Building resilience in a professional services community: The role of leadership development

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The Tasmanian Department of Health and Human Services Management and Leadership Program aims to increase the skills and knowledge of managers and leaders in order to create a workforce capable of meeting changing needs and future requirements.

The Program consists of a series of in-house programs for frontline and aspiring managers (the Foundation Course); senior nurses and allied health professionals; clinical leaders; and graduate trainees. Most programs include didactic methods and group learning as well as experiential learning activities such as shadowing, coaching, action learning and undertaking a workplace project. An academic pathway has also been developed, in partnership with the University of Tasmania.

The evaluation process involves participants completing an online survey before they attend the Foundation Course and repeating the survey nine months afterwards. Results indicate a statistically significant increase in self-esteem and social support. In addition, 40% of respondents have subsequently been engaged in a more senior position (on a permanent or temporary basis) and 21% have taken up the academic pathway.

These effects are being demonstrated in spite of the countervailing impact of significant organisational restructuring and downsizing in the sector. Participants are not displaying the stress, health issues and disengagement described in the ‘downsizing literature’. This suggests that the Program may be having a ‘prophylactic effect’ to the downsizing experience. In addition, it contributes to building resilience in this professional service community.

Keywords: leadership development, health and human services, downsizing

The Professional Services Community in Tasmanian Health and Human Services

Health and human services are typically delivered by professionals who hold considerable authority and autonomy in relation to the content and delivery of these services to clients/patients, largely by virtue of their qualifications, status and expertise (Brathwaite et al. 2011; Palmer and Short 2010). In most regional and rural areas, these professionals are likely to know (or know of) each other as they interact over time: in relation to client/patient cases; common places of work within and across the private and public sector; or are engaged by government as ‘stakeholders’ in consultation (Shannon 2005; Shannon 2010).

This common substantive interest, and consistency of interaction over time, is sometimes described as a ‘policy community’ (Coleman and Skogstad 1990; Kingdon 1984; Rhodes 1985; Richardson and Jordan 1979). This ‘community’ is developed through a broadly common set of beliefs and behaviours (Pross 1986), highly congruent with the professional ethos of many health and human services providers.

A community under threat: Downsizing and structural change

Over the last 18 months, the Tasmanian Government has pursued significant State Budget savings through a wide range of initiatives (Giddings 2011; Giddings 2012a) including a staff ‘downsizing’ of approximately 10% of the State Service (Denholm 2011). All government departments have been impacted, including the Department of Health and Human Services (DHHS) (O’Byrne 2011; O’Byrne 2012).

The literature suggests that a ‘downsizing environment’ results in a rise in employee stress, health issues and voluntary departures (Noer 2009). It also suggests that, during and after downsizing, employees are generally less motivated to contribute to organisational success and are less willing to apply discretionary effort to accomplishing tasks important to the organisation (Mishra et al. 2009). These ‘survivors’ are more likely to lose their trust, loyalty and commitment to
the organisation (Levitt et al. 2008). If they themselves have had to execute some of the layoffs, they are more likely to practice ‘distancing techniques’ (emotionally, cognitively or physically) in order to deal with downsizing stress (Gandolfi 2009).

For the DHHS, this threat to individual and organisational resilience has been compounded by radical organisational restructuring brought about by implementation of the National Health Reform Agreement (Council of Australian Governments 2011). This commits the Commonwealth, state and territory governments to implement new health system arrangements, from 1 July 2012, including the establishment of local hospital networks and Medicare Locals. At a local level, the implementation of this national agreement creates new, independent statutory authorities under the Tasmanian Health Organisations (THO) Act 2011.

The dispersion of the majority of DHHS health and aged care services to either the Australian Government or the THOs have resulted in both technical and practical changes in working arrangements for a significant number of DHHS staff. It is well documented that, even in the absence of organisational downsizing, large-scale organisational restructuring can have adverse impacts on staff physical and psychological health (Emmerik and Euwema 2008; European Expert Group on Health in Restructuring 2009; Lee and Teo 2005; Swanson and Power 2001).

More importantly, the restructure of health services in Australia introduces an activity-based funding scheme, at a ‘nationally efficient’ price, which will have a negative financial impact on services that are delivered above that price. This will strongly focus the attention of CEOs and Governments on further cost reductions, with additional downsizing and ongoing restructuring a real possibility into the future.

Leadership development and change management in public sector health services

The picture of a professional services community subject to downsizing and structural change is not unique to Tasmania but reflects the social, demographic and economic challenges faced by health services in many Australian jurisdictions and, in fact, in many countries throughout the world (World Health Organization 2010). In these circumstances, of significant change impacting on a core group of providers, it is not surprising that one of the key strategies utilised has been to strengthen the provider core through leadership development.

Internationally, Canada and the United Kingdom have invested heavily in public sector health services leadership development (Dickson 2007; NHS Institute for Innovation and Improvement 2010). The focus has been on both sustainability (in the face of increasing costs and demands) and change (with the emergence of new treatments, processes and disciplines) (Edmonstone and Western 2002; Oliver 2006).

Health Workforce Australia also recognises leadership as essential to the sustainability of the health care system due to its linkage to innovation and change (Health Workforce Australia 2012). Government health services in Australian States and Territories (particularly Queensland and New South Wales) have invested in this area for these reasons and also as a way of increase the safety and quality of treatment and patient care (Centre for Healthcare Improvement 2010; Clinical Excellence Commission 2012; Crethar et al. 2009).

In Tasmania, the Premier’s address to the Senior Executive Service (Giddings 2012b) emphasised the importance of leadership development across the whole of the Tasmanian public sector:

‘In these times we need leadership that gives people permission to do things differently. We need leadership that lets people try things, and learn from their mistakes. And we need leadership that gives others the space to lead ... I am keen to see every agency promote and support programs that encourage leadership development across the State Service.’

Leadership development in the Tasmanian Department of Health and Human Services

Since June 2009, after a decade-long hiatus, the DHHS has incrementally activated a multi-pronged management and leadership development program. It gives form to the Strategic Objective 5 – ‘Shaping our workforce to be capable of meeting changing needs and future requirements’ (Department of Health and Human Services 2009).

It includes a graduate recruitment scheme, a Foundation Program for middle and frontline managers, a university pathway, and a range of short courses and workplace activities for medical, nursing, allied health and management professionals.

The focus of this paper is the Foundation Program, which consists of a multi-day Foundation Course, plus a series of workplace activities, based on evidence based adult learning strategies (Schön 1983; Kolb 1984; Knowles 1990; Argyris 1991; Knud 2003):

- Shadowing (half a day with a peer and half a day with a senior manager)
• Coaching (four one-hour sessions with a coach of their choice)
• Action learning (six meetings in a facilitated group)
• A workplace project

Senior management take an active role as presenters, coaches, action learning facilitators and workplace shadows, as well as presenters at the Foundation Course.

The program is centrally funded by DHHS, so free to individual staff and business units. Other organisations attend on a cost-recovery basis.

At the time of writing (July 2012), almost 400 participants have undertaken the Foundation Course. With the exception of medical practitioners, who are under-represented (1%), participation in the Foundation Program reflects the distribution of the professions in the workforce, with nursing and midwifery (42%), administration and clerical staff (31%), allied health professions (19%) and ambulance officers (3%).

The Foundation Program reflects ‘best practice’ (Health Workforce Australia 2012) in its emphasis on applied, in-house activities; strong involvement by senior managers within the organisation and by managers from across the sector; and its multi-disciplinary approach. It also has a well-developed evaluation strategy.

These evaluation results provide insight into how leadership development has strengthened resilience within the professional services community, in spite of downsizing and structural change.

**Evaluation methods**

There are a range of instruments which aim to evaluate the outcomes of leadership programs (Black and Earnest 2009; Davidson et al. 2005; Hartley and Tranfield 2011; LeMay and Ellis 2008). Most evaluations of leadership development in health services, however, are largely ‘process’ oriented – relating to the organisation of the program and participant satisfaction with the program (McAlearney 2008). Some evaluations also include outcomes results in relation to the workplace projects that have been undertaken and a very few also look at participant and colleague perceptions of change (Clinical Excellence Commission 2009).

Two types of questionnaires are administered as part of the Foundation Program:

• A feedback questionnaire was developed for the first Foundation Course in April 2010. This ‘process evaluation’ measures participant satisfaction.

• In January 2011, an evaluation questionnaire was developed to measure the ‘impact’ of the Foundation Program on participant capabilities.

The evaluation questionnaire used (see Appendix) brings together the 10-item (Schwarzer and Jerusalem 1995) General Self-Efficacy Scale and the 4-item (Schwarzer, 2000) Berlin Social Support Scale (Instrumental Perceived Available Support), together with a question relating to positive job orientation.

The rationale for this combination is based on studies associated with management development programs (Roberts et al. 2005; Spreitzer and Quinn 1996) where it was found that managers likely to make positive changes that affected themselves and their organisation (described by the authors as ‘transformational leaders’) were individuals with significantly increased:

1. Positive agentic resources (self-esteem, self-efficacy).
2. Relational resources (social support within the workplace),
3. Positive affective resources (positive orientation towards their job).

This approach informs both the Foundation Program evaluation and key elements of Program content guide participants to examine their own management roles (Quinn 1988), organisational culture (Cameron and Quinn 2011) and leadership styles (Quinn 2005).

The evaluation questionnaire is administered twice in a ’pre and post’ sample design. Participants are asked to fill out the evaluation questionnaire both before they attend the Foundation Course and then nine months later. Data is grouped by Foundation Course cohort and compared across time (T1) and (T2). Analysis is conducted by converting results of both scales to percentages, in order to allow for comparison. There is an assumption of a normal distribution and of a statistical significance of 0.05 (or 5%).

Pre (T1) and post (T2) responses have been received from six cohorts of participants in the DHHS Management and Leadership Foundation Course participants. These staff filled out a preliminary survey before undertaking a Course held between February and September 2011, then filled out a second survey nine months later (between December 2011 and June 2012). This provided a sample size of n=110 for T1 and n=58 for T2: a 53% response rate.

Figure 1 (refer top p. 40) breaks down evaluation survey respondents by profession and illustrates that the professional profile of respondents is broadly reflective of the professional profile of participants.

In order to further explore and interpret the evaluation questionnaire findings, a case
study approach (Yin 1994) is also used to explore changes in participants’ leadership behaviours after completion of the Program. The case study looks intensely at a small pool of ex-participants and involves an in-depth description of the program being evaluated and the characteristics of the people involved in it (Mills et al. 2010).

At this stage nine semi-structured interviews have been conducted with participants from a variety of business units. The semi-structured interview method allows for the story ‘owned’ by the interviewee to surface and for the interviewee’s reflection on personal experience (Bridges et al. 2008). This process facilitates the collection of richer, more textured data from the participant than that obtained through formally structured scheduled questions.

The interviewed participants have completed all components of the Foundation Program. Participants have been recruited from different groups undertaking the Program (‘cohorts’), therefore the time elapsed from completion of the program to date of interview varies.

The limitation of the evaluation methods used (questionnaires and interviews) is that they are both subjective – based on self-assessment by the participant. This reliance on participant self-assessment is due to the diversity of participant roles and professions; the relative frequency of participants’ movement into different, often more senior, roles; and the associated difficulties with gathering relevant managerial or collegial feedback on performance over time.

**Evaluation results – Perceptions of threat**

The evaluation questionnaire was not designed to measure the impact of downsizing or restructuring. However, strength of this mixed-method evaluation is that the semi-structured interviews associated with the case studies shed light on these and other issues of relevance to respondents.

**Downsizing**

The threat of job losses was an issue of concern to a number of staff.

‘When I did the course the week before there was some budgeting stuff going on and there were talks of cuts and ... I think I was really worried I was going to lose my job I had only been here six months. I think it kind of helped me understand that this is a bit of a cycle that the department goes through. So I think it helped me feel a little bit more secure in my role to be honest ... and look at – I guess be willing to explore – other opportunities if things did go sour here’ (8).

‘We have had vacancy control processes which make managing change challenging and assessing risk challenging but look I just don’t think we’re alone in that. So I know CYS (Children and Youth Services) have had some downsizing in their central office which impacts on us because the work comes down rather than being able to push up’ (4).

**Structural change**

The impact of restructuring was also identified as a disruptive environmental factor.

‘All of these converging forces that are coming in at the moment which include activity based funding the deployment of Tasmanian Health Organisations, My Hospitals website, Australia Commission on Safety and Quality in Health Care, there’s a huge raft of things that are nationally driven. As well as state commissioning and a whole lot of issues around fiscal restraint’ (1).

‘We’ve gone from the my team have gone from the Clarence Community Health Centre into the Integrated Care Centre over there and that’s while it’s been a change of location so to speak but we’ve had to practice in a different way there because our rooms have been different you know the interaction we have with other services has been different’ (3).

**Evaluation results – The impact of leadership development**

The evaluation questionnaire results do indicate an increase in the three sets of resources
identified in the literature as key to transformational leadership. However, it is difficult to directly attribute this increase to participation in the Foundation Program. Face-to-face interview techniques add rich detail to the broad directions indicated by the data and make the link explicit.

**Positive agentic resources: Self-esteem and self-efficacy**

Change over time showed a statistically significant increase in self-esteem and self-efficacy, as measured by responses to this statement ‘I can remain calm when facing difficulties because I can rely on my coping abilities’. This went from 80% (T1) to 85.6% (T2). Similarly, responses to the statement ‘if someone opposes me, I can find the means and ways to get what I want’ started with an absolute score of 68.2% (T1), increasing to 73.1% (T2).

This is supported by statements from the case study participants.

‘So I think the Foundation Course – especially when I looked at my management styles and how I dealt with things - really reassured me that I did a really good job and that I was actually a good manager’ (6).

‘I had that epiphany about my ability ... it gave me more strength and courage to strive for more’ (6).

‘[You can] be more confident in your role and what you have to do because you have heard it from the top level and you have been directed and you have been given permission ... you have been told this is where we are headed and I think that, that’s a significant part of the impact’ (1).

**Relational resources: Social support within the workplace**

The strongest single response in the evaluation questionnaire results was in relation to social support within the workplace, as indicated by questions such as ‘I know some people on whom I can always rely’. This was 87% before undertaking the Foundation Course (T1) and 92.1% afterwards (T2).

This was strongly reinforced in the interviews. The Program has given participants the opportunity to find other staff within the large organisation that is DHHS; people with whom they would never have been able to connect with, under normal circumstances. This included peers from different parts of the DHHS and more senior staff within DHHS.

‘To know that I’ve got a group of peers out there that I can ask questions of and that we’re all coming from a common level and a common point of view. So no questions are stupid questions and we all realise we all have the same issues ... human resources, lack of money, perceived lack of understanding, not enough hours in the day, they are issues that we all face’ (6).

‘One of the big learning well one of the advantages has been contacts within the department, that’s been really helpful. I’ve found I did all the aspects of shadowing and coaching and they were all great but the opportunity to shadow at a higher level was really good and I shadowed [the Chief Nurse] who I hadn’t, I didn’t know about her role before that. So was really helpful really good to have access to such a high level leader’ (4).

Although only six action learning meetings are mandated as a requirement for the completion of the Foundation Program, a number of learning sets have continued beyond that time.

‘The action learning set still goes – after two years – quite a lot of the time we’re there to support each other’ (5).

**Positive affective resources: Positive orientation towards their job**

The question relating to positive orientation towards work: ‘I get a lot of satisfaction from doing my job’ showed a mild increase of 1.6% - from 83.6% (T1) to 85.2% (T2).

The interviews suggest that this is a more complex question as, for a number of participants, attending the Program helped clarify or confirm their thoughts about their career path, rather than increase their satisfaction with their current job.

Some found that it confirmed their move towards higher-level positions:

‘I feel a lot more confident within myself I guess and my ability where I didn’t before. I just saw myself as a little project officer and you know in my own little world ... it’s sort of given me more confidence to think about where I could head in the future’ (2).

Some realised that they did not want to move away from their current role. This was most clearly expressed by one of the Nurse Unit Managers interviewed:

‘I have actually to be perfectly honest I have looked at other jobs in recent times, but there’s not another job that I feel as passionate about and feel that the service that we are delivering is making a difference in peoples’ lives ... for career advancement you are really looking at a non-nursing role and I don’t want to be a bureaucrat so ... I think that was something that the Foundation Program probably helped clarify for me because I was sort of at that point where I wasn’t sure if perhaps that might be the career path I might like …’ (3).

Others decided to move away from the management role
altogether:

'I have been managing for a very long time – for nearly two decades – and I don’t want to be a manager any more. I’m over it ... and that is so brilliant because I’ve never known that before ... through that realisation it’s taken a load off ... So hey I can now be a specialist which is what I’ve always been really good at and I don’t need to be responsible for anyone but myself. I’m so happy!! So the whole, the whole Program has been a God-send for me – I want to wave that flag' (5).

Discussion: The role of leadership development in building resilience

Using a combination of existing, validated instruments, and semi-structured interviews, the DHHS evaluation speaks to an increase in self-efficacy and resilience: one’s belief about the ability and capacity to accomplish a task or cope with environmental demands (Bandura 1997). The perceptions of respondents are validated by actual changes in behaviour and role. Forty per cent of evaluation questionnaire respondents indicated that they have been engaged in a more senior position (on a permanent or temporary basis) since they undertook the Foundation Course. Twenty-one per cent indicated that they had subsequently commenced study in the university pathway.

The evaluation results suggest that there is a significant increase in individual self-esteem and self-efficacy, supported by an even greater increase in social support in the workplace. It does not suggest a strengthening in their positive orientation towards their job. The case study interviews clarify this point to being about clarification of their individual career path and 'best fit' for their skills.

It may be argued that the very high levels of social support are indicative of any group that can be described as a 'community'. During the interviews, several respondents made reference to the longevity of relationships within the sector.

'... a lot of them have been down here for 27-28 years you know' (7).

'... she had been a person who had worked in the service for a very long time so everybody knew her and knew her in lots

Appendix – The DHHS Management and Leadership Foundation Program Evaluation Questionnaire

Please answer these questions about yourself and your work environment.

1. I can always manage to solve difficult problems if I try hard enough.
2. I know some people upon whom I can always rely.
3. If someone opposes me, I can find the means and ways to get what I want.
4. It is easy for me to stick to my aims and accomplish my goals.
5. When everything becomes too much for me to handle, others are there to help me.
6. I am confident that I could deal efficiently with unexpected events.
7. Thanks to my resourcefulness, I know how to handle unforeseen situations.
8. I can solve most problems if I invest the necessary effort.
9. I can remain calm when facing difficulties because I can rely on my coping abilities.
10. There are people who offer me help when I need it.
11. When I am confronted with a problem, I can usually find several solutions.
12. When I am worried, there is someone who helps me.
13. I get a lot of satisfaction from doing my job.
14. If I am in trouble, I can usually think of a solution.
15. I can usually handle whatever comes my way.

The weighting given to the scoring responses is:

1. Exactly true
2. Moderately true
3. Hardly true
4. Not true
of different roles' (3).

However, it is clear that the leadership program has contributed to an expansion of networks and social support, beyond those that previously existed.

More broadly, this evaluation of the DHHS Foundation Program supports the notion that 'resilient communities withstand and respond creatively to adversity' and 'life-long learning nurtures this resilience in the face of challenging times' (Adult Learning Australia 2012).

References


Dickson, G. (2007). The Pan-Canadian Health Leadership Capability Framework Project,

Ontario: Centre for Health Leadership and Research.


Giddings, L. (2012b). 'Address to the Senior Executive Service.' Hobart.


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