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Quality improvement science

Leadership and management for quality

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ABSTRACT

This is the third in a series of articles about the science of quality improvement. Leadership and management are required for change and are therefore important for all quality improvement initiatives. We describe the differences between and features of each, and how they support change in individuals, groups and organisations according to the culture and characteristics of the latter. Finally, we see that leadership competencies are conceptualised in the NHS Leadership Framework and how this can be applied to quality improvement in general practice and healthcare more generally.

Keywords: general practice, leadership, management, organisational culture, primary care, quality improvement

Introduction

Management in healthcare is about getting things done to improve the care of patients. Leadership skills help doctors become more actively involved in planning and delivery of health services, but also support roles in research, education and health politics. Management competencies are crucially important to health professionals for ensuring that systems are in place to monitor and maintain the quality of care: the stuff of 'clinical governance' and the focus of this series.

The nature of management

Classical management theories evolved out of military theory and were developed as advanced societies industrialised. Although they recognised the need to harmonise human aspects of the organisation, problems were essentially seen as technical. Early theories made individuals fit the requirements of the organisation. Later theories borrowing on behavioural psychology and sociology suggest ways in which the organisation needs to fit the requirements of individuals.

Question: What do you think managers do?

Most front-line practitioners work closely alongside managers, understand what they actually do, and can therefore see them as partners in improving patient care.

We can think about management in terms of the tasks or actions a manager needs to perform (see Box 1), but it is also useful to think of management as having several different dimensions:[1]

- **Principles**: management is about people, securing commitment to shared values, developing staff and achieving results. These help determine the culture of organisations.
- **Theories**: management is underpinned by a plethora of different theories and frameworks. These, in turn, shape the language – and jargon – of management.
- **Structures**: the way organisations are set up, as bureaucracies, open systems, matrices, networks, etc.
- **Behaviours**: personal and organisational.
- **Techniques**: including communication skills, management by objectives, finance, accounting, planning, marketing, project management and quality assurance.

Box 1 Management tasks

Defining the task: Break down general aims into specific manageable tasks.

Planning: Be creative – think laterally and use the ideas of others. Evaluate the options and formulate a working plan. Turn a negative situation into a positive one by creative planning.

Briefing: Communicate the plan. Run meetings, make presentations, write clear instructions. The five skills of briefing are: preparing, clarifying, simplifying, vivifying (making the subject alive) and being yourself.

Controlling: Work out what key facts need to be monitored to see if the plan is working, and set standards to measure them against. To control others, you need also to be able to control yourself, e.g. managing your time to best effect.

Evaluating: Assess the consequences of your efforts. Some form of progress report and/or debriefing meeting will enable people to see what they are achieving. The people as well as the task need evaluating, and the techniques of appraisal are important tasks for the leader of the team.

Motivating: Simple ways often work best. Recognition, for example, of someone's efforts, be it by promotion, extra money or, more frequently, by personal commendation, seldom fails. Success motivates people and communicates a new sense of energy and urgency to the group.

Organising: See that the infrastructure for the work is in place and operating effectively.

Setting an example: Research on successful organisations suggests that key factors are the behaviour, the values and the standards of their leaders. People take more notice of what you are and what you do than what you say.

Communicating: Be clear and focused. Who needs to know what to get your aims realised?

Housekeeping: Manage yourself – your time and other resources. Have coping strategies for recognising and dealing with pressure for yourself and others.

Theories of leadership

Question: What qualities characterise the leaders you have encountered?

There are a variety of theories on leadership. Early writers tended to suggest that leaders were born not made, but no one has been able to agree on a particular set of characteristics required. The following are commonly listed as leadership qualities:

- above average intelligence
- initiative or the capacity to perceive the need for action and do something about it
- self-assurance, courage and integrity
- being able to rise above a particular situation and see it in its broader context (the 'helicopter trait')
- high energy levels
- high achievement career-wise
- being goal-directed and able to think longer term
- good communication skills and the ability to work with a wide variety of people.

Modern theories have proposed two types of leadership: transactional and transformational. Transactional leadership attempts to preserve the status quo, whereas transformational leadership seeks to inspire and engage the emotions of individuals in organisations. Transactional leadership concentrates on exchanges between leaders and staff, offering rewards for meeting particular standards in performance. Transformational leadership highlights the importance of leaders demonstrating inspirational motivation and concentrates on relationships.[2] Another popular concept to emerge in more recent literature on leadership is that of 'emotional intelligence'.[3] This is the capacity for recognising our own feelings and those of others, motivating ourselves and managing emotions well in ourselves.

Note that leadership and management are not synonymous. A manager is an individual who holds an office to which roles are attached, whereas leadership is one of the roles attached to the office of manager. Just being in a senior position will not make you a leader, and certainly not an influential one. Both leaders and managers wield power and must have the ability to influence others to achieve organisational aims.

How you carry out your managerial functions and the way you exercise power and authority – your management or leadership style – is central (Box 2). To be successful, it must be appropriate to the situation. Different styles are needed at different times and in different organisational contexts. All of us have preferred styles conditioned by personality and ex-

Box 2 Sources of power

Power based on the position of the individual

Positional power
Vested in an individual by virtue of the position they hold, e.g. team leader

Resource power
Control over staff, funds or other resources

Power based on the individual

Expert power
Specialist expertise, i.e. an NHS consultant

Personal power
What an individual brings personally, such as style, charisma, skills and so on

perience. The ability to adapt your approach to different circumstances is a major determinant of effectiveness, just as communication skills with individual patients require versatility according to circumstances.

In healthcare, increasing consideration is being given to the organisational context within which people work and what is required of a leader in that work situation. According to contingency theories of leadership, four variables have to be taken into account when analysing different circumstances:

- the manager (or leader) – his or her personality and preferred style
- the managed (or led) – the needs, attitudes and skills of his or her subordinates or colleagues
- the task – requirements and goals of the job to be done
- the context – the organisation and its values and prejudices.

Unsurprisingly, the one over which you have most control is you!

Theories of change

Surveying most health systems, two features are immediately apparent. The first is their extraordinary complexity as ever more sophisticated technology is developed to meet an ever expanding range of health problems. A second feature of modern healthcare is how fast new technologies and services are evolving. Leaders and managers in this environment are therefore concerned with understanding the need for and managing change.

Lewin developed the notion of 'forcefield analysis' to help understand drivers and barriers to change: reducing forces resisting change is considered to be more effective than strengthening driving forces but it is important to address both.[4] There are many management tools which can be used to analyse change and the forces that might support or hinder it. For example, a PESTLE analysis can be used to consider the context within which a specific change is occurring.[5] PESTLE is an acronym covering the influences on an organisation (Box 3).

Introducing a new service or changing an existing service in response to the kind of drivers identified by

Box 3 PESTLE analysis

Political
What is happening politically which could affect your organisation?
For example, government policy

Technological
How does changing technology impact on your organisation?
For example, new drugs, medical devices

Environmental
What environmental issues affect your organisation?
For example, carbon reduction requirements

Legal
What legal factors influence your organisation?
For example, medico-legal requirements, registration

Social
How do social factors affect your organisation?
For example, population growth, ageing

Economic
What are the implications of finances and economics on your organisation?
For example, taxes, payment models

using a tool such as PESTLE is difficult. Many people will initially resist change even if the results are likely to benefit them. The process of change involves helping people within an organisation or a system to change the way they work and interact with others in the system. Leaders need to understand how people respond to change in order to plan it.

Question: Think about your organisation or a healthcare system. You could use the whole of the NHS. Use the PESTLE model to analyse what is driving change in that system

Everett Rogers' classic model (Figure 1) of how people take up innovation is one model that can help us to understand different people's responses to change.[6] This was based on observations of how farmers took up hybrid seed corn in Iowa. The model describes the differential rate of uptake of an innovation, in order to target promotion of the product, and labels people according to their place on the uptake curve. Rogers' original model described the 'late adopters' as 'laggards', but this seems a pejorative term when there may be good reasons not to take up the innovation. How soon after their introduction, for example, should nurses and doctors be prescribing new, usually more expensive inhalers for asthma?

Individuals' change type may depend on the particular change they are adopting. This depends on the perceived benefits, the perceived obstacles, and the motivation to make the change. People are more likely to adopt an innovation:

- that provides a **relative advantage** compared with old ideas
- that is **compatible** with the existing value system of the adopter
- that is readily understood by the adopters (**less complexity**)
- where the results of the innovation are more easily noticed by other potential adopters (**observability**).

Pharmaceutical companies use this model in their approaches to general practitioners (GPs). The local sales representatives know from the information they have about GPs in their area whether a GP is an early adopter. Early adopters are often opinion leaders in a community. Early on in the process of promotion they will target those GPs with personal visits, whereas they may send the late adopters an information leaflet only, because those GPs will not consider change until more than 80% of their colleagues have taken up the new product.

Clinicians will be familiar with other psychological models of change from their 'day jobs'. For example, the transtheoretical model describes the process of behaviour change in terms of different motivational states during adoption of an innovation.[7] The process begins with precontemplation (not yet ready for change) and progresses through contemplation (thinking about change), preparation (for change), action (to implement change) and finally maintenance of change. The skills required to motivate individual behavioural change overlap with those required at an organisational level.

Organisational behaviour and motivation

It is important to understand how people operate within the organisation within which they work. Organisational behaviour can be studied at three levels, in relation to: individuals, teams and organisational

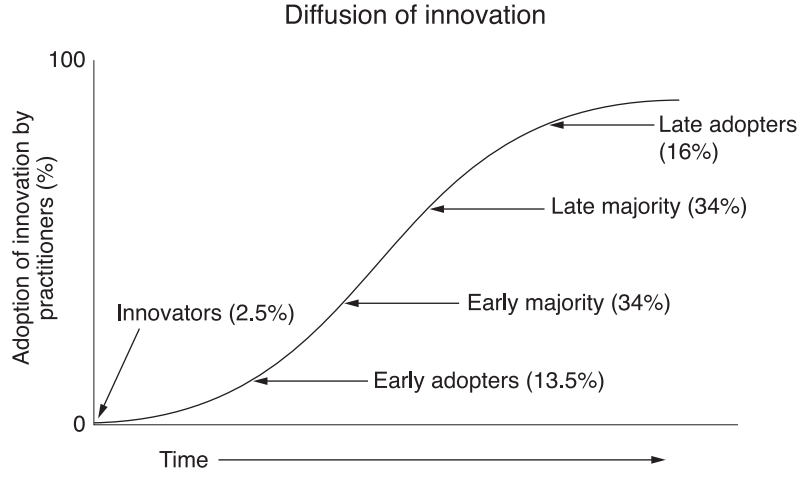

Figure 1 Diffusion of innovation

processes.[8] Managers everywhere are interested in how such concepts as job satisfaction, commitment, motivation and team dynamics may increase productivity, innovation and competitiveness.

Types of organisation (Box 4)

How organisations function is a combination of their culture and structures. Organisational culture has been described as a set of norms, beliefs, principles and ways of behaving that together give each organisation a distinctive character.[9]

Question: In what type of organisation do you think you work? How does this influence your ability to do your job?

There is as yet limited evidence linking organisational culture and performance in primary care.[10] Great methodological ingenuity will be required to unravel the relationship between these two variables.[11]

Question: What factors affect the behaviour of staff and teams in your workplace?

Types of team

Even relatively small organisations like general practices may at some point form different types of team to carry our specific functions. Teams are often described as:

- **Vertical or functional.** Teams that carry out one function within an organisation such as an infection control team within a practice or hospital.
- **Horizontal or cross-functional.** Teams that are made up of members from across an organisation. These may be formed for specific projects such as managing the introduction of a new service which might need operational, clinical and financial input or can be long-standing teams such as an executive team running an organisation.
- **Self-directed.** Teams that do not have dedicated leadership or management. These may generate themselves within an organisation to achieve aims or they can be specifically designed to give employees a feeling of ownership.

Tuckman's model (Figure 2) explains how teams develop over time and can be used to consider how individuals, including the leader, behave within those teams.[12]

Getting the right people on the team is critical to a successful improvement effort. Teams vary in size and composition; each organisation builds teams to suit its own needs. Effective teams include members representing three different kinds of expertise within the organisation: system leadership, technical expertise and day-to-day leadership.

Leading change in general practice

We have described a number of theories relating to management, leadership and change. But how can these be used in general practice? Nowadays, GPs occupy leadership positions exercising power with increasing managerial accountability for outcomes. They drive the changes that they believe – on the basis of evidence and experience – will result in improved health for their practice or CCG population. (In a later article in this series, we consider commissioning for quality.) Strategy is at the heart of the change process. Leadership and management skills are central to developing strategy for quality improvement (Box 5).

Question: How much do you think you will need achievement, power and affiliation in your future work?

The current reforms to the NHS highlight the role of clinicians, especially doctors as both leaders and managers. The UK Leadership Council's NHS Lead-

Box 4 Handy's types of organisational culture

Power culture
Power is held by a few and radiates out from the centre like a web
Few rules and beaurocracy mean that decisions can be swift

Role culture
Hierarchical bureaucracy where power derives from a person's position

Task culture
Power derives from expertise and structures are often matrix with teams forming as necessary

Person culture
All individuals are equal and operate collaboratively to pursue the organisational goals

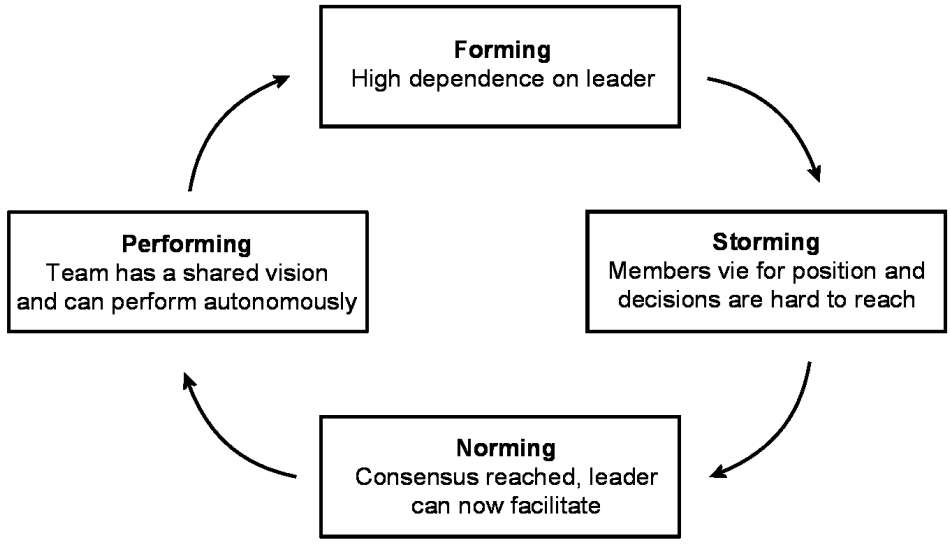

Figure 2 Bruce Tuckman's team development model

Box 5 Strategy development for QI

How do we make the case for change?	Assess local needs, taking account of national strategies Define the drivers for and against change, e.g. through PESTLE analysis
What are we aiming to do?	Clarify aims, objectives and desired outcomes Define local standards and set targets
How can we make change happen?	Understand the principles of change management and plan to address the factors that might resist change Include a description of the actions that are required, and an assessment of the resource implications of putting the new service into place with clear financial plans Consider the organisational context and how you need teams and individuals to operate in the new system
How do we engage with partners including patients?	Involve all those who are affected by the strategy including clinicians, managers and other staff in and in partner organisations Identify who will support and who will oppose it; develop an approach to overcoming this opposition Consider who has the power in these relationships and how that affects the strategy development
How do we know we have done what we wanted to do?	Evaluate impact by demonstrating achievement against the standards and targets through monitoring routine data and special studies
How do we make successful change become normal practice?	The change in practice needs to be sustained to ensure that it becomes routine, as people tend to revert to their old ways of working This requires individuals to change the way they do things. Continuing education and alterations to the work environment with a process of ongoing monitoring/audit/feedback may all be required Consider what motivates people and how to use leadership and management skills to build a culture of continuous improvement

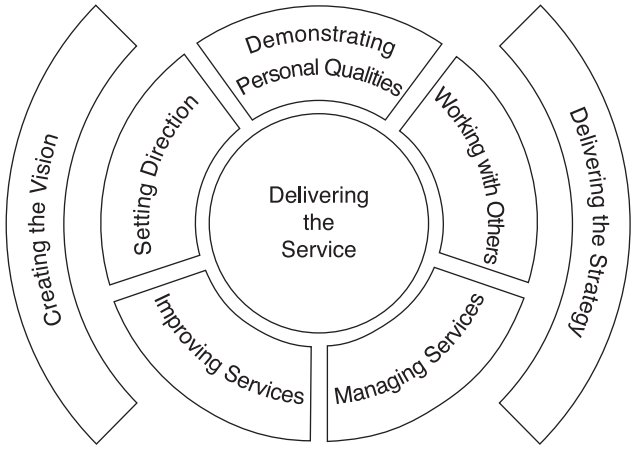

Figure 3 The domains of UK NHS Leadership Framework

ership Framework is built on a concept of shared leadership and sets out the competencies doctors and other NHS professionals need to run health care organisations and improve quality of care.[13] The domains of this framework are shown in Figure 3 (see online).

Such competencies in leadership and management develop over an individual's career. Leadership and management behaviours can be learned, but continuous improvement requires an open-minded approach to assessing our own skills level, an ability to seek and accept constructive feedback on our performance and a willingness to change. How can we lead and manage change if we are unwilling to lead, manage and change ourselves?

Question: Think of a new service or change, large or small, which would require leadership and management to deliver. Use the questions in Box 3 and the theory outlined in this article to consider how you would go about managing that change.

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CONFLICTS OF INTEREST

None declared.

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