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THE BOTTOM LINE

Partha Kar: To improve clinical leadership we need a dose of realism

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Review after review has concluded that one key weakness of the NHS is that it lacks strong leadership, especially clinical leadership. The NHS has many leaders without strong track records. It may have some good speakers and good motivators, but leaders able to deliver outcomes that matter to patients are a bit thin on the ground. As a leader you should always be judged on the basis of delivery—not of a document but of outcomes that matter to the people you serve.

Consider the basic question of what draws people to leadership roles. In general, rightly or wrongly, a few factors draw NHS consultants towards these roles: money, power and glory, and altruism.

Despite some exceptions, money often isn't much of a driver towards leadership roles, mainly because the financial rewards are pretty average. However, power and glory are a huge draw, and the NHS is awash with many such people. This doesn't diminish what they can offer: their passion is worth emulating, and there are examples of great care driven by these individuals. For them, glory—either for them or for their department—has been a major driver. I'll be honest and acknowledge that I started my leadership journey because I wanted to put Portsmouth on the map of diabetes care and to make it one of the best centres in the country. Time teaches you that a career position also leads to influence, thereby widening the scope of what one can change or affect.

Which brings us to altruism. For some people it will always play a significant part in attracting them to leadership roles in the NHS. The problem with altruism as motivation is that it's not necessarily sustainable. The NHS is astounding in its ability to ask those who do a bit more to do a bit more, one more time, and again one more time, for the patients. But every one of us has a limit—and an outside life. At some point the rubber band snaps, and you lose not just the power of that altruism but perhaps also those leaders from the workforce.

But the NHS needs clinical leaders, and it's quickly running out of willing volunteers. Can the current NHS leadership bodies find a way to tackle these challenges and deliver the leadership the health service needs? Or might a new group of leaders come up through the ranks, armed with the knowledge of what both success and failure look like?

At the moment, NHS leaders spend too much time describing a shiny new world. That optimism needs balance. It needs realism. It needs stories of leaders failing, of how the first hurdle was the toughest, of how adversity is a part of life in the NHS, and of how a lack of resources impedes progress. Otherwise, in the face of the challenges of the real world, disenchantment quickly sets in, and you lose the people who have been inspired to take on leadership roles. Leadership is rewarding, and it can be fun, but it's also tough and spiked with failure.

For me, the basic fundamental of leadership is: are you representing the needs of the patients and your staff to the higher echelons of power—or is it the other way around? The answer should be simple, but in many cases it's not. And therein sits the basis of leadership success. Or failure.

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