded as a single competency, but on the basis of the information gathered and analysed from the interviews it appears most appropriate to cast them as two separate, although closely related, competencies. *Understanding the perspectives of others* is a competency that enables a person to interpret the viewpoints, interests and motives of other individuals and groups, which can then be taken into account in understanding complex social systems. Without the competency of *Understanding the perspectives of others*, an individual's ability to understand complex social systems is likely to be limited, possibly effective in analysing functional patterns of performance or behaviour, but reliant on received opinion on why others behave as they do, or using no more than crude stereotypes of the perspectives of others. Without the ability to understand complex social systems, an individual with the competency of *Understanding the perspectives of others* may be very effective in a limited sphere of experience, but would probably encounter difficulties in working outside of this.

The behaviours associated with this competency were:

- the individual considers a sophisticated range of influences, causes and effects in making sense of the systems within which they act
- this includes an understanding of the economic, psychological, political and professional influences on elements of the system
- this includes an understanding of how other individuals and groups within the system interact, or are likely to interact, with each other
- the individual is able to see alignments and connections, actual and potential, between different elements of the system
- the individual actively seeks information on the workings of the system from a number of sources, including working with front line staff and exchanging information with colleagues in other departments or organisations, and encourages people within their own organisation to communicate openly with them

Achieving results

A strong characteristic of all the interviewees was a desire to achieve results, to improve on aspects of the quality of the service they managed, and/or to contribute to improving the wider healthcare system. This desire was evident in value statements made by the interviewees, and also in their behaviour in acting to achieve results and improvements. This characteristic was the most immediately obvious competency of some interviewees, the characteristic that made a strong first impression on this interviewer – the desire to improve, to make better, to resolve problems in the service, to transform organisations and change ways of working, to build on previous achievements. Perhaps this emphasis is natural, given that the request made of the interviewees was to talk about times when they had brought about change – with such a request the themes of improvement and development are likely to follow. However, with other interviewees this theme of achieving results was not the first impression, it emerged as the interview progressed, and the initial themes of the interview were more often that of working with people – the basis of the competency of *Working collaboratively*, which follows - or *Understanding complex social systems*, as above. Over the course of each interview, however, the *Achieving results*

competency emerged in every case, whether in the form of working over time towards planned goals or of tackling challenges where there were no obvious routes to success, whether by quiet, practical persistence over time in the face of difficulty and opposition, or by using personal and role authority to ensure that others worked towards results.

In some examples, interviewees were faced by a pressing challenge that fell within their role's responsibilities – such as to make sure a failing service met the target set for it, or to close an organisation or a department, or to negotiate agreement over different ways of working (eg UK03; UK04; UK05; UK11; UK25; UK28). In other cases they had put themselves forward for new jobs, with new challenges – such as re-shaping or creating new organisations, or developing and piloting new systems (eg UK01; UK02; UK08; UK09; UK10; UK12; UK20; UK24; UK29; UK30; AUS01; AUS02; AUS03; AUS06; AUS07; AUS09) – or had taken on or volunteered for activities outside of their core job role, because of a desire to improve an aspect of the service (eg UK13; UK14; UK15; UK17; AUS03; AUS04; AUS05; AUS08; AUS10). A common aspect of this competency was that interviewees proactively put themselves forward, and took responsibility for leading change and development. As one interviewee said: 'So I said, well it needs doing, that's the essence of it, it needed doing and it needed somebody to drive it'; another said: 'this isn't the way forward, I'm not being effective...do I leave and try and find a different career, [or] do I stay but try to do things differently?'; and another reflected, on his volunteering to take on a national role: 'I think you've got to step up to the plate and put your hand up and do the work.' Depending on their sphere of activity and their authority, the issues they worked upon might be strategic or might be more operational. At whatever level, whether it fell within the role or was a voluntary extension of it, the activity often involved the change agent in extra work and effort, in their own time, sometimes late at night or very early in the morning: achieving results took energy and commitment.

Particularly interesting dimensions of this competency were a concern for sustainable, long term achievements, and a focus on patient welfare – maintaining and improving services for patients.

A concern for sustainability was evident in the longer term concerns, plans and visions expressed by interviewees (eg UK02; UK06; UK07; UK08; UK09; UK13; UK14; UK17; UK25; UK27; UK29; AUS01; AUS02; AUS05; AUS07; AUS08; AUS10) and also in the contrast, as some interviewees saw it, between sustainable work on building, or rebuilding, the organisation and its capabilities, and the short term pursuit of compliance with targets, or the achievement of 'quick wins'. Several UK interviewees, for example, contrasted the achievement of sustainable results (which was their aim) with the achievement of short-term government or management targets (eg UK04; UK09; UK10; UK25; UK26). This concern was evident not only in efforts that individuals undertook in order to achieve agreed service outcomes, but also in a desire to improve services and to bring about change. One interviewee reflected that:

It's trying to... explain [to managers] that they're looking at a department that in many ways has been malfunctioning over the years, is not particularly robust, and that we need to strengthen that up. And that the only way we can strengthen that up I think is to very gently tear it apart and rebuild it. And of course all the NHS targets are short-term, so the managers jump up and down [over short term pressures] no matter how much I talk to them

Persisting with attempts to bring about change over a long period was also a feature of some examples, as a number of interviewees described how they needed to sustain their efforts in the face of a lack of progress (eg UK07; UK09; UK13; UK15; UK17). This often involved taking a long-term view, and working over a period of time: as one interviewee said, '[it was] a long two year battle which has finally borne fruit' (UK11 also UK02; UK30); it took 6 years to change one clinical working practice (UK09 also UK05) three years to change another procedure (UK23) twelve months to change a protocol (AUS06) two years to change a recruitment process ('and I'm not entirely sure we're there yet' - AUS10) fifteen grant applications to get funding (UK15) and five years to develop a directorate (AUS01; also UK29). One clinician, talking about developing his department, repeatedly used the phrase: 'slowly by surely'. He took a long-term perspective: 'there are certain attitudes that will never change and only time will sort that out as people retire' – but he was quite positive and optimistic about this. He said: '...it's very difficult to get people to try and see the longer term view, but I'm holding fast at the moment.' And: 'I think I'm slowly winning, but it's like crawling up the beaches at Normandy. You know, slowly..slowly...slowly getting there'.

There was an explicit focus on patient welfare and benefit in almost every interview, as clinicians and managers sought to improve the quality of care for patients, to improve communications with them, to improve patient experience and to empower them. This theme appeared in almost every interview in some form or another (38 out of 40 interviewees spoke about services for patients). As noted in the previous chapter, this was one of the objectives for change agents in making decisions about change, but this concern was also pervasive in the different stages of the change process. In speaking of problems with services that they had sought to improve, several interviewees talked in strong, value-laden terms of ‘unacceptable’ levels of service or unacceptable behaviours of staff in relation to patients (UK02; UK04; UK09; UK10; UK12; UK28; UK29; AUS03); for these, and other interviewees, a main motive for seeking change was to improve patient care. With those interviewees who were neither clinicians nor responsible for clinical services, this focus on patients was naturally more muted, although some managers of support services spoke of how their staff played key roles in a patient-centred system. Those executives who were responsible for clinical services – including chief executives – strongly emphasised benefit to the patient as a guiding purpose of their organisation (eg UK02; UK04; UK05; UK06; UK07; UK09; UK10; UK12; UK25; UK30; AUS01; AUS03; AUS10). As one said: ‘Patients are what we do, patients are why we get out of bed in the morning...’ Some interviewees, however, were explicit about needing to balance patient benefit and financial constraints, or achieving value for money.

Interviewees described how, in order to achieve results, they established priorities and set goals, and sought to make progress in achieving them. These activities have largely been described in the sections on the stages of the change process – and are incorporated in the competencies *Analysing issues and making decisions about change*, and *Implementing change* - in the previous chapter. However, two aspects of this behaviour were not emphasised in that chapter: one was that in a number of cases individuals made efforts to make progress and achieve results in times of great doubt or uncertainty, where they were unsure whether things would work out, and they did not have a clear plan or map, or they were facing problems, and proceeding to tackle them, even though they did not know the answer, or even admitted they ‘hadn’t a clue about how we were going to do it’ (UK12; also UK08; UK10; UK20; UK21; UK23; UK28; UK29; AUS09). A second, related feature was a willingness to be

flexible, even opportunistic, moving forward with broad – rather than detailed – plans and being willing to change course if a better opportunity to achieve their aims presented itself (eg UK04; UK06; UK20; UK26; AUS10). These behaviours might be grouped under *Analysing issues and making decisions about change*, (as described in the previous chapter) or even included as aspects of *Self belief* (as described below). They seem strongly linked, however, to a determination to achieve results, even in unpromising circumstances. As one executive recalled, in describing a particularly difficult confrontation:

...everybody said to me, you'll get in it and you'll not come up with an answer, and I thought, I can't not come up with an answer, I've got to do something. And actually, George, I went into the meeting not knowing what the hell I was going to do, because neither did I know the organisation very well, so I didn't know the ins and outs of how [this type of organisation] worked, or the implications of some of the things you might do, but I knew I had to do something.

Another aspect of this competency was that the interviewees held people to account for achieving results. This included behaviours such as enforcing deadlines, tackling performance problems, insisting that people delivered on the goals they had agreed they would achieve, ensuring that others 'accept and follow their responsibilities', and even removing under-performers from their posts. These behaviours appeared closely linked to the desire to achieve results, and dissatisfaction when staff failed to perform as required, and therefore they are grouped as part of this competency, rather than in another area of the framework. The approach that interviewees took to holding others to account included the tough and potentially confrontational, signified by statements such as: 'We don't listen to excuses about failure to deliver standards' and 'You'll always get one or two [people]... who think they're bigger than the system, and we have to sort those people out' and '[I] use processes to weed [poor performers] out and get in new blood, using performance data.' Other examples that were described, however, included an explicit balance of concern for task achievement and concern for people; for example, one manager expressed concern for 'how people work with people as well as the fact that we've got to hit this target, that target'; and there were examples of managers tackling performance problems with some compassion for the skills, the understanding and self respect of the individuals involved, yet at the same time taking action to ensure that poor performance did not continue (UK01; UK02; UK11; UK12; UK22; UK28; AUS03).

A final set of behaviours that appears logically to link to this competency of achieving results concerns demonstrating a degree of pride in achievement. Generally interviewees were pleased with achievements in their area of concern, or with progress towards goals, or improved star ratings, or were pleased with recognition (for their staff if not themselves). Several were pleased at what they had achieved in comparison with other providers (eg UK16; UK18; UK21; UK27) and some were evidently proud to have been in advance of national targets, or the first in the country to have achieved certain outcomes, or to be one of a very few nationally to be delivering a particular process (eg UK07; UK09; UK15; UK23; AUS05; AUS09; AUS10). In almost every case, this pride was expressed in terms of what a collective 'we' had achieved, as an organisation or a department, and in many cases the pleasure or pride was tempered by statements of what still remained to be achieved (eg AUS05; UK19; UK23) and by expressions of modesty – for example concerning the simplicity of the ideas they had applied (eg UK07; UK10; UK18; UK21) or the degree of luck involved, and the fact that the changes they had achieved were incremental rather than transformational (eg UK26; AUS08).

Signs of this competency were:

- a concern to make progress, achieve worthwhile, sustainable results, often linked closely to a focus on the welfare of the patient
- this was associated with a willingness to take responsibility for achieving results
- this entails being prepared to take action to achieve results even in times of doubt, when the way ahead is unclear
- this includes holding people to account for results they are expected to achieve
- this was also associated with a certain balanced pride in achieving results, being the first, or among the first, or the best

Working collaboratively

Interviewees frequently spoke of working collaboratively with others. These collaborations included simply working with another individual, working in larger groups, committees and boards, and working in formally constituted partnerships.

Examples of these behaviours occurred so frequently it appeared that the ability to work in this way was an important competency of the interviewees. This competency was demonstrated in a variety of situations, sometimes following lines of responsibility, but often going where there were no formal, organisational lines. It appears to be a separate competency from the more specialised competency displayed by some executives of working interdependently with their immediate team – which is described below as *Orchestrating the team*. This competency of working collaboratively is closely related to the competency of *Understanding the perspectives of others*, which is described immediately below.

The simplest form of the *Working collaboratively* competency was demonstrated by interviewees regularly working with other people in order to make sense of issues, and to achieve results. This entailed much face-to-face informal communication. Examples included: a director seeking out a colleague to discuss how they might develop strategies for both of their directorates, and then setting up discussion groups of directorate staff to gather their opinions; a chief executive developing, in informal discussion with the organisation's chairman, the founding principles of their new organisation; a director creating a strategy to develop part of the organisation in ongoing discussions with union representatives; a chief executive networking with peers from other organisations to make sense of the likely direction of Department of Health policy; a senior executive developing and implementing a set of regional consultative events in partnership with a senior clinician and her small team; another executive seeking the collaboration and commitment of workforce representatives to shape regional strategies; two chief executives describing how they sought out individuals from other organisations for mutual support; a number of clinicians who described teamworking on specific projects; a manager who followed an idea for funding a change project that grew out of a discussion among colleagues (UK01; UK04; UK05; UK08; UK10; UK12; UK14; UK16; UK21; UK29; UK30; AUS05; AUS06; AUS07; AUS08). Some interviewees appeared to collaborate with a very wide range of colleagues (eg UK13; UK16; UK17; UK19; UK20; UK23; UK30; AUS07).

As well as working alongside others in collaborative discussions, interviewees described seeking input, information and involvement of others in order to make decisions (eg UK01; UK02; UK12; UK20; UK25; UK30; AUS10). Some interviewees

described how they worked to bring individuals and groups together and encouraged them to take collective approaches to tackling complex problems (eg UK04; UK05; UK08; UK09; UK11; UK12; UK23; UK25; AUS05; AUS07). These specific aspects of the competency are closely linked to the activity of bringing people together to analyse issues and make decisions, as described in the previous chapter. As preparation for fruitful collaborative work, interviewees described how they invested time and effort into developing relationships with individuals and representatives of interest groups (eg UK05; UK06; UK08; UK25; AUS05). In some cases achieving collaborative relationships with different groups was almost an aim in itself, or at least an essential enabler or precondition for service change (eg UK13; UK26; AUS05; AUS06; AUS08; AUS09). More than one UK respondent emphasised that good, trusting relationships could only be developed over time: 'you don't get that [ie openness, good communication and trust] in 6 months, it takes years' (UK08; also UK07; UK10; UK13). Others illustrated this in their account of attempts to bring about change that were first met with resistance and only later with better communication and acceptance (eg UK26; AUS06; AUS08).

Collaborative working is not always without its drawbacks, and some interviewees talked of how they had needed to accept a range of interests and wishes from different people, that they needed to be flexible to work with different people, and how they had needed to accept that the pace of action would be slower, and some give and take would be necessary (eg UK01; UK08; UK12; UK17; UK27; AUS05) and some were explicit about the trade-off decisions to be made between involving others in wide consultation, or in large project groups, and making swift progress (eg UK07; UK12; UK18; AUS08). Whilst the broad notion of trade-offs and working with a range of views and interests can be placed in this competency of *Working collaboratively*, some of the specific behaviours used by interviewees to resolve differences of perspective and opinion – communication, persuasion, seeking consensus, negotiating etc - have already been described in the competency of *Winning support and overcoming opposition*. Another feature of this activity of working collaboratively was that some interviewees appeared to have a fine sense of the different roles that members of a partnership should play, and were conscious of leaving space and opportunity for colleagues to take action, so that they would be involved and committed to the project (eg UK05; UK08; UK12; UK25; UK30; AUS05). Issues of

ensuring clear communication were raised by some interviewees, who described how they took specific actions to ensure that there was good communication between disparate members of collaborative groups, such as by facilitating meetings in a way that encouraged junior and less assertive members of the group to participate or by arranging structured activities to help group members to share experiences and overcome differences in perceptions brought about by different experiences or professional backgrounds (eg UK01; UK08; UK17; UK22; UK23; UK30).

This competency, as with all the competencies, was demonstrated to different degrees by different interviewees. This may have reflected the different extent to which each individual possessed this competency, or may have been a function of the particular examples of change they chose to discuss - or may have been affected by a combination of these two factors. Some of the examples of change, and indeed some of the jobs of the interviewees, appeared to require careful and sustained collaborative work if they were to have any chance of success: many examples were characterised by shared or collective responsibilities, such that it was natural for decisions and actions to be undertaken by groups, and for ideas about how to solve problems to arise from discussions. Many of the examples, however, included collaborative discussions that were not necessitated by a requirement, legal or practical, to consult or involve others, but which were undertaken willingly, naturally, by the individual interviewee for the practical (sometimes psychological) benefit they could bring. Such relationships were not always uncomplicated. As one interviewee said, recalling how she had worked with her chief executive during a time of great stress and conflict: 'we were busy shouting at each other and holding each other's hands at one and the same time'.

A key collaboration in many of the examples was between managers and clinicians – there were numerous examples of interviewees tackling the business of communicating across the cultural divide between the tribes of clinicians (particularly medics) and managers, sometimes with success, sometimes without it. There was an emphasis, particularly from managers (but also from some clinicians), on acquiring the ability to relate to the other tribe in their own language, and some interviewees expressed frustration and described difficulties they had encountered in trying to work with the other tribe(s). This was a feature of interviews with some of the UK and

Australian executives, but it was also present in some of the interviews with UK (and to a lesser extent Australian) clinicians with management/ leadership responsibility.

Signs of this competency were that:

- the individual works effectively in partnerships with others in order to make sense of events and to achieve results, including working with other individuals, and also working in larger groups, committees and boards, and formally constituted partnerships
- this requires some flexibility and give-and-take to be able to work with different people with different priorities
- this may include investing time and effort in developing good relationships with others
- this may include bringing individuals and groups together and encouraging and helping them to take collective approaches to addressing complex issues
- in health service organisations, this competency includes working effectively with individuals and groups from different professions - in particular, executives and other managers being able to work collaboratively with clinicians, and clinicians being able to work effectively with executives and other managers

Understanding the perspectives and motives of others

There were many examples of interviewees demonstrating an understanding of the individuals and groups with whom they interacted. This included them apparently being able to see situations as though from the viewpoint of another person; in some cases this was accompanied by an evident sensitivity to the actual or likely feelings of others. This was a key component of being successful in working collaboratively with others, and there is an argument for clustering all these behaviours into that competency – but this ability to relate to the perspectives of others was also a key component in a range of the behaviours grouped together under the heading of *Winning support and overcoming opposition*, and so it is treated here as a separate competency, one that is closely linked to these other two.

A certain degree of the ability to understand the perspectives and motives of others is the basis of working with other people, and it is arguable that anyone completely deficient in this area would have difficulty managing even simple daily transactions. In this respect this competency is commonplace. Interesting demonstrations of the competency in relation to leading change concerned interviewees understanding what groups wanted from particular situations (eg UK19 – ‘the staff there had really been looking for people to be involved and enthusiastic’); being able to relate to the anxieties and stresses of others in particular situations (eg UK01; UK11; UK12; UK22; UK23; UK24); being sensitive to what others were and were not ready to hear – which led the interviewee to make decisions about when (and when not) to raise particular issues (eg UK02; UK07; AUS05); being sensitive to the perceived pressures (both cultural and organisational) on others – and therefore what it was ‘fair’ to expect others to do (eg UK05; UK08; UK17; UK22; UK30; AUS05); understanding the different perspectives of others in a conflict situation (eg UK13; UK19; UK28; AUS05); being appreciative of positive emotions of others, such as the pride that others could take in being recognised – which could lead the interviewee to take steps to provide that recognition, or seek that recognition for others (eg UK10; UK11; UK14; UK22; UK23; AUS05).

There were examples where the ability to understand the perspectives of different groups and individuals enabled the change agent to address them in different ways, directing effort and/or tailoring communication to those different interests and values (eg UK07; UK25; UK27; UK28; AUS02). Understanding the different perspectives of others was in some cases a key to reframing an issue or problem, and seeing it in a different way (eg UK01; UK11; UK28; AUS02; AUS07). As one interviewee said, linking this competency to winning support:

you’ve got to empathise with the individuals you’re trying to get to change Think like they think, work out what it’s all about and then... either you alter your views somewhat, because you realise there’s point here, you need to alter your initial position, or you marshal your arguments to effectively oppose what they’re putting in your path, and you win the argument and away you go. And either way you get an implementable change.

The strength of the competency in each example could also be gauged by the extent to which interviewees were able to understand and accept - accept in the sense of acknowledge and seek to work with - perspectives on an issue that differed

significantly from their own, even where the other parties were hostile (eg UK08; UK13; UK14; UK23; UK26).

Some interviewees spoke at length about the efforts they had taken to discover the perspectives of others; at times this appeared to be an essential part of agreeing on the nature of an issue and what should be done about it (eg UK01; UK08; UK12; UK13; UK19; UK26; UK30; AUS03; AUS10) in other cases this activity was evidently interesting and satisfying in itself (eg UK02; UK08). At times it seemed that this exploration was an obvious step to take, perhaps even a requirement before a decision could realistically be taken, in other cases the activity was initiated by the change agent as a matter of choice, part of a preferred way of working, perhaps an indication of the strength of the competency in the individual (eg UK02; UK08; UK14; AUS05; AUS07). Several interviewees were explicit in their belief that gaining this understanding was a mutual, two-way process - one executive even described the 'key turning point' in a project as being when the different parties realised each other's point of view and reached a 'mutual understanding' (AUS07 also UK07; UK08; UK13; UK28). Another said enthusiastically that through partnerships 'you get fabulous insights into what makes the other side tick and they get insights into what makes you tick'.

Demonstrations of this competency ranged from those framed in rational and pragmatic language, to those where there appeared to be a strong element of emotional resonance and even compassion. At the pragmatic and rational end of the scale, interviewees talked of the importance of understanding 'what makes others tick' – the 'need to work out what was important to them' - and 'what levers to pull', 'what might be the leys for them' (UK04; UK01; UK07; UK08; UK28; AUS01) while at the other end of the scale there was compassion for other people who were anxious or in distress (UK10; UK22; UK01). Some interviewees gave examples from both ends of the scale.

Signs of this competency were that:

- the individual is able to interpret and relate to the perspectives and motives of others

- the strength of the competency is indicated by the extent to which the individual is able to do this when the perspectives and motives of others are very different from his/her own, or when the others are in conflict with the individual
- the individual takes time and make efforts to gather information to enable them to understand the viewpoints and interests of others
- the individual is able to take this understanding into account in deciding how to behave, proactively or responsively, towards others

Orchestrating and developing the team

When interviewees described changes they had brought about, it was sometimes apparent that they had taken direct action in parts of the change process, but other parts they had delegated to members of their immediate team. Particularly among the executives, it was evident that they frequently achieved the end results of the change by taking action in concert with members of their immediate team, undertaking some aspects of the task personally, and expecting other members of the team to lead on other aspects of the change. This appeared to be a special strand of *Working collaboratively* – a strand where the interviewee had authority over the other team members and was able, to some extent, to orchestrate and guide their action, but in another sense was quite dependent on their team members to carry out their roles. Whereas *Working collaboratively* could be described as being a team player, this competency concerns being a team leader. The interviewee was also responsible for developing the team – including in most cases recruiting people to it, taking action to encourage members to work together as a team, and helping individual members to develop their knowledge and skills.

When the activity of working with and through a team of direct reports was evident in an interview, I asked direct questions and gathered more information about how the interviewee worked with their team. Some senior executives spoke of how they saw one part of their role being to ‘enthuse’ their team or to ‘act as a role model’ (UK09; UK12). Several interviewees saw a key part of their role as being a team facilitator or, as one said, an ‘orchestrator’; another interviewee said that her perception of doing her job was ‘trying to support my team in doing work’; another’s main lesson for

successful change was 'have a good team'; yet another, when asked 'what else has helped you to do what you do, the way you do it?' replied, 'Just having, you know, some good people around me that I can talk to' (UK02; UK11; UK26; AUS06; AUS07).

Interesting aspects of how interviewees worked with their team members included the ways in which they coordinated and alternated their own personal actions with those of their team members – taking a lead personally, for example, because of the difficulty of a particular task (such as leading a difficult meeting or taking an especially tough decision) or because of the symbolic need for the senior manager to be present at a certain meeting or a specific point in the change process, and at other times giving the lead to a member of their team and following the action at one remove (eg UK01; UK02; UK04; UK11; UK12; UK28; AUS05; AUS07). Sheer pressure of work on the senior executives evidently required them to operate in this way (UK25; UK28; AUS05). In addition, some interviewees were explicit in discussing their own preferences for some aspects of their role, and their own limitations, and how they worked with their team to manage and compensate for these (eg UK05; UK08; UK12; UK30; AUS09; AUS10). Good one-to-one communication was emphasised by some interviewees, and they spoke of how they sought to achieve this between themselves and individual team members, so that each was clear about what was expected (eg UK09; UK11; AUS05). Several interviewees spoke of how they sought to involve their team in developing strategies and devising ways of tackling problems (eg UK01; UK02; UK04; UK06; UK08; UK28; AUS05; AUS07).

In terms of developing their team, interviewees described how they established systems of meetings to enable good team communications, including arranging team development activities (eg UK04; UK05; UK06; UK08; UK09; UK17; UK19; UK26; UK28; UK29; AUS05; AUS07). For individual team members, development activities included providing individual coaching/mentoring support, training and help in career management (eg UK01; UK02; UK11; UK12; UK21; UK22; UK23; UK25; UK26; UK30). Recruitment to the team was mentioned in some cases, particularly where the interviewee was describing building a new organisation, or part of one: in rare cases, interviewees also spoke of how they took action to move people out of their team because of what they considered to be under-performance.

This competency was mainly seen in the actions described by executive interviewees. Some clinicians spoke of working well with members of their team – such as their business manager, or a nurse manager – but did not give examples of the interplay and interdependency of roles exemplified by the executives. This competency was not obvious in all executives, however – some appeared more inclined to this collaborative interplay while some appeared more individualistic. This may be simply because they had no team they could work with, or their examples happened not to involve team working, rather than a sign of a personal preference or capability. The interviews did not routinely check this aspect of how each individual worked, so it is not possible to say that a person did not possess or use this competency, simply that they did not volunteer information that showed this competency in action. Those who demonstrated this competency strongly in the information they provided were those who had also shown strong signs of the *Working collaboratively* competency.

Signs of this competency were that the individual:

- works in close and effective partnership with his/her staff, delegating some aspects of the task to staff members and tackling other aspects personally, based on a balanced assessment of task requirement, capability and development
- takes action to develop and support the team and individual team members in appropriate ways, through formal and informal activities

Establishing and developing systems and structures

All the interviewees worked within organisations with structures and systems, and the majority exercised some responsibility for making changes to these structures and systems. Among the executives, several described how they had developed new organisations, or had made significant changes to failing organisations, achievements that entailed establishing the necessary architecture of structures and systems – creating new allocations of responsibility and authority, new posts, new committees and boards, and new systems for sharing information, for coordinating activities and for making decisions (UK02; UK04; UK05; UK09; UK10; UK12; UK20; UK22; UK25; UK30; AUS03; AUS05; AUS06). Some interviewees talked about change the culture

of their organisations, but the most tangible signs of how they achieved this were changes to systems and structures (eg UK04; UK06; UK09; UK10; UK11; AUS03; AUS06).

In many of the change projects they discussed, interviewees described how they established systems and structures to bring people together for consultation on the change, or to make joint decisions about it (UK02; UK04; UK12; AUS07; AUS10) and how they established project groups to implement changes, which included in some cases deciding which groups would be needed and who should be involved in them (UK08; UK12; UK13; UK15; UK16; UK17; UK22; UK23; UK28; AUS05; AUS06; AUS07). Interviewees also described making changes to structures and systems in order to empower and engage staff in their organisations (UK02; UK06; UK10; UK11; UK13; UK17; UK25; UK29; AUS03; AUS05) and to improve accountability (UK10; UK11; UK22; UK26; UK28; AUS03; AUS07; AUS10). They described systems they established for training and developing staff (UK10; UK12; UK21; AUS03; AUS06) for monitoring and evaluating (UK23; AUS05; AUS06) for improved communication (UK02; UK12; UK23; UK25; UK26; UK30; AUS07; AUS10) for providing resources (UK14) for improving collaborative working across organisations (UK02; UK07; UK25) and for providing rewards and incentives (UK07; UK08; UK28; AUS02; AUS03; AUS07). Executive interviewees described how they established systems for decision-making and prioritising, where they sought to reach effective decisions and to demonstrate fairness and 'due process' (eg UK02; UK04; UK07; UK11; UK12; UK22; also UK17). Clinical interviewees frequently described how they made changes to systems by writing new protocols (UK14; UK16; UK18; UK23; UK27; UK29; AUS04; AUS06; AUS08; also UK28). As noted in the previous chapter, process mapping was frequently used to analyse how activities were carried out and how they could be improved, and a common outcome of a change project was that new working methods and processes were adopted, which often included changes in responsibilities and changes in systems: the change agents acted – either singly or collaboratively – to create these new pieces of architecture and their accompanying mechanisms (eg UK02; UK08; UK10; UK14; UK16; UK18; UK19; UK21; UK23; UK24; UK25; UK28; UK29; AUS05; AUS06; AUS08; AUS10).

Signs of this competency were that the individual:

- creates systems, and structures responsibilities effectively, in order to bring people together to share information and jointly decide on solutions to problems
- creates new systems and structures in order to enable and motivate people to undertake work more effectively/efficiently

Self belief and self management

The competencies I have described so far have been expressed in terms of how individuals relate to the world outside themselves, how they seek to make sense of events, systems and structures, and other people, how they endeavour to tackle issues and problems, how they attempt to cooperate with, persuade or convince other people, how they work to develop their team and to organise responsibilities and resources. There are good reasons for this outward focus: in an examination of how people lead change in organisations, I am naturally most interested in the actions they have undertaken and their interactions with other people; the interview methodology I followed is designed to encourage interviewees to talk about what they did on particular occasions (rather than, say, about their underlying values, or how they each coped with particular pressures or anxieties – alternative methodologies that would have provided more information about the internal aspects of the interviewee) and, on the whole, interviewees fell in with this methodology. However, when all the material that had been gleaned from the interviews had been analysed and organised and coded in what appeared to be reasonable, logical and useful ways there remained clusters of behaviours that concerned aspects of what could best be described as self belief or self confidence and self management or self development.

Situations that involved standing up to opposition, as described in the previous chapter, required self confidence and resilience. As one interviewee said: 'you had to be prepared to get assaulted on the way out of the presentation [of my proposals for change] to some degree'. Another said: 'you know my whole forehead's flat now from the repeated banging on the wall but I've finally penetrated this denial or resistance or whatever it is...'. Yet another talked said that they needed to 'tough... it out'; other comments included 'you need resilience big time'; 'it was sheer determination'; 'your backbone needs to be steel' (UK08; UK09; UK12; UK15; UK18; AUS10).

Circumstances where the way ahead was unclear, or progress was very difficult to achieve, required a degree of self belief in order for the change agent to continue with their efforts. Success required 'tenaciousness' – as one interviewee described it, or as another reflected: 'Persistence.... if I gave up easily we would never have had it [the funding].' Where the individual's assessment of the right course of action, after studying and making some sense of a complex set of circumstances, was disputed by others, conviction and self confidence were needed in order to make the case. This conviction was not always achieved without self-examination and doubt. For example, one clinician described how, over a period of time, under pressure from different stakeholders, she reviewed her assessment, making a detailed analysis of complex social, professional and technical factors affecting an area of clinical practice that was disputed between two professional areas, and decided how to proceed forward. Several other interviewees also shared occasions when they were nervous, or unsure how to proceed, and yet somehow gathered the confidence to make their case, or to continue with their course of action (eg UK01; UK03; UK13; UK14; AUS03; AUS07). The positive approach was expressed most clearly by one CEO who said:

you need to start every endeavour with an attitude that you are going to be successful [and] that the people you are working with are all going to give their best to try and succeed so long as they know and understand what's expected of them and they're given their say about how best things can be done

Many change agents indicated that their self confidence in tackling difficult situations was helped by a belief in a set of core values, which guided them in deciding what they should do and how they should behave. Information about values was not routinely sought in the interviews, but it was freely offered by a number of interviewees. An important value was to provide good services, and to improve services, for patients (as noted above, under *Achieving results*) but other values expressed by interviewees concerned treating people fairly and acting with integrity (eg UK01; UK02; UK03; UK05; UK08; UK10; UK12; AUS07). One executive emphasised the need to be genuine in working with others ('you can't act out the role'), while another, new in post, made a statement to his staff about 'who I was...as the person who was leading and managing the organisation and what were the things that were important to me'.

A further set of intrapersonal behaviours concerned aspects of learning and self development. Some aspects of learning are included in the competencies that have already been described, such as gathering information in order to analyse an issue – which sometimes led to interviewees improving their detailed understanding of an issue – gathering and processing information in order to come to an understanding of complex social systems, learning about how others perceived events and issues: as with self belief, personal learning was evident in the other behaviours that could be said to be primarily outwardly directed, but there were also other behaviours that indicated a concern for learning, and for self development, that included and then went beyond this. Some interviewees spoke enthusiastically of how they took part in structured activities for learning and self development (eg UK01; UK04; UK08; UK09; UK10; UK12; UK15; UK17; UK21; UK30; AUS03); others spoke of their experiences at times in terms of ‘lessons learnt’ or ‘what they learned over time’ (eg UK01; UK02; UK03; UK05; UK15; UK26; AUS08; AUS07; AUS09). Learning and development was sometimes related to career planning, but often not - interviewees varied – some spoke of having longer term career plans, others did not appear to do so, some explicitly denied having them.

Signs of this competency were that the individual:

- demonstrates self confidence and resilience
- acts on their values and principles, and aims to act with integrity
- undertakes learning and self development to enhance their knowledge, understanding, and abilities

Patterns of competency use

A reasonably common pattern for a change project was that the change agent became aware of a problem or opportunity through their *Understanding complex social systems* competency and/or their *Monitoring* competency, together with their concern for *Achieving results*. They then either took action personally to *Analyse the issue and make decisions about change*, or engaged in *Collaborative working* and perhaps *Establishing systems and structures* to bring a group of stakeholders together to analyse and decide (the decision about which stakeholders to involve would be informed by the change agent’s ability to *Understand complex social*

systems). Any difficulties in reaching an agreed decision about what to do about the problem or opportunity might be minimised by the use of *Understanding the perspectives and motivations of others*, and the use of relevant behaviours from the competency of *Winning support and overcoming opposition*. Once the decision has been reached, the competencies of *Implementing change*, *Achieving results*, *Establishing structures and systems* come into (further) play – perhaps with further use of *Collaborative working* and *Winning support and overcoming opposition*. Some executives may need some *Orchestrating the team* behaviours at the analysis and at the implementation stages – they are very likely to employ this at the *Monitoring* stage. The *Achieving results* competency continues to apply during monitoring, providing the motivation and effort to tackle any problems or take advantage of opportunities; *Understanding complex social systems* is also used to make sense of unexpected outcomes, or changes in factors that influence performance, and *Understanding the perspectives and motives of others* is used to interpret reactions at different stages of the change. The change agent is helped to face up to any opposition, doubts and challenges that arise by their own *Self belief and self management*.

Comparisons and limitations

Different individuals displayed these competencies and behaviours to different degrees in the accounts they provided in the interviews. This may be because a) individuals possessed the competencies in different strengths and/or b) different competencies are more relevant in certain situations. The individuals weren't deliberately assessed during the interviews against each of the competencies, so in most cases it was not possible to say with any certainty that interviewee A was not strong in competency X – simply that in the course of the interview, A showed little strength in competency X. In a small number of examples, it is possible to make a case that, say, interviewee B displayed weaknesses in competency Y – because the situation(s) described in the interview provided opportunities to use competency Y, but there was little sign of the competency being used. With these qualifications, it is possible to say, for example, that some interviewees appeared more individualistic, and some appeared more inclined to working collaboratively, some interviewees appeared more empathetic in *Understanding the perspectives and motives of others*,

while some seemed more emotionally distant, some demonstrated an extremely sophisticated use of *Understanding complex social systems*, while others displayed this only to a lesser degree.

Groups of interviewees could be compared with each other according to three different ways of categorising them: by job role, by gender and by country.

Twenty-four of the interviewees were executives or other managers – there were 12 chief executives, eight other executives at director level, and four managers at other levels. Sixteen of the interviewees were clinicians: ten of these were clinical directors, and one was an assistant clinical director, who had some responsibilities for managing their directorates, while five were consultants or other clinicians. There are overlaps of background in these categories: seven of the executives had clinical backgrounds, while 11 of the clinicians had some management responsibilities. The executives overall displayed greater strengths in *Understanding complex social systems* – although those clinicians who talked about change projects that cut across organisational boundaries (six of the sixteen) also displayed this competency to a high degree. Two clinicians, who were effective in bringing about change in their own sphere of responsibility, showed quite limited proficiency in this competency, and this appeared to restrict their ability to bring about change in a wider context. One clinical director reflected that when he was first appointed to the role he behaved rather like a 'bull in a china shop' and that he had since learned to act with more diplomacy (indicating a better understanding of the interactions within his directorate, his organisation, and the complexities of his local healthcare system).

In these groupings, the executives overall displayed more use, and more complex use, of the competency *Orchestrating the team*. This may simply have been that they faced more complex challenges, and more demands on their time, and therefore needed to work with their team in the interactive, complementary way indicated in this competency. Some clinical directors talked about how they worked well with their business manager and their nurse manager (and their project manager in some cases) but the team was smaller, and the complexity of interaction was of a lesser degree. Three of the four non-executive managers were also, evidently, working with smaller teams than the executives (the fourth was in a similar situation to the

executives, and described complex team working). A minority of executives and chief executives (three of 20) demonstrated in their examples of change a more individualistic, rather than a team-orientated, approach, although this may have been a function of the particular examples they chose.

Nineteen of the interviewees were female and 21 were male. There were no clear differences in the competencies on gender lines. Some commentators argue that women are more capable of being able to empathise and to work collaboratively, while men are more able to analyse systems and more inclined to use directive leadership styles (Alimo-Metcalfe and Alban-Metcalfe 2005; Eagly and Carli 2003; Baron-Cohen 2003; Appelbaum et al 2003) but in this research male interviewees displayed these 'typical' female skills, while female interviewees displayed these 'typical' male skills. Without a larger sample and/or a more intensive focus on this issue in the data-gathering and analysis it is not possible to distinguish any meaningful differences. (Similarly, the research on the NHS Leadership Qualities Framework found 'no evidence that there is a gender difference in leadership qualities demonstrated at Chief Executive levels' – Modernisation Agency 2003: 2.)

Thirty interviewees were working within the NHS in the UK, while ten were working within the Australian healthcare system. There were some differences between the two groups: these were largely more contextual than in terms of any of the competencies described in this chapter or the previous one. The NHS was subject at the time of the interviews to an ongoing target-driven campaign to improve performance, led by central government, and many of the accounts of interviewees described how they aimed to achieve, or had to work within the context of, these targets. The Australians, on the whole, volunteered more understanding of other healthcare systems, including the NHS, than the UK interviewees, but this may be because a) their system is smaller than the NHS and b) they volunteered this information because they were being interviewed by someone from the UK. In Chapter 3, I argued on the basis of published literature that the two healthcare systems were very similar. One of the Australian interviewees said:

you could actually put your legs under the table...in Queensland or Victoria or New South Wales and put your legs under the table in the NHS [and you'd find] the same problems, the numbers are bigger [in the NHS] but it's exactly the same.

Certainly with these interviewees there were no identifiable differences in terms of competencies.

Summary

This chapter has set out the other seven pervasive competencies that, together with *Winning support and overcoming opposition*, were demonstrated by interviewees at several different stages of the change process. It has explained the behavioural components of these competencies and, where relevant, explained the reasoning behind grouping behaviours into one competency rather than another. These competencies, together with those already described in Chapter 6, make up the whole framework that I have developed on the basis of the interview material.

The next chapter discusses the competencies in the context of literature on leadership competencies – including comparing this framework with other competency frameworks – and the detail of the literature on leadership and change. From the discussion of the competencies so far, however, it can be seen that a sophisticated contextual understanding has taken a more prominent position than it does in mainstream writings about leadership (although this ability is emphasised in the literature on leading change), that collaborative, collective leadership was important to the change agents, and that the issues of task-focused and people-focused leadership were significant in the actions of the interviewees.

8. The competencies in context

This chapter discusses the eleven competencies derived from the interviews in the context of other relevant frameworks and literature on leading change. The competency framework is first of all compared with the two frameworks recently developed for use in the UK health service, the Leadership Qualities Framework and the Alimo-Metcalfe/Alban-Metcalfe framework, which were described and compared in Chapter 4. The competencies in the framework are then compared with those in seven other frameworks, and with competencies in the extensive dictionary of competencies from Spencer and Spencer (1995), and each competency is discussed briefly in relation to relevant literature.

The chapter then discusses how the change agents used combinations of the competencies, with reference to different perspectives on leadership, and in relation to particular aspects of the change agent's environment. These perspectives and environmental aspects are:

- collaborative and persuasive leadership
- transactional and transformational leadership
- task- and person-centred leadership
- management and leadership
- the complexity of the environment
- the healthcare, clinical nature of the environment

The competency framework

The overall competency framework that was described in Chapters 6 and 7 is, to the best of my knowledge, unique in its structure and in the particular combination of competencies it comprises, although for most of the competencies it contains there are comparable individual competencies elsewhere, in one framework or another. With 11 competencies, it is smaller than the Alimo-Metcalfe/Alban-Metcalfe framework of 14 dimensions, or the Leadership Qualities Framework (LQF) of 15 qualities, or the Leadership Capability Framework of the Australian Public Service Commission (APSC 1998) with its 20 capabilities – but then, unlike these other three frameworks, it is concerned just with the activities of leading change, not the whole

business of leadership. The framework is also smaller than the list of 15 change agent competencies proposed by Buchanan and Boddy (1992). The shape of the framework is, to the best of my knowledge original, with three competencies concerned specifically with particular stages of the change process, supported by eight other competencies that are common, or pervasive, in that they may appear in several of these stages. The shape of the framework could easily be restructured, however, into a more conventional list (as in Table 8.1, below).

A comparison between this framework and that of Alimo-Metcalfe/Alban-Metcalfe and the Leadership Qualities Framework is set out in Table 8.1. As was the case when these other two frameworks were compared in Table 4.1, above, this comparison involves certain judgements and interpretations. Table 8.1 sets out where a competency from this proposed framework is the same as a dimension/quality from the other frameworks, or where there is a partial overlap – such as where the competency covers part of a dimension/quality and vice versa.

As with the previous comparison, in Table 4.1, there are partial fits between the frameworks, but few direct full-fitting comparators. The competencies of *Monitoring* and *Establishing systems and structures* are barely represented in the other two frameworks. *Understanding complex social systems* is touched upon in the other two frameworks, but is not emphasised (the LQF quality of *Political Astuteness* comes closest to an equivalent, but that, as the title suggest, highlights an understanding of the political environment, which is only one element of the competency of *Understanding complex social systems*). From the other two frameworks the qualities of *Seizing the future* and *Self awareness* are not well matched by competencies, nor are the dimensions of *Inspiring others*, *Building shared vision* or *Supporting a developmental culture*.

A comparison with Buchanan and Boddy's (1992) change agent competencies also produces a series of overlaps, and the APSC Leadership Capability Framework (1998) also has some equivalents or partial equivalents, particularly in relation to the conceptual capabilities/competencies, cooperation and teamwork, resilience and negotiation.

Table 8.1 Three frameworks		
Leading change competency framework	Alimo-Metcalfe/Alban-Metcalfe (2005)	LQF (2002)
This competency...	is comparable to this dimension or <i>(part of this dimension)</i>	and this quality or <i>(part of this quality)</i>
Analysing the issues and making decisions about change	Resolving complex problems <i>(Encouraging change)</i> <i>(Being decisive)</i>	<i>(Intellectual flexibility)</i>
Implementing change	<i>(Focusing team effort)</i> <i>(Showing genuine concern)</i>	<i>(Holding to account)</i>
Monitoring		<i>(Broad scanning)</i>
Winning support and overcoming opposition	<i>(Networking and achieving)</i>	<i>(Leading change)</i> <i>(Strategic influencing)</i>
Understanding complex social systems	<i>(Being accessible)</i> <i>(Facilitating change sensitively)</i>	<i>(Broad scanning)</i> <i>(Intellectual flexibility)</i> <i>(Political astuteness)</i>
Achieving results	Encourages change <i>(Being decisive)</i> <i>(Networking and achieving)</i>	<i>(Drive for improvement)</i> <i>(Drive for results)</i> <i>(Holding to account)</i>
Understanding the perspectives and motives of others	<i>(Networking and achieving)</i> <i>(Showing genuine concern)</i>	Collaborative working
Collaborative working	<i>(Acting with integrity)</i> <i>(Being accessible)</i>	Collaborative working <i>(Leading change)</i> <i>(Strategic influencing)</i>
Establishing structures and systems		<i>(Holding to account)</i>
Orchestrating the team	Enabling Focusing team effort <i>(Showing genuine concern)</i>	<i>(Leading change)</i> <i>(Empowering others)</i>
Self belief	<i>(Acting with integrity)</i> <i>(Being honest and consistent)</i> <i>(Being decisive)</i>	Self belief <i>(Self management)</i> <i>(Personal integrity)</i>

The competency framework suggested by this research, therefore, has its elements of difference from two recent accounts of the abilities of leaders in the UK healthcare system, from one framework of capabilities of senior executives in Australian public service, and from an older framework of competencies of change agents. The need to win support for change is unsurprisingly present in each of the frameworks, as is the concern for achieving results (the latter is more strongly emphasised in the LQF and in the APSC frameworks than by Alimo-Metcalfe/Alban-Metcalfe or Buchanan and Boddy). The importance accorded by interviewees to abilities and concerns that could be described as managerial or organisational – represented by the competencies of *Implementing change, Monitoring and Establishing structures and systems* – is unusual. For a broader comparison, Table 8.2 logs individual competencies against competencies from the following sources:

- Buchanan and Boddy's (1992) change agent competencies
- APSC Leadership Capability Framework (1998)
- Klemm and McClelland's (1986) senior executive competencies
- Spencer and Spencer's (1993) dictionary of competencies
- Harvey and Butcher's (1999) meta-competencies
- Goleman, Boyatzis and McKee's (2002) emotional intelligence competencies
- A framework of competencies for senior managers, published by the Management Charter Initiative (1993) and developed by a research team I led at the Northern Regional Management Centre
- Porter-O'Grady and Krueger Wilson's (1995) competencies for the 'reinvented leader' in healthcare organisations

Note that no attempt is made in the table in Table 8.2 to indicate, with italics or parentheses, the degree of fit of the comparator competencies.

These frameworks have been chosen for relevance or likely fit. Note that Klemm and McClelland, Spencer and Spencer, and Goleman, Boyatzis and McKee have (or had) affiliations with McBer, or Hay-McBer, or the Hay Group (who developed the LQF) and therefore these frameworks may have an affinity with one another. Note also that the comparison in Table 8.2 is not exhaustive, but is based on identifying individual competencies from these frameworks with some similarity with the competencies developed from the interviews in this research: a comparison of framework to framework would also note the competencies/ capabilities in other frameworks that have no similarity with competencies identified by this research.

Table 8.2	Comparable competencies
Leading change competency framework	<i>Overlapping capabilities/competencies/meta-competencies</i>
Analysing the issues and making decisions about change	Diagnostic information seeking - K&M Information seeking – S&S Managerial knowledge, Cognitive skills – H&B Analytical thinking, Conceptual thinking – S&S Judgement - NRMC
Implementing change	Planning/causal thinking – K&M Clarity – B&B Stimulating Motivation and Commitment – B&B Communication Skills – B&B Directiveness – S&S Inspires a sense of purpose and direction – APSC Steers and implements change and deals with uncertainty - APSC
Monitoring	Concern for order, quality and accuracy – S&S Ensures closure and delivers on intended results - APSC
Winning support and overcoming opposition	Directive influence, Collaborative influence, Symbolic influence - K&M Networking – B&B Selling, Negotiating and Influencing skills – B&B Nurtures internal and external relationships – APSC Negotiates persuasively – APSC Impact and influence, Relationship building – S&S Influencing Others – NRMC Change catalyst, Influence - GBM
Understanding complex social systems	Conceptualisation/synthetic thinking – K&M Sensitivity, Political Awareness, Helicopter Perspective - B&B Harnesses information and opportunities – APSC Shows judgement, intelligence and common sense – APSC Information seeking, Organizational awareness, Analytical thinking – S&S Managerial knowledge, Cognitive skills – H&B Systems thinking, Pattern recognition, Synthesis – POGKW Strategic Thinking, Judgement, Information search – NRMC Organizational awareness - GBM
Achieving results	Commits to action – APSC Achievement orientation, Initiative, Directiveness – S&S Achievement focus – NRMC
Understanding the perspectives of	Interpersonal Skills – B&B Values individual differences and diversity – APSC

others	Interpersonal understanding, Flexibility – S&S Perceptual acuity – H&B Communication, Judgement – NRMC Empathy - GBM
Collaborative working	Interpersonal Skills – B&B Marshals professional expertise – APSC Facilitates cooperation and partnerships – APSC Teamwork and cooperation – S&S Participation competencies, Communication, Facilitation, Interdependent leadership – POGKW Building teams – NRMC Teamwork and collaboration - GBM
Establishing structures and systems	Team Building – B&B
Orchestrating the team	Guides, mentors and develops people – APSC Developing others – S&S Team leadership – S&S Building teams – NRMC Developing others - GBM
Self belief	Self confidence - K&M Tolerance of Ambiguity – B&B Personal Enthusiasm – B&B Displays resilience – APSC Demonstrates self awareness and commitment to personal development – APSC Self knowledge, Emotional resilience, Personal drive – H&B Self control, Self confidence, Accurate self assessment – S&S Self confidence – NRMC Self confidence - GBM

APSC = Australian Public Service Commission (1998)

B&B = Buchanan and Boddy (1992)

GBM = Goleman, Boyatzis and McKee (2002)

H&B = Harvey and Butcher (1998)

K&M = Klemm and McClelland (1986)

NRMC = Northern Regional Management Centre; published by MCI (1993)

POGKW = Porter-O'Grady and Krueger Wilson (1995)

S&S = Spencer and Spencer (1993)

As Table 8.2 shows, there are equivalents – some close, some remote – of each of the competencies in the framework in Spencer and Spencer's (1993) dictionary of competencies (20 competencies are described in detail in the general directory of the

dictionary, and another nine are listed as being reasonably common) – except for *Establishing structures and systems*. This is the least well matched competency, with only Buchanan and Boddy's (1992) *Team building* capability, which includes the ability 'to bring together key stakeholders and establish effective working groups, and clearly to define and delegate respective responsibilities' coming close (One of the three elements of leading change, according to Buchanan and Boddy's analysis, was that of 'managing control', which included traditional project management activities.) However, some of the Spencer and Spencer (1993) competencies include the development of systems as behavioural indicators of advance level competencies – for example in *Concern for Quality and Order* a higher level behaviour is: 'Puts new, complex systems in place to increase order and improve quality of data' (p30) and the competency of *Achievement orientation* may lead to 'a more efficient system' (p27). Spencer and Spencer's *Team leadership* includes some behavioural indicators concerning team assignments, cross training and acquiring resources, that imply systems and structures. Therefore Spencer and Spencer evidently do not regard the development of systems as outside the scope of a competency – they simply have not chosen to make this the focus of a competency in its own right.

Porter-O'Grady and Krueger Wilson (1995), whilst they do not include a competency concerned with establishing systems or structures, write, in relation to their competency of *Patterning*, that 'Part of the leadership role is to create systems that take into account the thinking, learning and self-managing patterns of organizational staff' (p51). A survey of 49 corporate competency frameworks in use in the UK found that *Planning and organising* (or a competency with an equivalent title) was found in over 50% of the frameworks (Rankin 2006) – but the content of such competencies appears to be more about planning and objective setting than creating or adapting structures and systems (Competency and Emotional Intelligence 2004). Hamlin's (2002) framework of 'criteria of managerial effectiveness' included a factor of 'organization and planning' – but the components were a mixture of factors to do with reliability, being well-prepared and efficient, which have more in common with the *Implementing change* competency in this framework than with *Establishing structures and systems*.

Monitoring is the next least well-matched competency, simply judging by titles and numbers of competencies. Of the two matches noted here, the APSC capability includes some drive for achievement, and some implementing; the higher levels of the Spencer and Spencer competency, however, are similar to those demonstrated by the interviewees in this research.

Self belief and self management is probably the best-matched competency, with similar competencies/capabilities in six of the eight comparator frameworks. Self confidence has regularly appeared in McBer and Hay McBer frameworks, although Spencer and Spencer (1993: 80) wonder whether self confidence is an independent variable or an outcome: 'Is someone successful because they have self-confidence or do they have self-confidence because they are successful?' Self belief may be linked to 'presence' or charisma – and, as we saw in Chapter 2, there is disagreement among leadership scholars about whether charisma is an essential component of transformational leadership. The research methodology I employed is unlikely to be suitable for assessing the extent to which a person uses charismatic qualities in leading change. Some interviewees were charming, confident, personable and articulate in the interview, but it would be unsafe to make an assumptive leap from that perception to the attribution of charisma to them. Self management is strongly associated, as we saw in Chapter 4, with emotional intelligence, with being aware of one's emotions and being able to manage the more difficult or more disruptive moods or feelings (Goleman 1998, 2006). Several interviewees described feeling, in certain situations, these disruptive emotions, including nervousness, anxiety, stress, disappointment, anger, or frustration. I did not pursue in detail how they coped with these emotions, and therefore cannot confirm whether they actively managed them by following the kinds of processes advocated by Goleman, or other writers on emotional intelligence, or whether they coped in some other way. The reliance on values, which is incorporated in this competency, is commonplace in competency frameworks and leadership literature: integrity is a value of effective leaders that is noted by, among others, Storr (2004), Bennis (1989), Guo and Anderson (2005), Higgs (2003), Klemp (2001), Alimo-Metcalfe/Alban Metcalfe (2005) and the LQF.

The competencies of *Analysing issues and making decisions*, and *Implementing change*, are not matched exactly in any of the other frameworks, but what might be

called constituent parts are presented elsewhere, particularly those of the former competency, with different types of thinking described by Spencer and Spencer, Klemp and McClelland, and Harvey and Butcher. However, the way in which the behaviours are brought together in this competency are unusual, in comparison with other frameworks. In the literature on leadership and leading change, although some writers appear to start from the assumption that the need for change has already been established (eg Kotter 1996; Balogun and Hope Hailey 2004; Thompson and Martin 2005), other writers include these activities of identifying a need for change and of carrying out some analysis: for example, Hayes (2007) talks of a diagnosis stage in the change process, as do Paton and McAlman (2000), Kanter et al (1992), Senior and Fleming (2006) and Carnall (2007), and Clark (1994) talks of diagnosing the business case for change; Burnes (2004a: 469) writes of clarifying the problem or opportunity; Milner and Joyce (2005) talk of how public sector leaders need to learn the detail of the issues they are tackling. *Implementing change* is partially matched by competencies in other frameworks on setting targets, developing and communicating plans, and motivating others. Planning or agreeing systems to provide incentives – included in this competency – is an activity very similar to the practice observed by Balogun (2005) of change agents ‘adjusting measurement systems’ – including systems of rewards – to encourage individuals to support the change initiative – also by Christenson et al (2006). Hayes (2007) includes training and development as one of the ‘people issues’ in bringing about change.

Understanding complex social systems is partially matched by Spencer and Spencer’s *Organisational awareness* – but the closest match is Porter-O’Grady and Wilson Krueger’s *Systems thinking*, which considers systems connections other than the political, decision-making systems that are of most concern to Spencer and Spencer, Goleman et al and the LQF.

Understanding the perspectives of others and *Collaborative working* are well-matched in other frameworks (particularly by *Interpersonal understanding*, *Perceptual acuity* and *Empathy* in the case of the former and by *Facilitates cooperation and partnerships*, *Teamwork and cooperation* and *Interdependent leadership* in the case of the latter). *Understanding the perspectives of others* is seen in the Alimo-Metcalfe/Alban-Metcalfe dimension of *Networking and achieving* to the extent that this

dimension includes winning the trust of others by 'sensitivity to needs' (possibly it is also an unstated component of *Genuine concern for others*, if that dimension is to be exercised with some genuine insight into others), and it is an element of the LQF quality of *Collaborative working* ('understanding and being sensitive to diverse viewpoints'). The activity of understanding the perspectives of others has elsewhere been described – in whole or in part – as 'empathy' (eg Goleman et al 2002; Goleman 2006). Baron-Cohen (2001) has distinguished between the intellectual and the emotional abilities to appreciate that another person has a different perspective to one's own, and to relate to that perspective, and also between empathy (relating – intellectually and emotionally - to another's feelings) and sympathy (wanting to do something to help another person who is suffering). The competency of *Orchestrating the team*, with the interdependencies indicated in the interviews, however, is not well matched in other frameworks.

Achieving results is also, surprisingly, not matched by more than three of the other eight sets of competencies in Table 8.2, nor, in the explicit content described above in Chapter 7, is it well-matched in detail. Competencies concerning results orientation – which included *commitment and drive* and *achieving success* were, however, found in 59% of 49 UK corporate frameworks surveyed in 2004 (Rankin 2006; Competency and Emotional Intelligence 2004). Achievement orientation – a competency at the motive level - was originally identified by McClelland (1962, 1988) and was characterised by behaviours that included setting achievable targets, and seeking feedback on performance in order to improve. As it has been more recently construed, achievement orientation is more often associated with personal performance and high task standards, and with a 'pacesetting' style of leadership that may not be effective (Spreier et al 2006). In this framework, it appeared that the competency of *Achievement focus* needs to be combined with the competency of *Understanding complex social systems* – otherwise its effect may be limited to a narrow area in the organisation – and with the competencies of *Collaborative working*, *Understanding the perspectives and motives of others* and *Winning support* – otherwise the change agent's scope for success was similarly limited to areas that they, personally, could control. This is a competency that was necessary to bring about significant change, therefore, but not sufficient.

Winning support and overcoming opposition is partially matched by competencies in the other frameworks concerning networking, negotiating, selling and influencing. There was a rich range of influence tactics demonstrated across the interviews, which included consulting and seeking consensus, providing resources, impression management, reputation and credibility, winning support through achieving results and directly confronting opposition. Communication and persuasion approaches included: acting to raise the profile of an issue with a particular group, acting to educate others, carrying out repeated communications, undertaking formal presentations and launches, publishing newsletters, seeking confirmation that communications had been clearly understood, consciously considering what is the appropriate language for the recipient, carrying out private discussions in advance of and outside of group meetings, arranging to move items further up the agenda for a meeting, emphasising the benefits of the change in terms of the particular values and needs of the recipient, seeking to redefine terms and categories, and showing sensitivity to timing in raising and communicating issues. Communicating a vision as a means of motivating people to work towards a change was used by only a minority of interviewees: this issue is discussed in more detail below, in the section on styles of leadership.

This particular list of influence tactics is not explicit in other frameworks, but the literature on leading change supplies a comparable spread. Table 8.3 compares the behavioural categories derived from the interviews with two established lists of influence tactics, from Kotter and Schlesinger (1979) and Yukl (2002). Five of Kotter and Schlesinger's oft-cited six tactics for influence were evident: the one missing was 'manipulation and cooption'. Nine of Yukl's eleven 'proactive influence tactics' were evident: those missing were 'inspirational appeals' and 'personal appeals'. Areas not well covered by these two lists were the behaviours of impression management, establishing and maintaining reputation and credibility; and winning support by achieving results. Not all of the detail of the communication and persuasion behaviours from the interviews were apparent in either Kotter and Schlesinger's or Yukl's descriptions.

Table 8.3	Influencing tactics
Winning support and overcoming opposition	
Consulting and seeking consensus (may involve compromise or joint agreement)	K&S: Participation and involvement Y: Consultation
Communication and persuasion	K&S: Education and persuasion Y: Rational persuasion, Appraisal, Legitimizing tactics
Provide resources	K&S: Facilitation and support Y: Collaboration (also facilitating)
Trade and negotiate	K&S: Negotiation and agreement Y: Exchange
Develop and use alliances and partnerships	Y: Coalition tactics, Ingratiation (when used as a longer-term strategy)
Impression management, reputation and credibility	
Winning support by achieving results	
Facing up to opposition	K&S: Direction and coercion Y: Pressure

K&S = Kotter and Schlesinger 1979

Y = Yukl 2002

Impression management, however, is discussed by Huczynski (1996) and Buchanan and Badham (1999) – (and also by Yukl 2002:150-151, as a source of referent or expert power, rather than as a direct influence tactic). Of credibility – an ascribed attribute - Kouzes and Posner (1993: 22) have said it ‘is the foundation of leadership’. Pfeffer (1992) and Kotter (1985) note that reputation is a source of potential influence. The fact that change agents in the interviews reflected that they won more support for their project when it had demonstrated some initial success, when people could see some results, was an interesting finding, volunteered independently by a number of quite different interviewees. There is some resonance with Kotter’s (1996) injunction to leaders of change to plan for (and achieve) some early short term wins, and thus demonstrate some success, but only three interviewees explicitly indicated that they had thought in this way.

Kotter and Schlesinger (1979) included 'manipulation' as one of the tactics of a change agent and, along similar lines, Buchanan and Boddy (1992: 18) argued that 'manipulation and threat...must remain on the change agent's list of essential techniques'. Buchanan and Boddy (1992: 29) talked of the need for change agents to take part in 'backstage activity' (which they contrasted with 'public performance') consisting of 'the politicking, the wheeler-dealing, the fixing and negotiating, the coalition building and the trade-offs – which typically cannot be openly discussed in the organisation...'. In studies on cross-organisational collaborations in the public sector, Huxham and Vangen (2005) and Vangen and Huxham (2003) talk of 'manipulating the collaborative agenda' and 'playing the politics' – activities which include 'stealthy behaviour' and 'finding ways to exclude those who are not worth the bother'. There was little evidence of these backstage, wheeler-dealing activities in the accounts provided by the interviewees. There were examples of the use of assertive behaviours and even threats, as change agents stood up to opposition, or promised unpleasant consequences for non-compliance with implementation plans (and the accounts provided in the interviewees included a number of examples of threats being made against the change agents). There were examples of conscious impression management, as noted above, examples of thoughtful estimations of the power of different individuals and groups, examples of interviewees preparing the ground by having meetings with individuals before group meetings, and examples of efforts to tailor arguments to address the values and interests of different stakeholders, but not to the extent, as one interviewee said, that he might be found 'saying something that's palpably untrue, or leading people up the garden path'.

There were numerous examples of the more innocent activity that Balogun et al (2005: 267) call 'engaging in stage management' – which they defined as:

Manipulating situations in particular ways to ensure a message is delivered more effectively. For example, setting up meetings or discussions in a particular way, such as use of experts to reinforce particular points, or deliberately creating a particular self- image or impression, or making visible the added value of their work to others.

PowerPoint presentations and other forms of rehearsed oral and printed case-making were frequently part of the activities that change agents described using in order to make their case (eg UK01; UK13; UK16; UK18; UK22; UK27; AUS03). The other most extensive examples of 'stage management' described in the interviews were the

arrangements for awards ceremonies, designed to show appreciation to staff and/or trainees (UK10; UK22; AUS05). Some interviewees also described how they designed processes for facilitating meetings and workshops – but the examples were no more intended to manipulate responses in an underhand way than the average training session or organisational development workshop. The reason for this relative absence of negative politics, of backstage ‘wheeler-dealing’ and ‘fixing’, may be that such behaviours are not typical of people who would be recommended by my referees as effective leaders of change – or it may be that the interviewees were unwilling to volunteer examples of such behaviour on such a brief acquaintance with a researcher – or it may even be that such behaviours are not typically associated with effective leadership of change in healthcare systems.

Overall, this description of the competencies, derived from interviews with effective leaders of change in healthcare organisations, presents some different ideas, structured in a different way, from other frameworks of competencies/capabilities, and whilst many of its constituent parts are similar to descriptions of competencies/capabilities that are found elsewhere, there are some significant differences in the detail of the competencies that were demonstrated by the change agents in the interviews.

One of the criticisms levelled against competency frameworks, as discussed in Chapter 2, is that they are reductionist and do not relate well to the whole management task. The next section seeks to address this, at least partially by considering how the individual competencies appeared to interact in certain styles of leadership and leading change that were demonstrated in the interviews.

Styles of leading change in healthcare systems

The styles of many of the change agents, as they used their competencies could be described as collaborative/participative, persuasive, transactional and managerial/organisational. Only a minority were recognisably visionary and transformational, in the sense of the mainstream descriptions of such types of leaders, although more than this small number brought about, or helped to bring about, major changes in their organisation, directorate or profession. Even those who

exhibited some of the visionary style associated with transformational leadership reinforced this with transactional measures.

Participative, collaborative and persuasive leadership

A participative style was evident in the accounts of the majority of interviewees, who worked with others in a highly collaborative manner, with the accompanying need to be able to understand and relate to the perspectives of different stakeholders in the system.

In Chapter 2, I noted that several of the writers on leading change distance themselves from the 'lone hero' idea of an effective leader (eg Buchanan 2003; Caldwell 2003a), regard leaders of change as needing to adopt a mixture of direction and receptiveness (eg Kanter 1983, 2006; King and Anderson 1992; Weick 2000; Connelly et al 2000; Balogun and Johnson 2004), and that a number of scholars propose that leadership can be a collective activity, under the headings of dispersed, distributed or shared leadership (eg Bryman 1996; Bennett et al 2003; Rodgers et al 2003; Ross et al 2004a, 2004b, 2005; Gronn 2002; Pearce and Conger 2003; Martin 2005; Mehra et al 2006). In addition, the movement to regarding leadership as a distributed process has been given momentum by the increasing complexity of organisations: those who take a view of organisations as complex systems are almost naturally led towards perceiving leadership as a shared process (eg Senge 1990; Porter-O'Grady and Wilson 1995; Marion and Uhl-Bien 2001; Lichtenstein et al 2006; Schneider and Somers 2006; Attwood et al 2003; Palus and Horth 2002). One practical reason for this is that in complex changes, what Beckhard and Harris (1987) called 'soft' changes, there is no obvious 'right' solution to a problem requiring change, and the success of the change depends on the involvement and commitment of a number of stakeholders, and this will most likely be achieved by a participative, collaborative style (Heifetz and Linsky 2002; Schein 1987). Another reason is that in complex systems it is simply not feasible to restrict the leadership role to figures at the top of the organisation: the continual complex adjustments that are required indicate that leadership influence should be dispersed. Hayes (2002: 162) picks out six situational variables that may suggest to a change agent that a more collaborative or a more directive style is appropriate in a particular situation: three of these that favour

a collaborative style were present in many of the examples described by interviewees: the need for more information, the need to agree on what the change should achieve, and the need for the commitment of others.

The implication for the individual who wishes to bring about change is the need to learn how to work collaboratively, sharing information and other resources with others, bringing individuals and groups together to contribute to, and therefore ultimately to own, decisions about change. These activities, and these capabilities, were demonstrated in the research in many different settings by different interviewees, as described in the sections in the previous chapter on *Collaborative working* and *Orchestrating the team*, and individuals were able to engage in these collaborations by virtue of their ability to *Understand the perspectives of others*. To the extent that collaborations are not without disagreement (or even conflict) the need to seek consensus, to communicate and to persuade, even to negotiate and trade, were in evidence in some of the collaborations, as described in the competency of *Winning support and overcoming opposition*. The sharing of leadership functions evidently varied, including the pooling of ideas in informal, small partnerships or dyads; the more role-bound mixture of contribution, interaction, influence and compliance of larger groups (such as project steering groups); and the complex and structured interactions of the members of an individual's immediate team, described in the previous chapter as *Orchestrating the team*, with the need for the team leader to take action to sustain and develop the team and support the individual members. Participation-direction has been a long-established spectrum for consideration of appropriate leadership styles, presented in a contingency form by Tannenbaum and Schmidt (1958), where the most effective style was said to depend on the nature of the decision to be taken and expectations of the 'followers'. Senior and Fleming (2006) and Dunphy and Stace (1993) described a continuum of styles of leading change as collaborative, consultative, directive, coercive, and Kanter (2006), Weick (2000), Balogun and Johnson (2004) have all argued for some directiveness and some participativeness of style. In the leadership literature, the six leadership styles of Goleman et al (2002) include two that are particularly participative – the democratic and the affiliative styles – and two that are more directive – the pacesetter and the commanding styles. Although there were strong themes of collaboration and participation in the accounts of leading change provided by the majority of

interviewees, there were also examples of directiveness and (in a minority of cases - five of the interviewees, three of them chief executives) a pacesetting style.

Where directiveness was absent, many of the decisions that were described by interviewees required the cooperation and agreement of a number of stakeholders and it would not have been possible for the change agent, as a lone leader, to dictate the decision to others and to expect commitment or even compliance. This was the case not only in those decisions that spanned organisations, but also many of those that affected only a single organisation, but multiple professional groups. Where directiveness was present at the decision-making stage of changes, it was most often because of the urgent imperative to meet a set target: the change agent perceived they themselves had little room for manoeuvre, and acted to emphasise the need for others to do their bit to resolve problems quickly in order to meet targets. This did not mean that the change agent knew the detail of how to resolve the problem, but they directed others to take action to find a resolution. Directiveness was also present in some examples where the change agent had the authority to command others to address a problem in relation to other performance problems: this was highlighted in cases where the problem related to patient care. In almost all the other cases where directiveness was demonstrated in the examples provided by interviewees, it occurred at a later stage in the change process, when the aims and objectives of the change had been agreed, and yet the desired performance was not being achieved, or people were still resisting the change. In those circumstances a number of interviewees described how they used their authority to call individuals and groups to account, in some cases confronting others directly and forcefully in order to bring this about, as representing in the competency of *Achieving results*.

Persuasiveness was also used to a great extent by the change agents, as represented in the competency of *Winning support and overcoming opposition*. For anyone familiar with the literature of change, this will be of little surprise. As we saw in Chapter 2, the actions of change agents in overcoming resistance and managing the politics of change have for many years been a concern of writers and researchers in this field (eg Kotter and Schlesinger 1979; Kanter 1983; Hayes 1984; Buchanan and Boddy 1992; Pfeffer 1992; Kotter 1996; Bragg 1996; Buchanan and Badham 1999; Senior and Fleming 2006; Hayes 2007).

Transactional, pragmatic, personable (but rarely visionary) leadership

The transactional nature of the leadership styles adopted by many of the change agents was not entirely expected, nor was the very limited evidence of a visionary, transformational style. As we saw in Chapter 2, the idea of transformational leadership, with vision and the communication of vision as central elements, has been a dominant feature of the landscape of thinking and research into leadership since the 1980s (eg Bass 1985; Bennis and Nanus 1985; Hunt 1999; Bass and Riggio 2006) and is also a key component in ideas about leading change (Kotter 1990; Eisenbach et al 1999; Balogun and Hope Hailey 2004). In Chapter 3 we saw various writers argue that transformational leadership is needed in the health service (Alimo-Metcalfe and Alban-Metcalfe 2000, 2001, 2006; Xirasagar et al 2005; Millward and Bryan 2005; Edmonstone and Western 2002). However, visionary leadership did not feature highly in the accounts that the majority of interviewees gave of their actions to bring about change.

Of the 40 interviewees, only four Australian and 13 UK interviewees used the word 'vision' at all. Of these, nine spoke of establishing a vision and communicating it to convince others of its desirability, or achieving acceptance in other ways (such as by ensuring contribution to building the vision); another two interviewees spoke of achieving a shared vision, and one spoke of it in terms of establishing an implementation plan to translate the vision into reality. Of these 12, perhaps no more than seven could be said to have described using a vision or visions as a central part of their efforts to bring about change (four CEOs, two directors and one clinician) and of those seven, five talked of achieving cooperation not only through winning commitment to the vision, and in some cases by inspiring others, but also through transactional means such as setting standards, monitoring them and requiring compliance. There was no evidence to suggest that these seven leaders who described using vision as a central approach were more effective than all the other interviewees – ie there was no evidence that they represented the 'outstanding' group to the mere 'effective' rating of the others.

This is only one measure of whether the interviewees were exercising transformational leadership, and it requires a number of caveats. First, the interviews

did not seek out visions or visionary activity, and the word was never used in a question unless it had already been volunteered by the interviewee. It may be that if some way had been found to probe this issue with those interviewees who did not volunteer that they had developed a vision, I might have found that yes, in fact, they did have a clear idea of a desirable future state of affairs, something that could have been described as a vision. Secondly, establishing and communicating visions is commonly said to be a core element of transformational leadership, but it was evident that some interviewees were carrying out transformations of organisations, and were inspiring and developing people, without mentioning the word vision, or even indicating they had a long term, visionary goal in mind. Thirdly, it may be that the methodology employed is not entirely suitable for identifying this behaviour: Spencer and Spencer (1993:65) note of the competency behaviour of 'Communicates a compelling vision' that 'Examples of this [behaviour] are rare and are likely to be inferred from the results of activities, from reports by others, and from the interviewer's observation and impression rather than by direct quotes [in a Behavioural Event Interview].' The Hay competency frameworks of 1993 did not feature vision highly – but as we have seen, the LQF of 2001/2002, which was substantially developed using BEI did feature visionary activity by leaders (in fact the name of one of the qualities was only changed from 'Vision' at the last moment, in the final draft), and in this study the methodology was sufficiently sensitive to detect visionary leadership on the part of some interviewees.

However, there may be other reasons for the relative absence of vision. Of the visionary style of leadership, Goleman et al (2002) reflect:

...the visionary style doesn't work in every situation. It fails, for instance, when a leader is working with a team of experts or peers who are more experienced than he – and who might view a leader expounding a grand vision as pompous, or simply out of step with the agenda at hand. This kind of misstep can cause cynicism, which is a breeding ground for poor performance.

On cynical reactions, one of the interviewees talked of one of his staff attempting to win the buy-in of a group of clinicians:

The first challenge for her was to get up in front of all the clinicians... and communicate, or get their buy-in, to developing the vision for the future. That's hard. Because they come, they're cynical, not in tune, out of whack with where you want to go now, let alone the future, and [it's] 'ooh, here we go again' type of story.

Perhaps the dispersed power structures in healthcare, with their parallel and competing types of expertise, discouraged the use of a visionary style by the interviewees?

Whilst the interviewees provided fewer examples of one type of vision than might be expected – the type of vision of a future desirable state that would inspire people to action, associated with leading change (eg Kotter 1996; Conger 1999) – there were frequent examples of the inclusive kind of visioning that reminds people, in the midst of the complexity of targets and budgets and regulations and demarcations of job roles, of the contribution they make to a bigger purpose – particularly in terms of providing patient care. There was a high emphasis on patient care from interviewees, both in terms of an end that motivated their own activity and of a purpose they communicated to others in order to motivate them.

Most interviewees, however, whilst being effective in bringing about change, could be not be described as demonstrating traditional visionary leadership, and those that did reinforced it with measures that were clearly transactional (providing incentives, tackling failures to perform). This combination is not unheard-of: writers such as Bass (1985), Kakabadse and Kakabadse (1999) and Kent (2005) have argued that individual leaders can be both transactional and transformational. However, as was argued in Chapter 2, the exact meaning of transactional leadership is also not entirely clear: Yukl (1999: 289) has described its use by Bass as covering a variety of 'mostly ineffective' leader behaviours that 'lack any clear common denominator'. The exchange of something for something else (the original basis of transactional leadership from Burns 1978), and using direct authority to seek compliance with instructions or standards (from Bass 1985, management by exception) was evidenced by interviewees in this research in:

- trading and negotiating
- seeking consensus (including seeking/accepting compromise)
- standing up to opposition
- holding others to account (part of *Achieving results*)

Transactional leadership often suffers in print from its comparison with the transformational alternative. It appears dull, calculating, selfish, uninspired. It is associated with a Theory X view of humanity, compared to transformational leadership's Theory Y. However, in this research interviewees spoke of (and in many cases demonstrated) transactional leadership that was participative, fair and effective, as well as at times considerate and personable. Transactional leadership has been narrowly described as providing financial rewards for productivity or denying financial rewards for lack of productivity, whereas transformational leadership (among other things) aligns the objectives and goals of individuals, groups and the organisation (Bass and Riggio 2006: 3). This duality over-simplifies a complex interaction. As one clinical director reflected in an interview, in his opinion other clinicians were generally willing to try a new thing if it could be shown to be a reasonable thing to do, that would improve patient care, and would not result in too big a loss to them (the clinicians) of time or money. It was interesting that where financial transactions were described by interviewees, in the form of bargains that were struck in order to win support for change, they generally concerned funding for facilities, or for extra staffing, in order to improve services to patients, rather than for direct personal gain. This appears to be a significant extension of what Bass and Riggio define as transactional leadership.

A modern perspective on leadership that is non-visionary but other than transactional is provided by Michael Mumford and colleagues (Mumford 2006; Mumford and Van Doorn 2001; Strange and Mumford 2002) and their idea of 'pragmatic leadership'. Pragmatic leaders are those who use their sensemaking faculties to define problems and develop solutions. Rather than developing visions to influence others:

pragmatic leaders exert their influence through an in-depth understanding of the social system at hand and the causal variables that shape system operations. Pragmatic leaders are skilled not only at identifying socially significant problems but also at devising actions that allow them to manipulate current situations in such a way as to bring about efficient practical solutions to significant systems problems (Mumford 2006: 9)

This is an appealing way of interpreting some of the information provided by the interviewees about how they brought about change, and it fits well with the evidence of the importance for the change agents of being able to make sense of the complex social systems within which they operate – in other writings, as outlined in Chapter 2, Mumford and colleagues also emphasise the importance of this sensemaking skill (eg

Mumford and Connelly 1991; Mumford et al 2000). Mumford (2006) categorises individuals as pragmatic leaders (or ideological leaders or charismatic leaders – both a type of visionary leader) but allows for the possibility of leaders who could operate in a mix of modes, enabling us to talk of pragmatic leadership *behaviours*, and even a pragmatic leadership *style*.

Mumford and Van Doorn (2001) originally argued that pragmatic leadership was less likely to be effective when there is much disagreement about causes of problems or about the values that should be pursued – ie it may only be effective in tackling technical issues and problems, but Mumford's thinking on this progressed, and he later argues that pragmatic leaders may be better able to bring multiple diverse groups together to reach agreements, and to enable others to formulate their own visions of what they wish to achieve (Mumford 2006: 38-39). Mumford and his colleagues argue that pragmatic leadership represents an alternative route to 'outstanding leadership', a route that is more rational and less emotional.

From a combination of Mumford and Van Doorn (2001:302) and Mumford (2006:38-39) the core characteristics of pragmatic leadership emerge as the exercise of influence through

- elite social relationships (ie networks or other structures)
- appeals to existing shared values
- the effective communication of the merits of a plan
- persuasion and negotiation through demonstrations
- entrepreneurial ability to identify opportunities for innovation
- bringing together diverse groups to reach agreements
- enabling others to formulate their own visions of what they wish to achieve

There is an odd one out in this list of characteristics, to which we will return in a moment. Overall, the pragmatic leadership style would be one that works primarily behind the scenes, putting forward well-devised, rational proposals for change. This is a fuller picture than the limited description we have of a transactional leader, and the last two elements in the list are inclusive and would fit with the participative/ collaborative style that was evident in many of the interviews. There is a fairly wide

range of behaviours (although a narrower range of tactics for winning support than arose from my interviews), whereas the transactional leader, as defined by Bass (1985), and Bass and Riggio (2006) is limited to exercising control over those where he/she already wields authority. However, a consideration of a wider range of transactions could enable us to stretch the term to include many of those influencing behaviours described by writers on change such as Kanter (1983) such as 'tin-cupping', 'horsetrading' and 'bargaining'. The more rounded list of influencing behaviours of the pragmatic style of leadership still appears appealing, but if the main distinguishing factor is rationality and lack of emotion, one must have some concern that the type will not embrace the relationship-building behaviour demonstrated in many of the interviews and described in the literature on change agents (Buchanan 2003). The list of characteristics also contains an exceptional characteristic of the pragmatic leader, among the list of ways in which they exercise influence – the assertion that they possess entrepreneurial ability to identify opportunities for innovation. This is not so very different from Conger's (1999) assertion that the charismatic leader is concerned to find (and succeeds in finding) areas for improvement and change. A concern for improvement is not the sole preserve, nor the distinguishing feature, of either of these views of leadership types or styles.

Returning to the interviews, the main characteristics of the accounts of change were that the change agents were concerned to achieve improvements, that they often analysed issues in detail, usually combined this with a sophisticated understanding of the wider systems within which they were working, often worked participatively/ collaboratively, and sought to be persuasive in order to win the support they needed to bring about the change. The form of persuasiveness varied, perhaps depending on the situation and the resources available, and included transactional exchanges (or the promise of them) as well as appeals to shared values, demonstrations, effective communication and the other approaches used by the pragmatic leaders of Mumford and colleagues. The idea of pragmatic leadership is interesting, therefore, but contributes to an understanding of, rather than entirely explaining, the behaviour described in the interviews.

Task- and person-centred leadership

If the actions described by the interviewees did not easily fit with conventional wisdom about transformational and transactional styles of leadership, they did have some resonance with an older perspective on leadership styles, the interplay of task- and person-centred leadership. As set out in Chapter 2, studies at the universities of Ohio State and Michigan, identified two factors that influenced leadership behaviour (Yukl 2002): a concern for task achievement and a concern for people, or 'consideration'. This was developed by Blake and Mouton (1964, 1985) into a grid of five different styles of leadership, including a high focus on task, a high focus on consideration, and a high focus on both task and people.

A concern for completing tasks successfully, meeting targets, meeting the needs of patients was evident in the examples of behaviours described by the interviewees, and formed the basis of the competency of *Achieving results*. This was often displayed as a proactive, developmental competency, as discussed in Chapter 7, where interviewees identified and tackled improvements that could be made to the then current ways of providing services. The competency of *Implementing change* is also centred on task achievement, and includes planning, agreeing targets and protocols, and motivating people to achieve the objectives of the change project. A concern for people was demonstrated in the often empathic understanding of others that interviewees sought to develop, or practised; in the inclusion of others in cooperative working arrangements; in the pleasure that some interviewees took in the development of others – as contained in the competencies *Understanding the perspectives of others*, *Collaborative working*, *Orchestrating the team*, and in *Implementing change* (in the training and development element of this competency). There were perceived trade-offs, discussed by some interviewees between the need to consult with, and include, people, and the desire to make speedy progress with the task in hand, as discussed above, in Chapter 6, in relation to bring people together to analyse an issue and make decisions. The most striking examples of task- and person-centred concerns working together, however, were around cases where the interviewee tackled performance problems, and cases where they acted to train or develop staff.

Training and development activities were often discussed by interviewees, both in relation to helping staff to learn new clinical techniques and skills in order to implement a change in service, and also in relation to management and leadership skills, in order to improve organisational capacity. This function has been placed in the competency of *Implementing change* in the framework, but there is an argument for regarding it as a separate competency: just as the competency of *Establishing systems and structures* develops one aspect of an organisation, so too does the activity of developing the knowledge and skills of the organisation's members. The task orientation of the interviewees was often obvious – they needed people to be able to do things differently in order to be able to meet the (new) demands of the job; the people orientation in some cases was obvious, too, where interviewees described how they took pleasure in helping people learn, or in seeing others respond positively to training, or in seeing the increased confidence and pleasure that people took from training and learning (eg UK10; UK11; UK22; UK30; AUS05). The explicit combination of the task and people orientation was expressed by one interviewee in terms of the 'importance of development for individuals in order to build services and to really build a climate for change and to embrace it as an organisation'. And more simply by another: 'I learnt that if I supported people through problems, or as individuals, [by supporting] their personal development, I got so much more out of them'. This was not a cold calculation, but a statement from an executive who had already said:

what I want to do with [this organisation] is to have people that have come and worked for us...go out having learnt and grown themselves, [so they]... can go back to work in whatever field they're going back to, that have learnt and grown and feel fulfilled, and I think that's really important that you support them as individuals.

The other striking interplay between task-centred and person-centred styles concerned holding people to account for performance problems. This has been placed in the competency framework in *Achieving results* rather than in *Implementing change*, because it may occur at any stage in the change process (including at the outset, where performance problems may indicate that a change is required). Some interviewees took a tough approach to holding others to account for performance problems, emphasising standards, the achievement of targets, the duties of the job etc: as one said: 'I am ruthless when it comes to patient care. I am very, very intolerant of people who can't hack it.' Other interviewees, however, described

examples of how they tried to balance their concern for task achievement with their concern for people, to solve the problem that was affecting performance but with consideration for the people involved. This involved focusing on processes, systems and performance, rather than the individual and, in some cases bringing an understanding to bear on the culture within which the individual had been working, or the (lack of) support they had received relative to the difficulty of the task. Sensitivity to the individuals' feelings of anxiety, guilt or defensiveness was also a factor in some examples. Ways of tackling the issue might involve changing responsibilities, clarifying what was required, ensuring more support was provided in future, enabling people to feel better by helping to contribute to the solution to the problem. Quotations from four of the executives who demonstrated this high task/high person-centred style illustrate this:

...it got slightly difficult at some stages because I think people were starting to feel quite criticised.... [but] thanks to the facilitator I think who helped to put that skillfully, [the inquiry into the problem] became more about the process than about individuals' performance

...their concern was that they would all end up being sacked and goodness knows what. But you've got to recognise they're part of a system and they've functioned within a system that's had a particular culture and a particular way of working, and they hadn't had proper management and proper review to help them to understand that they weren't managing the caseload properly.

I think it's about trying to have a dialogue with people... [so that] they don't feel they're being beaten up... I think it's reminding people what their duty is, and taking them through the stages of how this could be [carried out]

...it became clear that the XXX Department was really struggling, not because of any fault [of theirs], they just didn't have the capacity to sort it out. And I just said, let's shift it into a new phase, let's do it in a different way, let's set up a committee, let's get one of our non-execs to chair it with the local people in it as a steering group. And I'll drive it with them.

Managerial/organisational leadership

A further feature of the change agent styles described in the interviews was that they were also managerial/organisational. I noted in Chapter 2 that, although some writers conflate the opposites of (transformational) leadership – transactional leadership and management (Bass 1985, Burnes 2004a:521; Flanagan and Thompson 1993) this

seemed wasteful of useful analytical tools. Persuasive and transactional leadership were evident in the interviews, and so too were different sets of behaviours that could be described as managerial and organisational. I noted in Chapter 2 that a limitation of many studies of leadership from a transformational/transactional perspective is that they focus on the motivation of 'followers', often those in one-to-one relationships with the 'leader' and ignore many of the activities associated with the exercise of leadership positions in organisations, such as creating and developing the organisation's structures and systems (Yukl 1999: 290; Kets de Vries 1994; Boal and Hooijberg 2001; Collins and Porras 2000). The activities of agreeing and monitoring business plans, for example, which are crucial to the effective functioning of most organisations, are often considered in the literature to be 'managerial' rather than leadership functions (eg Kotter 1996; Boyatzis 1982), although Kotter (1996) argued that management is needed in change, in order to deal with complexity.

However, there are minority views that these 'managerial' activities are indeed part of the leadership of change. As noted in Chapter 2, Nadler and Tushman (1990) talked of the need for 'instrumental leadership' in bringing about change, which included building teams and creating structures and creating systems and processes for control, Bryman et al (1999) found that 'instrumental leadership' - defined in terms of clarifying roles, organising, ensuring that sufficient resources are available - was regarded as important by respondents in their research, and Munshi et al (2005) talked of 'structuralist leadership' as being important for innovation – including undertaking tasks such as organisation design, the coordination of activities, and the provision of resources. Balogun (2005) talks of the structural practice of bringing in new measurement systems, or changing existing systems for target-setting, measurement and reward in order to provide incentives for individuals to support a change. Christensen et al (2006) promote the use of 'management tools', including control systems and standard operating procedures, to bring about change. Two of Quinn's (1988) roles of leaders were 'Monitor' and 'Coordinator'. Pfeffer and Sutton (2006: 210) write in terms similar to those of Collins and Porras (2000) on clock-building and time-telling when they write that in larger organisations leadership becomes a 'less direct and less dramatic process', one that entails 'building reliable systems' rather than being the 'heroic saviour who steps in and saves the day.' Hosking (1988: 293) suggested that 'leadership can be seen as a certain kind of

organizing activity' in a paper that Grint (1997: 290) presented as a significant alternative view of leadership, one where

an effective leader is...someone who is skilled at leading – it is an active not a passive affair but it is not one restricted to face-to-face interpersonal skill nor is it restricted to a single actor's behaviour

Interviewees in this research described their managerial/organisational/structural activities in a variety of contexts, as detailed in Chapters 6 and 7, as they spoke about how they established and structured steering groups for projects, created systems for analysing or monitoring aspects of performance, agreed relevant individualised targets for organisations or project leaders, resolved perceived problems by making changes to structures and systems, or established structures and systems simply in order to bring their new organisation into being. These are not areas that have been emphasised by scholars of leadership or leading change - although there are exceptions, as noted in the previous paragraph. These activities are mainly represented in the competency framework in the competencies of *Implementing change*, *Monitoring performance* and *Establishing structures and systems* – competencies which, as noted earlier in this chapter, are often not well-matched in other frameworks of competency or capability, and are under-represented in the Alimo-Metcalfe/Alban-Metcalfe and the LQF frameworks.

Taking Kotter's (1996: 25) categorisation of management as 'a set of processes that can keep a complicated system of people and technology running smoothly' and leadership as a set of processes concerned with creating or adapting organisations, and his argument that, where a high degree of change is needed and the system is highly complex, then considerable management and leadership expertise are needed, it is logically far from surprising that the interviewees in this research described undertaking a significant number of management activities. Kotter (1990:13) allows that some individuals may be strong in both leadership and in management skills (as he defines those skills) and that individuals and coalitions with a mixture of these skills are needed for success in major changes (Kotter 1996:58). Empowering employees to bring about change entails, at least, changing structures and systems in order to reduce obstacles (Kotter 1996:101-116) requiring some of the planning, budgeting, organising and staffing activities that Kotter allocates to management. As with the two-category framework proposed by Bass, however, Kotter seeks to

promote one of the two categories he has identified and, like Bass, whilst not denying the less important category has a contribution to make to achieving effective performance, tends to attribute the more human, personable behaviours to his favoured category, so that, for example, for Kotter it is leadership that seeks to empower, whereas management seeks to control (1990: 8). If that is the case, who then will create the systems and structures for consultation and empowerment? Who will design the systems for agreeing on fair and flexible targets, which take account of individual situations and aspirations? Or rather, by which process will these things be done - by leadership or by management?

Leading change in a complex environment

In this research, the ability to make sense of complex social systems was a competency that featured highly in many of the change agents' accounts of their activities. In this section I intend to link this to relevant literature on the leadership of change, and to discuss the relevance of some of the other competencies in the framework to leadership in a complex environment.

Healthcare environments are all potentially complex. Matters of concern to the welfare of an individual patient may involve a number of organisations and professions – each with slightly different perspectives, responsibilities, areas of expertise and concern. Numerous factors can affect the decisions of policy-makers and managers about strategic direction and funding. For any one problem or issue - such as a new approach to treatment – there may be a variety of active groups, locally, nationally and/or internationally. The complexity of the healthcare setting has been observed by a number of commentators. In Chapter 3, I noted that Iles and Sutherland (2001:80) argue that differences concerning leading in the health sector, as opposed to other sectors, include the complexities of leadership in large, multi-professional systems, where 'interrelationships, interdependencies and awareness of different views of purpose' are crucial. This endorses the need for the ability to understand the complex social systems that operate in health care (also Dawson 1999; Dawson and Dargie 2002; Boyne et al 2006; Edmonstone and Western 2002; Attwood et al 2003; Porter-O'Grady and Krueger Wilson 1995; Plsek and Wilson 2001). The American Healthcare Leadership Alliance Competency Directory (2005) identified, as one of its five major

domains, a knowledge of the healthcare environment, which includes an understanding of the healthcare system, and systems thinking skills.

Attwood et al (2003: 61) write: 'In the whole systems development context, leaders must be able to think systemically – to “map the system” – and to help others make sense of these realities'. Porter-O'Grady and Krueger Wilson (1995) include systems thinking as a key conceptual competency needed by healthcare leaders, along with the ability to recognise patterns and to synthesise information, as noted earlier in this chapter. They write (1995: 49):

Systems thinking is the most noteworthy of the conceptual competencies demanded of the reinvented health care thinker. A leader who is a systems thinker does not simply look at care delivery as a group of services to be configured along the continuum of health and illness but sees it as the product of their interactions

They note that this means – among other things – that problems should not be 'seen in isolation but as part of a larger universe of problems' (ibid) and therefore the analysis of a problem relies on systems understanding.

As described in Chapter 2, above, much of the literature on leading change emphasises the importance of context, and the need for leaders to understand context, and this is sometimes reflected in the abilities attributed to effective leaders of change. For example one of the five elements of Conger and Kanungo's Charismatic Leadership Scale concerns *Sensitivity to the Environment* – (Conger et al 1997). For Hayes, too, the first stage of a change is recognition – realising the need to change – which 'involves complex processes of perception, interpretation and decision making' (Hayes: 2007: 83). Similarly, Pettigrew and Whipp (1991) talk of 'problem-sensing' as an early stage of change, and Paton and McAlman (2000) and Senior and Fleming (2006) advocate systems analysis as a means of understanding the problem/opportunity that requires change. The ability to assess and understand the environment does not begin and end with this first stage of the change process, however. The ability of effective leaders to understand context was highlighted by Mumford, Zaccaro and colleagues, as described in Chapter 2, above. They took as a starting point that

organizational leaders need to be able to confront a variety of difficult problems and be able to fashion individual and organizational solutions in a complex and sometimes hostile environment (Zaccaro et al 1991: 320).

Zaccaro, Mumford and colleagues emphasise the need for leaders to understand the context within which they work, and therefore highlight the ability of leaders to make sense of their complex surroundings – an ability described as social awareness, or social intelligence (Zaccaro et al 1991; Mumford et al 2000; Zaccaro et al 2000), or the ‘social judgment skills’ required for operating effectively ‘within a complex organizational setting’ (Mumford, Zaccaro et al 2002).

Mumford, Zaccaro and colleagues linked these skills with the skills of understanding other individuals, and the ability to behave flexibly towards others in the light of your assessment of their perspective – an approach which aligns them with Goleman’s (2006) categorisation of the outward, social aspects of emotional intelligence – recognising emotions in others and being able to work with them – as ‘social intelligence’ – although Mumford, Zaccaro and colleagues are concerned to stress that their view is of ‘a distinctly cognitive model’ (Mumford et al 2000: 26). I have argued that *Understanding the perspective of others* can usefully be regarded as a separate competency, rather than one of a piece with *Understanding complex social systems*, but both competencies are extremely valuable in a complex environment. In a complex environment, with a wide range of stakeholders, the potential for difference and for conflict is higher, and therefore the ability to understand the perspectives and motives of others is at a premium, as a foundation for a) understanding the role they are likely to want to play in the issue at hand; b) working collaboratively with them and/or c) seeking to win their support or overcome their opposition.

An implication of the systems perspective on healthcare taken by Attwood et al (2003) and Porter-O’Grady and Krueger Wilson (1995) is that leaders must work collaboratively with others, helping them to learn and develop, and expecting them to take action. Thereafter the two sets of writers to some extent go their separate ways in suggesting how leaders can influence their systems, Attwood et al advocating particular approaches to helping others to learn, Porter-O’Grady and Krueger Wilson arguing (among other things) for the leader to think systemically about establishing structures and systems. The specific details of neither of these approaches are suggested by the information from the change agents I interviewed, although the general direction is in accordance with many of the interviewees’ accounts, and is

therefore reflected in the competency framework: collaborative working was seen to be important in most of the examples, and leaders of change needed to establish systems and structures in order to make things happen.

A feature of a complex environment, such as healthcare, which is not explored so much by Attwood et al (2003) or by Porter-O'Grady and Krueger Wilson (1995) is that a variety of influence tactics may be necessary in order to bring about change: these tactics may be guided by a good understanding of the systems in which the action is taking place, and a good understanding of the perspectives and motives of others, but after the change agent has come to some conclusions about the systems and individuals he/she has encountered, there is still a need to act to influence others. As Buchanan and Badham (1999: 67) argue:

Approaches [to influencing others] that are effective in one setting may be wholly inappropriate in another. The change driver thus needs an extensive behaviour repertoire of both political and conventional tactics in order to succeed

There is support from some quarters, therefore, from researchers into healthcare systems and from writers on leadership and leading change, for an emphasis on the ability of change agents to understand the complex social systems within which they operate. The need to be able to operate effectively in a complex, pluralistic environment also supports the need for competencies concerning understanding the perspectives and motivations of other individuals, working collaboratively with others, and being able to use a range of influencing approaches in order to win the support of others.

Leading change in a healthcare environment

There were a number of significant implications of the fact that interviewees were leading change in healthcare environments: the public sector setting; the financial arrangements; the responsibility (in the case of most interviewees) for matters of sickness and health, if not life and death; the dangers of public disquiet, publicity and political interference; the imperatives for UK interviewees of centrally-imposed targets - but two factors stood out in particular: the focus on patients, and the need for managers and clinicians to work together.

An explicit focus on patients and their welfare was found in almost every interview. In the framework, this is incorporated into the competencies of *Achieving results* and *Analysing issues and making decisions about change*. This focus was found not only in those interviewees who were clinicians, but also in executives at every level. One executive, for example, described the key question in understanding problems, and potential changes, as 'what does this actually mean for this patient?' Another said, with great credibility: 'I'm doing this job because I want to ensure that the care for people with [this illness] and their outcomes are improved, for no other reason'. Another executive said that in addressing issues of change, 'I adopt the position of the patient and articulate what's best for the patients, it makes... my decision-making very clear because it's a no-brainer to say, do I want the person to wait twelve months or six. It's a no-brainer.' Other executives credibly emphasised that patient care was their main concern, and their main argument, in seeking the changes they described.

The need for clinicians and managers to work effectively together is an obvious component of *Collaborative working*, but it is also a factor in the competencies of *Understanding the perspectives and motives of others* (managers and clinicians may have different perspectives and motives – as may different groups of clinicians), *Winning support and overcoming opposition* (tactics of persuading, negotiating, providing incentives, impression management and credibility, may need to be varied for different groups or individuals) and *Understanding complex social systems* (it is important to understand the function, place and powers of groups and individuals in the system). To focus on management-clinician relationships is not to underestimate the issues of clinicians working effectively with clinicians from other directorates or specialities, or the difficulties in clinician-clinician relationships across different organisations – say, for clinicians in secondary care in winning the cooperation of general practitioners for particular changes. Both of these were problem areas raised by interviewees: there are many different tribes and clans of clinicians, indeed there are many tribes of medics, with different professional backgrounds and different organisational responsibilities as Denis et al (2002), Ferlie et al (2005), Currie and Suhomlinova (2006) and others have observed, as we saw above in Chapter 3. However, as noted in that chapter, there is a recognised need for leaders in healthcare to win support from clinicians, especially from well-established medics (Ferlie et al 2003; Degeling 2004; Boyne et al 2003; Marshall et al 2003; Reinertson

et al 2005; Ham 2004). It is unsurprising, therefore, that executive interviewees and others with management responsibilities were concerned with issues of how best to work with this powerful group.

The clinical group that were most involved in this research were senior medics – all but three of the 16 clinician interviewees were doctors. Ten of the medics who were interviewed had management responsibilities as clinical directors, the ‘hybrid professional-manager role’ (Ferlie et al 1996:104) that has been mooted as the role that can ‘translate’ between medics and managers (Ferlie et al 1996; Llewellyn 2001; Roddis 2005). These interviewees spoke of seeking to manage and influence other clinicians, including other medical consultants, as well as seeking to influence executives and other managers.

In effective clinician-management relationships, individuals used the four competencies in combination, although in some statements one competency or another appeared to be dominant. For example, the competency of *Understanding complex social systems* (in relatively simple form) can be heard in the statement of one chief executive, that:

the medical staff...are a key constituency... there is a pecking order, I'm afraid, and they are at the top of it, it's sad, but they are and you need them to come along [with changes you propose]

Whereas in the following statement, by another chief executive, there is more emphasis on *Collaborative working*:

I've always seen my job as a Chief Exec... [as being] about working with these people [ie clinicians] and trying to ensure that they can do the best they can within the circumstances of finite resources and inevitable frustrations with large bureaucracy

And a concern with *Winning support*, reinforced by an element of *Understanding the perspectives and motives of others* was evident in the argument by another CEO that executives should always to focus their position on patient need: ‘if we do what the patients want, the professionals actually will follow in the end’. Anyone leading change, said this executive, has to ‘speak from the perspective of the patients’ because ‘waiting lists are political but, actually, patient suffering isn’t’ and arguments about patient suffering are matters that clinicians ‘can’t disassociate themselves from’.

Patient-focus and working well with, or winning the support of, clinicians, thus come together.

The importance of language, and being aware of the different values of different groups was emphasised by executives and clinical directors. One clinical director in particular said that it was important to be able to talk to 'the hospital' (ie the management of the hospital) in 'their language' and then to be able to talk to consultant colleagues in *their* language. He had convinced his colleagues of the benefits of a change to the provision of services on medical grounds, relating to quality of care. He convinced the hospital that the change would reduce 'bed days' (ie the time patients stay in hospital) which would mean savings. He then agreed to split the saving with primary care: he was able to fund more work and more facilities and grew his directorate. Three different stakeholder groups, plus the patients, plus the clinical director himself, were satisfied by this change. Success in bringing it about depended on being able to communicate with and to satisfy clinician and management groups. Another clinical director reflected, of his attempts to persuade the Trust executives of his ideas for new ways of working: 'it takes a degree of management speak as well, which is odd, if you use the right buzz words with them, then they ultimately become slightly more receptive'.

Interviewees said that credibility on both sides of the clinician-management dialogue was enhanced by a track record of producing results and honouring commitments, and of signs that the person on the other side had some understanding of your point of view. The signs (from clinicians) might be 'the right buzz words', or actually achieving savings or attracting funding, or achieving changes that helped executives to move in their preferred direction, or (from managers) a concern with patient care, or an understanding of clinical issues, or providing funding to develop services, or a willingness to commit to longer term development of a service – rather than 'over-reacting' to targets, or seeking only short-term wins. Executives with a clinical background said that this helped their credibility (four of the UK executives and three of the Australian executives were professionally qualified and had practised as clinicians before becoming managers).

A picture of a balanced relationship was expressed by one chief executive, who said:

we reached a shared understanding on many key issues because [although] we might not have the same perspective... they recognised that I had a job to do, that we had to have a serious regard for the government's agenda, and I recognised that that had to be balanced with an understanding of the priorities that they faced day-to-day in terms of their direct interface with patients. And I still think that's the recipe for the most successful management of this service at all levels.

This recipe was not achieved in every case, however, and a small number of clinicians expressed resentment over the decisions executives took about controlling resources, and a small number of executives expressed frustration over difficulties in managing clinicians.

Summary

This chapter has discussed the competencies derived from the interviews and compared them with competencies (or the equivalent capabilities, dimensions, qualities etc) from other frameworks, and relevant material from the literature on leadership and leadership skills. Many of the individual competencies in the framework have equivalents, or partial equivalents, in other frameworks, but – to the best of my knowledge - this framework is not quite like any other.

A key question for qualitative researchers, from Mason (2002), is 'are my conclusions supported by my data analysis?' The information from the interviews has been analysed carefully and in detail, and supports the conclusion that the behaviours described in the framework have been employed by change agents in successful efforts to bring about change, and that as they are described they are not unique to any one individual. The grouping of these behaviours into competencies is partly an issue of design, and I have included discussion in the chapter where decisions about grouping have been less than straightforward. Some of the omissions from the framework, in comparison to other frameworks might be explained by the method of gathering information: in particular, interviewees may have been unwilling to describe some of the 'backstage' political actions they carried out; also I did not deliberately pursue in the interviews how the change agents coped with difficult emotions, and therefore the framework has no evidence for including competencies dealing with emotional intelligence, such as those in the Leadership Qualities or the Goleman et al (2002) frameworks. A further omission from the framework, in comparison to current ideas about leading change, concerns developing and communicating a vision. These

visionary activities were described by only a minority of interviewees – indicating that the research method was sufficiently sensitive to register the activities, but they were less common than a reading of the literature might lead one to believe.

The chapter then discussed the competencies in action in relation to ideas about styles of leadership, and concluded that common, effective styles for leading change demonstrated in the interviews could be described as participative, collaborative and persuasive; transactional, pragmatic, personable (but rarely visionary); balancing task- and person-focus; and managerial/organisational. The chapter also argued that the complexity of the environment in which these leaders of change operate placed a high premium on the ability to understand complex social systems, and the healthcare environment was evident in the importance placed on patient care by executives and clinicians alike, and the importance of executives and clinicians to be able to work with one another.

The final chapter will summarise the framework that has emerged and identify those areas where this research has contributed to knowledge.

9. Conclusions and recommendations

This final chapter briefly summarises what the research has found, discusses the extent to which these findings have significant implications for the leadership of change in healthcare systems, and identifies where the findings represent a contribution to knowledge. The chapter then proposes five practical consequences of the findings of this study for policy in relation to effective leadership of healthcare systems. Finally, the limitations of the research are revisited, and areas for further research, building on this study, are proposed.

Summary of findings

This research has a number of significant outcomes. Based on the analysis of accounts of change in healthcare systems, the research presents a framework of competencies and behaviours that executives, managers and professionals used in order to lead change effectively in these systems (see Table 9.1). The research also identified how these competencies interacted with one another in the process of leading change, and related the competencies and behaviours to relevant contemporary theories of leadership and change.

It has been argued that, in order to be useful, a competency framework needs to be accurate, acceptable and accessible (Boak 2001; Rankin 2005, 2006). It needs to be accurate in the sense that it does not omit any competencies that are required for effective performance, and does not include any competencies that are superfluous; it should be acceptable to the people who are expected to use it, in terms of its face validity, the extent to which it accords with the users' own experiences, and the degree of harmony between it and other priorities affecting the users. The framework should also be accessible, in the sense that it is easy to use. This framework has been developed to its current state with these criteria in

Table 9.1 Leading change competency framework	
Competencies	Behaviours
Analysing the issues and making decisions about change	<ul style="list-style-type: none"> - analysing an issue thoroughly, or contributing to a collective analysis of an issue, and identifying potential options for change, - this might include arriving at new insights, and new perspectives on elements of the issue - establishing priorities, goals and objectives in relation to the issue you seek to change, and a preferred way of achieving them
Implementing change	<ul style="list-style-type: none"> - setting realistic targets, clarifying responsibilities for achieving the change - setting up systems, procedures and protocols for guiding and monitoring performance, in some cases providing incentives or disincentives - providing, or ensuring the provision, of any training that people need to achieve the change, and of any other required resource - encouraging, motivating and requiring people to work towards the change
Monitoring	<ul style="list-style-type: none"> - monitoring the outcomes of a change against targets or expectations and/or - monitoring performance of a service or a unit against targets or expectations - communicating positive results to show progress - initiating action where problems or shortfalls are indicated
Winning support and overcoming opposition	<ul style="list-style-type: none"> - consulting and seeking consensus - communicating and persuading - providing resources - trading and negotiating - developing and using alliances and partnerships - acting to manage your reputation and credibility - demonstrating progress or success - facing up to opposition
Understanding complex social systems	<ul style="list-style-type: none"> - considering a sophisticated range of influences, causes and effects in making sense of the systems within which you act, including - understanding the economic, psychological, political and professional influences on elements of the system - understanding of how other individuals and groups within the system interact, or are likely to interact, with each other - seeing alignments and connections, actual and potential, between different elements of the system - actively seeking information on the workings of the system from a number of sources, including working with front line staff, exchanging information with colleagues in other departments or organisations, and encouraging people within your own organisation to communicate openly with you
Achieving results	<ul style="list-style-type: none"> - being concerned to make progress, achieve worthwhile, sustainable results, often linked closely to a focus on the welfare of the patient - being willing to take responsibility for achieving results

	<ul style="list-style-type: none"> - being prepared to take action to achieve results even in times of doubt, when the way ahead is unclear - holding people to account for results they are expected to achieve - having a certain balanced pride in achieving results, being the first, or among the first, or the best
Understanding the perspectives and motives of others	<ul style="list-style-type: none"> - being able to interpret and relate to the perspectives and motives of others, even when the perspectives and motives of others are very different from your own, or when the others are in conflict with you - taking time and making efforts to gather information to enable you to understand the viewpoints and interests of others - taking this understanding into account in deciding how to behave, proactively or responsively, towards others
Collaborative working	<ul style="list-style-type: none"> - working effectively in partnerships with others in order to make sense of events and to achieve results, in formal and informal groups - demonstrating some flexibility and give-and-take to be able to work with different people with different priorities - investing time and effort in developing good relationships with others - bringing individuals and groups together and encouraging and helping them to take collective approaches to addressing complex issues - working effectively with individuals and groups from different healthcare professions
Establishing structures and systems	<ul style="list-style-type: none"> - creating systems, and structuring responsibilities effectively, in order to bring people together to share information and jointly decide on solutions to problems - creating new systems and structures in order to enable and motivate people to undertake work more effectively/efficiently
Orchestrating the team	<ul style="list-style-type: none"> - working in close and effective partnership with your staff, delegating some aspects of the task to staff members and tackling other aspects personally, based on a balanced assessment of task requirement, capability and development - taking action to develop and support the team and individual team members in appropriate ways, through formal and informal activities
Self belief	<ul style="list-style-type: none"> - demonstrating self confidence and resilience - acting on your values and principles, and acting with integrity - undertaking learning and self development to enhance your knowledge, understanding, and abilities

mind. Although it has not yet been thoroughly tested with potential users for acceptability and accessibility, it is small enough to remember, manage and apply; it is simply and clearly expressed; it can be related to common (and common sense) ideas about effective leadership and change as well as to recent research (eg Attwood et al 2003; Balogun and Johnson 2004).

The linking of the framework to stages of a change may go some way to answering one of the criticisms of competency frameworks raised in Chapter 4, that it is important to know when to use each competency (Burgoyne 1989; Buchanan and Boddy 1992; McKenna 2004). Tensions between competencies that pull in different directions are still evident within this framework, however, but they have been simplified to a point where they are manageable, not too confusing, and reflect the tensions that individuals experience in practice and need to balance – between

- analysing/seeking to understand
- pushing to achieve results
- working collaboratively with others

The research found that the leaders of change in healthcare organisations needed to use a sophisticated systems understanding in order to bring about sustainable change in anything other than a very narrow sphere of responsibility. This systems understanding included but exceeded the ‘political astuteness’ indicated in the NHS Leadership Qualities Framework, in that the competency of *Understanding complex social systems* comprises more than just understanding the political influences on action. The closest representations of this systems understanding found in the leadership literature are in Porter-O’Grady and Krueger Wilson (1995) and in the ‘social intelligence’ of Zaccaro (1991), Mumford et al (2000) and Zaccaro et al (2000).

One of Mason’s (2002) questions for the qualitative researcher – bearing in mind that qualitative research usually examines smaller samples than quantitative research – is ‘are my conclusions more widely applicable?’ Practically, this means does this analysis of the competencies employed by these change agents, and the styles of leadership they adopted, have any application to other leaders of change in healthcare? There are arguments to be considered on both sides of this question.

In favour of wider applicability, first, although this research did not set out to prove or disprove any theories of leadership or change, there is resonance between some of the findings and other portrayals of effective leadership of change (eg Mumford 2006; Balogun and Hope Hailey 2004; Attwood et al 2003) – although the

combination of findings brought together in the previous chapters has not, to my knowledge, been derived from any other study of leading change in healthcare. Secondly, the findings are based on detailed research into a wide-ranging sample of executives, clinicians and managers, who between them tackled a variety of types of change across a range of organisations, recommended as effective leaders of change by a number of different people. This research process enabled me to generalise about approaches to leading change, and relevant competencies and leadership styles, as set out in the previous three chapters. Thirdly, a key element of the activities that interviewees described carrying out is the importance of a sophisticated understanding of context and specific issues, which is represented in the competency framework in the competencies of *Understanding complex social systems*, *Understanding the perspectives and motives of others*, and *Analysing the issues and reaching decisions on change*. From the accounts provided by the interviewees, attempts to bring about change were often frustrated when these three understandings were not achieved. The message from the research, therefore, for practice elsewhere is not to apply some blunt behavioural tool that will be effective in every situation to bring about change, but to seek to understand the context in which you are working, and the issue that you are facing, and apply measures to bring about change that are relevant to the situation.

Against wider applicability, first, there is nothing to show that the interviewees comprise a representative sample of leaders in healthcare systems (and even if they did, it is a very small sample by the standards of quantitative studies); there may be leaders in healthcare who are effective in leading change in quite different ways from those derived from my interviews. Secondly, the interviews were carried out over a two year period, ending in the winter of 2005, at a particular time in the health services of both the UK and Australia, and it could be said that the culture of the health systems and the priorities applied to them have moved on since then. Thirdly, as I have admitted in discussing my methodology, the approach I have taken may have led to certain tactics in leading change being under-represented, because interviewees may have been reluctant to volunteer them – such as being very directive, pressurising or firing staff, carrying out ‘backstage’ politics or ‘wheeler-dealing’ – or because I did not deliberately check for the presence or absence of certain key behaviours, such as emotional intelligence, or displaying

charisma, or communicating a vision. Fourthly, and related to those 'missing' behaviours, if an argument for wider applicability in the previous paragraph is that some of the findings have resonance with theories of leadership of change, what about the relative absence of visionary leadership? This, surely, flies in the face of accepted wisdom about leading change?

Considering these arguments, I suggest a case may be made for wider applicability. First, empirical generalisation, based on the representativeness of the sample, is not possible – but this is a common situation for any qualitative research (Mason 2002: 195). Secondly, there may have been changes in the culture and systems of healthcare organisations since the interviews were undertaken, but decisions about change in healthcare still involve similar components today as they did at that time – such as patient need and impact on patients, financial considerations, changes in medical technology, the need to bring together clinical and managerial perspectives, the need to win support for changes, the need to analyse issues, the need to make organisational arrangements to implement decisions. The particular *types* of change may be different in different times (and possibly in different organisations), such as seeking agreement on a process analysis, or seeking more flexible methods of delivering services (although the accounts of some interviewees of influencing mergers or developing new organisations would be familiar to executives and leading clinicians in 2006-2007); the extent of the power of different groups or individuals may alter with time and place; the priorities to be taken into account, according to central government, may be different (a new financial squeeze for example, or the imposition of a new system of targets). But none of these differences logically requires different skills and competencies from those derived from the interviews. Indeed, published accounts of changes brought about in four UK acute trusts, in order to achieve financial turnaround, in August 2007, contain descriptions of leadership behaviours that are congruent with the competencies and styles I have identified in my interviews: detailed analysis of processes; analyses of systems; managerial/organisational behaviours to alter structures and systems; communication to inform and to win support; working together to develop effective teams; managers and clinicians working well together; demonstrating progress in order to win (or

maintain) support; collaborative cross-organisation behaviours (Vaughan et al 2007).

Thirdly, it may indeed be the case that the framework is incomplete, that some behaviours have been under-represented and therefore not included, but that is not to underestimate the practical value of the behaviours that *have* been described, which represent a credible description of change agents at work in a complex organisation. Finally, what about the (relatively) low incidence of visionary leadership in the interviews? This curious finding was a surprise, but it is based on careful, detailed analysis of neutral interviews that neither encouraged nor discouraged individuals to talk about visions of change. This finding is one of the contributions of this research to knowledge about leadership and change in healthcare organisations.

Contribution to knowledge

This research has produced an original framework of competencies that effective change agents used in leading change in healthcare organisations, and has provided examples of how the different competencies in the framework were employed in combination in a range of styles of leadership, in order to bring about change in complex healthcare environments. This framework of competencies differs to a significant extent from any other frameworks of competencies/capabilities, including the contemporary 'dimensions' and 'qualities' put forward in the Alimo-Metcalfe/Alban-Metcalfe and the Leadership Qualities frameworks, both designed to apply to individuals in UK healthcare organisations.

The research has also shown that leadership of change in healthcare systems can be carried out effectively without using a visionary style of leadership – without developing and communicating appealing visions of an attractive future state in order to motivate others to change. This is in contradiction to most mainstream contemporary literature on leadership and on leading change. This does not mean that a visionary style is inappropriate for leading change in healthcare systems – the minority of interviewees who described how they developed and communicated visions were evidently successful in their efforts – but far fewer interviewees

described developing and using visions to bring about change than one might have expected, given the emphasis on the role of vision in mainstream literature on leadership and leading change. Where a simple image of a desirable state of affairs (which might qualify as a 'vision' although it was not so described) was evident in the accounts provided by interviewees, it was more often used for reminding themselves and others of the connection between their daily activities and the ultimate purpose of their efforts (such as a good standard of care for the patient) than to inspire the motivation to change.

The research has shown that successful change in healthcare organisations can be brought about through a combination of leadership styles that could be described as transactional and pragmatic (Mumford 2006), but with a personal ability to communicate with, collaborate with, persuade, support and understand others that is seldom attributed to transactional leaders. The leaders of change also described a number of managerial/organisational activities they carried out, which they regarded as central to their ability to bring about change, including agreeing and monitoring structured plans for change and establishing or modifying organisational structures and systems, which are rarely included in competency frameworks.

Perhaps the most significant finding of the above is that effective leadership of change was often achieved through an approach to leadership that was highly collaborative and personable, which relied on pragmatic problem-solving and transactional agreements with others, and used effective managerial and structuring activities to make change happen. This is particularly significant, given the dominance of visionary/ transformational leadership in the literature of change, and the argument that this kind of leadership is needed in health service organisations (eg Edmonstone and Western 2002). To paraphrase Mumford (2006: 271): the widespread focus on visionary/transformational leadership may mean that leadership scholars have committed themselves to a model of effective influence that is too restrictive, and may mean that we lose sight of other important, and effective approaches to leadership.

How original is this finding? Interestingly, Bryman (2004b: 753) argues that qualitative research studies into leadership often produce findings about behaviours and styles that are sometimes 'more mundane than recent quantitative research on leadership with its emphasis on vision, charismatic leadership, and transformational leadership.' This includes a qualitative study into police leadership that Bryman himself undertook with others, which emphasised, among other findings, the importance of instrumental leadership (Bryman et al 1999), which has some similarities with aspects of the managerial/organisational behaviours found in this research. However, this observation by Bryman has not to date led to a more widespread acceptance in general leadership literature of the importance of these instrumental, managerial elements of leadership.

Whilst further work remains to be done on checking and possibly refining the detailed descriptions of the competencies and their constituent behaviours, the competency framework developed in this research will ultimately provide the basis for individual development needs analyses, and for relevant training and development, to ensure that the effective approaches to leadership exemplified by the participants in this research are understood, and can be applied more widely, by others who seek to lead change in healthcare organisations.

Implications for policy

What are the implications of the findings of this research for policies about leading and shaping healthcare? Five recommendations appear appropriate.

On developing leaders for healthcare systems: the competencies demonstrated by the effective leaders of change in this research all appear to be skills that can be learned; they combined in styles of leadership that can all be adopted by the average clinician or health service manager. When designing training and development for leaders for healthcare systems, it is important to look beyond the traditional visionary/transformational model of leadership and encourage also the use of the collaborative, persuasive, personable, transactional, pragmatic approaches that were demonstrated by change agents in this research. In particular, on the evidence of this research, it would be extremely useful to help

individuals who may move to executive positions learn to develop a sophisticated *Understanding of complex social systems*, and the competency of *Orchestrating the team*.

Secondly, healthcare systems are tribal, occupied by different professional specialisms. Effective change agents in this research on the whole understood the inter-tribal dynamics and behaved in ways that meant they were effective in collaborative work across professional boundaries. A key boundary is the one between managerial and clinical staff – but there are also significant boundaries between different clinical groups. There is evident benefit, therefore, in any measures that will enable members of one profession to communicate, and to work more effectively, across these professional boundaries.

Thirdly, many of the examples of change recounted by UK interviewees concerned dealing – directly or indirectly - with changes imposed on the NHS by central government initiatives. Some of these were significant structural changes – and more changes of this sort followed in 2006 and 2007 – creating disruption and uncertainty. At the same time, from the interviews, a core component of being able to work effectively with other groups and significant individuals in the healthcare system was said to be establishing good relationships, and developing them over time. Reorganisations, and changes to funding streams (in particular sudden cuts in funding to some of the clinical projects led by interviewees) were destructive of these good relationships. Central government has the levers to change structures, and to reduce funding in areas where it has previously been provided, and in this way can stop activities on the ground, but in order to make new, productive things happen, to make new structures and systems work effectively, healthcare systems need the energy and commitment of individuals on the front line, and good relationships between them, and these ingredients are at risk of being damaged by regular, radical restructuring.

Fourthly, it was evident that national projects, such as those promoted by the Modernisation Agency (and the state-wide projects in Australia) were very beneficial for the services that the system provides and for the clinicians who took part in those projects. The scope for learning in such projects appeared to be

great, not only in terms of members of the healthcare system sharing and learning about the particular function or disease area, but also in terms of enabling clinicians to develop and practise their leadership abilities in an environment that often provided more scope than, and a different challenge from, that of their own locality, their own clinical directorate. More national projects, with clear funding schedules, could achieve these benefits.

Finally, a theme in a number of interviews was the conflict between achieving sustainable change and achieving short-term compliance with central-imposed targets. The debate on the benefits of targets is ongoing among practitioners. On the one hand, they may encourage gaming behaviour, short-termism and cynicism (Hood 2006), on the other hand, they can provide leverage for change agents in the service to overcome traditional and ineffective methods of working, and thus benefit the patient. This clash between longer term, sustainable benefit and being able to show short-term compliance is an interesting issue, where further specific research would be useful. In the implementation stage of the changes they sought to bring about, a number of interviewees emphasised the value of using individualised (rather than standardised) goals and targets, as realistic and effective measures. Perhaps this individualisation can play a part in the solution to the tension between the policy centres of the health service and the delivery of healthcare on the ground.

Limitations of this study and questions for further research

The limitations of this study were discussed in Chapters 5 and 8. To summarise: the research focused on a relatively small number of change agents (40 in total) in healthcare systems, and was reliant on the recommendations of referees to identify people who were effective in leading change. The research methods used, which relied on accounts from individuals of their own behaviours, appear to suit some interviewees more than others, and it may be that the interview method employed emphasises the behavioural repertoires of those individuals it best suits. It is also possible that the research methodology may have led to certain behaviours in leading change being under-represented in the findings, because interviewees may have avoided describing some tactics they actually employed, such as being very

directive, pressurising or firing staff, or engaging in political activities that may have appeared unethical. Finally, the design of the research, which did not compare groups of 'effective' and 'ineffective' leaders of change (or 'average' and 'outstanding' leaders) means that it is not possible to show that the competences that have been identified are those that make the difference between effective and ineffective leaders of change.

A number of questions for further research arise from this study, including work on testing and refining the details of the framework of competencies. Further inquiry into the competency of *Understanding complex social systems* is of particular interest. 'Whole systems thinking' is often evoked in healthcare organisations, but perhaps less often practised. From the information gathered in this research it is possible to begin to build a framework setting out what specific aspects of complex social systems change agents at different levels needed to understand. Further research will extend and consolidate this framework.

In addition, of particular interest is further research, based on this study, to refine and develop a more sophisticated understanding of transactional leadership, for so long characterised in contrast to transformational leadership as selfish, narrow and limited. There is scope to extend this study with more research into examples of transactions in leadership in healthcare organisations, combining ideas from the literatures on leadership and on leading change, including those of Mumford's pragmatic leadership, which may enable the identification of characteristics of socialised (as opposed to personalised) transactional leadership, and so to exemplify the lighter as well as the darker sides of transactional leadership (to paraphrase Howell and House 1992).

Finally, it was observed above that in the competency framework developed in this study there are tensions, and the need for balance, between individual competencies. There will be a value in further, focused research, building on this study, into how individuals resolve the tensions between the three activities of understanding/analysing, driving to achieve results, and working collaboratively with others.

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Appendix 1; The interviewees

Code	Job role	M/F	Referee	Time (mins)
UK01	Director	F	A	62
UK02	Director	F	B	53
UK03	CEO	F	C	50
UK04	CEO	M	A	45
UK05	CEO	M	A	51
UK06	CEO	M	A	
UK07	CEO	M	D	53
UK08	Director	F	D	60
UK09	CEO	F	A	
UK10	CEO	F	GB	61
UK11	Director	F	B	52
UK12	CEO	F	E	75
UK13	Consultant	F	GB	46
UK14	Consultant	F	F	53
UK15	Other clin	F	HSJ	53
UK16	CD	M	G	61
UK17	CD	M	G	56
UK18	CD	M	G	52
UK19	CD	M	G	52
UK20	Director	F	H	43
UK21	Manager	M	HSJ	47
UK22	CEO	F	B	75
UK23	Manager	F	J	59**
UK24	Other clin	F	HSJ	59**
UK25	CEO	F	GB	62
UK26	CD	M	K	59
UK27	Consultant	M	L	54
UK28	Director	M	K	39
UK29	CD	M	L	32
UK30	CEO*	F	M	47
Aus01	Director	F	N	
Aus02	CD	M	O	
Aus03	CE	M	N	60
Aus04	CD	M	O	59
Aus05	Director	M	N	59
Aus06	Ass CD	M	N	60
Aus07	Manager	F	N	60
Aus08	CD	M	O	60
Aus09	CD	M	O	66
Aus10	Manager	M	N	68

Referee: the referee is indicated by a code to show which interviewees were recommended by which referees. Interviewees where the referee is marked GB were identified by me; interviewees marked HSJ were contacted following awards for innovative practice from the Health Service Journal in 2004.

Time: this is the time of the recorded interview. In four cases the recording equipment did not work properly and the transcripts were based on notes. One interview (UK23 and UK24) was a joint interview with a total time of 59 minutes.

* equivalent

** joint interview

UK interviewees

11 CEs or equivalent – 6 female, 5 male
6 Directors – 6 female, 1 male
2 other managers – 1 female, 1 male
6 Clinical Directors – all male
3 consultants – 2 female, 1 male
2 other clinical – 2 female

17 female, 13 male

Australian interviewees

1 CE - male
2 Director – 1 female, 1 male
2 other managers - 1 female, 1 male
4 CDs – all male
1 assistant CD - male

2 female, 8 male

Note: all but two (Aus05 and Aus10) have clinical backgrounds

Whole sample, is 19 female, 21 male

Settings

	PC	Acute	SHA	Other	Total
CEOs	2	4	3	3	12
Directors	3	4	-	1	8
Other managers	-	3	-	1	4
CDs + ass CD	-	11	-	-	11
Consultants	-	3	-	-	3
Other clinical	1	1	-	-	2

Settings: the settings are indicated as PC (primary care), Acute (secondary care, ie working in a hospital), SHA (pre-2007 strategic health authority in the UK) or Other (none of the above)

Appendix 2

Sample of a transcript

This extract from a transcript contains slightly less than half the whole interview. It begins with the second event described by the interviewee.

The marginal notes are the text of the original coding notes handwritten in the margin of the transcript.

The summary notes taken forward for thematic analysis across the range of interviews are at the end of this excerpt. These were written from the marginal notes and a further consideration of the transcript.

Part of this transcript was used in a coding exercise with a group of MA students, and the results of this are noted after the summary notes.

Note: all names have been changed to preserve confidentiality.

.....

*GB: OK. That's a great example, from my point of view that was an excellent example of something that you've done over the past 12 months. What else have you done?

XY: Well I'll give you an example that L--- suggested to me the other day when I said, I've got no idea what I'm going to say. Because I think this is probably more typical of how I think I would probably tend to work. Which is, we've got huge financial problems within this PCT...[provides details of the financial problems].. so we've got massive financial problems. And clearly a huge effort over the year has been made a) to try to get to a break-even position this year, not recurrently, but also [b)] to look at how we're going to get into recurrent balance over the next three years because we can't keep on coping as we are at the moment. We had a CMT time-out which is our corporate management team which is essentially the exec team. And in advance of that I guess I'd been thinking, what are we going to do about this over the next few years? how on earth are we going to start to get to grips with it? And what is very evident is that inevitably you have practices that you look at and you think, I don't think this is probably the most cost effective or high quality way of delivering these services, and we're probably not getting the best patient outcomes. But we're locked into it. And when you're in it then you don't notice it, so it's one of the advantages I guess of coming in new. So in advance of that time-out I probably talked to three or four individual colleagues within the team to say, what do you think about ways in which we could tackle some areas of practice and look at some projects that would deliver change in practice that potentially could also deliver us either immediate savings or ways of delivering services that would potentially mean that we don't have such a demand for secondary and specialist services? We got to the CMT and what I'd done is put onto the agenda for that, 'finance strategy' as an opportunity to start to have that kind of discussion. And it was all a bit twitchy that first day and I think everybody was feeling very stressed and edgy. And we got into the finance strategy session and to be honest just didn't get to a point where it made logical sense to introduce that particular proposal. So I left it because I thought, timing is everything and it's clearly not the right time, we'd not ended up at a point in the discussion where that will come in. And then the next morning everybody had had a good evening and we were all much more relaxed and we were sitting talking about things and the opportunity came up. And essentially that was the modernisation programme that we'd set up which was a series of seven project areas that everybody basically signed up to, that we could deliver change that would potentially also deliver us cost savings. So that I think is an example. What I don't like is people to be too surprised. Because what happened was, it came up naturally as part of that discussion and because we'd had earlier informal corridor-type conversations then nobody's particularly surprised by it and everybody's sort of already half way there in thinking, yes that makes sense and yes I can contribute to that or how about this, that or the other

*GB: How did you go about working out those seven projects

BEI issue: chooses an example

Financial break-even as an objective

Forward thinking about how to solve problems

Judges practices on patient outcome and cost effectiveness

Prepares people for decisions

Systems thinking

Senses thoughts, viewpoints of others
Delays discussion of a strategic proposal when it is not the right time - sensitive to readiness of others

Takes opportunity when time is right

areas?

XY: Let's think about what some of them were. One of them was continence. Well I'd had some discussions because they were reviewing the contracts for continence and were reviewing the product range and all the rest of it and I'd just been keeping a watching brief I guess on what had been happening around that. And it had become quite apparent to me that we'd got real problems about where the clinical accountability for assessment lay and where the financial accountability lay, and those two should really be as close together as possible. And they aren't currently. And I'd talked to district nurses and discovered that they didn't have basic equipment they need to assess patient with incontinence problems. So you start to put together a picture. And the budget is huge and it overspends every year. And you just get a picture that says to you, this ain't working. The clinicians on the ground who see the patients who are assessing them, haven't got the basic kit to do the assessments, they haven't got clinical accountability because they then have to send their little documents off to be marked by the continence team. And they haven't got the financial accountability because they haven't got the budget. So you know, why would you be surprised that the budget is massive and overspending? And basically from a patient's point of view, you've got patients probably on products who if they were given proper management programmes, would be continent. So you haven't got good patient outcomes either. So that was one which over a period of time, just from different sources just putting a picture together that said to you, this is a big area that's probably really poorly managed. Tissue viability is another. And that was much as anything because we get a very poor service from the specialist service which is managed by South West Button PCT, so that instantly rings alarm bells, because if you're not getting specialist advice and training, then people won't have the skills. And then it was that we'd got district nurses again basically running around with huge caseloads of patients with leg ulcers. And you shouldn't have that. Because if you're treating them properly, if they're managed properly then you heal them. So if they've got huge caseloads of patients with leg ulcers, they're not managing them properly. So you pick things up as you go round I think and put together a little picture that says, these are the half dozen or so areas where things aren't working. CAMHS was another. Mental Health Tier 1 you know. Health Visitors and School Nurses are all saying to me, we get qualified, we can't then access the training and education we need to develop specialist skills we need to work properly and effectively with quite difficult client groups. Now I'm talking to CAMHS, Child and Adolescent Mental Health Services, who have a huge waiting list. Well the two go together. If your primary workers can't manage basic early intervention then you'll end up with a long waiting list for the specialist service. So that's really...

*GB: So one thing leads to another?

XY: Yes, I think you see patterns. And I've been doing this sort of work a long time. So it's not like coming in fresh into it. You know, I've worked in all these things, I've done continence and all the rest of it, so you don't need many triggers before you can look at it and say, right I actually know what the problem is here

*GB: Thank you, that's another great example. That's great.

What else have you been tackling over the last 12 months?

Monitoring how things work

Assessment of system dysfunctions re divided responsibility

Uses clinical and financial info to 'put together a picture'

Puts a picture together

Good understanding of how the system works

Uses clinical experience to diagnose systems problems

Gathers info from front line staff

[Note: text from here used in a coding exercise]

XY: I think an interesting area probably is complaints. The NHS on the whole manages complaints really badly and I think it does that for two reasons, first because the NHS is very good at concentrating on the wrong thing - so targets is a good example of that you know, let's concentrate on two week cancer waits or twelve hour trolley waits - when I was in Northfield and we then had patients dying in ambulances outside the A & E doors because they weren't allowed off the ambulance because of the trolley waits... And you just think, that's not actually what the point of the targets is. But complaints is another area because what you end up is quite a bureaucratic system that doesn't really concentrate on achieving the best outcome for the complainant, it's more concerned with getting rid of the complaint. I think the other reason that complaints are generally poorly managed in the NHS is because you usually have... essentially the complaints management is administrative in that it manages the process, and what you don't have is people who are sufficiently skilled in investigating and asking the right questions. And when I came here, one of my responsibilities was complaints, and I was finding that I actually couldn't get proper investigations done. And I'd be asking a senior manager to investigate a complaint and I'd get back... a classic example was a patient who died... and I got back this letter which just basically said, it's the patient's own fault because she wouldn't let us test her blood sugar. And I said, no I don't think that's quite adequate. And I thought, right ask the questions. So I asked all the questions and I got back another letter which essentially said the same thing as the first. And then it transpired they didn't actually have any complaints procedures and they had never clearly investigated a complaint in their lives. And the whole culture was one of defensiveness and hide it and don't do anything about it. So I think what we've managed to do really around complaints is to improve the process a lot, so we go to a...you know, a lot of complaints are fairly straight forward but we usually try to ring a complainant up when the letter first comes through and say, can you just take me through this and make sure I understand it properly? And then if necessary... for example, in that particular case, we met with the complainants, so we actually had face-to-face contact with them and spend a couple of hours with them in fact going through it all and understanding and making sure that they were clear that we were going to be honest, and what the timescales would be for responding and making sure that we investigated it properly and all the rest of it. What I've also done is to put in a clinical lead for complaints, so that's actually, she's an ex-midwife and she managed a midwifery unit up in G--- so she's very used to complaints and litigation. She's very experienced in that. And she then provides on-the-spot help. She gets copies of every complaint that comes through. She contacts the manager responsible for investigating, and can offer them support with the investigative process, particularly if it's a complex complaint. She'll actually go out with them, talk them through it, work with them with the team if they need help with the investigation so they get a good quality investigation done. And then obviously we deal with the response. But if it's a particularly difficult one like the patient who died, we then arrange to meet with them again to make sure that we've spent time on... for example in that case we admitted fault, so it was

(Low level)
understanding of how
systems work

Systems analysis

Valuing role of skills in
the system

Investigates, analyses

Concern for quality of
service for patients

Reading of 'culture'
and perceptions of
others in how the old
system worked

Creates new org
structures, employs
people with experience
and skills

really important that we spent the time with the family, so this is what went wrong. And actually it wasn't your responsibility, it wasn't your errors, we let you down. And I think that's the sort of culture that we're trying to get established, that we learn from it, it's not about blaming the staff, it's just about saying, things do go wrong sometimes and we need to understand why and make the necessary changes so that staff aren't placed in that position again because it's very traumatic for them as well. But also that patients are suffering. And that complainants are treated as having a legitimate reason to complain, it's not seen as a problem. And I think we've done some good quality work with complainants where probably they hadn't necessarily had that kind of experience in the past.

*GB: It sounds a tremendous system, that you've put together a set of process, how in the beginning was it received inside the PCT?

XY: I think... I guess there's probably still mixed feelings about it. We're running training at the moment for all staff because clearly they need to understand... and certainly for that team for example, it was very, very traumatic because they had to face the fact that actually they were culpable, and that actually they hadn't delivered care in a safe effective way and a patient had died as a consequence of that negligence. Which was clearly very difficult for them. I think the important thing is making sure that you do support them through it, and that they understand that it isn't about blame. And yes, things have gone wrong and things haven't been done that should have been, but nobody was disciplined out of that. Which clearly their concern was that they would all end up being sacked and goodness knows what. But you've got to recognise they're part of a system and they've functioned within a system that's had a particular culture and a particular way of working, and they hadn't had proper management and proper review to help them to understand that they weren't managing the caseload properly. So I think it will be experience over time for the staff, that they have to see that actually what we did was... we got involved in action planning to look at how we improve practice but that they were then part of the solution. So we moved them on if you like from just being left with this huge problem of things that went wrong to actually, you can be part of introducing best practice across the Trust, so you can actually lead the best practice. So I think the culture is there still, which is to me, still quite defensive, not necessarily patient-focused in the way that I'd like to see it. But you can't change it overnight. And you have to do it by experience with each time that you go in there

[Note: coding exercise finishes here]

*GB: So changing the system there and helping people to work through what that change meant sounds like another tremendous example of looking to bring about change inside the organisation. You talked just now about changing the culture, what do you mean by that?

XY: I think... When I first came into the Trust - and there's always a risk that when you come into a new area that you can be deeply critical, because it's very easy to start spotting all the things that aren't right - but there was a particular culture that I found quite difficult if I'm honest, which was that financial decisions were made at a county-wide level by a little group of finance specialists. And fundamental decisions about clinical care were actually being made by a group of responsible finance

Patient focus - aims to provide support and empathy

Seeks learning from mistakes, not to blame staff

Sees and empathises with perspectives of others

Systems perspective on behaviours of others

Involves staff in positive action when things go wrong, to 'move them on' - empathy

Sees different perspectives of finance people and clinical people

people and they were making those decisions in good faith based on financial criteria but actually not necessarily decisions that you know... my view is that finance is part of a team which is a multidisciplinary team and it's a multidisciplinary team for good reason which is that everybody has a different perspective and can contribute something different. But we'd got this set of systems in Buttonshire which seemed designed to separate that team out and have different people making quite different decisions in little cabals (laughs). That's a culture I do struggle with and I think we're moving away from. But an example would be around individual named patient agreements for treatment. And there's about four different categories of those types of treatments that people may put in requests for, on an individual patient basis. And they're basically for us to fund treatment for procedures or for other treatment that isn't part of our usual bog-standard portfolio of work. And we've got a county-wide system that's led by West Button PCT, by the DPH over there, for some of those, and then some of them come directly into the PCT. So instantly you're starting to think, well this isn't a very sensible system because you've got several different routes of things coming in. And over the course of the year I get quite a high proportion of complaints about the decisions that are made in relation to those named patient agreements. And what's become apparent is that basically those decisions are made by a person with a public health hat on. So a public health perspective is applied to whatever the request is but people are more complex than that and their situations are more complex than that, and you can make a decision which is perfectly valid and reasonable from a public health perspective which is actually not valid and reasonable if you look at it in the round. And one example of that would be a patient who's attending an alternative therapy unit, which they've actually been attending for 20 years, funded by the health authority in London. They moved up here and we then refused to fund treatment at this... it got refused. So in the end I set up a meeting with this DPH and the patient's G.P. to understand why it was that this patient had had treatment successfully for 20 years and now couldn't have it. And essentially it was a perfectly valid public health decision, that there was no evidence-base for the treatment and that there were concerns actually about this particular centre which were being explored nationally. But from a clinician's perspective this patient was actually very effectively managed as an individual on that treatment and they were clinically improved. And so...and it was cheap. Because she was on cheap drugs from the NHS and cheap treatment from this place, which actually amounted to less than if she'd been on the most up-to-date NHS treatment. So the whole case sort of crumbled around you when you started to get a better perspective on looking at, what does this actually mean for this patient? So I think we have got undoubtedly a culture that is a bit inclined to hive off decision-making and not to have that patient outcome focus. And around that we're trying to now get the system changed so that we have a full multidisciplinary panel that includes independent lay representation, that looks at all main patient agreements not just some of them that come in via different routes, and that has a separate independent appeals process. You'd think that sounds a bit basic really, wouldn't you? But that's the situation we're in, that's how it's been managed up till now you know, that was

Values different perspectives and seeks to include them in decisions

Detailed understanding of system

Normal monitoring reveals a problem

Understanding of different perspectives of others

Investigates the detail of an issue

Understanding of different perspectives

Patient focus

Seeks transparent process in a changed system

clearly the way it was managed in the Health Authority. And there was an acceptance that that was a reasonable and acceptable way for it to operate. And I just don't think that I would support that really.

*GB: How have you got agreement from people that that's the way to go?

XY: I think I've just got on their nerves. If I'm honest, I think over that particular one I've just all year whittled about it. And every time a complaint comes through which is regularly, about a decision that's been made, then we almost always end up reversing it, because it's flawed. When you actually get down to it. We had a classic example of a patient who had gone to P--- [a city about 100 miles away] for private treatment to have a cataract removed. And her family had had to scrape around to gather up the funding for this because it had gone to West Button and had been turned down on the grounds that we've got other local providers with whom we'd already got service level agreements who could do that surgery. I got a letter of complaint in from the family because she needed to have a second cataract removed from the other eye and they couldn't afford to fund the private treatment for that. When we really got into it, it could have gone either way really... her family all lived in P---, so they were willing to transport her up there and would then have been able to provide her with the aftercare once she'd had the treatment. So that would have been a very valid reason for us to support it. In actual fact the reason that she'd requested it was because she believed that the waiting list for that surgery were over a year locally and she was 83 and a year's a long time at 83. In actual fact we could get her treated with a local provider within 3 months. And so we basically offered her the choice, go to P--- and we'll pay for it and you'll have your family to support you, or we can arrange transport and so forth to T--- [a city about 20 miles away], and you can be treated within 3 months. And in actual fact she took that second option. But it does seem to be a classic example of, nobody had ever picked the phone up and said to her, why do you want to go to P---? And her whole family had gone through all the stress and expense - which they could clearly ill-afford in funding her to have private treatment - when she could have gone to T--- in the first place. And that's...you know, you can't live with systems like that. You just have to change the system

(Note: interview continues for another 3700 words).

Persistence in making a case

Investigates, seeks information

Patient focus and empathy with patient

Value-based action when systems are wrong for the patient

(notes made on themes in interview, taken forward to identify themes across interviews; seven minor changes made from original to protect anonymity)

Strong patient focus ref needs of patients, redressing failures to meet those needs; concern for quality of service; empathy; value-based action when systems are wrong for the patient; value-based action ('you can't accept that')

Takes action based on values ('fundamentally wrong' options are 'unacceptable')

Speaks out to resist proposals from more senior/more powerful actors where they do not meet the needs of the population: prepared to confront people in this situation: makes a clear, open statement of her position in a confrontation and is successful in achieving change

Makes a political assessment of influences in a situation

Forward thinking about how to address issues over the next few years

Judges practices on patient outcomes and cost effectiveness

Sensitive to thoughts and viewpoints of others

Deliberately preparing people for decisions: delays discussion of a strategic issue when it seems not the right time: sensitive to the readiness of others: takes opportunity when time is right

Systems thinking: considers how systems work Identifying patterns and problems on the basis of experience: understanding how systems work: assessment of system dysfunctions re divided responsibilities; role skills of people in systems; reading of 'culture' and perceptions of others in how the old system worked

Uses clinical experience to diagnose system problems

Monitors how things work: monitoring reveals problems that require action

Investigating – seeking facts: gathers information from frontline staff: investigates the detail of issues when problems arise

Creates new organisational structures and responsibilities, employs people with experience and skills

Seeks learning from mistakes – not to blame staff

Involves staff in positive action when things go wrong, to 'move them on': empathy

Sees different perspectives of finance people and clinical people, and different types of clinical people; values different perspectives and seeks to include them in decisions; likes learning about different perspectives and different jobs – importance of being able to understand that in order to 'make sense...or produce things that are going to make sense to them'; sensitive to how things appear to staff (after the merger)

Seeks transparent processes of making decisions; importance of due process in making decisions; fits difficult cases within the process

Persistent in making a case

Seeks to involve others in collaborative decisions

Perception of job is about supporting the team

Stands on values: offers to quit job if unsuccessful in a project in order to win cooperation of others: takes responsibility

Develops sophisticated collaborative system to achieve results

Concern for sustainable results

Encourages systematic open communication

Sets up structures and processes for clinicians to analyse needs and decide on service development

Aware of need for staff development: meets staff 1:1 and mentors them, and encourages them to develop individually and as a team

Seeks input into strategy from front line staff

Makes time to be open and accessible to front line staff; networks, contacts, in order to learn and pick up info

Chairs meetings that are difficult or where staff are 'too new'

Seeks to use an enabling style of management (cf quote)

Interview analysis example

An excerpt from the interview, as indicated above, was shown to a group of experienced health service practitioners and managers who were undertaking an MA course, on 22 June 2005, as part of their research methods module. The purpose of the interview was explained, in terms of my wishing to identify what people need to do to bring about change in health service organisations. The group was split into sub-groups and invited to analyse the text. The exercise followed a brief exposition of the four-stage process of grounded theory methods in analysing observations, based on Locke (2001). When the groups fed back I made notes on a flipchart, which are the bases of these notes:

Group 2

Behaviours shown in the excerpt:

- Highlighting deficiencies in the current system
- Helping people to understand the implications and the outcomes of the current system
- Clarifying the problem: actions taken alone and also with others
- Asking the right questions (*in discussion it was agreed that this might be a sub-category of a behaviour of collecting evidence*)
- Trying to change people's motivation
- Recognising others' psychological need for support
- Focus on action planning to bring about change

Group 3

- Learning from the past
- Conscious actions to change the culture
- Honesty and openness
- Involving the team in action planning and implementing best practice
- Concern to establish a non-blame culture

(Group 1 completed the task very quickly and produced very high level abstractions which they subsequently found difficult to link clearly to the text, and I didn't write down their suggestions.)

Another member of the teaching team suggested that the person's behaviours indicated certain values: he began this list, and other members of the group added suggestions

- Concern for improvement
- Concern for being honest
- Working with people – sharing information; caring for them; importance of face-to-face communication
- Placing a high importance on accountability
- Sense of process in addressing complex issues

Appendix 3

Word searches were carried out on all the interview transcripts for certain items – an example is shown below. Other words searched for included stakeholders, details, culture, mission, learning (for self).

	Vision	Syst'm	Values	Patient	Learn Teach etc others	Complex
UK01	0	✓"	0	2	0	✓
UK02	0	str	0	many	✓	str
UK03	0	✓	0	*	0	0
UK04	✓	✓	0	✓	✓	✓**
UK05	0	str	✓	✓	✓	1
UK06	✓	✓	✓	✓	✓	0
UK07	many	✓	0	many	0	✓
UK08	✓	***	✓	✓	✓	0
UK09	✓	str	✓	✓	✓	0
UK10	✓	0	1	✓	✓	2
UK11	0	str	0	✓	✓	0
UK12	✓	str	✓	✓	✓	✓
UK13	✓	0	0	0	✓	0
UK14	✓	✓	0	many	str	0
UK15	0	1	0	many	str	0
UK16	0	✓"	0	many	✓	0
UK17	✓	✓"	0	✓	0	✓
UK18	0	✓	0	many	✓	1
UK19	0	str	0	✓	✓	0
UK20	0	0	0	✓	0	✓
UK21	✓	✓	0	✓	✓	0
UK22	0	✓	0	✓	str	0
UK23	0	✓	0	✓	0	0
UK24	weak	✓	0	✓	0	0
UK25	✓	✓	0	✓	✓	0
UK26	0	✓	0	✓	0	✓
UK27	0	✓	0	many	0	0
UK28	0	✓	0	many	0	0
UK29	0	✓	0	many	str	1
UK30	0	✓	✓	many	str	1

str = strong

* used as descriptive of a service – 'in-patient'

** as well as 'complex' he talks of a 'very complicated world of multiple priorities'

*** only in respect of engineering systems etc

" means a particular method of doing things (process mapping, or particular business systems) not systems more generally or the system as a whole

Appendix 4

The following notes are from the first systematic application of change as a series of stages to an interview transcript.

The notes concern the main scenario described in the interview ('Example 1'). The stage model was also applied to two other scenarios discussed in the interview; I came to the conclusion that one of these examples was a part of Example 1 (it was a monitoring-implementation-confronting opposition adjustment) whereas the second example, although smaller than the main scenario, could realistically be analysed using the stage model. This led me to design the competence framework on the basis of stage-specific competencies and common, or pervasive competencies, as described in Chapters 6 and 7.

These notes have been edited in minor ways (six amendments) to preserve confidentiality.

Change model analysis

Interviewee "BB"

Main scenario:

BB aims to bring in major culture change, as a new CEO going into a failing organisation.

Example 1

Identify issues

Previous CEOs had all produced quick wins at expense of long term viability of organisation (eg by moving resources to hit short term targets, and away from activities needed in the longer term – an issue that was revealed by an inspection). BB aimed to achieve sustainability.

BB doubted the competence and trustworthiness of executive team

There was poor communication between exec team and staff, and low level of trust by staff of management

Identifies need to build infrastructure (of team and organisation)

Identified a range issues for improvement, including: communication; how people behaved towards each other; clear responsibilities; capability of staff; confidence

Acknowledges own need to learn and develop

Analyses aspects of operations in detail to improve performance

Staff feel under-appreciated

Reach a decision

a) worked towards organisation that is effective and sustainable, based on original idea that BB took into job

- b) needs top team to deliver. Sees this as the main priority, so decided to replace the executive team s/he inherited, and not to have a major reorganisation below that level in the first year
- c) decides to stick with his/her original ideas for the first year
- d) focuses on a limited range of issues s/he has identified for improvement
- e) refines the strategy after 12 months, with corporate objectives etc: develops the strategy from a number of sources: by talking to staff; from DH documents which indicate 'the direction of travel'; from negotiations with other NHS organisations
- f) restructures in order to get clear lines of accountability; provides more learning support for managers
- g) seeks personal learning and development: also develops mutually supportive relationships with others, in other organisations
- h) identifies changes that can be made to systems, procedures and technology in order to make change to improve performance
- i) creates award ceremonies to recognise and value staff

Get support or overcome opposition

- a) Comes under pressure from SHA to meet targets in the short term: doesn't get the 'honeymoon' period s/he hoped for.
Seeks advice from 'wise old owls' who tell him/her to stand up for him/herself
Stands up to SHA CEO: SHA CEO backs off
- b) clearly sets out his/her position to executive team members, who move into other jobs, or who are moved out of the job: takes action against non-performers: this builds up credit for him/her with front line staff, who had little confidence in their managers
- c) Seeks support for and feedback on his/her ideas: seeks better communication with staff – goes out to meet them, does shifts with them: communicates widely with staff on a 1:1 basis; promises that s/he won't aim for quick wins but will aim for sustainability; encounters doubt and opposition, but asks to be judged on results; attributes much of his/her success to being honest with staff.
- d) Expresses what needs to be developed (part of the strategy) in a simple form in order to communicate it
- e) Constantly communicates the strategy and develops clear statements of it, and role models communicating it, in order to enable all managers to do the same.
Communicates it internally and externally. For members of other organisations, the strategy shows how BB's organisation will benefit them
- f) clear communication about reasons for re-structure and what it will and won't entail
- h) some changes are technical and can be achieved easily; others require changes in working practices: s/he seeks feedback from front line on their difficulties, addresses the ones s/he can address, negotiates changes in working practices with representatives of staff in order for them to be more proactive to meet patient and community needs: negotiation includes providing staff incentives and new equipment and giving staff 'input'; agreement has been partly brought about by improved communication; sends firm message about change
- i) persuades senior figures from other organisations to attend first award ceremony

Implement

- d) puts in management training and IPDs; workshop to help Board work; uses numerous ways to communicate positive messages to the staff to influence their attitudes

- f) brings in new structures and also provides extensive coaching and mentoring support for ADs
- i) runs and attends award ceremonies

Monitor

Performance improvements shown in stars and performance monitoring stats

Monitors SHA CEOs' reactions

Regularly monitors performance figures: role models this concern with monitoring and controlling performance ('you find the minute you take your eye off the ball, so does everybody else')

Publicises performance figures regularly within the organisation, to make people feel responsible for results

Gets personal feedback from staff on award ceremonies

Other

nb emphasises simple nature of change

Capacity building: appointing competent people s/he can trust; clear responsibilities through new structures and systems; improved communication with staff; seeking agreement on a new strategy; carrying out detailed analyses of systems and processes and focusing new resources at key points; improving capacity through management training and coaching/mentoring; focusing staff on performance and results

Values: strong focus on performance and working for patients; strong focus on providing support, structure and direction for staff; seeks challenge in job and wants to produce results

Appendix 5 Change areas

These are summaries of the notes I made on the types of change that interviewees undertook, abridged to fit within the wordcount for this thesis. Interviews varied – in some cases the interview concerned the details of only one change, in other cases there were as many as six items listed.

UK Executives and managers

New organisation – setting up and getting settled
Developing and getting agreement on a series of projects to reduce expenditure, and to improve effectiveness of services for patients
Improving the complaints process
Changing systems for making decisions about care in order to improve the focus on patient outcomes
Cross-organisational work to provide healthcare support in schools
Organising, and communicating with health teams across the organisation, and developing multi-professional working
Develops the nursing strategy
Changing a particular process – an area where there was a problem when she moved into the job
Managing part of the processes of a merger with another acute trust
Developing and implementing a directorate strategy
Creating a body to link with and attempt to influence Health policy
Creating a robust management structure within a merged acute trust
Ensuring the trust meets its targets: includes setting and enforcing standards, supervising system/process re-design
Handling a CHI inspection
Working on design of cross-organisational care when a whistle-blowing incident arises
Trying to develop a strategy for financial recovery when a threat arises to close a service of the hospital
As a new CEO, changing hospital structure, systems and culture to make it less hierarchical, and to involve clinicians more in strategy and running of organisation
Attempting to develop a cross-organisational clinical strategy
Merger of acute trusts
Leading a cross-organisational strategy to move more care into primary care
Meeting targets (addressing a performance problem in an acute trust)
Working to expand capacity in the health system, by exploring/promoting different ways of delivering care
Creating/supporting leadership development programmes for senior management
Setting up a new organisation
Lead a programme with social and economic orgs on employability in the region
New ways of managing support services, and service reconfiguration
Handling industrial relations
Setting up structures jointly to manage a large change project
Achieving more flexible working
Creating a new organisation, result of a merger between different organisations
Achieving a quick change concerning meeting access time targets

Introducing overseas clinical teams
 Creating a change in the services offered in primary care (historical, in early 90s)
 As a new CEO, work to change culture, working practices and behaviours in a failing organisation in order to meet targets
 CEO in a merger
 Reorganising care in a number of different areas
 Negotiating changes to working practices with clinicians to improve care for patients, and to provide new and more flexible service arrangements
 Introducing innovations into the service
 Making a successful case for getting a new hospital built
 Developing a teaching facility in the trust
 Re-structuring, reorganising services
 Creating a new PCT – setting up a new organisation
 Managing the closure of an organisation in an NHS reorganisation
 Improving systems and training staff to improve the performance of her organisation
 Developing clinical staff and supporting them so they can lead innovations
 Making decisions about closing a ward, due to financial pressures
 Contributing to setting up a new organisation
 Development and implementation of supported open learning in a cross-organisational scheme, to improve patient care and to recognise skills of healthcare workers
 Developing skills of lay members of a key management committee
 Reengineering of services, involving changes to systems, job, responsibilities, and primary-secondary care cooperation, to improve patient care.
 Translating national best practice into local action to redesign services, to help in financial recovery
 Tackling an urgent performance problem in relation to A&E targets in two hospitals
 Improvement of hospital systems and processes for carrying out diagnostic tests
 Developing a pathway across primary and secondary care regarding a particular condition
 Setting up a new organisation
 Influencing Healthcare Commission to carry out a survey of patients
 Setting up and running events in all SHAs to promote [disease area] care
 Seeks to introduce 'a performance and delivery culture' into an acute trust
 Making changes in children's services in order to meet NSF targets and to achieve financial savings
 Reduces numbers of medical wards in order to achieve savings
 Resolves performance problem, changes working practices
 Supports clinical director in taking action to improve performance against targets
 Helps clinicians establish a new clinic

Australian executives and managers

Taking charge of a hospital as a CEO, and taking steps to change the values and the culture of the organisation so that it provided a better service
 Summarises inquiry report and publicises it nationally to improve awareness of need for good clinical care and clinical governance
 Leads a state quality council in order to encourage state-wide communication and improve care
 Changing way in which care is delivered – delivering more care in the community

Purchasing and managing the implementation of a standardised state-wide IT system
State-wide project to bring in performance indicators for a certain clinical area, and improving work practices in that area
Providing education and training resources for people in a clinical profession
Bringing a more 'business-like' approach to support services
Introducing e-procurement to the health service in his State
Supporting quality improvement projects
Changing recruitment and workforce management systems within the hospital
Creating a clinical governance programme

UK Clinicians

Two changes in clinical practice, to improve care and reduce risks
Supporting the development of a new role, as part of a regional/national project
Work on a national project to develop a new training programme for clinical staff
Reducing waiting lists and changing processes in his area of clinical responsibility
Developing a programme to educate patients to enable them to take more responsibility for managing their own care
Making a change to processes and responsibilities in his directorate
Leading a national MA project to support innovations in his clinical area
Improved outpatients processes in his own directorate
Chairing a group in his Trust to review and improve performance [in a particular area]
Development of systems to improve how patients are booked into, and discharged from, hospital for elective surgery and diagnostic tests
Makes changes over time to how services are provided in his directorate.
Developing new approaches to managing patients with certain medical problems across primary and secondary care
Clarifying inter-organisational agreements on provision of services
Tackles performance problems by clinicians
Tries to build his directorate, getting new staff in, changing roles, changing the way they work; including giving more information to patients
Tries to get better working relationships with other hospitals
Develops a system for clear prioritisation of patient need and allocation of staff
Seeks to set up a short stay medical unit to deal with a particular type of patient
Increases amount of teaching and research carried out in the hospital

Australian clinicians

Getting agreement on standard protocols for risk management in a specific area of healthcare, across a range of clinical groups
Spreading lessons from his first project to a number of other hospitals
Has grown his department
Set up a private company to provide services
Ensured his department took over an area of medical care, to improve quality of care
Established different working practices/policies to improve the service
Data analysis of patient care in a number of hospitals to improve how individuals deliver services, and to improve systems of care
Changes systems and procedures concerning how drugs are prescribed to improve patient safety, within his own hospital and then in a number of other hospitals
Brings together and coordinates multidisciplinary group to agree and implement a coordinated patient pathway for a particular condition