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What kind of leadership does integrated care need?

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Key message(s)

New models of shared and collaborative leadership are needed to address the challenges of integrated care in London.

These require a shift from thinking about leadership as a control process to a focus on building communities of practice and leading incremental revolutions to generate transformation at a local level.

Why this matters to me

As an educator I frequently encounter 'change' projects which go nowhere because the change agent has failed to recognise the scope of his or her power within the project. Typically agents fail to engage all relevant stakeholders at the start of a project and as a consequence miss crucial information, fail to identify project champions and opponents and underestimate the forces for inertia. When the project starts to unravel a common response is to assume an autocratic leadership style. This frequently alienates those stakeholders who have been involved. Clinical leaders need permission to experiment with alternative leadership strategies and behaviours in an ever more complex world.

As a patient and carer within a context of changing structures, accountabilities and relationships I have an interest in integrated service provision and improved outcomes.

Ethical approval

This was an education paper which did not involve primary data collection so did not need ethical committee approval

ABSTRACT

Primary care clinicians and clinical commissioners are the current focus for much leadership investment and development. In this article I propose that we need to look beyond traditional thinking about effective leader behaviour and conventional approaches to leader development based on this thinking. The paper identifies some of the lessons that can be learnt from both the current academic discussion of collaborative leadership, and from an analysis of successes and failures of leadership within the NHS. Two leadership strategies are considered: the development of communities of practice and the use of connected mini-transformations to generate wider system transformation. In a period of systems change, with potential for conflict between providers and commissioners, these strategies are helpful in encouraging the 'mindfulness' that is needed to ensure integration across the complex landscape of healthcare in London.

Keywords: collaboration, commissioners, healthcare networks, shared leadership

Introduction

The quest for 'better' leaders has been a preoccupation of governments, organisations and professional bodies since the creation of the NHS. Policy makers are increasingly interested in the development of the clinician's role as practitioner, partner and leader.[1] There is an irony to this – at the same time that large amounts of public money, organisational attention and educational effort are allocated to leader develop-

ment, patients, in some parts of the health system, are dying or suffering from extreme neglect as a result of failures of leadership.[2] Primary care clinicians and clinical commissioners are the current focus of much of this leadership attention and, in some quarters, regarded as the future saviours of the healthcare system.

> 'To ensure healthcare of the highest quality, there needs to be outstanding leadership demonstrated by clinical commissioning groups.'
>
> Dr Shikha Pitalia, GP and Chair of the United League Commissioning Consortia for Wigan and St Helens.[3]

The purpose of this paper is to explore the questions: what kind of leadership does integrated care need? What are the lessons that can be drawn from analysis of integrated care failure and success? How should leaders of integrated care and clinical commissioning behave in the complex and turbulent world of London healthcare?

Transactional views of leadership: better people, better training, better decisions

An example of leadership failure, familiar to all, will be that of Mid Staffordshire NHS Foundation Trust. The first Francis Inquiry criticised managers within the Trust whilst 'clinical staff at the hospital largely escaped blame'.[4] The short message of the report is that Governors and senior managers were incompetent and incapable. The earliest focus of academic researchers, and still the focus of journalistic attention, is consideration of the qualities and behaviours of high profile figures: a search for heroes and villains. Using this lens we could argue that:

1 The Trust lacked natural leaders or senior staff with the right qualities to deal with difficult situations. We have some evidence that personality plays a part, with traits such as extraversion, self-confidence, conscientiousness and openness to experience related to effectiveness.[5] In terms of this explanation, failure can be explained in terms of poor selection processes.
2 Trust leaders had not received appropriate training in how to behave as they moved up the organisation hierarchy. Specifically they failed to modify style to suit the demands of increasingly complex situations requiring governance and risk management. By the 1970s writers on leadership[6] were arguing for a 'contingency' approach to leadership– the idea that effective leaders are behaviourally flexible, capable of modifying style to the demands of different situations.

It is easy to understand the popularity of these traditional, leader-centric explanations, with their focus on fixed, top-down institutional hierarchical models of leadership. Sometimes labelled 'transactional', this approach takes for granted that senior clinicians and managers exercise top-down control over staff and patients. Leaders work 'on' the system to drive improvement. The idea of a simple relationship between cause and effect that allows prediction is appealing. Transformation is achieved when 'better' people, with 'better' training make 'better' decisions.

Yet this transactional model has its challenges.

- The concept of 'followership' sits uneasily when dealing with patients, carers, peers and colleagues from multi-disciplinary backgrounds. In the context of integrated care, many decisions are taken by different members of a team rather than individual leaders. Professionals often share leadership[7] depending on the nature of the issue or problem and the mantle of leader is passed to the professional best placed to offer expert advice at that point in time.[8]
- Issues of power and culture are largely ignored. Leadership is seen as a process of making a rational choice of a behaviour that will 'fit' the assessed demands of the situation. The reality of the many healthcare situations is that our choice of options is constrained by policy, professional boundaries or patient choice. Compromises have to be struck and decision-making partnerships have to be created.
- The world is dynamic and people may be less behaviourally flexible than theorists suggest.[9] We must also question whether the qualities and styles of behaviour identified as appropriate in hierarchical organisations can be transferred to modern healthcare environments where networks of organisations must function to provide care

Shared leadership: transformation through collaboration and learning

Tellingly, not everyone shared the Francis Inquiry's analysis of the causes of failure:

> 'I agree with Kenneth (Lownds, Chair of Cure the NHS Stafford).... where is the professionalism of the nursing staff and doctors allowing patients to become dehydrated, unwashed for days and unfed. This type of treatment by ''highly educated'' employees is gross negligence and should be treated as such – even prisoners guilty of

> murders are treated with more dignity. As usual however the ''blame'' culture puts it down to managers'
>
> Service user's comments[4]

This comment surfaces an alternative reality, where transformation is a product of collective behaviour, and not simply the concern of one team in one part of the system; a reality where all share responsibility for service reform. Views such as this, which gave rise to public insistence on a second Inquiry, demonstrate that assumptions cannot be taken for granted. They need to be deliberately surfaced and discussed. An alternative explanation of the events in Mid Staffordshire could be that few understood that they were part of an integrated care system, seeing no option other than to operate in isolation. Viewed in these terms, failure of leadership extends to educators who did not adequately assess professional competence, General Practitioners who continued to refer patients into a dysfunctional system, commissioners who failed to manage risk, and some patient groups who were too tentative in their challenge of standards of care. Anyone within the system could and should have exercised leadership by:

- helping individuals to understand diverse, alternative perspectives
- helping teams and professions to connect their work with broader more collaborative efforts
- using networks for 'disruptive' innovation'[10]
- supporting democratic ways of working to challenge assumptions that power and authority should reside with one or two groups.

Contemporary writers on leadership have shifted their focus to *collaborative and shared leadership,* with consideration of team behaviour, followership and leadership across systems of care.[11] Complex healthcare systems demand a different management style.[12] They require leaders to look outside the confines of their part of the system and to collaborate across boundaries, to replace complex plans with minimum specifications, to focus on 'attractors' rather than on 'resistance to change' and to understand that innovation requires a degree of variation. Increasingly evidence suggests that, with effective cross-boundary networking comes better knowledge-sharing, deeper overall insight and expanded capacity across the network.[13]

One of the most important contributions of this new perspective is a focus on the leader's role in generating organisational learning and innovation so as to build adaptable and responsive cultures:

> '(Leaders) are responsible for building organizations where people continually expand their capabilities to understand complexity, clarify vision, and improve shared mental models—that is, they are responsible for learning.'[14]

A perspective which Sir Stephen Moss, Chair of the Mid Staffordshire NHS Foundation Trust in the immediate aftermath of the Healthcare Commissions report into its failings in 2008 endorsed.[15].....

> 'Fundamentally the Trust wasn't a learning organisation .... If you looked at the systems and processes for managing risks, you might be forgiven for being impressed .But a closer look would show they weren't getting to the heart of issues....Staff who did raise concerns were ostracised or sidelined . ...So staff came in, heads down not feeling engaged or part of making the Trust better.'

Theory in action: leading improvement in London

In addition to a thriving literature on how organisations, communities and whole systems can transform their cultures through a series of collective and interconnected learning activities, we have examples in North West London[16] of a range of improvement projects which demonstrate this theory in action. For example, the DIMPLE project in Harrow and Hammersmith and Fulham which aims to improve and spread self-care management for people with and at risk of type 2 diabetes. To date significant benefits have been realised – both in terms of behaviour change and return on investment. Such projects offer insights into the practical, leader behaviours which deliver integrated service improvement. Two such insights are discussed here:

1 The creation of 'communities of practice'[17] – groups of people who share a passion for a topic or series of problems and who are prepared to interact and share their expertise and knowledge on the subject on a long-term basis. DIMPLE is a 'grass-roots' project led by local communities involving peer-led education programmes and community recruited and located mentors and diabetes champions. Strategies used include a broad process of participation in whole community development, involvement of networks of networks, adoption of a holistic view of health which encompasses patients, carers and community as well as clinicians, and spanning the boundaries of health and social care (as well as primary and secondary care). This broader systems thinking has largely evolved from patient challenges to narrow professional or organisational ways of thinking. As with the Mid Staffordshire example the real issues and opportunities were spotted by those outside the confines of healthcare organisations.
2 The use of connected mini-transformations to generate wider system transformation – an 'incremental

revolution'. Changing too much at one time is costly and destabilising and for these reasons is difficult to achieve. A more realistic approach was adopted by the project involving a series of smaller transformations that allow those who are relevant to the change to go as far as they are prepared at that stage.

Mindfulness

Both of these strategies provided an opportunity to surface mental models. These may be quite different from what people actually say but are more powerful predictors of how they will behave. Surfacing of mental models fosters mindfulness – a conscious awareness of self, others and the environment, which helps us to explore the unknown through engagement with others and their ideas. Mindfulness enables leaders to make choices about how to respond to others whilst remaining consistent to their professional or organisational values, it helps leaders to challenge mental models, to break out of their habitual patterns of problem solving, encourages opportunistic decision making and creative problem solving.[18]

In the current system there is potential for conflict and misunderstanding between leaders of Integrated Care projects (concerned with facilitating the development of services through inter-organisational collaboration) and Clinical Commissioning Group Board members (concerned with contracting and budget deficits and managing demands from on high). Mindfulness may help leaders to find ways to accommodate creative tensions, rather than viewing such tension as dysfunctional and to be managed out of the system.

Conclusion

Healthcare in London does not need heroes in the sense of individuals who operate alone. It does need leaders of transformation who are prepared to guide learning rather than impose controls – and from this facilitate the development of whole communities and improve whole systems of care. Evidence from 30 years of research suggests that powerful and significant transformations can be achieved through adoption of relatively simple strategies such as working in democratic communities of practice and championing connected mini-transformations across traditional professional and organisational boundaries. This might not need leaders with special qualities or advanced education; it will need leaders who work 'in' the system and are mindful that their role is to help everyone to collaborate for the sake of the system as a whole.

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