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Implementing successful transformational leadership competency development in healthcare

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Purpose

Over the previous 20 years The Institute for Working Futures Pty. Ltd. has designed, authored and assisted implement industry, regional and organisational Capability Frameworks. Our approach will typically involve the integration of competencies derived from vendors and industry bodies that use inconsistent approaches. In recent years it has become clear than some academic experts and vendors of competency models have become more intransigent about the need to pursue one 'correct' competency model. This approach is creating confusion. It is neither helpful nor necessary. Multiple approaches to competency can reside within one organisational framework. This paper show how this can occur while dealing with a pressing need many of our clients have: to improve leadership while raising their readiness and capacity to change.

Key words

This study will traverse the very noisy issues surrounding **competencies**, **leadership development**, and **transformational leadership**. We will undertake a review of research and select literature and in so doing demystify the interrelationship between these topics. The result will be a more concise view on how to build a **transformational leadership competency development model**. The resulting model will be designed so any healthcare organisation can tailor it to their needs.

Introduction

Time, effort and scarce financial resources are being exhausted as healthcare organisations efforts to improve their capacity to change are being frustrated by the poor success rate of their efforts to raise the transformational competence of their leaders. With the advent of the Global Financial Crisis, healthcare organisations know they have to balance the risk of previous failures against the growing criticality of having leaders that can inspire others and champion change.

This paper will explore how healthcare organisations can successfully build transformational leadership competency frameworks. Examination will initially be made of the nature of change in healthcare and what a transformational leadership approach must encompasses. Study will then explore some of the myths that have caused the failure of many initiatives. By addressing the myths we will provide a viable approach any healthcare organisation can use to build a transformational leadership competency development framework while leveraging investment in existing competency and leadership development systems.

Why is transformational leadership important?

James MacGregor Burns writing in his book *Leadership* (1978) initiated the concept of "transforming leadership". To Burns transforming leadership "occurs when one or more persons engage with others in such a way that leaders and followers raise one another to higher levels of motivation and morality…" (1978:20). At its heart, transformational leadership is about appealing to and engaging people at an emotional level and inspiring trust, loyalty and respect. It is about building the cultural scaffolding that is pivotal to an organisation's capacity to change and achieve its desired future (Russell, 2006:125).

Transformational leadership is often considered to be an exclusive approach to leadership. It isn't. Effective leadership may, and usually will, require adoption of transactional or operationally-oriented leadership roles. Transactional leadership focuses on the physical and security needs of subordinates (Bass, 1995, Bass & Avolio, 1993). Transactional leadership approach places an emphasis on the leader:

- setting clear goals
- establishing performance targets for each individual and the team
- identifying performance gaps
- coaching the direct reports
- gaining commitment to performance and goals through pay, reward and recognition.

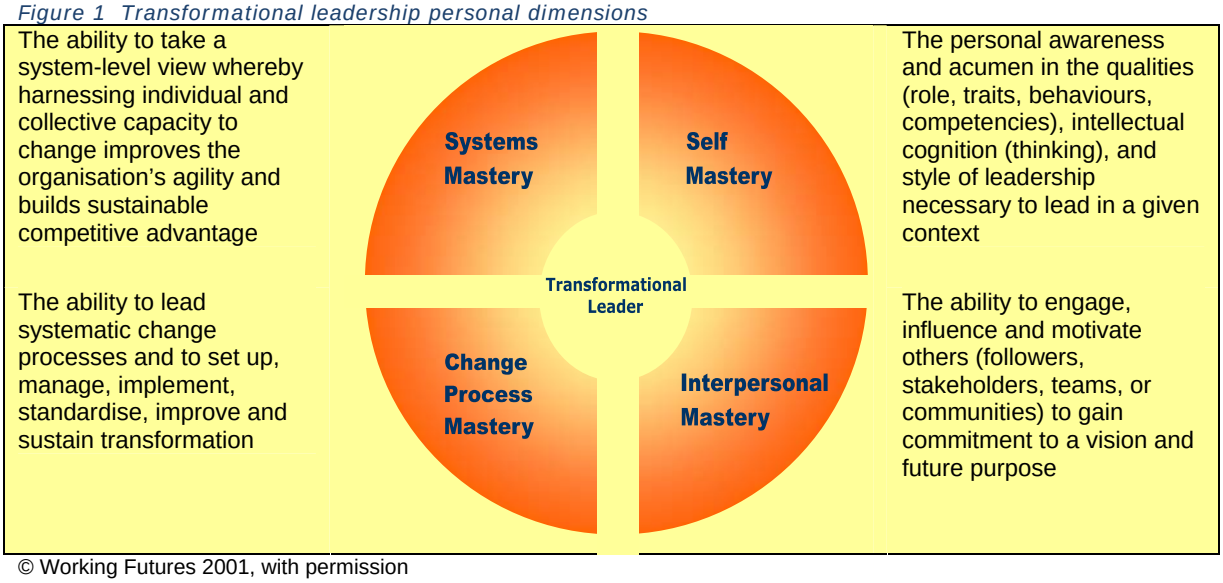
The 'full leadership range' concept proposed by Bass and Avolio (Avolio, 1997; Bass & Avolio, 2002 & 2004) suggests that transactional and transformational aspects may occur in the same person and leadership role. This infers that to be effective transformational leaders in healthcare competency development should not be just limited to transformational behaviours. It has to consider transactionally-oriented competencies.

Table 1 Comparison of transactional and transformational leadership (Covey, 1992)

Transactional leadership…	Transformational leadership…
builds on man's [sic] need to get a job done and make a living	builds on man's [sic] need for meaning
[is] preoccupied with power and position, politics and perks	is preoccupied with purposes and values, morals, and ethics
is mired in daily affairs	transcends daily affairs
is short-term and hard data oriented	is oriented towards long-term goals without compromising human values and principles
focuses on tactical issues	focuses more on missions and strategies
relies on human relations to lubricate human interactions	realises human potential—identifying and developing new talent
follows and fulfils role expectations by striving to work effectively within current systems	designs and redesigns jobs to make them meaningful and challenging
supports structures and systems that reinforce the bottom line, maximise efficiency, and guarantee short-term profits	aligns internal structures and systems to reinforce overarching values and goals.

At a personal level the development of transformational leadership should occur across all the main domains of transformational competence an individual leader will need to evidence. The four main domains are summarised below.

Figure 1 Transformational leadership personal dimensions



The nature of organisational change in healthcare

The disposition of healthcare organisations towards the transformational leadership model over the last decade has occurred for a few important reasons, all of which have been confirmed by recent research.

While many theories on leadership abound, the movement towards transformational leadership in healthcare has gained momentum since it has become clear a positive relationship exists between the effectiveness of transformations and leadership competence, especially with respect to clinical leaders (Iles & Cranfield, 2004; Mountford & Webb, 2009:1 & 3).

A review of literature and research on change in healthcare organisations confirms unique needs. Healthcare organisations are depicted as complex professional organisations with knowledge-based procedures and systems that support performance within an environment dominated by competing stakeholders' interests and priorities (McNulty & Ferlie, 2002:8-12, & 45; Fitzgerald, *et al*, 2006:29). Given parallels with other organisations these conditions make change very difficult to orchestrate and to lead.

Healthcare organisations are complex and interactions between structure, functions and people that will be impacted by and, in turn, affect change processes. Some of the characteristics or themes of change in healthcare organisations that have emerged include (Fitzgerald, *et al*, 2006:29; Greenhalgh, *et al*, 2004:35; Golden, 2006:11):

- Rapid policy and public sector regulatory frameworks affect the pace of change and the regularity with which it occurs
- Quality improvement requires credible leaders who can influence change
- Professionals hold a considerable amount of power in the change process and can directly affect change
- As complex systems healthcare organisations still have to adapt to change that is often ambiguous and uncertain
- Evidence and information required to support change needs to be valid and robust
- Readiness for change is often not measured or understood
- Complexity and uncertainty caused by having to managing multiple missions and multiple stakeholders

- Personal and professional autonomy needs to be balanced against organisational needs
- Ability of leaders to motivate others to engage the change process
- Collaboration or the concept called 'A Guiding Coalition' (Kotter, 1996:Chapter 4) between leaders and across functions can positively influence change.

The importance of clinical leaders with personal and leadership role competence

The role of leaders in healthcare organisations is complex. Roles at different levels of responsibility can be forged from a hybrid mix of clinical and managerial responsibilities. Research in the UK on the change capabilities of healthcare organisations has shown that, beyond their professional competence, individual healthcare leaders' successful contribution to change could be determined by their competence in two roles:

1. leading organisational outcomes; and
2. being a personal agent of change (Fitzgerald, *et al*, 2006:15).

The credibility and importance of clinicians in healthcare organisations has meant their engagement and championing of change will critically affect the success of any initiative (McNulty & Ferlie, 2002:151-3; Ferlie, *et al*, 2005; Fitzgerald, *et al*, 2006:15). This also included using competencies to address how different professional roles could be redesigned to accommodate leadership and change responsibilities. Research in both the UK and USA has reinforced the emphasis transformational leadership places on consultation and engagement at all levels of the organisation because it acknowledges the fact that:

> … hospitals and other health-care organisations have an inverted power structure, in which people at the bottom generally have greater influence over decision-making on a day-to-day basis than do those who are nominally in control at the top (Ham, 2003:1-2).

Yet improving transformational leadership attributes will have a positive impact on the satisfaction and performance of the workforce (Bass, 1985; Bass & Avolio, 1994; Conger, et al., 2000; Menaker & Bahn, 2008:987). This positive relationship has been found to endure for public, private and community healthcare organisations across the globe and for leaders from all major occupations, including clinical professions (Menaker & Bahn, 2008; Beinecke & Spencer, 2007; Calhoun, et al, 2008; Iles & Southerland, 2002; Fitzgerald, *et al*,2006; & Mountford & Webb, 2009).

Why transformations fail

Despite the imperative to build transformational competence, leadership development has become somewhat of a poisoned chalice for executives in the healthcare sector. This is because effort to develop the transformational competence of leaders has all too often been marked by the same failures as other change initiatives. The evidence of the failure and the benchmark for assessing transformational readiness can be summarised by loosely borrowing from factors John Kotter identified in his seminal article on "Why transformation efforts fail" (1995:59-67). Transformational leadership competency frameworks need to address, and in turn develop, leaders that can raise the organisation's ability to:

1. **Establish a sense of purpose and urgency**
   - Anticipate and eliminate any false sense of security
   - set standards of achievement that are high enough so as to make "business as usual" an insufficient response
   - broaden functional goals and their measurement against organisation goals
   - use feedback and external networks to clearly articulate performance requirements
   - make customer needs explicit and visible to the employee
   - reality test key concepts through external consultants and expert input
   - facilitate and encourage positive discussions, not just "happy talk"
   - build a shared future that all can identify with and want to achieve

2. **Create a guiding coalition**
   - navigate organisational politics
   - build sufficient intellectual horsepower to understand and implement change
   - build credibility and trust
   - overcome resistance
   - engage and build commitment
   - posses legitimacy and support from executive leaders or the board
3. **Develop and communicate a vision and strategy**
   - Be a role model for the values and behaviours being sought
   - make the vision simple
   - tie the vision to a metaphor people can immediately translate into everyday work
   - go beyond a written vision and ensure it can be communicated in multiple forums visible in every workplace
   - ensure the vision is shaped and grows through individual input
4. **Empower broad-base action**
   - removing barriers to action
   - give people time to make personal changes in thinking and practice
   - vest the authority and resources necessary for employees to really be empowered to act
5. **Generate short-term wins to build longer term gains**
   - set realistic goals
   - celebrate success but realise it is one step on a longer journey
   - make goals more aspirational as change competence improves
   - use external experts to set up the change plan that span the politics and biases of stakeholder groups
   - decentralise and empower leaders to make rapid gains
   - consolidate and leverage gains to produce longer term change
6. **Anchor new approaches in culture**
   - Ensure values reflect the culture and visa-versa
   - Tie core leadership competencies to corporate values
   - Align individual norms and beliefs with corporate culture
   - Communicate and allow the culture to grow through individual input
   - Ensure everyone has a sense of the underpinning purpose and values the organisation aspire toward in the future

If healthcare organisations increasingly understand the value of transformational leadership and we know what actions can improve the success of change initiatives, why have so many initiatives faltered?

The reason for the lack of momentum in improving the transformational competence of leaders can be attributed to three unnecessary actions.

Addressing the myths to implement an effective transformational leadership competency development framework within healthcare

The effort to improve transformational leadership has usually seen new, specific competencies being written. These competencies have then been laminated onto the existing leadership development and/or competency systems in the organisation. Unfortunately they have tended to add complexity to competency system while still being expensive to incorporate into existing leadership or talent development processes.

The design of the systems and competencies required to support transformational leadership development are subject to what we will classify as three myths:

1. Transformation leadership competencies require 'special' treatment within the organisation's competency and people management system
2. Transformation leadership require dedicated, new behavioural leadership competencies be written
3. Transformational leadership development frameworks cannot fit existing leadership and talent development processes unless major investment occurs in training or contracting specialist assessors

Myth 1: Transformation leadership competencies require 'special' treatment within the organisation's competency and people management system

In the public, private and community healthcare organisations there seems a universal propensity to base people and learning systems on standards of performance. The result is a preponderance of competency frameworks. Unfortunately, in the leadership field homogeneity in approach is rare and made more complex by professions that have distinct approaches to setting competence. Further compounding this situation is the fact competencies may span both behavioural competencies (about the person) and occupational competencies (about the role outcomes).

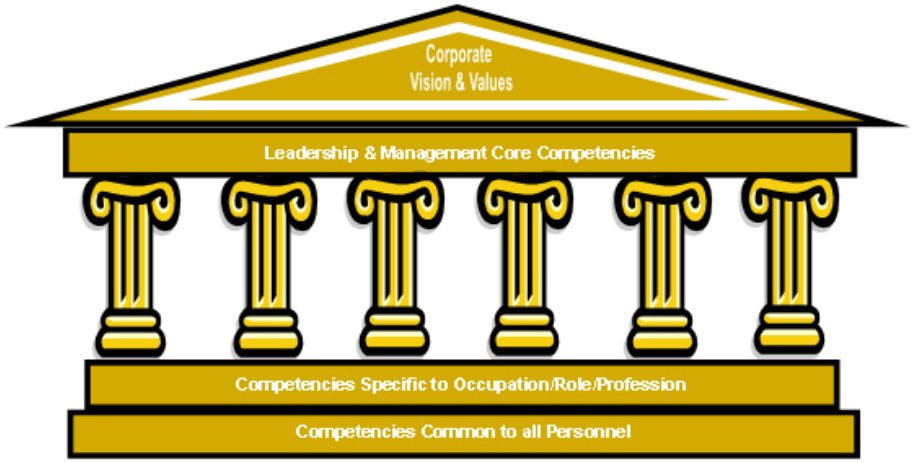
To avoid upsetting 'owners' of other professional or national competency dictionaries consultants developing competencies to address change management in healthcare organisations have pushed purpose-written, unique descriptors. While these are separate they are most often laminated over the existing competencies and competency models.

The separation of transformation leadership competencies from other competencies further exacerbates complexity and adds costs. It is unnecessary.

Transformation leadership competencies can be isolated within existing competency frameworks or added to the existing leadership and management core competencies.

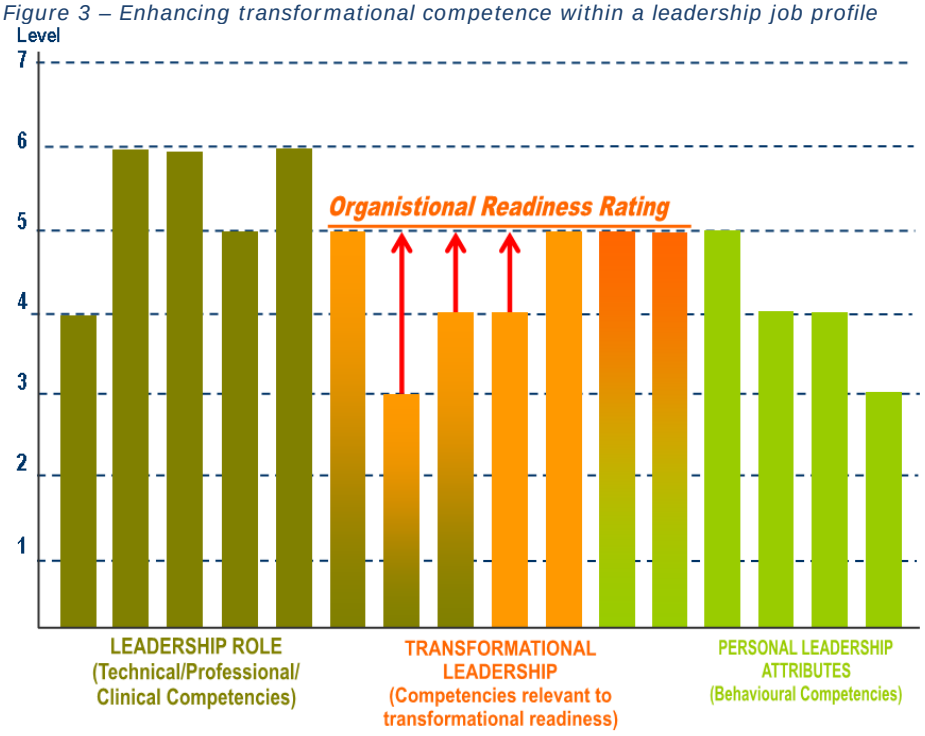
Examine the very general depiction of a standard organisational competency framework provided below (Figure 2). Transformational leadership competencies should reside in the Leadership and Management Core Competencies dictionary. As with other core leadership and management competencies, they must mirror and reinforce the organisation's core vision and values. Any profile of a leader (position, talent, etc.) would join the core competencies with competencies associated with their occupational and specialist roles (the two foundation steps in the pavilion model shown below). By way of explanation, a transformation core leadership competency would apply to all clinical leaders and potentially all other leaders. As may common competencies such as communication or IT skills. But the specific clinical competencies would be specific to their professional discipline or specialisation.

Figure 2 – Conceptual overview of an organisational competency framework



Development effort and especially rating individual competence can cover **all** relevant competencies within a leader's profile. Examine the image below. It shows a 'typical' profile for a Level 5 Clinician who is leading a function within a hospital. What is shown below are the leadership role competencies (common to leaders) and behavioural competencies relating to the person. In addition the profile could have 'technical - professional' clinical competencies related to the individual's professional body of knowledge. These are not shown but would be derived from the professional body (relevant College). All competencies would fit within the organisation's competency framework. The profile below shows some competencies have been identified as relevant to transformational practices or change.

Figure 3 – Enhancing transformational competence within a leadership job profile



For the leadership profile represented above, and typically, approximately half of the profile has competencies that impact transformational leadership. All except two have come from leadership role or personal competency dictionaries. Two were developed to specifically deal with change.

The "Organisational Readiness Rating" is the level set by the organisation as the benchmark for the effective implementation of change. This could be tied to Kotter's six aspects of organisational transformation competence or set at a desired level of competence. A level may be set for a specific competency or for a group of competencies. In the above scenario

the organisation has determined all leaders at Level 5 must hold identified transformational competencies to Level 5, even where they may not be required for immediate job performance. Individual competencies or all transformational competencies may then be targeted to ensure leaders (or anyone with the competencies in their profile) reach the desired level of proficiency. In the case above the profile has three competencies that have been targeted to raise the transformational readiness of the job incumbent, and thence the organisations to Level 5.

Transformational competencies can be targeted without independent, dedicated descriptors, or diluting or 'trading off' personal and professional competence.

Myth 2: Transformation leadership require dedicated, new behavioural leadership competencies be written

Healthcare organisations need to develop transformational leadership competencies that cover both how the individual behaves and the standards required when performing in a leadership role. As suggested earlier, both behavioural descriptors that deal with the person's competence and occupational competencies that deal with technical or professional competence can be addressed when building a transformational leader.

In the health sector a balanced approach should see the leader posses both transformational competencies that develop both their personal abilities in a given situation, and raise transactional competence to the required standard of performance. Transformational leadership competencies can and should have two layers:

Layer 1: Transformational leadership role competencies (occupational attributes)
Role competency being the skills and knowledge specifying the ability to perform particular tasks and duties to the standard of performance expected in the workplace
Layer 2: Transformational leadership personal competencies (behavioural attributes)
Personal competence being skills, knowledge and attitudes individual behaviours that indicate a level of proficiency in a given context

Transformational leadership competencies encompass two major sets of attributes:

> **Skills and knowledge attributes** may be demonstrated and assessed. Attitudes may be included where they relate to how the individual thinks and behaves. When attitudes cannot be tied to demonstrated performance they fall into the identity attributes category.
>
> **Identity attributes** are the sum of beliefs, motivations and traits embodied in the individual within a given context. The concept of identity encompasses behaviours including an individual's inner sense of self, their motivation, their social interaction, and traits such as how they think (cognition) and typically will react (McClelland 1973, 1976 & 1985; Raven, 1977; Boyatzis, 1982; Spencer, 1983; Spencer & Spencer, 1983; Spencer, *et al*, 1994).

It is possible to merge behavioural and occupational competencies into a transformational competency framework. Designing a dual-layered transformational leadership competency model involves three core steps.

a) Level all competencies using a consistent set of rules
b) Identify relevant leadership role competencies
c) Identify relevant personal competencies

a) Level Transformational Leadership Competencies

Effectively using and reporting competencies will require all competencies in the transformational leadership framework be 'levelled'.

Firstly we need to understand the concept 'levels of competency'. Occupational competencies are typically levelled to confirm the height, depth and breadth of an individual's competence for a given role, at a level within an occupational hierarchy or at a level of employment (industrial award, grade, technical proficiency, etc.). Not all behavioural competencies are levelled.

Levelling all competencies can be undertaken based on the three dimensions outlined below.

Figure 4 Dimensions to levelling leadership competency descriptions

Leadership authority
The level and range of responsibility and accountability for actions

Process or contextual complexity
The depth and breadth of complexity faced, from routine to highly complex and variable situations

Role
The specific outcomes requirements that delimit how a competency will be described and the attributes required such as the skills, knowledge and/or behaviours required to perform.

Competence will vary with the level of application. Using role authority and process complexity dimensions progressive leadership structure can be written for an organisation. The following table suggests a typical model with seven levels of leadership competence.

Table 2 Levels of leadership competence in a healthcare setting

Level	Roles
1	**Individual Contributor – developing leader** Team 2IC and/or individual contributor with foundation professional knowledge or clinical skills
2	**Team leader** Independent frontline leader, clinical specialist and/or professional with responsibility for others
3	**Middle manager** Seasoned professional, specialist and/or manager
4	**Senior manager** Senior professional, clinical or service leader with subject matter expertise and/or leader of other professionals and managers
5	**Executive leader** Senior professional, institutional leader with broad expertise leading multi-disciplinary clinical/professional teams and/or leads other leaders
6	**Organisational leader** CEO; President; MD. Leader in specialist body of knowledge and/or principal executive in an organisation

b) Identify relevant leadership role competencies

Many occupational competencies exist that cover leaders in the healthcare sector. The Generic Leadership and Management Competencies presented below is derived by Working Futures™ from work conducted across multiple national, professional and enterprise-specific leadership competency and qualification frameworks. This framework has been developed to permit multiple competency approaches to coexist. It serves as a 'Rosetta Stone' able to align different descriptors to the same outcomes at a level of application.

Those domains in italics have been directly mapped to attributes possessed by effective transformational leaders. Further details for each competency are included in Attachment 2.

A. ACT STRATEGICALLY	B. LEAD PEOPLE AND TEAMS	C. ACHIEVE RESULTS
Create a vision and sense of purpose	Manage occupational, health and safety	Knowledge of the business
Build relationships	Manage operational outcomes	*Build agility and organisational success*
Plan strategically	Manage people	Manage financial resources
Lead change	Manage teams	
D. MANAGE SERVICE EXCELLENCE	**E. DEVELOP SELF AND OTHERS**	**F. OVERCOME BARRIERS**
Improve customer service quality	Develop personal and professional standards	*Communicate with others*
Improve Quality Continuously	*Foster a positive culture*	Solve problems
Implement best practice	*Model company values and behaviours*	Stimulate innovation and creative thinking
	Develop others	

c) Identify relevant personal competencies

Just as there are many occupational leadership competency frameworks, so there are even more behavioural leadership competency models. While personal competencies abound, their proprietary nature and diversity prevents listing all of them in this document. The most robust behavioural models usually have competencies written with indicators that discriminate outstanding performance from typical performance at each level from entry to executive leadership (after the models codified by Spencer, McClelland, and Spencer, 1994). The following tables below list some of the competency headings from more robust, widely validated frameworks. The first two (Lominger and Egon Zehnder International) are commonly encountered in New Zealand and Australia. The HLCM 2008 Model was introduced in the United States as a behaviourally focused approach for evaluating leadership competence across healthcare professions - including health management, medicine, and nursing - and across career stages (See Appendix 1 for more detail). The Working futures™ list is derived from analysis of 15 international organisations and their competency frameworks (See Appendix 1, Working Futures, 2008; & Hunt, 2002).

Table 3 Comparative listing of behaviourally-based leadership competencies

Egon Zehnder **Leadership Competencies** http://www.egonzehnder.com	**Lomenger** **Leadership development competencies^ *** http://www.lominger.com
1. Strategic Thinking 2. Change leadership 3. Relationships & Influence 4. Commercial Orientation 5. Results orientation 6. Market knowledge 7. Customer focus 8. Team leadership 9. Strategic Change 10. Developing Organisations & People 11. Analytical Thinking 12. Process Orientation	1. Action oriented 2. Dealing with ambiguity 3. Business acumen 4. Customer focus 5. Managing vision and purpose 6. Understanding others 7. Listening 8. Integrity and trust 9. Intellectual horsepower 10. Interpersonal savvy 11. Motivating others 12. Perseverance 13. Building effective teams 14. Drive for results
HLCM **Transformational competencies** http://www.nchl.org	**Working Futures** Comparative analysis of 15 international organisations by frequency of use*
1. Achievement Orientation 2. Analytical Thinking 3. Community Orientation 4. Financial Skills 5. Innovative Thinking 6. Strategic Orientation	1. Team building 2. Coaching 3. Strategic thinking 4. Decision making 5. Communication 6. Relationship building 7. Self awareness/ Knowledge 8. Ethics

Unfortunately all too often competency frameworks encountered in health and community service organisations have been developed without due analysis or because they are low cost alternatives to writing new ones. All too often these frameworks simply have a single competency header, a short description and no further detail on behavioural indicators. The competency is not levelled as described in the previous section, but simply assessed using a 5 point Likert Scale. The height breath and depth of individual competence is most often

^ Most used Lominger competencies in leadership development assessment tools as encountered by Working Futures' when working with enterprise clients. * These competencies are not levelled.

objectively assessed and lacks comparative validity when assessed across individuals, occupations or functions.

In principal just using competency headings may be fine but without proper definition of indicators at different levels they are still being used for everything from workforce planning, job design, training needs analysis, and management of leadership development, recruitment or talent. Without levelling or a robust sense of progression within a role or across occupations and functions (height, depth and breadth), such uses become unreliable.

For many psychologists even the thought that personal competencies could be used for assessing work-based outcomes is anathema. As behavioural descriptors they are intended for assessment using psychological constructs and considered to have no validity or reliability when applied to rating job performance outcomes (Ones, *et al*, 2008). Measurement of outcomes could only occur if psychometric indicators and assessment instruments are used. Even then, assessment should only focus on testing an individual's knowledge, abilities, attitudes, and personality traits.

Without a bank of psychometric indicators and assessment instruments one has to question using abbreviated personal competency descriptions to rate individual performance, skills development or pay. Extending measurement to outcomes such as an organisation's change readiness would not be considered reliable.

We can use the personal competencies that are shared by many robust frameworks and our earlier analysis to build a list of transformation leadership competencies.

The following figure and table targets transformational leadership using *Layer 1 Role (occupational) leadership competencies* and *Layer 2 Personal (behavioural) leadership competencies* drawn from those listed above as being commonly found in existing competencies frameworks.

Figure 5 Integrated view of transformational leadership competencies

KEY: Competencies numbered - 1, 4, 9 and 12 above represent Personal Competencies (Behavioural dimension). All the remainder are Leadership Role Competencies (Occupational dimension)

Table 4 Integrated transformational leadership competency development framework for Level 1 to 4, by domain, field and title, and by layer and four levels

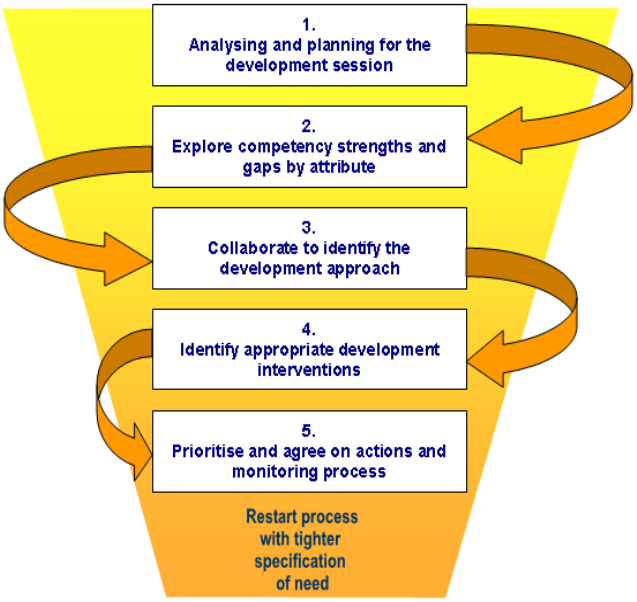
Competency	Level 1	Level 2	Level 3	Level 4
Layer 1: Personal Competencies (Behavioural dimension)				
1.1 Strategic thinking	Understands immediate issues	Identifies short term opportunities	Articulates medium term priorities	Defines strategy for own area
1.2 Strategic Change	Identify change imperative	Enables change and removes barriers	Plans change and gains commitment	Advocates change
1.3 Self knowledge	Knows personal strengths and limits	Actively seeks feedback and opportunities to improve	Shows self-control	Certain of self-worth
1.4 Interpersonal acumen	Relates well to a variety of people	Builds rapport and empowers others	Resolves conflict and builds positive relationships	Supports participative leadership
Layer 2: Role Competencies (Occupational dimension)				
2.1 Create a vision and sense of purpose	Inspire a sense of purpose and commitment	Lead others	Lead operations	Lead the way
2.2 Stimulate innovation and creative thinking	Promote innovative thinking and practice	Model and cultivate innovation and creative thinking	Lead innovation and creative processes	Foster and sustain an environment of innovation
2.3 Communicate with others	Communicate with clarity and purpose	Receive and provide constructive feedback	Negotiate effectively	Protect and enhance the business and the brand
2.4 Foster a positive culture	Embrace difference and diversity	Promote collaborative decision making processes	Foster collaboration across functions	Build a positive organisational culture
2.5 Improve Quality Continuously	Implement continuous quality improvement	Manage continuous quality improvement systems	Plan and review continuous quality improvement systems	Improve continuous improvement systems
2.6 Lead change	Foster and promote change	Manage change	Lead change planning and processes	Monitor and review change
2.7 Build relationships	Work effectively with others in the team	Communicate and influence others	Build networks and relationships with other organisations	Promote strategic partnerships
2.8 Build agility and organisational success	Identify and assess opportunities to improve business success	Build operational capabilities and responsiveness	Build organisational agility	Seize organisational commercial opportunities

Myth 3: Transformational leadership development frameworks cannot fit existing leadership and talent development processes unless major investment occurs in the training or contracting specialist assessors

Transformational Leadership Competency Development may be conducted as part of any standard approach to leadership development. Significant investment in training or contracting specialist assessors is not a requirement for success.

A standard leadership development process can be broken into (5) steps. The image below shows the steps and a suggested 'spiral of improvement' the development process will move through.

Figure 6 Leadership development process



1. Analysing and planning for the development session

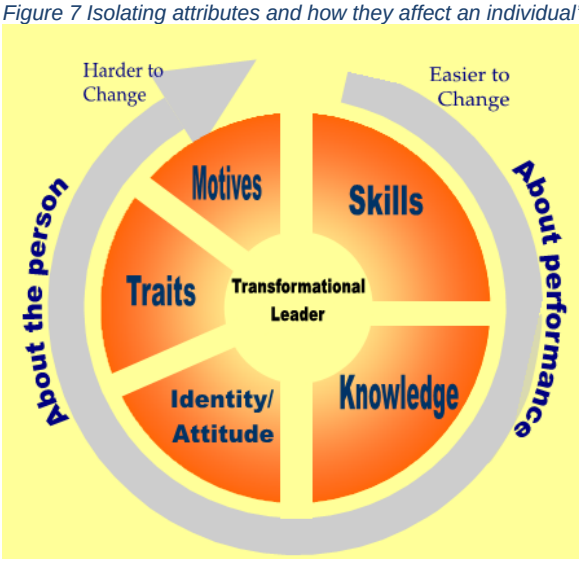
This step would involve the use of an agreed tool or form to assess against agreed attributes; usually based on core leadership and management competencies relevant to the level and role.

2. Explore root cause per competency gap

Development gaps are linked to competencies used by the organisation and/or by the profession. Each capability and competency is composed of knowledge, skills and other attributes. These reflect the broad range of attributes an individual may require personally or to achieve a certain standard of perform.

Each of the five attributes may have a gap that further isolates the cause that requires the individual undertake development in each competency.

Figure 7 Isolating attributes and how they affect an individual's competence



Skills	Ability to do something, eg. operate a computer; "I cannot program that computer"
Knowledge	Knowledge of, know how, know why, eg. knowledge of programming; "I don't know anything about programming"
Identity	This is what I want or perceive myself to be. eg. I'm analytical, "I love theory"
Traits	Enduring characteristics eg. intellect, shy, precision; "I find that hard to do"
Motives	Underlying emotional drivers eg. ambition, power; "I don't want to do that"

The model in Figure 7 acknowledges that some attributes may be far harder to change than others. This supports the importance of targeting leadership development across all attributes. This is totally consistent with developing transformation competence. In the past processes for development of transformational leadership competencies have failed because clinical leaders

have high credibility but healthcare organisations have had difficulty changing their personal beliefs and attitudes towards change or their leadership role (Mountford & Webb, 2009:5).

3. Collaborate to identify the development approach

In step 3 of the leadership development process development options are isolated that best fit the need. Options typically fall into three broad categories explained below.

1. Education and training options

Best for formal, recognised learning and transfer of codified (explicit) knowledge.
Examples: Training = workshops, vocational modules, competency-based modules, etc. or
Education = Degrees, academic learning, consultative training, executive courses, etc.

Specific example: Strategic planning unit of study at Australian Graduate School of Management

Advantages	Disadvantages
▪ Often builds underpinning knowledge and more flexible foundations ▪ Structured time and place ▪ Many options available	▪ Intellectual rather than pragmatic ▪ Often more generic than tailored to the individual ▪ Difficult to identify best-practice with so many options

2. Experiential structured options

Best for role-specific knowledge and self-reflection on personal skills and thinking
Examples: Job rotation, job exchange, expanded role to present challenges, special projects, role in special team (ie. cross-functional, project team, etc.), study tours, orientation into another workplace/role

Specific example: Study tour of international company identified as best practice

Advantages	Disadvantages
▪ Can change hard to shift personal attitudes ▪ Lead to new insights and better practices ▪ Can be highly specific to an individual's need	▪ Needs guidance to make sense of experience ▪ Developmental roles not always available ▪ Can be expensive to resource and harder to measure business benefits

3. Coaching and mentoring options

Best for complex people skills and informal (tacit) knowledge – things that have not been well defined yet and are best learned by apprenticeship or personal guidance
Examples: on the job coaching; development coaching session, mentoring of leader with potential, off the job coaching by subject matter expert, act as mentor, training delivery assignment (coach others)

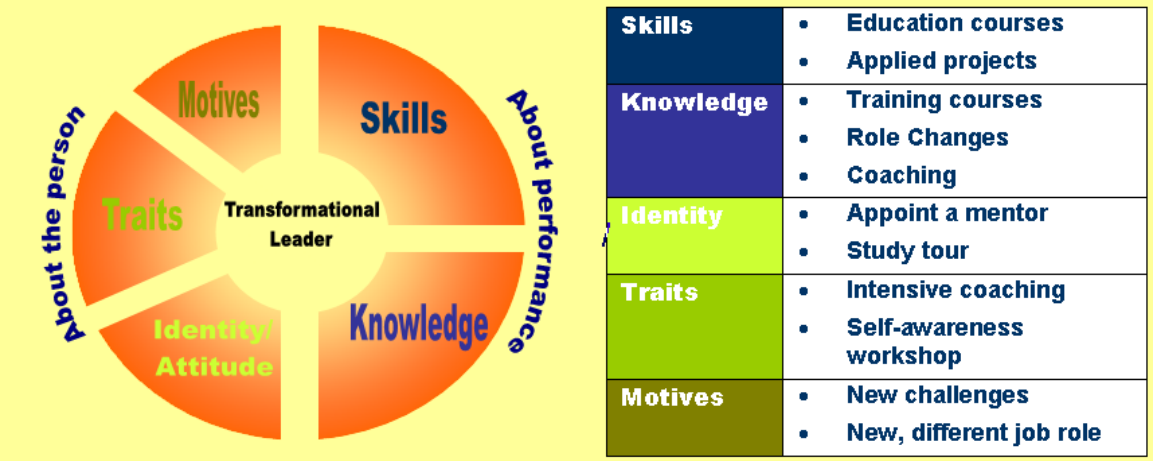
Specific example: Appointment of retired executive to mentoring and provide guidance eg. Weekly coaching sessions with country manager over six months

Advantages	Disadvantages
▪ On-demand ▪ More personal ▪ Highly customised and contextualised to individual and business needs ▪ Flexible ▪ Can be very cost effective	▪ Expensive if using external, expert coach ▪ Often hard to match mentor/coach and participant's personality ▪ Outcomes often not formally assessed ▪ Risk of scope creep: needs discipline, clear goals and monitoring of progress

4. Identify appropriate development interventions

When identifying the appropriate intervention you need to be aware certain attributes are best addressed with specific approaches to learning and development. These are mapped below.

Figure 8 Tying certain attributes of a competency to development opportunities



To further refine this matching of gap with development intervention it is possible to establish which competency is being addressed. The competencies that relate to transformational leadership have previously been identified as:

Personal competencies	Leadership Role Competencies
1.1 Strategic thinking	2.1 Create a vision and lead the business
1.2 Change leadership	2.2 Stimulate innovation and creative thinking
1.3 Self knowledge	2.3 Communicate with others
1.4 Interpersonal acumen	2.4 Foster a positive culture
	2.5 Improve Quality Continuously
	2.6 Lead change
	2.7 Build relationships
	2.8 Build agility and organisational success

Working Futures™ has mapped generic development interventions to each attribute within the competencies listed above. Each organisation can then prepare or substitute generic development options with specific options. Where certain transformational attributes are known to be important to the organisation they can invest in ensuring the development interventions achieve the optimal, consistent outcomes required.

5. Prioritise and agree on actions and monitoring process

This step would involve use of the agreed template to codify the development priorities into a plan with allocated responsibilities, resources, and timing. An overall strategic process would also be established so the organisation and individuals involved can monitor and report on the activities set out in leadership development plans.

Conclusion

This study has outlined not only how to build a transformational leadership competency development framework, it has confirmed an approach that can succeed. The success, like any transformation, is grounded in a vision that inspires commitment and action.

The proposed approach to implementing a transformational leadership competency development model will inculcate the competencies necessary to deliver what John Kotter suggests will underpin successful transformations (1995):

1. Establish a sense of purpose and urgency
2. Create a guiding coalition
3. Develop and communicate a vision and strategy
4. Empower broad-base action
5. Generate short-term wins to build longer term gains
6. Anchor new approaches in culture

Further, the approach outlined herein can be more cost effective and gain more immediate momentum because they will:

- be consistent with the identified benefits research suggest can be derived from transformational leadership in healthcare;
- be designed to address all four dimensions to transformational leadership: systems mastery, self mastery, change process mastery and interpersonal mastery;
- require no special treatment of competencies derived from any robust, standard organisational competency and people management system;
- not require unique competencies if the principles of validity and levelling for both leadership role competencies and personal competencies are advanced; and
- be implemented within existing robust, standard leadership development processes.

References

Avolio, B. J. (1997). The great leadership migration to a full range leadership development system, *Transformational Leadership Working Papers*. Kellogg's Leadership Studies Project, Academy of Leadership Press, Retrieved March 2005 at http://www.academy.umd.edu/publications/klspdocs/bavol_p1.htm

Avolio, B. J. & Bass, B. M. (2002). *Developing Potential Across a Full Range of Leadership Cases on Transactional and Transformational Leadership*. Lawrence Erlbaum: NJ.

Avolio, B., Waldman, D. & Yammarino, F. (1991). Leading in the 1990's: The four I's of transformational leadership, *Journal of European Industrial Training*. Vol. 15, No. 4. pp. 9–16.

Bass, B. M. (1985). *Leadership and Performance Beyond Expectations*. Free Press: New York.

Bass, B. M. & Avolio, B. J. (1994). *Improving Organizational Effectiveness through Transformational Leadership*. Sage: Thousand Oaks, CA.

Bass B.M. & Avolio B.J. (2004). *MLQ A Manual and Sampler Set*. Revised third edition. Mind Garden: Menlo Park, CA. Available at web site. http://www.mindgarden.com/products/mlqr.htm

Beinecke, R.H. & Spencer, J. (May 31–June 2, 2007). 'Examination of Mental Health Leadership Competencies Across IIMHL Countries', *Leading the Future of the Public Sector: The Third Transatlantic Dialogue.* University of Delaware: Newark, Delaware, 19 pages.

Boyatzis, R (1982). *The Competent Manager: A model for effective performance*. Wiley: London.

Bowles, M. (2008). *Review of competency frameworks in 15 international public and private organisations*. Investigative Research Report. Working Futures: Launceston.

Burns, J. M. (1978). *Leadership*. Harper & Row: New York.

Calhoun J.G., Dollett L., Sinioris M.E., Wainio J.A., Butler P.W., Griffith J.R., & Warden G.L. (November/December 2008). Development of an Interprofessional Competency Model for Healthcare Leadership. *Journal of Healthcare Management.* Vol. 53, No. 6. pp. 375-390

Conger, J.A., Kanungo, R.N., & Menon, S.T. (2000). 'Charismatic leadership and follower effects', *Journal of Organizational Behaviour*. Vol. 21, No. 7. pp: 747-767

Covey, S. (1992). *Principle-Centred Leadership*. Fireside—Simon & Schuster: New York.

Ferlie, E., Fitzgerald, L., Wood, M. & Hawkins, C (2005). 'The nonspread of innovations: the mediating role of professionals', *Academy of Management Journal.* Vol. 48, No. 1. pp: 117–134. Retrieved December 2008 at http://www.hpme.utoronto.ca/Assets/events/hsr07/langley2.pdf.

Fitzgerald, L., Lilley, C, Ferlie, E., Addicott, R., McGivern, G. & Buchanan. D. (February 2006) *Managing Change and Role Enactment in the Professionalised Organisation.* National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO):London. Retrieved February 25, 2009 at http://www.sdo.nihr.ac.uk/files/project/21-final-report.pdf.

Golden, B (2006) Transforming Healthcare Organizations, *Healthcare Quarterly*. Vol. 10 (Special Issue on Change). pp:10-19. Source February 2009 at http://www.longwoods.com/product.php?productid=18490.

Greenhalgh, T., Robert, G., Bate, P., Kyriakidou, O., Macfarlane, F. & Peacock, R. (April 2004). *How to Spread Good Ideas: A systematic review of the literature on diffusion, dissemination and sustainability of innovations in health service delivery and organisation*. Managing change in the NHS Resource. National Co-ordinating Centre for NHS Service Delivery and Organisation (NCCSDO): London. Retrieved December 2007 at www.sdo.nihr.ac.uk/files/project/38-final-report.pdf.

Ham, C. (25 March 2003). Improving the performance of health services: the role of clinical leadership, *The Lancet*. Published online. Retrieved December 2008 at http://image.thelancet.com/extras/02art8342web.pdf.

Iles, V. & Southerland, K. (September, 2002). *Organisational Change: A Review For Health Care Managers, Professionals and Researchers*. Managing change in the NHS Resource. National Co-ordinating Centre for NHS Service Delivery and Organisation (NCCSDO): London. Retrieved December 2007 at http://www.sdo.nihr.ac.uk/files/adhoc/change-management-review.pdf.

Iles, V. & Cranfield, S. (September, 2004). *Developing change management skills: A resource for health care professionals and managers*. Managing change in the NHS Resource. National Co-ordinating Centre for NHS Service Delivery and Organisation: London. Retrieved December 2007 at http://www.sdo.nihr.ac.uk/files/adhoc/change-management-developing-skills.pdf.

Kotter, J.P. (March-April, 1995) Why transformation efforts fail, *Harvard Business Review*, pp. 59-67.

Kotter, J.P. (1996). *Leading Change*. Harvard Business School Press: Boston, MA.

McClelland, D.C. (1976). *A Guide to Job Competency Assessment*, McBer & Co: Boston.

McClelland, D.C. (1973). Testing for competence rather than 'intelligence', *American Psychologist.* Vol. 28, pp.1–14.

McClelland, D.C. (1985). *Human motivation*. Scott, Foresman: Glenview, IL.

McNulty, T. & Ferlie, E. (2002). *Reengineering health care: The complexities of organizational transformation*. Oxford University Press: Oxford, England.

Menaker, R. & Bahn, R.S. (September, 2008). How Perceived Physician Leadership Behavior Affects Physician Satisfaction, *Mayo Clinic Proceedings*. Vol.83, No. 9. pp: 983-988. Available at www.mayoclinicproceedings.com.

Mountford, J. & Webb, C. (February, 2009). 'When clinicians lead', *The McKinseyQuarterly*. McKinsey&Company. pp: 1-8. Available at http://www.mckinseyquarterly.com/When_clinicians_lead_2293.

Ones, D.S., Viswesvaran, N. & Schmidt. F.L. (May, 2008). No New Terrain: Reliability and Construct Validity of Job Performance Ratings, *Industrial and Organisational Psychology*. Vol. 1, No.2. pp: 174-179.

Raven, J (1977). *Competence in modern society*, Royal Fireworks Press: Unionville, NY.

Russell, L. (2006). *Change Basics: A Complete How-to Guide to Help You*. American Society for Training and Development: New York.

Spencer, LM (1983). *Soft skill competencies*. Scottish Council for research education: Edinburgh.

Spencer, LM & Spencer, SM (1983). *Competence at work*. Wiley: New York.

Spencer, L.M., McClelland, D. C. & Spencer, S.M. (1994). *Competency Assessment Methods: History and State of Art*, 3-44. Hay/McBer Research Press: London.

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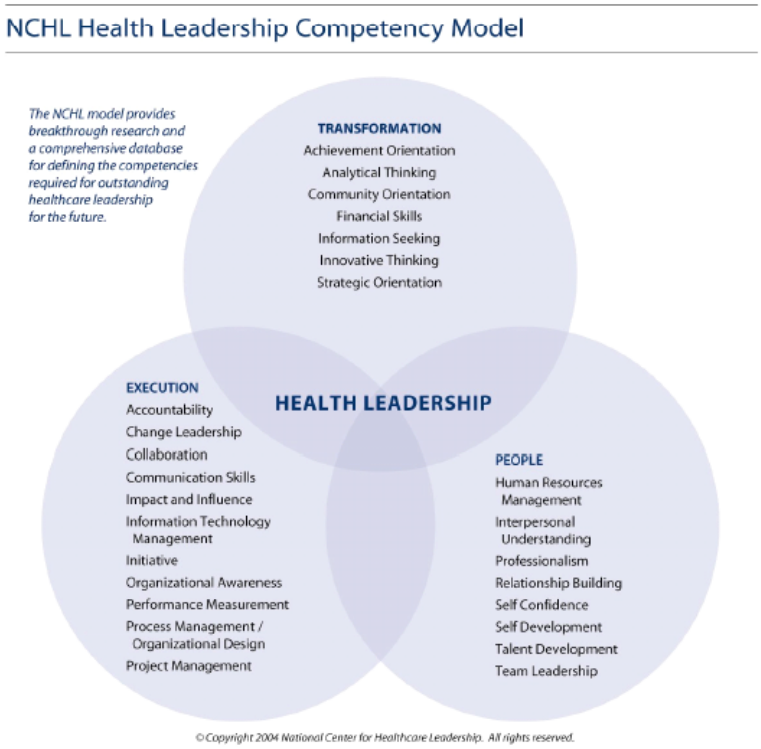
Appendices

Appendix 1 Comparative personal competency models



(NHCL (2005). *National Center for Healthcare Leadership Health Leadership Competency Model summary*. Version 2 .page 3. Available at http://www.nchl.org/ns/documents/CompetencyModel-short.pdf)

Top 20 competencies found in 15 top public and private organisations by frequency of occurrence:

Shared competencies (NB: Titles may vary slightly by framework)	Frequency of use	Frequency use of levels
1. Coaching	12	4
2. Team building	11	4
3. Strategic Thinking	9	4
4. Communication	9	4
5. Relationships and influence	8	4
6. Customer focus	8	4
7. Change management	7	3
8. Leadership and influence	7	3
9. Knowledge/ Self-development	7	2
10. Commercial acumen	7	1
11. Decision making	5	3
12. Visioning	5	2
13. Ethics	5	1
14. Listening	5	1
15. Political awareness/savvy	4	1
16. Innovation	4	3
17. Learning	4	3
18. Cultural understanding/awareness	4	1
19. Technical expertise	4	1
20. Persuasion	3	0

Tables shows confidential research completed by The Institute for Working Futures (Bowles, 2008) analysing personal competency frameworks in 15 major organisations; including BHP Billiton, Australian Public Service Commission, Qantas, 3M, Santos, Woolworths, Department of Health (WA), Global Health Council - World Health Professions Alliance, American College of Healthcare Executives, Caltex, John Holland, Canadian Public Sector health services, National Center for Healthcare Leadership (USA), Shell Canada, and CSR. Table shows headings and frequency of use across 15 frameworks and how often they were levelled.

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8. Leadership and influence	7	3
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10. Commercial acumen	7	1
11. Decision making	5	3
12. Visioning	5	2
13. Ethics	5	1
14. Listening	5	1
15. Political awareness/savvy	4	1
16. Innovation	4	3
17. Learning	4	3
18. Cultural understanding/awareness	4	1
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Appendix 2 - Generic occupational/role competency matrix Levels 1 to 4

MANAGEMENT AND LEADERSHIP GENERIC OCCUPATIONAL COMPETENCY FRAMEWORK – SUMMARY				
DOMAINS AND COMPETENCIES	LEVELS			
	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
A. ACT STRATEGICALLY				
Create a vision and sense of purpose	*Inspire a sense of purpose and commitment*	*Lead others*	*Lead operations*	*Lead the way*
Build relationships	*Work effectively with others in the team*	*Communicate and influence others*	*Build networks and relationships with other organisations*	*Promote strategic partnerships*
Plan strategically	Implement and review business goals and indicators	Plan program and business outcomes	Manage and review business plans	Coordinate and evaluate corporate plans
Lead change	*Foster and promote change*	*Manage change*	*Lead change planning and processes*	*Monitor and review change*
B/. LEAD PEOPLE AND TEAMS				
Manage occupational, health and safety	Monitor OHS processes	Manage and report on OHS processes	Plan OHS systems and procedures	Establish and review OHS policies and systems
Manage operational outcomes	Achieve work priorities and work outcomes	Achieve team outcomes	Achieve functional outcomes	Achieve divisional outcomes
Manage people	Develop individual skills and performance	Manage learning and performance	Plan and report on performance and learning	Manage workforce planning
Manage teams	Identify goals and allocate work	Build effective teams	Improve team performance	Manage teams and their leaders
C. ACHIEVE RESULTS				
Knowledge of the business	Identify and confirm the organisation's regulatory and operational context	Analyse organisation's current and future competition and market position	Determine business opportunities and organisational politics	Position the business
Build agility and organisational success	*Identify and assess opportunities to improve business success*	*Build operational capabilities and responsiveness*	*Build organisational agility*	*Seize organisational commercial opportunities*
Manage financial resources	Process daily financial reports and data	Coordinate and monitor routine financial reporting	Set and monitor budgets and financial reports	Establish and monitor budget processes and financial management reporting
D. MANAGE SERVICE EXCELLENCE				
Improve customer service quality	Identify customer expectations and needs	Improve service excellence	Set and review service excellence standards	Build a customer-focussed culture and enabling service standards
Improve Quality Continuously	*Implement continuous quality improvement*	*Manage continuous quality improvement systems*	*Plan and review continuous quality improvement systems*	*Improve continuous improvement systems*
Implement best practice	Investigate and identify best practice	Implement best practice	Develop 'best of class' functional systems and practices	Develop world class divisional systems and practices
E. DEVELOP SELF AND OTHERS				
Develop personal and professional standards	Develop personal skills and specialist knowledge	Improve specialist professional competence and future career opportunities	Influence thinking and practice within the organisation	Contribute to the professional body of knowledge and practices
Foster a positive culture	*Embrace difference and diversity*	*Promote collaborative decision making processes*	*Foster collaboration across functions*	*Build a positive organisational culture*
Model company values and behaviours	*Model personal drive and integrity*	*Act with integrity and compliance to values and organisational culture*	*Plan and commit to actions that support values and organisational culture*	*Communicate and gain alignment of others to organisational values and culture*
Develop others	Identify learning and development needs of others	Coach others to promote skills and engagement	Build productive relationships	Guide and mentor other leaders
F. OVERCOME BARRIERS				
Communicate with others	*Communicate with clarity and purpose*	*Receive and provide constructive feedback*	*Negotiate effectively*	*Protect and enhance the business and the brand*
Solve problems	Identify and assess problems	Promote collaborative problem solving	Anticipate and manage operational problems	Evaluate problem solving processes and outcomes
Stimulate innovation and creative thinking	*Promote innovative thinking and practice*	*Model and cultivate innovation and creative thinking*	*Lead innovation and creative processes*	*Foster and sustain an environment of innovation*

Italicised listings are commonly found in Transformational leadership/change management frameworks.

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