Darzi and Leadership – it's too important to get wrong this time!

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Abstract

The Darzi Review has provided the NHS with a second major opportunity since the introduction of the Government's Modernisation Agenda to transform its culture such that it can markedly improve the quality of care it delivers and the well-being of its staff, namely, by focusing on its leadership capability. Furthermore, this opportunity has a significantly greater likelihood of success because it unequivocally places clinical leaders centre stage in relation to their critical role in demonstrating the sort of leadership that could deliver the transformation of the kind that is desired.

Darzi has also described how the transformation should be undertaken, which is by a move away from top-down bureaucratic change to change that is owned and driven locally through staff who are engaged, energised and committed. However, we believe that by adopting an exclusively competency-based approach to leadership it is not only at variance with recommendations from numerous research findings, and is, therefore, inconsistent the Department of Health's own edicts on adopting evidence-based practice, more importantly, it might endanger patients.

In this article we outline our reasons, and provide evidence from a recent three year longitudinal study of the impact of leadership on the effectiveness of multi-professional teams.

Keywords

Darzi review, leadership, medical competencies, engagement.

The Darzi Review (Department of Health, 2008) has provided the NHS with a second major opportunity since the introduction of the Government's Modernisation Agenda to transform its culture such that it can markedly improve the quality of care it delivers and the well-being of its staff by focusing on its leadership capability. Furthermore, this opportunity has a significantly greater likelihood of success because it unequivocally places clinical leaders centre stage in relation to their critical role in demonstrating the sort of leadership that could deliver a transformation of the kind that is desired.

As Darzi states: "Leadership has been the neglected element of the reforms of recent years. That must now change." (p.66).

Darzi has also described how the transformation should be undertaken, namely by a move away from top-down bureaucratic change, to change that is owned and driven locally through staff who are engaged, energised and committed. However, as the Review noted, "Greater freedom, enhanced accountability and empowering staff are necessary but not sufficient in the pursuit of high quality care. Making change happen takes leadership". Those familiar with the research literature on what contributes to the success of change initiatives will recognise that such an approach is entirely consistent with best practice (Jones, Jimmieson and Griffiths, 2005), and it reflects our own recent empirical research on the successful implementation of change in the NHS (Alimo-Metcalfe et al, 2007).

Encouraged as we are by the Darzi Review's support for such an approach to leadership and change, we are anxious that the way in which the NHS has previously approached leadership from the centre - by focusing predominantly on competencies - will seriously jeopardise the achievement of the vision articulated by Darzi, and may even harm patients. In this article we outline our reasons.

Medical Leadership Competencies Framework

The Medical Leadership Competencies Framework

(MLCF) which has been adopted by the Royal Colleges is based, in part, on the NHS Leadership Qualities Framework (LQF). Our concern is that despite having been in use for several years, the validity of the LQF has yet, as far as we are aware, to be supported by evidence published in academic peer-reviewed articles, of its impact on the effectiveness of NHS organisations or staff, or on staff attitudes and well-being, which are critical factors in sustaining high quality performance. Such a lack of validity is conspicuously at odds with the Department of Health's regular exhortations regarding the use of evidence-based practice in relation to clinical practice.

The dearth of studies supporting the validity of the competency approach to leadership should come as no surprise, given the burgeoning of articles criticising this kind of approach to assessing leadership.

The competency debate

There has been a substantial increase in the use of competencies as the basis of leadership frameworks across the UK public sector in line with the government's modernisation agenda, and what we believe to be a misguided understanding of the relationship between competencies and effective leadership practice, the latter clearly being all about getting things done with and through others.

It is important to state from the start that we **do** believe that competencies or 'skills' are crucial for the effectiveness of anyone, whatever their job, and unquestionably for clinicians; it would be a nonsense to believe otherwise. However, it is becoming more and more evident that competency frameworks alone are not sufficient for assessing the full range of leadership behaviours that are required for effective leadership and organisational success (Alimo-Metcalfe and Alban-Metcalfe, 2007).

We are not alone in pointing to the dangers of adopting a competency approach. UK writers Bolden and Gosling (2006) who reviewed 29 such frameworks, have pointed out that: (i) the competency approach has been criticised for being overly reductionist, fragmenting the role of the manager/leader, rather than presenting an integrated whole; (ii) competencies are frequently overly universalistic or generic, assuming that they are the same, no matter what the nature of the situation, individual or task; (iii) competencies focus on past or current performance, rather than future requirements, thereby reinforcing rather than challenging traditional ways of thinking; (iv) competencies tend to focus on measurable behaviours and outcomes to the exclusion of more subtle qualities, interactions and situational factors; and (v) they result in a rather limited and mechanistic approach to development. Buckingham (2001) argues that the competency approach is based on three flawed assumptions; (i) that individuals who excel in the same role display the same behaviours; (ii) that such behaviours can be learned; and (iii) that improving one's 'weaknesses' necessarily leads to success. Certainly, there is evidence that individual leaders achieve similar results using different approaches, and despite significant personal flaws (1998).

From a US perspective, Hollenbeck and colleagues (2006) criticise what they regard as the false assumptions upon which the competency approach is based, namely (i) that, 'as a descendent of the long-discredited "great man" theory, competency models raise again the spectre of one set of traits, abilities, and behaviours… that make up the "great leader"'; (ii) that effective leaders are not the sum of a set of competencies, and that the research demonstrates that "what matters is not a person's sum score on a set of competencies, but how well (or as we would put it, in what way) a person uses what talents he or she has to get the job done". They add "we see little evidence that these systems, in place for years now, are producing more and better leaders in organizations". Indeed, most competency frameworks are singularly characterised by a lack of empirical evidence of their criterion or predictive validity.

To summarise the limitations of competencies in encapsulating the critical characteristics of leadership: "a competency framework could be considered like sheet music, a diagrammatic representation of the melody. It is only in the arrangement, playing and performance, however, that the piece truly comes to life." (Bolden and Gosling, 2006).

Thus, the critical determinant of leadership is not simply being competent in one's job, but in how one applies one's competencies as a leader in interactions with others; that is, what impact does a leader's behaviour have on those around them, including for clinicians (and non-clinicians), junior and senior staff, and of course, patients and their families.

A way to move forward

The question is, "What else is required?". To answer this, it is necessary to look at the purpose and intended effects of investing in clinical leadership in the NHS.

Leadership is essentially about the impact of individuals on others' psychological states, including their motivation, self-confidence, well-being, and morale, all of which have been shown to impact significantly on performance at work (eg Harter, Schmidt and Hayes, 2002; Patterson, Warr and West, 2004). The Darzi Review emphasises also the need for clinical leadership to increase effectiveness in the NHS by driving change, increasing innovation, and aiming for continuous improvement in the quality of care delivered.

Models of leadership have changed over the years, in part, in response to changing social, economic, political and technological factors (Alimo-Metcalfe and Alban-Metcalfe, 2005), though the current focus is undoubtedly on increasing employee levels of engagement. 'Engagement' can be defined as "a positive attitude held by the employee towards the organisation and its values. An engaged employee is aware of business context, and works with colleagues to improve performance within the job for the benefit of the organisation (Robinson, Perryman and Hayday, 2004)". It can also, and perhaps more importantly, be assessed as "a measure of the extent to which employees put discretionary effort into their work" (Alimo-Metcalfe and Alban-Metcalfe, 2008). There now exist several studies based on survey data across a range of organisations in the private sector, in particular, that reveal a strong and significant association between high engagement levels of staff and organisational performance, as measured by a range of financial outcomes, including enhanced operating margin and profit and reduced absenteeism and turnover (Towers Perrin, 2005; Watson-Wyatt, 2006). However, until we conducted our own empirical investigation of leadership in the NHS and across the wider public and private sectors in the UK, there was little, if any, research conducted into the nature of the leadership behaviours that contribute to increased staff engagement and – importantly – organisational performance.

Before describing our research, it is important to distinguish between the methodologies adopted for investigating the nature of competencies in a particular role, and those investigating the nature of engaging leadership.

To understand the nature of the competencies required for a particular role, such as a clinician or clinical leader, it is crucially important to gather data from current job occupants as well as from others who might be regarded as 'experts'. Although the information provided is limited, it would appear from a perusal of the website of the NHS Institute for Innovation and Improvement, that this methodology was adopted, at least in part, in the development of the Medical Leadership Competencies model (NHS Institute for Innovation and Improvement, 2008). However, this is not the kind of methodology that should be adopted when one is attempting to understand what it is about the way in which a person enacts their competent or skilled behaviour, that relates to their 'leadership'. Here, what is at issue is the **impact** of the behaviour on the motivation, morale, well-being and effectiveness of their staff and other colleagues, and indeed in relation to clinicians, on their patients. In this context, the focus for the research becomes the perceptions of their staff and colleagues, which means that direct reports - not line managers - are the appropriate source of the most valid data.

The distinction between possessing the competencies of a clinical leader, and having the most powerful positive impact on others, might best be described as distinguishing between the 'what' and the 'how' of leadership; both are essential to being an effective leader, but they are different dimensions. Figure 1 in the Appendix describes this relationship.

What do we know about the 'how' of leadership?

We conducted a three year empirical study to investigate what distinguishes those in leadership roles at various levels of the NHS who have a positive impact on the motivation, morale, and well-being of their staff, from those whose impact is less positive, or indeed, negative. The sample comprised over 2,000 managers and professionals, inclusive of age, ethnicity, gender & level, and which included a substantial proportion of clinicians, at all levels of the NHS (Alimo-Metcalfe and Alban-Metcalfe, 2000). The findings were replicated in UK local government with a sample of around 1,500 staff (Alimo-Metcalfe and Alban-Metcalfe, 2001), and later across the wider public sector, and in three FTSE100 companies (Alban-Metcalfe and Alimo-Metcalfe, 2007). A high degree of consistency was found in the model of leadership to emerge, irrespective of sector or organisation in that

sector. An independent study by the Home Office adopting the same methodology to investigate the nature of leadership among 1,022 police officers and staff (Dobby, Anscombe and Tuffin, 2004) also established the criterion validity of our findings.

It is important to note that our investigation (which is arguably one of the largest-ever investigations of the nature of leadership) was focused on the nature of 'near-by' (day-to-day behaviours of bosses/line managers) as opposed to 'distant' leadership (characteristics associated with chief executives and those in very senior posts with whom most people have little or no personal contact), and on which much of the US 'heroic' models of charismatic leadership have been based. Since the purpose was to understand the impact of a leader's behaviour on their staff, we focused on individuals' perception of outstanding, average, and poor bosses, with whom they had worked, and their constructs of an 'ideal' boss. Over 2,000 behavioural constructs emerged, and from these data a 360-degree instrument was developed, which was distributed across a random stratified sample of 200+ NHS organisations. Over 2,000 responses were factor analysed to identify the dimensions of leadership.

The model to emerge comprises 14 dimensions of what we refer to as 'engaging' leadership behaviour. There are at least six published academic peer-reviewed articles supporting its convergent and discriminant validity (eg Alban-Metcalfe, and Alimo-Metcalfe, 2000), all of which provide evidence that displaying such behaviours significantly impacts on staff's motivation, job satisfaction, self-esteem, job and organisational commitment, and reduced stress. This has been possible by analysing the data collected from the use of a 360-feedback instrument based on the model, the *'Engaging' Transformational Leadership Questionnaire (TLQ)*™ which includes both, items representing leadership behaviours, plus items assessing the effect of the behaviours on their staff. Figure 2 shows this model

Firstly, the emphasis is not on heroism, but on supporting others and enabling them to display leadership themselves. At its core are two dimensions relating to transparency and integrity.

Secondly, it contains a persistent theme of team-working, collaboration, and 'connectedness', and of removing barriers to communication and encouraging the sharing of ideas, whether between individuals in one's team, or between different teams and departments, or with

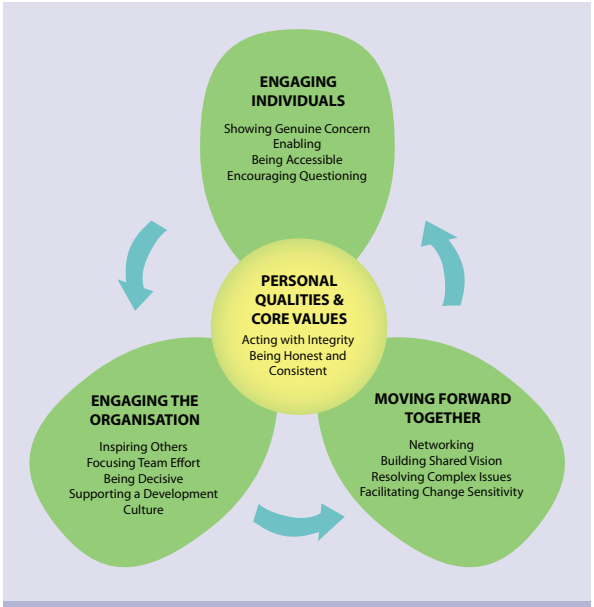

Figure 2 *– The Model of Engaging Leadership*

outside 'stakeholders' and partners. It reflects a respect for others' views and experiences and a willingness to take on board their concerns, perspectives on issues, and to be open to working with their ideas.

Another persistent theme is to encourage questioning and challenging of the status quo, and to ensure this happens by creating an environment in which these ideas are sought, listened to, and valued; and in which innovation and judicious experimentation is encouraged. It includes behaviours that encourage the creation of a culture that supports individuals' personal development, in which the leader is a role model for learning, and in which the inevitable mistakes are exploited for their learning opportunities.

Gone is the heroic approach to leadership, along with the notion of one person – the solipsistic leader – with a monopoly on the vision. It is replaced by a 'distributed' approach, with a commitment to building shared visions with a range of different internal and external stakeholders. It exploits the diversity of perspectives and the wealth of experiences, strengths and potential that exists within the team, department, or organisation, and with partners and other stakeholders.

Leadership in medicine – a cautionary tale

To emphasise the importance of understanding the distinction between being competent, and displaying effective leadership, we can relate these points to examples of clinical practice and even patient safety. Let

us take the example of surgeons. As with other professionals in the NHS, it is not difficult to think of examples of highly competent surgeons who, although highly qualified and technically skilled, behave in ways that have a negative impact on the motivation, morale, and self-confidence of their (junior) colleagues. As undesirable as the effect might be on their colleagues, it can also have an impact on the effectiveness of their team, and ultimately patient safety.

One US study conducted by Harvard-based researchers (Edmondson, Bohner and Pisano, 2001) aimed to identify what differentiated the 'successful' from the 'unsuccessful' implementers of a new technology for cardiac surgery, referred to as Minimally Invasive Cardiac Surgery, by analysing data collected from 669 heart operations in 16 hospitals. It found that it was not the seniority of the surgeon, nor their experience nor their technical competencies that differentiated levels of success. Rather, success was associated with factors such as 'creating a learning team' and 'creating an environment of psychological safety' that fostered communication and innovation.

Teams that learned the new procedure most quickly, shared certain characteristics, such as selecting appropriate team members

> "not only on their competence, but also on factors such as their willingness to deal with new and ambiguous situations, and confidence in offering suggestions to team members with higher status".

They also

> "emphasized the importance of creating new ways of working together over simply acquiring new individual skills. They made it clear that this reinvention of working relationships would require the contribution of every team member [and data gathered from interviewing team members revealed that] "teams members uniformly emphasized the importance of experimenting with new ways of doing things to improve team performance – even if some of the new ways turned out not to work",

and because

> "new technologies often render many of the skills of current 'experts' irrelevant. Neutralizing the fear of embarrassment is necessary in order to achieve the robust back-and-forth communication among team members required for real time learning. Teams whose members felt comfortable making suggestions, trying things that might not work, pointing out potential problems, and admitting mistakes were more successful in learning the new procedure. By contrast, when people felt uneasy acting this way, the learning process was stifled."

How was the environment of psychological safety provided? The answer is that it was through the actions and words of the surgeons who acted as teams leaders. For example, one surgeon told team members that they were selected not only because of their competence but also because of the input they could provide of the process. Another repeatedly told the team, "I need to hear from you because I'm likely to miss things."

The article concluded by pointing out that teams are often led by people who have been chosen on the basis of their technical expertise or skills, rather than their ability to lead teams in ways that they become effective learning units. Such choices can lead to disaster, not least of which when they are involved in healthcare.

One such example was described in an article which appeared in the *The Independent* newspaper (Feinmann, 2006). It concerned the case of a 39 year old woman dying as a result of medical error in what was regarded as a routine operation. The woman, Emily Bromiley, was being operated on because a sinus problem turned into an infection of her eye socket. At the independent investigation, conducted by Professor Michael Harmer, a former president of the Association of Anaesthetists of Great Britain and Ireland, it transpired that Emily's death was avoidable.

It found that there was no shortage of knowledge, equipment or manpower in the theatre at the time – an ENT consultant, two consultant anaesthetists, and four nurses were present – to manage the emergency that presented shortly after Emily was anaesthetised. When her airways collapsed, all three consultants attempted to intubate, "But there was an obstruction..." The consultants appear to have become fixated on intubation as the only option. What made the situation worse was that two of the nurses stated that they "knew exactly what needed to happen". It transpired that one had brought tracheotomy equipment into the theatre but was not acknowledged, and another booked an intensive care bed but was led to understand that she was overreacting and so cancelled it.

"Both of these nurses knew how to save Emily's life, but they didn't know how to broach the subject with their bosses".

At the inquest, Emily's husband said, "This was not a case of one man being incompetent. The team made mistakes as a whole. It was a failure of the system".

Such tragedies serve to emphasise the critical importance of leadership, including most importantly in the NHS, clinical leadership.

Leadership and change in the NHS

To return to the Darzi Review and its emphasis on the importance of leadership in handling change, the question must be asked as to whether there is empirical evidence that the model of engaging leadership that emerged from our research does significantly affect performance and effectiveness in healthcare settings, and the implementation of change initiatives? This question formed the basis of a second three year longitudinal investigation we recently completed in the NHS.

Last year, together with colleagues from Kings College London, we concluded a three year Department of Health-funded longitudinal study entitled 'The impact of leadership factors in implementing change in complex health and social care environments' (Alimo-Metcalfe et al, 2007; Alimo-Metcalfe, 2008). It was designed to investigate whether leadership quality in multi-professional teams, in this case specific mental health teams referred to as crisis resolution teams (CRTs), is directly related to team effectiveness. Team effectiveness was judged by the achievement of the government's targets for the reduction of in-patient admissions. Since effectiveness in performance could be at the cost of staff attitudes to work, and their well-being at work, we were also concerned to investigate these variables. Clearly, sustainable change can only be achieved if the leadership behaviour impacts both on organisational performance and the morale and well-being of staff.

Quality of leadership was assessed on an instrument based on the 14 TLQ dimensions identified in our earlier research, to which certain competencies which had been identified by the relevant 'experts' in the NHS, were added. In other words, both competence and engaging leadership behaviours were assessed. Controlling for nine contextual variables, which included the size of the team and the length of time it had been in existence, the resources available to the team, including medical expertise, and their locality and case load, and using structural equation modelling, we found (i) that competencies did not predict organisational performance (measured in terms of productivity), but (ii) that 'engaging with others' was the only significantly predictor of productivity, even allowing for the effect of contextual variables. 'Engaging with others' also emerged as the only predictor of all seven dimensions of attitudes to work and all five dimensions of well-being at work, including reduced job-related stress and emotional exhaustion.

Can leadership be developed?

Space permits only a brief response to this question, but from our vast experience of working in the NHS and other organisations to support leadership development and culture change, we resoundingly respond 'Yes'. We also have evidence from both qualitative data gathered from colleagues of individuals who have undertaken leadership development, as well as from statistical analyses comparing pre and post intervention 360-feedback ratings of individuals' leadership behaviours as rated by others anonymously, that significant changes are perceived to have occurred (Alban-Metcalfe, 2003; Alimo-Metcalfe and Alban-Metcalfe, 2008).

Doctors and 360-feedback

As part of doctors' revalidation they will be required to provide feedback on their performance, including data from 360 assessments. This is a wonderful opportunity for doctors to benefit from the process, however, given the power of the rich data obtained from 360-feedback, it is of critical importance to be aware that the process can be mishandled, and be more destructive than constructive (Alimo-Metcalfe, 1998).

How to get clinicians on board?

Key to the transformation of individuals' leadership effectiveness is individuals' openness to feedback from others as to the effect of their behaviour on them, and perhaps their team. The use of 360-feedback is crucial in providing rich and relevant data (Alimo-Metcalfe, 2008 ref 29), but the instrument must be based on evidence-based models of what leadership involves (which is more than

just being competent), nor on a tool which may have 'face validity' but is not supported by academic research into its validity. And this is where all organisations need to be particularly thoughtful in introducing the concept of 360-feedback for individual development of clinicians. Clinicians, not surprisingly, are more convinced by rigorous data than by merely the exhortation that practices such as 360-feedback can increase their effectiveness – as both colleague and leader. This task is made easier when research data are provided of the impact of leadership on clinical effectiveness (including team effectiveness), and evidence that 360 can provide support for strengthening one's leadership. One danger is that adoption of a 360-feedback instrument which has not been supported by academic research may increase cynicism, rather than confidence in its use.

Conclusions

In this article, we have sought to draw the attention to those in the NHS, including the Royal Colleges, of the dangers of adopting a simplistic and potentially dangerous path of approaching the crucially important issue of clinical leadership by relying on a purely competency-based framework. There is a dearth of academic literature providing empirical evidence that competencies alone improve efficiency and, more importantly, leadership effectiveness. It thus places the clinical leadership initiative in its present form at variance to the Department of Health's own exhortations for evidence-based practice in healthcare. Indeed, we would go so far as to suggest that pursuing such a path could endanger patients, and have provided two examples from the healthcare literature which support this possibility.

Interestingly, there had appeared to be some hopeful signs that the Department of Health was reconsidering its approach to leadership, when it invited one of the authors to address the first combined NHS SDO and Health Services Research Network Annual Conference in June last year with reference to the question "Do we have the right kind of leadership in the NHS?", and specifically:

> "…are the models of leadership espoused by the[se] [competency] frameworks relevant to the NHS of tomorrow or are they grounded in a philosophy of centrally-determined targets and performance management that is now in retreat?" (Alimo-Metcalfe, 2008).

Our answer to the first part of the question was, 'No', and to the second, 'Yes'. We do not underestimate the importance of competencies (or indeed of targets); they are essential pre-requisites for effective leadership and clinical practice. However, as research has established, simply having practitioners who possess leadership competencies will not result in high quality health outcomes. What the NHS requires is leaders who perform their leadership role in an ***engaging*** way. Only in this way will they create a culture in which teams communicate and interact in such way that it makes the best use of the skills, experiences and ideas of all working together.

We now have evidence that an engaging approach to leadership significantly predicts effectiveness of NHS teams, plus high morale and promotes well-being. It seems to us that it is beholden on the Department of Health and the Royal Colleges to stand by their own proclamations that research evidence should form the basis of best practice in healthcare. It is also important that organisations in the NHS scrutinise practices of recruitment, appraisal, development, and performance management in relation to leadership, to enable this to be embedded in the culture. As the Harvard study described above concluded:

> "Those responsible for choosing team leaders need to re-think their own approaches … appointing a team leader solely on technical competence …can lead to disaster; we've all known superstar technocrats with no interpersonal skills … senior managers need to look beyond technical competence and identify team leaders who can motivate and manage teams of disparate specialists so that they are able to learn the skills and routines needed to succeed".

Appendix

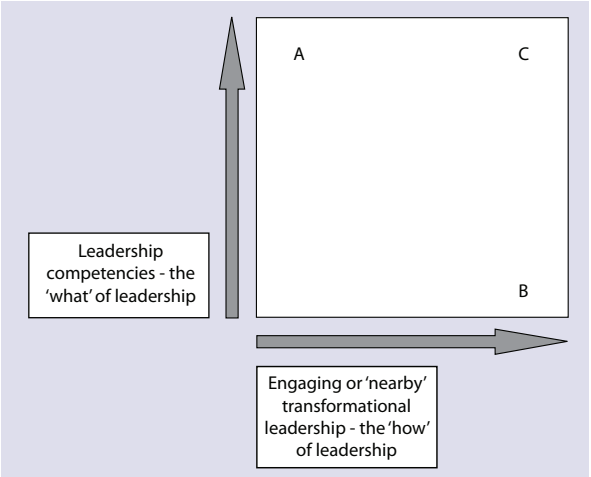

Figure 1 *– Relationship between 'leadership competencies' and 'engaging' leadership behaviours*

Thus, person A can be seen to be highly competent, but not very engaging in their behaviour – perhaps the kind of person who is very technically skilled, but who shows a lack of understanding, or concern, for the needs of others and the impact of their behaviour on others. This could result in low morale, confidence and effectiveness in their team, and minimal learning and innovation.

Conversely, person B is someone who, perhaps, is sensitive to the impact of their behaviour on others, is engaging, and creates a supportive environment in which all staff are valued, but who is not competent at their role. This is likely to reduce team effectiveness and may well create frustration and a sense of lack of clear direction.

Person C, then, is the kind of manager or professional who, by acting in an engaging way, with all that entails, can use their competency as a leader in ways that are relevant to the particular individual or situation and have a positive impact on the motivation, well-being and discretionary effort of others. This is the combination most likely to lead to high levels of team effectiveness.

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