

# The NHS and leadership

A number of recent initiatives show that the NHS is serious about leadership development. It has declared the attributes it expects of its leaders (Department of Health, 2002a), published a code of conduct for NHS managers (Department of Health, 2002b) and established a significant number of leadership programmes for managers and clinicians alike. Fundamental to this initiative is the NHS Leadership Centre which has its origins in the NHS Plan and which is an integral part of the Modernisation Agency.

The work of the Modernisation Agency is key to the delivery of the NHS Plan and it sees leadership as an essential component of its three-pronged strategy:

1. Leadership
2. Improvement 'science'
3. Care delivery systems.

Leadership is defined as the art of getting things done through others. Improvement science is the study and practice of enhancing the performance of process and systems of work. Care delivery systems define the realities and future possibilities of how care is experienced by patients, professionals and the public.

The NHS Leadership Centre is new and, like all new organizations, is a blend of the past and the future. The past is reflected in the coming together of a number of pre-existing programmes including the National Nurse Leadership Programme, the Chief Executive Programme and the Management Training Scheme. Human resources and finance leadership initiatives have also joined the Leadership Centre and appointments have been made to address the needs of doctors and allied health professionals. Consequently, the majority of offerings to date have been uniprofessional but the future strategy of the Leadership Centre will reverse this balance in favour of multiprofessional development to better reflect the environment in which health-care professionals work. Within that move, there is the recognition that some uniprofes-

sional development opportunities will be both necessary and desirable.

In addition to programme delivery, the Leadership Centre has a key role in research and development and in 2002 the Chief Executive of the NHS launched the NHS Leadership Qualities Framework (Department of Health, 2002a) ([www.NHSLeadershipQualities.nhs.uk](http://www.NHSLeadershipQualities.nhs.uk)) which defines, under three broad headings, the characteristics, behaviours and attitudes to which NHS leaders of all professional persuasions should aspire (Figure 1). This is accompanied by a 360° feedback tool for which training is available through the Leadership Centre.

At the core of the three headings is 'personal qualities' which equates to the emotional intelligence described extensively by Goleman (2001) and which is widely acknowledged to be an essential prerequisite to good leadership and performance. There is evidence in medicine that personal development is increasingly being seen as an important component of clinical training (Crockard and Kelly, 2002), which is a very positive step.

Emotional intelligence reflects the shift in the accepted style of leadership which took place in the 1970s and 1980s. Hitherto, most of the thinking on leadership came from the military and hence, even now, the heroic leader is the model which is often foremost in people's minds. Previously it was assumed that good management

achieved the best results and hence the so-called transactional leader was seen as the ideal model. The new leadership paradigm is less hierarchical and teamwork is clearly in vogue. This poses a significant challenge to those who have historically been seen as the leaders – the art of knowing when to lead and when to follow.

The transactional leader is typified by a number of characteristics which include (Covey, 1999):

- Getting the job done
- Focus on hierarchy
- Orientation towards short-term goals and hard data
- Focus on treatment rather than prevention
- Focus on tactics rather than strategy
- Fulfilment of role by maximizing efficiency of current systems
- Focus on the bottom line.

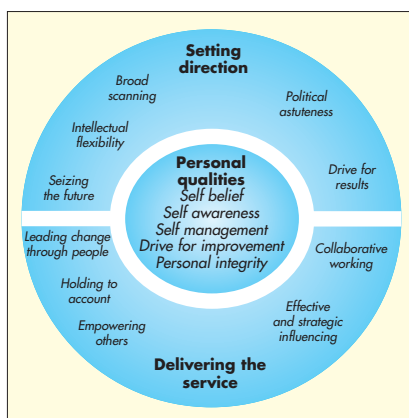
These are not negative attributes and without transactional leaders many organizations would founder. However, transactional leaders today are regarded more as managers than leaders and there needs to be a good balance between transactional and transformational leadership.

Transformational leaders are more visionary, more strategic and aim to achieve by inspiring people rather than by reward, adherence to protocol and a strict adherence to the bottom line. Characteristics of transformational leadership include (Department of Health, 2002a):

- A preoccupation with values, morals and ethics with the aim of achieving longer term goals without compromising these principles
- A proactive, catalytic and patient approach
- The preference to design and redesign jobs to release human potential and make the role meaningful
- Focus on prevention rather than cure
- The ability to flexibly align internal structures to get the best out of people.

For doctors there has been no systematic nationally funded leadership development before the Leadership Centre. The leadership development that was

Figure 1. The NHS leadership qualities framework.



available was provided by altruistic organizations such as the British Association of Medical Managers and the large provider organizations.

Against this background, the initial strategy of the Leadership Centre has been pragmatic (Empey et al, 2002): leadership development has been designed for the most senior medical leadership roles and a suite of programmes have been delivered in partnership with Keele University and through their partnership arrangements with the Universities of Sheffield and York. In secondary care, programmes have supported clinical directors, associate medical directors and medical directors.

However, the divisions between primary and secondary care seem increasingly unhelpful to patients and therefore the opportunity to engage primary care, public health and secondary care doctors jointly in leadership development has been taken. From April 2003, the medical director programmes have been replaced by a new 12-month multiprofessional programme designed to explore and develop the leadership challenge of working across the different sectors of health care, in particular primary and secondary care. There will also be a joint foundation leadership programme for professional executive committee chairs, directors of public health and medical directors who are new in post.

Now that the needs of senior medical leaders have begun to be addressed, there is a need to look further. A more intelligent approach, however, may be to look to where leadership development could have its maximum impact rather than simply picking through the various groups. This will inevitably lead to a multiprofessional approach and closer working with the large change management movement led by the Modernisation Agency.

### ROLE OF THE LEADERSHIP CENTRE

Given the large potential numbers of health service staff who have leadership responsibilities in their roles, it is neither appropriate nor indeed possible for a relatively small national leadership centre to deliver development for all.

Indeed, there are considerable advantages in building leadership development around local issues: this approach adds relevance for both individuals and their organizations and has the potential to solve matters of local concern.

This poses a number of challenges: first there needs to be local investment both in the value and importance of leadership development and also in the resources to provide it. Second there needs to be a good working relationship between the many groups that traditionally have education and development as part their role – for example workforce development confederations, postgraduate deans, departments of education and human resources. The obvious candidates to ‘hold the ring’ are the new strategic health authorities – their population size is sufficient for economies of scale and their knowledge of local issues and organizations is ideal to steer development to address local need.

With successful local ownership and devolution of the bulk of leadership development to a local level, the Leadership Centre can play an important role in design, evaluation and research and development. Through good contact with local networks it can identify gaps in the market and design, pilot and evaluate new ‘products’ for local consumption. It must also capitalize upon its position within the Modernisation Agency and lend the leadership development support to the extensive range of organizational and change management which the Agency leads. There is a growing number of initiatives along these lines and a growing practice of leadership development complementing service redesign.

The Leadership Centre also has a clear advocacy role to support continued investment in leadership development and, at a local level, to ensure

that leadership development does not die after initial enthusiasm. The NHS does not have a strong history of good personal development for its staff and for far too long has functioned in ‘safe’ transactional mode. That will not deliver the significant change called for in the NHS Plan; that demands transformational leadership.

### CONCLUSION

We have a unique opportunity to build on the leadership potential of many committed staff in the NHS. This has come about through the alignment of political objectives, a significant investment in the Modernisation Agency and its integral Leadership Centre. The timing is important: the NHS Plan is the Government blue-print to meet the major contemporary challenges facing so many of the world’s health-care systems. Its delivery requires sustained change management – a fundamental driver of change is good leadership. **HM**

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### KEY POINTS

- Leadership development is now mainstream NHS business.
- The NHS has invested in a Leadership Centre which sits within the Modernisation Agency.
- The NHS has defined what it means by leadership.
- The NHS Leadership Centre is developing a growing portfolio of multiprofessional leadership development.