ANGLIA RUSKIN UNIVERSITY

THE EFFECT OF MARKETISATION ON THE LEADERSHIP OF NATIONAL HEALTH SERVICE (NHS) HOSPITALS

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A thesis in partial fulfilment of the requirements of Anglia Ruskin University for the degree of PhD

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DEDICATION

In loving memory of

Beatrice (Betty) Leech

15th April 1922 – 1st Sept 2000

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Thank you.

ANGLIA RUSKIN UNIVERSITY

ABSTRACT

LORD ASCROFT INTERNATIONAL BUSINESS SCHOOL

PhD

THE EFFECT OF MARKETISATION ON THE LEADERSHIP OF NATIONAL HEALTH SERVICE (NHS) HOSPITALS

DARREN LEECH

Supervisory team: Dr Rob Willis, Cassie Jones and Dr Rhidian Lewis

September 2013

This thesis tests and explores the impact of increasing competition (marketisation) on the leaders of NHS hospitals in England. The research was prompted by the researcher's observations in practice that language and behaviours were changing to reflect an increasing sense of competition between NHS hospitals.

Whilst published opinions are not difficult to find in relation to changing NHS policy, this unique academic investigation provides a new contribution to knowledge through evidence generated from a mixed methodological research process. A qualitative case-study involving telephone interviews with leaders at a single hospital site were conducted in late 2009. The findings were tested for generalisability across 20 NHS hospital sites as a larger cohort of comparable NHS leaders were targeted using a multi-site, on-line questionnaire in 2010.

This thesis concludes that hospital leaders believe that competition exists between NHS hospitals. A significant proportion also believes that the sense of competition is increasing. This is evidenced through culturally significant research findings related to changes in leadership behaviour, language and actions as a consequence of increasing marketisation. Furthermore, hospital leaders are divided and clearly unconvinced that increased competition would be a good thing for the NHS. This has numerous implications for policy, leadership in practice, leadership and market theory and specifically, the NHS leadership development model - the NHS 'Leadership Qualities Framework' (LQF).

Key words: Leadership; Competition, NHS, Hospitals, Marketisation, Culture

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ABBREVIATIONS

Business research and healthcare are both fields of work that are heavily populated by abbreviations. Readers of this thesis are likely to have different levels of familiarity and background knowledge for each area. A comprehensive list of the abbreviations used in this thesis has been compiled below. This - the researcher hopes – will provide an easy reference source and therefore, make for an easier and more enjoyable read.

ARU	Anglia Ruskin University
BPR	Business Process Re-engineering
CQC	Care Quality Commission
DHSS	Department of Health and Social Security
DoH	Department of Health
DH	Department of Health
EI	Emotional Intelligence
FT	Foundation Trust
GP	General Practitioner
HHCT	Hinchingbrooke Healthcare NHS Trust
HHCT REC	Hinchingbrooke Healthcare NHS Trust Research Ethics Committee
IT	Information Technology
LAIBS	Ashcroft International Business School
LMX	Leader Member Exchange theory
LQF	Leadership Qualities Framework
LPC	Least Preferred Co-worker (contingency model of leadership)
MBA	Masters in Business Administration
MoH	Ministry of Health
MTS	Management Training Scheme (NHS)
NHS	National Health Service
NHS REC	National Health Service Research Ethics Committee
NICE	National Institute for Clinical Excellence
OFT	Office of Fair Trading
PbR	Payment By Results
PCTs	Primary Care Trusts
PEST	Political, Environmental, Social and Technological influences
RESC	Research Ethics Sub-Committee (ARU)
RPSGB	Royal Pharmaceutical Society of Great Britain
SHAs	Strategic Health Authorities
TME	Trust Management Executive (at case study site, HHCT)
UK	United Kingdom of Great Britain and Northern Ireland
US	United States of America

INTRODUCTION

Background to the research

This thesis and the research described within it, provides the reader with a unique insight into the NHS and its leaders of the often large and complex organisations that are NHS hospitals. The basis of the research is practice based in nature and the active research stages were undertaken with the direct participation of leaders from many hospitals across England and as such, the research was conducted 'inside the NHS'.

The researcher identified a gap in health related management research in the period immediately prior to consideration of a PhD research project. This research gap primarily related to the impact of a number of policy changes and these are described in the comprehensive literature review chapter of this thesis. Essentially, it seemed that health policy was driving an increasing sense of competition between NHS hospitals and their leaders.

Until the end of the last century, the prospect of competition for the right to provide NHS services was discussed conceptually but it never translated into policy as it had done other public sector service areas (Walsh, 1995). A brief experiment in the 1990's with an 'internal market' (DoH, 1994) was followed by the publication of an NHS plan that included, not only an increased use of the private sector for provision, but explicit reference to creation of a market driven system (DoH, 2000). This general philosophy has been continued in policy terms, regardless of governmental changes since.

Policy that drives and encourages a more competitive ethos between care providers (DoH, 1989; DoH 2000) challenges some of the fundamental founding principles of the NHS (Rivett, 1998; Clarke-Kennedy, 1955). This has led to a well-documented culture clash between traditional public sector principles and the notion of a more competitive, marketised and overtly commercial ethos for the health sector in England.

The researcher observed in practice, a number of attitudinal and behavioural changes in many employees over time – particularly those managers and clinicians working in positions of leadership. This sense of changing leadership and management practice, set alongside the NHS 'Leadership Qualities Framework'

(DoH, 2004a; DoH 2004b; DoH, 2006a) led the researcher to question whether the impact of increased competition between NHS hospitals had already, or was likely to further change the requirements and expectations of those in positions of leadership. Thus, practical and theoretical concepts conspired to lead the researcher toward undertaking this research.

The research 'gap'

Many commentators agree with the sentiment contained in an early statement from the NHS Leadership Centre in 2002 (DoH, 2002b), when they said, 'Effective leadership is critical to managing and delivering transformation of the NHS' (p 3).

Given the importance of leadership to the future of the NHS, the researcher was intrigued to find at the outset of this research that whilst there were a number of primarily opinion based articles covering the development of market based systems in healthcare, particularly those affecting hospitals, that there were few – if any – published works that were evidence based. None of these articles observed or asked the views of hospital leaders in practice and therefore, none had properly considered or questioned how the language of leadership had evolved in line with an increasing sense of competition between hospitals. Further, the evidence and likely implications of marketisation upon the style, competency and capabilities required of the next generation of health service leaders remained unconsidered.

The research issues that arise from this situation relate to leaders of NHS hospitals operating in what has been and will no doubt remain, a complex and changing environment. The changing requirements of leaders in NHS hospitals as they move from a state run public service background to an increasingly marketised, more commercially driven health service along with the cultural impact of these changes and the implications for existing NHS leadership development models are all critically important issues for the successful delivery of healthcare and the future public policy agenda (Deffenbaugh, 2007; Leech, 2007).

The aim of the study is examine this 'research gap' and to identify the evidence base – as marketisation has begun to take effect – at source. Targeting the leaders of NHS hospitals to understand fundamentally whether there is, or isn't, a widely held sense of marketisation among hospital leaders, as observed in practice by the researcher. Further, the research explores whether there are resultant changes or

developments relating to the behaviours, activities and language of leaders as they operate in a new and emerging epoch for NHS hospitals.

The research questions

The aim of the research is to identify – as marketisation has begun to take effect – the views of NHS leaders in the hospital sector. The study explores their views and gathers insight around the level of competition between NHS hospitals, the implications of it for NHS hospitals and their leaders and in addition, any emerging variations in the language, behaviours and activities of leaders given the historical and cultural background of the NHS in this changing environment. Essentially then, the key research questions are;

1. Do leaders currently working within NHS hospitals feel that there is competition between hospitals ?

2. Has any sense of competition in the NHS increased, decreased or not changed in recent years ?

3. Do leaders in NHS hospitals think, if the level of competition in the NHS were to increase, that this would that be good thing ?

4. Have the leaders in NHS hospitals changed their behaviour or language as a consequence of competition with other hospitals and providers ?

5. Have leaders in the NHS hospitals changed their perceptions of the skill set and qualities required of leaders in their field, as a direct consequence increased levels of competition ?

6. Taking the above into account, how well utilised by hospital leaders is the NHS Leadership Qualities Framework (LQF) and can it be described as “fit for purpose” in the current environment. Do hospital leaders believe that there are key gaps in the framework, that increasing marketisation may widen further still ?

The research process

The research was conducted over the period described on pages 117 to 119. In terms of formal approval and permission for the research to be conducted, the

researcher received final confirmation from the University's Research Degree Sub-Committee on 30th March 2009 (see Appendix II), as at that point ethics approvals had also been received (see Appendix III, Appendix IV and Appendix V).

A comprehensive description of all aspects of the research methodology and the underpinning conceptual framework is contained in the methodology chapter of the thesis (see page 89). The research was based on a critical review of existing leadership literature and theory, along with a historical analysis of the NHS from its inception to the period relevant to this research. This evaluation is also complimented by a review of the relevant theoretical texts relating to public service provision and in particular, the contrast between models of state controlled provision and those based upon the principles of competition and the market.

These issues were tested through a single-site case study in which telephone research interviews with NHS leaders in that hospital were conducted. This primarily social research approach, phenomenological in concept, was triangulated and tested from a more positivistic standpoint, through a multi-site on-line research questionnaire, targeted at the leaders of numerous NHS hospitals throughout England.

The research targets

Access to hospitals and to the leaders of these large public organisations offered the researcher an excellent platform from which to operate and undertake this research. The researcher was keen to gather credible research data, directly from hospital leaders in practice. This distinct research environment and the evidence it generated provided the researcher with an opportunity to explore and to critically evaluate the very existence of 'marketisation' in the NHS. Further, it enabled informed reflection upon both the extent and impact of marketisation and the subsequent implications for hospital leaders.

Specifically, a single hospital was selected as a case-study site. This hospital was known to the researcher in practice (see page 91) and its senior leadership individually targeted to elicit a rich vein of research data. The results of this case study were then tested by targeting leaders at twenty other hospital sites. The leaders in both phases of the research were made up of executive directors, clinical directors and general managers, reflecting the common hierarchy and senior leadership roles in NHS hospitals.

Research implications

The implications of this research and the issues arising from it cover the spectrum of theory, practice and research. The primary conclusions and implications are described in the conclusions chapter of the thesis (see page 179).

Given the nature of the research setting, the methodology employed and the research questions posed, the researcher firmly believes that the research undertaken and described in this thesis provides a number of original, new contributions to knowledge from a unique research perspective.

This research also provides a distinct set of theoretical and practice based research markers, from which further research into other aspects of health service management and leadership related to competition and marketisation could be developed and explored in future.

The relationship between the research and the researcher

The researcher was employed in a number of senior roles at the initial case-study research site between November 2003 and June 2008. The financial position of the organisation made the national news (Timmins, 2007) and later in the same year, expenditure reduction measures to bring spend into line with revised levels of income associated with the introduction of a market based tariff - including job cuts - were also reported in the national press (Barker, 2007).

Toward the end of that period, the researcher was in a Director level position and was also, partly employed by the commissioning organisation following a strategic review of clinical services and an associated public consultation (Cambridgeshire PCT, 2007). Since, the researcher has continued to work in the NHS holding a range of board level positions (Leech, 2012b) and therefore, careful consideration as to the role and position of the researcher at the time of the active research has been given. This is described in the ethics section of the methodology chapter, on page 107. At the time of completing this research and the resulting thesis, the researcher remains employed in the health service and hospital sector, as an executive director (Chief Operating Officer) of an NHS Foundation Trust.

The changing environment, the practice based-context and a high level of personal curiosity and reflection on the part of the researcher, led to the evolution of this thesis and the research questions within it. This context provides the reader with an

understanding of the relationship between the research environment and the researcher and in doing so, the relevance of the research to the researcher in practice.

The researcher has maintained an active interest in sharing his research since registering with the University. This has been complemented by regular meetings with academic supervisors, the generic research training modules required of all PhD students and a wide variety of other research and practice based courses, conferences and events including publications and presentations by the researcher (see Appendix I and References, page 208-210). This evidence has provided the researcher with some assurance that when compared to the relevant literature, that the depth and breadth of the overall research experience is of the level required for the award of PhD (Dunleavy, 2003).

Presentation of the thesis

In terms of the structure, style and presentation of this thesis, the researcher has taken note of some of the key texts related to drafting and writing a doctoral text. A key source of reference has been the work of Dunleavy (2003), who provides a considerable number of helpful suggestions related to the organisation and presentation of a thesis such as this. His advice is derived from years of experience and therefore, it is certainly credible in the eyes of this researcher. Whilst Dunleavy's counsel transcends the traditional 'formatting and font advice' contained in lighter tomes of guidance, perhaps in a candid moment, he also admits that such evaluations are, 'notoriously subjective' (p 103).

In this instance, despite that warning, the researcher has attempted to match the academic requirements of the University, the level of work undertaken by past contemporaries when seeking the award of PhD and at the same time, conduct research that is meaningful, interesting and useful.

The author has attempted to write this thesis in a way that it appears uncomplicated to the reader. Yet, it still retains a depth of knowledge and sufficient evidence of scholarship to merit the award for which it has been submitted. This difficult balance in style was never far from the researchers mind throughout the research process. However, the following passage provided helpful sanity when issues of balancing presentational simplicity with a complex, data rich research project;

‘Every difficult work presents us with a choice of whether to judge the author inept for not being clear, or ourselves stupid for not grasping what is going on…Writing with simplicity requires courage, for there is a danger that one will be overlooked, dismissed or simpleminded by those with a tenacious belief that impassable prose is a hallmark of intelligence’

Alain de Botton (adapted from Dunleavy, 2003)

LITERATURE REVIEW

Introduction to the literature review

According to Hussey & Hussey (1997), a successful literature review is dependent on three important factors. First, it should show an improved knowledge of the subject area, second it needs to demonstrate the researchers' understanding and third, have a significant impact on the research process. These are the criteria by which the researcher provides some degree of self-evaluation, as the literature review chapter of the thesis concludes on page 87.

A literature review is not a simple exercise, regardless of the research topic and there are a number of particular 'dangers' associated with research degrees, according to Gill & Johnson (1997). They say that literature reviews can bog you down, so much so that this part of the research process can stifle the generation of original ideas, as the researcher, 'becomes submerged in those [ideas] of other people' (p 21).

The intention of the researcher in this instance has been to respect the literature review process and undertake a thorough and critical examination of the literature. Whilst confident that an extensive review has been conducted, it has been undertaken in a manner that attempts to take heed of this advice, avoiding the pitfall of becoming 'bogged down', whilst at the same time retaining what is hoped as being an appropriate level of depth, rigour and critical analysis for what is an important chapter within a PhD thesis.

An overview of structure to the literature review

This research covers the intersection of three major areas of theory and history;

1. Market theory, with a particular focus on former public services
2. The NHS and its history, providing the cultural context for the research
3. Leadership - both published academic theory and the current development models that are particularly relevant to those in contemporary practice within the NHS

Reflecting these three primary areas of focus, this literature review has been ordered into a series of logical sections that broadly flow from these key headings.

Firstly, from page 9, the theoretical foundations behind 'marketisation' are explored. An examination of traditional 'state run and provided' models of public service provision to citizens, contrasted to the 'market based' alternatives is undertaken. This assessment spans both extremes, from the model of state sanction and provision through to a totally free market.

In order to contextualise the research setting and environment, a relatively concise but culturally relevant history of the NHS, as informed by the literature, has been provided from page 19 onward.

Numerous theories relating to leadership are then introduced in a structured fashion from page 31. A comprehensive overview of the major theoretical schools of thought, from early research to more modern approaches is followed by a targeted examination of literature specifically related to leadership in the research area, the National Health Service.

Market theory

State provision or the free market – those are essentially the polar theoretical standpoints behind any debate around the provision of public services, including health. The aim of this section of the literature review is to explore and explain these arguments. The implications of each are then explored in relation to leadership and leaders in organisations.

The traditional 'state run' model for public service provision

The essence of state run public service provision is provided in the researcher's view by Walsh (1995) when he cites the description given of the Swedish model for public service provision by Premfors (1991). This, he contends, captures the 'essential nature of the welfare state in the UK';

'The big problems of [Swedish] society….were seen to require big solutions. Big solutions meant nationwide and uniform social programmes, planned and administered in a centralised fashion by big, hierarchically organised government agencies, and financed out of all-purpose tax funds. In some services, local governments would be appropriate producers and distributors [of services], but only following a radical programme of amalgamation and centralisation (pp 83-95)'.

This basic theoretical construct that underpins the state provision of goods and services is often seen as an insurance against 'market failure' (see page 15). It is also contended that large scale collective decision making, planning and public provision will be more effective in progressing programmes for social progress than individual, local exchange. The moral basis for this model is concerned with equity, fairness and justice, as it can also be said to prevent or right the failings and inequities that could precipitate from a purely market based approach. Taken a step further, it is argued that some activities are of such moral significance that they should not be provided by the market, because they would then be tainted by association with financial exchange and profit. Walzer (1983) expresses this broad concern for a loss of the public service ethic, contending that the market is not an acceptable model for delivery of, for example education or health services. In their work on prison services, Ryan and Ward (1989) offer a clearer if not blunter position, contending that private profit should not be made where there is an element of human suffering involved. Clearly, this moral position could equally be applied to the provision of health services. At the outset of the National Health Service there was certainly evidence of this idealistic ethic, centred on a post-war vision for health care in the UK, free at the point of care for all citizens (see page 19).

In health, numerous reasons have been cited for steering away from a market-based system. Many of these arguments focus on the additional cost brought forward by a market system. Thus, 'before the internal market, NHS transaction costs were around 6%. In the US healthcare market, they exceed 25%. Essential features of a market system – contracts, billing, accounting, legal services, marketing – all cost money' (Unison, 2002). It would certainly be true to say that the current Government is wrestling with how to regulate competition in the NHS (Dowler, 2012; Plumridge, 2012). This view is perhaps unsurprising when contrasted to the classical literature from many social theorists who in essence, suggest that the market-model leads to undue exploitation of labour (Lukacs, 1971) and that the market model becomes 'self-realising' when applied to public services (Bourdieu, 1999).

In addition, Marquand (2004) contends that the public domain is essential as it is fundamental to a civilised society, allows democratic citizenship to flourish, is built on trust, encompasses the value of equity and needs to be protected from the incursion of the market. Therefore, it should not be subject to a process of commodification, attempts to do so will undermine the service ethic on which it is built (p 51).

In this context, Le Grand (2007) asks a series of searching questions relating to a shift from state provision to markets. Thus, 'when ill, should we be patient and simply trust the doctor to make us well again? Should we have the right to choose the hospital where our illness is to be treated..?....Or would such choice lead to destructive competition…competition that would damage not only the people making the choices but also those who work within those institutions and indeed the wider social interest?' (p1)

The alternative offer of 'marketisation'

Unlike the proponents of state provision, there are those who extoll a belief that market based systems can produce co-ordinated results, without the need for any conscious co-ordinating processes from the state. For example, Williamson (1975, 1985) argues that optimal service and organisational form will evolve in ways that naturally reduce the cost of transactions and that organisation will need to be less or more complex dependent on a number of critical factors, such as the complexity and certainty of the operating environment. A largely convincing case in support of market-systems is undermined somewhat, when he goes on to state that in complex scenarios the transaction costs often result in market failure.

Governments of all persuasions in England have had the modernisation and reform of public services as a central theme of public policy since the mid-1970s. This has led to partial or full marketisation of a range of formerly state controlled services. The list is extensive, as moves in this direction primarily began as early as the 1980s. Evidence is provided by Helm & Jenkinson (1998) during whose research on competition in areas such as bus services, coal, electricity, gas, rail and water, it was contended that, 'state ownership was abandoned as the preferred option in the 1980s' (p 1). Interestingly, their comprehensive review of regulated industries makes no reference to health services at all and further, it omits the impact of competition on both organisations and their leadership and management. In other texts focussed upon marketisation in former public service industries, there also appears to be little narrative around health or similar implications of competition being introduced (Marquis, 2001; Clarke & Pitelis, 1993). However, a clue as to why perhaps lies in the work of Roberts *et al* (1991) who, when discussing free markets and competition in the electricity sector specifically, state that, 'The introduction of competition to some parts of the UK electricity supply industry was the cornerstone of that industry's total privatisation' (p 10).

Health service privatisation, in conceptual policy terms, was voiced in the 1980s. This included an explicit denouncement of the NHS in the paper of Redwood & Letwin (1988). The main contention put forward here was that there was a 'monopoly supplier holding the consumer to ransom' (p 21). It is this fear of privatisation perhaps, which rubs against the long-standing notion of universal access regardless of financial contribution applied to health services since the 1940s, that has led policy away from further suggestions of total private sector provision. This important variation – still found in policy today – is simply and perhaps best described by Paton (1998) as, 'preserving public financing, yet seeking competition in supply' (p 22). Latterly, this is illustrated in the manifesto of the previous government in which it is stated that the regime would, 'Use new providers where they add capacity or promote innovation, give choice/power to patients' (Labour Party, 2005). Shortly after this, Paton went on to state that the consistent drive for 'increased efficiency and quality' (p 558) as a common theme running through health policy for the past 20 years (Paton, 2006). The means to achieving this universally agreed objective however, has been a point of contention and debate within the health service itself, in political circles and in the country at large for some time. The policy reality, according to Lewis & Gillam (2003), has been a clear move to create 'market orientated services' (p 81). A sentiment that has come to dominate (Clover, 2012; Lansley, 2012)

Advocates for the concept of market-based provision have long predicted that such a system could provide the means to reduce costs, drive up quality and improve access and this thinking is still very evident today. An extreme example of this viewpoint is that put forward by Willis (2006), who compares the health service to Vodafone and asks the question;

'What's so different about the health system? Is there competition within organisations such as Vodafone? Of course there is. Organisations like these grow, develop and enhance people, products and services. The health service [therefore] needs an injection of competitive tension too' (p 97).

The slightly eccentric comparison and opinions of Willis in this instance may have some substance however, as Carvel (2006) makes clear reference to academic research showing enhanced quality of provision. He says 'Evidence from the Medicare programme in the US showed how providers respond when the government fixes the price and they are left to compete on quality' (p 9). This

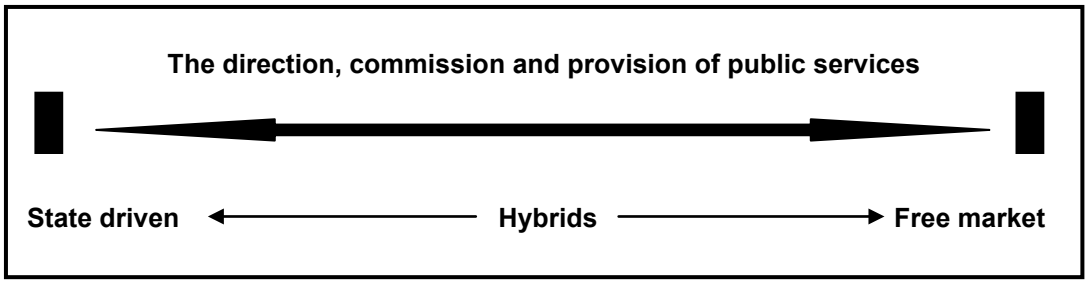
research echoes of the 1990's, 'internal market' created by a Conservative administration, during which the then Chief Executive of the NHS, Alan Langlands, stated in a policy document that, '[the policy] takes some of the lessons that economists have learnt from the operation of markets both inside and outside of the health sector and applies them to the NHS internal market', he goes on to say that, 'if properly followed through, then the health service – its patients, its purchasers and its providers - will be the better for it' (DoH, 1994).

State provision v free market – the relevance to NHS leadership

The reality of a truly market based system in the English health sector is unlikely to happen overnight. In theoretical terms, the state controlled, centralist model described by Premfors (1991) is unlikely to be able to switch to market-driven mechanisms quickly. As such, there is a process of incremental transition underway, as the NHS shifts from a state directed, commissioned and provided service toward a more 'market-like' environment. Patient choice is one such example and whilst at the outset, there were those associated with the medical profession who argued that 'choice in the NHS is limited to waiting times' (Coombes, 2004), it seems that contemporary policy is making the marketplace for provision of NHS services a reality, across far more than access related issues (DoH, 2010i; DoH, 2013)

Between the two public service extremes, of 'state driven' and 'free-market' a variety of market models and organisational types now exist. Aspects of previously state run infrastructure have now been exposed to various forms of privatisation, marketization and pseudo-competition. This has created 'hybrid' public-private environments and organisations. These economies have graded degrees of commodification, commercialisation and privatisation with 'a range of social transactions that include; networks, levels of trust, co-operation, competition and other bonds' (Smelser & Swedburg, 1994). This is shown in Figure 1.

Figure 1. Hybrid models of public service direction, commission and provision



Adapted from Smelser & Swedburg (1994)

Primary examples of 'hybrid' arrangements, caused by changes in the political environment in several countries are given by Kotler & Andreasen (1991). They also list five mechanisms commonly used by the state to achieve such change;

1. *Short term contracts or subcontracts for the delivery of specific services such as refuse collection or security in public buildings.*
2. *Long-term monopoly franchises for the provision of basis services such as gas and electric power.*
3. *Management contracts to run public services such as hospitals or food services in government buildings.*
4. *Joint ventures between government and private firms.*
5. *Total divestiture of public programmes.*

Adapted from Kotler & Andreasen 1991, (p 6)

In the business sector, there is indeed evidence that influential social or business movements are created to generate and deliberately promote change, perhaps through new business models. Business Process Re-engineering (BPR) is one such movement that was tinkered with in the NHS (Hammer & Champy, 1993; Powell & Davies, 2001). Whilst not seen as a fast-moving environment in any sense, it could be that the increasing rhetoric and reference to competition in the NHS is part of such a movement. Indeed, the researcher is aware of previous publications suggesting that when leaders want to help their organisation see, understand and run their activities in a distinct and specific way, they define business models around the management thinking and practices they wish for (Chaharbaghi *et al*, 2003).

In both state driven and free market systems of provision, failures and weaknesses can be identified. Whilst the consequences are different, the primary failures and weaknesses of each are summarised in Figure 2. Not yet answered, in terms of NHS providers such as hospital trusts in a market-based system, is the consequence of failure. In both state driven and free market systems, failure can occur. In a truly competitive and commercial market, companies go out of business. It has been suggested recently that if NHS hospitals lose their market share and cease to be financially viable, they too could face closure (Palmer, 2005).

Figure 2. Primary failures and weaknesses of both state and market based provision models

State failure	Market failure
Supply and demand fluctuations makes for lack of precise costing	Lack of over-arching direction, market dictates (e.g. immunisation programmes)
The struggle to manage in a timely way the adoption of revolutionary technological and scientific advance (e.g. new drugs and medical technologies)	Market produces inequity of access and quality
Lack of local efficiency	Lack of economy of scale

Adapted from Kotler & Andreasen (1991) and Palmer (2005)

Clarity is also lacking in a number of other key areas. In an era where government policy makers seem to view 'citizens as customers' for example, how 'customer driven' can a public service truly become – especially if customer choice conflicts with medical evidence or opinion ? Also, how predatory can organisations that might be looking to expand their 'market share' be? At the time of this research, there had been one organisational acquisition in the health service, the widely reported takeover of Good Hope Hospital in the west midlands by Birmingham Heartlands Hospitals NHS Foundation Trust (Mooney, 2007). If this is an indicator of what is to come for hospitals who find themselves insolvent (Clover, 2013) there will need to be careful consideration of not only the implications for patients, but for the regulation of the market itself (Harrison & Dixon, 2012).

The general move from state provision to a market system has been reflected in changes to public policy. From 1945 to the 1970s, there was a social democratic consensus, where Government played a large role in the economic system, having redistribution and accessibility/universal provision at its core, with public services free at the point of use, as the keystones of social policy. In the period from 1979-1990, under the period of Thatcherism, the social democratic consensus was dismantled. Here, government provision was viewed as a major part of the problem, not the solution – the balance of the mixed economy shifted to the private sector. Put simply, government did not have a role in terms of redistribution and promoting equality. This continued during the period 1997-2007, under new Labour and the 'Third way'. There was a commitment to the mixed economy, but the free market was best at distributing resources; this led to the continued introduction of markets or market-like arrangements in public service provision. In terms of welfare reform, this began the process of the end for automatic universal entitlement and the introduction of

targeted benefits. The public services, generally, were now viewed as ‘enablers’, not providers of services.

According to Le Grand (2007), these general shifts to a more market based system was supported by a change of main drivers within the public policy agenda, with six key themes emerging as;

- Privatisation
- Modernisation
- Marketisation
- Performance management and targets
- Joined-up Government
- Choice and competition

In terms of privatisation, this included the transfer of public sector assets to the private sector, the introduction of compulsory competitive tendering and increased third sector provision. The overall aim was to reduce the size and influence of the public sector. For the public services that remained, an on-going process of modernisation was introduced. This involved a shift in emphasis of what the public sector did, including;

- The shift from reactive to proactive organisations
- The decentralisation of public provision
- The shift from supplying to enabling
- The strategising of the public sector
- The empowering of end users

The focus was on restructuring the public sector, with the aim of transforming a bureaucratic sector into one of innovation. The underlying rationale was that;

- Government can act as a catalyst to allow other organisations to provide services
- Citizens could empowered by transferring power and control from bureaucracies to communities
- Competition should be promoted between service providers
- Government should be driven by vision, mission and strategy - not by rules and regulation (the entrepreneurial state)
- Government should be judged by outcomes (what it achieves), rather than inputs (the resource it uses)
- Market mechanisms are preferable to bureaucratic mechanisms

This shifted the focus of public service activity from an emphasis on;

- Hierarchical decision making to delegation and empowerment
- Quantity to quality
- User orientation to customer focused service providers
- Internal procedures to external outcomes
- Professional judgement to management of contracts and market relationships
- Stability and conformity to innovation, diversity and constant change

Since 1997, there was another major shift, with marketisation being used by the Labour government to improve the efficiency and effectiveness of public services. The key principle was to exploit the benefits of competition, as a means to maximise performance whilst minimising cost. This has been an on-going process, with the first policy tool being that of performance management. Here, government, through organisations like the Audit Commission, Care Quality Commission or others, set targets of various kinds - usually numerical - and offer rewards and penalties for those who achieved (or fail to achieve) targets. This, in some respects, can be seen as a precursor for introducing a market-based system as it set acceptable standards

of performance, allowed for a system of best practice to emerge and the transfer of these practices across public service organisations.

The emphasis then shifted to 'Joined-Up' Government. This relates to public services working in conjunction with other public organisations, the private sector and third sector organisations. Collaboration was seen as a means of using networks to tackle underlying problems and bringing in the capabilities of private organisations along with the closeness to the end-user provided by the third sector. For this work, this is important as working in networks, in a digital age could be the future of public service management (Dunleavy *et al*, 2005). More generally, it has significant implications for how organisations, like the NHS, are managed and led. For example, it has major implications for the skills sets required by those who lead hospitals organisations.

In terms of choice and competition, this revolves around a choice for end users in terms of the provider, the service, the time it is accessed and how it is accessed. Competition refers to the presence in public services of a number of providers, each of which are motivated to attract users of a particular service. It is this final strand of policy which is in its nascent stage in the NHS and which is now having a major impact on the NHS.

These major public policy trends are all on-going and have had implications for service delivery. Accompanying these policy drivers was a significant theoretical change with the emergence of the New Public Management (NPM) school of thought. The term was first coined by Hood (1991). In its first derivation NPM had a number of central characteristics. These were;

- An emphasis on entrepreneurial management rather than a traditional bureaucratic focus
- Explicit sets of standards and measures of performance
- An emphasis on outputs rather than inputs
- A disaggregation and decentralisation of services
- The promotion of competition in public service supply
- The encouragement of private sector management practices and a belief in their superiority

- The promotion of discipline and a 'more for less' approach in resource allocation

Whilst there is an on-going debate surrounding the impact of NPM (McLaughlin *et al*, 2002; Pollitt, 1995; Hood, 2004; Mathiasen, 1999), most would agree with McLaughlin *et al* (2002) that NPM has become the dominant paradigm for public managers across the globe and Pollitt & Bouckaert (2004), that it has also become a way of thinking for a generation of public service managers.

Against this general background of a shift from state provision to increasingly market-orientated service provision models, it is necessary to explore the accompanying evolution of the NHS and the concomitant policy shifts. This will allow discussion of the leadership issues to be developed and contextualised.

The NHS, its evolution from 1948 to contemporary policy

This section of the thesis provides an insight into the history and historical culture of the NHS. The researcher has set out clearly, each of the main eras from inception in the late 1940's, to the modern day policies that in part, triggered the questions underpinning this research.

The creation of the NHS – underlying principles

The National Health Service (NHS) was formally created in July 1948 by Nye Bevan (Rivett, 1998). The foundations of the service were laid against a general backdrop of post-war welfare state creation (Timmins, 1995) and its principles were of universal, standardised access to health care, free from direct charge to the user (Rivett, 1998).

Bevans' NHS was created from an amalgamation of the disperate health services in existence prior to its inception. Indeed the Rt Hon Jennie Lee (Bevans' widow) stated of the NHS that,

> *'Of course the health service in this country did not begin in the 1948. Many of us have associations with the between the wars health service; a great patchwork, a good deal of good intentions, a great deal of inadequacies'.* (DHSS, 1968)

The service was to be funded almost entirely from taxation, which was a revolutionary aspect of the system in the UK. Whilst it is recognised that the NHS model has influenced others, few countries have introduced a directly comparable system for the provision of general health care (Westin, 1998). The structure was agreed to satisfy a variety of interests, most notably the medical profession (Pater, 1981). It is interesting that whilst Pater (1981) also cites the medical profession generally as being the 'most notable' interest group at the time of NHS inception, other historical references from the medical profession itself provide an indication as to the constituent parts of a much wider, inter-dependent 'patchwork' of health services (Clarke-Kennedy, 1955). In 1948, the National Health Service was organised into three distinct sections, as shown in Figure 3;

Figure 3. Organisation of the NHS in 1948 – three distinct sections

Organisation of the NHS in 1948 – three distinct sections;

1. Hospitals (fourteen regional hospital boards funded and supervised local management committees for each hospital)
2. Family Doctors (GPs), Dentists, Opticians and Pharmacists who all remained self -employed under specific contracts
3. Community Nursing, Midwifery, Health Visiting and Immunisation

Adapted from Rivett (1998) and Clarke-Kennedy (1955)

The NHS; 1948-1959

Structurally, in the first decade or so after its inception, the NHS was 'settling down'. This period, according to Warren (2000), 'presented tensions that emerged that have challenged its senior management and successive Governments ever since' (p 14). These included, 'how best to organise and manage the service, how to fund it adequately, how to balance the often conflicting demands and expectations of patients, staff and taxpayers' (Rivett, 1998). During the 1950's, a 'command and control' approach from government to the NHS was taken, which reflected the ethos of the era. This central instruction through a chain of command was applied to hospital boards and to community services. The exception, as independent contractors, were GPs who held a centrally agreed national contract for services. Not surprisingly perhaps, the focus of attention for change was given to hospitals, where most direct central influence could be exerted. In hospitals, the management

structure included a combination of medical, nursing and administrative staff (MoH, 1968) and a report in 1956 detailed concerns about that structure and its ability to tackle problems that remain, albeit on a differing scale, today (MoH, 1956). These concerns are shown in Figure 4 below;

Figure 4. 'Guillebaud' Enquiry into the cost of the NHS key concerns (1956)

Report of the ('Guillebaud') Committee of Enquiry into the cost of the National Health Service key concerns (1956) :

- Changing trends in illness and health
- The importance of prevention of illness
- The need for GPs and hospitals to work closer together
- The need to make adequate provision for the care of older people in their own homes
- Whether the NHS would in practice be able to meet every demand justifiable on medical grounds

Adapted from MoH (1956) 'the Guillebaud report'.

The NHS; 1960-1969

Despite the early challenges, there was little explicit reference to management or leadership. The reason for this was that the NHS of the time was administered, not managed. The overarching objective was to follow central policy and balance this with local clinical opinion. This may sound like a recipe for disaster, but NHS providers thrived amid building plans in the early 1960s for 'District General Hospitals' – a concept aimed at bringing all services under one roof for specific geographical populations (MoH, 1962). This is indeed the model upon which the hospital in the site specific case study for this research was founded. Certainly, for those areas that struggled to attract consultants in particular specialties there were gains in terms of public access to treatment and today, many still hail the 'DGH' as a longstanding testimony to the NHS and its success (MacPherson, 1998) and many more still, campaign for the model to be further protected (Richards & Gumpel, 1997; Milewski, 2005) whilst some academics and clinicians are now asking fundamental questions about the future viability of the DGH in both management (Ham, 2005) and clinical terms (Darzi, 2007).

During the 1960s the Ministry of Health also published a comprehensive review of hospital work and its organisation (MoH, 1967), in which it recommended more medical input into the administration of these new hospitals. This review was undertaken at the same time as major changes to the GP contracting arrangements,

which saw for the first time a funding formula that mixed a fixed capitation payment with additional payments per item of service, designed to improve the quality of general practice (Webster, 1998).

The NHS; 1970-1979

During the 1970s, the Ministry of Health appears to have commissioned and consulted upon the findings of research (MoH, 1968; DHSS, 1971; DHSS, 1972), in order to re-organise and re-structure the NHS. The research and implementation spanned Conservative and Labour administrations and the 1974 reforms, more about services and buildings, focussed upon two major issues facing the service;

i. The NHS funding mechanism, based on population
ii. The fact that hospitals, community services and public health were separate

The reforms did a number of things including;

- They set clear geographical boundaries within which co-ordination and management was focussed
- There were 14 Regional Health Boards (strategic planning authorities) oversaw the work of local Area Health Boards, which had a balance of professional members on their board (doctors, nurses, trade unionists) and 'lay administrators' – the equivalent of today's NHS Directors
- Joint committees were established with Local Authorities, which provided social services, housing, education and general public health matters relating to food hygiene and environmental health for example, whilst the NHS took responsibility for health related, preventative public health measures.
- They brought together preventative public health, hospital and general practice as single management team
- All staff were employed on national grades, terms and conditions and pay-scales

Whilst the NHS increased in size and matured as an organisation, more and more attention focussed on structure, rather than management and leadership. The notion that since these reforms in the 1970s, the NHS has been subject to frequent re-

organisation and re-structure is well accepted (Klein, 1995). The reforms were designed to improve clarity and accountability for decision making, which was supposed to become delegated. In the end, a number of problems were encountered;

- The arrangements were inflexible, based upon rigid central instruction
- Decisions were based on consensus which, whilst attractive in theory led to problems of slow or non-existent decision making. There was no single, accountable leader.
- The changes didn't provide any improvement for those with mental illness, who were only centred on because of a series of incidents and scandals, leading to a re-prioritisation of different services and the introduction of increased investment in community care (DHSS, 1976)

The NHS; 1980-1989

Until the 1980s, the NHS was run and seen as being an administrative bureaucracy, akin to that described and advocated by Weber (1947). The reason was, until this period there had been little pressure to reduce administrative costs or management. However, the Conservative government of 1979 had an agenda that focussed on removing tiers of management and administrative costs were targeted as a key area for reduction (Harrison & Goose, 1993). Therefore, the concept of management and leadership were not a prominent feature of the NHS until the introduction of general management in 1983 (Flynn, 1997). This change was implemented on the back of a landmark report by Sir Roy Griffiths (DHSS, 1983). This introduced the concept of 'general management' and included many of the points shown in Figure 5 below.

Figure 5. 'NHS General Management' – themes arising from the Griffiths report (DHSS, 1983)

'NHS General Management' – themes arising from the Griffiths report (DHSS, 1983);

- One individual at every level of the organisation being responsible for having authority and accountability for planning and implementing decisions
- Explicit decision making
- A greater emphasis on leadership
- More flexibility in teams and their structures

Adapted from DHSS (1983)

Throughout its implementation in the 1980s the Griffiths report put in place the foundations for further health reforms; including the establishment of NHS Trusts (DoH, 1989). For this research, the key thematic importance of this report lay in the introduction of a 'business ethos' and the first clear mention of competition and mechanisms to support this. Critics worried about a lack of co-operation between organisations, privatisation by stealth and some GPs reacted by choosing another initiative set-out in the paper, to go 'fund holding'. This meant that GPs theoretically ran their own budgets, with which they purchased care from hospitals for their patients. This introduction of separate 'purchaser' and 'provider' was one of a series of measures, detailed in Figure 6.

Figure 6. A summary of new initiatives within the 'Working for Patients' reforms (DoH, 1989)

A summary of new initiatives within the 'Working for Patients' reforms (DoH, 1989)	
Initiative	**Description**
Creation of the 'internal market', separating purchasers from providers	*To create competition and improve standards of service, rewarding efficient and popular providers (no real mention of approach to inefficient or unpopular providers)*
The creation of 'stand-alone' NHS Trusts	*To delegate responsibility for decisions around finance, staff conditions and patient care, closer to the 'front line'*
The creation of (voluntary) fund-holding by GPs	*Through enabling GPs to negotiate and buy hospital services (mainly diagnostic, elective procedures) will create improvement through competition*
The establishment of contracts (non-legal) between purchasers and providers	*Aimed to establish greater clarity around volumes (activity), standards (quality) and workload for hospitals, whilst enabling clear choice on the part of the purchaser (commissioner)*
Change to a capitation (weighted population based) funding formula for purchasers (and by default, providers)	*Looked to promote greater equity between different parts of the country and to help alleviate specific public health issues in certain geographical areas.*
The introduction of capital charges for buildings and equipment	*To encourage efficient use of land and capital assets*
The promotion of job plans and medical audits for consultants	*To increase clinical performance and accountability for hospital doctors*

Adapted from DoH (1989)

Whilst policy changed, the introduction of competition was rejected by most in the health service because it was seen as not delivering on its main objective. As Soderland *et al* (1997) stated, 'competition between hospitals had no significant impact on productivity' (p 8). It is here that the researcher believes it important to set

out, from the analysis and research conducted, what are thought to constitute the key learning points for future NHS leadership from this first foray into a more competition based NHS system.

Typically, there are opinions divided in the professional literature. Dixon & Glennerster (1995) for example, report that tangible savings against both prescribing expenditure and the volume of hospital referrals were a, 'direct consequence of GP's holding their own budgets' (p 727). In a rather balanced way, they go on to acknowledge that during implementation the budget for those GP's who chose to 'opt-in' to the fundholding system increased, when contrasted to those who did not. Dixon & Glennester go on to reflect further, that that this could call into question the evidence supporting the comparative benefits of the fundholding based system.

This argument is put more strongly by Kay (2002), who argues that the system wasn't fully tested prior to a politically driven policy change, abolishing the system. Kay describes the decision as 'hasty', arguing that it was based upon, 'no evidence, in a situation too soon from the start of the policy being put into practice' and, 'based upon information derived from the voluntary opt-in phase of implementation, rather than a comprehensive evidence base allowing proper comparison of benefits against the previous system' (p 141).

Appleby (2013), provides a clue as to where the more comprehensive analysis and lessons for the future can be found. Whilst he argues that 'competition, such as GP fundholding, isn't always the best option' (p23), he goes on to point to the wide ranging report into choice and competition in the public sector (including health) published by the Office of Fair Trading (OFT) in 2010. The researcher has summarised the key (health) learning points for the future, extracted from the research below;

- Awareness of choice and competition (public)
- Reliance on vested interests for advice (e.g. GPs holding budgets)
- Location of service is a primary factor (e.g. geographical location of hospitals)
- Competition has been focussed on planned activity, which financially underwrites emergency service provision
- Competition requires excess capacity – there is no or little scope for new or exit / contraction of providers (e.g. failure regime, closure of hospitals)

- Clarity about the grounds for competition is required (e.g. quality or price)
- Regulatory systems for such a (complex health) market are immature (e.g. advertising rules, multiple points of conflict of interest)

Adapted from the Office of Fair Trading (OFT, 2010)

The NHS; 1990-1999

During the late 1980s and into the 1990s however, 'mangerialism' increased. Perhaps partly due to the introduction of management and attempts by those engaged in it, to legitimise their role and the political climate at the time. Certainly in the 1980s Margaret Thatcher was hostile to civil servants, perhaps influenced to some extent by the US president Ronald Reagan who according to Walsh (1995), lived in a country where, 'there has always been a strong belief in the managerial capabilities of the private sector, and private sector managers have routinely been brought in to manage public sector organisations' (p 64).

This signified a major shift. Until the end of the 1990s, the government maintained that clinical services would not be privatised. However, the NHS Plan (DoH, 2000) gave the first sign of policy change for the decade ahead. It indicated that some service provision would be offered up to the private sector as part of a market driven system, on the basis that it would offer much needed additional capacity to the NHS.

The 21st Century NHS – today's policy of competition for NHS provision

In organisational terms, as the NHS entered the 21st Century the situation in some areas had seemingly failed to move at all from the hierarchical and bureaucratic stereotype. This view was confirmed during the Bristol Royal Infirmary Inquiry which, when published in 2001, was generally critical of leadership within the NHS and it emphasised how NHS leadership and management should move from an inherently 'transactional' style to one described as 'transformational' (DoH, 2001).

The 2000's saw a major shift in the language and rhetoric surrounding the health service. For example, Deffenbaugh (2007) argued for a shift in NHS management ethos, from the traditional role of 'general manager' to that of 'commercial manager', stating that it [commercial management] would mean, 'adding a hard commercial dimension to the general management role' (p 30). This change in management

philosophy fits well with the picture painted of the future NHS, in both the policy of the Labour government and that of the coalition from 2010 onward.

From 1998, the government instigated a wide range of performance initiatives, financial changes and structural alterations. These changes were brought about by the successive Health Secretaries shown in Figure 7.

Figure 7. Health Secretaries since 1997

Health Secretary	**Tenure**	**Prime Minister**
Frank Dobson	3 May 97 – 11 Oct 99	Tony Blair
Alan Milburn	11 Oct 99 – 13 Jun 03	
John Reid	13 Jun 03 – 6 May 05	
Patricia Hewitt	6 May 05 – 27 Jun 07	
Alan Johnson	28 Jun 07 – 5 Jun 09	Gordon Brown
Andy Burnham	5 Jun 09 – 11 May 10	
Andrew Lansley	11 May 10 – 4 Sep 12	David Cameron
Jeremy Hunt	4 Sep 12 - *present*	

Source: Author (2010)

On the back of the election-based 1997 white paper, 'The new NHS modern, dependable' (DoH, 1997) and the then grandly titled 'NHS Plan' (DoH, 2000), the financial investment recommended by the 'Wanless report' (DoH, 2002c) brought large scale investment into the NHS. This investment came with 'strings attached' in the shape of a raft of ideas, changes and initiatives, many of which are included in Figure 8.

Figure 8. Big ideas, wide-ranging initiatives and wholesale NHS change since 1998

Big ideas, wide-ranging initiatives and wholesale NHS change since 1998:

- The NHS is a service provided to all without payment, but not necessarily by a public owned infrastructure
- Competition between providers and patient choice
- The introduction of a market through, "Payment by Results"
- Recognition that larger medical and nursing staff numbers were required, new schools established
- Reductions in waiting times for treatment through additional capacity
- Creation of PCTs (with subsequent re-structure)
- Re-structure of SHAs
- Creation of 'Foundation Trusts'
- New central bodies and regulatory authorities established (e.g. NICE, Healthcare Commission, CQC, Monitor)

Adapted from Rivett (1998)

Taken together, these initiatives were designed to put in place the structure and processes that provide a different solution to the questions of 'how is the NHS structured and how does it work ?'. The solution was to be based on a marketised system to deal with the increasingly complex organisation that is the NHS. This complexity can be highlighted by briefly examining the constituent NHS services functions and how they inter-relate to each other. One of the clearest graphical depictions of the entire NHS found by the researcher is that referred to by NHS Choices (DoH, 2008) as part of its explanation to members of the public of how the NHS, as the largest organisation in Europe, works. Although some areas are now outdated and the model appears to the researcher to have omitted specialist or 'tertiary' care completely, it does clearly distinguish between 'primary and secondary' care settings and shows how the service providers interact with each other and with policy makers and commissioners.

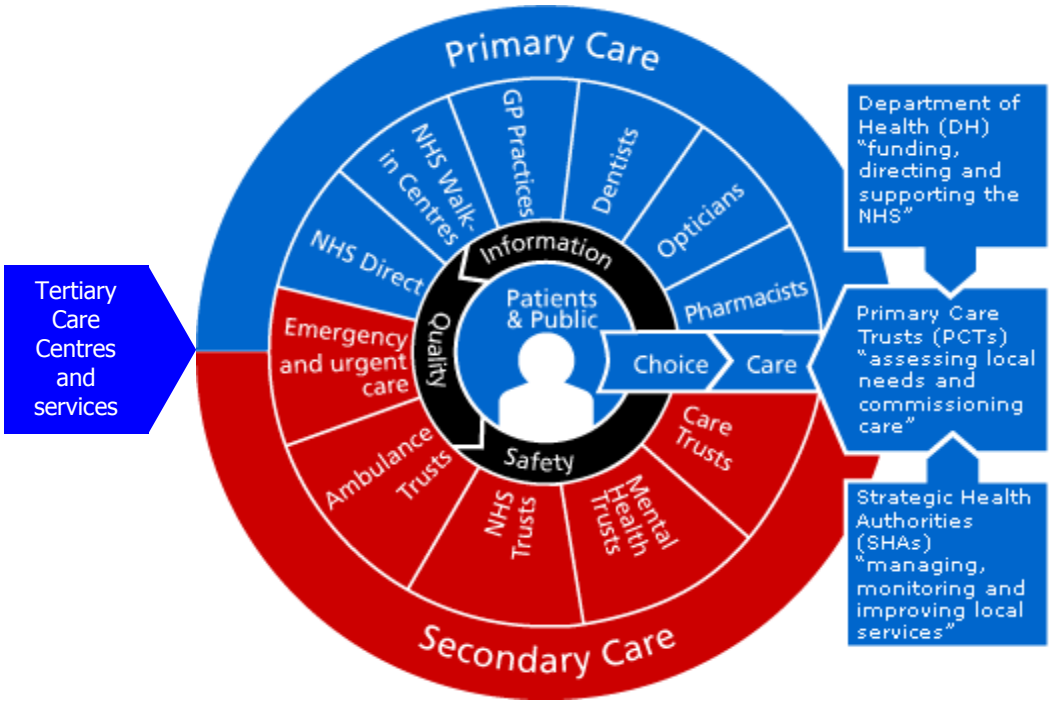
Adapting the model, by way of including a reference to the existence of tertiary centres, is perhaps the clearest graphical depiction of the NHS in England and this is shown in Figure 9.

Within the United Kingdom, there are other healthcare structures and systems such as those in Scotland, Northern Ireland, Wales, Jersey, Guernsey and the Isle of Mann. Whilst of interest, they are not covered in any detail as this research is predominantly focussed upon the English NHS.

The underpinning commissioning and financial systems required to facilitate, manage and regulate a market began to take shape. In 2006, new and larger Primary Care Trusts (PCTs) were created to commission health services on behalf of their catchment populations (DoH, 2006). These organisations commissioned services from many providers of healthcare including GPs and traditional NHS hospitals. Increasingly however, the government has made it clear that more NHS services will be provided by private, or 'independent sector' providers, expanding the choice for patients (McGauran, 2004). At this stage, the types of services involved were predominantly planned or 'elective' episodes of care, which could include outpatient appointments and assessments, diagnostic tests along with routine, relatively low risk surgical procedures. This embryonic stage of was also supported by a complex financial system to facilitate competition, launched under the banner of 'payment by results (PbR)'. The government of the day said, 'PbR supports the introduction of

patient choice by ensuring that diverse providers can be funded according to where patients choose to be treated' (DoH, 2002a).

Figure 9. NHS structure 2008



Adapted from NHS Choices (DoH, 2008)

Despite questions and contradictory views, it seemed that a direction of travel towards the creation of a market for healthcare provision was clear among both policy makers and a growing number of professionals within the NHS (Shapiro, 2005; Lewis & Gillam, 2003). Public awareness and understanding of the gradual change was generally low (Rose *et al*, 2004) and the market itself is far from mature. This lack of maturity is evidenced by the findings in research a number of years before (Baggot, 1997). Here, it was explained that there is, 'little evidence to suggest that patients are displaying consumer qualities' (p 291).

At the end of the decade, a new Conservative and Liberal Democrat government emerged from the 2010 general election. For a considerable period of the former government's reign, the Conservative Party's man on health was Andrew Lansley and he became Minister for Health and Social Care in May 2010 until Sept 2012. At that point Jeremy Hunt took up post and continued to develop and deliver the initial strategy of the government, 'Equity and Excellence: Liberating the NHS' (DoH,

2010a). Set against a backdrop of a national recession, the plan was billed as being the most radical shake up of the NHS since it was formed. The key aims of the plan were to;

- Set out major structural change to the NHS, including the abolition of SHAs, PCTs and many arm's length bodies associated with the service (DoH, 2010b)
- Transfer commissioning responsibility to GPs
- Ensure that all provider organisations were Foundation Trusts (FT)
- Create an OFGEM / OFCOM type regulator in Monitor to regulate the market

Two further consultation documents to compliment the new strategy were also published, providing more colour and detail behind the strategic headlines in the policy. These focussed on information and making data far more readily available to the public on both quality and safety (DoH, 2010c) and the process for enhancing the concept of patient choice and increasing contestability between provider organisations (DoH, 2010d).

Subsequent to publication of policy and the associated Health and Social Care Bill (DoH, 2011a) reasonably predictable noises backing and opposing the plans were heard. The scale of opposition however, reached such a point that in April 2011 a 'listening exercise' was announced. The outcome of this rather rapid exercise conducted by a "Future Forum" was reported in their findings (DoH, 2011b).

The response to this, seen by some as a significant dilution of the original policy, was a revised plan (DoH 2011c). This plan detailed new intentions to

- include a wider range of clinical professions
- relax the absolute FT cut-off date of 2013
- set out integrated care pilots to test collaboration against competition

In terms of definition, the researcher is aware that concepts of 'marketisation' have previously been applied to higher education in the UK (Jongbloed, 2003) and to health services overseas (Chau & Yu, 2003 and Casparie *et al*, 1990). In terms of the health care system in England, the term 'marketisation' has been defined and used for the purposes of this research as being;

The incremental process through which government policy has begun to create, via patient choice and associated funding mechanisms, an increasing level of contestability between organisations that provide services for the NHS (whether they are traditional public sector providers or increasingly, the private sector - it is the same emerging market).

The researcher's view is that the notion of 'marketisation' and the uncertainties associated with it will influence, and to some extent dominate, the agenda of leaders in the NHS for some time (Leech, 2007a; Eames, 2010; King's Fund, 2011).

The concise history of the NHS detailed above provides a general cultural context. In terms of organisational culture, 'history' and 'tradition' are cited as strong influencing factors (Johnson & Scholes, 1999) and therefore, whilst the focus of this research is targeted at leaders and managers currently employed in the NHS organisations of today this background cannot be ignored.

After examining the general issues surrounding the 'state versus market' debate and contextualising this by exploring how the provision of health services has shifted overtime, this literature review now turns to explore academic models and theories related to leadership, leadership in a health context and their relevance to this research.

Leadership – a review of the major theoretical schools of thought

In this section of the literature review, after a brief insight into the researchers' interest in both the literature and the subject of leadership generally and a section framing the scope of the literature and schools of thought investigated, the researcher sets out to critically explore and explain each of the major theoretical schools of thought on leadership.

The researcher's interest in the literature and the subject of leadership

Since the end of the 1990s the researcher has held a growing interest and fascination with the subject of leadership. The reasons for this interest are firstly, the researcher has 'walked the talk', by leading organisations in practice at local, regional and national level (Andalo, 2003). Whilst continuing to work in a number of senior leadership positions, the researcher has found a personal, intrinsic value in contrasting and comparing his own practice with that cited in not only the grounded theoretical texts, but those contained within opinion based articles of leaders

practicing in other organisations. The second reason, not unrelated, is the additional benefit of reflecting on leadership theory and practice from and within completely different organisational contexts. The researcher has found for example, that comparing and adapting private business sector leadership and management theory has not only enabled critical analysis of current leadership and management practice in both a pharmacy and general healthcare setting (Leech, 2000; Leech, 2001; Leech *et al* 2007), but it has also stimulated new ideas and innovation – both in practice and conceptual terms (Leech, 2003 and Leech & Willis, 2007).

Through the centuries leadership in general has been discussed and debated. This is evidenced through the work of Grint (1997) and Adair (2002), who each cite classical writings from Plato, Sun Tzu, Machiavelli and Pareto and then provide both further analysis of leadership as seen each age contrasted to the modern day.

The researcher is far from alone in his area of interest, as Van Maurik (2001) says that leadership has been the subject of literally thousands of books, papers and other publications and he goes on to state, with specific regard to 1996, that a 'staggering total of 187 books and articles were published with the word leadership in their title' (p 1). Whilst no reference is made to the substance of this statement or the evidence behind it, it certainly concurs with Handy's (1999) observation that, 'The search for the definitive answers to the leadership problem have prompted hundreds of studies and as many theories' (p 97). Indeed, in the same classic publication Handy refers to one of the many well respected 'leadership gurus' of the twentieth century, Warren Bennis. It is Bennis who supplies in his text, an almost unnoticed quote that to the researcher is particularly profound. Its description, as a self-confessed failure to define leadership, is indicative of why so many practitioners, academics and other commentators (including the researcher) have a fascination with the subject;

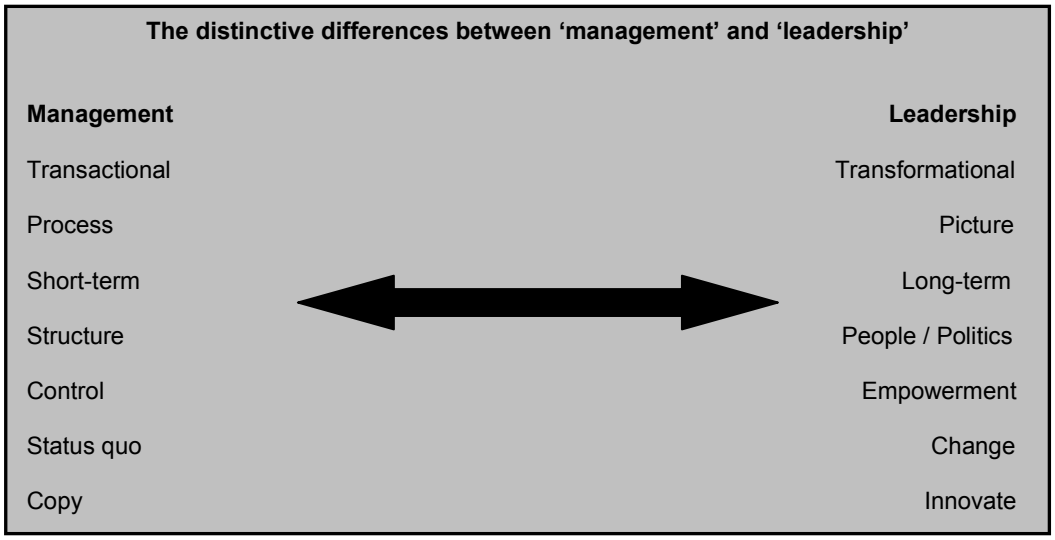
Leadership is like beauty; it's hard to define, but you know it when you see it.
Bennis & Nanus (1985)

The first distinction that needs to be made is the difference between 'management' and 'leadership'. This demarcation between the two terms is an important one to make for a number of reasons. The two terms are frequently, in both business practice and to some extent academia, used interchangeably. In terms of definition

and accuracy of meaning however, there is a difference – both in the view of the researcher and many well respected academics with an interest in business research (Zaleznik, 1977). Therefore, in terms of this thesis, the researcher wishes to set out clearly a definition that applies throughout the text and as a consequence, allows no room for misinterpretation or subsequent criticism of the research itself.

The researcher offers clarity through a published interpretation of the differences between the terms, 'leadership' and 'management' as illustrated below in Figure 10.

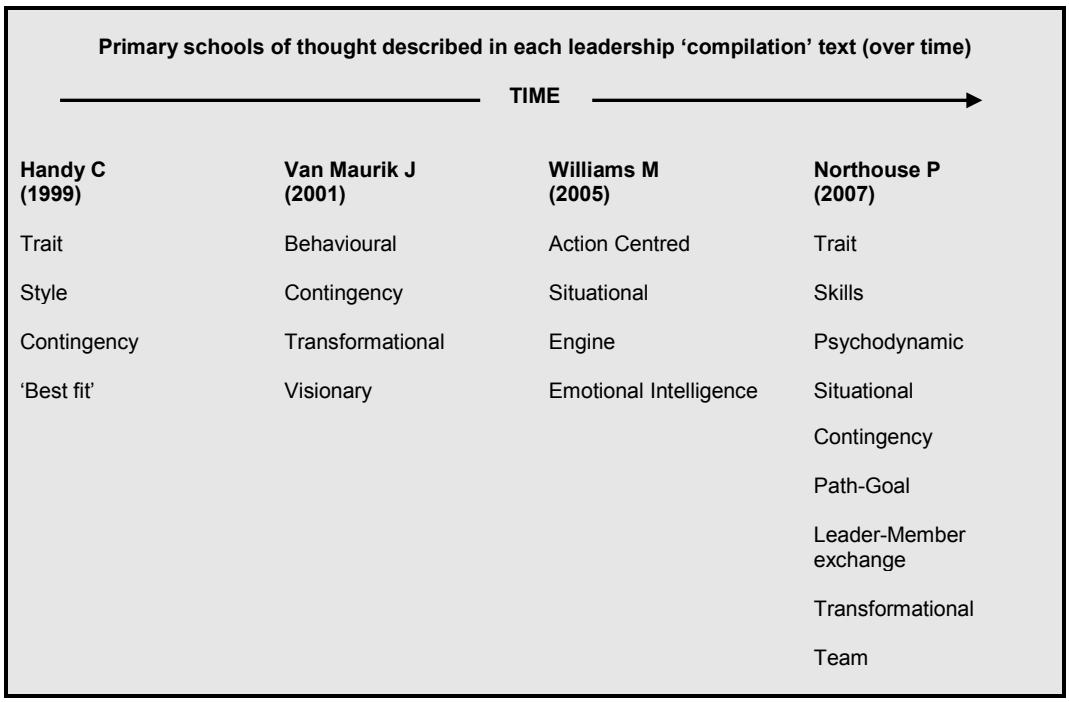
Figure 10. The distinctive differences between 'management' and 'leadership'



Adapted from Leech, 2007 (p 3)

Unsurprisingly perhaps, given the volume of published work, there are a number of authors who seem to specialise in summarising the main schools of thought in single 'compilation volumes' of leadership theory. These compilation texts are varied in their scope, depth and quite often their theoretical and critical standpoints. It is interesting to note that over time, since 1999, the four examples shown in Figure 11 below seem to cover an increasingly diverse range of theoretical schools of thought.

Figure 11. Primary schools of thought described in each leadership 'compilation' text (over time)



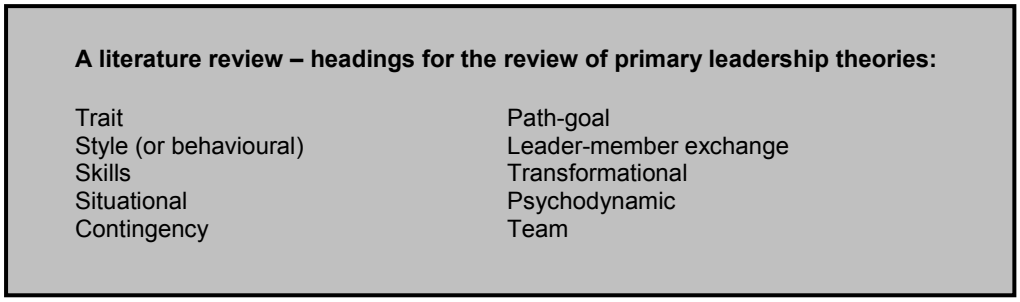
Adapted from Handy (1999), Van Maurik (2001), Williams (2005) & Northouse (2007)

Leadership theory – a structural overview

This section is structured so that it critically reviews each of the primary schools of thought on leadership, clearly describing, defining and analysing them. This sequence of broadly descriptive texts, based upon grounded-theoretical definitions leads into a series of critical analyses, which contrast and contextualise each of the major theories against the researchers' experience in practice.

The major headings under which leadership theories are reviewed in this thesis, are illustrated in Figure 12 below;

Figure 12. A literature review – headings for the review of primary leadership theories



Source : Author (2008)

As the list in Figure 12 indicates, there are clear limitations to this section of the literature review. There are certainly historical references and lessons for leaders in the works of those such as Lao-Tzu (Krause, 1995; Krause, 1997). These, along with reference to work specifically related to leadership models outside of the field of business and management, such as those relating to leaders in war, sporting or political circumstances are not within the scope of this review. This chapter of the thesis concentrates on theoretical and conceptual literature relating to leadership from broadly, after the mid-20th century onwards. It also should be stated that the literature review process does not cover every single industry or business specific model, as this in itself could be a never-ending task.

What is investigated and critically reviewed, in order to inform the research process, are the major academically acknowledged leadership theories and models. In addition, leadership models specific to the NHS and UK health professions are explored in some detail. A summary of major situational and theoretical contexts considered to be 'out of scope' and therefore excluded from this literature review and research is given in Figure 13.

Figure 13. Literature sources considered 'out of scope' within the literature review

The situational and theoretical context considered 'out of scope' in relation to this literature review and research:

- Theoretical and conceptual writings prior to the mid-20th century (related to leadership)
- Industry specific leadership models outside of the NHS and UK health professions.
- Writing on leadership in the context of war, sport, politics and other non-business circumstances

Source : Author (2008)

The Trait Approach to Leadership

The first systematic attempts to study leadership have been collectively defined as the 'trait' approach. In essence these studies focussed on identifying the innate qualities and characteristics of 'great men'. This was based on the assumption that

leaders were born with specific traits that distinguished them from followers (Bass, 1990).

In his description of how the range of research associated with leadership trait theory has evolved Northouse (2007), contends that of the list of leadership traits and characteristics only five are central; 'intelligence, self-confidence, determination, integrity, sociability' (p 19).

To distil down to five key traits and characteristics is an achievement in itself, as perusal of the publications shows that virtually every complimentary and virtuous human attribute is listed somewhere in the wealth of theory and research available. The subjective and imprecise nature of trait selection alluded to by the researcher in this instance, is acknowledged in part by Northouse (2007), as he admits to a 'lack of precision' (p 18) when selecting his 'top five' from a range of traits shown in a table he adapted from the earlier work of Cartwright & Arbor (1959). The range of traits and characteristics referred to, present all researchers and with a dilemma of equal magnitude and is shown in Figure 14. There are two further areas of research closely aligned to the overall trait school of thought on leadership. These are theories aligned to 'personality' and 'emotional intelligence'.

Figure 14. Studies of leadership traits and characteristics

Studies of leadership traits and characteristics				
Stogdill (1948)	**Mann (1959)**	**Stogdill (1974)**	**Lord *et al* (1986)**	**Kirkpatrick & Lock (1991)**
Intelligence	Intelligence	Achievement	Intelligence	Drive
Alertness	Masculinity	Persistence	Masculinity	Motivation
Insight	Adjustment	Insight	Dominance	Integrity
Responsibility	Dominance	Initiative		Confidence
Initiative	Extroversion	Self-confidence		Cognitive ability
Persistence	Conservatism	Responsibility		Task knowledge
Self-confidence		Cooperativeness		
Sociability		Tolerance		
		Influence		
		Sociability		

Adapted from Cartwright & Arbor (1959)

Personality traits, were commonly classified under the 'big five' headings shown in Figure 15. The researchers' view on this basic classification system is that, on the face of it, direct contradictions appear. Whilst the researcher accepts that many leaders will have changes of mood and outlook over time, to lurch from one or a combination of all the 'big five' would certainly make them unpredictable at best and at worst, most likely psychologically and behaviourally dysfunctional. Some academics, such as Northouse (2007) do refer specifically to personality under the umbrella of the 'trait approach' to leadership, but the researcher has found it more commonly discussed in texts relating to psychodynamic studies of leadership, hence they are primarily reviewed and described in this thesis, in a separate section relating directly to psychodynamic leadership theory (see page 60).

Emotional intelligence (EI) can also be viewed as being a sub-set of the overall trait school of thought on leadership. In his classic texts, Goleman (1996; 1998) takes the broad view that emotional intelligence is a set of personal and social competencies that in essence overlap when well developed, enabling leaders to perform effectively. This is illustrated in Figure 16. Golman is very forthright in his assertion that emotional intelligence can, 'help people be successful in life' (Golman, 2006), whereas Mayer *et al* in their later work on the same subject, as cited by Sternberg (2000), suggest that whilst emotional intelligence is certainly useful in terms of leadership in the business sense, they do not exert the same wide ranging and perhaps 'salesman like zeal' of Golmans' hypothesis that the EI concept can be applied to all people, in aspects of their lives.

Figure 15. The 'Big Five' personality factors associated with leadership

The 'Big Five' personality factors associated with leadership:

Neuroticism……	A tendency to be depressed, anxious, insecure, hostile and vulnerable
Extraversion……	A tendency to be sociable and assertive and to have 'positive energy'
Openness……	A tendency to be informed, creative, insightful and curious
Agreeableness……	A tendency to be accepting, conformist, trusting and nurturing
Conscientiousness…	A tendency to be thorough, organised, controlled, dependable and decisive

Adapted from Northouse, 2007 (p 21)

Figure 16. Emotional Intelligence

Adapted from Golman (1996)

Taking an overview of the trait based approach to leadership this school of thought has some major strengths;

- There is a wealth of research to support the approach
- It fits with the general notion that there is something special about leaders. Many people feel that their leaders should be seen as extraordinary, having special traits that mark them out from their 'more ordinary' followers. The trait approach certainly provides comfort to those with this view of leadership.
- The trait approach provides a defined list of personality and character traits, which can be used for assessment, development and analysis of leaders and those aspiring to a leadership position.

However, in order that a rounded picture is provided to the reader, the researcher should also point out areas of potential weakness or criticism of the trait approach, as follows;

- Whilst the list of traits shown in Figure 14 could be viewed as evidence of a wealth of research, it could also be seen as evidence of an inability to limit the number of personality or character traits seen as desirable for leadership. Not only does this result in ambiguity in terms of definition, but in practice the researcher would assert the

view that it would render anyone using an exhaustive list of desirable traits as part of a leadership assessment or development programme with an unachievable task, as there are very few people who can be honestly described as having all such traits.

- The trait approach does not take situational context into account, as it implies that all traits are required and indeed, applicable to all circumstances

Finally, and most importantly, the researcher has two further primary criticisms of the trait approach derived from experience in practice. The approach lends itself to subjectivity, through a focus on one or two traits in particular which can result in people being placed into positions of leadership, without well-balanced insight into the different characteristics and traits expected of a leader over time. Also, because personality and character are to some extent engrained they are not easily or quickly changed – something which, when contrasted to the changing NHS environment, is picked up in general literature on the topic (King's Fund, 2011).

The style (or behavioural) approach to leadership

In contrast with the trait approach, which places a general emphasis upon the personality and character of the leader, the style approach to leadership places a clear and distinctive spotlight upon the behaviour of the leader. The focus here is on what leaders do and how they act. The classic research in this field was conducted by Stogdill over a period of many years (Stogdill, 1948; Stogdill, 1974). Here, leadership behaviour is separated into two categories:

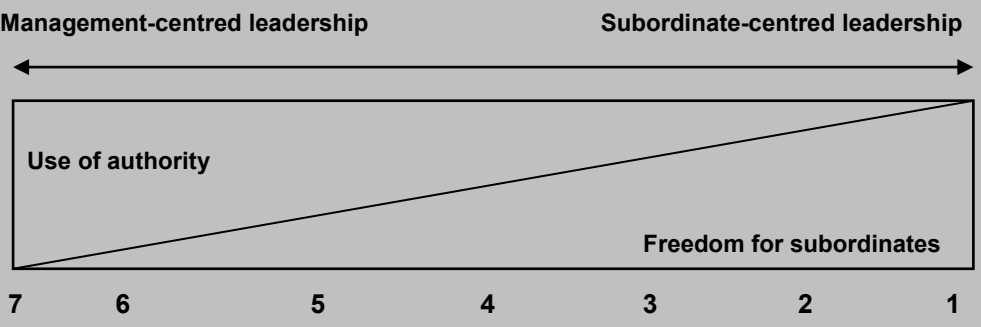
- Task behaviours
- Relationship behaviours

Tannenbaum & Schmidt (1958) also produced a very simplified continuum described as a 'behavioural' model of leadership (Van Maurik, 2001). This model does resonate with some of the challenges described in contemporary opinion on the changing NHS environment and leadership (Leech, 2012).

The Tannenbaum & Schmidt (1958) model, illustrated in Figure 17 is similar in composition and overall approach to the later developed and perhaps more commonly cited 'grid' model (Blake & McCanse, 1991). It is adapted in Figure 18 below as shown it changes Stodgill's original terminology, but retains effectively the same two categories, describing them as either a 'concern for people' (relationship behaviours) or 'concern for results' (task behaviours). A test rates the leaders level of concern for both factors and then, depending on where the results place the leader on each axis of the chart, an alignment to one of five core-leadership styles can be derived.

Figure 17. The 'behavioural' leadership model

Tannenbaum & Schmidt's (1958) 'behavioural' leadership model;



1.
Leader permits subordinates to function within limits set by him or her. Leader has confidence in subordinates and occasionally checks activities.

2.
Leader defines limits within which the group is to operate. Allows it to make own decisions as to how to undertake tasks involved.

3.
Leader presents a problem to the group, asks members for suggestions and then makes a decision about what is to be done.

4.
Leader makes a decision, subject to change. However, the decision is made before presentation to the group.

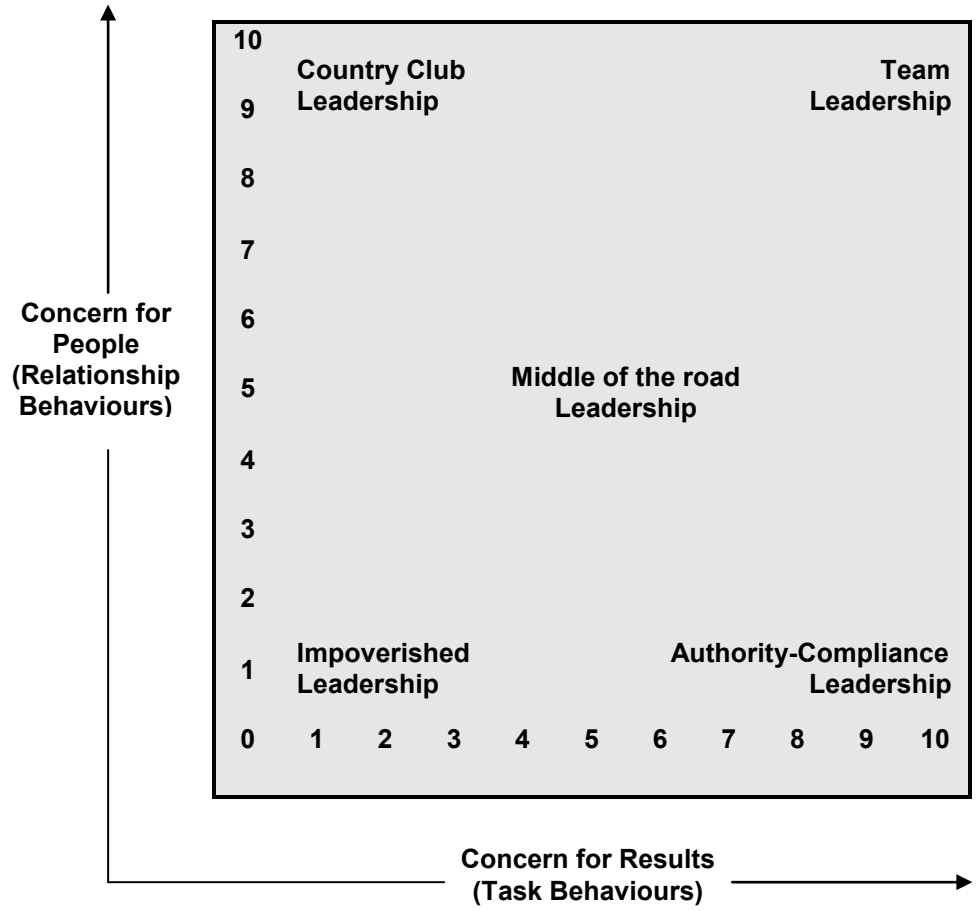
5.
Leader presents ideas to the group and invites questions.

6.
Leader 'sells' decision he or she has made, but allows no scope for discussion or questioning

7.
Leader makes a decision and announces it. Everyone is expected to comply.

Adapted from Tannenbaum & Schmidt (1958)

Figure 18. Behavioural leadership : The grid model



Adapted from Blake & McCanse (1991)

To complement the basic 'grid' model shown in Figure 18, the researcher has further compiled an adapted reference list explaining the detail, in terms of the actions and behaviours that underpin what is probably the most frequently cited leadership 'style' model;

Impoverished Leadership…… Unconcerned with task or relationships. Going through the motions of leadership. Described most commonly as indifferent, resigned, apathetic.

Authority-Compliance Leadership… A heavy emphasis on the job. Regards people as tools for getting the job done. Seen as controlling, demanding and hard-driving.

Middle of the road Leadership…… Immediate concern for task and people. Often compromisers, avoiding conflict and settling for average, rather than either high production or employee satisfaction. Seen as a moderator in times of conflict.

Country Club Leadership…… A low concern for the task, but high emphasis on people and relationships. Ensures people's needs are met, perhaps at expense of task (important if the task is not 'people orientated'. Often a friendly, comfortable workplace.

Team Leadership…… A strong emphasis on both tasks and interpersonal relationships. Achievements are through committed people, who are interdependent and have a common stake. Relationships of trust and respect.

In addition, there is one further sub-category of 'Opportunistic Leadership' which is defined by Blake and McCanse (1991) as being someone who has the ability to adapt and shift to any given point on the grid to gain maximum advantage. Performance and effort in this instance is usually through a system of self-gain or reward.

As described in the introductory text to this section of the thesis (see page 32), Tannenbaum & Schmit and Blake & McCanse are all academics who have chosen to some extent, adapt and use interchangeably the words 'management' and leadership' in relation to their work. This is evidenced again through earlier publication of a very similar, if not the same 'grid' model, albeit by Blake & Moulton (1985) at that point, but with the over-label 'management' applied to it. This model, in all its derivative formulations, has a number of strengths:

- The style approach to leadership takes into account a number of fairly limited situational factors, so in that sense, the criticisms applied to the trait approach cannot be applied here as the style school of thought is that much wider in scope

- The model provides a broad context, rather than a narrow and prescriptive sense of leadership. Leaders can use the model to appraise themselves and others, in the context of both the tasks they face and the people they deal with every day – after all, for many leaders in practice tasks, results, people and relationships are all core elements of the job-description

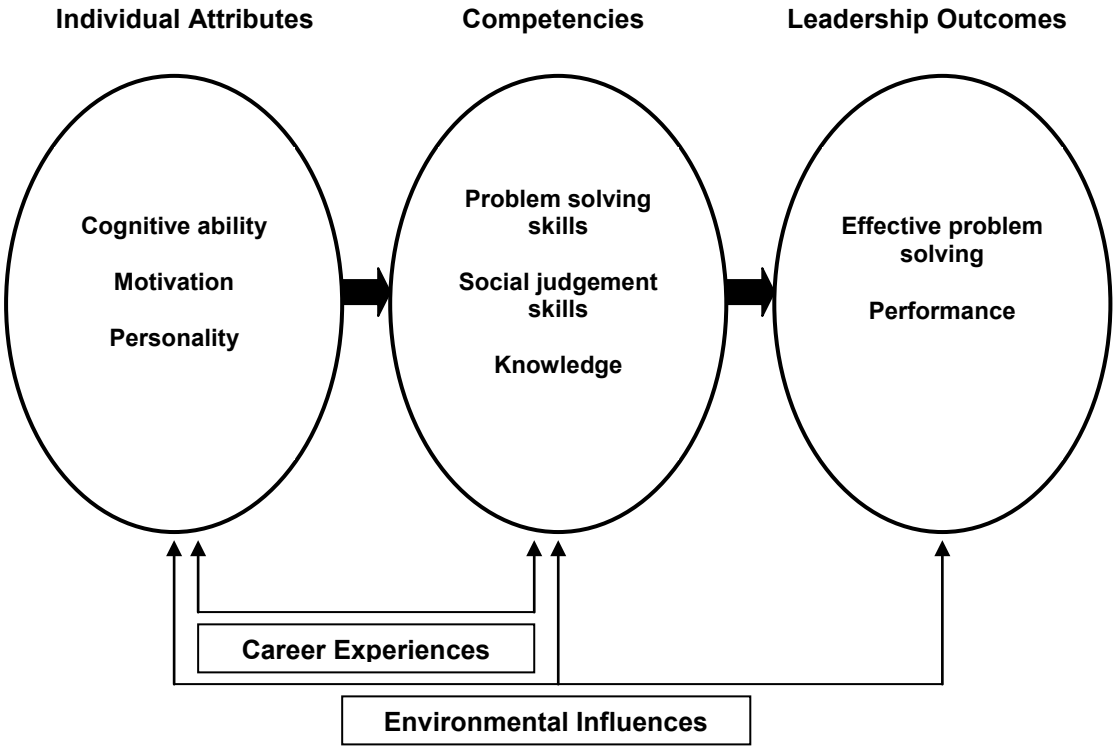
The style based approach and research associated indicates that leaders who act in a considerate way (those with a high concern for both people and relationships) have followers who are more satisfied with their performance. However, this does not mean that the performance of the followers will be optimal. As Yukl (1994) states, the research underpinning it is 'mostly contradictory and inconclusive' (p 75). To add to this matter the research, through the very structure of the grid model, intonates that the 'team leadership' approach derived from a dual high score is optimal. This, again, is not necessarily the case. In practical terms, complex industrial environments (like the NHS) may require a high focus on task, with a focus on people being important too – but certainly less of a priority. Conversely, businesses primarily concerned with people and valued for it by their customers, may have exactly the opposite approach, depending on the circumstance. This criticism may be a little harsh, as whilst the model only offers five primary leadership categories (see Figure 18 on page 39) the scale of each axis is ranked 0-10 and therefore, many more than five categories could be identified through further development and more detailed, open minded consideration of the model.

The skills approach to leadership

The skills approach to leadership is distinctively different again from both the trait approach and the style approach. Here, the focus is primarily on the leader and the leadership skills and abilities that can be developed or learnt over time, thus making for more effective leadership performance. Following a classic publication in the 1950s (Katz, 1955) the impetus around the skills approach to leadership was not developed further until the 1990s, when Mumford *et al* (2000) published their 'capability model'. The basic model, shown in an adapted form in Figure 19, focussed on the inter-relationship between leadership performance and the individual knowledge and skills, or capabilities, of the leader. When the influences and experiences of life are also taken into account, this model appears to be fairly comprehensive, in spite of the exclusion of any real detail in the publication relating

to the types of experiences and influences that are most helpful to the development of a good leader.

Figure 19. A skills approach to leadership – the capability model



Adapted from Mumford *et al*, 2000 (p 23)

Essentially, the skills model describes the key components of leader performance and central to that, are problem-solving skills, social judgement skills and knowledge. In both the early work of Katz (1955) and that later work of Mumford *et al* (2000) it is suggested that anyone aspiring to become a leader can improve their leadership performance through experience and training to improve these core leadership competencies.

As an approach to leadership, the skills route certainly offers a logical model that covers many areas – cognitive ability, motivation, personality, problem solving skills, social judgement and knowledge. The model also, unlike the trait model, acknowledges that experiences during a career or in the wider environment will all influence leadership performance. In terms of the researchers contextualisation of this, it is certainly true that the NHS expects its leaders to be experienced, perhaps more so than in other industries in which more creative skill sets are valued.

It is the sheer scale of the skills approach that on one hand, provides a complicated but quite clear 'road map' to leadership as a concept but on the other, could be viewed as a weakness. This is exacerbated by a lack of quantification when it comes to both the individual characteristics and core-competencies the model uses to derive its leadership outcomes. For example, whilst Zaccaro *et al* (2000) have expanded upon the degree of descriptive text supporting the headings 'problem-solving' and 'social-judgement' for example (see Figure 20), the reader is left without a suggested mechanism to measure performance or the impact of developmental activities upon it when looking at the skills model of Mumford *et al* (2000) in isolation.

Figure 20. Key-components to leadership competencies within skills model

An illustration of key-components to leadership competencies within skills model:

Problem solving skills -	**Social judgement skills -**
Able to define and describe problems	Understands other perspectives
Gathers problem information	Senses and knows what is important to others
Formulates new understanding about the problem	Demonstrates ability to flex behaviour
Generates prototype plans for solutions	Persuasive in communication

Adapted from Zaccaro et al, 2000 (p 37)

Whilst a distinction from the trait approach has been alluded to previously, the researcher would draw the reader's attention to the trait like term, 'personality' within the skills model shown in Figure 19. Any claim therefore, that the skills approach to leadership is unrelated to the trait approach or that leadership skills developed in absence of or without due consideration for a leader's traits would be flawed in the researchers view. This conclusion was subsequently re-enforced to the researcher by the classic Stogdill (1974) leadership compendium. Observing that, perhaps for reasons of pragmatism or a similar belief that when combined leadership traits and skills form a comprehensive platform from which models might be developed further, Stogdill also combines the two approaches into a single summary illustration. This is shown in Figure 21.

Figure 21. Leadership traits and skills

The main leadership traits and skills, as identified by Stogdill (1974);

Traits	Skills
Adaptable to situations	Clever (intelligent)
Alert to social environment	Conceptually skilled
Ambitious and achievement orientated	Creative
Assertive	Diplomatic and tactful
Cooperative	Fluent in speaking
Decisive	Knowledgeable about group task
Dependable	Organised (administrative ability)
Dominant (desire to influence others)	Persuasive
Energetic (high activity level)	Socially skilled
Persistent	
Self-confident	
Tolerant of stress	
Willing to assume responsibility	
Charismatic	

Adapted from Stogdill (1974)

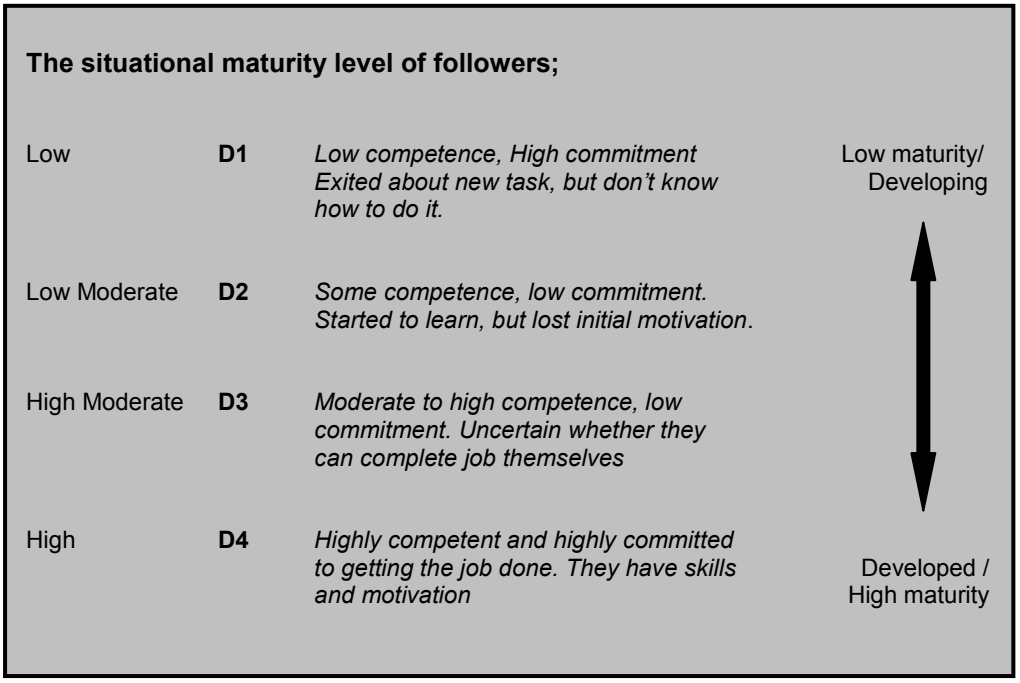
The situational approach to leadership

In the mid-20th century a series of studies, analysing the trait based approach to leadership were conducted. These were primarily qualitative studies of some repute (Bird, 1940; Mann, 1959; Stogdill, 1948) and they gave rise to theoretically different perspectives on leadership, driving what was has become known as 'the rise of alternative leadership theories' (Northouse, 2007). Essentially, this research found that leaders who excelled in one situation may not do so in another - different - setting. Subsequently, leadership could no longer be defined as solely an individual trait based phenomenon, but one with variable factors for success. This research gave rise to a series of 'alternative' leadership theories including primarily, the situational theory.

The situational approach views leadership conceptually as being driven by the specifics of each situation. For example, some situations will require an autocratic style to produce the optimal outcome and in other situations a more participative and engaging approach will generate the best results. The most commonly referenced model within the situational school seems to be that developed originally by Blanchard *et al* (1985) and further refined again by Hersey & Blanchard (1988; 1993).

Situational leadership, like the behavioural model, provides a range of situational categories which in this instance are related to the maturity of the followers. Once the leader has determined the position of their followers, they can then determine which leadership style in the situational model to use in that situation. This is explained diagrammatically in Figure 22.

Figure 22. The situational maturity level of followers



Adapted from Hersey & Blanchard (1993).

Once the situational context has been established, the model can then be used to determine the style best suited to the situation. The suggested styles are summarised in Figure 23. So, for example, if followers are at the first level of development (D1), then the model suggests that a highly directive style, giving little support (S1) would be best. As they mature, the correlation between the maturity of followers and the leadership style best employed is;

- D4 = S4,
- D3 = S3,
- D2 = S2
- D1 = S1

Unlike the trait model, which advocates 'fixed' leadership behaviours, the situational model positively encourages leaders to be flexible in their approach from one

maturity level to another, depending on the situation at that time as followers will move back and forth along the maturity continuum.

Figure 23. Situational leadership styles

The situational leadership styles;

High Directive Low Supportive	**S1**	**Directing** *leadership style, a focus on instruction and goal achievement, with supervision rather than support*
High Directive High Supportive	**S2**	**Coaching** *leadership style, similar focus on goal achievement as S1, but also involves and encourages subordinates making sure their personal and emotional needs are met.*
High Supportive Low Directive	**S3**	**Supporting** *leadership style, uses supportive behaviours and tactics (such as praise and delegation) with subordinates in order to enhance performance. Lower level of focus on goal achievement than S2.*
Low Supportive Low Directive	**S4**	**Delegating** *leadership style, makes much less use of social support and less focus on task. Encourages individual Motivation and confidence, through delegating responsibility for achievement of task.*

Adapted from Hersey & Blanchard (1993).

In practice, the situational approach – in particular the Hersey & Blanchard (1993) model appears to have stood the test of time. In the researchers' experience, it is still referred to on leadership development programmes and as indicated previously, has gone through a number of adaptations and enhancements. The model also, is relatively simple to understand and apply and in the researchers opinion, could be used in a variety of settings. In a world where the heightened pace of change for anyone in a leadership role, appears even to exceed the predictions of management gurus such as Handy (1989; 1994; 1996), another positive aspect to the situational model is that it positively encourages leaders to adapt and flex their style, whilst simultaneously warning them off of using styles that are less likely to work. For example, in a situation where followers are highly competent and motivated to achieve the task, a 'directing' leadership style is unlikely to yield good results, nor good employee relations. To extend this rationale further still, it could be argued that the situational model – as it asks the leader to assess each individual or group of individuals according to the task of the moment – is much more likely to provide the type of environment in which there are opportunities to identify training needs, build development programmes and generally enhance the calibre of the workforce

through creation of a 'culture of learning', as advocated by training and development experts such as Reid & Barrington (1999).

Despite the strengths of this model, there are also a number of potential pitfalls as it seems that there is a lack of research to support some aspects of the model - particularly the lack of contrast with other leadership approaches (Graeff, 1997; Fernandez & Vecchio, 1997). A further conceptual ambiguity is that the weighting mechanism applied to determine the maturity level of followers, is not explained by Hersey & Blanchard (1993). This is reflected in other academic critiques of the situational model (Graeff, 1997; Yukl, 1998). It is this lack of clarity, which also provides another potential weakness in the model, in that demographic factors such as experience, age, gender have not been assessed. Academics including Vecchio (1987), have taken issue with this gap, identifying it as a 'failing in the basic prescriptions suggested by the situational leadership model' (p 444).

The contingency approach to leadership

A further refinement of the situational school of thought is the contingency approach. This focuses, upon identifying the situational variables which then determine which leadership style would best fit the circumstances. In essence, the contingency school of leadership is primarily focussed upon situations and styles. One of the most commonly cited contingency theory references is the work of Fielder (1967). Fielder contends that there is no single best way for leaders to operate. The solution to each leadership situation with the contingency approach is contingent upon the factors that impinge on the situation. Fielder looked at three primary factors that define the leadership task and provides a model matching the situation to leader and their style;

1. Leader member relations; *how well do the leader and employees get along?*
2. Task structure; *is the job highly structured, fairly unstructured, or something in between?*
3. Position power; *how much authority does the leader have?*

Van Maurik (2001), places the work of Adair (1983) within the 'contingency' school and puts forward the assertion that, 'it is necessary for both leader and team to search out the answers to questions in three potent areas' (p 29);

1. Task; *why is the task worthwhile? What is its value to society? How is value measured?*
2. Team; *what is the commonly accepted framework for values – including ethics – that hold this group together?*
3. Individual; *do I share the same values as this group? Is the task worthwhile in my eyes?*

In essence, whilst Adair (2002) has gone on to make much of his contingency based 'Action Centred Leadership' (p 76), he poses his three questions to not only the leader but the followers also – perhaps an advantage in his more recent model than the original Fielder (1967) approach – as his questions are, in general terms, focussed upon the same three areas.

The researcher has primarily focussed upon Fielder's work as technically, it seems to be supported by a larger volume of empirical evidence than that of Adair (Fielder & Chemers, 1974; 1984, Fiedler & Garcia, 1987; Peters *et al*, 1985; Strube & Garcia, 1981). That said, when it comes to the general strengths and weaknesses of the contingency approach, they can be applied broadly to the work of both Fielder and Adair.

In basic terms, Fielder's model rates leaders as to whether they are relationship or task orientated. In terms of leadership style, a 'Least Preferred Co-worker' (LPC) scale was developed. Leaders with a high LPC score are relationship focussed and those with a low score, task focussed.

With regard to situational variables, three question headings are used – leader member relations, task structure and position power. Leader-member relations have two primary classifications within the model – good and poor, depending on factors such as loyalty, positive or negative atmosphere and views of followers for their leader. Task-structure also has two categories. If the task is clearly stated and understood by those required to carry it out and there are few alternatives for achieving it, then the task structure is 'high'. Task structure classed as 'low' are situations in which means and mechanisms to complete the task is not defined. Position power is essentially, the level of authority and power the leader has over their followers.

Contingency theory suggests, based upon the situational factors described above, that certain styles are effective in each varied situation. People with a low LPC score (task orientated) tend to fare well at either situational extreme – in both instances where things are going well and in organisations where things are out of control. Those with high LPC scores (relationship orientated) generally succeed in moderate situations – those where there is a degree of uncertainty but things could not be described as 'out of control'. One issue raised with this model is clarity surrounding how leaders with low LPC scores excel at opposite ends of the situational spectrum. A more recent explanation is provided by Fielder (1995) in which he gives a lengthy and detailed rationale as to why leaders can be effective in both favourable and unfavourable scenarios. Northouse (2007) provides a clear précis of Fielder's report and it is adapted below;

'leaders who are working in the "wrong" (i.e. mismatched) situation are ineffective [because];
a) a leader whose LPC style does not match a particular situation experiences stress and anxiety
b) under stress, the leader reverts to less mature way of coping that were learned in early development
c) the leader's less mature style results in poor decision making, which results in negative work outcomes' (p 116)

The researcher is not wholly convinced by Fielder's explanation, despite the apparent support of Northouse for it. In terms of the researchers' own experience in practice, it is rare for a leader who thrives in organisations that are relatively dysfunctional, with poor employee relations and ill-defined processes for tasks to enjoy working in environments that are comparatively smooth running, with good relationships between leader and followers. The researchers experience would indicate that individuals such as that, once a dysfunctional organisation is 'fixed', would get bored and strive to find the next challenge. In fairness, whilst the researchers' view is informed by contemporary practice and experience it has no published research to support it. It is also worth noting that Northouse (2007), qualifies the support cited above with a postscript of, 'Although various interpretations of contingency theory can be made, researchers are still unclear regarding the inner workings of the theory' (p 116).

Contingency theory is supported by a weight of research and in academic circles, which provides a strong justification for this approach. A further strength is that it stretches both trait and situational schools of thought further, by placing an increased emphasis on context generally. It provides some degree of predictive success, in that it enables decisions 'up front' about what type of leadership approach is most likely to yield success. This model also factors in that there are limitations to leadership. The contingency model does not require, or advocate people to strive for success in all scenarios. The work of Fielder (1967) in particular, alongside modern day authorities such as Adair (1983; 2002; 2002a) extol the virtue of placing leaders into situations where they will succeed, because some evaluation of their approach has been undertaken. When leaders do not match the situation, corrective action through replacement is advocated.

The contingency model does have its critics, which tend to focus on the questionnaire that informs the LPC score. Observations tend to focus on the instructions not being clear, the clumsy and cumbersome applications of the exercise in the work place and perhaps most importantly for those in practice – if the exercise is completed and there is a non-alignment between a leader and workplace there is little by way of recommended actions. All of these criticisms have been acknowledged by Fielder, as he contributed to a publication that centred on critical analysis of leadership theory (Chemers & Ayman, 1993), in which it appears to the researcher to provide evidence of an almost unique, 'academic confessional'.

The path-goal approach to leadership

Path-goal theory explains how leaders motivate their subordinates. The focus of the path-goal approach is the relationship between the leader and their followers. In terms of published research, the works of House (1996) and Evans (1996) provide the backbone of this school of leadership thinking. It seems that path-goal theory, whilst on one hand theoretically complex is also rather pragmatic when described in practice.

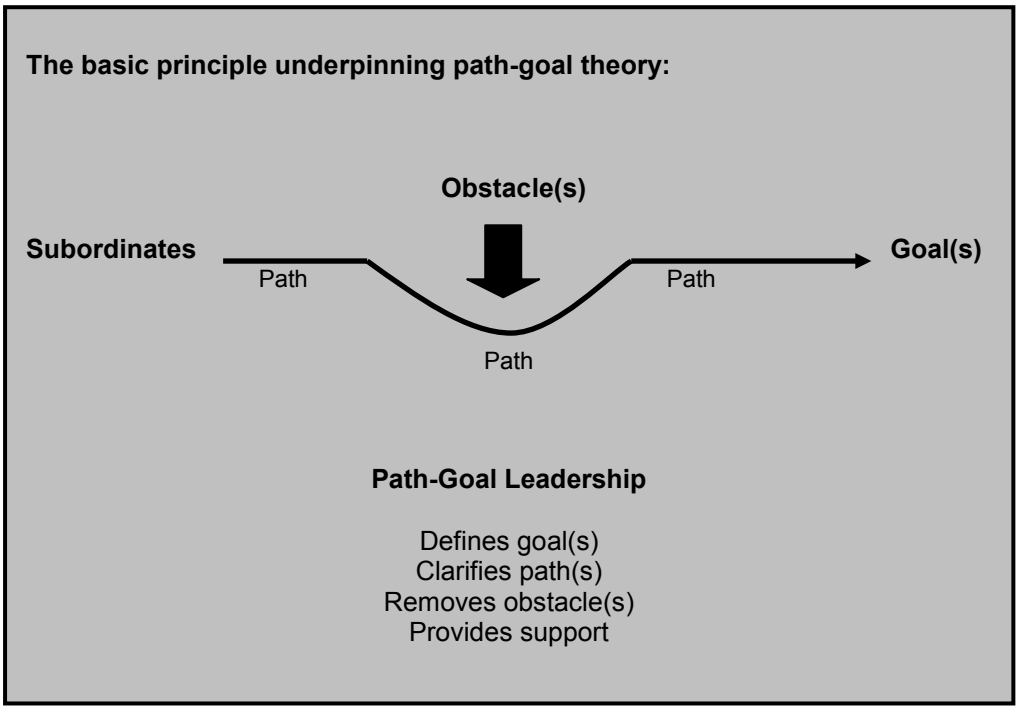
Path-goal theory illustrates and therefore guides leaders in helping subordinates along a path to achieving a goal. They do this by selecting specific behaviours that are best suited to their followers needs, relative to the situation (Jermier, 1996).

These behaviours are directive, supportive, participative, achievement orientated, work facilitation, group orientated decision processing, work group representation

and networking, and lastly – value based leader behaviour. By considering the both the characteristics of subordinates and the task in making their selection, leaders enhance expectation of success and satisfaction among their followers.

The basic principle behind path-goal theory is shown in Figure 24.

Figure 24. The basic principles underpinning path-goal theory



Adapted from House (1996)

In terms of assessing subordinate characteristics and needs, and the likely impact of the task, the research points to a classification system that includes four relatively self-explanatory categories for factors worthy of consideration. For assessment of the task, a similar list of three factors worthy of consideration is offered. These factors are shown below;

Follower characteristics (factors);

a) need for affiliation
b) preferences for structure
c) desire for control
d) self-perceived level of task ability

Task characteristics (factors);

a) design of task
b) formal authority system
c) primary work group

Path-goal theory is theoretically quite complex. It states that a directive style of leadership is best employed when subordinates are dogmatic and authoritarian, and

the task itself along with the organisational structure and rules are ambiguous. In such situations, even as far back as the 1970s, House and colleagues are cited by Hunt & Larson (1974) as being advocates for the directive approach, arguing that in relation to achieving the task, it provides, 'guidance and psychological structure for subordinates' (p 90). In his later work, House (1996) provides more detail on each of the four primary leadership behaviours, along with the characteristics of group members and the task most suited. This is summarised in Figure 25.

Figure 25. Path-goal theory : leadership behaviour and group characteristics

Path-goal theory: a table showing leadership behaviour application, in accordance with characteristics of group members and the task:

Leader behaviour	Group members	Task
Directive *Gives guidance and structure*	Dogmatic Authoritarian	Ambiguous Rules unclear Complex
Supportive *Provides nurturance*	Unsatisfied Need affiliation Need human touch	Repetitive Unchallenging Mundane, mechanical
Participative *Encourages involvement*	Autonomous Need control Need clarity	Ambiguous Unclear Unstructured
Achievement orientated *Provides challenges*	High expectations Need to excel	Ambiguous Challenging Complex

Adapted from House (1996)

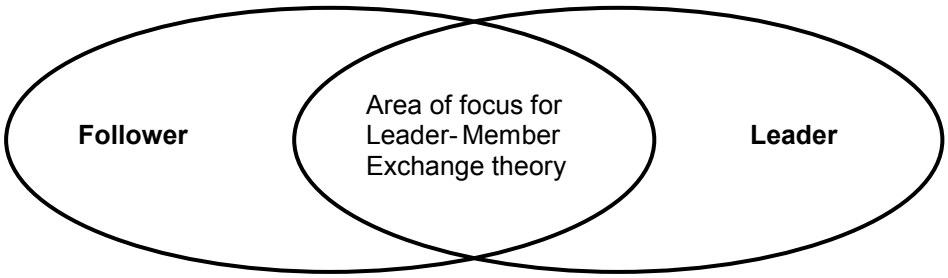
The path-goal approach to leadership appears to have a major strength, in that it accepts leadership behaviour directly affects the productivity and motivation of employees and that the nature of the subordinate therefore, has a direct relationship with the leadership style employed and how successful that proves to be. Having said that, the researchers view is that the task characteristics in the model (shown in Figure 25) are limited as in three out of the four task characteristics, the task is described as being 'ambiguous'. In addition, thinking about application in complex organisations like NHS hospitals, the 'group' can be divided and sub-divided into a hugely diverse range of sub-groups. The range of variability and diversity in terms of intellectual ability, motivation and tasks undertaken within such an organisation is huge. Whilst there are likely to be examples in which the group and other variables are set and clearly defined, the path-goal theory does not - at face value - appear to

consider circumstances in which there is a high degree of flexibility in task and complexity of variables. This is perhaps just one example of its limited application in contemporary business settings.

The leader-member exchange approach to leadership

The approaches to leadership described so far in this literature review, have primarily centred on leaders (trait, skills and style approaches) or the follower and/or the context in which leaders operate (situational, contingency and path-goal approaches). Leader-member exchange theory is essentially a hybrid approach to leadership, as the primary area of focus, is the interaction between leaders and their followers. This is illustrated in Figure 26.

Figure 26. Leader-member exchange theory



Adapted from Graen & Uhl-Bien (1995)

There is an implication within other leadership models that suggests 'leadership' is something done to followers and that leadership is applied in an even-handed and uniform way. Leader-member exchange theory, often referred to by the abbreviation 'LMX', challenges this assumption and clearly argues that there are differences in the relationship and interactions between leaders and each of their followers.

Leader-member exchange theory describes two sets of people in a leader's organisation, the 'in-groups' and the 'out-groups' (Graen & Uhl-Bien, 1995). A leaders' relationship with individual employee will vary slightly. However, research has shown that these types of relationships can be clustered into two categories of relationship, known as 'in-groups' and 'out-groups'. These are defined as follows:

The *In-group* – based upon expanded and negotiated responsibilities, over and above the defined (contractual) role. These individuals tend to receive more

information, influence, confidence and concern from their leader (than those in the out group)

The *Out-group* – responsibility only extends to the basic contractual agreement. They are seen as being less compatible with their leader and out-group employees tend to turn up for work, do their job and go home.

The research in this field seems to grow in the 1990s, accumulating evidence to show that the better the leader-member exchange across the organisation, the lower the employee turnover, greater the commitment of employees to the organisation and ultimately, more enhanced the performance (Liden *et al*, 1993; Harter & Evanecky, 2002; Scandura, 1999). In order to maintain the optimum performance of the 'in-group' and also enhance the performance of the 'out-group' to improve overall outcomes for the organisation, Graen & Uhl-Bien (1995) propose targeting leaders in a structured way to achieve this, through 'leadership making' (p 231).

Leadership-making in relation to the 'out-group' occurs in three phases, the stranger phase is first – in which the relationship between leader and follower is primarily rule bound, and exchanges relate to the task with the leader exerting control through hierarchical status.

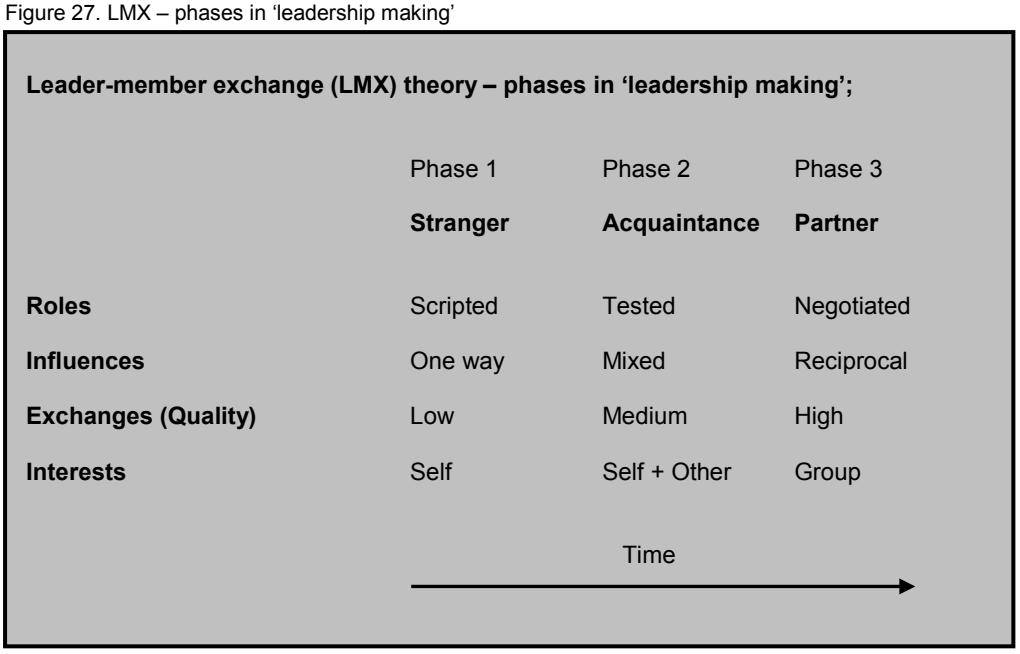
This is followed by the acquaintance phase, in which offers by the leader – or follower – for improved career-orientated exchange. At this stage they will inevitably involve some form of reward, through new challenge or status which in turn brings praise or financial return. Over time, these exchanges change the relationship from that of 'transactional' strangers, to acquainted co-workers.

The most mature phase occurs next, as the relationship builds mutual trust, respect and obligation to organisational commitments and each other's responsibilities. This phase is described as the 'partner' stage. These 'leadership making' phases within the leader-member exchange theory are illustrated in Figure 27.

In terms of its contribution and value to the study of leadership, leader-member exchange theory, it seems to be unique in its focus upon the point of interaction between individual leaders and individual employees. The theory acknowledges the often difficult or uncomfortable subject of 'in' and 'out' groups in the workplace. In dealing with this issue up-front, it accepts the reality found in almost every workplace.

In doing so, it provides some comfort against those who criticise the theory, largely on the basis that it seems to run against an instinctive ethical stance of fairness between individuals and groups of employees (Harter & Evanecky, 2002).

Figure 27. LMX – phases in 'leadership making'



Adapted from Graen & Uhl-Bien, 1995 (p 231)

In addition, it has been argued that as long as a leader does not deliberately keep individuals in the 'out' group and provides opportunity for them to change the relationship, inequality may not be a concern (Scandura, 1999). In fact, one could argue that it is the only approach to leadership with a built in check, to alert leaders to any explicit or implicit bias or discrimination.

Aside from the claim that the approach opens the door to discrimination, in neither the work of Graen & Uhl-Bien (1995) or that of others is there any guidance to employees or leaders, with regard to tactics or strategies for gaining access to the 'in-group'. This is an omission in the literature, which, again, could be related to the discomfort of some in acknowledging that most organisations have a political element to their everyday function. However, the political aspect of most organisations, especially the NHS, cannot be ignored.

The transformational approach to leadership

The central focus of leadership in the transformational approach is generating and implementing a vision that transforms an organisation or business, by transforming the motivation, outlook and culture of the people within.

One of the earliest references to this approach is MacGregor-Burns (1978). Here a definition of the role of the leader within transformation is provided;

'*people who tap the motives of followers in order to reach the goals of leaders and followers*' (p 18)

MacGregor-Burns (1978) highlights the linkage between leaders and their followers. However, unlike other schools of thought, he goes on to distinguish the transformational model, by separating leadership into two categories. These categories are 'transactional leadership' and 'transformational leadership'. The term transactional leadership seems to be applied by followers of the transformational approach to almost every other model of leadership. The distinguishing features between the two, adapted from the work of Covey (1992) are shown in Figure 28.

Figure 28. Transactional leadership v Transformational leadership

Transactional leadership v Transformational leadership

Transactional leadership	**Transformational Leadership**
Builds on the basic need to make a living, through getting the job done.	Builds on employees need for meaning
Focus on power, position, politics and perks.	Focus on purpose, values, morals and ethics
Primary focus on immediate daily affairs.	Transcends daily affairs
Tactics.	Missions and strategies
Fulfils expectations through strive to work effectively within current systems.	Designs and redesigns jobs to make them meaningful and challenging
Reinforces the bottom line, maximising efficiency and short-term profit.	Aligns structures and systems to reinforce overarching values and goals

Adapted from Covey (1992)

The early definition of transformational leadership and research provided by MacGregor-Burns (1978) was cited in the more recent and frequently referenced work of Bass (1985). His work extended the transformational and transactional leadership model, to acknowledge 'laissez-faire' leadership and to assign to the three categories, seven different leadership factors between them. This model was first developed in the literature of Bass (1985) and then updated and published in a later

text, Bass & Avolio (1994). The models have been adapted, in Figure 29, to include definitions.

There are many models and variations under the umbrella term, 'transformational leadership'. In his review, Northouse (2007) states that, 'many scholars are studying transformational leadership, and it occupies a central place in leadership research' (p 175). Taking this into consideration, the researcher has identified three of these 'variants', to provide depth and breadth to this section of the literature review without going through endless variations on the central theme. The three works of note centre on the research of Bennis & Nanus (1985), Kouzes & Posner (1987; 2002) and lastly, Hooper & Potter (1997). These three works are summarised in Figure 30.

Figure 29. Transformational leadership

	Transformational Leadership	
Transformational Leadership	**Factor 1** Idealised influence, charisma	*Strong role model, high standards of moral / ethical conduct. Respected and trusted by followers who are provided with a sense of mission and purpose.*
	Factor 2 Inspirational motivation	*Inspires motivation and commitment through shared vision, communicated through high expectations. Uses symbols and emotion to focus team effort*
	Factor 3 Intellectual stimulation	*Encourages followers to be creative and challenge their belief and values as well as those of the organisation and leader. Creates innovation and encourages problem solving*
	Factor 4 Individualised consideration	*Listens, coaches and advises individual employees. Creates a supportive climate.*
Transactional Leadership	**Factor 5** Contingent reward, constructive transactions	*Effort is exchanged for reward. Leader obtains agreement as to what needs doing and what the reward will be.*
	Factor 6 Exception management, active and passive, corrective exchanges	*Active form involves watching closely and taking corrective action when employees make mistakes. Passive form involves negative reports on work, without communication. Both use negative re-enforcement*
Laissez-Faire Leadership	**Factor 7** Laissez-Faire, non-transactional	*Essentially, this represents an absence of leadership in any form. The leader takes a 'hands-off' approach, taking no decisions, giving no feedback and providing little advice or support for employees.*

Adapted from Bass (1985) and Bass & Avolio (1994)

Figure 30. Three examples of 'Transformational Leadership' theories

Three examples of leadership theory that sit under the umbrella term, 'Transformational Leadership'

Examples	Leadership strategies, practices and key competencies	Description
Bennis & Nanus (1985)	Have a clear vision	*Simple, understandable, beneficial and energy creating. A picture of the future that grows out of the needs of the organisation. Leaders articulate the vision that develops from both the leader and their followers.*
	Social architects of the organisation	*Leaders create the shape and form of the organisation, so it provides shared meaning for followers, giving them shared values, norms and culture.*
	Trust creation	*Leaders create trust by articulating a direction of travel and then consistently implementing that direction. Provides integrity for the leader and the organisation*
	Deploy positive self-regard	*Transformational leaders know their strengths and weaknesses, emphasising their strengths in order to grow organisational confidence. Aware of their own competence, leaders focus on learning, so their organisation has a consistent emphasis on education.*
	Model the way	*Leaders who set standards by personal example. They follow through on promises and affirm common values.*
Kouzes & Posner (1987 ; 2002)	Inspire a shared vision	*Able to visualise positive and compelling visions that inspire and align with the aspirations of followers.*
	Challenge the process	*Changes the status-quo, willing to innovate, grow and improve. Will take risks, learning from mistakes.*
	Enable others to act	*Build trust and collaboration. Treat others with dignity and respect, supporting decisions of others.*
	Encourage the heart	*Rewards others for accomplishments. Praises those who've done well, using authentic celebration of success.*
	Setting direction	*Being clear about the vision for the future.*
	Setting an example	*Expects others to replicate own behaviour*
	Communication	*Listens attentively, careful to ensure 2-way communication.*
Hooper & Potter (1997)	Alignment	*Ensures all employees are aligned to direction of travel.*
	Bring out the best in people	*Uses varied techniques and own charisma for developing and enhancing performance.*
	The leader as a change agent	*Changes established process without fear, learns through experimentation and gathering evidence for change.*
	Provide decision in crisis or on the ambiguous	*Leads from the front, does not shirk responsibility for the organisation and its people during 'tough times'.*

Adapted from Bennis & Nanus (1985), Kouzes & Posner (1987; 2002) and Hooper & Potter (1997)

There are clearly common themes across the transformational leadership literature. In summary, it seems that transformational leadership has the following key aspects to it;

- Create a vision, with the organisation and its people, clarifying values and the culture aspired for
- Act as a role model for others, exhibiting the behaviours and approach to work that you'd like followers to replicate
- Raise the consciousness of followers with regard to the vision and their role, above self-interest, in helping to achieve it

- Empower and nurture employees to maximise effectiveness, contribution and value for the organisation
- Throughout, build trust and confidence through people. Collaborate in order to foster good feelings among employees about themselves and their task

In addition to the literature referenced above, there is a wealth of supporting research related directly to transformational leadership. In their paper reviewing a decade of published research, Lowe & Gardner (2001), pronounce that over a third of it related directly to transformational leadership. The weight of research and publications in this field, do lend to an impression of robustness with regard to the strength of theoretical foundation. This academic weight is combined for many, with an instinctive liking and support for the transformational approach, as it centres on charisma and traditional notions of leadership being more about character than competency. Lastly, in terms of the positive aspects of this approach, the transformational school of thought provides a fairly unique degree of emphasis on morals, values and needs - not just the transactions required to achieve a task. In today's business world, where the ethical aspects of a leader's business model appear to be gaining increasing importance (Harvey, 1994; Crane & Matten, 2007; Ferrall *et al*, 2008), the popularity of the transformational approach among academics and those leading in practice should not be a surprise.

Again, there are challenges that can be put to the proponents of this model - as Bryman (1992) states, the approach treats 'leadership as a personality trait or personal predisposition rather than a behaviour in which people can be instructed' (p 100). If this is true, training leaders in this approach would seem to have limited, if any benefit to performance. The other major concern in the literature with regard to the transformational approach is that transformational leaders can be elitist and anti-democratic (Avolio, 1999).

Avolio (1999) also, in a contradictory sense, contends that transformational leaders can be directive and participative as well as democratic and authoritarian. This anomaly is highlighted by Northouse (2007), who says of the apparent contradiction, 'the substance of the criticism raises valid questions about transformational leadership' (p 193). A final, cautionary note – no doubt disappointing the likes of Collins (2001) and the growing band of transformational disciples - relates to the potentially destructive nature of transformational leadership. Conger (1999) alerts his readers to significant risks for organisations as a consequence of charismatic

individuals using their coercive powers to lead people to evil deeds, as evidenced throughout history. In a balancing and sobering response to such a claim Northouse (2007) refutes such argument by stating that, '[transformational leadership] has a moral dimension. Therefore, the coercive uses of power by people such as Hitler, Jim Jones and David Koresh can be disregarded as models of leadership' (p 192).

In practice, the NHS has had its share of 'transformational change' advocates (Bevan, 2012; Bevan, 2013; Britnell M, 2013). Whilst the researcher would certainly acknowledge that such an approach can add structure and motivation into projects within individual NHS organisations such as hospitals, the primary vision setting is still undertaken at a central political level and therefore, is not 'owned' within each organisation and certainly not to the extent that the devout transformational change disciples would wish. For this reason, transformation projects in the NHS are often time limited and linked to capital investment.

The psychodynamic approach to leadership

Transformational leadership requires charisma and this is partly related to personality. This connection enables us to explore this area in greater depth, by entering the realms of the 'psychodynamic' approach to leadership; which primarily focusses on the personality of the leader. It differs from all other approaches to leadership research in that regard, as they are primarily focussed upon the traits, behaviours, skills or styles of leaders in any combination and the interaction between leader and follower(s).

In relation to personality types, Bass's (1990) comprehensive handbook of leadership refers, to both the classic Myers-Briggs personality indicator (Myers & McCaulley, 1985) and it also cites the very early work of Jung (1923) on psychoanalytic conceptualisation, thought to be the basis from which the contemporary Myers-Briggs classification model was eventually developed. These appear to be some of the most commonly cited business orientated researchers in this area, although there is some degree of overlap with general psychology and the works of say Freud (1938), or Berne (1961). In relation to this area, there are several others who have tried to emphasise the importance of personality to leadership in the business world and of leaders being aware of their own personality type, in order to perform more effectively (Zalenznik, 1977; Maccoby 1981; Berens *et al*, 2001).

Depending on their response, the Myers-Briggs indicator sorts leaders into four main categories, with sixteen sub-categories. Leaders are primarily classified as being extroverted or introverted. Then, other classification types are assigned dependent on the response to the questionnaire.

The basis for personality classification is shown in Figure 31, along with information showing the strengths and weaknesses of leaders, aligned to their personality type, as indicated by the test.

In terms of personality and the psychodynamic approach to leadership, there is a further interesting notion put forward by Maccoby (2003), who cites the 'productive narcissist' as being the ideal personality, 'in time of crisis and change' (p 95). Maccoby (2003) goes on to describe the positive and negative aspects of working with a leader of narcissistic tendency. As indicated by the summary in Figure 32, it seems that whilst Maccoby may have a valid point in terms of appropriateness for leadership whilst an organisation is in turmoil or distress, the researcher would argue that the negative aspects are likely to make the development of long-term relationships with employees and colleagues rather difficult.

Figure 31. Psychodynamic approach to leadership : personality classification

Classification of personality and the strengths and weaknesses, aligned to the 16 personality types;

(E) Extravert	v	**(I)** Introvert	(focuses energy externally or internally)
(S) Sense	v	**(N)** Intuition	(evidence gathered precisely or insightfully)
(T) Thinker	v	**(F)** Feeler	(makes decisions rationally or subjectively)
(J) Judgement	v	**(P)** Perception	(organised or spontaneous)

Type	**Value**	**Appearance**
ESTP	Competition	Active, pragmatic, incisive, demanding
ISTP	Efficiency	Active, capable, concrete, proficient
ESFP	Realism	Energetic, inquisitive, encouraging
ISFP	Cooperation	Flexible, synergetic, pragmatic
ESTJ	Organisation	Methodical, focussed, planned
ISTJ	Productivity	Persistent, logical, practical
ESFJ	Harmony	Helpful, supportive, practical
ISFJ	Consideration	Cooperative, committed, understanding
ENTJ	Command	Analytical, blunt, planned
INTJ	Effectiveness	Analytical, tough minded, systematic
ENTP	Knowledge	Assertive, competitive, resourceful
INTP	Ingenuity	Conceptual, analytical, critical
ENFJ	Collaboration	Warm, supportive, inclusive
INFJ	Creativity	Inventive, idealistic, insightful
ENFP	Innovation	Imaginative, enthusiastic, expressive
INFP	Empathy	Passionate, intuitive, creative

Adapted from Myers & McCaulley (1985) and Berens *et al* (2001)

Figure 32. Leaders with a narcissistic personality - positive and negative aspects

Leaders with a narcissistic personality - positive and negative aspects;	
Positive	**Negative**
A vision to change the world and create meaning for people	Unwilling to listen
Independent thinking, risk taker	Sensitive to criticism
Passion	Paranoia
Charisma	Anger, puts people down
Voracious learning	Over-competitive
Perseverance	Isolation and controlling
Alert to threats	Lack of self-knowledge
Sense of humour	Grandiosity

Adapted from Maccoby (2003)

In essence, the psychodynamic approach to leadership, in contrast to other models of leadership points itself almost entirely at the personality characteristics of the leader. The theory encourages leaders to become aware of their own personality type and that of those around them in the organisation, so they can better understand how to interact with employees and determine why interactions pan out the way they do.

The psychodynamic approach places great emphasis on awareness of the relationship between the leader and follower(s), which in terms of positive working relationships and an ability to influence is important. As ever, there are negative aspects to this leadership approach and the major criticism here is that much of the research to inform the model was conducted via the treatment of people with psychological problems. Therefore, the rationale of critics such as Stewart & Jones (1991) is that the model is based upon the psychology of the abnormal personality, rather than the normal. A further, often noted criticism, as with other models that involve tests or questionnaires, is the robustness and clarity of the assessment process. In terms of evidence to support this claim, the researcher has certainly witnessed criticism and error in the completion of the Myers-Briggs model and this appears to be borne out in the research of others, such as For example, Kline (1993) who when discussing the Myers-Briggs model stated that, ‘The scales are reliable and thus all turns upon the validity of the test’ (p 77).

The team approach to leadership

The final, major school of thought in relation to leadership is the team approach. Leaders can use many aspects of the work in this area to evaluate the current effectiveness of their team and also to gain insight into decisions or actions they might take to improve team effectiveness overall.

This basic interpretation, suggesting that the role of leader is the lynchpin within successful teams appears to concur with the general notion of team leadership defined in the literature. As Zaccaro *et al* (2001), state;

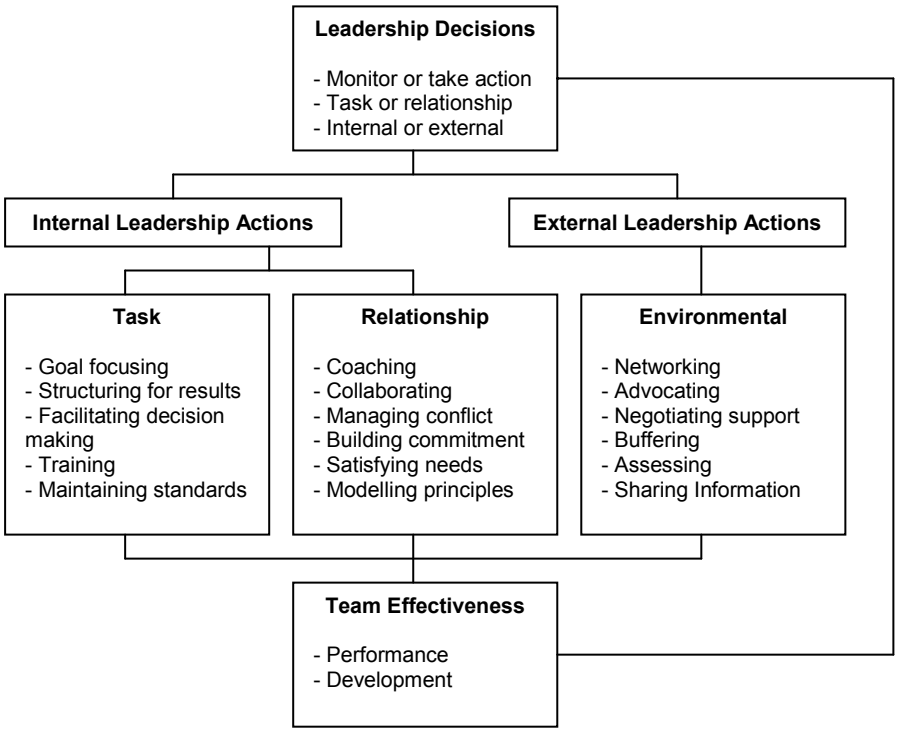
'*Indeed, we would argue that effective leadership processes represent perhaps the most critical factor in the success of organizational teams*' (p 452).

In terms of the processes they refer to, the team approach to leadership offers a number of theoretical models. Hill (1984), offers a comprehensive process map for team leadership, which leaders can follow in a continuous or cyclical way. The initial decision of the team leader is fundamental and relates to whether or not an intervention is required. Parameters for the scope of this decision include further considerations, as to whether the intervention is required for task related or relationship related reasons and whether these are acute to the team themselves, or have a wider external basis. Once the intervention area has been identified as being internal or external, the model offers a series of potential routes for leadership action. On the face of it, the guidance is fairly straightforward. However, task, relationship and environmental considerations are not applied or considered appropriate for both internal and external actions. For example, if team members are experiencing relationship problems with a key external client the model does not offer a route to solve the problem – as managing conflict, collaboration and satisfying needs all of which could be routes to solving such a problem sit in the relationship box, linked only to internal actions. Avoiding the pitfalls of specific process-map models, Kinlaw (1998) offers more rounded advice for leaders of teams. He applies actions and interventions to both the team and external stakeholders with equal focus throughout the team leadership process, with equal consideration given to task (performance) and maintenance (relationship) aspects. The Hill model referred to has been adapted, in Figure 33.

With regard to successful teams and the actions of leaders LaFasto & Larson (2001), after considerable depth of investigation provide a 'checklist' of six core-leadership functions:

i Keeps team focussed on goal(s)
ii Maintains collaborate climate
iii Builds confidence of team members
iv Demonstrates technical competence
v Set priorities
vi Manages performance

Figure 33. A comprehensive process map for team leadership



Adapted from Hill (1984)

In a publication centred on the team leadership school of thought, Belbin (1993) provides a helpful distinction between what he describes as 'solo' leaders and 'team' leaders. He contends that the traditional leadership construct is built around an individual who heads up a team of followers. They are assumed to be able to turn their hand to any task within the group and therefore, can identify and take

responsibility for under-performance intervening to take up any task or role as needed. This model, is described as 'solo' leadership and it is contended that in a changing world where complexity and discontinuity present greater problems to team function, management and therefore, leadership – that a new model is required. To support this, Belbin (1993) argues that 'solo' leadership is inappropriate in the modern world and 'team' leadership is increasingly the more effective approach – he draws a clear distinction drawn between the respective behaviours and levels of participation, as illustrated in Figure 34, adapted from his work.

The team approach to leadership has a number of positive aspects to it. For the practitioner, the model enables thought and reflection on what makes a good team, whether their team is performing well and what changes in leadership approach might enhance or improve things. The basic aspects to the team approach, as cited by LaFasto & Larson (2001) provide a relatively simple checklist for leaders, which not only gives some structure to a complex task, it leads on to deeper reading and therefore understanding of the complexities of team behaviour and team dynamics. The team approach may also aid with the recruitment and selection of leaders, as it gives a sense of potential fit between a team and potential leader.

Figure 34. Solo leadership v Team leadership

Solo leadership	Team leadership
Plays an unlimited role – the solo leader interferes in everything	Chooses to limit own role to preferred team role – delegates others within the team
Strives for conformity – the solo leader tries to mould team members to particular standards	Builds on diversity – the team leader values differences between people
Collects acolytes – the solo leader collects admirers and sycophants	Seeks talent – the team leader is not threatened by people with special or new abilities
Directs followers – subordinates take their leads and cues from the solo leader	Develops team members - the team leader encourages the development of personal strengths
Projects objectives – the solo leader makes it plain what everyone is expected to do	Creates the mission – the team leader projects the vision which others can then act on

Adapted from Belbin (1993)

As with all theoretical approaches to leadership, the positive aspects to the team approach are counter balanced by a series of criticisms. The main academic criticism related to the team approach centres on the early validity of the research base.

Hackman (1990) questions this, as much of the early work in developing models such as that cited in Figure 34 was 'not derived from real teams in functioning organisations, but academic models and work groups (p 13)'.

Despite the attempts of LaFasto & Larson (2001) to simplify the team leadership approach through their provision of a simple checklist, in practice many leaders find it difficult to find and apply such easy generic answers when leading a team – especially in a rapidly changing environment. This environmental change factor, whilst acknowledged in the work of Belbin (1993), is becoming an increasingly relevant pressure upon the credibility of the team approach. New organisational models that have evolved since the derivation of theory continue to mutate and evolve at a pace. More tasks and roles that, in traditional organisations, were seen as the domain of the leader are being devolved to team members. This is especially so in virtual and geographically dispersed teams (Handy, 1989).

A final weakness with the team approach, common to many of the theoretical leadership models, especially those such as that cited in Figure 34, is that long lists of skills and abilities deemed necessary for effective leadership. In practice, this makes it difficult for anyone to see how it's possible for one individual to be proficient and in all such areas. This can lead to frustration and unrealistic expectations for leaders in their own development and for the expectations of followers of their leader.

Leadership theory – a summary

The breadth and depth of critical appraisal within this section of the literature review is sizable, despite the clear limitation to the scope set out on page 8. This may go some way to demonstrating a 'considerable and improved level of knowledge' required in a research degree thesis (also discussed on page 8).

In order to bring together the plethora of models and the issues surrounding, a comprehensive summary table is beneficial within any critical appraisal document. Aside from the practical benefits for future reference purposes of constructing such a table, this method of presenting summary data is recommended by Hussey & Hussey (1997), who state that, 'Research shows that some people prefer data presented in tabular form' (p 295).

A précis of the main theoretical approaches to leadership, elicited from the literature and critically reviewed as part of the research process, is shown in Figure 35. The

table, spread over pages 69 and 70 lists each approach to leadership, briefly describes it and goes on to provide a summary of the strengths and weaknesses outlined in the literature review.

Figure 35. A summary of the main theoretical approaches to leadership

Theoretical approach to leadership, with summary statement	**Strengths**	**Weaknesses**
Trait – *focuses on traits and the innate qualities and characteristics of great leaders*	Considerable research to support the approach. Fits common perception that leaders have 'special traits' and provides clear list of desirable personality and character traits.	Doesn't consider situational factors. Could lead to unfocussed approach as list of desirable traits is vast and therefore, unachievable. Also, personality and character is engrained and difficult to change.
Style (or behavioural) – *focuses on the actions and behaviours of successful leaders*	Situational factors as well as those related to leaders themselves are taken into account. Enables appraisal of the leader and the people / tasks they face.	Pays minimal service to scenarios in which prioritisation of concern for results over people might be needed and also, give the impression that high scores in both areas is optimal, again – a leap to far for many? Some academic criticism of the research behind this approach.
Skills – *focuses on the skills and abilities that can be learnt or developed over time to improve leadership performance*	Logical approach that provides a clear 'road map' for skills required of leaders. Acknowledges that experiences during a leader's career and environmental factors are important.	Considerable number of skills to master, with little detail on best means to develop the skills. Also, little direction as to mechanisms for measuring the impact or value of skills development on leadership performance.
Situational – *places a focus on situational factors, suggesting that successful leaders adapt and change their approach dependent on multi-situational factors at the time*	Encourages leaders to 'flex' their approach, thinking carefully about followers and the situation - which the model acknowledges will change over time. A relatively simple approach that has stood the test of time, as still used in practice and enables development for both follower and leader.	Ambiguous mechanisms for assessing and categorising followers, which could lead to subjective analysis and poor outcomes when using the model. Criticised for this by some academics in addition to lack of demographic considerations.
Contingency – *stresses the importance of a number of dynamics in relation to leadership approach: relations with followers, the task, values and power.*	Supported by research. Acknowledges the limitations of leaders, suggesting that leaders cannot succeed in all settings. Unlike other theoretical approaches, it considers the values held by followers and organisations.	The assessment questionnaire associated with the primary model has been criticised by some academics and being unclear. Also, the approach does not provide detail or recommendations for action when non-alignment of leader and workplace occurs.
Path-goal – *focussed directly on the relationship between leader and followers and leadership interventions to support and motivate as they attempt to achieve a task*	Accepts that leadership behaviour affects employees and therefore, the leader relationship with employees is critical to success.	Limited task categorisation, in terms of complexity and motivation of followers could limit application of the approach in some contemporary business settings.

Theoretical approach to leadership, with summary statement	Strengths	Weaknesses
Leader-member exchange – *this approach centres on the individual exchanges between a leader and followers, predominantly on a one-to-one level, but acknowledging the existence of group dynamics.*	Focus on point of interaction between leader and individual follower. Acknowledges issues of discrimination, bias and organisational politics through classification of 'in' and 'out' groups.	Lack of guidance regarding tactics for leaders to gain access to pre-existing 'in groups', in order to exert influence and change.
Psychodynamic – *places a focus on the personality of leaders, categorising personality - usually through psychodynamic testing - and then applying leaders to followers with a 'best fit' typology.*	Enables classification of leader personality types and encourages leadership awareness own personality and that of others. The focus on relationships and personality also enables reflection and prompt for development and learning.	Some questions over early research, particularly the research subjects. Also, the main vehicle for classification of personality is a questionnaire, which attracts similar criticisms to those referred to for the contingency model, above.
Team – *this approach applies to leader to the dynamics of building a successful team – in terms of the internally and externally relationships, as well as the task*	Viewed as enabling leaders to understand what makes and enhances well performing team. Teams are complex in nature and this approach can provide structure. Can help in the selection of leaders, by matching the team with the leader and the qualities they hold.	Questions over validity of early research as not derived from 'real' teams. Does not, despite attempts to do so, provide easy answers to team leadership. As the nature and structure of teams evolves, it is questioned whether some of the more traditional 'team leader' models remain relevant and useful. Again, a long list of desirable skills makes it difficult for individuals to meet the criteria or realistically plan to do so.

Source (Author, 2010)

Leadership in the NHS

This section is focussed primarily on the major recognised models for leadership, still used to some extent in practice today. They are advocated by the Department of Health (DH) and have often been published through the NHS Institute for Innovation and Improvement. In order to inform the reader as well as the research process however, attention is also given to other leadership models promoted and used by a number of the main clinical professions and sub-groups within the health service. This review also brings to the readers' attention, a conceptual model published by the researcher.

NHS leadership – a history of sub-culture and silos

As the NHS has evolved, the medical profession – central to NHS delivery and a key influence during its formation over 60 years ago – appears to have kept a degree of distance when it comes to leadership and accountability for organisational decision making, often preferring to cite politicians and managers when public or media

criticism for service failings arise. As a consequence, an accepted and long-standing divide between “managerial leaders” and “clinical leaders” has evolved to some extent and in many organisations this still persists today. The divide is even acknowledged by clinicians who have decided to take on a management role within the NHS (Edwards, 2005).

There are those, such as Handy (1999), who question whether a prescription can be written for developing leadership capability generally. This is symbolised in his fundamental question, ‘Are leaders born or made?’ (p 96).

Exploratory research into the literature, suggests that each professional or cultural sub-group within the NHS has traditionally had its own models and distinctive train of thought with regard to leadership - what it is, how it is developed and the value it might add. Such organisational sub-cultures are referenced by Schein (2004) and in this case, professional or cultural sub-groups are defined as groups of healthcare staff who due to hierarchical, functional or occupational variation develop their own sub-culture, as a variation or ‘strain’ of the NHS culture overall. Reference to profession-specific journal articles re-enforce the concept as distinct interpretations of leadership, leadership development and practice, often translated ‘inwardly’ for the professional group concerned are found. Whilst the range of literature referred to is sizable and could include a multitude of health professions such as pharmacy (RPSGB, 2011), physiotherapy (Pope, 2011) and many others, examples for medical, nursing and managerial staff groups are shown in Figure 36.

Figure 36. Evidence of Leadership in Professional “silos” within the NHS

Professional “Silo” Groups	**Examples of evidence from healthcare literature that supports the notion that leadership development and practice occurs in professional “silos”**
Managerial Silo	Nolan (2005), Dearlove & Crainer (2005), Peck in Walshe & Smith (2006), Goodwin (2006), Kings Fund (2013), Stonehouse (2013), McComb (2013)
Medical Silo	Empey *et al* (2002), Willcocks (2005), Mullins (2006), Leahy (2006), GMC (2012), Dickinson *et al* (2013), Spurgeon *et al* (2012)
Nursing Silo	Jasper (2004), Agnew (2005), Hancock & Campbell (2006), Jones (2007), Koc *et al* (2013), Bish *et al* (2013), Wong *et al* (2013), Reyes *et al* (2013)

Source: Author (2013)

Examples of ‘joined up’ good practice are rare in terms of multidisciplinary leadership development or leadership models. For a public service organisation that has not changed its core purpose in over 60 years, it is perhaps surprising that those charged with delivering services to the public in line with that purpose could learn, develop and often ‘lead’ almost entirely separately – perhaps a recipe for conflict if ever there was one. There is strong evidence that by working, learning and developing together, healthcare practitioners from different professional disciplines develop more effectively. Perhaps more importantly, there is also an argument that this improves patient care (Craddock *et al*, 2006; Poddar, 2013). In terms of overall organisational efficiency and effectiveness, which also – ultimately - affects the experience and quality of care patients receive, perhaps these models should incorporate an element of management and leadership development? By bringing clinicians and managers together in both learning and practice, such engagement might bring increased insight, understanding and trust between not unusually ‘conflicting’ parties. The researcher also notes in the post-Francis NHS, that some of the more contemporary references cited in Figure 36, such as the work of Wong *et al* (2013) and the King’s Fund (2013) deliberately incorporate the perspective of service users in their development and evaluation.

There are of course more examples of ‘joined up’ NHS leadership in theory, such as the work of Rodrigues & Bladen (2013), for example. In practice, the researcher would point to the work of Raper and Vaughan-Lane (2006) which, whilst the systems and relationships have taken time to develop, certainly support the general ethos of trust and understanding and ultimately, provides evidence of improvement for patients. Equally, in the learning environment Shepherd (2006) advocates more joined up leadership development and practice in the health sector. Bringing together professional and cultural groups in both practice and education is not likely to happen quickly, as many working relationships - whatever the setting - are often complicated and require time to mature and this seems especially so in the NHS. The time and effort required could be a worthwhile investment for the health service however, as a high level of mutual understanding, common purpose and trust between individuals and cultural groups have been described as critical to delivering any organisational objective (Katzenbach & Smith, 2004). When considering the notion that understanding, common purpose and trust all require time to build and develop, there is clearly a case for giving senior NHS leaders – both managerial and clinical - time to build relationships that harness each of these important facets. However, the level of turnover among the medical workforce is high in some areas of the country, with

many Doctors facing an uncertain future (Sibbald B *et al*, 2003) and Blackler (2006) citing a 12-month period in which 20% of Chief Executives either resigned or were sacked. It is pretty certain that current levels of turnover will not enable relationships to be built and cohesive leadership to develop, so 'failure' could become perpetual within the NHS unless some resolution can be found to these issues.

The NHS leadership framework

What is clear is that the various professional and cultural sub-groups within the NHS have acknowledged the conceptual requirement for leadership, whether it be born or made. In terms of national guidance, the Department of Health has published a framework that clearly sets out the expected qualities of those working, or thinking of working in positions of leadership in the NHS.

The document, "The NHS Leadership Framework", (DoH, 2010e), is perhaps the best known model and reflects an over-arching framework expected of all NHS leaders. It is published by the NHS National Leadership Council (Dent, 2009) and builds upon a range of other similar guidance documents for staff in the NHS, including the Doctor specific "Medical Leadership Framework" (DoH, 2010f), the more general "Leadership Framework" (DoH, 2010h) and also proclaims to reflect the core-values of the NHS, as set out in the NHS Constitution (DoH, 2010g). This keystone document for NHS leaders is a revised version of the previous long standing document, the, "NHS Leadership Qualities Framework" (DoH, 2004a).

The latest work at the time of this research, sets out the 15 qualities deemed to be the most important for leaders in the NHS. The framework, within the NHS, is often referred to by the abbreviated term, 'LQF' and was the primary reference point at the time of this research. The 15 qualities within the LQF were divided into 3 clusters, 'personal qualities', 'setting direction' and 'delivering the service'. In summary, this is shown in Figure 37.

The researcher has referred to professional and cultural sub-groups within the NHS. This is recognised within the LQF documentation through a desire to create a 'common language' with regard to leadership (DoH, 2004a). The researcher, in Figures 38 to 52, has researched the development of the model (DoH, 2006a; DoH, 2004b) and summarised each of the 15 LQF qualities applicable at the time the primary research within this thesis was conducted. This not only places the LQF in context, but aided the researcher in contextualising his research questions.

Figure 37. NHS Leadership Qualities Framework (LQF)

NHS Leadership Qualities Framework	
Personal Qualities	Self-belief Self-awareness Self-management Drive for improvement Personal integrity
Setting Direction	Seizing the future Intellectual flexibility Broad scanning Political astuteness Drive for results
Delivering the Service	Leading change through people Holding to account Empowering others Effective and strategic influencing Collaborative working

Adapted from 'NHS Leadership Qualities Framework' (DoH, 2004a)

Figure 38. LQF 'Personal qualities / self-belief'

LQF Cluster / Quality	LQF Description
Personal Qualities / Self-belief	Outstanding leaders maintain a positive 'can do' sense of confidence which enables them to be shapers rather than followers, even in the face of opposition. This prime personal quality is built upon success and learning in a broad range of varied situations over time. Features of this quality include: ● Relishing a challenge. ● Being prepared to stand up for what they believe in. ● Working beyond the call of duty, when this is required. ● Speaking up if this is needed. In doing so, their integrity and their motivation for service improvement will sustain them.

Source: Author (2012)

Figure 39. LQF 'Personal qualities / self awareness'

LQF Cluster / Quality	LQF Description
Personal Qualities / Self-awareness	Outstanding leaders have a high degree of self-awareness. They know their own strengths and limitations, and they use failure or misjudgement as an opportunity for learning. Features of this quality include: ● Being aware of their own emotions. ● Being aware of their personal impact on others, particularly when they are under pressure as they have an understanding of the 'triggers' to which they are susceptible.

Source: Author (2012)

Figure 40. LQF 'Personal qualities / self-management'

LQF Cluster / Quality	LQF Description
Personal Qualities / Self- management	Outstanding leaders are able to pace themselves, staying for the long haul when necessary. Self-management, supported by emotional self-awareness, enables them to regulate their behaviour, even when provoked. Features of this quality include: ● Being tenacious and resilient in the face of difficulty. ● Being able to cope with an increasingly complex environment – with the blurring of organisational boundaries and the requirement to work in partnership across the health and social care context.

Source: Author (2012)

Figure 41. LQF 'Personal qualities / drive for improvement'

LQF Cluster / Quality	LQF Description
Personal Qualities / Drive for Improvement	Outstanding leaders are motivated by wanting to make a real difference to people's health by delivering a high quality service and by developing improvements to service. Features of this quality include: ● A deep sense of vocation for public service driven by identification with the needs of patients and service users. ● A primary focus on achievement of goals for the greater good of others, and not the leader's own reputation. ● Investing their energy in bringing about health improvements – even to the extent of wanting to leave a legacy which is about effective partnership, inter-agency working and community involvement.

Source: Author (2012)

Fig 42. LQF 'Personal qualities / personal integrity'

LQF Cluster / Quality	LQF Description
Personal Qualities / Personal integrity	There is much at stake in leading health services. Outstanding leaders bring a sense of integrity to what they do that helps them to deliver to the best of their abilities. Features of this quality include: ● Believing in a set of key values borne out of broad experience of, and commitment to, the service which stands them in good stead, especially when they are under pressure. ● Insistence on openness and communication, motivated by values about inclusiveness and getting on with the job. ● Acting as a role model for public involvement and the dialogue that all staff, including the front line, need to have with service users. ● Resilience that enables them to push harder, when necessary, in the interests of developing or improving the service.

Source: Author (2012)

Fig 43. LQF 'Setting direction / seizing the future'

LQF Cluster / Quality	LQF Description
Setting Direction **/** **Seizing the future**	High performing leaders ACT NOW to shape the future. They are motivated to take action to achieve a radically different future – one in which health services are truly integrated and focused on the needs of patients. Features of this quality include: ● Making the most of current opportunities to bring about improvements that are of benefit to staff, carers or patients. ● Being able to interpret the likely direction of changes in the health service and beyond – using their political astuteness. ● Using their insights into the broad strategic direction of health and social care to help shape and implement the approaches and culture in their organisation, and to influence developments across the wider health and social care context. ● Underpinning their vision and action with a strong focus on local needs. ● Being prepared to undertake transformational, rather than just incremental, change where this will achieve service improvement.

Source: Author (2012)

Fig 44. LQF 'Setting direction / intellectual flexibility'

LQF Cluster / Quality	LQF Description
Setting Direction **/** **Intellectual flexibility**	High performing leaders are quickly able to assess a situation and to draw pragmatic conclusions. They are able to switch between the significant detail and the big picture to shape a vision – for their own service, organisation or across the wider health context. Features of this quality include: ● Being receptive to fresh insights and perspectives from diverse sources, both internal and external to the organisation (driven by their values of inclusiveness and service improvement). ● Understanding that change may have to be radical to achieve health improvement. ● Being open to innovative thinking and encouraging creativity and experimentation in others too.

Source: Author (2012)

Fig 45. LQF 'Setting direction / broad scanning'

LQF Cluster / Quality	LQF Description
Setting Direction **/** **Broad scanning**	High performing leaders in the health service demonstrate high levels of seeking and networking for information. By keeping abreast of developments, both locally and nationally, they are best positioned to shape the vision for a service or organisation as well as understand how to influence others. Features of this quality include: ● Making it a priority to know about how services are being delivered and what the experience is of patients and users on the ground. ● Being persistent in getting the key facts of a situation. ● Having systematic ways of informing themselves about key developments.

Source: Author (2012)

Fig 46. LQF 'Setting direction / political astuteness'

LQF Cluster / Quality	LQF Description
Setting Direction / Political astuteness	Outstanding leaders demonstrate a political astuteness about what can and cannot be done in how they set targets and identify service improvements. Features of this quality include: ● Understanding the climate and culture in their own organisation and in the wider health and social care environment. ● Knowing who the key influencers are – both internally and externally to the organisation – and how to go about involving them, as required. ● Being attuned to health strategy and policy at a national and local level and being able to plan a way ahead that takes account of these strategies. ● Understanding that the role of leader in the health service is now broader than simply being responsible

Source: Author (2012)

Fig 47. LQF 'Delivering the service / drive for results'

LQF Cluster / Quality	LQF Description
Setting Direction / Drive for results	High performing leaders are motivated to transform the services for patients and thereby to improve quality. The personal qualities at the core of the framework provide the energy and the sheer determination which fuel Drive for results. Features of this quality include: ● Setting ambitious targets which may exceed the minimum standard required and taking calculated risks – all with the aim of delivering added value to the service. ● Focusing their own, and others', energy on what really makes a difference, rather than being constrained by methods which were used in the past. ● Actively seeking out opportunities to improve delivery of service through partnership and new ways of working.

Source: Author (2012)

Fig 48. LQF 'Delivering the service / leading change through people'

LQF Cluster / Quality	LQF Description
Delivering the Service / Leading change through people	Outstanding leaders are focused on articulating the vision with compelling clarity, keeping the focus on change and inspiring others to be positive in their support of service improvement. Features of this quality include: ● Gaining the support of others by ensuring that they understand the reasons behind the change. ● Sharing leadership – with the team and others in the organisation and in partner organisations. ● Encouraging others, especially front line staff, to find new ways of delivering and developing services and to take the lead in implementation of change. ● Demonstrating a highly visible, authoritative and democratic leadership style which is underpinned by strongly held values around equality, diversity and openness. ● Taking a collaborative or facilitative approach in working in partnership with diverse groups. ● Enabling teams, within the organisation and across the health community, to work effectively together. Helping to unblock obstacles, identifying and securing resources, and taking care of teams and of the individuals within them.

Source: Author (2012)

Fig 49. LQF 'Delivering the service / holding to account'

LQF Cluster / Quality	LQF Description
Delivering the Service / Holding to account	Effective leaders have a strength of resolve that they can use in both holding others to account, as well as being held to account, for targets to which they have agreed. Features of this quality include: ● Setting clear targets and standards for performance and behaviours, ensuring the processes are in place to support individuals in achieving these standards ● Insisting upon improved performance if standards are slipping ● Creating a climate of support and accountability, rather than blame climate ● Holding people to account for what they have agreed to deliver ● Being prepared to be held to account by others for what they have contracted you to do as the leader

Source: Author (2012)

Fig 50. 'Delivering the service / empowering others'

LQF Cluster / Quality	LQF Description
Delivering the Service / Empowering others	Outstanding leaders support the long-term capability of their own and other organisations, essential for development of services by empowering others. Features of this quality include: ● Having the humility to work in the background, creating the space for others to take the lead on particular issues and to grow in confidence and capability. ● Being able to spot potential and support the development of people across the organisation. ● Taking personal responsibility for ensuring that diversity is respected and that there is genuine equality of opportunity. ● Fostering the development of others across the health community so that health improvement and service development agendas can be created and owned by the communities themselves. ● Engaging and involving users in service improvement. ● Developing relationships with service users which are equal, open and honest, and modelling the power-sharing which is required if solutions are truly to be at the discretion of the patient.

Source: Author (2012)

Fig 51. LQF 'Delivering the service / effective and strategic influencing'

LQF Cluster / Quality	LQF Description
Delivering the Service / Effective and strategic influencing	Leadership in the health service is characterised by an unusually high and complex level of influencing, which is seldom seen in leadership roles in other sectors. This particular quality runs through the whole framework; the most effective leaders make things happen by using high levels of influence. Features of this quality include: ● Getting results by working in partnership, within their organisation and with a wide range of agencies/ individuals over whom they have no formal authority. ● Influencing relationships which are critical to achieving change in terms of service improvement. ● Being able to cope with ambiguity, as organisations continue to change role and shape, and the agenda for change in health gathers pace. ● Employing a range of influencing strategies – ones that will work for the long term and bring about change in modernising the health service. ● Combining Effective and strategic influencing effectively with Empowering others, to ensure that the health agenda is driven and owned by local people, by staff throughout the organisation, and by other agencies.

Source: Author (2012)

Fig 52. LQF 'Delivering the service / collaborative working'

LQF Cluster / Quality	LQF Description
Delivering the Service **/** **Collaborative working**	Leaders in the health service work with a wide range of internal and external stakeholders. Effective leaders understand that truly collaborative working is therefore essential. Features of this quality include: ● Ensuring that the strategy for health improvement, and the planning, development and provision of health services, are cohesive and 'joined up'. ● Understanding and being sensitive to diverse viewpoints. ● Striving to create the conditions for successful partnership working.

Source: Author (2012)

Critical review of the LQF model

An exploration and critique the 'corporate' NHS leadership model, the "Leadership Qualities Framework [LQF]" (DoH, 2004a) applicable at the time of this research will be undertaken in this section of the literature review.

The studies of Goleman (1996) and Boulter *et al* (1996) already indicate that these types of framework have a number of significant gaps, especially in a health service for which a policy of contestability is fast becoming a reality. As an example, the LQF model was developed using information and evidence gathered at a time when the concept of competition had not gained pre-eminence for leaders in service provider organisations such as hospitals. Consequently, it is likely that this model (and others) do not include qualities that, since the shift in policy and practice associated with marketisation and the NHS, have subsequently come to the fore. The leadership styles adopted within the health service and the organisational culture overall are likely to change, as major policy shifts are still cited as a primary means to trigger change in both behaviour and language within organisations (Knott D *et al,* 2007).

Due to the evolving nature of the area, there is a dearth of evidence-based research on leadership and the impact of marketisation in health care. Whilst the work of writers such as Dixon *et al* (2003) is focussed upon the impact of market forces and provides a very interesting consideration of practical and predominantly regulatory issues, the lack of direct application to leadership in terms of behaviour, language and competencies for effective practice supports the assertion that there is little direct research in this specific area. Considering the relevance of styles, behaviours and language to both leaders and followers, especially in relation to changing environments and organisational culture (Schein, 2004), the published theory in

these subject areas will be considered carefully in the analysis, discussion and conclusions.

Broadly, many NHS derived leadership models, including the NHS Leadership Qualities Framework, were developed at a time when politicians might have intonated that a market based system was being considered, but practice and policy had not (and still has not) shifted entirely or particularly explicitly. As a consequence, a contemporary discussion can now take place with regard to the NHS Leadership Qualities Framework (LQF), the changes associated with 'marketisation' and the task of leaders in an evolving healthcare environment. Specifically, the LQF document itself explains that the model was developed through information and evidence from chief executives and directors of all disciplines, within the NHS (DoH, 2004b). At the time, these leaders and their organisations were not subject to contestability. It is possible therefore, that some key leadership qualities – more relevant in an increasingly market-driven environment - were overlooked or given a low priority.

One such example is the comparative benchmark data showing that NHS leaders, when compared to those in the private sector or head teachers, have a lower level of performance when it comes to 'achievement orientation', (DoH, 2004b). At the time, this was not seen as important as there was little contestability between organisations and therefore, little requirement for NHS leaders to take risks in order to achieve objectives. The reason for comparative low performance in this area was given as, 'the current climate does not encourage risk taking but focuses on managing and controlling risk' (p 12).

This apparent lack of competitive or commercial 'task-focus' within the NHS Leadership Qualities Framework is re-enforced by another 'gap' related to customer or client orientation. There is a marked absence of the word patient [or any other word(s) used to describe 'customers' or 'clients'] within the LQF. The technical documentation underpinning the framework also gives sparse mention to patients and the researcher can only assume that either the framework was developed within the NHS and therefore, perhaps a patient-centric ethos was assumed or, a focus on service users (customers) or service purchasers (clients) was missed altogether.

'Drive for Improvement', another leadership quality cited in the Leadership Qualities Framework presents a further, potential area of incompleteness. 'Drive for Improvement' is a worthy aspiration on the face of it, but interpretation of what

constitutes ‘improvement’ may change as the market evolves and becomes more competitive – for example, providers may decide to improve their process, price or service in line with the requirements of those tendering contracts, over and above the true health or service requirements of local populations. Clearly there is potential for conflict between contractual and clinical care priorities. Recognition and understanding of these dynamics will be important. An ability to manage relationships with and between stakeholders so that priorities for improvement and change can be identified in this context and focussed upon key business and health care objectives will become increasingly important leadership qualities.

Another of the personal qualities in the Leadership Qualities Framework is ‘integrity’. The ‘Code of Conduct for NHS Managers’ (DoH, 2002b), clearly sets out the standard of conduct required and expected of NHS managers. Whilst the author certainly believes in having a level of regulation for NHS managers and leaders - for patient and public protection purposes at least - it could be argued that the Code of Conduct was written from very much a ‘public service’ perspective. It does not really consider the impact of additional pressures that might come with a market-driven system. Of those working in positions of leadership within the health service, Moore (2006) says, ‘[NHS] managers must learn to compete and collaborate simultaneously - and live with uncertainty about their careers’ (p 13). This contradictory situation will present yet another tough balancing act for NHS leaders to grapple with. It could, in a ‘harder’ organisational environment lead to individuals putting ‘self’ above ‘service’. This could present new challenges to those who regulate NHS managers, especially those in positions with influence over quality and quantity of services provided. The balance between collaboration and competition has been explored in other business sectors (Brandenburger & Nalebuff, 1997) but application in the emerging UK health care market is not evident and therefore, an understanding and ability to deal with these issues will also be an important leadership quality.

In a marketplace, setting direction for NHS provider organisations is likely to become more complex. Health service leaders will need not only the ability to scan broadly, flex their intellect and be politically astute, they will also need to be mindful of what gives them the ‘edge’ over their competitors. They will need to be able to innovate quickly, implementing new products and services in line with customer demand. Traditionally, the NHS has tended to have ‘long-term’ national service plans, which cover anything up to ten years. The ‘NHS Plan’ (DoH, 2000) was one such example, relevant at the time of this research. Whilst the researcher would not argue against

leaders having an eye on the longer-term, a market driven environment often requires faster paced innovation and service development, often based upon short-term or 'emergent' strategy. This again, relates partly to 'customer/client demand' and is primarily focussed on protecting or increasing financial margin and/or market share. These are two additional business drivers that NHS leaders will need to understand and apply to their organisations, as they develop systems and accounting techniques to analyse and use information for maximum benefit.

When it comes to service delivery, the NHS has not always focussed on user or 'customer' satisfaction, often paying lip service to the concept without making it a key performance target. This may be linked to embedded cultural selection processes for hiring staff, including those with direct 'customer' contact. When selecting people to deliver services, hierarchical succession continues to be the cultural assumption of many within the NHS. Leaders are still appointed on the basis that they are, 'a good nurse' or a 'good doctor'. Drummond & Ensor (2003) point out the risks within such systems stating that, 'Often leaders acquire their leadership position by means of technical expertise. This can be dangerous' (p 252). In many market driven businesses, where customer satisfaction linked to reward is a major component of the culture, individuals are selected for customer facing positions on the basis that - whilst they might require technical skills of an acceptable standard - they certainly need good interpersonal and customer relationship skills. When it comes to decisions about front line leadership, length of tenure or an individual's technical ability are likely to have less relevance in a harder commercially orientated organisation. This new ethos would conflict with traditional bureaucratic or 'nurturing' characteristics of NHS management, where productivity or results-based reward is either non-existent, frowned upon or where it does exist in some format, kept 'low-profile'.

Whilst the majority of the leadership qualities within the LQF model still apply, the issues raised and reflected upon by the researcher in this critical analysis, have helped to inform a basic sense of where the LQF model might be further enhanced. The key 'gaps' in the current LQF model are summarised in Figure 53.

The set of qualities contained in the 'corporate' NHS Leadership Qualities Framework compare relatively well to the recognised academic texts and theories on leadership and leadership styles, particularly those models with collaborative, participative and generally feminine or 'soft' cultural and conceptual emphasis. Whilst very recently there has been a subtle suggestion that NHS general managers need to develop a

'hard' commercial edge (Deffenbaugh, 2007) it is recognised that historically, a 'softer bias' in management and leadership has been present across NHS management (Lynas, 2006).

Figure 53. Emerging gaps in the current LQF model as a consequence of marketisation

Emerging gaps in the current LQF model as a consequence of marketisation:

- Greater focus on clear achievement of tasks/objectives
- Enhanced disposition to risk taking in order to deliver results
- Awareness and understanding of customer / client, who will increasingly inform the quality agenda (as opposed to service providers)
- Increasing focus on the prioritisation of improvement and change, based upon business case for key development, rather than untargeted 'improve all' approach
- Capacity to develop sustainable services in a market – able to understand and balance competition and collaboration
- Accepts and not afraid to use 'emergent' strategy as the 'market' evolves
- Greater understanding and use of information / systems relating to catchment area (local and surrounding) and associated financial margins / market share
- Recruitment and retention – increased focus on skills and productivity v tenure

Source: Author (2007)

An example of contrasting hard and soft organisational cultures is shown in Figure 54. Occasionally these polarised extremes have been referred to instead, as 'masculine' or 'feminine' (Usunier, 2000). The researcher has referred to these terms as they are recognised within the research of others. However, the use of 'hard / soft' as primary descriptors is preferred. This avoids any confusion as 'hard / soft' appear more commonly and also, it avoids any inference that these qualities or issues are in any way linked to gender.

Figure 54. Organisational Cultures – Hard and Soft

Organisational Culture	
Hard ← (Masculine)	→ **Soft** (Feminine)
Assertive	Nurturing
Individualist	Collectivist
Earning money	Interdependence
Caring little for others	Caring for others
Short-term	Long-term
Tough	Flexible

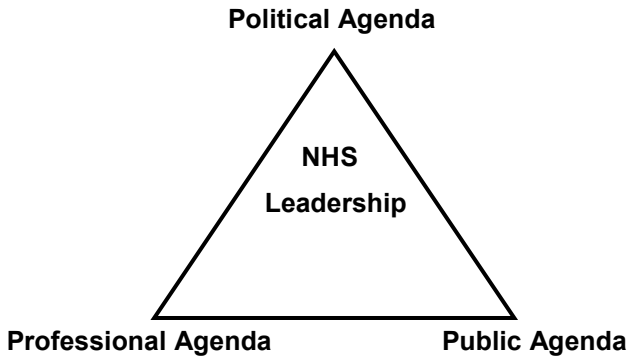
Adapted from Usunier (2000, p 66)

The '3P' leadership model – a basic leadership model derived in practice

Leaders, whatever their walk of life will need to adapt and change their style of practice as the environment changes around them. The is true of those operating within the NHS, whatever clinical or cultural sub-group(s) they might belong to and indeed, the evidence to support this general notion goes as far back as Machiavelli (1513) who, when discussing the qualities of a leader, says that, 'he should have a flexible disposition, changing as fortune and circumstances dictate' (p 57).

A basic, low-definition model illustrating this for NHS leaders, who are often required to balance and achieve outcomes that suit the political, professional and public agenda, (the '3P' model), is shown in Figure 55. The researcher believes that the different agendas are unlikely to subside entirely as a result of an increasingly market driven system, but the relative priority and influence of each may change. Qualities that will help NHS leaders to achieve this difficult balance will certainly be a requirement for the future.

Figure 55. NHS Leadership – political, professional and public agendas (the '3P' model).



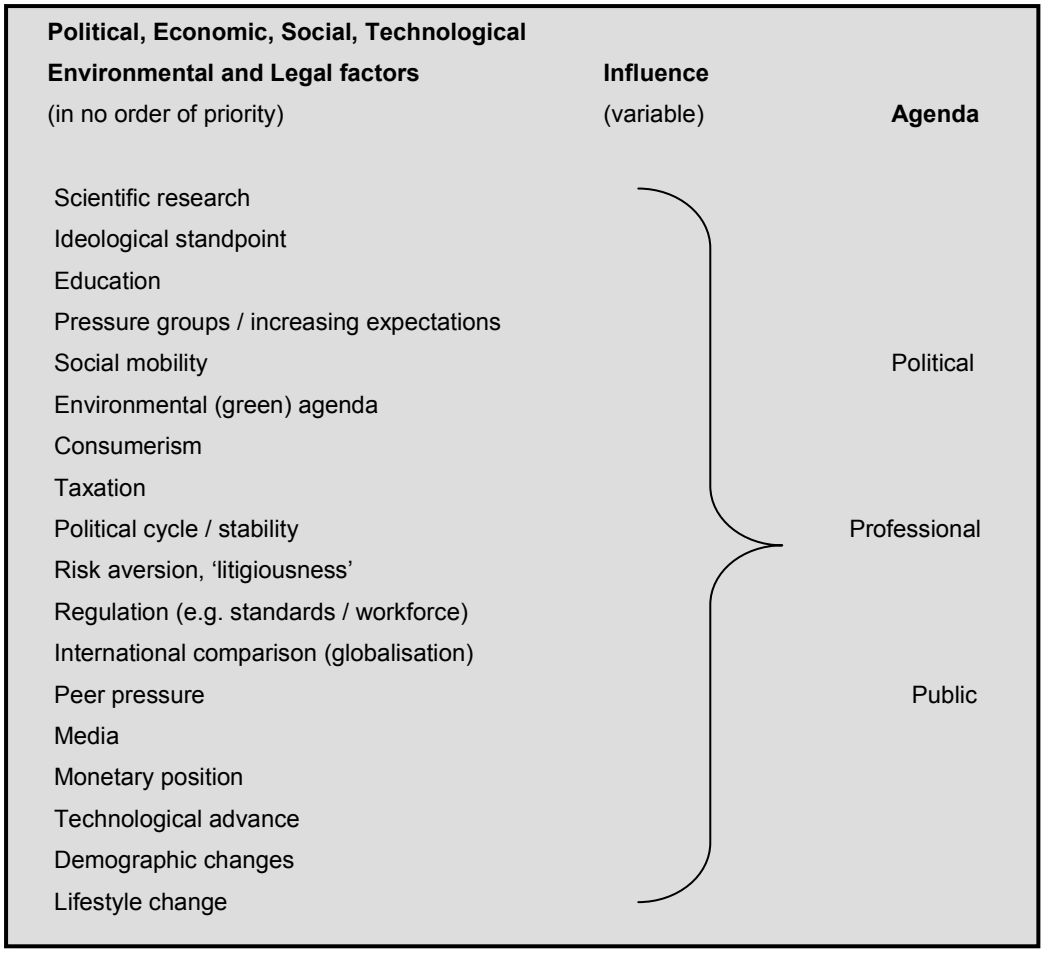
Adapted from Leech (2007, p 4)

This simple practice based model can be further developed, when the factors that influence each area of the '3P' model are considered carefully. There are a considerable number of inter-relationships between these factors and the primary '3P' areas themselves and it could be argued that all of the influencing factors will affect the position of Political, Professional and Public perspectives differently, re-enforcing the definition above, that the relationship between the 3 constituent P areas is dynamic and therefore, their relative priority and influence will continually change. The researcher's argument in support of this basic concept is supported by Pascale and Athos (1981) who - when discussing the comparative success of Japanese

companies - say that, ‘To build a great corporation anywhere takes a long time and involves complex goals, that meet the needs of many human groups, while honouring the values of its culture’ (p 29).

The researcher, when collating the factors that are likely to have a significant or growing influence on Political, Professional and Public perception and opinion with regard to healthcare has used a slightly modified version of the ‘PEST’ analysis cited by Johnson and Scholes (1999), in that Political, Environmental, Social, Technological, Economic and Legal drivers all have a bearing on healthcare provision and how it evolves and therefore, will have a bearing on models attempting to define or describe contemporary NHS Leadership. Influencing factors derived from this process all have a variable degree of influence over the ‘3P’ model and therefore, variable influence on how NHS Leaders interact with and balance complex Political, Professional and Public agendas. Influencing factors are illustrated in Figure 56 below.

Figure 56. Factors that have a significant or growing influence on the ‘3P model’.

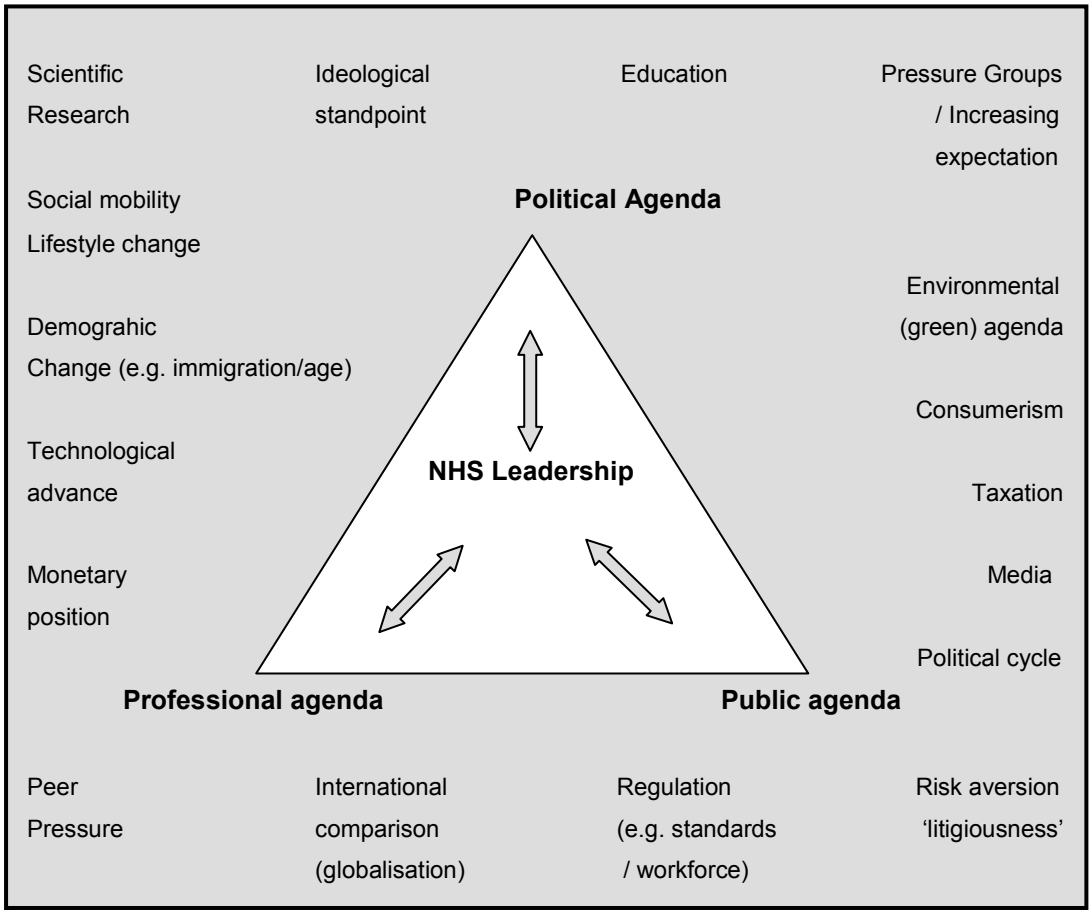


Source: Author (2007)

To illustrate this conceptual enhancement of the basic '3P' model referenced in Figure 55, the influencing factors in Figure 56 can be shown integrated around the triangular model, expanding and bringing together the conceptual components into a single, better defined model – see Figure 57. It is this model that the researcher proposes as a clear, practice based, illustration of the complex environment in which all NHS Leaders are currently working and therefore, it will form a clear reference point and framework at the conclusion of this thesis. In using this model, the researcher is confident and clear that the findings of the research are contrasted to leadership in practice and therefore, that the conclusions will have relevance and meaning to not only the academic community, but importantly, leaders in practice.

Considering this '3P' model, along with the consequences of increasing 'marketisation' for the leaders of NHS Organisations, it leads the researcher to ask whether the NHS Leadership Qualities Framework requires further refinement, in order that it points to the type of leadership qualities truly needed by those already in, or thinking of joining the NHS as leaders.

Figure 57. An enhanced 3P's model, illustrating NHS Leadership task and the operating environment.



Adapted from Leech D (2007b)

Literature review - summary

The researcher believes that an in-depth review of literature in the relevant subject areas has been undertaken in this chapter of the thesis. At the outset of this section (see page 8) it was intended that the following areas would be critically explored;

1. Market theory, with a particular focus on former public services
2. The NHS, its' history and the cultural context for the research
3. Leadership, both in terms of grounded theory and the current models that are specifically relevant to those in contemporary practice within the NHS

The researcher found this phase of the research process an absorbing an interesting one and in terms of reflections on both personal development and the research process overall, it;

a) significantly increased the researcher's breadth and depth of knowledge relating to the relevant theoretical and historical literature

b) informed the research process overall, enabling informed reflection and consideration during the analysis, discussion and concluding phases of the research process

c) provided a useful theoretical base for future reference, research and possibly, further publication

METHODOLOGY

Methodology – an overview

This chapter of the thesis is related to the research methods employed by the researcher and by its nature the chapter is a 'catch-all', covering several issues that need to be described clearly to the reader.

Contextually, the conceptual framework in which the research has been conducted is dealt with upfront. This covers a range of issues from the extreme positivistic and phenomenological research paradigms to the position of research and researcher in relation to ontological, epistemological, axiological, rhetorical and methodological assumptions.

This is followed by a comprehensive description of the research methodology employed. Here the researcher has described the overall rationale behind the research design and the target research population. A rationale is provided for the selection of the data collection methods employed, a description of research design considerations and the process undertaken to derive the research questions asked of the research participants. This section of the thesis ends with a section related to issues of replicatability, generalisability and reliability.

The important matter of research ethics is dealt with in turn and here, the researcher has set out clearly the ethical considerations made in relation to the research. This includes both a demonstration of the researchers understanding and awareness of theoretical considerations surrounding research ethics but also, a description of the formal processes undertaken to ensure that the research undertaken was compliant with academic and practice based requirements for conducting research.

This leads into a descriptive section of the thesis covering the research design, whereby the researcher has set out precisely, the processes and procedures undertaken as the research was undertaken.

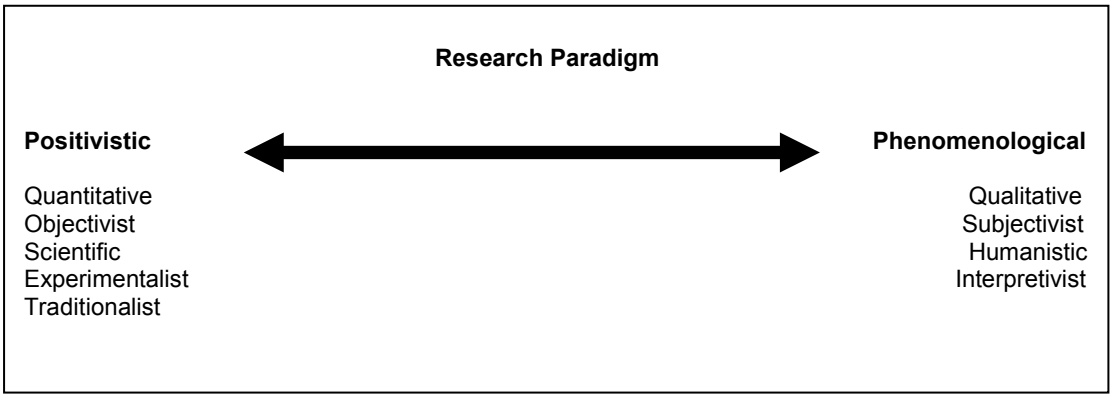
Finally, this chapter of the thesis ends with a section relating to data analysis. In this concluding section of the methodology chapter, the reader will find reference to how research data was kept secure, analysed and ultimately presented in the results chapter of the thesis.

The conceptual framework

The researcher's professional background was originally in pharmacy, a profession that often sees the world through traditional, experimentalist, scientific eyes. However, after more than a decade of involvement in the pharmacy profession, the researcher subsequently changed career path and took up a leadership role in what is often referred to as 'NHS general management' (DoH, 2012). The researchers' employment at the outset of this research was as a member of the trust board at a medium-sized NHS general hospital and the portfolio of responsibility consisted of operational, business development and strategic components. Whilst work of this nature does rely on hard numbers, it also requires a degree of interpretive and qualitative consideration too. In terms of a 'world view' therefore, whilst open to critical challenge, the researcher believes that he holds a reasonably well balanced outlook.

When considering the research paradigm in which this research project resides and therefore, the paradigm in which the researcher has operated the first points of attention for the reader are the two philosophical extremes – the 'positivistic paradigm' and the 'phenomenological paradigm'. These, along with other terms used to describe them, are illustrated in Figure 58 below;

Figure 58. Positivistic and phenomenological research paradigms



Adapted from Hussey & Hussey (1997)

The two main paradigms shown in Figure 58 are underscored by a further set of conceptual assumptions. To illustrate these, the researcher draws upon the work of Creswell (1994) in which he neatly brings research in the field together to illustrate the Ontological, Epistemological, Axiological, Rhetorical and Methodological assumptions behind both the positivistic and phenomenological paradigms. This is shown clearly, in Figure 59.

Figure 59. Assumptions behind the positivistic and phenomenological paradigms

Assumption	Question to define or illustrate assumption	Positivistic (Quantitative)	Phenomenological (Qualitative)
Ontological	What is the nature of reality?	Reality is objective and singular, apart from the researcher	Reality is subjective and multiple as seen by the participants in the study
Epistemological	What is the relationship of the researcher to that researched?	Researcher is independent from that being researched	Researcher interacts with that being researched
Axiological	What is the role of values?	Value-free and unbiased	Value-laden and biased
Rhetorical	What is the language of research?	Formal language. Based on set definitions. Impersonal voice. Use of accepted quantitative words.	Informal language. Evolving definitions. Personal voice. Use of accepted qualitative words.
Methodological	What is the process of research?	Deductive process. Cause and effect. Static design - categories isolated before study. Context free. Generalisations leading to prediction, explanation and understanding. Accuracy through validity and reliability.	Inductive process. Mutual simultaneous shaping of factors. Emerging design – categories identified during research process. Context bound. Patterns, theories developed for understanding. Accuracy and reliability through verification.

Adapted from Creswell (1994)

The researcher, from an ontological perspective, views the world as a predominantly social construct, through which better understanding can be gained through an examination of the views and perceptions of those within it.

This fits reasonably well with the researcher's belief that the research undertaken here has been primarily inductive in nature. That is to say that the conclusions have been developed from observation and empirical reality, with specific inferences and theory developed as consequence of testing and moving them from a specific area to a general one.

Epistemologically, the researcher recognises that a positivistic outlook that is largely reliant on what is measurable from a distance and is dismissive of that which is not, often carries more weight and credibility in scientific fields of research. However, many social science researchers get close to their research population in order to

explore and interpret widely held beliefs, which they often present as fact. It is this long-held polarity between the conceptual extremes that fascinates the researcher and, in his view, vindicates the use of triangulation in research where-ever possible. In doing this, the researcher is less-likely to be challenged on the accuracy, reliability or validity of their research outcome, as the traditional weaknesses cited by each philosophical camp about the other, are in-part negated through the employment of research techniques that are conceptually acceptable to each.

In this study, there is an axiological factor too. The researcher is known to the majority of the first phase, single site case-study research population. The level of familiarity is generally not that deep and results from direct contact in a work-based setting between 2003 and 2007. Therefore, it is acknowledged that the researcher is perhaps more likely than a neutral to have transmitted some sense of his own beliefs and values to research participants. It has been discussed widely in academic texts how research might be influenced by the researcher's own beliefs and also, that participants may have a perception of the researchers' beliefs and respond accordingly. These are indeed considerations in 'practitioner research' according to Robson (2002). That said, it is also acknowledged in the work of Tedlock (2000), that research may be enhanced through information or insight gained through inside knowledge that is not available to the outsider and that, despite any 'power relationship' issues, research participants may feel more comfortable in responding to questions posed by someone they know. The researcher believes this to be the case and evidence to support such an argument is seen the introduction to the thesis, where the researcher describes how observations in practice led to the fundamental research questions that this thesis is based upon. The phenomenological approach in the initial phase of the research is complimented by a more positivistic questionnaire method in the second phase. This latter phase also targets a geographically wider, non-familiar, multi-site research population. This triangulation of the first case-study phase with the second wider population, unknown to the researcher should negate any significant philosophical or axiological challenge from either the devout positivist or phenomenological research camps.

The researcher has written using a personal voice throughout the generation and publication of this thesis and this rhetorical approach has been carefully considered. Creswell (1994) refers to the personal voice as a commonly used rhetorical writing method in qualitative studies, whilst an impersonal, descriptive technique is cited as the favoured style of quantitative researchers. The observation of Creswell may be

true, but the researcher has read both styles of thesis and from a readers' perspective, would argue that the personal voice is often more palatable when reading long, heavy documents of this nature. These considerations were shared by the researcher at an early stage with supervisory team and this style of writing was agreed as being;

a) a comfortable style for the researcher
b) clear to the reader
c) reasonably suited to the conceptual approach outlined thus far

Reference to some of the conceptual assumptions that support the methodological approach employed during this research have already been made – for example the use and reference to the 3P model (Figure 57 on page 86). This is perhaps unsurprising, as *methodology* refers to the overall approach to the research process. There are however, a number of other conceptual factors that have led the researcher to adopt the conceptual and methodological approach described. These are that previous research specific to leaders in NHS hospitals, as described in the literature review, appears to be scant in volume, with publications reliant largely on individual opinion with little use of replication or positivist methodologies to triangulate often interesting initial concepts and thought processes. Also, the approach is partly determined by the practice-based nature of the research and the work-place route through which the research questions were originally derived.

The respective phenomenological and positivistic conceptual standpoints have been discussed, each having a set of strengths and weaknesses associated with their use as a philosophical anchor, from which researchers conduct their business. In the researchers view here, these respective strengths and weaknesses appear to mirror each other when contrasted. This is illustrated in Figure 60

Conceptually, the researcher wishes to combine the "high reliability, low validity" research outcomes associated with the more positivistic paradigm, with the "High validity, low reliability" outcomes of phenomenological research methodologies, in order to gain maximum validity and reliability.

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Figure 60. Strengths and weaknesses of phenomenological and positivistic conceptual standpoints

Conceptual approach	Strengths	Weaknesses
Phenomenological (Qualitative)	- aims to gain wider understanding of all perspectives, from 'real' first-hand data - can adapt to the changing nature of the 'real' research environment - holds a holistic view of the research topic - develops mechanisms to identify and measure relevant phenomena - can be used to interpret and explain quantitative data	- can only be used within the 'live' context of the research environment, difficult to repeat or generalise - research methods can be time-consuming
Positivistic (Quantitative)	- strives to control bias, so that facts can be gathered and understood in an objective manner - research mechanisms identify and isolate individual variables within the research environment - can be used to interpret and explain qualitative investigations - can be generalised and is seen as reliable	- data collection usually has to occur under controlled conditions - seen only as an accumulation of facts and causes - ability to truly replicate findings can be an area of concern

Adapted from Hussey & Hussey (1997) and Silverman D (1994)

As stated, the researcher has previously worked at the case-study site in question and during this time, he observed a change in behaviour and language among many of the leaders of that particular NHS hospital. This appeared to be in response to contemporary health policy changes. Confirmation of this change, merely observed in practice at the outset, provided the original research rationale for the local case study, which is very much of phenomenological type.

The second phase of the research employs a multi-site on-line research questionnaire which could be described as more positivistic in nature. Conceptually, this serves to feed the scientific background and quantitative hunger of the researcher, who has acknowledged previously his professional background. Moreover, and importantly, it serves to mitigate some of the weaknesses inherent in a 'single research technique' study, focussed on a narrow and small sample.

The mixed approach employed is not viewed by the researcher as a weakness but a strength, as it provided the scope for triangulation of the two research methodologies and the research data, derived from the conceptual paradigms at each end of the

spectrum shown in Figure 58. Of course, reflection upon and consolidation of the conceptual framework in which the research has been conducted also occurred and is reflected in Figure 76.

To summarise, the respective components of the research, their location, the research method employed and the principle conceptual paradigm against which they 'best fit' are described as below;

Phase I.....single-site case-study…….telephone interviews.…….Phenomenological

Phase II……..remote, multi-site……..…..on-line survey……...Positivistic

Rationale and research methodology

The conceptual standpoint developed and described in the previous section of this chapter informs the application and use of both qualitative and to some extent, quantitative research techniques. This section describes, for both the single-site case-study telephone interviews and the following multi-site on-line research questionnaire phases of the research process, the;

- Research population
- Rationale for selection of data collection method and design considerations
- Process for derivation of research questions (to the research population)

Prior to consideration of these methodological factors however, the researcher believes that an explanation for the use of mixed research methods is necessary and this is detailed below.

Mixed research methodology

The conceptual rationale underpinning the researcher's important decision to use a mixed methodology, when contrasted to grounded research theory, can be validated and supported by the literature as being an academically sound. For example, the researchers' decision was partly informed by Denzins' (1970) work, where he argues that the use of different methods when studying the same phenomenon, should lead to 'greater validity and reliability than a single methodological approach' (p 297).

To be clear, the researcher would align the nature of this research as having a good degree of fit with the category of 'methodological triangulation', as described in the management research text of Easterby-Smith *et al* (1991) and shown in Figure 61.

Figure 61. Research triangulation – a typology

Research triangulation – a typology	
Data triangulation	*Where data is collected at different times or from different sources in the study of a phenomenon*
Investigator triangulation	*Where different researchers independently collect data on the same phenomenon and compare results*
Methodological triangulation	*Where both quantitative and qualitative methods of data collection are used*
Theoretical triangulation	*Where a theory is taken from one discipline and used to explain a phenomenon in another discipline*

Adapted from Easterby-Smith *et al* (1991)

Another term that may be applied to the research methodology employed within this thesis is that of 'Analytic generalisation'. This is a term used by Yin (1984) when discussing whether the outcome of research can be generalised. He argues that, 'Generalisation is not automatic. A Theory must be tested through replications of the findings through a second or even third neighbourhood, where the theory has specified that the same results should occur' (p 44).

As the researcher in this instance is seeking to determine whether the impact of competition is affecting all leaders of NHS hospitals in the same or similar ways to those at the case-study site, there is some aspect of analytic generalisation to the research. However, as each hospital is different and will have its own set of subtle influences on leadership in practice, the researcher is also mindful of the advice of Kidder (1981) who states that, 'When you are uncertain whether external conditions will produce different case study results, you may want to articulate these relevant conditions more explicitly at the outset of your study and identify a larger number of cases to be included' (p 58).

Within the text of this thesis, the researcher demonstrates an awareness of local variation in NHS hospital leadership through experience in practice. This, along with the theoretical evidence provided by researchers such as Easterby-Smith (1991), Yin (1984) and Kidder (1981) further evidences the mixed methodology employed.

The initial phase of the research will involve a site-specific case-study approach. This is congruent with the views and methodology advocated by Yin (1989) who cites, 'organisational and management studies' as an area in which, 'As a research strategy, the case study approach is used in many settings' (p 13). However, the researcher is aware of a weakness in the case-study approach as a stand-alone research technique, in that more general application of the results – away from the specific area under scrutiny – are often limited. This weakness is also identified in the work of Hussey & Hussey (1997) who, whilst they acknowledge the richness of research information that can be gleaned, state that the use of case-studies is often described as only 'exploratory research' (p 66).

In order to enhance the research output from the initial site-specific case-study, a quantitative questionnaire was used across a wider relevant research population. Clearly, this methodological triangulation has had a practical impact on the research process overall – in terms of planning, execution and analysis. The researcher

contends that whilst it has certainly taken longer to conduct a mixed methodological study than a single method study, the research outcomes are supported by a greater depth of evidence as a consequence. In general terms, the contention of greater quality through methodological triangulation can be found in a number of texts within the established research literature. Specific to management and leadership research it is Hussey & Hussey (1997) who initially state that whilst, 'triangulation cannot be used to rectify a poor research design', they go on to cite evidence that triangulation 'has vital strengths, encourages productive research, enhances qualitative methods and allows complementary use of quantitative methods' (p 75). In this instance the researcher has developed an overall research strategy based upon methodological triangulation outset, derived from careful consideration of the underpinning conceptual framework.

The target research population

It is from here in the thesis, that the researcher will describe the research population targeted at each stage of the research and the supporting rationale for their selection.

The research participants in this research project are all people employed and working within the NHS and their positions within their respective organisations and areas of responsibility, by definition, all have an element of leadership associated with them.

Whilst no longer employed by Hinchingbrooke Health Care NHS Trust, the researcher was known to many of the target research participants at the hospital. This carries with it, a series of pro's and con's relating to the integrity of the research. The researcher is very candid about this and has listed the possible considerations in Figure 62 as part of a wider set of considerations.

On balance, taking all of the conceptual research considerations into account, alongside all of the circumstances and factors that mitigate why those considerations might affect the research population and the responses likely, the researcher believes that the research stands on its merit, as due consideration has been given and every effort made to address the considerations prior to the practical research processes taking place.

Figure 62. Considerations relating to target research population.

Considerations relating to the target research population at the Hinchingbrooke Health Care NHS Trust case-study site	
Consideration	**Mitigating factors**
At the time of the research process, the organisation had been through a very challenging financial period, culminating in a strategic review on its future and therefore, perhaps the site is not representative of the "average" hospital (and by default, the research participants are not deemed as "truly representative" of leaders in today's NHS hospitals)	Given the level of organisational change afoot in the acute hospital sector of the NHS generally, Whilst the situation was certainly challenging in scale, it couldn't be argued that the situation at the target organisation was 'unique' and therefore, that the leaders within the hospital were hugely different to those elsewhere.
The researcher knows many of the research participants and has previously occupied a number of senior positions within and related to the organisation. It could be argued that participants would be less candid than with a "neutral" researcher, perhaps declining to participate.	The research participants were, in general, senior and experienced professionals, familiar with expressing opinions or views that are open to challenge from colleagues – be they senior or junior to them in organisational status. The level of familiarity could also be an asset, in that participants may have felt more comfortable with a familiar researcher and have been less open with a 'stranger'.

Source: Author (2008)

In relation to the target research population itself, it is best described as the operational and strategic management group within the organisation that – at the time - informed decisions made by the full trust board. Structurally, the group is described within the organisation as the 'Trust Management Executive (TME)" and is seen as the forum through which managers and leaders from a number of sub-groups within the organisation come together and generate a 'collective sense' of direction and leadership which is subsequently conveyed to the organisation.

These sub-groups are as follows, a) Executive Directors who are also members of the trust board. b) Medical Managers who are some of the most senior clinicians within the hospital and – in addition to their clinical work – have dedicated management and leadership responsibilities for their particular area of the organisation, as well as a generic corporate responsibility as part of TME. Lastly, c) there are the general / middle managers who head up particular areas of the organisation and – often with a medical manager linked – they are seen as the day-to-day operational managers, akin to the role of the general manager in many commercial organisations.

This sub-structure to the research population at the Hinchingbrooke Health Care NHS Trust case-study site is illustrated more clearly for the reader, along with the respective job-titles in Figure 63.

Figure 63. Target research population(s) for case-study phase of research.

Target research population(s) for case-study phase of research;

The Trust Management Executive (TME) at Hinchingbrooke Health Care NHS Trust is constituted from three distinct sub-groups, as illustrated below:

Executive Directors (Board Member	Chief Executive Officer Director of Nursing, Midwifery & Operations (Deputy CEO) Director of Finance & Facilities Director of Corporate Services (Human Resources, IT & Information) Medical Director (most senior Doctor)
Medical Managers	Associate Medical Director – Elective Services (clinical lead for Trauma & Orthopaedics) Associate Medical Director – Emergency Services (clinical lead for Medicine) Associate Medical Director – Clinical Support Services (clinical lead for Pathology) Clinical Lead – Peri-Operative & Critical Care Clinical Lead – Obstetrics & Gynaecology Clinical Lead – General Surgery Clinical Lead – Accident & Emergency Clinical Lead – Radiology
General / Middle Managers	Associate Director – Elective Services Associate Director – Emergency Services Associate Director – Clinical Support Services Associate Director – Capacity & Productivity Associate Director – Information Associate Director – Quality & Governance Associate Director – Commissioning

Source: Author (2009)

The data generated through the initial case-study research from Hinchingbrooke Health Care NHS Trust, whilst rich in content and representative of the situation in that organisation at the time of the research being conducted, will be site specific and therefore arguably unrepresentative of NHS hospital leadership *per se*. In order to generate a wider sense of the case-study specific results and test whether they are generalisable across NHS hospitals, the researcher targeted individuals at a wide ranging series of NHS hospitals, with an on-line research questionnaire.

Access to research participants at these hospitals was organised with the permission and support of the Chief Executive Officer at the case-study hospital and the Managing Director of NHS Elect, the network through which access to sites and research targets would be enabled. Correspondence confirming such is shown in Appendices VI and VII.

This support has enabled the researcher to access research participants and also some of the practical steps relating to the research procedure itself, such as the issue of electronic questionnaires (see page 117).

By way of background, NHS Elect was originally founded in 2003 by Lord Darzi and four hospital Chief Executive Officers. Its founding purpose was to encourage best practice across its network of organisations by encouraging and helping its member managers to improve efficiency and effectiveness of NHS services – particularly planned surgical care. NHS Elect's original scope has expanded considerably and not only includes the exploration and application of new models of care for hospitals, but supporting the Department of Health's 18 week wait programme, implementation of the patient choice agenda, helping managers and organisations with marketing and promotional work, supporting partnership with independent (private) sector organisations and more recently, NHS commissioning too. NHS Elect is a relatively small organisation, employing only a dozen or so people. It receives funding from the Department of Health and through fees charged to its affiliated organisations.

In line with the research population described in the first phase case-study at Hinchingbrooke Health Care NHS Trust, the researcher targeted the 3 leadership sub-groups:

- Executive Directors,
- Medical Managers
- General Managers

The researcher replicated the job titles of those at the hospital in Cambridgeshire as they are broadly common across hospitals in England. In doing this, a reasonable level of confidence can be achieved that individuals in comparable positions at other hospitals would respond, enabling comparison and trend analysis across all of the hospitals and the first-phase case study.

The twenty specific organisations targeted for the second phase of the research process, via NHS Elect, were as set out in Figure 64.

Figure 64. Target organisations for the second phase of the research.

Target organisations for the second phase of the research:	
Dartford & Gravesham NHS Trust	Kingston Hospital NHS Trust
Derby Hospitals NHS Foundation Trust	The Lewisham Hospital NHS Trust
East Kent Hospitals University NHS Foundation Trust	North West London Hospitals NHS Trust
Epsom & StHelier University Hospitals NHS Trust	South London Healthcare NHS Trust
George Eliot Hospital NHS Trust	West Middlesex University Hospital NHS Trust
Great Western Hospitals NHS Foundation Trust	Weston Area Health NHS Trust
Heart of England NHS Foundation Trust	West Suffolk Hospital NHS Trust
The Hillingdon Hospital NHS Trust	The Whittington Hospital NHS Trust
Homerton University Hospital NHS Foundation Trust	Winchester & Eastleigh Healthcare NHS Trust
Imperial College Healthcare NHS Trust	York Hospitals NHS Foundation Trust

Source: Author (2009)

Data collection methods and design considerations

The researcher opted to use one-to-one telephone research interviews for the first phase case-study of leaders at Hinchingbrooke Health Care NHS Trust.

For the second phase of the research, targeting a higher volume of individuals across a wide range of hospital sites in England, the researcher employed an on-line research questionnaire method.

Clearly, decisions relating to which method of data collection to use for any research project are defining moments in the research process itself and in this instance, the researcher gave thought to this throughout the research process (Leech, 2008; Leech, 2012a)

To illustrate the researcher's level of understanding and explain the decision making process and underpinning rationale for these decisions within this research, the researcher has set out in Figure 65 a summary of the main data collection methods cited in academic research literature.

Figure 65. A summary of the main data collection methods cited in academic research literature.

Author	Gill J & Johnson P (1997)	Yin R K (1989)	Bryman A (2001)	Hussey J & Hussey R (1997)
	Sage (p 157)	*Sage* (p 85)	*Oxford* (contents)*	*Palgrave* (p 151)
Methods described / listed to collect data	Questionnaire	Documentation	Sampling	Critical Incident Technique
	Interview	Archival Records	Structured Interviewing	Diaries
	Critical Incident Analysis	Interviews	Self-completion questionnaires	Focus Groups
	Diary	Direct Observation	Asking questions	Interviews
	Activity Sampling	Participant Observation	Structured Observation	Observation
	Unstructured Observation	Physical Artifacts	Content Analysis	Protocol Analysis
	Structured Observation		Secondary Analysis and Official Statistics	Questionnaire
	Secondary Sources			

* Bryman does not offer a summary table or list of research methods, but in his text (and therefore the contents page) he discusses a variety of research methods.

Adapted from Gill & Johnson (1997), Yin (1989), Bryman (2001) and Hussey & Hussey (1997)

This information was used to inform further work, in which the researcher goes on to explore the theoretical and practical advantages and disadvantages associated with each data collection method, along with the issues relevant to this research project.

The researcher has compiled a list of the 11 primary data collection methods from Figure 65. Some are practical variations on a theme, but in order to gain and evidence a thorough understanding of each, all data collection methods were properly considered for their use and application within the scope of this research.

1. Questionnaire – Paper (postal)
2. Questionnaire - On-line
3. Questionnaire – Telephone
4. Interview - Face to face
5. Interview – Telephone
6. Interview - Teleconference
7. Analysis of archival records
8. Critical Incident Analysis
9. Use of a diary / blog
10. Observation of research population
11. Use of focus groups

Some data collection methods were obviously more serious contenders for use within the scope of this research than others, but for each a full description of the relevant considerations and issues begins below, with the variations on the use of questionnaires in Figure 66.

Figure 66. An illustration of the issues in applying research questionnaire techniques in this research

Questionnaire	1. Paper (postal)	Allows response at own convenience and can spend more time considering response. Relatively low cost. Good control over target sample.	No scope for explanation of complex issues or questions. No opportunity to probe for more detail on open questions. Respondents can skip questions and if random sample, low response.	This traditional method does not allow, easily, any real clarification opportunity for the research target. It is deemed as very formal and practically time consuming to collate. In a 'paper free' business era, some respondents may have 'paper aversion' and be less likely to respond.
	2. On-line	Can monitor access via 'read receipts', can follow-up with electronic reminder. Can enables quick analysis and very wide sample target. Allows for response at own convenience. Low cost, given the right technology and can allow for respondents to clarify questions.	Low response rates if email associated with junk or spam. Assumes research target has technology and skills to respond.	Low response rates are unlikely, as NHS IT systems filter and block almost all junk email. Assurance of data security and genuine response is also more likely, given this factor. Would allow monitoring of responses and follow-up to increase response rate. Likely to suit both the researcher and research targets, as IT literacy high in target group. Whilst not a primary consideration, will not involve significant financial cost.
	3. By telephone	Fast and if computer aided can offer quick results. Cost efficient (if call rates are at minimal cost). Good control over sample target.	Unable to show visual aides. Probing can be more challenging as respondents can feel rushed on the telephone. Not sight of body language or reaction. If unplanned, can interrupt business or domestic time so respondent unfocussed resulting in poor quality response.	Practically, not likely to suit the researcher or research targets, resulting in delays to research and possibly limited or even non-response. Time during the working day, the size of the research population being the major constraints with this technique.

Source: Author (2009)

Clearly, whilst one of the most popular techniques for gathering research data, there are other widely tried and tested techniques. Interviews with research targets are one such method, see Figure 67.

Figure 67. An illustration of the issues in applying research interview techniques in this research

Interview	Face to Face	Visual aides can be used. Long or complex issues or questions can be explained clearly. Avoids group dynamic if interviewer not perceived as domineering or 'senior'.	Can take a lot of time. Open to interviewer leading answers / bias.	Practically, this technique is unlikely to suit the researcher or research targets, due to logistical issues and geographical distances involved. This could result in delays to research and possibly, limited or even non-response.
	Telephone	Fast and if computer aided can offer quick results. Cost efficient (if call rates are at minimal cost). Good control over sample target.	Unable to show visual aides. Probing can be more challenging as respondents can feel rushed on the telephone. Not sight of body language or reaction. If unplanned, can interrupt business or domestic time so respondent unfocussed resulting in poor quality response.	Whilst time commitment may be an issue with this method, it is more practical to organise. The depth and volume of information elicited from interviewees is likely to be quite high – particularly during the initial, local stage of research.

Source: Author (2009)

A further long-standing technique for data collection particularly favoured by the traditional academic research community is the analysis of archival records. This technique is often favoured because it in relation to business research, it often reflects the organisation's or research subject's own record of events. This method is potentially data rich and of course, can be accessed on numerous occasions. However, access to archived information may be an issue – both in terms of time to gain access, time limits on access and also the limitation of access only to public documents, not those deemed as 'private' or of 'commercial confidence'. In addition, lengthy time to collate and analyse large volumes of paper records could prove challenging to researchers and obviously, any trends or inferences generated would require further testing for future application and generalisability.

Critical incident techniques involve simple, open questions relating to specific incidents, rather than incremental changes such as those defined by the research questions here. Whilst this technique can generate a lot of data in situations that lack focus or where research participants find it difficult to express their opinions, these potential advantages are outweighed in this instance by the incremental nature of the change at the heart of the research.

Diary or Blog based research has a number of potential benefits such as the ability to cover large numbers of people of a wide geographical range and to analyse their perceptions and experiences over a period of time. However, the researcher was concerned about the commitment needed by busy people and therefore, the

likelihood of poor participation rates and as a consequence, the prospect of unreliable or low rates of data recording at the end of the diary or blog exercise.

Given the researcher's full-time employment, the use of direct observation of all research participants as a data collection method was not practical or realistic. The use of focus groups was also excluded for practical reasons, as getting the research participants to commit to gathering for the purposes of the research together was practically unrealistic.

Replication, 'the repetition of a research method to test the reliability of the results' (Raimond, 1993) has been built into both the case-study and research questionnaire phases of the research design. Each of the participants at the case-study site were asked the same set of questions and during multi-site second phase of the research, all participants across all 20 target sites were asked the same questions using the same question format, albeit on-line.

By employing prescribed research methods for data collection in both the first and second phases of the research (case-study telephone interviews and multi-site on-line questionnaire), the researcher has enabled the possibility of further replication of this research at a later stage.

In terms of generalisability, 'the extent to which you can come to conclusions about one thing (often a population) based upon information about another (often a sample)' (Vogt, 1993), the author specifically developed the second phase of the research to enable a higher degree of confidence when arguing that the findings derived from the initial case study could be applied more generally across NHS organisations.

Derivation of research questions (to the research population)

This section of the methodology chapter relates to the questions asked of research participants during both phases of the research process.

The research questions are primarily informed by a number of sources. These obviously include the themes from the primary research questions posed at the beginning of this thesis – as set out below;

- Has competition increased between NHS hospitals?
- In terms of culture, have the leaders in NHS hospitals changed their behaviour or language as a consequence?
- What is the impact of competition upon the skill-set needed to be a successful leader in an NHS hospital?

In addition, the nature and context of the questions were also influenced by;

a) the literature review

b) the researcher's work in practice

c) the researcher's links to academic and research orientated networks (such as the Global Leaders Network, sponsored by the European Health Management Association and the Kings Fund).

The researcher has compiled a table, illustrating clearly the underlying rationale (in summary) for the research questions in the case study interviews. This is shown in Figure 68, over 2 pages.

In addition, the variations and changes made to the questions for the on-line questionnaire are also indicated, in order that a complete picture of the research is provided.

This summary is expanded and discussed further later in the thesis, such that the research questions and rationale are refreshed as a pretext to the results, analysis and conclusions within the thesis.

Figure 68. The development and rationale for the research questions

Question	Rationale	Links themes of competition and market forces, leadership and cultural context
	Section 1	
1*	Enables examination of data against all later questions for variation in responses between male and female participants	Links to research theory chapter and also, the organisational culture section of the literature review
2	Enables examination of data against all later questions for variation in responses between the different age groups within the Trust Management Executive	
3	Enables examination of data against all later questions for variation in responses between the 3 sub-categories within the Trust Management Executive	
4	Enables examination of data against all later questions for variation in responses between the lengths of service at Hinchingbrooke Hospital	
5	Enables examination of data against all later questions for variation in responses between the lengths of service in the NHS	
6	Enables examination of data against all later questions for variation in responses between those who have worked only for the NHS and those who have worked in other sectors	
7	Enables examination of data against all later questions for variation in responses between those who have worked in each of the employment sectors listed.	
	Section 2	
8	Introductory question to test participant perception of the relationship between hospitals in the NHS. Provides them a 'non-prompted' opportunity about collaboration, to mention competition.	Cultural context and competition - tests affiliation with the ethos and founding principles of Bevan's NHS
9	A straight yes or no question to determine whether it is acknowledged that competition exists.	Practice based evidence (contrasted to policy) - tests the 'reality' of leadership 'on the ground' in today's NHS v the intent of policy set to enhance levels of competition through market forces, as set out in Lit Rev.
10	If competition indicated in response to Q9, confirms explicitly their thinking on this matter and the evidence base for it. If competition not mentioned or indicated in response to Q9, provides a direct question to test participant's opinion.	Personal principles – culture and competition - particularly that relating to contemporary policy development (the last 10 years) and the "latest thinking" with regard to competition and collaboration.
11	Extracts evidence and opinion from leaders in practice as to the likely impact of current policy on patient care in NHS hospitals. Backs up basic question with a request for rationale / evidence to substantiate.	Personal principles – culture, tests leaders beliefs, which in turn inform organisational culture. Also tests validity of state provision v free market pros / cons in a contemporary NHS context. Links to styles of leadership also.
12	Extracts evidence and opinion from leaders in practice as to the likely impact of current policy upon financial efficiency within the NHS. Backs up basic question with a request for rationale / evidence to substantiate (Links to theoretical difference between state model and market).	Personal principles - tests leaders beliefs, which in turn inform organisational culture. Also tests validity of state provision v free market pros / cons in a contemporary NHS context. Links to styles of leadership also.
13	Tests the 'comfort level' of NHS leaders in practice with regard to the prospect of working in an increasingly competitive environment (links to organisational culture and the published view that public sector = zero desire for change)	Practice based evidence (contrasted to policy) – tests leadership and cultural 'buy-in' to national policy. Observes reaction of impact upon the prevailing culture, resultant from a historical context described in Lit Rev.

	Section 3	
14	Seeks the opinion of current NHS leaders in practice, as to what the purpose of leadership is. Will enable description of what constitutes a 'good leader'. Enables contrast with both the NHS 'LQF' and also the leadership models outlined in grounded theory.	Leadership - practitioner insight, contrasted with leadership theory – both grounded leadership theory and leadership literature specific to the NHS
15	Enables clear quantification of the response to the previous question (in case the question doesn't elicit a clear answer)	Leadership - practitioner insight – rationale for change. Gauge quality of current leadership in the NHS versus the aspiration set out in recent policy around leadership development
16	Tests whether there are perceived constraints on leadership in today's NHS hospitals and if so, what they are.	Practitioner insight – generates evidence to help understand the constraints (real or perceived) upon the leaders in today's NHS hospitals
17	Enables contrast to Question 11 (i.e. tests the notion that because/if competition within the NHS has increased that the nature of leadership in NHS organisations has changed too)	Competition and market forces, leadership and culture - practitioner insight (impact of policy link) – see Q 11
18	Tests the commitment of leaders to self-development and their views as to whether leadership can indeed be 'developed or learnt' (link back to primary schools of thought) and whether leadership development is an organisational priority.	Practitioner insight. Some link to theoretical schools of thought (leaders develop by practice or by applying theory)
19	Tests awareness of NHS leaders in practice of a) the NHS 'LQF' and b) more general models	Practitioner insight – will provide sense of orientation to any particular school of thought and the true extent of 'silo' thinking outlined in Lit Rev
20	Tests specifically the awareness of NHS leaders in practice of the 'LQF'	Leadership and leadership development - practitioner insight (impact of policy)
21	Builds, if positive response to Q21, an understanding of use.	Tests the "value" placed upon NHS specific leadership frameworks by leaders in practice.
22	Tests 3 Ps	Practitioner insight. Tests theory (3 Ps) and also gives some sense of where 'best' leadership development might be targeted in future.

* this is not technically a question, but an observation

Research ethics – process and considerations

The researcher has been conscious of the requirements relating to research ethics from the outset of the research journey described within this thesis. The University itself sets out clearly for researchers in both its annually published 'Research Student Handbook' (ARU, 2010a) and the Research Degree Regulations (ARU, 2010b) what is expected in terms of ethical standards. In addition, the University provides specific training for research students on the issues relating to research ethics (see Appendix I for research student training record).

In terms of the formal ethical approval procedures associated with this research, the researcher sought and gained ethical approval from three organisations. These were;

1. Anglia Ruskin University (ARU), Research Ethics Sub-Committee (RESC)

2. NHS, Research Ethics Committee (NHS REC - Cambridge 3)

3. Hinchingbrooke Health Care NHS Trust, Research Ethics Committee (HHCT REC)

A summary timeline illustrating the relevant correspondence (contained in Appendices II to V) relating to the process of application and confirmation of ethical approval from each organisation is shown in Figure 69 below;

Figure 69. Summary of correspondence relating to research ethics applications and approvals

Date	Correspondence
22 May 2008	Ethics approval application submitted to NHS REC – Cambridge 3
04 Jun 2008	Ethics approval application submitted to RESC
13 Jun 2008	Ethical review confirmed by NHS REC – Cambridge 3, further clarification sought
30 Jun 2008	Ethical approval application re-submitted to NHS REC – Cambridge 3
04 Aug 2008	Ethical approval confirmed in writing by NHS REC – Cambridge 3
20 Aug 2008	Ethical approval confirmed in writing by HHCT REC following review of NHS REC – Cambridge 3 approval

Source: Author (2009)

There were a variety of ethical considerations relevant to this research, all of which were covered to a greater or lesser extent by ethical approval processes described above. They were as follows;

- Physical safety and emotional wellbeing of research participants and the researcher
- The process of selecting research participants
- Consent
- Confidentiality
- Financial considerations
- Data storage and security

The physical and emotional wellbeing of both the research participants and the researcher during the research process is paramount. The researcher obtained a risk assessment from an NHS Occupational Health service confirming the low risk to physical health the research process presented. In addition, due consideration was given to the types of emotional and mental wellbeing issues that can arise during research, which might include contraventions of research participants dignity through embarrassment or intimidation (Coolican, 1992). Therefore, professional Occupational Health advice was also sought on what to do should participant become distressed during an interview (see Appendix XXIII). Along with confirmation of existing indemnity arrangements and a clear message to participants that they could stop their involvement in the research process at any point, the researcher is pleased to report that whilst this advice and information was sought during a period of diligent preparation for the research interviews and the questionnaire, it was ultimately not required as no such issues arose.

Interestingly, the NHS ethics process – perhaps used to more clinically orientated research projects – focussed more on the research participant selection process and the reasons for inclusion and exclusion. However, both the academic and health related ethics approval criteria had a strong emphasis on ensuring consent from participants prior to any research being conducted. Equally, there was similar focus on matters relating to confidentiality and ensuring anonymity for respondents both during the research and in subsequent publication or presentation of the results. Related to this, was a strong requirement to confirm data storage and security arrangements – both to the ethics committees and indeed to potential research

participants. Matters of wellbeing, selection, consent, confidentiality and data storage and security are all referred to in the 'participant information sheets', interview scripts, letters and introductory questions produced and provided to potential research participants in preparation for both phases of the research. Copies of these are evidenced in Appendices Appendix X, Appendix IX, Appendix XXI and Appendix XXII.

Lastly, in terms of financial considerations or conflicts of interest, the researcher confirmed in all applications to ethics committees that there was no financial relationship or payment between research participants or the researcher. As a consequence there can be no basis upon which any subsequent academic critique could reasonably suggest or suspect any financially derived bias in the research process, akin to the type described by Kervin (1992).

Research activation process

Following the preparation and planning described earlier in this chapter, there were two main active research phases undertaken. Firstly, a process of inviting 20 potential research participants at a specific NHS hospital site to undergo a case-study research interview by telephone and the organisation and delivery of those interviews. Secondly, a process of inviting 60 potential research participants to complete a multi-site on-line questionnaire was undertaken, along with the organisation and delivery of the process.

This section of the thesis documents and describes the specific processes undertaken during the active research period for each of the two research phases described above.

Case study site interviews – the research activation process

For the first phase of the research, a case-study involving 20 senior leaders within the target organisation a coding process for potential research participants was derived, as shown in Figure 70 below.

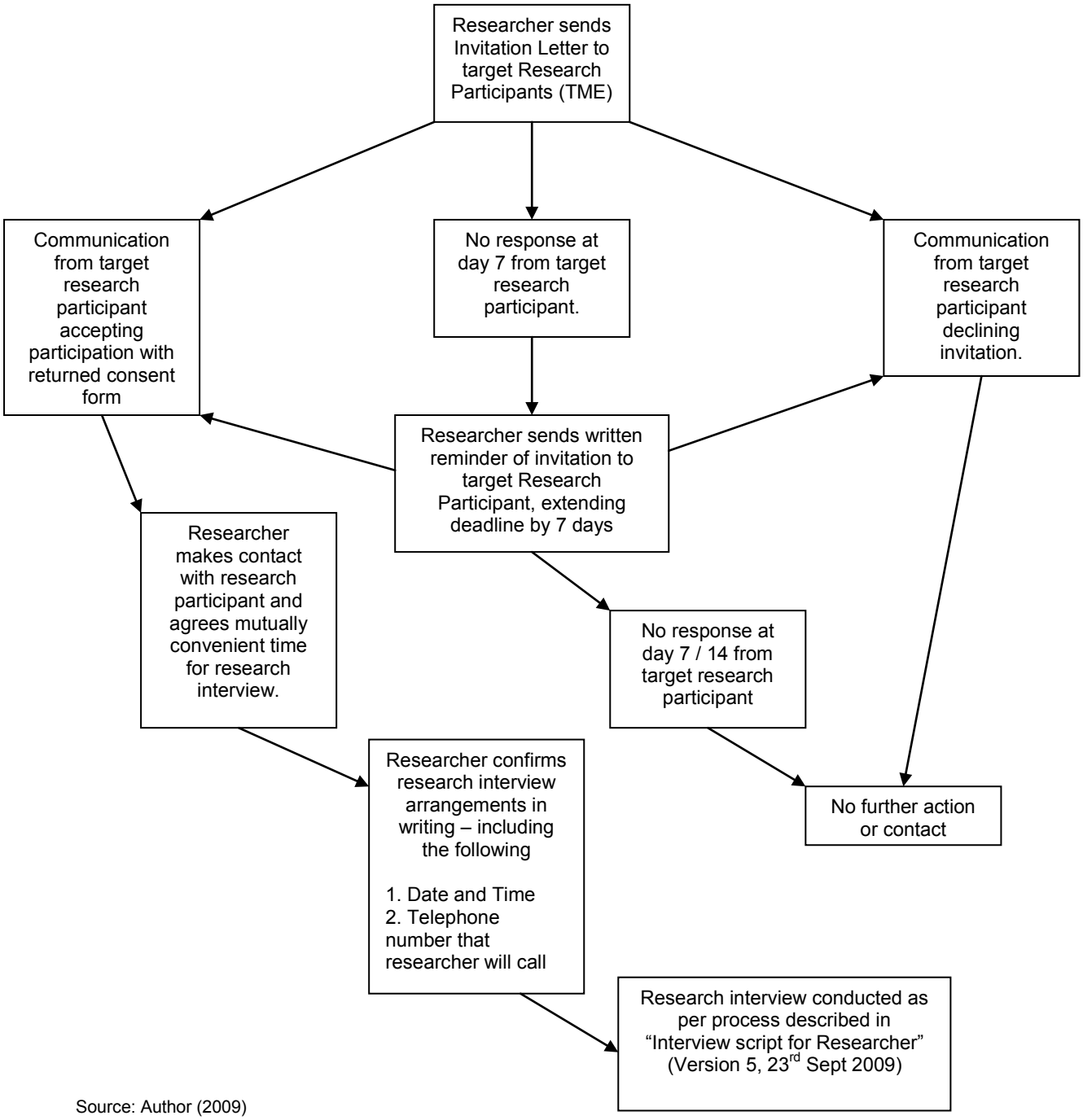
Figure 70. Coding process for target case-study interview participants

Code	Random allocation	Title
1E1	)	Executive Director of Human Resources & Organisational Change
2E2		Executive Director of Finance & Performance
3E3		Executive Director of Nursing, Midwifery & Operations
4E4		Chief Executive Officer
5E5		Executive Director of Strategy
6E6		Medical Director
7M1	)	Clinical Director – Radiology
8M2		Clinical Director – Trauma & Orthopaedics
9M3		Clinical Director – Peri-Operative & Critical Care
10M4		Clinical Director – Obstetrics & Gynaecology
11M5		Clinical Director – General Surgery
12M6		Associate Medical Director – Medicine
13G1	)	Associate Director – Emergency Services
14G2		Associate Director – Elective Services
15G3		Associate Director – Quality
16G4		Associate Director – Strategy
17G5		Associate Director – Capacity & Productivity
18G6		Associate Director – Medical Workforce
19G7		Associate Director – Nursing & Practice Development
20G8		Associate Director – Sustainable Hospital

Source: Author (2009)

There is clear demarcation between the executive, medical and general manager groups to and each potential research participant was given a unique randomised identifier code. This enabled both anonymisation of the results, but also aided analysis by staff group. The process map (Leech D, 2010a) shown below in Figure 71, shows quite clearly the process undertaken during phase I of the research.

Figure 71. Process map for case-study research interview process



Source: Author (2009)

Multi-site on-line research questionnaire – the activation process

During the second phase of the research, a similar process was followed, although there were differences in the research methodology employed and the potential research participants. During this phase, there were 60 potential research participants at 20 different NHS hospital sites in England. Once again, the potential research participants were randomly coded to enable analysis by staff group and organisation, whilst at the same time retaining research participant anonymity. This coding process is illustrated in Figure 72.

Also, during the second phase of the research process, a similar process mapping exercise was undertaken to clearly aid and show the practical steps within the overall research process. This process map is shown in Figure 73.

During the first research phase, all potential research participants received the following paper documents – an invitation letter, a participant information sheet and a consent form. Examples of these documents are shown in Appendices VIII, IX and X. Similarly, during the second research phase, all potential research participants received the following documents by email attachment – an invitation letter and a participant information sheet. These documents are shown in Appendices XXI and XXII. The matter of consent, whilst mentioned in the correspondence clearly, was dealt with at the beginning of the on-line questionnaire.

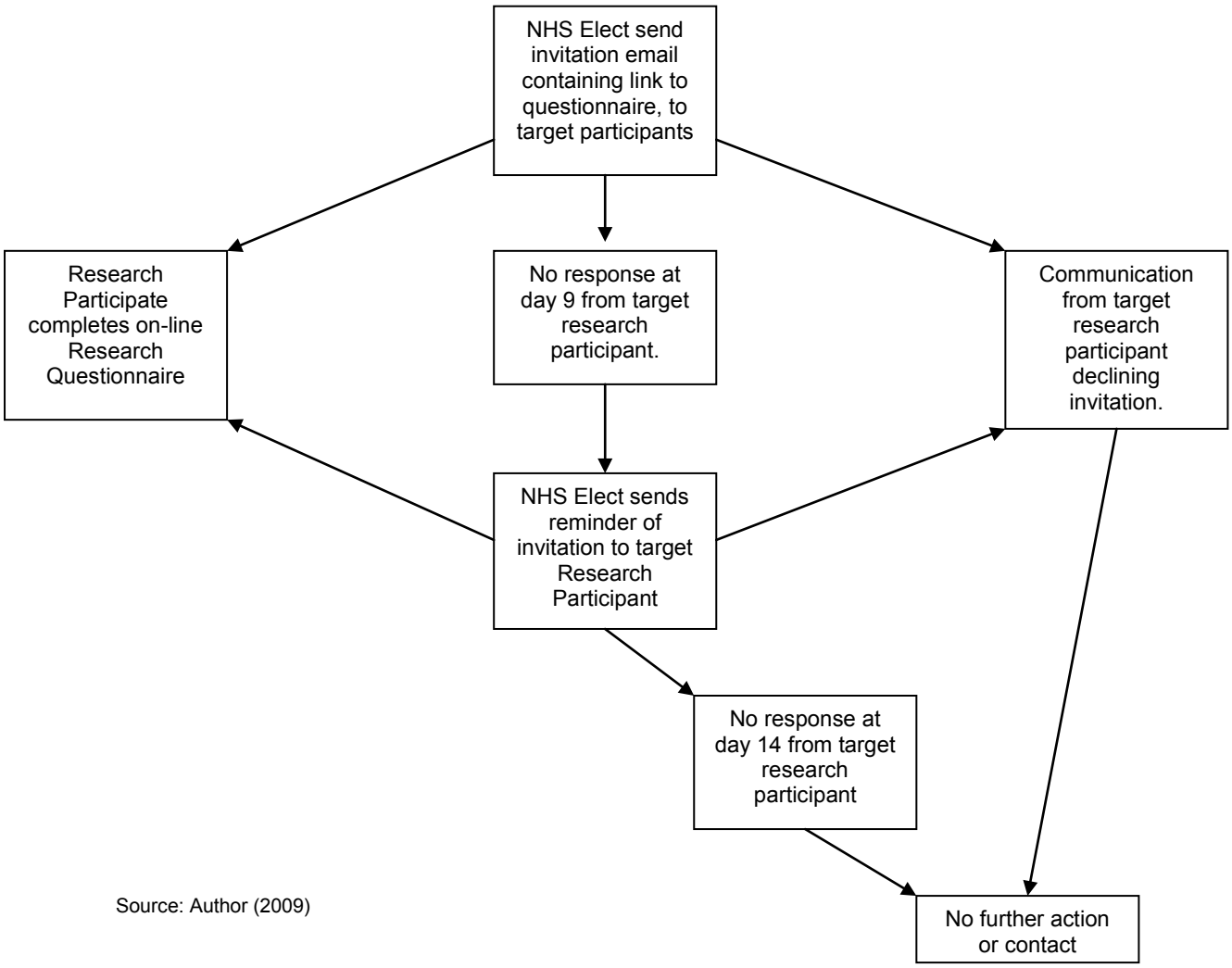
During the research interviews conducted in the case-study phase of the research, a standard telephone with speaker phone functionality was used during the interview and this was recorded using a digital recording device. The technical specifications of the equipment are shown in Figure 74. This equipment was 'tested' by means of using a small number of work colleagues to check both that the equipment functioned properly and to see if the estimated time for participation was correct. In addition, this testing enabled the researcher to familiarise himself with the equipment and procedures for its use. This meant that the interviews were approached more confidently and with a focus on the interview itself, rather than the technical kit used to facilitate it.

Figure 72. Coding process for target multi-site on-line questionnaire participants

Organisation	Random allocation	Code
Dartford & Gravesham NHS Trust		01E
		01C
		01G
Derby Hospitals NHS Foundation Trust		02E
		02C
		02G
East Kent Hospitals University NHS Foundation Trust		03E
		03C
		03G
Epsom & StHelier University Hospitals NHS Trust		04E
		04C
		04G
George Eliot Hospital NHS Trust		05E
		05C
		05G
Great Western Hospitals NHS Foundation Trust		06E
		06C
		06G
Heart of England NHS Foundation Trust		07E
		07C
		07G
The Hillingdon Hospital NHS Trust		08E
		08C
		08G
Homerton University Hospital NHS Foundation Trust		09E
		09C
		09G
Imperial College Healthcare NHS Trust		10E
		10C
		10G
Kingston Hospital NHS Trust		11E
		11C
		11G
The Lewisham Hospital NHS Trust		12E
		12C
		12G
North West London Hospitals NHS Trust		13E
		13C
		13G
South London Healthcare NHS Trust		14E
		14C
		14G
West Middlesex University Hospital NHS Trust		15E
		15C
		15G
Weston Area Health NHS Trust		16E
		16C
		16G
West Suffolk Hospital NHS Trust		17E
		17C
		17G
The Whittington Hospital NHS Trust		18E
		18C
		18G
Winchester & Eastleigh Healthcare NHS Trust		19E
		19C
		19G
York Hospitals NHS Foundation Trust		20E
		20C
		20G

Source: Author (2009)

Figure 73. Process map for multi-site on-line questionnaire process



Source: Author (2009)

Figure 74. Technical specifications for equipment used during case-study research interviews

Equipment used during case-study telephone interviews

- Digital dictation device :

  Olympus AS500 Pro Transcription

- Telephone :

  BT Converse 1200

Source: Author (2009)

The recordings were then typed using Microsoft Word, by the researcher. This approach is advocated by a number of research academics, including Wilson (2010). This process, whilst labour and time intensive, was a deliberate act. The researcher believes that conscious typing of interview texts by researchers' personally, adds to the understanding derived from the interview itself and enables trends, themes and 'missed points' to be spotted more readily than reading a transcript provided by a third party typist.

The timeline during which the case-study interviews were undertaken is as detailed below;

19th October 2009	Potential research participants sent letter of invitation and supporting documents
26th October 2009	Original planned reminder date – delayed due to unanticipated postal strike (Groom, 2009).
30th October 2009	Original deadline for responses, reminder sent at this stage to non-responders and mutually convenient interview dates and times agreed with those who had responded.
7th November 2009	Extended deadline closed and mutually convenient interview dates and times agreed with those who had responded.
1st November to 23rd December 2009	Research interviews undertaken and first phase case-study completed

As can be seen from the timeline detail, the unexpected postal strike meant that the researcher's original plans had to be changed at short notice, with an extension made to the original schedules. It is clear from this incident that even the best laid plans and procedures for conducting research can be disrupted by things that even the most diligent research student will find are out of their direct control – in this case, militant post-workers.

Reflecting upon the text of Dunleavy (2003), who cites the 'off-putting and obsessional character of the doctorate [researcher]' (p 155), in this case the researcher managed to adapt the research process in such a way that the response rate was largely unaffected (see page 126).

During the second phase of the research, the on-line questionnaire, the researcher set out a similar timeline for correspondence with potential research participants, with deadlines and reminders built into the process.

On this occasion, the technical specification of the programme used to facilitate the secure on-line responses from participants, along with the website and the point of contact for technical support to the researcher is shown (with his permission) in Figure 75.

Figure 75. Technical specifications of the IT programme(s) used during the multi-site on-line questionnaire

Website function used:	PHP version 5.2.10
On-line survey software used:	LimeSurvey, Version 1.86 (build 7697)
IT / Technical support:	Patrick Cavill, Computer Services, Business Technology Centre, Ashcroft International Business School, Anglia Ruskin University, East Road, Cambridge, CB1 1PT ☎ Tel ++ 44 (0)1223 363271 ext 2250 🖷 Fax ++ 44 (0)1223 417700

Source: Author (2009)

Once again a number of work colleagues were used to 'road-test' the functionality and timing of the process. The timeline to which the research was actually conducted is shown as follows;

18th October 2010	Invitation email sent to potential research participants with supporting documents attached
27th October 2010	Reminder email sent to potential research participants who had not responded or completed the on-line questionnaire at that point

30th November 2010 Extended deadline closed for responses.

Here the reader will see an extended deadline for responses was given. This was due to an oversight in research planning by the researcher, in that the invitation was sent out during a period of 'school holidays', where more potential research participants were likely to be away from their work email addresses than originally anticipated. This was quickly confirmed by a greater than expected email 'out of office' rate. Once again, the researcher had an ability to change the timetable and allow greater time to maximise the response rate which he did – albeit this time for reasons which if the research process were to be repeated, would be built in as a pro-active research consideration, rather than a re-active one.

Once the on-line questionnaire was completed, the results were exported into Microsoft Excel for analysis.

Data Analysis

The previous sections of the methodology chapter have focussed upon the conceptual framework and setting for the research, the optimum research methods contrasted to the established theory and literature on research, the ethical aspects of undertaking the research and of course, setting out clearly the practical aspects of carrying out the research itself.

This final section of the methodology chapter describes the way in which the data derived from the research processes described earlier in the thesis was analysed.

It also provides a clear description of how the researcher has conceptualised the issues arising from the literature review, linked to the primary areas of research and how this relates to and is informed by practice. In essence, this section of the thesis expands upon, informs and re-iterates to the reader of the rationale behind the research questions used in the case-study interviews and the multi-site questionnaire.

This distilled overview will illustrate for the reader, the context and evidence behind the research gap that this thesis addresses. It is hoped therefore, that this will provide a clear set of themes, indeed 'the story' behind the research, prior to the results, analysis and conclusions sections of the thesis.

Case-study site interviews – data analysis

During the first phase of the research - the single site case study interviews - the rich data generated from the individual interview accounts was self-transcribed by the researcher. Whilst a valuable, solid method of underpinning discourse analysis it proved to be a time-consuming process. However, in terms of understanding the research participants' responses to questions, spotting trends or useful areas of insight relating to the research questions, the process was invaluable. Whilst the researcher felt that this was the case, he subsequently discovered academic insight backing this view (Yin, 1984; Silverman, 1984).

In addition, the researcher would argue that the rigour of self-transcribing and as a consequence absorbing and considering properly all of the interviews in detail, also reduced scope for bias towards any particular participant or indeed, bias of interpretation.

Opinion and analysis was also aided greatly by the use of tabular formatting, by thematic area. This style, whilst not to everyone's aesthetic taste, also proved useful for the management and manipulation of large volumes of text based data and ultimately, it proved to be an optimal way of displaying the research data generated in a concise and informative manner (See Figure 95, page 161 for an example of tabular data analysis).

Comparison between the respective professional groupings under analysis (Executive Director, Clinical Director and General Manager) was also aided by this methodology for data analysis. Ethnographic variables within the research participant population were also shown clearly and cross-comparison enabled in a similar fashion.

Multi-site on-line questionnaire – data analysis

As shown in Figure 76, the importance of triangulating between the single-site case study interviews and the multi-site questionnaire was key to the derivation of original insight and the generation of conclusions from this research.

The researcher formatted the tabular style data analysis in both phases to aid this process of cross comparison and triangulation. As stated earlier, it also enabled a clear and reasonably consistent method of managing and displaying the research data.

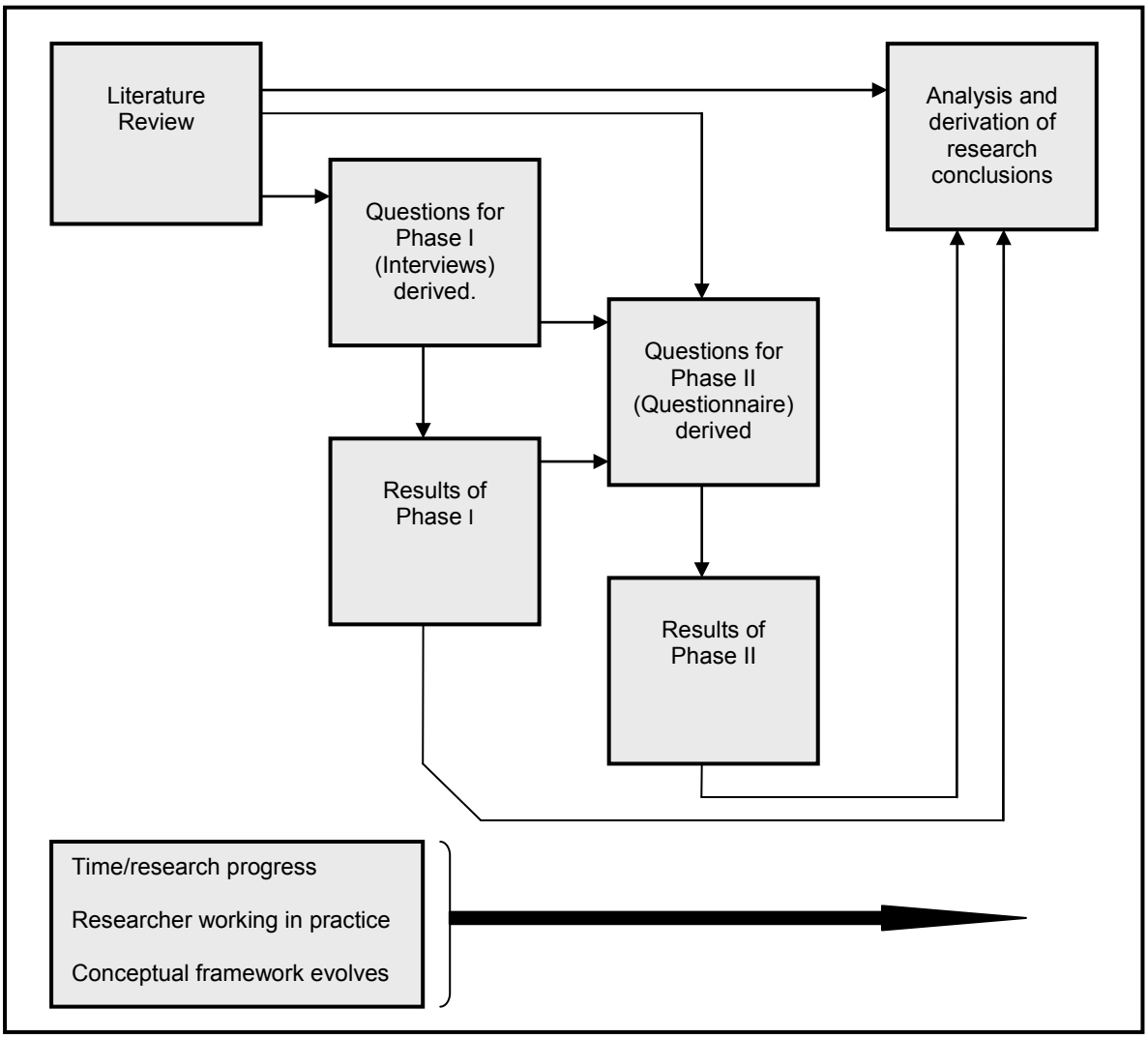
This reads through the thesis, as in the analysis and discussion section in which the data is interrogated and interpreted against theoretical and practice based research questions. There is again a clear extrapolation and evolution of the research findings.

An overview of the entire research process; the story

In terms of the data analysis process, this is of course set within the much broader context of the overall story behind this research thesis. This is more than just a prescribed method for generating and then analysing research data. The data analysis phases are important but equally, so are careful consideration of the underpinning theory and relevant literature, the development of the conceptual framework and critically, practice based insight from 'the real-life research setting' that the researcher may bring. This rounded research process – including data

analysis as shown in Figure 76 – illustrates a clear, structured and well-rounded research framework.

Figure 76. Pictorial representation of information flow, from initial literature review to research conclusions.



Source: Author (2010)

The introduction to this thesis set out how the researcher had, in practice, reflected upon what was observed to be a change in language and behaviour among NHS leaders. This was also set against an increasing sense of competition between NHS hospitals.

This set of observations intrigued the researcher, particularly given a background interest in leadership and organisational culture studied at masters level (MBA) and a practice based involvement in the leadership at, and development of, of NHS hospitals. Further combined with an interest and appetite for pursuing greater

academic study and research through a PhD, this led the researcher to submit a research proposal (see Appendix II). In doing so, the research process has expanded the researcher's level of knowledge and understanding of both the historical and theoretical background to the issues. Ultimately, the themes and research questions arising from this, present a number of gaps for research to fill.

The research questions this thesis addresses, as introduced on page 3, can be broken into key themes – competition and marketisation, leadership and leadership culture. Contrasted to the literature and to practice, these research gaps and themes inform and crystallise the research questions asked of participants, which in turn answer the headline research questions posed in this thesis. Further, this evidence informs a set of broader theoretical and practice based research conclusions and implications.

Competition and marketisation

The researcher poses the argument that the NHS was created in a post-war culture whereby the population was actively encouraged to work collaboratively, for the greater good and the same went for public organisations and institutions such as the health service. This is reflected further in the policy that formed the 'District General Hospital', (MoH, 1962) and the general argument is further supported by the previously referenced Guilleband report (see page 21), in which the founding tenets of the NHS are re-iterated clearly, including the need for 'GPs and hospitals to work closely together' (Guilleband, 1956). In practice, the researcher has observed that the cultural 'norm' of NHS hospitals tending to sit at the 'state driven' end of the spectrum is challenged by policy and resulting practice that moving that cultural foundation toward a more 'free market', competitive model (see Figure 1, page 13). Testing whether leaders in NHS hospitals have a sense that levels of collaboration and collaborative behaviours between hospitals changing would evidence the substance or otherwise of the researcher's practice based observation. Whilst this in itself would provide an evidence base from which a position of increasing competition could be demonstrably argued, further questioning research participants around not just their perspectives on changing levels of collaboration, but any overt sense of competition would provide enhanced evidence. Contextually, given this research is conducted in contemporary working environments where, at the time of the research and still, there has been little – if any – research that is based upon the insights of those working in NHS hospitals in positions of leadership. The researcher has

deliberately asked research participants to evidence their views in further questioning, so the substance of their responses can be seen.

In addition to the critical question of NHS leaders in English hospitals and the contemporary sense of 'buy-in at the coalface' to the policy direction overall, the researcher wished to develop the questioning in this research further, such that it reflected and tested the two primary arguments used by advocates of state provision and marketisation alike - quality and financial efficiency.

In the literature review, the researcher has previously referenced US models such as Medicare and the theoretical advocates that purport increases in quality (Carvel, 2006) and similarly, the notion that financial efficiency can be derived from a market based model of provision (Williamson, 1975).

Equally, moving away from services that are state directed and provided brings forth counter arguments around increasing health inequality as well as rising transaction costs (Unison, 2002) and regulatory considerations (Dowler, 2012; Plumridge, 2012).

The researcher developed questions to test opinion and understanding around both the direct and consequential issues arising from increased competition. Specifically, questions around how this relates to quality and financial efficiency in the minds of hospital leaders in the NHS help to fill the research gap, in which only opinion rather than evidence has previously resided (see page 2).

Given the historical significance and cultural basis of the NHS described earlier (see page 19) and the changing nature of the public sector generally (see pages 15-18), the researcher has also tested a further significant line of questioning - the appetite of NHS hospital leaders for further enhancements to the level of competition perceived currently.

Leadership and leadership culture

Given the fundamentally important role of NHS leaders, particularly those in the hospital sector, the derivation of research questions that test and seek to gain further understanding of the impact that increasing marketisation is having upon the leadership of NHS hospitals (as observed in practice by the researcher) is a significant part of this research. The implications for those operating in practice as

leaders within NHS hospitals today and in future are central, as are the results from a theoretical and leadership development perspective too.

The questions derived here, start with a direct question relating to the purpose of leadership. Here, the researcher is expecting to contrast the many theoretical models of leadership described in the literature review chapter of the thesis, with the practice based model used in earnest across the NHS, the 'LQF'.

In analysing the literature, the researcher has already argued that the 'LQF', as a consequence of the changing environmental arising from increasing marketisation in the hospital sector, is not fit for use in practice (see page 82). Given this, along with the perception of the researcher in practice and the opinion of many commentators and observers that the NHS model for leadership is moving toward the 'harder' end of the cultural spectrum (see Figure 54), the opinion of leaders in practice should form an important evidence base from which the case - either way - will be proven or disproven on the question of whether the 'LQF' retains a comfortable synergy with the perceptions of those operating in practice. The theoretical and leadership development implications can then be properly considered, particularly is this is set against the outcome of further research evidence, whereby leaders in practice are asked whether their peers match up to their own self-assessment of what's required to effectively lead NHS hospitals in England.

The researcher, based on the literature and evidence from other sectors, suggests that some of the implications for leaders in the NHS and those using the LQF in an environment whereby competition is increasing, will include;

- A need for greater focus on tasks/objectives
- An enhanced disposition to risk taking
- A customer / client (not provider) informed and driven quality agenda
- An increasing focus on the prioritisation of improvement and change, rather than untargeted 'improve all' approach
- The capacity to develop sustainable services in a market – able to understand and balance competition and collaboration
- Not being afraid to change and use 'emergent' strategy as the 'market' evolves

- A greater understanding and use of financial margins / market share information
- A workforce focus on skills and productivity v tenure

The substance underpinning this set of implications (as laid out and discussed more fully in Figure 53 and surrounding sections of the thesis) will be tested in the questioning of research participants too. This will be achieved through both questions relating to what makes a good leader in the sector and whether that has changed in the eyes of NHS hospital leaders. In addition, this will expanded through exploration of the constraints the research participants feel are faced by those operating in practice. Clearly, the outcome of this questioning can be analysed from a theoretical and conceptual angle, as well as a practical perspective too. For example, from an operational standpoint, it will be important to understand what the perceived constraints are, such that leadership development programmes and tools can be adapted or devised such that they enable leaders to confidently and competently address constraints to service delivery.

Organisations and those who lead them need to change and adapt over time. Whilst these changes are often environmentally driven and vary in pace, the obvious consequence is a need for leadership development, such that leaders adapt and remain effective. The NHS is no different and therefore, testing the extent to which the current leaders of NHS hospitals have undertaken leadership development activities as part of this research process will provide an interesting insight at a basic level.

When further tested through questioning research participants about the derivation and type of leadership development they undertook, the researcher will be able to draw conclusions around the overall extent to which leadership development is seen as a priority, or a prerequisite for hospital leaders in practice. The theoretical contrast to leadership models that could be argued as advocating leadership by right, by application of academic or time-served criteria or through a more rounded development route could also be considered.

The nature of the development activity undertaken and the level of knowledge relating to theoretical leadership models more generally, may also provide cultural indicators and clues related to and relevant in considering the primary research questions – particularly those around the perceived skill-set and qualities required of

leaders. This can be considered at a collective level, but also given the organisational, professional and cultural silos described in the literature review (see Figure 36 on page 71). Obviously, this line of questioning will also set context to and test the level of awareness and utility of the Leadership Qualities Framework (LQF), already considered in part against the established literature on leadership (see page 82). Directly asking research participants about their use of the LQF, will test the level of 'buy-in' that leaders have in terms of such national development programmes and indeed, the 'value' overall that they present to the NHS and ultimately therefore, the taxpayer. Given the high profile afforded to the LQF by the senior hierarchy of the NHS at national level, the extent of engagement with this will also provide perhaps, an indicator as to the level of engagement by hospital leaders in the NHS with non-mandated initiatives from the central policy making hub of the Department of Health.

Finally, the critical nature of those with significant influence in the NHS has historically been very significant in the development of the service and its cultural makeup. This is illustrated in the pre-text to Figure 3 on page 20 and is particularly pronounced in the work of Westin (1998), Rivett (1998), Clarke-Kennedy (1955) along with others who cite medical, political, managerial and numerous other factional conspiracies of dominance and influence over service structure and changes to policy or purpose. The bearing that this will have for the future, in terms of policy development and deployment and in relation to leadership and leadership development will be an important consideration. Navigating the real or perceived levels of influence within and across the different sectors and organisational layers of the NHS, will be a key facet for anyone working with or within the hospital sector – whether that be as an operational leader or as an influencer or developer of policy or leadership development.

RESULTS

Results – a structural overview

This chapter of the thesis provides the reader with a clear summary of the information derived from the research process as described in the methodology chapter (page 88).

This information is presented in a clear, concise and ordered fashion, utilising wherever possible the use of tabular presentation techniques, which aid the reader to follow and digest the volume of information and variables in a structured way.

Further, the comprehensive - but bulky – research data derived from both the narrative case-study interviews and the multi-site questionnaire is referenced clearly throughout the chapter. The raw research data from the case-study interviews is detailed in Appendices XI to XX. However, the results of the on-line questionnaire are presented fully in this chapter. The researcher has established that one of the constraints of the questionnaire software utilised for this research, is the limited manipulation and presentational options available for the raw data. Whilst this doesn't detract from the quality of the data, its validity or indeed its application in this research context, the researcher would think carefully prior to any proposed replication based study.

Response rate – summary

Overall, this research process targeted 80 potential participants; 20 at a single case-study site and 60 across twenty different comparator sites.

The overall response across both phases of the research was from 24 participants (10 at the single site case-study and 14 from the multi-site questionnaire). This represents, overall, a response rate of 30% as shown in Figure 77.

Figure 77. Response rate summary

	Target	Response	Percentage
Research interview response rate	20	10	50%
Research questionnaire response rate	60	14	23.3%
Overall response rate	80	24	30%

Source: Author (2010)

More detailed information on the respective response rates for both the site-specific case study and the wider research questionnaire along with respondent detail, is provided below.

Case-study site interviews - response rate and participant information

The target participant group totalled 20 people. This group consisted of three main sub-groups – Executive Directors (6), Clinical Directors (6) and General Managers (8)

Overall, ten of the total target group participated in the research, representing an overall response rate of exactly 50%

The total target participant group is made up of 11 males (55%) and 9 females (45%). In overall gender terms, the ten people who participated were made-up of seven males (70%) and three females (30%)

- Of the six Executive Directors, 4 responded (66%). The Executive Director group is evenly split between the sexes and this balance was reflected in the make-up of the four participants (50% male, 50% female)

- Of the six Clinical Directors, 3 responded (50%). The Clinical Director group is entirely male and therefore, all three participants were male (100%)

- Of the eight General Managers, 3 responded (37.5%). The General Manager group is female dominated by a ratio of 3:1 (six female and two male). The make-up of the participants does not reflect this ratio, as two of the three participants were male (100% response from male General Managers) and only one female (16.5% response from female participants)

The total participants were made up of the following age bands – 1 person aged 60 or over, 5 people between the ages of 50 and 59, 3 people between the ages of 40 to 49 and 1 person aged between 30 and 39

- Of the 4 Executive Directors who responded, 3 were between the ages of 50 and 59 and 1 was between the ages of 40 and 49

- Of the 3 Clinical Directors who responded, 2 were between the ages of 50 and 59 and 1 was between the ages of 40 and 49

- Of the 3 General Managers who responded, 1 was aged 60 or over, 1 aged between 40 and 49 and the other, aged between 30 and 39

The participants had worked at their current employers for a mixed period. 2 had worked there for over 15 years, with the remaining 8 participants equally divided, with 4 working between 5 and 9 years and 4 working between 2 and 4 years

- Of the 4 Executive Directors who responded, 3 had worked at their current employer for between 2 to 4 years, with 1 working between 5 and 9 years

- Of the 3 Clinical Directors who responded, 2 had worked for their current employer for between 5 and 9 years, with 1 working for over 15 years

- Of the 3 General Managers who responded, 1 had worked for their current employer for over 15 years, 1 between 5 and 9 years and the other, between 2 and 4 years

The total participants had worked for the NHS for a long period, with 7 participants having worked for the NHS for over 20 years. Of the remaining 3 participants, 2 had worked for the NHS for between 15 and 19 years and 1 for between 5 and 9 years

- Of the Executive Directors who responded, 3 of the 4 participants had worked for the NHS for over 20 years, with 1 having worked for 15 to 19 years

- Of the Clinical Directors who responded, all 3 had worked for the NHS for over 20 years

- Of the General Managers, 1 had worked for the NHS for over 20 years, 1 for between 15 and 19 years and 1 for between 5 and 9 years

From the total participant group, exactly half had only worked in the NHS during their career

- Of the Executive Directors who responded, only 1 out of the 4 had only worked in the NHS with the other 3 all stating that they had worked in a non-NHS setting previously and of the 3, all stated that they worked for commercial, competitive organisations. It should be noted that one participant gave further information, indicating that they'd worked for the Post Office, a previously state run public service.

- Of the Clinical Directors who responded, all 3 had only worked in the NHS during their career, with no experience in other sectors or organisations.

- Of the General Managers who responded, 1 had only ever worked in the NHS. The remaining 2 respondents both stated that they'd also worked for non-NHS organisations previously. These 2 participants both described the organisations they worked for as being commercial, competitive in nature with 1 participant adding that whilst that description was correct, that they previously worked in the legal profession.

Multi-site on-line questionnaire - response rate and participant information

The target participant group totalled 60 people. This group consisted of three main sub-groups – Executive Directors (20), Clinical Directors (20) and General Managers (20) across 20 different NHS Hospital sites in England.

Overall, 14 people responded and participated in the research questionnaire. As a percentage, this represents a response rate of 23.3%

The total target participant group is made up of 32 males (53%) and 28 females (47%). In overall gender terms the 14 people who responded were made up of 8 males (57%) and 6 females (43%). This broadly reflects the make-up of target participant group.

- Of the 20 Executive Directors, 3 responded (15%), two of whom were male (66.6%) and the other, female (33.3%)

- Of the 20 Clinical Directors, 5 responded (25%). The General Manager respondents were 3 male (60%) and 2 female (40%)

- Of the 20 General Managers, 6 responded (30%). The Clinical Director respondents were equally split, 3 male (50%) and 3 female (50%)

The participants who responded made up of the following age bands – 1 person aged 60 or over, 3 people between the ages of 50 and 59, 7 people between the ages of 40 to 49 and 3 persons aged between 30 and 39. There were no respondents aged below 30.

- Of the 3 Executive Directors who responded, they were all aged between 40 and 49

- Of the 5 Clinical Directors who responded, 3 were aged between 50 and 59 and the other 2, aged between 40 and 49.

- Of the 6 General Managers who responded, 1 was aged 60 or over, 2 between 40 and 49 and 3 between 30 and 29.

The duration of employment tenure at their current hospital, was mixed across the research sample. 3 were 2 years or less, 4 were 2-4 years, 3 were 5-9 years, 1 was 10-14 years and 3 were over 15 years.

- The Executive Directors had a comparatively short tenure, with 1 having worked less than 2 years and the other 2, between 2 and 4 years.

- Clinical Directors had a comparatively long tenure of employment with their current hospital, with 3 over 15 years, 1 between 10-14 years and the other, between 5-9 years.

- General Managers were a mixed bunch, all serving less than 10 years. 2 were under 2 years, 2 between 2-4 years and 2 between 5 and 9 years.

The participants total length of service in the NHS were grouped in a marked pattern, with 6 between 5-9 years, 4 between 15-19 years and 4 over 20 years.

- The Executive Directors, all three of them, were at 15-19 years

- The Clinical Directors also, were long serving with 1 between 15-19 years and the other 2 at over 20 years

- The General Managers, all 6 of them, had worked in the NHS for between 5 and 9 years.

In headline terms, 8 of the 14 participants had worked previously outside the NHS, with 6 stating that they had only worked in the NHS.

- The Executive Directors were split, with 2 having worked outside the NHS and 1 not.

- The Clinical Directors, all 5 of them, said that they only worked for the NHS although 4 of the 5 mentioned that they also practiced privately.

- The General Managers, like the Executive Directors, had a like split with 2 having worked outside the NHS and 4 not.

- None of the participants had worked in the charitable, academic or legal sectors.

- One of the General Managers had worked in a non-profit, public service organisation.

- All 8 of the participants that said they'd worked outside of the NHS had worked in organisations they thought of as "competitive / for profit".

Research participant consent

In both the site-specific case study and the multi-site questionnaire, all of the research participants provided their consent to the research process, as detailed in the methodology chapter of this thesis (page 108).

The researcher can confirm that during the case-study interviews, no questions about the ethical basis of the research or the research methods were raised by either those who participated, or those who declined or did not respond. No

research participant indicated any discomfort during the interview process or requested to pause or stop their interview at any stage.

The researcher can confirm that during the multi-site questionnaire process, no questions about the ethical basis of the research or the research methods were raised by those who participated, or those who declined or did not respond. No research participant indicated any concern or raised any questions during the questionnaire process.

Case-study site interviews - results

A precise transcript for each of the ten research interviews undertaken with leaders during the site-specific case study phase of this research is contained in Appendices XI to XX.

The information detailed below, is derived directly from the information rich interview transcripts and as such, represents a concise summary of the results from the site-specific case study interviews.

Case-study site interview results – question 8-13 (Competition)

Research participants were asked whether the level of collaboration between NHS hospitals had changed in recent years (Question 8)

- All research participants responded to the question and expressed an opinion

- All research participants thought that there had been a change in the level of collaboration, with no response suggested that there had been no change

- Analysis of all responses from research participants shows a clear majority with a view that the change was that there is now less collaboration between NHS hospitals than previously. 7 (70%) of the research participants expressed this view, with only 3 (30%) expressing the opposite opinion, that there is greater collaboration than previous.

- Of the Executive Directors, there was an exact 50:50 split of opinion between the 4 research participants

- Of the Clinical Directors, there was a unanimous opinion that there was now less collaboration between NHS Hospitals than previous

- Of the General Managers, there was a divided opinion with 2 research participants being of the opinion that NHS Hospitals now collaborated less, whereas 1 research participant suggested that the level of collaboration was now 'marginally more'

The question as to whether there is competition between NHS Hospitals was asked of research participants (Question 9)

- All research participants answered the question, forwarding an opinion

- An overwhelming majority of 9 (90%) of the research participants were of the opinion that yes, there is competition between NHS Hospitals, with only 1 (10%) of the research participants giving an answer of "yes and no", depending on the circumstances. Broadly, this response seemed to reflect that NHS systems were set up to drive that sense of competition and is illustrated perfectly by respondent 2E2;

  "There is [competition] because of the tariff and choose and book itself" (see Appendix XI)

- The respondent with mixed views on this research question was a General Manager, meaning that all Executive Directors and Clinical Directors were of the opinion that there is competition between NHS Hospitals, along with the 2, of the 3 General Managers.

Research participants were asked what evidence they might have to suggest that competition exists between NHS Hospitals (Question 10)

- All research participants answered the question, with only one (Clinical Director) not offering a clear answer

- The research participants provided a broad range of opinions on what might constitute evidence that competition exists between NHS Hospitals. A list of the differing responses is given in Figure 78 below :

Figure 78. Research interview participant evidence of competition between NHS Hospitals

Tab	Example of evidence	Given by	Frequency
A	*Targets / Performance metrics for comparison of hospitals*	2 ED, 1CD	3
B	*Increased communications and / or marketing function within*	1 ED, 1GM	2
C	*Reduced level of collaboration between hospitals (where previously higher)*	1 ED	1
D	*Choice for patients / "Choose & Book"*	1 ED	1
E	*Attitude of people in NHS Hospitals*	1 ED	1
F	*Less sharing of information / best practice between hospitals*	1 ED, 1 GM	2
G	*National Tariff / Service Line Reporting / Focus within hospitals on "best paid" services*	1 CD, 1 GM	2
H	*Enhanced capacity analysis and planning*	1 GM	1
I	*PCTs putting services out to tender*	1 GM	1

Source: Author (2012)

- Executive Directors, between them, offered 7 examples of what might constitute evidence to suggest that competition between NHS Hospitals exists, General Managers provided 5 examples, with only 2 examples given by the Clinical Directors, one of whom did not provide a clear answer.

Research participants were asked the question as to whether they thought increased competition would drive up quality for patients. (Question 11)

- All of the research participants responded to this question, although one (Clinical Director) did not offer a clear answer and another (Executive Director) answered 'yes', but contradicted themselves in a later part of the discussion by stating 'no'.

- Opinion was very mixed in response to this research question.

- Of the Executive Directors, whilst one wasn't clear in their response (initially saying 'yes', but then contradicting that response by later saying 'no'), two

others were cautious in their response, stating that increased competition could potentially drive up quality for patients and the remaining respondent was of firm opinion, giving a clear 'yes' in response. Of those that were cautious, one interesting insight was gleaned from respondent 4E4 who said;

"I think there is less sharing of information and good practice than there used to be. It is not as open" (see Appendix XIII)

- Of the three Clinical Director research participants that responded, again the response was mixed. One Clinical Director did not give a clear answer, with the other two divided in their opinion, with one agreeing that competition would increase quality for patients and the other of the opinion that it would not. The complexity of the NHS, set alongside the simplicity of national political policies contrasting performance and designed to improve but perhaps precipitating other confidence concerns among the public was illustrated in the answer of respondent 12M6;

  "…increased competition is a lemon, if you are going to have increased competition, you have got to have increased capacity haven't you ?…the area I deal in which is emergency, has no choice...the ambulance are going to you to the nearest hospital. If you compare the data, saying your local hospital is dire is completely unhelpful. You haven't got any choice about where you go and it's just going to increase anxieties to the local population". (see Appendix XVII)

- The General Manager respondents were also divided in their opinion, with two respondents saying that competition would not drive up quality for patients and the remaining research participant giving a view that yes, competition would drive quality up.

Research participants were asked the question as to whether they thought increased competition would enhance financial efficiency for the NHS. (Question 12)

- All of the research participants responded to this question. Their responses were again divided, many giving conditional answers.

- The Executive Directors all gave conditional answers and were divided equally in their opinions. Of the two sceptical Executive Directors, one said

that increased competition would 'not necessarily' derive financial efficiency for the NHS, with the other stating that they were 'not convinced'. The other two Executive Director respondents were more positive in response, with one saying of increased competition driving financial efficiency for the NHS that it, 'could do', with the other similarly positive saying that such benefits might be derived 'indirectly' from such a move.

- The Clinical Directors were less sure. Two of the three responded were firmly against the idea, saying that competition would not drive financial efficiency for the NHS. The other Clinical Director said that increased competition could give the NHS an efficiency gain, but the response was a conditional one.

- Respondents from the General Manager group, were divided also. One firmly in the 'yes' camp and another with the 'no' respondents. These clear opinions were not mirrored by the third General Manager respondent, who after some consideration thought that financial efficiency could be a consequence of increased competition, 'probably'.

The final question relating to NHS Hospitals and competition asked research participants whether they would be comfortable with an increase in the level of competition between NHS Hospitals (Question 13)

- Every research participant that participated in the interviews gave an answer to this question. Interestingly, 5 (50%) of the respondents gave a positive, but cautiously conditional answer, whilst 3 (30%) were not comfortable with any increase. Their remaining 2 (20%) colleagues expressed a view that they'd be comfortable with more competition.

- Two of the Executive Directors gave a conditional 'yes' answer to the question, with one giving a clear unconditional 'yes' and the remaining Executive Director provided a negative response, saying that increased competition was not the next 'first step' for the NHS.

- The Clinical Directors again were conditional in their answers, with two giving similar 'yes' answers with conditions applied. The third Clinical Director participant gave a clear and resounding 'no' in response to the question.

- General Managers were the only group to give clear, unconditional answers to this question with two giving a clear 'no' and the other a 'yes' answer. Respondent 18G6 gave through their answer, an indication as to why the General Manager cohort of research participants were divided to an extent, as they could see beyond the simple "yes or no" response;

  *"I think it is difficult really, because I think patient care and service delivery is sometimes actually more than just economical commercial performance, it's about a lot of holistic issues around governance, safety and I am not absolutely convinced that actually focusing on commercial demand would not cause detriment to some of those issues, to be honest with you". (*see Appendix XX)

Case-study site interview results – questions 14 to 23 (Leadership)

The first research question asked of participants in this section on leadership, asked respondents what they thought the purpose of leadership was (Question 14)

- All of the research participants answered this question.

- The list of words or phrases used by respondents to describe the purpose of leadership is shown below

inspire	empower
direct or give direction	understand the organisation
provide a vision	make decisions
set the environment	horizon scan
motivate	prioritise
support / help	gain consensus

- There were only three of these words or phrases that were mentioned more than once, these being "direct or give direction" (5 times), "motivate" (3 times) and "provide a vision" (twice). All of the others were referred to by one respondent only.

The next question in this section asked respondents to reflect on their previous answer, asking them to give a view as to how many leaders in the NHS currently fulfil the criteria they just described (Question 15)

- Two of the Clinical Directors could not answer this question. One did not give a reason and the other said, that they couldn't answer as it was "an impossible job". All of the other respondents did give an answer.

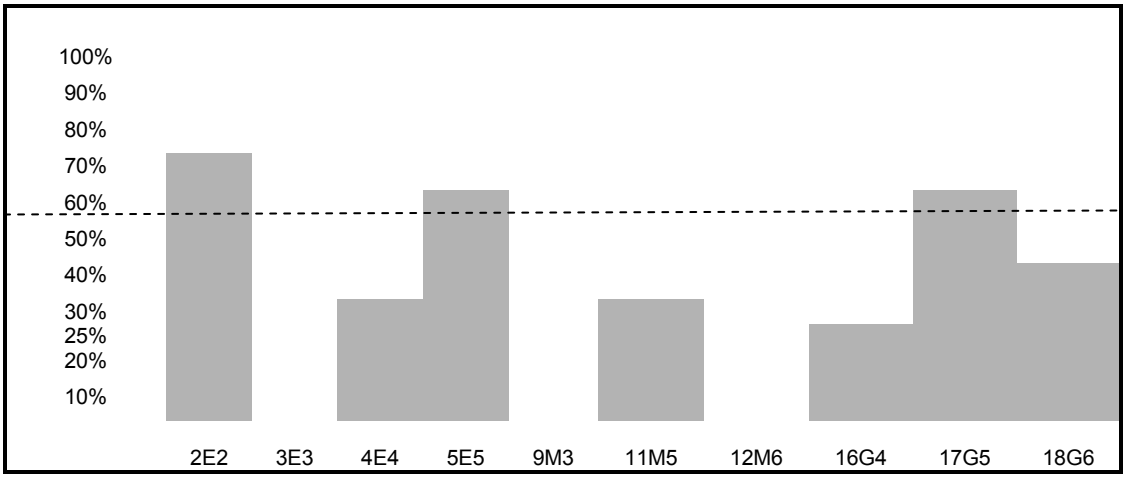
- The responses were all expressed as percentages, or a number out of ten which could easily be translated into a common currency.

- Looking at the research participants who did answer the question overall, 5 out of the 8 thought that under 50% of current NHS leaders met their own perception of what leadership was about. Of the other 3 respondents, their views expressed as percentages were 70%, 60% and 60%.

- One Executive Director said that they couldn't think of anyone, which chimes perhaps with the non-response of the 2 Clinical Directors mentioned above.

- A pictorial representation of responses is shown in Figure 79 below.

Figure 79. The percentage of NHS leaders who meet research interview participants criteria for leadership



Source: Author (2012)

Research participants were then asked what are the constraints facing leaders in the NHS (Question 16)

- All of the respondents answered this question.

- The list of words or phrases used to describe the constraints upon leaders in the NHS is shown;

Changing political policy	Current mindset
Public perception	Clinician and Management divide
Bureaucratic rules	Financial constraints
Fear	Workforce constraints
Operational pressure / targets	Constraints in NHS Estate (e.g. PFI)

- There were only three of these words or phrases used more than once, these being “changing political policy” (6 times and within that, by all 4 Executive Directors), “operational pressure and targets” (4 times and within that, by all 3 General Managers) and “workforce constraints”, twice.

The next question related as to whether research participants felt that the criteria for what constituted good leadership had changed in the NHS? (Question 17)

- All of the research participants answered this question, with only one (Clinical Director) not giving a clear answer.

- The headline response was an overwhelming “yes”, with all participants who provided a clear response believing that the criteria for good leadership had changed.

- A range of rationale and reason was provided, with the words and phrases used to describe their view being provided below

  More public now, with greater accountability
  New financial regime needs new skills
  Need to understand business, not just health, a “commercial approach”
  More complicated

More organised
Significantly harder (tied by targets)

- The most commonly cited reason, was the need to adopt of more "commercial approach" (5 respondents) and this is represented well by the response of participant 3E3, who said;

  "I think they need to be educated in a particular way that makes them understand how businesses are run, rather than just how health services are run". (see Appendix XII).

  The only other issue mentioned more than once, was the suggestion that leaders are now "more public, with greater accountability" (mentioned twice).

The question next, asked research participants whether they had undertaken any form of leadership development activity previously (Question 18).

- All of the respondents answered this question and all of them answered "yes", confirming that they had previously undertaken some form of leadership development activity.

This was followed by a question that asked research participants to describe the type of leadership development activity they had undertaken (Question 19)

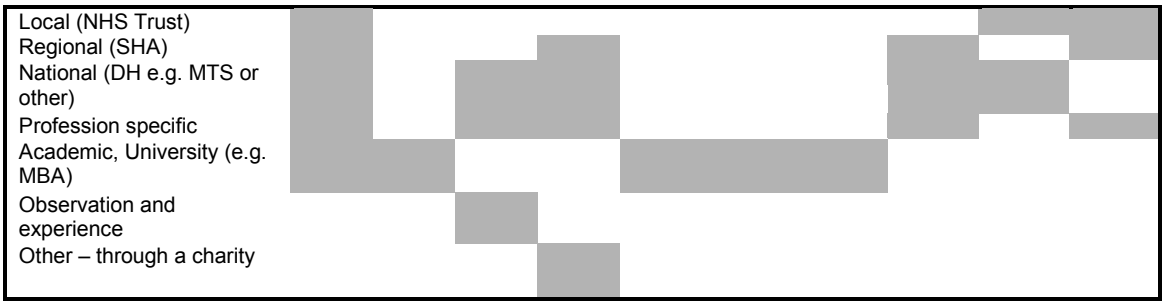
- All of the research participants responded to this question.

- The types of leadership development activities described were as follows

  Local to employer (NHS Trust)
  Regional (SHA)
  National (DH e.g. MTS or other)
  Profession specific
  Academic, University (e.g. MBA)
  Observation and experience
  Other – through a charity

- The diagram in Figure 80 below gives an indication of the type and amount of development activity undertaken by respondents.

Figure 80. Types of leadership development undertaken by research interview participants



Source: Author (2012)

- It is interesting to note that the Clinical Director group, all cited only one method of leadership development and that was through academic or university based programmes such an MBA or MSc.

Following on from this, the next question asked research participants whether they were aware of any theoretical models that describe what leadership is (Question 20).

- All of the research participants responded to this research question.

- The responses were interesting, in that only one participant (a Clinical Director) responded by saying that no, they weren't aware of such theoretical models, with all of the other participants answering "yes". However, of the 9 respondents who answered yes, only 2 were able to name any model or programme relating to leadership theory. The other 7 respondents all said that they knew of them, but could not name or describe them.

- Of the two participants who named theoretical models or programmes derived from such (one Executive Director and one Clinical Director), they offered up "Myers Briggs leadership personality model", "traits", "the 5 disciplines of leadership" and "personal qualities".

The next question asked research participants whether or not they had heard of the LQF, the NHS Leadership Qualities Framework (Question 21).

- All of the research participants answered this question.

- Overall, the responses were split evenly with 5 respondents saying yes, that they had heard of the LQF and the other 5 saying no, that they'd never heard of it.

- The response was mixed across the respondent sub-groups, with no group having a uniform response.

- That said, 3 of the 4 Executive Directors had heard of the LQF, where as for Clinical Directors and General Managers, the balance of knowledge was the other way, with 2 out the 3 in each group saying that they hadn't heard of the LQF before.

This was supplemented by a question applicable to only those research participants who'd answered yes to Question 21, as it asked them whether they had or were using the LQF in any way (Question 22)

- Of the 5 research participants asked this question, all of them responded.

- 2 of the respondents said that they had used the LQF for their own development (one Executive Director and one General Manager)

- Only one of the respondents (an Executive Director) said that they had used the LQF to directly support the development of others, although one of their Executive colleagues said that they had used the LQF "indirectly" as it had been part of a development programme for an employee.

- None of the respondents said that they were currently using the LQF at the moment. This is perhaps quite a material finding, when combined with the previous question that found the other 5 research participants hadn't heard of the LQF (i.e. half of the leaders in this organisation had not heard of it and the other half had, but where not using it).

The final question of the research interview with research participants asked them who, in their view, had the most influence in the NHS (Question 23)

- All of the research participants answered this question and gave an opinion.

- The list of those holding the most influence in the NHS, as described by the respondents is shown below

  Hospital consultants
  Doctors
  Clinicians
  Consultants and GPs
  GPs (as commissioners)
  SHAs
  PCTs
  Acute hospitals, particularly tertiary (rather than PCTs)

- There are some potentially interesting trends within the responses. For example, all of the Executive Directors describe consultants or doctors in some way as being those with most influence, as indicated by the response of participant 5E5;

  "Medical Staff, either internal or external, so I think Consultants and GPs". (see Appendix XIV)

  This is contrasted to the responses of Clinical Directors (doctors) of whom 2 cite SHAs as holding greatest influence and the other hospitals overall (rather than PCTs). Whilst this was certainly the view and it is illustrated clearly in the response of respondent 9M3, it would be fair to say that there was also some criticism of how that engaging those with that influence were seen to be;

  "I'd say that the SHA has a huge responsibility and at times speaking to some of the people from the SHA…I am surprised that they are disconnected with what I think should be the shareholders, which is the population, your public". (see Appendix XV)

The General Managers however, all cite commissioners in some way - by either stating that PCTs hold sway like respondent 17G5;

"The word that comes straight away is the commissioners. I would like to say patients, but I am going to say commissioners". (see Appendix XIX)

or that GPs in their emerging role as commissioners of acute healthcare, as reflected in the succinct and clear response of respondent 16G4;

"GPs I think. I only think that as they dictate where referrals go, where the activity goes. In reality, I think that they control how the money flows". (see Appendix XVIII)

Figure 81. Summary of research interview participant demographics (derived from responses to Questions 1 to 7)

3	Questions	1	2	4	5	6	7
Code	Response YES / NO	Male / Female	Age	Length of service – current (years)	Length of service – NHS (years)	Always NHS?	Industry type
1E1	NO	F	X	X	X	X	X
2E2	YES	M	50-59	2-4	>20	NO	Commercial, competitive
3E3	YES	F	50-59	5-9	>20	Just NHS, Yes	n/a
4E4	YES	M	50-59	2-4	>20	NO	Commercial, competitive (Post Office)
5E5	YES	F	40-49	2-4	15-19	NO	Commercial, competitive
6E6	NO	M	X	X	X	X	X
7M1	NO	M	X	X	X	X	X
8M2	NO	M	X	X	X	X	X
9M3	YES	M	40–49	5-9	>20	Just NHS, Yes	n/a
10M4	NO	M	X	X	X	X	X
11M5	YES	M	50-59	5-9	>20	Just NHS, Yes	n/a
12M6	YES	M	50-59	>15	>20	Just NHS, Yes	n/a
13G1	NO	F	X	X	X	X	X
14G2	NO	F	X	X	X	X	X
15G3	NO	F	X	X	X	X	X
16G4	YES	M	30-39	2-4	5-9	Just NHS, Yes	n/a
17G5	YES	F	> 60	>15	>20	NO	Commercial, competitive (Legal)
18G6	YES	M	40-49	5-9	15-19	NO	Commercial, competitive
19G7	NO	F	X	X	X	X	X
20G8	NO	F	X	X	X	X	X

Figure 82. Summary of research interview participant responses to Questions 8 to 13 (NHS Hospitals and Competition)

	Questions	8	9	10	11	12	13
Code	Response YES / NO	Has the level of collaboration changed? More, or less?	Is there competition between NHS Hospitals?	What evidence have you seen that competition might exist?	Will increased competition drive up service quality?	Will increased competition drive financial efficiency?	If competition increased, would you be comfortable with that?
1E1	NO	X	X	X	X	X	X
2E2	**YES**	**More**	**Yes**	**A, B**	**Yes**	**Not convinced**	**Yes**
3E3	**YES**	**More**	**Yes**	**A, C**	**Yes (although no later)**	**Could do**	**Conditional**
4E4	**YES**	**Less**	**Yes**	**D, E, F**	**Potentially**	**Not necessarily**	**Not the first step**
5E5	**YES**	**Less**	**Yes**	**C, D**	**Potentially**	**Indirectly, maybe**	**With conditions**
6E6	X	X	X	X	X	X	X
7M1	X	X	X	X	X	X	X
8M2	X	X	X	X	X	X	X
9M3	**YES**	**Less**	**Yes**	**No clear answer**	**No clear answer**	**No**	**With conditions**
10M4	X	X	X	X	X	X	X
11M5	**YES**	**Less**	**Yes**	**G**	**Yes**	**With conditions**	**With conditions**
12M6	**YES**	**Less**	**Yes**	**A**	**No**	**No**	**No**
13G1	X	X	X	X	X	X	X
14G2	X	X	X	X	X	X	X
15G3	X	X	X	X	X	X	X
16G4	**YES**	**Less**	**Yes**	**B, I**	**Yes**	**Yes**	**No**
17G5	**YES**	**Less**	**Yes and No**	**F**	**No**	**No**	**Yes**
18G6	**YES**	**More (marginal)**	**Yes**	**G, H**	**No**	**Probably**	**No**
19G7	X	X	X	X	X	X	X
20G8	X	X	X	X	X	X	X

Figure 83. Summary of research interview participant responses to Questions 14 to 18 (Leadership)

	Question	14	15	16	17	18
Code	Response YES / NO	What is the purpose of leadership?	How many meet your criteria?	What are the constraints on leaders in the NHS?	Has criteria for good leadership in the NHS changed?	Undertaken leadership development?
1E1	NO	X	X	X	X	X
8M2	**YES**	**Inspiration, Direction**	**70%**	**Changing political policy on NHS, Public perception of NHS**	**Yes, more public, new financial regime brings new skill needs**	**Yes**
3E3	**YES**	**Visionary, Direction, creating the environment**	**'can't think of anyone'**	**Changing political policy, rule based bureaucracy**	**Yes, need to understand business, not just health**	**Yes**
4E4	**YES**	**Helps set direction, motivates, has desirable traits / respect**	**30%**	**Fear. Inconsistency at SHA / DH level due to changing political policy**	**Yes, far more complicated**	**Yes**
5E5	**YES**	**Direction, empowering, supporting a clear vision**	**60%**	**Changing political policy, targets and operational pressures**	**Yes, more commercial approach. Greater accountability**	**Yes**
6E6	X	X	X	X	X	X
7M1	X	X	X	X	X	X
	X	X	X	X	X	X
9M3	**YES**	**Must understand the organisation, makes decisions**	**'could not answer'**	**Division between clinicians and management**	**Not answered clearly**	**Yes**
10M4	X	X	X	X	X	X
11M5	**YES**	**Support, help and motivate**	**30%**	**Engrained mindsets, workforce and financial constraints**	**Yes, more organised, no longer who shouts loudest**	**Yes**
12M6	**YES**	**Establish direction, ensure people are signed up**	**'could not answer, as impossible job'**	**Changing political policy, workforce constraints and inflexible estate (PFI)**	**Yes, significantly harder, hands tied by targets**	**Yes**
13G1	X	X	X	X	X	X
14G2	X	X	X	X	X	X
15G3	X	X	X	X	X	X
16G4	**YES**	**Horizon scan, prioritise and manage people**	**20% - 30% (25%)**	**Operational pressures and changing political policy.**	**Yes, more commercially aware**	**Yes**
17G5	**YES**	**Direct, support and remain positive**	**60%**	**Operational pressures**	**Yes, more accountable, needs business mind**	**Yes**
18G	**YES**	**Set expectations (of people) and enable**	**40%**	**Operational and workforce pressures**	**Yes, focus on commercial value**	**Yes**
19G7	X	X	X	X	X	X
20G8	X	X	X	X	X	X

Figure 84. Summary of research interview participant responses to Questions 19 to 23 (Leadership)

	Question	19	20	21	22	23
Code	Response YES / NO	What type of leadership development activities?	Are you aware of any theoretical leadership models?	Have you ever heard of the Leadership Qualities Framework (LQF)?	Have you used the LQF?	Who, has the most influence within the NHS?
1E1	NO	X	X	X	X	X
2E2	**YES**	**Local, profession specific, regional (SHA) and national (DH)**	**Yes, Myers Briggs (personality) and trait**	**No**	**n/a**	**Hospital Consultants**
3E3	**YES**	**Self-initiated MSc**	**Yes, but couldn't name**	**Yes**	**Self – no, others – yes. Not using now**	**Doctors**
4E4	**YES**	**Absorbing experiences, profession specific and national**	**Yes, but couldn't name**	**Yes**	**Self – yes, others – no. Not using now**	**Clinicians**
5E5	**YES**	**Profession specific, regional (SHA), national (DH) and self-initiated (charity)**	**Yes, but couldn't name**	**Yes**	**Self- no, others – indirectly. Not using now**	**Consultants and GPs**
6E6	X	X	X	X	X	X
7M1	X	X	X	X	X	X
8M2	X	X	X	X	X	X
9M3	**YES**	**Self-initiated MBA**	**Yes, '5 – disciplines of leadership' and personal qualities**	**No**	**n/a**	**SHA, PCT**
10M4	X	X	X	X	X	X
11M5	**YES**	**Self-initiated University provided**	**No, not at the moment**	**Yes**	**Self- no, others – no. Not using now.**	**SHA**
12M6	**YES**	**University provided management course decades ago**	**No**	**No**	**n/a**	**Acute hospitals, particularly tertiary (rather than PCTs)**
13G1	X	X	X	X	X	X
14G2	X	X	X	X	X	X
15G3	X	X	X	X	X	X
16G4	**YES**	**Profession specific, regional (SHA) and national MTS (DH)**	**Yes, but couldn't name**	**No**	**n/a**	**GPs (as commissioners)**
17G5	**YES**	**Local, national (DH)**	**Yes, but couldn't name**	**No**	**n/a**	**PCTs**
18G6	**YES**	**Local, profession specific and regional (SHA)**	**Yes, but couldn't name**	**Yes**	**Self – yes, others – no. Not using now.**	**PCTs**
19G7	X	X	X	X	X	X
20G8	X	X	X	X	X	X

Multi-site on-line questionnaire results – questions 13-18 (competition)

Research participants were asked whether the level of collaboration between NHS hospitals had changed in recent years (Question 13)

- Overall, most of the participants (12) thought that the level of collaboration had changed, with only 2 stating that there had been no change (both Clinical Directors)

- 7 respondents said that the level of collaboration between hospitals was less than before (All 3 Executives, 2 Clinical Directors and 2 General Managers)

- 5 respondents said that there was more collaboration between hospitals than before (1 Clinical Director and 4 General Managers)

The respondents were asked if they thought that there was competition between hospitals in the NHS (Question 14)

- All 14 respondents answered "yes" to this question.

Respondents were asked to indicate those things that they thought might indicate that competition does, or might, exist between NHS hospitals (Question 15)

- The top three things cited by respondents were market share papers, new work patterns and new roles/jobs within the organisation.

- The Executive Directors cited market share papers and new roles/jobs (2 respondents) and also, all of the other options including outsourcing of work, new work patterns, increased emphasis on communications (1 respondent). Interestingly, in the narrative responses, all 3 Executive Directors added comments

- One alluded to the "*results bar for cancer service provision was being raised*"

- Similarly, another suggested an "*elitist approach to clinical planning*"

- And finally, the other Executive Director said that there'd been "*an increase in strategic partnerships"*

- The Clinical Directors cited two main indicators – market share papers (5 respondents) and new work patterns (4 respondents). A single Clinical Director also cited new roles/jobs and outsourcing of work. Interestingly, in the narrative responses, 2 Clinical Directors offered further comments. Firstly that organisations were trying to "*influence the clinical specifications that inform future service configuration*" and secondly that "*there had always been clinical rivalry between hospitals, but more recently it was more evident*"

- The General Managers cited far more indicators than the other two groups. The indicators they gave were new roles/jobs (4 respondents), market share papers (5 respondents), outsourcing (1 respondent), new work patterns (5 respondents) and an increased focus on communications (3 respondents). None of the General Manager participants made further narrative comments.

When asked whether increasing competition between hospitals will increase the quality of service for patients (Question 16), the responses were as follows.

- 57% (8 respondents) overall said that they thought competition would not increase the quality of service for patients. Conversely, 43% (6 respondents) thought that competition would increase the service quality for patients.

- Opinion between the staff groups was largely divided. Executives were divided 2 to 1 against, Clinical Directors were divided 3 to 2 against and General Managers were divided equally, with 3 saying 'yes' and 3 saying 'no'.

- There was one narrative comments added by an Executive Director respondent, as follows

    - *it will mean that organisations focus on doing only the work (care) that they think they are commercially competent at. This could lead to worse access for patients, who may have to travel further if their local provider can no longer sustain viable services (because competitors have sucked up all of the work)*

- Four Clinical Directors added further narrative comments about this issue

  - *will make providers think more carefully about what they offer*
  - *Local services may be lost as big institutions influence policy to centralise services.*
  - *clinical networks between different hospitals help bring services locally to patients and enable retention of expertise on a reasonably local basis (against a backdrop of increasing medical sub-specialisation). Organisations that work in silo will fail.*
  - *No more than it has done in the past - patients have very different perceptions of what quality is. Some will accept mediocre care in a plush setting, some are minded to seek out the best clinical outcomes, regardless of how difficult access or poor the environment is. That's just one example, but I hope it illustrates my point?*

- In terms of the General Managers, three offered further narrative comments

  - *Competition and new tariff policies will increasingly make retaining quality more difficult.*
  - *Increasing competition will improve waiting times, car parking and flexibility in appointment times which all have a small positive impact on quality. However, it reduces collaboration between providers and for many specialities there are huge quality benefits to be had from collaboration. It also redirects resources towards reputation management and away from genuine quality improvements.*
  - *it means that we'll have to think about the customer service experience we provide to patients, compared to other places like private hospitals who might do NHS work now*

Respondents were asked (Question 17) whether they thought that increased competition between hospitals would improve the financial efficiency of the NHS overall. Their responses were as follows

- Similarly to the previous question, opinion overall was divided but 57% (8 respondents) favoured a negative response, whilst 43% (6 respondents) gave 'yes' as their answer.

- In terms of the groups of staff, all 3 Executive Directors said that competition would not increase efficiency for the NHS. Clinical Directors were divided, with 3 saying similar to their Executive colleagues and 2 answering 'yes'. Unlike their Executive or Clinical colleagues, the General Managers largely felt that competition would increase efficiency for the NHS, with 4 answering 'yes' and 2 answering 'no' to this question. A good number of respondents overall provided further narrative responses to the question.

- All 3 Executive Directors offered further insight as to their views on this issue, as follows

  - *lots of admin costs if multiple providers. Also, less joined up, so greater chance for people to profit at expense of taxpayer*
  - *certainly not - more complexity = more cost*
  - *Not a chance - although it may move some of the administrative costs off of the NHS books directly, into other organisations. A cynical view might be that perhaps that's the intent?!*

- All 5 Clinical Directors provided additional comments on this matter, as follows

  - *will increase cost to the taxpayer ultimately*
  - *It may lead to more and more clinicians becoming aware of costs and finances. Most are somewhat distant from this in their NHS work at the moment and by including them and sharing information as a consequence of competition, perhaps costs may be driven down?*
  - *cost will inevitably rise - to be competitive and stay that way, you need to invest in the latest medical technologies and there aren't cheap*
  - *If implemented and regulated well, may be, yes*

- *More points of access to NHS services equals more cost to administer and manage. Any fool can see that (except perhaps our current Health Minister)*

- Half of the 6 General Managers gave further points for consideration in response to the question, as follows

  - *Genuine financial efficiencies in providing healthcare come from working more productively, and often that requires collaborating with others, or at least sharing ideas and innovations quickly. Increasing competition reduces the incentives for sharing good ideas. I have experienced NHS staff in a neighbouring hospital refuses to share a useful spreadsheet for managing cost reductions because "we are in competition after all".*
  - *it might make the NHS more focussed on costs compared to other providers*
  - *Yes, as hospitals will need to find ways of becoming more commercially viable whilst retaining the ability to provide better services than the competition.*

Question 18 asked research participants if they would feel comfortable if the level of competition were increased further through new commissioning policy. The responses were as below

- Opinion here was clearly against the prospect of enhancing competition. 79% (11 respondents) overall replied ‘no’, whilst 21% (3 participants) said ‘yes’.

- Interestingly, all of the Executive Director (3) and Clinical Director (5) respondents were unanimous in their opposition to the prospect of enhanced competition, whilst General Managers were split 50:50 with 3 saying ‘yes’ and 3 saying ‘no’. Nine of the participants offered further comment.

- Two Executive Directors added the following

  - *at a time when there's a shrinking public purse, it does not make any sense to introduce a system that inevitably, will cost more to run*

- *because I believe in uniform standards and access to services. Competition will encourage people to spend taxpayers money on finding the commercial edge to attract patients, rather than the clinical care one.*

- Again, Clinical Directors offered most comments additional to their headline view, with 4 of them as follows

  - *Certainly not!*
  - *as less money for patient care, more on contracting etc*
  - *ticked no, but I really do not know*
  - *Certainly not!!*

- General Manager provided 3 further comments, as follows

  - *Trying to generate a market economy where in many geographies there is effectively a monopoly on skills and qualified people, is not a good use of management time.*
  - *it would make life in the NHS more like what I think it might be like in the private sector*
  - *I think there should be a decision made to say that the market is the mechanism through which NHS services will be delivered. At the moment, it\'s a halfway house where failure is politically a problem, as failing hospitals cannot be closed or sold on.*

Multi-site on-line questionnaire results – questions 19-30 (leadership)

Participants were asked (Question 19) what they thought the purpose of leadership was. It enabled them to choose from a selection of potential purposes and to add their own view in free text. The results are summarised in Figures 85 and 86.

Figure 85. Research questionnaire participants views on the purpose of leadership (1)

	Direct	Inspire	Connect	Do	Decide	Coach	Enable	Delegate	Plan	Motivate
ED	0	2	2	0	0	1	1	1	1	0
CD	4	2	0	1	3	0	0	3	2	1
GM	4	4	2	2	3	5	2	2	3	3
Total	**8**	**8**	**4**	**3**	**6**	**6**	**3**	**6**	**6**	**4**

Source: Author (2010)

Figure 86. Research questionnaire participants views on the purpose of leadership (2)

	Create	Nurture	Control	Scan Horizon	Under-stand	Regulate	Organ-ise	Moral Guide	Other / comment
ED	0	0	0	2	0	0	0	0	"All of these" (1)
CD	0	1	0	1	0	1	0	3	
GM	1	2	0	5	2	0	3	4	"Innovate to out-do the competition" (1)
Total	**1**	**3**	**0**	**8**	**2**	**1**	**3**	**7**	**(2)**

Source: Author (2010)

Question 20 asked participants to state, given their responses to Question 19, how many NHS leaders now, measure up to the standard respondents gave for what makes a 'good leader'. The results are as below.

- Overall, the average score from all participants was 4 out of 10.
- Executive Directors rated current NHS leaders at an average of 4 (3+3+6)
- Clinical Directors rated current NHS leaders at an average of 4, with a broader range of individual opinion (4+9+3+2+2)
- General Managers again had a broader range of opinion, but averaged just over 4 (4.3) with scores from 1 to 7 (1+6+5+1+7+6)

The question of leadership constraints arose in Question 21, which asked all participants what things constrained NHS leaders. Their responses are shown in Figure 87.

Figure 87. Research questionnaire participants views on leadership constraints in the NHS

	Policy	Targets / Operating Pressures	Financial	Estate	Workforce	Other
ED	3	2	2	1	3	need a more flexible workforce terms and conditions, especially if supposed to compete with private sector - not level field otherewise (1)
CD	5	1	1	1	1	
GM	4	6	1	0	0	Inability to break out of old-style NHS culture (1)
Total	**12**	**9**	**4**	**2**	**4**	**(2)**

Source: Author (2010)

Research participants were asked in Question 22, to advise whether they thought that the criteria for what makes a good leader in the NHS had changed in recent years. They were also invited to comment. The results are shown in Figure 88.

Figure 88. Research questionnaire participants views on whether what makes a good leader in the NHS has changed

Group	Response Yes or No	Comment
	Yes	More complex world now, with more frequent policy changes
Executive	Yes	complexity and need to understand political change has increased a lot
Directors	Yes	Absolutely it has. Far more complex roles at the top (middle and bottom) of organisations now, so the criteria has had to change.
	Yes	Far more complex than in the old days of hospital administrators. More of them, but it\'s certainly more complex with far more regulation and rules to follow than ever
Clinical	Yes	during my career, the role of those leading hospital trusts (as they now are) has become far more complex than it ever used to be. More plates to spin, with more people
Directors	Yes	things are more complicated now, with more boxes to tick and more people to report to.
	Yes	The job is more complicated than in the old days. More red tape, more bureaucracy to contend with.
	Yes	far more complex
	Yes	Requirements today are the same as in a major commercial organisation, previously they centred around managing a fixed pool of resources
General	Yes	Leaders in FT\'s have to be much more self driven and accountable. They are not
Managers		obliged to report to others and so have to direct their own agenda much more.
	No	
	Yes	
	No	I don\'t know
	No	

Source: Author (2010)

Question 23 asked participants if they had undertaken any specific leadership development activities during their career. Every single participant responded saying yes, that they had.

Participants were asked in Question 24 to indicate the types of leadership development activities they had undertaken. All participants responded and the results are summarised in Figure 89.

Figure 89. Types of leadership development undertaken by research questionnaire participants

Type of leadership development activity	Executive Director (3)	Clinical Director (5)	General Manager (6)
Local to hospital	2		1
Specific to profession	1	1	3
Regional (e.g. SHA)	1	1	1
National (e.g. DH)			
Academic (e.g. MBA)	2	2	2
N/A			
Other		1 (watched others)	1 (external programme)

Source: Author (2010)

Question 25 asked participants if they were aware of any theoretical models that explain or suggest what constitutes effective leadership. All participants responded and the results are shown in Figure 90.

Figure 90. Research questionnaire participant awareness of theoretical leadership models

Are you aware of any theoretical models that explain or suggest what constitutes effective leadership?	Executive Director (3)	Clinical Director (5)	General Manager (6)
Yes	3	2	3
No	0	3	3

Source: Author (2010)

Participants were asked in Question 26 whether or not they had heard of the 'Leadership Qualities Framework'. All participants responded and the results are shown in Figure 91 below.

Figure 91. Research questionnaire participant awareness of the 'Leadership Qualities Framework'

Honestly, have you heard of the 'Leadership Qualities Framework'?	Executive Director (3)	Clinical Director (5)	General Manager (6)
Yes	2	0	5
No	1	5	1

Source: Author (2010)

Questions 27, 28 and 29 asked participants who had responded positively to question 26, whether they had used the LQF to develop themselves or others and whether they were using it for any purpose now. The results from all 3 questions are summarised in Figure 92 below.

Figure 92. Research questionnaire participant utilisation rates for the Leadership Qualities Framework.

Question	Executive Directors (2)		General Managers (5)	
	YES	NO	YES	NO
Have you used the LQF to develop yourself?	0	2	3	2
Have you used the LQF as an aid to developing others?	1	1	1	4
Are you currently using the LQF for any purpose?	0	2	2	3

Source: Author (2010)

The final question (Question 30), asked participants, 'When we think of NHS organisations generally (not necessarily the one you currently work for), which stakeholder groups hold the most influence?'. The numerical results are shown below in Figure 93, along with a further illustration showing comments by group in Figure 94.

Figure 93. Research questionnaire participant views on influence in the NHS

Most influential group	Executive Directors (3)	Clinical Directors (5)	General Managers (6)
Doctors	3	3	2
Board of the organisation	0	3	2
SHA	0	3	1
Politicians	1	0	1
PCTs	0	0	2
Deanery	0	2	0
GPs	0	0	1

Source: Author (2010)

Figure 94. Research questionnaire participant views (narrative) on influence in the NHS

Group	Comments
Executive Directors	• *Doctors* • *Usually the doctors, although politicians (who aren't part of the NHS) can unduly mess around with things!* • *The clinicians, Doctors in particular*
Clinical Directors	• *The SHAs really, as a front for the Department of Health. Within the organisation itself, the Doctors are very influential.* • *The CEO and Directors. Outside of the organisation, the SHA and Deanery* • *The consultant workforce and the executive team (in that order!)* • *Should be patients, but it is the professionals (largely medical)*
General Managers	• *GPs, PCTs* • *Medics* • *PCT* • *The Doctors, no doubt – along with the SHA. These are the people that make our senior managers jump.* • *The board and executives* • *Clinicians and board members mostly. Politicians too much!*

Source: Author (2010)

In terms of demographics and the background of the research participants who responded to the on-line questionnaire, these questions were explored at the outset of the questionnaire. Along with questions that confirmed participants had read the Participant Information Sheet and agreed to undertake the research and had opportunity to stop at any point, the initial questions covered participant background and status. The output of these questions is shown in Figure 95.

Figure 95. Research questionnaire participant demographics and background.

Research participant	Male or Female	Age band	Current role	Service in current role	NHS Service duration	Worked in other sectors?	Examples
18E	M	40-49	ED	2-4	15-19	Other	Commercial
11E	F	40-49	ED	2-4	15-19	NHS	n/a
08E	M	40-49	ED	<2	15-19	Other	Commercial
02G	M	>60	GM	2-4	5-9	Other	Commercial
19G	F	40-49	GM	<2	5-9	Other	Commercial
06G	M	40-49	GM	5-9	5-9	Other	Commercial and non-profit
20G	F	30-39	GM	5-9	5-9	Other	Commercial
16G	F	30-39	GM	<2	5-9	NHS	n/a
10G	F	30-39	GM	2-4	5-9	NHS	n/a
04C	M	50-59	CD	>15	>20	NHS	Private health
12C	F	50-59	CD	>15	>20	NHS	Private health
01C	F	40-49	CD	5-9	15-19	NHS	n/a
19C	M	50-59	CD	>15	>20	NHS	n/a
03C	M	40-49	CD	10-14	>20	NHS	n/a

Source: Author (2008)

ANALYSIS AND DISCUSSION

Analysis and discussion – an overview

At each stage of the research, the NHS leaders targeted have been made up of three distinct types, Executive Directors, Clinical Directors and General Managers. At each stage of the research, whilst there is some minor variation in response rates between these groups, each individual that has participated, has engaged fully in the research process.

If the researcher had not been limited in terms of time and resources, and therefore the breadth of research methods available, greater engagement and response rates may have been possible.

With regard to the openness, honesty and integrity of participant responses, it is also possible that something in the approach may have led some potential participants to fear what might happen if they responded in such a way that was seen as, 'non-party line'. Whilst the more recent landmark report of Robert Francis QC (Francis, 2013) was not published at the time of the research, nor in the minds of the researcher or the participants, the cultural regime was certainly in place (Timmins, 2013). Steare's strongly worded cultural comparator with the banking sector, driven by his own cultural research, did give the author some pause for thought;

'Our research into 'moral DNA' demonstrates that the integrity and virtue of bankers is above average. This is also true of healthcare workers. And yet just as the Francis report right points the finger at target-setting, box ticking bureaucrats in the NHS, so too we must challenge the impact of totalitarianism and the culture of fear' (Steare, 2013)

Whilst there is a debate about the nature of organisational culture within the NHS throughout and particularly at the time of concluding this research (Sweetman, 2013), the researcher would argue that whilst this may have varied slightly from hospital to hospital, all research conducted at this time would have been subject to the same embedded cultural platform. More importantly, no informal or formal concerns or questions were raised during the entire research process. This was the case for those who actively participated and those who chose not to. Given this, the researcher can only conclude that non-participants were too busy, or were simply harder to reach. Whilst all non-responses are disappointing, the researcher referred

to Frey & Oishi (1995) for re-assurance on the matter as they state, 'higher refusal rates in one group than another may not be down to the interviewer ; the group being contacted may be harder to enlist' (p 143). In relation to those who did participate, the researcher's experience was a uniform openness and enthusiasm to share insight, experiences and views from all research participants at all stages of the research. This, combined with the absence of any concerns or questions being raised at any stage bolsters the level of confidence the researcher has in relation to the integrity of the information gleaned through the research process.

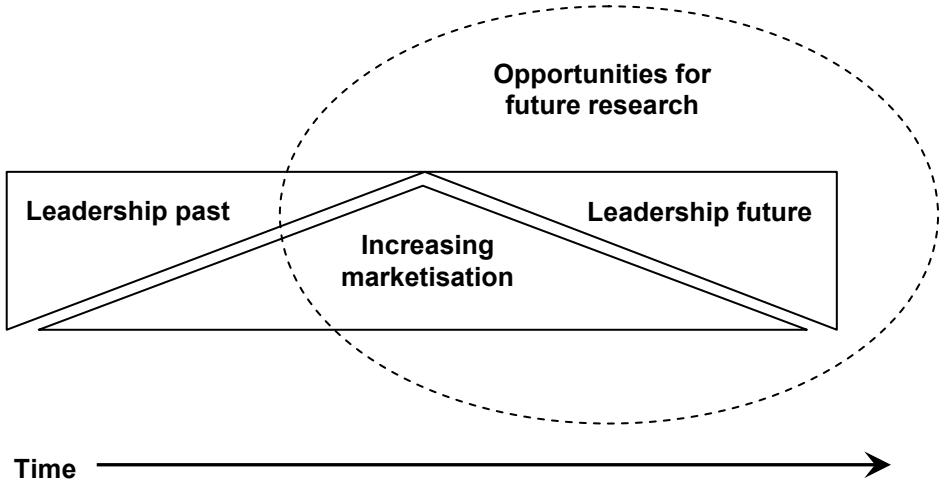
With regard to the general level of engagement shown by potential research participants, there are a number of important points.

At the case-study site, where research participants were targeted and asked to undertake a telephone interview, the response rate of 50% is credible in the researchers view. This standpoint is informed not only by discussion with other researchers and research supervisors, but the literature too.

At the higher end, Hague (1993), cites a poor response rate as being, 'less than 50%' (p 74). With specific reference to those conducting organisational research, a critical review undertaken by Baruch & Holtom (2008) found that the average response between 1995-2005 was a similar 48% (p 1151). When contrasted to academia and marketing research, these levels of response are certainly at the higher end of the spectrum. Nulty (2008) reviewed 9 different academic papers and pronounced that the, 'average response rate expected would be 33%, with a range of 20%-47%' (p 31). This lower response rate is also replicated in the marketing research sector, with Markovitch (2009) citing a 'maximum of 22%' research response rate in that industry. The researcher was reassured once this evidence base had been reviewed and understood, as a very credible comparison can be made between the response rates seen at each stage of this research (and indeed, the overall response rate shown in Figure 77, page 128) and those cited in the relevant literature.

The cultural context in which this research has been conducted, along with the timing of the research means that, as marketisation continues to evolve, not only could this research be conducted and placed in context, but as leadership in the NHS and in NHS hospitals changes and adapts, there will be opportunities for further research too. This is illustrated in Figure 96.

Figure 96. Marketisation will change the future of leadership and present opportunities for research



Source: Author (2013)

Competition and collaboration

The empirical results from the research undertaken show clearly that the view of leaders in the NHS, is that competition is increasing and collaboration is reducing. Contrasted to the literature, this development holds true when compared to the previously cited work of Le Grand (2007), in which he sets out his six key themes for driving health policy toward a more market based system (see page 16). This majority view was uniformly expressed across all leadership disciplines and organisations who participated in this research and it raises a number of issues.

Firstly, in addition to a reduced level of sharing good practice across hospitals and NHS institutions, this phenomenon has seemingly started to lead to a number of behaviours and actions that 'rub-up' against the founding ethos of the NHS. This lack of sharing best practice in a uniform fashion, so that maximum benefit is gained from research and enterprise without inequity of access or quality is of course, one of the primary issues that the researcher cited in the literature. To illustrate this point, it is evident in the work of Kotler & Andreasen (1991) and that of Palmer (2005), as summarised by the researcher in Figure 2 (page 15). In practice, protectionism over ideas, innovation and – in the extreme – non-sharing of risk related or commercially sensitive information could be to the detriment of NHS users and set the NHS in England back, both in terms of its comparative standing against other health systems

in the world and more importantly, in the eyes of patients and the public who use and interact with hospital services every day

One of the traditional strategies during periods of financial strain or stress, is to seek out opportunities for mutually beneficial collaboration. This is certainly the case in the commercial business sector (Slatter & Lovett, 1999) and indeed, the NHS itself (Leech D, 2009a). It could quite reasonably be contended that these models when set in an increasingly competitive and uncooperative culture, are more unlikely to work, regardless of whether there are evidence based cases for change that would have positive effects on the health of the population. This situation will not only have implications for hospital leaders, but the knock-on effects will be felt by service users and clinical professions alike. Of course, it will also present a number of further regulatory and political headaches to an already complex NHS.

Hybrid models such as 'co-opetition' (Brandenburger & Nalebuff, 1997) do not seem to have been employed as either covert or explicit stepping stones toward an NHS market (Leech, 2008). Given the benefits extolled by the co-opetition movement, this is somewhat of a surprise. The NHS has many core-functions which could be looked at for economy of scale and some degree of uniformity, leaving the market to develop under a 'choice' policy for clinical services supported by a series of integrated and relatively uniform core functions.

The evidence of change and the developing presence of competition in the NHS hospital sector was clear to see in the results of this research. Research participants cited numerous material changes in practice or language that in their view, informed their general opinions and these included;

- Business lines / business units
- Business development
- Marketing
- Market share / Market growth
- Divestment
- Loss leaders
- Profit & Loss
- Customer / relationship management
- (old) General manager v (new) commercial manager

In addition to providing clear evidence of change, these numerous developments indicate that the situation in the NHS is becoming more closely aligned than ever to the notion of 'New Public Management' (NPM) as outlined in the work of Hood (1991) who applied in his work, applicable to the public sector more generally, a number of characteristics to his NPM and these of course included the promotion of competition and choice in public service supply (see page 18). If correct, then the NHS is only just catching up with the rest of the public sector and hospital leadership in the NHS will require a new form, more comfortable with commercial decision making in a previously care centric culture. The researcher says 'previously', as the argument that commercial, market based policy and the decisions likely to arise from it will fit comfortably with the founding principles of the NHS is flawed. It is clearly evidenced in the work of Rivett (1998) that the NHS was based upon principles of universal access to free, standardised healthcare care and this has held true for many decades (see page 19). Hospital leaders, as evidenced through this research, do not believe in the concept of marketisation in healthcare and as a consequence, the researcher would argue strongly that the public, the clinical 'caring' professions and indeed many in management positions will struggle at many levels with implementation (Leech & Matthews, 2008).

Once of the key factors cited by hospital leaders during the research, was of likely concern to the clinical professions in particular and it related to wider public health agenda around access to care. It is long advocated that the more complex a health system is to access and navigate, the more likely it would be that the 'sharp elbowed', well-educated and more able members of society will prevail, leaving a 'health underclass' languishing in their wake as victims of the market (Leech *et al*, 2007). This argument is well founded in research. For example, in the extensive work of Kotler & Andreasen (1991), they make the case quite clearly that 'the market produces inequity of access and quality' (p 12).

The use of metrics, market analysis and measurements considering the relative performance, actions and impact of competitors in developing strategic advantage in the market, are all practical things that leaders in NHS hospitals will need to grapple with. They may not have considered this previously, either in practical terms or in relation to leadership and management development. There is a clear risk that this focus rather than that of service, quality and clinical outcome, could detract from the core tenets of the NHS. Despite the central rhetoric that clings to and supports the founding spirit of the NHS and indeed, the LQF (DoH, 2010g; CMI, 2010), the fear is

that this blurring of focus on patient care related to commercial and financial prioritisation may already have begun. Indeed, it has already begun to show itself in the press and the public domaigns (Francis 2013; Nuffield Trust, 2013; Neville & Kuchlev, 2013).

Leadership

The mounting sense of competition in the rhetoric of hospital leaders as research participants in the hospital sector was hard, clear and seemingly reflective of everyday practice and contemporary life 'at the coalface'. This toughening of leadership as it evolves and develops will pose new challenges for those in practice, as well as those with a stake in developing the new theoretical frameworks under which future leadership models will form – particularly those specific to the NHS and the health sector generally.

The harder edged commercial skills and behavioural attributes described by the research participants in their responses certainly need active consideration. When contrasted to the literature, the researcher would point to some of the behavioural leadership models, such that developed by Blake & McCanse (1991). Here the scale of concern for people (relationships) is set against the level of concern for results (tasks) and reflecting upon the results of the research undertaken here, there is certainly a legitimate argument to say that hospital leaders in the NHS seem to be gravitating from 'country club' to 'authority-compliance' behavioural traits (see Figure 18). That said, the researcher would still advocate a degree of caution as the consequences of marketisation, such as organisational merger or take-over will still need in practice, leaders with a good number of the softer, people centric behavioural strengths held in such high regard previously (Leech, 2010).

The language changes cited by research participants have a potentially wider significance in terms of culture. Given the profile and standing of the NHS in the psyche of the nation overall, the findings of this research are hugely significant. For the first time, we have primary research data showing that the language used by those leading NHS hospitals in England has changed. Language, titles and roles along with other symbolic changes described in the findings of this research are all, according to the grounded theory, indictors of organisational culture and should be observed very carefully for change (Johnson & Scholes, 1999; Schein, 2004). Given these changes and the links to marketisation, the researcher would argue that marketisation is directly, or indirectly, driving a significant and fundamental cultural

change in NHS hospitals and the mind-set of those who have leadership roles in those organisations.

It is clear however, that in terms of driving up quality and financial efficiency, opinion among NHS leaders in the hospital sector is unclear. Whilst a majority (57%) at the site specific case study believed that quality and financial efficiency would not improve as a consequence of enhanced competition between hospitals, both they and those who had determined the opposite view were conditional in many of their responses. The researcher would summarise these conditional answers as being, 'in theory yes, in practice not sure'. In terms of credibility, over half (13 of the 24 - around 55%) of the research respondents overall had never worked in a non-NHS setting. This must be taken into account when weighting ones' view of the evidence. That said, in terms of implementing policy in this area, it cannot be argued that a significant proportion of those leading NHS hospitals do not believe that increasing marketisation in the NHS will drive up quality or improve financial efficiency (Leech, 2011). Respondents also understood the basic premise that transaction costs are likely to rise, as this was reflected in a number of responses. Those setting policy and leading the NHS at a national level, will need to consider how, given this lack of belief, further progress will be made toward the destination of a market based system for provision, as described in policy.

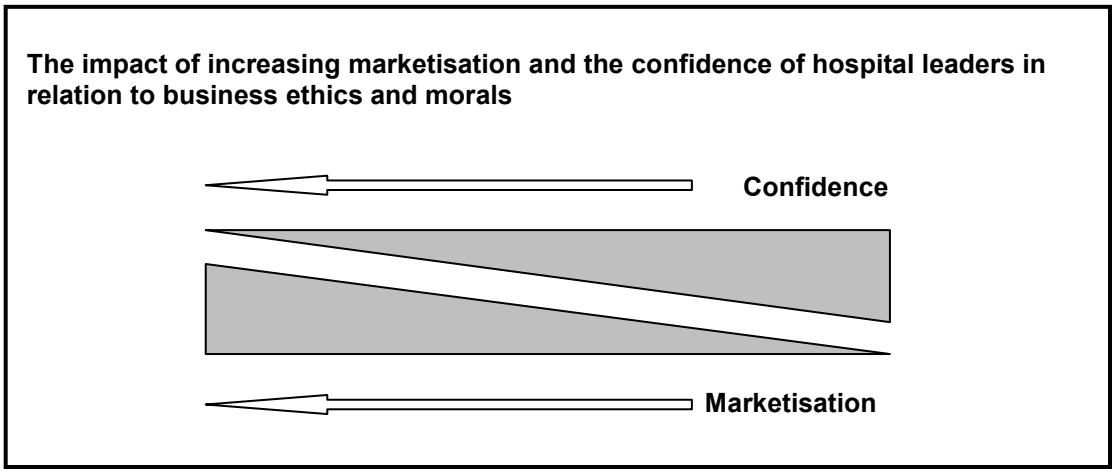
There is no direct and therefore true comparator to the NHS. Therefore, research based within or targeted at other former public service industries is interesting of course, but limited in terms of utility as any research is unlikely to match the size, complexity and emotive value of the health service in England. It would be fair to say that in terms of public opinion, the introduction of increased competition – albeit coupled with privatisation – in the former public utility sectors has not been met with universal accolade (Clarke & Pitelis, 1993; Marquis, 2001). It could be this lack of comparative or credible evidence or the questionable record in former public services that also contributes to the lack of confidence found among those leading NHS hospitals. In both the site-specific case-study interviews and the wider, multi-site questionnaire the clear majority of hospital leaders are uncomfortable with and demonstrate a clear lack of belief in the prospect of further increasing competition. This is a worrying signal, as even at a local level, the ability to take people with you during change is imperative to success and this is clearly evident in the vast catalogues of literature relating to leadership much of which features in the literature review section of this thesis – both generally, as well as that specifically orientated

toward the NHS (Handy, 1999; Van Maurik, 2001; Williams, 2005; Northouse, 2007; DoH, 2006a; Goodwin, 2006; King's Fund, 2006; Leech, 2009b).

In terms of hospitals leaders and their expectations around leadership and its purpose, there was minor variation between the interviews from the site specific case-study and the wider population sampled in the on-line questionnaire phases of the research. However, strong messages about leadership providing 'direction', 'motivation', 'vision' and an ability to 'horizon scan' came out commonly. Contrasted to some of the theoretical work undertaken around situational leadership, the researcher notes with interest that the expectation of leaders here, seems to align to a more directive style, perhaps that of 'S2', rather than 'S1' given the largely professional nature of the clinical workforce (see Figure 23, page 48). In terms of the theoretical maturity of followers in this instance, whilst the clinical workforce is largely professional and likely to be regarded as 'high' in maturity, the workforce of an entire hospital is large and of course, very diverse. One could argue that these wishes for greater direction and clarity about the future are symptomatic of life in the NHS and reflective perhaps, of the research participants' major criticisms around what hinders NHS leaders. In a reflective sense, the hospital leaders involved in this research cited continual policy change for example, hence perhaps the often stated desire for leaders to provide clear direction and see what's coming over the horizon. Interestingly of course, the LQF contrasts markedly to life in practice and the clamour for clear direction, as it continually insinuates that all NHS leaders have an ability and freedom to craft their own visions of the future – see Figure 45 (page 76). A holistic and collaborative mantra pervades the development model generally which, when set against the views of the research participants working in practice, appears to now be almost entirely defunct and based upon a historical set of values that are not coterminous with the policy of competition and marketisation in health.

One surprise to the researcher was the occasional reference in both the interviews and some of the narrative accompanying the on-line questionnaire, around leaders seeking guidance or being unclear in some way about what was expected of them from a business ethics or moral standpoint. The conclusion drawn here, can only be that as they practice in a more commercial and competitive environment hospital leaders personal and professional confidence around moral and ethical matters in practice is undermined. This is illustrated in Figure 97.

Figure 97. Increasing marketisation and hospital leaders; the impact on business ethics and morals



Source: Author (2012)

Professional codes of conduct and regulatory standards for clinicians may rub-up against the competitive ethos inherent within a market based system, particularly if it conflicts with patient care – for example, the hospital that asks its clinicians not to share the precise techniques or innovations it has developed in order to attract and retain a lucrative patient population (Leech, 2011a). Professional managers and leaders in a 'post Francis and Keogh NHS' will also need to consider this, as certainly the research participants here also reflected in some part, a sense of increasing public scrutiny and accountability (see page 141).

When asked about their peers and leadership, those hospital leaders who responded to the research questions stated that over 50% of current NHS leaders didn't measure up, in that they were far from meeting the criteria for good leadership they had described in a previous research question (see response to Questions pages 140 and 156). Whilst the researcher acknowledges the question was a generic NHS wide one and therefore could have been open to some level of interpretation (for example, leaders of commissioning organisations in the NHS may have been considered by participants when responding to the question), it is clearly a damning peer-assessment by those managing and leading NHS hospitals.

Evidently, the NHS leaders at the time of this research felt that the main constraints they faced related to targets, policy (and policy change) along with the workforce. Citing policy change as a major constraint is an interesting finding, as it leads to a number of observations and perhaps, further questions. In terms of the market,

continual policy change may put off new entrants to the NHS market. A perception of instability of operating environment for example, combined with a perception that the workforce and business itself is inflexible or overly regulated could be enough to deter. The researcher would also argue, given the propensity of the media to negatively report on the NHS overall, that any commercial organisation considering entry into the sector, would be foolhardy not to consider potential reputational or brand damage, should risks not be managed sufficiently well. This could also lead to some of the most capable leaders exiting the sector.

It would take a brave politician indeed to extoll the virtues of the true market and argue their application to the NHS. Whilst this would work against the clamour for national standards of service, increasing inspections and regulation, it would also require a very clear failure regime for those organisations (hospitals) that cannot find a successful operating model, or lose significant market share. The researcher would argue that, much like the banking sector, whilst organisations may fail in the market, government is very likely to intervene when organisations carry huge public interest and are “too big to fail” (Sorkin, 2009).

Operating as a leader in what is obviously a complex and changing environment (see Figures 87 and 88 on pages 157/158), it is not surprising perhaps to find that hospital leaders participating in this research were overwhelmingly of the view that leadership in NHS hospitals and the criteria for good leadership has changed. The only sub-group of hospital leaders who were a little less adamant in their views, were the General Managers. It has to be noted however, that this group in both the site-specific case study and the multi-site questionnaire were the least experienced in terms of their years served in the workplace and indeed, experience of the NHS. This demographic is clearly shown for both the single-site telephone interviews and the multi-site on-line questionnaire phases of the research, on page 133 and in Figure 95 on page 161. The hospital leaders responding to the research question, cited a “more commercial approach”, as the most common change. Following that, increasing complexity, bureaucracy and public accountability were all cited. These factors, when set against the LQF which was in operation and *de-rigour* in terms of leadership development at the time of the research, evidences clearly that policy developments around marketisation had out-paced the very leadership development framework designed to equip and prepare leaders for the workplace in NHS hospitals.

Leadership development

During the active research process, the researcher asked all research participants a series of further questions relating to leadership development. The first of which, asked simply whether the hospital leaders surveyed had undertaken leadership development activities previously. The overwhelming response (of 100%) was 'yes'. To be clear, every hospital leader who participated in this research stated that they had previously undertaken leadership development activities of some form or other. The researcher would suggest that this evidence leads to a number of potential conclusions, or further lines of enquiry, including;

- That those in positions of leadership in NHS hospitals recognise the importance of leadership development

- That perhaps people do not get appointed to positions of leadership without such development, or the promise of it (as we cannot tell whether the development activities were undertaken prior to, or after appointment)

- That NHS hospitals and those in positions of leadership within those organisations are more likely to have a propensity toward structured development, rather than an informal nepotistic approach to career development

These headline research findings related to leadership development offer a series of other interesting variations in response, when considered in more detail.

Clinical Directors at the case-study sites cited only formal academic leadership development and this, whilst not uniform, was broadly reflected in the multi-site on-line questionnaire results too. It is likely therefore, that this is a general trend rather than a specific policy or cultural norm for the case-study hospital site.

A further, noticeable variation in response was evident from the views of research participants at executive level. They listed the broadest range of leadership development activities. The researcher would suggest that this should not be too surprising, given their core role is to provide clear leadership at the very 'top' of their respective hospital organisations.

This range of leadership development approaches as described by research participants, is likely to reflect tradition, policy, funding routes or indeed, personal preference of learning styles. Regardless, when looking at the research participant cohort overall, the researcher would conclude that the range of development activities outside of the formal academic route, is relatively broad. The researcher would also suggest, that whilst this may be the case, attaining skills and direct experience through exposure to other sectors and environments outside the NHS as a development option, is clearly not used by the hospital leaders who participated in this research, as none of them described or even hinted at it during the research process. It is likely that this reflects a general position across the hospital sector, in which this type of leadership development activity is not actively considered or used (Leech, 2010b). Reflecting upon some of the theoretical analysis undertaken, it is clear that when contrasted to some of the skills-based leadership models, that a wide range and depth of career experiences and environmental influences are often seen as important components to good leadership development, as these enhance individual attributes, competencies and outcomes (see Figure 19, page 44).

Despite the propensity of Clinical Directors and other senior leaders toward academically based leadership development methods and their stated level of awareness of leadership theory (90% in the case-study interviews), the researcher noted with interest that the collective ability of respondents to subsequently describe any such theoretical models was very limited (corresponding 20%). There a number of variables that may have driven this outcome and these could include;

- That the academic level of the leadership programmes undertaken was very basic
- that the level of knowledge retained as an outcome of the programmes was poor (regardless of the academic level or standard of the programme)
- that the delivery of the academic programmes could be improved
- that the initial level of confidence in, or integrity of, research participants initial responses in which they claimed a high degree of knowledge, was somewhat questionable.

More seriously, it seems that the appetite for academic development among hospital leaders is high. This could present obvious opportunities for providers of academic, evidenced based leadership development, if they could also address a number of the

other relevant research findings here. For example, research participants clearly require leadership development;

- with a ‘commercial edge’
- that develops people to comfortably and confidently navigate and lead in uncertain operating environments
- that enables leaders to effectively deal with ever heightening levels of public and political scrutiny, in a changing world of communication and medical technology

As previously described in Figure 37 (page 74), the Leadership Qualities Framework (LQF) was well established at the time of the research and was seen as the primary NHS reference point for anyone wanting to undertake leadership development (DoH, 2006a; DoH, 2004a). It is disappointing then, that in an NHS that has more recently made assertive noises about developing and empowering clinicians to lead (Lansley, 2012) that none of the Clinical Directors asked in the multi-site questionnaire had even heard of the LQF.

The results improve for Executives, with two thirds claiming a level of awareness. General Managers described an impressive level of awareness of the LQF programme. The researcher would question whether this high rate of awareness was in-part related to the increased likelihood that General Managers would more likely be products of the NHS Management Training Scheme (MTS) or an affiliated programme that uses the LQF as its core. Regardless of what is driving the level of engagements, 83% of General Managers reported that they were well aware of the Leadership Qualities Framework.

Given the Clinical Directors previous declaration of preference for academic programmes, it is perhaps this that means NHS’s national flagship development programme for aspiring leaders hasn’t registered on their collective radar (as they were looking for academically orientated development instead). None the less, we can safely conclude that not one single Clinical Director asked during the multi-site questionnaire phase was aware of, or had knowingly used the LQF to develop themselves or others and they certainly weren’t currently doing so at the time this research was undertaken. This is reflected at the case study site too, as whilst two Clinical Directors were aware of the LQF, none had or were using it in practice.

The researcher would argue that the situation with regard to the Leadership Qualities Framework is in fact slightly worse than that portrayed through simple analysis of awareness levels. The true test of utility for any management or leadership development programme is the level of active engagement. In this instance, the research evidence clearly shows that only 2 individuals – both General Managers – said that they were using the LQF for any purpose at the time of the research. In stark terms, this represents only 2 out of 24 hospital leaders (8%) who actively participated in this research and therefore, the researcher would have to start questioning the value for money, organisational penetration and indeed, the operational and practical relevance of the LQF for hospital leaders if these figures are truly illustrative of the position across the hospital sector of the NHS.

In terms of why it is that leaders in NHS hospitals are not aware of, or more importantly are not directly using the LQF, there are a number of possible explanations. These could include;

- a question as to whether the values extolled within the LQF are now at variance with life in a 'marketised' hospital management culture and therefore, not as relevant

- a lack of commercial edge to the LQF

- the accommodating and inclusive nature of the LQF does not seem to fit with the evidence generated by this research about the perceptions of hospital leaders of what constituted good leadership. To illustrate this, whilst the research participants advocated a leadership model that is – directive, motivational, inspiring and provides a clear vision - the Leadership Qualities Framework, in terms of fit with these requirements, does not advocate a particularly directive approach.

In terms of the Leadership Qualities Framework itself, given the responses of research participants in this study, there is surely a case for overhaul. Contrasting the views of those working and leading in NHS hospitals at the time of this research, against the LQF and what those hospital leaders now see as prerequisites for good leadership, there must be a wealth of leadership theory and associated models one can draw upon to inform a more useful development tool for those in practice.

A further conclusion that can be drawn out of this research is a general, but very important point. According to the hospital leaders who engaged with this research process, there is no overall sense of 'who is in charge' and has the 'most influence' in the NHS. This statement is evidenced through examination of research participant responses, as summarised in Figure 98.

This interesting mix of responses and the evidence it generates, shows us a clear lack of cohesion among those leading NHS hospitals in England. Clearly, clinical directors feel that SHAs as regional offices of the DH hold influence and power in the NHS, more than the Executives who clearly see Doctors and to some extent politicians as those with a real hold on influencing the future of the NHS. General Managers, as slightly more junior leaders, cited boards and commissioners as having the influence. At the time of the research, the case-study site hospital was under review by its commissioning organisation, but any conclusion that suggests this situation would have skewed the outcome is misplaced, as a similar pattern of response was seen during the multi-site questionnaire and therefore the researcher would contend that the view is indeed a generalised one, common to general managers across the hospital sector.

Figure 98. Influence in the NHS by professional and managerial groupings

Group	**Viewed as having most influence in the NHS**
Case Study Site – Executives	Consultants/Doctors
Case Study Site – Clinical Directors	SHAs
Case Study Site – General Managers	Commissioners
Multi-Site Questionnaire – Executives	Doctors/Politicians
Multi-Site Questionnaire – Clinical Directors	SHA/Deanery/Boards/Doctors
Multi-Site Questionnaire – General Managers	Commissioners/Doctors/boards

Source: Author (2012)

What does this tell us about leadership development ? The research would contend that it tells us where the NHS could direct its resources in terms of bringing these incoherent sub-groups together from a hospital centric perspective. In terms of influencing change in the NHS, this research could also provide us with clues as to where engagement and leadership development activities might be best targeted. That said, an interesting piece of research, not within the scope of this thesis, would be to pose further research questions around who SHAs, Commissioners, Deanery and Political leaders see as holding most influence in terms of the NHS.

The researcher's analysis of these research findings also tell us, in a marked and slightly concerning way perhaps, that not a single respondent mentioned the level of influence held by the public or patients themselves. This could be for a number of reasons, including - obviously - that as far as leaders in NHS hospitals are concerned the public and patients genuinely have very little or no influence at all.

Given the political and media focus on both NHS accountability and patient and public involvement in service development, design and delivery in the wake of Francis, Keogh and recent scandals (Francis, 2013), it is perhaps disappointing that the people for whom the NHS was created to serve, are lowest if not non-existent, on the list of those who the leaders of NHS hospitals see as having influence.

When considering the implications of this particular research outcome, the researcher reflects back on other research findings already discussed and in this instance, would argue that perhaps the self-acknowledged lack of 'commercial awareness' among hospital leaders is also partly reflected here. To illustrate this final point of analysis and discussion, the researcher would suggest that in the commercial world, the 'customer is king'. This well-known phrase is commonly reflected in the ethos of many business leaders, organisations and indeed, in the work of a number of leadership focussed academics (Slater & Narver, 1998; Gulati & Oldroyd, 2005). Given the clear research findings, the situation can only be that either;

- there is a true lack of public influence in relation to the NHS and its hospitals
- that the leaders of those hospital organisations simply do not recognise the influence and therefore, the importance of the public

The general public are the primary service user of hospital services in the NHS. They are also, in the main, voters and therefore, from a political point of view the public perception of hospitals and their services is important too. When combined with the relationships with and between health professionals and the public, this complex web of influence (shown in Figure 57, page 86) illustrates why hospital leaders might wish to consider carefully the implications of not recognising and engaging with their primary customers in an increasingly complex and marketised NHS and to reflect this in their future organisational strategies.

The analysis and discussion within this chapter of the thesis is based upon the findings drawn from the research process described in the methodology chapter (pages 88 to 127).

CONCLUSIONS

Introduction to research conclusions

The research described within this thesis was conceived in a practice based context in 2008/09. The research questions arose from a primary objective to explore the impact of marketisation upon the leaders and leadership of NHS hospitals.

Since the very inception of the research project, there have only been a series of minor policy and practice based changes to the nature and delivery of NHS hospital services in England. Fundamentally therefore, the environmental context within which this research has been undertaken has not changed markedly. In terms of relevance, the research process, the primary research questions and the research findings derived, they all remain contemporary in their status. Consequentially, the researcher is hopeful that the research remains relevant, useful and of interest to academic and practice based circles within the NHS for some considerable time.

To the researcher's best knowledge, this research and its subject matter are original in terms of derivation, context and overall methodology. This is equally true for the conclusions and the overall content of this thesis. Like many academic institutions ARU advocates the use of the 'Turnitin' software tool, which is essentially an on-line originality and plagiarism checker (Gordon, 2012). When this research thesis was reviewed by 'Turnitin' in September 2013, it was designated with a 'green' status and the <1% similarity ratings highlighted were often that of work already published by the researcher. A number of these publications are listed in the reference section (pages 208 to 210).

As a consequence, the researcher is confident that the research findings here are new and that therefore, this research adds a further, original contribution to knowledge.

This section of the thesis provides the reader with four key sections describing clearly what has been derived from the research process overall. Reflecting on the primary research questions posed at the beginning of the research process, it begins with a description of some of the key factual research conclusions resulting from the evidence generated.

There are then two further sections, in which both a number of additional conclusions and implications from the research are set out. These relate to theoretical conclusions and implications, as well as those relating to practice. Structurally, these further conclusions and implications are themed similarly to the previous work by theme, in relation to competition and market forces, and leadership and culture specifically.

Finally, as expected with almost any PhD thesis (Dunleavy, 2003), there is a succinct description of a number of opportunities for further research, all of which arise as a consequence of this research.

Primary evidence based research conclusions

The primary research questions, posed at the beginning of this thesis (see page 3) were;

1. Do leaders currently working within NHS hospitals believe that there is competition between hospitals?

2. Has any sense of competition in the NHS increased, decreased or not changed in recent years?

3. Do leaders in NHS hospitals think, if the level of competition in the NHS were to increase, that this would that be good thing?

4. Have the leaders in NHS hospitals changed their behaviour or language as a consequence of competition with other hospitals and providers?

5. Have leaders in the NHS hospitals changed their perceptions of the skill set and qualities required of leaders in their field, as a direct consequence increased levels of competition ?

6. Taking the above into account, how well utilised by hospital leaders is the NHS Leadership Qualities Framework (LQF) and can it be described as “fit for purpose” in the current environment. Do hospital leaders believe that there are key gaps in the framework, that increasing marketisation may widen further still?

The evidence and information generated through the research undertaken has informed confident and clear answers to the primary research questions;

1. The results of the case-study research interviews, conclusively show that the vast majority (90%) of NHS hospital leaders believe that there is competition between hospitals (see page 135). The researcher found that the views of NHS leaders at this single site case-study were indeed symptomatic of a general cultural construct across NHS hospitals in England. This argument is backed by clear research data that shows, across a multi-site on-line questionnaire spanning 20 different hospitals, that 100% of the practising hospital leaders who participated in this research expressed the same belief ; that competition exists between NHS hospitals (see page 151)

2. The clear belief of hospital leaders that competition exists was further tested through this research. The research data generated provides evidence to show that whilst 70% (see page 132) of research participants at the case-study site believed that competition had increased in recent years, a very similar sense of increasing competition was replicated in 50% of the responses from hospital leaders in the multi-site on-line questionnaire (see page 149). The researcher, in light of these findings, would contend that this confirms a significant sense of increasing competition among the leaders of NHS hospitals and that this is not restricted to a single organisation, but many hospitals throughout England.

3. In terms of pushing the policy of marketisation in the NHS further, it can be concluded from this research that hospital leaders in the NHS are divided in their opinion; clearly not convinced that if the level of competition were to increase further that it would be a good thing for the NHS, the hospital sector or indeed patients and service users. This conclusion is derived directly from research participant responses during the case-study interviews and is replicated and generalised through the responses of the wider research population in the multi-site on-line questionnaire.

   In the case study interviews, opinion was clearly divided. It was not possible to determine a firm sense of opinion or view on this topic, as neither a favourable or unfavourable opinion prevailed among all the research participants, regardless of their role – Executives, Clinical Directors and

General Managers (see pages 136 to 138). Whilst this set of clearly conflicted views was evident in the results of the research process, the researcher noted that there was a marginally prevalent view that increasing competition further still would neither improve quality for patients or financial efficiency in the NHS overall (Leech, 2013). However, when probed specifically about quality, Executives and Clinical Directors in the multi-site questionnaire were very clearly of the view that increasing competition would not provide a route to improvement (see pages 152 and 153).

In addition, we can also conclude that whilst 50% of research participants at the case-study site gave cautious, guarded answers indicating that they'd be comfortable, under certain conditions, with increased competition in the NHS (see pages 138 to 139), if this were combined with the 30% who clearly were not in favour, then the results derived from the multi-site questionnaire would be comparable, as 79% of research participants were resoundingly opposed to any increased levels of competition. The researcher is confident in this conclusion, as it should be noted that Executives and Clinical Directors in particular, gave a unanimously negative response to the prospect of further exacerbation of the competition policy (see pages 155 to 156).

4. The results of the case-study interviews shown in Figure 78 on page 136 clearly provide evidence of changing language and behaviour as a consequence of increasing competition in the NHS. Research participants listed increased marketing and communications functions, less sharing of information between hospitals, a greater focus on service line reporting for profit / loss analysis and wider, comparative performance metrics between hospitals.

   These explicit changes in behaviours and language were further substantiated across the multi-site questionnaire respondents (Leech, 2008a) and additionally, they cited market share analysis along with new job roles and work patterns. Outsourcing of work was also mentioned as a new trend, along with deliberate influencing of commissioners for commercial purposes and the development of strategic partnerships between some providers. (see pages 151 to 153).

5. The perceptions of hospital leaders in the NHS as to whether the skill-set and qualities required of leaders has changed, is clear from results of this research. Given that all but one of the research participants in the single-site case-study interviews said that yes, the criteria for good leadership had changed (see page 141) and that this was also supported by 79% of the participants across the multi-site research questionnaire, the researcher is confident in concluding that the research evidence demonstrates that the perceptions of leaders in the NHS, is that the skills and qualities required have changed.

6. In terms of the Leadership Qualities Framework (LQF), this research shows definitively that practising leaders in hospitals were not utilising the national NHS model for leadership development, either for their own development purposes or indeed that of the people who work those organisations. In the single-site case-study interviews, all of the research participants said that they were not using the tool at all and of those, only 50% had even heard of the LQF (see page 143)

   This damning position was extrapolated over many NHS hospitals, through the multi-site on-line questionnaire responses. Only 50% of the research respondents said that they had heard of the LQF (with not a single Clinical Director having heard of it) and of those, only 2 respondents (14%) had actually admitted to using the LQF development tool (see page 159). Whilst the utilisation rate across the NHS hospitals in the multi-site phase of the research is higher (than zero), the researcher would strongly contend that 14% does not represent a ringing endorsement of the Leadership Qualities Framework and therefore, given this poor utilisation rate, a further concluding outcome of this research must be, that practising hospital leaders do not believe that the LQF model is fit for purpose.

   This research provides insight into why the LQF is so underutilised and why, key gaps may widen the gulf of utility between hospital leaders' perceptions of what is needed and the LQF model advocated by the centre of NHS policy, the Department of Health. The case-study interviews provide a key set of data that enable understanding in this area. The primary issue cited by respondents in terms of their rationale for arguing that the requirements of contemporary hospital leaders had changed from the past, was the need for

leaders to adopt a more commercial approach (see page 141). In addition, factors such as complexity, public accountability and increased regulation, were all issues raised and replicated in the wider multi-site questionnaire responses (see page 158). The researcher can only conclude that hospital leaders in practice do not believe that the LQF development model in its current form, is likely to meet these emergent requirements.

Theoretical conclusions and implications

Clearly, there are a number of theoretical implications and conclusions resulting from the research undertaken within this thesis. Further to the primary research questions and the conclusions drawn out and detailed already, there are an additional set of significant conclusions and implications relating to the primary areas of research – competition and market forces, leadership and organisational culture within NHS hospitals. These further theoretical implications are;

Competition and market forces

- In terms of the cultural platform upon which NHS services rest generally, the hospital sector in England has been central to perpetuating the founding ethos of, 'state co-ordinated, provided and free at the point of use' model. This has pervaded into the psyche and culture of our politicians and the public and this also, forms a strong part of organisational culture in hospitals. This research shows quite clearly that the old collaborative, national model of state driven and provided services has, and is, changing markedly. If contrasted to Figure 1 on page 13, the evidence generated through this research provides a robust foundation from which the researcher is confident in concluding that the NHS has moved toward a more competitive 'free market' model, as defined and described in the established field of literature and described in this thesis.

- If change is to be achieved and sustained in any organisation, it needs the support or 'buy-in' from its leaders. NHS hospitals each employ thousands of people and as such, are large and complex organisations. They are no different in this regard and clearly, policy based upon a theoretical construct of 'less state and more market' needs further thought. This new policy, based upon a clear philosophy, is not resonating with the leadership of an important and high profile sector of the NHS. The initial case-study evidence generated

through the research process, further triangulated and tested across multiple hospital sites demonstrates quite unequivocally, that the leaders of hospitals in England – at best – offer only very marginal support for greater marketisation.

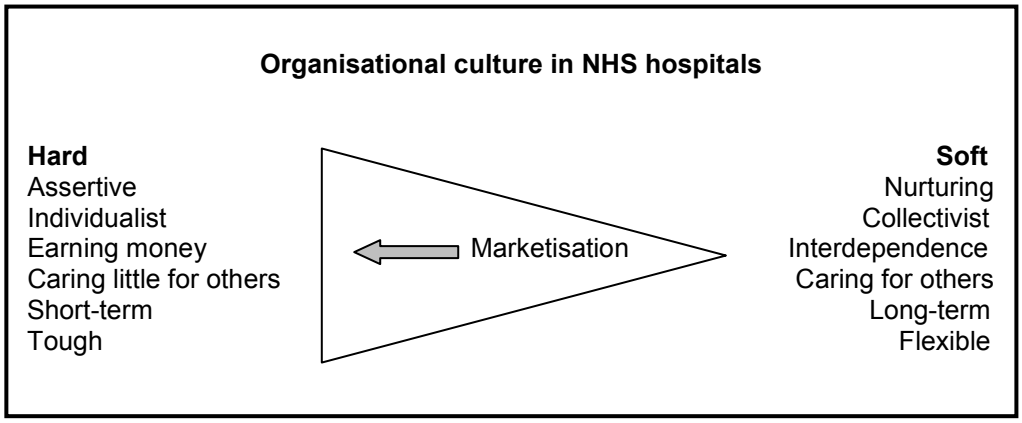
- The theoretical construct behind a market requires a clear structure of pricing and volumes. It is clear in the NHS, that pricing and market structure needs to be examined further, as in a truly complex environment such as healthcare and the NHS getting this wrong can have significant implications for the future of hospitals and indeed, health care services overall to the populations in some areas of the country (Leech & Cox, 2008).

Culture and leadership

- The theoretical models for and relating to organisational culture are explained and critically analysed in this thesis (see Fig 54, page 83). The response of hospital leaders to a range of questions posed during the research process demonstrates clearly that the behaviours, working practices and the very language of leadership has changed in NHS hospitals. The researcher has earlier concluded that when contrasted to the theoretical continuum between the 'state driven and provided and the free market' models for public service provision, that the hospital sector is not stationary. The signals found and reported through this research relating to the associated and consequential changes to the language, roles and other cultural signals suggest that hospitals and their leaders are journeying more toward 'free market'. Building upon this, the researcher would argue further, that as marketisation increases one of the key theoretical implications will be a continuing change to the organisational cultures within NHS hospitals, as they gravitate away from their historical norms, toward the harder end of the organisational culture spectrum. This further conclusion is illustrated in Figure 99.

  These research findings, however marked, will have implications for those who are studying the organisational culture of NHS hospitals - an area of study that the researcher believes will likely expand at pace, following the public criticisms within the Francis report, whereby organisational culture was strongly linked to safety, service and governance standards for public services (Francis, 2013)

Figure 99. Organisational culture in NHS hospitals as marketisation increases



Source: Author (2012)

- In terms of theory, the NHS has had a long-standing theoretically based leadership development model (DoH, 2004b). Through this research, the LQF has firstly been shown to be grossly underutilised by those in positions of leadership at NHS hospitals and furthermore, this research has also demonstrated a clear position in which leaders are changing the way in which they operate, given the move toward marketisation.

  This change will require a 'harder' set of commercially orientated leadership skills and attributes. Building on the general conclusion around organisational culture and marketisation, these two factors are illustrated in Figure 100 and the researcher contends that this undermines the theoretical construct behind the LQF and therefore, increasingly demonstrates that its utility in the new leadership environment will become increasingly limited.

  The researcher would also conclude that a new model for leadership and leadership development in the NHS - particularly the hospital sector - is needed. This development model, drawing upon the primary and secondary conclusions of this research relating to organisational culture, should be built upon a 'harder' theoretical and cultural construct and the leadership qualities should reflect this new epoch.

Figure 100. Leadership qualities in the NHS; a cultural comparison of the LQF in the new environment

	NHS Leadership Qualities Framework **'Softer' organisational culture** ◄——►	**Leadership Qualities in a market-based environment** **'Harder' organisational culture**
Personal Qualities	Self-belief Self-awareness Self-management Drive for improvement Personal integrity	Confidence Self-starter (assertive) Able to sell Drive for market share Personal interest
Setting Direction	Seizing the future Intellectual flexibility Broad scanning Political astuteness Drive for results	Ahead of competition Innovates product Tracks market Understands P&L v quality Short-term goals
Delivering the Service	Leading change through people Holding to account Empowering others Effective and strategic influencing Collaborative working	Happy customer Punish/sanction failure Reward success Retains contracts Competitive

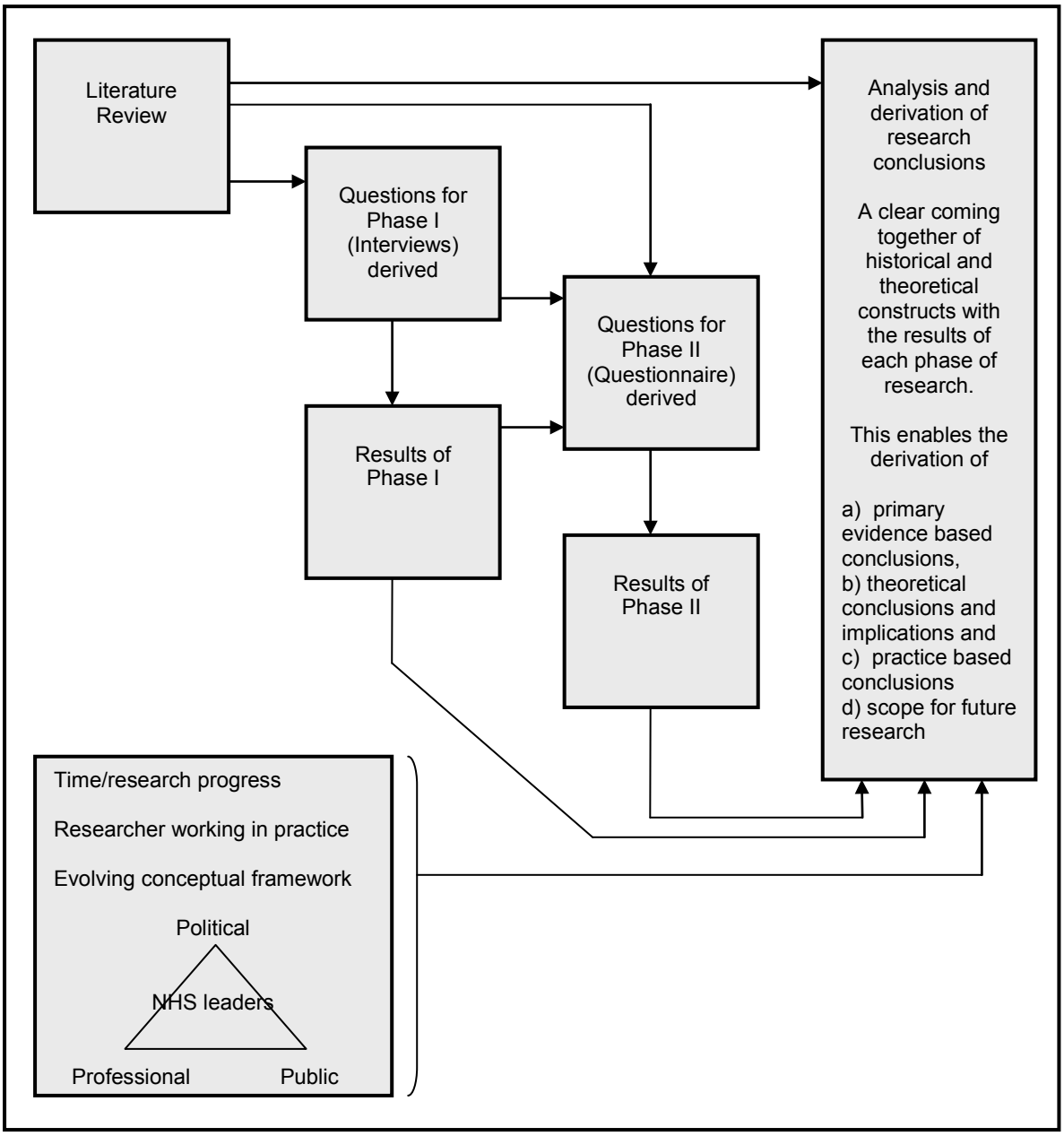
Adapted from Leech (2007)

Practice based conclusions and implications

Theoretical implications and conclusions are clearly important outcomes of any research. However, the reader is unlikely to be surprised given the practice based position of the researcher and the resulting conceptual framework within which the research has been undertaken, to learn that the researcher believes that the practical implications and conclusions derived from the research are equally important.

During both the literature review section focussed upon leadership in the NHS (see page 87) and the conceptual considerations outlined in the methodology chapter of this thesis (see page 95), the researcher has referenced the 3P model (see Figure 58, page 89) as a practical mechanism for reference and reflection when deriving practice based conclusions and implications from the research process overall. This general principle, applied to a further developed research model from that shown in Figure 76 (see page 122) is illustrated in Figure 101 below;

Figure 101. The derivation of practical research conclusions using the 3P model



Source; Author (2013)

It is here then, using this construct as a primary reference point, that the researcher sets out a series of key practice based conclusions and implications as described below.

Competition and market forces

- Vulnerable patients or those with little motivation or ability to access information about the 'market', will make uninformed choices or no choices at all, which could lead to a 'health underclass' if marketisation were taken to the full market driven model (Leech *et al*, 2007). Politically, this may cause public consternation or concern, undermining the historical principle of 'equal access for all' to NHS services. Clearly, there will be professional and public concern if the 'health gap' in society were to widen.

- The balance between competition and collaboration has enabled many good things in the NHS, like clinical networks for scale and local access to specialist services. In almost any market, there is an inherent business pressure to grow and further secure market share. This could be exacerbated in a financially pressured environment. In instances where organisations have previously worked together as 'networks' to provide services to the same or similar markets (based upon clinical condition or most likely, geography), pressures to dominate rather than divide the market could bring new tensions to inter-organisational relationships. The consequence from a patient perspective, are that services at one provider site will eventually become commercially 'non-viable' and are therefore rationalised or stopped in the interests of 'efficiency'. The results of this research shows, that senior clinicians see the value in networks and collaboration. A political drive toward full marketisation could put that at risk, unless an alternative model, perhaps akin to 'co-opetition' (Leech, 2008) is found.

- The public have little influence, this is clear. The implications of this are interesting as again the politicians point to public involvement and influence as a key component of their policy (DoH, 2010j).

Culture and leadership

- The implications of this research include careful consideration of how the NHS is led from a historically hierarchical perspective. Research participants provided a rich source of data showing clearly, that from a political and public influence perspective, the range of influential stakeholders is wide and there

is no clear, cohesive view of the world from leaders with different backgrounds and roles (Leech & Willis, 2007)

- If the new, competitive NHS landscape continues to evolve, NHS leaders and those with an interest in their education and development will need to consider carefully, not only the skills, traits and values that they will want to instil through development programmes, but where they recruit and develop those leaders. Planning to recruit from or deploy leaders into commercial environments could provide a useful way of recruiting and developing leaders with the required 'commercial edge' (Leech, 2010b).

- Commercial businesses usually describe their organisational developments, be it planned market penetration, take-over or merger using numbers as part of the narrative. Organisational and business development projects sometimes fail however, not because the numbers were incorrect, but because the important 'softer' issues around workforce development and people are overlooked. These issues primarily relate to organisational culture and they are harder to quantify and describe as business risks. In the NHS, historically, these factors have had a high significance historically and therefore, whilst consideration for the development of 'harder' business and commercial skills may be appropriate given the results of this research, retaining some of the 'softer' skills may also be wise (Leech, 2010)

- The drive for more commercially minded leaders in NHS hospitals may well lead people to the development and recruitment of those from the 'harder' end of the cultural spectrum. Those harder commercial edges however, in a fiscal squeeze may not suit all circumstances, such as when softer people skills are required to manage the "greatest resource" of the NHS, its workforce (Leech, 2010)

- Whilst regulation of the market is one political aspect of marketisation, another key implication is that relating to the regulation of those operating within it. Ethical leadership sets standards for beliefs and values that guide conduct, behaviour and activities in any organisation. Ethical and moral leadership considerations are likely to grow in their importance as the sense of competition grows stronger – particularly among those health professions with strong moral aspects to their pre-existing professional codes of conduct.

In an environment where - for the next 3 to 4 years at least - less money will reduce the overall size of the NHS market this additional tension in the system is likely to 'test' the ethical and moral conduct of leaders and managers in NHS hospitals. The research found that NHS leaders and managers wanted to see a greater focus on 'ethical' and 'moral' leadership. In other words, people wanted their leaders to model the behaviour expected.

Opportunities for further research

The limitations of this research have been described within the thesis and of course, there are therefore a series of opportunities available to further consolidate, develop and understand the subject area and themes arising from the research. These opportunities are not limited to, but could include;

- Replication of the research methodology. This could offer scope for both further understanding and longitudinal trends to be explored.

- The use of alternative data collection methods could generate further weight, or academic challenge to, the arguments and conclusions drawn from this research.

- Equally, replication over a larger research sample could stimulate an equally interesting research proposition.

The historical and cultural context and significance of this research has been described earlier in the thesis, both in terms of the NHS itself and the development and practice of leadership within it. It is clear that that the direction of travel toward a growing level of 'marketisation' will not only impact upon leadership and its development going forward but also, that this continually evolving environment will offer many further opportunities for research. This could be limited to the impact of marketisation on the leaders of the NHS hospitals, but the researcher is conscious that increasing marketisation will have implications across all sectors of the NHS and all areas of business and society related to it. This has already been illustrated clearly, in Figure 96 (see page 162).

The research experience

The researcher has balanced this research alongside a young family, a busy full-time professional career and a number of personal events and circumstantial changes. Throughout the research journey, an ongoing commitment to actively discuss, present, publish and interact with research supervisors and the wider communities of academic business research and with those operating in practice has already been alluded to (see Appendix I and References, pages 208 to 210).

This complex combination of commitments and circumstances has been both challenging to the researcher and, has in some ways built character, commitment and the very beginnings of a reputation in the field of research. Regardless, the researcher retains an enthusiasm to continue an affiliation in some form with Lord Ashcroft International Business School, ARU and also, to continue exploring and understanding a professional and academic interest in the subject area.

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References throughout the thesis have been provided in the Harvard format, as prescribed in the Research Degrees Regulations (ARU, 2013; ARU, 2010) and in keeping with the overall format described elsewhere, such as the Research Students Handbook (ARU, 2010a).

The researcher has found that when using some academic textbooks all of the reference text is shown in a single block. This style of presentation does not enable easy reference for the reader. Therefore, whilst fully compliant with the guidelines of the University, the researcher has shown the full reference sources, but has presented them in a manner that clearly distinguishes between the three core components of the reference

- Author(s) and date of publication
- Title
- Source of publication

References appear in alphabetical order (by author) and further, in chronological order where more than one reference is made to a particular author's publications

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APPENDICES

Appendix I	A record of the researcher's training, supervisory interactions and other relevant meetings related to this research
Appendix II	Approval of research proposal from the Research Degree Sub-Committee, ARU
Appendix III	Approval of research proposal from the Research Ethics Committee, ARU
Appendix IV	Approval of research proposal from the Research Ethics Committee at Hinchingbrooke Health Care NHS Trust
Appendix V	Approval of research proposal from the NHS (Cambridge 3) Research Ethics Committee
Appendix VI	Letter of support for research proposal from CEO, Hinchingbrooke Health Care NHS Trust
Appendix VII	Letter of support for research proposal from Managing Director, NHS Elect
Appendix VIII	Example of consent form used for case-study research interviews
Appendix IX	Example of invitation letter used for case-study research interviews
Appendix X	Example of participant information sheet used for case-study research interviews
Appendix XI	Research interview transcript (2E2)
Appendix XII	Research interview transcript (3E3)
Appendix XIII	Research interview transcript (4E4)
Appendix XIV	Research interview transcript (5E5)