CHLNet
Canadian Health Leadership Network
Le Réseau canadien pour le leadership en santé

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LEADerShip at a Glance

LEADS "Top Ten" Suggested Readings[1]

Currie, G. and Lockett, A. (2011). Distributing Leadership in Health and Social Care: Concertive, Conjoint or Collective? *International Journal of Management Reviews,* Vol. 13: 286-300.

Summary

The field of Distributed Leadership (DL) is growing as an area of research interest. The authors explore this construct in the field of health and social care in the United Kingdom. They did so for two reasons: first, health and social care is an exemplar of how contextual influences linked to professional hierarchy and policy impact on attempts to distribute leadership. Second, the implementation of DL in a health and social care context faces institutional challenges related to professions and policy.

There are two main findings. First, the policy emphasis upon performance management and accountability in the UK tends to drive leadership towards concentration rather than distribution. They suggest that in England, professional hierarchy and traditional power relationships, combined with a strong centralized performance regime, act to stymie policy-makers' aspirations for enacting DL. Second, in the English health and social care system, centrally set targets for which leaders are accountable drive a more individualistic orientation, so that leadership is concentrated with an elite at the apex of the organization.

The authors provide an interesting model of the contingencies that frame Distributed Leadership, and use that model to explain why results in the UK differ, in part, from results in Canada.

Focus: Conceptual article on Distributed Leadership in the UK Health System and Canada

Implications

- Distributed Leadership is both a theory and a concept: it is not well understood and the ability to accomplish it is a function of many factors that define the environment and context in which DL is intended to be practiced.
- An interesting model describing the factors that are part of DL is presented for further investigation.

[1] As recommended by Dr. Graham Dickson (CHLNet Academic Advisor) and Bill Tholl (CHLNet Executive Director).

Link to LEADS and CHLNet Mission

This article is relevant to **LEADS** and to the mission of CHLNet in that the statement is made on the **LEADS** brochure that it endorses Distributed Leadership. Further examination of the factors that allow DL to emerge in a health system is valuable. It is particularly relevant to CHLNet in that CHLNet is in the midst of defining whether or not it endorses a DL philosophy or not in its soon to be new strategic plan.

de Souza, L. B. & Pidd, M. (2011) Exploring the Barriers to Lean Health Care Implementation. *Public Money & Management*, Vol. 31, No. 1: 59-66.

Summary

There are three main reasons for the growing interest in using lean techniques in the NHS. First, cost pressure (despite increased funding), has stimulated a search for improved working practices. Second, national targets (now regarded as standards) for waiting times have encouraged time compression and the removal of non-value-adding tasks. Third, there are promising initial results in health care organizations in other countries and occasional reports from the UK. This article explains the implementation barriers to applying lean ideas in health care, based on our experience and that of others. The barriers discussed are based on experience gained in case studies in three NHS acute trusts.

The authors state that lean methodology can be successfully applied in health care without major modification, provided implementation barriers are understood and overcome. Many of the barriers are people-based or organizational but performance measurement, inappropriate jargon and a worry that people will be treated like “widgets” are also significant barriers.

The implementation barriers for lean health care have considerably delayed its adoption compared to manufacturing. Some barriers are common to other change and improvement programs, but others seem to be much more important in lean.

Focus: Directors, managers and health care practitioners re the experience of applying Lean thinking in several UK NHS trusts.

Implications

- Lean is a very popular and well-used methodology to improve efficiency and effectiveness particularly in health care (primarily hospital settings). It makes the point that Lean is more difficult to implement in health care as opposed to the private sector.
- This study has value in helping managers understand the challenges in implementing lean.

Link to LEADS and CHLNet Mission

This article is relevant to **LEADS** as Lean is a methodology that operationalizes the *Achieve Results* and *Systems Transformation* domains of **LEADS**. It is relevant to CHLNet because as a popular "change" tool, leaders need the skill sets to implement Lean, and CHLNet can become a source of support for such implementation.

DelliFraine, J.L., James R. Langabeer II, J.R., Nembhard, I.M. (2010). Assessing the Evidence of Six Sigma and Lean in the Health Care Industry. *Quality Management in Health Care*. Vol. 19, No. 3, pp. 211-225.

Summary

Although there are many Quality Improvement (QI) tools used in health care management today, Six Sigma and Lean (SS/L) are 2 relatively new, but popular, QI tools being used in the health care industry. The authors conducted a systematic review of 177 articles in relevant journals. The trend in publications on these topics is rising.

Some clinicians and managers are questioning whether there is solid evidence that the use of SS/L is positively associated with QI and results in improved clinical outcomes. The purpose of this article was to examine the evidence of the effectiveness of SS/L QI tools in the health care industry, identify gaps in the health care management literature regarding these QI tools, and identify practical recommendations and conclusions from the SS/L literature for health care managers.

The review shows that the evidence that these QI tools improve health care quality is relatively sparse, both in the number of studies and in the diffuse nature of the studies. First, they found that the level of evidence supporting a positive relationship between the use of SS/L and performance improvement was weak. Second, most studies focused on SS/L to improve processes of care, while few studies focused on SS/L to improve clinical outcomes.

This review demonstrates that there are significant gaps in the SS/L health care QI literature and very weak evidence that SS/L improve health care quality. While there is little solid evidence of the effectiveness of SS/L, managers may be using these tools as a means to achieve best practices and improve quality of care.

Focus: Systematic review of evidence supporting value of SS/Lean for change in health.

Implications

- There is little evidence—from an improved patient outcomes perspective—of the value of Lean and Six Sigma to the health reform agenda. Its value is process improvement.

Link to LEADS and CHLNet Mission

This article operationalizes the *Assess and Evaluate* capability of the Achieve Results domain of LEADS, providing evidence as to whether or not Lean/Six Sigma are valuable tools to employ for organizational change. It is relevant to CHLNet because as a popular "change" tool, leaders need the skill sets to implement Lean, and CHLNet can become a source of support for such implementation.

Infofinders. (2010-11). *Leading Practices in Emergency Department Patient Experience.* Ontario Hospital Association: Toronto.

Summary

This is a "grey literature" paper chronicling leading practices from a number of efforts to improve the patient experience in Ontario hospital emergency wards. Often, the change initiatives included multiple strategies, commonly consisting of process changes to improve patient flow and reduce wait times.

All hospitals noted that change requires ongoing reinforcement. Upon analysis, the hospitals most skilled with the execution of change management were most successful in embedding or institutionalizing changes to improve patient satisfaction. Hospitals encouraged sustainability by regular data mining, sharing performance indicators regularly with staff and assigning a staff member to be in charge of the ongoing sustainability efforts.

The CEO needs to drive the change process. There is no substitute for a strong leader to set the direction, and the priorities. The Senior Management Team must work together to define the vision and identify the resources required for success. Part of the Senior Management Team's work involves an assessment of the skill level within the organization and a realization that external consultants may be beneficial to push the required change.

Several hospitals faced considerable staff and physician resistance and emphasized the importance of physician engagement and front-line staff and physician buy-in to the changes required. Many hospitals also used incentives in order to increase accountability for changes and to reward and recognize the hard work that change requires. It does not matter which improvement method or model (LEAN thinking, Six Sigma, or the theory of constraints) is used in the redesign process, as long as it is applied with rigour and persistence.

Focus: Leading change in Canadian (Ontario) hospitals.

Implications

- The article reinforces, through a Canadian example, the need for strong and distributed leadership throughout an organization in order for change to be successful.

Link to LEADS and CHLNet Mission

This article supports many of the **LEADS** domains, as it relates to leadership of change in a Canadian hospital setting. From a CHLNet perspective, it highlights the importance of growing leadership capacity in the health system in Canada if reform is to be successful.

Alimo-Metcalfe, B., Alban-Metcalfe, J., Samele, C., Bradley, M., Mariathasan, J. (2011). ***The Impact of Leadership Factors in Implementing Change in Complex Health and Social Care Environments: NHS Plan clinical priority for mental health crises resolution teams*****. Real World Group & King's College London Sainsbury Centre for Mental Health. www.netscc.ac.uk/hsdr/projdetails.php?ref=08-1201-022**

Summary

Recent research in the US, UK and more widely, has pointed to the significant impact of an engaging style of leadership on organizational performance among a wide range of medium to large-size companies. The principal hypothesis was: that the quality of leadership exhibited by Crisis Resource Teams (CRTs) is directly related to team effectiveness. Research conducted in the NHS and local government in the UK, (and replicated in FTSE 100 companies) that was inclusive of gender, ethnicity, and level, has provided a robust metric, of proven validity for assessing this kind of leadership behaviour.

The hypothesized link between quality of leadership and a transformational approach to change management proved impossible to test. This was largely owing to practically all team leads describing the approach they had adopted as transformational in nature. However, what the study did reveal was that team leads appeared to use models of change that they themselves did not overtly recognize as having any particular theoretical base. A total of 46 mental health crisis resolution teams (CRTs) from different parts of England were included in this study.

Focus: Leadership in Mental Health.

Implications

- Increasingly, organizations concerned with the need to build internal leadership capacity see leadership development as vital to creating organization process change.
- The development of leadership competencies results in an increase in "human capital", which, can be turned into "social capital".

Link to LEADS and CHLNet's Mission

This paper emphasizes the value of the *Build Teams* capability of the *LEADS* framework. It also emphasizes that other attributes of the ***Engage Others*** domain—*Communicates Effectively; and Fosters the Development of Others*—are important for leaders to practice. It

also suggests that leadership development for all is required in order to raise human capital to support change.

Battilana, J., Gilmartin, M., Sengul, M., Pache, A-C., Alexander, J. A. (2010). Leadership Competencies for Implementing Planned Organizational Change. *The Leadership Quarterly* 21, 422-438.

Summary

A challenging task is implementing change in the organization once a direction has been selected. Change agents' leadership characteristics and behaviors influence the success or failure of organizational change initiatives. Yet, most of the leadership studies that account for the relationship between leadership and change do not account for the complexity of intra-organizational change processes.

An implicit common assumption of most of these studies is that change agents already possess the requisite competencies, skills, and abilities to engage in the different change implementation activities. The authors point out that one limitation of most change models is that they do not consider whether managers possess the skills needed to engage in the activities involved in planned organizational change implementation.

The authors argue that managers' likelihood to emphasize the different activities involved in planned organizational change implementation varies with their mix of leadership competencies. They adopt the task-oriented and person-oriented behaviors model to explain this process. They emphasized three key activities involved in organizational change implementation: communicating the need for change, mobilizing others to support the change, and evaluating the change implementation.

Focus: Clinical managers in the United Kingdom National Health Service.

Implications

- Most organizations do not see implementation of change as a complex enterprise shared by leaders/managers at many different levels in the organization.
- Treating planned organizational change as a generic phenomenon might mask important idiosyncrasies involved in the change implementation process, and the situation specific competencies required in that leader's situation.
- Managers/leaders need to develop the capabilities of leadership required to lead change commensurate with the role they play in the organization.

Link to LEADS and CHLNet's Mission

The dual "task-people" orientation of this study is also foundation to the LEADS framework: Achieve Results speaks to an emphasis on task; the other four domains on dealing with people (relationships, change dynamics). It relates to CHLNet's mission in

that, the authors contend that modern health organizations do not do enough to ensure that managers in the system have the appropriate skills required to lead change.

Chuang, E.; Jason, K.; Morgan, J. C. (2011). Implementing Complex Innovations: Factors influencing middle manager support. *Health Care Management Review*, 36(4), 369-379.

Summary

Over the past 30 years, health care organizations have increasingly begun to adopt complex innovations, defined as novel sets of behaviors, routines, or other work processes that require coordinated use by multiple organizational members. Successful implementation is critical to the effectiveness and sustainability of these innovations. The purpose of the study was to better understand the organizational and relational factors that influence middle managers' support for the innovation implementation process.

The authors describe an organizational framework commonly utilized to explain the determinants of effective innovation implementation in the U.S. health care sector. These included management support, financial resource availability, implementation policies and procedures, innovation–values fit (the extent to which employees perceive that innovation use will foster the fulfillment of their values), and implementation climate (employees' perception of the extent to which use of the innovation is supported and expected).

Middle managers who opposed innovation implementation did so because they felt that the initiative would negatively influence their unit's performance. Middle managers opposed the program even if they felt that that it would benefit the organization overall. Very few middle managers were inclined to prioritize the benefit for the entire organization or for the workers themselves as motivation for supporting the implementation. Policies and practices that helped improve middle manager support for the program included (a) communicating early and often with managers to solicit their input in the implementation process, (b) maximizing middle manager's discretion, and (c) assigning a designated staff member to coordinate or otherwise facilitate the program.

Focus: Implementation of work-based education in US hospitals for front-line workers.

Implications

- Middle managers are a vital link to effective implementation of change, especially if the change is initiated by the senior people in the organization.

Link to LEADS and CHLNet Mission

This article addresses the *Lead Self* and *Systems Transformation* domains of LEADS…in that it shows how the internal orientation of middle managers combined with organizational interventions can improve implementation success. It is relevant to CHLNet's mission in

that it emphasizes the importance of championing the role middle managers in a system if indeed change is to successfully happen.

Bingham, D., Main, E.K. (2010). Effective Implementation Strategies and Tactics for Leading Change on Maternity Units. *Journal of Perinatal Neonatal Nurs*ing, Vol. 24, No. 1, pp. 32-42.

Summary

Change is particularly difficult to implement within healthcare because of silos among clinical disciplines and government agencies that lead to a lack of coordinated and timely feedback. The Institute of Medicine estimates that it currently takes approximately 17 years for research to be translated into practice in healthcare settings even when leaders are actively working on implementation projects.

This article outlines effective strategies and tactics tailored to mitigate common barriers to implementation of change. Barriers can vary depending on the change project topic and the local context. Barriers to change may consist of leader barriers, clinician barriers, characteristics of the project, (for example, did the change require making major or minor work flow adjustments), and implementation climate (for example, what were the resources available and the amount of general organizational support for the change).

The authors outline strategies and tactics aimed at implementing change. They also discuss the benefits of external pressures and national measures of quality for motivating and accelerating change. External forces allow leaders to more quickly shift from answering questions of why a change needs to be actively worked on to answering questions of how to implement the change. External quality measures facilitate teamwork by helping leaders and the team rally together to meet the goal, fostering a cooperative attitude. External pressures can sometimes be negative, however.

Focus: Leading Change on Maternity Units; Hospital Setting.

Implications

- Most systematic reviews of the overall effectiveness of implementation methods in healthcare fail to adequately explicate the many potential barriers to change, and therefore the diverse and varied range of implementation strategies and tactics required in particular contexts.

Link to LEADS and CHLNet Mission

This article addresses many of the issues implicit in the *Systems Transformation* domain of the *LEADS in a Caring Environment* Capabilities Framework. It is relevant to CHLNet's mission in that it emphasizes the importance of learning about leadership of change in order for implementation to be effectively accomplished.

Friedman, R. M. (2010). Real Change in the Real World: An Achievable Goal Policy. *Mental Health,* Vol. 37: 154-159.

Summary

This article emphasizes the importance of better understanding the process of change-making if real change in the real world is to be achieved. Major change requires knowledge and competency in three complementary and overlapping areas. First, there should be a vision of what one is trying to accomplish based on a set of values and principles. Second, there should be a strong knowledge base on the technical aspects of achieving the vision, based on a well-thought out theory of change, and the best available knowledge and research on technical and implementation issues. Third, there should be knowledge of what it takes to make change at the micro and macro levels (and more likely at both levels).

The author argues that over the past two hundred years, human society has developed exceptional ingenuities, proficiencies, organizations and systems for the task of making things—from steam engines to microchips. Going forward, he states, our society must learn to be equally adept at the task of making change. It's an essential modern competency. The challenge is to develop the best balance between top-down dissemination of interventions that have been found to be effective under specified conditions, and system and community capacity-building.

Friedman argues that the self-organizing and non-linear nature of complex systems is why inflexible prescriptions for making change at organizational and system levels is of limited value. What is important is to understand complex adaptive systems, and to create conditions which increase the likelihood of success. To do so clearly goes beyond the realm of any single discipline, and likely requires the involvement of partners not only from many different academic disciplines but also from different spheres of life: transdisciplinarity.

Focus: Conceptual paper on complexity theory and systems thinking.

Implications

- For those leaders who are persuaded that organic systems thinking and complexity theory has merit, the article is a helpful treatment of the challenges of leadership.
- Solutions to any major social issue or concern must involve experts from many disciplines working together to contribute their part of the knowledge required for change.

Link to LEADS and CHLNet Mission

This article operationalizes the ***Systems Transformation*** domain of LEADS, as it relates to leadership of social change. From a CHLNet perspective, it highlights one of the many different world views that affect both our understanding of leadership and its practice.

Nicolson, P., Rowland, E., Lokman, P. Fox, R., Gabriel, Y., Heffernan, K., Howorth, C., Ilan-Clarke, Y., and Smith, G. (2011). Leadership and Better Patient Care: Managing in the NHS. *NHS National Institute for Health Research*. www.netscc.ac.uk/hsdr/projdetails.php?ref=08-1601-137

Summary

Leading change depends upon ensuring those within the system have a sense of how the system works and an awareness of the culture that might be tested as a reality or not.

The article's recommendations on distribution of leadership and qualities of effective leadership are positioned as essential for those at every level who are delivering change whether on time-limited, small-scale projects or larger-scale policy-driven ones.

Changes in working relationships bring anxieties which need to be understood and anticipated by leaders if they are to support staff to position themselves differently in the system. Leading change depends upon ensuring those within the system have a sense of how the system works and an awareness of the culture that might be tested as a reality or not (p. 132).

Focus: Three NHS Trusts, including one Foundation Trust, specifically to explore whether any variations in the qualities of leadership affected patient care.

Implications

- The paper emphasizes the importance of "distributed leadership" in nested systems such as health care in Canada (i.e. nested systems meaning front-line change to policy change at the provincial level). It re-emphasizes the importance of quality leadership and management to change and in particular to improved patient care.
- Leadership and patient care are linked at a number of levels from Department of Health and NHS policy impacting upon the population in general, to Trust management which impacts upon the local community and practices in clinical teams that in turn impact upon the way face-to-face care is delivered.

Link to LEADS and CHLNet Mission

This article operationalizes the ***overall importance of leadership development as expressed by*** LEADS, as it relates to improving patient care through organizational/system change. From a CHLNet perspective, it highlights the value of a national initiative to grow leadership capacity.