A study of the impact on Leadership styles within the Health Service Executive as a result of the economic downturn in Ireland (2008-2013)

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Abstract

The fundamental aim of this thesis was to examine whether leadership styles of managers within the Health Service Executive (HSE) had changed as a result of the impact of the economic downturn in Ireland. The focus period was 2008-2013 following on from the repercussions of the Global Financial Crisis (GFC) of 2008.

The literature review demonstrates how this study relates to the work of other researchers in this field, and covers some of the key contemporary leadership theories. The assertions made in this dissertation are based on qualitative data as a result of the researcher interviewing seven of his colleagues, who are key stakeholders across a variety of disciplines in healthcare. The study was focused in an area of North Dublin; further research will be required to validate the findings within other geographical areas in the wider HSE organisation.

Events of recent years have had a dramatic effect on resources both financial and physical, and this research would suggest that as a leader, one has to wear many 'different hats' and be able to co-ordinate all of the personnel towards a common goal. The research suggests that managers have becomes significantly aware that they, and their teams now require a 'blend' of skills to manage the transitioning service and requirements of the ever evolving health service across many different affiliates.

Ulrich et al, (2008) demonstrate this in their research, that the effective leader is seen as the linchpin holding the group together. They must also be able to manage current staff taking cognisance of succession planning, whilst also delivering on current requirements, with an eye to the future, demonstrating a short term plan with a long term vision.

The key discovery of the participants of this study was that as middle managers, currently they were carrying out all of the above tasks. However, as they were under so much pressure, they were almost like the entertainer in the circus, spinning several different plates in the air, and if one fell, it affected the others.

The HSE is a fantastic organisation to work for, and the majority of staff are diligent and hard working. However it could work much better. This research has made some recommendations which in this author's view point should be examined, in an effort to

improve the health service as an organisation, which will have a direct impact on the population of Ireland which it currently serves.

Submission of Thesis and Dissertation

National College of Ireland

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Chapter 1 – Introduction

1.1 Research question

For the purposes of this thesis the following statement will be examined

> *"A study of the impact on Leadership styles within the Health Service*
> *Executive (HSE) as a result of the economic downturn in Ireland (2008-2013)"*

Prior to explaining the rationale for the study, it is important that the reader has a clear understanding of the organisation that is the HSE, and the challenges it currently faces.

1.2 Background to the HSE

1.2.1 HSE at Macro level

The HSE was established under the Health Act 2004 and is the statutory body responsible for the provision of health and personal social services in Ireland.

The Global Financial Crisis of 2008 has had an adverse effect on all countries, (Public Affairs 2009) Ireland has been subjected to this also. With an increase in unemployment, consequential increase in social welfare transfer payments, and reduction in GDP figures, coupled with slow economic growth, have had a consequential impact on all public services, the largest of which, is the Health Service Executive (HSE). Currently the HSE employs 100,600 whole time equivalents (WTEs), according to their National Service Plan (2014); they intend to reduce this by 2600 WTEs in 2014 to a figure of 98,000.

To put the impact of the reduction in funding into perspective, along with the increase in the demand for services, here are some brief statistics taken from the Health Service National Service Plan 2014 (2014) to illustrate the challenges this organisation is facing.

1.2.2 Health Statistics in brief (2014)

- 'The population has grown by 8% since 2006'

- 'The number of people over 65 years of age increased by 14% since 2006'

- 'The current economic downturn and high unemployment rate means that more individuals than ever have Medical cards. As of September 2013 more than 1.8 million Medical cards were in circulation, covering 40.6% of the population. This is an increase of almost 590,000 or 46% since the start of 2006'

- 'Chronic diseases continue to increase and the number of adults with chronic conditions is expected to increase by 40% by 2020. Currently 61% of adults are overweight and the estimated cost of obesity alone per annum is €1.13 billion (bn). Dealing with the consequences of the use and misuse of alcohol which contributes to the chronic disease burden, costs the State €3.7 bn annually. Between €1 bn and €2 bn per annum of the health budget is spent on treating tobacco related disease'

- 'Advances in the development of medical technologies, while they improve patient outcomes, are highly cost-intensive. Examples include developments in interventional radiology, a new drug for cystic fibrosis, new oral and anti-coagulant drugs and developments in orthopaedic implants'

1.2.3 Financial Statistics of HSE in brief:

- 'The current budget for the Health Service (Including Children and Families) in 2014 is €13.120 bn. Between the period 2008-2013, the Health Service Budget has been reduced by €3.3 bn (22%). Additional savings totalling €619 million are required in 2014, which will bring the total level of reductions to almost €4 bn over 6 years.'

1.2.4 HSE at Micro level

For the majority of people in Ireland the consequences of the downturn have been severe. Many people within the country have experienced reduced income, with many losing their job, and are now perhaps reliant on social welfare payments and the HSE.

Within the public sector and HSE, there have been particular changes in terms and conditions of employment, paycuts, pension levies and a prolonged freeze on pay.

From examining the government statistics (Public Affairs Ireland 2009), and the implications of the Public Service Agreement 2010-2014 (Croke Park Agreement) and the Public Service Stability Agreement 2013-2016 (Haddington Road Agreement), there are now far more metrics for performance and attendance within the Public sector and subsequently the HSE. It is very evident that the Public sector and HSE is in great need of continuing reform and management of its services in the best possible manner.

Many of our participants highlighted the difficulty of managing change in an organisation that at times can have too much political influence. In this instance, Health can be an emotive topic, which further complicates the outlook. As detailed by the independent report by Wright (2010), regarding the Department of Finance, there is a requirement for senior civil servants to be more assertive about the advice that they provide to Ministers. They need to be able to present plans that may not always align with the Political/Government stance of the day.

As there is growing pressure on the HSE to perform better, improving efficiencies, while facing reductions in budgets, this has had an effect on leadership styles and functions within this public body.

1.3 Rationale for the study

This study seeks to explore leadership styles within the HSE across middle manager level (Grade VIII Level), identifying common approaches and/or styles of leadership. In doing so, the research seeks to understand any perceived changes in approach that these report, as a consequence of the changed environments (HSE) and external environment, (Economic environment in Ireland in the period 2008-2013).

1.4 Why is this topic worthy of research

The economic boom of 2002-2008 within Ireland unfortunately created an unsustainable reality within Ireland. All government spending now needs to be re-examined and refined in order to reach budgets and targets for the years ahead. The HSE falls into this category.

As alluded to in the King's Fund (2012) on leadership, it is important to differentiate between management which is about control and leadership which is about 'influence'. This paper concluded that the National Health Service (NHS) in the United Kingdom was over-administered and under-led. This points to Kotter's theories which states that organisations are frequently over managed, lacking leadership (1990).

Following on from the brief health statistics stated above, where chronic diseases account for €3.7 bn in annual funding, the systems of treatment are becoming more complex. For example, the elderly patient who calls to the health centre, who is diabetic, has congenital heart disease, a sore foot and is suffering from depression; this person's treatment now spans four different pillars of the HSE. Edgren (2011) indicates that effective integration between health and social care is facilitated when leaders adopt the mind-set associated with complexity thinking, recognising that better outcomes are strongly facilitated through better relationships and breakdown of traditional boundaries.

So in essence we have now developed very complex adaptive systems, where leaders and managers are under extreme pressure to deliver a service. Coupled with reductions in funding of 22% over the last five years, we are also dealing with a workforce who have taken several pay reductions and are working longer hours, and who are exhibiting poor levels of morale. These staff also work for an organisation which is constantly in the eye of the media in a negative way, and their organisation has not experienced such contraction of its workforce or financial allocations since it was established in 2005. It is for this reason I feel that leadership within the HSE is worthy of research.

1.5 Literature on this topic

The phenomena of leadership theories have been studied extensively. It is somewhat clearer in the business sector, where there is a more tangible *raison d'être* which centers around creating profit and improving shareholder value. Profitability for Health Care

organisations is not the driving concern, but to have their performance objectives, such as the supply of their own service (be it elderly, acute, mental health, social care etc.) delivered under a specific ethos and need to achieve certain objectives.

Van Wart (2003, p.215) noted a surprising lack of literature on public service leadership in particular, compared to "Prolific" mainstream literature on leadership. He also cited a need for more empirical testing to take into account 'the variety of situations and factors inherent in the vast world of public-sector leadership' (p.225).

According to Garavan, Hogan and Cahir-O'Donnell (2009) they state that within times of crisis and major change, leaders who adopt accountability approaches to leadership prove more effective than autocratic and charismatic styles of leadership. Their evidence would also suggest that during a time of change, it is most important to have trust, quickly followed by technical competence, vision and the ability to effectively lead and manage change.

By examining Goldsmith (2006), 'We all have a tendency to revert back to behaviours that were correlated with success in the past', however, one has to recognise that both the internal environment (within the HSE) and the external environment (Ireland) has changed considerably over past years, and is unlikely to revert back to the 'boom' times of 2002-2008 any time soon.

The literature tends to define leadership styles as different types, and a person can normally be a blend of types, with a dominant or two dominant styles e.g. mostly democratic with a lean towards task orientated tendencies. There have not been many publications regarding leadership qualities in healthcare in the past five years, taking cognisance of the government reductions in funding as a result of the economic downturn. However, one publication called, *The Future of leadership and management in the NHS - No More Heroes*, (2011), published by the King's fund in May 2011, brought together evidence from many areas and sources to make the case for excellent leadership and management within the National Health Service in the United Kingdom.

The core message in this report was there can be *No More Heroes*, i.e. one cannot rely on any one individual. Leadership must be seen as a shared concept and distributed amongst teams and organisations. The report establishes that for real change, effective leaders must work through their line managers and direct reports to create an organisation that achieves their objectives by motivating and engaging people and working across several different

sectors - 'This is seen as the only way to deliver transformational improvements on which the healthcare system of the future depends' (p.iv).

1.6 What this research hopes to achieve

By carrying out an exploration of the leadership styles within the HSE, it was the intention to glean information from a series of interviews with managers responsible for delivering services across a range of disciplines. Although initially unaware of what one expected to find, the information obtained provided a richness of data which will enlighten the reader of the difficulties and subsequent approaches now being adopted by leaders and managers, trying to deliver a service whilst operating in a difficult climate.

1.7 Structure of the thesis

Chapter One gives a general introduction to the HSE, from both a macro and micro organisational level, and outlines the current challenges the organisation faces. It also details the rationale for the study.

Chapter Two considers the literature and examines the concepts, key elements, perspectives and supporting theories. It also considers the leadership theories and their impact within a health care environment.

Chapter Three describes the different research methodologies employed and explains the rationale behind them. It also describes protocols, who took part, how they were chosen, and provides details on the participants. It expands on the research objectives.

Chapter Four considers the various findings. These are each brought into context with the literature review, theories and previous readings.

Chapter Five considers the results in conjunction with the knowledge acquired of the organisation, its procedures and practice, hypothesis and reality. It details conclusions and final thoughts.

Chapter 2 – Literature Review

2.1 Introduction

As Leadership is such an extensive topic, the following paragraphs will examine the types of leadership styles, with emphasis on the public sector, taking cognisance of the economic conditions which Ireland has been through since the Global Financial Crisis of 2008. As part of the literature review, and to put this study in context, this research will also examine the effects of the Global Financial Crisis (GFC).

2.2 Defining Leadership Style:

Fernandez (2004) defined "leadership style" as a style that gives subordinates greater discretion in their duties. Warrick (1981) advocates the following: "Leadership Styles can be identified by their style characteristics, an implicit leadership philosophy, and a set of management skills typical of each style" (p 81).

Warrick also notes the importance of differentiating between Style and Skills and this is often misinterpreted. Style refers to the emphasis a person places on performance or tasks, and people and the characteristics, attitudes, mannerisms and personality, often of the leader. Skills he advocates refer to the specific techniques that a person uses to accomplish a goal or task. According to Blake and Mouton (1985), leaders adopt 4 different styles:

1. **Laissez-faire Leader** (low emphasis on performance and people) sometimes referred to as an impoverished style of management. Assumes that people are unpredictable and uncontrollable and that a leader's job is to do enough to get by, keeping a low profile, staying out of trouble, and leaving people alone as much as possible. Relies on abdicating to whoever will rise to the occasion to get the job done. According to Blake and Mouton, they often do not differentiate between delegation and abdication.

2. **Autocratic Leader** (high emphasis on performance, low emphasis on people). Assumes that people are lazy, irresponsible, and untrustworthy and that planning,

organising, controlling, and decision making should be accomplished by the leader with minimal employee involvement. Relies on authority, control, power, manipulation and hard work to get the job done.

3. **Human Relations Leader** (low emphasis on performance and high emphasis on people) sometimes referred to as Country club management. Assumes that all people are honest, trustworthy, self-motivated and want to be involved and that a participative, permissive, and supportive work environment will lead to happy workers that are productive workers. Relies on teamwork, human relations, participative decision-making, and good harmony and fellowship to get the job done.

4. **Democratic leader** (high emphasis on performance and people) often referred to as team leader. Assumes that most people are honest, trustworthy, and will work hard to accomplish meaningful and challenging goals. Strives for a well organised and challenging work environment with clear objectives and responsibilities and gets the job done by motivating and managing individuals and groups to use their full potential in reaching organisational as well as their own personal objectives.

Blake and Mouton's four leadership styles

Country Club	Team Leader
Middle of The Road	
Impoverished	Autocratic
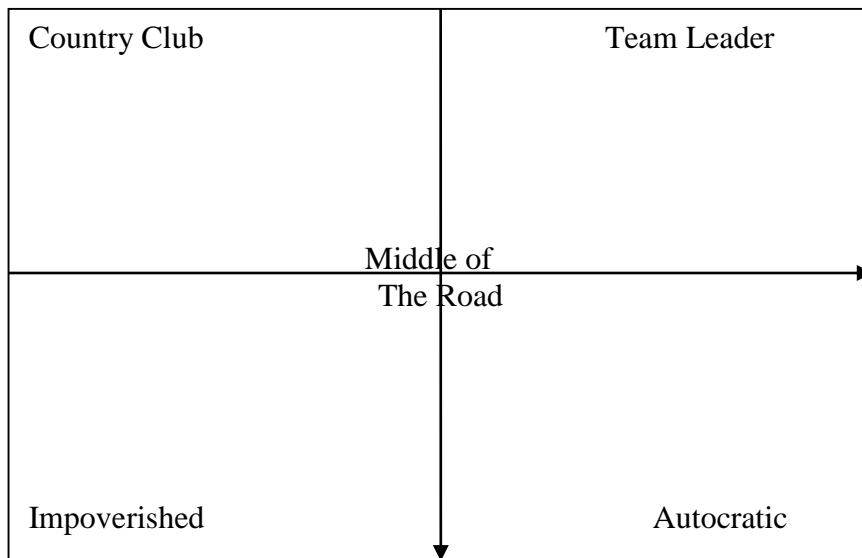
Source: Adapted from Blake and Mouton (1985) The Managerial Grid III

According to Blake and Mouton (1985), the best managers are those who are a combination of both task orientated and people orientated:

- **Transformational Leaders:** Leaders who inspire followers to make major changes or to achieve at very high levels.
- **Transactional Leaders:** Emphasises the exchange of rewards for follower's compliance.
- **Authentic Leadership:** Model self-awareness and regulation and motivate followers to act more authentically too.

These skills illustrated above, and in the managerial grid, seem to suggest that one can achieve highly in both areas, however, according to Northhouse (2009), the ideal of being superb in both; in that one scores highly in both transactional and transformational leadership has not been substantiated by research. Another criticism Northhouse makes is that these styles do not take into consideration the situation and nature of followers. Warrick (1981) maintains that it is important to differentiate and understand the difference between style and skills. He observes the following: 'what an effective contingency leader changes

is not his or her style, but rather the selection of skills and the way they are applied depending on the situation' (p 97).

In effect, Warrick alludes to the concept that a leader may change skills depending on the requirements of the situation and still maintain a consistent leadership style. As a consequence of the GFC, it has led to a re-examination of leadership styles across both the private and public sectors of management.

2.3 Consequences of each style of leadership:

Figure 1: Warrick (1981) implies the consequences of each style of leadership, which this research has condensed into the following table.

Laissez Faire Leader: Employees become apathetic, disinterested and resentful of the organisation. This results in the lowest employee productivity and satisfaction of all the leadership styles. This style works best when the employees are skilled, loyal, experienced and possess a high intellect.
Autocratic Leader: Although the emphasis is on high productivity, it often breeds counter-forces of antagonism and restriction of output. Frequently results in hostile attitudes, a suppression of conflict, distorted and guarded communications, high turnover and absenteeism, low productivity and work quality, and preoccupations with rules, procedures, red tape, working conditions, status symbols, and trying to cater to the whims of the boss. Tends to develop dependent and uncreative employees who are afraid to seek responsibility. However, the advantages are that decisions are taken quickly and greater productivity under the supervisor's direct supervision.
Human Relations Leader: While this style may keep employees happy, there is little evidence to support the notion that keeping the employees happy and treating them well results in high productivity. The preoccupation with keeping people happy and involved often interferes with high achievement, causes employees to lose respect for their leader and causes problems to be smoothed over. Such an atmosphere can be frustrating to goal-orientated people.

Democratic Leader: Results in high employee productivity, satisfaction, cooperation, and commitment. Reduces the need for controls and formal rules and procedures. Results in low employee absenteeism and turnover. Develops competent people who are willing to give their best, think for themselves, communicate openly and seek responsibility. This is very much *hands-on* and is seen as very inclusive where the leader is guiding the employees on what to perform and how to perform. The one drawback is that it can be very time consuming.

2.4 Introductions to Theories.

Bennis and Nanis (1985) advocate that 'managers do things right' but leaders 'do the right thing'. This is in contrast to Mintzberg (1973), who argues that leadership traits are part of the managers overall role. He identified 3 areas of Interpersonal, informational and decisional skills as essential for any manager or leader to possess; these areas covered qualities such as Spokesperson, Figurehead, Resource Allocator and Negotiator.

According to Burns (1978), a transactional style was often defined as autocratic leadership or 'top down'. 'Transactional' leadership is passive and focuses around exchanges or rewards for compliance with leader's requests. It often appeals to the follower's self-interests to motivate their performance. Burns also advocated that 'transformational' leadership is characterised by vision, influence, personal relationships and creativity.

It would appear that Carmichael et al., (2011) believe that in the current business environment, we do not have the luxury to segregate the type of leader, into such categories. Sirisetti (2011) advocates the following:

> Effective leadership is integral to organisational effectiveness. Effective leaders create
> positive organisational cultures, strengthen motivation, clarify mission and organisational
> objectives, and steer organisations to more productive and high performing outcomes
>
> (Sirisetti, 2011, p.45)

Sirisetti (2011) is of the opinion that a blend of attributes of both transactional and transformational are required in the current economic environment of ever changing demands on businesses. This would concur with the viewpoint of Bryant (2003), who states that the constant theme, favouring a blend of transactional and transformational leadership, based around the specific application which one finds oneself in, is the best approach.

This 'application' can differ between the public and private sector, and according to Anderson (2010), the differences in styles can be traced back to organisational differences (Public or Private) leading to behavioural differences. Another aspect which can affect differences has to do with choice of profession or vocation. Finally, Anderson advocates that the way in which people are promoted can affect the overall structure. In conclusion, despite the differences between Private and Public, they face the same basic challenges of achieving organisational goals with or through other people.

Hersey and Blanchard (1988) advocated a situational model which focuses on follower's readiness to engage in learning new tasks. There are two sub factors to this, which are as follows:

- Ability in a specific task
- Motivation to take on the new task.

Also, there are from the leader's perspective, is it one of supportiveness (People Orientation) or Directiveness (Task Orientation).

Leader Member Exchange (LMX) is another theory which focuses on the types of relationships between a leader and a follower; the natural tendency for groups is to develop into subgroups and create a clique of an "in-group" versus an out-group, according to Bass (1990). Also, according to ILies, Nahgrang & Motegeson (2007), they found that the *in-group* were also found to be more likely to behave in a way that benefits the group; these include helping other members, supporting changes, and common courtesy.

Nadler & Tushman (1990) identify three behaviours that are characteristic of leadership activities in complex organisational change; these are Charismatic Leadership, Instrumental Leadership and Good communication skills by leaders.

The opposite of these core competencies has been researched also. Thornton (2011), states that where leaders sometimes fail can be around lack of clarity or from follow on support of not recognising or rewarding efforts. Also, current reality is essential; many leaders fail to stay open and curious. Thornton also states that one should ask questions and listen for what is new, not what you already know. This is a subtle difference, one often missed by leaders. According to Garavan et al., (2009, p.469):

Values are generated through experience and inherited characteristics. They state that values form the basis for authentic leadership, however, in their opinion; the leader will only achieve a full understanding of these values when they are tested under pressure. Where the leader has a solid base of values, it is then possible to develop principles that will be used in leading.

Often the research would suggest that the real test of a leader is when he/she is outside of their comfort zone, and being tested under extenuating circumstances.

2.5 Leadership within Healthcare

The King's Fund (2011) Commission on leadership within the National Health Service (NHS) in the United Kingdom, subtitled *No More Heroes*, stipulated that two of the biggest challenges facing leadership within the NHS was the need to engage clinicians, notably doctors in management and leadership roles. Secondly, it notes that engagement with staff and patients is not an optional extra; it is essential in making change and improvement happen.

The King's Fund (2012) also found that it was essential to engage with all staff in the decision making process, disregarding their level of engagement. If an exclusive approach is adopted, they can spiral downwards into burnout. This can lead to feelings of cynicism, exhaustion and depression. But where staff are engaged, studies across a range of areas show performance rises considerably.

Evidence to back up this up review comes from Prins et al, (2010), who noted that out of 2000 doctors surveyed in Holland, those who were more engaged were significantly less likely to make mistakes. This is in stark contrast to Santry (2011), who found that because the NHS applies a dominant approach of 'pace-setter' as a leadership style, typified by laying demanding targets, leading from the front, often being reluctant to delegate and collaborating little. This is the result of the Health service focusing on process targets, with recognition and reward dependent on meeting them. This has resulted in the NHS reaching impressive targets; however, this can be done so at the cost of too many NHS leaders adopting this approach. This often excludes other types of leadership such as "affiliative"; otherwise known as creating harmony and trust – or coaching. They found that the truly

high performing leaders adopt a blend of leadership approaches, depending on the demands of each specific situation.

The Commission on Dignity in Care for Older People (2012) identified the top-down culture as a prime cause of poor care, and advocated that often a 'command and control' culture demoralises staff and denies them of the authority to make decisions often leading to poor levels of care.

By comparison, within the Irish context, De Burca and Williams' (2010) studies of the HSE, linked leadership style with organisational control. They found that corporate leadership style is orientated to the autocratic (56%) and authoritative (17%). This is in direct contrast with predominately democratic (34%), transactional (22%), and autocratic (18%) styles attributed to the immediate supervisor.

One important aspect to note is that with De Burca and William's studies, organisational control is polarised at the extreme of being highly centralised, and prescriptive. They found that 51% of staff do not have any budget to control, while 19% reported a budget of €10 million or more; this in an organisation with an annual budget of €16 billion (based on 2008 figure).

In 2013, according to the HSE Annual reports, this budget was cut to €12.17 billion. The key priority of a health system is that it must continue to reform to ensure financial workforce and service performance is actively managed.

These cost reductions are to be managed in the context of cost reduction, attendance policies, achievement of service targets and productivity. The HSE (2013) is to use CompStat to support performance management at local service delivery unit level, with service managers being held accountable. It would appear from the HSE Annual report (2013) that there is now a process of a changing accountability environment. Almost one third of the HSE annual budget of €4bn, goes to agencies funded by the HSE; accountability along with clear and transparent performance expectations are required by these agencies also.

In 1980, Peter F. Drucker wrote a book, entitled *Managing in Turbulent Times*, which although geared towards issues around the oil crisis, makes some exceptional points that can be applied today to the health sector. Drucker (1980) advocates that problems will pass,

but it is essential to position a company for positive post-turbulent times. It is also normal during a crisis for fear and anxiety to permeate all levels of the organisation, with three corporate fundamentals that must be managed: liquidity, productivity and future costs. The HSE (2013) according to its annual report is addressing these three core issues.

The King's Fund Commission (2012) on leadership and management concluded that the NHS is over-administered and under-led. This recalls Kotter's study (1990) which stated that organisations are frequently over-managed and lack leadership.

The King's Fund Commission (2012) segregates management into two distinct categories.

1. Defining purpose, planning, deploying and controlling resources. (*Leadership role*)
2. Supporting accountability through monitoring and reporting. (*Managerial role*)

The former group is largely proactive and has close affinity to concepts of leadership, while the latter group of activities is predominantly reactive and often administrative. The biggest weaknesses within the NHS were its failure to engage with clinicians (notably, doctors) in management and leadership roles. They also discovered that this is not optional but essential for change and improvement to happen.

According to the HSE Annual report (2013), the challenge that Leaders face include, developing different services such as public health, primary, community care, mental health, secondary and specialist tertiary care and end-of-life care. They all have different budgets, however, a patient could end up using three/four of these services in one week.

As one is researching the HSE in difficult economic times, the next section will address the effects of the GFC briefly.

2.6 Financial lessons from the GFC.

Fox 2013 states the following:

> In the early 1930s, policy errors by governments and central banks turned a financial crisis into a global economic disaster. In 2008 the financial shock was at least as big, but the reaction was smarter and the fallout less severe. We *had* actually learned something in the intervening three-quarters of a century about how the economy and the financial system fit together (Fox, 2013, p, 101).

Drucker (1963) states: 'There is surely nothing quite so useless as doing with great efficiency what should not be done at all'. Also, as a result of the GFC, it has refocused thoughts on the fundamental difference between doing the right things and doing things right.

Reithmeier (2010) advocates that across Europe, two of the main goals for most European countries regarding reform of their healthcare systems, is to shift from curative medicine (hospitals) towards preventive medicine, (primary care - local GP) and to search for solutions with the highest levels of access to quality medical services. If we examine the two main resources available to Healthcare, money and people, it is the objective of the HSE to maximise these resources as effectively as possible.

The manipulation of these two valuable resources requires essential leadership qualities throughout every level of the organisation.

2.7 Conclusion:

The HSE have to develop a whole health approach. Currently, there are siloes of policy and services, placing demands on leadership of whole systems. According to the HSE (2013) service plan, the HSE will be primarily focused on delivering Health Service reform, and the phased implementation of "Money Follows the Patient".

There are also developments of new community, personal and social care structures, and new trust structures for Hospitals. In effect, Health Care is very complex. Edgren (2011) advocates the importance of viewing integrated care systems through the lens of complex adaptive systems. Welbourn, Fathers and Holbourn (2011) have applied the metaphors from both engineering and nature to describe the whole-systems challenge in Health Care.

According to Yergler (2011), when one groups "Whole systems" with communication challenges and leadership of complex adaptive systems, one is faced with challenges far beyond the boundaries of traditional organisational leadership.

According to the Kings Fund Commission (2012), the increasing financial constraints on Healthcare, coupled with more demands from the Public, traditional competence based leadership approaches will come under strain:

> However a new mindset has every chance of powering whole systems to unpredictable success, potentially with greater satisfaction and ownership distributed in the most unlikely of stakeholders.

Finally, Ulrich, Zenger and Smallwood (1999) advocated that all of the leadership styles detailed above were centred around the organisational capabilities or leadership capabilities. Ulrich et. Al., ague that what is missing from the literature is the connection between these critical capabilities and results. They presented the following equation:

Effective Leadership = attributes X results

Ulrich et. al, (1999, viii) advocated that the leader must strive for: 'Excellence in both terms; that is, they must demonstrate attributes and achieve results. Each term of the equation multiplies the other, they are not cumulative'.

This body of work looked at 'whole systems', where the leader must align desired results with strategy and create results across the four key stakeholders in the context of the HSE. These stakeholders are:

- Employees (In this instance Public Service)
- Organisation (HSE – Health Services)
- Customers (Patients/health and social care)
- Investors (Government Funding)

They, Ulrich, Smallwood and a new partner of Sweetman (2008), delivered a new work. They synthesised the thicket of leadership competency model into a unified view of leadership. This model called the Leadership Code (Ulrich et al. 2008) is presented below in Fig 2.1 below.
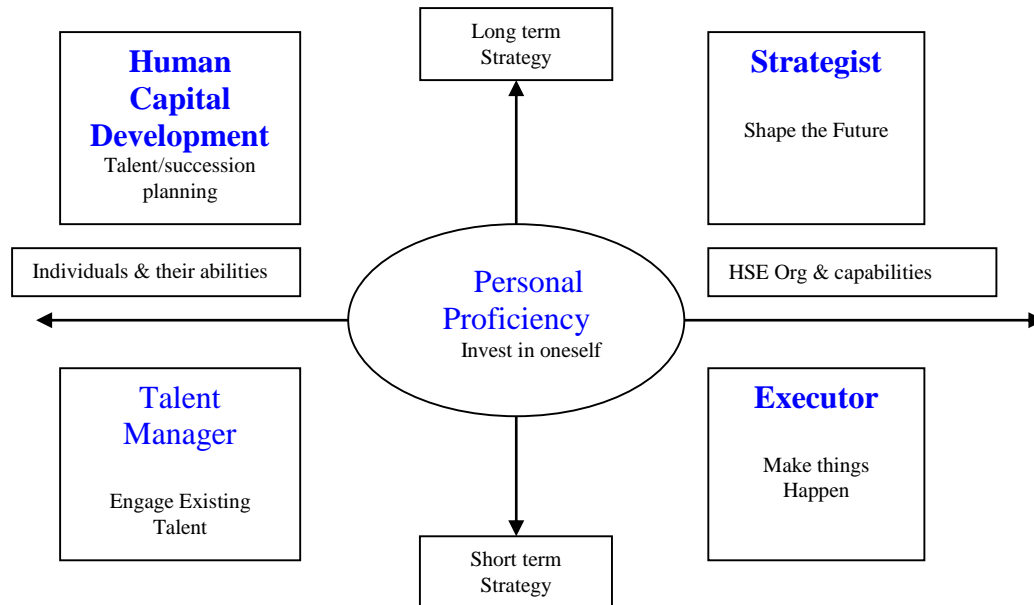
Figure 2.1 The Leadership code (Source Ulrich et al, 2008:18)

Ulrich and his colleagues asked the following questions in order to obtain a unified view of leadership. The leader must model what that which others want to master.

1. *Question 1:* Seek direction; where is the company headed. What is the direction of your own career? Leaders are strategists. They formulate the strategy. As they are best placed to decide where the company is headed, they figure the direction the company must take based on current and planned resources. They work out effectively how to get from the present to the future.

2. *Question 2:* You must make things happen. They put systems in place that focus on getting things done.

3. *Question 3:* Who are the right people for the organisation? Leader's that optimise today's talent are referred to as *talent managers*.

4. *Question 4:* Leaders look to long term leadership, assuring growth and progress of their organisation. Spot future talent and how to develop those who possess it.

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5. Question 5: Leaders are learners, they learn from their success and failures, they constantly develop personally. Decisive and have a passion for making bold and courageous moves.

Chapter 3 – Research Methodology

3.1 Rationale for Research:

This study seeks to explore leadership styles of managers/leaders within the HSE, to identify common approaches and/or styles to leading. In doing so, the research seeks to understand any perceived changes in approach that these report as a consequence of the changed external environment. (Economic downturn)

3.2 Aims and Objectives

Leadership styles within Healthcare have been studied before, however, within the Irish context, this study aims to address the direct implications of leadership style as a direct result of the effects of the Economic Downturn in Ireland, which developed as a result of the Global Financial Crisis (GFC).

In particular, many challenges were faced by leaders/managers as a result of the outcome and impact of the Public Service Agreement 2010-2014 (Croke Park Agreement) and the Public Service Stability Agreement 2013-2016 (Haddington Road Agreement). These national agreements were developed with the public service unions to address overspend/cost containment within the public purse, covering civil servants, teachers, health workers, Gardai and the Defence forces.

This thesis will attempt the following:

1. To carry out an exploration of the leadership styles within the HSE. Although unaware of what one expects to find, it is intended that this research will provide a richness of data that will highlight for the reader, the difficulties and subsequent approaches now being adopted by leaders and managers, operating in a difficult climate.

2. To establish whether *perceived* leadership styles have changed as a result of the External environment (Economy) influencing the internal environment (HSE).

3.   To establish where, if any, recommendations could be made for improvement with regard to the leadership processes within the HSE.

3.3 Research Framework and Methodology

Aborisade (2013) advocates there are two main types of research methodologies - qualitative and quantitative. He advocates that the strength of qualitative research 'lies in the use of interviews, which allow qualitative researchers to conduct an in-depth investigation into their subject of inquiry' (p.48).

Malhotra and Birks (2002) state that in-depth interviews serve as unstructured, direct personal interviews, in which a single respondent is probed by the interviewer to uncover underlying motivations, beliefs, attitudes and feelings on a certain topic. Also, Stokes and Bergin (2006) maintain that individual interviews are superior over group interviews in uncovering important underlying issues. They also state that, although group interviews have 'extrinsic' advantages of being less expensive and faster in terms of data collection, individual interviews have 'intrinsic' advantages in terms of the quality of the outcome.

This theory is reinforced by Swanson and Holton (2005) who confirm the interview as an authentic tool in qualitative research, emphasise the following:

> Qualitative methods are better suited for collecting, analysing and interpreting respondent constructions than are quantitative methods, because they are better suited for collecting, analysing and interpreting respondent constructions than are quantitative methods, because they are immediate, processual, elaborative and amenable to inter-subjective interpretation" (p. 231)

Conger (1998, p.107) endorses that, 'Qualitative studies remain relatively rare[…]the methodology of choice for topics as contextually rich as leadership'.

3.4 Qualitative over Quantitative

3.4.1 Qualitative

Green and Thorogood (2009, p.94) they advocate the following:

> In a semi-structured interview, the researcher sets the agenda in terms of
> The topics covered, but the interviewee's responses determine the kinds of
> information produced about these topics, and the relative importance of each
> of them

They also recommend that the less structured interview, over the structured interview, is more qualitative based, which invariably produces rich detailed accounts from the perspectives of the interviewees. There are limitations to interviews also in that they only provide access to what people say, not what they do. Also according to Green and Thorogood (p.120):

> 'the analysis of the interview data relies on considerable local, cultural as well
> as linguistic knowledge. However they are a relatively efficient way of
> generating data on almost all health topics'

This concurs with Hoinville & Jowell (1983 p 9) who state:

> The essence of qualitative research is an unstructured and flexible
> approach to interviewing that allows the widest possible exploration of
> views and behaviour patterns

Also, according to Patton (1990), the beauty of the semi structured interview lies in its ability for discoveries of new themes and efficient data analysis.

3.4.2 Quantitative:

According to Williams (1992), quantitative methods are preferable when the phenomenon under study needs to be measured in a quantifiable way, or when hypotheses need to be tested, or when generalisations need to be made of the measures. Williams notes the following (1992, p.6): 'If measures are not apparent or if researchers cannot develop them with confidence, then quantitative method are not appropriate to the problem'.

For this body of research, it was felt that a more open dialogue, and more richness of data would be obtained, pertaining to this topic of style of leadership, through the interview process.

3.4.3 Different methods of qualitative

According to Green and Thorogood (2009, p.4), when one examines the health agenda, there are two broad strands of research within healthcare itself, which are as follows:

1. 'First are critical studies *of* health from various local social science perspectives, which address issues such as health and illness'
2. 'Secondly are studies *for* health, from within the disciplines of public health, health promotion or health services research.'

There is a subtle difference between these two forms, however, according to Green and Thorogood (2009, p.5):

> The Principles of qualitative research are, therefore exactly the same, whether the study is primarily academic (Such as a PhD thesis in Anthropology) or more 'applied' such as a funded evaluation of a health care project

So how does one choose a strategy? Although not abundantly clear, Green and Thorogood (2009, p.6) attempt to use a basic metric of differentiation:

> The most basic way of characterising qualitative studies is to describe their aims as seeking answers to questions about the '*what*', '*how*', or '*why*' of a phenomenon, rather than questions about '*how many*' or *how much*

As this study seeks to study leadership styles, which can be very subjective, it would appear that the qualitative method of study would be preferable.

3.4.4 Varieties of qualitative research.

Green and Thorogood (2009) detail the different types of research, stipulating that they depend entirely on the purpose and nature of the enquiry. These are summarised below:

1. Ethnographies, in which a cultural group is studied over a period of time.
2. Grounded theory, where data is continually used, categorised, and refined to inform a theory.
3. Case Studies, in which a single bounded case or multiple cases are explored using a variety of data-gathering techniques.
4. Phenomenological studies, which examine human experiences and their meanings.
5. Qualitative research, which can also include active participation of the researcher in an intervention, a practice normally labelled as participatory action research.

For the purposes of this research, the grounded theory in conjunction with a deductive/research approach was adopted.

3.5 Deductive/Inductive research approach

Taylor-Powell & Renner (2003) outline the strategy for analysing qualitative data. This is a combination of a deductive and inductive approach. Deductive theory is often referred to as top-down research, as seen from Fig. 3.1 below.

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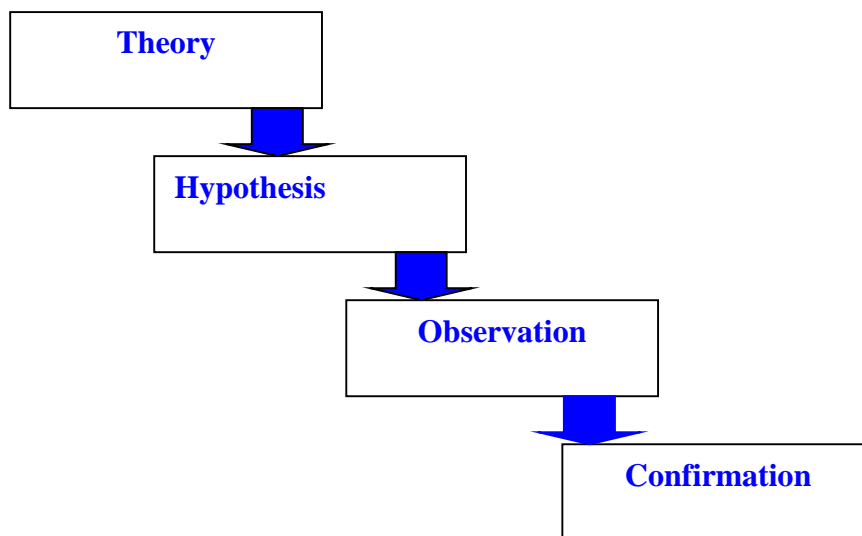
Fig 3.1: Deductive Theory approach

Through this approach, we start with a theory or a specific framework (as detailed in the introduction/literature review). We then test the theory (by analysing the data of the interviews), then we reject or accept the theory (as detailed in conclusions chapter of the thesis). This can be further broken down into the following stages which this process followed:

Stage1: Create a set of themes which one wished to explore (the changes in leadership styles). This stage also analysed the literature on this topic. This was based around a theoretical concept. For example, the analysis of differences between transactional and transformational leadership styles.

Stage 2: This stage involved breaking up the interviews into "chunks" of data. After the interviews were transcribed, these transcripts were then analysed by breaking the interviews into relevant sentences and paragraphs. This involved labelling or coding each sentence/paragraph with a colour/code from the list of themes identified. This was done by this researcher by highlighting the text in a different coloured font.

Stage 3: Stage three involved bringing all of the individual quotes or themes together. This information was collated for each participant, so all of the themes identified in question 1

were analysed together across the seven participants. This was done on an A3 sheet. These themes were then examined and ideas within that theme were examined. These became sub-themes. All of the themes and sub themes were analysed, with an analysis on how each of these relate to each other across the seven participants. These are detailed in the findings section (Chapter 4).

Stage 5: When all of the interviews and analysis had been completed, this researcher then constructed a narrative to support the ideas and relationships between the ideas. Also, there were some quotes from the interviews to support the interrelationships between the ideas which this research seeks to present. These interrelationships are detailed in Chapter 5, Conclusions and Recommendations.

Stage 5: At all stages, this researcher allowed new ideas and themes to emerge, across stages 1-4. This was one of the main reasons why this research was chosen. Patton (1990) argues for this point, which substantiates this chosen methodology. Also, at all stages, this researcher endeavoured to be systematic by following the same steps and procedures while carrying out this analysis, making them transparent, coherent and explicit to the reader.

3.6 The interview process.

When interviewing, this researcher found that the more at ease the participant was, the more relaxed and open the interview was. This evidence is ratified by Cormack (1991) and Poht and Hunger (1991), who advocate using open ended questions in health related interviews, leading to more robust data being obtained. According to Guba and Lincoln (1981), the quality of data generated is largely dependent on the skills and expertise of the interviewer, along with the environment or location of the interview.

Interviews can be very time consuming; the 7 interviews from which the data was analysed ranged from 28 minutes to 110 minutes. The transcription of interviews for the purposes of data recording and coding was also very time consuming; averaging 3 hours to transcribe a 30 minute interview.

For the purposes of this thesis, this researcher conducted one "trial" interview of a health care leader to establish trends and pertinent issues. This interview did not form part of the

thesis, however, it did help focus the research questions and interview question prompts somewhat.

3.4 Participant profile

A brief profile of the participants is provided below. The majority of leaders interviewed were from the middle level of management (Grade VIII), however, to avoid an elitist bias, there were also interviews both above and below Grade VIII. The following participants are found in these interviews:

1. Male senior manager, 62 years of age, with over 37 years' experience in healthcare; the last 15 in a senior specialist role.

2. Female senior clinical manager, 52 years of age, with over 34 years' experience in healthcare; the last 10 as clinical lead in a specialist area.

3. Female senior office manager, 42 years of age, with over 22 years of administration experience; the last 7 as office manager.

4. Female operations director over acute treatment facility, 51 years of age with over 30 years of healthcare experience; the last 5 as operations director.

5. Male projects manager, circa 48 years of age with over 26 years' experience of managing construction projects; the last 15 within healthcare.

6. Male general services manager in an acute facility, 45 years of age with over 20 years of healthcare experience; the last 8 in his current role.

7. Female general administration manager, 56 years of age with over 30 year's healthcare experience; the last 15 in her current role.

3.6.2 Procedure adopted

The interviewees were contacted two weeks in advance of proposed date, and sent the initial question. The atmosphere was always relaxed. The format was explained to each participant and any questions were answered prior to the interview starting. Out of the 7 interviews, there were no distractions in any interview. The interviews took place outside of the participant's normal office, which helped with the process. All interviews were digitally recorded.

3.6.3 Sample Size

The sample size was seven participants with a gender mix of 3 male and 4 females. There was a blend of clinical and administrative roles. There were also different levels of responsibilities and service areas covered.

3.6.4 Ethical Considerations

There were no ethical considerations to consider in the interview process, as there was no sensitive information regarding patients or staff members discussed.

3.7 Limitations of study

From a geographical point of view, all of the participants were based in Dublin. The research aimed, however, to get a blend across a level of management and specialities that are replicated across the country.

3.8 Bias in research

It was important within the context of the chosen methodology to recognise at times there can be an element of bias on behalf of both the interviewer and interviewee. By examining multiple sources of evidence and re-examining the raw data several times, this researcher aimed to minimise or eradicate bias in both cases.

To assist in this process, the interviewer aimed to reduce any inhibitions that participants may have had, by ensuring that their responses would always remain anonymous. Some had reservations that their responses may reflect poorly on them, however, once this fear was removed, the interview opened up, resulting in a frank and honest discussion.

3.9 Conclusion

Leadership is a very emotive topic. Everyone has an idea on it. However, this researcher endeavoured to analyse data from an objective and qualified viewpoint, by examining the styles and observations of individuals at a certain level within the HSE.

The core objective was to examine people under unforeseen circumstances, namely, those, as a result of the financial and personnel constraints manifested as a result of the economic downturn.

These external, and subsequent internal, forces shape how people react and respond to situations. It is intended that these responses will now be examined in the next two chapters of findings, and conclusions.

These leadership forces centre around individuals, beliefs, skills, resources, circumstances, political agendas, organisational structures, culture and the existence or non-existence of change.

Chapter 4 – Research Findings

4.1 Introduction

As outlined in the previous chapter, a series of semi structured interviews were conducted for the purpose of qualitative primary research. The purpose was to investigate different leadership styles and to further explore the theories behind Blake and Mouton's (1985) four leadership styles.Each participant was asked the following opening question:

> *As a leader over a team, are you aware that the recent economic events (Economic Downturn 2008-2013) has affected how you manage/lead your team?*

In order to ensure that the research was reliable, objective and meaningful, this researcher ensured that all participants had sufficient time to take part in the interview and that they were relaxed. Each interview took place outside of the respondent's normal office. To encourage openness and responsiveness, all participants were informed that all names and locations would be anonymous, and they were also reassured that they would not be recognisable through any comments made.

Participants were eager to take part, as the HSE organisation had gone through major transactional and transformational changes within the previous five years, and had affected all participants from both a professional and personal point of view. The research presented some interesting and challenging disclosures.

4.2 Participants

As previously stated, here is a brief outline of each of the participants from a personal and professional point of view.

1.   Male senior manager, 62 years of age, with over 37 years' experience in healthcare; the last 15 in a senior specialist role.

2.   Female senior clinical manager, 52 years of age, with over 34 years' experience in healthcare; the last 10 as clinical lead in a specialist area.

3.   Female senior office manager, 42 years of age, with over 22 years of administration experience; the last 7 as office manager.

4.   Female operations director over acute treatment facility, 51 years of age with over 30 years of healthcare experience; the last 5 as operations director.

5.   Male projects manager, circa 48 years of age with over 26 years' experience of managing construction projects; the last 15 within healthcare.

6.   Male general services manager in an acute facility, 45 years of age with over 20 years of healthcare experience; the last 8 in his current role.

7.   Female general administration manager, 56 years of age with over 30 year's healthcare experience; the last 15 in her current role.

Each of the participants were asked the open-ended question above. From that question, each was asked a series of prompt questions, to ensure continuity across all interviews. They had no prior knowledge of the prompt questions.

4.3 Findings from Research

4.3.1 Question 1: Leadership style changes

All 7 participants agreed that in previous years, their style of management/leadership had changed considerably. Let us look more closely at the nuances of how this style changed.

Participant 1 stated that his style had changed, however, his manager's style had changed considerably. The easiest thing for his manager to state was that there "no money", however, the Health Service Executive (HSE) had statutory, regulatory and legal obligations and it was important at all times to highlight these to his manager and ensure compliance. He stated that there was a distinct difference between delegation of duties and abdication of duties, and that it was important to differentiate between the two. He felt it

important that, as an organisation, the HSE had to serve the public, and should not lose sight of this, disregarding the economic climate or lack of funds. *Participant 2* acknowledged that her style of how she managed people had definitely changed. She was now far more focused on money (budgets), staff (whole time equivalents, WTE's) cost containment, and dealing with external agencies such as HIQA (Health Information Quality Authority) where these elements were not so prevalent anymore.

Participant 3 and 4 acknowledged that their style had changed, and that they felt everything was being watched. *Participant 3* stated that there were several performance/measurement structures in place, however, the system was not seen as fair. Her direct reports were working extra hours for less pay; where as others in her department were not bound by such measures and flouted the rules. She also found that, within her building, her colleagues at the same grade were not subject to the same scrutiny or rules and regulations and she found this unfair and frustrating. Under the Haddington Road Agreement (HRA), some did extra hours and some did not.

Participant 4 found that she was under the same scrutiny regarding staff, but her objectors focused on the amount of agency staff she employed, however, with the moratorium on recruitment, she was caught in a bind of having to run a service with agency staff, (at a higher cost), but had no option or else the service would cease. All of her staff were carrying out duties at a higher grade than they were originally employed to do, i.e. a Grade III carrying out the roles and responsibilities of a grade V. The only assistance she could give her staff was a 'letter of comfort' acknowledging their increased workload and responsibilities.

Participant 5 confirmed that his style had changed in how he interacted with people; as a project manager, he managed professional designers, (Architects, Engineers etc). Due to the downturn in the economy, particularly in the construction industry and associated professions, he had concerns that such professionals were under huge financial pressure to sustain their practices and that this underlying premise could impact on their ability to carry out their duties to the best of their ability. As a result of the government's new form of construction contracts (2008) in the period 2008 onwards, the government stipulated lowest price on professional services, which further exacerbated his concerns.

Participant 6 stated that his primary focus regarding his work now centred around balancing budgets, WTE's and dealing with external agencies such as HIQA (Health Information Quality Authority). *Participant 7* concurred with *Participant 6's* viewpoints, and added that a lack of funding had had an adverse effect on everything, and subsequently had created less leadership; she now had no judgement calls and she referred them on all the time. She found herself second guessing herself also, as a direct result of her supervisor micro-managing her. In the past, she had the discretion to make unilateral decisions in terms of staffing, budgets and different things. Now, she can no longer do that, because she now has to find what they do on the 'other side' (her line managers section). She did not blame her managers, as she felt they were under the same pressure, however, she stated it was 'leadership by paranoia'. By just looking at budgets, numbers (WTE's) and cash flow, in effect it has killed the creative leadership piece. She understood that it had to be fair and equitable, but it actually frustrated the leadership process. As a manager on the service side, (front line) she felt she fitted into her manager's world, rather than the other way round.

4.3.2 Question 2: Absenteeism

The question was asked of the participants - Did they find that the new rules and regulations regarding absenteeism/attendance policies had changed their environment, and if so, how did they manage.

Participant 1 found that the system was somewhat unfair and inequitable; some people he felt had 90 days annual leave, or had the normal amount, but just took 90 days. He found that the merger of the old Eastern Health Board (8 of these) into the Easter Regional Health Authority in 2001, was like merging 8 fiefdoms. For example, people in Kildare got time off for the Punchestown races, getting three extra annual leave days. When you merge Boards (Health Boards), it is difficult to eradicate these types of separate deals. He welcomed the new attendance policies but felt that unless it was managed properly, it would be of no benefit to the Health Service Executive.

Participant 2 welcomed the new attendance policy, and was glad that some formal structure was now in place.

Participant 3 concurred with *Participant 1* in that she welcomed the new attendance policy, but had found that since its inception, it was not being implemented in a fair manner. Her department witnessed a lot of 'dodgy' stuff going on; this was leading to HR issues festering due to the inequality of the policing of the systems.

Participant 4 found that there were historical problems with people and sick leave, particularly around long term sick leave. She found it bizarre that staff would go sick for two weeks and return to work with a sun tan. However, on further investigation she found that there were underlying reasons why staff were out for such long periods. Once she addressed these underlying issues, the sick leave reduced considerably.

Participant 5 felt that in order to address a problem, you have to quantify it, and so he welcomed the new attendance policy (2009), however, he felt it was not managed correctly. He also felt the people who formulated these policies without implementing them correctly, did not have to deal with the consequential problems they created.

Participant 6 stated that he always had attendance policies. For years he had been carrying out back to work interviews. He had found that he had a very open communication policy and stressed to staff that it was not to be seen as a punitive exercise. He had found in the past that his early intervention with people in his organisation who may have had personal problems, for example substance abuse, be it alcohol or drugs, by offering assistance of professional help, occupational health or counselling, had led to his location having the lowest absenteeism rates in the country (2.3%).

Participant 7 had welcomed the formalisation of the attendance policy. She had always managed back to work interviews through each team leader, and now it was formalised through the attendance policy, but it had made no difference whatsoever. In fact, the attendance policy had led to more paperwork, for her staff with no visible gain.

4.3.3 Question 3: Accountability

The question was asked - Did the participants feel that they were under more pressure regarding accountability of their departments?

Participant 1 felt that the easy answer for some mangers regarding their accountability was that they now had no money. He outlined that repeatedly he had to explain to his managers their obligations from a regulatory, legal and financial perspective. He stated that the downturn has forced his managers to plan in a better fashion and prioritise projects on a structured business case/needs analysis, and not pander to somebody who may have a 'hobby horse' of a project. This he felt had been beneficial. He also felt that the HSE had huge experience in-house, but in the past there was a tendency to outsource everything from consultants to office/clinical accommodation, which now has proven too costly. The HSE owns a huge land bank of buildings/properties, however, in the past he felt that these assets were not maximised to their optimum use. He felt it important that at all times to accept accountability to external and internal stakeholders for delivering the requisite obligations discussed above.

Participant 2 emphasised that, as a result of the cutbacks, she was now forced to use far more metrics, which she felt were beneficial, as she could now link the metrics to clinical outcomes. Although this was positive, it was never ending, and the system was not equitable; where she may make a saving in an area due to prudent management, the savings in her area were often used to shore up an underperforming area, which was frustrating. She found it exhausting year on year when considerable energies have to be expended in trying to secure sufficient resources just to run her service.

Participant 3 maintained there were far more metrics in place, particularly in relation to money and staff tracking, however, she did not feel either were of any benefit. She felt that in relation to money in particular, her department, which managed large amounts of money, felt that it was wasted on professional fees with no material gain. She also received endless circulars from Human Resources (HR) on staffing issues but were extremely vague, and she relied on her more experienced colleagues for guidance and support. She found that personnel who had either long term sick leave, or part time workers, took up the majority of her time in relation to dealing with their respective attendance challenges.

Participant 4 indicated that many of her problems centred around the moratorium on recruitment, coupled with the fact that she had so many agency staff. She could not get rid of the agency staff, as they were essential to run her service, yet she could not employ any permanent staff. She often became frustrated over the inequality of new permanent posts, in that it was often not on a clinical need, or business case, rather, it was granted by the person who shouted the loudest. This also annoyed *Participant 2* who had an urgent need for clinical staff, which was constantly refused; this participant would then meet someone socially, who got a nursing job overnight at perhaps an acute hospital.

Participant 5 acknowledged that we had to 'balance the books', however, he felt that integrity and trust had been lost within the HSE. From Grade III to General Manager Level, he also felt your perceived value had been undermined, and the sense of security as an employee had been eroded. He felt that his peers/supervisors were spending money on designs (professional teams) and he knew there was no money to bring the project to fruition. He felt this was disingenuous and his department was not correctly managing people's expectations, and was giving them false hope and wasting money.

Participant 6 felt at all times he was running to a standstill, however, in all financial exercises, he felt there always came a *breakeven* point, for example, by reducing cleaning services constantly there comes a point that your infection control rates will start to increase; at this point you have to stand your ground and believe in your approach and maintain an acceptable level of cleaning to reduce infection. Once he took this stance, he was happy with his decision, but he did re-iterate it was based on facts and figures.

Participant 7 concurred with *Participant 6*, however, she felt at times that she was experiencing *Leadership by paranoia*, where by constantly being asked to examine budgets, numbers, cash flow etc., she felt she could no longer make any judgement calls; everything had to be referred on, and in effect, had created less leadership and not more. Like *Participant 2*, she felt that by constantly focusing on numbers, it made it quite difficult to suggest reform. Since her reduced staff numbers were under pressure, she felt that decisions made were not afforded adequate time to analyse them, resulting in a higher risk of making the wrong decision. She understood the pressures her line managers were under, but felt she was being micro-managed and could not make any unilateral decisions as a result of this style of management.

4.3.4 Question 4: Value their jobs

Participants were asked - Did they feel that their staff under their remit valued their jobs more as a result of the economic downturn?

Participant 1 felt that many people in the HSE had suffered hugely as a result of the economic downturn and personally knew of several people who had to contact the Department of Social Protection for supplemental income. He also found that media coverage focusing on the Private vs. Public worker appalling, stating that it was not the Public sector that had ruined the country but the bankers and developers. He used the analogy of vilifying the public sector worker almost like the Second World War, where in Germany people of the Jewish community were identified by pinning a yellow star to their coats by the Nazi regime.

Participant 2 indicated that there were two cohorts of workers within the service, those who worked for the HSE and those who felt that the HSE worked for them. This dichotomy has always been present, however, the bigger issue for her was that her staff no longer felt 'valued'. This was a bigger concern for her, as she was always trying to get her staff to see merit in their work, and get them to view the glass as half full, rather than half empty. She did add that in reality there was very little turnover of staff in her area of remit, and that there was a good sense of collegiality within her areas.

Participant 3 felt disheartened by the approach taken by her managers. She felt similar to *Participant 2*, in that there was always that mixture of people who did or did not appreciate their job, however, there was no recognition for any work done. In the past she was allowed more flexibility, and could also allow more flexibility to her team. She felt that all the attendance policies issued by the HSE were vague, and received no support from HR. Although she understood the need for cost cutting, she was not made part of a team, and kept in the dark, which further undermined her perceived value. There were many secret meetings in her department and then a new approach/strategy would be born out of nowhere. She felt there was no collaborative approach taken with regard to ideas and strategy within her department.

Participant 4 was of the opinion that some of the practices and procedures were quite old fashioned in her area. The staff had become regimented in their approach and solely stuck to their job description. At first, she found this frustrating but slowly started to reform and

reshape their perceptions of what they were supposed to do. She attributes a lack of communication between management and their respective staff, and also between the staff themselves as the root cause for many industrial problems. She found that by explaining the strategic decisions that the HSE had to make, it made the development process easier, and her staff were more receptive of change. This concurs with *Participant 1*, who advocated that people can get caught up in job descriptions, and people constantly monitor others to see if they are within their respective job roles and responsibilities. Both *Participants 4 and 1* recognised the need to look at the job/project at hand, rather than the job description of the people involved, to make the process inclusive rather than exclusive. Creating a culture that makes needed changes happen, involving the right skills mix, getting commitment all round from internal and external stakeholders, led to more successful projects.

Participant 5 recognised that people valued their jobs, however, in his opinion, people felt undervalued. He also felt that sense of security within the public sector had diminished. He felt that the Haddington Road Agreement was handled very badly as a stick and carrot approach, rather than the other way around. It had been railroaded in, and attributed the government's lack of experience as being detrimental to the whole process. He felt it important to foster a culture that builds trust and fairness and proactively change systems that reinforce inappropriate patterns of behaviour. On a more serious note, he felt that the long term effect of the economic downturn would not manifest itself for some years, both within the private and public sector, in the form of serious mental health issues. The economic outlook will improve, but sadly the mental scars will be there for some time. To further frustrate the process, it is detrimental to all when it transpires that funding to mental health is then cut.

Participant 6 felt that people did value their jobs more, however, they were working longer hours for less pay, which had a detrimental effect on their levels of morale. As a manager, he tried to emphasise to his team the importance of the work they carried out, and the direct benefits to the hospital and subsequent patients who were treated there. He emphasised the need for a team based approach for all projects from the porter right up to the surgeon, he felt this inclusive approach worked well.

Participant 7, like the other participants, felt that there is always a mixture of appreciative employees and unappreciative employees, however, the issue of being valued came to the

fore again. She recounted how two porters had recently retired with a combined service of 80 years and they got no formal recognition for the years of service in the HSE. Perhaps even a letter, pin, or plaque, or some cost effective method of the department appreciating your time served with the HSE. She felt the lack of this recognition had a detrimental effect on the remaining staff also, as it sent a clear signal to the remaining 'working' employees.

4.3.5 Question 5: Scrutiny/Visibility

Participants were asked - Did they feel that they were under more scrutiny since the economic downturn?

Participant 1 felt that the he personally was not under a different level of scrutiny than before, but he felt his line managers were. One aspect was a reduction in the rate of travel paid to employees. This was not an issue for him, however, he did see his line manager's abusing mileage despite the fact that there was policy and procedures asking staff to be cognisant of mileage. He found it difficult that leaders espouse values but don't live by them.

Participant 2 emphasised that there were far more metrics in place in relation to money, staff, service and outcomes. This she felt was a good thing, as it made everything quantifiable.

Participant 3 confirmed that she was under more scrutiny from both a financial and staff management point of view. She felt that it was all fine once it was going well, but if it went wrong, no one in her department would have her back. She felt isolated. With her direct reports, she endeavoured to lead by example, in that she would not ask one of her staff to do anything that she would not do herself. This she found worked, however, it was not replicated throughout the department.

Participant 4 expanded on the viewpoints of *Participant 3*, and felt that there still exists within the HSE, a chauvinistic attitude to women in management and that female managers are not given the respect they deserve. She gave the example of working with a group on a policy document, an area which she had extensive knowledge, as did some of her female colleagues, but since the chair had limited knowledge of the subject, he found it difficult to deal with the informed women on the group. This she found frustrating.

Participant 5 also found that there was far more scrutiny in the HSE. He found that the HSE has created many siloes for management, and there is little interaction across the siloes. He felt that his managers were afraid to admit mistakes, or admit that they did not know everything. That aspect of *esprit de corps*, (working for the common good), had disappeared from the HSE. His line managers were afraid to examine current reality, instead, going with a distorted version of the situation. Some leaders wanted people reporting into them, who said yes all the time, rather than question their motives. This he found annoying.

Participant 6 highlighted the need for even more scrutiny and visibility in tough times. In his hospital, the Board formulated a series of information sessions once a month, in a public area within the hospital, where anyone from the porter, right up to the consultant surgeon, could come along for coffee/tea and biscuits and ask the Board any question they wished. This he felt gave a great sense of comfort to the staff, and did not isolate anyone. The Board were also happy to promote this as it made all issues open and transparent. As an organisation, they needed a greater connection with the staff, and the feedback was very positive for adopting this approach.

Participant 7 stated that she was under far more scrutiny, and they had many systems which tracked all types of activity, from Childcare systems/Maternity systems/Older person systems. The problem was that none of these systems talked to each other, and from a software point of view, were drastically different in their operations. She also stated that, as she was under more financial scrutiny, no one system exists that can tell her exactly where she is, from a financial perspective at any one time in the year, despite millions having been spent over the years developing SAP (Accounting package) systems.

4.3.6 Question 6: Work/Life Balance

Participants were asked - Did they feel that their domestic life had been affected as a result of the stresses they now faced in work?

Participant 1 felt that nothing had changed whatsoever. He felt that as he was of a particular age, his mantra had always been to save for something and then buy it. So he had not been impacted by the economic downturn as much as his children had. His children often said to him, 'Ah you only live once', but his reply was, 'yes but you tend to live for quite a long time, and so does debt'. Regarding workload, he always tried to take a certain ethical stance, which had not changed over the last 6 years.

Participant 2 felt that her domestic life had been impacted, but it was self-inflicted. She found that in order to clear her head, she had to give thought to the following day's work. If, for example, she was interviewing, she would have to clear her emails the night before, to 'give her head space', otherwise she knew it would affect her interviewing skills.

Participant 3 felt that what bothered her most at home was her reflection on the inequalities she experienced in work, not the work itself. The unfairness of how people were treated bothered her.

Participant 4 used her commute home to de-stress. She stated that calling in to see her grandchildren often allowed her to think of other non-related work things. On average, she did a 12 hour day, and found at times it was exhausting, but loved it.

Participant 5 felt at times work was frustrating and could be brought home, but he felt when he carried out successful projects it far outweighed the bad days.

Participant 6 felt at times there was no escape, but the variety was always challenging and interesting.

Participant 7 found it very stressful, but knew herself that part of her problem was that she 'internalised' things, which was wrong, however, the reason she did this was that she had a core set of values and beliefs which she felt very strongly about, and was not going to compromise on these core values.

4.3.7 Question 7: Optimism

Participants were asked - Did they feel optimistic about the future of the HSE?

Participant 1 felt that working for an organisation that is politically driven will always have a problematic future, where the long term view is not considered. He felt there were many good people in the organisation, but they can often be seen as the troublemakers, as their view of reality is not real and current, but rather, dated and distorted.

Participant 2 felt optimistic that the current model of care that they had was very good and worked well. As the current system works, her view point was to 'stick to the knitting'. If it works, leave it; don't change it for the sake of change. She found many initiatives were excellent which had been developed from the SDU (Special delivery unit - unit examining delays in the system). She found that although many initiatives began, they were not brought to fruition. In effect, she felt to roll out stages 2, 3 and 4 of any plan takes energy and commitment.

Participant 3 felt that the system could work a lot better. They had more staff now in her department than 7 years ago, and less money, and found this bewildering, with nobody aware of what is going on.

Participant 4 found that the pace frustrating, at which the service develops. Her view point was that if you are to develop sophisticated clinical programmes, they do need administrative support staff to make them work. Revenue is required not just capital investment.

Participant 5 felt that there is a requirement to manage colleague's expectations of service/capital delivery. Some leaders want 'yes men/women' and at times colleagues adopt the attitude of 'go along to get along' which is always a concern for him. He would endeavour to re-establish trust within his department, as it was non-existent, and he felt that a stronger team culture would lead to a more productive workforce.

Participant 6 felt that it was important to view the Health Service as a cash cow that has to be managed to the best of your ability. In 10 years, or in 20 years, we will still be providing healthcare. That will never change so it is best to adopt a long term view, and improve the operational and infrastructural elements as much as possible. There is a need to not get

caught up in the 'latest' political agenda, as that will always be changing. The needs of healthcare will remain the same however.

Participant 7 felt disillusioned as a result of being micro-managed, and also felt she had been down-skilled. She had to work for financial reasons; with the consensus being that although the organisation was much 'leaner', it was not more efficient.

Chapter 5 - Conclusions and Recommendations

5.1 Introduction

The following discussion interprets and relates the research findings to the published literature outlined in chapter 2 and the research aims and objectives outlined in chapter 3 along with the key findings of the research detailed in chapter 4. These observations will be detailed in this chapter.

5.1.1 Application of the rules

As a result of the Public Service Agreement 2010-2014 (Croke Park Agreement) and the Public Service Stability Agreement 2013-2016 (Haddington Road Agreement), there are far more metrics for performance and attendance within the HSE. The underlying feeling from the respondents was that any policy or procedure is only as good as the manager implementing it.

An example of this was the Attendance Policy (2009), where an inconsistent approach appears to have been taken, where subjectivity and discretion take precedence over objectivity and consistency, the latter attributes being necessary to ensure credibility. Heinrich and Marschke (2010) state that within the Public sector, highly subjective performance measures are frequently used in performance management systems, preventing greater clarity on how performance is measured.

Also, as this research paper is on different leadership styles, an element of subjectivity is inevitable, however, some managers use it for their own benefit, while others allow personal relationships with staff become a factor. This can lead to considerable inconsistency with regard to attendance policies, recruitment procedures, promotions and the allocation of projects/workload.

The two agreements listed above have extensive performance and efficiency measures built into them, however, according to DeNisi and Griffin (2008), assessment and rating should

reflect the true picture of the situation of who is performing well and who is not, by highlighting their specific strengths and weaknesses. Rao (2008) also adds that the focus of any performance metric should be on objectivity, consistency and fairness; there can be no place for politics or manipulation. This it was found to not always be the case in the HSE.

A very positive outcome in relation to the metrics detailed above, was in relation to bed stays etc; when a manager is making a business case for a clinician, they can now validate the business case with the medical metrics, for example, by having a physiotherapist for so many days in an elderly facility, the rehabilitation period for an elderly person improved by X number of days. Once these metrics could be demonstrated, the senior level manager backed the business case.

5.1.2 Accountability/Due Diligence

There was a strong feeling that senior leaders within the HSE should be held accountable for their actions, however, this was not currently the case. As a result of the impact of the Global financial crisis in 2008, and the consequential reduction in Government spending, managers took comfort in the additional Needs/Business case analysis now required for all resources, be it from a personnel, revenue or capital perspective. In effect, the system has become more Bureaucratic (following policies and procedures) and Task orientated (defining key roles, tasks and structures). Once this was seen as equitable, managers were content to follow a more thorough process.

Each manager felt strongly over past 'squandering' of monies, two examples were noted of the PPARS Payroll system, where costs were circa €131 million (€57 million went directly to consultants and contractors). This was a dominant theme where interviewees felt senior leaders who became over enamoured with their vision, had lost, in effect, the capacity for self-doubt. The consequences, in the case of the PPARS, were financially catastrophic in this case as a result.

The more recent expense of the development of the Children's hospital on the Mater site, where design/development costs were circa €40 million was another example of wasting money. At times, the participants found that the arrogance or hubris of government departments can be frustrating. As one participant alluded to in simple terms, if government monies were your own, would you waste €40 million, before deciding when to say 'stop'.

These points reflect back to the Wright report (2010), regarding the Department of Finance external review. This report infers that senior government advisors, (Department of Health/HSE officials) need to be more assertive about the advice that they provide to Ministers and have the conviction and courage to present policies, plans and procedures objectively to Governments, which may not always align with the political and/or government stance of the day.

However, most managers welcomed the introduction of the new National Business Support Unit (NBSU) pertaining to new governance structures, particularly in relation to Section 38 (Non Statutory Agencies). These guidelines relate to where HSE funding would now be linked to service level agreements and quality standards. It welcomed the adoption of a more "hands on" approach to ensure quality, efficiency and effective use of available resources for such agencies.

Also, the enactment of the Health Service Executive (Governance) Act 2013 has strengthened the accountability relationships between the HSE and the Department of Health; this too was welcomed by the mangers interviewed.

5.1.3 Rigidity of organisational structure and process

As detailed above, the structure can be quite rigid. People can become obsessed with job descriptions, which can have a detrimental effect on the system, especially when people distance themselves from the job or shirk responsibility, saying "that is not my job". If we examine De Burca and William's study (2010), organisational control is polarised to the extreme of being highly centralised and prescriptive. They note 51% of staff do not have any budget to control, however, if leaders are to initiate change, this becomes very difficult when they have little or no authority, but have all of the responsibility for running a service. This theme was quite dominant in the responses received from the interview participants.

5.1.4 Lack of trust

The central tenet of the Health Service Executive to provide health and social care had diminished. Many of the participants felt that trust had been lost across all levels. There

was an element of micro-managing now taking place, which led to a lack of trust between managers and their line managers, which further led to an uncomfortable outlook for all.

Many found it disheartening that leaders would issue policies and procedures, for example, around mileage and subsistence, but then clearly circumvent the rules; this ties in with 6.1.2 Application of the rules, but the startling revelation were that leaders who espouse values, but then don't live up to them are very soon found out. In difficult times, the interviewees felt that leading by example was not optional but mandatory.

On a positive note, one Board of a hospital that was discussed in the findings showed elements of being accessible, visible and accountable. Their actions of being available for consultation once a month spoke volumes to the staff involved, and provided much needed reassurance and connection. People felt more comfortable, with the option of a face to face forum should they wish to avail of it.

5.1.6 Political Influence and competing priorities

One clinical director felt that the current model of care in her location was working extremely well. With some additional funding it could work even better. What frustrated her was the lack of a long term vision. She felt that, at times, they were over managed and under led. There was a lack of a two, four or six year plan. If they were doing a good job, lets 'stick to the knitting' and don't change just for the sake of change. This was an example where the environment in which the public servant operates can be hampered by a change of government, or minister for that matter.

One participant had a very simple view of health care, he said the following:

> In ten years' time we will still be providing the same health care, governments will come
> and go, staff will come and go, however the basic need will always remain. From an
> operational and infrastructural point of view, you endeavour to make your facility the best
> it can be, within the constraints that you are bound by, however in simple terms the HSE
> is a large cash cow that needs to be managed

This is reminiscent of the famous quote by Sir Winston Churchill - 'However beautiful the strategy, you should occasionally look at the results.'

5.1.6. Culture of change

The general feeling of the participants was that the HSE had changed considerably over the past six years. Six years ago, people had the luxury of additional staff and more financial resources. Now as per the National Service plan (2014), the message was quite clear from Director General Mr. Tony O'Brien - 'do more with less'. For this to work, the participants felt for real change to take place (doing more with less), it was vital that staff embraced change, be open-minded and have a structured approach to communicating with each other and encouraging input from stakeholders. Currently this is more the exception than the rule. All of these attributes were low cost, but reflected on leadership style. People found that the departments that were most successful, generally had leaders in place who put the interests of the patients, staff and visitors over their own self interests of power, ambition and kudos.

Participants felt that if they were supposed to be exiting the recession, they hoped that the relentless pressure on resources, coupled with the annual cycle of debate and justification over resources would cease, as this yearly exercise had a negative effect on planning.

5.1.7 Lack of Systems that enforce accountability

There are many software systems, policies, procedures, templates etc within the HSE. One major criticism was that there are different systems used by the child and family division, older persons, maternity, etc; all the systems in their own right work, but none of the systems talk to each other. Also, from a financial perspective, there is not one package that can tell a manager exactly where they are from a cash flow point of view at any one time. Unfortunately, these systems rarely get mentioned, or take the brunt of the blame, when the HSE get vilified over lack of accountability particularly in relation to finances.

There was also criticisms that there are no systems in place to deal with underperformance within the HSE. There is a tendency to defend all actions, even when they are indefensible. Many middle managers were pleased that the system of bonuses were deferred for the foreseeable future for senior management staff. Some managers felt that while bonuses should be paid, it should be based upon tangible results, and not on results which are

fabricated and unwarranted. One participant highlighted this – 'Fire the arrow at any target, and when it lands, go down with the paint and paint the bulls-eye around it'.

This is a focal point pertaining to the topic of leadership and results. Also, resentment can build up amongst managers when they achieve their targets and save money, but then see their savings being used to shore up other underperforming areas. The inequity of performance metrics was a constant source of frustration.

5.1.8 Esprit de corps

'The common spirit existing in the members of a group and inspiring enthusiasm, devotion, and strong regard for the honour of the group'

As a result of the Croke Park deal and Haddington Road agreement detailed above, resulting in pay cuts for staff, limited resources, extra work loads, and negative publicity from the media, the morale is quite poor at the moment in the HSE. This has subsequently led to an apathetic workforce.

However, according to Radnor and McGuire (2004), one cannot just look at performance measures, as staff view them as an added formality that is of little benefit. Such measures should be viewed in conjunction with other aspects such as teamwork, improved communication, a shared vision, employee involvement, leadership and ownership of review procedures.

Where the collective benefit of policies and procedures were explained to staff, the morale has increased in those locations. At one location, HIQA (Health Information Quality Authority) called to site and were there for circa ten hours. The outcome was positive, the net effect was that since the staff were part of the process, kept informed and provided the clean work environment, there was a certain pride in the Hospital's achievements, and genuine satisfaction at the outcome.

There is no formal recognition for years served within the HSE. An example of this was the recent retirement of two members of staff who had over 80 years combined service between them. A local informal party, collection and card was organised by staff, but there was no

formal recognition from the HSE. A suggestion of perhaps a letter, a pin, or a plaque from your Area manager would be a low cost solution of recognition, for years of diligent service. When morale in the organisation is low, and people leave without formal recognition it does not help the collective morale. Public recognition of service costs little, but can make both the retirees and current staff feel more valued.

5.1.9 Synopsis of conclusions

There have been many findings highlighted above which relate back to the original objectives, I will examine some of these under the following headings.

5.2 Relationship between the findings and research objectives

The research findings were predominantly positively correlated to the research aims and objectives. Styles had changed as a result of the economic downturn, and this body of work has highlighted the concerns of middle managers within the system. There were both strengths and weaknesses highlighted as a result of the qualitative research.

5.3 Appropriateness of chosen methodology

The researcher is confident that the correct research methodology was chosen for this body of work. By using the qualitative method of interviews, this led to a richness of data being delivered, which enhanced the original research objectives, and also led to the researcher garnering rich and at times surprising results. Perhaps given more time, the researcher would have liked to duplicate the interviews with their corresponding colleagues in a different geographical area for the purposes of a diverse approach to this body of work.

5.4 Validity of research

This researcher believes that the research design and strategy were well orchestrated, and fully addressed the original objectives. Also, it was felt that the chosen methodology and subsequent analysis of the data, produced an accurate reflection of the leadership styles

under examination. Consequently, the aims and objectives set out in chapter 3 have been sufficiently answered to justify the validity of the research.

5.5 Limitations of research

In hindsight, this researcher would have liked to interview more people, particularly in relation to middle managers at front line level. (Community services / acute / psychiatric / elderly / child and family). By carrying out this further research, it may have added a degree of completeness to the study, by giving feedback to the middle managers who make these important daily decisions. In effect, it would have helped look at the problems from both sides. However, all interviewees were acutely aware of the challenges which their staff faced on a daily basis.

5.6 Practical implications of future research

With all systems, be it attendance policies or financial regulations, there is a constant requirement to evaluate these systems and take a 360^0 review of them. This involves the manager reviewing their own position, and identifying the strengths and weaknesses of each system. Failure to acknowledge the findings will only serve to undermine the organisation's ability to move forward, further damaging its reputation and stifling the opportunity to meet its potential as a world class health service.

Cheng et al (2007) highlight the need for all performance metrics to be evaluated within the Public Service. Systems are developed to help the Public service, however, unless properly managed, it will result in being cumbersome for staff to manage and will eventually be either ignored or implemented in a haphazard manner.

It is the intention of this researcher to highlight the findings of this thesis to the relevant decision makers with the HSE at corporate level. It is hoped that the conclusions and recommendations would be reviewed and acted upon, to assist in making the HSE a better place to work, while also helping to delivering a better quality of service.

5.7 Final Thoughts

Wallis and McLoughlin (2007) conducted a diagnosis of leadership effectiveness in the Irish Public Service. The used the Leadership Effectiveness Analysis Model and cite the following: 'that there would seem to be a need to develop competencies in "Innovative", "persuasion", "excitement" and "achieving results" behaviour sets"' (p.35).

Ulrich et al (2008) developed a very good model of leadership shown below:

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                    ┌──────────────┐
                    │  Long term   │
                    │   Strategy   │
                    └──────────────┘
                           ▲
 ┌───────────────┐         │         ┌───────────────┐
 │    Human      │         │         │  Strategist   │
 │   Capital     │         │         │               │
 │ Development   │         │         │ Shape the     │
 │Talent/succession│       │         │   Future      │
 │   planning    │         │         │               │
 └───────────────┘         │         └───────────────┘
┌──────────────────────┐   │   ┌──────────────────────┐
│Individuals & their   │  ╱─╲  │  HSE Org & capabilities│
│     abilities        │ │   │ │                        │
└──────────────────────┘ │Personal    │
◀─────────────────────────│Proficiency │─────────────────────────▶
                         │Invest in   │
                          ╲oneself╱
 ┌───────────────┐         │         ┌───────────────┐
 │    Talent     │         │         │   Executor    │
 │   Manager     │         │         │               │
 │               │         │         │  Make things  │
 │Engage Existing│         │         │    Happen     │
 │    Talent     │         │         │               │
 └───────────────┘         │         └───────────────┘
                           ▼
                    ┌──────────────┐
                    │ Short term   │
                    │   strategy   │
                    └──────────────┘
```
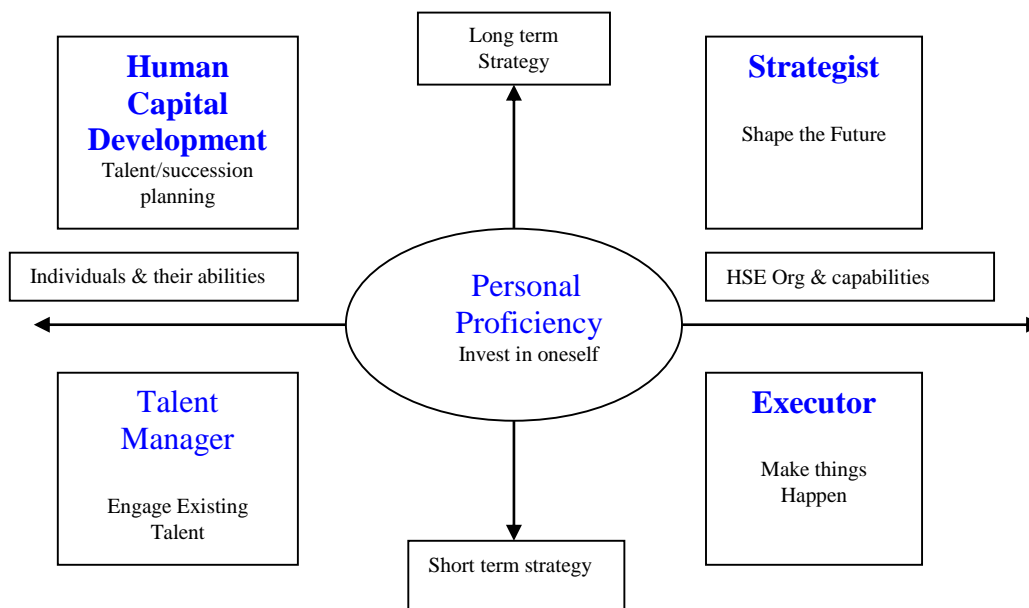
This diagram best illustrates the findings of the most successful leaders within the HSE. Currently the leaders are doing the majority of the obligations within this diagram, however, the problem is that all are not doing it in a systematic manner.

For example, take a manager who is examining the future need of elderly care based on the profile of the population. According to the National Health Service Plan, (2014, p.4), 'Life expectancy in Ireland has increased by a full four years since 2000 to reach 80.6 years today'. This is over the OECD average of 80.1 years. In effect, we are living longer due to advancements in Health care. Therefore, management must take a long term view of the future requirements of the service. The important key point is that his/her manager has to be looking at the same statistics, and making the same provision; ultimately, senior

management have to back the plan right up to ministerial level, as the requirements are not going to change.

The necessity is for all managers, both senior and middle, to view the same picture. If not, they will always be at cross purposes. This diagram best illustrates the challenges leaders within the HSE face, but also forms a framework that will work once there is 'buy in' at all levels of the organisation.

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