Distributed leadership: Building capacity to maximise collaborative practice in a new teaching research aged care service

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Chapter 2: Literature Review

This chapter presents the relevant theoretical background required to position this research within the context of current scholarly literature. The conceptual framework which was developed as a result of this literature review is also presented in this chapter. The theoretical background includes a review of the professional literature related to leadership in health and aged care.

The literature review strategy was carefully crafted to navigate, interpret and apply the research relevant to solving the business problem of how to create the conditions for staff to exercise distributed leadership at ViTA South. The literature review sought to understand the nature of distributed leadership and demonstrate the tight conceptual and practical link between methods of action research approach and the goal of creating distributed leadership. It also identified relevant theoretical constructs associated with leading strategic organisational development initiatives. The literature review informed the development of the conceptual framework (which is summarised at the end of this chapter), which in turn informed the choice of methodology outlined in Chapter 3.

This chapter has been structured into three sections. With the first and second sections presenting the professional literature and academic literature reviewed for this research. The third section presents a summary of the theoretical constructs identified from the literature review which were included in the conceptual framework for this research.

2.1 Review of the Professional Literature

The review of the professional literature focussed on exploring leadership in the context of health and aged care. One of the main outcomes was the identification of contemporary leadership frameworks designed for application within health and aged care settings. The review of the professional literature concludes by expanding on what ‘collaborative practice’ means to practitioners.
2.1.1 Leadership in health and aged care

Substantial international research informing leadership development in health and aged care is currently being undertaken. In reviewing national approaches to guiding leadership efforts there are three well known international frameworks:

1. National Health Service (NHS) Improvement Centre Leadership Framework
2. LEADS in a Caring Environment
3. Health LEADS Australia

All three frameworks were reviewed by the researcher and identified as incorporating distributed leadership. Two of the frameworks that stand out as embracing principles consistent with the leadership expectations of this business problem are LEADS in a Caring Environment and Health LEADS Australia. The latter was chosen as the reference point for this study as it was most relevant to addressing the business problem.

LEADS in a Caring Environment sets out key skills, abilities, and knowledge required to lead at all levels of a health organisation. It was designed to align with and consolidate the competency frameworks and leadership strategies found in Canada’s health sector (Dickson & Tholl, 2014).

This framework reflects an increased understanding of the importance of balancing distributed leadership with designated leadership (Best, Greenhalgh, Lewis, Saul, Carroll, & Bitz, 2012). The evidence from the research that generated LEADS in a Caring Environment suggests ‘heroic’ leadership models in the health care sector are no longer practical (Dickson & Tholl, 2014). (Heroic leadership is explained in section 2.2.2). In this regard LEADS was developed and supported by research and expert opinion. In the Canadian context it has been demonstrated that developing quality leadership in health care requires a multi-pronged and collaborative approach if it is to achieve large scale, transformational change (Dickson & Tholl, 2014).
LEADS in a Caring Environment has now become Canada’s preferred health leadership learning platform and more importantly is seen as providing a common language and focus for developing health leadership. A Canadian Health Leadership Network benchmarking study has shown that approximately 63% of Academic Health Sciences Centers have adopted LEADS or similar frameworks (Canadian Health Leadership Network, 2014). It has shown that adopting the LEADS framework has provided a useful basic building block for leadership in complex adaptive systems with distributed leadership at its core. It demonstrates that leadership is not about the transfer of implied leadership knowledge which is difficult to transfer to another person, but rather something that can be developed through role modelling and mentorship (Canadian Health Leadership Network, 2014).

2.1.2 Health LEADS Australia

Policy around health leadership in Australia has drawn from the Canadian experience. Health Workforce Australia, (whose functions are now part of the Australian Department of Health), led the development of a health leadership framework. Health LEADS Australia: the Australian Health Leadership Framework incorporates contemporary health leadership theory. It is built on existing and validated local and international research, and focuses on capabilities required to deal with contemporary Australian health issues.

Informed by distributed leadership the framework was developed through research and dialogue which included consultation with over 700 organisations and individuals during its development. It has been designed to provide a common language as a foundation for collaborative practice. Figure 2 shows a diagrammatic overview of Health LEADS Australia: the Australian Health Leadership Framework.
The Health LEADS Australia framework is built on research which demonstrates that “best practice and quality of care are directly and indirectly impacted by the quality of health leadership” (Health Workforce Australia, 2012a). While acknowledging that other factors are important, it is leadership that is seen to play a central role in mobilising people towards a common goal (Health Workforce Australia, 2012b).

The health system in Australia can be characterised as a very complex system requiring adaptive and action-reflection research approaches. This understanding of its complexity underpinned the development of the Health LEADS Australia framework. This is in contrast to the more traditional, problem solving approaches more suitable for technical or standard task delegation and traditional positivist research (Australasian College of Health Service Management and Society for Health Administration Programs in Education, 2013). The focus of the Health LEADS Australia framework is in developing leadership capability and capacity within and across the workforce. To drive
this focus three key principles guiding *Health LEADS Australia* (Health Workforce Australia, 2012a) were developed.

1. **Everyone owns leadership** – Effective leadership is a public good for which everyone shares responsibility. Leadership where everyone shares responsibility is distributed leadership. The literature on distributed leadership has been presented in Chapter 2 (section 2.2.1).

2. **Developing capable leaders builds health leadership capacity** – Personal and professional development is seen as essential and part of lifelong learning. *Health LEADS Australia* is designed for use by leaders and potential leaders at any place in the system who are intent on improving their ability to engage with others to influence for better health outcomes. Leading in health, individually and together is seen as requiring courage, passion and the capabilities to follow through.

3. **The person you are is the leader you are** – People will express the capabilities in this framework differently in different contexts and in a manner consistent with their personality, style, strengths and role (Health Workforce Australia, 2012a).

*Health LEADS Australia* aimed to provide a framework that is easy to understand but also to apply, where the application of leadership is contextual and related to the situation. The call for integrity and simplicity of the framework to be maintained and preserved has been made by a number of commentators (ACHSM & SHAPE, 2013). In their joint submission regarding *Health LEADS Australia*, the Australasian College of Health Service Management (ACHSM) and Society for Health Administration Programs in Education (SHAPE) recommended that the framework being developed be kept broad to enable flexibility in how organisations could apply the framework at a local level to inform the development of their own tailored leadership activities (ACHSM & SHAPE, 2013).

ACHSM and SHAPE further stated that in their view they believe the rationale for the framework should adopt a similar approach to the NHS Leadership Academy who
have further developed the NHS Leadership Framework with the development of the Health Care Leadership Model (ACHSM & SHAPE, 2013). The approach adopted by the NHS Leadership Academy is that the framework needs to remain broad and flexible enough to enable health care organisations at the local level, ‘to map and link their own more specific leadership activities’ (ACHSM & SHAPE, 2013).

In Australia the delivery of health care is carried out within organisations and by people whose primary purpose is to improve healthcare. The development of leadership in this context is to be carried out within and together with health care organisations. For leadership development to work it must be deeply embedded in and drawn from the specific organisational context and problems that leaders are collectively facing (James, Slater, & Bucknam, 2011). The goal of leadership development ultimately involves action not knowledge alone. Therefore, leadership development today means providing people opportunities to learn from their work in a ‘situated leadership practice’ rather than taking them away from their work to learn (Spillane, 2012).

A key driver of the change required to the health care system in Australia and a key feature of the Health LEADS Australia framework is the view that leadership needs to be considered not in isolation but at both the individual and organisation level (Philippon, 2013). This is because an individual, even if they have great leadership potential, may have their efforts undermined in an organisation that is not receptive to change (Philippon, 2013). Also organisations with people who are open to change are unlikely to make significant progress unless some individuals can lead (Philippon, 2013). So the need for leadership development strategies at both individual and organisational levels becomes an essential strategy (Philippon, 2013). This also further supports the decision to adopt single and double loop learning as an organisational development process embedded within the ViTA South operational model. (Single and double loop learning are explained in section 2.3.5).

To meet these challenges requires new models for training and developing future Australian health leaders at all levels (HWA, 2012b). The development of the Health LEADS Australia framework can be seen as an important step in supporting the
workforce in reaching the desired capabilities required for effective leadership (HWA, 2010). Furthermore, the development of leadership capacity in health care advocated by Health LEADS Australia requires health care workforce planning and development approaches to be adapted to maintain the integrity of the health system and to drive innovation and reform (ACHSM & SHAPE 2013).

Health LEADS Australia shares a number of characteristics with leadership frameworks designed to support change in other national jurisdictions (Dickson & Tholl, 2014; West et al., 2014). Key to this research are the constructs of complexity and systems thinking; personal agency, power of distributed leadership, collaborative relationships, and aligned action to create desired results, all of which are explored in this thesis.

2.1.3 Australian Aged Care Leadership Capability Framework

Shortly after Health LEADS Australia was endorsed for use by ACH Group a further leadership framework specifically designed for aged care was released. The Australian Aged Care Leadership Capability Framework aims to define knowledge, skills and behaviours necessary for effective leadership of, and within, aged care organisations (Aged and Community Services Australia, Leading Age Services Australia, & Community Services and Health Industry Skills Council, 2014). The Australian Aged Care Leadership Capability Framework has many similarities with Health LEADS Australia. The similarities include articulation of leadership capabilities across five domains. The Australian Aged Care Leadership Capability Framework defines a range of capabilities according to five key domains: self, others, purpose, business and change. Similarly the Health LEADS Australia has five domains: leads self, engages others, achieves outcomes, drives innovation and shapes systems.

After reviewing the alternative aged care specific framework ACH Group decided to continue with the adoption of Health LEADS Australia. This was because Health LEADS Australia provides a common language for leadership which has applicability across the health sector, rather than being unique to aged care. This is an important
factor as a number of ACH Group staff concurrently work in the acute hospital system (e.g. work shifts in hospitals and work shifts in aged care facilities). Similarly many health professionals transition from working in the acute sector to working in aged care.

The Australian Aged Care Leadership Capability Framework is another example of focus, effort and energy going into researching and developing leadership frameworks with (at the time this research commenced) limited guidance on how to apply these frameworks in practice. This research aims to move beyond developing or critiquing frameworks towards applying a framework in practice. In the case of this research this means applying the underlying principles of Health LEADS Australia in practice at ViTA South.

2.1.4 Collaborative Practice

The evidence base associated with current Australian aged care workforce supports the importance of holistic care for older people and the benefits of collaborative team work (Health Workforce Australia, 2010). In today’s health and aged care environment team members including regulated and unregulated staff are required to work together toward optimising health and wellbeing outcomes. There has been much discussion around the importance of multidisciplinary practice and its contribution to health outcomes (Xyrichis & Lowton, 2008). More recently there has been a further evolution to promote collaborative practice (Milburn & Colyer, 2008).

There is a distinct difference between collaborative practice compared to ‘multidisciplinary practice’ (Milburn & Colyer, 2008). While on the surface they may seem similar, the research literature indicates they are in fact different approaches (Milburn & Colyer, 2008). Multidisciplinary practice involves several disciplines working together in parallel to assess care needs and set up treatment goals according to their specialist discipline (Royeen, Jenson, & Harvan, 2011).

Applying a multidisciplinary practice approach involves different aspects of a patient’s case being managed independently but often simultaneously and without
coordination. Rather than being integrated, the range of patient needs is subdivided and treated separately with each provider responsible for his or her own area (Royeen et al., 2011).

Collaborative practice involves a process of communication and decision making that enables the separate and shared knowledge and skills of health care providers to synergistically provide services to the resident. It is a way of working, organising and operating within a service in a manner that effectively utilises the provider resources to deliver services in a cost-efficient and safe manner to best meet the needs of the person receiving the service (Way et al., 2000). Expanding this collective knowledge of a group is also a key principle associated with collaborative practice (Meads, Jones, Harrison, Forman, & Turner, 2009; Suter., Arndt, Arthur, Parboosingh, Taylor,, & Deutschlander, 2009).

In relation to advancing collaborative practice there has been a focus on the training of health professionals to practice collaboratively, known in the tertiary sector as ‘interprofessional education’ or an ‘interprofessional learning approach’ (Centre for the Advancement of Interprofessional Education, 2016). The Centre for Advancement of Interprofessional Education defines interprofessional education as “learning from, with and about one another to improve collaboration and quality of care” (CAIPE, 2016). Much of the research demonstrates that while this training is important the impacts are not being fully realised in practice as often the systems within organisations inhibit collaborative practice (Leathard, 2003; Williamson, 2005; Xyrichis & Lowton, 2008).

2.2 Review of the Academic Literature

The review of the academic literature involved an in-depth review of distributed leadership and leadership development. This review identified a number of tools which were adopted for use in the research which are also presented in this section. Five organisational development theoretical constructs were identified as part of this review and are also presented in this section.
2.2.1 Distributed leadership: theoretical foundations

For the purposes of this research distributed leadership is understood as a broad concept where the role of formal leaders is less about leading from the front but rather is focused on enabling others to lead. A general concept adopted by theorists is that distributed leadership empowers individuals to contribute ideas and expand the collective knowledge of the group and organisation (Bennett, Wise, Woods, & Harvey, 2003; Gronn, 2002; Harris & Spillane, 2008; Hartley & Benington, 2010; Spillane, 2012).

From this broad perspective there are varying interpretations of distributed leadership. However, the following four key principles of distributed leadership provided the parameters that framed this study as well as the organisational development work adopted by ACH Group:

1. Distributed leadership encourages self-direction rather than external control. When people work together it is expected they pool their initiative and expertise. The outcome is a product or energy which is greater than the sum of their individual actions (Bennett et al., 2003).

2. Distributed leadership does not replace formal leadership but rather it encourages and supports staff across an organisation to exercise leadership skills in day to day operations. It is based on trust in the expertise of individuals rather than direct management or regulation (Gronn, 2009; Spillane, 2012).

3. Distributed leadership encourages staff at all levels to work together in planning for and achieving outcomes. This includes staff being a part of change, systems improvement and continuous quality improvement (Gronn, 2009; Nadeem, Olin, Hill, Hoagwood, & Horwitz, 2013).

4. Distributed leadership puts the focus on leadership as a process rather than individual actions of individuals (Gronn, 2009; Spillane, 2012).
Building on these four key principles it is recognised that distributed leadership evokes an aspiration for how leadership is configured, and draws attention to iterative relationships between leadership, followership and context (Currie & Lockett, 2011). While distributed leadership is regarded as important in health and social care, particularly when change and improvement are required, beyond a limited number of studies there is little consideration of how distributed leadership is enacted on the ground (Currie & Lockett, 2011; Lemieux-Charles & McGuire, 2006; San Martín-Rodríguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005).

As will be shown a move toward distributed forms of leadership requires a change in the role of the formal leader within an organisation. Distributed leadership promotes and supports the idea that every individual has an opportunity to demonstrate leadership. Further, distributed leadership is a practice whereby leadership is examined and organised in a way that is inclusive of all staff in the organisation – in this case ViTA South. In this way, leadership is viewed as a series of activities and interactions in which members of an organisation find themselves engaged (Gronn, 2009). The move requires a review of the role and function of a formal leader which has been incorporated into this research study toward solving the business problem.

According to Spillane (2012), distributed leadership, like all leadership theory, can benefit practice by providing a framework that helps individuals to interpret and reflect on practice as a basis of rethinking and revising it. As a result distributed leadership can prove to be a powerful tool for transforming the practice of leadership if developed effectively.

Distributed leadership is non-exclusive and can be realised through the social interactions between distributed leaders and followers (Spillane et al., 2004). In the context of leadership within an educational setting, it is the contention of Spillane et al. (2004) that socio-cultural context is an essential element of leadership practice which also contributes to shaping it. Adopting their distributed perspective leadership practice can be seen to consist of an ongoing interaction of leaders together with their social and material situations.
Central to distributed leadership is collegiality and the opportunity and capacity to collaborate. Members share leadership and followership responsibilities throughout the organisation. According to Diamond (2007) this is different to delegating responsibilities. Diamond (2007) suggests that in order to conceptualise distributed leadership as it applies to practice a shift in thinking is required; to see and understand leadership through actions. To understand distributed leadership Diamond (2007) suggests that it is constituted through a combination of interaction between leaders, followers and the situation. Diamond (2007) argues that distributed leadership provides a powerful way to better interpret and develop shared understandings of leadership activity in complex environments.

The effectiveness of distributed leadership practice relies to a large extent on the willingness and capacity of individuals within an organisation to work together to improve their practice. Spillane et al. (2004) contend that leadership is embedded in various organisational contexts and not vested in a formal leader, position or person holding office. The distribution of leadership needs to be accomplished after identifying clear, observable and measurable goals. Goals include task identification, acquisition, allocation, coordination and use of social, material and cultural resources tied to the core work of the organisation (Spillane et al., 2004).

Distributed leadership can be seen as providing a framework for understanding how leadership operates within an organisation. It also can help to shape understanding of how leadership influences, and is itself influenced by the development of its members. It further provides a means by which an organisation can develop an approach to leadership that is inclusive and incorporates the skills and abilities of all members of an organisation in the pursuit of its goals.

Distributed leadership has been shown to be a key determinant in achieving positive healthcare outcomes, particularly when engaging with complex adaptive systems (Greenfield et al., 2009). This research specifically focused on the
organisational development associated with developing a leadership strategy, which encompassed distributed leadership, for the complex adaptive system of ViTA South.

Distributed leadership is a perspective rather than a prescriptive approach to leadership (Spillane et al., 2004). There are only a few studies which provide insight into the organisational development process involved with developing distributed leadership in a practice setting within a health context. For example Buchanan, Addicott, Ferlie, Baeza, and Fitzgerald (2007) described distributed leadership in practice in the health context as happening without a plan. This view did not provide the insights required to guide the choice and type of organisational development to be adopted within a new operational model which would create the conditions for distributed leadership such as required at ViTA South.

Much of the existing literature related to distributed leadership in healthcare has focused on why it is required and the definitions and history behind its evolution. The research literature on distributed leadership in health and aged care indicated that distributed leadership could have positive impacts on the quality and safety in healthcare (Greenfield et al., 2009; Jeon, Merlyn, & Chenoweth, 2010). The need for distributed leadership is well documented, but there is a lack of evidence of approaches in creating the conditions for staff to exercise distributed leadership which may be transferrable to other collaborative healthcare contexts, in particular health and aged care settings (Hartley & Benington, 2010; Woods, Bennett, Harvey, & Wise, 2004). Therefore uncertainty around the processes and systems through which health and aged care organisations can promote, apply and embrace distributed leadership remains, giving significance to this study, which contributes to the advancement of research into distributed leadership as it is applied in practice (Currie & Lockett, 2011; Hartley & Benington, 2010; Lemieux-Charles & McGuire, 2006; San Martín-Rodríguez et al., 2005; West et al., 2014; Woods et al., 2004).

Chreim, Williams, Janz, and Dastmalchian (2010) suggest what is needed to advance understanding of distributed leadership in practice is to go beyond studying traits such as the qualities of ‘successful leaders’. They call for future research to include
There has been some research into the application of distributed leadership in practice in the education sector; a sector that is also recognised as being largely fragmented (Harris & Spillane, 2008). This research has shown the effects of a more holistic approach on engaging members of a school or university, creating a positive impact on the quality of teaching and learning (Harris, Leithwood, Day, Sammons, & Hopkins, 2007; Jones, Harvey, Lefoe, Ryland, & Schneider, 2011; Spillane & Coldren, 2011). Despite the extensive research into distributed leadership in education there are still calls for further research into the application of distributed leadership practice in education (Harris, 2012; Jones, 2014; Spillane, 2009).

2.2.2 Distributed leadership: within a preferred model of leadership

To understand the true intent of distributed leadership it is critical to recognise it within the context of leadership theory which can be broken down into two broad categories. These are theories and studies that are psychology-driven and those that are sociology-driven (Schedlitzki & Edwards, 2014).

In psychology-driven studies the emphasis is on the importance of the skills, traits and behaviours of individuals. Often they focus on the question of what characteristics make an effective leader (Schedlitzki & Edwards, 2014). In sociology-driven studies, emphasis is on the importance of understanding the process between leaders and followers and predominantly explores the action of leading in context (Schedlitzki & Edwards, 2014).

This research study aligns with the criteria of a sociology-driven research study. It is concerned with the action of leading and in particular the impact of situation, in terms of organisational routines and tools which can be unique to a particular environment or context such as ViTA South. Identifying this alignment was significant as it provided a focus and direction for the ongoing literature review.
A prevailing theme in the current leadership literature is a discussion on the requirement to shift from heroic leadership models to shared models (Schedlitzki & Edwards, 2014). This shift is in response to the increasing complexity of organisations during the 21st century. In reflecting on what is deemed heroic leadership it is largely hierarchical in nature and places the actions of followers as passive or reactive to the actions of leaders (Schedlitzki & Edwards, 2014). The shift from heroic to shared models of leadership shares similarities within the shift taking place in relation to moving from multidisciplinary practice toward collaborative practice discussed earlier. These strategies to change practice aim to work toward addressing the increasing complexity of health and aged care.

Since 2000 the research literature shows that there is a distinct shift away from the ‘top-down’ heroic model of leadership. The move is toward a form of leadership that is distributed, collaborative and shared. Terms used in the literature include distributed leadership, collective leadership, shared leadership, and relational leadership; which have many conceptual similarities (Uhl-Bien, Marion, & McKelvey, 2007; West, Eckert, Steward, & Pasmore, 2014). While the literature reflects a move toward distributed models of leadership, the process by which this shift occurs has not yet been documented. This research seeks to address this gap by documenting a process one organisation has used to shift toward a distributed approach to leadership.

2.2.3 Sociological considerations for developing distributed leadership

Youngs (2012) recommends that applying a sociological understanding of practice as it relates to distributed leadership can mitigate the risk of oversimplifying research and organisational development associated with distributed leadership. Emergent distributed forms of leadership tap into the human, cultural and social capital existing within groups and individuals in the form of deference (Youngs, 2012). Youngs identifies that symbolic power can be generated through deference and authority is generated through the jurisdiction that is embedded in a role (Youngs, 2012). Youngs describes four types of organisational capital:
1. Human capital – expertise, skills and knowledge
2. Cultural capital – disposition toward cultural practices
3. Social capital – networked relations, relations of trust, membership of a group, collective identity
4. Authoritative capital – jurisdiction embodied in a role and the expectations associated with this

These sociological considerations have influenced the organisational development design required to support strategies aimed at creating the conditions for staff to exercise distributed leadership at ViTA South. For ViTA South to meet Aged Care Accreditation Agency requirements, a formal leadership team was needed to maintain the overall responsibility and accountability for the site operations at ViTA South. In introducing distributed leadership into ViTA South the plan was not for formal leadership roles to be abolished, but rather, it was anticipated the formal leadership team role would evolve and include creation of conditions for staff to exercise distributed leadership as part of its function. Youngs (2012) explains that in establishing an environment that creates the conditions for staff to exercise distributed leadership formal leaders need to become comfortable in simultaneously holding onto and letting go of responsibility which will enable innovation and risk taking to emerge.

This concept of stepping in and stepping back is what Young (2014) describes as ‘hybrid configurations of leadership’. It includes stepping in to orchestrate leadership amongst others, stepping back to allow individual and group leadership to emerge, and ensuring supportive organisational structures allow distributed leadership to occur in parallel with formal leadership (Youngs, 2014). It encourages organisational-wide system thinking and boundary-spanning within groups (Youngs, 2014).

Therefore the leadership strategy developed for ViTA South represents what Gronn (2009) labels as a ‘hybrid form of distributed leadership’. Youngs (2012) describes hybrid configurations of leadership as a spectrum between distributed forms of leadership and hierarchical arrangements for leadership (see Figure 3). At one end of the spectrum leadership is driven by ‘authority’. This includes ‘role based authority’
where leadership is distributed through a demarcation of role functions which include specific leadership responsibilities. Leadership at the opposite end of the spectrum is driven by ‘symbolic power’ (Youngs, 2012).

The leadership strategy for ViTA South aligns most appropriately with a hybrid configuration as seen in the highlighted area of Figure 3. This configuration, which was facilitated at ViTA South through ‘organisational forms’ of planned leadership development and complemented by ‘emergent forms’ of leadership, was expected to unfold as the conditions for staff to exercise distributed leadership were created.

![Figure 3 Theorising distributed forms of leadership with authority and symbolic power (Youngs, 2012, p.230)](image)

2.2.4 Previous studies involving distributed leadership modelling in health

A systematic review was undertaken as part of the discovery stage of the second action research cycle. Details of the systematic review critical appraisal, data extraction and synthesis process have been included in the presentation of the research design set out in Chapter 3. This section presents an overview of each of the six studies which were included in the review. The synthesised findings identified from the systematic review are presented in Chapter 5 as they were considered as part of the discovery undertaken within cycle 2 of the action research process.
It was anticipated that this systematic review would provide some insight into the strategies other organisations had used to create the conditions for staff to exercise distributed leadership and how these strategies were intended to work in practice.

During the systematic review a total of 140 papers were identified from database searches. A further seven papers were then added after identification from reference lists. After removal of nine duplicates, title and abstract checking was undertaken for a total of 138 papers with 78 retrieved for verification, of which 60 were excluded. Many of the papers extracted were excluded as they were opinion pieces. Seventy-eight studies were critically appraised, of which 72 were excluded in line with the systematic review protocol, leaving a total of six studies for data extraction and inclusion in the review. The six studies which were appraised and considered suitable and were included for data extraction and synthesis are now described individually.

The first study by Chreim et al. (2010) involved a qualitative, longitudinal case study to map the evolution of a successful model of leadership. The research tracked changes and agents’ roles over a four year time frame. The study sought to understand the dynamics of collective or distributed leadership by attending to change agency roles (Chreim et al., 2010). This was specifically discussed in a context which involved collaboration across health organisations and specifically drew conclusion from the examination of how change agency roles develop, evolve, interact, and complement each other. The study also examined the basis of the change agents’ ability to exercise influence (Chreim et al., 2010).

The Chreim et al. (2010) study presented three key findings. The first finding showed that distributed leadership potentially evolves over time (Chreim et al., 2010). The next outlines the need for change leaders to build a winning coalition of people or what they describe as ‘agents’ who bring complementary skills and resources to support the desired change (Chreim et al., 2010). Further, it identified the investment of time to facilitate the development of common ground across stakeholders toward building credibility and trust. The final conclusions within the Chreim et al. (2010) study outline
the importance of having an agent whose main responsibility is to facilitate the change process. Chreim et al. (2010) contend that it would be optimum to allocate a dedicated resource in the form of a staff member to facilitate the change, rather than asking busy health care practitioners to take on a competing workload to their existing role. At ViTA South there was no dedicated resource allocated to manage the change process associated with introducing distributed leadership for ViTA South, however the researcher was an appointed agent who took on the main responsibility of facilitating the change as part of an additional workload.

Also of particular relevance to the research for ViTA South was the Chreim et al. research which illustrated that distributed leadership has both planned and emergent components (Chreim et al., 2010). It also indicated that distributed leadership can contribute to success in bringing about change associated with the social capital, prevalent within an organisation or clinical area (Chreim et al., 2010). Similarly the importance of developing shared understandings is discussed (Chreim et al., 2010).

The next study by Martin, Beech, MacIntosh, and Bushfield (2015) examined three co-located health-care organisations within the UK National Health Service over a three year period. Each of the three organisations had introduced a new leadership framework which incorporated distributed leadership (Martin et al., 2015). The research adopted a methodology which examined how the concept of leadership is created, institutionalised, and reproduced by the leaders within, and by the followers acting on their interpretations and knowledge of the phenomena (Martin et al., 2015).

The research identified several areas of disconnect being power, distance and value. The outcomes within the research were dependent on who had the power, where others were located and what their values were. The outcomes of this research noted several areas of concern in creating distributed leadership. These related to a resistance to change, the power struggle when leadership is shared, the issues of blaming others and a lack of accountability (Martin et al., 2015). It was also observed that there was resistance from social groups within different areas of work and that leaders’ interactions
were restricted to their in-groups in mutual isolation, thus increasing power and control (Martin et al., 2015).

Once again the recurring theme of the need to develop shared understandings between staff was required in order to introduce a climate within the organisation conducive to the change required to create the conditions for staff to exercise distributed leadership (Martin et al., 2015).

A third study by Dearmon, Riley, Mestas, and Buckner (2015) presented a descriptive case study with a participant group of frontline nurses. At the time of the study the nurses were participating in a leadership program known within the research as ‘frontline innovation’. Dearmon et al. (2015) hypothesise that leadership at all levels of organisations is required to transform broken health care systems. The study, similar to Martin et al. (2015), identified that frontline nurses were unaccustomed to resolving system problems and commonly lacked sufficient confidence and leadership skills to partner with administration in decision making and accountability (Dearmon et al., 2015). The recommendations from the research were the potential value of a mentoring approach embedded within research and quality improvement processes as a process to develop the leadership capacity of frontline nurses (Dearmon et al., 2015). Within the research program the staff used research and quality improvement processes to resolve operational failures (Dearmon et al., 2015). The study concluded that a partnership between practice and academia could strengthen the mentoring process (Dearmon et al., 2015). Utilising their leadership development process they evidenced that frontline staff initiated a shared governance model to sustain the work (Dearmon et al., 2015).

The next study, conducted by Klein, Ziegert, Knight, and Xiao (2006), narrowed the focus from an organisational level to a unit based level. The focus of the research paper was to examine the commonalities that describe the team within the trauma unit (Klein et al., 2006). The team was described in terms of those members that provided the care and those attending the trauma emergency unit (Klein et al., 2006).
The findings within this paper indicated a hierarchical, de-individualised and dynamic system of shared leadership from, and within, the teams. The responses from the teams indicated various layers of leadership from the consultant through to resident and senior nurse (Klein et al., 2006). The response from participants indicated a more shared and distributed approach was dependent on the skill and care requirements needed. Four key leadership responsibilities were evident of formal leaders: to provide strategic direction, to monitor situations, provide hands on treatment, and teach other team members (Klein et al., 2006). These findings were consistent with other research papers included within the review that specifically focus on areas of hands on treatment (Tomlinson, 2012) and teaching other team members (Dearmon et al., 2015).

The findings suggest that organisations whose members come together with little or no prior shared experience to perform complex, urgent and often highly consequential tasks, may achieve coordination and reliable performance, by joining hierarchical and bureaucratic role based structures with flexibility enhancing processes. The bureaucratic structures provide the order, balance and stability with the flexibility enhancing processes, allowing staff autonomy and adaptability to practice. Of relevance to this research, the key findings illustrated that distributed leadership has both planned and emergent components, and within the emergency trauma unit the success of the quality of care provided was dependent on a shared and distributed leadership approach.

A further research study included in the systematic review was conducted by Tomlinson (2012). As part of this research 20 nurses from acute surgical wards in Scotland were interviewed. The research utilised an interpretivist phenomenological perspective to understand whether different leadership styles have different effects on clinical teams (Tomlinson, 2012). The findings presented within the research suggest that a distributed leadership approach was present, however the significance of stress was identified (Tomlinson, 2012). The research acknowledged that distributed leadership was apparent in each of the interviews (Tomlinson, 2012).

It is not dissimilar in nature to the findings from within the emergency trauma unit research conducted by Klein et al. (2006). However the outcomes of this paper reiterate
the stress response by participants with the accountability of a distributed model of leadership (Tomlinson, 2012). Stress was identified as a factor in their daily working lives as was tension in the nursing teams (Tomlinson, 2012). The tension they referred to related to the perceived need to meet organisational goals whilst concurrently delivering patient-centred care (Tomlinson, 2012). The research noted that the organisation’s participants tended to place greater importance on audits and meeting targets than on quality of care and a focus on the outcomes of the work at hand (Tomlinson, 2012).

Importantly, the Tomlinson (2012) research identified that on the whole, support for the premise of a transformational leader with a distributed approach worked well. This is not dissimilar to the paper by Dearmon et al. (2015) and also the outcomes identified by Klein et al. (2006) as in both of these research studies patient-centred care was a norm, and organisational goals were achieved. Within the research by Tomlinson (2012) no direct correlations between the variables could be ascertained, however it was suggested that a transformational leader was key (Tomlinson, 2012). The distributed approach linked decision making and accountability to be kept as close to the clinical front line as possible (Tomlinson, 2012).

The final research study included was undertaken by McKee, Charles, Dixon-Woods, Willars, and Martin (2013). The study explored the views of strategic level stakeholders on leadership for quality and safety in the UK National Health Service (McKee et al., 2013). This research study differed from the others in that it sought to understand the experience from formal leaders who held strategic positions within the UK National Health Service (McKee et al., 2013). The research was extensive with 107 interviews conducted. Consistent with the literature, the research sought to distinguish between traditional hierarchical ‘concentrated’ leadership characteristics associated with particular positions, and distributed leadership involving those with particular skills and abilities across multiple institutional levels (McKee et al., 2013).

The findings presented in this research articulated an identified role for distributed leadership (McKee et al., 2013). The leadership approach described within the research by McKee et al. (2013) outlines the value of leadership coalitions between
managers and staff. The research paper expresses concern that distributed leadership may create an environment of uncertainty about who was in charge, with particular relevance to the trauma unit and the need at times for clear direction and approach in care decisions (McKee et al., 2013). At a national level it risked creating confusion of who had the authority, with tiers of authority and the possibility of mixed messages, and conflicting expectations and demands (McKee et al., 2013). The participants within the research argued that hierarchically based leadership was needed to complement a distributed approach (McKee et al., 2013). This was based on the need for a leader to provide focus, and be able to provide practical support and expertise, and managerial influence (McKee et al., 2013). Despite the concerns the research argued that leadership at every level of staff within an organisation is essential to patient safety and quality (McKee et al., 2013). Participants saw that leadership for quality and safety was the responsibility of everyone and should not be left in the hands of a few (McKee et al., 2013). The research identified that in reconceptualising ‘new’ leadership, organisational development needs to provide a clear strategic and well-versed direction (McKee et al., 2013).

The systematic review process identified four key considerations when deciding how to utilise distributed leadership theory in practice in health and aged care. These were:

1. Mobilise agents of change toward developing distributed leadership.
2. Tailor leadership governance structures.
3. Ensure visibility and accessibility of the organisational strategic plan and make explicit how operations align with and contribute toward achieving strategic goals.
4. Understand the importance of understanding the characteristics of team dynamics needed to enact distributed leadership.

These considerations are referenced and discussed in both cycle two of the research and within the presentation of the research findings. These considerations directed the literature review in exploring considerations around choice of strategy for leadership development.
2.2.5 Leadership development

Traditional leadership development has primarily focused on the qualities, characteristics, skills and capabilities of leaders as individuals (Bolden, Jones, Davis, & Gentle, 2015). It is often espoused that effectiveness in an organisation is dependent upon the success of these individual leaders (Avolio, Walumbwa, & Weber, 2009; Bolden et al., 2015; West et al., 2014). While the skills of the individual are important in creating the conditions it is too narrow to place the emphasis on just a few people (Bolden et al., 2015).

In traditional leadership development there has not been the focus on developing collective capability (The King’s Fund, 2012). Similarly there has not been a process for embedding the development of people within the context of the organisation they are working in (West et al., 2014). It is recommended that contemporary leadership development should factor in the shift from a focus on leadership by a person in a position to leadership as a process (Grint, 2005). Once again this reinforces the decision to adopt double loop learning within leadership development to create the conditions for staff to exercise distributed leadership at ViTA South.

The traditional approach to leadership development is common in health and aged care. Leadership programs in health and aged care traditionally focus on individual traits (Dickson & Tholl, 2014; Forman et al., 2014; Health Workforce Australia, 2012b). However it is recognised that health practitioners working within health and aged care organisations don’t work as individuals and need to work collaboratively. Even if they are sole practitioners they are part of a broader team (Dickson & Tholl, 2014; Forman et al., 2014; Health Workforce Australia, 2012b).

In contemporary leadership development the shift in focus is away from purely leadership ‘inputs’ toward a focus on leadership ‘outcomes’ (Bolden, 2011; Jones, Lefoe, Harvey, & Ryland, 2012). Leadership ‘inputs’ in this sense are leaders, followers and tasks, whereas leadership ‘outcomes’ are a shared sense of direction, alignment and
commitment (Bolden et al., 2015). This holistic approach to leadership development was adopted and embedded within the ViTA South operational model.

2.2.6 Leadership strategy development

A leadership strategy is the result of a process of consciously and purposefully describing the type of leadership culture the organisation aspires to (The King’s Fund, 2012; West et al., 2014). The goal of a leadership strategy is to enhance leadership (West et al., 2014). This includes identifying the skills and behaviours needed at an individual and collective level to implement and sustain the desired leadership culture (West et al., 2014).

An organisational effort is required to develop a leadership strategy which incorporates distributed leadership (The King’s Fund, 2012; West et al., 2014). It views leadership development as a means of creating collective capability in the organisation and endorses the integration of leadership development with organisational development (West et al., 2014).

This focus on organisational effort contrasts with traditional leadership development work, which has focused on developing individual capability while neglecting the need for developing collective capability or embedding the development of people within and across the context of the organisation they are working in (West et al., 2014).

A leadership development plan flows from the strategy setting out how to achieve the desired future state. It is a process that is considered, contextual and informed by data and requires disciplined commitment and action. By implication, leadership development will be fundamentally contextualised in the culture and strategy of the organisation concerned. It will not be a process of training individuals by sending them to an external provider for a training course. While training is important, more important are the structures, supports and processes which create the conditions for staff to exercise distributed leadership (West et al., 2014).
The leadership strategy developed for ViTA South aimed to utilise leadership development as a way of developing collective capability within the organisation, by building a research process that enabled both individual leadership development as well as collective (organisational) leadership development. The aspired leadership strategy aimed to align the integration of leadership development as part of organisational development; and recognised the importance of unique organisational context as a major factor in shaping the leadership required to inform organisational development and resolve the business problem of this study.

2.2.7 Distributed leadership: modelling

Planning and modelling for enabling distributed leadership requires a shift in the traditional thinking about the allocation of responsibility, resources, power and influence (Jones et al., 2012). The Australian Learning and Teaching Council (ALTC) funded a project that focused on enabling distributed leadership in the university sector. The project identified four important factors when introducing distributed leadership:

1. A focus on actions rather than simply processes or structures
2. The design of a reflective process to scaffold action through cycles of change as new issues and ideas emerge
3. The development of a dynamic process to enable distributed leadership that goes beyond evaluation
4. Recognition of the hybrid nature of distributed leadership that values working alongside, rather than replacing, formal leaders (Jones et al., 2012).

The ALTC project was integral in developing a set of resources to assist Australian universities to build leadership capacity in learning and teaching using a distributed leadership approach (Jones et al., 2012). The resources developed from this project included the 6E Conceptual Model, the Action Self Enabling Resource Tool (ASERT) and also Benchmarks for Distributed Leadership. An overview and discussion of these tools is provided below.
The 6E Conceptual Model was based on six key principles which were identified as necessary for planning a distributed leadership strategy. To date the 6E Conceptual Framework has only been tested in the university sector. The principles are outlined in Table 3.

Table 3 The 6E conceptual framework (Jones et al, 2014)

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Engage with people</td>
<td>a broad range of leaders in positions of institutional authority (termed formal leaders), employees respected for their leadership but not in positions of institutional authority (termed informal leaders), experts in learning and teaching and formal and informal leaders and experts from various functions, disciplines, groups and levels across the institution who contribute to learning and teaching.</td>
</tr>
<tr>
<td>2. Enable through relationships</td>
<td>development of context and culture of respect for and trust in individual contributions to effect change through the nurturing of collaborative relationships.</td>
</tr>
<tr>
<td>3. Enact via intentional practice</td>
<td>design a holistic process in which processes, support and systems encourage the involvement of people.</td>
</tr>
<tr>
<td>4. Encourages with activities and acknowledgement</td>
<td>a plethora of activities to raise awareness and scaffold learning through professional development, mentoring, facilitation of networks, communities of practice, time, space and finance for collaboration, and recognition of, and reward for contribution.</td>
</tr>
<tr>
<td>5. Evaluate for learning and development</td>
<td>benchmarks against good practice examples that evidence increased engagement in learning and teaching, collaboration, and growth in leadership capacity.</td>
</tr>
<tr>
<td>6. Emergent through participative action research (PAR)</td>
<td>a sustainable ongoing process of cycles of action through PAR.</td>
</tr>
</tbody>
</table>

2.2.9 Action Self Enabling Resource (ASERT)

The Action Self Enabling Resource (see Table 4), otherwise known as the ASERT, was designed to assist universities to self-evaluate their capacity to engage with a distributed leadership approach and presents the means to identify action required to support a distributed leadership approach (Jones et al., 2012).
Table 4 The Action Self Enabling Resource (Jones et al, 2012 p.613)

<table>
<thead>
<tr>
<th>Criteria for Distributed Leadership</th>
<th>Dimensions and Values to enable development of Distributed Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Context</td>
</tr>
<tr>
<td>People are involved</td>
<td>Expertise of individuals is used to inform decisions</td>
</tr>
<tr>
<td>Processes are supportive</td>
<td>Informal Leadership is recognised</td>
</tr>
<tr>
<td>Professional development is provided</td>
<td>Distributed Leadership is used to build leadership capacity</td>
</tr>
<tr>
<td>Resources are available</td>
<td>Space, time and finance for collaboration are available</td>
</tr>
</tbody>
</table>

Within the ASERT there are four common dimensions and value descriptors for distributed leadership inherent within this resource, which are listed below:

**Context** – where leadership is regarded as relying less on positional power and more on placing trust in expertise

**Culture** – in which leadership relies less on control and more on respect for experience and expertise

**Change** – where leadership is recognised as emanating from multiple levels and functions as a mix of top-down, bottom-up and middle-out contributions

**Relationship** – based on collaboration between individuals that together contribute to a collective identity.

(Jones et al, 2012, p603-619).
Additionally, the *ASERT* has four associated criteria for a collective approach to distributed leadership listed as follows:

- **People** – the involvement of a broad range of experts contributing their knowledge
- **Processes** – that are supportive of enabling individuals to share their expertise across traditional functions and structures
- **Professional development** – provided to develop individual and collective skills, traits and behaviours
- **Resources** – provided to encourage collaboration, networks and partnerships.

(Jones et al., 2012. p603-619)

The intersection of these dimensions, values and criteria are presented as a grid (*the ASERT*) shown in Table 4. The presentation in a grid format is purposely designed to assist in the process of planning for creating the conditions for distributed leadership. It is not designed to provide a prescriptive step-by-step approach but is intended to enable the mapping of what currently exists in an organisation against what needs to be developed. The intention of this approach is to provide flexibility to individualise an approach and map mutually reinforcing actions and conditions (Jones et al., 2012).

*ACH Group* adopted the *ASERT* and *6E* to define the criterion, dimensions and values to enable distributed leadership within the *ViTA South* operational model. While the *ASERT* and *6E* were not specifically designed for the health or aged care sector, the potential for transferability to this study was recognised by the researcher and the *ACH Group Leadership Team*. The research literature on distributed leadership shows that at times there can be resistance to the adoption of distributed leadership related to misunderstandings in its purpose and outcomes (Bolden, 2011; Bolden et al., 2015). The *ASERT* was identified as potentially useful in providing a frame of reference to assist in communicating a conceptual model which underpins distributed leadership. The *ASERT* provides a detailed identification of actions required to encourage and assist with development of the conditions for staff to exercise distributed leadership (Bolden, 2011; Bolden et al., 2015).
2.2.10 Benchmarks for Distributed Leadership

In building on the work undertaken to develop the ASERT resources (Jones et al., 2012) a further resource was developed. This tool aimed to provide an evaluative process (through benchmarking) of distributed leadership across universities. The distributed leadership benchmarking tool developed by Jones, Hadgraft, Harvey, Lefoe and Ryland (2014) outlines benchmarks which are designed to evaluate distributed leadership against previously determined reference points.

Benchmarking is undertaken as a common process in a range of areas across Australian universities. It is a process by which Australian higher education institutions can measure and evaluate their current practices against previously determined standards. This enables comparison within and across universities.

The intention of the distributed leadership tool was for it to be used to enable ‘good practice benchmarking’ as the comparator selected is believed to be the best in the area to be benchmarked (Jones et al., 2014).

The criteria are established as definitions of the attributes of perceived good practice in distributed leadership. They were identified by working with Australian higher education institutions which had been using a distributed leadership approach to achieve change to improve learning and teaching.

The benchmarks articulated in Table 5 have been designed to be used as a collaborative benchmarking tool. It is focused on processes as a tool to support collaborative learning and self-improvement as part of a continuous action learning and/or action research cycle. At the time of this review the benchmarking tool had not been validated for use within research. However the distributed leadership benchmarking tool was adopted by the ACH Group Leadership Team as a tool for use within the organisational process of leadership development within ViTA South.
Table 5: Benchmarks for Distributed Leadership (Jones et al, 2014)

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>SCOPE</th>
<th>ELEMENTS</th>
<th>GOOD PRACTICE DESCRIPTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENGAGE</td>
<td>Distributed leadership engages a broad range of participants from all relevant functions, disciplines, groups and levels. This includes formal leaders, informal leaders and experts</td>
<td>Formal leaders (academic and professional)</td>
<td>Formal leaders proactively support initiatives through attendance at meetings, publication of activities and other sponsorship activities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Informal leaders</td>
<td>Staff participate in learning and teaching enhancement and are recognised for their expertise through good practice.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discipline experts</td>
<td>Academics from relevant disciplines contribute their discipline expertise to initiatives either through self-nomination or peer nomination.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Functional experts</td>
<td>Professional staff contribute their relevant functional expertise to initiatives either through self-nomination or peer nomination.</td>
</tr>
<tr>
<td>ENABLE</td>
<td>Distributed leadership is enabled through a context of trust and a culture of respect coupled with effecting change through collaborative relationships</td>
<td>Context of trust.</td>
<td>Decisions made in initiatives are based on respect for and confidence in the knowledge, skills and expertise of academics and professional staff in addition to the relevant rules and regulations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Culture of respect</td>
<td>Decisions made in initiatives are shared between all participants based on their expertise and strengths.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acceptance of need for change</td>
<td>Initiatives combine formal leadership authority, relevant rules and regulations and the expertise of staff in an integrated top-down, bottom- and middle-up approach.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Collaborative relationships</td>
<td>Participants in initiatives are provided with professional development opportunities as well as experienced facilitators and mentors to encourage collaborative decision making.</td>
</tr>
<tr>
<td>ENACT</td>
<td>Distributed leadership is enacted by involvement of people, the design of processes, the provision of support and the implementation of systems</td>
<td>Involvement of people</td>
<td>Initiatives identify and encourage the participation of experts from among all relevant academic and professional staff.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Design of participative processes</td>
<td>Communities of practice and other networking opportunities are encouraged and supported.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provision of support</td>
<td>Space, time and finance for collaborative initiatives are provided.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Integration and alignment of systems</td>
<td>Systems are aligned to ensure that decisions arising from initiatives are integrated into formal policy and processes.</td>
</tr>
<tr>
<td>ASSESS</td>
<td>Distributed leadership is best evaluated drawing on multiple sources of evidence of increased engagement collaboration and growth in leadership capacity</td>
<td>Increased engagement</td>
<td>Performance review processes acknowledge individual engagement in initiatives.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increased collaboration</td>
<td>Data (such as university cultural surveys; collaborative grant applications related to learning and teaching enhancement; and collaborative publications) identify evidence of increased collaborative activity between staff.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Growth in leadership capacity</td>
<td>Participation in initiatives is recognised and rewarded.</td>
</tr>
<tr>
<td>EMERGENT</td>
<td>Distributed leadership is emergent and sustained through cycles of action research built on a Participative Action Research methodology</td>
<td>Participative action research process</td>
<td>An action research process that encourages participation through cycles of activity underpins the initiative.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reflective practice</td>
<td>Reflective practice is built into initiatives as a formal practice and stage of the initiative.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Continuous improvement</td>
<td>Output from each stage of the initiative will be sustained.</td>
</tr>
</tbody>
</table>
This first two sections of the literature review have discussed the relevant professional and academic literature. The next section provides the practical link between methods of action research and the goal of creating distributed leadership.

2.3 Practical link between methods of action research approach and the goal of creating distributed leadership

During the literature review a practical link between methods of action research and the goal of creating distributed leadership was identified. This practical link is now presented in terms of five organisational development theoretical constructs. The justification for the choice of action research is then expanded within the presentation on research design in chapter 3.

2.3.1 Dynamics of leading strategic organisational development initiatives

Five organisational development theoretical constructs were adopted for use within this research. These constructs help to explain the dynamics of leading strategic organisational development. These theoretical constructs are:

1. Complex adaptive systems
2. Theory of action
3. Logic modelling
4. Action research (discussed in Chapter 3)
5. Single and double loop learning

The theoretical constructs influenced the choice of how and why the organisational strategies were chosen and were intended to work in practice at ViTA South. A discussion of the academic literature relevant to these theoretical constructs is now presented.

Together these theoretical constructs enabled a ‘diagnosis and a design’ approach to developing distributed leadership which is recommended by Spillane and Coldren (2011). A diagnosis and design approach involves scoping barriers to
distributed leadership which can then inform system design by allowing for the tailoring of strategies to overcome the identified barriers (Spillane et al, 2011).

### 2.3.2 Complex adaptive systems

Health systems are some of the most complex social organisations that exist (Philippon, 2011). Many theorists describe health and aged care services as complex adaptive systems (Anderson et al., 2003; Best, Greenhalgh, Lewis, Saul, Carroll & Bitz, 2012; Dickson & Tholl, 2014; Plsek & Greenhalgh, 2001). *ViTA South* was recognised is described by the researcher as being a complex adaptive system as it shares the characteristics of a complex adaptive systems which Rouse (2008) describes as follows:

- They are non-linear and change dynamically. They do not inherently reach fixed equilibrium points. As a result of system behaviours they may appear to be random or chaotic
- They are composed of independent agents whose behaviour is based on physical, psychological, or social rules rather than the demands of system dynamics
- Because agents’ needs or desires (reflected in their rules) are not homogeneous, their goals and behaviours are likely to conflict
- In response to these conflicts or competitions, agents tend to adapt to each other’s behaviours
- Agents are intelligent. As they experiment and gain experience, agents learn and change their behaviours accordingly. Thus, overall system behaviour inherently changes over time
- Adaption and learning tend to result in self organisation. Behaviour patterns emerge rather than being designed into the systems. The nature of emergent behaviours may range from valuable innovations to unfortunate accidents
- There is no single point(s) of control. System behaviours are often unpredictable and uncontrollable, and no-one is in charge. Consequently the behaviours of complex adaptive systems can usually be more easily influenced than controlled.
Understanding these characteristics of complex adaptive systems influenced the perspective of change management adopted for this research. That is, while change cannot be ‘managed’ it can be understood (Mintzberg & Westley, 1992). It is recommended within complex adaptive systems that leadership has a focus on influence rather than power and control through hierarchy (Rouse, 2008). The recognition that aged care services operate as complex adaptive systems reinforces the importance of distributed leadership. As an alternate approach to traditional hierarchical leadership distributed leadership has a focus on influence rather than power (Jones, 2014). A significant consideration for this research as it relates to ViTA South was the need to understand how to create change within complex adaptive systems. To support system change within a complex adaptive system, leaders must create the conditions for the emergence of the change sought (Gilson, Elloker, Ockers, & Lehmann, 2014). This can be undertaken through enabling cycles of action, feedback and learning that empower operational staff to think and work differently (Gilson et al., 2014).

2.3.3 Theory of action

A theory of action explains the underlying assumptions behind how a strategy is expected to work (Newcomer, Hatry, & Wholey, 2015). It has been incorporated into the research design as it recognises distributed leadership as the action of a group. In order to create the conditions for staff to exercise distributed leadership an understanding of the underlying theories of action which inform individual and group thinking and action is required. Logic modelling is a process and a format to identify and articulate theories of action to explain how chosen strategies are expected to work in practice.

2.3.4 Logic modelling

The process of logic modelling was chosen as an approach to shape new shared understandings in how to create the conditions for staff to exercise distributed leadership. The process of developing a logic model helps develop a shared understanding and expectations (Newcomer et al., 2015). This fits well with distributed leadership which requires development of shared understandings (Gronn, 2002; Jones, 2014; Spillane, Halverson, & Diamond, 2004).
Logic modelling has proven to be a useful process to conceptualise, plan and communicate concepts and strategies to others (Knowlton & Phillips, 2012 & Newcomer et al., 2015). The process involves making explicit the explanation or logic around how an intervention can contribute to either an intended or actual outcome (Knowlton et al., 2012). Logic modelling can help to identify and create an intentional transformation of specific resources toward developing processes to achieve certain organisational outputs. There is no set structure for a logic model and they vary quite considerably. Some may be in a narrative form and others in a table form (Knowlton et al. & Newcomer et al., 2015).

The process of logic modelling was used to capture information gained through understanding and then communicate strategies and interventions designed for ViTA South. The logic models developed within this research aim to articulate the thinking behind the strategies developed and the expected results from implementing the strategies. For the benefit of the wider research audience the logic models also enabled a clear presentation of the logic behind how and why the strategies developed for ViTA South were intended to work in practice. They allow for a comparison between the ‘theory of action’, which is the theory behind how a strategy is expected to work and the ‘theory in-use’ which is the theory behind how the strategy appeared to actually work, or not work. The difference between the anticipated theory in action and actual theory in use helped further refine strategies and develop new strategies.

2.3.5 Single and double loop learning to facilitate change

The process of logic modelling was identified by the researcher as an explicit framework which would contribute to enabling the organisational learning process known as double loop learning. With the value of double loop learning being that it contributes to facilitating organisational development (Argyris, 2002).

Single loop learning is recognised as the process of recognising a problem and identifying a solution or correcting errors (Argyris, 2002). If something goes wrong a first
step is to identify a strategy that will address and work within specific governing variables (Argyris, 2002). It is often the case that specifically chosen goals, values, plans and rules are implemented and rarely questioned (Argyris & Schön, 1974). Single-loop learning can happen when goals, values, frameworks and, strategies are implicit (Usher & Bryant, 1989).

Double loop learning is presented as an additional response which involves questioning governing variables themselves and critically appraising them (Argyris & Schön, 1974). Double loop learning may then lead to an adjustment in the governing variables and a shift in the underlying thinking and assumptions underpinning strategies and their linked consequences (Argyris & Schön, 1974).

In enabling double loop learning an understanding is required of how the choice of strategy is intended to work in practice. This intention can then be compared with the actual outcome. For a strategy to be successful there must be a match between intention and outcome. Where consequences are unintended then a review of how the strategy was intended to work in practice enables organisational learning (Argyris & Schön, 1974).

Argyris and Schön use two models known as Model I to and Model II that describe features that either inhibit or enhance double-loop learning (Argyris & Schön, 1974). In Model I, orientation and practice work to control environment and task unilaterally, together with protecting self and others unilaterally. Strategies are usually implemented by making covert attributions and evaluations. With consequences of creating defensive relationships, low freedom of choice and minimal public testing of ideas. Model I can lead to deeply entrenched defensive routines and these can operate at individual, group and organisational levels.

In Argyris and Schön’s (1974) Model II orientation and practice share control and encourage participation in design and implementation of action. This is enabled through evaluation with relatively directly observable data (Argyris & Schön, 1974). In the case of ViTA South it was planned that logic modelling would contribute to enabling the features
associated with Model II, enabling double loop learning at ViTA South. The orientation and practice in Model II welcomes conflicting view as a point of dialogue and discussion toward improvement (Argyris & Schön, 1974).

In acknowledging the potential value of the process of double loop learning working through and facilitated by both logic modelling and the action research methodology adopted for this research. Similar to double loop learning, action research contributes to facilitating change. Therefore an assumption was made that as action research would provide a mechanism to stimulate a transition from one way of practicing leadership to the distributed leadership approach. It would do so because action research as a methodology embraces many of the principles of effective organisational development.

During the 18-month planning and commissioning stage for ViTA South action research and logic modelling were chosen by the researcher to enable double loop learning processes. It was determined that the process of logic modelling would be developed to become an embedded business process within the ViTA South operational model. This would enable the processes of double loop learning to be sustained beyond the life of this action research study.

2.4 Conceptual framework – guide to leadership development for ViTA South

The literature review discussed distributed leadership and organisational development and identified five key theoretical constructs to explain an action research approach as a methodology to create change. When combined they created the conceptual framework which was used to guide this research study.

The theoretical constructs influenced the choice of how and why the organisational strategies chosen were intended to work in practice at ViTA South. Firstly it provided the framework for understanding the business problem and what the research and organisational development aimed to achieve. This framework is presented on the left hand side of Figure 4. Secondly, it conceptualised an approach to how leadership
development would be planned and undertaken at ViTA South. This provided the theoretical foundation for the use of action research as a methodology which would both document and inform organisational development. This approach incorporated a series of organisational development tools and concepts which would be applied within leadership development for ViTA South. This included the use of logic models which described what distributed leadership looked like in practice. This approach is presented on the right hand side of Figure 4.
Figure 4 Visual overview of the conceptual framework for this research
The conditions and behaviours which this research study aimed to create were drawn from *Health LEADS Australia*, the *ASERT* and based on the situational needs of *ViTA South*. Table 6 presents the attributes of distributed leadership expected of staff which were incorporated within the leadership strategy for *ViTA South*.

**Table 6 Attributes of distributed leadership expected of staff which will guide the creation of an operational model for ViTA South**

<table>
<thead>
<tr>
<th>Criteria for Distributed Leadership (i.e., enabling conditions from the ASERT)</th>
<th>Desired Collaborative Behaviours (based on <em>Health LEADS Australia</em>)</th>
</tr>
</thead>
</table>
| People are Involved | • Staff seek to establish positive working relationships with other team members  
• Staff show willingness to engage constructively and respectfully in difficult conversations and keep communication channels open  
• Staff feel they are listened to and involved in decision making  
• Staff feel their expertise is respected |
| Processes are supportive | • Staff are able to make suggestions for improvement  
• Staff agree that decisions that are made are made collegially when their professionalism and knowledge is required in making the decision  
• Individuals step forward to solve problems rather than waiting for others to do so |
| Professional development is provided | • Individuals participate in training that is offered  
• Staff take advantage of mentoring opportunities  
• Show enthusiasm for new ideas and learning  
• Seek out opportunities to learn from colleagues |
| Resources are available | • Utilise time provided to engage with colleagues to develop and maintain health work practices  
• Take advantage of supports available to create effective interprofessional teams  
• Actively engage residents, family members, colleagues and staff in service improvement |

The operational model developed for *ViTA South* aimed to develop and embed actions that would create the enabling conditions which are presented on the left hand side of Table 6. The intent of these conditions which associated with distributed leadership criteria are ‘drivers’ for collaborative practice. The collaborative behaviours are consistent
with *Health LEADS Australia* framework and the concept of distributed leadership presented on the right hand side of Table 6.

The research design was tailored to use action research as a methodology to both document and inform organisational development consistent with the conceptual framework outlined in this chapter. The justification and overview of the research design will now be discussed in Chapter 3.