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Distributed leadership patterns and service improvement: Evidence and argument from English healthcare ☆

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ABSTRACT

This article focuses on the pattern and impact of change leadership in complex, pluralistic, public sector settings, and specifically in English healthcare. The argument draws on evidence from ten comparative cases, exploring links between leadership patterns and organizational outcomes. Our analysis builds three themes. First, a pattern of widely distributed change leadership is linked to delivering improvements in service outcomes. Second, professional/managerial hybrids are shown to perform crucial lateral facilitation activities, adapting and extending their roles to suit their organizational context. Third, a foundation of good pre-existing relationships underpins the capacity of distributed leadership to implement service improvements. Conversely, poor relationships and conflicts erode the concerted capacity of distributed change leadership. The key contribution of this article thus concerns the establishment of links between situated patterns of distributed leadership, and service improvement outcomes, based on the cumulative effects of actors – managers and clinical hybrids – at different organizational levels.

1. Introduction

Our aim is to explore patterns of leadership in multi-professional healthcare organizations, and their impact on mandated service change. Using empirical data from the English National Health Service (NHS), we ask: *what patterns of change leadership are observed, and are those patterns associated with a differential ability to effect service improvements?* Research has traditionally focused on links between leadership styles and organizational outcomes. In this study, in contrast, we explore relationships between patterns of distributed leadership, on the one hand, and the progress of specific change initiatives designed to improve the quality, safety, and outcomes of hospital care for patients. This is one organizational setting, therefore, where approaches to leadership can have a substantial impact on the lives of others. We address debates derived from the literature of small team and distributed leadership in the public sector.

1.1. A relational perspective on change leadership: the role of hybrids in context

Given the aim of this study, we adopt a relational theory of leadership (Denis, Langley, & Sergi, 2012; Uhl-Bien, 2006). This perspective "changes the focus from an individual to a collective dynamic (e.g., to combinations of interacting relations and contexts), seeing appointed leaders as one voice among many in a larger coordinated social process" (Uhl-Bien, 2006, 662). A contextualized

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approach to investigating leadership has been widely advocated (e.g., Osborn, Hunt, & Jauch, 2002; Osborn & Marion, 2009) and we propose that context be subsumed into the definition of distributed leadership (Bolden, 2011; Currie & Lockett, 2011). Here, we have conceptualized context as a set of interacting influences, which can be analyzed at the macro, meso and micro levels (McNulty & Ferlie, 2002; Pettigrew, 1990, 1997; Pettigrew, Ferlie, & McKee, 1992). Analytically, our attention has focused on the meso and micro levels, conditioned by macro level national drivers for change.

We argue that, in professionalized organizations, change leadership is an ambiguous and interactive process (Fitzgerald, Ferlie, Wood, & Hawkins, 2002; Grint, 2005). It is generally recognized that leadership is central to changing organizations (Bennis, 2003; Yukl, 2006), and in healthcare contexts, substantial attention has centered on the influential leadership roles performed by medical hybrids in facilitating change (Contandriopoulos & Denis, 2012; Ferlie, Fitzgerald, Wood, & Hawkins, 2005; Fitzgerald & Dufour, 1997; Llewellyn, 2001; Locock, Dopson, Chambers, & Gabbay, 2000). In commercial professional settings, research has focused on global market trends and the implications for new organizational structures and governance arrangements (Greenwood, Hinings, & Brown, 1990; Hinings, Greenwood, & Cooper, 1999), with less attention to individual change and leadership roles (Empson, 2007; Lorsch & Mathias, 1987). This focus is mirrored in healthcare, with attention to structural changes resulting from policy reforms (Ferlie, Ashburner, Fitzgerald, & Pettigrew, 1996).

"Hybrids" are clinicians who move from a purely clinical role to assume substantial managerial responsibilities, while continuing their clinical practice in order to maintain professional credibility. Conceptually, our definition of change leaders includes individuals at any level of the organization with formal responsibilities for change implementation, and those who informally encourage and support others to implement changes. Thus we suggest that the pattern of change leadership can be conceptualized as the set of actors perceived to be central to the implementation of a particular service improvement at any given point in time in a given context.

1.2. Patterns of leadership in the public sector

Research in both public and private sector professional service organizations suggests that leadership in those contexts has distinctive features. Public organizations, like healthcare and education, have different governance and ownership structures different from private firms. However, they face similar issues in relation to the intellectual nature of their primary tasks, with control exercised through training and standardization (Greenwood et al., 1990; Scarbrough, 1996; Teece, 2003; Von Nordenflycht, 2010). A number of commentators also highlight the divergent objectives and diffuse power in pluralistic public service organizations, and emphasize the role of small mixed teams or 'leadership configurations' in driving change at unit level (Currie & Suhomlinova, 2006; Denis, Langley, & Rouleau, 2005; Dopson & Fitzgerald, 2005; Ferlie et al., 2005). Pettigrew et al. (1992) and Denis, Lamothe, and Langley (2001) report the collective leadership of strategic change by senior managers, while others, (Buchanan, Addicott, Fitzgerald, Ferlie, & Baeza, 2007; Gronn, 2000, 2002, 2003; Leithwood, Day, Sammons, Harris, & Hopkins, 2006; Leithwood, Mascall, & Strauss, 2009) report evidence of distributed leadership. The accounts of both Gronn (2000, 2002) and Leithwood et al. (2006) with regard to distributed leadership are drawn from public sector schools. Currie, Boyett, and Suhomlinova (2005) note individual entrepreneurial, transformational leaders in the revival of failing schools, but in a broader analysis, Currie, Lockett, and Suhomlinova (2009a, 2009b) suggest the co-existence of professional and value-based leadership, historically prevalent in this institutional context. Gronn (2009) suggests exploring combinations of concentrated and distributed leadership in differing organizations. Despite widespread use of the term, there is no agreed definition of distributed leadership; the review by Currie and Lockett (2011) offers two definitions, based on Gronn (2002) and Spillane (2006). In this article, therefore, we develop an empirically based definition of distributed change leadership with three components. These are first, senior leaders with the capability and the interest to support change; second, credible opinion leaders at middle levels, who hold general management or hybrid roles and third, individuals who are willing to engage in change efforts.

1.3. Service improvement in healthcare

Our research questions also consider the impact of change leadership on service improvement in the NHS. There has been sustained policy pressure to improve the quality and consistency of healthcare through structural changes (CMND 7615, 1979; Department of Health, 1990, 2011; Griffith's Report, 1983) and by setting performance standards and targets (Department of Health, 1998, 2000a, 2001, 2004a). Service improvement activity is conceptualized here as relating to service quality, as a proxy measure of organizational performance. It has been argued that evidence concerning the impact of leadership on performance indicators in public sector service settings is weak, perhaps due to the polyvocal and polysemic attributes of performance (Boyne, 2003; Boyne, James, John, & Petrovsky, 2010; Talbot, 2010). Clinical research has measured service quality in terms of outcomes from specific interventions on single conditions (e.g., de Vegt et al., 2000; Khunti et al., 2012). The National Institute for Health and Clinical Excellence, a standard-setting body, has codified these data into the national service frameworks that were used as quality standards in this study. Another tranche of literature spearheaded by Berwick (1989, 2008, 2009) assesses the process-outcome link. Other research has sought to measure financial, behavioral and organizational dimensions of service quality in healthcare (Bandura, 1998; Hoffman, Badamgarav, & Henning, 2004; Ovretveit, 2011). In one of the few studies of the impact of distributed leadership in schools, Heck and Hollinger (2010) develop and test a multi-level model of the effects of leadership change on schools' overall performance, using the single outcome of student performance. In this article, we seek to take initial steps in identifying and mapping change leadership patterns in healthcare, exploring the impact of these patterns on service improvement.

"Service improvement" can be defined as a planned and targeted effort to improve patient-facing outcomes from a service, whether process outcomes, such as throughput; or final outcomes, such as treatment. Service improvement is thus a useful