

The practice of system leadership

Being comfortable
with chaos

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Foreword

The unprecedented service and financial challenges facing the NHS require staff and leaders to work and behave differently. A critical skill for the future is the ability to work across services and organisations to meet the needs of the growing number of people with complex medical conditions and those who rely on care and support from different agencies. In some cases, this will involve frontline teams working to overcome professional barriers so that they can co-ordinate care effectively, whereas in others it will require senior leaders to work together to remove organisational obstacles to deliver better value for the populations they serve.

In this report, Nicholas Timmins draws on the stories of 10 senior leaders to identify the skills needed to work in this way. These leaders were selected because of their proven experience of delivering improvements in the NHS and related services without necessarily having formal authority over others. They come from a range of backgrounds and operate in a variety of contexts. What they have in common is a track record of having tried to bring about change (though not always successfully) through the exercise of soft power, as well as an ability to reflect honestly on their experiences.

While for the most part resisting the label of ‘system leader’, this is, in fact, the best way to describe their role. Unlike successful organisational leaders, they are distinguished by their experience of working across services and organisations, almost invariably in circumstances of considerable complexity. The challenge they faced was how to build relationships with others to improve outcomes for the populations they served. Their dislike of the label ‘system leader’ derived less from its inaccuracy than from a belief that whatever success they may have achieved was due to working behind the scenes rather than leading from the front.

The leaders whose testimonies are brought together here have acquired skills that will become ever more valuable in public services in future. Whichever party or combination of parties is in government in the next parliament, there will be further cuts in public spending and an urgent need for leaders to work differently. The plans to devolve responsibility to local authorities and their NHS partners in Greater Manchester illustrate the direction of travel, with a renewed focus on looking at



public services and public spending in the round. The political consensus behind integration of health and social care point in the same direction.

What this reports shows is that effective system leaders are not heroic individuals who, through force of will or personality, achieve changes that others find impossible. Rather, they recognise the need to build alliances and collaborations by engaging their peers and many others in working towards a better future. They lead through influence and persuasion, recognising that delivering sustainable improvements usually takes time. They are also resilient in the face of obstacles, keeping faith with their purpose even when they encounter resistance. They have learnt how to work across organisational boundaries through networks that bring together services around the needs of populations and people who use these services. In the words of one of the leaders interviewed for this report, system leaders succeed by ‘being comfortable with chaos’.

System leaders exemplify the kind of collective leadership that The King’s Fund has argued is needed in the NHS in future ([Eckert et al 2014](#); [West et al 2014](#)). Collective leadership means everyone taking responsibility for the success of the organisations and systems in which they work, with a focus on learning and improving the quality of care delivered to patients and service users. It is characterised by a belief that leadership is the responsibility of teams, not individuals, and is needed at all levels. Collective leadership enables organisations to develop cultures in which patients receive high-quality care and it supports organisations to work collaboratively for the greater good of the populations they serve.

The King’s Fund is grateful to Nicholas Timmins for undertaking this work and to the senior leaders whose stories he relates. We shall build on the findings of the report in our leadership development programmes to ensure that the NHS and its partners have the staff and leaders they need to respond to the challenges ahead.

Chris Ham
April 2015



1 Introduction

Thirty years ago, Roy Griffiths in his landmark inquiry into the management of the NHS declared that ‘if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge.’ It was the right diagnosis for the time.

If Florence Nightingale was walking the wards of the NHS today, however, she would be looking beyond them. Out into general practice. Into community services. Into the private and voluntary sectors. And out into social care and other local authority services. She would be looking for the other inspirational leaders who would help her make her wards work better. Among those to whom she would be looking would be patients. And all those other people would be looking back at her for exactly the same result.

More recently than the Griffiths report, some four years ago, The King’s Fund published *The future of leadership and management in the NHS: no more heroes* ([The King’s Fund 2011](#)). Its core message – aside from a vigorous defence of management and its role – was that the NHS needed to move beyond an outdated model based on heroic leadership of institutions by individuals to one where leaders focus on systems of care, and on engaging staff in delivering results. The report argued that leadership of the 21st century health system needed to be ‘shared, distributed and adaptive’ ([The King’s Fund 2011](#), p 22). Today, the case for that style of leadership is even stronger, for myriad reasons.

The requirement for better integration of primary, community and secondary health care has long been recognised – if too infrequently acted on – and it requires work across NHS institutions and organisations. There is also a need for much closer collaboration with social care if patients are to get the whole-person, integrated care they seek. Rising up the agenda (and none of this is new) has been the desire to translate cutting-edge research into practical action much more quickly – at the bedside, in the surgery, in people’s own homes – for reasons that include not just delivering better treatment and a better experience for patients, but also because the application of such research can be exported from the United



Kingdom as a currency earner. And to compound all that, there is the money – and the need to get better value from it.

Back in 2010 the NHS was contemplating at least four years of little or no real-terms growth – something that has now become a reality. It is becoming increasingly obvious that even the strongest NHS institutions will not be able to dig the NHS out of its collective financial hole without working with others.

The good news is that there is now mounting evidence that, unsurprisingly, more integrated care provides both a better experience for patients and better outcomes. There is good evidence that it also provides better value for money. And there is the hope – still, as yet, based on a belief rather than a strong evidence base – that it may actually save money, at least in the longer run.

To achieve all that, however, demands leadership across organisations and working with others – not just at the level of chief executives or clinical leaders, but within and throughout organisations. System leadership has become less of a ‘nice to have’ and more of a ‘must have’.

That is increasingly recognised not just in health and social care but in the many walks of life where seemingly intractable problems need to be tackled – see, for example, the very recent article by Peter Senge and colleagues on ‘The dawn of system leadership’ in the *Stanford Social Innovation Review* ([Senge et al 2015](#)).

Since the ‘No more heroes’ report, The King’s Fund has published a series of papers on the issue. They include: *Making integrated care happen at scale and pace: lessons from experience* ([Ham and Walsh 2013](#)); *Patient-centred leadership: rediscovering our purpose* ([The King’s Fund 2013](#)); *Developing collective leadership for health care* ([West et al 2014](#)); *Medical engagement* ([Clark and Nath 2014](#)); *Staff engagement* ([Collins 2015](#)); and *Reforming the NHS from within* ([Ham 2014](#)).

The most recent publications include a paper by David Fillingham and Belinda Weir ([2014](#)) on the experience of AQuA’s integrated programmes in the north-west, and one on the evidence base for *Leadership and leadership development in health care* ([West et al 2015](#)). All these publications are available on The King’s Fund website.



For this paper, which has been written to inform the Fund's fifth annual leadership summit in May 2015 – almost four years to the day since the Commission's report was published – we have interviewed 10 people who might reasonably be argued to be engaged in system leadership. We defined that very simply as seeking to make change across organisations where people did not have a direct, line management responsibility.

In no particular order, they include the chief executive of a large county council, people who have led integrated care projects, people working with clinical networks and senates and academic health science networks, a whistle-blower (given that the actions of whistle-blowers can change systems and not just the organisation within which they work), the head of a large voluntary organisation, the chief executive of a large teaching hospital, and individuals who have led or who still lead elements of the NHS at regional and national levels.

The core set of questions we asked included whether they actually see themselves as 'system leaders' (interestingly, many were highly resistant to claiming such a role for themselves). What do they understand by the term 'system leadership'? What motivates them to do this work? What skills does it take, and what qualities are needed? What challenges does it involve? What can they offer by way of examples of success and failure? What can be done to develop system leaders?

The final section of this report contains edited accounts of their words – edited for inevitable reasons of space, but also to bring out common themes and issues of divergence. The detail of what they say makes fascinating reading and, taken together, they almost amount to a handbook on system leadership. A number of common themes emerged from the interviews.

- System leadership is not easy.
- It requires a conflicting combination of constancy of purpose and flexibility.
- It takes time – often a lot of time – to achieve results.
- It starts with a coalition of the willing.
- It is important to have stability of at least a core of the leadership team across those involved.
- Patients and carers are crucial in helping design the changes.



- System leadership is an act of persuasion that needs to have an evidence base for change – not least because that is the key tool for persuading the unconvinced.
- As several interviewees put it in one form or another, ‘you can achieve almost anything so long as you don’t want to take the credit for it’. You have to ‘give away ownership’.
- In most people’s eyes, financial stringency has yet to lead to a fundamental acceptance that system working is key to the future of health and social care.
- The pressures of regulation, financial balance and organisational targets are still leading people and organisations to draw in their horns and ‘hunker down’ to survive, rather than seeing the way forward in terms of changes that will alter and, in some cases, downsize what their organisation does. Regulation, in particular, needs to be reformed. All too often, the current system gets in the way of system change, and thus system leadership.
- Although strategic health authorities (SHAs) were unloved by many, they are being missed, at least by some, because at their most effective they helped people to engineer the kind of changes being discussed. None of those interviewed wanted to see another reorganisation: but there is a strong sense of a vacuum that needs to be filled.
- Not enough is being done to develop system leaders.

This report explores these and other themes, though in a somewhat different order, and largely through the interviewees’ words. The King’s Fund is immensely grateful to those who gave up time to make this possible, and we trust we have represented them fairly. Any influence this report may have lies in the content of the interviews, not in the analysis.



2 Do system leaders see themselves as such?

Most of those we interviewed recognised that they were, in some way, system leaders. But many were reluctant to claim the role for themselves. Indeed, some saw claiming such a position as entirely counterproductive.

David Fish has been Managing Director of UCLPartners since it was formed in 2009, starting out as a collaboration between University College London and four NHS trusts in north-central London. It has grown to embrace more than 30 organisations, covering Hertfordshire, Bedfordshire and Essex as other NHS organisation and academic institutions have volunteered to join. It describes itself as an academic health science partnership whose role is to ‘translate cutting-edge research and innovation into measurable health improvement and wealth creation for patients and populations’, not just locally but globally given its international standing. It has more than 50 projects, many aimed at primary and secondary prevention, although it has also played a key role in helping to reorganise, for example, secondary and tertiary stroke and cardiac care as the far end of those patient pathways.

But David says, ‘I don’t see UCLPartners as a system leader. I don’t see myself as a system leader.’ To claim that, he says, ‘is to put yourself 40-love down before you start. It can have really negative connotations. It sounds as though I am telling you what to do. And we don’t do that. We are, instead, a catalyst, an enabler. We are trying to help good things go faster, and catalysts can make things go orders of magnitude faster. It is not a shortage of ideas we are dealing with, it is pace of change. So we try to be an enabler to help change happen faster.’

Jan Vaughan is Director of Strategic Clinical Networks for Cheshire and Merseyside. She says, ‘I suppose if I stopped and thought about it I would describe myself as a system leader, but really it is all about relationship building. I can’t tell anybody to do anything. I have to advise them to do things that are best for patients.’



Sally Davies, Chief Medical Officer, says that ‘by definition I am a system leader, but I don’t like the word. It sounds as if you are trying to manipulate all the pieces rather than help people to do the right thing. I may be a reluctant leader in one sense, because I am not interested in power. I am interested in influence. It goes back to the question “do we want charismatic leaders?” No. We want facilitative leadership, and if you talk too much about leadership, you don’t do the job. But it is a difficult issue, because the system does have to be led.’

Thirza Sawtell, Director of Strategy and Transformation for the North West London Collaboration of Clinical Commissioning Groups (CCGs), is part of a major transformation of acute services in that corner of the capital and has played a strong part in the North West London Whole Systems Integrated Care programme. She says: ‘My immediate response to the question “am I a system leader?” would be to say no – because I have none of the traditional authority or legitimacy a leader would need in terms of moving things forward. But if by system leader you mean someone who sees their role as being... to “nudge” is the wrong word... to help people coalesce around a vision and ensure that there is forward movement, then I would say yes.’

‘It is almost as if we are using old terminology to describe a new way of working. The people who are leading the system are doing it in an entirely different way, and would not automatically see it as leadership, because it hasn’t been mandated in the way leadership has in the past. So, am I one of the people who has a responsibility to ensure that the north-west London health and care system moves in a direction in which the leaders of the system have decided they want to move? I would say absolutely yes. Could I say that I am the only one that has that vision, or that it was my vision that’s then gone to them, and I am now leading it? Absolutely no. That would not be my role.’

Sue Page is currently Interim Chief Executive at Liverpool Community Health NHS Trust, but was Chief Executive at Cumbria Primary Care Trust (PCT) as it pioneered what have now become known as clinical commissioning groups. Before that, she sought to run a highly integrated system out of Northumbria Healthcare NHS Trust. Does she think of herself as a system leader? She laughs. ‘Oddly enough, I have never thought about myself as that, but apparently other people tell me I am.’



Dr Kim Holt is a paediatrician with Whittington Health NHS Trust who ‘blew the whistle’ in the Baby P case in Haringey. She later founded Patients First, which is a support network for whistle-blowers. Whistle-blowing, she says, is about system change, because ‘80 per cent of the time, when things go wrong it is a system thing.’

Those who have been particular types of chief executive find the concept of being a system leader, and the claim to the title, somewhat easier – probably because of the precise nature of their jobs.

For example, Ruth Carnall (Managing Partner, Carnall Farrar), who was Chief Executive of the London Strategic Health Authority (SHA) from 2007, says ‘I thought of myself as two things. One as a system leader – somebody whose job it was to bring people and organisations together to try to get more than the sum of the parts out of them. But I also saw myself as accountable for performance, so that, however silly it might seem, I did feel very accountable for performance in London – operational performance, financial performance, complaints, public opinion, whatever... and even if it happened in a foundation trust, even though I could have pointed to a rule book that said it wasn’t my job to manage them.’

‘But there were some direct tools for system leadership. Primary care trust chief executives were accountable to their chairs and to the strategic health authority. Chairs of PCTs were accountable to the chair of the health authority. And chief executives of NHS trusts were accountable to the chief executive of the SHA as well as to their board. So there were some direct lines, some direct power – quite a lot actually. It wasn’t possible for a PCT to plough ahead with a change programme that it fancied without the support and approval of the health authority. Even with foundation trusts, there was an indirect element in that the provisional withholding of support for major projects was a powerful but indirect lever.’

Equally, Joanna Killian, at the time of the interview Chief Executive of Essex County Council and chair of the Society of Local Authority Chief Executives and Senior Managers, says ‘I do regard myself as a system leader, because we have to look beyond our insular boundaries to have a real impact. Whether it is for health, or social care, or criminal justice, the next few years will require a different order of collaboration to deal with the resources that will be available.’



Victor Adebowale, Chief Executive of Turning Point, observes that ‘it is almost the nature of local government... that if you are the chief executive of a big council you have a responsibility for a whole series of direct services to individuals, but those individuals will also assume you have influence over others.’ If local government is to be effective, he says, it has to ‘lead systems and think across organisational boundaries, if it is to have any value’.

There is a view (although not shared by all) that local government may be better at system leadership than the NHS – the result, perhaps, of long-running history. Going back at least as far as the Second World War, local authorities have seen many of their powers and direct responsibilities removed or weakened. Their direct involvement in water, sewage and other utilities went. They lost much of their direct role in health services – first in 1948, with the nationalisation of hospitals, and later, in 1974, when district nursing, maternity, health visiting and ambulance services were moved to the NHS. Their polytechnics became universities; most of their housing stock has been transferred to housing associations or arm’s length bodies; and their role in schools has been and is being circumscribed.

Since at least the mid-2000s, however, local government has increasingly come to see its role as being an enabler, bringing together groups of people who affect what happens in their area, from transport to economic growth, regeneration, troubled families and, increasingly these days, health – becoming ‘place shapers’ (to use the rather ugly phrase popularised by Sir Michael Lyons’ local government reviews) rather than just direct service providers. Recent initiatives such as Total Place and the current Community Budget trials involve local government seeking to influence, and at times even have some direct control over, elements of local public expenditure other than their own. The embryonic health and wellbeing boards are part of this trend, while the proposal for Manchester to take control of the total health and care budget is the most advanced example in this sector.

Nonetheless, there remains something of a paradox here: there is widespread recognition among our interviewees of the need for system leadership but, in the new NHS – in the absence of strategic health authorities – there is a reluctance to claim that role, as well as a fear that to do so risks being counterproductive.



3 How do you achieve system change?

Start with a coalition of the willing, build an evidence base, build outwards

In a sense, this strategy is obvious. But that does not mean it is not crucial. This message came through time and again, and in all sectors. As Ruth Carnall says, engaging clinicians to lead is vital. ‘You need the best, most diverse group of clinical leaders that you can possibly muster. One of the biggest sources of influence was your ability to get powerful clinical leaders on side and then to take responsibility for leading it on your behalf.’ The reorganisation of stroke services in London is the classic, oft quoted, example. But it is ‘essentially the same’ in other more diverse areas of change, she says.

This view was echoed by Victor Adebowale: ‘If you take Bromley by Bow, which everyone goes to, you clearly see system leadership – the ability to attract the willing, work with the willing, and grow that with the team of the willing so that it impacts on the system.’

Ruth Carnall adds that much of the time, ‘if you want to make changes to hospital services then unless you take into account the social care dimensions, the community care, the primary care, it isn’t going to happen.’ The North West London Whole Systems Integrated Care programme, which is still part way through, is a good example, she says. But like stroke services, ‘it all starts with the case for change. What is wrong with what we are doing at the moment? Who is prepared to stand up and say that... both on the basis of the evidence but with an emotional compulsion as well? So in that case, we needed some in local government saying “this is not the way to care for elderly people with long-term conditions” and GPs saying “there are some 200 people in North West London who have lost their limbs because of our crap diabetic care”. So that involved a wider coalition than stroke, but on a narrower geography.’

Equally, David Fish says: ‘You need to have thought leaders and co-owners. It is about assembling thought leaders who are attractive enough to their peers to get



recruitment going. Finding a cadre of people who want to be more innovative about the integration agenda, and who will make this appealing to a wider audience, so people get excited about the superordinate goal – improving health for their populations – rather than just looking down at their boots.’ It is, he says, a bit like ‘building a social movement’. Assembling a decent evidence base is crucial, to persuade clinicians and the public of the need for change.

Involve patients, service users and carers

Involving patients, service users and carers is vital, because they help identify which elements of service redesign are needed. Sue Page says that when she was chief executive in Northumbria, clinicians were doing baseline clinical audits of their work to examine their outcomes, but at the same time were asking patients what the service felt like, how would they like it to change. ‘And we were getting messages like “we don’t like what you do”, “I don’t want to keep coming to the hospital to have my blood tested” or “I don’t want pills for weight management, I want to understand my disease and control it, so refer me to a walking group”, or whatever. So we gave the clinicians space to think and to change the recipe book for the service which they owned. I’ve seen some magic worked in those sorts of rooms.’

Jan Vaughan says that those seeking change have to assemble the best evidence, garnered locally, nationally and internationally. But ‘one of the really big things that makes networks work is to involve patients. It is very hard to say to a patient you are not going to do something because your trust will lose out – when the patients want good services and don’t mind travelling the extra 10 miles if they feel they are going to get the best treatment.’

Thirza Sawtell echoed the importance of involving patients, service users and carers: ‘One of the factors of success in North West London had been genuine co-production with lay people.’

Constancy of purpose, but combined with a degree of flexibility

This point was highlighted by David Fish. ‘It is important in this business that you get runs on the board – that people can see that they are making a difference. And you need constancy of purpose.’ One project was not getting anywhere,



but ‘we didn’t change the goal, we changed the methodology... It is very important that you see things through, even if you have to change how you do them as you go along... however long it takes, almost. Because, if you do that, people actually believe what you say, and maybe the resistance to change is less the next time. Whereas if they see you start and then abandon something, they say, “oh, well, if we’re a bit difficult they’ll abandon it”. So you adjust your methodology; you don’t adjust your objectives.’

Thirza Sawtell says one of the local councils was much less keen on north-west London’s integrated care programme than others. ‘How we have coped with that is that we have just kept going. So I think one of the unique bits about our programme is that it has just kept going. It has kept a momentum, and people can decide to be a part of it or not. But they know if they are not, it’s not a case that we are all going to pause for them.’ But that also requires a degree of flexibility. ‘So we work with “irregular geometry” where you work together where it makes sense, and then you don’t where it doesn’t or can’t for the time being.’

‘And I think that’s part of the system enabler role. You have to be flexible and fleet of foot enough to recognise how to change something so that it is acceptable locally, and will resonate locally. If you go in with too fixed a view you can get nowhere – and I would argue you can’t do that even if you have command and control. But certainly, if you are working on a sort of distributed leadership, then you’ve got to be sure that you can listen to people and flex to their needs... [but] you need [as well] constancy of purpose and resilience, and you need to recognise that it takes longer than people want it to take. We are much too keen to say something hasn’t worked when it never stood a chance of working within that timescale.’

Sue Page touched on this too: ‘There is definitely something about continuity... doing the things you said you were going to do. Some managers go in and out of places too quickly for my liking.’ This point leads onto our next theme.

Stability of leadership

The people we interviewed for this report were far from a scientifically selected sample. But it was notable, in retrospect, how many had been doing what they



were doing, or something very similar, for a long time – some for at least five years, others for much longer.

As Thirza Sawtell says, ‘The chairs of our clinical commissioning groups had worked together as clinical leads in the PCTs for longer than in many other places. They were used to working together, on leading reconfiguration. When the PCT clusters were undone and moved into CCGs, I watched across London and the people that had been forced to work together actually sprang back further than ever. But because, I think, our chairs believe strongly that they were doing it through their own choice, their own free will – and because it made sense for their own populations rather than because some organisation somewhere else had told them to do it – they kept going. So they had the relationships. They knew it was good to share knowledge and expertise. And they knew they worked in a provider landscape which meant that if they didn’t, they could get picked off, and they had a purpose through the reconfiguration.’

‘And you need stability in the core leadership of all this. The times when things wobble, completely, is when – and it always happens, so it is just going to happen – too many people go all at once, and they take too much with them, and then there isn’t the momentum to keep going. So while you can’t guarantee stability, you can always be working on how to push it out further from just a core group of people that believe in it.’

Jan Vaughan also commented: ‘I do think stability is important. I’ve worked in the North West for 20 years, so I know a lot of people. And while a lot of us had to change jobs 18 months ago, we all still know each other in different but often similar roles. I don’t think that happened in all areas. We were very lucky because we are such a small, compact area, and we kept a lot of that history and knowledge that other people lost – which I think has been really helpful to keep us moving forward.’

Joanna Killian says one of the difficulties in achieving integrated care in Essex – where there have been troubles at NHS hospitals in Colchester and Basildon – is the turnover of NHS leaders. ‘On the health side, people come and go so frequently. The stability of leadership there is an issue. So in places where people have hung around, those relationships are stronger, inevitably.’



And Victor Adebawale says: ‘I have been at Turning Point long enough to know that longevity of leaders and leadership in organisations is important. I think the evidence backs me up on that. It is important because you learn as much by failing as by succeeding, and you have to be there long enough to do the learning. At Turning Point, I have made attempts to understand the organisation, and the context in which it has operated, and apply my understanding of leadership – and it has worked. But I have been here long enough to learn from mistakes and pick up the learning and apply it in different contexts and carry on.’



4 What skills do system leaders need?

Although many interviewees were reluctant to call themselves system leaders, they were clear that the role requires very different skills from pure line management, which in most of these jobs simply does not exist. A repeated theme, expressed in various ways, was that ‘you can achieve almost anything if you don’t want to take the credit.’

Sue Page used those words almost exactly. David Fish says: ‘We don’t try to claim the credit. It wouldn’t be appropriate anyway because it is others who are delivering this on the ground. It’s not helpful. Do you want to claim the credit, or do you want others to do that and stick to the values we are talking about, and deliver? You have to have a frame that excites people, and you have to co-create and develop it with them, not tell them it’s yours and will they now take it on? So it is more like helping create a social movement.’

Thirza Sawtell says: ‘If you are someone who needs to take credit and needs recognition, you are probably not going to fulfil the role of working across systems and taking pride in other people’s credit and achievements. I am not making the role sound very attractive, am I? “No one notices what you do, it’s hard work, it takes a long time...” It’s not much of a sell, so far! But I would not see it as a success of the programme if people were crediting me with it, because it is others who are making the real things happen.’

Jan Vaughan expressed a similar view: ‘You can’t have too much of an ego. Because if you are one of those people who likes to be centre stage and take the credit, these roles don’t work, because it is not about you. It is about the end game, the outcome for patients. And I should be the person in the background that people at the end of the day forget about – because you’ve facilitated the change, but they have actually done the work. You’ve disappeared. But you have left them with the skills to carry on.’



There was a lot of talk about what goes under the label ‘emotional intelligence’. As Sally Davies says: ‘In the old days, I can remember wanting to change how the service was run in my hospital and it didn’t work – because I said “this is what we have *got* to do”. So I did learn years ago that I’ve either got to get other people to say it, or I’ve got to find a way of doing it very openly so that people can then buy into it. I mean, I give myself a brownie point every time somebody comes back to me with my idea. I say “that’s great”. I don’t say “I told you that a week ago”. I say “well done”.’

David Fish comments: ‘You have to walk in other people’s shoes. Understanding the world they are in, and the pressures they are under, so that you can frame this in a way that gets their attention.’

And Jan Vaughan says: ‘You have to persuade people. You have to bring them along and make them think it is their idea – because they have got to own it. They don’t like people telling them what to do.’

‘So you have to change your personality really, depending on who you’re talking to. With some people you have to be very forthright and have direct conversations. With others you know it’s going to take you about three months to get to the same place. Because you have to drop the seeds, work through with them, leave it alone, go back, slowly, slowly... and then all of a sudden it’s “do you think it would be a good idea if we did this?” and you think “gosh I’d never have thought of that – that’s a great idea”. That makes it sound rather Machiavellian, doesn’t it? But it isn’t really.’

Thirza Sawtell also reflected on this: ‘You have to be very sensitive to what people say, and to interpreting what people say. You have to be good at that to take on this role. Emotional intelligence is your phrase, but you have to filter what people are saying in a way you may not have to when you are working in one organisation, or you are in charge.’

‘So sometimes people will be saying things and if you don’t listen you will be entirely wrong. But sometimes they will be saying they can’t do this or that, but what they need is for you to keep going and they will get their courage back, or their determination or whatever... And I have sounding boards, both internally and externally. People I can go to and say “why do you think this is happening, or why are they saying that?” You have to understand why people are saying what they are saying.’



Finally, some interviewees discussed not so much the skills but the personal attributes needed to be an effective whistle-blower – recognising that whistle-blowers can be powerful agents in changing systems. From the account of Kim Holt, the paediatrician who blew the whistle in the Baby P case, it is clear that whistle-blowers need a thick skin, a core of steel and a well-adjusted personality to take what is likely to come at them, for all the talk of developing a no-blame culture in the NHS. Changing how the system deals with whistle-blowers – so that it is not the original error but the cover-up which becomes the crime – is clearly a journey that is still under way.



5 What are the barriers to system leadership?

Unfortunately the barriers to effective system leadership are myriad. They include money, training, incentives and the current system architecture, not least regulation. They are also often interconnected, which makes it difficult to break this section down into sub-themes, nice though that would be.

Julie Moore is Chief Executive of University Hospitals Birmingham NHS Foundation Trust. In her view, ‘There is no system leadership... right now it is too fragmented, and larger teaching hospitals are usually regarded with suspicion. One of the bad side-products of the foundation trust legislation was that it created independence for its own sake, rather than to drive up quality. So we have some very small foundation trusts – some community services and acute trusts, for example – who want foundation trust independence for its own sake rather than for the good it can do. So we have created an army of people who fiercely guard their independence for its own sake, and people who cannot separate out their own personal position from that of the organisation, and so they defend it.’

‘One of the trusts we worked with was in danger of losing a £1 million contract for some of its services. It was desperate to keep it because it needed to keep its income above a certain level because of its foundation trust status. So it had spent the better part of £2 million on management consultancy just to keep the contract there. Sometimes people believe size is the most important factor.’

As Ruth Carnall says: ‘Making change in the NHS is controversial. It involves judgement – difficult choices between investment in one thing and investment in another, quality against access... a whole series of complex trade-offs, where many, many parties have a perfectly legitimate interest in aspects of it, and a degree of authority over that. It is an exposed business politically in the media, it is a pressured business financially, and the business of leading change is a controversial and complex one. So you do need authority, because otherwise how do you decide? You need authority that matches the scale of the change.’



And what I see are a lot of small commissioning organisations who lack that authority, that scale; and an accountability structure for the NHS as a whole that is hugely divisive. So there is Public Health England, the Department of Health, the NHS TDA [NHS Trust Development Authority], Monitor, CQC [the Care Quality Commission], NHS England and its regional structure. It isn't clear to people in the system how all of that works together – to support, or at least to legitimise, a process of change. So people don't know how you get stuff decided.'

'So you can see individual CCGs doing some fantastic things locally and they are doing things that health authorities could never have done – because they have a connection and an ownership of a place that health authorities could never have had... The problem is that the scale of the transformation needed requires change at scale and at pace, and they are clearly unequipped to deliver. There is a lack of a clear structure for them to come together, no structures for them to be brought together, nowhere where it is clear that there is decision-making power.'

'Some of the academic health science networks are doing really good things, making change on the basis of clinical evidence. But they are not doing it at pace, that's for sure. If you were to say the health science network should sort out the configuration of all services in central London, they wouldn't be able to do it. They lack the authority to do it – it is not their role, it is not within their remit.'

Joanna Killian has already made the point about stability of NHS leadership. But it is worse than just that, she says. 'The things that continue to make it difficult are the different performance regimes and cultures. So we receive a lot of grant from central government, but we don't have to account for much of it to central government – which is great. It's a very different world for colleagues who work in the NHS. They look upwards all the time, and it is difficult for them to operate with a system where they are held to account by others who may not share the same system view. And that is true for the police and some other parts of the criminal justice system. I don't personally feel that I am forever looking over my shoulder, or looking up to government, in the way that my NHS colleagues are.'

David Fish considered what would make this easier. 'Well, some changes to the regulation. We asked elderly people in West Hertfordshire – people you would term frail and elderly – what they wanted from health care. They started by saying they didn't like being called frail, and they wanted as many useful days at home



per year as possible. It is not rocket science – you and I would want the same. But when the CQC goes and inspects all the organisations in West Hertfordshire, it asks whether the individual building blocks are meeting their targets, quite rightly. But they are not inspecting against what the patient, who interacts with many building blocks, actually wants – “how many days did I spend at home?”. So the regulation of individual organisations can miss the point. It can drive people away from the co-ordinated care they want to deliver.’

‘The CQC and I are very aligned on this. So we have a piece of work going on to see if we can help to create a regulatory framework for partnership working, so that it would be inspecting what the patients actually want, not just the individual building blocks. You can’t get away from the individual building blocks. But can we look at what the patient wants and the population health outcomes – which seem, to someone like me, more important than some of the other targets for which people are held to account.’

‘And if you want to deliver at pace the *NHS five year forward view* [NHS England *et al* 2014], with its proposals for several different models of care, you need a change in the regulatory framework – rather than if you miss your four-hour target for the trolley wait, “well, I’m sorry, but you have lost your job”. That will not encourage partnership. For me, you’re not going to succeed unless the regulatory framework eventually aligns with your goals and ambition.’

A key issue that is too rarely talked about, Ruth Carnall says, is the sheer bureaucracy of getting service changes through. ‘It is probably an exaggeration to say this, but every time the NHS gets restructured, the old set of rules about how things get approved do not get swept away, they just get built on.’

‘So Andrew Lansley purported to strip away bureaucracy and replace it with four simple tests for change. And that is absolute rubbish. I have just been helping with a piece of work about changing services across Manchester and there are over 200 elements of assurance applied to that. It all purports to be helpful, but it is actually a set of hurdles, a set of barriers to change. So there is the statutory consultation process, the inequalities impact assessment, NHS England’s assurance process, the Finance and Investment Group process, the Independent Reconfiguration Panel, judicial review, the TDA [NHS Trust Development Authority] process, the Monitor process, and it just goes on and on.’



‘So you have a group of inexperienced organisations without a clear structure to work within, required to do something beyond heroic, and then what you apply to help them is a set of bureaucratic constraints. You *can* find a way through – it is possible to do that. But that’s not the way to deliver transformation – making people jump through all these hoops so that they don’t want to do it a second time. And we are losing clinical leadership, including in CCGs, because they are just having barrier after barrier put in their way and they don’t want to go through it again.’

‘A new government should have a genuine review of all the red tape. What is it? What are the different steps in the process that have to be gone through? Why are they needed? We once added up how long it would take as a minimum, with all the consultation and hoops, to get a significant change through, assuming you were not subject to judicial review. It was two and a half years. It would be worse now.’

Nigel Edwards, currently Chief Executive of the Nuffield Trust, once quipped that the only things guaranteed to survive nuclear war were cockroaches and regional health authorities. They – or their equivalents, the strategic health authorities – did not survive this time around. Nobody we interviewed recommended another restructuring. But the SHAs are clearly being missed, at least by some.

As Julie Moore commented: ‘There is, at the moment, no place that brings people together. I was not a fan of the SHAs. I think they missed many opportunities to reconfigure and make lasting improvements. But there is now no place where people can come together with one organisation which oversees commissioning and can say “actually this isn’t coherent”. We have loads and loads of commissioners and public health people, but I don’t see anyone actually doing an assessment for a whole population and saying “this is how many hospital beds we need in this neighbourhood, these are the outpatient services we need and the A&E [accident and emergency] and so on, and this is where we need to buy things and send people”. It is done piecemeal on too small a scale, and instead people make the projections of demand fit their business case. That makes system leadership very difficult.’

Julie Moore recalls going to the area team to try to get patient flows from a number of CCGs sorted, only to be told ‘that would require system leadership and we don’t have that any more.’



Sue Page had a similar lament. ‘I never thought I would say it, but I would go back to the regional health authority days tomorrow. There are limits to how the current architecture can ultimately hold the system together. You have got CCGs and NHS England, and CQC and the TDA [NHS Trust Development Authority] and Monitor. So system leadership is very difficult.’

Sally Davies too worries about implementation of the vision set out in the Forward View. ‘Is everybody doing what they are supposed to be doing, and are they talking to each other? I think the strategic health authorities played a big role, and we are rueing their loss because, at their best, they used facilitative leadership, and even sometimes, when it was needed, bossy leadership. They weren’t all good. But there were good ones. Will people come through and fill this role? I don’t know.’

There are some worries too about the reform landscape – a somewhat cluttered one with clinical networks, clinical senates, academic health science centres and networks, the leadership academy, and NHS Improving Quality – aside from the commissioning structures. Some interviewees feel the need for a degree of clarification of roles, if not rationalisation.

And there are concerns too about where the next generation of system leaders will come from. As Sue Page ponders: ‘Would I want to be a young chief executive in the system now? Well, I was nurtured and trained by some really good people and I was very fortunate. But it’s a scary place to be a youngster. One slip and you can be in deep trouble. And when we appoint these new young chief executives to their first job, I really think we need to buddy them up, and have someone to help them.’ And, as another interviewee put it, requesting not to be attributed, ‘we seem just to set them up to compete, not to co-operate.’



6 So, is it time to despair over system leadership?

The answer to this question is an emphatic ‘no’. Far from it. As a considerable number of our interviewees made clear, the Forward View has brought together the multi-headed hydra that might be described as ‘the top of the NHS’ (ie, NHS England, Monitor, the NHS Trust Development Authority, the Care Quality Commission (CQC), Public Health England and Health Education England) to present a vision of system change, and it has done so collectively in a way that has not quite been seen before in the new post-Lansley dispensation. It expresses a view of the future that undoubtedly requires system working, beyond the boundaries of existing organisations, including their own.

And, as the interviews demonstrate, good things are happening, although much could change to make it easier. And there is some evidence that experience can speed change. UCLPartners, for example, is specifically dedicated to speeding change, and David Fish says that a programme it originally took two to three years to deliver in one area has, on the back of that experience, now been achieved in just six months in another.

And, aside from the territory covered in the previous section, interviewees had other suggestions about how to drive progress. Julie Moore, whose hospital has experience of ‘buddying’ with four other NHS trusts, says: ‘I do think that the idea of chains, as in the Dalton review, is one of the ways to go. It is not a magic bullet, when there are many causes of the problems in the NHS. But the question is, can we afford not to use the good procedures and techniques that we have in the NHS, and can we afford not to spread them out rapidly? Everyone needs to learn from everyone. And we can’t afford to have as many organisations as we have, as many back offices and as many fiefdoms.’

‘Plus we haven’t got enough good managers to go round. There are some people who are very good at being managing directors but don’t want to take the ultimate step to being chief executives – after all, we have 10 per cent vacancies for chief



executives and finance directors. And it is hugely difficult to get good chairs and non-execs. So why don't we spread the ones we have got around a bit better?'

'When I say this, people say "you just want to take over" or "you want to suck in all the patients". But we don't want to suck in all the patients. Here, at UBH [University Hospitals Birmingham], we are at capacity, and I'm getting pretty near retirement. So personally, I am not bothered about my personal position. But chairs could indeed help, although it is not going to be easy when the chairs and chief executives of struggling trusts so fiercely guard their independence.' As Julie says though, a crucial part of that is that 'we need to intervene earlier, before trusts in trouble have hit rock bottom.'

Ruth Carnall echoes that view. 'I think the Forward View has done a great job, but I wonder what the means of following it through will be. So there needs to be some transitional funding, and NHS England, the TDA [NHS Trust Development Authority] and Monitor in particular need to figure out how they are going to provide coherent national system leadership.'

'I think they need to intervene at an early stage, not at a late stage, which is what happens at the moment. So... What is your case for change? Tell us. Show us the evidence, and then instead of saying yes and meaning no, throw everything you have got at supporting those local systems to work through the barriers, and then use the learning from that.'

'So, create a local steering group that has a very senior person from Monitor, a very senior person from NHS England, and from the TDA [NHS Trust Development Authority], helping them to do it. That then becomes a model for how stuff is done, and you replicate it elsewhere. And then you don't need the most senior people. So do it with a limited number of places to start with.'

'The right thing would be for Monitor, the Trust Development Authority and NHS England to decide on five or six systems in the country where big change is needed, where there is a compelling case for change, and then commit their leadership to achieving it.'



‘People will say “she can’t see beyond the end of the job that she used to have, and she is just recreating a strategic health authority”. But I do think those three organisations are going to have to find a way of providing coherence.’

‘An alternative model may lie in some of what is also in Dalton and the Forward View. So the big teaching hospitals will survive, and if nothing is done will just suck in more resource and people and activity. So you could say to one of them “you’ve got the budget for the whole of this chunk of London, and here is what we expect to see you deliver in terms of outcomes for that”. But that would require an awful lot of legislative and policy change. They would have to be able to employ GPs, and public health would be less with local government. It would be difficult to make it a great solution for integrating care for the frail, the elderly, where what you need in Barnet, say, or Redbridge is something that is sensitive to Barnet or Redbridge. You could lose a lot of diversity and access. You would have to guard against that. But it is a potential leadership model, and I do think it is worth piloting in one place.’ Manchester, she says, may prove to be another route through.

There remains a chance that – and quite aside from the intrinsic merits of better integrated care across systems – financial stringency will drive this faster. As David Fish asks: ‘Does this get easier as the finances get tighter? It might. It crystallises the issue. There is always a risk that financial pressures will drive rational organisational behaviours that are irrational for the system. But the cake is only so big. And the crisis is not purely local. So if we don’t collaborate in partnership, in the end, although we might triumph in the short term, we can’t in the long term. The more we can get over the narrative that there is no point in being the last man standing, the better the chance.’

‘And anyway it is not what taxpayers are paying for. They are paying for a healthier population and having their needs met, not the individual organisation. But you could easily lose track of that when you look at the regulatory framework.’

Joanna Killian says that in Essex and elsewhere, there is ‘a realism that the next few years require a different order of collaboration to deal with the resource situation.’

The challenges are clearly huge. But the desire to meet them is also evident in many, if not all, areas. And, as Jan Vaughan says, to get there we may need to be comfortable with chaos – or at least a degree of it.



7 What more can be done to develop system leaders?

All of those we interviewed were clear that more needed to be done to develop system leaders. But there was an interesting debate about whether system leadership can be taught, or whether it simply has to be learnt by those with the inherent skills and personality traits to do it.

Thirza Sawtell, like others, makes the point that individuals who feel the need to take the credit for achieving change are unlikely to make good system leaders. ‘Which is why I say I think the skills needed for this can be learnt, but I am not sure they can be taught. Because if you have to be taught, you might actually prefer a different way of working.’

Sally Davies, by contrast, argues that the requisite skills can be both learnt and taught. She learnt, she says, by experience, which included attempting, in the example quoted above (*see p 19*), to lead a change too dogmatically in her hospital in her earlier years, but also, later on, being sent off on a course on system leadership which underlined the ‘emotional intelligence’ needed to do that. ‘It was life-changing and career-changing,’ she says.

Joanna Killian is in the ‘this can be taught’ camp, having instituted a training programme for staff in Essex County Council. UCLPartners, in conjunction with others, has just launched up to 20 fellowships for an NHS Innovator Acceleration Programme (*see p 48*), which is absolutely about system change.

Sue Page outlines how, when the Cumbrian GPs started out on what would now be dubbed ‘clinical commissioning’, the PCT provided training to equip them with the skills needed to have difficult conversations with their peers about performance. And in Northumbria ‘all the leadership programmes were system-wide and everyone then did things together in a similar way and learnt to work together in a similar language. That’s how they learnt to trust each other,’ she says. Others, however, also stress the importance of experience – Victor Adebowale,



for example, in the quotation earlier on the benefits of making mistakes and learning from them (*see* p 17).

Some of the skills needed are plain enough. They include being able to walk in other people's shoes, to understand their world and the pressures they are under – as David Fish puts it, 'so that you can frame this in a way that gets their attention'. They include being able to spot, as Jan Vaughan puts it, those with whom a very direct conversation is needed, and those for whom an idea has to be planted and allowed to grow. Then there is the ability to identify those who will form a 'coalition of the willing' in order to do what it takes to achieve change, and to recruit others to join their efforts. And being able to get people to own the common idea, which they may not have thought of, as their own. There are indeed some striking parallels with what is involved in creating a 'social movement'.

Sue Page and Ruth Carnall both put across the message that more must be done to protect young managers and young clinical leaders, buddying them with more experienced individuals and with their contemporaries; while Kim Holt underlines the need to protect whistle-blowers – those who take considerable personal and professional risks to highlight persistent failures.

And underlying it all is that odd mix of flexibility allied to constancy of purpose. This means facilitating the conversations about what needs to change and how, being flexible about how it might be achieved, but then ensuring that the momentum is there for change to actually happen rather than just be a conversation. And in the end – in a world without SHAs which, at their best, provided facilitative leadership to agree changes but could also do the 'bossy bit' to ensure delivery – it means assembling enough authority among those involved to make it happen, and to do so in the face of what will almost always involve some residual opposition.

8 In their own words: the interviewees

Lord Victor Adebowale CBE *Chief Executive, Turning Point*



Victor Adebowale is Chief Executive of Turning Point, a health and social care organisation providing services for people with complex needs, including those affected by substance misuse, mental ill-health and those with a learning disability.

Victor has a passionate interest in public service reform and reversing the inverse care law (those who most need public services tend to get them least). In pursuit of this he lectures and speaks widely on the subjects of poverty, social exclusion, equality and human rights, leadership and change management.

Victor is a non-executive Director of NHS England, on the board of English Touring Theatre, President of the International Association of Philosophy and Psychiatry and Chancellor of Lincoln University. He is the founder and Chair of Collaborate at London South Bank University.

In 2000, Victor was awarded the CBE for services to the New Deal, the unemployed, and homeless young people, and in 2001 was appointed a cross bench member of the House of Lords.

I am in a system and I'm a leader of it, so I suppose I am applying system leadership as I understand it. Turning Point operates at some 206 locations in England and Wales and we employ some 3,800 people, most of whom do not work in my office. They work in drug treatment, mental health, primary care, commissioning and we do some employment work, and they do it in a huge variety of locations from prisons to police stations to hospitals to hostels to people's homes. So we are a system. We are legally defined as an organisation, but we are really a



system that has to work with others. And in my view, a huge amount of it depends on the values of the person who is called chief executive, and how they act out those values, and how their colleagues act them out.

My view is that we are in the foothills of system leadership in health and social care. The NHS has a wonderfully coherent and sometimes effective, but more usually over-intellectualised and over-complicated, view of system leadership that does not have very much impact on the day-to-day.

There is some really excellent leadership across boundaries in health and social care. In Brighton, for example, where the police work really well with social services and the NHS on mental health, or in Stockport, where there is good leadership across health and social care. But they are rare, and they are too few when we need to be doing this at pace.

A lot of it comes down to the people. It is always the people. Sometimes it is accidental that the leader happens to have developed a certain understanding intellectually and emotionally of what system leadership is. So if you look at the Bromley by Bow Centre, which everyone goes to, you clearly see system leadership – the ability to attract the willing, work with the willing and grow that with the team of the willing so that it impacts on the system. It is also the ability to change oneself from the inside so you can impact the outside, and constantly doing that, so that it is fully focused on citizen and patient care and the outcomes, rather than the elegance of organisational design or professional boundaries.

You can achieve this by reflection and training. I don't think system leadership is as rare as people say it is and it is perfectly possible to train and develop system leaders, though it can be a difficult journey for the individual, both emotionally and intellectually. We don't do enough of it. We do spend quite a lot of money in the NHS – some £120 million – on leadership and leadership development of some kind or another. But I wonder how far it has a real impact.

There are some excellent examples of leading across boundaries in local government, but that's because it is almost the nature of local government. If you are the chief executive of a county council, you may have responsibility for a whole series of direct services to individuals, but those individuals will also assume you have influence over others. And indeed since the Health and Social Care Act



that has become more and more apparent. So there is a need for local government, if it is to be effective, to lead systems and think across organisational boundaries if they are to have any value. But the same goes for the NHS. And I am so conscious of the tensions – sometimes personal – between local government and health that it does not help to get into an argument over who is better than who. There is a plague on all their houses if it is not done.

But it is being done. The Forward View has all the arm's length bodies getting together to recognise that this is a system, that NHS England, Public Health England, Health Education England, Monitor, the Trust Development Authority [NHS Trust Development Authority] and CQC [Care Quality Commission] are all roped together. That is an act of system leadership in defining the context in which we are operating and therefore defining what needs to happen next. There are implications in the Forward View for the type of leadership needed to deliver it. It underlines the need for system leadership. So the question now becomes, how do we accelerate that, and ensure that system leadership is the way things get done around here?

That will involve a shift in the way we allocate and design with the resources available and that is not a question, in the first instance, of more resources. And I've just read the excellent piece of work by The King's Fund on leadership and leadership development ([West et al 2015](#)), which looks at the evidence base, which is the way we need to be going.

In terms of successful work I've been involved in, I suppose changing the Met Police's response to people in mental health crisis is one that others have said has worked well. I judge the outcome on what it has done for the punter rather than what I did. But I can point out a shift in what happens at police stations, in section 136, and in what happens to black and ethnic minority people in London. I am not saying it is perfect. But I know we have shifted the experience of very vulnerable people as a result of that work, which involved working across the police, social services, health, ambulance.

I have been at Turning Point long enough to know that longevity of leaders and leadership in organisations is important. I think the evidence backs me up on that. It is important because you learn as much by failing as by succeeding, and you have to be there long enough to do the learning. At Turning Point I have made attempts



to understand the organisation and the context in which it has operated, and apply my understanding of leadership, and it has worked. But I have been here long enough to learn from mistakes and pick up the learning and apply it in different contexts and carry on. The work on connected care, where I was trying to create a methodology which supports communities in designing and creating integrated health and social care... It was gleaned from my learning in working in failed regeneration systems in London and other places. And my first attempt to invest in it and deliver it failed because basically what I learnt was that power matters in local government and health and people hang on to power sometimes even in the face of being presented with the means to do things better. And so you have to take into account the politics of power. And in health and social care the people who wish to do the greatest good do not take into account the motivations of people who – it is not that they don't want to do good – but they don't want to lose power.

How do you overcome that? You have to put the people on the receiving end of services in the centre of the room so that you make it very difficult for people to hang on to what is not of use to those people. So one of the pieces I am keen to develop with NHS England, and Malcolm Grant, the Chairman, had been kind enough to support this, is the NHS Citizen process. So that we develop a means for having consumers in the largest consumer-facing service to the public – ie, the NHS – develop a means of having them hold a mirror up to our core business, and say 'well, you said you were going to do this... And it ain't happening, or it is happening, or how are we involved?' That is one of the ways we force power to take account of its purpose – to provide health and social care that makes a difference to the people of this country. That forces a change in the culture.

Ruth Carnall

Managing Partner, Carnall Farrar



Ruth Carnall is a managing partner at Carnall Farrar. Ruth has extensive experience as a chief executive in NHS London. In this capacity, she oversaw an extensive programme of performance improvement and strategic change. The results of this work are widely recognised in the United Kingdom and internationally.

Ruth has worked at all levels of the NHS for more than 30 years and worked as an independent consultant with public and private sector clients including Department



of Health, Monitor, health authorities, NHS trusts, Glaxo and Astra Zeneca, as well as the Prime Minister's Delivery Unit, the Cabinet Office, the Home Office and the Ministry of Justice. Ruth also has experience as a non-executive director of a public company, chair of a private company and trustee of a charity. She has also provided coaching support to senior executives. Ruth has a strong reputation in leadership development and the creation of high-performing teams. She is frequently asked to speak about her experience in the United Kingdom and abroad.

When I was chief executive of the London SHA, I saw my job as two things. One, as a system leader, somebody whose job was to bring people and organisations together and try to get more than the sum of the parts. But I also saw myself as responsible, accountable for performance. So, however silly it might seem, I did feel very accountable for performance in London – operational performance, financial, strategic change, public opinion, complaints, whatever. If it happened in London, I felt accountable for it and, weirdly, even if it was in a foundation trust. I could have pointed to a rulebook that said it wasn't my job to manage that. But David Nicholson's attitude [when he was chief executive of the NHS] would have been 'it is on your patch, sort it'. And indeed many foundation trusts, not all, looked to me for leadership on some issues even if the rulebook said they weren't accountable to me.

And we had some tools for accountability. Some were direct. PCT chief executives were accountable both to their chairs and to the strategic health authority. Chairs of PCTs were accountable to the chair of the health authority, so there were some direct lines. Chief executives of NHS trusts were accountable to the chief executive of the health authority as well as to their board. And the health authority had oversight responsibilities for signing off plans. So it wasn't possible for a PCT, for example, to plough ahead with the change programme that it fancied doing without the support and approval of the health authority. So there was some direct power – quite a lot actually. And for foundation trusts, the provisional withholding of support for major projects was a powerful if indirect lever.

Take the stroke changes, which involved quite a lot of foundation trusts. We said there were going to be eight hyperacute stroke units and one of them could have said 'we don't care, we are going to do a ninth.' But they didn't.

And that was because we achieved the change by producing a powerful case for it. 'Why are we doing this, what is the evidence at the back of it, does everybody agree?'



Yes they do. And here is the evidence that effectively eight networks is the right number. Here is the evidence for that. Here is the clinical backing for that. Does everybody agree? Yes. Okay, we need a process then to select which are the eight. It is a balance of quality and access. Do you agree? Yes. Okay, here is the process. Do you think it is fair? Yes. Okay, we have applied it, and it means this teaching hospital doesn't get one.' And if they argued, you could point to all these steps which demonstrated that if they took that position, it was being taken out of self-interest.

So it was possible to corral commissioner power (the PCTs across London), political power (the joint committee for London), and clinical power, with David Fish and others saying 'this is about the greater good, and you are going out on a limb if you say it is unacceptable'.

And the clinical leadership is vital. You need the best, most diverse group of clinical leaders that you can possibly muster. One of the biggest sources of influence was your ability to get powerful clinical leaders on side and then to take responsibility for leading it on your behalf. And I think, to be fair, it is a lot easier to do that in London. There are a lot more clinical leaders, and some incredibly capable ones.

And there is a sense of place – 'we are going to improve services for the population of London' – even if that may well involve moving services, changing where they are delivered. There isn't really something called the south-west, or the East Midlands, where if you talk to a clinician their affiliation will be to Exeter, to Plymouth, to Nottingham, or wherever. So you can get a coherence in London, and I think it is easier in the big cities like Manchester and Birmingham and Newcastle, because of the sense of place and of a whole population. The downside is that if you drop a pin in London you have Number 10 on your case before you can turn around. But the upside is that if you get that right, the balance of political power right, it can just take a change forward in a way that in other places it can't. And the stroke case is interesting because what that demonstrated, in the end, was that the power of that clinical collaboration overcame the personal position of the Secretary of State at the time.

I think it is essentially the same, whatever you are trying to do. If you want to make changes to hospital services, then unless you take into account the social care dimension, the community care, the primary care, it isn't going to happen. So if you take the big integrated care plan for North West London, that all started



with the case for change... ‘What is it that is wrong with what we are doing at the moment? Who is prepared to stand up and say that?’ Both on the basis of the evidence and with an emotional component as well. It needed some aspects of local government to be saying ‘this is not the way to care for elderly people with multiple long-term conditions’ and some evidence for that, and for the GPs to be saying ‘some 200 people in North West London have lost their limbs unnecessarily because of our crap diabetic care’. So that involved a wider coalition than the stroke case, but in a narrower geography.

And, of course, you get people who are opposed. Take Barnet and Chase Farm, where one of the local councils was opposed for 25 years. But there does come a tipping point, where people will go from saying ‘we don’t want this done, we are going to combat it’ to them saying, ‘well, this has dragged on so long, why don’t you get on and implement’. It took 20-odd years, but it is now happening, and there are some very positive noises about the gains from that change.

It doesn’t always work. I’ve talked before about Lewisham and South London, and the original compromise we made there, which I bitterly regret. I didn’t recognise that I was trying to push a boulder up a hill that wasn’t going to make it – that it wasn’t going to work because of the dynamics. So that leadership judgement is a very inexact science. I had 30 years’ experience at that point and I got it wrong. I have 38 years’ experience now and would probably get that one right. But I would probably still get others wrong.

But that’s the past. The question is where are we now? I should preface all of this by saying I lost a job I really loved, and didn’t want to lose it, and I would have done it until I retired. So people may say I am jaundiced and prejudiced. But I go round now trying to help people deliver changes in the current NHS – and it is so much more difficult.

Making change in the NHS is controversial. It involves judgement – difficult choices between investment in one thing and investment in another. Quality against access... A whole series of complex trade-offs, where many, many parties have a perfectly legitimate interest in aspects of it, and a degree of authority over that. It is an exposed business politically in the media, it is a pressured business financially, and the business of leading change is a controversial and complex one. So you do need authority, because otherwise how do you decide? You



need authority that matches the scale of the change. And what I see are a lot of small commissioning organisations who lack that authority, that scale; and an accountability structure for the NHS as a whole that is hugely divisive. So there is Public Health England, the Department of Health, the TDA [NHS Trust Development Authority], Monitor, the CQC, NHS England and its regional structure. It isn't clear to people in the system how all of that works together – to support, or at least to legitimise, a process of change. So people don't know how you get stuff decided.

So you can see individual CCGs doing some fantastic things locally and they are doing things that health authorities could never have done – because they have a connection and an ownership of a place that health authorities could never have had... Local relationships that are delivering important things on the ground. Where they are genuinely GP led, they live there, they work there, their kids go to school there, they stay in the same practice forever. They have a far better understanding of the population, its needs, and the community than any health authority ever could have done... And often good relations with the leadership of local government and with religious communities, which, in some places, is very important.

The problem is the scale of the transformation needed requires change at scale and at pace and they are clearly unequipped to deliver. There is a lack of a clear structure for them to come together, no structures for them to be brought together, nowhere where it is clear that there is decision-making power.

Some of the academic health science networks are doing really good things, making change on the basis of clinical evidence. But they are not doing it at pace, that's for sure. If you were to say the health science network should sort out the configuration of all services in central London, they wouldn't be able to do it. They lack the authority to do it – it is not their role, it is not within their remit.

So how do CCGs work together where there is nobody to provide any structure for them to work with? So they are left to develop their own networks, supported sometimes by NHS England, but those networks are really weak in the face of the scale of change that is needed and the financial pressure. So that's one problem.



The second problem – which people don't talk about, and which we should – is that every time (although that is probably an exaggeration), but every time the NHS gets restructured, the old set of rules about how things get approved do not get swept away, they just get built on.

So Andrew Lansley purported to strip away bureaucracy and replace it with four simple tests for change. And that is absolute rubbish. I have just been helping with a piece of work about changing services across Manchester and there are over 200 elements of assurance applied to that. It all purports to be helpful. But it is actually a set of hurdles, a set of barriers to change. So there is the statutory consultation process, the inequalities impact assessment, NHS England's assurance process, the Finance and Investment Group process, the Independent Reconfiguration Panel, judicial review, the TDA [NHS Trust Development Authority] process, the Monitor process, and it just goes on and on.

So you have a group of inexperienced organisations without a clear structure to work within, required to do something beyond heroic, and then what you apply to help them is a set of bureaucratic constraints. You *can* find a way through, it is possible to do that. But that's not the way to deliver transformation – making people jump through all these hoops so that they don't want to do it a second time. And we are losing clinical leadership, including in CCGs, because they are just having barrier after barrier put in their way and they don't want to go through it again.

A new government should have a genuine review of all the red tape. What is it? What are the different steps in the process that have to be gone through? Why are they needed? We once added up how long it would take as a minimum, with all the consultation and hoops, to get a significant change through, assuming you were not subject to judicial review. It was two and a half years. It would be worse now.

I am not in the 'let's have another reorganisation' camp. That would be dreadful after all the upheaval that has happened. So I think it is about finding a way to provide the right sort of support to CCGs, incentivising providers to participate, and making sure that the regulatory framework reinforces that.

I think the Forward View has done a great job, but I wonder what the means of following it through will be. So there needs to be some transitional funding, and NHS England, the TDA [NHS Trust Development Authority] and Monitor



in particular need to figure out how they are going to provide coherent national system leadership.

I think they need to intervene at an early stage, not intervene at a late stage, which is what happens at the moment. So... 'What is your case for change? Tell us. Show us the evidence.' And then instead of saying yes and meaning no, throw everything you have got at supporting those local systems to work through the barriers, and then use the learning from that.

So, create a local steering group that has a very senior person from Monitor, a very senior person from NHS England, and from the TDA [NHS Trust Development Authority], helping them to do it. That then becomes a model for how stuff is done, and you replicate it elsewhere. And then you don't need the most senior people. So do it with a limited number of places to start with.

The right thing would be for Monitor, the TDA [NHS Trust Development Authority] and NHS England to decide on five or six systems in the country where big change is needed, where there is a compelling case for change, and then commit their leadership to achieving it.

People will say 'she can't see beyond the end of the job that she used to have, and she is just recreating a strategic health authority'. But I do think those three organisations are going to have to find a way of providing coherence.

An alternative model may lie in some of what is in the Dalton review. So the big teaching hospitals will survive, and if nothing is done will just suck in more resource and people and activity. So you could say to one of them 'you've got the budget for the whole of this chunk of London, and here is what we expect to see you deliver in terms of outcomes for that'. But that would require an awful lot of legislative and policy change. They would have to be able to employ GPs, and public health would be less with local government. It would be difficult to make it a great solution for integrating care for the frail, the elderly, where what you need in Barnet, say, or Redbridge is something that is sensitive to Barnet or Redbridge. You could lose a lot of diversity and access. You would have to guard against that. But it is a potential leadership model, and I do think it is worth piloting in one place.



What can be done to develop system leaders? It is difficult. There are two ends to it. One is that there are still some highly experienced people in the NHS who have got their gong and got the wisdom. We should persuade them to go to places that need significant change and tell them they are not going to be sacked and their pension is safe, and help these places do it. At the other end, we have to find ways of protecting some very bright, very enthusiastic, young managers and chief executives who are struggling with the system as it is. And an important part of that is making the system easier for them to operate.

Professor Dame Sally Davies *Chief Medical Officer (England)*



Professor Dame Sally Davies is the Chief Medical Officer for England, she retains responsibility for Research and Development, and is the Chief Scientific Adviser for the Department of Health.

Sally is independent adviser to the UK government on all medical matters, with particular responsibilities regarding public health.

She provides professional leadership for directors of public health across England. Her interest in public health includes an active call for action on antimicrobial resistance.

Sally has been actively involved in NHS Research and Development since its establishment and founded the National Institute for Health Research. Her own research interests focused on sickle cell disease.

By definition I am a system leader, yet I don't like the word. It makes it sound as if you are trying to manipulate the pieces rather than trying to help people to do the right thing. Perhaps I am a reluctant leader in one sense, because I am not interested in power. It goes back to your question, do we want charismatic leaders? No, we want facilitative leadership. And I worry that if you talk too much about leadership you almost defeat the object of the exercise.

It is a difficult issue because the system has to be led. But then there are so many different levels of the system. And in this building [the Department of Health] it usually means how do we play out stewardship of all these different bodies, with different legal powers doing different things, and yet try and bring it together into something that is greater than the sum of its parts?



And we do, in the health sector, seem to have lost strategic planning. The Forward View is wonderful, so there is not any longer a visionary vacuum now we have got Simon Stevens. But in the implementation, is everybody doing what they are supposed to be doing, and are they talking to each other? I think the strategic health authorities played a big role, and we are rueing their loss, because at their best they used facilitative leadership, and even sometimes, when it was needed, bossy leadership. They weren't all good, but there were good ones.

Will others come through and fill this role? I don't know. The good bit of the present system is we are giving much more prominence to public health, and on preventable deaths and all of that. Simon Stevens is very supportive and concerned about public health. But that's a much more difficult system because it's got so many partners and players, and they're not all statutory. Everything about it is disseminated. So we need totally different leadership styles. We need to look at how you create a social movement. How can you do something when you are not in control? And that's not the strength of people in the NHS, is it? I think Duncan Selbie [Chief Executive of Public Health England] is very good at that, and he is building good relationships with local authorities.

You can take the R&D stuff [development of the National Institute for Health Research] as a study of system leadership. You develop an inspiring vision, you sign people up to it, you persuade people you should be allowed to do it, and you get on and deliver it.

Many of the powerful academics didn't like it at first, and the powerful hospitals in London, because they reckoned they would lose money. But where I came from (a district general hospital), all wanted it because it was based on the values of fairness and competition, and the good shall get it, and no one has a right to the taxpayer's pound, which must be spent fairly in the patient's interest, and openly and transparently.

It was all based on those values. So whenever anyone stood up to shout at me, and many of them did, I'd say, 'but if you are as good as you think you are, then surely you will win the money back? But even if you lose some money can't you see that that's fair and just? The money is in the system and you will be able to get it back if you are good enough.' Now they turn round and say 'yes, you were right, and it is a much better system.'



But we took a long time. And we didn't come in and just say 'this is the vision, boys and girls, let's go and do it'. I didn't know the best way of doing it. I had a kind of idea. But we went out and built it, and we built it with everyone, with meetings all around the country, asking people what was wrong with the present system, and what they wanted. And we published a consultation document, and changed some of it when we got the answers in. A lot of it happened under the radar. You never saw me stand up and say 'I am a leader and I am doing a big thing.' It was much more 'we want to be the best nation in the world at this, and our patients deserve it'. And I did, in the end, have the backing of government to do it. We did it with a three-year transition, which actually turned out to be four or five years.

And we've resisted giving the programme more to do. The minute something looks successful, everyone says 'oh, that's good, let's give it this or that'. And I have to say 'no, keep its focus on what it was supposed to do'. Because if you give it the next job that needs doing, which wasn't what it was set up to do, and it doesn't have the skills, then the wheels come off.

So we need this visionary leadership, we also need this collaborative, facilitative leadership to get the change. And I don't think that it is bossy leadership that is needed.

You can train people to help them do this. I was very lucky. Ron Kerr [currently Chief Executive of Guy's and St Thomas'] ensured I learnt emotional intelligence and leadership back in 2000. It was life-changing and career-changing. So you can learn. A lot of us can learn different skills, and what to do. Think about where the other person is coming from, try and find the win/win. In the end, I've woken up to the fact that the whole of life, but definitely all of work, is a negotiation. And good negotiators know they have to close the deal somewhere.

In the old days, I can remember wanting to change how the service was run in my hospital and it didn't work – because I said 'this is what we have got to do'. So I did learn years ago that I've either got to get other people to say it, or I've got to find a way of doing it very openly so that people can then buy into it. I mean, I give myself a brownie point every time somebody comes back to me with my idea. I say 'that's great'. I don't say 'I told you that a week ago'. I say 'well done'.



So it is perpetual negotiation, and I have no line control. So much of what I do is advise. And the antimicrobial resistance work is going quite well globally. We are managing to get people signed up, and the Foreign Office is working on it, and it is just amazing how fantastic they are. They are doing masses. Because they can see it's good for Britain and also good for everyone. Persuading people around that sort of common interest is how you get change.

Professor Sir David Fish *Managing Director, UCLPartners*



Professor Sir David Fish has been Managing Director of UCLPartners since it was established in June 2009. Under David's leadership, UCLPartners has been designated both an academic health science centre and an academic health science network and is a lead provider of medical and dental education for more than 2,000 trainees. David has also supported the development of the local NIHR Clinical Research Network North Thames, the NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) North Thames.

Prior to joining UCLPartners, David was Medical Director of the Specialist Hospitals Clinical Board at University College London Hospitals NHS Foundation Trust. He previously worked as an academic clinical neurologist at the National Hospital for Neurology and Neurosurgery. David is an active member of the NHS Innovation Health and Wealth Board and has previously served as Chair of the Medical Advisory Group supporting Monitor and a member of the NHS Future Forum. David was knighted in 2014.

Do I think of myself as a system leader? No. I don't see UCLPartners as a system leader, I don't see myself as a system leader, absolutely not. I think you put yourself 40-love down before you start if you claim that. It can have very negative connotations. It implies we are trying to get people to do what we want them to do – 'Oh, it's bloody UCLPartners telling us what to do'.

System leadership comes from Simon Stevens – the direction setting. What we are trying to do is get things to happen at scale and pace, to provide a tool to help delivery. There are plenty of other people providing strategic direction, so I would



not describe what we do as leadership but as being catalytic, or enabling...
Trying to help good things go quicker.

There is no shortage of good ideas, and some of them are rolled out in individual places. The question is how do you go faster and scale them up? We use the word 'catalyse' a lot round here – and in a chemical sense, catalysts can make things go orders of magnitude faster.

So it is about co-ownership, about assembling thought leaders who are attractive enough to their peers to get recruitment going... Finding a cadre of people who want to be more innovative about the integration agenda, and who will make this appealing to a wider audience, so people get excited about the superordinate goal – improving health for their populations – rather than just looking down at their boots.

And we don't try to claim the credit. It wouldn't be appropriate anyway because it is others who are delivering this on the ground. It's not helpful. Do you want to claim the credit or do you want others to do that and stick to the values we are talking about and deliver? You have to have a frame that excites people, and you have to co-create and develop it with them, not tell them it's yours and will they now take it on? So it is more like helping create a social movement.

I think it is important that people have some skin in the game. So each organisation in UCLPartners makes a contribution – £50,000 a year for each organisation and a further £50,000 for those who are the most biomedical research-intensive as this requires additional infrastructure support. Not a lot, but enough to have some skin in the game. And as soon as you are looking to deliver any sort of programme – our cardiovascular programme for example – you are talking about the more than 100,000 people who work across UCLPartners in the partner organisations, not the 70 people who work here.

We all recognise that there is a tension between the individual building blocks of the organisations which deliver health care, whether it is University College London Hospitals [UCLH] or the Royal Free or the GP practice or whatever. There is an obvious tension that you have your own legal entity, with your own values and aspirations and goals and legal requirements and targets, and your desire to work within the system. So you have to ask: how does that fit together and align?



You need to build the case for change. That was done with the reconfiguration of hyperacute stroke services across London. People are rightly very proud of that. If you look at one of the people who really championed that – Dr Charlie Davie at the Royal Free, who is now Director of our Academic Health Science Network – he had some of the best results for stroke in London. But he said ‘you know, we could do even better if we stopped doing this at the Royal Free and consolidated with UCLH’. Now that’s what I call leadership. But that’s not the point of the story. Stroke reconfiguration saves about 100 lives a year. And maybe, if we had not achieved that, he and we could not then have moved on to the harder problem which he and we ask: ‘wouldn’t it be better to look at prevention?’ There are some 700 avoidable strokes a year across the 6 million population served by UCLPartners. So what’s the best way to minimise that number?

It’s a very compelling thing. Someone needs to stand up and tell me why you wouldn’t want to do that. There can’t possibly be a person who could stand up and say ‘well, that’s a bad thing to do’.

But it is difficult to do, very laborious. There is NICE [National Institute for Health and Care Excellence] guidance on it. But if I sent out a note to every GP pointing that out, the response would be close to zero. I am not criticising GPs; the same would happen in secondary care. So we went out to 35 GP practices in Camden and found the GPs interested in atrial fibrillation, which significantly increases your risk of stroke. There is a quite simple screening algorithm for it, and if you switch people to the right anti-coagulation therapy, you reduce their risk by 67 per cent. So identify these people and call them in. It is one of the highest priority things you can do if you want to save lives in the community. And interestingly, the clinical commissioning group supported us in this, even though it does not have any formal role in telling GPs what they should or should not do. And now we are helping to roll this out across another three CCGs in north central London alone.

It is important in this business that you get runs on the board – that people can see that they are making a difference. And you need constancy of purpose. We tried something similar elsewhere, and we were not making much progress. So we didn’t change the goal, we changed the methodology. And in some places we have now been able to deliver in six months what it previously took us two to three years to do. You build your credibility by delivering. As soon as you stop delivering, people will say, ‘well, why should we align with these people?’



So it is very important that you see things through, even if you have to change how you do them as you go along – however long it takes, almost. Because, if you do that, people actually believe what you say, and maybe the resistance to change is less the next time. Whereas if they see you start and then abandon something, they say, ‘oh, well, if we’re a bit difficult they’ll abandon it’. So you adjust your methodology; you don’t adjust your objectives.

It is a bit like building a social movement. But social movements are more structured than people often imagine. You think it happens spontaneously, but you have to be quite organised to make it work. A lot of work in the background... People there to answer the phones and be responsive. And you have to walk in other people’s shoes – understanding the world they are in, and the pressures they are under, so that you can frame this in a way that gets their attention.

What would make this easier? Well, some changes to the regulation. We asked elderly people in West Hertfordshire – people you would term frail and elderly – what they wanted from health care. They started by saying they didn’t like being called frail, and they wanted as many useful days at home per year as possible. It is not rocket science; you and I would want the same. But when the CQC goes and inspects all the organisations in West Hertfordshire, it asks whether the individual building blocks are meeting their targets, quite rightly. But they are not inspecting against what the patient, who interacts with many building blocks, actually wants – ‘how many days did I spend at home?’. So the regulation of individual organisations can miss the point. It can drive people away from the co-ordinated care they want to deliver.

The CQC and I are very aligned on this. So we have a piece of work going on to see if we can help to create a regulatory framework for partnership working, so that it would be inspecting what the patients actually want, not just the individual building blocks. You can’t get away from the individual building blocks. But can we look at what the patient wants and the population health outcomes, which seem, to someone like me, more important than some of the other targets for which people are held to account? I’d be slightly pushed towards thinking that if you saved all those strokes, I wouldn’t mind waiting an extra minute or two in A&E and not have had my stroke in the first place. But that is for others to judge. It helps that West Hertfordshire just happens to be one large CCG – one acute provider with social and primary care, so it is a good place to start to look at this.



And if you want to deliver at pace the Forward View, with its proposals for several different models of care, you need a change in the regulatory framework – rather than if you miss your four-hour target for the trolley wait, ‘well, I’m sorry, but you have lost your job’. That will not encourage partnership. For me, you’re not going to succeed unless the regulatory framework eventually aligns with your goals and ambitions. When I show a picture on UCLPartners these days, I always start with the 6 million people they cover, and not organisations – because it’s the people and their problems that produce the alignment, not the organisations.

How do we develop more system leaders? For our part, we’ve just launched, with the Health Foundation and NHS England, an NHS Innovator Acceleration Programme, the NIA. It is offering fellowships to up to 20 people from around the world to help create the conditions and cultural change necessary for proven innovations to be adopted faster and more systematically in the NHS. And we will be working with all sorts of other people on that, from patients to other academic health science networks to international experts. And again we will be working with a co-ownership and co-funding model. Applicants can be founders, leaders or representatives of such innovations – people who want to take a high impact innovation to benefit a wider population. And we’ll support them in that. We have a high-powered set of mentors who will help them. That’s one way of helping develop a cadre of people who are going to be more innovative about the integration agenda.

Does this get easier as the finances get tighter? It might. It crystallises the issue. There is always a risk that financial pressures will drive rational organisational behaviours that are irrational for the system. But the cake is only so big, and the crisis is not purely local. So if we don’t collaborate in partnership, in the end, although we might triumph in the short term, we can’t in the long term. The more we can get over the narrative that there is no point in being the last man standing, the better the chance. And anyway it is not what taxpayers are paying for – they are paying for a healthier population and having their needs met, not the individual organisation. But you could easily lose track of that when you look at the regulatory framework.



Dr Kim Holt

Paediatrician, Whittington Health NHS Trust



Dr Kim Holt is a consultant paediatrician, trained in London and Manchester. Her first consultant post was in Salford where she developed a 'one-stop shop', for children with visual impairment. Always striving for excellence in community child health provision, she was a member of a newly formed community team recruited to develop and improve community services in Haringey in 2004.

Her experience in raising concerns, speaking up and campaigning for a 'just culture' has led to her being awarded clinical leadership awards. She currently works as Designated Doctor for Children in Care Haringey and continues to contribute to improving services in the borough, and patient safety.

It was only very late on that I realised basically that what I was doing was showing leadership. It eventually dawned on me that that's what was happening!

There's a high probability, if you do what I did, that you will get attacked in some way or another. Not everyone is going to be agreeing with you. So that's one of the real challenges. And you do need to have quite a good support network. I've had a very strong support network, which grew bigger and bigger and bigger. The most important support in the first instance is the people close to you.

So you take a particular position, and you find that you survive that particular position, and you get more support, and that then gives you the confidence to continue. But it still hasn't got to the point where it is all plain sailing.

So I am back at work now, doing fully what I was trained for. And it was four and a half years to get back to that, so that is a completely different situation to the one it was. I was placed on secondment for two and a half years. And I did a Masters degree and some voluntary work for Kids Company. So in terms of not working at all, and totally doing nothing, it was only about six months.

And doing the Masters in complex care and child protection, I've learnt quite a lot about organisational systems, and unconscious processes, and group thinking and things like that. So that was really helpful in terms of my understanding about what had been happening to me, and why I was facing such hostility. It helped me



a lot to depersonalise it. It just happened to be me; it could have been someone else who raised all this. So that's been really helpful.

You are talking about this to me in terms of system leadership. But I think of it simply as leadership. You can be a manager and not be a leader. And you can be both. And leaders have particular qualities – very strong values, and having a very clear vision of where things should be, where we should be trying to go.

Even now, with the work I have been doing at the Care Quality Commission, I get attacked by others. Because they don't trust the CQC and they don't trust the system.

Working with other people who have been whistle-blowers, some of them slip into some of the negative bullying behaviours that they were trying to address. So I'm quite interested in bullying, why people start behaving in these negative ways. Some of it is around unresolved issues... People who haven't been able to resolve their own situation... They haven't been able to move on from their own position and see the bigger picture. And I was able to do that relatively quickly, and see that it was the system, not me, that was the problem.

People attacked me, but actually they would have attacked anyone who challenged that culture, who challenged that system. So the system, at the moment, does not support and protect whistle-blowers. We have to raise awareness about that.

I was traumatised by it, and if I talk about it in depth I still am, even though I have moved on, long ago, from my personal problems and my personal position. I lived it. I know how bad it feels. I haven't forgotten that.

But I know that I was fortunate because the very high-profile situation that Haringey was in made it very difficult for my employers to sack me. That's the key reason I survived – that, and the fact that some journalists did lots of investigation and found the truth in a way that I would not have been able to. I know that there are other people who don't have that. So I recognise that. So that's why I fight for the system to be changed so that they will be protected, other people will be protected.



And it can be very difficult for those whose situations have not been resolved. So I still get attacked. Because if you're somebody who's stood up and done the right thing, and then lost your job, and lost your career and lost all your money, and you are possibly losing your house, and you've suffered in your health as well – then to see somebody else, like me, who is in employment, who has done some work with the CQC – they feel that you, that someone like me, has gone over to the other side, so to speak... That I've betrayed them. That maybe I have moved to the other side. Obviously I know, myself... I know I've not done that.

So [at the time of the interview in January 2015] we've had some very difficult weeks in Patients First. So we have put together a code of conduct – so that if you disagree with something, there is a process by which you can discuss it. You can't just have wild allegations thrown around. So, despite being seen by some as possibly a rebel and not very corporate because I blew the whistle, you end up being quite corporate because you have to have structure. We are not going to tolerate bullying, even if it is from another whistle-blower, and – sadly – whistle-blowers can bully.

I came to realise that what I was involved in was a system issue – that our department was very dysfunctional, and that if it wasn't sorted out it would happen again. I went to my MP, Lynne Featherstone, and she took up the mantle, and she put me in touch with Ed Balls who put me on to NHS London. And I thought that was the system, and it would all be fine. Maybe I was naïve. And I was being offered money to leave my job – sign a gagging clause and go.

The unions don't support people very robustly. The British Medical Association, by the end, were very good. But at the beginning it was very hit and miss. They were more like 'take the money, go and find another job'. You know? 'Leave and just put this behind you.' They even supported (and still do) the confidentiality clause aspect.

On the whole, unions let health professionals down. They're not involved early enough; they don't deal with the bullying issues. If it does progress into a whistle-blowing case, it's very difficult because of the problems with the law in terms of winning the case. So they tend to go for a compromise agreement, which is not what is needed – either for the individual or for patient safety.



And when I went public, it was in fact very refreshing. The first journalist I spoke to said, ‘look, they’re trying to bribe you.’ They just understood it straight away, because journalists see corruption all over the place.

There’s something very strange about the culture in the NHS. You have this set of beliefs, that everyone is going to do the right thing, and everyone is going to support you, but, actually, pretty blatantly, they are doing completely the opposite. And yet somehow we try to convince ourselves that they’re going to do the right thing because it’s too painful for us to believe otherwise. So it’s a bit like having to acknowledge sexual abuse... Having to recognise that such injustices are happening within the health service to very professional, very highly skilled members of staff. It’s almost as bad as recognising that sexual abuse happens, because it’s so appalling. It’s so appalling that people who’ve stood up and done the right thing have been treated in such unjust ways. That is a real shock.

I do think the Care Quality Commission have understood it. In their inspections they are now looking at the ‘well led’ domain. How well do you support your staff if they raise concerns? Do you encourage them to raise concerns? How do you respond to them if they raise concerns? What’s your bullying policy? How are you monitoring your bullying policy? How are you monitoring your whistle-blowing policy? And so on. And they have started to identify a number of trusts who have bullied their staff quite badly, and they’ve been quite critical of them. So there is a recognition on the CQC side of the link between bullying, whistle-blowing, and patient safety, which, basically, is the key thing. They are taking it very seriously. But it takes a lot of determination and a lot of persistence to change the culture.

The law isn’t really the answer to this. It needs to be there as a back-up. But it should be very far down the line, a last resort. What is needed is an early intervention policy, so that if you are raising concerns and you are getting nowhere, then there is somewhere you can go.

One part of the problem is that when things go wrong, people look for a head on the block. And it can be the whistle-blower, not just others, who is looking for a head on the block – that someone, or a certain person, needs to be fired. And that doesn’t really help the patients, you know? It might help the patients in that it sends a message. But 80 per cent of the time, when things go wrong it is a system thing.

What is wrong is the cover-up. It is the cover-up that needs to be held to account. If people deliberately hide the truth, that's what we need to hold to account. And if we are encouraged and supported to raise concerns, we are less likely to have as many bad things go wrong. Obviously, things will still go wrong. But it will reduce the risk of that happening... Reduce the scale of the problem.

Joanna Killian

Chief Executive, Essex County Council



At the time of this interview Joanna Killian had been Chief Executive of Essex County Council since 2006. In May 2015 she left Essex County Council to join KPMG.

At Essex County Council Joanna delivered major programmes of change, reducing operating costs by £550 million and delivering improved outcomes to the 1.4 million residents, service users and businesses in the county. Essex County Council is a commissioning-led council and is known for its innovation, partnership working and creativity in responding to both the needs of its customers and the challenges presented by the tough fiscal environment. In October 2012 Joanna was appointed as Chairman of the Society of Local Authority Chief Executives and Senior Managers. In this role she has worked to transform the operating model and commercial infrastructure of the society.

Previously Joanna was Director of Local Government Performance and Improvement with the Audit Commission, working with partners across the sector and in government to improve the quality of outcomes for people in their local communities.

Joanna's background is in housing and regeneration. Housing remains her passion and she has been a board member for the London and Quadrant Housing Group since 2011.

This interview was conducted at the height of winter pressures in accident and emergency.

I do regard myself as a system leader. And we've been thinking more and more about the need to develop a very coherent leadership model across Essex. From all my experience, you can build technical programmes and you can develop incredibly



coherent business cases. But what makes these things go is strong personal relationships across organisations, and the governance that drives better leadership.

So how do we get a much stronger sense of mission and purpose, and feel a trust bond between leaders to get these things done? And then how do we create the conditions for success in our own organisation so that people feel that in the middle of the organisation and at the front line? It requires the application of emotional as well as business intelligence.

Health – in terms of the issue of the moment – achieving the benefits of some sort of health integration is critical. I think over the last few weeks, with colleagues in the health service coming under real, real pressure, we've been able to achieve more because we have had a shared mission with much of health.

It meant that in the current crisis we have been mobilising people and going beyond our statutory responsibilities to respond. So in Essex we have had very low numbers of delayed discharge from hospital from a social care perspective. We've put in extra resources, and extra people on to wards in a couple of the hospitals. I have felt as responsible for sorting out this A&E crisis as my colleagues have in the CCGs. I don't feel the pain of being a hospital chief exec. But I have felt compelled to try and help them. I think that's what starts to happen if you believe you are jointly accountable for the outcomes in a system. It is built on strong and developing relationships with health in some parts of the country.

It doesn't work uniformly well across it. And that is partly because, on the health side, people come and go so frequently. The stability of leadership there is an issue. So in places where people have hung around, those relationships are stronger, inevitably.

For a number of the big organisations operating in Essex, whether it is health or criminal justice, I think there is a realism that the next few years require a different order of collaboration to deal with the resource situation. Some of the policy drivers – the need to get more integrated services – are also equally clear. The things that continue to make it difficult are the different performance regimes and cultures.

So we receive a lot of grant from central government, but we don't have to account for much of it to central government – which is great. It's a very different world for



colleagues who work in the NHS. They look upwards all the time, and it is difficult for them to operate with a system where they are held to account by others who may not share the same system view, and that is true for the police and some other parts of the criminal justice system.

We, as a county, have only limited control over our overall finances at the moment. But we get to set priorities locally and determine how we exercise our functions. I don't personally feel that I am forever looking over my shoulder, or looking up to government, in the way that my NHS colleagues are.

There have been some fantastic pieces of work driven by some of our Community Budgets and Whole Place programmes. We've had a programme called Family Solutions, which predated the Troubled Families initiative, which brings together agencies to really tackle families that are in crisis. It uses deep demographic research tools to really understand how people feel, what they want from their lives, and therefore how we should be designing public services to respond. The benefits have been significant numbers of families that are less troubled, more families in work, evidence of improving educational outcomes. Some of those children in families who were on the edge of some sort of child protection programme are now being supported, and that's involved the council and colleagues from health, probation, Jobcentre Plus and schools. And you just can't do that as one agency. It is impossible.

If you really put the customer in the middle of your thinking, it requires a system leader approach, you get better outcomes and, in most instances, it saves money too.

But we still have failures. Essex is a two-tier system so we have district councils that are responsible for the collection of bins from individual households, and it's not unusual for each of those districts to have their own provision, either in-house or out to market. So there are 12 different collection systems, 12 different types of disposal arrangement. But as the county council we have to process all of that waste to find a strategy for dealing with it. We've tried to get a single programme or some more creative partnership to drive out cost, but it's been a no go. If you are district council it is central to what you do. Not doing it is a challenge to your purpose and your very existence, in a way.

The biggest challenge in system leadership is not the getting going, because we can often find programmes or projects for which people have appetite. It is the next



couple of stages that are difficult. How do you jointly invest to deliver the outcome? How do you put the mechanics in place to get activity working effectively across organisations? How do you share the benefits?

How do you develop system leaders who see beyond the boundaries of their organisations? I think you have to do it in many ways. My senior leaders and my colleagues in other organisations have to develop a critical mass of people who believe in it, and behave it. Not all of them feel the same because they have so much going on in their own organisations that they cannot see beyond that. But when we do, we need to give people the tools and have a performance management system that requires collaborative working. So we have just put in a big learning and development programme, at the heart of which is building confidence and competency about outward-facing collaboration in our staff. So you have to do it on lots of dimensions.

I don't know what the answer is for health. Where we are working really well with them, it is because we have two or three really innovative, outward-looking, very strategic people who will be powerful in their own sort of organisations, articulating need for change, and getting their boards to go with them. So you know there are individuals that can do it. But it does feel like a very command-and-control environment for them. Most of the colleagues that I know in the NHS do want collaboration and meaningful integration, because they know it would really make a difference, but they struggle to have consistent structures and leadership. It is the sustainability and continuity of it all. Local government changes less than the NHS, in terms of both people and structures.

Dame Julie Moore

Chief Executive, University Hospitals Birmingham NHS Foundation Trust



After a variety of clinical, management and director posts, Dame Julie Moore was appointed as Chief Executive of University Hospitals Birmingham (UHB) in 2006. She is a graduate nurse who worked in clinical practice before moving into management.

UHB is recognised nationally and internationally for quality of care. It has 1,250 beds, £700 million turnover, 8,000 staff and treats more than 800,000 patients annually.



Julie is an independent member of the board of the Office for Strategic Co-ordination of Health Research and a member of the international advisory board of the University of Birmingham Business School; the Court of the University of Birmingham; and the faculty advisory board of the University of Warwick Medical School. She is a founder member and past Chair of the Shelford Group, ten leading academic hospitals in England.

Julie was made a Dame Commander of the British Empire in 2012. She holds an honorary chair at Warwick University and has honorary doctorates from the University of Birmingham and Birmingham City University.

There is no system leadership. I'd like to take more of a role. But right now it is too fragmented, and larger teaching hospitals are usually regarded with suspicion. One of the bad side-products of the foundation trust legislation was that it created independence for its own sake, rather than to drive up quality. So we have some very small foundation trusts – some community services and acute trusts, for example – who want foundation trust independence for its own sake rather than for the good it can do. So we have created an army of people who fiercely guard their independence for its own sake, and people who cannot separate out their own personal position from that of the organisation, and so they defend it.

One of the trusts we worked with was in danger of losing a £1 million contract for some of its services. It was desperate to keep it because it needed to keep its income above a certain level because of its FT [foundation trust] status. So it had spent the better part of £2 million on management consultancy just to keep the contract there. Sometimes people believe size is the most important factor.

The 2012 [Health and Social Care] Act has compounded that. So we have some clinical commissioning groups who cannot see beyond their boundary and don't see how changes they make in their local economy impact on surrounding services. And we have some quite senior people who believe that you have got to go out to tender on almost anything, because you have to have more than one potential provider, and because they think competition is all about tendering for services all the time. So you spend half your life just filling in huge complicated bids.

So, for example, someone decided that a screening programme had to go out to tender, when it turned out that what was wanted was common standards across



the patch and some cost-cutting. It took a very senior person to intervene and the directors of the service were asked ‘can you achieve that?’ And when they said ‘yes’, it was all done without a multi-million pound tender. It was an outbreak of common sense, and it has worked really well.

And we have some problems in Birmingham that we need to sort out. So we have three pretty big acute trusts, and five smaller trusts, and several more just outside the boundaries, and everyone agrees that that is too many. And they all tend to do their own internal reconfiguration of services. As a result, patients flow elsewhere, putting pressure on other providers. At the same time, some of the clinical commissioning groups have introduced referral management systems for their local hospitals. That gets CCG numbers down and helps with their finances. But the GPs, who are smart people by and large, bypass that by referring to the other hospitals who then, due to the marginal rate, don’t get the full tariff. But when we went to the area team and said there are problems here we have to sort out, someone said to me, and I quote, ‘that would require system leadership and we don’t have that any more.’

So we haven’t got a managed system and we haven’t got a market. We’ve got neither fish nor fowl. Now, you can argue which one of those is right or wrong, and actually I don’t mind. I’d just rather have a system that actually works. Have a managed system and say if you’re a GP in area A, you refer to this hospital or whatever. But don’t say everyone’s got free choice of where to go, when you can only have choice if money follows the patient. If the money doesn’t follow the patient, then you’re penalising the popular hospitals.

On top of that, there are so many organisations around now that it makes system leadership really hard. The King’s Fund graphic [www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england] of them all is pretty impressive. But there are even more of them now than when that was drawn. There are so many interlocking circles in so many areas that you could spend your whole life just trying to negotiate with them all if you tried to work outside your area.

It is hard even for something within your area. Birmingham City Council convened a meeting about acute care in Birmingham because of some of the issues we face in A&E, and it backfired spectacularly. It started out with the three acute trusts and the ambulance service. But then the mental health trust said they had acute beds too and needed to be there. Then the community people said



they needed to be there, and then the commissioners, and in the end there were 27 people in the room and it was such a big meeting that nothing was achieved. Nobody wanted to be there, but nobody didn't want to be there. It got so involved that nothing was achieved.

There is, at the moment, no place that brings people together. I was not a fan of the SHA – I think they missed many opportunities to reconfigure and make lasting improvements. But there is now no place where people can come together with one organisation which oversees commissioning and can say 'actually this isn't coherent'. We have loads of commissioners and public health people, but I don't see anyone actually doing an assessment for a whole population and saying 'this is how many hospital beds we need in this neighbourhood, these are the outpatient services we need and the A&E and so on, and this is where we need to buy things and send people'. It is done piecemeal on too small a scale, and instead people make the projections of demand fit their business case. So even to achieve one tiny little thing in terms of system leadership takes a phenomenal amount of effort.

All that said, purely on the provider side, we have made some progress with the 'buddying' arrangements in which we have been involved. But that depends crucially on whether people recognise that they have a problem or not, and whether they welcome the help. Buddying is an informal process and we have no authority to make actual changes if the trust being buddied does not agree.

Where we have had an executive team that was willing to work with us and eager to put things right, buddying has helped. When you've got somebody that doesn't want to work with you, you can't force yourself on them. At one of the trusts, they just didn't believe they had a problem and didn't turn up to meetings – and you haven't got the authority to make that happen.

There are definitely things you can bring. At one trust, we were able to talk to some difficult clinicians in private and say to them 'you can't carry on like this. Your bad behaviour is contributing to the bad performance and you need to get your act together.' It is easier for an outsider to come in and say things like that because we have no long-term interest in the place and we can actually tell people the truth in a way that is harder for an interim chief executive to say.



I do think, however, that we need a proper failure regime where some of these things can be dealt with earlier. And that is not a failure regime that ‘lets them go bust and close down’ because we are never going to let many of the places that do get into serious trouble close down completely.

At the moment, however, you can see somewhere is going down a slide, but we wait for them to hit rock bottom before we intervene, when it would be a lot easier to arrest things and pull them back beforehand. So trusts need to go into special measures before anyone can intervene, when it would be better if help could be brought in earlier, rather than just propping them up year after year until they go down completely.

I do think that the idea of chains, as in the Dalton review, is one of the ways to go. It is not a magic bullet, when there are many causes of the problems in the NHS. But the question is, can we afford not to use the good procedures and techniques that we have in the NHS, and can we afford not to spread them out rapidly? Everyone needs to learn from everyone. And we can’t afford to have as many organisations as we have, as many back offices and as many fiefdoms.

Plus we haven’t got enough good managers to go round. There are some people who are very good at being managing directors but don’t want to take the ultimate step to being chief executives – after all, we have 10 per cent vacancies for chief executives and finance directors. And it is hugely difficult to get good chairs and non-execs. So why don’t we spread the ones we have got around a bit better?

When I say this, people say ‘you just want to take over’ or ‘you want to suck in all the patients’. But we don’t want to suck in all the patients. Here, at UHB, we are at capacity, and I’m getting pretty near retirement. So personally I am not bothered about my personal position. But chains could indeed help, although it is not going to be easy when the chairs and chief executives of struggling trusts so fiercely guard their independence.



Sue Page

Interim Chief Executive, Liverpool Community Health NHS Trust



Sue Page is interim Chief Executive of Liverpool Community Health NHS Trust and has more than 30 years' managerial leadership experience in the NHS. She has worked in London, where she became chief executive of a large acute hospital, and also spent 16 years leading Northumbria Trust. Sue subsequently held a role in the National Performance Support Team to help turn around low-performing hospitals and was formerly the Chief Executive of Cumbria Primary Care.

The odd thing is, I've never thought about myself as a system leader, but apparently other people tell me I am. But from the very beginning I have been interested in integrated care.

I was very lucky because as a very junior management trainee, I was buddied up with a young lady who was the same age as me and who worked for Kaiser Permanente in California. When she moved to Atlanta, Georgia, she was trying to run the Kaiser model, but with no ownership of hospitals, and trying to get the complete integration of services they seek. And we just continued working together, and it was very good to have an insight into an environment that was very different from the conversations happening in the NHS at the time.

So when I was working in Northumbria we were integrating out of the hospital with children's services and elderly services, trying to avoid unnecessary admissions wherever possible, and trying to get completely integrated care from cradle to grave. All the leadership programmes were system-wide and everyone then did things together in a similar way and learnt to work together in a similar language. That's how they learnt to trust each other.

For example, we had Sue Roberts, who became the National Clinical Director for Diabetes. She and others were helping people take control of their own disease, so that we could avoid unnecessary admissions and empower patients.

The clinicians were getting together in rooms and doing baseline clinical audits of their services, asking 'what, in fact, are our clinical outcomes?', and doing it with patients, asking them what does the service feel like? How would you like it to change? And getting messages like 'we don't like what you do', 'I don't want to



keep coming to the hospital to have my blood tested’ or ‘I don’t want pills for weight management, I want to understand my disease and control it, so refer me to a walking group, or whatever’. So we gave the clinicians space to think and to change the recipe book for the service which they owned. I’ve seen some magic worked in those sorts of rooms.

Now I am told they are continuing to take that approach forward; integrating with social care and GPs, with referral systems to the third sector, and doing that under my successor who was my deputy. What’s been really important is the continuity of both clinical and managerial leadership in Northumbria over 25 years, which has led to fantastic clinical standards for patients and joined-up leadership at all levels in the local system, where people actually trust each other to take risks to make things even better.

So there is something about continuity... Doing the things that you’ve said you were going to do. Some managers go in and out of places too quickly. And there is something about making things work despite the system. But you have to be quite sure of yourself to do that. You’ve got to come in in the morning to do the right thing, and to make it easier for your staff to do the right thing. And that can be easy to say and hard to do.

When I was in Cumbria, I set a deficit budget even though the system above me was telling me that I shouldn’t do that. But I’ve always believed that if you do what is right for patients, the money will come right in the end.

Here in Liverpool I have a badge that says I am a chief executive and I control £140 million of resource for the population of the city and surrounding area. But put that power and resource in a room with all the GPs, community matrons, nurses and other community clinicians in Liverpool, and think what you can achieve. It is that old thing, ‘there’s nothing in this world you can’t achieve if you are prepared not to take the credit for it’.

So I see too many chief executives who see power as becoming bigger and bigger, taking more control, rather than spending their time giving control away. And by doing the right thing, the money will sort itself out. If you get the clinicians in the room, with the patients, get the right recipe books for care and the right journey to good care – and that includes social care – then the money will be used much



more effectively. So you need the right debate, with the right data and the right information, and you get there.

In Cumbria, we started doing clinical commissioning before clinical commissioning became a national issue. So we gave the power to the GPs, and gave them leadership training so that they could go and have conversations with other GPs about how they needed to do things differently – but in a good way, not a blaming, shaming way.

As for the future, I never thought I would say it, but I would go back to the regional health authority days tomorrow. There are limits to how the current architecture can ultimately hold the system together. You have got CCGs and NHS England, and CQC and the TDA [NHS Trust Development Authority] and Monitor. So system leadership is very difficult.

And system leadership does require different skills beyond line management. It means being able to take risks and do things which might be to the detriment of your organisation. And that is very difficult in the current climate.

The Forward View seems to recognise a lot of the current issues and actually sets out a really bold and credible solution to many of the problems that have beset the system.

Would I, however, want to be a young chief executive in the system now? Well, I was nurtured and trained by some really good people and I was very fortunate. But it's a scary place to be a youngster. One slip and you can be in deep trouble. And when we appoint these new young chief executives to their first job, I really think we need to buddy them up, and have someone to help them.

When it comes to change, a lot of clinicians have said to me over the years, 'well, we get to the planning stage and we get to the point where we have put all this effort in, and then nothing happens'. Because sometimes the system hasn't always held the right people to account to get the change. I am sounding rather negative, which is not like me. I do have high hopes for the Forward View and the direction of travel Simon Stevens and others have set.



In Liverpool, this was a challenged trust, and I think we are really turning the corner. I think when the CQC come back, we will have improved. But it would be great if the system had a collective methodology to make these improvements. If we had a system where people could come to trusts on a similar journey and say ‘can we learn from this?’. I’m a big believer in peer reviewing, asking what has worked and what hasn’t, and can we learn to try to get other trusts that are in a difficult position pointing in the right direction? A collective methodology, and a system that enables change, had to be part of that.

Thirza Sawtell

Director of Strategy and Transformation, North West London Collaboration of Clinical Commissioning Groups

Thirza Sawtell is the Director of Strategy and Transformation working across the eight CCGs of north-west London. Prior to coming into this post she was Director of Commissioning in Brent and Harrow and then Director of the Delivery Support Unit. In this role she had responsibility for co-ordinating the development of the out-of-hospital strategies for the eight primary care trusts of north-west London.

In her current role Thirza is the SRO for the North West London Whole Systems Integrated Care Pioneer Programme. There are 32 partners in the programme including CCGs and local authorities, NHS provider trusts, voluntary sector and academic and research institutions across north-west London. Built upon the principles of co-production and co-design, the partners work collaboratively to support the introduction of innovative new models of care within each locality, including the system changes needed to ensure early and sustained success.

Do I regard myself as a system leader? It is an interesting question. My immediate response would be to say no – because I have none of the traditional authority or legitimacy or all of the things a leader would need in terms of moving things forward. But if by system leader you mean someone who sees their role as being... to ‘nudge’ is the wrong word... to help people coalesce around a vision and ensure that there is forward movement, then I would say yes.

It is almost as if we are using old terminology to describe a new way of working. The people who are leading the system are doing it in an entirely different way, and would not automatically see it as leadership, because it hasn’t been mandated in the



way leadership has in the past. So am I one of the people who has a responsibility to ensure that the North West London health and care system moves in a direction in which the leaders of the system have decided they want to move? I would say absolutely yes. Could I say that I am the only one that has that vision, or that it was my vision that's then gone to them, and I am now leading it? Absolutely no. That would not be my role.

My background is that I have never worked in hospitals apart from my training. I was a midwife and a health visitor and moved from a provider where I was working on integrated care into commissioning, then strategic commissioning, and for the last few years I've worked across London with the PCTs moving into clinical commissioning groups. So I am a community person.

The logic for me of integration is overwhelming, because it delivers so many benefits. So I suppose you do take a career path where some people are interested in providing, some people want to commission; but if you are interested in the whole system changing, you have the challenge of helping people understand how all the different bits, including social care, fit together – and you have to think differently. It is intellectually very interesting.

So what's being proposed in terms of integration can work absolutely beautifully when you have a beautifully contained health and care economy and no one strays outside their boundaries because actually there is a great big bit of countryside or something on the edge. So you can do part of a Torbay in London, and that can get you so far. But in London it is incredibly hard to work in one borough with a provider that's working across five or six boroughs. So you have to collaborate with lots of people and the question is, how do you get the whole system to change, and what are the rules of how the system changes?

There are eight CCGs and eight boroughs in the North West London Whole Systems Integrated Care programme, and I think the eight CCGs have been ahead in thinking about how, without giving up their sovereignty, they can see benefits from working together. The chairs had worked together as clinical leads in the PCTs for longer than in many other places. They were used to working together, on leading Shaping a Healthier Future [the major reconfiguration of acute services in North West London].



When the PCT clusters were undone and moved into CCGs, I watched across London and the people that had been forced to work together actually sprang back further than ever. But because, I think, our chairs believe strongly that they were doing it through their own choice, their own free will – and because it made sense for their own populations rather than because some organisation somewhere else had told them to do it – they kept going. So they had the relationships. They knew it was good to share knowledge and expertise. And they knew they worked in a provider landscape which meant that if they didn't, they could get picked off, and they had a purpose through the reconfiguration. So I would say that they are the system leaders, and maybe I would describe myself as the system enabler.

Seven of the eight councils supported the integration project, and one didn't. But it works very closely as part of the West London Alliance, which is where a number of the local authorities come together. So we work with 'irregular geometry' where you work together where it makes sense, and then you don't where it doesn't or it can't for the time being.

And I think that's part of the system enabler role. You have to be flexible and fleet of foot enough to recognise how to change something so that it is acceptable locally, and will resonate locally. If you go in with too fixed a view you can get nowhere – and I would argue you can't do that even if you have command and control. But certainly if you are working on a sort of distributed leadership, then you've got to be sure that you can listen to people and flex to their needs.

And I think there are still some councils where driving down price is the answer to everything because they probably haven't had to do that before. So they have still got that opportunity, and they will at some stage go through that and recognise that it is not enough.

How we have coped is that we have just kept going. So I think one of the unique bits about our programme is that it has just kept going. It has kept a momentum, and people can decide to be a part of it or not. But they know if they are not, it's not a case that we are all going to pause for them.

The question you didn't ask, which would be a harder one to answer, is if no one wanted to take part or a bulk of people didn't want to. But if it is just one, or where they don't want to be in this bit of it, then you can be as flexible as you like. If the



bulk of people don't want to take part, then you should have noticed that before you start, and you should have rethought your strategy and your plans.

So at different times, with different people, we have had differences. And whole integration is about how you override organisational interest, or how you make sure that it is in their interest to be part of this.

So you have to be very sensitive to what people say, and to interpreting what people say. You have to be good at that to take on this role. 'Emotional intelligence' is your phrase, but you have to filter what people are saying in a way you may not have to when you are working in one organisation, or you are in charge.

So sometimes people will be saying things and if you don't listen you will be entirely wrong. But sometimes they will be saying they can't do this or that, but what they need is for you to keep going and they will get their courage back, or their determination or whatever.

And I have sounding boards, both internally and externally. People I can go to and say 'why do you think this is happening, or why are they saying that?'. You have to understand why people are saying what they are saying.

Can this be taught? I think it can be learnt, which is not quite the same thing as being taught. And are we doing enough to help people acquire these skills? I would say for North West London, which is the only area that I can really talk to, absolutely not.

Because what we are talking about in system leadership needs to happen at every level. So just to do it at one level will make no difference if you have not addressed it at every level. How do you recognise a barrier, recognise what's been said, and work your way through it, rather than ignore it or try and fight your way through it?

Again, this is in North West London, but we don't analyse enough how we can be in one room talking about how we are working collaboratively and then find no contradiction in going into another room and entering into a contract negotiation that almost tosses out what we've agreed in the other room. So I think there's that sort of insight bit, which can be learnt, or reflected upon perhaps, more than we currently provide people with the opportunity to do.



We have some really good chief executives in the area who are good at calling out what has been dubbed ‘partnership shafting’... where you pretend it’s all wonderful and then you go outside and you do something that’s totally out with what you’ve just agreed as the principles of how you are going to work together. But we don’t allow people enough space to understand that.

And if we need more system leadership – and we do – it is probably the people who would benefit most from that who would least see the need for it. So how do you package it in a way that makes it relevant to people who have spent a long time climbing up a very different leadership ladder?

So you need constancy of purpose and resilience, and you need to recognise that it takes longer than people want it to take. We are much too keen to say something hasn’t worked when it never stood a chance of working within that timescale.

And you need stability in the core leadership of all this. The times when things wobble, completely, is when – and it always happens, so it is just going to happen – too many people go all at once, and they take too much with them, and then there isn’t the momentum to keep going.

So you have to think about what you do that keeps a core. The change we have made is for people to think that integration is the right way to think. That wasn’t there two years ago. It was this novel idea that some people had. So while you can’t guarantee stability, you can always be working on how to push it out further from just a core group of people that believe in it.

So, in terms of success, one in North West London has been genuine co-production with lay people... So that is a big success. And more people seeing that whole system integration as the way that we are going to solve the problems that we are in. So in terms of critical mindset changes, I think that those are successes. Failure would be if we don’t let go and allow our enabled local areas to move forward at a pace that is right for them – so the fastest move forward more quickly. Sometimes your planning can become so perfect that you never move onto that messy bit called implementation. And if we don’t do that in 2015/16 and 2016/17, that would be a catastrophic failure. So the big test is still to come.



And there is something about taking the credit. If you are someone who needs to take credit and needs recognition, you are probably not going to fulfil the role of working across systems and taking pride in other people's credit and achievements.

I am not making the role sound very attractive, am I? 'No one notices what you do. It's hard work. It takes a long time.' It's not much of a sell, so far! But I would not see it a success of the programme if people were crediting me with it, because it is others who are making the real things happen. Which is why I say I think the skills needed for this can be learnt, but I am not sure they can be taught... Because if you have to be taught, you might actually prefer a different way of working.

Jan Vaughan

Director, Cheshire and Merseyside Strategic Clinical Networks



Jan Vaughan has worked within the network environment since 2002, first in cardiac and stroke. Jan was appointed Director of Clinical Networks in April 2011 and the role encompassed cancer, cardiac, stroke, neurosciences, kidney care, critical care and neo-natal care networks. In 2012 she was appointed Associate Director for Strategic Clinical Networks and Senates for Cheshire and Merseyside.

Jan started her career as an accountant in industry and joined the NHS in 1993. Since then she has held senior positions in finance and general management in primary and secondary care as well as strategic health authority level. In addition she has sat on a number of national working groups and has presented her work both nationally and internationally.

Jan has an MSc from Manchester Business School and postgraduate certificates from both Harvard and Berkley universities. She is currently undertaking her PhD at Manchester Business School.

Do I consider myself a system leader? I suppose if I stopped and thought about it, I would. I've been doing this role, or a similar role, since 2002. So it is a way of life, really. I started off in 2002 setting up the old cardiac network when nobody actually knew what a network was.



There was not much guidance coming out from the centre. So we actually all did our own thing, rather than wait to be told. And I think the essence of networks is that you have to develop a model that suits your own local economy, rather than have a top-down prescribed model that does not always fit. Sometimes things that work in London won't work in Liverpool and Cheshire and Manchester and all those areas – because of populations, politics, personalities, history... All those sorts of things. And in these roles you have to be really mindful of that, because at the base this is all relationship work. All the work I do is around relationship-building. You could bring in PricewaterhouseCoopers to do what I do, but it would take them three times as long because it is all about relationships.

So I have a team of about 30 who work in the clinical network covering 12 disease areas, and there are 12 clinicians who work on a sessional basis and who are all either clinical directors or medical directors. But I can't tell anyone to do anything. I think, for some of the clinical leads who work for the majority of the time in an environment where they can tell people to do things, it is quite a shock at first that they have to do all this relationship-building in the background.

I was an accountant in industry before I came into the health service to set up finance when trust status was introduced back in the 1990s. I then moved into general management within mental health and an acute trust, and then into general practice to set up fundholding, before going into a health authority doing reconfiguration – all in the north-west. I think that last was what started me down this network role without me realising it.

You do have to unlearn things to do it. If you are in finance, it is so black and white – the books either balance or they don't. The world in which I work now is very much the grey, fuzzy area, where there's often not an entirely right or wrong answer. You have to persuade people. You have to bring them along and make them think it is their idea – because they have got to own it. They don't like people telling them what to do.

So you have to change your personality really, depending on who you're talking to. With some people, you have to be very forthright and have direct conversations. With others, you know it's going to take you about three months to get to the same place. Because you have to drop the seeds, work through with them, leave it alone, go back, slowly, slowly... And then all of a sudden it's 'do you think it would be a



good idea if we did this’ and you think ‘gosh I’d never have thought of that – that’s a great idea.’ That makes it sound rather Machiavellian, but it isn’t really.

You can’t have too much of an ego. Because if you are one of those people who likes to be centre stage and take the credit, these roles don’t work, because it is not about you – it is about the end game, the outcome for patients. And I should be the person in the background that people at the end of the day forget about because you’ve facilitated the change, but they have actually done the work. You’ve disappeared. But you have left them with the skills to carry on.

You need to be a good chess player, or remember in a jigsaw where all the pieces are. So if we need a bit of blue sky to finish off, you know it is over there, but you have to leave it there until it is the right time to put it in. You also need to be flexible, because things change and politics change. You can’t just set down one road. You have to have a plan B.

The majority of the time, when you get all the clinicians in the room and you talk through an issue, they will all agree that X is the best solution for patients. That, for example, you’ve got eight trusts doing something, but the rationale is you only need five, and three of them are going to lose out. They all agree that is fine. But when they go back to their trusts and the chief executive gets involved, that becomes a different conversation. So what they say in one room together and what they say outside can be different.

So we have to make sure that everything we do is transparent – that we have the best evidence to base it on, locally, nationally and internationally. And sometimes we bring in people from outside the area to look at what is being proposed with fresh eyes, so there are no hidden agendas. And one of the really big things that makes networks work is to involve patients. It is very hard to say to a patient you are not going to do something because your trust will lose out, when the patients want good services and don’t mind travelling the extra 10 miles if they feel they are going to get the best treatment.

How do we deal with the maverick clinician who simply says ‘I am not agreeing to this’? Peer pressure mostly. The other clinicians handle them well. They come to feel isolated. And we get the clinicians to sell the changes when services move. The *Daily Mail* hates managers. But patients trust their clinicians. So we had to move



some services from Clatterbridge on the Wirral to Liverpool, and that wasn't entirely popular. But we had the clinicians at the public meetings who explained that some services would remain locally, but if people wanted world-class treatment we had to move some services to Liverpool because we could not attract the top-quality clinicians without a university research base. And since that was done they have worked in partnership and recruitment has gone up. So having those things to say to patients has worked. It was a rocky start, but the community has come round.

A big success was primary PCI [percutaneous coronary intervention], where patients go straight to the heart and chest hospital, and the ambulance bypasses the local one. The clinicians were passionate about it. And we involved the patients in it. We put it in the *Liverpool Echo* – that this was a revolutionary thing, and how many lives it would save. And I don't think we had any opposition to that at all. Whereas with vascular surgery – which was not done by us – the Liverpool end is sorted but the Cheshire end isn't, because they didn't do what was done with cancer at Clatterbridge. They didn't involve enough people. The engagement wasn't there.

So, with diabetes we are working with patients about why they don't take up education about their condition. That really frustrates the clinicians. And the patients say 'well, you just talk at us, and it is too much information, too soon'. So they've started using social media with video clips on iPhones because a lot of people have smartphones. I am sure it's been done elsewhere. But the clinicians now own it, and a lot of network working is about sharing learning – and there is a lot of energy around it now.

This sort of network working does not suit everyone. A lot of people are used to hierarchy and working in that linear way. We work in a knotted ball of string, where you have to be comfortable talking to chief executives one day and patients and health care assistants the next, and where you know it is not linear like a railway track. There are lots of branches off on the way. It is about persuading, not ordering, asking not telling, everybody's equal – that sort of thing. You have to be comfortable with chaos. And it does need a different sort of manager with different skills, not the tub-thumping showman who needs to be centre stage. You need to have people who can make connections and relationships, and that's a totally different set of skills. Some of the things we do, people in the NHS would not traditionally have put a lot of value on.



I do think stability is important. I've worked in the north-west for 20 years, so I know a lot of people. And while a lot of us had to change jobs 18 months ago, we all still know each other in different but often similar roles. I don't think that happened in all areas. We were very lucky because we are such a small, compact area, and we kept a lot of that history and knowledge that other people lost, which I think has been really helpful to keep us moving forward.

But this does all take time, and people have to recognise that. You can say 'that's the solution and we will jump to it in three months'. But I guarantee that if you do, in six months it won't be there, because people won't own it and it'll just disappear. You need to take time if you are serious about change. What we do try to do is look for a quick win to start people realising that working together works – so you get more engagement and people say 'it is starting to pay off'. If you sit people in the room and ask 'if we had to change one thing quickly, what would it be?' it is usually the same thing, but for some reason nobody has done it. So we do that, or rather they do it.

We do a lot of work with local authorities and police and education and one of my team was a deputy chief executive in a local authority for many years. And I've always thought it was vital to have that because the language is different. She'll say to me after a meeting 'that isn't what they will think you have said, so you need to email them and make it plain'. It's vital to have that engagement.

Has the money getting tighter made our job easier? I would've thought it would make life easier, because clinical commissioning groups are less well-resourced than the old PCTs were. So I would have thought more would be coming to us and saying 'can you help in this area?'. But the penny has only dropped with some of them. That might be because they are only 18 months in and still finding their feet. Once they actually lift up their head, they might start looking at wider issues.

It doesn't help that strategic clinical networks and clinical senates and all that are being reviewed at the moment. It doesn't help people to come to us, if they think we might not be here in six months' time. And I can see that with us, and the clinical senates and academic health science centres and networks, and the leadership academy and NHS IQ [Improving Quality] it does look a rather crowded landscape. But there is enough work there for all of us, not least because there are many fewer improvement people in trusts than there were 10 years ago. You need

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people with those skills, and there is a great deal of this type of work to do around reconfigurations.

What is needed is that people are clear about who is doing what, so we don't duplicate and stamp on each other's toes by accident. We had been doing a lot of work round atrial fibrillation, working with pharmacists and stroke physicians and GPs around the new anti-coagulation drugs and what we do across the network – only to discover that the academic health science network was also doing a piece of work on it. So we now share our work plans, and that shouldn't happen again. If there were some clear boundaries, that would be helpful. I don't get the sense that they are going to pull the rug out from either clinical networks or senates.

I love doing this. No two days are the same. It swings from being incredibly satisfying to being the worst thing in the world, you know – you feel as though you're on a rollercoaster all the time. It's chaotic, and I like that. But I am comfortable with chaos.



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What skills do you need to be a system leader? What are the barriers to more collaborative working? And what more needs to be done to develop system leaders?

The practice of system leadership: being comfortable with chaos draws on the experiences of 10 senior leaders to explore these and other questions. Interviewees include the chief executive of a large county council; people who have led integrated care projects; those working with clinical networks, clinical senates and academic health science networks; a whistle-blower; the head of a large voluntary organisation; the chief executive of a large teaching hospital; individuals who have led (or still lead) NHS organisations at regional and national levels.

The report identifies the best strategies for achieving system change.

- Start with a coalition of the willing, build an evidence base, and build outwards; it is vital to engage clinicians to understand the need for change and lead efforts to deliver it.
- Involve patients, service users and carers because they can play an invaluable role in helping to identify how services need to be redesigned.
- Strike the right balance between constancy of purpose and flexibility, facilitating conversations about what needs to change and how, being flexible about how that might be achieved, and ensuring the momentum is there to deliver change despite the inevitable opposition.
- Pursue stability of leadership, something that has proved very difficult in a context of frequent reorganisation of the provider and commissioning landscape.

The 10 interviewees set out - in their own words - the main challenges involved in bringing about the kind of system change needed so that the NHS can deliver the models of care people want, while at the same time tackling the unprecedented financial and service challenges ahead.

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