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**The reforming appeal of distributed leadership: Recognizing concerns and contradictory tendencies**

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**ABSTRACT**

With a systematic literature review, this article examines the significance of distributed leadership in health care, assessing the extent to which it reflects a consistent set of values, meanings, practices and outcomes. It identifies key mediating factors and their importance in enabling or constraining distributive leadership processes. The findings indicate that clinicians without formal leadership titles are inspiring change and driving improvements, although countervailing pressures are limiting this in practice. Distributed leadership is evident in the way that clinical teams function, and more could be made of this for the modernization of health care. At present this potential tends to be constrained, and subject to competing interpretations that reflect distinct occupational identities. Greater attention could be given to educational and developmental programmes that claim space for distributed influence among current and aspiring leaders, and for enabling arrangements that can help ‘ordinary leaders’ to feel less vulnerable and more confident about this aspect of their practice. Established approaches to leader development could be usefully refocused to prioritize collective processes and refine relational abilities, ideally with more inclusive, joint venture initiatives that bring formal and informal leaders together for mutual learning and effective engagement.

**Key Words:** Distributed leadership, Shared leadership, Ordinary leadership, Leadership in context

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Distributed leadership has emerged as an influential concept in discussions about how to achieve sustainable improvements in health care. It has been endorsed by advisory groups and policy makers as a means of extending the influence of clinicians and investing more of the authority and accountability for quality and patient safety with front line providers. The expressed intent is to reconstruct leadership as a shared responsibility rather than just the province of executive elites at the top of managerial and medical hierarchies. The King's Fund, for example, has argued for leadership that extends 'from the board to the ward', with partnership arrangements that devolve decision-making to doctors and nurses who do not typically think of themselves as leaders or managers (The King's Fund 2011). Policy-makers have been encouraging the National Health Service (NHS) to move in this direction, with initiatives aimed at empowering a broad community of clinical leaders to collaborate in directing, developing and running their employing organizations (Department of Health, 2010; Scottish Government 2009).

At one level, this reflects degrees of disenchantment with orthodox notions of leadership and 'leaderism' (O'Reilly and Reed, 2010), which have been linked to serious care failures and shortfalls in performance relative to expectations. The recent interest in distributed leadership within the NHS was accentuated by scandalous revelations about the callous treatment of patients, initially centred on the Mid-Staffordshire Foundation Trust. The subsequent Francis Report (2013) raised questions about the narrow preoccupations of aloof executives who were impervious to front line concerns. Further reports from different contexts around the world have magnified the limitations of top-down leadership in health care, adding impetus to the case for more active clinical involvement to counteract public perceptions that doctors and nurses are often powerless to intervene and prevent service failures (Gordon *et al*, 2015).

Distributed leadership has also gained traction from accounts of the growing complexity of health care (Currie and Lockett, 2011; Chreim *et al*, 2013). The prevalence of 'wicked problems' (Grint and Holt, 2011) ostensibly stretches the capacity of concentrated hierarchical leadership. These draw on numerous interconnecting events that are difficult to pin down and beyond the control of executives. The corollary is that future challenges relating, for example, to service integration and community-based care are so involved that collective intelligence and shared decision-making arrangements are required to deliver viable patterns of work organization. Relying on traditional leadership structures and the concentrated knowledge of executive elites is considered to be unrealistic and potentially damaging.

Distributed leadership ostensibly offers a pragmatic means of harnessing relevant expertise to tackle long-term pressures, in addition to restoring public confidence and containing the problems posed by orthodox approaches. It delivers valuable outcomes by drawing more fully and effectively upon available talent, with role-sharing and collective influence improving the quality of decision-making. There is also an aspiration with distributed leadership to change traditional role relations and demarcation lines between leaders and followers. In theory, as leadership becomes a collective endeavour, the responsibility of communities rather than an aspect of positional authority, influence is applied formally from the lower levels of existing hierarchies and not exclusively or predominantly from the top. The qualities of leading and following become interdependent, with people at different levels moving in and out of these

categories as they respond to the insights and initiatives of others, adding their own contributions to group deliberations and influencing processes as they deem appropriate.

While these ideas are proving popular and the virtues of distributed leadership are frequently discussed, the boundaries of the concept have been blurred by the range of terms and fusion of arguments now applied to leadership innovation (Gronn, 2008, 2015; Currie *et al*, 2009; Carroll and Nicholson, 2014). Some references to group leadership and collective responsibility are rather vague, and seem to be at odds with contrasting appeals for a realignment of authority or redistribution of decision-making influence. The language of empowerment, employee engagement and partnership working is also frequently blended together with contrasting references to relational, transformative, dispersed and post-heroic leadership which suggest or present a distributive logic of approach.

The purpose of this review is to establish whether there is a core set of characteristics and values that distinguish distributed leadership and inform the assessment of practical initiatives. Four research questions were specified: Is there a consensus in the literature about the requirements for distributing leadership responsibilities and the terms for sustaining this approach in practice? How is distributed leadership thinking translated into action ‘on the ground’? Is there convincing empirical evidence that leadership roles are being devolved and that clinical and operational groups are responding in ways that are consistent with the prescriptive literature? What mediating factors have been identified as enabling and constraining distribution?

## **Method**

A comprehensive search was conducted to identify English language research articles and policy documents published over a six year period, from January 2010 through December 2015. This timescale was significant for the media interest generated in the topic by the King’s Fund Commission on leadership in the NHS, and the extent to which this stimulated academic and practitioner reaction (King’s Fund 2011). Three online bibliographic databases were used to ensure broad geographical coverage, MEDLINE (via Ovid), CINHALL (via Ebsco) and EMBASE (via Ovid). Separate journal lists were also searched to capture relevant social science articles, in addition to those in medical, nursing and health related periodicals. Government and Department of Health websites were accessed to identify policy reviews and independent reports. A manual search was also conducted to source relevant literature from the citations and reference sections of peer-reviewed articles located via the electronic resources. The same search terms were used at each stage, including closely associated variations on distributed leadership and followership (dispersed, collective, collaborative, relational, and post-heroic leadership, empowerment and distributed change agency). The search strategy linked these to ‘nursing’, ‘delivery of health care’ and ‘patient care team’.

The inclusion criteria extended beyond the language and date-range requirements noted above to cover leadership and leader development in all types of care setting. There was no restriction on methodology, job title or professional category. Since distributed leadership is a relational

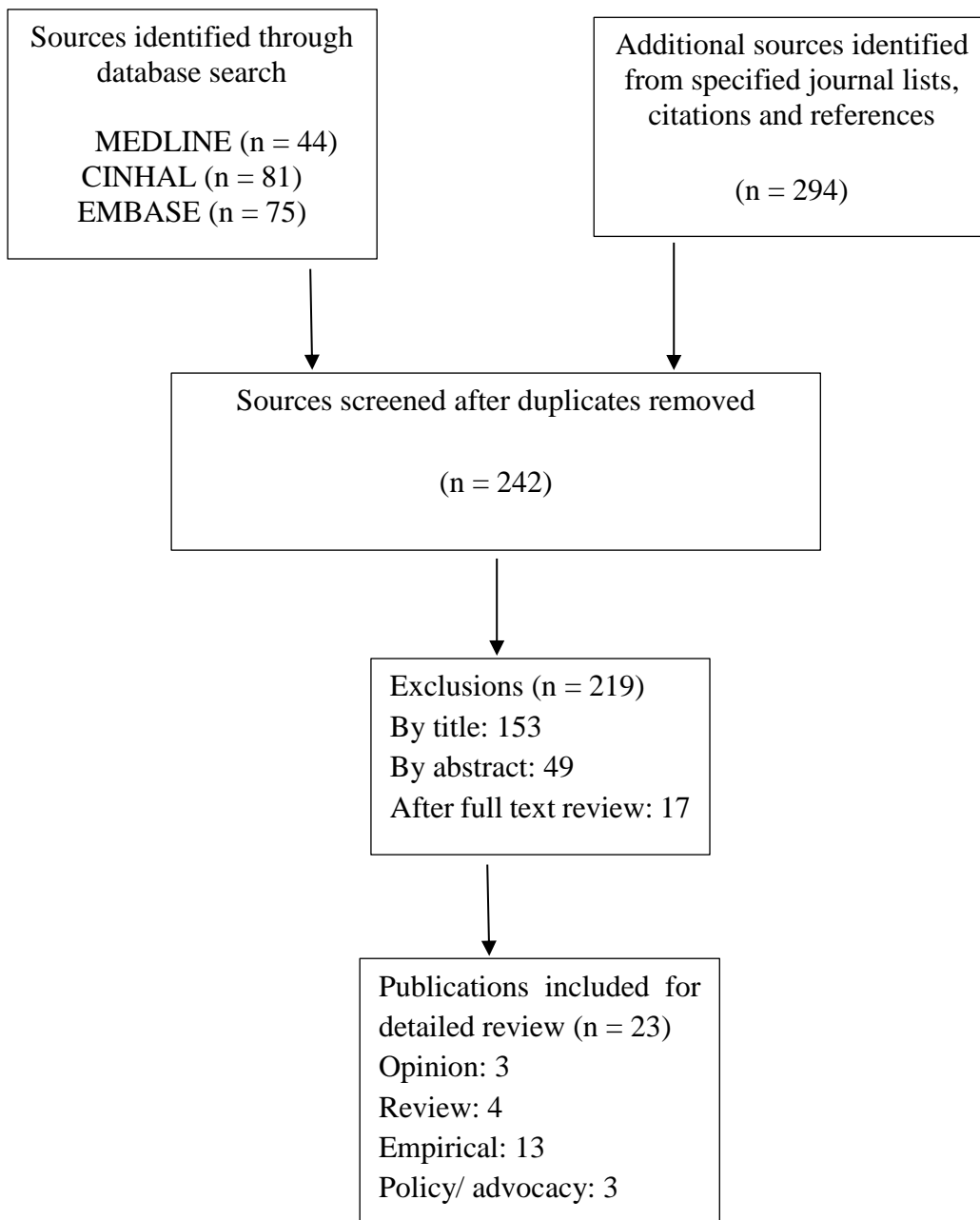
concept, theoretical discussions that relied upon directional and hierarchical understandings were excluded. Studies that conceptualised distributed responsibilities and empowerment as motivational tools and means of eliciting commitment rather than sharing decision-making influence were also excluded, although empirical research presenting this as an outcome of distributed leadership innovations were reviewed. The abstracts, overviews or executive summaries of material located during the search were screened, and where there was insufficient information about the precise focus, content or theoretical framework the full publication was retrieved and assessed for relevance.

The database and manual searches produced a total of 494 sources. After duplicates were removed and 242 potentially relevant publications had been screened, 20 peer-reviewed articles and 3 policy documents were accessed for detailed review. The journal articles included 4 literature reviews, 3 opinion pieces and 13 empirical investigations. Figure 1 provides a summary of the selection process and outcomes at each stage.

## **Findings**

The available literature suggests that there are clear distributive tendencies in health care leadership, certainly at the level of delivery with the development and running of clinical teams and service improvement projects. Effectiveness often depends upon the voluntary inclinations of staff to share insights, anticipate requirements and accept responsibility for work adjustments, rather than rely on decisions transmitted down through hierarchies. Empirical research found that influence was exercised jointly through the regular interactions of clinicians and others, and that care improvements and change events could not be attributed straightforwardly to specific agents or formal role relationships (Cleary *et al*, 2011; Chreim *et al*, 2013).

There was some evidence of health organizations and regional authorities taking a strategic approach to distribution, with policies or initiatives that devolved authority and established degrees of freedom for clinicians to take a more interventionist stance on management and organization and lead from the front lines (Howieson, 2013; Martin *et al*, 2015). Most of the case research presented this as a fluid and dynamic process, however, emerging naturally or spontaneously from group interdependencies and understandings. Group members, including junior nurses and doctors, were moving in and out of informal or grassroots leadership roles, supporting each other with ‘back and forth’ interventions (Haycock-Stuart and Kean, 2013; Chreim *et al*, 2013). McKee *et al* (2013) described them as ‘ordinary leaders’, members of decision-making units who are conscious of wielding sufficient influence to tackle complex and contextually sensitive problems of quality and safety.



**Figure 1. Search results and selection process**

There were echoes in these discussions of some earlier research on the nature and impact of ‘leaderless groups’ in the NHS. This was published in 2007 (Buchanan *et al*, 2007), focusing on an acute hospital that experienced problems with executive appointments, and where ‘nobody seemed to be in charge’ or to be driving cancer care services. In this instance, committed practitioners assumed responsibility for implementing important changes, covering the decisions associated with this informally and collectively as they balanced the demands on their time and expertise. The more recent research in this review demonstrates that this pattern

of intervention and achievement is more common than reactions to the original article may have anticipated. Front line nurses and doctors are intervening to accept and fulfil leadership roles jointly, autonomously and effectively across a range of contexts and specialisms (Cleary *et al*, 2011; Fulop, 2012; Haycock-Stuart and Kean, 2013; Chreim *et al*, 2013; Byres, 2015).

The benefits attributed to this include better outcomes for patients (Richardson and Storr, 2010; McKee *et al*, 2013; Whitlock, 2013) and, relatedly, higher levels of job satisfaction and staff engagement, more supportive clinical environments, faster problem-solving and safe innovation (Dean, 2014). Studies of distributed leadership in mental health nursing (Cleary *et al*, 2011) and acute clinical wards (Tomlinson, 2012) provided the clearest indication of a positive link between autonomous influence, quality of working life and organizational performance. Shared leadership was found to be consistent with nursing values and ethical practice, signalling respect for local knowledge and concerns for constructive engagement across traditional organizational and professional boundaries. Positive reactions were evident in higher morale, diminished burnout and lower staff turnover, as well as more active engagement and enhanced collective performance.

For some commentators, these outcomes are strong enough to secure a fundamental shift towards distributed leadership (Tomlinson, 2012: 31; Byres, 2015). Ostensibly, it offers an effective means of delivering improvements, restoring public confidence and satisfying regulatory concerns and is therefore likely to attract wider recognition and support. The majority of writers were more cautious, however, acknowledging advantages though also difficulties and a potential for slippage to compromised results in practice.

### **Stakeholder Interpretations**

A number of studies focused on the meanings that stakeholders applied to distributed leadership, following a social constructionist approach to consider whether or to what extent practitioner views align with those in the academic and wider promotional literature. Groups of managers, nurses and doctors were covered by this research, which revealed multiple meanings and competing interpretations that tended to reflect occupational identities.

McKee *et al* (2013) examined the views of those who occupy executive positions, revealing concerns about fragmented and even chaotic decision-making. Despite some professed enthusiasm for shared responsibilities to promote quality and safety, positional authority and traditional top-down controls were considered vital to prevent excessive pluralization and the loss of direction and coherence. The difficulties of dealing with organizational politics and informal power structures provided one justification for overarching executive leadership. By these accounts, 'ordinary leaders' lacked the authority and political skills necessary to secure their improvements as part of the routine practice of their organizations, and so required the resourcefulness of traditional heroic leaders. Distributed leadership could only work if combined with, or 'complemented' by, hierarchy and credible controls.

Some senior nurses (Viitala, 2014) and doctors (Currie and Lockett, 2011; Fulop, 2012) offered similar arguments for combining concentrated and distributed leadership, often acknowledging that their views were at odds with the prescriptive literature. Nurses in formal leadership roles were more likely to stress the importance of enabling, guiding and supporting front-line responsibilities. Their narratives tended to connect distribution with notions of transformative or authentic leadership in which the collective influence of followers is actively managed by the thoughtful occupants of more senior positions (Viitala, 2014:615). For these respondents, post heroic leadership was more than a matter of distributed influence. It related to the personal qualities and style of appointed leaders, and their capacity to engage with followers and encourage them to pursue approved objectives with their discretionary contributions.

This paternalistic concern to nurture and focus the influence of fellow professionals is quite distinct from executive inclinations to direct and control (McKee *et al*, 2013). The attachment to hierarchy and to functionalist thinking about the value of line management authority is shared, however. Front-line interpretations were far less accepting of this, and more obviously in tune with academic opinion on the tensions between traditional and distributed leadership (Gronn, 2008 and 2015).

The values and practices of supportive leaders seem to be widely appreciated within nursing communities, with the personal morality and reflective behaviour of senior figures linked to constructive employee relations (Cleary *et al*, 2011; Eneh and Vehvilainen-Julkunen, 2012; Anonson *et al*, 2014; Wing *et al*, 2015). Endorsements were usually qualified, however, with nurses magnifying the limits placed on their own autonomy and the difficulties confronting leaders who try to sustain a permissive approach (Haycock-Stuart and Kean, 2013). There were regular expressions of frustration in interview data, alongside claims that meaningful distribution is a long way off (Dean, 2014). The impression here is that distributed influence is short-lived and episodic. 'Ordinary leaders' were conscious of stepping-in to address problems in the absence of effective centralised leadership, although their influence was subsequently curtailed. Official leaders subsequently tried to recover control (Martin *et al*, 2015), to co-opt ideas or embed distributed activity within traditional organizational norms (Currie and Lockett, 2011; McKee *et al*, 2013; Haycock-Stuart and Kean, 2013). These constraining pressures were attributed to the persistence of professional as well as managerial hierarchies, calling attention to divergent interests and the power politics of care delivery.

Nurses and nurse leaders were frequently pulled between managerial claims for authority and those of doctors based on their professional expertise and jurisdiction (Jefferson *et al*, 2012). Consequently, they struggled to sustain whatever influence they exercised against competing perceptions and entrenched ways of thinking about leadership. Doctors were highly sceptical about distributed influence, and more obviously comfortable with established traditions of heroic leadership within the profession (Martin *et al*, 2015). The overwhelming commitment here was to medical hierarchies and prerogatives, to the extent that doctors who became involved in senior management experienced dual role tensions and tended to prioritize their clinical-professional roles and orientations (Chreim *et al*, 2013). From this viewpoint, distributed leadership clashed with medical thinking about boundaries of authority and who has the 'final word'. Leadership may have group dimensions, though for doctors these were



legitimately shaped and bounded by medical expertise and professional standing. Their interpretation of leadership was very traditional, privileging hierarchy and reputation within the medical profession, even from the earliest stages of medical training (Gordon *et al*, 2015).

Unsurprisingly, given the range of competing interpretations, a number of researchers concluded that strong countervailing forces are impeding the progress of distributed leadership (Currie and Locket 2011; Martin *et al*, 2015). One major observation is that distribution is at odds with prevailing structures and cultures, and that obstructions are built-in to the fabric of health organisations. Front-line staff are taking responsibility and exerting influence within heavily constrained environments.

## **Discussion and Conclusion**

Table 1 connects these findings to the research questions set for this review. The following discussion provides further detail on the links.

Against a background of care failures and intense scrutiny, it is perhaps unsurprising that health executives should recognize and reproduce arguments for distributed leadership. Yet their propensity to manage distribution suggests that a conservative interpretation is quite common, and also distinct from sceptical medical views and more receptive nursing opinion.

The literature indicates that front line nurses are generally more accepting of the logic and benefits of distributed influence, and often find it easier to make an active contribution or at least be drawn into collective leadership activities than managers, doctors and even senior nurses (Richardson and Storr, 2010; Cleary *et al*, 2011). They also tend to be pragmatic about the limiting effect of traditional structures and orientations (Cooke, 2006; Cleary *et al*, 2011). Studies of distribution in practice adopt a similar approach, providing insights into various double-edged realities of benefit and constraint, intervention and restriction (Viitala, 2014; Higgins *et al*, 2014).

There is a consensus among researchers that clinicians without formal leadership titles are making independent decisions regularly, inspiring change and driving improvements informally and collectively as front line units or teams. There is clear evidence of a grass roots willingness to intervene, to apply influence and accept responsibility for leading on quality and safety issues by turn-taking and task-sharing to balance clinical and organizational demands on time. Having said that, much depends upon the values and inclinations of line managers, with researchers indicating that distributed leadership develops and delivers beneficial outcomes more effectively within protected spaces (Cleary *et al*, 2011; Hoyle, 2014). Where senior clinicians use their hierarchical position to encourage or defend the involvement of ‘ordinary leaders’, either from a value standpoint or pragmatic concern to sustain cooperation and ‘get things done’, distribution is more likely to become a confident and trusted aspect of regular

**Table 1**  
Summary of findings

Research questions	Key findings	Major corroborating sources	Study type
<b>RQ1</b>			
Requirements for DL	Staff concern	Haycock-Stuart & Kean 2013 Howieson 2013 Hoyle 2014 Cleary <i>et al.</i> 2011	Qualitative/focus group/interview Review Interview Review
	Local initiative		
	Senior support		
	Protected space		
Sustainability	Limited/constrained Short-lived/episodic Countervailing pressures	Haycock-Stuart & Kean 2013 Currie & Lockett '11 Jefferson <i>et al.</i> 2012	Qualitative/focus group/interview Review Review
<b>RQ2</b>			
DL in Practice	Group/project based Informal/locally driven Shifting to hybrid forms	Cleary <i>et al.</i> 2011 Chreim <i>et al.</i> 2013 Fulop 2012	Review Qualitative case Qualitative case
	Benefits: Staff commitment/morale Enhanced group performance Improved safety/care		
<b>RQ 3</b>			
Devolved roles	Rarely formal strategy Voluntary/informal/local Mutually supportive	Martin <i>et al.</i> 2015 McKee <i>et al.</i> 2013 Viitala 2014	Qualitative case Interview Longitudinal case
Responses	Variable & competing Consistent with Occupational identity	Chreim <i>et al.</i> 2013 Currie and Lockett '11 Ott & Ross 2014	Qualitative case Review Interview
<b>RQ 4</b>			
Mediating factors	Enabling: local commitment Some senior support	Keen <i>et al.</i> 2011 Higgins <i>et al.</i> 2014 Martin <i>et al.</i> 2015 McKee <i>et al.</i> 2013 Gordon <i>et al.</i> 2015	Interview Qualitative case Qualitative case Interview Interview
	Constraining: Traditional orientations /hierarchies/opposition		

DL denotes distributed leadership

practice. This can be difficult, however, and out of line with mainstream thinking and hierarchical manoeuvring (Ott and Ross, 2014).

As researchers have developed a clearer understanding of reactions to distributed leadership and how it is enacted on the ground, organizational and professional power relations have become more important. Despite the local agency of grass roots leaders and any rhetorical commitment from above, qualified or enthusiastic, distributed influence is exerted within complex environments in which competing managerial and professional interests intervene to set limits on what is possible and considered legitimate at particular points in time. Available empirical evidence suggests that distributed leadership is a radical step too far for many at the senior levels of health care, who are unable analytically or ideologically to accept it as a viable alternative to top-down positional authority and direction. It sits uneasily with their taken-for-granted notions of what leadership involves, so they act, even subconsciously, in ways that contain distributive tendencies. From here, distribution is permissible as a means of ensuring 'good' followership (Gibbons and Bryant, 2013). It is not a matter of sharing influence and executive authority.

The corollary is that traditional and distributive approaches to leadership coexist in health organizations, combined in uneven and shifting hybrid forms of influencing and decision-making. The empirical evidence detects a mixture of tendencies, with top-down and local leadership combined in various ways rather than conforming unambiguously to a single model or movement. Some commentators, notably Fulop (2012), present this in a positive light, as a corrective to polarised thinking. They see complementary elements compensating for weaknesses in each and offering compromises that may have more relevance for leadership development than prioritizing one approach over the other.

There may be some truth in this, although interpretations remain important and the tension between concentrated and distributed leadership is more significant for many participants than complementarity. There is little doubt from the empirical data that 'ordinary leaders' consider their influencing to be episodic and difficult, repeatedly drifting away from them as senior figures reassert their authority and prerogatives. Inclinations towards, and perceptions of, such top-down shaping make constructive combinations of distributed and concentrated leadership difficult to sustain.

### **Implications for research and practice**

Conventional hierarchical thinking about leadership is deeply engrained within health care, though also under considerable pressure. The research collated in this study demonstrates that distributed leadership is already making a difference. The leadership contributions of front line clinicians have an important bearing upon care quality and patient safety. They also provide valuable insights into levels of voluntary intervention and achievement that could have much wider relevance for organizational learning and improvement, certainly if appointed leaders accommodate the local and tacit activities of 'ordinary leaders' within formal support structures and decision making arrangements. However, there is no sign of any general movement in this

direction at the moment. Distributed leadership is happening despite the established conventions of leadership and management rather than as a result of carefully crafted strategic or enabling initiatives.

This means that translating current practice and developmental promise into sustainable forms of ‘ordinary leadership’ will be less than straightforward. If health organizations are to make the most of distributed influence and harness it as a means of addressing the wider challenges of modernising their services, significant changes will be needed in the way leadership is conceptualized, developed and enacted. There is scope here for cultivating applied research on ways of tackling constraints and devising consistent forms of leadership education and development.

For researchers, one obvious way forward is to promote longitudinal research towards a deeper understanding of the interconnections between traditional and distributed leadership tendencies, and a clearer sense of any longer term effects on the resilience of clinicians who are prepared to intervene for care improvements or in the inclinations of those who are initially reticent. Some action research would also be valuable to identify innovative ways of counteracting inertia and resistance, and establishing conditions that are conducive to an expansion of ordinary leadership. The reviewed publications suggest that distributed influence produces calls for support and constructive engagement, with participants looking to those above them in the hierarchy to make this sort of personal and structural commitment. It also shows greater longevity when this is forthcoming, when supportive senior figures use their position to claim or protect space for ordinary leadership interventions.

Turning to education and development, there is significant potential to draw upon established critical learning initiatives that disconnect leadership from positional authority and focus on cultivating capacities for negotiation and participation (Cunliffe and Eriksen, 2011; Carroll and Nicholson, 2014). Much of this is directed at existing and aspiring leaders, challenging traditional assumptions, demonstrating the limitations of positional authority and refocusing attention on leadership as a collective practice.

Making leadership development a joint venture between appointed and *de facto* grass roots leaders could widen the appeal of distributive thinking, or at least promote serious engagement in place of reticence and cultivate some mutual understanding and shared learning. It may also weaken some of the boundary lines and entrenched views by channelling attention towards the respective contributions of formal and ordinary leaders and the practicalities of building complementary leadership capacities. Unfortunately, most of the existing provision for leadership development in health care is focused on individuals rather than collective processes (Keen *et al.*, 2011; Carroll and Nicholson 2014). Encouraging self-reflection and cultivating personal qualities to engage in leadership remains important, of course. Sensitising senior figures to the effects of constraining distribution and folly of treating followers as just recipients of leadership could be a more active part of this, however. Shared development initiatives may provide an effective means of reinforcing this, while also attending to the developmental needs of ‘ordinary leaders’.

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