A real paradigm shift in NHS Leadership?

...from a focus on the power vested in position to influencing through personal authority.

By Robin Douglas and Jane Keep, February 2012.

The expected trajectory has changed radically - there is now no predictable pathway towards senior leadership.

One minute you are a senior NHS leader, a director or CEO, the next your role is changed in yet another NHS structural review. You find yourself faced with continuing your work as a leader, without your previous positional authority, and the influence or privileges that go with that. The other important shift has been the sense of continuity that employment in the NHS has traditional given. Additionally, there is now no sense of security or predictability about work in and with the NHS. The recession is partly the source of this change – along with the £20 billion efficiencies required, along with a much longer shift from the ‘public service ethos’ towards a market led system of health care.

You are committed and dedicated to the health service, and you have a wealth of experience, skills and knowledge. And yet, you aren't ready to go for a redundancy package or to reinvent yourself as a management consultant. You feel a sense of loss and helplessness. The old ways you did business no longer work, and at times you feel unseen and unheard. Worse still you see around you many things that need leadership attention otherwise someone is going to 'drop the ball'. Once these initial reactions, of defence, blame, anger and sadness, for example, have passed, you feel the loss, yet you know deep down there must be another way. How can you unlearn, let go of old ways, and work your magic in a newly emerging landscape, not just within your organisation, but across organisations to do what is needed? You know that you have a positive contribution to make; how can this be done in the new and changing environment?

During the last 12 months we have both worked with a number of NHS leaders around the country, whether via leadership programmes, organisational development or change projects, board team development, CCGs or health and wellbeing board development, or simply one to one coaching, and the scenario above is a common one. We have observed visible shock, trauma, grief, and anger as well as despondency, and frustration, in addition to puzzlement and, more positively, a willingness to give the new situation a go.

What we have realised though is that there is a new leadership era dawning, and a new way of working, and the evolving understanding of *peer leadership* may well hold the key to this.

Effective peer leaders:

* Don’t rely on positional authority alone, and they are skilled in building new sources of power and influence.
* Recognise that they don’t achieve things through direct control, rather by developing their ability to encourage others to work towards their vision.
* Move away from an organisational and output focus, to a strong attention to health outcomes.
* Concentrate their focus more towards working with complex, wicked dilemmas rather than tame problems.
* Develop and encourage leadership in all the other people they work with, knowing when to act as the leader in any given situation.
* Tend to be working across and beyond the organisations in which they are employed

One of the most important areas of behaviour that peer leaders develop is the ability to influence others whatever their role or position, as well as the art of challenging others’ behaviour, in order to get things done. And they concentrate on enabling systems, organisations, and people to work simply and seamlessly together, maximising the synergy of the collective rather than the individual. They also draw the best from diverse groups to enable a source of collective or shared governance where felt responsibility for achievement is stronger than imposed systems of accountability.

What then are the main differences between conventional leadership and peer leadership? Drawing from our recent experience in working with leaders throughout the health system, we suggest the following strands are emerging as indicators of a new paradigm for leadership:

* The key is in understanding where authority is derived from - in conventional leadership this is most often from role, position and status. Whereas in peer leadership, the ability to develop personal influence and authority through the use of knowledge and understanding, wisdom drawn from experience, and trusting relationships built from shared values. This personal authority is strengthened by a clear vision of the real reasons for effective leadership – health and wellbeing outcomes.
* Conventional leaders often focus on strengthening their role, then understanding the tasks they face, then building their personal skills to deliver. Whilst peer leaders, without the reliance on role tend to reverse the process by first concentrating on how I can add value to this challenge, and then on what positional authority it might be useful to acquire - a focus on person, task, then role in that order.
* Peer leaders use their energy to work co-creatively with others to name, understand and overcome dilemmas, whereas conventional leadership may be more effective with tamer issues, and orchestrating managerial improvements within organisational boundaries
* Peer leaders focus on building understanding, developing a shared language, process and testing things out, whereas conventional leaders focus on task, action and goals.
* Peer leaders use diversity and build from this, also using resourcefulness to build on assets. Conventional leaders can overly focus on functionality, and fixing deficits.
* Peer leaders also take the time to test out assumptions, and create the conditions and foundations upon which work takes place.

So how do they make the leap from what we would call conventional positional leaders to true peer leaders?

This approach starts by developing self observation, self awareness towards self honesty about how they feel, what is going on and what the options are. It requires leaders to ask openly for the support they need, and to give themselves a transition time to unlearn the old ways and try and test new ways. They recognise the need to let go of old notions of how work gets done through traditional hierarchies, and they learn to express what they feel is needed to get the process moving. They allow time to create the right conditions for peer leadership to flourish, which includes back stage and front stage honest discussions, and they stand back and observe, to support and understand others. They learn to reframe things so as not to give solutions, but to enable others to co-create. And, overall, they show grit and tenacity and through this, they re-develop personal resilience and confidence.

**NOTES:**

Robin Douglas and Jane Keep are independent consultants and Associates of the Centre for Innovation in Health Management at the University of Leeds.

The Centre for Innovation in Health Management is based at the Business School at the University of Leeds. CIHM offers world class leadership programmes for public service leaders, as well as organisational development for NHS Trusts.

The 2008 Research Assessment Exercise showed the [University of Leeds](http://www.leeds.ac.uk/) to be the UK’s eighth biggest research powerhouse. The University is one of the largest higher education institutions in the UK and a member of the Russell Group of research-intensive universities. The University’s vision is to secure a place among the world’s top 50 by 2015.

For more information please contact Juliet Brown at CIHM on [j.l.brown@leeds.ac.uk](mailto:j.l.brown@leeds.ac.uk) or 07725 215362.