Leaders in Healthcare 2020

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Many of the stumbling blocks faced by healthcare organisations attempting to improve the quality and safety of the care and work more efficiently lie in the underlying culture and values of the organisation. Often organisations bring in new technologies and ways of working as a solution, but even where such solutions have a proven track record of success in other settings, they are doomed to failure unless any underlying problems in the culture of the system and the wellbeing of the workforce are addressed. Leadership sets culture, and the right leadership can create a more positive place for staff to work, leading to better ways of working, and in improved outcomes for patients as well as saving money.

Participants

James Mountford, editor BMJ Leader, director of quality at Royal Free London Foundation Trust

Victor Adebowale, crossbench member of the House of Lords, chief executive Turning Point, visiting professor and chancellor at the University of Lincoln, cofounder of co-founder of Visionable, a video collaboration platform for teams which aims to make healthcare more equitable and accessible, former board members NHS England

Amanda Goodall, associate professor, Cass Business School, City University, London

Jamiu Busari, consultant paediatrician, Dr Horacio Oduber Hospital, Aruba, former department chair of paediatrics, Zuyderland Medisch Centrum, Heerlen, and associate professor, educational research and development department, faculty of health, medicine and life sciences, Maastricht University, the Netherlands

Andy Haynes, former medical director Sherwood Forest Hospitals Trust and now the executive lead of the Integrated Care System (ICS) executive lead for Nottingham and Nottinghamshire

Henry Carleton, cofounded strategic solution consultancy Four Eyes Insight, established health tech company Zircadian Ltd, first investor and non-executive director (NED) in fin tech company ReceiptBank, former emergency department (ED) doctor

Roger Kline, research fellow at Middlesex University, former trade union representative, worked on NHS England's workforce race equality standard, research on why BME doctors more likely to be referred to GMC

On 5 November 2019, during BMJ and the Faculty of Leadership and Management's three-day Leaders in Healthcare Conference in Birmingham, a roundtable sponsored by Allocate Software was held where participants (see box) discussed what kind of leadership was needed to achieve a supportive, inclusive and creative culture in the NHS and other health systems.

The meeting was chaired by James Mountford, editor of BMJ Leader, who began by asking participants to describe what a "great" organisation looked like and what the chief executive might be doing differently.

"When Individual members of staff feel valued, respected, and listened to and can bring their differences to work," replied Roger Kline, research fellow at Middlesex University. When an organisation has got it right, inclusiveness is evident from their data and from conversations with staff, he said, pointing to Wrightington, Wigan and Leigh NHS Foundation Trust as a good example.

In 2014 staff at the trust asked a dying cancer patient if there was anybody she wanted to see, and she requested to see "Rosie", a horse that she had looked after while working at Haydock racecourse. "Without telling the chief executive, because they felt empowered not to need to, staff arranged for the horse to be brought into the car park and wheeled the patient's bed outside," Kline said.

Five years later the same chief executive, Andrew Foster, ordered a patient off the premises after he had racially abused a doctor.

"Those sorts of things have sent a message that say: these are the values; this is the culture," he said. On a visit to the trust, Kline was impressed to see that Foster seemed to know the name of every single staff member they met, and even details about their lives and those of their families. "That to me is inclusive leadership," he said. "Inclusion is not the only thing, but it is the central thing, and for many places it is still seen as a bit 'fluffy'."

Henry Carleton, founder of Four Eyes Insight and Zircadian Ltd, singled out Sir Andrew Morris, former chief executive of Frimley Health Foundation Trust as another exemplary chief executive. Like Foster, Sir Andrew was visible in the organisation and knew people's names. "He made it his business not to be in an ivory tower but in there at the coalface," Carleton said. "He was very inclusive, but the thing that really struck me was that he knew and understood his 'business'. By knowing this, he knew what good looked like, or should look like, and as a result he had a vision and he could lead."

Kline also highlighted Andy Haynes, executive medical director of Sherwood Forest Hospital Foundation Trust as a model leader who had helped turn around a failing trust. Haynes was a haematologist and cancer services lead at Nottingham University Hospitals NHS Trust when he was diagnosed with prostate cancer in 2008. With an uncertain future when the cancer relapsed in 2012 he decided that if he was ever to change tack and try something different now was the time. That opportunity presented itself in 2014 when Sherwood Hospital Foundation Trust went into special measures and needed a medical director.

Haynes said that when he took the post he saw two priorities: help to get Sherwood out of its difficulties and to tackle health inequalities. The trust serves a population with one of the highest smoking in pregnancy rate in England, and high rates of obesity among children and pregnant women. The health inequality challenge is illustrated by one street in Mansfield, where on one side of the street the healthy life expectancy is 15 years higher than on the other side: one side is a private estate, the other is a council estate.

He has succeeded with the first task - last year NHS Improvement rated Sherwood good overall and outstanding in two areas – and to tackle the second task he has taken the post of clinical director for the Nottingham and Nottinghamshire Integrated Care System (ICS). "I have moved into the ICS space because I think if we carry on just mending people who are broken, we will fairly rapidly not be sustainable," he said.

In the ICS organisational hierarchy is not helpful, Haynes said. "As an ICS lead all I can do is talk to people and try to get them to trust each other and build relationships."

"We need to start thinking about populations rather than just individual patients. If you try and make their lives better, which is what ICS and the Long Term Plan[1] are about, you start to get into a very different world."

1. The NHS Long Term Plan, NHS England, January 2019. https://www.longtermplan.nhs.uk/

Doctors and other clinicians as leaders

Research by Amanda Goodall, associate professor, Cass Business School, City, University of London, found that the best research universities are most likely to be led by outstanding scholars,[2] and that in the US, the best hospitals are more likely to be led by doctors than professional managers,[3] a finding that has recently been built on and replicated in the US,[4] and also in Iranian data.[5]

At a local service departmental level, doctors with the right qualities can be exceptional leaders, said Carleton. "They have a vision, they understand their service." But when you go from running a service to leading across a whole NHS organisation or wider system, he added: "In my mind you don't have to be a clinician to be a great leader."

Goodall said that her research showed that the pattern of doctors being good leaders was apparent at organisational level and in middle management. "It is not a black-and-white thing, but these patterns are replicated not just in medicine but across many other different sectors," she said.

Not *every* doctor or clinician will make a great leader, conceded Goodall, who now runs a part-time leadership course for doctors at Cass. "For senior leadership positions, ideally we don't just want any doctor, we don't just want any nurse, we want outstanding clinicians," she emphasised. "The standard bearer must first bear the standard."

There are many outstanding people who are not doctors leading NHS organisations, she added, such as John Lawlor, chief executive of Cumbria, Northumberland, Tyne and Wear Foundation Trust. "He knows what he doesn't know, so he's put in an outstanding psychiatrist as an executive medical director and that teamwork is fantastic."

The skills that makes someone a successful clinician lend themselves to making them a good manager, Haynes pointed out. "They are translatable."

But he pointed out: "Historically we haven't given doctors leadership training, we just assume that they will be competent." There should be a leadership module in every college postgraduate exam, he said, because there are benefits from all doctors being better leaders. And doctors in leadership roles need to be confident in managing conflict among their colleagues. An additional challenge in the NHS today is that too often, doctors in leadership roles are seen by their peers as "failed doctors" whereas as Goodall point out leadership roles actually need excellent doctors, those who first "bear the standard".

Haynes transitioned to a leadership role in a special measures trust from a safe and secure clinical career where he was at the top of his game, knowing that he could be sacked within a year. "I gave up clinical practice because it was such a big job I had to focus entirely on it, I had to be comfortable losing the comfort blanket of clinical work," Haynes said. "That is a huge barrier to people.

"I am not sure I would've taken the step if I hadn't had the health issues. The illness was a catalyst to do something different and the timescale meant it was an opportunity I couldn't miss."

2. Goodall, A.H. 2009b. Highly cited leaders and the performance of research universities. Research Policy 38, 1079-1092.

3. Goodall AH. Physician-Leaders and Hospital Performance: Is There an Association? Social Science and Medicine 2011; 73(4): 535-539.

4. Tasi, M. C., Keswani, A., Bozic, K. J., 2019. Does physician leadership affect hospital quality, operational efficiency, and financial performance? Health Care Management Review 44(3), 245-262.

5. Kakemam, E. & Goodall, A.H. 2019. Hospital performance and physician leadership: New evidence from Iran. BMJ Leader doi: 10.1136/leader-2019-000160.

Bringing more diversity into leadership

A common mistake made by organisations is "serving what we want people to see rather than looking at what people have to offer," said Jamiu Busari, associate professor of medical education at Maastricht University, the Netherlands and a leading global figure on leadership and minorities in health care. "I'd rather have a non-minority person serving on the board who understands the needs of our patients and staff than a minority person if that person doesn't have those qualities."

Mountford asked what kind of diversity is needed, and the view was that all three types: demographic diversity, cognitive diversity and experiential diversity.[6]

"We want demographic diversity at every level but we also need cognitive diversity," said Kline. "They overlap but they are not the same.

"If you get that, you will get more creativity, more innovation, better staff engagement, higher productivity and so on."

However, he warned that organisations will not leverage the benefits fully unless diversity is accompanied by inclusion.

Recruiting more black people or people of other minorities to boards in the name of diversity is not enough, cautioned Victor Adebowale, chief executive Turning Point. "It is about whose voice gets heard. Often the voices that are heard in this country are not BME voices and it is shocking because they are going to be affected by the poor decisions others make.

"A team which is not diverse is more likely to make poor decisions."

"I think differently because of the experiences I have had," he explained. "The visible differences are there, but I see things differently because I have had different experiences."

"It is the diversity of the contribution that is important, and making sure that diverse voices are heard and not just present is crucial," Haynes agreed. Sherwood Forest Hospitals Foundation Trust serves a predominantly white population in a former mining area which has a very male dominated working-class culture. While 75% of staff were born and bred in that area, 75% of the consultants were not white Caucasian.

When Haynes arrived at the trust the board was not diverse in gender or race; now it is.

Mountford asked what had been done to ensure the diversity of voices were heard.

"That comes back to some of the tenets of leadership which are about honest conversations, listening, building trust, understanding difference and accepting it and actually seeing the opportunities within it," Haynes said. "There is no reason why you can't find people who are good at IT or who are good at finance from the whole spectrum of society. It is the experience that they bring and allowing that to be heard that is important. You have to create the right board environment, and you can't get the culture of the organisation right if you haven't got the board culture right."

Kline said BME doctors are more likely to be referred to the GMC partly because many NHS organisations avoid difficult conversations about race.[7] His research found that good organisations talked openly when things went wrong and explicitly avoided blame. "That particularly benefited BME doctors, but actually benefited everybody, including female doctors who are often ostracised and isolated within the medical profession," he said. "If you start with race, because it is the most difficult issue, and if you can get that right, it will benefit everybody."

It has been suggested that women do not get to the top jobs because they do not ask for pay rises and promotions,[8] but Goodall has been involved in research which showed

that women ask for pay and promotions to the same extent as men, but they do not get them to the same extent as men.[9]

"Instead of people at the top making decisions about what they think we need in terms of representation from certain groups, such as women and BME, they should ask them," she said. "Then create the pipeline, create the organisation that suits the types of people you want to go into leadership."

6. De Anca C, Aragón S. The 3 Types of Diversity That Shape Our Identities. Harvard Business Review May 24, 2018. https://hbr.org/2018/05/the-3-types-of-diversity-that-shape-our-identities

7. Atewologun D, Kline R, Ochieng M. Fair to refer? Reducing disproportionality in fitness to practise concerns reported to the GMC. GMC, June 2019. https://www.gmc-uk.org/-/media/documents/fair-to-refer-report_pdf-79011677.pdf

8. Babcock L. Laschever S. Women Don't Ask: Negotiation and the Gender Divide. Princeton University Press, 3003.

9. Artz B, Goodall AH, Oswald AJ. Do Women Ask? Industrial Relations: A Journal of Economy and Society 2018; 57 (4): 611-636.

Improving the performance of boards

Many NHS executive board members are drowning under operational, financial and other pressures and don't have enough time in their day jobs to reflect on the bigger picture, Carleton said. In a few instances board meetings "are almost a distraction", where they present their report and hope the non-executives don't ask too many questions. Board agendas need to be focused on the key points on which the chief executive wants to hear views". In order to create a successful board, "the members need time to talk and reflect", he added.

NEDs may also need help to objectively determine how well services are performing, or what a services' potential might be, Carleton said. Boards can be incredibly valuable but they need to be made up of informed people who can hold the executives to account, while also helping them, he stressed.

If chief executives really want to make change happen, they need to appoint people who are smarter than them, who will challenge them, Busari said. Clinicians are evaluated regularly, have to maintain their skills, are reprimanded if they perform poorly, and if sacked would find it difficult to find another post, he added. "I don't see that transparency when it comes to board executives." It is striking that many executives and board members in the NHS might see accountability and job risk differently.

For the last two decades the national NHS leadership has incentivised the wrong sorts of behaviour, Kline said. "It has been a focus on finance. And then we reluctantly said, after the Francis enquiry, focus on patients, and finally we are now understanding that if you get the proposition for staff right that will help with patients and with finance."

"A great leader who communicates well also creates safety," both operational safety for organisational processes and psychological safety for staff, Busari said. "Systems that are inclusive create safety." Junior doctors have to work to protocols but as professionals, they should have the capacity to think differently when a protocol doesn't fit a particular patient, Busari explained. In practice, he encourages junior doctors to challenge and diverge from protocol if necessary, but they must then report their reason for changes and the outcome, because the learning in this could produce improvement. The opportunity to contribute and the abilities acquired in the process improve safety and job satisfaction, he pointed out.

Metrics and data

Using metrics can empower staff to get involved and make small changes, Carleton added.

Mountford asked what metrics NHS organisations and systems should be using.

Patients should be asked not just "what is the matter", but also "what really matters to them", Kline said.[10] "We are not very good at looking at the very difficult metrics and that's part of a wider problem."

Haynes said Sherwood Forest had used a number of methods to improve and metrics to assess progress, and it has now demonstrated sustained improvement to become one of top performing trusts in the staff survey. Approaches used include the medical engagement scale,[11] which gave interesting information (but only from doctors), and the Pascal patient safety culture questionnaire,[12] which gave a lot of useful information about culture and team as well as patient safety, enabling trends to be tracked by discipline and division. "You can then start to triangulate that with absenteeism or HR metrics and safety, so you actually start to get a very different picture of your organisation," Haynes explained.

"Process has to match intention," Adebowale cautioned, saying he had seen a number of situations where there's been an attempt to change the culture but it had unhelpfully reduced to numbers. For example, the sustainability and transformation partnerships (STPs) were a great idea, he said, but the notion of people coming together and working together too often became subsumed by meeting the numbers.

"Many healthcare organisations run blind," Carleton said. "They are awash with data but it is just non-utilisable data, it is not accessible data."

Even where there are agreed metrics that allow organisations to track performance in real time against plan, they can be overlooked, he said. "There seems to be this fear or reluctance to use data."

"We are right on the cusp of a data revolution. Data systems are opening up to share their information with other systems," he added, "and that has to happen. We are already seeing a large number of health tech companies springing up with highly innovative and disruptive products designed around particular services and patient groups."

These solutions are key to helping health services scale to meet growing demand, improve patient care and balance the books, he emphasised. "This health tech ecosystem is only set to grow as data starts to flow more. It will disrupt the market hard bringing that nudge change on a large scale. It's going to happen massively."

Finally Mountford asked what characteristics or values should the NHS and other health systems be looking for in young recruits and potential future leaders to build the right culture within and across organisations?

Evidence of emotional intelligence, compassion and the ability to communicate and listen effectively, Busari replied. A good leader is somebody who can connect with people, listen, and inspire and engage people from the heart, he explained although having that alone does not make someone a good manager.

Haynes said it was important to identify and connect the small number of existing, aspiring and future leaders with "strategic action focus" – people capable of strategic vision, and then communicating and delivering that vision.

"If the leader does not have a credible and shared vision, then I can't see how they can engage individuals and communities," Adebowale said. "I've always taken the view that the difference between leadership and management is that leadership involves an emotional investment in the outcome."

10. Barry M J. Edgman-Levitan S. Shared Decision Making — The Pinnacle of Patient-Centered Care. New England Journal of Medicine 2012; 366 (9): 780-781.

11. https://www.fmlm.ac.uk/resources/an-introduction-to-the-medical-engagement-scale

12. https://www.pascalmetrics.com/real-time-pso-services/culture-survey