

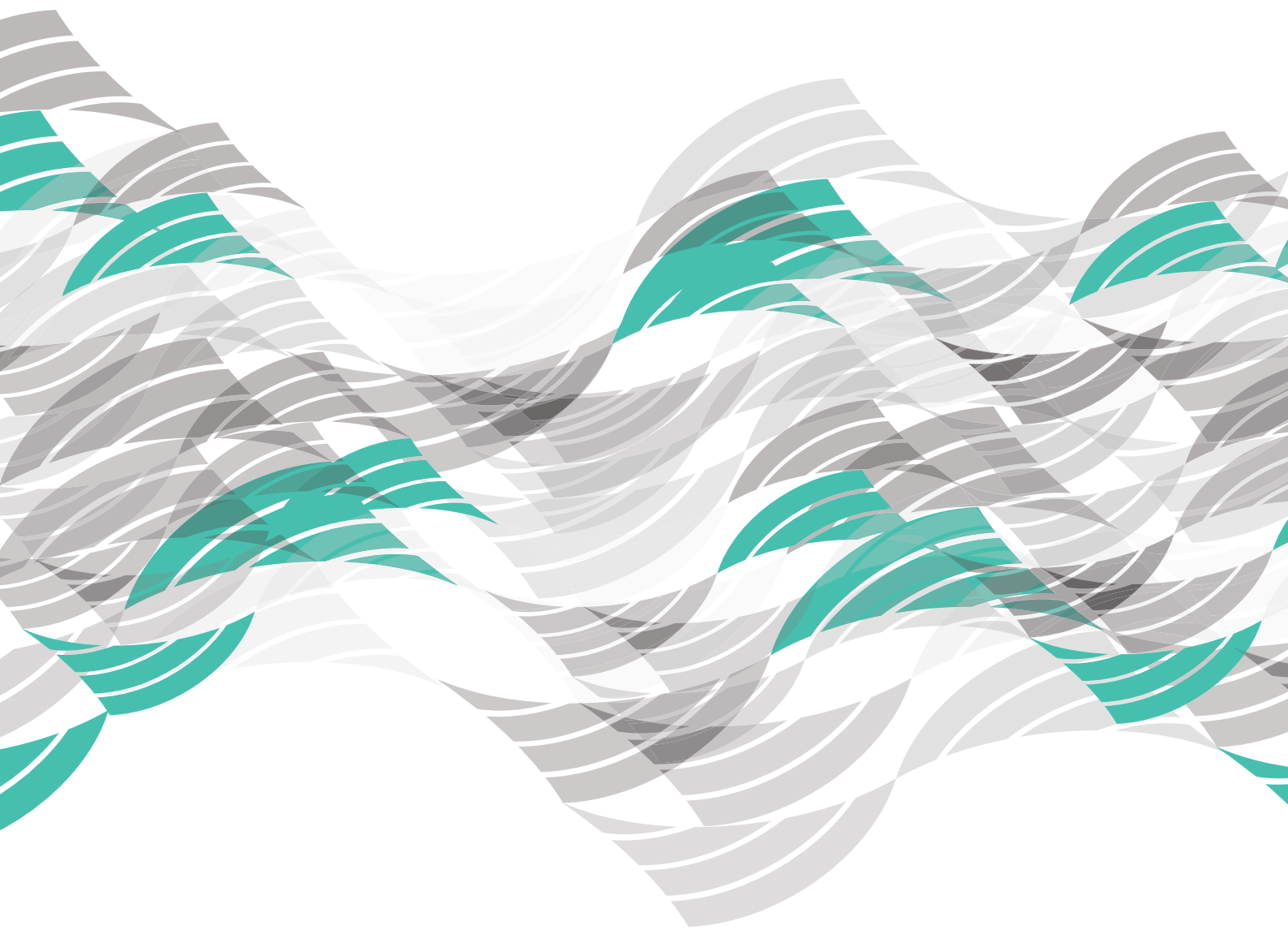
WHITE PAPER

Delivering a Collective Leadership Strategy for Health Care

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Foreword

“Old people sit in the shade of a tree because they planted seeds many years ago.” This Ugandan proverb captures the leadership challenges we face in the NHS.

The strategies and tactics that worked in the past are not sufficient to address the challenges and opportunities of the future. The leadership that has worked in the past is equally ill-suited to overcome the demands resulting from a changing demography and increasing complexity of health care delivery.

While there are no easy ways of adapting to a rapidly changing environment, it is incontrovertible that a sustainable leadership culture is a necessary condition for delivering safe, integrated and compassionate care within budget. Helping the NHS achieve this goal is the *raison d’être* of the collaboration between The King’s Fund and Center for Creative Leadership (CCL®), resulting in two reports that outline the imperative, substance and development of collective leadership for health care. The reports advance our understanding of the importance of collective leadership for health care and how it can be implemented to deliver sustainable culture change and improvements in patient care.

From decades of research, we know that quality of leadership can improve the effectiveness of individuals, teams and organisations. We also know that leadership development efforts focusing only on individual leaders and teams often fail to produce desired impact at the collective level. Focusing on collective leadership requires organisations to challenge

some basic operating assumptions. It means that leaders must emphasise collaboration as a key principle of success and embrace their organisation as a learning organisation in which the capabilities of individuals and teams are continually enhanced.

Leaders in formal roles must create the conditions in which responsibility, power, authority and decision-making is distributed within and throughout an organisation rather than at the top of a hierarchy. They must redefine their leadership role to focus on empowering collective leadership amongst all staff, and embrace their responsibility for ensuring that these staff are valued, supported and engaged in fulfilling the organisation’s mission, vision and strategy.

And it means that organisations must span their boundaries and work together, rather than implement effective leadership within organisational silos.

Our reports are a call to action for leaders in the NHS to think and act differently about how to build and lead the type of sustainable organisations that will ultimately determine whether the NHS meets the future health and health care needs of the people it serves. Will we plant enough seeds to build forests for collectives or will the seeds we plant provide shade only for the privileged few? The choice is in our hands.

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This paper is a collaboration between the Center for Creative Leadership (CCL[®]) and The King's Fund. CCL and The King's Fund are currently developing an offer to support NHS organisations in the design of a collective leadership strategy. For more information please contact:

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The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

Executive Summary

We have witnessed the impact of organisational culture on quality of care, safety, and organisational effectiveness in the NHS. Prominent failures such as Mid Staffordshire highlighted that a good organisational culture is a necessary condition for organisational strategy to succeed, and leadership is the pre-eminent influence factor for organisational culture.

Leadership culture must be understood as the product of collective actions of formal and informal leaders acting together for organisational success. It is not simply the number or quality of individual leaders that determine organisational performance, but the ability of formal and informal leaders to pull together in support of the organisation's goals.

We believe that collective leadership in health care is necessary for overcoming challenges that the NHS now faces. Collective leadership means the distribution and allocation of leadership power to wherever capability, expertise and motivation sit. The responsibility of leadership is shared by each and every member of the organisation.

A collective leadership culture requires new mind-sets, not just new skills. These take time to develop. Many health care organisations have focused their development efforts only on individual leader competencies. For sustainable change, they need to advance both individual and collective leadership mind-sets. Making the shift to collective leadership in an organisation requires strategic implementation.

Developing and implementing an effective collective leadership strategy comes in three phases: **Discovery, Design, and Delivery.**

- The **Discovery** phase involves collecting data and intelligence about the strategy, vision, mission, future challenges, political context and opportunities for the organisation. This process enables organisations to identify the leadership capabilities required to face the future and the gap between current and required future capabilities.
- The **Design** phase involves identifying required leadership capabilities for individual and collective leadership and the means to acquire, develop and sustain those capabilities.
- The **Delivery** phase involves elements from organisational and individual leadership development alike, targeting culture, systems and processes, as well as leadership development in synchrony.

While the process of developing collective leadership starts at board level, all staff across the organisation will need to be involved in this endeavour with their respective expertise, contributing to the collective leadership process.

Collective leadership offers huge opportunities for creating cultures of continually improving, high quality, and compassionate care. But it requires courage, persistence and professionalism from all leaders (informal and formal) to fully realise its potential. The complete dedication of the board and leadership team to empower all staff as leaders, and trust in the process of collaboration in the organisation as the foundation for its leadership culture are keys to success.

We believe that the challenges that face health care organisations are too great and too many for leadership to be left to chance or to piecemeal approaches. Through working together with health and social care organisations and in consultation with patients, we can develop leadership strategies that will ensure the NHS confidently faces the future and delivers the high quality, compassionate care that is its mission.

What is the Need for a Collective Leadership Strategy?

Like most health care systems worldwide, the UK National Health System (NHS) is experiencing increasing demands and is subject to changing external pressures to improve quality of care in spite of budgetary constraints. Success in responding to these challenges depends on a robust supply of leaders and a leadership culture with the capability to enable large scale and sustained systems change. As outlined in our companion paper “Developing Collective Leadership for Health Care” (West, Eckert, Steward & Pasmore, 2014), leadership is at the core of organisations’ efforts to nurture cultures that provide high quality, continually improving and compassionate care.

Specifically, we argue that it is *collective leadership*—the engagement of all members of staff in the organisation and patients into the leadership process—that is needed to create the cultures that NHS organisations need now and in the future.

However, for a sustained positive impact on organisational culture, collective leadership needs to be implemented strategically. **The leadership culture must be understood as the product of collective actions of formal and informal leaders acting together to influence organisational success.** It is not simply the number or quality of individual leaders that determine organisational performance, but the ability of formal and informal leaders to pull together in support of the organisation’s goals.

In this publication, we describe the components of a sustainable and comprehensive collective leadership strategy for health care.

Most organisational managers are aware of the value of well-defined strategy. Few, however, give thought to the leadership required to deliver fundamental changes in the direction or capabilities of the organisation. Without proper leadership, even the best and boldest strategy dies on the vine, its potential never realised. This paper explains what a collective leadership strategy is (based on Pasmore, 2009) and how to develop and implement a leadership strategy for health care organisations. It requires that health care organisations fundamentally change the way they develop leaders and create new leadership capacity with parallel and integrated development of individual and organisational capabilities.

Over the past few years we have witnessed the impact of organisational culture on quality of care, safety, and organisational effectiveness. Prominent failures such as Mid Staffordshire have highlighted that a good organisational culture is a necessary condition for organisational strategy to succeed, and leadership is the preeminent influence factor for organisational culture.

Leadership is comprised of individual leaders, of course, but also of the *relationships* among them. Research and practice from the Center for Creative Leadership and The King’s Fund show that, where leaders and leadership relationships are well developed, organisations benefit from *direction*, *alignment* and *commitment* (Drath et al, 2008; The King’s Fund, 2012, 2013).

Direction means agreement among people at every level about the real purpose of the organisation; that is, what the collective is trying to achieve together. This can include hard goals and targets, for example about care quality and safety, as well as softer goals for an organisation's mission and values such as compassion, transparency, engagement and patient-centricity.

Alignment refers to the effective coordination and integration of the different aspects of the work so that all efforts fit together in service of the shared direction.

Finally, **commitment** means that everyone in the organisation takes responsibility and makes it a personal priority to ensure the success of the organisation as a whole, rather than focusing only on their individual or immediate team's success in isolation.

Good leadership ensures that these three outcomes—direction, alignment and commitment—are balanced with each other, creating the foundation of a strong and supportive organisational culture. Direction, alignment and commitment are constantly co-created, changed, and re-created by the actions and interactions of both formal and informal leaders in the organisation and the roles they assume. Communication, influence, negotiation, innovation and collaboration occur up, down and across organisations.

Yet these processes are not random. A collective leadership strategy ensures that the actions and choices of all leaders are aligned with the organisation's strategy, mission and values. It ensures that collective leadership is not only established but also sustained so that cultures of high quality and compassionate care can flourish.



Delivering a Collective Leadership Strategy

Implementing a collective leadership strategy is a complex endeavour. It involves a series of steps, which we refer to as **Discovery, Design, Development, and Evaluation** (see Figure 1). These elements of a leadership strategy target leadership at the individual, team and organisational level.

In the **Discovery** phase, deep analysis focuses on current and future capabilities of individual leaders as well as the organisations' capacity to introduce and sustain the desired collective leadership culture. Leadership strategy needs to be based on a thorough analysis of the current situation and an informed view of the future—including challenges and opportunities—faced by the health care organisation and the consequent requirements of leadership for this future. The discovery step answers the question, **“What do we need from our leadership to successfully implement our strategy and fulfil our mission?”**

In the **Design** phase, the requirements for individual leaders and collective leadership in the next three to five years are specified and translated into a leadership strategy that is framed to respond to the challenges that the health care organisation faces. The design step answers the question, **“What skills, capabilities, competencies and behaviours must our leaders demonstrate in order for them to shape the cultures of care we require?”**

In the **Delivery** phase, specific strategies and programmes of action are formulated. Individual and organisational development are aligned, and action steps are taken for culture change, cross-organisational collaboration and greater use of teamwork. At the same time, a leadership development strategy ensures that the organisation has the right number of individual leaders with the capability for collective leadership and to grow organisational capacity for collective leadership. The delivery step answers the question, **“How will we develop the leadership we need for the future?”**

Finally, in the **Evaluation** phase, the impact of a well-implemented leadership strategy is assessed through staff-centred and patient-centred metrics, such as clinical effectiveness measures, measures of safety, patient satisfaction, employee engagement, turnover, burnout, satisfaction, financial performance, innovation and quality improvement. The assessment answers the questions, **“Is our leadership performing as required, and are we producing the outcomes we need?”**

Figure 1

The stages in leadership strategy implementation





Discovery

Defining an organisation's leadership strategy begins with understanding what the organisation is trying to achieve. This is inherent in the organisation strategy, and in its performance objectives. A review of the information arising from the discovery process yields insight into what leaders must do to create the desired future. Such insights are derived from asking questions of those who know the organisation and its strategy well, such as:

1. What must leaders do differently to achieve better care for patients?
2. Where would increased collective effort among leaders and others across the organisation aid in the execution of the strategy?
3. In what areas does the direction need to be made clearer for people working in this organisation and where could greater clarity for stakeholders be achieved if leaders had a more shared approach?
4. In what areas is more alignment needed between the work that people are doing and the work that needs to be done to create the desired future?
5. What is the current level of commitment throughout the organisation to the strategy and performance targets? What will need to be done to increase that level of commitment even further?
6. How do we measure commitment to patient well-being and compassionate care?

Discover the Gaps in Individual Leader Capability

The implications of organisational strategy and objectives for future leadership actions need to be understood in order to develop specific criteria for a “gap analysis”—what leaders are doing currently versus what they will be required to do in the future. Criteria might be the extent to which leaders are working together effectively across departments in pursuit of better patient-centred care, or engaging informal leaders in developing solutions to front-line problems. For example, the problem of excessive waiting times for MRI might best be solved by asking the radiographer for a more effective pre-assessment process. The criteria will relate both to actions required of individual leaders and to actions that can only be carried out by leaders working together.

In order to achieve the vision for the future (e.g., “Salford Royal has a vision to be the safest hospital in the NHS”, or “Nottingham University Hospitals are determined to be the best acute teaching trust in the country by 2016”), it is important to look forward and build a profile based on future leadership needs and not be constrained by the current cadre of leaders. Organisations may well need to consider recruiting additional leadership talent, phased in over time. The current organisational structure, policies and processes might also inhibit what leaders can achieve in the future and these too should be assessed against the future vision. Thus, although a discovery process begins with an examination of the organisation’s leadership, it will also consider structures, policies, operations and relationships.

Planning what capability will be sought in the leaders of the future should be a creative process grounded in frameworks for health care leadership. Collective leadership purposely promotes diversity among leaders and employees as a source of innovation, adaptability, patient-centricity, and overall health care performance (King et al., 2011; Kline, 2014). Therefore, a wide range of qualities in leaders needs to be specified including professional background, managerial, medical and clinical leadership experience, demographic profile, subject matter expertise, as well as suitability in terms of general leader characteristics such as supportiveness, humility, energy, and commitment.

A generic statement of required leadership qualities in the NHS has been proposed by the NHS Leadership Academy (NHS Leadership Academy, 2013). This model provides a possible foundation for organisation-specific leader competency frameworks that may be used for the selection, promotion and development of staff with formal management responsibility. In addition to health care-specific competencies, we emphasise the importance of communication for collective leadership—both for information flow as well as for relationship building and maintenance (Yammarino, Salas, Serban, Shirreffs & Shuffler, 2012). This is because, in collective leadership cultures, communication flows along formal hierarchical as well as informal network paths. Thus leaders need to be able to influence, moderate and shape both streams of communication in order to nurture appropriate cultures of continually improving, high quality and compassionate care. The development of adequate communication capabilities at individual, team and organisational levels is crucial for successful collective leadership.

How to Conduct a Leader Capability Analysis

An analysis of current and future individual leader capabilities might include the following criteria:

Quantity: How many leaders will be needed over the next five to ten years, taking into account growth, changes in organisational structure, integration of services, specialty focus, and projected turnover of staff?

When will they be needed?

Where in the organisation will these leaders be located?

At what level in the organisation will they be placed?

Qualities: The characteristics individual leaders, and leadership overall should possess, such as:

Demographics: age, gender, ethnicity, education, experience

Background: Subject matter expertise; Identity (managerial/medical/clinical)

Diversity: Ethnic and gender diversity by level and location

Skills/behaviours: The specific skills, behaviours, knowledge, competencies or abilities leaders need in order to implement organisational strategy:

- 1. Generic behavioural** competencies that apply to all leaders in the organisation e.g., Health care Leadership Model (NHS Leadership Academy, 2013)
- 2. Specific behavioural competencies** by level or function e.g., clinical competence, understanding of quality improvement methodologies, dealing with intimidating behaviour and poor performance
- 3. Generic skills and knowledge** required by all leaders in the organisation e.g., nurturing culture, promoting reflexive practice, leading across specialty and organisational boundaries, promoting efficacy, optimism and cohesion, leading for compassion
- 4. Skills or knowledge required by level or function** e.g., skills of ward manager or clinical director
- 5. Skills, knowledge or capabilities by location** e.g., ICU, midwifery and A&E leaders

A really important aspect of individual capability for collective leadership, which is only just becoming recognised, is the cognitive capacity of senior leaders to not just understand the complexity and interdependence of the local health economy, but also to build effective collaboration in the best interest of their patients. In the past, this capability has not been emphasised sufficiently.

Moreover, senior leaders have mostly “cut their teeth” in organisations that have no concept of collective leadership. They have been socialised in largely hierarchical, siloed organisations, which often are governed too rigidly by targets and terror. So there is usually an element of “unlearning” before new cultures can emerge.



Discover the Gaps in Collective Leadership Capability

The next step in developing the leadership strategy is to assess the current collective leadership capabilities and leadership culture and compare them to the desired future.

In this step, two aspects of organisational leadership are examined:

- a) The **collective leadership capabilities** of leaders acting together in groups and across boundaries to implement organisation strategies, create cultures of compassion, promote continuous learning, ensure continual quality improvement, listen to and involve patients and carers, solve chronic system problems, adapt to change, integrate services, support innovation.

- b) The desired **leadership culture**, including the leadership practices in use, such as collaborating across boundaries, engaging staff at all levels, involving patients and caregivers at all levels of the organisation, transparency and openness, accepting responsibility for outcomes, welcoming the learning from errors or failures, promoting clinical leadership, supporting and appreciating staff, creating opportunities for others to lead and developing new leaders.

Analysing these aspects is often a lot of work—real behaviour and interactions are taken into account and documents, formal practices and policies on organisational leadership are reviewed. This analysis enables us to gauge organisational readiness for collective leadership and the organisation's capacity for change.

The leadership strategy, effectively designed and implemented, will fill the inevitable gaps between what capability the organisation has now, and what capability it need for the future. The following example shows how the thinking for future leadership is built up. Frameworks like these are a practical guide to action and as they are developed collectively, they become powerful tools for the organization in shaping its own meaning about the kind of culture it wants in the future.



An example of individual and collective leadership capabilities now and as required in the future, from which implications for an organisation's leadership strategy are derived, is given below.

Leadership Dimension

Analysis

Skills/behaviours/ qualities required by leaders	Current	<ul style="list-style-type: none"> • Mostly managerial backgrounds • Few with clinical background • Emphasis on meeting targets and budgets • Self-contained, managing within given resources • Hierarchical and directive • Battle with the system but also know it serves a necessary function
	Future	<ul style="list-style-type: none"> • Majority of leaders with clinical background • Top priority is improving quality of care and compassion • Engaging with patients and learning from patient experience • Commitment to transparency • Participative leadership encouraging proactivity and voice amongst staff • Nurturing culture of positivity, efficacy, cohesion and optimism • Effective in utilising the ambiguity and complexity of the system for better patient care
Collective capabilities required by strategy	Current	<ul style="list-style-type: none"> • Delivery of patient care driven by deadlines • Uphold organisation policies • Maintain care quality • Team harmony through homogeneity • Getting things done • Focus on success of my department
	Future	<ul style="list-style-type: none"> • Using quality improvement methods continually • Successful innovations in patient care implemented quickly and continually • Better/faster coordinated response to external organisations such as CCGs • Talent development across functions • Broader team perspectives through interdisciplinary and diverse team membership • Innovation and representativeness through empowered BME staff • Cross-functional and cross-organisational collaboration to achieve interdependent goals • All leaders prioritise the success of the organisation above their own department, team, directorate success
Leadership Culture	Current	<ul style="list-style-type: none"> • Mix of dependent and independent cultures • Leaders' formal responsibility used for blaming them for failure, but responsibility does not match their actual scope of control • Difficulty in coordinating patient care or organisation policy implementation across functions
	Future	<ul style="list-style-type: none"> • Primarily interdependent culture across functions to enable more effective delivery of care, support more rapid innovation in patient care, and support compassionate culture, patient involvement and responsiveness • Collective leadership culture in which all staff proactively engage in leadership behaviour • Intense communication flow across organisational boundaries • Identity as a member of an integrated health system

Leadership Dimension

Implications of Gap for Leadership Strategy

<p>Skills/behaviours/ qualities required by leaders</p>	<ul style="list-style-type: none"> • Formulate a compelling value proposition for clinicians to choose a leadership career path • Design and communicate on clinical leadership career development routes available at all levels • Highlight positive examples of leaders nurturing a culture of compassion • Coach or remove leaders who do not demonstrate primary emphasis on improving care • Select for and coach appreciative, supportive, open, participative, positive leaders
<p>Collective capabilities required by strategy</p>	<ul style="list-style-type: none"> • Changing and learning by example: Need for executive team to show willingness to learn in an open space forum with all employees • Create “head room” with senior leaders, freeing them from operational pressures to reflect on the overall organisation and strategic changes that are needed • Behaviours are new and will need good conflict management processes as staff learn to work together differently
<p>Leadership Culture</p>	<ul style="list-style-type: none"> • Senior leaders must engage others in changing leadership culture by role-modelling collective leadership as a team • Reward and recognition policies should highlight good leadership shown by informal leaders and should encourage collective leadership in teams. • Establish storytelling as a method to make collective leadership come alive in staff’s heads and hearts • Active promotion of diversity as a strategic need • Working collaboratively across organisational boundaries is built into everyone’s expectations

Design

The team that works on the design phase should know the organisation intimately and work alongside others familiar with processes for acquiring, retaining and developing leadership talent (HR and others). The first step is to identify the drivers of the organisation's strategy—those things the organisation has to get right in order to achieve its vision. They might include goals such as outstanding paediatric care for a children's hospital or working well with social care to achieve really effective discharge of the elderly.

Drivers dictate where trade-offs will be made between alternative investments of resources, time and energy. Drivers are few in number and help to identify what is absolutely essential for leaders and the collective leadership of the organisation to accomplish.

In discussions about changing leadership culture, it is critical to demonstrate a clear line of sight between leadership and desired organisational outcomes. Senior leaders need to be able to articulate key drivers for leadership culture to all staff, and to give motivating examples of how leadership impacts care quality, patient and carer satisfaction, staff engagement and well-being, the organisation's financial health, talent retention, and other key metrics that we outlined in our companion paper *Developing Collective Leadership for Health Care*.

How to Identify the Organisation's Key Drivers

Key Drivers of the organisation are the relatively few (e.g., three to five) determinants for *ensuring continually improving, high quality and compassionate care* for a particular health care organisation. They will be both present- and future-oriented because the demographic and political environment of the NHS is constantly changing.

Key drivers are not themselves detailed strategies; instead, they highlight the decisions leaders must make about what the organisation must do. For example, a primary care team might define patient satisfaction as a key driver to maintain and expand their patient base, while an acute organisation might define optimised A&E throughput times as a key driver for improving patient care. Patient satisfaction and optimised throughput times are not strategies; rather, they drive the formulation of detailed organisational strategies. The primary care team must develop strategies for producing high levels of patient satisfaction, and the acute organisation must develop strategies for increased efficiency in dealing with emergency admissions.

Key drivers can be identified by asking a few fundamental questions:

- Is this an organisational capability that is *absolutely vital*? Could something else be more essential to the organisation's vision/mission?
- What is most important for us in order to provide constantly improving, high quality and compassionate patient care?
- Will doing this well translate *directly* into continued future success?
- Would not doing this well cause the organisation to fail?

Below are examples of leadership strategy implications for some relevant key drivers.

Key Driver	Leadership Strategy Implications
Becoming more patient-focused	<ul style="list-style-type: none"> • Need to develop and implement new processes for hearing the patient voice at every level and basing organisation processes on their priorities and needs • Must create solid linkages across the organisation between all elements of patient care, so that the patient experience is that of seamlessly integrated care • Need to understand the needs of different patient groups and move beyond “one size fits all” approach • Must instil a culture of compassionate care
Developing capacity to adapt and change	<ul style="list-style-type: none"> • Greater interdependence among leaders to create more effective collaboration across functions and organisations in promoting innovation and capacity for change • Need to increase leadership engagement across functions in using patient feedback to develop ideas for improved care • Must anticipate capital, space, talent implications of radically improving integrated care pathways • Need cultural change to create a commitment to change and innovation versus a culture of risk aversion at top levels of the organisation
Improving operating efficiency	<ul style="list-style-type: none"> • Must introduce quality improvement methodologies in line with best practice to all operational processes; these must be led from the top and supported by leaders at every level • Must create a culture of continuous improvement that is authentically and collectively led

Finally, a comprehensive leadership strategy is created, which reflects the current leadership capability of the organisation and the implications for future leadership in all its totality (collective leadership, capacity, competencies etc.) and considers these in relation to the key drivers. An example is given below although actual strategies would be much more detailed and specific for each leadership dimension. The strategy will also include specific target dates for each action, who is responsible, barriers to success, costs, and implications for leadership development or talent management processes.

Example Leadership Strategy

Leadership Dimension	Key Strategies	Actions to Create Required Leadership	Other Implications
Quantities	<ul style="list-style-type: none"> • Double number of clinical leaders in the next 5 years • Increase applicants for clinical leadership positions by 200% 	<ul style="list-style-type: none"> • Identify attractive career paths for clinicians • Achieve 60% of growth in clinical leadership from internal promotion • Communicate advantages of taking clinical leadership roles to all clinical staff • Mainstream leadership responsibility into care-giving functions 	<ul style="list-style-type: none"> • Work with Royal Colleges to encourage clinicians to take on leadership roles • Seek potential clinical leaders from wider NHS pool
Qualities	<ul style="list-style-type: none"> • Increase proportion of leaders under age 50 in top three levels • Increase percentage of female and BME leaders at senior levels 	<ul style="list-style-type: none"> • Preferred selection of younger, female and BME talent for executive succession plans • Comprehensive development of internal talent at mid level 	<ul style="list-style-type: none"> • Understand and remedy causes for females and BMEs to decline leadership opportunities • Initiate fast-track career development paths
Skills/behaviours	<ul style="list-style-type: none"> • Increase compassion, communication, positivity, values-driven and mission-driven leadership behaviour, take reasonable risks while not sacrificing quality of care or (to a lesser extent) focus on cost reduction opportunities • Develop business acumen of clinical leaders • Develop clinical acumen of managerial leaders 	<ul style="list-style-type: none"> • Incorporate behavioural assessments of desired qualities into promotion criteria • Create focused and effective development experiences to enhance desired skills • Invest in development of local leaders particularly in midwifery and A&E 	<ul style="list-style-type: none"> • Need succession planning for mission critical positions • Diversify leadership development staff to reflect mission • Emphasize to staff that they are delivering care as part of their local health and care economy
Collective Capabilities	<ul style="list-style-type: none"> • Capability for practicing collective leadership • Collective capability for faster integration of services for patient care, more responsiveness to patients and enhanced talent development 	<ul style="list-style-type: none"> • Use three initiatives in an “action development” style to develop collective leadership capabilities while addressing strategic requirements • Identify senior executives to lead each of these three initiatives 	<ul style="list-style-type: none"> • Make action development projects a priority in terms of time invested • Showcase both project success as well as collective learning and development through these projects
Leadership Culture	<ul style="list-style-type: none"> • Move from a directive, siloed, function-oriented culture to an interdependent culture with cross-functional and cross-organisational collaboration at its core 	<ul style="list-style-type: none"> • Support senior leaders to become role models of this leadership culture • Strengthen trust, feedback and support for each other within the senior leadership team • Use action development initiatives to engage employees at all levels in leading changes required • Anchor individual and team-based, shared responsibilities for organisational outcomes in annual performance reviews 	<ul style="list-style-type: none"> • Promotions to the executive team over the next five years must be people capable of role-modelling and powerfully facilitating collective leadership



Delivery

Collective leadership by definition involves all staff, and this involvement needs to be mirrored in the process of delivering a collective leadership culture into an organisation. In particular, delivery focuses on activities around organisational culture change, in order to nurture a culture that fosters collective leadership, on

team working as a necessary and structural ingredient throughout the organisation, and on cross-organisational collaboration. These activities are complemented by a comprehensive leadership development strategy that ensures the long-term development and sustainability of collective leadership.

Delivering Culture Change

The goal of culture change for collective leadership is to purposefully and actively guide the organisation to embrace collective leadership into its every day way of working. Culture change fosters the new thinking, beliefs, tools and processes that will help the organisation deliver high quality and compassionate care despite the challenges and complexity it faces in its local health and care economy.

As stated in our companion paper, health care organisations need a collective leadership culture for future success. This requires the organisation be skilled in mutual inquiry, learning, cross-organisational collaboration and a capacity to work with complex challenges. Yet the question is how to start the journey towards such a culture in organisations that work by principles of hierarchical authority, functional expertise, and rigid targets on measurable output.

A collective leadership culture requires new mind-sets, not just new skills (McGuire, Palus, Pasmore & Rhodes, 2009). These take time to develop. Many health care organisations have focused their development efforts only on individual leader competencies. In doing so, they have over-relied on the human resource function to manage change through individual skill development. For sustainable change, they need to advance both individual and collective leadership mind-sets.

In order to begin culture change, hidden assumptions and beliefs must be unearthed. This is often an uncomfortable process, because hidden assumptions are such a powerful basis for our confidence in leadership and decision making. Yet they need to be examined and possibly revised if they are to nurture a collective leadership culture. Unexamined beliefs control an organisation and prevent any meaningful change. Years of

valuing hierarchy, status, authority and control can lead to assumptions and behaviours that undermine collective leadership and are unnecessary, unhelpful, and at odds with the strategic direction of the organisation.

Boards and leadership teams need to be clear that changing the culture also means changing themselves. Senior leaders who move the needle toward organisational transformation also experience significant personal transformation. That commitment to personal change is a fundamental part of their readiness to deliver collective leadership throughout their organisation.

Paradoxically, it is sometimes necessary to use command-and-control to move the organisation away from command-and-control. This can be very stressful for employees in the beginning and requires senior leaders to listen, learn and show empathy. Senior leaders, individually and as a team, need to engage in real dialogue with each other and with staff throughout the organisation. This is a rather different way of practising leadership than the typical pattern of advocacy, influencing, persuasion and politicking found in hierarchical leadership cultures. What senior leaders hear during this phase will help them on their own personal transformation journey as they recognise the value of multiple perspectives and get a better sense of their own organisation's readiness for change.

Developing new beliefs and mind-sets is hard, but the collective leadership practices they generate will permanently alter the way leadership is experienced and accomplished in the organisation. Therefore it is important to ensure this step is not done in haste.

Delivering Cross-organisational Collaboration and Teamwork

In a collective leadership culture, the abilities of leaders to build networks and alliances across and outside the organisation are considerably more important than in other types of leadership culture. Looking at the way health care delivery is conceptualised by regulators in the future (Monitor, 2014), collaboration inside the organisation as well as with other partners across the local health and care economy will be the “new normal.”

For collaboration to be the basis of future health care delivery, effective teamwork, multi-directional communication, clear information and versatile conflict resolution mechanisms need to be put into place across the organisation. We already know that effective teamwork, i.e. working in real teams with joint responsibilities, mutually interdependent tasks and individual accountability, is linked to better patient care (Lyubovnikova & West, 2013). Leadership in such teams is both distributed among the team and focused on a few formal leaders. Basing health care delivery on teams requires effective collaboration also between the different teams in the organisation.

The ability to create direction, alignment and commitment not only within teams, but also among various groups and teams, spanning professional and physical boundaries, is key for achieving positive patient outcomes and more efficient, integrated and adaptive health and care delivery. For this to happen, trust within and among teams needs to be developed based on open and supportive communication, candid and mutual feedback, and a sustainable emphasis on joint mission and goals focused on better patient care.

A target-focused, command-and-control type of leadership culture emphasises competition among teams, leading to friction, conflict and broken trust among different teams in the organisation because they conceive of their targets as incompatible. There’s evidence that current stress levels amongst health care staff often stifle any efforts to regain trust between teams, letting such conflict linger on. In a collective leadership culture, teams are aware that their goals are interdependent with each other and need to engage in dialogue to identify win-win solutions (often innovative ones) that ensure that one team’s gain is not another team’s loss.

By conceiving the local health and care economy as a networked economy, team working is lifted to a cross-organisational level. A collective leadership culture enables organisations to see themselves as mutually interdependent in their mission to deliver high quality, effective patient care; the ability to collaborate with each other is seen as fundamental to create necessary synergies at multiple levels. These synergies are then used to enhance patient and social care.



Delivering a Collective Leadership Development Strategy

A Leadership Development Strategy must be formulated to support the collective leadership strategy. If an organisation is planning to undergo the significant change needed to establish a collective leadership culture, how will it go about developing leadership on organisational, team, and individual levels?

A collective leadership development strategy specifies the actions that must be taken to retain, develop, or attract the leaders and nurture the leadership culture required by the organisation's strategy. The leadership development strategy will include the areas described below. We recommend that all leadership development activities are evidence-based (their effectiveness is supported by previous research and rigorous evaluation). Recommended activities include:

Induction and socialization (“on-boarding”)

processes: Leaders in a collective leadership culture behave differently from those in a directive culture by engaging all staff as potential leaders in the collective leadership culture. This means they conceive of their leadership responsibility in a quite different way from that of a hierarchical organisation. Collective leadership also puts high demands on staff members in that they need to understand and assume their own responsibility for co-creating collective leadership. These fundamental differences in collective leadership cultures are important to highlight in induction processes.

Individual, team, and organisational assessments:

Assessments are necessary for the organisation, teams and individuals to know where they stand on their development path for collective leadership. At regular intervals, such “assessments for development” should be conducted to provide feedback on whether collective leadership development really works, and where actions or strategies might need to be improved. It is important to ensure that these assessments are evidence-based and are well conducted. (Some assessment methods used in the NHS, even at the most senior levels, show inadequate reliability and validity, and very little connection to strategically necessary leadership capabilities.)

Individual development plans:

These plans specify development goals and development paths for staff members who play critical roles in the collective leadership process. They are negotiated with supervisors and HR representatives and feed into broader talent development plans developed by HR. Good individual development plans also specify responsibilities of others (supervisor, HR, coach, peers) in a person's development and include measures of development “readiness.” They outline how each member of staff can grow in a collective leadership culture, and what is required from the individual for such growth—lateral or hierarchical—to happen.

Required/core learning experiences:

Certain learning experiences are required to hold a position or accept a leadership role at a particular level in the organisation. Those at senior levels should have ample experience of leadership responsibility and how collective leadership is achieved at different levels and in different parts of the organisation. Some of these learning experiences might take place in other NHS or non-NHS organisations.

Elective learning opportunities: These are internal or external courses or experiences that are made available to leaders on a voluntary basis. These might be within the NHS (e.g., The Leadership Academy), outside the NHS but within health (e.g., The King's Fund) or outside the NHS altogether (e.g., Center for Creative Leadership). Key is ensuring the quality of leadership development and evidence that these approaches are effective.

Work assignments: Work assignments are often overlooked as opportunities to help leaders develop specific competencies or practice key behaviours. To enhance the focus on learning from work assignments, it is important to have specific goals, opportunities to receive feedback on progress, and a coach or mentor with whom to discuss learning. In the process of delivering collective leadership, specific work assignments for team leaders might include for example: establishing effective communication flow across different care teams; engaging all staff in implementing innovative and more patient-centric care practices; mapping stakeholder relationships with other organisations and devising stakeholder management practices; supporting BME staff members' development and recognising the value of diversity for more compassionate patient care.

Coaching/mentoring/feedback: In a collective leadership culture, shared responsibility for leadership includes the need for timely, accurate and developmental feedback between people and across different parts of the organisation. Coaching, mentoring and feedback can be powerful ways of developing leadership.

Executive engagement in talent development: Many of the benefits of leadership development are not achieved unless senior executives buy into the process by supporting the investments and modelling collective leadership behaviours. The creation of a different leadership culture

starts with board members who demonstrate their personal engagement and support for change and role-model the type of leadership they would like to see across the organisation. This includes role modelling as individual leaders and as a leadership team, practicing collective leadership in a public space and showcasing necessary elements of collective leadership that need to be developed in their organisation, e.g. joint vision crafting, patient centricity, peer feedback, mutual care, balanced risk-taking and learning from mistakes.

Leadership by level, function, and location: The leadership development strategy should take into account differences in requirements by position, function and location. Collective leadership, even if based on the principles of shared ideas, co-creation, mutual accountability and joint vision, will look different in different parts of the organisation, depending on task and situational requirements. Collective leadership in parts of the organisation that provide direct patient care will look different from leadership in the estates or HR departments.

Development over time: Rather than the one year outlook driven by budget cycles that is typical in most leadership development curricula, we suggest that the leadership development strategy should look forward three to five years, from the perspectives of both the organisation and individual leader. Collective leadership takes time, and so does its development. By matching time frames for leadership development and leadership strategy to an organisation's overall strategy, an emphasis can be placed on the development of strategically critical yet difficult development areas over time. With this more holistic perspective, time, energy and resources for development can begin to shift to where the greatest potential for relevant learning and critical application lie.



Developing collective leadership should be thought of systemically, not simply as a curriculum composed of programs. Collective leadership development activities blend individual, team and organisational development because of their recognized interdependence. Thus, “off-the-shelf” or “sheep dip” programmes will not be sufficient to achieve the leadership strategy, which means that the organisational strategy will not be effectively implemented.

A cursory examination of how NHS organisations currently approach this reveals that leadership development usually consists of an assortment of programmes that are roughly tied to the level and background of participants rather than a careful concurrent assessment of individual and organisational needs. Competency models, even where they have been customised to fit the organisation or even the NHS more generally, are often overly generic, backward looking, or only loosely tied to the learning activities that take place. Different units or locations in organisations often have their own approaches to leadership development, using different activities, programmes and providers.

Frequently, offerings from outside providers are designed generically, to appeal to a broad target group, rather than tied to the strategic needs of any one organisation. Transferability of learning contents from such training is therefore limited.

Participants in non-strategic development programmes may sense that they are being “put through the mill” and that what’s important is “ticking the box” rather than applying what they are learning to achieve key organisational objectives. Even if they are able to derive personal insights that they want to put into practice, they will often find that there is no support for them to do so. In particular, many participants in NHS leadership training programmes come back to their organisations after an externally provided course and report finding that their efforts to implement their learning are at best not supported and at worst are actively resisted.



Because the links between organisational strategy, leadership strategy and leadership development strategy are often non-existent, many organisations in the NHS do not have either a defined leadership strategy or leadership development strategy. However, the new CQC inspection criteria will probably assess whether NHS organisations have well-developed leadership strategies so this might well become a “must have.”

A well thought-through collective leadership development strategy will return benefits at the individual, team and organisation levels that simply cannot be achieved by assembling off-the-shelf programmatic components, no matter how good their content. Moreover, individual-level offerings alone will not be able to bring about a culture of collective leadership across the organisation. While shortcuts may appear to save time and money, in the long run they are a poor investment because they do not produce organisational transformation. For collective leadership, learning must take place in the collective, not just on the part of individuals.

Realigning Talent Management with Collective Leadership Practices

The leadership development strategy will in turn have implications for talent management processes and leadership practices that affect individual leaders as well as the leadership culture. Unless these HR systems, processes and policies are aligned with the leadership strategy, they will at best fail to reinforce progress towards the desired culture and at worst become barriers to success. Below we briefly review the most important processes that impact talent sustainability and how these processes are linked to leadership strategy and leadership development strategy.

Executive Commitment and Engagement: Talent management must be a priority for NHS executives. Currently there are vast differences in the level of support demonstrated. The occasional talk by a senior executive at a leadership program is not sufficient to shape the leadership culture, attract and retain the best talent, and plan a leadership strategy that ensures the organisation strategy is implemented. The responsibility for talent management cannot simply be delegated to the Human Resources department. It must be accepted at the highest levels of the company, held by the Chief Executive, members of the executive team and the Board as a shared commitment to the future of the organisation. Boards must hold executives to account in terms of their engagement in talent management activities.

Reward and recognition: When rewards do not reinforce collective leadership, the door is opened for other types of leadership cultures to establish themselves. Leaders must accept responsibility for making the success of the organisation as a whole the priority above the success of their individual areas of responsibility. Collective leadership is difficult to implement so rewards and recognition need to be used to sustain it.

Knowledge management: Knowledge management systems can greatly simplify learning, and also capture important information that might otherwise disappear as talented individuals retire or move on to other assignments. Collective leadership makes use of both shared knowledge as well as individual, specific expertise and access to networks; thus knowledge management systems need to ensure that unshared knowledge is somehow catalogued (“who knows what, who knows whom”) and available to the organisation even if when individuals leave.

Performance management: In a collective leadership culture, responsibility for leadership is shared and staff are acutely aware of their interdependence in creating high quality and compassionate care. Yet even with shared responsibility, individuals need to be held accountable for their performance and their contribution towards organisational goals.

**Competency development and deployment:**

Competencies provide helpful directional guidance for staff with formal or informal leadership responsibility, because competencies give direction in terms of what to do, as well as what to develop. However, in many organisations, too much emphasis has been placed on competencies relative to other elements in leadership development. In cultures of collective leadership, competence needs to be defined and assessed at both individual and collective level, and be integrated with organisational strategy. Only then can such competency frameworks provide useful anchors for talent management decisions.

Sourcing and recruiting: As organisations adopt new approaches, expand into new areas of activity, or adopt bold new strategies, they often try to get there with the leadership they already have instead of getting the leadership they need. Current research shows that collective leadership, at least on team level, may be best performed by groups and teams that bring a blend of expertise and backgrounds that can contribute to the co-creation of leadership in the team over time (Morgenson, Lindoerfer & Loring, 2010).

Leadership Practices: Leadership practices are the observable shared behaviours that shape and ultimately define the leadership culture. The leadership culture can be discerned by listening to what people say about leaders in the organisation. The stories people tell will be based on behaviours they observe, especially during unusual times that “test” the true nature of the leadership culture. When results aren’t achieved, what happens? Do leaders start looking for scapegoats or do they engage people in problem solving? When strategies are not implemented, do leaders “finger-point” or do they pull together across units and levels to figure out what is going wrong and try something new? Speeches do not determine how people view the leadership culture. People listen to speeches, but watch closely to see what really happens. That is why defining the leadership practices that are essential to implementing the leadership strategy is so important.

Assessing Impact on Organisational Performance

With the right leadership strategy in place, the right leadership development process designed, and the appropriate talent acquisition, talent sustainability and leadership practices in place, there's a much better chance that organisational strategy will be successful. Collective leadership has a distinct advantage over other leadership approaches and cultures in that, if done well, it enables the organisation to be more adaptable to change, nimble in its processes, and innovative. It

also means all members of the organisation are more acutely aware of their joint mission to provide high quality and compassionate care, and collaborate with each other to achieve this mission. As a result, there are likely to be improvements in clinical effectiveness, patient safety, patient satisfaction, patient outcomes, staff engagement, staff satisfaction, absenteeism, turnover, integrated care, financial performance and capacity to change.





Conclusion

With the current structural and governance changes in the NHS, organisations cannot hope to run effectively, achieve their goals and execute their strategies without giving thought to the leadership and leadership culture of the organisation. Yet many still do, seeing strategy implementation, organisational leadership, and leadership development as unrelated. As we argued in our companion paper, *Delivering a Collective Leadership Strategy for Health Care*, sustainable and strategic transformation of health care organisations can work and receive compassionate, high quality care can only be achieved if there is an appropriate collective leadership culture, developed from a conscious and intelligent leadership strategy.

In this paper, *Delivering a Collective Leadership Strategy for Health Care*, we have offered guidance on the key elements of developing and delivering leadership strategies.

Collective leadership offers huge opportunities for creating cultures of continually improving, high quality, and compassionate care. But it is not easy to implement. It requires a high degree of professional-

ism for all leaders (informal and informal) to recognise the interdependence of their goals. It requires leaders and staff to give up power based on withholding information and to engage in constructive dialogue about the use of joint resources. It requires trust and healthy relationships between individuals, groups, teams and departments across the organisation. These relationships form the basis for collaboration that transcends organisational structure and creates synergies, innovation and efficiencies at various levels. Most importantly, it requires the complete dedication of the Board and leadership team to empower all staff as leaders, and trust in the process of collaboration in the organisation as the foundation for its leadership culture.

The challenges that face health care organisations are too great and too many for leadership to be left to chance or to piecemeal approaches. Through working together with health and social care organisations to address this profoundly important issue, we can develop leadership strategies that will ensure they confidently face the future and deliver the high quality, compassionate care that is their mission.

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