

**New Public Management and Leadership-Whether there is any contingent relationship between leadership style and performance status: Evidence from an English National Health Service (NHS) Trust**

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***Effective leadership is a key ingredient in modernising today's health services. Better leadership means better patient care and improved working practices for NHS staff.***

*(NHS Modernisation Agency, 2004a)*

## **Introduction**

This paper investigates the leadership requirements for the National Health Service (NHS) in UK in the context of a complex and dynamic environment of shared power arrangement for health services in the UK by examining the evidence from a PhD research project in an English ambulance service (for confidentiality referred to as Delta trust). The authors argue that effective leadership style in the NHS will necessitate a successful partnership and team work between individual organisations, politicians, healthcare professionals and other stakeholders within the complex network of the NHS to improve performance requirement, service delivery and care given to the patients. The opening quote symbolizes the importance of effective leadership in the UK health sector.

This paper will examine the leadership role of the ambulance services within the NHS network and analyse how their peripheral position in that network affects not only their own performance and targets but also has serious implications on the outcomes of other sectors in the wider NHS by evaluating the evidence from the research. This paper is structured as follows. The first section looks at the changing face of leadership theory. The next section reviews the literature on leadership in the UK NHS and its implications for the organisation. The third section analyses the leadership role of the ambulance services within the wider NHS network. The fourth section presents research findings drawn from the case study. This is followed by discussion and conclusion in the final section.

## **The changing face of leadership theory**

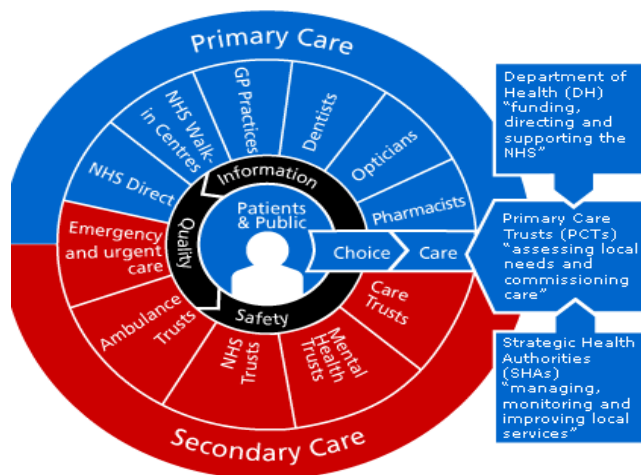
Leadership has been historically and typically defined and understood in terms of traits, qualities, the situation in which the leader exists and the behaviour of the leaders (Bass, 1985; Bernard, 1926; Blake, et al., 1964; Fiedler, 1967; House and Mitchell, 1974; Yukl, 1994). Although Leadership (*seshemet*) and Leader (*seshemu*) appeared in Egyptian hieroglyphics 500 years ago (Bass, 1990) much of the research is relatively (last 100 years or so) recent. Implicit in the research is that leadership is a good thing and if we can identify exactly what it is then we could replicate it elsewhere.

However there is no academic agreement on what essential leadership competencies are most important let alone if they can be taught or are effective. As Stogdill points out, "there are almost as many different definitions of leadership as there are people who have tried to define it (1974, p. 7). Horner (1997) argues that the current theories of leadership view leadership as a process in which leaders do not lead the followers, but are seen as more of a member of a community of practice. Drath and Palus (1994, p.4) define a community of practice as "people united in a common enterprise who share history and certain values, beliefs and way of doing things". The complexity and interdependent nature of leadership is being increasingly acknowledged by

researchers (Bruner, 1986; Manz and Sims, 1989). Modern public sector organisations by their very nature are complex and the NHS in UK is one such example. Nygren and Levine (1995) argue that organisations are moving from a more traditional hierarchical structure to one which is more team based. Network based organisations are emerging as a new and innovative organisational form in the public sector reflecting in many ways, the private sector (Addicott, et al., 2007). However a definition of a successful leader in a team environment is missing due to lack of empirical evidence. Horner (1997) argues that due to the changing nature of work, more creativity, innovation and flexibility is required and successful leaders may not solely depend on applying the right behaviour in a given situation (as contingency theory suggest) by looking at the interpersonal and environmental factors.

Effective teams have been consistently shown to have effective team leadership (Larson & LaFasto, 1989; Zaccaro et al., 2001). Mans and Sims’(1989) idea of ‘Super Leadership’ and Milkin’s (1994) research on ‘leadership in team structures’ contribute to our understanding of the dynamic and complex environment in which modern organisations, especially in the public sector, operate. The complex character of the NHS in comparison to many other types of organisations is also supported by other evidence (Alimo-Metcalf and Alban-Metcalf, 2001). This tie in with the view of Senge (1997) who talks of conceding the myth of leaders as isolated heroes and replacing it with distributed leadership amongst individuals and teams who share the responsibility to create the future of an organisation. Teams have become more essential to the differing organisational contexts and most NHS organisations rely heavily on an effectively led team. The complexities and challenges posed by the changing needs and expectations of people present a significant opportunity to understand more about leadership within the public sector. A network based approach may be more suitable for complex and rapidly changing environments (like the NHS) than hierarchies which are more appropriate for stable and routine situations (Thompson *et al.*, 1991). The following exhibit captures the complexity of the accountability relationship in the NHS structure in England and the place of the ambulance service within that network.

**Exhibit 1: The NHS structure in England**



Source: (NHS, 2007)

## **Leadership and management in the UK NHS**

There is growing body of literature which looks at various aspects of leadership and their relationships with performance (Alimo-Metcalfe and Alban-Metcalfe, 2002; Moshavi et al., 2003). However, such studies in the healthcare systems are far too few (Vance and Larson, 2002). In one such recent empirical study in UK, Mannion et al., (2005) after studying the primary and acute trusts in the NHS in UK concluded that high-performing trusts are characterised by a tradition of a strong, top-down or transactional style of management with an emphasis on establishing robust systems to monitor and improve performance. Such trusts may decide then to gradually adapt more participatory or transformational styles of management to consolidate their high performance position. Further empirical evidence will help to substantiate the above hypothesis. Organisational performance would depend on several factors including resource availability, technological factors and policies of the government and the leadership role of the individual organisation within the complex network of the wider NHS. Leadership research in healthcare has been largely undertaken within organisations and our understanding of network- based leadership which focuses on partnership and collaboration is rather limited (Goodwin, 2006).

The UK NHS is the largest organisation in Europe. With a revenue allocation of £ 135 billion for 2006-07, it employs almost one million people (DoH, 2007). Established in 1948 by the post-Second World War Labour Government, the NHS is funded by the taxpayer and managed by the Department of Health, which sets overall policy on health issues (NHS, 2007). It is the responsibility of the Department of Health (DoH) to provide health services to the general public through the NHS.

The Thatcher government in the 1980s initiated several changes in the NHS structure in order to improve delivery and efficiency of public services (Goodwin, 1998). Few broad features of these changes included privatisation programmes; introduction of managerial techniques; clear emphasis on efficiency and improving leadership of public services (Ferlie et al., 1996). These changes have been often referred to as the new public management (NPM) agenda in many of the Organisation for Economic Co-operation and Development (OECD) group of countries in the late 70s and 1980s (Hood, 1991; Aucoin, 1990; Politt, 1990). One remarkable feature of many of such NPM reforms has been the importance given to organisational performance (and leadership) despite variations within the reform movement (Carter, et al., 1995; Hood, 1995; Modell, 2001; Pollitt and Bouckaert, 2000).

New Labour has attempted to initiate a culture driven by performance improvement (DoH, 1997, Le Grand et al., 1998). Specific long-term objectives and targets were identified within the new strategic plan (DoH, 2000). Local Health Authorities (subsequently replaced by the Strategic Health Authorities) were given the crucial role in leading their local health organisations (e.g. NHS Trusts) to deliver central government's targets. A Performance Assessment Framework (PAF) has been developed within the NHS which identifies six key dimensions (including both financial and clinical targets) according to the long-term objectives of the NHS Plan, 2000 indicating a multi-dimensional performance management approach to benchmark performance (NHS Executive, 1999). One of the commitments of the government in the NHS Plan (DoH 2000) was to establish the NHS Leadership Centre as a part of NHS Modernisation Agency (in

2001). In response to the Kennedy report, a “code of conduct” for the managers was published by the government (DoH, 2002). In addition; a Leadership Qualities Framework (DoH, 2002a) was also put into practice and which is now being increasingly promoted in the NHS. Exhibit 2 illustrates the leadership qualities framework.

**Exhibit 2: The NHS Leadership Qualities Framework**



Source: National Leadership Qualities Framework, 2002

The leadership qualities framework is designed to provide a blueprint for effective leadership in the NHS. There are fifteen qualities within the framework which cover a range of personal, cognitive and social qualities. They are further arranged in three clusters: Personal Qualities, Setting Directions and Delivering the Service (DoH, 2002a). The framework describes the key characteristics, attitudes and behaviours to which leaders in the NHS should aspire. The NHS Leadership Qualities Framework has been developed specifically for the NHS and sets the standard for outstanding leadership in the service. The framework can be used across the NHS to underpin leadership development, for individuals, teams and organisations. A detailed analysis is beyond the scope of this paper but the authors would however argue that while personal qualities and values are at the core of the Framework, it supports a team leadership approach in ‘setting the future direction’ of the organisation and ‘delivering the service’. The Framework strongly advocates a collaborative working style of leadership ensuring effective partnerships with the internal and external stakeholders to improve service delivery in a complex and changing health and social care environment (p. 31).

The NHS in UK is a complex web of accountability relationships which involve citizens, government, managers, patients, regulators and tax payers. There are tension between the doctrine of accountability to the centre and the fact of delegated responsibility to the periphery

(Klein, 1989). Some commentators have debated if the NHS in UK (there are separate NHS in England, Scotland, Wales and Northern Ireland) would benefit from a single identifiable leader or from developing leaders at a local level (Berwick et al., 2003). The works of Leadbeater and Goss (1998); Kotter and Lawrence (1974) and Ramamurti's (1987) four-way typology of leadership styles for chief executives of state owned enterprises (SOEs) analysing the behaviour of public service managers suggest the possibility of many contextual and behavioural leadership models Dawson et al., (1995) in a study involving more than 250 senior Trust and health authority executives, analysed the impact of the external environment and external relationships in the NHS. One major barrier to personal effectiveness amongst the respondents was the degree of control of their external circumstances. Ferlie and Pettigrew (1996) have commented about the use of a networking approach in the NHS. *Leading in the NHS, A Practical Guide* (Stewart, 1993) emphasises that although the need for external leadership has always existed in the NHS it has become even more important, essentially for the post-1990 emphasis on consumerism; and due to the changes to health services having to be explained successfully to an increasingly knowledgeable public. More research is thus needed to explain the context in which leaders operate in such a complex environment to influence their behaviours.

The implications for a leadership style in a network based approach have been studied by Bass (1990) who argues that the performance of leaders in a network will depend upon their influence, contacts and the extent of their position within that network. In networks which are based on authority, information tends to flow from people who are in position of authority to their subordinates and in networks based on information, the information flows primarily upwards from those who provide it to those collecting it for making decisions (Goodwin, 2000). This leads to potential conflicts in hierarchical organisations like the health services to make an effective response since key policy information is disseminated by government to the majority of key players at the same time presenting further problems of policy implementation and managing change locally. The next section analyses the relative efforts of the ambulance services in developing strong inter-organisational relationships in the NHS network which in turn, has a direct bearing on their performance requirements and targets.

### **Network based leadership and ambulance services**

The ambulance service is the first point of access for a wide variety of health problems. Unlike other sectors (Acute Trusts, Primary Care Trusts and Specialist Trusts) within the NHS, there is little evidence of detailed research into how the ambulance service carries out its operations and their relative contribution within the wider health economy. They are still considered as only a patient transport service answering to 999 emergency calls. However, with an expenditure of £760 million on emergency ambulance services alone in 2003-04 and not taking into account the expenditure on ambulance trusts, their contribution is quite significant (DoH, 2005).

The lack of integration of the ambulance services with the emergency care network within the NHS was highlighted in a review of ambulance services carried out by the University of Sheffield (Ambulance Service Association, 2000). The study argued the need of the ambulance service to change the perception of being seen as the health care arm of the emergency services rather than the emergency arm of the healthcare services in future. This would require, the study argued "developing close partnerships in managed care networks with other emergency and first

contact care services within the wider NHS” (p. 4). Another review (NHS Modernisation Agency, 2004) concluded that there was a need to fund ambulance services as healthcare providers and not just as transport providers (p. 43). A ten year strategy, *Reforming Emergency Care* (DoH, 2001) emphasised the importance of a changed approach to emergency health care. *Taking Healthcare to the Patient*, the national ambulance review (DoH, 2005a) lists the need for developing enhanced partnership and team work with other NHS organisations as one of the four key challenges for the ambulance services for a better service delivery and call for greater investment and level of attention on leadership and organisational management. It strongly argues for improving leadership with ambulance service in order to match the organisational structure and styles with that of the new models of care being developed. One of its key recommendations for the ambulance service is to be “led in a way that promotes collaboration, builds networks and encourages management and staff development both within the organisation and across the local health and social care community” (p. 27).

One implication of this peripheral role the ambulance service play in the NHS network is the general perception that they have not been funded as well as the other sectors of the health service. With an annual rise in demand by 6-7%, there is a greater need to address the way their services are commissioned (DoH, 2005). Coupled with the relatively peripheral position of ambulance services within the wider NHS network affecting better coordination with other parts of the NHS and other emergency services, leaders in ambulance services face a greater challenge than any other NHS organisation in dealing with internal changes within their organisation due to several reasons. Frontline staff is based on stations which are scattered over a large geographical area away from the headquarters and mostly work without direct supervision. This makes communication difficult within the ambulance service. Often there are no medical or nursing professionals within ambulance services. There are also cultural differences especially between the three staff groups-the crews, control room staff and the managers (Audit Commission, 1998). The different nature of work of these three groups put different pressures on each group which in turn have implications for effective leadership and performance management.

Response time performance has been used as an indicator of ambulance service quality for many years. Standards for performance have been in place in England since 1974 after the ambulance services were integrated into the NHS. Following a review (Chapman, 1996) these standards( established in 2001) specify that 75% of category ‘A’ calls (life threatening) should be responded to within 8 minutes and 95% of Category ‘B’ calls (serious but not life threatening) within 14 minutes. Although the workload for any particular day or hour is roughly predicted based on the IT systems used, the exact level can never be known in advance. This requires staff to be constantly vigilant and prepared. For each patient journey performed, the ambulance crew goes through a sequence of tasks, ‘the job cycle’ which involves mobilising the vehicle; driving to the scene; assistance given at scene; transporting patient to hospital and time taken at the hospital (Audit Commission, 1998). The average length of the job cycle is under an hour (about 56 minutes). In its study, the Commission also found that the average time at the scene varied between different services visited by three minutes, and the time at the hospital by six minutes. It concluded that a reduction of three minutes in either component can increase productivity by 5 %.

Performance of an ambulance service will improve if the cycle is completed more quickly and the crew become available for the next call. This will require better co-ordination with the other sectors in the NHS. There are issues regarding the handover of patients at the Accident and Emergency (A&E) departments. Often ambulance crews are seen waiting outside the A&E departments unable to respond to other calls. This is sometimes due to the need of the A&E departments to achieve their own target that no patient should wait for more than four hours from arrival in A&E to admission, transfer or discharge (Commission for Health Improvement, 2003). This example illustrates how performance requirements for one service and lack of central leadership role of the ambulance services in the NHS network by implication, works against good cooperation between different services within the health economy. Ambulance services can actively contribute to improve services. For instance, with proper training and equipments, the crew can take appropriate cardiac arrest patients directly to coronary care units reducing pressure on the A&E departments (Audit Commission, 1998). The next section details the evidence from the research as to how the peripheral position of the ambulance service within the NHS can adversely affect its own performance and put pressure on the organisation.

### **Research Findings**

This paper has argued the importance of a network based leadership approach in the NHS by examining the position of the ambulance service within the wider health economy through evidence gathered from one NHS ambulance trust in England. The one issue identified for discussion in the paper pertains to 'hospital closures' in the NHS in England which has important implications for performance of ambulance services and also reveals their relative position within the wider NHS network.

In an interview to the *Guardian* (Carvel, 2006) David Nicholson, Chief Executive of the NHS revealed that there would be up to 60 "reconfigurations" of NHS services, affecting every strategic health authority in the land. He admitted that some changes were to squeeze out overcapacity that contributed to the NHS's £512m deficit in the last financial year. He also identified A&E departments, paediatrics and maternity services as areas where provision would have to be overhauled.

This decision of the government has major implications for ambulance services in terms of their job cycle and can seriously undermine their performance targets. The average job cycle times for ambulance services have been discussed in section 3. It's important for ambulance crews to complete their job cycle in time and be available for the next job. Additional travel time to relocated A&Es or delay in transferring the patients there would further delay the crews with one job. As stated by an executive director of the Delta trust:

*I think the hospital issue about reconfiguration is a really serious one because even if you look at the hospitals that have reconfigured already, they can be actually furthest from all previous hospitals. A further problem in one of the A & E units – they ask us to not take into their units. It's not seen as a hospital diversion because it's within a hospital in that it's all completely separate sites. **Well that increases the travel time which means their availability for 999s back in the job cycle they have come from is obviously reduced (emphasis added).***

*Executive Director 1*

Different commissioning arrangements with the local hospitals existed for ambulance services prior to their merger in July 2006. The reorganization of the ambulance services means that they now serve large geographical area and have to renegotiate commissioning contracts with their local hospitals, through a lead commissioner ( PCT) appointed by the Strategic Health Authority. The performance of ambulance services can also be affected due to peculiar commissioning arrangements.

*Unless the Commissioners and us and the hospitals can all start to agree that actually we need to rethink the way we commission ambulance services, because ideally what you should do in these circumstances is change the commissioning base so that actually they commission the three 999 service separately to the transfer service, separately to core handling and you actually separate it out.*

*Executive Director 2*

Coupled with this fact, there is also a general impression that the ambulance services have not been consulted over the issue and will have to face the consequences, political and financial, for not meeting their targets. Views of another senior executive were more critical:

*There's always a great load of talk about silo working isn't there? But the people who silo work the most are the Government. I think fundamentally they don't care because the agenda which is driving that is a political one; it is not a clinical agenda. You have to understand why do they want to close hospitals?*

*Executive Director 3*

From a financial viewpoint, longer journeys will increase job cycle times which will further mean increase in the reference costs for the organisation. Apart from having a bearing on organisational performance, this issue can have some legal implications not only for the ambulance services, but also for the wider NHS. As stated by another senior executive:

*The hospital closures mean that we have to take more clinical risks than we would have to. For example there is a danger of more babies being born at the back of the ambulance. Paramedics are not trained midwives. If you look at the history of the NHS litigation authority and the way they assess risk, maternity services have a big chunk of those cases.*

*Executive Director 4*

The lack of integration of the ambulance services with the emergency care network within the NHS has already been highlighted been mentioned in the paper. The above findings confirm that position of ambulance services within the wider NHS and their relative lack of ability to

influence events which have important implications for meeting their performance targets within that network. As admitted by another executive member of the board:

*Delivering that change is going to depend on our interactions with the rest of the health economy in particular and how much we can persuade them that they should invest in us, at the speed necessary to deliver the change. Because one of the challenges in the NHS is actually giving the investment in your service so that you can deliver the change within the time frames you've been given and if it involves education, generally speaking the time frames are too long.*

*Executive Director 5*

His further comments reflect the frustration and the reality of the lack of integration of the ambulance trust within the wider NHS network:

*They understand that emergency departments are unregulated front doors and that if you can close them, you can then put in systems to regulate the front door. What they are trying to do is put the responsibility for regulating not only the clinical care but also the finances of clinical care within HMO's (Health Maintenance Organisations) which over here will be practice-based commissioners. They don't want to hear what we have to say that it will cost you more money if you do that. So I am not at all surprised that we are not being consulted.*

*Executive Director 5*

Admission of a peripheral leadership role and poor coordination amongst different organisations within the wider NHS came from another Executive Director:

*What's really important actually is what happens at the end, you know what difference it made because that trauma patient that we took in that had their leg amputated in the*

*road traffic accident and how much time did you save them being in hospital by what you did to reduce their in-stay by 2 weeks, 2 days, 2 hours, whatever. No idea.*

*Executive Director 6*

The case for a more central leadership role in the network was further echoed by another executive of the trust in order to change the perception about ambulance services within the wider health economy:

*Ambulance services did not get even an invite earlier when key decisions were made. But now if there is even a whiff of any service redesign or restructuring, we are there and shouting. Ambulances were low down in the chain in the NHS. However in public perception, we are at the top and people love us. Any change or perceived threat to ambulance service is front page news. **The message is quite clear in my area; ignore us at your peril (emphasis added).***

*Executive Director 7*

Similar views were expressed by some of the non exclusive members of the trust. One member argued for a more proactive role for the ambulance services in order to pull its might to apply for funds to the Strategic Health Authorities (SHA) or the government:

*I would like to see the ambulance services being part of discussions at the top level. Unless they (ambulance) engage with the health economy, patients would not get full benefits.*

*Non Executive Director 1*

Need for better coordination with the PCTs who commission the services of the ambulance trusts was also highlighted by another senior executive of the trust who held the view that one needs to understand each other's service objectives within the whole system :

*Ambulance services have a very particular culture and they need to have to be more sensitive to the commissioner agenda and the wider NHS agenda. It seems to me that you either got to bring people in with that perspective in the short term but in long term, you also got to reach out and get people engaged to the wider NHS. In my perspective, what we need is a whole system's approach.*

*Executive Director 2*

Evidence from the research also suggests that there is a lack of understanding and appreciation of how the ambulance services carry out their functions on part of the Commissioners (who fund the activity of the ambulance services). An executive report to the recent Delta trust board meeting raised concerns around hesitation on the part of Commissioners towards funding a new national target and still considering it as part of the internal modernisation agenda of the ambulance services. The above findings point out to the relative peripheral position of ambulance services within the wider NHS. This puts greater emphasis on the role of the external environment in implementing any change programme and dealing with national policies and performance target regimes. Given the increasingly complex, multi-sectoral and a collaborative approach to health care management within the NHS, there is an urgent need to understand the role and influence of inter-organisational networks both within and beyond health care organisations (Goodwin, 2006).

## **Discussion and Conclusion**

The NHS context is a challenging one in which leaders in health and social care are constantly tackling a major change agenda. Many of their organisations within the NHS such as PCTs, Strategic Health Authorities (SHAs) Care Trusts and Foundation Trusts, are relatively new institutions having to work effectively across complex health and social care systems, raising standards and redesigning services to improve the quality of the patients' experience (DoH, 2002). New relationships are being established with the public and service users in order to meet the growing expectation of patient choice. Reflecting on this complexity, the NHS Leadership Qualities Framework provides NHS staff with a means of analysing their leadership roles and responsibilities within this dynamic environment.

Achievement of the four hour total waiting time for the patients in the A&Es is a key performance requirement both for Primary Care Trusts (PCTs) and acute trusts. This joint

responsibility also highlights the necessity of a ‘whole systems approach’ in the NHS network which includes the local ambulance trusts. The NHS standard is 100% with a performance requirement that at least 98% of all patients spend 4 hours or less in A&Es (NHS Modernisation Agency, 2004). Delay in the turn around time of the ambulance services has been discussed earlier in the paper and ambulance services still experience significant delays at A&E departments which diminishes their own efficiency. It is increasingly being acknowledged that ambulance trusts can make an important contribution to the performance requirements of the 4-hour performance time requirement for the Primary Care Trusts (PCTs) and the Acute Trusts (NHS Modernisation Agency, 2004). Talking to the ambulance crews and travelling with them as observer confirms this aspect and their visible frustration in not being able to be released for their next job. The issue of hospital closures have further affected the job cycle times for the ambulance services. A more central leadership role within the wider NHS network will further help the ambulance services to address such important issues with other healthcare providers and will result in better coordination and planning. This will in turn help them to meet their own performance requirements by ensuring these delays are eliminated. The relationship between management of change process, leadership and organisational performance thus remains an important one and needs to be further researched (Pettigrew et al., 2001).

Evidence from the research confirms the view discussed earlier in the paper that there is a widespread agreement amongst the staff of the ambulance service to be seen as an integral part of the NHS network rather than being viewed as healthcare arm of the emergency services. The need for better cooperation and sharing of resources is acknowledged by the Chief Executive of the trust and other senior executive and non-executive board members. This view is further reinforced during the interviews with frontline operational staff and middle managers, most of whom share a vision of developing a clinically skilled ambulance service which is well integrated within the complex NHS network. By implication, ambulance services will need to play a more central leadership role within the NHS network. Close partnerships with other emergency and other healthcare services will enable the ambulance services to quickly develop their role within the NHS network in enhancing their clinical skills and carrying out their tasks more efficiently with improved planning and coordination. The merger of ambulance services from 31 services to 11 in England from July 2006 and the various recommendations for effective leadership and modernisation as set out in ‘Taking Healthcare to the Patient’ (DoH, 2005a) provide an opportunity for ambulance services to play this much needed bigger role.

This is not to suggest that the position of the ambulance service has not changed. There are growing number of instances suggesting that senior managers from other NHS services are beginning to come into the ambulance services and there is a growing movement of paramedics and nurses in different sectors of the NHS. Four out of five non-executive directors of the Delta trust come from a non-ambulance background either from other public services or have worked elsewhere in the NHS. One executive director who comes from a commissioning background is working in the ambulance service for the first time. These developments along with other initiatives like investment in technology and increase in strategic capacity will encourage greater collaboration between the ambulance services and other healthcare providers within the wider NHS and will enable them to occupy a more central role within the NHS network and develop better and strong team leadership. Future research can broaden our understanding of the

contribution of networks and networking literature in defining and explaining leadership (Goodwin, 2006).

## **Conclusion**

Though the internal leadership of healthcare institutions will remain important, Goodwin (2000) argues that health service leadership in future will require much more than traditional networking with other organisations and groups and will need to focus on developing and securing external agreement to an agenda for positive change, turning the apparent constraints of the external environment, determined primarily by government policies, into opportunities. Most of the early theories on leadership were written during relative stable times but modern world is complex and public leadership is much more complex phenomenon than the private sector (Brookes, 2006). Further research will help us answer some of the issues raised here and our understanding of the complexity of leadership and performance in the public sector. As the opening quote suggests, effective leadership has and will remain an important factor to make a difference both to the NHS organisations and ultimately to the patients.

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