

The NHS and leadership

Sir,

Peter Lees' editorial (vol 64(7), 2003, p. 388) nicely encapsulates the current thinking in the NHS regarding the importance of leadership and how it can be developed. It would be all too easy to dismiss this as the latest in a trend: doctors as administrators, clinicians in management, now NHS professional leaders. But this would be to miss the point, supported by evidence from the Commission for Health Improvement (CHI) that a lack of good leadership may lead to serious failings in the delivery of a safe clinical service to patients.

Like 'teamworking with colleagues', with which leadership is strongly connected and forms a pillar of 'good medical practice', measuring the quality of leadership is difficult but is usually evident by its absence. Of the eleven published CHI investigations into serious service failures, clinical leadership was found to be lacking in ten, together with unclear accountabilities and poor multidisciplinary working.

Good transformational leaders inspire their colleagues by example, change behaviour by influence and encouragement, and empower them to develop through defined objectives supported by a good appraisal system. Those organizations that invest in the development of their staff can demonstrate not only improved recruitment and retention but also better outcomes.

The work of the Leadership Centre should be seen as fundamental to improving patient care; it is not a bolt-on extra. Medical students and other health professionals in training establish patterns of behaviour based on role models to whom they are exposed from day one in their training. Good leaders help to establish those core behaviours expected of health professionals by professional regulators and patients.

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Sir,

Dr Lees makes some pertinent points in his editorial in respect of the need for additional leadership development, that development being more multiprofessional, and paradigmatically different in being more transformational than transactional.

I doubt, however, if most senior clinical professionals would agree that traditional transactional leaders (themselves, by implication) were not imbued with transformational attributes such as a preoccupation with ethics, values, patience and attempting to release individual personal and professional potential. This area of endeavour does not lend itself easily to individual or group categorization, and the NHS, in truth, needs individuals with a breadth of aptitudes. More transformational leadership is but one of the catalysts for change necessary for the future of the NHS.

Unfortunately, to most clinicians, the shift from a trait-orientated, transactional approach to leadership towards a transformational approach is taking place in the context of perceived increasing political and civil service transactionality. Squaring that circle, eventually, will be the true test of the NHS Plan.

Additionally, the evidence for the success of transformational attributes in leadership remains patchy. Tools for its assessment may have face validity, but the predictive validity is unknown, and intuitively may well be poor. There is also the question as to whether these attributes can be developed in individual cases, which begs the question of alternative modalities and balances being introduced into the selection of potential future senior professionals, including at undergraduate entry level.

In Wales, while structures may be different the issues are the same. The Welsh Centre for Health Leadership, in conjunction with the Postgraduate Deanery and the All-Wales Medical Director's Group, runs tiered management and leadership programmes consisting of a specialist registrar programme, a newly appointed effective consultant programme, a clinical director's programme and action learning sets thereafter. There is, as yet, little

move to multiprofessional development, although a lot of effort has been put into enabling boards to function effectively. To date, those processes have largely excluded primary care, although, for the reasons Lees observes, that will have to change, and probably include social care as well.

Professionals are not easily led, and they are appropriately sceptical of under-evaluated change and of authority. Being led is also not easy in itself, and also needs developmental work. Moving from an autonomous professional paradigm to one that is more team orientated, has permeable boundaries and is more consumerist is possibly the greatest challenge facing the UK health professions.

Transformational leaders have much to contribute to that development, but there is more to cultural and change management than the transformational model. There is an urgent need for constructive debate about reform, stratification, deregulation, reduction in demarcation and how to engage in meaningful, informed dialogue with the consumers of health care, the patients and carers. Transformational leaders should be beginning that debate.

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Sir,

Clinical leadership is a key policy initiative in Scotland. The 2003 White Paper in Scotland Partnership For Care places more emphasis on valuing and empowering the staff who deliver care. There is widespread recognition that, given the right opportunities and incentives, front-line staff can redesign and deliver integrated services around patients. As in England, this requires investment in staff development and resources to enable change to happen.

There is a stronger emphasis in Scotland on leaders engaging in partnership with staff, patients and the public to improve services across NHS Scotland. Developing leadership in senior managers and clinicians is rec-

ognized already by leadership programmes integrated across the public sector, but now there is more emphasis on the development of clinical leadership within multidisciplinary teams.

The purpose of clinical leadership is clearly linked to improvements in services for patients, and explicit links are made for the development and reward of clinicians who lead with the new community health partnerships (joint medical and social health improvement and care at community level), managed clinical networks and emerging care networks.

A new Centre for Change and Innovation will capture the improvement science already happening across NHS Scotland, England and Wales, with the aim of turning best practice into working practice. NHS Education Scotland is developing programmes to take forward changes in professional leadership and workforce development for nurses, allied health professionals, pharmacists and others.

Scotland is moving to fully integrated health systems with much fewer accountable chief executives, matched to a devolved style of leadership and resource accountability; to be successful this will not only need to be highly transformational and supportive, but also will need to take into account the extensive research from Alimo-Metcalfe which clearly demonstrates that public sector staff will respond best to leaders who nurture. It will be all too easy for old hierarchies and habits to frustrate staff-led improvements for patients.

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Sir,

Leadership is a way of doing things better, and doing the right things. In his editorial Peter Lees makes an impassioned and compelling case for multiprofessional leadership programmes as reflected in the new programmes developed by the NHS Leadership Centre. These are competency based with core qualities and not restricted to an artificial, uniprofessional dimension.

This redirection reflects the realities of the working environment, and allows for the development of shared values and performance goals, while nurturing the development of individual and mutual accountability necessary for high performing teams. It will facilitate cross-fertilization and in time the Leadership Centre will produce a genetically modified crop of its own 'fit for purpose' and the new NHS. Joint meetings of the British Association of Medical Managers and the Institute of Healthcare Managers would be progress.

There is much outstanding leadership in the NHS, but we face immense problems and pressures. There is a risk we may mistakenly interpret this as a need for more management and less leadership. Transformational leadership will result in happier staff, less stress, better teams and ultimately better organizations, as shown in the research by Beverly Alimo-Metcalfe and John Alban-Metcalfe. After all leadership effectiveness is ultimately determined by the perceptions of staff.

What of Northern Ireland? Undoubtedly the political stagnation of recent years has inhibited innovation. Until recently most leadership programmes for doctors were largely supported by large provider organizations such as my own Trust. The Department of Health, Social Services and Public Safety in Northern Ireland, in a very welcome initiative, has recently engaged with the NHS Leadership Centre. I would see this as the first step in the establishment of local and more specific leadership development programme as Peter Lees suggests.

What of the future? We need to introduce more health-care management into undergraduate curricula. While our own Postgraduate Deanery has invested significant resource and effort into their medical management programme for specialist registrars, it needs further innovation to develop leaders with the competencies and qualities for tomorrow's NHS. Let's start sowing the seeds.

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Sir,

I was delighted to read Peter Lees' July editorial on the development of clinical leadership. The Health Foundation views the development of leadership as a priority, and supports it through a range of award schemes.

Lees proposes that clinicians must increasingly exercise transformational leadership, a component of which is a concern for the ethical framework in which long-term goals are pursued.

The NHS Confederation recently brought together representatives of clinicians and managers to discuss ways of improving doctor-manager relations. Their report (NHS Confederation, 2003) refers to differences in perspective, with doctors focusing on their responsibility for individual patients while managers focus on resources and patient populations. Leaders in health care must find an ethical balance between these perspectives.

An ethical framework for physician leadership has been proposed by Chervernak and McCullough (2001) who argue that it derives from the relationship of trust between physician and patient. They spell out four components of trust: avoidance of bias in clinical judgment and management processes; restraint on self-interest, including organizational self-interest; compassion in dealings with patients and colleagues; and integrity, the physician leader making management decisions based on evidence, well-documented outcomes, reliable clinical judgments, and balanced economic judgments.

This is not easy to achieve. But as Chervernak and McCullough (2001) note, thinkers as far back as Plato and Confucius 'have taught that living according to the virtues we have described here sustains leaders and their subordinates in ways that money, prestige, and power cannot'.

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Chervernak FA, McCullough LB (2001) The moral foundation of medical leadership. *Am J Obstet Gynecol* **184**(5): 875-80

NHS Confederation (2003) *Medicine and Management: improving relations between doctors and managers*. NHS Confederation, London