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What, why and how of leadership and management standards in health and social care

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INTRODUCTION

The *Health and Social Care Review: Leadership for a Collaborative and Inclusive Future*, by Messenger and Pollard, reviewed the state of leadership and management in the National Health Service and social care.¹ The review was published in June 2022, and stated that effective leadership and management needed to become embedded and instinctive across the workforce to drive the improvements needed.¹

While highlighting areas of ‘outstanding practice’, the review also identified areas ‘where change and improvement are necessary’.¹ The authors stated that ‘although excellent in some instances’, leadership and management training and development ‘is not based on any consistent or agreed universal standards’.¹ Messenger and Pollard, therefore, recommended their introduction. Indeed, this is not the first time that such a recommendation has been made. Rose in 2015 highlighted the need for a body to set and maintain management standards.² What, then, might this recommendation mean in practice?

The development of effective ‘training bundles’¹ to meet these standards rests on a clear understanding of three questions: first, what are standards? Second, why do they matter? And third, how could they be created? We aim to answer these questions, and in doing so we seek to advance leadership and management education and work-based practice for health and social care.

WHAT ARE STANDARDS?

Standards are viewed as ‘the means by which the model of competence is specified in the current occupational context’ (p.26).³ This suggests that standards should be precise statements which describe what is needed for effective performance.³ In practice, examples include procedures to be followed, time taken and levels of quality.³ They can also be considered as the minimum levels that need to be achieved.³

Standards for leadership and management

Standards for leadership and management in health and social care pose a particular challenge as the occupational context is highly variable and our understanding of what is acceptable (eg, in terms of knowledge or behaviour) can vary depending on a multitude of factors.

To elaborate, a literature review found over 90 dimensions that may constitute leadership.⁴ Among the many, variables ranged from people who direct,

to people who serve; and from people who focus on their self, to people who facilitate others.⁴ The situational theories of leadership also identified the environment as an important consideration for what leadership traits and behaviours are most effective.⁵

Now, more contemporary theories have added even greater complexity to the landscape. Some have started to explore leadership through the lens of systems and networks, suggesting that leaders need to enable adaptive spaces.⁶ Others have started to look at leadership ethics, focusing on values and morals.⁷ The focus on space and virtuousness, rather than behaviour, task or environment are deviations from what has come before.

This suggests that there is a wide array of ever-evolving knowledge, skills and behaviours that leaders and managers could do to be effective, but what these specifically are and the exact level they need to be exhibited at, are likely to be dependent on the appropriate analysis of self and context (including networks, systems, environment and space).

A definition

Having taken the above into account, we propose the following definition for standards for leadership and management:

The level of demonstrable knowledge, skill, awareness, and/or qualities a person, or group of people should achieve to uphold performance in their unique context.

This means that a standard may relate to the level of one or more elements including knowledge (eg, evidence of understanding), closed skills (eg, performance of a task), awareness (of self, others and/or environment), and qualities (eg, values). In real-world settings, these elements could combine to result in behaviours at work, that themselves could also become standards. In health and social care, performance may be quality-related outcomes,⁸ such as safety, effectiveness and patient or staff experience.

This definition then has a consequence on how standards need to be developed, and perhaps more importantly, continually evolved. For instance, it suggests that they need to be informed by work which is contextually relevant and not diluted by work which is not, with codesign involving those who are expected to demonstrate the standards.



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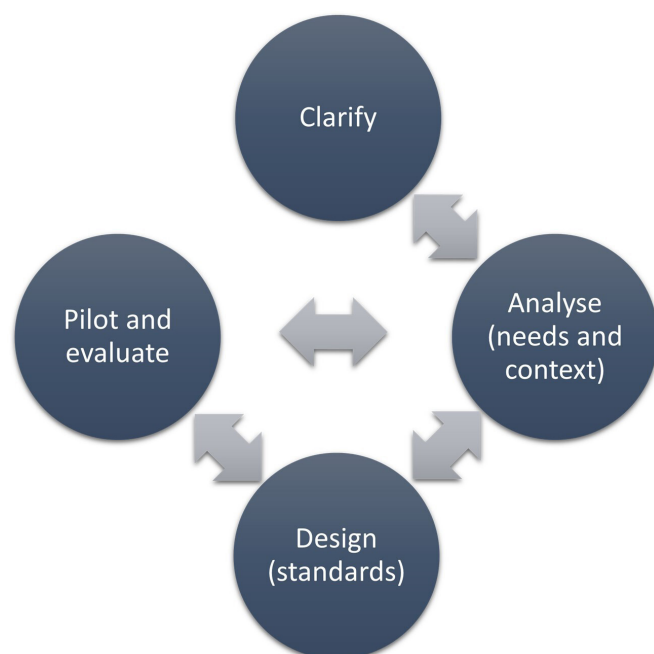


Figure 1 Illustrates a dynamic and cyclical process to developing standards including the phases of: clarify, analyse, design, pilot and evaluate.

Why might standards for leadership and management be helpful for health and social care?

Considering that standards are intended to be precise statements that are needed for effective performance³, an individual, or group, attaining and maintaining standards in health and social care should help themselves and/or others meet staff and patient-orientated outcomes. This is because standards should provide clarity on what level of performance is expected and may contribute towards eliminating unwanted variation.⁹ Those who reach the standards set would likely then have the greatest opportunity to act appropriately (eg, effectively, efficiently, safely) in the circumstances they find themselves.

HOW CAN STANDARDS BE CREATED?

Below, we suggest an approach to creating standards for leadership and management in health and social care. We suggest that this process is not seen as linear, instead it should be seen as dynamic and cyclical (see figure 1). This will enable the standards to keep up with environmental changes and evolutions in the leadership and management landscape.

All phases require widespread workforce involvement, including those to whom standards will apply, as well as their peers and colleagues. Critical appraisal of literature, relevant to health and social care, could also be used to inform primary research. Transparency and robustness are very important to ensure the process can be replicated, critiqued and if needed, improved. The breadth and depth of this work should be proportional to the considerations raised in each phase.

Clarify: articulate why standards are needed and who the standards are for

To begin this process, one must clearly understand the reasons why standards for leadership and management are needed and to whom they will apply. Outcomes that standards are expected to contribute towards should be identified and evidence for how standards will help these be realised must be communicated.

These elements are the basis for all subsequent phases. Crucially, this phase will support political and practical engagement with relevant stakeholders. Failure to clearly articulate the answers to this phase could negatively impact the relevance and quality of standards produced and prevent their adoption across the health and social care sector.

Analyse and design: conduct a needs and situational analysis to understand what is required to deliver important health and social care outcomes

The knowledge, skills, awareness and/or qualities required to deliver the outcomes identified in phase one must be known so they can inform the standards. The quality of a standard is dependent on the correct elements being used to inform it.

Simultaneously, we suggest contextual understanding be brought to the fore. This requires in-depth understanding of where and how successful leaders and managers (ie, those that can evidence their contribution to meeting outcomes) achieved success.

Where standards do not just apply to one specific group, they must be layered to make them applicable to everyone identified in the preceding phase as being integral to the achievement of the intended outcomes. This may be based on factors including profession, levels of seniority and/or their extent of influence. The level of knowledge, skill, awareness, qualities and contextual understanding to be demonstrated could differ depending on the layer of standard. For example, senior leaders may be required to demonstrate greater breadth and depth than those who are more junior. Everyone within the hierarchy must meet a standard that contributes to the overall outcome, and their role should be measurable through evaluation.

Pilot and evaluate: check that the standards are attainable, measurable and have positive consequences

The aim of this phase is threefold. First, to check that standards are attainable for all they will be applied to. This means that any pilot will require a representative sample. Second, to explore the extent to which the standards can be objectively measured and if not, then understand what the most accurate assessment methods would be. Lastly, to analyse the consequences of the standards being introduced and met - to understand its influence on the outcomes identified in the 'clarify' phase, as well as any additional unintended consequences.

CHALLENGES AND FUTURE DIRECTIONS

Depending on the purpose of the standards, their introduction will likely mean that a mechanism is needed to identify when they are being enacted (and when they are not). Any measurement should strive to be accurate and fair. It should also not reinforce a blame culture, nor should it be too onerous to an already pressured workforce. Instead, the approach should be compassionate and developmental, while also quickly eliminating practices that have negative consequences. However, the extent to which knowledge, skills, awareness and/or qualities of a person or group can be measured in these ways is still unclear. Further research needs to identify what this assessment might look like in practice. This could be informed by exploring how this is done with existing standards elsewhere and how it can be improved.

Standards without training and development alongside them could be difficult to achieve and maintain. New programmes may need to be developed or existing programmes may need to be aligned to the standards to ensure the expected elements (ie, knowledge, skill, behaviours) can become embedded into health

and social care. This could result in considerable financial costs, meaning that robust evaluation, dissemination of findings, and use of insights will be of utmost importance.

Finally, there is a lack of research on how standards have been previously developed for leadership and management in health and social care. Indeed, the process in this paper is theoretical and has not been tested. Therefore, more research is needed to share lessons on what processes work, and we encourage people to share their expertise and experiences to inform practices in this area.

CONCLUSION

A definition for standards in relation to leadership and management has been proposed. Their introduction could have a range of potential benefits, principally, to minimise unwanted variation which could lead to better outcomes. However, leadership and management, and the health and social care landscape are complex, meaning that our understanding of what works is constantly evolving. This suggests that to develop standards well, extensive input from the workforce could be key, and they also need to be fluid and able to change.

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