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EDITORIALS

Leadership in the NHS

Professionals respond better to inclusion than to coercion

Jonathan Shapiro *senior lecturer in health services research*, Sabina Rashid *honorary research associate*

University of Birmingham, Birmingham B15 2TT, UK

Leadership and management in the NHS have become the focus of much attention over recent years, and the recently published report by the King's Fund is an excellent primer.[1] The report helpfully tackles the two subjects separately, but their distinction is worth exploring further; management is perhaps the more generic term, and an understanding of how this has changed may offer insights into the role and manner of leadership.

The overarching task of the NHS is not that complicated; it provides healthcare to the population in a fair manner (with perhaps a nod towards health improvement). It only becomes complex when the number of variables that influence this aim are considered: a politically accountable system with a tax based budget that accounts for a 10th of the entire gross domestic product; delivery of care to a diverse population largely by professionals trained to be autonomous and self directed, using interventions whose effectiveness varies enormously; and a workforce of nearly 1.5 million people spread across several hundred separate organisations.

In organisational terms delivering these objectives requires management, leadership, administration, and bureaucracy. Recent reforms have emphasised transactional tasks (for example, how we do things such as reduce waiting times) rather than core aims (what we do to make people better), inadvertently making the NHS a morass of perverse incentives and conflicting interests, where organisational (and even individual) self interest may trump implicit core values.

The "targets and terror" regimes that have emerged over the past 20 years have focused on immediate, easily measurable, process interventions to provide quantifiable evidence of performance.[2] This has forced NHS organisations to divert their professional, largely value driven, staff away from "doing the right thing" to achieving externally imposed goals instead.

These pressures have led to the "over administration" described in the King's Fund report and changed the perceived locus of control,[3] so that health service professionals who traditionally felt that they controlled clinical services now feel that they have to carry out instructions in which they have little personal investment and hence ownership.

In any managed system, the commissioning or procuring agency (in NHS terms, ultimately the Department of Health) carries the risks and defines the operational tasks for those delivering the service, who in theory merely do what they are told. Such systems need active management, with all the infrastructure associated with control and accountability. They require strong leadership, not only to determine strategy and provide direction, but to generate and if necessary enforce enthusiasm and performance.

There is another way, however: professionally based systems. These depend on self driven autonomous individuals (lawyers and accountants as much as doctors and nurses) who essentially carry the risk for their own activity, with its inherent responsibilities and rewards. In this system, the responsibility for measuring effectiveness as well as delivering it passes from the commissioners to the providers, within an agreed resource. Thus, those responsible for the service also own the information associated with it, and so have a vested interest in its provision.

However, in this kind of scenario contracts are generally based on outcomes rather than simple "process" mechanisms, such as readmission rates, and providers should be able to show control and accountability without commissioners needing to define or pay for every separate mechanism. In this way, professionals maintain the locus of control, and "own" the problems, their solutions, and the resources associated with them; this is the case whether the service involves manufacture, retail, or healthcare delivery. Because the professionals are signed up, a different and less didactic form of leadership is needed, one that determines strategic direction and facilitates the coordination of service delivery, but should rarely need to pressure practitioners. It is here that the equally professional, motivated healthcare managers should be able to work alongside clinicians to ensure that their jointly owned interpretation of central policy can be delivered effectively and with a genuine sense of pride.

The political nature of the NHS has mitigated against this more developmental form of stewardship, and the many leadership initiatives created and funded by the Department of Health (such as the Darzi review) have generally been predicated on the managed care model.[4] With the current moves towards more

j.a.shapiro@bham.ac.uk

devolved leadership,[5] there seems to be a growing realisation that the traditional "heroic" models of leadership are becoming increasingly archaic. However, the holy grail still seems to be in an alternative model of leadership, whereas it actually needs to encompass the notion of ownership.

Certainly the language is now about engagement, but the nature of that engagement is often still described in terms of organisations getting clinicians "to see things our way." Projects such as the National Institute for Health Research's collaborations for leadership in applied health research and care (CLAHRC) go some way towards trying to link engagement to the priorities of those delivering the service.[6] But it is only by engendering a better sense of true ownership that genuine engagement will ensue. It is unclear whether this is best achieved by the introduction of smaller and more "local" organisations modelled on private sector companies,[7] by making employees "partners" in the style of John Lewis,[8] or by introducing service line management.[9] What is obvious though, is that telling people that (in the words of the old adage) "the floggings will continue until morale improves" is not sustainable in the longer term.

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