

BRISTOL ROYAL INFIRMARY INQUIRY

PHASE TWO

Leadership, Vision, Change and Learning from Experience

Summary Report

This is a summary report of the key points emerging from the seminar discussion on *Leadership, which* took place in London on 23 February 2000.

The following points were put to the Panel in discussion; they do not necessarily reflect the views of the Panel.

Summary of the discussion

The purpose of the seminar was to look at the concept of leadership and how it may be exercised in organisations, drawing on experience from a wide range of public, private and voluntary sector settings, but with a particular focus on the NHS. The seminar included participants from education, local government, the arts, the armed forces, central government and the private and voluntary sectors as well as clinicians and managers from within the NHS. The seminar started with a discussion of the different models and principles of leadership and identifying some features of good and bad leadership. Attention was drawn to the influence of context on leadership and there was extensive discussion of the characteristics of the NHS as an organisation and the implications of these for leadership within it. Discussion then focused on particular leadership roles within the NHS, including those of clinicians in management and of Trust Boards. Finally consideration was given to how failing leadership within an organisation might be identified and to the appropriateness of whistleblowing as a means of drawing attention to problems. The key points on each of these topics are summarised below. Many of the issues are elaborated further in the position papers that were submitted in advance of the seminar and are available on the Phase 2 section of the Inquiry's website.

1. Models and principles of leadership

(i) Participants drew a distinction between leadership and management. They identified that leaders may need to be good at managing, because vision alone is insufficient without the ability to translate it into action. In addition, it was agreed that people do not need to hold management positions to lead, but that leadership occurs at all levels and appropriate skills are needed in every team from the top of an organisation to its base; strategic leadership provides the context for others in the organisational chain.

(ii) The group debated the aspiration for all leaders within the organisation to be moving in the same direction - 'to have their pencils pointing the same way' – for the organisation to be effective. It was thought, however that such a uniformity of purpose as opposed to uniformity of overall vision, is inappropriate in complex organisations such as the NHS, where the legitimate diversity of roles and objectives needs to be acknowledged and accommodated.

(iii) A variety of different models of leadership were discussed including the distinction between transactional leadership, where the emphasis is on being accountable and getting things done and transformational leadership, where the focus is more on inspiring and empowering others. It was suggested that effective leadership requires a blend of both approaches. Leadership was also described as a combination of persuasion, example and compulsion. It was argued that good leadership generates willing cooperation. Only where inspirational leadership fails does the need for compulsion arise and this is unlikely to provide effective incentives for constructive change.

(iv) Some characteristics of good and bad leadership were identified. Participants drew attention to the difference between “positional” leadership, where an individual is overtly designated as team or organisation leader, and “behavioural” leadership, where any individual, no matter what their position in an organisation, can demonstrate the qualities and behaviours of a leader. Components of good leadership included:

- * sensitivity to context and flexibility of approach;
- * having a clear direction and strategy for pursuing it;
- * accepting the legitimacy of staff and user views and ensuring they are heard;
- * getting to other people's ways of thinking to ensure that the vision makes

sense in their terms;

- * ensuring that everyone within the team has a clear view of what is wanted and how it will be achieved;
- * leading upwards and outwards, so that both higher tiers of the organisation and the wider public is well informed;
- * ensuring there is sufficient 'down time' (i.e. time set aside from routine activities) and resources allocated to provide appropriate training, development and opportunities for reflection; examples of relevant activities in the NHS included 'clinical ward leadership' developed by the RCN for ward sisters to look at their practice and 'clinical benchmarking' as part of clinical governance
- * credibility and
- * providing appropriate rewards and incentives, which are not just about benefits such as money or promotion but also include acknowledgment and appreciation of effort and ideas.

Conversely, bad leadership strategies included:

- * rigid attachment to particular approaches, regardless of context;
- * naming, blaming and shaming, as this creates fear and distrust; undermines confidence and damages morale;
- * excessively tight command and control which leaves no room for manoeuvre and
- * asking for ideas and suggestions and then ignoring them.

(v) It was recognised that the wider political, economic or cultural environment within which an organisation exists can have a powerful influence on what happens within the organisation. In circumstances where the wider context is particularly adverse, even good leaders may be ineffective in sustaining morale or turning round a failing organisation.

2. The context of leadership in the NHS

There was extensive discussion of the characteristics of the NHS as an organisation, and the wider context within which it functions. A number of key influences on the nature of leadership in the NHS were identified.

These included:

(i) *Political context*

In the public sector leadership is political by its very nature, because the service is value driven and resources are mostly the product of taxation. There are tensions between the short-term perspective of politicians devising policies at the centre, and the longer view required to run services to meet the needs of the local population. Leaders need the ability to synthesise these different perspectives and to deal with potentially conflicting pressures i.e. to pursue “win-win” solutions, rather than to become embattled.

(ii) *Centre-periphery relationships*

In the NHS, as in other public sector areas such as education, participants commented that there tends to be a gap between central government's understanding of the service and the reality on the ground. There are also low levels of trust between politicians and many public sector organisations including the NHS, which is reflected in poor, and often untimely, communication of government intentions to those who have to implement them. Leaders have to deal with problems of communication in both directions between the service and the centre.

(ii) *Risk and complexity*

Medicine has changed dramatically over time. In the past it was relatively simple, ineffective and safe. Treatment was provided in the context of the individual relationship between a patient and their doctor. Now, medical care is complex, more effective but also more hazardous; understanding and managing risks is imperative. Treatment is provided by teams involving many disciplines. Leadership is correspondingly more complicated.

(iii) *The patient's journey*

The key perspective on the NHS is that of patients and carers as they encounter different aspects of the system over time. Leaders should focus on following the patient's journey from referral to treatment and discharge and into the community.

(iv) *Professional staff*

The NHS contains powerful professional groups, particularly medicine, with a long history of influence and independence and a professional value set that involves primary allegiance to individual patients rather than collective or corporate objectives. Health professionals have stronger ties to their professional bodies, such as the Royal

Colleges, than to the immediate organisation in which they work. It can be very difficult to create and sustain multi-professional teams where “tribalism” is strong.

(v) *Managerial-professional interface*

The interface between clinical and corporate leadership in the NHS is complex. The service is largely run and managed by people who are not trained healthcare professionals, although clinicians are increasingly becoming involved in managerial roles. There is a tension between the values of contract and conscience and a need to find an appropriate balance between the two, without turning the 'professional bureaucracy' into a 'machine bureaucracy'.

(vi) *Constrained resources*

Resources are limited in the NHS, as in the rest of the public sector. Leadership occurs in a context of staff shortages and high pressure on those who are employed. In contrast to the army, where staff are likely to be operationally committed 40 % of the time. In the NHS almost 100% of staff time is deployed on the “business of care and cure. It is therefore hard to identify and protect 'down time' for staff development.

(vii) *Perpetual change*

The NHS is in a state of constant and, at times, intolerable change driven by new policy directives, changing patient expectations and innovations in patient care. No NHS White Paper is ever carried through in its entirety. One consequence is that the NHS contains many young organisations, and others that have experienced major re-configurations. Leaders need to help staff on the ground to find confidence to deal with the scope and pace of change.

(viii) *Public knowledge and attitudes*

There is considerable public interest in health care and members of the public are increasingly knowledgeable about health issues. At the same time there is a great appetite for health stories, particularly scare stories, in the media. The health service cannot control the media but it must make a commitment to ensuring that the media and the public are genuinely and constructively informed.

(ix) *The broader partnership*

NHS organisations do not exist in isolation, but increasingly work in partnership with each other and with, for example, local authorities and voluntary organisations. Leadership has to extend across teams of people both within and across

organisations, relationships must be built with all the stakeholders involved and traditional barriers made permeable.

(x) *Uncertainty*

It was suggested that the life of those holding formal leadership roles in the NHS can be “nasty, brutish and short” – that is to say, contracts are fixed term and there is a tendency to change the person at the top when things go wrong.

3. Formal leadership roles in the NHS

Discussion focused on the roles of clinicians (specifically doctors and nurses) in formal leadership roles at Board level.

3.1 Doctors in formal management and leadership roles

(i) Since the introduction of general management in the NHS in the early 1980s and the subsequent development of medical and clinical directorates, it has been anticipated that clinicians will take a greater formal leadership role by taking up management positions, but relatively few doctors have been enthusiastic about doing so. There was discussion of possible reasons for this widespread reluctance. These included:

* **Scepticism about the role of management**

In comparison to medicine, management is not regarded by many doctors as a 'proper' job. Managers appear not to have a defined skill set, criteria for success, or clear career structure. In addition the conditions of employment as a manager are less attractive, with much less job security than medicine and lower financial rewards. Most doctors have relatively little interest in the management process, and do not recognise its power to affect patient care and outcomes.

* **Reluctance to relinquish a clinical role**

Doctors may be concerned about the risk of losing their professional skills, the freedom to exercise them and the satisfaction that comes from caring for patients. They may also be concerned about relinquishing the good will and esteem of their professional peers and thus their professional clinical credibility. In some other professions, and in the private sector, the move to management from a technical role, is seen as a natural progression, but in medicine, far more kudos is attached to academic excellence and/or to a senior role in a Royal College than to a senior role on the Trust board.

(ii) There was a general consensus among seminar participants that greater involvement of doctors in formal leadership roles is beneficial, although it was acknowledged that not all doctors are suited to such a role. Concern was also expressed about 'losing' skilled practitioners. It was pointed out that the potential for leadership and management roles is not a criterion used in selection of medical students and that training in leadership and management does not feature in most medical curricula. With regard to concerns about loss of skills, it was suggested that the mechanisms for revalidation currently being developed by the GMC will support the maintenance and development of skills for doctors who become involved in formal leadership and management roles.

3.2 *Nurses leadership roles within management*

(i) Nurses have tended to be more willing than doctors to move into management roles, even though the potential for loss of skills and clinical identity is in some ways more acute, because nurses in management do not maintain any direct clinical input at all. The reasons for their relative enthusiasm to embrace management and senior management positions lies within both differences of incentives and experience which make this option more attractive. Nurses in clinical practice reach a level where they cannot earn more or take on more responsibility without relinquishing their clinical work. Nurses are more accustomed than doctors are to working in teams and within finite resources and often have to acquire some management skills in the course of their clinical work, which may make them more, attuned to management values.

3.3 *The role of the Trust Board*

(i) The seminar discussed the role of the board as a leadership entity and its role in the NHS. It was noted that the Trust chief executive is the accountable officer in parliamentary terms, not only for corporate governance, but also now for clinical governance. Other key members of the board are the chair (non-executive) and the medical director and the director of nursing (executive).

(ii) With regard to accountability relationships below board level, these are not always clearly defined in practice, even though they may exist as lines on paper. For example, it was suggested that a consultant would not necessarily consider him or herself to be accountable to a clinical director; and a clinical director would not necessarily consider him or herself accountable to a medical director. Thus a board can be in an uncertain position, not having secure accountability relationships below.

There was discussion of the need to distinguish between professional accountability (to the governing body that looks after professional qualifications) and managerial accountability, also between general management and functional management and between clinical leadership, professional leadership and leadership of the organisation. It was agreed that whatever lines of accountability were agreed, these must be clear and understood and they must come together at some point in the Trust, probably with the chief executive.

(iii) The position of non-executives was discussed. In the private sector, they tend to have a clearly defined role for probity, for asking difficult questions, and for “holding” the wider shareholder interest. On NHS boards, particularly Trust boards, it was suggested that non-executives’ roles differ and vary between Trusts, and there can be a lack of clarity generally as to what is expected of them. They do not have the expertise, or sometimes the inclination, to challenge the Chief Executive or the Medical and Nursing director.

(iv) It was pointed out that the autonomy and authority of Trust boards is limited. For example, negotiations between the professions and the NHS do not involve NHS Trust or Health Authority Boards at all, but take place between the Colleges, the GMC and the Department of Health. The boards simply inherit the decisions that are made. It was noted that in primary care the role of the primary care group 'board' (which is formally a sub-committee of the health authority) has a different, more facilitative role because GPs, being independent contractors, are not actually accountable to it.

(v) Seminar participants from outside the NHS commented on, the complexity of the accountability relationships in the NHS and the extent to which it appears that a board can be disempowered by strong professional groupings beyond the chief executive's control. It was observed that doctors do not respond to senior management, but to professional peers whom they respect, who may not even be in the same organisation. Seminar participants noted that it was difficult, and probably not appropriate, for a manager to tell a doctor what to do on a clinical issue. The leadership roles of the medical and nursing directors, who give professional advice to the chief executive but also share corporate responsibility for the organisation as board members, were identified as crucial.

4. Indicators of failed leadership

(i) Consideration was given to the question of how failing leadership in an organisation might be identified. In the case of a school, it was suggested that indicators of a problem might include:

- * high staff turnover;
- * reducing recruitment of students;
- * poor exam results;
- * low attendance figures and
- * high exclusion rates.

In the case of the NHS, suggested criteria for assessing leadership within a ward or hospital included:

- * whether patients are comfortable;
- * whether the environment is clean;
- * whether nurses know what they are doing and
- * whether “lots of alarm bells are ringing”.

On the other hand, all these problems may simply reflect endemic shortages of resources or staff. Other measures available at an organisational level include:

- * performance management data;
- * staff sickness, turnover and vacancies and
- * patient complaints and satisfaction survey results.

It was pointed out that serious failure may be hard to pick up, because people may try to fudge issues or hide problems for fear of the consequences of them being revealed. It was suggested that the most sensitive way to pick up what is going on is to observe how people behave with one another and to talk to staff, other key stakeholders and, above all, patients. Non-executive board members who spend time informally in the organisation can be a key resource for identifying problems in this way.

5. Whistleblowing

The last part of the seminar focused on the issue of whistleblowing, and the question of whether its occurrence represented a failure of leadership. It was suggested that recourse to whistleblowing was a stage in an evolving process of movement from a closed to an open organisation. It was argued that there should be clearly laid down procedures to make whistleblowing unnecessary, but that it should always remain as

an acceptable final option if these fail. Factors suggested as likely to help prevent the need for whistleblowing, and create a working environment where people no longer feel the need to lie or to hide, included:

(i) *trust*

A culture of trust and openness increases people's willingness to express their concerns.

(ii) *teamwork*

Small, well functioning teams are better able to notice change and to spot mistakes.

(iii) *choice*

A variety of places for people to go with their concerns is important so that if, for example, communication upwards is constrained by a bad team leader, this person can be bypassed. The example was given from the military context of how the doctor or padre may fulfil this role. In the NHS, junior staff fearful of speaking up within the professional hierarchy may choose to talk to their educational adviser who is separate from the consultant for whom they work directly. In primary care and in health authorities there are no set procedures or local policies for how concerns should get expressed.

(iv) *a duty of honesty*

In medicine the culture was said to have changed dramatically in recent years. Where previously the pressure was to keep quiet about a professional colleague's failings, the GMC now places an obligation on any doctor to make known in the relevant place, any anxieties they have about a colleague. If they do not do this, they are themselves at risk. This is slowly making a difference, and people are becoming more willing to come forward. It was noted that the nurses' code of conduct in the UK included a responsibility not only to speak out about issues concerning patient care, but also to make it known if they think resources are not adequate.

(v) *constructive responses*

People are encouraged to speak out if they know that problems will be dealt with as constructively as possible, for example through providing mentorship, training or counselling rather than humiliation or punishment.

(vi) *listening to users*

Participants were reminded that users of the service also need opportunities and encouragement to raise issues of concern. It was noted that the NHS complaints

procedure was introduced on a nil resource basis, with no training or facilitation to begin to change the organisational culture to be more responsive.

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