Cronfa - Swansea University Open Access Repository

_____

This is an author produced version of a paper published in:
British Journal of Hospital Medicine

_____

Cronfa URL for this paper:
http://cronfa.swan.ac.uk/Record/cronfa39267

_____

_____

http://www.swansea.ac.uk/library/researchsupport/ris-support/

Inclusive and person-centred leadership: Creating a healthcare culture that involves everyone

Dr Maslah Amin, GP Registrar, Health Education East of England (Welwyn Garden City), Care Quality Commission Specialist Advisor, National Medical Director's Clinical Fellow

Dr Alex Till, Psychiatric Core Trainee, Health Education North West (Mersey), Leadership and Management Fellow, Mersey Care NHS FT, Honorary Clinical Senior Lecturer, Swansea University Medical School, National Medical Director's Clinical Fellow 2016–17

Professor Judy McKimm, Professor of Medical Education and Director of Strategic Educational Development, Swansea University Medical School, Swansea UK, SA2 8PP

Corresponding author: Dr Maslah Amin (m.amin@doctors.org.uk)

The authors have no conflicts of interest to report.

This article summarises the findings from a literature review into inclusive and person-centred leadership and discusses its relevance to clinical leadership and healthcare settings.

Abstract

Contemporary leadership theory is based on the dynamic processes that occur between leaders and followers. One such theory is inclusive leadership, which is a person-centred approach that focuses on the empowerment and development of followers. It has roots in other leadership theories such as transformational leadership, but there are distinguishing features. This review discusses these features and presents a case study. Inclusive leadership is also viewed in the context of diversity, organisational culture and innovation. This is then further explored in regards to the diverse workforce of the NHS, with particular focus on the black and minority ethnic (BME) groups.

Introduction

Most discussions about leadership focus on the high-ranking 'senior' leader: with a focus on their personality, actions, behaviours, impact and styles. The importance of the individual senior leader (e.g. a consultant or chief executive) is undoubted, both as a figurehead and where

ultimate accountability resides. Contemporary leadership theory however describes leadership not as a process of one way influence (leader to those who follow) but as a complex dynamic process in which multiple leaders and followers co-exist and influence one another. This perspective sees leadership and change processes as emerging through networked forms of communication, relationships and influence. If leadership is viewed like this, then traditional leadership approaches and styles (such as heroic leadership or 'command and control' leadership) are largely inappropriate, particularly when organisations are complex and in constant flux. Health services are hugely complex systems comprising multiple 'actors' who can behave in unpredictable ways. If leaders are to have influence in such systems then they need to be aware of how their organisation functions within the larger system and utilise appropriate leadership approaches. We suggest that an inclusive, person-centred approach which acknowledges the strengths of a diverse 'followership' is highly appropriate to leading in contemporary health services. This article summarises the findings from a literature review into inclusive and person-centred leadership and discusses its relevance to clinical leadership and healthcare settings.

The broader leadership context

The concepts of inclusive and person-centred leadership are relatively recent but they have roots in other leadership theories, some of which have been highly influential. One of these is transformational leadership, a concept introduced by Burns (1978) who was one of the first writers to direct attention away from a focus on the actions of leaders towards assessing the impact of followers. Other writers have further developed the concept of transformational leadership (e.g. Bass and Avolio, 1990), but essentially transformational leadership is based on achieving change through connecting and building a relationship with followers. Leaders identify and exploit the agenda of a potential follower through role-modelling acceptable behaviours, and motivating and inspiring followers to achieve higher-order goals. Whilst the focus is on how the leader can best spur their followers on to effect planned changes, it is a person-centred approach that empowers followers and promotes them to becoming leaders. Burns' work gave more attention to followers and the affective (emotional) aspects of leadership. His assertion that leadership is inseparable from

followers' needs has greatly influenced leadership research, and many studies have since shown significant relationships between transformational leadership and positive outcomes (Lowe et al., 1996, Eisenbach et al., 1999, Cavazotte et al., 2013, Sun and Henderson, 2016).

It is also evident that effective followers support their leaders and contribute to achieving such positive outcomes. Whilst the followership literature is receiving more attention in contemporary research, (e.g. Malakyan, 2014; Martin, 2015) the numbers of studies are small compared to those on leadership. A key feature of discussions on transformational leadership and followership is the importance of building and maintaining effective relationships. Other theories and concepts such as servant leadership (Greenleaf, 2002); relational leadership (Uhl-Bien, 2006); collaborative leadership (West, 2017) and collective leadership (West et al., 2014), also focus on the importance of the leader-follower relationship which enables people to work collaboratively to achieve shared goals. Of course it is important that leaders and followers must complete various tasks in the process of achieving goals, but is it vital to pay equal (if not more) attention to understanding the views and needs of the people involved, actively drawing on the diversity and richness of different perspectives, backgrounds and experiences. This is where a person-centred and inclusive leadership approach can add value to the leadership repertoire.

Person-centred leadership

Whilst much of the leadership literature implicitly focuses on the involvement of individuals, the literature on 'person-centred leadership' as a discrete concept is limited. A person-centred approach is where the leader builds a shared vision, ensures regular and intentional engagement, understands and works from their strengths, and enables others to compensate for weaknesses. Person-centred leaders are those who understand the psychological aspects of human values, aspirations and needs (Plas, 1996, Plas and Lewis, 2001). These leaders promote empowerment, individuality, creativity and self-leadership. Drawing from some of the literature cited above, West (2017) promulgates the ideas of collaborative and compassionate leadership as central to creating and sustaining a healthcare system that meets the needs of both patients and staff. The overarching idea is that by optimising the individuals you optimise the organisation.

The emergence of inclusive leadership

Globalisation has produced increasingly diverse workplaces and leaders now have to work with teams of followers with different values, needs and skills. In all cultures and contexts, certain groups are subject to prejudice and discrimination, whether this is overt (as in racism or sexism) or more subtle (e.g. being marginalised in meetings or consultations). A growing body of evidence identifies that tapping into diversity improves organisational performance (Horwitz and Horwitz, 2007, Herring, 2009, Hewlett, 2013, Deloitte, 2013, Devillard et al., 2016). The positive effects of diversity are attributed to increased innovation because a diverse team provides a range of perspectives and thus is likely to outperform a team of like-minded individuals (Page, 2007). All individuals in diverse teams need to be able think freely, express themselves and contribute ideas that are valued. However, research shows that over half of leaders are unappreciative of ideas that they do not personally relate with (Hewlett et al., 2013). Through their behaviours and actions, leaders therefore need to create an inclusive environment so that they can capitalise on the potential of each follower in a diverse team.

Inclusive leadership is a person-centred style based on the following 5 principles:

(1) building mutually beneficial relationships – though collaboration and partnership

(2) doing things *with* people rather than *to* them - the essence of inclusion

(3) incorporating leadership activities into the roles of followers – to help develop people's skills and experience

(4) avoiding leader-centric approaches – the leader is not the whole focus

(5) actively addressing conscious and unconscious biases – through awareness raising, training and development.

Other similar leadership approaches include distributive (Bolden, 2011), shared (GMC, 2012) and democratic leadership (Goleman, 2000) but inclusive leadership has a key distinguishing feature which is a consideration of biases which can adversely affect the relationship a leader forms with a follower. As with person-centred leadership, the research

on inclusive leadership is still in its infancy. Despite the large body of research on organisational inclusivity, as a theory, inclusive leadership is yet to be fully modelled, and the studies discussed here do not offer a consistent definition.

The book, Inclusive Leadership: The Essential Leader-Follower Relationship, by Hollander (2009) reviewed the literature on inclusive leadership. Hollander (2009) explains the importance of engaging followers in a dyadic relationship based on the principle of "doing things **with** people, not **to** people", stating the need for authenticity, fairness, interpersonal evaluation and upwards influence. He relates inclusive leadership to Burns' (1978) transformational leadership concepts discussed above and describes how inclusive leaders lead through the relationships they foster with followers, rather than their positional authority.

Inclusive Leadership in Action – *A Case Study*

Within the NHS, and mental health care in particular, co-production (Realpe and Wallace, 2010) is on the rise. Services should no longer be designed by the leader, for they are not the focus. They should instead be designed *with* rather than *for* service users, and through processes such as 'Design Thinking'(Puttick, 2014), inclusive leadership is epitomised. Embracing diversity, collaborative relationships are built between not just experts by profession but experts by experience. This allows a focus on both what the proposed service user needs and also, crucially, what they want. Over a series of workshops teams are delegated leadership activities to model both 'common' and 'complex' patient presentations from which service prototypes are created. There is no hierarchy, the power is shared, and all are considered equal by the leader. There is a mutual trust, respect and commitment from those involved. Existing biases such as the over-representation of people from black and minority ethnic groups detained under the mental health act in forensic services are not shied away from, but actively addressed, with further unconscious bias minimised due to the range of stakeholders involved. Of course, there is more ambiguity and more risk, there needs to be a tolerance of failure but with the right organisational support, there is an opportunity to create a more thoughtful and person-centred approach to services.

Inclusive leadership as a positive approach

The concept of inclusive leadership was first linked with psychological safety: the sense of being able to express one's true self without the fear of negative consequences (Kahn, 1990). Nembhard and Edmondson (2006) coined the term 'leader inclusiveness' and assessed how leaders used words and deeds to create an inclusive environment in neonatal intensive units. They describe leader inclusiveness in terms of the leaders' words and actions that invite and show appreciation for others' contributions (Nembhard and Edmondson, 2006). Their findings show that leader inclusiveness leads to increased quality improvement work. This was attributed to the increased psychological safety that develops

in team members when led by an inclusive style. They also argue that when people feel psychologically safe they will attempt innovation, be open for feedback, challenge systems and contribute ideas (Nembhard and Edmondson (2006). Two further studies show how an inclusive approach links with psychological safety. Carmeli et al. (2010) studied inclusive leadership as an extension of relational leadership. They describe it as a style that focuses on "openness, accessibility, and availability in their interactions with followers" (Carmeli et al, 2010, p. 250) and demonstrate that increased psychological safety leads to greater creativity among followers. Hirak et al. (2012) find that increased psychological safety supports learning from failures and improved work performances. An inclusive approach which enables psychological safety appears to encourage the development of Kelley's (1988) 'effective followers'.

Another perspective is offered by Nishii and Mayer (2009) who studied inclusive leaders in terms of leader-member exchange (LMX) and turnover within groups. LMX is a measure of the quality of the dyadic relationship between leaders and followers. The model specifies that leaders form unique relationships with their followers. Poor relationships do not go beyond the basics of salary and job specification, whereas optimal relationships are social and characterised by trust, respect and commitment (Graen and Uhl-Bien, 1995). Evidence shows that a high mean LMX score improves inclusivity through elements such as effective power-sharing (Hollander, 2009), equity and reduced hierarchy (Scandura, 1999) and lower conflicts (Boies and Howell, 2006). The use of turnover as an outcome of diversity is based on the associations of turnover and diversity in the literature. Nishii and Mayer (2009) showed lower rates of turnover in diverse teams where there was a high LMX score between the leader and all the followers, concluding that inclusive leaders improve staff retention.

Overcoming unconscious bias

Bias is a prejudice for or against, a person or group as compared to others. It can lead to disadvantaging or advantaging people or groups, unfair practice and negative or positive discrimination. Personal characteristics (which do not necessarily affect the job someone does) such as ethnicity, gender, age, social class, religion, and disability can be subject to

bias, as well as other more subtle biases around attributes such as accent, weight, height, name, dress, tattoos, piercings etc. Biases can be held by individuals or groups and present as either conscious or unconscious. Unconscious biases can perpetuate social stereotypes we hold outside our conscious awareness. These stereotypes arise from mental associations the mind forms from external stimuli about different groups of people (Staats et al., 2016). When the mind perceives a certain characteristic from a group of people it creates an identity, which it then starts to unconsciously associate to anyone from the group, irrespective of the reality, such as thinking about nurses as women, surgeons as men, or chief executives as tall, mature, white men. Unconscious biases begin to form in childhood (Dunham et al., 2008) from parents, teachers and the media. Implicit bias is broadly the same as unconscious bias and the term is often used interchangeably. We all have unconscious biases, which arise from our culture and experiences, and because they are deeply ingrained they underpin our immediate, automatic responses to other individuals and groups, or to situations. Whilst some biases lead to negative perceptions or behaviours, because humans inherently tend to like people that are similar to them (Christakis and Fowler, 2014), this can also affect work relationships. If leaders are unaware of these biases, then in-groups (those similar to the leader, who the leader likes and trusts) and out-groups (those who are different in some way and thus become marginalised) can form within a team. Inclusive leadership therefore aims to surface these biases and assumptions about people and instead value diversity and difference rather than similarity and like-minded people (McKimm and Wilkinson 2015).

The effects of unconscious bias can be suppressed (Rudman et al., 2001, Monteith and Mark, 2005, Plant and Devine, 2009, Devine et al., 2012, Teal et al., 2012). This is mainly achieved through education which raises awareness of biases so individuals can actively suppress them and modify their behaviours accordingly. Alongside legislation which provides a framework for action and redress for those who are discriminated against, the organisation and team must also promote an inclusive and unbiased, welcoming culture. Evidence has shown that women (Moss-Racusin et al., 2012) and ethnic minority groups (Wood et al., 2009) are still disadvantaged due to unconscious bias. In 2014, Google attributed their lack of diversity to unconscious biases and is actively addressing it (Bock, 2014). Leadership relies on effective relationships between leaders and followers and

unconscious biases can sabotage this and create inequalities within teams. The modern workplace is increasingly diverse, and if a leader is unaware of their unconscious biases they can express prejudiced behaviours and attitudes, even though they may think they are unprejudiced.

Inclusive leadership and the NHS

Diversity does not necessarily mean that a culture is inclusive, and the NHS is a good example. The NHS was launched in 1948 and with 1.7 million employees it ranks fifth in the world's largest employers (Taylor, 2015). A number of issues have been identified in terms of how various groups are treated in the NHS. A staff survey showed that some NHS staff with disabilities reported lower job satisfaction compared to those without disabilities (Ryan et al., 2016). Women continue to experience inequalities (McKimm et al., 2014). In medicine they face challenges in career progression (Jefferson et al., 2015), remuneration (Rimmer, 2014), and in the wider NHS despite making up the majority of staff (77%) women are under-represented in senior roles (Women in NHS Infographic, 2014). Another group that faces equality challenges in the NHS is the black and minority ethnic (BME) employees and this analysis focuses on their suboptimal treatment and opportunities. In response to growing evidence, the Workforce Race Equality Standard (WRES) was developed in 2015 (Kline et al., 2017). The WRES is based on 9 workforce equality indicators against which NHS organisations are mandated to demonstrate progress. The indicators assess diversity and differences in treatment and experiences of white and BME staff.

Key findings from the 2016 survey indicate that:

- NHS boards lack diversity
- White short-listed applicants are 1.57 times more likely to be appointed
- BME staff are more likely to face disciplinary action and negative treatments from other staff (e.g. discrimination, bullying and harassment)
- BME staff are less optimistic about opportunities (Kline et al., 2017)

These statistics do not reflect an inclusive environment. Low staff morale is another challenge in the NHS and it is a risk to patient safety (Gilliland, 1997, Beyea, 2004, Rimmer,

2016, Rimmer, 2017). The WRES has raised the awareness of the disparities between white and BME staff and the poor statistics will arguably further dishearten BME staff. In a cross-sectional study, Dawson (2009) found a strong correlation between discrimination against BME staff and low patient satisfaction scores, suggesting that discrimination impacts negatively on patient care.

Organisational culture

Increasing emphasis is placed on the importance of organisational culture for the effectiveness of healthcare organisations (Parmelli et al., 2011). Organisational culture is a system of shared values and beliefs that are expressed through the interactions and behaviours of individuals. Human behaviour varies across situations, for example people are expected to (and do) behave differently at a formal meeting from a social event with friends. With self-insight and feedback, we learn quickly how to behave in different cultural and social settings, however, when people behave inconsistently in a group they are likely to receive social sanctions such as being ignored or marginalised, being told off or excluded from a group. A good leader will help individuals to become more aware of their behaviours and the (positive or negative) impact on the rest of the group, whilst encouraging the acknowledging the positive and diverse contributions each member brings. Leadership is at the core of shaping the organisational culture, while the ensuing culture nurtures the type of leadership that develops across the different levels in the organisation (Bass and Avolio, 1993). The NHS needs inclusive leadership to shape an inclusive culture to improve the integration and progression of its BME and other staff. A lack of inclusive leadership could explain the WRES results. For instance, unconscious bias could be to blame for why shortlisted white applicants are more likely to be appointed and why BME employees are subject to worse treatment from colleagues. The fact BME employees believe their employer does not provide equal opportunities for career progression can be indicative of a number of issues such as not being valued, needs not being met, limited leadership responsibilities and poor supervisor relationships. If the performance of an organisation is optimised by optimising the individual, in healthcare organisations, person-centredness is patient-centredness.

With nearly a fifth of the NHS workforce of BME origin (Kline et al., 2017) an inclusive approach that would empower BME groups would in theory translate to better patient care. Inclusive leadership strives to tackle disparities through fair human resource procedures and processes. However, the perception of fairness ultimately lies with each individual (Brockner, 2006). Process fairness differs from outcome fairness (Brockner, 2006). It does not guarantee that everyone gets what they want. However, the practices of process fairness such as requesting and considering opinions, consistency and transparency in decision-making and implementing leadership with integrity are likely to limit any grievances. Lastly, in addition to an inclusive environment the NHS needs greater diversity at the board level. Research shows that organisations with the most diverse boards perform better (Barta et al., 2012). Homogeneity at the top can inhibit innovation because a unrepresentative board can limit the connection between leaders and subordinates (Hewlett et al., 2013). The lack of ethnic diversity of the NHS's senior leadership teams has been labelled "snowy white peaks" (Kline, 2014). Considering that innovation is a central theme in the Five Year Forward View (NHS, 2014) diverse and representative NHS boards may improve the engagement with its diverse workforce and capitalise on ideas.

Conclusion

Success is not only dependent on leaders. Effective followership contributes to organisational successes and leader-centric approaches can hinder this. Person-centred approaches encourage contribution from a range of diverse individuals and groups, and capitalises on their strengths. Inclusive leadership is a person-centred approach that empowers everyone to contribute, and actively addresses behaviours that limit inclusion. The modern workplace is increasingly diverse and organisations have to be inclusive. Diversity is a catalyst for innovation and inclusive organisation can exploit this. The NHS is one of the largest organisations in the world and the challenge of effectively integrating its diverse workforce can be assisted through an inclusive leadership approach.

Key points

- Leaders working in contemporary complex environments need to be able to tap into the diverse views, experiences and talents of their followers;

- Inclusive leadership has proven benefits in terms of staff satisfaction and organisational performance;
- An inclusive, person-centred, compassionate approach which values and rewards health workers leads to improved patient safety and satisfaction and stimulates creativity and innovation.

References

2014. *Women in the NHS infographic.* [Online]. Available: http://www.nhsemployers.org/~/media/Employers/Publications/Women-in-NHS-infographic.pdf [Accessed 22/12/ 2017].

BARTA, T., KLEINER, M. & NEUMAN, T. 2012. Is there a payoff from top-team diversity? *McKinsey Quarterly*.

BASS, B. & AVOLIO, B. J. 1990. Developing Transformational Leadership: 1992 and Beyond. *Journal of European Industrial Training,* 14**,** 21-27.

BASS, B. M. & AVOLIO, B. J. 1993. Transformational Leadership and Organizational Culture. *Public Administration Quarterly,* 17**,** 112-121.

BEYEA, S. C. 2004. Employee morale and patient safety. *AORN J,* 80**,** 1123-6.

BOCK, L. 2014. You don't know what you don't know: How our unconscious minds undermine the workplace. Official Google Blog. Available from: https://googleblog.blogspot.co.uk/2014/09/you-dont-know-what-you-dont-know-how.html.

BOIES, K. & HOWELL, J. M. 2006. Leader–member exchange in teams: An examination of the interaction between relationship. *Leadership Quarterly,* 17**,** 246-275.

BOLDEN, R. 2011. Distributed Leadership in Organizations: A Review of Theory and Research. *International Journal of Management Reviews,* 13**,** 251–269

BROCKNER, J. 2006. It's so hard to be fair. *Harv Bus Rev,* 84**,** 122-9, 150.

BURNS, J. M. 1978. *Leadership,* New York, Harper & Row.

CARMELI, A., REITER-PALMON, R. & ZIV, E. 2010. Inclusive Leadership and Employee Involvement in Creative Tasks in the Workplace: The Mediating Role of Psychological Safety. *Creativity Research Journal,* 22**,** 250-260.

CAVAZOTTE, F., MORENO, V. & BERNARDO, J. 2013. Transformational Leaders and Work Performance: The Mediating Roles of Identification and Self-efficacy. *Brazilian Administration Review,* 10**,** 490-512.

CHRISTAKIS, N. A. & FOWLER, J. H. 2014. Friendship and natural selection. *Proc Natl Acad Sci U S A,* 111 Suppl 3**,** 10796-801.

DAWSON, J. 2009. Does the experience of staff working in the NHS link to the patient experience of care? Aston Business School.

DELOITTE 2013. Waiter, is that inclusion in my soup? A new recipe to improve business performance.

DEVILLARD, S., SULTAN-SANCIER, S., DE ZELICOURT, A. & KOSSOF, C. 2016. Women Matter 2016: Reinventing the workplace to unlock the potential of gender diversity. Mckinsey&Company.

DEVINE, P. G., FORSCHER, P. S., AUSTIN, A. J. & COX, W. T. 2012. Long-term reduction in implicit race bias: A prejudice habit-breaking intervention. *J Exp Soc Psychol,* 48**,** 1267-1278.

DUNHAM, Y., BARON, A. S. & BANAJI, M. R. 2008. The development of implicit intergroup cognition. *Trends Cogn Sci,* 12**,** 248-53.

EISENBACH, R., WATSON, K. & PILLAI, R. 1999. Transformational leadership in the context of organizational change. *Journal of Organizational Change Management,* 12**,** 80-89.

GILLILAND, M. 1997. Workforce reductions: low morale, reduced quality care. *Nurs Econ,* 15**,** 320-2.

GMC 2012. Leadership and management for all doctors. General Medical Council.

GOLEMAN, D. 2000. Leadership that gets results. *Harvard Business Review,* 78**,** 78-90.

GRAEN, G. B. & UHL-BIEN, M. 1995. Relationship-based approach to leadership: Development of leader–member exchange. *Leadership Quarterly***,** 219–247.

GREENLEAF, R. K. 2002. *Servant Leadership [25th Anniversary Edition]: A Journey into the Nature of Legitimate Power and Greatness,* New Jersey, Paulist Press.

HERRING, C. 2009. Does Diversity Pay?: Race, Gender, and the Business Case for Diversity. *American Sociological Review,* 74**,** 208 - 224.

HEWLETT, S. A. 2013. How Diversity Can Drive Innovation. *Harvard Business Review.*

HEWLETT, S. A., MARSHALL, M., SHERBIN, L. & GONSALVES, T. 2013. Innovation, Diversity, and Market Growth. Center for Talent Innovation.

HIRAK, R., PENG, A. C., CARMELI, A. & SCHAUBROECK, J. M. 2012. Linking leader inclusiveness to work unit performance: The importance of psychological safety and learning from failures. *The Leadership Quarterly,* 23**,** 107-117.

HOLLANDER, E. P. 2009. *Inclusive leadership: The essential leader-follower relationship,* New York, NY, Routledge.

HORWITZ, S. K. & HORWITZ, I. B. 2007. The Effects of Team Diversity on Team Outcomes: A Meta-Analytic Review of Team Demography. *Journal of Management,* 33**,** 987 - 1015.

JEFFERSON, L., BLOOR, K. & MAYNARD, A. 2015. Women in medicine: historical perspectives and recent trends. *Br Med Bull,* 114**,** 5-15.

KAHN, W. A. 1990. Psychological Conditions of Personal Engagement and Disengagement at Work. *The Academy of Management Journal,* 33**,** 692-724.

KELLEY, R. E. 1988. In Praise of Followers. *Harvard Business Review,* 66**,** 142-148.

KLINE, R. 2014. The "snowy white peaks" of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England. Middlesex University Business School. .

KLINE, R., NAVQI, H., RAZAQ, S. A. & WILHEM, R. 2017. NHS Workforce Race Equality Standard 2016 Data Analysis Report For NHS Trust.

LOWE, K. B., KROECK, K. G. & SIVASUBRAMANIAM, N. 1996. Effectiveness correlates of transformational and transactional leadership: A meta-analytic review of the mlq literature. *The Leadership Quarterly,* 7**,** 385-425.

MALAKYAN, P. G. 2014. . Followership in Leadership Studies: A Case of Leader–Follower Trade Approach. *Journal of Leadership Studies,* 7**,** 6–22.

MARTIN, R. 2015. A Review of the Literature of the Followership Since 2008: The Importance of Relationships and Emotional Intelligence*. *SAGE Open,* 5.

Edwards, SL, Taylor, C, Greenhill, J, Sergio da Silva, A. 2014. 'Women and leadership in medicine and medical education'. Chapter in, Tsouroufli, M (ed) *'Gender, Career and Inequalities in Medicine and Medical Education: International Perspectives',* pp69-98, part of the 'Inequality at work' series. Emerald Publishing http://dx.doi.org/10.1108/S2051-233320150000002005

MONTEITH, M. J. & MARK, A. Y. 2005. Changing one's prejudiced ways: Awareness, affect, and self-regulation. *European Review of Social Psychology,* 16**,** 113-154.

MOSS-RACUSIN, C. A., DOVIDIO, J. F., BRESCOLL, V. L., GRAHAM, M. J. & HANDELSMAN, J. 2012. Science faculty's subtle gender biases favor male students. *Proc Natl Acad Sci U S A,* 109**,** 16474-9.

NEMBHARD, I. M. & EDMONDSON, A. C. 2006. Making it safe: The effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams. *Journal of Organizational Behavior,* 27**,** 941-966.

NHS 2014. Five Year Forward View. *In:* HEALTH, D. O. (ed.). London.

NISHII, L. H. & MAYER, D. M. 2009. Do inclusive leaders help to reduce turnover in diverse groups? The moderating role of leader-member exchange in the diversity to turnover relationship. *J Appl Psychol,* 94**,** 1412-26.

PAGE, S. E. 2007. *The difference : how the power of diversity creates better groups, firms, schools, and societies,* Princeton, Princeton University Press.

PARMELLI, E., FLODGREN, G., BEYER, F., BAILLIE, N., SCHAAFSMA, M. E. & ECCLES, M. P. 2011. The effectiveness of strategies to change organisational culture to improve healthcare performance: a systematic review. *Implement Sci,* 6**,** 33.

PLANT, E. A. & DEVINE, P. G. 2009. The active control of prejudice: unpacking the intentions guiding control efforts. *J Pers Soc Psychol,* 96**,** 640-52.

PLAS, J. M. 1996. *Person-Centred Leadership,* New York, SAGE.

PLAS, J. M. & LEWIS, S. E. 2001. *Person-centered leadership for non profit organizations : management that works in high pressure systems,* Thousand Oaks, Calif., Sage Publications.

PUTTICK, R. 2014. Innovation Teams and Labs: A Practice Guide. *Nesta*.

REALPE, A. & WALLACE, L. M. 2010. What is co-production? *The Health Foundation*

RIMMER, A. 2014. Why do female doctors earn less money for doing the same job? . *BMJ Careers*

RIMMER, A. 2016. Junior doctors' low morale is putting patients at risk, Royal College of Physicians warns. *BMJ,* 355**,** i6493.

RIMMER, A. 2017. RCP survey highlights workload, morale, and patient safety concerns. *BMJ,* 356**,** j1313.

RUDMAN, L. A., ASHMORE, R. D. & GARY, M. L. 2001. "Unlearning" automatic biases: the malleability of implicit prejudice and stereotypes. *J Pers Soc Psychol,* 81**,** 856-68.

RYAN, P., EDWARDS, M., HAFFORD-LETCHFIELD, T., BELL, L., CARR, S., PUNISKIS, M., HANNAH, S. & JEEWA, S. 2016. Research on the experience of staff with disabilities within the NHS Workforce: A joint report between Middlesex University and the University of Bedfordshire. Middlesex University Research Repository.

SCANDURA, T. A. 1999. Rethinking Leader-Member Exchange: An organizational Justice Perspective. *Leadership Quarterly,* 10**,** 25-40.

STAATS, C., CAPATOSTO, K., WRIGHT, R. A. & JACKSON, V. W. 2016. State of science: Implicit bias review. Kirwan Institute for the Study of Race and Ethnicity. Kirwan Institute for the Study of Race and Ethnicity.

SUN, R. & HENDERSON, A. C. 2016. Transformational Leadership and Organizational Processes: Influencing Public Performance. *Public Administration Review,* 77**,** 554–565.

TAYLOR, H. 2015. *Who is the world's biggest employer? The answer might not be what you expect.* [Online]. Available: https://www.weforum.org/agenda/2015/06/worlds-10-biggest-employers/ [Accessed 18.07.2017].

TEAL, C. R., GILL, A. C., GREEN, A. R. & CRANDALL, S. 2012. Helping medical learners recognise and manage unconscious bias toward certain patient groups. *Med Educ,* 46**,** 80-8.

UHL-BIEN, M. 2006. Relational Leadership Theory: Exploring the social processes of leadership and organising. *The Leadership Quarterly,* 17**,** 654-676.

WEST, M. Collaborative and compassionate leadership. Seventh Annual Leadership and Management Summit 2017 London. https://www.kingsfund.org.uk/audio-video/michael-west-collaborative-compassionate-leadership.

WEST, M. A., LYUBOVNIKOVA, J., ECKERT, R. & DENIS, J. 2014. Collective leadership for cultures of high quality health care. *Journal of Organizational Effectiveness: People and Performance,* 1**,** 240-260.

WOOD, M., HALES, J., PURDON, S., SEJERSON, T. & HAYLLAR, O. 2009. A test for racial discrimination in recruitment practice in British cities. Department of Work and Pensions