



# Future of leadership

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PAPER 1

## Reforming leadership development... again

### Key points

- Debates about improving management and leadership in the NHS are not new and continuous reform suggests that previous attempts may not have tackled the right problem.
- The leadership role in the NHS is very different from ten to 15 years ago.
- The new Leadership Council needs to look at the system issues that prevent good leadership and make the top jobs unattractive, not just talent development.
- Line managers throughout an organisation must see leadership and management development as a core part of their role.
- A better theoretical base to support the practice of NHS management and leadership is needed.

### Background

Health minister Professor Lord Darzi's NHS Next Stage Review contains the important insight that delivering change is not just the result of incentives, competition and policies, but also requires high-quality leadership at all levels of every organisation and across local systems, particularly by clinicians. The final report proposes a number of policies to develop high-quality leadership, including:

- incorporating leadership development into professional education and training
- developing a range of leadership qualifications up to master's level
- identifying and supporting the top 250 leaders
- producing guidance on talent management
- creating a clinical leadership fellowship scheme

- removing the barriers to allow a greater proportion of leadership posts to be filled by clinicians, women, people from black and minority ethnic (BME) groups and individuals with experience beyond the NHS

- establishing a Leadership Council.

### New Leadership Council

One of the Leadership Council's first tasks will be to conduct a thorough analysis of the gaps in the current approach, and develop strategies to deal with these and deliver the other leadership policies set out in the NHS Next Stage Review. But this raises two important questions: firstly, what is the real problem with NHS leadership and, secondly, what solutions can best be provided by central or regional action?

To help shape our contribution to the work of the Council, on which the

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The NHS Confederation annual conference and exhibition, **Local leadership: a national service**, in Liverpool from 10 to 12 June 2009, will offer the opportunity to progress the discussion further. Visit [www.nhsconfed.org/2009](http://www.nhsconfed.org/2009) for more information about the conference.

## “Diagnosing the problem of NHS leadership is less straightforward than has been assumed”

NHS Confederation has a seat, we conducted interviews with members and other health leaders including NHS chief executives, academics, regulators and consultants, to look at these questions. This paper does not represent our official position on these issues, but is intended to form the basis of further discussion with members.

### What is the problem?

The NHS Next Stage Review report, *High-quality care for all*, states that leadership has been a neglected component of the reforms until relatively recently. But investment in leadership development and significant changes to delivery were a feature of the 2000 NHS Plan (which mandated the creation of the Leadership Centre) and the creation of the NHS Institute for Innovation and Improvement. In fact, this appears to be the fourth reorganisation of leadership development in ten years, which suggests that diagnosing the problem of NHS leadership is less straightforward than has been assumed, and the consequent changes in direction and personnel may also have contributed to the lack of success. We would argue that debates about the need to improve management and leadership in the NHS have been going on at least since the Griffiths Report on NHS management in 1983.

The problem is often framed in the context of difficulties in filling key chief executive roles. There is also concern that high-quality, director-level managers and clinicians are not coming forward. Our interviewees told us that there were problems with the shortlists for many key director and other senior posts.

There has been a long-standing focus on top management and adherence to a now discredited heroic model of leadership, which ignores the significance of leadership at all the different levels of the NHS. The Next Stage Review does not fully repeat this error, but there is a danger of it being perpetuated if the Leadership Council does not ensure that there is a wide definition of leadership. The proposal to create a list of the top 250 leaders may not send the right message about this (although at the time of writing we understand this proposal is under review). The people we talked to thought that 250 was far too low a number, perhaps by a factor of 100. For example, University College London Hospitals has a group of 400 leaders, with 80 at the top level. But there is a danger of creating an artificial elite and vehicle for patronage; it can only ever be a top group and it would be very damaging if it was seen as *the* top group.

Concentrating on the top jobs misses the fact that a shortage of talent at chief executive level may be the result of similar problems further down the pipeline. Much of the criticism of NHS management is directed at the quality of middle

management rather than chief executives. This group was mentioned in a number of our interviews as needing attention. As a result, our interviewees suggested that any analysis of the problem should look at the following three areas:

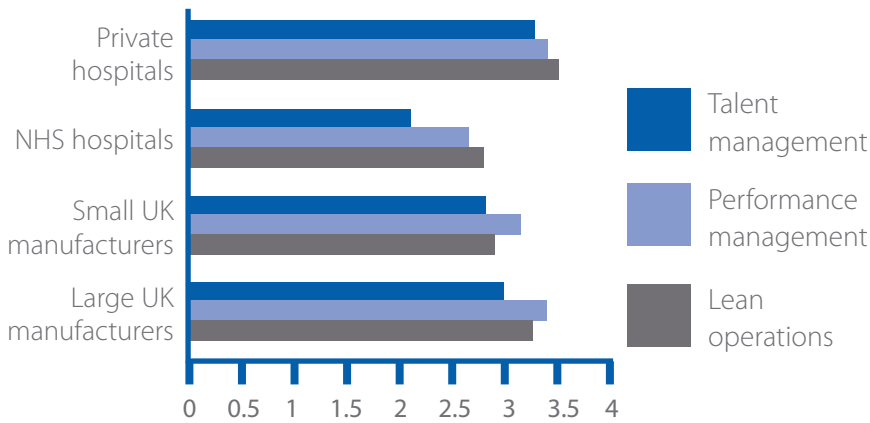
- the quality of the people coming through the pipeline
- whether the key jobs in the system are attractive
- the way that people are prepared for leadership roles.

### The people

A number of our interviewees said that many of the senior managers and chief executives they work with are at least as good as their counterparts in other sectors. However, they were concerned that there were not enough individuals of this calibre for the number of posts in the system. Reducing the number of posts through mergers would not necessarily solve this as, while organisation size increases arithmetically, complexity may increase exponentially.

Unfortunately, our interviewees commented that they also encounter a relatively high proportion of senior managers who exhibit a troubling level of passivity and risk aversion and who lack sufficient entrepreneurial flair or willingness to take the initiative. They were concerned that these individuals have an overly short-term and narrow focus, with a limited ability to understand the wider system and think strategically.

### Average management score by sector



Source: McKinsey Quarterly

“The leadership role in the NHS is very different from ten to 15 years ago”

into line with other large organisations in the rest of the economy, in terms of providing space for developing and implementing an organisational strategy, requiring a new set of skills (commercial, marketing, financial and project management), a more strategic outlook and different ways of working. But a number of other changes were seen as being even more significant in terms of the demands made on staff:

- extending leadership and management into the organisation, delivery of clinical services and the large range of technical skills needed to be effective in doing this
- much more rigorous performance management that requires a large number of different and potentially conflicting objectives to be balanced
- the ever increasing need for organisations to work as part of a larger health and social care system
- the much faster pace with which the system operates.

For reasons we explore later in this paper, this is not so much a criticism of the people, but of the system in which they operate and the behaviours that they learn.

### Skills gaps

Research by McKinsey & Co suggests there are significant skills and knowledge deficits in middle and senior management compared with their counterparts in industry and private healthcare.<sup>1</sup> The study, based on an assessment of 126 NHS and other hospitals across the UK, suggests that improved operational effectiveness, performance management and talent management are associated with a number of success criteria, including lower infection rates, lower readmission rates, more satisfied patients, more productive staff and better financial margins. They found a considerable gap between the average management-practice scores of the NHS hospitals and the average scores

in their research into UK industrial companies. There was also a large gap between the management scores of NHS hospitals and those of private hospitals.

Our interviewees agreed that there were deficits in the technical knowledge of many future leaders, particularly in quality improvement techniques. This would be less of a problem if there were sufficient junior staff with these skills who could help fill the gap. This deficit has emerged because, as a number of interviewees commented, the leadership role in the NHS is very different from ten to 15 years ago. It is now more complex, there is greater involvement in clinical issues and the pace is much faster. There was also concern about the extent to which leaders were connected to current research and leading-edge thinking. The absence of curiosity in this area is a source of some concern.

The development of foundation trusts was seen as bringing providers more

### Theory behind the practice

More worryingly, the problem with who is in the pipeline may also have resulted from some aspects of the approach to management in the NHS. A number of our interviewees

<sup>1</sup> Castro, P, Dorgan, J and Richardson, B. 2008: ‘A healthier health care system for the United Kingdom’. *McKinsey Quarterly*

## “Additional pay is not seen as adequate compensation for the very large increase in risk associated with becoming a chief executive”

commented that there is a lack of a strong underlying theory to support the practice of management and leadership in the NHS. This matters because, as the quality guru William Edwards Deming wrote: “Experience by itself teaches nothing. Without theory, experience has no meaning. Without theory, one has no questions to ask. Hence, without theory, there is no learning”.

A recent review by Manchester University of large-scale change in the NHS seems to confirm the need for an underpinning theory. There are a number of good competing models, and which one is chosen does not seem to matter. The relative weakness or absence of such a theory will undermine the design of high-quality leadership development interventions.

## Seeking solutions

One solution is to bring in talent from outside, with the additional advantage that it may bring new skills. The level of complexity and some of the cultural aspects can be an unpleasant surprise in this situation, but can often also be stimulating and challenging. However, the people we spoke to thought there is still suspicion about managers from outside the NHS and this seems to extend to NHS leaders who take time

out to work in other sectors or overseas. Our interviewees saw this type of development activity as particularly valuable but, worryingly, they thought assessment centres and selection approaches may be further reducing this type of diversity. Another solution is to widen the talent pool by including more clinicians in management. Some of the issues related to bringing more doctors into management will be considered in the next paper in this series.

## Problems with the jobs

Our interviewees thought it very likely that there are a significant number of people, particularly clinicians, who are interested in leadership roles and have the potential to be excellent, but who are put off taking the step because of the nature of the job or how they perceive it. For many directors the additional pay is not seen as adequate compensation for the very large increase in risk associated with becoming a chief executive and this is particularly true for clinicians. The demands of top jobs are very significant, particularly in terms of working hours. Our previous work in this area found that chief executives work very long hours.<sup>2</sup>

Several of our interviewees identified a problem of a perceived or real toxicity in the wider system inhabited by chief executives, describing the environment as “brutal”, “arbitrary”, “prone to favouritism” and intolerant of risk-taking that isn’t successful. This has been a recurring theme of any discussion about NHS leadership for a

long time. Whether apparent or real, people at director level and below believe that these behaviours are prevalent. They may be a significant factor in deterring them from seeking chief executive roles and are likely to have an especially off-putting effect on clinicians. This culture of blame may also shape the behaviour of those already in leadership posts – breeding the passivity and risk aversion we refer to earlier in this paper – and was also a strong theme in 2007 when we investigated this issue. The emergence of foundation trusts was seen as a way of addressing many of these issues for providers and our interviewees thought there were some early signs that this is the case.

There is a significant issue about leadership in troubled organisations. The people we spoke to said that individuals who take on failing organisations tend to find they are quickly seen as part of the problem and are often given inadequate support. There are also unrealistic expectations of the time it can take to reverse organisational decline or a failure to understand that performance often initially gets worse as further problems are uncovered. This is compounded by a perverse tendency to appoint new chief executives to these roles and provide inadequate support. As a result these organisations often have a high casualty rate, which in turn deters applicants, particularly the more experienced chief executives, who may also be more aware of the hazards associated with the organisation.

<sup>2</sup> *The challenges of leadership in the NHS*, The NHS Confederation, 2007

## Key challenges to leadership development

We heard that some elements of the environment are not conducive to creating a good basis for leadership talent development:

**Rapid turnover** – a rapid turnover of chief executives undermines the support needed for leadership development.

**Risk and experiment** – our interviewees thought that the NHS was still risk averse and tended to create incentives to maintain the status quo. This removes a lot of the potential for learning or for encouraging potential leaders to adopt an inquisitive and innovative approach. The risks and mistakes that promote this sort of learning are often not welcomed. They also highlighted that the attitude to mistakes seemed to be that people who were forgiven tend to be those who already 'fit in'. This does not bode well for creating the innovative cultures that require diversity and an environment where people who do not quite fit in can prosper.

**Top-down and directive style** – this aspect of NHS management has tended to eliminate the space where potential leaders could acquire strategic change management skills. It is expected that changes in primary care trusts and the development of foundation trusts will improve the situation.

**Complexity** – the pace and complexity of NHS management has reduced the time for reflection and learning, and the size of many organisations has reduced the contact between chief executives and up-and-coming leaders.

**Diversity** – it is recognised that the NHS has more to do to encourage this, but diversity in terms of experience, age, gender and ethnicity may be of much less value than it could be, if there is still homogeneity in ideas and approach. There is resistance to experience from outside the NHS and healthcare and to ideas that challenge the current model of management.

**Professional networks** – there is a need for strong professional networks which have senior involvement to provide support for mentoring, secondments and career planning. Our interviewees felt the professional bodies have more to do to fulfil this role and senior people in leadership may need to do more to help them achieve this.

“Supporting leadership development and talent management are key roles for board members”

## Preparing for leadership

Our interviewees were clear that there are significant problems with the way that the system prepares future leaders. All of them agree that supporting leadership development and talent management are key roles for board members, particularly the chief executive. This is because most development comes as part of doing the job rather than being classroom-based.

The NHS chief executives we talked to are deeply involved in talent spotting and leadership development. They do this by creating project jobs and rotating staff through challenging line management roles, combined with a certain amount of formal development and education where necessary. They also put aside a significant amount of their own time for providing support.

We heard of another two key steps:

1. making sure that leadership development is underpinned with a supportive and well-defined approach to organisational development
2. top leaders continuously helping those further down the organisation understand the context in which they are operating.

It is not clear if this structured approach is happening on a

## “Competencies have their place, but knowledge, values and experience may have been undervalued”

sufficiently large enough scale across the NHS or further down within organisations. Chief executive and organisational support for the national management training schemes remains strong, showing that there is a good commitment to leadership development, at least at the entry level. But, once people have left the schemes and for those who do not enter by this route, the path is much less clear and there is little formal help with career planning.

There is some concern about the approach of some parts of the leadership development industry and its perceived emphasis on formal learning and competencies. Competencies have their place, but knowledge, values and experience may have been undervalued, meaning there has been insufficient emphasis on how they are applied, rather than whether they had been acquired. More could be done to provide a theoretical base for leadership and management that would help practitioners make sense of their experience. In the past there appears to have been too much emphasis on learning away from the job and far too little time spent in the learning environments that offer the opportunity for reflection and sharing experience with peers.

The tendency to treat NHS leadership as a generic set of skills seems to

be increasingly questionable in a system with a more clearly defined commissioner/provider split. Different skills are needed for diverse providers, commissioning, network leadership and partnership working. Not enough emphasis has been given to leadership in functional areas – for example, commissioning, human resources and public health – which will also be required.

## Other issues

A number of our interviewees thought that the focus on leadership means that some wider problems have been missed and that leadership is sometimes used as a scapegoat for these. Most importantly, the focus on leadership obscures the importance of developing followers – people who understand the contribution of leadership and how to work with it, but do not have to lead themselves. Some of the Next Stage Review’s proposals address this but the focus on leadership could mean that this insight is lost. We have previously argued that the emphasis on leadership means that key functions of management, implementation, administration and the detail of getting the basics right – essential to patients and staff having a positive experience – are paid insufficient attention.

Some interviewees commented on the introspective nature of the debate about leadership and talent management, and lessons from the independent and third sector in health and social care are potentially being

missed. There are also lessons from elsewhere in the economy although a number of our non-NHS interviewees pointed out that the complexity of NHS leadership jobs makes non-health comparison more difficult.

## Principles for leadership development

On the basis of these discussions there seem to be some clear principles that should underpin the approach to leadership development:

- Leadership development is a key chief executive and board responsibility and not a function that can be led from outside the organisation.
- Different NHS organisations require quite different skills.
- Leadership needs to encourage interchange within the NHS and with other sectors.
- We need a focus on leaders at all levels.
- Attention should be paid to the development of ‘followership’ – the appreciation of the role of leaders among those they are required to lead.
- Management development should be for people with some element of managerial practice in their jobs – for clinicians this may mean finding projects and other opportunities to practise management.
- Managers should remain on the job so that their experiences can be woven throughout the educational

process, which can then extend back to the workplace.

- Insightful theories are needed to help managers make sense of their experience. The absence of strong theories is a significant weakness in NHS leadership.
- Thoughtful reflection is the key to learning. This means that sharing their practices is a key way for leaders to understand how to use their competencies.
- Leadership development should be measured by its impact on the organisation as well as on the individual. Often leadership development focuses on how the individual benefits and, while important, it should not be the exclusive purpose. We need to guard against creating a self-serving approach by those being developed and cynicism in those around them.

This list owes a debt to researcher and writer Henry Mintzberg and Gordon Best of OD Partnerships Network who have advised us on this.

## Conclusions

Some of our interviewees suggested that the debate on leadership is held back by the domination of leadership development professionals who have a particular position and a vested interest in promoting models based on assessment centres, testing, formal learning and off-site events. Much of this thinking may need to be challenged given that previous solutions, often informed by

‘professional’ views, have clearly not succeeded.

If the Leadership Council only pays attention to leadership development and talent management, neglecting the systemic issues that create barriers to good leadership and make top jobs unattractive, then it will fail. Paying attention to behaviours in the system and how it supports leaders will therefore be very important. If effort is only directed towards leaders at the top of organisations, a significant part of the problem and opportunity for change will be missed.

Most of the effort made on developing the next generation of leaders has to be the responsibility of chief executives and boards in individual organisations. This responsibility has to be devolved down the organisation as well so that line managers see leadership and management development as a core part of their role. To make this work effectively, structured processes are needed within the organisation. Methods for achieving this in a system where organisations cannot simply be instructed to change require some thought. Boards, particularly non-executive directors, need to ensure that a long-term view is taken and that the necessary investment takes place.

Our interviewees emphasised the important role of a collective effort across the NHS to provide:

- mentoring
- formal development and courses
- secondment opportunities

**“Leadership development should be measured by its impact on the organisation as well as on the individual”**

- elements of the missing theoretical base for healthcare leadership
- frameworks for development that organisations can adapt
- a better approach to appointing and supporting teams and leaders in failing or challenged organisations
- new talent in leadership and address some of the barriers for people with experience in other sectors
- personal involvement by senior leaders in professional networks to foster talent.

The Leadership Academy in the North West seems to be a useful model for this type of collective work. It was created in 2007 following consultation with North West chief executives, ensuring that activity is routed in the support of the chair/chief executive community. The member-led academy seeks to design and deliver leadership and management development regionally. A talent management approach is being developed to identify, develop and track individuals who are identified as having the potential for senior leadership roles.

However, scope for the type of planned movement approaches to talent management is lacking, at least in the provider side of the NHS. Previous attempts to make this happen failed even when providers were directly managed.

## Questions

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This paper is designed to stimulate discussion and we look forward to hearing from members and others with their views on the following:

### Diagnosis

- Is there a problem with leadership?
- Do you agree with our assessment of the problems with the talent pool?
- Do you have any additional thoughts on this?
- Do you accept the diagnosis relating to the wider system and middle management?

### Actions

- Where are the most significant gaps in skills, knowledge and experience?
- How do we get a more diverse leadership community?
- In a plural system, what are the incentives to ensure that all organisations take this issue seriously?
- What is the role of a central body such as the Leadership Council?
- How can strategic health authorities best add value?
- What should the principles for leadership development be?
- Is the emphasis on formal qualifications in the Next Stage Review helpful?
- What else can be done?

Have your say on these questions at [www.nhsconfed.org/leadership](http://www.nhsconfed.org/leadership). For further information on the issues covered in this paper, please contact [nigel.edwards@nhsconfed.org](mailto:nigel.edwards@nhsconfed.org)

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