Putting service back into healthcare through Servant Leadership

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Abstract

Servant leadership theory is little reported on in NHS leadership development strategies despite clear alignment with the core values underpinning healthcare for all. This article reviews the key concepts of servant leadership and suggests that it should be viewed as a core leadership style for those working in healthcare organisations.

Introduction

Last year marked the 70th year of the UK National Health Service (NHS), a time for celebration, but also a year where the future and sustainability of the NHS are being questioned (NHS Improvement, 2018). Despite severe challenges and financial pressures, the founding principle that good healthcare should be available to all, regardless of wealth or status, is still extolled today. Those first foundations have evolved to form seven guiding principles and a set of core values enshrined within an NHS constitution, binding together the people it serves and the staff who work for it (Table 1) (Department of Health and Social Care, 2015). Service is a strong theme throughout the ethos of the NHS and reflects why many employees work within it.

Table 1: NHS Core Values (Department of Health and Social Care, 2015)

- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Working together for patients
- Everyone counts

Like any large organisation, the NHS has to deliver high standards of performance, across a complex organisation whilst implementing huge change. Leadership development has increasingly been the focus for tackling this and is recognised as vitally important for the future of the NHS (Kings Fund, 2011). Traditional leadership and management theories such as autocratic and pace-setting leadership (Goleman, 2000) have often been employed to achieve this in a target driven climate. These leadership styles are perhaps in contrast to those which might be expected from a public service organisation. The seven principles of public life include:

1. Leadership
2. Selflessness
3. Integrity
4. Objectivity
5. Accountability
6. Openness

7. Honesty (Committee on Standards of Public Life, 1995).

Whilst the 'principles' do not specify what leadership approach should be adopted, it seems appropriate that health leaders should adopt a style that reflects these principles, and whilst some of the principles are included in theories such as inclusive and transformational leadership (Bass and Bass, 2009) the principles are not integral to either theory.

In 2013, the Francis (2013) report outlined a number of failings. Key among them was a 'culture of doing the systems business - not that of the patients' and identified that those in positions of leadership had to integrate the essential shared values of the common culture into everything they do. This report and other recent high profile failings has led the NHS to reflect about what type of leadership is required to influence change in its organisational culture. As reported by The King's Fund, NHS leaders and advisers identified that shared, distributive and adaptive leadership should be adopted as a move away from the more traditional hierarchal and heroic leadership styles, asserting that leaders at all levels have a responsibility to ensure that the core purpose of the NHS is at the heart of what they do (The King's Fund, 2011; The King's Fund 2012). However, the authors suggest that servant leadership should be included alongside the more collective approaches as an essential leadership style, in order to ensure the core values of health care remain at the centre of all we do.

It seems somewhat surprising that servant leadership does not seem to be central within healthcare, particularly in the publicly owned NHS. However, because it was previously viewed as a philosophical model, with application extolled in religion, education and foundations (Greenleaf, 2002), it might not seem so relevant to a large, complex and turbulent healthcare organisation.

Current evidence and literature on the role and benefits of servant leadership in health care comes primarily from the United States. In these environments it is often evaluated in the context of actively seeking out methods for improving efficiency and reducing costs as opposed to wider benefits (Schwartz, 2002). However improved patient care, efficiency and cost savings are of equal benefit to a free at the point of delivery system, compelling a clear need to evaluate its concepts as a leadership theory within the NHS, an organisation with service at its heart.

Servant Leadership theory

The concept of servant leadership is longstanding, with references reaching back to Lao-Tzu from 570 BC., however, it was not until 1970 that Robert Greenleaf coined the management concept in his essay 'The Servant as a Leader'. Strongly based in ethical and moral principles it has a natural alignment with caring behaviours (Spears, 2010). A successful servant leader is one 'who achieves results for their organisations by attending to the needs of those they serve' (Greenleaf, 2002). A focus on the strength of the team, emphasis on trust and integrity and ensuring the needs of all its patients are served with equity, make the adoption of servant leadership in healthcare compelling.

The key principle of servant leadership theory is that the prime motivation for leadership is a desire to serve (Greenleaf, 1970). A survey of 45 NHS Chief Executives by the Health Services Journal reported 86% of chief executives cited 'making a difference to patients' as a reason for high job satisfaction (Pitcher, 2015). However, despite the increasing push towards doctors' engagement in leadership and management, many doctors see taking a leadership position as a specific move away from patient care, undermining the fundamental reason they joined the profession. Embracing the concept of servant leadership and servant organisations could provide the perceived missing link between health professionals' motivation for helping patients and undertaking a leadership role.

Spears (2010) identified 10 key attributes consistent with Greenleaf's writing on servant leadership. Subsequent analysis has suggested over 20 attributes that are linked with this topic (Table 2) (Stone et al, 2004). These attributes can be grouped together to assist with leadership development as either functional or accompanying. Many of these attributes (such as listening, trust, honesty, and integrity) are already expectations for all doctors, as set out in the General Medical Council (GMC) Duties of a Doctor (2013) and are also representative of how society expects public office leaders to behave, with similarities to those laid down in the 7 principles of public life (Committee on Standards in Public Life, 1995).

Table 2: Servant Leader attributes (From Stone et al, 2004)

Functional	Accompanying
• Vision • Honesty • Integrity • Trust • Service • Modelling • Pioneering • Appreciation of others • Empowerment	• Communication • Credibility • Competence • Stewardship • Visibility • Influence • Persuasion • Listening • Encouragement • Teaching • Delegation

Vision

Vision is an important component of many leadership models including Kotter's (1996) 8-step model of change and the terms 'foresight' and 'conceptualising' are used to describe this attribute within servant leadership. The benefit of servant leadership in vision development is the central role that followers, and not leaders, occupy which led to the theory being criticised as being soft and not outcome focused, an important requirement in a target driven, competitive landscape. For this reason, whilst previously rarely used at a whole organisation level, there are now well-documented examples of success in corporate organisations (Ellis 2004; Bull *et al* 2018).

In health care, reported improvements in nurse job satisfaction following the introduction of servant leadership were linked strongly to increased patient satisfaction (Neubert et al, 2016). However when creating a vision with followers at the centre, it is important for leaders to remain cognisant of who is being served, and ensure the result is not improving staff satisfaction to the detriment of patients.

The NHS Healthcare Leadership Model (2015) also places emphasis on vision with dimensions of inspiring shared purpose and sharing the vision. Combining servant leadership theory and the Healthcare Leadership model should allow leaders at any level to ensure that the core values of the NHS remain central, from a ward based front-line project through to large organisational change. Progression, unlike in the Healthcare Leadership model, may be harder to determine using a servant leadership approach alone. This could potentially result in difficulty in providing the evidence of individual competency often required for annual career reviews because the focus of a servant leader is about improving and developing others, rather than the leader's own development.

Honesty, integrity and trust

Honesty, integrity and trust are central components of Greenleaf's theory and must be present in order for success as an authentic servant leader (Stone et al, 2004). These are also reflected in professional standards for health workers and are essential for building organisational trust. Leaders must learn to align the reputation of the organisation with their personal values. The current public perception of the NHS is changing with a 6-percentage point drop in 2017, although quality of care is still the top reason for satisfaction (The Kings' Fund, 2018). Whilst the underlying principles of the NHS continue to have unwavering support, this fluctuating satisfaction has a resulting impact on leaders, causing frustration at measures such as funding and reform that are outside of their control. The adoption of aspects of servant leadership will help to ensure the focus remains on the patients and communities being served, but in doing so may create difficulty for leaders battling external pressures and focus.

Communication for a servant leader is closely linked to integrity, trust and honesty. In a large complex organisation such as a hospital, communication and the visibility required can often be challenging and therefore actions can be as important as what is communicated. In order to achieve this, leaders need exceptional people skills. These skills are often developed early in the caring professions, aligning well with the ethical basis of this concept. Empowering individual leaders to model and emulate these behaviours should also align with the culture of health-care organisations.

Empathy, care and compassion

Empathy should be embedded as an essential component of a health-care organisation. However with increasing financial and demographic pressures and ever-more complex, turbulent organisations, it is easy to lose sight of the founding goals and values of the NHS: to serve the patient. A skilled servant leader should be able to understand compassion fatigue in employees and create a culture where empathy for each other and patients are at the centre of everyday work. Servant leadership appears to increase the satisfaction of employees, commitment and well-being and positively influences the performance of an organisation (Trastek et al., 2014). In this time of low morale and staff burnout, a servant leadership approach could help ensure all staff are valued and feel appreciated (Neill & Saunders, 2008).

Servant leadership's emphasis on collaboration and setting clear objectives to enhance the growth of individuals and increase teamwork all resonate with the King's Fund's (2011,

2012) urging for a new style of NHS leadership. Furthermore, there are clear similarities between the guiding NHS values and principles and Laub's (1999) six key areas of an effective servant-minded organisation: empowering and developing people; expressing humility; authenticity; interpersonal acceptance; stewardship, and providing direction. Compassionate and inclusive leadership is thought to impact on decreased bullying and undermining staff behaviours through empowerment (The King's Fund, 2017). Culture, leadership and management are now all being surveyed and assessed through General Medical Council surveys and Care Quality Commission (CQC) visits (CQC, 2018). Compassionate and servant leadership appear to be extrinsically linked with the same focus on followers. It is therefore perhaps somewhat surprising that servant leadership appears to not have a place in modern NHS leadership teaching, despite clear parity with the nine dimensions of the NHS Healthcare Leadership model (NHS Leadership Academy, 2015).

Stewardship

Both Greenleaf (2002) and Laub (1999) place strong emphasis on stewardship, the willingness to take care of the whole organisation, to look after something which is not yours, and to give it back in better shape than you found it. This shifts the focus from control and self-interest to service, and because it also requires social responsibility, resonates well with the reasons why people enter health professions: to make a difference. Whilst the stewardship or caretaking role of leaders can be empowering , because the NHS is a publicly funded organisation, political and economic decisions which do not act in the interests of patients can lead to anger and frustration in leaders who have to defend decisions which have been imposed upon them. Such strong emotions however can stimulate leaders to shift from an advocacy role for patients and communities to becoming more activist, using their own and the NHS's core values and beliefs to work politically to challenge decisions they feel are wrong in the interests of the patients and communities. The focus on values and serving others is one of the central strengths of servant leadership and servant leaders.

Implementing servant leadership

Whilst servant leadership involves role modelling by those with power and influence, shifting to a new leadership approach will need more than just role modelling. Appointment, reward and recognition systems (such as promotion criteria) need to be able to define servant leadership as essential and provide measures and examples of what is expected from employees (van Dierendonck, 2011). In the early stages of introducing what is a culture shift, the core tenets of servant leadership and expectations of what this means

in practice will need to be explained to staff and throughout the culture shift, examples of good practice should be shared and formally valued. In an organisation experiencing severe staff shortages, low morale and a retention crisis there is a current drive and willingness to embrace initiatives and models with employees at their centre and build feelings of belonging to a community. One way of implementing servant leadership is through establishing projects in the areas of staff engagement and wellbeing. Using servant leadership as a leadership approach (with its focus on building team strengths and service of colleagues) helps to provide authenticity and equip front line workers with the ability to make small changes with whole organisational impact.

The benefit to employees and employers should be mutual in servant leadership as a result of the emphasis placed on values, follower empowerment and need. Leaders following the guiding principles will ensure that they serve the needs of the followers when initiating change, thereby avoiding conflict between organisational need and employee outcome. Servant leadership is associated with favourable employee-related outcomes as a result of positive role modelling from the servant leader, and through increased value in the work environment. These outcomes include improved psychological safety, increased commitment to the organisation, and improved work engagement and job performance (De Clercq et al, 2014; Liden et al, 2014).

The value of servant leadership for healthcare organisations is that it can be scaled up or down, thus changing the culture within a workplace. Start with a senior nurse for example, who leads with a servant leadership style, and that role modelling will positively impact on the ward nurses who, in turn, will create a serving environment focused on the needs of their patients. A Chief Executive serving the needs of their followers will set the impetus for senior management to conduct their leadership similarly, with downstream impacts on their followers.

Challenges

With all leadership theories or approaches, there are challenges in embedding new concepts within an organisation, often requiring significant leadership resource and effort. Garber et al (2009) found differences between attitudes towards collaboration and servant leadership between nurses, physicians and residents. Nurses were found to be more positive about servant leadership, possibly due to the underlying or perceived values associated with a nursing role (caring, compassion, direct patient care etc.). Physicians were less positive in relation to both physician-nurse collaboration and servant leadership, possibly due to a

more traditional perspective of what leadership is and how it should be portrayed. With an increasing push for medical leaders this perception must be challenged in order not to create disparity between doctor and nurse leaders.

The danger of trying to promote collaboration and a voice for all within a large hospital is ensuring that listening does not become tokenistic. If it is difficult to engage with certain staff groups this could result in one staff group having a perceived preference over another. Ensuring the results of collaboration results in tangible, visible change or improvement is a further challenge. Carrying out a staff and patient survey and gathering information on various activities will give a benchmark against which future changes can be measured and some scales exist that aim to measure servant leadership (e.g. Reed *et al*., 2011). Promoting and sharing good practice about innovations and improvements made would help to disseminate the value of these activities and give wider recognition to the emerging servant leaders throughout the organisation. In the early stages, gaining some 'quick visible wins' (Kotter, 1996) will be important to start embedding the value of the new leadership approach in the organisational culture, so eventually servant leadership becomes 'the way we do things round here'.

Most leaders practice a combination of leadership approaches and styles, and this should also be the case with servant leadership. For example in an acute situation, this leadership approach will lack speed and collaboration may not be appropriate if 'command and control' is needed. However the personal attributes already displayed by a servant leader should command the respect to lead in a high-pressure situation. Conflict situations could also be viewed as a potential difficulty for servant leaders, but keeping the patient at the heart of decision-making can help lead people to compromise solutions. For servant leadership to work effectively there has to be commitment and dedication. For example, the longevity of Chief Executives is associated with increased performance, however most Chief Executives only stay in post for around two years (Pitcher, 2015). While the reasons for this are not fully understood, regulations and external pressures are key complaints. If NHS national leadership could also embrace servant leadership and shift focus to ensuring more positive experiences, more of the chief executives might stay for longer in their posts, which would positively impact across the whole NHS.

Despite the inherent serving nature of leadership in the NHS, this concept appears to not be well understood. Any introduction of new leadership theory results in change and a learning process, this can often make it difficult to implement and slow to penetrate an organisation.

However the concepts of service, compassion and inclusivity, whilst not specific to servant leadership, are increasingly being understood and promulgated. All staff can enact and create quick wins around some aspects of servant leadership and, whilst the overall culture will be slower to change, grassroots embracing of the concept will start to shift the focus of a board or executive leadership team.

Finally, self-reflection and awareness-raising is a key element of a leader understanding his/her own and the organisation's values, principles and beliefs (Trastek et al., 2014). This takes personal development time and is part of a process of developing self-knowledge. Servant leadership is not a quick change and this is likely to risk the role it can play. Many view servant leadership as a calling, which can be a disengaging idea for those coming into leadership roles later in careers and after clinical roles. This is not the case and should be seen as a further embracement and expression of the values, which all employees of the NHS already work towards.

Conclusion

The adoption of a servant leadership approach has many benefits for health-care organisations: aligning organisations to serve patients and one other, creating a caring work environment, and empowering for increased creativity and innovation throughout an organisation. Implementing a servant leadership approach throughout a whole organisation is challenging and it will need to be utilised alongside other leadership and management approaches. However, servant leadership provides a means to bring heart back into everyone's work and aligns with the founding principles of the NHS: to care for patients and communities through service.

Key points

- Service is a strong theme throughout the ethos of the NHS, enshrined the constitution and demonstrated by its employees.
- Health leaders should look to adopt a leadership style that reflects the core principles of the organisation in which they work.
- Servant leadership is not widely taught in health-care leadership but is an important missing theory with moral alignment to the increasingly recognised need for compassionate and inclusive working.

- Vision, integrity, trust, honest, empathy, care and compassion are essential components of the servant leadership concept.
- Servant leadership has many benefits for leaders and their organisations through the creation of a caring and innovative work environment with service at its centre.

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