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Potential challenges facing distributed leadership in health care: evidence from the UK National Health Service

Graeme Martin, Nic Beech, Robert MacIntosh, and Stacey Bushfield

The discourse of leaderism in health care has been a subject of much academic and practical debate. Recently, distributed leadership (DL) has been adopted as a key strand of policy in the UK National Health Service (NHS). However, there is some confusion over the meaning of DL and uncertainty over its application to clinical and non-clinical staff. This article examines the potential for DL in the NHS by drawing on qualitative data from three co-located health-care organisations that embraced DL as part of their organisational strategy. Recent theorising positions DL as a hybrid model combining focused and dispersed leadership; however, our data raise important challenges for policymakers and senior managers who are implementing such a leadership policy. We show that there are three distinct forms of disconnect and that these pose a significant problem for DL. However, we argue that instead of these disconnects posing a significant problem for the discourse of leaderism, they enable a fantasy of leadership that draws on and supports the discourse.

Introduction

Leadership in healthcare continues to attract considerable attention from policy makers and academics internationally (Degeling et al., 2006; Kirkpatrick et al., 2009). This interest is especially keen in the UK NHS where a succession of initiatives have attempted to improve organisational and clinical effectiveness by focusing attention on the nature, role and attributes of leaders and leadership. The political focus has been accentuated by a series of high profile scandals including the failings that occurred in Stafford Hospital in Mid Staffordshire NHS Foundation Trust between 2005 and 2009. The two inquiries by Robert Francis, which reported to the UK government into these failings highlighted serious deficiencies in the standard of patient care and raised questions about the leadership and culture of front line services in the NHS (Francis, 2010; 2013). The 2013 report made 290 recommendations designed to improve quality and create an open patient-centred culture across the NHS. These recommendations, together with the clinical leadership aspirations contained in the Darzi Report (2008), have led to a number of leadership initiatives including the establishment of the NHS Leadership Academy in England (and similar ones in Scotland, NI and Wales), the sponsorship of clinical leadership research, and reports from the Academy of Medical Royal Colleges (AMRC) and the Kings Fund (2011; 2012).

An underpinning assumption of many such initiatives is that perceived failings in the service, and their solutions, can be attributed to leadership in some significant part (Storey and Holti, 2013). Our purpose in this paper is to examine critically Distributed Leadership (DL), one of the more recent solutions to this perceived leadership deficit. Prima facie, the idea of the distribution of leadership, and hence empowering experts throughout the system, may be seen as answering some of the criticisms of traditional leadership, which has been regarded as tending to localise power in the 'centre' or 'top' of the organisation.

We will argue that leadership can become not simply distributed but also *disconnected* and we offer an empirically-grounded conceptualisation of the nature of the disconnects which can occur in a health organisation when seeking to implement DL.

Distributed Leadership

Distributed leadership in general is intended to engage and empower so that there is a vertical flow of power from the centre downwards, and perhaps even beyond the boundaries of the organization (Brookes, 2008). Hence, it is argued that power should be distributed more equally than in a traditional hierarchy (Currie et al., 2009b) and that staff at a variety of levels should be able to make decisions and act upon them in a concertive manner (Gronn, 2002). Sometimes DL is used is as little more than a synonym for a particular style of leadership that goes back to the 1930s when democratic and more collaborative/engaging leadership styles were proposed as an alternative to autocratic and directive styles (Bryman et al., 2011). However, elsewhere, DL is referred to in a more structural sense where leadership roles and responsibilities are formally devolved to clinical units and teams functioning at operational levels (Fitzsimmons, et al., 2011). Thus, competency frameworks have been introduced into the NHS, setting out the nature of leadership roles in which doctors and other clinicians are expected to participate. These are based on a recent derivative of DL – shared leadership (Bolden, 2011). Drawing on the work of Pearce and Conger (2002), shared leadership is seen as a new 'philosophical leadership model' and is defined by the NHS Leadership Academy (2011: 7) as 'an activity that is shared or distributed among members of a team that will underpin this way of working.

DL is usually contrasted with traditionally focused or leader-centric models because of its emphasis on leadership as dispersed both organizationally and socially (Currie and Lockett, 2011). Traditional theories of leadership have tended to cast the leader as hero (Gronn, 2009)

and this is potentially problematic as it focused the praise for success, and the blame for failure in the individual leader. DL has been proposed as an approach that can be of benefit in an increasingly complex or even unknowable world (Grint, 2008) in which policymakers in healthcare have to address pluralistic settings with competing perspectives on what is of value (Gronn, 2011). It is argued that there is a need to incorporate knowledge from experts throughout health systems into leadership, and The King's Fund, for example, has argued for distributing leadership to clinicians:

> *'One of the biggest weaknesses of the NHS has been its failure to engage clinicians — particularly, but not only doctors — in management and leadership" (2011: 3).*

Although there are different variants of DL, including shared leadership (Pearce and Conger, 2002), team leadership and, followership (Kellerman, 2008; Bligh, 2011), much of the current debate over DL was framed by Gronn's early research (2002). He identified two dimensions along which DL can be distinguished from other forms of leadership: *concertive* action and *conjoint agency*. Concertive action refers to the institutionalised levels of collaboration and sharing of leadership roles within workgroups. According to Gronn, institutionalised action should result from overt learning and a degree of subsequent formalisation. In contrast, conjoint agency relates to the nature and quality of interactions among leaders, specifically the levels of synergy among individuals in workgroups and their willingness to engage in mutual influence or reciprocity with one another. Shared leadership, the NHS preferred term for DL, is intended to embody both dimensions, since it is defined as 'a dynamic, interactive influencing process among individuals in groups for which the objective is to lead one another to achievement of group or organisational goals or both' (NHS Institute for Innovation and Improvement, 2009:1).

Thorpe et al. (2011) take Gronn's ideas a stage further by developing a matrix based on two dimensions. First, whether DL is *planned* by an organisation's senior leaders to create concertive action, so rendering such action amenable to centralised influence, or whether it is more *emergent*, driven in a 'bottom-up' manner, so rendering DL less amenable to centralised control. Second, whether DL practice is *aligned* or *misaligned*, that is, whether actors across the organisation act with the same or different interpretations of purpose. They argue that DL can be planned and aligned, but in a qualitatively different way from the focused, top-down

leadership model (see Figure 1).

Thus, in Option 1, we argue that two newer versions of DL theory can be located, both attempting to deal with the strengths and weaknesses of focused and dispersed leadership by recommending a hybrid model combining the strengths (and weaknesses) of both. These are Gronn's (2011) and Day et al.'s, (2006) 'hybrid leadership' and Grint's (2011) 'mission-command' model. Gronn, has recanted his earlier advocacy of purely decentralised DL by proposing a more empirically and conceptually grounded hybrid theory of leadership, combining focused *and* dispersed variants. He describes hybrid leadership as an empirical likelihood since individualist leadership and DL patterns will emerge over time in organisations and, importantly, co- exist. One or the other pattern may dominate for certain periods during an organisation's history, or they may co-exist depending on environmental or situational challenges. Howieson (2013) has elaborated a strongly de-centralised version of DL, proffering it as a solution to the health and social care problems facing the UK NHS and social services. He claims that the setting of a clearly defined mission and strategy by senior leaders allows them to distribute high degrees of freedom and flexibility to staff at operational and tactical levels. This, he argues, creates a set of empowering and high- trust relationships.

INSERT Figure 1. Four options for distributed leadership (adapted from Thorpe et al., 2011)

Other possibilities exist, however. Option 2 suggests that DL can emerge from the conjoint agency of doctors and their clinical teams taking action in the absence of centralised leadership to treat patients. Such actions may be aligned with the organisational strategy and context but may mean that subsequent centralised coordination and control is more problematic. Empirically, this was the basis of a case presented by Buchanan et al. (2007) of the most successful of three so-called leaderless groups in the treatment of cancer in a regional health authority in the UK. One of these groups emerged as particularly successful in treating cancer, despite a lack of leadership from the top, given that the CEO role changed hands five times during the period of research.

Option 3 suggests that there is also the possibility that DL may neither be planned nor aligned with the organisation's mission or culture. Thus, DL may result from the conjoint

agency of clinicians individually or in groups, which, while appropriate at a local level for short periods to get things done, may be inconsistent with the planned organisational mission, strategy and culture of the strategic leadership team. Such a pattern may also be socially constructed and enacted by boards, senior managers and/or other professional groups as 'chaotic', so rendering it liable to be replaced by focused leadership to 'recover' control.

Finally, Option 4 suggests DL can be planned but misaligned with existing professional culture and aims. Although senior leaders seek to secure the benefits of involving people in the leadership process, these are deemed to be inconsistent with the prevailing structure and culture of a healthcare organisation or with the interests of individuals and groups in local units. This has traditionally been the situation in the UK NHS, where clinical professions have opposed being incorporated into the management of the service, especially the subordination of their professional autonomy and judgement to organisational and financial logics. As a result, they have shown a long- standing resistance to being co-opted into organisational-level leadership because of their professional education, culture, and negative beliefs about managers' motivations, education and skills (Degeling et al., 2006; Dickinson and Ham, 2008; Kirkpatrick, et al., 2009), poor relations between clinicians and managers (MacIntosh et al., 2012; Storey and Solti, 2013),and the debate over the relevance of leadership as a concept in healthcare (Martin and Learmonth, 2012). Thus, clinicians who become involved in leadership are often regarded as second-rate or disloyal practitioners who have crossed an important 'line in the sand' (Llewellyn, 2001).

A weakness of much of the literature on DL is its focus on the micro-foundations of organisations. However, the NHS is embedded in specific societal and political logics, which can be regarded as effectively constraining the agency of those who may seek to exercise leadership (Thornton et al., 2013). Blackler (2006) and Blackler and Kennedy (2004) argued that the structural constraints on NHS CEOs' agency made their jobs unsustainable, so questioning whether they were capable of implementing significant change. Their improbable task included:

> "*CEs are responsible to government both for the finances and for the clinical performance of their organizations; they must enact national priorities for healthcare and lead local change programmes; develop good working relations with*

the many professional groups working in their organizations; work with the chair of their board; build relationships with relevant local agencies to develop services for the public; and generally foster public
confidence in the NHS in line with governmental imperatives."

Blackler and Kennedy, 2004: 182

Nevertheless, more than a decade later, the faith in leadership agency and associated practices, training courses and public expectations appear to be increasing rather than declining within what has been termed the discourse of leadership (Martin and Learmonth, 2012) or 'leaderism', a somewhat term used by O'Reilly and Reed (2010) to refer to a set of emerging discourses about leadership and a set of framing metaphors that encapsulate ideas of the process of 'leading change' in the public services. In general this discourse embodies a unitary frame of reference (Fox, 1974). Thus, much of the leadership literature is concerned with integration and connection. Even DL, which advocates broad empowerment and engagement, can be seen as an attempt to incorporate different skills and knowledge towards a shared vision. In contrast, our focus is on disconnection, and particularly on what happens when there is an attempt to enable the more liberal form of connection envisaged by DL. In addition, given the arguments questioning the discourse of leadership, we seek to understand some of the implications of DL for this integrationist project. Thus, our research questions are: What is the nature of the disconnections that can occur when a health organisation is seeking to implement DL? And, given the potential for disconnections, why might DL still be part of a sustained discourse of leadership in and around the NHS?

We will argue that there are three distinct forms of disconnect and that these pose a significant problem for DL. However, instead of this in turn posing a significant problem for the discourse of leadership, we will argue that they enable a fantasy of leadership that draws on and supports the discourse.

Methods

To explore our research questions, we have adopted an interpretivist view of the world in which social actors make sense of social phenomena (Guba and Lincoln, 2005), such as leadership. Such a perspective is associated with a social constructionist approach to studying

leadership perceptions, talk and interactions in specific settings, and, in this context, refers to how the concept of leadership is created, institutionalised, made known and reproduced by leaders and followers acting on their interpretations and knowledge of the phenomenon (Cunliffe, 2008; Tourish and Barge, 2010). Our research strategy involved a study during 2007-10 of three co-located healthcare organisations undertaking all aspects of primary and secondary care in a particular UK region, which, in turn, was directly accountable to a government minister for the overall mission of the NHS in this region. These three case study organisations were the largest and most significant employers in the regional health authority and, between them, accounted for approximately seventy-five percent of the total number of regional healthcare employees. As a consequence, these three organizations had a major influence on the operationalization of the mission and strategies of a regional health authority.

The regional health authority had introduced a new leadership vision and framework in 2004, incorporating key policies on DL, especially concerning clinicians. This policy asserted that 'Leadership was not the preserve of a few people at the top' but needed to be exercised at the levels of ward, community and functional teams because 'front-line leaders make the difference'. To help facilitate this policy, the regional health authority introduced an on-going programme of clinical leadership development in 2006, which has taken in approximately twenty-four participants each year since its inception, the majority of which were employees of our three case study organizations.

In line with our social constructionist approach, our data collection involved qualitative interviewing in three phases, all of which were intended to shed light on the theme of leadership in healthcare in the region. First, we conducted fifty-six focus groups, each lasting about two hours in the three co-located organisations. Focus groups were sampled in proportion to relative employee headcount of the organisations and included a cross section of clinical, non-clinical staff and general managers. Issues raised by interviewers included the values, expectations and perceptions of their organisation as well as their levels of engagement with their employers and workgroups. Second, we conducted forty-six individual interviews with participants attending senior management meetings, which we also observed as part of a larger action research study aimed at evaluating leadership effectiveness. Third, data were gathered from twenty-five, in-depth individual interviews with senior and junior participants in the regional clinical leadership programme as part of the evaluation exercise. Prior to the introduction of the programme in 2006, most leadership development in the regional health

authority and the three case study organizations was carried out in professional 'silos'. One of the aims of the programme was to develop greater understanding of common leadership issues among the disparate clinical professions in the participant organizations. Care was taken to ensure that no individual was interviewed more than once during these three phases of data gathering. All interviews were recorded with the agreement of participants and transcribed.

Taken together, the resulting data set was large and provided a rich source of insights into DL in the three case organizations and, thus, the effectiveness of the regional healthcare authority's vision and policy on leadership in general and DL in particular.

Our analysis followed an abductive process of coding and recoding interviews over a series of iterations in relation to DL theory (Cunliffe and Eriksen, 2011). Interviews were analysed, to capture emerging themes (Daly, *et. al* 1997) that shed light on participants' engagement with DL and the potential and problems associated with aligning DL to organisational and regional health authority mission, structures and cultures. In this paper, we focus on how individuals constructed their role, their sense of engagement in that role and how they understood DL within their employing organisations. Ethics approval was gained through the respective university ethics committees. NHS ethics approval was not required for those parts of the data set that were deemed to be evaluation studies.

Findings

With regard to the first research question, our analysis highlighted three 'disconnects' concerning power, distance and values.

Disconnects Concerning Power. As discussed earlier, DL (or shared leadership) is intended to engage and empower clinical employees in concertive action and conjoint agency (Gronn, 2002). However, our research revealed many instances where views of *power of others* were raised and discussed rather than the empowering nature of DL. These constructions created perceptions that the voices of senior non-clinical managers and clinical staff in leadership roles were unlikely to be heard, resulting in misalignment in Thorpe et al.'s (2011) conceptualisation.

In common with Blackler and Regan's (2004) view, some participants sensed real power lying outside immediate care environments, so voicing an externalised, hierarchical perception of power. For example, legislation and regulations were regarded as being unquestionable, even when they were perceived to be nonsensical. Hence, managers and clinicians were often positioned as *subject to* the power of policy makers with little ability to influence policy. As one senior clinician leader from the largest case setting reflected:

> *'There are things that are given to us [by Governmental Policy Makers] and people just can't change it and that's the honesty bit.'*

Non-clinical leaders also disputed the perception they enjoyed strong internal power. Instead as one Chief Executive Officer (CEO) in our study ruefully claimed:

> *'when it comes to prioritising, I have over seventy key performance measures that I absolutely cannot drop the ball on. There's no choice for me in that. The [regional health department] say they want me to meet targets and I just have to comply. It doesn't even matter that some of these targets are in tension with others. You're just left to get on with it.' (CEO #1, Interview)*

Internal power within the organisation was also disputed. Many senior non-clinical leaders contrasted their lack of internal power with that of clinical staff, pointing to doctors' access to the resources provided by a medical professional logic. Thus a CEO and senior non-clinical leader complained:

> *'I can tell these guys [clinicians] what to do! Who are you kidding? They might listen to another medic but I don't pretend to myself that I hold much sway over them.' (CEO#4 Interview)*

> *'…, you kind of get this constant barrier... I think clinical leaders would like to think that they have different priorities than managerial leaders, it is almost like "you can't tell me what to do because you are not a clinician".' (General Manager, Interview)*

This was in contrast to the views of some clinical leaders, who saw themselves as subject to a detached managerial logic. For example, a Medical Director expressed the opinion that:

> *'some of the staff like nursing staff or AHP (allied health professional) staff feel they haven't been involved and things have been happening to them and around them, not with them, if you see what I mean. The management in this place really needs to get over that hurdle'.*

Even clinicians participating in the regional leadership programme, probably those most likely to be engaged with the idea of leadership, saw themselves as caught up in the classic 'responsibility-without-authority' dilemma. As one Clinical Director reflected:

> *'The job never quite, didn't end up being what I thought it was going to be. I thought I would be part of a management team of an autonomous unit … But in fact it kind of crystallised into being lots of responsibility and no power which is just the worst place to be, I think.'*

These illustrations also show how clinical and non-clinical leaders held contested and, at times, contradictory perceptions of power. Across the data set, each party tended to perceive power to be in the hands of others – both outside and inside of the care environment - thus disconnecting them from believing their voices would be heard and would actually matter even if heard.

Our observations during in-group meetings and interviews led us to conclude these processes were relatively insulated from outside influences since outsiders were not routinely afforded access to the perceptions formed by in-groups. They only became visible away from *joint* fora when in-group members (or, in our case, trusted researchers) alone were present. Such contexts provided fertile ground for constructing *fantasies of the power of others*, because most members of the in-group were able to provide corroborating stories. Indeed, membership of the in-group seemed to have been predicated on shared experiences and on the ability and the willingness to engage in such storytelling. So, for example, those clinicians who had a positive attitude towards management were often regarded as no longer part of the in-group because they had 'crossed the line in the sand' or as one GP clinical leader commented '*you will get people saying 'Oh, you've gone to the dark side' or 'you've joined the enemy'….'*. This view was explained by a senior surgeon as follows:

> *'In some specialties like surgery and general medicine you just don't get applicants [for clinical leader posts]. They've all got other priorities. They don't seem to want to run the show. Also these disciplines don't attract the kind of people that want to run the show. Surgeons aren't team players in any way whatsoever. They all think they're chiefs..... Anyone who does volunteer is seen as having lost the plot.'*

Moreover, even those clinical staff which had attempted to engage in a DL role saw themselves in a difficult position in reconciling the dual demands of leadership and clinician. A recently appointed Medical Director summarised the feelings of their colleagues:

> *'The eternal problem of medical leadership is that you need the medical background to do the job that you're doing but there's a tension between doing the two…. I find it really difficult to do the two jobs to the full extent that they need to be done … at what point do I say that it's no longer tenable to be able to continue the clinical side of things as well as the medical management? '*

Disconnects Concerning Perceived Distance.

Our data also spoke to perceptions of distance in multiple settings (Grint, 2010). These perceptions were two-fold. The first was the physical scale of the organisations. All three employed tens of thousands of staff across dispersed geographies with multiple sites, which fed the perception concerning little contact with senior management. As one senior consultant doctor commented:

> *'I've never even seen (the CEO), never mind met him/her, in all the years I've worked here'.*

Through observing regular business meetings involving different staff groups, the perceived importance of proximity and visibility became clear. Consultant doctors, acting as the head of clinical teams worked in close and regular contact with both their own staff and peers. Similar patterns were true with other health professionals but in sharp contrast to the experience of attending meetings with non-clinical colleagues. Many of those in administrative roles would work in teams located across different geographic locations, with infrequent face-to-face meetings. Non-clinical leaders would often be met with "*it's nice to put a face to the name*" (field notes).

> *'We feel like the proverbial small cogs (nods all around from the rest of the group) – this comes from senior managers…our line managers have to cope with this and they do their best not to make us feel under-valued' (Nurse, Focus Group, 17)*

The second form of distance went beyond "seeing others in the flesh" and suggested that "not being seen" might actually result from professional differentiation in healthcare, with different staff groups occupying "different worlds", even when they worked in close physical proximity. For example, a senior nursing leader complained:

> *'these guys [non-clinical leaders] might work in the same building, but with most of them they feel like they're a long way away, bigger fish to fry, you know. [name of non-clinical leader] is a bit different, in that he always seems to strike up a conversation with you.' (Senior Nurse, Interview)*

This perception was also evident from interviews with clinical leaders. As one medical clinical leader observed:

> *'Doctors tend to act as leaders and don't take on the comments of others. I think often you think that your own profession is the only one that is really stressful and busy until you see how other people have busy and stressful jobs and also how they handle things'.*

However, while being a part-time leader was perceived as source of disconnect, but it was also deemed to be necessary to bridge the worlds of leaders and junior clinicians.

> *'It's actually very difficult maintaining a senior leadership role and a clinical role at the same time because you pulled in so many directions. But to be honest even if the clinical aspect is even just low key it is very important because otherwise you enter into a sort of stratified area where the atmosphere is very different and where awareness of what life is like on the front lines of the NHS begins to go. So I think it's important for managers to have clinical experience and some clinical input still'* (Bio-Chemist Clinical Leader)

Interviews with non-clinical senior leaders concerning these issues, however, tapped into a contrary set of perceptions. Most believed they made strenuous efforts to be seen within and beyond the organisation because they saw themselves as figureheads. A CEO explained:

> *'[we] were reflecting on this last week. [It] became a very big ask when [name of colleague] and I were meeting 30 sets of [name of staff grouping] not once but twice, three times, with seven rounds of meetings with the senior clinical staff at [name of hospital] to talk through the implications of moving toward more community-based services. I mean that's a lot of town halls, community centres and cafeterias to spend your evenings in but it's part of the job' (CEO #2 interview)* .

A lack of engagement with senior managers was also attributed to structural arrangements.

> *'I've got two General Managers. I've got one General Manager [A] and I've got an Assistant General Manager [B] that I report to. It was a bit messy, really, … they were peers and then they were reorganised for one to report to the other which was never going to work … they have a very difficult working relationship. I sometimes get sucked into that but I try to avoid it if I can...'. (Clinical Psychologist Leader)*

Again highlighting structural problems, an allied health professional (AHP) clinical leader observed:

> *'I know what my role is … to do a lot of the cross-working in the (organisation), because at the level that I'm at..., we don't tend to work terribly well across, you know, we tend to be in internal silos...'.*

These perceptions of structural impediments were further fuelled by a tendency to romanticise former arrangements, especially among senior managers. As one medical director reflected:

> *'Well we could go right back to the [FORMER STRUCTURAL ARRANGEMENT], which was actually quite good fun if you were a medical director because you were running a hospital which is actually easier and you can actually deal with it. … you could go home at night and think "I sorted that problem out". …the job I'm now doing, everything is frequently so massive that all you're doing is sitting round getting people together to start them sorting something out.'*

However, we also found contexts in which DL engendered greater levels or expectations of

engagement. Typically, these involved disruption to existing arrangements, such as the creation of new service delivery teams or partnership organisations, or as a result of the development programme in making space for connections and potential alignment

> *'So I think in [name of newly formed partnership organisation], we've laid some of those cornerstones or foundations on which to build better two-way dialogue and I think secure that sense of people wanting to be engaged more. When you actually get into the engagement you still have that broad spectrum of engagement from people…. but I guess engagement is engagement and the fact people feel they've got something new to aim at is probably quite enough at this point in time.' (Medical Director)*

> *'I think as doctors we need to spend more time chatting to our AHPs….It was quite eye opening to see how other healthcare professionals handle particular issues' (Participant on development programme)*

In summary, in much the same way that fantasized views of powerful others created a disconnect, perceptions of distance in physical, attitudinal or temporal terms created further problems for the connections which are the aim and assumption of DL.

Disconnects Concerning Values.

The third form of disconnect emerging from our data was the perceived values of others. One common perception was that there was of two competing institutionalised logics - a 'medical logic', which valued patients and care-provision, and a 'managerial logic', which was concerned with resources and targets (Reay and Hinings, 2009). For example, two clinical leaders on the programme summarised their colleagues' views:

> *'Any time I've got involved in managerial decisions I've lost a few "friends" who felt I've taken leave of my senses. Doctors just don't do this kind of thing to other doctors. It makes it hard to go back into your clinical role' (Clinical lead consultant surgeon, Interview).*

> *'they [senior management] lead the organisation and it's all about the targets. There isn't a lot that can be done in terms of influencing [by clinicians] except in the form of threatening to walkout.' (Nurse Clinician Leader, Interview)*

This last quotation suggests a sense of exclusion, which would evidently be undesirable. However, we also spoke to many managers who had spent much of their working lives in the NHS. Most claimed a sense of vocation about their work and this might be expected to connect well with the values of clinicians. As one board level director explained:

> *'I've been in the NHS for almost thirty years. It's a choice to work here and to try to do things that will make a difference. Yes there are pressures, yes it is difficult, yes the pay*

might be better elsewhere but there's something about it, a public service thing really. Trying to make a difference.'

However, despite what appeared to be compatible value sets, our observation of meeting fora suggested that, seating arrangements often reflected a tendency for professional groups to remain intact over time. Contributions to meetings could be seen as perpetuating a perception that non-clinical managers were unsympathetic to, or at least incapable of engaging with, patient care, while clinicians were portrayed as being unrealistic about funding shortfalls either through naivety or self-interest. Typical of clinicians' views was the following episode recalled by a participant on the regional programme:

'I was in a situation...where there was an issue with regards to the delivery of [name of services], and we had a myriad of different managers, some of whom were clinicians, some of whom weren't. And we were going through a very managed conversation and what came out of it was a manager was hugely threatened by my role because they saw the management of their service as contradictory to my leadership role for [name of speciality]; which in my head I saw it entirely complementary…. That conversation highlighted to me that actually there was a mismatch between clinical leadership and management.' (Clinical Leader interview)

On the other hand, managers' perceptions of clinicians' values were best summarised by two non-clinical directors seeing clinical leaders and their junior colleagues as a disloyal opposition or harbouring unrealistic values:

'the trouble with getting clinicians to engage is in trying to get them to be anything other than a shop-steward for the Doctors Party' (Non-clinical NHS Director, Field Notes from Management Meeting)

'we've got a real issue in trying to manage the expectations of those at the coal- face. We can't do everything and we've got finite resources yet there is this sense in which they'll be disappointed if it's not perfect' (Director 4, Interview)

Discussion

The theory of DL is differentiated from traditional forms of leadership in seeking to allow people across the organisation and at different hierarchical levels, 'voice', decision-making power and the ability to lead in their own fields of expertise (Grint, 2011; Gronn, 2009). This would appear to be particularly attractive in health organisations (Curry and Lockett, 2011) because of the different roles and functions that relate to clinical and other specialisms. DL is supposed to work not only by allowing different voices to be heard (Thorpe et. al. 2011) but also by integrating efforts in different functions and parts of the organisation to be integrated around shared values or purpose. Thus, although leadership

may be exercised in different situations by different people, the outcomes are proposed as mutually supportive and sufficiently consistent to enable organisational effectiveness. However, although the leadership literature in general and DL in particular has often focused on organisational integration, our interest was in problematizing such integration, and so our first research question was: What is the nature of disconnections that can occur when a health organisation is seeking to implement DL?

In our analysis we identified three types of disconnect: power; distance; and value. When DL is enacted and encouraged, even though it is intended to draw people together, we found significantly different perceptions concerning who had power, where the others were located and what their values were. Interestingly, these perceptions appeared to be robust in the face of counter evidence. For example, even when it was clear that the other party did not have power, blame would still be attributed to them for an undesired outcome; regardless of whether managers had been present in a clinical area. Clinicians would report never seeing their non-clinical leaders. Moreover, the similarities of values between clinicians and non-clinical leaders which we heard and observed being enacted were very rarely acknowledged by the groups.

Thus, the disconnects were fundamentally ways of distancing the self from the other and in strengthening in-group ties: witness, for example, the social sanctioning of a clinician who had 'gone over to the dark side' by taking on a leadership role.

Others have argued that romantic or ironic narratives prevail in health organisations (Learmonth, 2003), but the forms of disconnection we saw would appear to fit better with a tragic narrative style. Within this style, a fantasy of leadership can be produced in which agency (and blame) are located in the Other ('they' exercise undue power, fail to listen etc.). This sets up a dialectical relationship with the self, possibly as a struggling hero, working against the odds, or as righteous victim, struggling in the face of adversity. Hence, one of our CEOs could exclaim: 'I can tell these guys (clinicians) what to do! Who are you kidding...?', at the same time as a clinical director can assert their job is '…lots of responsibility and no power, which is the worst place to be'. The impact of this dialectical fantasy of the Other is an ever-greater distancing. The three disconnects can be mutually reinforcing, with 'evidence' from one being used to support another, for example, (apparently) never seeing the managers (distance) might also be taken as support for the perception that they are uninterested in real clinical matters (value). The disconnects also appeared to be positive for groups as their shared perception of the Other as distant/oppositional helped with increasing in-group ties and the telling of familiar stories of unfairness.

Our second, follow-on question was: Given the disconnections, why might DL still be part of a sustained discourse of leadership in and around the NHS? We identified multiple problems with DL: people were sceptical about it and there was little accepted evidence that it would bring about a better state of affairs. Why, then, should it apparently be contributing to a discourse of leadership (Martin and Learmonth, 2012) and be increasingly popular (Currie and Lockett, 2011, King's Fund, 2012) despite the identification of significant problems with the possibilities for significant leadership agency a decade ago (Blackler and Regan, 2004; Blackler, 2006).

One possible interpretation, which represents our view, is that the disconnects draw from and also reinforce a fantasy of leadership in which the Other is strongly distanced and that this can be advantageous at individual, group and discourse levels. For the individual it shifts blame away from the self and leads to a self-identity in which one's virtuousness is increased by contrast with the Other. Within the in-group, social ties are reinforced by the appearance of a shared experience, mode of sense-making and frame for story- telling and jokes. Hence, the in-group can be strengthened by talk and action in line with the fantasy. In individual and group (inter)action people draw upon and reinforce the discourse. It provides 'resources' such as story frames into which they can fit their latest experiences, terms and ways of thinking that can be used to good effect with little effort. Hence, even when people are advocating change, the status quo fantasy may be reinforced because change is likely to be framed in terms of the fantasy (the Other needing to change). Hence, we would see DL, though well-intentioned in spreading voice and empowerment more broadly in an organisation, as a form of institutional work (Lawrence et al., 2009) that has the potential to reproduce the dominant institutional structures by creating a fantasy of the Other which is not amenable to change through counter-evidence. Hence, both for participants in the discourse who need to produce the latest practical innovation, and for those who remain in a place of social comfort by reinforce the social order of the dialectic between self and other, the fantasy functions effectively.

We might ask what, if anything, might be done to improve the situation? One option might be to seek to improve the quality of *dis*agreements. In our analysis, leaders' interactions which are restricted to their in-groups, in mutual isolation, increases their fantasies of the power of the other and decreases the sharing of values among occupational groups. Our data point to

mutually incompatible fantasies of the Other, which could be unintentionally reinforced when the Other was encountered because of the dominating discourse and selective perception that allocates other actors into pre-existing roles in the tragic narrative. Although in-group talk commonly reinforced such narratives, it is also the psychological space where there is potential for experimenting with other ways of thinking particularly if a questioning of 'who we are, and who others are' is enabled. This may require more radically 'distributed' leadership in which high status group members were able to challenge the current ways of thinking. By considering equivocal vision (Gioia et al., 2012), perhaps incorporating ambiguous purposes such as 'public value' (Bennington and Moore, 2010), it may be possible to undo some of the entrenched views of the Other. However, we should be cautious in view of the dominant discourse and the reinforcing cycles of the leadership fantasy.

Conclusions

Blackler (2006) and Blackler and Kennedy (2004) drew a conclusion that leadership could not occur within the NHS until and unless significant changes took place within the macro socio-political and NHS field level institutional frameworks. This conclusion fits with a fantasy-narrative of leadership exemplified by Learmonth's (2001, 2003) analysis in which leaders occupied the role of hero in an epic narrative. In this fantasy- narrative, agency, activity and praise are centred on the (heroic) leader. However, in our analysis, the fantasy focused not on heroes but on the Other, onto whom was projected agency and, typically, blame. Efforts to introduce DL in our case organisations, the rhetoric of which lays stress on empowerment and engagement, turned out to incorporate significant forms of disconnect that, in turn, were mutually constitutive of a tragic, rather than epic, fantasy.

In closing, it could be argued that we now live in a period in which the epic fantasy narrative has less purchase for some social actors. This is particularly so in the UK NHS, which has been resistant to repeated attempts to reform the system through leadership initiatives (Grint, 2008). Thus politicians may increasingly seek to disclaim responsibility for overall leadership

of healthcare in Britain. For, by doing so, they can repel the inevitable blame when things go wrong. In turn, the fantasy of DL may also serve to deflect responsibility away from NHS CEOs and clinical leaders onto others, including GPs, social care and an increasingly demanding general public. Thus a question for further research arising from this work might be as follows: to what extent and under what conditions are these distributed others willing and able to share in leadership of health services, particularly when the incentives to do so remain ambiguous?

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