Title: Health Education North West Annotated Bibliography: Medical Leadership Training

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Agius S, Brockbank A, Baron R, Farook S, Hayden J. The impact of an integrated Medical Leadership Programme. *Journal of Health Organization and Management.* [in press for March 2015 publication]
This paper reports on the impact of an integrated Medical Leadership Programme (MLP) on a cohort of participating specialty doctors and the NHS services with which they were engaged. This was a qualitative study designed to obtain rich textual data on a novel training intervention. Evidence of the positive impact upon trainees and NHS services was identified, along with challenges. The study has provided valuable lessons for the design of future leadership programmes aimed at doctors in training. Identifying the effectiveness of an innovative model of delivery with regard to the medical leadership curriculum may assist with medical staff engagement and support health service improvements to benefit patient care.

Atkinson, S., Spurgeon, P., Clark, J. and Armit, K. (2011). *Engaging Doctors: What can we learn from trusts with high levels of medical engagement?* NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, University of Warwick, Coventry.
This report shares the key findings from a study of seven trusts which achieved high Medical Engagement Scale scores from an initial survey involving 30 trusts in England. It describes the actions and initiatives taken by these Trusts to achieve high levels of engagement and seeks to make this 'best practice' available to others.

Bagnall P (2011). *Facilitators and Barriers to Leadership and Quality Improvement.*
Available at: www.kingsfund.org.uk/leadershipreview
The 2012 leadership review examined the concept of leadership for engagement in health care, promoting engagement within teams, organisations and across the system to drive improvement.

Baker GR, Denis J-L (2011). 'Medical leadership in health care systems: from professional authority to organizational leadership'. *Public Money & Management*, vol 31, no 5, pp 355–62.
Transforming health care organizations to improve performance requires effective strategies for engaging doctors and developing medical leadership. Most efforts in the US and UK to develop medical leadership have focused on structural changes that integrate doctors into administrative structures, but these have had limited impact. Recognising the distributed and collective character of effective leadership, some health care organizations are now attempting to create greater alignment between clinical and managerial goals, focusing on improving quality of care. These initiatives aim to create effective systems at a team and organizational level, not just the development of medical leadership competencies.

Baker G (2011). *The Roles of Leaders In High-Performing Health Care Systems* London: The King's Fund.
Available at: www.kingsfund.org.uk/publications/articles/leadership_papers/the_roles_of_leaders.html
Health care organisations are large, complex and difficult to manage; the role of leaders and their contribution to the success of organisations needs to be better understood.

This paper reviews five health care systems that are viewed as 'high-performing', using cross-case methods to identify the key factors linked to their success, examining their leadership strategies, organisational processes and the investments they made to create and sustain improvements in care.

Baker E, Kan M, Teo STT (2011). 'Developing a collaborative network organization: leadership challenges at multiple levels'. *Journal of Organizational Change Management*, vol 24, no 6, pp 853–75.
The purpose of this paper is to examine a collaborative non-profit network which is undergoing organizational change. The authors present a case study of an employment-services network in its first year of change, as the

network implemented various activities to enhance its performance. A grounded-theory approach was adopted to study the organizational and collaborative processes within the member-site and Head-Office levels.

It was found that member-site leadership was the critical factor influencing site culture and site performance, and that high-performing sites were initiating collaborative activities with other sites. Head-Office leadership also influenced site performance and collaboration, but its initiatives were only moderately successful. The findings also indicate that change efforts should focus on leadership at both the site and network levels, and may need to begin with low-performing sites. The paper discusses the implications of leadership on the implementation of collaborative networks in the employment services sector. The qualitative findings of the study add to, and help to explain, earlier research findings on the questions of how public sector organizations utilize various activities to implement collaborative networks and their impact on managerial practice.

Benington PJ, Hartley J (2009). *Whole Systems Go! Improving leadership across the whole public service system*. Ascot: National School of Government.
This report addresses the question: 'What would it take to create more effective leadership of the whole govern mental and public service system?' The current economic crisis provides a significant catalyst for this review. The new paradigms include thinking about government and public services as 'complex adaptive systems' and organisms, rather than as machines or physical structures (e.g. 'levers' or 'silos'). This also requires a radical re-design of provision for leadership and management development, in order to stimulate continuous self-improvement in performance across the whole public service system, and visible and measurable outcomes for users, citizens and communities.

Bohmer, R. (2012). *The Instrumental Value of Medical Leadership: Engaging doctors in improving services.* The King's Fund.
Available at: www.kingsfund.org.uk/leadershipreview
For the purposes of stimulating debate, this paper takes a specific position on a number of these issues, framing medical leadership as a diverse set of behaviours – predicated on the nature of patients' care – by frontline clinicians intended to bring about an improvement in patients' medical outcomes. This definition echoes the definition of leadership given by last year's King's Fund Leadership Commission: …the art of motivating a group of people to achieve a common goal (The King's Fund Commission on Leadership and Management in the NHS 2011). But this paper will also argue that medical leadership, if it is to deliver performance improvement, needs to focus on the clinical enterprise.

Bohmer R (2010). *Managing the new primary care: the new skills that will be needed*. Health Affairs, vol 29, issue 5, pp 1010–14.
Developing new models of primary care will demand a level of managerial expertise that few of today's primary care physicians possess. Yet medical schools continue to focus on the basic sciences, to the exclusion of such managerial topics as running effective teams. The approach to executing reform appears to assume that practice managers and entrepreneurs can undertake the managerial work of transforming primary care, while physicians stick with practicing medicine. This essay argues that physicians currently in practice could be equipped over time with the management skills necessary to develop and implement new models of primary care.

Cikaliuk M (2011). 'Cross-sector alliances for large-scale health leadership development in Canada: lessons for leaders'. *Leadership in Health Services*, vol 24, no 4, pp 281–94.
This paper aims to examine the benefits and challenges of enacting cross-sector alliances as a strategy to meet the health leadership capacity and capability requirements to effect improvements in health service delivery.

Clark J, Nath V (2014). *Medical engagement: A journey not an event.* The King's Fund.
Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/medical-engagement-a-journey-not-an-event-jul14_0.pdf
This report builds on earlier work from The King's Fund including the National Institute for Health Research (NIHR) Service Delivery and Organisation Programme Report (Dickinson et al 2013), Are we there yet? Models of medical

leadership and their effectiveness: an exploratory study, as well as recent annual leadership reports (The King's Fund 2011, 2012, 2013; West et al 2014).

It also reinforces the conclusions of the authors' published qualitative assessment of the impact to date of revalidation and the behaviour of doctors and the culture of organisations (Nath et al 2014). This revalidation report suggested that culture is changed 'when behaviour is so internalised that doctors are motivated to improve the quality of patient care – 'when no one is watching'.

The organisations profiled in this report share a common goal of achieving and exceeding their current levels of medical engagement so that it becomes core to the culture of the organisation. It specifically focuses on what lessons can be drawn from a study of four NHS foundation trusts with acknowledged high levels of medical engagement. Its aim is to help organisations think through how to create cultures in which doctors want to be much more engaged in the management, leadership and improvement of services and where boards and executives genuinely seek such a way of working.

Clark J. (2012). ***Medical Engagement: Too important to be left to chance*****. The King's Fund.**
Available at: www.kingsfund.org.uk/leadershipreview
This paper reviews the evidence which supports the view that securing greater engagement of doctors in management, leadership and service improvement is critical to improving performance. It will also draw on examples of good practice nationally and internationally, as well as offering some frameworks for obtaining and securing greater medical engagement.

Curry N, Ham C (2010). ***Clinical and Service Integration: The route to improved outcomes*****. London: The King's Fund.**
Available at: http://www.kingsfund.org.uk/publications/clinical-and-service-integration
The report considers how clinical and system integration makes a significant contribution to improved outcomes by:

- describing integrated care and identifying the different forms it takes
- exploring the different levels within the system at which it operates
- setting out the evidence for the different systems.

Integration can take a variety of forms, involving either providers, or providers and commissioners, who work together to deliver better outcomes at a number of levels within the system. This report summarises relevant evidence about high-profile integrated systems in the United States, such as Kaiser Permanente and Geisinger Health System and outlines examples of integrated care in North America and Europe for particular groups, such as older people or patients with long-term conditions – for example, the integrated health and social care teams in Torbay. It also explores the range of approaches to improving co-ordination for individual patients and carers – for example, the Care Programme Approach in mental health.

Department of Health (2008) ***High Quality Care for All: NHS Next Stage Review Final Report [The 'Darzi' Report].*** **Norwich: The Stationery Office.**
The final report of Lord Darzi's NHS Next Stage Review. It responds to the 10 NHS Strategic Health Authority strategic visions and sets out a vision for an NHS with quality at its heart.

Dickinson, H., Ham, C., Snelling, I., and Spurgeon, P. (2013), ***Are We There Yet? Models of Medical Leadership and their effectiveness: An Exploratory Study. Final report,*** **NIHR Service Delivery and Organisation programme.**
The main aims of the study are to provide an up-to-date picture of the nature and range of medical leadership structures in NHS trusts in England; to analyse how different structures operate in practice and the processes at work within these structures, for example between doctors, nurses and managers; and to relate evidence on structures and processes to available data on organisational performance.

Eckert R, West M, Altman D, Steward K and Pasmore B. *Delivering a Collective Leadership Strategy for Health Care*. Centre for Creative Leadership and The King's Fund.
Available at: http://www.kingsfund.org.uk/sites/files/kf/media/delivering-collective-leadership-ccl-may.pdf
This paper argues that it is collective leadership—the engagement of all members of staff in the organisation and patients into the leadership process—that is needed to create the cultures that NHS organisations need now and in the future. Implementing a collective leadership strategy is a complex endeavour. It involves a series of steps, which we refer to as Discovery, Design, Development, and Evaluation. These elements of a leadership strategy target leadership at the individual, team and organisational level.

Edgren L (2011). 'Complex adaptive systems for management of integrated care'. *Leadership in Health Services*, vol 25, no 1, pp 4.
The purpose of this paper is to examine how a complex adaptive systems (CAS) approach can be used to promote the integration of health and social care for the benefit of the user. This paper is a research review and a conceptual analysis of key issues identified in the growing literature on CAS. An application of the CAS approach to the field of integrated care is presented. The paper identifies crucial issues, notably: bringing together different providers and the place of the user as a co-producer of care.

The benefits of the CAS approach to integrated care are distilled. Above all CAS provides managers of health and social care with an alternative mindset. Guiding principles are offered to these managers to facilitate development towards a more integrated system of health and social care. The possibility to benefit from the user's own resources is increased when organizations are viewed from a CAS perspective. CAS promotes emergent ways of working. The CAS approach makes possible a significant improvement in relationships between providers and users and managers and providers; a possibility of more productive relationships and better care outcomes, not least in terms of user satisfaction.

Edmondson AC (2012). *Teaming: How organizations learn, innovate and compete in the knowledge economy*. San Francisco: Jossey-Bass.
Amy Edmondson shows that organizations thrive, or fail to thrive, based on how well the small groups within those organizations work. In most organizations, the work that produces value for customers is carried out by teams, and increasingly, by flexible team-like entities. The pace of change and the fluidity of most work structures means that it's not really about creating effective teams anymore, but instead about leading effective teaming.

Edmonstone J (2011). 'Developing leaders and leadership in health care: a case for rebalancing?' *Leadership in Health Services*, vol 24, no 1, pp 8–18.
The paper aims to describe the emerging critique of leader development in health care and to describe an alternative approach. The paper explores the growing critique of leader development, highlighting the concentration on the development of individual human capital. The creation of social capital through an emphasis on leadership development is explained. Design principles and potential obstacles are identified.

A rebalancing of the field from an over-concentration on the development of individual leaders to an emphasis on context and relationships is necessary. Although the basic building-blocks of development will remain the same, there is a need to rebalance them towards leadership rather than leaders. The paper brings together in one place various strands of concern over leader development in health care and makes a case for change.

Fillingham D and Weir B. (2014) *System leadership: Lessons and learning from AQuA's Integrated Care Discovery Communities*.
Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/system-leadership-october-2014.pdf
This paper: describes the work carried out by AQuA (the Advancing Quality Alliance) and The King's Fund in the north-west of England between 2011 and 2014, which has taken a 'discovery' approach to developing integrated care and the leadership capabilities to support it; considers why the style of leadership currently dominant in much

of health and social care does not lend itself well to leading across complex integrated networks and the implications for developing system leaders; sets out in general what we have learned about the skills, knowledge and behaviours displayed by the most effective 'system leaders' and system leadership teams; explores in more detail the learning from an in-depth case study in relation to one particular community – the City of Manchester; concludes with reflections on this work for those interested in the development of the system leaders of the future.

Faculty of Medical Leadership & Management (2014). *Professional standards*. FMLM.
Available at: https://www.fmlm.ac.uk/professional-development/accreditation-and-standards/fmlm-consultation-on-professional-standards of

Franco M, Almeida J (2011). 'Organisational learning and leadership styles in healthcare organisations: an exploratory case study'. *Leadership and Organization Development Journal*, vol 32, no 8, pp 782–806.
This paper aims to understand the association between organisational learning and leadership styles in the healthcare context. A qualitative approach was applied in two continuous care units in the same Portuguese healthcare organisation (single case study).

Data were obtained from a survey of 28 collaborators and an interview with its manager-leader/general director. Documental analysis was also used. The findings attested to the central role of organisational learning and leadership in organisational performance/effectiveness within healthcare organisations. Different levels of performance were identified in the organisation selected. The practical implications of findings are also discussed. The study of a single case has been analysed, with the consequent disadvantage of not considering generalisation. For this reason, further research should be carried out to detect structural and cultural differences in healthcare organisations. On the other hand, most of the writing on organisational learning and leadership is conceptual, so this empirical study was important. Despite the vast quantity of studies in the domain of leadership and organisational learning, very little work associates these two topics. Taking into account the relevance of these research topics for healthcare organisations, the findings give additional support to the argument that leadership plays an important role in instilling organisational learning in the healthcare sector.

General Medical Council (2012). *Leadership and Management for all doctors*. GMC.
Available at: **http://www.gmc-uk.org/guidance/ethical_guidance/11788.asp**
This guidance sets out the wider management and leadership responsibilities of doctors in the workplace, including: responsibilities relating to employment issues; teaching and training; planning, using and managing resources; raising and acting on concerns; helping to develop and improve services. The principles in this guidance apply to all doctors, whether they work directly with patients or have a formal management role.

Goldstein J, Hazy JK, Liechtenstein B (2010). *Complexity and the Nexus of Leadership: Leveraging nonlinear science to create ecologies of innovation*. London: Palgrave Macmillan.
Using leadership to generate greater innovation, connectivity, and organizational transformation is crucial for success in this challenging era. The authors present here a new approach to leadership based on findings from complexity science, integrating real case studies with rigorous research.

Goodwin N, Smith J, Davies A, Perry C, Rosen R, Dixon J, Ham C (2011). *Integrated Care for Patients and Populations: Improving outcomes by working together: A report to the Department of Health and the NHS Future Forum*, The King's Fund.
The authors assert that integrated care is essential to meet the needs of the ageing population, transform the way that care is provided for people with long-term conditions and enable people with complex needs to live healthy, fulfilling, independent lives. This report examines: the case for integrated care; what current barriers to integrated care need to be overcome and how; what the Department of Health can do to provide a supporting framework to enable integrated care to flourish; options for practical and technical support to those implementing integrated care, including approaches to evaluating its impact.

The report asserts that developing integrated care should assume the same priority over the next decade as reducing waiting times had during the last.

Gosfield A, Reinertsen J (2010). *Achieving Clinical Integration with Highly Engaged Physicians*. Available at: http://www.ihi.org/resources/Pages/Publications/AchievingClinicalIntegrationHighlyEngagedPhysicians.aspx
This paper presents a framework that may be used as a roadmap by leaders who wish to achieve clinical integration, that is, engaging physicians for true clinical process redesign that can change culture and lead to lasting differences in the way care is delivered.

Grint K, Holt C (2011). *Followership in the NHS*.
Available at: http://www.wtsinternational.org/assets/65/7/Followership_in_the_NHS-2.pdf
This review of followership in the NHS begins with a brief review of the clamour for leadership in the recent past as a way of transcending the apparent failure of the prior governance and targets approach. It then provides a succinct review of the recent literature on followership, provides a typology of followers based on the original typology of problems originally undertaken by Rittel and Webber, and its final section considers what this all means for followers in the NHS.

Ham, C. (2008), "Doctors in leadership: learning from international experience", *The International Journal of Clinical Leadership*, Vol. 16 No. 1, pp. 11-6.
This paper describes the arrangements for involving doctors in leadership roles in Australia, New Zealand, The Netherlands, Germany, Denmark, Finland, Sweden, Canada and the United States. While it is rare for doctors to be appointed to chief executive posts, it is common for them to be involved as medical directors in hospitals and other healthcare organisations. Doctors also take on leadership roles as heads of clinical departments and directorates. A wide range of leadership education and development is offered in these countries and Denmark stands out for the commitment it has made to supporting doctors to take on leadership roles. In the United States, Kaiser Permanente is an exemplar of medical leadership. Kaiser Permanente is unusual because of the high proportion of doctors in leadership roles, the value placed on these roles, and the career structures that enable doctors to move into and out of leadership roles. The United Kingdom has the opportunity to learn from experience in other countries to strengthen the role of doctors in leadership.

Ham, C. and Dickinson, H. (2008). *Engaging doctors in leadership: What we can learn from international experience and research evidence*, NHS Institute for Innovation and Improvement.
Available at:
http://www.institute.nhs.uk/index.php?option=com_joomcart&main_page=document_product_info&products_id=458&cPath=78
Key points from two reviews commissioned in support of the Enhancing Engagement in Medical Leadership project, providing a systematic and research based overview of the evolution of medical leadership and the reasons why a concerted focus on the training and support for doctors taking on leadership roles is needed.

Hamilton P, Spurgeon P, Clark J, Dent J, Armit K (2008). *Engaging Doctors: Can doctors influence organisational performance? Enhancing Engagement in Medical Leadership*. London: Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement. Available at: http://www.aomrc.org.uk/doc_view/197-engaging-doctors-can-doctors-influence-organisational-performance
This report outlines how the medical engagement scale can measure and improve medical influence and the impact of good medical engagement on organisational performance. This document explains how the Medical Leadership Competency Framework will embed clinical engagement into the culture of the NHS. It shares findings from a literature review, outcomes of interviews with chief executives and medical directors and provides real examples of good practice in medical engagement.

Heifetz RA, Grashow A, Linsky M (2009). *The Practice of Adaptive Leadership: Tools and tactics for changing your organization and the world*. Boston, Mass: Harvard Business Press.

This book describe the tools and tactics for change. When change requires a leader to challenge people's familiar reality, it can be difficult, dangerous work. Whatever the context, whether in the private or the public sector, many will feel threatened as the leader pushes though major changes. But the leader will need to find a way to make it work.

Ibarra H, Hansen M (2011). 'Are you a collaborative leader?' ***Harvard Business Review*****, vol 89, no 7/8, pp 68–74.**
The authors explore how leaders must adapt to thrive in a world which has become much more interconnected, where leaders must be able to harness ideas, people, and resources from across boundaries of all kinds. That requires reinventing their talent strategies and building strong connections both inside and outside their organizations. The paper considers how differences in convictions, cultural values, and operating norms inevitably add complexity to collaborative efforts but argues that they also make them richer, more innovative, and more valuable, which is at the heart of collaborative leadership.

Jonsen K, Maznevski ML, Schneider SC (2010). 'Gender differences in leadership – believing is seeing: implications for managing diversity'. ***Equality, Diversity and Inclusion: An International Journal*****, vol 29, no 6, pp 549–572.**
The paper considers whether there are real gender differences in leadership, whether beliefs regarding gender differences in leadership differ across cultures and how these beliefs influence diversity management. The authors aim to demonstrate how different beliefs regarding gender differences and leadership can influence company diversity policies and initiatives. They review the research evidence on the relationship between gender and leadership. Then they explore the effects of gender stereotyping. Furthermore, they consider the role of culture on these beliefs. This review serves as the foundation for the discussion of three different perspectives regarding gender and leadership: gender-blind; gender-conscious; and perception-creates-reality (or believing is seeing). The authors suggest that adhering to these different paradigms can influence actions taken to managing diversity and human resource policies. Revealing these different paradigms can help companies and managers reassess their diversity practices.

Karp T, Helgø T (2009). 'Reality revisited: leading people in chaotic change'. ***Journal of Management Development*****, vol 28, no 2, pp 81–93.**
The purpose of this paper is to describe a way for leaders to lead chaotic change. By chaotic change it is meant changes in an organization when the external and internal complexity and uncertainty are high. The paper is based on a conceptual discussion. The paper contributes to concepts of change management in organisations faced with increased complexity in internal and external environment. The study challenges mainstream change management concepts and its chance of success when faced with increased complexity. The authors make suggestions on how to lead chaotic change by influencing the patterns of human interaction. It is recommended to focus change management on people, identity and relationships by changing the way people talk in the organisation.

The King's Fund and Foundation Trust Network (2014). ***Future organisational models for the NHS: perspectives for the Dalton review*****. London: The King's Fund/Foundation Trust Network.**
Available at: www.kingsfund.org.uk/publications/future-organisational-models-nhs
This publication explores some of the organisational options available, including how high-performing NHS organisations might support providers in difficulty. It provides an evidence review and a range of individual perspectives on some of those new organisational arrangements, in health and other sectors, nationally and internationally – in a bid to inform the work of the Dalton review. The individual contributions highlight the benefits and challenges of different organisational models.

The King's Fund (2013). ***Patient-centred leadership: Rediscovering our purpose*****.**
Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/patient-centred-leadership-rediscovering-our-purpose-may13.pdf
This report draws on a wide range of contributions from within The King's Fund and elsewhere to identify what now needs to be done to ensure that what went wrong at Mid Staffordshire does not happen again. It builds on previous work by the Fund in which the authors argued that there are three lines of defence against poor-quality care:

frontline clinical teams, the boards leading NHS organisations, and national organisations responsible for overseeing the commissioning, regulation and provision of care (Dixon et al 2012).

The King's Fund (2012). *Leadership and engagement for improvement in the NHS: Together we can*.
Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/leadership-for-engagement-improvement-nhs-final-review2012.pdf
This report seeks to present evidence that leaders who engage staff, patients and others deliver better results on a range of measures. The business case for leadership and engagement for improvement is compelling at a time when the NHS needs to deliver unprecedented efficiency savings over many years.

The King's Fund (2011). *The Future of Leadership and Management in the NHS: No more heroes*. London: The King's Fund.
Available at: www.kingsfund.org.uk/publications/nhs_leadership.html
This paper reports the conclusions of The King's Fund commission on leadership and management in the NHS which had a brief to: take a view on the current state of management and leadership in the NHS; establish the nature of management and leadership that will be required to meet the quality and financial challenges now facing the health care system; recommend what needs to be done to strengthen and develop management and leadership in the NHS.

Lane DA, Down M (2010). The art of managing for the future: leadership of turbulence. *Management Decision*, vol 48, no 4, pp 512–27.
The paper aims to explore themes in Drucker's work which provide messages for current turbulent times. Based on a literature review of both Drucker's work and contemporary studies in the field of complexity theory the paper's aim is to explore turbulence as a feature of levels of agreement for objectives and predictability of outcome. Drucker's concept of management as a social enterprise is seen as central together with his warning that the tools and techniques of management should not obscure its purpose. The paper provides a literature review and a brief case study. The review identifies that contemporary complexity theory can be used to explore Drucker's work on turbulence. The case study shows how approaches based on dialogue can enable conflicting objectives to be explored and agreed outcomes achieved. The paper concludes that in turbulent times Drucker's concept of management as a social enterprise forms a core framework that can be used within complex situations to agree objectives through dialogue.

Leslie K, Canwell A (2010). Leadership at all levels: leading public sector organisations in an age of austerity. *European Management Journal*, vol 28, no 4, pp 297–305.
The authors report a study based on interviews and surveys of 50 senior civil servants and local government officers, mainly in the UK, and data from intensive leadership development programmes that we have designed and delivered in the UK public sector. They identified a consensus that meeting organisational challenges does not require the identification of more people into new leadership roles nor identifying innate leadership attributes – it is about exercising more leadership at all levels. Leadership for the researchers is tied into the successful delivery of results and, importantly, requires multiple actors across an organisation or system. Thus leadership is not about an individual in a senior role, it is about many people across an organisation involved in leadership activities for which core capabilities are required. The paper argues that senior public sector leaders will need to demonstrate four key leadership capabilities: developing the insights necessary for successful change within complex systems; building the cognitive skills to manage effectively in demanding environments; demonstrating the emotional intelligence to motivate their people; building leadership at all levels of the organisation, by developing capability and ensuring that overly complex structures do not impede the ability of individuals across the organisation to exercise leadership.

Macdonald R, Price I, Askham P (2009). Leadership conversations: the impact on patient environments. *Leadership in Health Services*, vol 22, no 2, pp 140–60.

The aim of this study is to examine 15 NHS acute trusts in England that achieved high scores at all their hospitals in the first four national Patient Environment audits. No common external explanations were discernible. This paper seeks to examine whether the facilities managers responsible for the Patient Environment displayed a consistent leadership style. The research found common leadership and managerial behaviours, many of which could be identified from other literature. The research also identified managers deliberately devoting energy and time to creating networks of conversations. This creation of networks through managing conversation is behaviour less evident in mainstream leadership literature or in the current Department of Health and NHS leadership models. The findings of this study provide insight into the potential impact of leaders giving an opportunity to re-model thinking on management and leadership and the related managerial development opportunities.

MacGillivray A (2010). Leadership in a network of communities: a phenomenographic study. *The Learning Organization*, vol 17, no 1, pp 24–40.
Canada's Chemical, Biological, Radiological, and Nuclear Research and Technology Initiative (CRTI) uses an operating model that is unusual in government. It is created to enable cross-boundary capability and capacity building and learning. Some consider it a model for other federal science initiatives. The purpose of this paper is to explore the nature of leadership – and its relationship to perceived effectiveness – in this complex network of counter-terrorism communities, where parts of the network are functioning better than others. At a more academic level, it explores whether complexity theory can inform leadership theory. This qualitative, empirical study uses phenomenography and elements of ethnography as methodologies.

McAlearney A. S. (2008) Using leadership programs to improve quality and efficiency in healthcare. *Journal of Healthcare Management*, 53(5):319-31.
This article uses data from three qualitative studies of leadership development in healthcare to answer the question, "What opportunities might exist to use leadership development programs to improve quality and efficiency?" Interviews from 200 individuals were conducted between September 2003 and December 2007 with hospital and health system managers and executives, academic experts, consultants, individuals representing associations and vendors of leadership development programs, and program participants. Analyses of these data showed that leadership development programs provide four important opportunities to improve quality and efficiency in healthcare: (1) by increasing the calibre of the workforce, (2) by enhancing efficiency in the organization's education and development activities, (3) by reducing turnover and related expenses, and (4) by focusing organizational attention on specific strategic priorities.

Mountford J, Webb C (2009). When clinicians lead. *McKinsey Quarterly*, February.
The conventional view of health care management divides treatment from administration—doctors and nurses look after patients, while administrators look after the organizations that treat them. This paper describes the lessons from a number of health care institutions that have achieved outstanding performance by challenging this assumption. The research also highlights the barriers that hold back the development of effective clinical leadership. Understanding these barriers offers pointers toward the best ways to build clinical leadership across health systems. Health care systems that are serious about transforming themselves must harness the energies of their clinicians as organizational leaders.

Nelson EC, Batalden PB, Godfrey MM, Lazar JS (Eds) (2011). *Value by Design: Developing clinical microsystems to achieve organizational excellence*. San Francisco: Jossey-Bass.
Value by Design is a practical guide for real-world improvement in clinical microsystems. Clinical microsystem theory, as implemented by the Institute for Healthcare Improvement and health care organizations nationally and internationally, is the foundation of high-performing front line health care teams who achieve exceptional quality and value. These authors combine theory and principles to create a strategic framework and field-tested tools to assess and improve systems of care. Their approach links patients, families, health care professionals and strategic organizational goals at all levels of the organization: micro, meso and macrosystem levels to achieve the quality and value a health care system is capable of offering.

NHS Leadership Academy (2013). *Leadership for integration*. NHS North West Leadership Academy: Manchester. Available at
The NHS North West Leadership Academy's *Leadership for Integration* programme plays an integral role in the development of senior clinical leaders and managers in both commissioning and provider organisations within the region. This brochure highlights and celebrates key learning and outcomes from the 2013 Leadership for Integration cohorts, as well as introducing the 2014 Leadership for Integration and Innovation programme

NHS Institute for Innovation and Improvement & Academy of Medical Royal Colleges. (2010), *Medical Leadership Competency Framework* (3rd ed), NHS Institute for Innovation and Improvement.
Available at: www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Leadership-Framework-Medical-Leadership-Competency-Framework-3rd-ed.pdf
The Medical Leadership Competency Framework (MLCF) was jointly developed by the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement in conjunction with a wide range of stakeholders. The MLCF describes the leadership competences that doctors need to become more actively involved in the planning, delivery and transformation of health services.

NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges. (2010), *Shared Leadership: Underpinning of the MLCF*. NHS Institute for Innovation and Improvement.
Available at:
http://www.leadershipacademy.nhs.uk/wpcontent/uploads/2012/10/776bc9c27b6e8741d0ff42e593ba44cf.pdf
The philosophical leadership model that underpins this approach is that of shared leadership, a more modern conception of leadership that departs from traditional charismatic or hierarchical models. In working with the MLCF it is useful to understand the shared leadership approach and this paper is an attempt to provide a simple description and guide to the shared leadership model, and to answer some of the questions about shared leadership that have been asked during the development of the MLCF: what is shared leadership? How does shared leadership underpin the MLCF? How does shared leadership relate to positional leadership? Where is the evidence that shared leadership works and what can we learn from other settings? What evidence is there from health care and how do we apply shared leadership in a clinical setting? What do the critics of shared leadership say?

NHS Institute for Innovation and Improvement & Academy of Medical Royal Colleges. (2009), *Medical Leadership Curriculum*. NHS Institute for Innovation and Improvement.
Available at: http://www.institute.nhs.uk/images/documents/Leadership/Medical%20Leadership%20Curriculum.pdf
The Medical Leadership Competency Framework (MLCF) developed by the Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement outline the leadership competences doctors need to become more actively involved in the planning, delivery and transformation of health services through their day to day practice. This includes developing the personal qualities required to be an active team member; supporting others who are in leadership roles; and taking an active role in leadership when appropriate.

NHS Confederation (2009) *Future of Leadership*, Paper 1 March. London: NHS Confederation. Available at: file:///C:/Users/s.fahey/Downloads/1317118627_xPNB_future_of_leadership_reforming_leadership_developm.pdf
Professor Lord Darzi's NHS Next Stage Review contains the important insight that delivering change is not just the result of incentives, competition and policies, but also requires high quality leadership at all levels of every organisation and across local systems, particularly by clinicians. The final report proposes a number of policies to develop high-quality leadership, including: incorporating leadership development into professional education and training; developing a range of leadership qualifications up to master's level; identifying and supporting the top 250 leaders; producing guidance on talent management; creating a clinical leadership fellowship scheme; removing the barriers to allow a greater proportion of leadership posts to be filled by clinicians, women, people from black and minority ethnic (BME) groups and individuals with experience beyond the NHS; and establishing a Leadership Council.

Nowell B, Harrison LM (2011). 'Leading change through collaborative partnerships: a profile of leadership and capacity among local public health leaders'. *Journal of prevention and intervention in the community*, vol 39, no 1, pp 19–34.
The paper considers how collaborative partnerships have grown in prominence as vehicles for systems change and organizational development among a network of organizations, particularly in the complex field of public health. Likewise, how supporting the functioning and effectiveness of collaborative partnerships has become a key interest among organizational development scholars and community psychologists alike. The authors argue that, in the question of capacity-building, no aspect of collaborative capacity has received greater attention than that of leadership. Research on collaborative partnerships has highlighted the importance of shared leadership while at the same time acknowledging that specific individuals do and often must emerge and assume more prominent roles in the partnership in order for the work of the partnership to move forward. However, there is limited knowledge of these key individuals and the roles that they play in non-hierarchical, voluntary partnerships. This study is a comparative case study of prominent leaders in three regional public health partnerships. The aim of this investigation is to explore the questions: (1) What does it mean to be a leader in a context where no one is "in charge?" (2) What roles do those individuals identified as leaders play?, and (3) What are the specific capacities that enable the enactment of these roles? We find that those viewed as leaders by their partnerships shared a similar profile both in the range and types of roles they play and the capacities that enable them to carry out these roles.

Obolensky N (2010). Complex Adaptive Leadership. Farnham: Gower Publishing.
The key aim of this volume is to highlight the damage that is caused by adhering to what are described as out-dated, traditional "oligarchic" notions of leadership that fail to recognise the role of subordinates in providing solutions that ensure success on the ground. In answer to the question, "What percentage of solutions for implementing significant change within your organisation came from the top?" the author's research involving some 1000 executives from over 40 countries suggests a rather low figure – less than 10% on average for top executives (but always below 15%), compared to 30% and 60% from within the middle and bottom levels respectively. According to the author oligarchic notions of leadership encourage inertia: top executives often do not have solutions for dealing with the complexity of rapidly changing technology, yet they act as if they do know, while those at the bottom of the organisation (who usually do have solutions) are content to wait for solutions to emanate from the top. The authors argue that out-dated role-playing based on oligarchic leadership models can have disastrous consequences for an organisation.

Palmberg K.(2009). 'Complex adaptive systems as metaphors for organizational management'. The Learning Organization, vol 16, no 6, pp 483–98.
Available at: http://www.emeraldinsight.com/doi/abs/10.1108/09696470910993954
The purpose of this paper is to explore the concept of complex adaptive systems (CAS) from the perspective of managing organizations, to describe and explore the management principles in a case study of an organization with unconventional ways of management and to present a tentative model for managing organizations as CAS – system management. There is a need for the development of knowledge, metaphors and language for management of the new forms of organizing, for example, value networks, which are evolving as a response to the increased demand for efficiency, flexibility and innovation. The frame of reference is based on a literature review of the area of CAS and an inductive and interactive approach is used to identify the management principles in the case study.

A classification of the components of a CAS is suggested and described as properties of, and approaches for, managing CAS. The identified management principles in the case study are: a clearly formulated mission, delegation of responsibility and authority, diversity and competition, and follow-up and feedback. As a result of analysing the frame of reference and the case study, a tentative, conceptual model for managing organizations as CAS – system management – is presented including; metaphor, components and approaches. The case study contributes to the empirical body of knowledge of organizing and management. The tentative model is a contribution to the ongoing discussion about managing organizations as CAS.

Rosen R, Mountford J, Lewis G, Lewis R, Shand J, Shaw S (2011). Integration in Action: Four international case studies. London: Nuffield Trust.

Delivering high-quality integrated care is challenging. This report highlights the experience of four successful international case studies. The case studies identify the factors that supported or hindered integration, and examine in detail the organisational methods used to align incentives and coordinate professional practice in order to deliver integrated services. The four organisations analysed were: Community Care North Carolina, US: a government-funded network that aims to improve access and quality levels for Medicaid beneficiaries; Greater Rochester Independent Practice Association, US: an independent practice association in upstate New York; Regionale HuisartsenZorg Huevelland, the Netherlands: an organisation providing support to GPs to deliver integrated diabetes care; North Lanarkshire Health and Care Partnership, Scotland: an NHS and social care partnership.

The experiences of the four organisations suggest strongly the influence of six groups of operational activities ('integrative processes') that served to embed coordinated care into daily practice: clinical, organisational, informational, financial, administrative and normative (see Figure 1 below). In addition national policy, regulation and payment systems were found to be important enablers – or inhibitors – of integrated care.

Schalk R, Curseu PL (2010). 'Co-operation in organizations'. Journal of Managerial Psychology, vol 25, no 5, pp 453–59.
The authors introduce the papers in this special issue which highlight the importance of cooperation in organizations, and outline future research directions. The issue brings together studies that enhance theoretical understanding of cooperation, addressing core issues related to the role of cultural differences, virtual communication, team processes, leader behaviour, and the impact of norms on cooperation. Factors that facilitate or hinder cooperation in organizations are highlighted, and suggestions on how to deal with those issues in practice are provided. The papers facilitate understanding of the role of cultural differences, communication, team processes, and leader behaviour on cooperation in organizations.

Spurgeon P, Clark J, Ham C (2011). *Medical Leadership: From the dark side to centre stage*. London: Radcliffe Publishing.
The purpose of this book is to provide an account of the key aspects of medical leadership. It explores how the medical profession has evolved in tandem with administrative and structural aspects of the NHS: previously reluctant leaders, doctors are increasingly positive about adopting management and organisational responsibility. Assuming leadership roles at all stages of their training and career is a progressively vital component of the definition of a 'good doctor'. The book features developments such as the embedding of the Medical Leadership Competency Framework as a statutory element of the training and development of all doctors, and the establishment of a new Faculty of Medical Leadership and Management.

Stanton E, Lemer C, Mountford J (eds) (2010). *Clinical Leadership: Bridging the divide.* London: Quay Books.
The focus of this publication is a cohort of junior doctors who believe that if clinicians take leadership roles within health systems, results will be better for patients and work will be more stimulating for clinicians. In doing this, they are challenging traditional career paths and hierarchies. Each of them shares their expertise with others and to support others to become a leader. This book sets out pointers for those who want to become clinical leaders. It seeks to inspire clinicians and managers from all disciplines to consider what clinical leadership could mean for them, their organisations and their patients.

Stoll L, Foster-Turner J, Glenn M (2010). *Mind Shift: An evaluation of the NHS London 'Darzi' Fellowships in Clinical Leadership Programme.* London Deanery/Institute of Education.
Available at: www.ioe.ac.uk/IoE_fellowship_evaluation_report_final_July_2010_Final.pdf
The authors describe how clinical leadership is an increasing priority for the NHS, with associated interest in designing high quality experiences to develop future clinical leaders. Work-based learning is common within the health sector, but it is an innovative idea to create a leadership fellowship for new leaders, with leadership learning through work experience at its core and a supporting development programme. Furthermore, the paper suggests that although fellowships emphasising service transformation and quality improvement have been available to senior clinicians, the idea of offering such opportunities to those nearing the end of their training is also new.

The 'Darzi' Fellowships in Clinical Leadership Programme, based on these ideas, started in April 2009 and is nearing the end of its first iteration. This report is the outcome of an independent external evaluation that began in November 2009. Its brief was to explore the impact of the Programme thus far on participating Fellows, organisations in which they spent their Fellowship year and stakeholders, and make recommendations for the future.

Stoller JK (2009). 'Developing physician-leaders: a call to action'. *J Gen Intern Med*, vol 24, no 7, pp 876–8.
The author argues that the many challenges in health care today create a special need for great leadership. However, traditional criteria for physicians' advancement to leadership positions often regard academic and/or clinical accomplishments rather than the distinctive competencies needed to lead. Furthermore, physicians' training can handicap their developing leadership skills. In this context, an emerging trend is for health-care institutions to offer physician-leadership programs. This paper reviews the rationale for developing physician-leaders. Factors that underscore this need include: (1) physicians may lack inclinations to collaborate and to follow, (2) health-care organizations pose challenging environments in which to lead (e.g., because of silo-based structures, etc.), (3) traditional criteria for advancement in medicine regard clinical and/or academic skills rather than leadership competencies, and (4) little attention is currently given to training physicians regarding leadership competencies. The intention here is that definition of these competencies of ideal physician-leaders will inform the curricula and format of emerging physician leadership development programs.

Vize R (2014). *The revolution will be improvised: stories and insights about transforming systems*. A report for the Systems Leadership Steering Group.
Available at:
http://www.localleadership.gov.uk/docs/Revolution%20will%20be%20improvised%20publication%20v3.pdf
The author describes how organisations across the public, voluntary and private sectors are coming together to find new solutions to seemingly intractable problems by radically transforming their approach to services in their area. Whether they are tackling alcohol abuse or supporting people with dementia, their success is being determined by people and culture. This report draws on insights from 25 multi-agency programmes around the country to discuss how people break or make collaboration and service transformation, and what we can learn from their experiences.

Welbourn D, Warwick R, Carnall C, Fathers D (2012). Leadership of Whole Systems.
Available at: www.kingsfund.org.uk/leadershipreview
This 2012 leadership review examined the concept of leadership for engagement in health care, promoting engagement within teams, organisations and across the system to drive improvement.

Welbourn D, Fathers D, Holbourn A (2011). 'A new vision for care: looking beyond the NHS to the whole care ecosystem'. Perspectives in Public Health, vol 131, no 109.
Dr David Welbourn, Dean Fathers and Alison Holbourn from the Centre for Better Managed Health and Social Care, London put forward a new vision for healthcare.

West M, Steward K, Eckert R, Pasmore B. (2014) *Developing collective leadership for health care.* The King's Fund and the Centre for Creative Leadership.
Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/developing-collective-leadership-kingsfund-may14.pdf
This paper argues that collective leadership – as opposed to command-and-control structures – provides the optimum basis for caring cultures. Collective leadership entails distributing and allocating leadership power to wherever expertise, capability and motivation sit within organisations. NHS boards bear ultimate responsibility for developing strategies for coherent, effective and forward-looking collective leadership. This paper explains the interaction between collective leadership and cultures that value compassionate care, by drawing on wider literature and case studies of good organisational practice. It outlines the main characteristics of a collective leadership strategy and the process for developing this.

Yergler JD (2011). Complex adaptive leadership: embracing paradox and uncertainty. *Leadership and Organization Development Journal*, vol 32, no 3, pp 316–8.

The book is in four main parts, and is designed to encourage action by the end. The first three parts look at: why is there a need for Complex Adaptive Leadership (CAL) , and why it has evolved in the context of polyarchy (leadership of the many by the many); what CAL looks like at the organisational; level and how can it be applied day-to-day by individual leaders at the personal level.