Towards a New Model of Leadership for the NHS

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Foreword

I am delighted to introduce this paper which shares the beginning of the evidence base underpinning our new leadership model. The NHS has and continues to be really well served by leaders from all professions. Although change in the NHS is often preceded by enquiries into failures of care we tend to be less quick to learn from success and what has gone well.

The NHS' Leadership Framework (LF) has for over a decade described what good leadership looks like and supported those entering their career as well as those well established, to think more deeply about what they know and what they can do as a leader. The LF has been an example of how learning from what works well can inspire, encourage and improve our leaders.

But times are changing and what we need from our leaders is changing too. As described well in this paper our leadership community need to continue to learn, develop and flex their style and behaviours. A relentless focus on improving leadership improves the climate and conditions for staff, which improves the care and treatment of our patients and communities. Technical competence, professional skills, managerial excellence all contribute to good leadership but the real test of what separates those people in an organisation such as the NHS is the care, compassion and genuine investment in staff that great leaders recognise as being the key difference between adequate technical clinical care and great healthcare service.

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Preface

This paper was commissioned by the NHS Leadership Academy as a contribution to thinking about the future development of leadership in and around the NHS. It was prepared in collaboration with the Hay Group.

The backdrop and one of the triggers was the launch of a new suite of professional development programmes sponsored and organised by the NHS Leadership Academy.

The programmes are:

'The first set of national programmes to combine successful leadership strategies from international healthcare, private sector organisations and academic expert content. The difference is not just in the reach, these are available for everyone in health and NHS funded care, but in scale, quality and approach. For the first time we are taking a single, national approach to leadership development looking to support our next generation of leaders. There are five programmes, designed to develop outstanding leaders for every tier across the healthcare system.'

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The NHS is facing a whole array of unprecedented changes and challenges. There are resource constraints, new demands, new institutions, and high expectations from patients and the public that service and care will be delivered efficiently, effectively and with compassion. To meet such an array of needs it is recognised that appropriate leadership is vital. Over the past decade, leadership frameworks for the NHS have been developed, including the current Leadership Framework (LF), which has done much to organise thinking about what good leadership behaviour should constitute. These have fed into leadership development, selection, appraisal and reward.

However, given the scale of contemporary change and challenge it is timely to review the leadership behaviours deemed appropriate for current and future circumstances. The new suite of leadership development programmes at all levels in the NHS need to be properly informed and supported by a common vision of behaviours based on research evidence. Prioritisation of the required behaviours has begun to shift. There are concerns about leadership in the NHS as a whole. It is timely and necessary to revisit the research evidence about effective healthcare behaviours and the role of leadership in creating the right climate for these to flourish and be sustained. The purpose of this paper is to review the body of evidence which could contribute to a new Leadership Model for the NHS fit for current and future purpose.

In the immediately forthcoming period, the NHS will need to accentuate different, or at least newly-prioritised, staff behaviours. This, in turn, means there will be a requirement for different priorities in leadership behaviours. Compassion, respect and humanity from frontline staff will evidently need to be better supported and engendered by a leadership community that holds these qualities as central to the core mission and purpose of the NHS.

In professional service organisations such as the NHS there is an understandable leaning towards shared forms of leadership. But confusion has arisen about 'distributed', 'dispersed' and 'shared leadership' as counterpoints to top-down, 'heroic' leadership. While shared leadership has been productive, the idea has unfortunately also led to a lack of clear thinking about the role to be played by those persons occupying leadership positions.

In recent years a command and control culture and matching set of mechanisms and styles has been seen to be prevalent. This has run alongside the Leadership Qualities Framework (LQF) and other frameworks which extol other more collaborative or participative approaches. This tells us that there can be dissonance between expressed values, hard-wired regulatory mechanisms and everyday routine practices. Ideally, an effective Leadership Model would address both kinds of priorities. The currently desired shift in emphasis towards autonomy, responsibility and accountability with a strong orientation towards patient care and compassion - as well as timely and effective clinical interventions and practice - represents a contemporary modification in the desired Leadership Model for the NHS. These emerging high priorities need to be reflected in a leadership model suitable for the time. However the model also needs to allow space for other more directive aspects of leadership that may be crucial for particular circumstances, and which may also need to be present more broadly. Leadership can be seen as a process which involves finding temporary resolutions between opposing principles, meeting the need to mobilise human motivation, whilst also regulating it and making it dependable and predictable.

'The currently desired shift in emphasis towards autonomy, responsibility and accountability with a strong orientation towards patient care and compassion - as well as timely and effective clinical interventions and practice - represents a contemporary modification in the desired Leadership Model for the NHS.'

Executive Summary

This paper stems from a request from the NHS Leadership Academy and from Hay Group for a re-examination of the relevant literature on leadership. This request was in turn triggered by the launch of a new national suite of leadership development programmes and deep anxiety about the nature and adequacy of leadership in the NHS following the scandals in Mid Staffordshire and elsewhere. While extensive work had been done over a decade and more on leadership competences in healthcare, there was a concern that more of the same was questionable for the forthcoming period of increased investment in leadership development across the NHS at all levels. It was suggested that it was timely to take a fresh look at the issue.

We undertook an extensive review of the literature on leadership in healthcare and related services industries in order to identify critical attributes.[1] On the basis of this review, we propose the following elements for a new Leadership Model for the NHS organised under three main headings. Each heading relates to a category which in turn contains a set of behaviours. The approach is intended to help deal with the duality of shared leadership forms while also clarifying the behaviours expected of those occupying leadership positions in the NHS.

The first category is **'Provide and justify a clear sense of purpose and contribution'**. This embraces behaviours and skills which enable an explicit focus on the needs and experiences of service users, continually reinforcing an inspiring vision of the mission and social contribution of the organisation or unit, couched in terms of service quality. It also includes behaviours which foster attention to and interpretations of the wider environment, including policy frameworks, systems of accountability and evidence on effective health care.

The second category refers to behaviours and skills related to **'the motivation of teams and individuals to work effectively'**. This also concerns the wider ability to work in closer collaboration with other organisations or occupations. It also entails defining clear and challenging goals with teams and individuals.

It includes building team commitment and constructing a positive emotional tone or climate. This also requires a demonstration of the belief that both staff and service users are valued. Effective leaders encourage high staff involvement and engagement by allowing autonomy within a framework of values and goals focussed on meeting user needs. They also provide and operate meaningful designs for organisations, sub-units and individual jobs which are underpinned by HRM systems that provide relevant staff development and reward. Such leaders manage and improve performance rather than merely report it. They utilise a variety of perspectives to manage performance including the use of 'soft' intelligence, rather than focussing only on a narrow range of hierarchically imposed targets or indicators. They also listen to staff and respond to their voice; they validate and engage positively with difficult or negative emotions evoked by the experience of delivering care rather than seeking to suppress or deny them.

The third category refers to a **'focus on improving system performance'**. This means enacting and encouraging the practice of service improvement, constructing compelling cases for change and carefully constructing plans for change based on a variety of kinds of evidence. It also means addressing system problems and pursuing innovation, initiating new structures and processes, and finding ways to intervene informally in patterns of thinking and acting. Finally, it means modelling the learning of new behaviours. This in turn requires the forming of accurate assessments of their own and their unit's effectiveness, identify new ways of working appropriate to changing circumstances while demonstrating a willingness to reveal some self-doubt and acknowledge mistakes.

Each of the elements and the sub-elements are grounded in the research literature.

The Questions

The overall goal of this paper is to offer a view on the emerging consensus as to what 'good leadership in healthcare' looks like. It draws on existing leadership frameworks in health care, academic theory and analysis about the nature of leadership currently required in healthcare, and rigorous empirical research about the outcomes of leadership. It will seek to answer two main questions:

• What should be the core elements in a new Leadership Model fit for the NHS of the future?

• What evidence is there, in health care or any other relevant sector, of a link between these leadership elements and service outcomes?

It is important to draw not only upon research conducted within the NHS and indeed within health care but also to consider insights gained in other sectors and other countries. Significant research has taken place on the role of leadership in fostering high levels of customer service in retail and other competitive settings. Likewise, important research on safety has taken place in airlines, oil drilling rigs and nuclear fuel generation. Other work has revealed the ways in which service-focused enterprises in retail, hospitality and other service-oriented organisations have used leadership as a means to drive customer satisfaction and customer loyalty.

Elements for a new Leadership Model

We propose the following elements for a new Leadership Model for the NHS as organised within three main categories.

1. Provide and justify a clear sense of purpose and contribution

1.1 Focus explicitly on the **needs and experiences of service users**, continually reinforcing an inspiring vision of the mission and social contribution of the organisation or unit, couched in terms of service quality

1.2 Interpret the **wider environment**, for example policy frameworks, systems of accountability and evidence on effective health care; making sense of what these require of the organisation and staff, including the need to work in closer collaboration with other organisations or occupations.

2. Motivate teams and individuals to work effectively

2.1 Define **clear and challenging goals** with teams and individuals

2.2 **Build team commitment** and **a positive emotional tone or climate**, articulating that both staff and service users are valued, and attending to staff well-being

2.3 Encourage **high staff involvement and engagement**, allowing autonomy within a framework of values and goals focussed on meeting user needs

2.4 Provide and operate meaningful design for **organisations, sub-units and individual jobs,** with underpinning **Human Resource Management (HRM) systems** that provide relevant staff development and reward

2.5 **Manage and improve performance** rather than merely reporting it, with **openness to a variety of perspectives on performance including 'soft' intelligence**, rather than focussing on a narrow range of hierarchically imposed targets or indicators

2.6 **Listen to staff and respond** to their voice, validate and engage with difficult or negative emotions evoked by the experience of delivering care, rather than suppress or deny them

3. Focus on improving system performance

3.1 Enact and encourage the **practice of service improvement**, with compelling cases for change and carefully constructed plans for change based on a variety of kinds of evidence

3.2 **Address system problems and pursue innovation**, initiate new structures and processes; find ways to intervene informally in patterns of thinking and acting

3.3 **Model learning of new behaviours:** form accurate assessments of own and unit effectiveness, and identify new ways of working appropriate for new and changing circumstances, coupled with a willingness to show some self-doubt and acknowledge mistakes.

The Case for these Elements

In what follows, we now summarise under each main heading and individual element the underlying thinking and research evidence as drawn from a variety of sources including academic papers, existing competency models and recent NHS policy documents that have led us to proposal this model of leadership fit for contemporary circumstances and challenges.

We have been mindful of the healthcare - and indeed more specifically the NHS - context. Thus, the selection of proposed categories and sub-categories is influenced by healthcare challenges. Accordingly, these categories are somewhat more focused than the four category taxonomy proposed by Gary Yukl directed at multiple settings and diverse industries (Yukl 2012).

1 Provide and justify a clear sense of purpose and contribution

2 Motivate teams and individuals to work effectively

3 Focus on improving system performance
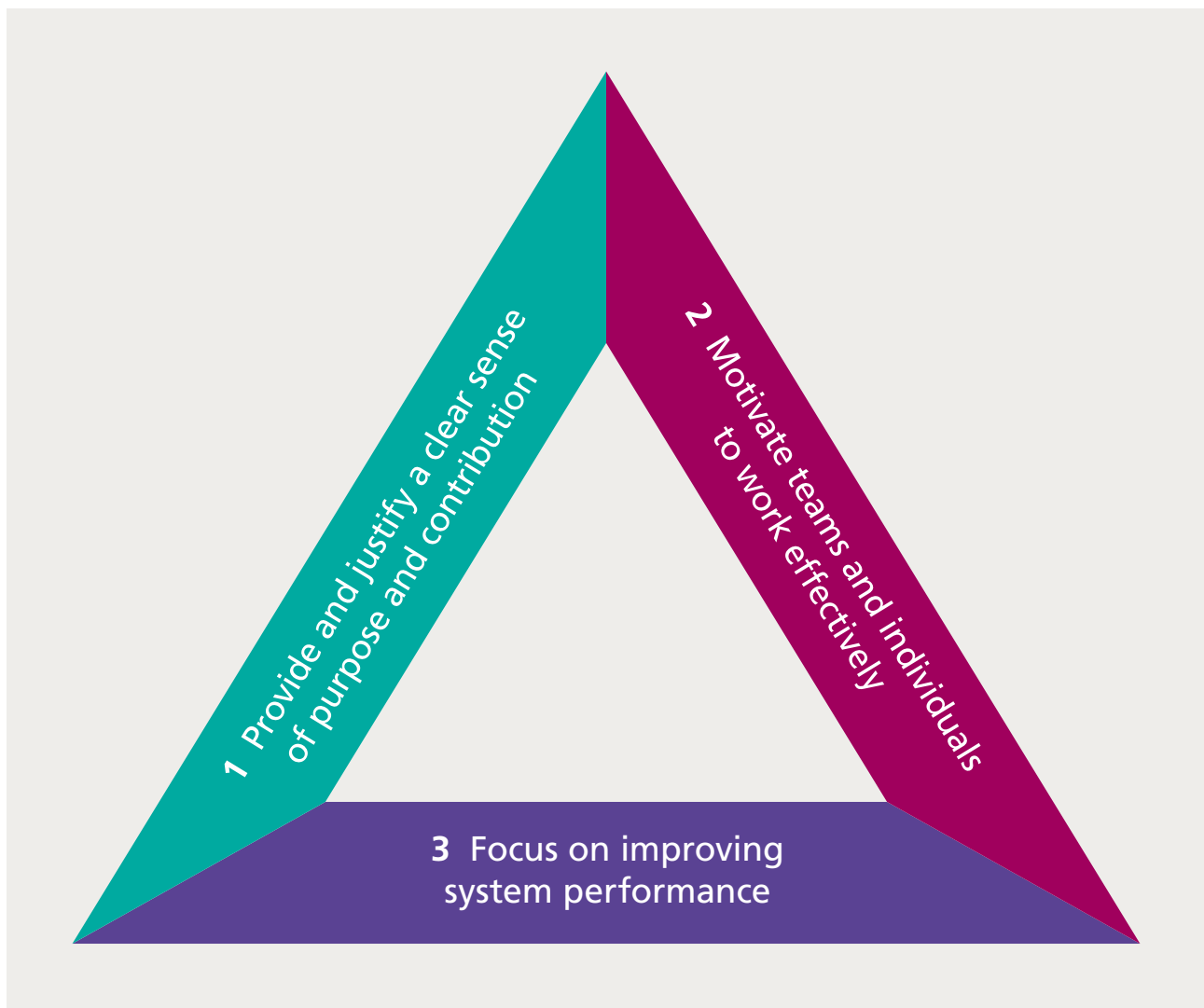
1. Communicate a clear sense of purpose and contribution

The idea of defining the direction for organisations or subunits is a central component of almost all conceptions of leadership and leadership frameworks. It is represented in the Leadership Framework (LF), within the domains of Setting Direction, applicable at all levels, and Creating the Vision, applicable at senior levels. In the current context, following the Francis Report (2013) there is arguably a need to bring more to the foreground the social purpose and meaningful contribution of NHS and NHS-funded organisations. Providing overall direction includes needs to encompass strengthening a sense of the responsibility and contribution to society that organisations, teams and individuals are charged with, in accord with NHS values. This gives rise to the following two elements.
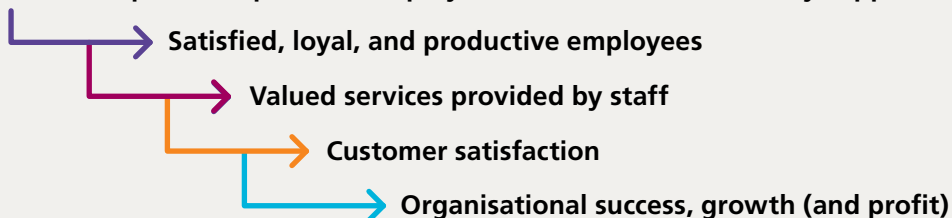
1.1 Focus explicitly on **the needs and experiences of service users**, continually reinforcing an inspiring vision of the mission and social contribution of the organisation or unit, couched in terms of service quality

The needs to focus on patient safety and to understand the needs of users in shaping the development of health services are present in the LF. They are a central theme in Liberating the NHS (2011), the White Paper underlying current health service reforms. The Francis Report (2013) emphasises the role of leadership in prioritising patient safety and in listening to and learning from patients. The significance of this strategic focus on patients and users is supported by a growing body of recent research on service effectiveness in health care as well as in other kinds of services.

One of the more influential frameworks is the 'customer service profit chain' concept (Heskett, Jones et al. 1994; Heskett, Sasser et al. 1997). The service-profit chain framework seeks to show relationships between profitability, customer loyalty, and employee satisfaction, employee loyalty, and productivity. The proposition is that, in a service industry, profit and growth derive from customer loyalty. This in turn is a direct result of customer satisfaction, and satisfaction is largely influenced by the value of services provided to customers by employees. Hence, value is created by satisfied, loyal, and productive employees. Employee satisfaction stems primarily from high-quality support services and policies that enable employees to deliver results to customers. The service-profit chain, summarized in the diagram below, is defined by a mode of leadership that emphasizes the importance of each employee and customer. The work was illustrated in the United States in the case of the retailer Sears amongst others (Heskett et al. 1997).

Leadership that emphasises employees and customers + Quality support services and policies

→ **Satisfied, loyal, and productive employees**

→ **Valued services provided by staff**

→ **Customer satisfaction**

→ **Organisational success, growth (and profit)**

The specific role of the leader within the service-profit chain framework has been explored. Such leaders develop and maintain a culture that is focused on service to customers and employees. They are effective listeners with both the ability and willingness to listen. These are high engagement leaders that spend time with their employees and customers, test their service delivery processes, and actively seek employee suggestions for improvement. In addition, they demonstrate real care and concern for employees as demonstrated by how they select them, tracking and guide their development, and proactively recognize them (Reichheld and Sasser 1990).

This work has been built on by Hong et al. (2013) who focus strongly on the mediating role of 'service climate' as the 'missing link' between HR practices and leadership behaviours as antecedents and outcomes of various kinds including employee attitudes and behaviours and customer outcomes. This work would seem to have direct relevance to leadership and management in the NHS. The authors argue that the role and work of leadership is to construct a positive service climate. Their meta-analysis of 58 studies provides convincing statistical support for a strong association between this linkage and the subsequent linkages to employee outcomes and in turn customer outcomes (satisfaction and loyalty).

The studies suggest that effective leadership therefore has twin components: general high-performance orientation supplanted by a special service-orientation. Transformational leaders who excel in service settings engage in behaviours such as:

'Articulating a compelling vision of customer service, inspiring enthusiasm and optimism about winning customers loyalty, serving as employee's charismatic role model in service, encouraging new ways of serving customers, and recognising employees' individual needs and contributions.'
Liao and Chuang, 2007

1.2 Interpret the **wider environment**, for example policy frameworks, systems of accountability and evidence on effective health care; making sense of what these require of the organisation and staff, including the need to work in closer collaboration with other organisations or occupations.

This element is again already represented within the LF within the Setting Direction and Creating the Vision domains. These emphasise the importance of understanding stakeholders and the range of requirements they place on an organisation or a unit, as well as the need to assimilate relevant evidence on new or improved ways of organising or providing care. Such priorities also widely present within other recent analyses of health care leadership. For example the Health Foundation (Hardacre 2011) identified key leadership behaviours including:

• Explains the need for change and inspires commitment to the process

• Unites staff around an inspiring vision and aligns staff capabilities with planned activities

• Takes a helicopter view of the system to oversee short and long term issues

Given the complexity and continual change in systems of NHS organisation and accountability, there are strong arguments that making sense of what is required of organisations and teams will become increasingly important (Storey et al 2010). The need to recognise the importance of collaboration and effective working across organisational boundaries is widely recognised in a wider range of policy documents concerning the desirability of improving integration between primary and acute health services, and between health and social care (National Association for Primary Care, NHS Confederation and NHS Alliance 2013).

The significance of this element is well grounded in recent academic debates and research. (Hartley and Bennington 2011) emphasise both political astuteness and the importance of making cases for change based on evidence and argument. Numerous surveys reveal that large numbers of respondents identify leadership as a process involving the display of vision, strategic sense, an ability to communicate that vision and strategy, and an ability to inspire and motivate (Council for Excellence in Management & Leadership 2001; Storey 2011).

Recent years have witnessed increased use of targets. But findings from a three-year research project by Tamkin and colleagues from The Work Foundation (Tamkin et al 2010), suggests that 'outstanding leadership' is a subtle process. It is, they conclude, more effective when it is people-oriented in the sense of being able to elicit understanding of goals and commitment from people than it is when based on cruder forms of target-setting and measurement.

One recent stream of theorising focuses on the meaning-making behaviour of leaders (Polodny. et al. 2010). Here, 'leaders' are those who interpret the complexities of the given unit within the environment on behalf of the followers. Leaders thus make sense of the plight of the collective - weighing up threats and opportunities in the environment, and evaluating the strengths and weaknesses of the unit within that environment. The capabilities required are those frequently described in recent transformative literature: clarity of vision; environment scanning and interpretation, ability to condense complex data into simple compelling summations; and ability to communicate clear messages.

'Big picture sense-making' includes the ability to scan and interpret the environment; to differentiate threats to, and opportunities for, the organisation; to assess the organisations' strengths and weaknesses; and to construct a sensible vision, mission and strategy. As is constantly emphasised in the literature and in the dominant mode of thinking over the past couple of decades, the result of this big picture work may entail a transformative agenda for the focal organisation. Indeed, the distinct impression is easily gained that in modern perception, leadership work is of this nature almost by definition. Steady-state maintenance, it often appears, is not so much one variant of leadership as one might logically suppose, but rather is a function of that 'other' subordinate position, namely, management. What this expresses of course is that leadership is closely identified with change-making. The crucial capability here then is to correctly discern the direction of change.

The importance of explaining the need for effective working across established service and organisational boundaries has been identified by (Fisher and Sharp 1998) who explain 'how to lead when you are not in charge'. A further capability concerns inter-organisational representation and the ambassadorial role. While this is a vital capability for a chief executive in a private sector company it is one which has reached special prominence in the public sector as a result of the increasing requirement for inter-agency working. Indeed, the cluster of capabilities required to 'lead' in a network context is one of the key current themes in the leadership debate. Skills such as coalition building, understanding others' perspectives, persuasion, and assessing client needs in a holistic rather than a single agency manner become the premium requirements.

> *'Numerous surveys reveal that large numbers of respondents identify leadership as a process involving the display of vision, strategic sense, an ability to communicate that vision and strategy, and an ability to inspire and motivate.'*

2. Motivate teams and individuals to work effectively

Working with teams to deliver and indeed improve services features prominently in the LF and several other frameworks for describing good leadership in health. This is borne out by a number of academic studies which conceptualise good leadership as that which encourages and inculcates a set of behaviours which are positively oriented to the service quality experience of the end-user (Alimo-Metcalf and Alban-Metcalf 2012; King's Fund 2012; Hong, Liao et al. 2013). These studies make the case that in service organisations such as the NHS an optimal approach to leadership is one which has and communicates clear objectives, and which focuses on creating a supportive and positive climate which encourages staff to give their best. This leadership approach also seeks to create an appropriate emotional environment that is in tune with a caring and personal service such as healthcare.

There are two levels to this overall capability. The first level includes team or group leadership - or as it is sometimes termed, 'near leadership'. At this level inter-personal skills are at a premium.

The second level is termed 'distant leadership' and it refers to those situations where the leader is not in direct personal contact with the followers - perhaps because of their large number - and so has to lead through the multiple tiers using means other than inter-personal skills. Different kinds of leadership capabilities are needed for the accomplishment of these different roles. It is also worth noting that there may be misalignment of the perceptions between distant and near group followers (Waldman 1999).

We now summarise the academic and research basis for a numbers of elements identified under this heading.

2.1 Define **clear and challenging goals** with teams and individuals

A classic conceptualisation underpinning much recent work on leadership behaviour stems from the Ohio State University studies of the 1940s which distinguished between two broad leadership orientations: consideration versus initiating structure (Stogdill 1950; Stogdill 1974).

Consideration is a leadership behaviour showing a concern and respect for followers; initiating structure are those behaviours accentuating goal attainment. A meta-analysis conducted by Judge et al found that both consideration and initiating structure had moderately strong relations with leadership outcomes (Judge, Piccolo et al. 2004).

As expected, consideration was more strongly associated with follower satisfaction while initiating structure was more strongly associated with group-organisation performance. Judge et al conclude that while there had been some relative neglect of these two constructs in recent years, the results of the meta-analysis were strong enough to merit a revived attention to their importance. Much contemporary work whether explicitly referencing these two dimensions or not owes a good deal to them.

The perceived over-emphasis in the NHS on structure, task and targets and the suggested re-balancing towards a staff support orientation echoes the consideration theme. In the new NHS it will be important for leaders to pay close attention to setting the tone, having and communicating clear objectives and attending closely to culture and behaviour. Leaders must seek and encourage far more than compliance-seeking behaviours and box-ticking.

2.2 Build team commitment and a positive emotional tone or climate, articulating that both staff and service users are valued, and attending to staff well-being

The proposition for the importance of a leadership mode which sets the appropriate emotional climate and which in turn can lead to positive 'emotional contagion' is that through which these processes employee attitudes will influence customer attitudes (Pugh 2001). Employee behaviours underpinned by a service climate will create a pleasant customer experience and induce a higher perceived service quality, customer loyalty retention, and higher expenditure (Gracia, Cifre et al. 2010). And as a result, the service profit chain theory suggests that customer satisfaction of this kind will also result in superior financial performance for those organisations and units able to induce such satisfactions (Schneider and Ehrhart 2005).

The core purpose of constructing a service climate is to link leadership with the customer and beyond that with the ultimate purpose of the organisation whether that be profit or public service impact. That relationship is achieved via a series of chain linkages built around desirable behaviours among employees. Hence, service-oriented leadership means consciously attending to this above and beyond the baseline of more general high-performance or good practice HR.

'The finding that 'service-oriented leadership contributed to service climate more strongly than general leadership suggests that training and performance assessment programmes can be developed to specifically improve leaders' service orientation. Having a precise understanding of the relative strengths of service oriented HR and leadership over general HR and leadership will furnish useful guidance for managers balancing such trade-offs in allocating resources'
Hong, Liao et al. 2013: 253

In similar vein, a study of service levels in US restaurants (Liao and Chuang 2004) used a multilevel approach to study 257 employees, 44 managers, and 1,993 customers from 25 restaurants. This demonstrated that both individual- and store-level factors were significantly associated with employee service performance. In particular, conscientiousness and extraversion explained within-store variance whereas service climate and employee involvement explained between-store variance. Additionally, employee service performance aggregated to the store level explained between-store variance in customer satisfaction and loyalty (2004).

The implication of many of the studies cited so far is that leaders need to shape the conditions which allow positive emotions and orientations to thrive and negative ones to be subdued or minimised. In turn this points to a need to attend to leader behaviour because employee behaviour is in large part shaped by what leaders do.

Leaders who occupy immediate supervisory roles have been identified by some researchers as especially critical (Kozlowski and Doherty 1989; Salvaggio, Schneider et al. 2007). Hence, even if higher-level leadership has sought to promulgate the service message, there will be a problematic filter unless the immediate supervisor also reinforces the employee's climate perceptions.

Such research is part of a wider trend which emphasise the role of leadership in creating the emotional environment of work. This builds on extensive work in the area of 'organizational citizenship behaviour' (OCB). This refers to individual behaviour which is 'discretionary, not directly or explicitly recognized by the formal reward system, and that in the aggregate promotes the effective functioning of the organisation' (Organ 1988). OCB has been a very influential construct for two decades though it is not without controversy. It is a multi-dimensional construct which includes, for example, notions of altruism, compliance and the exercise of discretion. Field studies in the areas of service work have explored these non-contractual aspects such as courtesy, smiling, and related customer-friendly behaviours. This work is of clear relevance to healthcare work and seems especially relevant to current concerns about compassion and caring and of their neglect and/or presence. Related work of relevance concerns concepts such as 'emotional contagion' (Pugh 2001). This refers to the tendency for people to be influenced by the emotions felt by others in a social group.

A contagion of negative emotions would not be productive for most organisations - and certainly not service organisations in particular.

A further highly relevant body of research in organisational psychology and in organisational sociology is devoted to the nature of 'emotional labour' (Hochschild 1983). This deals with the management of emotions so that they are consistent with organisational and occupational expectations. Workers in service industries such as healthcare, retail and hospitality are often expected to smile at customers and to display other outward sides of positive emotions. For example, clinical empathy during the patient-clinician encounter can be considered as emotional labour (Larson and Yao 2005). Such emotional displays may, or may not, be discrepant with internal feelings. Emotions can be shared and individuals - including leaders - can influence the emotions of others. A relevant theme here is the idea of 'emotional contagion' (Hatfield, Cacioppo et al. 1993). This may work in a negative direction - that is, a set of negative feelings and behaviours can become normalised. This can include cynicism, pessimism, fear, anger, anxiety, distrust, frustration and discontent. Conversely, emotional contagion can work in a positive way so that constructive feelings become normalised. Where surface acting develops into deep acting, emotional contagion is the by-product of intentional affective impression management (Kelly and Barsade 2001). The crucial point concerning leadership in healthcare settings is that leaders should seek to help create a climate which discourages the negative sets of emotions such as indifference and cynicism and encourages positive emotional sets such as compassion, commitment, empathy and optimism.

2.3 Encourage **high staff involvement and engagement**, allowing autonomy within a framework of values and goals focussed on meeting user needs

The constructs of service orientation and positive attitudes have in recent times also been approached through the notion of 'employee engagement.' In the case of the NHS this is seen strongly in the work of the King's Fund which in recent reports has linked leadership and engagement (King's Fund 2012). This accords with the idea of 'Engaging Leadership' (Alimo-Metcalf and Alban-Metcalf 2012).

Practitioners tend to use the term engagement as associated with involvement in managerial decision making. And they quote the NHS Constitution which pledges 'to engage staff in decisions that affect them and the services they provide, individually through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families' (Department of Health 2009). Thus, from this perspective engagement is about involvement and participation. The implication for leadership is that opportunities for involvement should be provided and staff encouraged to participate, and to be involved. While taking such steps naturally cannot guarantee the state of psychological engagement, such measures can be seen as logical steps in that direction.

Empirical support for the link between engagement and performance can be found in a number of studies. A study in the Netherlands used data from a survey of 2115 resident physicians and found that doctors who scored more highly on engagement were less likely to make mistakes (Prins, Hockstra-Weebers et al. 2010). A study of more than 8,000 nurses found higher work engagement was associated with safer patient outcomes (Laschinger and Leiter 2006).

The King's Fund has recently stressed the importance of moving from the pace-setting, command and control and target-driven approach. This is seen as having delivered achievement of some targets but at a cost. They cite the Commission on Dignity in Care for Older People which identified the top-down culture as a cause of poor care: 'If senior managers impose as command and control culture that demoralises staff and robs them of authority to make decisions poor care will follow' (cited in King's Fund 2012).

In the report on the Commission on Leadership subtitled No More Heroes (King's Fund 2011) there was a call for the NHS to shift from the old 'heroic' model of leadership by individuals typified by the 'turnaround chief executive' to make way for a more inclusive form of leadership. A year later a further report amplified that case and elaborated the characteristic features of an engaged form of leadership (King's Fund 2012). This made the case for engaging staff, patients, the board and other stakeholders. Six different styles of leadership were sketched by a consultant from Hay Group (Santry 2011). Of this repertoire NHS managers were said to be too reliant on 'pace-setting' - that is an over-reliance on demanding targets, leading from the front, and a reluctance to delegate. It has been argued that an over-reliance on pace-setting leadership reflected the priority to move the NHS from a low base. It now needs to be complemented more often with other styles of leadership to meet new circumstances. The damage caused by over-dominant chief executive on Trust Boards was demonstrated by research conducted across all NHS Trust, Foundation Trusts and Primary Care Trusts (Storey et al 2010).

This research and others like it have emphasized the crucial need to engage clinicians and other staff in owning the joint enterprise to improve and sustain care. This different approach to leadership emphasises building shared visions across a range of staff and a range of stakeholders.

The Kings Fund find some signs of optimism in the expressed intent of the NHS Commissioning Board (now NHS England) in its publication Developing the NHS Commissioning Board that it will not seek to micro-manage the clinical commissioning groups (CCGs) but will seek to coach and develop them (Department of Health 2011).

The antecedents of engagement in healthcare can be varied. A study of 409 Finnish health workers found that job control was the best predictor of the level of work engagement. This was followed by management, self-esteem and job security (Mauno, Kinnunen et al. 2007). This indicates that if leaders and managers want to promote staff engagement in healthcare they may need to attend to factors ranging from job design to resource availability as well as the promotion of self-esteem and the creation of a positive climate.

These findings are given further support by the analyses of the NHS staff attitude surveys (West 2012). Drawing on data from the annual NHS Staff Survey and other sources, the report 'shows how good management of NHS staff leads to higher quality of care, more satisfied patients and lower patient mortality' (2012: 2).

'By giving staff clear direction, good support and treating them fairly and supportively, leaders create cultures of engagement, where dedicated NHS staff in turn can give of their best in caring for patients. The analysis of the data shows this can be achieved by focusing on the quality of patient care; ensuring that all staff and their teams have clear objectives; supporting staff via enlightened Human Resource Management practices such as effective appraisal and high quality training; creating positive work climates; building trust and ensuring team working is effective.'
West 2012

The authors say that these elements together can lead to high quality patient care and effective financial performance. Employee engagement is shown to be especially important. This in turn is seen as fostered by effective leadership and management. A number of correlations were revealed with staff engagement 'having significant associations with patient satisfaction, patient mortality, infection rates, Annual Health Check scores, as well as staff absenteeism and turnover. The more engaged staff members are, the better the outcomes for patients and the organisation generally' (West 2012).

These correlations are shown in more detail in Appendix 1. The results reported were derived from a variety of methods, data sets and years.

2.4 Provide and operate meaningful design for **organisations, sub-units and individual jobs**, with underpinning **HRM systems** that provide relevant staff development and reward

The analysis of the results of the staff surveys just referred to shows that good leadership is not just about generally supportive orientation. It is also associated with having effective human resource management systems in place. These include ensuring well-structured appraisals are designed and used, including the setting of clear objectives, and making sure that the appraisal is relevant and helpful in improving how to do the job, and that the employee is left feeling valued by their employer. Another associated factor is working in a well-structured team environment where teams have clear shared objectives, work interdependently and meet regularly to discuss their effectiveness. Another factor is having good job design. This means having meaningful, clear tasks for both individuals and teams, so that it is possible for individuals and groups to feel responsibility for managing their own performance, with some opportunity to be involved in appropriate decision making. These are also 'linked to employee health, which is also important for engagement: high levels of work pressure and stress can lead to disaffection and disengagement' (West 2012: 2).

Similarly the model developed by Hong et al (2013) includes 'general HR practices' as well as 'service-oriented HR practices' as part of the package. In other words, they are not suggesting that leadership alone can produce and sustain a positive service climate, rather leadership and management systems need to be mutually supportive and mutually reinforcing. So, for example, service-oriented HR systems need to be in place to underpin the required behaviours. Selection and training should target service-related skills and behaviours. Evaluations and rewards are also made relevant to service performance. In other words, high performance HR systems are further enhanced with a specific service orientation. Leadership behaviours then need to support these with appropriate signals and guidance.

2.5 Manage and improve performance rather than merely reporting it, with **openness to a variety of perspectives on performance including 'soft' intelligence,** rather than focussing on a narrow range of hierarchically imposed targets or indicators

The LF emphasises measuring and improving service performance, drawing on a wide range of data and perspectives. This broad based view of performance and performance management is found in several other reports on the nature of health care leadership, notably Hartley and Bennington (2011). The Health Foundation (Hardacre et al 2011) emphasises the need to combine recognition, praise and indeed celebration of success with constructive feedback to staff that can be used to improve performance.

2.6 Listen to staff and respond to their voice, validate and engage with difficult or negative emotions evoked by the experience of delivering care, rather than suppress or deny them

A considerable amount of academic analysis has now been devoted to understanding the incidences of absence of compassion in some instances of care, and even apparent cruelty to patients and carers, documented in distressing detail by Francis (2013). One compelling line of analysis is developed by Ballat and Campling (2011) and Dartington (2010).

They argue that involvement in front line care often evokes strong emotions, through contact with pain and vulnerability. While individual members of staff may have a normally compassionate and caring outlook, there is also an innate and usually unconscious need to limit one's exposure to vulnerability and distress in order to protect oneself from fears of one's own vulnerability and of being inadequate to help those in great need. This can give rise to dynamics of displacement, projection, rationalisation, reaction formation and sublimation within care teams.

No matter how hard a leader may work to establish a positive emotional climate, the task of care tends to evoke strong emotions that are difficult to bear, which can result in the projection of hostile feelings on to patients or indifference to recognising their humanity. The implication is that leaders need to acknowledge the existence of such complex and difficult emotions, and provide forums for them to be expressed and worked with. The real danger comes from denying the reality of these difficult emotional aspects of care, which can lead to intensification and social legitimation of dangerous defence mechanisms, such as denial and projection. These may too easily result in a distancing from the experience of patients and even discounting or disrespecting patients and their experiences.

3. Focus on improving system performance

The LF makes it clear that leadership involves engaging with improvement and innovation as a central task. The domains of setting direction, creating vision and delivering the strategy require leaders at all levels to range widely in terms of evaluating opportunities and drivers for change and to marshal evidence as to the nature of possible improvements. More senior leaders are expected to draw on 'evidence and experience of national and international developments' to propose plans for more far reaching innovations in service design or delivery. Such ideas are common to most current accounts of health care leadership, for example the Health Foundation's conclusion that leadership involves 'demonstrated commitment to innovation and to continuous improvement'.

The three elements we identify under this heading are an attempt to clarify further what such a commitment means in the current NHS context. Before describing these elements and the ideas underlying them, it is worth noting that engagement with performance improvement, change and innovation is a fundamental component of most accounts of leadership in general, highlighted intensely from the 1990s onwards in the leadership literature with the concepts of charismatic and transformational leadership. It was John McGregor Burns who emphasised the meaning and significance of transformational leadership by contrasting it with transactional leadership (Burns 1978). This theme was picked up and elaborated by Bass (Bass 1985; Bass 1990). According to Bass, transformational leadership has four components:

i)   Individualised consideration (the leader is alert to the needs of followers and also takes care to develop them)

ii)   Intellectual stimulation (the leader encourages followers to think in creative ways and to propose innovative ideas)

iii) Inspirational motivation (energising followers to achieve extraordinary things)

iv)   Idealised influence (offers followers a role model)

The component which most centrally captures the idea of transformational leadership is that of 'inspirational motivation'. This notion is decidedly change-focused. It holds forth the idea of ordinary people achieving extraordinary things through the influence of the leader. This kind of leader reduces complexity, doubt, cynicism and ambiguity by cutting through to the 'essential' elements and these are expressed in simple, readily understandable language. Moreover, these simple truths are expressed with conviction. The goal - or better still the vision - is rendered clear and it is made to seem both desirable and achievable. Organisational members are asked to forsake mediocrity and routine and aspire instead to reach a future state of such high achievement that it deserves the willing expenditure of extra discretionary effort and commitment (Bass 1985; Bass 1990).

This kind of deep commitment to galvanising innovation is clearly relevant to the challenges facing the NHS, and the description of transformational leadership has a great deal of relevance to the first two elements described below. Our third element, however, offers a cautionary reworking of the idea, indicating that transformational inspiration needs to be held back from the brink of becoming overly heroic and needs to be subtly combined with humility and a transparent approach to learning.

3.1 Enact and encourage the **practice of service improvement**, with compelling cases for change and carefully constructed plans for change based on a variety of kinds of evidence

This is a logical extension of the performance management element discussed above. Recent writing on improvement in health care has tended to emphasise the importance of moving beyond single models for understanding the improvement process, and the need to draw on a wide range of kinds of evidence for making the case for improvement and a variety of approaches to working with change (Marshall 2009). Evidence of the need for change may come from established performance indicators for services or organisations, including patient satisfaction data, data on waiting or transit times, or cost

information. It may also come from data on breaches of patient safety, or from patient stories (Bate and Robert 2006), from staff suggestions and reports, or from new perspectives offered by healthcare 'social movements' (Bate, Robert et al. 2004). Hartley and Bennington (2011) bring out the importance of recognising multiple forms of evidence and approaches to change, bearing in mind the preferences and priorities of different constituencies: 'influencing and persuading based on evidence and argument, analysing opposing viewpoints, negotiating, finding common ground, building networks'.

3.2 Address system problems and pursue innovation, initiate new structures and processes, or find ways to intervene informally in patterns of thinking and acting

This element focuses attention on the role of leadership in bringing about innovation, in the sense of ways of working that break with established ways of operating in order to improve performance. In the current NHS context at least three kinds of innovations are crucial. The first concern service redesigns that streamline care, breaking down barriers between primary and acute services or between health and social care, in order better to meet the needs of users. Such redesigns are also widely seen as offering significant cost savings, through eliminating unnecessary hand-offs, overlapping assessments and redundant administrative processes. The second kind of innovation involves supporting patients or service users in managing their own care, often through use of some form of remote monitoring or condition reporting technology. The third kind involves changing ingrained patterns of behaving within staff groups in the direction of becoming more patient-centred.

Studies of health service innovations reveal a need for an effective alliance between clinicians and administrative managers in thinking through a range of administrative and information technology related aspects of the new service, as well as new clinical protocols and divisions of labour, and new criteria for judging service performance (Storey and Holti 2013).

Leadership for successful innovation involves the exercise of political astuteness, developing alignment and sometimes coalitions across different interests implicated by the innovation, in both formal and informal alliances. It also involves an ability to mobilise a variety of resources (Hartley and Fletcher 2008; Alford J, Hartley et al. 2013). Informal relationships between clinicians and managers can mobilise funding and gain legitimacy stemming from national strategies targeting new service models in particular clinical areas (Storey and Holti 2013). So, leadership for innovation involves mobilising existing relationships, and developing new ones, to encompass the range of practices involved in innovation, as well as seeking out backing and funding from centres of power in the health service.

Complex service innovations, such as the establishment of region-wide network of cancer services, seem to require a multi-level and multidisciplinary array of clinical and administrative leadership roles, sometimes referred to as a 'leadership constellation' (Touati, Roberge et al. 2006: 120; Fitzgerald, Ferlie et al. 2007). Similarly, Fitzgerald et al (2007) concluded that, even for these more limited service improvements, 'distributed change leadership' is needed, comprising united senior level support from both formal clinical leaders and senior managers, credible opinion leaders at the level of senior clinicians in the services concerned, and 'willing workers', front line clinicians prepared to embrace the new way of working. Service innovations were more likely to progress if grounded in good established relationships between clinicians and managers (Humphrey 2002; Fitzgerald, Ferlie et al. 2007; Greenhalgh, Humphrey et al. 2009). The argument here is that trusting and well-established relationships provide a basis for problem solving and resilient adaption of innovative ideas to local circumstances, and this has been found in other settings (Rashman et al. 2005).

3.3 Model learning of new behaviours: form accurate assessments of own and unit effectiveness, and identify new ways of working appropriate for new and changing circumstances, coupled with a willingness to show some self-doubt and acknowledge mistakes

This element concerns the way that leadership is needs to temper vision and the advocacy of a clear goal with a spirit of inquiry as to how to get there, with a modelling of learning, and including humility and the self-doubt that are appropriate to genuine inquiry (Hartley and Bennington 2010: 84). Such themes are increasingly found in the more general leadership literature, and can be seen as a counterbalance to earlier enthusiasms for doubt-free transformational or charismatic figureheads. There have been recent shifts in understanding about what constitutes appropriate modes of leadership.

The Work Foundation set out to find the qualities of leadership 'for our time' (Tamkin et al. 2010). They say this was based on empirical research, although the profile constructed is based on interviews with 262 leaders giving opinions as to what they thought are the key leadership qualities. In such a study it is difficult to disentangle conventional orthodoxy from genuine insight gained form reflection on experience. The study, however, crystallises a number of behaviours typical of 'outstanding' leaders which differentiate them from merely 'good' leaders. Three features are picked out by Tamkin et al as characteristic of outstanding leaders: they think and act systemically (whole organisation not units and departments); they perceive relationships as the route to performance (they see other people as the resource that matters most); they are self-confidently humble (they have sufficient self-doubt to avoid becoming blinkered).

Doubts about the transactional and the charismatic models of leadership are growing (Mumford 2008). There has been increasing interest in the ideas of 'servant leadership' and integrity as crucial dimensions of leadership along with 'distributed leadership', 'followership' and diversity (Riggio, Challeff et al. 2008; Sendjava

2008; Liden 2008; Spillane 2006) and 'authentic' leadership. 'Authenticity' is a significant theme (Avolio and Luthans 2005; Goffee and Jones 2006; Irvine and Reger 2006). For example, an influential book in the US builds a notion of leadership around the following eight attributes and qualities (Irvine and Reger 2006):

- **Clarity**
- **Integrity**
- **Courage**
- **Service**
- **Trust**
- **Humility**
- **Compassion**
- **Vulnerability**

A similar critique, albeit from a different perspective, is mounted by Michael Maccoby. Writing prior to the burst of the dot.com boom and the corporate scandals which burst on to the scene in 2001 and 2007/8, he warned presciently of the risks and downsides of the eager search for, and celebration of, corporate leaders with charismatic qualities (Maccoby 2000). He argues that the 1980s and 1990s provided fertile ground for the rise to prominence of the type of personality which Freud termed 'narcissistic'. Narcissists were one of Freud's three main personality types. Unlike the popular stereotype, the term as used in clinical psychology denotes a set of orientations which have positive as well as negative attributes. Among the important positive aspects, such people help disturb the status quo and stimulate change.

However, Freud also noted the negative side to narcissism. Narcissists are distrustful, suspicious and even paranoiac. Their achievements feed tendencies to arrogance, and 'feelings of grandiosity' (2000: 70). They are poor listeners and tend to have an over-blown sense of their own good judgement even in the face of opposition. They thrive on risk and are prepared to destroy current practices and strategies. They seek power, glory and admiration. They present a persona of supreme self-confidence and hubris. They suggest to themselves and others that they can do no wrong.

Maccoby's case is that the last two decades of the twentieth century provided the environment which allowed an unprecedented number of narcissistic personalities to occupy prominent leadership positions.

'With the dramatic discontinuities going on in the world today, more and more organisations are getting into bed with narcissists. They are finding that there is no substitute for narcissistic leaders in an age of innovation. Companies need leaders who do not try to anticipate the future so much as create it. But narcissistic leaders - even the most productive of them - can self-destruct and lead their organizations terribly astray. For companies whose narcissistic leaders recognize their limitations, these will be the best of times. For other companies, these could turn out to be the worst.'

Maccoby 2000: 77

People are beginning to look for alternatives to the charismatic transformational leader. There is a growing realisation that there are no easy answers and that an alternative mode of leadership must be one which promotes learning and is more capable of being sustained than the quixotic heroic concept normally allows. Michael Fullan's work presents an implicit model of post-charismatic leadership based around embedded learning, devolved leadership in teams and learning as a product of conflict, experimentation and false starts (Fullan 2001).

Conclusions

The objective of this review was to re-examine the literature on leadership in health services and beyond in order to assess what studies were of relevance to current concerns in NHS England. Emphasis was given to those studies which were based on research evidence.

Particular attention was paid to explorations of both distributed leadership and also the elements which were constituents of behaviours expected of those occupying formal leadership positions. We sought to re-think the interrelationship between these modes.

With these different requirements in mind, the results revealed that contemporaneous expectations of leadership in the NHS will include balanced attention to a clear focus on the needs of service users, efficiency, compassion, clarity in setting challenging and clear goals and a building of a positive emotional climate and team commitment. This involves a set of skills in building and utilising staff engagement. These elements will be underpinned with a focus on improving system performance. This includes three sub-elements of encouraging and supporting service improvement; addressing system problems by pursuing innovation; and the modelling of the required new behaviours including a willingness to show self-doubt at times and a willingness to acknowledge mistakes and a firm intent to address systematically ways to learn from these mistakes.

Appendix 1

Outcomes associated with Staff Engagement

The figure below shows that when staff engagement scores are low, standardised mortality rates are higher and when staff engagement levels are high, standardised mortality rates are lower.
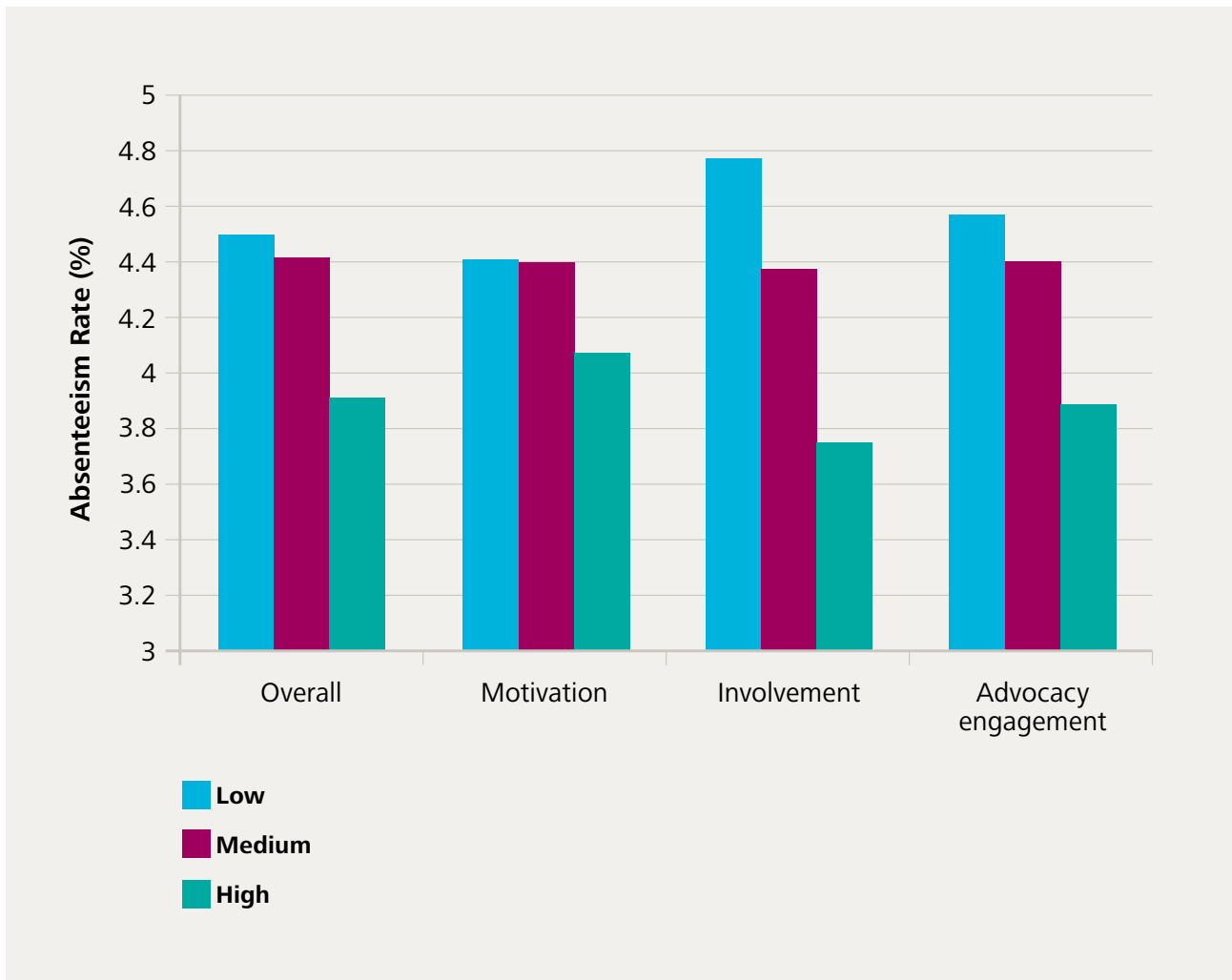
Figure 1: Patient mortality by engagement
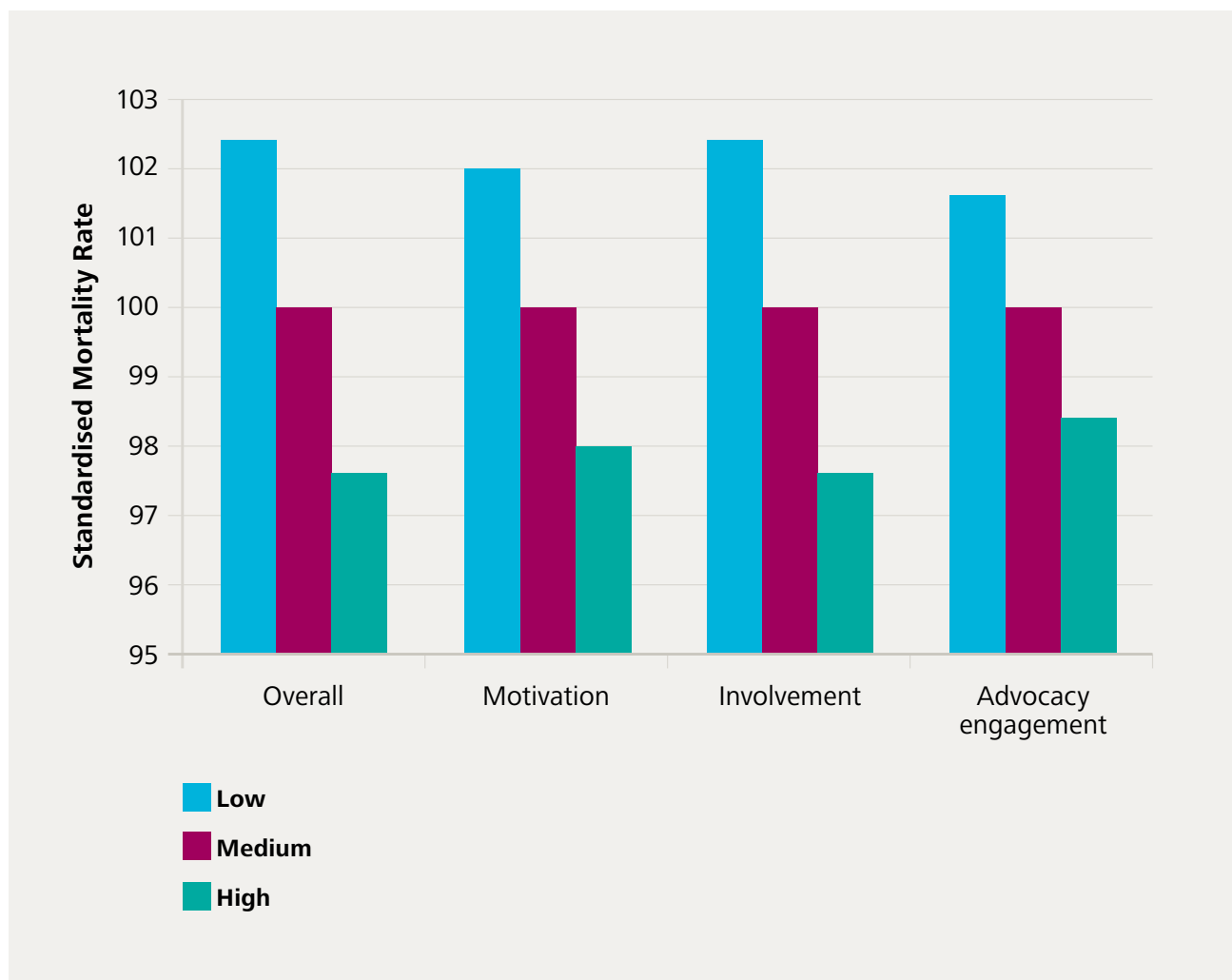
Source: (West 2012:11)

Similarly, staff with high levels of engagement were less likely to be absent from work; those with low levels of engagement were more likely to be absent. The broad results are shown in Figure 2 below.

Figure 2: Absenteeism by engagement

Source: (West 2012:12)

Staff engagement scores were also correlated with overall organisational performance measures as indicated by the Annual Health Check as used by the Care Quality Commission (CQC). The Health Check is based on two main indicators one for quality of service and one for financial management. Both indicators are positively associated with staff engagement.

Figure 3: Overall engagement by AHC performance
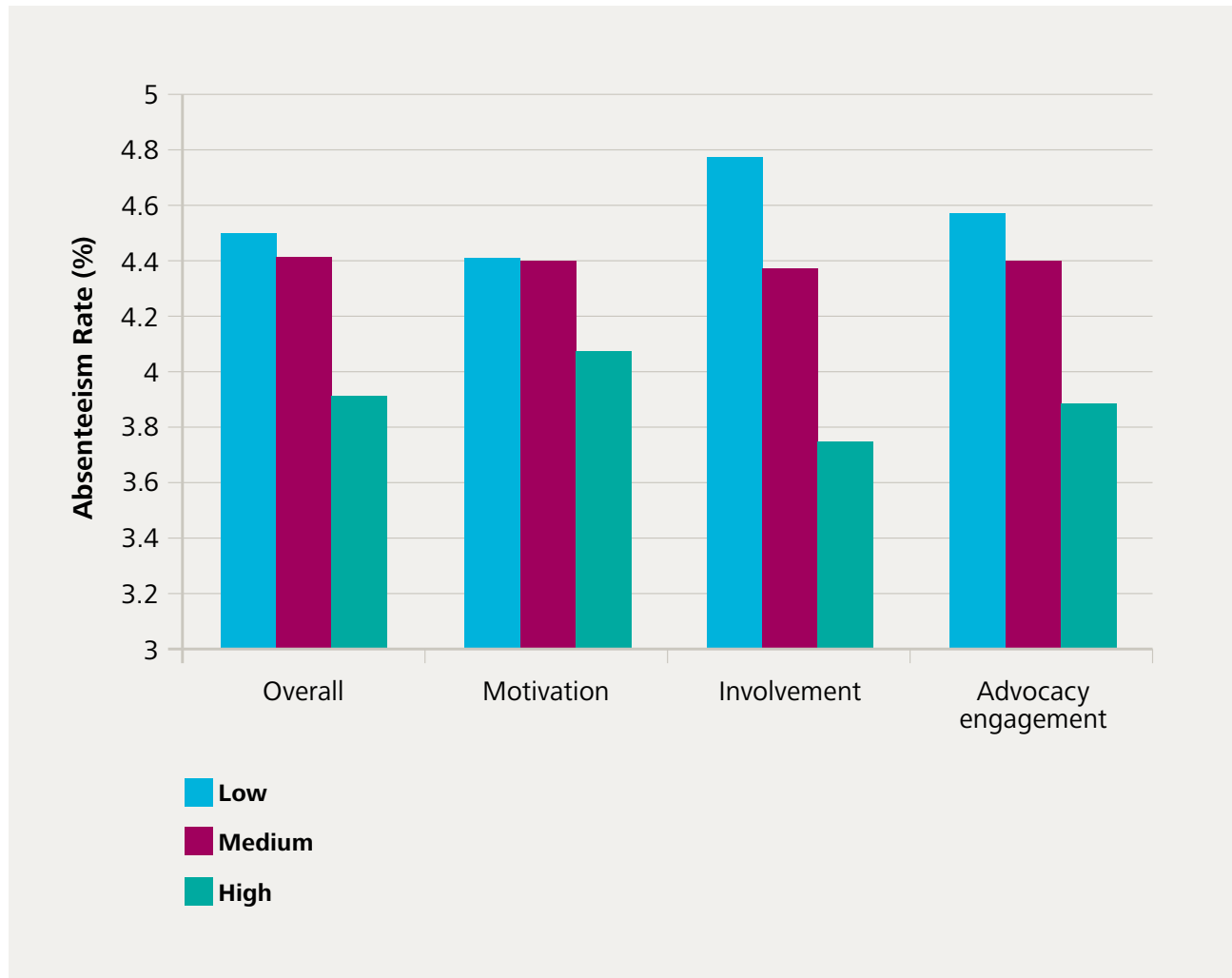
Source: (West 2012:13)

Other factors associated with higher scores in the Health Check were well-designed appraisals, higher levels of training and flexible working.

Appendix 2

Summary of the main theories of Leadership

For many years, the focus of leadership studies derived from a concern in organisational psychology to understand the impact of leader style on small group behaviour and outcomes. Moreover, the focus as we saw above when discussing consideration and initiating structure, was further directed to just two main dimensions 'task focus' versus 'people orientation' and there were various re-workings of this theme (Blake and Moulton 1964; Vroom and Yetton 1988).

In the 1980s, attention shifted dramatically to the elaboration and promotion of the concept of transformational, charismatic, visionary and inspirational leadership. This school was labelled the 'New Leadership' theories (Bryman 1992).

> *'The essence of the debate however is switching to the key task requirements and the contribution of leaders/managers. This more practice-oriented agenda is itself evolving.'*

This has shifted attention to leadership of entire organizations rather than the leadership of small groups. With the work of Alimo-Metcalf and others there are some important current attempts to pull the agenda back to distributed leadership and teams. While on the face of things, much of the debate over the past two decades appears to have been about 'styles of leadership' in reality, the sub-text was mainly about a propounded dichotomy between 'leadership' versus 'management'. This message was extolled graphically and influentially in a Harvard Business Review article by Abraham Zaleznick (Zaleznik 1992) - originally published in HBR 1977.

This article argued that 'It takes neither genius nor heroism to be a manager, but rather persistence, tough-mindedness, hard work, intelligence, analytical ability and perhaps most important, tolerance and goodwill' (1992: 127). Leaders, it is said, 'think about goals, they are active rather than reactive, shaping ideas about ideas rather than responding to them'. Managers, on the other hand, aim to 'shift balances of power towards solutions acceptable as compromises, managers act to limit choices, leaders develop fresh approaches' (1992: 128). Evidently, the controversy about the essential differences between leadership and management will continue for some time. The essence of the debate however is switching to the key task requirements and the contribution of leaders/managers. This more practice-oriented agenda is itself evolving.

In order to gain broad oversight of this and other main trends in leadership theory it is useful to view the summary of leadership theories shown in Table 1. Reviews of the journey through the sequence of theories can be found in Yukl (2009) and Storey (2011).

Table 1: Summary of the Main Theories of Leadership

Trait theory; innate qualities; 'great man theories'	Carlyle (1841); Bernard (1926); Hong, Liao et al. (2013)
Behavioural theories: task related and relationship related; style theory (e.g. autocratic vs. democratic)	Ohio State University studies; University of Michigan, Katz and Kahn (1951) Likert (1961); Blake, (1964); Lewin (1939)
Situational and contingency theory; repertoire of styles; expectancy theory	Fiedler (1967) Vroom and Yetton (1973) Yukl (2009); Hersey and Blanchard (1969); Thompson and Vecchio (2009)
Exchange and path-goal models (relationship between leader and led as a series of trades)	Graen and Uhl-Bien (1995); House (1996)
'New Leadership'; charismatic and visionary leadership; transformational leadership	Burns (1978); Bryman (1992) Conger and Kanuungo (1988); Bass (1985); Tichy and Devanna (1986); Kouzes and Posner (1997)
Leadership as performance	Mangham (1986); Peck (2009)
Constitutive, constructivist theory	Grint (2000)
Leadership within Learning Organizations: leadership as a creative and collective process; distributed leadership	Senge (1990)
Post charismatic and post-transformational leadership theory; spiritual leadership; authentic leadership; leadership with compassion	Khurana (2002); Maccoby (2000); Fullan (2001a); Fullan (2001b); Boyatzis and McKee (2005); Tamkin et al (2010); Avolio and Luthans (2005)

The 'shadow side of charisma' has been noted by a number of writers (Conger and Kanungo 1998; Howell and Avolio 1992; Sankowsky 1995). The dangers of narcissism and the associated misuse, and even abuse, of power were thus known about even at the height of the period when charismatic and transformational leadership were being celebrated. There were even specific case analyses where malign effects had been experienced in corporations such as Peoples Express, Polaroid-Kodak and Disney (Garrett 1986; Berg 1976; Sankowsky 1995).

Sankowsky explored the problems of exploitation of dependency among the followers of charismatic, narcissistic leaders. And the highly regarded Manfred Kets de Vries has been especially notable for his clinical reflections on some of the dysfunctional aspects of leadership (De Vries 1994; De Vries 2000).

But these isolated warning signs have been brought together in a far more developed way in recent times to such a degree that the charismatic- transformational model itself is now being questioned. The research has also become more systematic and critical. For example, following a study of CEO successions in the US, Khurana (2002) found that the widespread faith in the power of charismatic leaders had resulted in a number of problems. There was an exaggerated belief in the impact of CEOs on companies because recruiters were pursuing the chimera of a special 'type' of individual. There was a further tendency for companies to neglect suitable candidates while entertaining unsuitable ones. Finally, appointed charismatic leaders were problematic because it was found they 'can destabilise organisations in dangerous ways' (2002: 4).

A common trait in the charismatic leaders studied was their willingness to deliberately fracture their organisations as a means to effect change. The destructive impact of a charismatic leader is exemplified by the case of Enron. Its CEO Jeff Skilling, 'induced blind obedience in his followers', and while his abilities as a 'new economy strategist were overrated' (he instigated the shift to an asset-light position for the company), what he excelled at was 'motivating subordinates to take risks to think outside the box - in short to do whatever pleased him' (Khurana 2002: 7). The case illustrates the dangerous downside of charismatic leadership - the dismissal of normal checks and balances and the impatience with, if not complete disregard of, convention and rule. These are of course the qualities which prompted their appointment and which helped shape their remit in the first place. As Khurana observes (2002: 8) the recent display of 'extraordinary trust in the power of charismatic CEO resembles less a mature faith than it does a belief in magic.'

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