

THE FUTURE OF LEADERSHIP AND MANAGEMENT IN THE NHS

No more heroes

Report from The King's Fund Commission on
Leadership and Management in the NHS

TheKingsFund >

The King's Fund seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

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The King's Fund
11-13 Cavendish Square

London W1G 0AN

Tel: 020 7307 2591

Fax: 020 7307 2801

Email: publications@kingsfund.org.uk

www.kingsfund.org.uk/publications

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Foreword

The King's Fund established a commission in September 2010 to investigate and report on management and leadership in the NHS with a brief to:

- take a view on the current state of management and leadership in the NHS
- establish the nature of management and leadership that will be required to meet the quality and financial challenges now facing the health care system
- recommend what needs to be done to strengthen and develop management and leadership in the NHS.

The commission began its work at a time when the NHS was entering a period of unprecedented financial and quality challenges. The scale of these challenges was compounded by the coalition government's radical plans to reform the NHS, announced in July 2010, and the background of a general election campaign in which politicians from all parties criticised the increases in the number of managers working in the NHS and the share of the budget spent on management costs.

In setting up the commission, The King's Fund was aware of the urgency of the issues facing the NHS, and for this reason decided that a report would be produced within nine months. The commission's work included: inviting submissions from individuals and organisations with an interest in management and leadership; commissioning papers from experts in this field (available at: www.kingsfund.org.uk/leadershipcommission); arranging a series of seminars led by recognised leaders in health care and beyond; and meeting on four occasions to consider all of these contributions and discuss the recommendations that follow from them. The commission was supported by Beccy Ashton of The King's Fund and Nicholas Timmins, public policy editor of the *Financial Times*, who took the lead in drafting this report.

The starting point for the work of the commission is succinctly summarised in a contribution to a debate in the House of Lords made by one of the commission's members, Lord Tugendhat. Speaking in June 2010, Lord Tugendhat, who is Chairman of Imperial College Healthcare NHS Trust, said:

Of course the government want to maintain frontline services and to free the professionals who staff them to get on with their jobs, but they must remember that doing that in a time of cuts requires skilful and careful managers – the fewer the resources, the greater the management challenge... we need to bear in mind

that, if the government are to carry through their programme, which I support, they will need the support of managers in the public sector. I urge them to value those managers and to show understanding of and sympathy with what they will be required to do and the losses that some of them will suffer. The government should avoid the mistake of conflating reductions in public sector expenditure with the denigration of those who have to carry them through.

(Hansard 2010)

The work of the commission in the past nine months has confirmed members in the belief that the NHS will be able to rise to the financial and quality challenges it faces only if the contribution of managers is recognised and valued. It is also essential that the number of managers in the NHS, and expenditure on management, is based on a thorough assessment of the needs of the health service in the future rather than arbitrary targets and is supported by continuing investment in leadership development at all levels. In taking this approach, the commission emphasises the contribution of both general managers and clinical managers to leadership, the fact that leaders exist at all levels – from the board to the ward – and the increasing importance of leadership across systems of care as well as in individual organisations.

Looking to the future, it is essential that there is a clear national focus for leadership and its development to take forward the work that has been initiated by the National Leadership Council. At the same time, leadership development must be a priority for every NHS organisation and there is likely to be value in organisations collaborating with each other to support leadership development. This has already started in some regions. Leadership development needs to support individuals to become more effective and to locate development in the context of the organisations and systems in which they work.

The bottom line is that an organisation as large and complex as the NHS cannot be run without high-quality management and leadership. This will happen only through a commitment of time and resources and a willingness to value the role of managers whatever their background.

I would like to thank the members of the commission for the work they have done and the experts whose research and evidence underpin this report and its recommendations.

Chris Ham
Chief Executive of The King's Fund and Chair of the Commission

Members of commission

Professor Chris Ham, Chief Executive, The King's Fund (Chair)

Professor G Ross Baker, University of Toronto

Dame Jacqueline Docherty, Chief Executive, West Middlesex University Hospital NHS Trust, and Trustee of The King's Fund

Dr Peter Hockey, Deputy Medical Director, NHS South Central and former Harkness Fellow

Kate Loble, Director of Leadership, The King's Fund (from December 2010)

Lord Tugendhat, Chair, Imperial College Healthcare NHS Trust

Professor Kieran Walshe, Manchester Business School, University of Manchester

Recommendations

- It is important, now more than ever, to promote the value of good NHS managers and leaders. Denigration of managers and the role they play in delivering high-quality health care will be damaging to the NHS and to patient care in the short and long term.
- The coalition government's current plan to cut administration costs by 33 per cent and the number of management posts by 45 per cent must be revisited. There is no persuasive evidence that the NHS is over-managed, and a good deal of evidence that it may be under-managed. While administration and management costs will have to take at least their fair share of the pain as real-terms growth in NHS spending ceases, a more sophisticated approach to the reduction in both is needed.
- There is appreciable evidence that the NHS is over-administered as a result of extensive, overlapping and duplicating demands from both regulators and performance managers. There has not been a substantive review of the information demands placed on the service and its providers for many years. A review leading to a rationalisation of those demands is essential.
- Over recent years there has been considerable investment in both management and leadership development. These gains must not be lost in the transition to a redesigned health system.
- Every NHS organisation and provider must take responsibility for their leadership and management development. This includes the new GP consortia or commissioning bodies. Organisations should collaborate to undertake leadership development where this makes sense.
- The health service does need a national focus on leadership and management development, potentially delivered through a national NHS leadership centre. This should build on existing good practice in both the public and private sectors. Such a centre could play an important part in facilitating this. It should have the resources to support investment in leadership development of national importance; help to accredit and signpost development programmes; and support the evaluation of these programmes, including the return on investment from leadership and management development.

- Leadership development needs to extend ‘from the board to the ward’. One of the biggest weaknesses of the NHS has been its failure to engage clinicians – particularly, but not only doctors – in a sustained way in management and leadership. Individuals within the service, and its providers, need to be given both the ability and the confidence to challenge poor practice. Management and leadership needs to be shared between managers and clinicians and equally valued by both.
- The service also needs to recognise that the type of leadership the NHS requires is changing. The old model of ‘heroic’ leadership by individuals needs to adapt to become one that understands other models such as shared leadership both within organisations and across the many organisations with which the NHS has to engage in order to deliver its goals. This requires a focus on developing the organisation and its teams, not just individuals, on leadership across systems of care rather than just institutions, and on followership as well as leadership.
- Board development and recruitment need particular attention, most notably, but far from exclusively, in the case of foundation trusts where governors are to take on a new role as the autonomy of foundation trusts is significantly enhanced.
- The same applies to the governance arrangements for the new commissioning bodies. The Commons Health Select Committee has recently made powerful points about the need for proper governance of commissioning bodies which this commission endorses.
- In the light of a run of serious failures of both leadership and management in the NHS, the commission acknowledges the need for a more effective mechanism to debar individuals who have clearly been culpable from holding executive positions in health care. It has reservations about professional accreditation of managers or the creation of a full-blown disciplinary body for them. Boards must ensure that they have competent, effective senior managers and leaders and hold them to account. A national NHS leadership centre should consider whether the effectiveness of senior management and leadership should be considered by the Care Quality Commission as an important determinant of organisational performance and be taken into account in processes for registering and licensing health care providers.

Recent debates about management and its costs have already resulted in the loss of experienced leaders at a time when the NHS is facing the biggest financial and quality challenges in its history. It is imperative that action is taken urgently to retain the leaders needed to enable the NHS to rise to these challenges and to invest in the people and talent required in the future. The Commission endorses the view of the cross-party Commons Health Select Committee which concluded in a recent report:

The Committee is mindful that this unprecedented requirement to manage a process of change ... will require effort and commitment from NHS managers whose work we believe should be valued, alongside the work of the clinical staff of the NHS. The Committee regrets the fact that the work of NHS management is sometimes the subject of unjustified populist criticism.

High-quality leadership and management at all levels is a prerequisite for a National Health Service that delivers both the highest possible quality of care to patients and the best possible deal for the taxpayer.

Introduction

Management matters. Without it, nothing happens. From deciding on and buying the weekly grocery shop to designing, building and running the giant atom-smasher at Cern, nothing effective happens without budgeting, scheduling and implementation.

Beyond that, in any organisation of any size someone – and in a half-decent-sized organisation some people – have to provide leadership: setting priorities and a direction of travel, or, in the jargon, deciding the organisation’s vision and strategy and engaging staff.

In addition, an organisation with good leadership and management will get nowhere without administration, the gritty day-to-day filling-in of forms, ticking of boxes, settling of invoices, issuing of payment notices, providing data to regulators.

There is no clear-cut distinction between these three roles. Without leadership there can be no effective management – because the organisation will not know what it is meant to be doing – and without good administration management can be rendered ineffective. The three are interdependent.

In most of business, the requirement for good management is almost a given. No company would reckon to stand a chance of running well without it. Publicly quoted companies are assessed by analysts in part on the quality of their leadership and management.

Yet in the public sector – and in the NHS in particular – whenever politicians talk about management it is almost invariably a pejorative term.

It is often equated sneeringly with bureaucracy. Whole political careers have been built on attacking it. Alan Milburn first made his name as an opposition health spokesman by attacking the ‘men in grey suits’ who he reckoned had proliferated as a result of the Conservatives’ introduction of an internal market in health care.

Recently, Anne Milton, a current health minister, derided primary care staff who are currently responsible for around £80 billion of NHS spend as ‘pen pushers’ (*Hansard (House of Commons)* 2010–11). The government’s most recent contribution on the issue was a booklet making the case for its reforms. It contained a graphic showing that since May 2010 the NHS in England has 2,500 more doctors and 3,000 fewer managers.

The public is no more sympathetic. Perhaps it takes its cue from the political attacks on bureaucracy. A recent poll conducted by Ipsos MORI (2009) showed

that 85 per cent of the public supported proposals to reduce the number of managers in the NHS by one-third.

Yet the distinction between the 'front line' and management, or between 'front line' and 'back office', is far from helpful. No surgeon will operate efficiently without a theatre manager. No general practitioner can see patients without a receptionist to arrange appointments and a manager to look after budgets, staff and buildings. And no public health department can prepare for emergencies or plan for a flu pandemic without excellent planning.

Consider a 999 call centre: at what point does which part of the service cease to be 'front line'? The call taker clearly is. But they cannot operate without an office to sit in and information and communication technology that enables the despatch of police, fire and ambulance staff. They need well-maintained vehicles if the public is to receive an effective service. Yet most people would not describe information software and vehicle maintenance as front line.

One area where criticism is frequently levelled, by politicians and others, is towards those who add to the growing 'burden of regulation' whether that burden is carried by private sector business or public services. A review carried out in 2009 showed that NHS organisations were subject to some 35 different regulators, auditors, inspectorates and accreditation agencies that can demand information from the various parts of the system (NHS Confederation and the Independent Healthcare Advisory Service 2009).

Their numbers have grown over the past decade with some large additions to their ranks, for example, the Care Quality Commission, the foundation trust regulator Monitor, and the National Institute for Health and Clinical Excellence. While there have been recent attempts to reduce the number of arm's length bodies, the NHS is still faced with significant pressures from regulators and performance managers. It is hardly surprising, therefore, that parts of the NHS are indeed a bureaucracy which feeds this regulatory machine.

Politicians of all parties who criticise the level of bureaucracy within the NHS should recognise that they cannot have their cake and eat it. Some of the things they desire of the future health service – greater transparency, comparable performance data to inform choice, drive accountability and improve quality – all come at a cost.

Managers in the NHS

How many managers are there?

Measuring the level of administration and management in the NHS is immensely difficult. The NHS has a plethora of statistics about managers, management and administration, but little information that can be easily analysed about who they are, what they do, and what their impact is. Any attempt to do that is compounded by inexact definitions that change over time.

The result is cheap headlines and a reliance on both sides of the argument on anecdotes about the merits of management in the NHS, as the following examples show.

Figures from the NHS Information Centre show that over the decade to 2009 total staff numbers in England rose by 333,650 to 1.43 million, a 30 per cent increase (Office for National Statistics 2010b).

Within that, professionally qualified staff rose by almost 34 per cent – a higher percentage point increase than the average. Workers from support to clinically qualified staff – which confusingly includes bank, agency and nursery nurses as well as clerical, administrative and some maintenance staff – rose by just over 27 per cent.

Infrastructure staff, which includes some managers along with finance, IT, personnel and estates, and services such as cleaning, catering and laundry (but not when those services are outsourced) rose by just under 38 per cent. The number of managers and senior managers, as defined in the survey, rose by a mighty 84 per cent.

The result was headlines about management numbers growing at getting on for three times the rate for doctors and nurses over the decade, and five times the rate of increase for nurses in the most recent year. It brought from Andrew Lansley, the then Conservative health spokesman, the comment that ‘box ticking and bureaucracy seems to be more important than ... caring for patients’ (Conservative Party 2010).

Yet the absolute increase in senior manager and manager numbers over the decade was just over 20,000 while the increase in professionally qualified staff was just under 184,000. The percentage of managers in England has risen from just over 2 per cent of total NHS staff in 1999, measured by headcount, to just over 3 per cent in 2009, and has since dropped back slightly. On a full-time equivalent basis, the number of managers rose from 2.7 per cent to 3.6 per cent of NHS employment.

The NHS in England is a £100 billion-a-year-plus business. It sees 1 million patients every 36 hours, spending nearly £2 billion a week. Aside from the banks, the only companies with a larger turnover in the FTSE 100 are the two global oil giants Shell and BP. If it were a country it would be around the thirtieth largest in the world. It might just as sensibly be asked, how can it be run effectively with *only* 45,000 managers (although the figure is almost meaningless as many managers with a clinical background such as medical directors and directors of nursing are excluded from the official definition of management)?

By contrast in the anecdote stakes, the coalition government is in the process of scrapping the ‘bureaucratic, top-down, process-driven’ target for waits in accident and emergency (A&E) departments.

In place of the single measure of whether or not a four-hour wait for treatment is breached, the government is bringing in 11 measures of A&E performance. These are indeed subtler and more informative than just the four-hour wait. The substitution of 11 measures for one, however, can only add to NHS administrative and possibly management costs at a time when administrative costs are to be cut by a third and senior management costs by 45 per cent.

The commission asked Kieran Walshe, professor of health policy and management at Manchester Business School and a member of the commission, and his colleague Liz Smith to use a separate information source to shed some light on the issue.

Key findings from Walshe and Smith (2011)

- Using data from the independent Binley's Database of NHS Management (which contains data on managerial roles and functions across the UK, not just in England) we found that between 1997 and 2010 the numbers of NHS managers in the UK had risen by 28 per cent over a period in which health spending had doubled in real terms.
- Manager numbers had risen by 37 per cent in England, but had declined slightly in Wales, Scotland and Northern Ireland. This may be because of differences in health policy – targets and performance measurement, the internal market, and the creation of foundation trusts in England may all have increased management numbers and costs.
- Most NHS managers work in health care provider organisations in acute and primary care, and though successive reorganisations of the NHS have moved managers around, there is little evidence that reorganisations have reduced the numbers of managers, though that has often been their stated aim.
- There are around 6,600 board members of NHS organisations in the UK, of whom about half are non-executive chairs and directors. Numbers have been largely static over the last 14 years. About 37 per cent of board members are female, but women are less likely to hold roles such as chair, chief executive or finance director.
- There are many doctors in management positions. About 700 doctors hold medical director appointments in NHS organisations, and at least 2,000 more are in managerial roles as clinical directors.

Binley's database uses different definitions to the NHS Information Centre. But it produces a 28 per cent rise in manager numbers between 1997 and 2010 at a time when spending on the NHS doubled in real terms. That suggests, Professor Walshe concludes, 'that the rise of NHS "bureaucracy" may have been somewhat exaggerated' and that 'the NHS management workforce has not expanded disproportionately' (Walshe and Smith 2011).

According to the Office for National Statistics, the proportion of managers in the UK workforce as a whole in June 2010 was 15.4 per cent. These statistics use a different definition from that of the NHS Information Centre. But they show that there were 77,000 hospital and health service managers across the United Kingdom, or 4.8 per cent of the NHS workforce. In other words, the NHS has a managerial workforce a mere one-third the size of that across the economy

as a whole (ONS 2010). If anything, that points to the conclusion that the NHS, particularly given the complexity of health care, is under- rather than over-managed.

What do managers cost?

Having considered the workforce numbers, what about the costs? What evidence there is – and it needs to be treated with caution because of the measurement difficulties – suggests that the NHS not only lacks an excessive management cadre, but it also has relatively low costs, either by comparison with other sectors of the economy or with other health care systems.

Stephen Black of PA Consulting calculates that in England primary care trusts spend around 1 to 2 per cent of their budgets on management and ‘only the most outstandingly frugal charities spend as little as 1 per cent of their turnover on management’. In the United States, where charities have to categorise such expenditure, typical large charities such as the American Diabetes Association, American Cancer Research Fund, and American Red Cross spend 3–5 per cent. But some big health charities spend much more: the Mayo Clinic 12.5 per cent, the Salk Institute 19 per cent (Black 2010).

Equally, evidence submitted to the commission by David Buchanan, professor of organisational behaviour at Cranfield School of Management, analysing the NHS workforce data referred to above, concludes that ‘rather than complain about excessive growth, the NHS may be an under-managed service’. Using data from seven assorted but representative NHS trusts, he points out that a clinical directorate consisting of a consultant, general manager and senior nurse may well be managing a £40 million a year business in a hospital with a £350 million turnover (Buchanan 2011).

After the Commons Health Select Committee in the last parliament declared itself ‘appalled’ that the health department could not provide accurate figures for staffing levels and commissioning and billing costs in primary care trusts and hospitals, NHS Chief Executive Sir David Nicholson has provided some figures. He told the Commons Health Select Committee that the administrative and management costs for strategic health authorities, primary care trusts’ (PCTs) commissioner arms, the health department and the various regulators and arms-length bodies are now calculated to be £5.1 billion – a figure that will reduce to £3.4 billion as administration costs are cut by one-third over the spending review period from 2011 to 2015. This £5.1 billion equates to just under 5 per cent of the health budget. To that, however, would have to be added management and administration costs in hospitals, general practice and parts of the community service.

There is no good data on administration and management costs within general practice. However, an analysis undertaken for this commission by the Audit Commission shows the service in England spending about £2.5 billion in 2009/10 on management in NHS trusts, including mental health and ambulance services – an average of 4.4 per cent of their income. In addition, the Audit Commission estimates that primary care trusts spent a further £0.4 billion on management of their provider arms. The figures come from the 2009/10 NHS accounts (Audit Commission 2011).

Foundation trusts do not have to report their management costs, so the figures for those are extrapolated from figures for NHS trusts – which in 2009 still accounted for about half of all NHS hospitals.

Nonetheless, taken together, these figures suggest that the NHS is spending, very approximately, £8 billion on management within the Department of Health, the regulators and arm's length bodies, in strategic health authorities, primary care trusts and the providers of care – or appreciably under 10 per cent of a £100 billion budget.

The figure is, however, an estimate. It does not include time spent by a wide range of clinicians on various forms of management, and it does not include the lower levels of administration, where the definition of administration is extremely difficult and where the costs are even harder to quantify.

What the figures also demonstrate, however, is that any attempt to produce a reliable estimate of the costs of administration and management in the NHS is like squeezing a block of unconstituted jelly – and attempts to make any precise comparison of costs between countries is an even more thankless task.

What effect do managers have?

Returning to the workforce numbers, Professor Walshe's study shows that all the growth in NHS management numbers since 1997 appears to have occurred in England, with figures for the other three countries of the United Kingdom static or falling.

The commission can only speculate on the reasons for that. There have, however, been sharp contrasts, notably between England, Scotland and Wales, in the way the NHS has been run since devolution in 1997. While Wales and Scotland have reverted to delivery models closer to that in England before the introduction of the internal market in 1991, England has seen a plethora of policy initiatives that have increased the requirement both for management and administration.

These include ‘targets and terror’ – Labour’s introduction of waiting time targets along with a clutch of new regulators, such as the CQC, to produce published measures of hospital and primary care trust performance; extensive and expensive staff and patient surveys; Payment by Results – a national tariff of hospital prices, which requires both the hospital and purchasing side to check on data quality; new staff contracts, which in the case of general practice, for example, include a quality and outcomes framework that requires data collection for performance measurement; and the publication of much other data (with more to come) on clinical performance – as well as patient choice of hospital for a first outpatient appointment. All that requires much administration and some management.

Furthermore England has seen a number of initiatives that have had a complex impact on management and administration costs, for example the private finance initiative, growing purchase of clinical services including NHS operations from the private sector, and more extensive contracting out of a wider range of support services than in either Scotland or Wales. These latter contractual changes may in some cases have reduced direct administration costs within the NHS and outsourced the management of these services. But they will also have increased the numbers of contract managers in the NHS.

Last year’s four-country study from the Nuffield Trust showed that England spent less on health care and had fewer doctors and nurses per head, but delivered more patient care and – where the comparison was possible – had shorter waiting times than any of the other three countries (Connolly *et al* 2010). Even the north-east of England, which has a comparable population, income and health status to Scotland, delivered appreciably better results. So, even within the UK health systems, it is at least possible that higher management costs deliver better performance, even though the conclusions of the Nuffield Trust’s study have been challenged by NHS leaders outside England (British Medical Association 2010).

This is not to argue that all NHS management is effective. Repeated reports from the National Audit Office, the Audit Commission and others demonstrate that far better value for money, amounting to savings running into the hundreds of millions if not billions of pounds a year, could be achieved by improved management of procurement, back-office functions and estates, with the skills needed to do that in short supply across the public sector. And there have, of course, been a number of spectacular management failures in recent years involving paediatric surgery deaths, devastating outbreaks of hospital-acquired infection and extremely poor care.

Brief history of leadership and management in the NHS

The health service has a long history of attempting to improve both management and leadership. Many reports have either touched on management and leadership or been specifically focused on it. The most notable include the Cogwheel report of 1967, which called for more involvement of clinicians in management, with clinical divisions taking more responsibility for the management of resources.

Its impact was dissipated by the 1974 reorganisation of the NHS and the arrival of the ill-fated 'consensus management' through multi-disciplinary teams. This could work well, but in practice gave everyone a veto on any decision. The result was rarely highest common factor, most often lowest common denominator, and sometimes no decision at all.

The crucial reaction to that was the Griffith's report of 1983. Its memorable diagnosis was that 'if Florence Nightingale were carrying her lamp through the NHS today, she would be searching for the people in charge' (Griffiths 1983). The report is chiefly remembered for the introduction of general managers who, during the creation of the internal market in the 1990s, rapidly came to re-style themselves as chief executives. It is too often forgotten that Griffiths also saw a central role for doctors in management, both as chief executives and as the critical managers of resources within clinical directorates.

More recently, the last Labour government sought much more involvement of general practitioners and other primary care staff in the commissioning of care through its 1999 Health Act, before primary care groups transmuted into the current primary care trusts. It also had a policy of encouraging practice-based commissioning by GPs. In a similar vein, Lord Darzi's Next Stage Review final report (Department of Health 2008) placed heavy emphasis on clinical leadership while the current Health and Social Care Bill involves the biggest shift of power and accountability in the history of the NHS as it seeks to abolish primary care trusts and strategic health authorities, placing the commissioning of care in the hands of GP consortia.

Other parts of the coalition government's reforms, for example, the move to more of a regulated market in the provision of health care, the transformation of all, or almost all, hospitals into foundation trusts, and the government's desire for significant numbers of staff to leave the NHS and sell their services back through various forms of mutual and social enterprise (as set out ahead of the government's decision to 'pause, listen, reflect on and improve' its proposals) are also certain to impact on NHS providers, not just on care commissioners. The scale of the reforms makes the issues of leadership and management in the NHS ever more important.

Key reports

Porrirt Report 1962

A BMA Committee of Inquiry into the NHS which suggested that tripartite services should be brought together under a single area board, on which the profession was adequately represented and whose chief officer was a doctor (Porrirt 1962)

Farquharson-Lang Report 1966

Published in Scotland, suggested that regional health boards and local boards should employ a chief executive, who need not necessarily be medically qualified (Farquharson-Lang 1966)

Salmon Report 1966

Aimed to raise the profile of the nursing profession in hospital management, recommending a new hospital nursing structure under the direction of a chief nursing officer (Ministry of Health and Scottish Home and Health Departments 1966)

Cogwheel Report 1967

Encouraged the involvement of clinicians in management, recommending the creation of clinical divisions (Ministry of Health 1967)

King's Fund/Institute of Hospital Administrators Joint Working Party 1967

Proposed that there should be a clear chain of command with a general manager supported by medical and nursing directors, a director of finance and statistical services, and a director of general services (Howard 1967)

The Grey Book 1972

Recommended a system of consensus management by multi-disciplinary management teams consisting of an administrator, treasurer, nurse and doctors (DHSS 1972)

NHS Reorganisation Act 1973

Created 14 regional health authorities and 90 area health authorities each with a Chair and non-executive members

Royal Commission 1979

Explicitly rejected general (as opposed to consensus) management in the NHS (Royal Commission on the National Health Service 1979)

Health Services Act 1980

Created 192 new district health authorities in England. Within districts, an emphasis was placed upon devolving management down to smaller units

Griffiths Report 1983

Found that the NHS had no coherent system of management. Key among its recommendations was that general managers be introduced into the NHS and that doctors should become more involved in management (Griffiths 1983)

Working for Patients 1989 and the NHS and Community Care Act 1990

Proposed an internal market in the NHS by separating purchasers from providers. GPs also would be given the option of becoming fundholders, able to purchase some services on behalf of their patients (Department of Health 1989)

Managing the New NHS 1993 and the Health Authorities Act 1995

Abolished the regional health authorities and created eight regional offices and the merger of district health authorities and family health services authorities (Department of Health 1993)

Health Act 1999

Replaced GP fundholding with primary care groups and established the Commission for Health Improvement (later the Healthcare Commission) and introduced the National Institute for Clinical Excellence

The NHS Plan 2000

Proposed significant new investment, together with large numbers of performance targets and standards with annual assessment of NHS organisations and publication of results (Department of Health 2000)

NHS Next Stage Review 2008

Placed renewed emphasis on clinical leadership, and a national leadership council was established by the NHS chief executive in 2009 (Department of Health 2008)

Liberating the NHS 2010

Set out radical plans for reforming the NHS, removing strategic health authorities and primary care trusts, and establishing a National Commissioning Board, with local commissioning carried out by consortia of GPs (Department of Health 2010)

What do we mean by leadership and management?

Definitions of leadership are many and contested, and there are heated debates around its nature and style, and disputes about its impact. One of the most cited definitions is from John Kotter who delineates between management processes that are concerned with planning, budgeting, organising, staffing, controlling and problem-solving and leadership processes that involve establishing direction, aligning people, motivating and inspiring (Kotter 1996).

The commission defines leadership as the art of motivating a group of people to achieve a common goal. This demands a mix of analytic and personal skills in order to set out a clear vision of the future and defining a strategy to get there. It requires communicating that to others and ensuring that the skills are assembled to achieve it. It also involves handling and balancing the conflicts of interests that will inevitably arise, both within the organisation and outside it where, even in the private sector, a wide variety of stakeholders will have a legitimate interest.

In the private sector these will include regulators and in some cases politicians, as well as customers, suppliers, banks and shareholders. In the NHS the stakeholders encompass not just an extensive range of regulators but patients, the public, the Department of Health the soon-to-be established NHS Commissioning Board, the embryonic health and wellbeing boards, and a wide variety of local and national politicians whose views will not always coincide. In this context, leadership is as much about systems leadership as about leadership of individual organisations.

Leadership clearly requires considerable management skills. But it is more than just management, which might be concisely summarised as ‘getting the job done’. It essentially involves marshalling the human and technical resources needed to achieve the organisation’s goals – ensuring that the administration needed to do that is in place, while ideally excising all administration that is not needed. These definitions make clear the commission’s view that leadership in the NHS is needed from the board to the ward and involves clinicians as well as managers.

There is a sizeable literature that illustrates the importance of leadership and its impact on organisational performance. Much of this comes from business where studies argue that companies with effective leadership produce higher shareholder returns and that the best-performing companies in turn go out of their way to foster leadership talent and succession planning, as a review carried out for the commission by Chris Roebuck of the Cass Business School found.

In most organisations that are quoted on the global stock markets intangibles now could account for over 70 per cent of share value. Intangibles include the capability of the current leadership, the quality of the current strategy (set by the current leadership), the brand value (a product of past leadership), the quality of future leadership and sustainability of earnings (again determined by the current leadership and their development of the future leadership). In relation to specific financial measures top tier leadership development organisations outperform their peers in Total Shareholder Return (TSR) by 10 per cent over a three-year period. This means that an organisation of £2 billion market value increases market capitalisation by approx £200 million due to leadership development and talent management.

As well as good leadership having a benefit, poor leadership has a cost. Low quality leadership organisations lose about 6 per cent on TSR over a three-year period and about £110 million on market capitalisation. Further, organisations with stronger leadership development systems have up to 7 per cent higher return on earnings and profit than competitors.

At operational level it is possible to gain benefit from good leadership even if an integrated approach to leadership at strategic level is not present. Practical improvements that are simple, quick to implement and low-cost can be delivered day-to-day by quality leadership at the operational level. At the highest level of improvement, if the organisation can get disengaged staff to become engaged this will improve the individual's performance by up to 57 per cent.

In many cases it is simple actions that can be taken by leaders day-to-day that make a real difference to performance and thus service delivery. For example, making clear the line of sight from individual to corporate objectives can improve discretionary effort by up to 28 per cent, and giving fair and accurate feedback by up to 39 per cent. These cost the organisation nothing to implement and not only deliver better performance but also start to create a culture where further improvements and benefits are more likely in the future.

(Roebuck 2011)

In health care too, both at the lower levels of organisations and at the top, there is evidence that leadership matters. Research commissioned by the government of Ontario on high-performing, but very different, health systems in the United States, Sweden, England and Canada established that a key element they had in common was a focus on quality allied to leadership development at all levels. The research, conducted by Ross Baker of the University of Toronto, one of the

commission's members, showed that these organisations developed expertise in improvement, not just for individuals but for leadership teams, as in the examples set out below (Baker 2011).

Why leadership matters

So does leadership matter? The commission believes so.

Leaders make improvements in service and outcomes

Intermountain Healthcare in Utah has achieved an enviable reputation for high-quality care at lower than average costs. Sustained efforts to improve care have yielded substantial results in part by developing advanced electronic clinical information systems used by skilled staff who have highly developed skills to analyse and improve care. The scale of improvement has come to the attention of President Obama and others. Intermountain Healthcare has invested heavily in the development of its leaders through the Advanced Training Programme, which enables managers and clinicians to acquire skills in service and quality improvement.

Leaders promote professional cultures that support teamwork, continuous improvement and patient engagement

The message to staff from former CEO Sven-Olof Karlsson of Jönköping County Council, which governs Swedish health care in the region, was that everyone has 'two jobs: improving care as well as providing care'. The statement underscores the organisational focus on improvement. It was an expectation that all staff members would be responsible for improving work and that information and results about performance would be transparent. The council has also helped clinicians to put the patient at the centre of system redesign, using the persona of 'Esther' who represents the needs of patients in the system.

High performance requires distributed leadership including clinical champions

Effective leadership for improvement requires engaging doctors to participate in redesign efforts and to build support for these activities among their colleagues. At Intermountain Healthcare doctors took key leadership roles in each clinical programme. These medical directors worked with the frontline clinical staff, identifying issues in the implementation of clinical process management, setting clinical goals, and holding clinical teams accountable for performance. At Jönköping, doctors played key roles in the redesign of services and the integration of care across the continuum in paediatrics and later in seniors' health services.

Recent work from McKinsey and the Centre for Economic Performance at the London School of Economics examining the performance of around 1,300 hospitals across Europe and the United States points to well-managed hospitals producing higher quality patient care and improved productivity, with those having clinically qualified managers also producing better results (Dorgan *et al* 2010). Higher scoring hospitals gave managers higher levels of autonomy than lower scoring ones. The study noted that this is consistent with the use of service line reporting and management, which Monitor has been encouraging foundation trusts to adopt. Its use enables decision-making and accountability to be devolved as close as possible to the clinical front line.

This research is underlined by the work of the Healthcare Commission. For many years the Commission used surveys in which staff rated the quality of leadership in their organisation. Higher ratings for senior managers by their staff correlated to higher performance ratings, higher scores for clinical governance and lower numbers of patient complaints (CQC 2011). Research from Aston University provides further evidence of the link between the quality of leadership, staff engagement and outcomes (Admasachew and Dawson (in press); Topakas *et al* (in press)).

One of the other key findings from Ross Baker's work is that high-performing health care organisations were also characterised by having long-serving leaders at the top and managing transitions between chief executives in order to maintain strategic direction (Baker 2011). The importance of that finding for the NHS should not be underestimated given the high rate of turnover of NHS chief executives. Sir David Nicholson, the NHS Chief Executive, is on record as saying: 'We find it very difficult to recruit people who want to be chief executives – the average time they spend in post is just 700 days' (Santry 2007).

Successful performance requires sustained leadership and leadership succession that maintains a focus on improving performance. Thus high-performing health care systems are likely to have long-serving senior leaders, and transitions that preserve their achievements. Gail Warden was the President and CEO of the Henry Ford Health System in Michigan for 15 years. When he retired in 2003 Warden was followed in the President and CEO role by Nancy Schlichting, previously the executive vice president and chief operating officer. Scott Parker, CEO at Intermountain Healthcare from the late 1970s, was succeeded by Bill Nelson in 1999 who had been the system CFO. Sven-Olof Karlsson was succeeded after nearly 20 years as Jönköping CEO by Agneta Jansmyr in 2008. Jansmyr had been director of care administration in Vaxjo, Sweden before her appointment, but had worked for the Jönköping County Council in operations and quality improvement for many years before that (Baker 2011).

If anyone doubts that leadership matters, they have only to look at the actions and pronouncements of Sir David Nicholson, the NHS Chief Executive and chief executive designate of the NHS Commissioning Board, on what needs to be done to manage the NHS during the current transition, and on the likely pace and extent of change. Sir David has, for example, repeatedly stressed the requirement for leaders to maintain financial control and to ensure that the quality of patient care does not suffer at a time of major organisational change. He has also made clear that not all GP commissioning consortia – assuming that they go ahead in their current form – will be ready by 2013 and that other consortia, or the NHS commissioning board, will carry some or all of their responsibilities until the consortia are ready. His actions are likely to provide some continuity of leadership to the service at a difficult time of transition.

Investment in leadership development

There is also evidence of the return on investment in leadership development. This is illustrated by the experience of NHS South Central.

South Central High Potential Leaders Programme

- The South Central high potential leaders programme suggested that raising the skills of senior staff allowed them to take on tasks usually outsourced to expensive external consultancies, while reducing staff turnover and increasing job satisfaction.
- Despite a £3 million investment – a figure that included the indirect costs of time lost through participation, as well as direct costs – organisations had only to reduce their use of external consultancy by 10 per cent a year, and have staff stay in post for an additional six months, for the investment to be recouped.
- The study suggests that high quality care is in fact cheaper, or at the very least cost neutral, and that developing staff is not a luxury but a necessity for good patient care.

(Vaithianathan 2010)

On the other side of the equation recent hospital scandals – the paediatric heart surgery deaths at the Bristol Royal Infirmary (Kennedy 2001), hospital-acquired infections at Maidstone and Tunbridge Wells, and preventable deaths at Mid-Staffordshire – have demonstrated painfully and acutely what can happen when leadership and management fail. They show not just when they fail at board and chief executive level, and even when a medically qualified chief executive is in charge, but when failure occurs throughout an organisation, and among stakeholders who should have been aware earlier what was going wrong – GP practices and the service commissioners, for example.

What sort of leaders does the NHS need?

Much of the recent public discourse on leadership in the public services has focused on leaders as ‘superheroes’ – ‘super heads’ in schools, for example, elected mayors in local government (with very mixed results), and the rapid passage through parts of the NHS of ‘turnaround’ chief executives. However, the operation of all public services is becoming more complex. And there is evidence from both the public and private sectors that the superhero approach can be fine when things are on the up, but its virtues can be vices on the way down or when serious misjudgements are made.

A recent survey by the Institute for Government asked political academics to rate the most successful government policies of the past 30 years and to judge what had made them successful (Institute for Government 2010). Their view of the latter was that the successful policies had strong political leadership and managerial commitment. But as Colin Talbot, professor of public policy at Manchester Business School, subsequently pointed out, precisely the same attributes applied to some of the biggest public policy disasters of recent years – the poll tax and the child support agency (Timmins 2011).

Furthermore, because the way that the NHS operates is changing, the model of the ‘romantic’ or ‘superhero’ leader is ill-suited to current demands. Increasingly, and not just because of the current government’s emphasis on localism, NHS leaders, whether commissioners or service chief executives, have to influence as much as lead heroically – a model requiring additional, if not entirely different, skills. Health care and prevention has to be delivered through both co-operation and contracting with a wide range of bodies outside the NHS – local government in particular, but also private and voluntary suppliers of care, the education and police services and local communities.

The ability to work across boundaries and persuade others over the right course of action has become more important than the cavalry charge on behalf of a single institution or organisation. In a paper prepared for the commission, Jean Hartley and John Benington of Warwick Business School emphasise that ‘organisations in the public, private and voluntary sectors need to picture themselves not only in terms of machines and pyramids, but also in terms of organic living systems, continuously evolving and adapting as they interact with a changing external environment’ (Hartley and Benington 2011). They illustrate this using the example of a programme in Leicestershire focused on alcohol

and drug misuse, designed to create a cadre of public leaders from different organisations to address the needs of the population.

Assessment of what is needed to produce good leadership has moved decidedly against the 'great leader' model – a model in which individuals are perceived, almost single-handedly, to drive organisations to success. In its place has emerged the 'post-heroic' model of leadership, the key features of which have been summarised by Kim Turnbull James of Cranfield Business School in a paper prepared at the request of the commission.

The 'post-heroic' model of leadership

Involves multiple actors who take up leadership roles both formally and informally and importantly share leadership by working collaboratively. This takes place across organisational or professional boundaries. Thus shared and collaborative leadership is more than numerically having 'more leaders'.

Leadership can be distributed away from the top of an organisation to many levels. But this distribution takes the form of new practices and innovations not just people at lower levels taking initiative as leaders – again more than simply 'leaders at many levels'.

As a result, leadership needs to be understood in terms of leadership practices and organisational interventions, rather than just personal behavioural style or competences. The focus is on organisational relations, connectedness, interventions into the organisation system, changing organisation practices and processes.

(Turnbull James 2011)

This model has implications for some of the current proposals for improving leadership and management in the NHS. As Turnbull James has argued, many contributions are needed for an organisation to achieve success:

However enticing in a pressured environment, the fantasy that getting the right leader in place will be enough to change the system, is untenable. The healthcare context requires people who do not identify with being a leader to engage in leadership.

Leadership must be exercised across shifts 24/7 and reach to every individual: good practice can be destroyed by one person who fails to see themselves as able to exercise leadership, as required to promote organisational change, or who leaves something undone or unsaid because someone else is supposed to be in charge. The

NHS needs people to think of themselves as leaders not because they are personally exceptional, senior or inspirational to others, but because they can see what needs doing and can work with others to do it.

(Turnbull James 2011)

She adds: 'Health care requires colleagues from diverse professions and with competing perspectives on what is important to work collaboratively to meet organisational aims. The NHS requires complicated leadership arrangements with negotiated authority between clinicians and professional managers, between clinicians from different professional backgrounds, across one NHS entity to another and for innovations and change projects that involve different directorates' (Turnbull James 2011). In this 'post-heroic' age, it is an ability to hold together the diversity of talents that distinguishes a successful from an unsuccessful leader.

These ideas echo arguments about the importance of 'engaging leadership' (Alimo-Metcalfe *et al* 2008) that draws on research into leadership styles in health care settings and other contexts to emphasise the role of leaders in maximising the potential of their people. As Keith Grint and Clare Holt of Warwick Business School argue in a paper prepared for the commission, leaders must understand that leadership involves a relationship and cannot be understood in the absence of followership (Grint and Holt 2011). In support of this argument, Grint and Holt invoke the work of Mintzberg who highlights the importance of developing leaders in the context of the organisations in which they work.

This view is echoed by Turnbull James who contends that leadership development needs to be deeply embedded and driven out of the context and the challenges that leaders in the organisation face collectively. Such leadership development focuses on roles, relationships and practices in the specific organisational context and requires conversations and learning with people who share that context. One of the implications is that the recent focus on leadership development needs to be matched by a greater appreciation of the role of followers and the needs of the organisation as a whole.

While these arguments apply to all organisations, they have particular relevance to professional service organisations such as those found in health care because of the autonomy granted to clinicians in their work. To give a specific and current example, GP commissioning consortia will need skilled leaders but they also require a much larger number of willing and committed followers if they are to fulfil their functions effectively. This has to be more explicitly recognised in the future, both in debates about the role of leaders in the NHS and the content of leadership development.

Who should be developed?

More diffuse styles of leadership underline the point that the NHS needs strong leadership and management ‘from the ward to the board’. Clearly, managers require development and support but there is mounting evidence that where doctors and nurses and other health professionals are provided with clear information about costs, along with the authority to tackle them – for example, through service line reporting in hospitals or prescribing costs in general practice – higher quality and better care results. This has been demonstrated both in the NHS and in reviews of evidence from the experience of health care systems in other countries (Ham 2003; Ham and Dickinson, 2008).

It is the commission’s firmly held view that one of the defining weaknesses of the NHS over the decades has been the lack of involvement of clinicians in management when it is the decisions of clinicians – in particular doctors – that chiefly influence how the budget is spent. From Cogwheel to Griffiths to the current work of Sir Bruce Keogh, the NHS medical director, the importance of this has been regularly recognised. But there have been as many reverses as advances, for example the recent demise of the British Association of Medical Managers. The creation by the medical royal colleges of the Faculty of Medical Leadership and Management offers some hope of an advance.

Development in both leadership and management is needed for a much wider range of staff than just doctors. It needs to include nurses and allied health professionals, and the emergence of nurse and allied health professional consultants brings with it a greater requirement for these staff to take on much more responsibility for budgets, management and leadership. Leadership development must not focus purely on technical competencies, but on the ability to create climates in which individuals can themselves act to improve services and care. Staff at all levels need to be given the skills to have the courage to challenge poor practice.

Across the country, there have been good results from various ‘buddying’ arrangements between clinical staff entering managerial or leadership roles and managers. Such informal arrangements should be encouraged. There is anecdotal evidence that where specialist registrars taking postgraduate managerial qualifications do so alongside NHS management trainees the relationship is productive.

Ross Baker’s research (Baker 2011) underlines the importance of clinical leaders working in partnership with experienced managers. High-performing health care organisations throughout the world have learned this lesson and not only invest

in the development of doctors and other clinicians as leaders but also ensure that they work hand-in-hand with managers. The partnership between clinical leaders and experienced managers is a further example of the emergence of post-heroic forms of leadership.

What does this mean?

The NHS needs to move beyond the outdated model of heroic leadership to recognise the value of leadership that is shared, distributed and adaptive. In the new model, leaders must focus on systems of care and not just institutions and on engaging staff and followers in delivering results. At a time of huge transition and challenge, leaders at all levels and from all backgrounds have a responsibility to ensure that the core purpose of the NHS – to delivery high-quality patient care and outcomes – is at the heart of what they do. The Commission cannot over-emphasise the importance of ‘leadership for a purpose’ and the imperative not to lose sight of this.

Conclusions

So what are the commission's broad conclusions?

■ **Leadership and management in the NHS matter, and the role of managers should be celebrated and not undermined.**

The service faces its biggest efficiency challenge ever. Finding 4 per cent of efficiency savings a year for four years is a target so large that no health care system anywhere in the world has achieved anything like it.

On top of that, whatever the outcome of the coalition government's decision to 'pause, listen, reflect on and improve' its NHS plans, it remains clear that the health service is about to go through one of the most dramatic structural upheavals in its history.

Neither the efficiency gain nor the new structures can be delivered successfully without high-quality leadership and management, not just from the board to the ward but across primary and community services and social care. Many experienced leaders have already been lost and this puts at risk delivery of the government's plans.

To equate NHS management simply with bureaucracy, as politicians of all parties have repeatedly done, is an insult not just to managers but to all the clinically qualified staff who are engaged in management at every level of the NHS.

The charge that managers are unnecessary bureaucrats:

- damages the morale of existing staff
- discourages clinicians of all types and at all levels from taking on the role
- warns off outside talent from joining, whether from the private sector or other parts of the public sector
- reduces the chance of the best newly qualified graduates from applying to be the future leaders of the National Health Service.

■ **From the deeply imperfect data available, the commission's conclusion is that the NHS is almost certainly over-administered in the sense that there are extensive, overlapping and duplicating demands on it for information. This does merit the charge of bureaucracy.**

Some of this is due to performance management, some to regulation and audit, and some to overlap and duplication which comes in two forms. First between

performance management and regulation, and second between the various demands of regulators, auditors, accreditation bodies and others. Ministers need to acknowledge that the bulk of these demands have been placed on it by politicians and the public, not by ‘faceless bureaucrats’. Politicians of all parties need to deal with their conflicting desire to reduce the level of bureaucracy within the health system and yet to increase the drivers that build it up, such as strengthening regulation and making more information on health care performance and outcomes available to the public.

- **There is no substantive evidence that the NHS is over-managed.** There is appreciable evidence, as outlined above, that it is under-managed – even if some of that management may not always be highly effective and is centred on the wrong things. There is also persuasive evidence from both public and private health care providers that it is overburdened with administrative tasks (NHS Confederation and the Independent Healthcare Advisory Services 2009).
- **Health ministers and their department should therefore re-think the planned 33 per cent cut in administration costs and 45 per cent cut in the number of managers and senior managers.** At a time when the service faces the most severe spending squeeze in its history, management and administration will have to take at least its fair share of the pain. But the numbers announced are simply arbitrary. They have been backed by no published analysis whatsoever. And they come at a time when good leadership and management will be at a premium, for all the reasons outlined above.

Furthermore, if the outcome of the desire for GP commissioning consortia is to create 200–300 commissioning bodies to replace 150 primary care trusts and 10 strategic health authorities, plus the creation in local government of 150 health and wellbeing boards, the result is likely to be an increase in management and administrative posts, not a reduction, and not necessarily an improvement in either management or leadership.

Some of the tasks can, of course, be done differently, notably by sharing back-office functions such as payroll, finance and procurement. But the current policy of creating more commissioning and oversight organisations while slashing management and administration costs is more likely to lead to financial failure than an improvement in patient care. If the government genuinely wants to see a reduction in administration costs, then it needs to analyse how they arise – and how the information burden of regulation and performance management can safely and sensibly be reduced.

Despite recent work done by the Care Quality Commission (CQC) and its provider advisory group (NHS Confederation and the Independent Healthcare Advisory Services 2009), there has not been a substantive review of the information demands placed on the system for many years. In any health system, but particularly a tax-funded one, it is essential that all the information necessary to measure performance and to hold organisations and individuals to account is available. At a time when big cuts in administration are being sought, new regulators created, and existing ones given a different role, now is the time to review what is actually needed, and by whom, to achieve those ends, and what it is that can be discarded.

- **Management in the public sector and the NHS in particular has more in common with that in the private sector than is often recognised.**

Richard Sykes – who has extensive private sector experience as chief executive of GlaxoSmithKline and had a bruising experience as chairman of NHS London – made this point forcefully in his lecture for the commission (Sykes 2011). Many of the same skills are required in both sectors. That argues, up to a point, against treating training in NHS management as something entirely unique and separate.

Where there is a big difference, however, is the environment in which the NHS operates. Business is essentially answerable to its owners and shareholders. It has to pay close attention to the law and its regulators. And it has important relationships with its suppliers and customers.

The NHS, like other public services, operates in a much more complex world. It has a duty to the financial bottom line, like business. But it cannot pick and choose its customers. More than most other services, it operates in an area that is highly emotive, for both patients and the public. Many other private and public businesses have to engage with professionals – from engineers to professionally qualified finance staff, for example, who are subject to their own professional codes of conduct and disciplinary procedures – but none with the huge range of professional interests involved in the NHS. It also operates in a goldfish bowl of media scrutiny while being subject to political pressures both nationally and locally. And it cannot achieve its objectives in isolation.

This makes managing and leading in the NHS an immensely challenging – if potentially also an immensely rewarding – task. As a result, politicians in particular need to recognise that leadership in the NHS can in the end only be as effective as the environment in which it is allowed to operate.

■ **Leaders in the NHS need to be given room to lead.**

The creation of foundation trusts as freestanding businesses was meant to unleash a degree of innovation in the provision of health care that – with some notable exceptions – has not materialised. Partly because of the political environment in which the NHS operates, they have remained risk-averse. They have few incentives to expand or take over other under-performing NHS organisations, and there is much personal and political downside for their leaders if they attempt that and it does not go well.

Bill Moyes, in his final interview as chairman of Monitor, suggested that foundation trusts have not been as innovative as had been hoped, offering the opinion that the United Kingdom – unlike the case with universities – does not have any hospitals that are world class across the whole range of what they do. Even with their existing freedoms, he said, ‘they still feel the heavy hand of the Secretary of State is coming in their direction’ and spend too much time worrying about what the Department of Health and ministers want (Timmins 2010).

The government is attempting to tackle that, distancing ministers from day-to-day involvement in the running of the service through the creation of a commissioning board. But the early signs that this will make any substantive difference are not encouraging. The coalition government halted all hospital reconfigurations into which much time, effort, consultation and leadership had been devoted.

If politicians and the public really want better leadership and more innovation in the NHS, then its leaders – using sound evidence where service reconfiguration is involved – have to be given the room to lead, and political backing when they so do. Leaders do not just shape events, they are shaped by the external forces on them and in the NHS these are extensive.

■ **The government needs to recognise that its current proposals for reform raise serious issues around governance, leadership and management.**

The Commons Health Select Committee has recently made powerful points about the need for proper governance of commissioning bodies which this commission endorses.

But there are also big issues around leadership and management. GP practices in the main are small businesses. The consortia or commissioning bodies that they will form, or become part of, will require extensive management and leadership skills.

The Department of Health and the NHS Commissioning Board need to ensure that the best of management and leadership skills in primary care trusts and strategic health authorities are not lost in the transition to GP commissioning.

There is a major question emerging over the governance of foundation trusts. Under current plans these will eventually cease to be subject to bespoke regulation by Monitor. They will be much more genuinely freestanding businesses. This will place vastly greater responsibility on their governors for the viability and effectiveness of their organisations. In effect, governors will become something more like a supervisory board overseeing the work of the board of directors.

This change appears to have received little attention. Yet if foundation trusts are to survive as viable businesses in the long term, it is vital that governors have high-quality business skills in addition to a commitment to NHS values. Despite the tight budget, money must be found for training to allow governors to effectively exercise their much greater responsibility.

Furthermore, it is already difficult to recruit to boards. Yet it is essential that these non-executives have the experience, authority and skills to hold executives to account. At present, for non-foundation trusts, chairs are paid only between £18,437 and £23,366 a year and other non-executives only £6,096 (Appointments Commission 2011). This produces boards which tend to be heavily biased towards the retired or semi-retired, or those who do not need the money.

It is noteworthy that foundation trusts have broken this mould, paying both chairs and non-executives significantly more. Critics may see this as these bodies taking advantage of their relatively new-found freedoms to reward themselves. The commission does not see it that way. It is simply essential that the best skills are recruited, and that the over-riding qualification for non-executive board membership is bringing the right skills to the job.

The days when a position as a non-executive was seen simply as an honorary public duty are gone. An improvement in remuneration may also encourage younger people from more diverse backgrounds to take on the task. The commission believes that where such appointments remain governed by national rules, a considerable increase in the current pay is required.

We would add that if one of the outcomes of the government's 'pause' in its reforms is greater representation of councillors, hospital doctors, nurses and possibly others on commissioning bodies, it is essential that such people

understand that their role is to act as leaders and decision-makers, not as representatives. One of the huge weaknesses of health authorities in the wake of the 1974 reorganisation was that their representative nature – or more precisely that the way many of those appointed from particular interests saw their role to be one of representation – militated against effective decision-making. It would be a mistake to repeat that experience.

- **The NHS needs leadership and management, not just ‘from the board to the ward’ – essential and central though that is – but across NHS boundaries into social care, local government, the voluntary sector and the wide variety of other agencies with which it interacts and without whose co-operation it will not achieve its primary objectives.**

This requires not heroic leadership but leadership that is shared, distributed and adaptive. Leaders must focus on systems of care and not just institutions and on engaging staff and followers in delivering results. Leadership development should focus on organisations and systems, not simply individuals, and should give much more attention to shared leadership between managers and clinicians.

- **It is the commission’s view that National Health Service organisations and suppliers to the NHS need to own the requirement to improve management and develop leaders.** As the evidence from both the private and public sectors cited above shows, organisations that invest in leadership and management development, and in succession planning, tend to do appreciably better than those that do not. Ross Baker’s research into high-performing health care organisations reaches the same conclusion (Baker 2011). Some larger foundation trusts – such as University College Hospitals London and Northumbria Healthcare NHS Foundation Trust – already make a significant commitment to leadership development in recognition of this.

Leadership and management development is thus a core part of the business and needs to be paid for from core income. However, not just providers of NHS services but the new commissioning bodies have to recognise that such development is essential to the business, and the boards of all organisations need to monitor both what is being spent and how well it is being spent. Furthermore, it is vital that the sorts of studies that NHS South Central has undertaken on the return on investment in leadership and management development are established more widely to help boards make the case to themselves and the wider public for the value of such expenditure (Vaithianathan 2010).

- **To do that, it is important not just to capture the gains of recent years, which include the establishment of the National Leadership Council, and investment by SHAs and a significant range of individual NHS organisations, but to develop them.**

While the commission does not support the creation of an ivy-covered building lined with portraits of great managers past that might be seen as an NHS staff college, it does see the need for a focus to help the NHS and its providers establish centres of excellence for management and leadership development. Some models already exist at the regional level, as in the north-west of England where a leadership academy has been formed by NHS organisations to provide some of the expertise needed and to commission programmes from a range of sources.

The King's Fund itself provides leadership development for both clinical and non-clinical staff. Monitor has worked with City University and Manchester Business School. Internationally, Jönköping County Council, which governs health services, has its own development centre, Qulturum (Bodenheimer *et al* 2007). And the royal colleges have recently established an embryonic faculty of medical leadership and management to provide a focus for work in this area.

In the private sector, General Electric established a global leadership centre at Crotonville near New York in 1956 to develop its leaders. The leadership centre has been at the forefront of practical application of thinking in organisational development, leadership, innovation and change management. Every year thousands of GE employees take part in programmes organised at Crotonville and these programmes are focused on the practice of leadership at GE. Central to these programmes is the development of teams, not just individuals, and a focus on tackling real world problems (Tichy 1989).

These models need to be built on, with NHS organisations – from commissioners to providers – combining to create and buy such services. All providers of leadership development should seek wider links not just with the public sector – most obviously social care and local government – but with the private sector and business schools, in recognition of the fact that the best of NHS management needs to measure itself against and learn from the best of management in other spheres.

A national NHS leadership centre could play a central role in facilitating this. It should have the resources to: support investment in nationally important leadership development; help accredit and signpost development programmes; and support the evaluation of these programmes, including the return on investment from leadership and management development.

- **Amid its emphasis on the importance of NHS management and leadership, and its support for it, the commission is acutely aware that there have been some spectacular failures in both. Bristol, Maidstone and Tunbridge Wells and Mid-Staffordshire are the most extreme known examples.**

This has brought forth a number of proposals for professional accreditation of NHS managers, stretching to the idea of a formal educational and disciplinary body that would have the power to debar a manager from management, along the lines of the General Medical Council (GMC), the Health Professions Council, or the Nursing and Midwifery Council.

The commission fully accepts that serious failures of senior leadership and management can do at least as much damage to patients as purely clinical failures – arguably much more as far greater numbers of patients can suffer as a result.

The commission, however, has reservations over creating a new form of professional accreditation for NHS management. The skills needed are diverse and in many cases generic. Establishing a system of accreditation and then making the acquisition of a qualification a prerequisite for certain jobs would run the risk of creating an entire new industry of NHS qualifications that could itself become a bureaucratic barrier to hiring the best talent – particularly when some of the best talent will come from outside the NHS itself and from the ranks of clinicians.

To go a step further and create – in effect – a GMC for the managerial profession would be a larger error; partly for the reasons cited above, and partly because it is unclear that the benefits would outweigh the costs.

At board level, it is worth noting that clinical and finance directors are already subject to professional standards and discipline, and there have been – admittedly very rare – examples where serious under-performance in a management role by a clinician or finance director has resulted in disciplinary action by their respective professional bodies. It is essential that health care organisations are run by senior managers and leaders who are demonstrably qualified for, and competent to hold, such demanding and challenging positions – and substantial NHS experience or clinical expertise are not sufficient. It is first and foremost for organisations and their boards (especially their non-executives) to ensure that they have competent, effective and sustainable management arrangements; to review the performance of senior managers and leaders and to hold them to account. A national NHS leadership centre should consider whether the effectiveness of senior management

and leadership should be considered by the Care Quality Commission as an important determinant of organisational performance and be taken into account in processes for registering and licensing health care providers.

In arguing for the importance of leadership, we conclude by emphasising that while high-quality leadership is essential to improving performance in the NHS, other factors also contribute. Ross Baker's work found that high-performing organisations had a number of characteristics in common, including having quality as a core goal, using information to guide improvement, developing organisational skills to support performance improvement, and having learning strategies that test improvement and scale it up when it succeeds (Baker 2011). So although this report has focused on the role of leadership and management for the reasons explained at the outset, we would not want to leave the impression that all of the problems of the NHS will be solved if our recommendations are acted on. Action is needed on several fronts at the same time if the goal of transforming the NHS into a truly world-class system is to be met.

Appendix

Submissions to the commission

The commissioners sought evidence from interested individuals and organisations. They were invited to submit views both on the current state and future needs of management and leadership in the NHS and to submit examples of good practice.

Organisations

Association of Directors of Public Health

British Medical Association

Centre for Better Managed Health and Social Care

Centre for Workforce Intelligence, Cass Business School

Chartered Management Institute

Cranfield School of Management

Emerging Clinical Leaders Network

Foundation Trust Network

The Health Foundation

Healthcare Financial Management Association

Heart of Birmingham PCT

Mills & Reeve

National Association of Primary Care

NEDNET

The Network

NHS Institute

NHS Sustainability Development Unit

NHS Top Leaders

NIHR King's Patient Safety and Service Quality Research Centre

Nottingham University Hospitals NHS Trust

Office of Public Management

PA Consulting

Royal College of General Practitioners

Royal College of Nursing

Royal College of Physicians

Royal College of Physicians of Edinburgh

Individuals

Dr Hesham Abdalla, Clinical Leaders Network

Mark Butler, The People Organisation

Geoffrey Catlin, foundation trust governor

Ruth Catlin, foundation trust governor

Brian Cox, leadership and management consultant

Neil Goodwin, GoodwinHannah

Joe Hegarty, Chair, NHS Westminster

Dr Ian Johnstone, University of Newcastle upon Tyne Hospitals NHS Trust

Peter Molyneux, Chair NHS Kensington & Chelsea

Dr Donal O'Donoghue, NHS clinical director

Raoul Pinnell, Chair, Bromley Healthcare

Beverly Provost, Non-executive Director, Central & North West London NHS Foundation Trust

Dr Emma Stanton

Dr Oliver Warren

Jane Winder, Chair, NHS City and Hackney

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