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What makes a top hospital?

LEADERSHIP

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THE
top hospitals 11
PROGRAMME

Contents

Foreword

CHKS has judged the *HSJ* Acute Organisation of the Year since its inception. In addition, CHKS celebrates success with its annual Top Hospitals programme. As a result, we have seen many examples of excellence in the delivery of healthcare by acute sector organisations. The idea behind this series of five reports is simply to share these examples of success in the hope that other organisations can take something from each of them.

While there are many examples in the literature of high performing healthcare providers, they are often drawn from international comparisons where the environment is very different. These reports reflect excellence in healthcare that has been recognised within the past few years. Our aim is to share the energy and enthusiasm for providing high quality care that we have found in the NHS in the UK.

The reports are based on the collective view of the judges of the 2010 *HSJ* Acute Organisation of the Year award, who produced an overview of what they had seen across the successful trusts (see panel below). No single trust was excellent across the board but, together, they provided a set of themes from which we can share insight. These themes provide the focus for each of the five reports. While there may be little of surprise about the themes, it is important to recognise that they are based on current observation, so this series is not a definitive guide to good management.

Much of the focus and energy for NHS leadership has understandably concentrated on making improvements in those trusts where performance is below average. This often means the best organisations are left to get on and move their organisations forward as they see fit.

Being left to make your own way can lead to isolation. It is often difficult to find out what is going on in other high performing organisations. This series is designed to help people get a better understanding of what is happening in other trusts by sharing case studies that highlight what organisations have already achieved.

What makes a top hospital: the observed themes

Quality and change
- Cost reduction through quality improvement
- Disciplined execution of change at scale
- Using data for improvement, not judgement

Safety
- "Getting to zero" – zero tolerance of harm
- Deliberate focus on reducing mortality and on other safety measures

Leadership
- Strong, stable leadership with continuity of chief executive
- Distributed leadership model that empowers clinical leaders and shifts power to patients and their families
- Investment in development
- The totality of the approach

Organisational culture
- Profound sense of mission and direction
- A mobilised workforce with a passion to get things right for patients
- Defining and promoting values and living them every day

External influence
- Seeing the hospital as part of the wider community
- Corporate social responsibility
- Risk sharing with commissioners
- Learning from other healthcare providers and other industry sectors
- Comparison not just with peers but worldwide

Executive summary

There is extensive debate about how we should define leadership and, indeed, which styles of leadership can contribute to better performance. However, if we do seek a definition, it becomes clear to all of us involved in assessing top performing NHS trusts that the individuals running them share a number of key qualities.

These leaders tend to have been in the same post or at the same organisation for a number of years – usually a decade or more. They are therefore able to provide strong and stable leadership, which in turn means they are respected throughout the trust.

They understand that they do not have the entire skillset necessary to run the organisation from the top down. Autocratic leadership is not a guarantee of top performance, and bringing in the right talent to fill gaps is something these leaders do naturally.

The best leaders appreciate the importance of defining and communicating a vision for their organisation. This vision, or narrative, is often delivered hand-in-hand with the devolving of power to those able to make the changes that will help the trust meet its objectives. Forward-thinking leaders do not hoard power but share it instead; they ensure that everyone working for the trust feels they are supported to make changes to the way services are delivered. This distributed leadership model often starts with senior clinical staff but will include people working throughout the organisation's structure. Involving patients in the design of care pathways is also part of distributed leadership. This level of empowerment is not yet widespread in the NHS but where it does exist, the organisation benefits. We believe that focusing on listening to patients is going to be the key for the next generation of top performing trusts.

Sustained performance relies on giving upcoming leaders the support they need and also helping newly empowered staff with training and development. These leaders recognise the need to invest in development – especially for clinical staff, who can find the world of management alien to them. The NHS is facing budget constraints but the best leaders are finding ways to tread the path between nurturing talent and controlling their budgets.

Crucially, these leaders are able to make sense of the changing world in which NHS trusts operate and then put this in context alongside the day-to-day challenges their organisations face. This totality of approach is what many argue is lacking in the majority of NHS trusts.

All these elements can be found in different degrees within top performing trusts. However, the historical development of the NHS and the structures in place often work against leaders who try to incorporate them into the way they work. The way the NHS has been run – from the top down – has encouraged a style of management that is described in this report as 'learned helplessness'. If the NHS is to meet the challenges it faces, it is the responsibility of every leader to shake off the past and learn from those who embody these key qualities.

Introduction

The question of motivation is at the core of how we lead in difficult times. You don't really have to be as motivated to lead when times are easy. But the next decade of leadership within the NHS is going to involve some very hard tasks and those at the helm will only succeed if they really want to lead. In the next 10 years, NHS leaders won't just be in the role for the salary or the pension; their motivation to steer their trusts through tough times will have to stem largely from strong values about socialised healthcare.

Over the next decade, the level of change dictated by the economics and the politics of the NHS will be considerable. But even that will be insignificant compared with the change that will take place in medicine and methods of healthcare.

To succeed in this environment, a leader will have to learn to transform the organisation from one that is largely concerned about its real estate into one that will win favour with the public and with patients through the application and development of the most advanced knowledge and the prioritisation of convenience.

Intellectually, we already know that most NHS healthcare takes place away from clinics and surgeries, in people's homes. Good leaders will learn to create better health outcomes around the lives that patients lead. To improve the efficacy of the NHS, good leaders will have to encourage staff to make sure that patients themselves can add value to their care.

Above all, the leaders best equipped for the challenges ahead will need a combination of strength and agility: strength to pilot more change over the next decade than we have had in the past three; and agility to ensure healthcare organisations will be able to evolve quickly into the new and different forms that emerge. Some of this can be achieved by learning from colleagues within the NHS, but we will also need to look to external organisations for guidance.

Paul Corrigan
Chair of the CHKS Advisory
Board, management consultant
and an executive coach

The importance of strong, stable leadership

It is often said that the 'half-life' of an NHS chief executive is around 400 days. Yet it is widely recognised that the best-performing organisations are those where there is strong and stable leadership. This is reflected in the experience of the judges of the *HSJ* Acute Organisation of the Year award. Those trusts commended by the judges all had chief executives who had been in post for more than 10 years. This is also a feature of the trusts that have won awards in the CHKS Top Hospitals Programme.

Professor Naomi Chambers, co-author of *Spot the Difference: a study of boards of high performing organisations in the NHS,*[1] carried out a study that supports the view that longevity in senior management roles is an important factor for high performing trusts.

Professor Chambers and colleagues from Manchester Business School wanted to test the idea that if they examined top performing organisations, they would find stable leadership teams. They identified the top 19 NHS organisations in England using a combination of measures. Metrics over several years were examined to exclude the influence of chance, and unsustained high performance. Then, using publicly available information including analysis of board agendas and minutes, the key features of these boards were compared with other NHS organisations. A number of positive links were found between high performers, which included having a chief executive in post for more than four years.

Given that there is a link, it is worth noting that only a minority of NHS leaders have been in the same post for a number of years. The NHS, however, is not alone in this. Professor Chambers comes across a similar pattern in the military when teaching senior officers from the armed services who are transitioning out into civil or public service. "Their experience of leadership in the armed services is striking," she says. "They say that senior officers too often don't stay around long enough to live with the consequences of their grand plans. There are plenty of glorious strategies but it is left to others to come in, pick up the pieces and deliver on these."

Professor Chambers fears that stable leadership is also at risk from what she calls the 'inverse leadership law', similar to the inverse care law, whereby those most in need have poorer access to care. The inverse leadership law suggests the best leaders are drawn to top NHS organisations.

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> **Stephen Thornton, Health Foundation**

She argues that although these top performers attract attention, there is a lot of work to be done to take organisations from poor to good. "Often with poorly performing organisations, you have a situation where, for a variety of reasons, the trust has been in trouble for decades and the sort of managers it attracts are not able to improve the situation. It's much easier to move from good to excellent than from poor to good," she says .

Jan Filochowski, chief executive of West Hertfordshire Hospitals NHS Trust, has a reputation as a leader who is brought in turn organisations around. He agrees that, all too often, leaders find themselves drawn to top performing organisations, like teaching trusts. As for the link between stable leadership and performance, he believes it is highly plausible.

"Certainly if you look at the NHS leaders who are around now, not many have been in post, or at the same organisation, for a significant amount of time. The NHS also suffers from that irresistible penchant for reorganisation. At the same time, there inevitably comes a point when individuals become less effective," Filochowski says.

Personal experience has shown Professor Chambers that healthcare systems outside the UK are surprised by the high level of turnover at senior level in the NHS. She cites the example of childrens' services in the Netherlands, where it is common for senior management to be in place for 20 years. However, there is a balance to be struck. "There is a danger of staying on too long, which is why boards are so important because they can tell a CEO that it's time to go," she says.

As for the UK, she says two of the trusts that stood out for her were Derby Hospitals NHS Foundation Trust and Newcastle upon Tyne Hospitals NHS Foundation Trust. "One of the characteristics in these organisations does seem to be stability of leadership," she emphasises.

Stephen Thornton, chief executive of the Health Foundation, also cites the example of Newcastle Upon Tyne. "Two recent visits have been to Newcastle and University College Hospital London, where the chief executives in question have been in post for many years. I cannot but feel that this has had a positive effect on these institutions' sustained excellent performance," he says.

CASE STUDY 1
Diane Whittingham, chief executive, Calderdale and Huddersfield NHS Foundation Trust

Diane Whittingham was appointed to lead Calderdale and Huddersfield NHS Foundation Trust in April 2001. She has more than 30 years' experience of health service management and has previously worked in the West Midlands, Manchester and Lancashire.

"I believe stable leadership is a key issue," she says. In addition to her role in West Yorkshire, Whittingham was brought into manage a transitional period at East Lancashire Hospitals NHS Trust. "The trust had seen six chief executives in as many years and I found that it was an organisation devoid of vision. It was noticeable by its absence.

"What stable leadership does for an organisation is to set the tone, style and culture. It's not just about what you do but how you do it – about the values that you want the organisation to hold.

"The first thing I did was talk to people so that I could listen and hear their story. From there, I started working with individuals to build on what was going right, focusing on the trust's strengths and at the same time working out what we needed to do to plug any gaps."

Whittingham highlights the importance of developing a new narrative focused on quality. "We also started talking about the vision for

the organisation, which was built around it being an integrated care organisation," she says. "This meant we could put in place a strategy to take over running community services from the PCT."

This change in focus has meant that East Lancashire Hospitals NHS Trust has started to reach out into the community and is placing itself at the centre of a 'healthcare group'. Whittingham describes this as a number of organisations working together as preferred partners for the benefit of each organisation. "We have now created a vision that is owned by others and can be constantly refreshed."

Newcastle upon Tyne Hospitals NHS Foundation Trust's chief executive is Sir Leonard Fenwick. Sir Leonard has worked in the NHS since he joined at the age of 18 as a management trainee at the Newcastle General Hospital. He went on to become senior management lead of the Freeman Hospital and then, in 1977, was appointed as chief executive when it successfully became The Freeman Group of Hospitals NHS Trust. Ten years ago, a merger of the three teaching hospitals in Newcastle led to the birth of The Newcastle upon Tyne Hospitals NHS Trust. Newcastle was one of the first trusts in the country to achieve foundation status.

Stable leadership brings with it a number of benefits. The loyalty of staff is one factor that is often attributed to the fact that a leader has stayed with an organisation for many years. It is argued that someone who begins their career in a junior post and works their way up is likely to have a sound understanding of what drives staff at all levels within the organisation and therefore commands greater respect. Professor John Burn, lead clinician for NHS North East, who has known Sir Leonard for many years, believes his long service is important in this respect. "His rise through the ranks ensures he has the respect of the legion of unsung, and often lowly paid, staff who keep the hospital running," says Professor Burn.

Strong leaders also have to gain the consent of staff to be led – which has given rise to the concept of followership. It is often said that the essence of a good leader is someone who encourages others to follow. In their paper *Followership in the NHS*[2], Keith Grint and Clare Holt argue that: "To focus upon leadership, and a particular form of leadership, is to underestimate the role of followers." With this in mind, it seems clear that stable leadership is of increasing importance to the NHS, particularly in view of the rocky road to be travelled over the coming years.

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What stable leadership does for an organisation is to set the tone, style and culture. It's not just about what you do but how you do it – about the values that you want the organisation to hold

Diane Whittingham, Calderdale and Huddersfield NHS Foundation Trust

What is leadership?

There are many definitions of leadership and almost as many theories about leadership styles. The impact of leadership is also something that is hotly debated. One of the most-cited definitions is from John Kotter, who contrasts management processes that are concerned with planning, budgeting, organising, staffing, controlling and problem-solving, with leadership processes that involve establishing direction, aligning people, motivating and inspiring.

Distributed leadership

A common thread to emerge from the CHKS Top Hospitals Programme awards and interviews relating to the *HSJ* Acute Organisation of the Year award, was that top performing leaders share responsibility with empowered staff, including clinicians.

Organisations that are able to ensure that staff have responsibility, autonomy and support have always been among the successful trusts in both awards. There is a great deal of support for the link between this distributed leadership and performance. The report of the King's Fund Commission on Leadership and Management in the NHS, *The future of leadership and management in the NHS: No more heroes*[3] goes a step further, stating that high performance *requires* distributed leadership, including clinical champions. "Effective leadership for improvement requires engaging doctors to participate in redesign efforts and to build support for these activities among their colleagues," the report says.

King's Fund chief executive Professor Chris Ham is a firm believer that leadership is an important ingredient when it comes to making a top hospital. However, he points out that top performing organisations often demonstrate collective leadership, rather than heroic leadership. "A good leader is someone who engages from the board to the ward. They will have good clinical leaders and great managerial support behind them," he says.

Professor Ham is convinced there is no single leadership style that works the best, believing there is a great deal of variation between good leaders. However, the King's Fund report suggests there are common characteristics and that being able to work well with colleagues and recognising that you cannot do everything yourself are among them.

In *Healthcare Management*[4] Professor Naomi Chambers highlights six leadership and governance challenges (see box, page 10). One of these is the 'Power of the professions: need

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CASE STUDY 2

Liz Childs, deputy chief executive and director of nursing, South Devon Healthcare NHS Foundation Trust

Distributed leadership is something that runs to the core of South Devon Healthcare NHS Foundation Trust. As Liz Childs, deputy chief executive and director of nursing, explains, the management team has been extended to include three associate medical directors and other key clinicians. The approach has been to turn the traditional model on its head, in that clinicians lead with management support.

"Getting medical staff engaged is a priority for the NHS because they carry ultimate accountability," she says. "We think it's important to have medical staff involved in all our major decisions. For example, when it comes to our cost-improvement programme, our starting point was to ask clinicians for the key areas where we could redesign care so that harm could be reduced and care could be delivered in a more efficient way."

To help senior clinicians understand the imperative for efficient working, the trust has sent them on 'lean management' courses. Once they capture the essence of lean management, they will drive change in clinical practice. It is then up to the organisation's leaders to support the clinicians and help make this change happen.

Childs cites the example of the fractured neck of femur pathway, where the clinicians have helped to redesign care to benefit patients and make best use of their time. Ambulance crews phone ahead when they have a patient and they are met at the door by clinicians, who ensure the patient is escorted through the new pathway, with the aim of operating the same day.

For South Devon, this is an important pathway because of its relatively high proportion of elderly people. "We are now treating patients in a timely and safe way and at the same time

making better use of our resources. The change is not driven by the need to release cash, but shorter stays and more efficient use of expensive resources such as theatres and clinicians does deliver cash benefits."

The next logical step for distributed leadership is to shift power to patients and their families. Childs explains that the trust has already started working with patients through its simulation unit. "Simulations are used to take patients through different pathways to explore what to them are the important aspects of care, so that we can get it right first time.

"All this work engages the right people," says Childs. "As a leader, it's really motivating because you see clinical staff re-energised. It helps to create a 'can-do' culture by giving clinicians the autonomy to provide good care, with managers supporting the whole process."

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for negotiation and influencing skills rather than command-and-control approaches'. Professor Chambers says professionals, particularly doctors, who deliver the services can sabotage attempts to make changes if they make no sense to them. "The only realistic way forward is through co-ownership, management by influence and distributed forms of leadership," she says.

"An effective leader is able to receive as well as transmit. Some good leaders still need to accept the challenge – to listen well. This is the difference between a good leader and an excellent leader. A really excellent leader is able to ask questions and listen to the response without worrying about being caught out. He or she is able to recognise and respect the range of different skills in their clinicians and non-execs. Excellent leaders appoint people who are intelligent and who can complement their weaknesses."

Recent work by McKinsey and the Centre for Economic Performance at the London School of Economics, *Management in Healthcare: Why good practice really matters*[5], found a link between the extent to which leaders distribute autonomy and the performance of a trust. The work was part of a joint project set up in 2001 to determine whether management practices were likely to have a strong effect on performance. There was a belief that this effect might be stronger than other factors that determine success, such as national culture, market conditions and regulation.

In 2006, the project team began to examine the performance of healthcare providers. Initially, 104 NHS hospitals and 22 private hospitals in the UK were included in the research but in 2009 this was extended to 1,194 hospitals in the US, UK, Canada, Sweden, Germany, France, and Italy. The team used scoring to determine performance and found that higher-scoring hospitals gave managers higher levels of autonomy than lower-scoring ones.

Six system and leadership/governance challenges in healthcare

- Financial pressures: need for comprehensive controls
- Quality and safety of care: need for good systems and implementation
- National and local politics: need for astuteness over competing forces
- Consumer demands: need for prioritisation tools and patient focus

- Power of the professions: need for negotiation and influencing skills rather than command-and-control approaches
- Complexity of the health system: need for inter-organisational governance and collaborative leadership

Healthcare Management, 2nd Edition: Chapter 19 Leadership and Governance, page 378w

CASE STUDY 3
Ann Farrar, chief operating officer, Northumbria Healthcare NHS Foundation Trust

Ann Farrar, chief operating officer, Northumbria Healthcare NHS Foundation Trust has a highly specific challenge as a leader: she has to ensure that services across a large rural area meet expectations when it comes to equity of service and access. For her, distributed leadership is vital.

"It means having local clinical managers who can be innovators in terms of clinical practice," she says. "A good leader encourages clinicians by empowering them to come up with ideas that match the vision. This is, of course, subject to challenge by clinical colleagues and requires an open and safe culture," she says. Farrar is in favour of trying ideas out to assess whether they are working to everyone's advantage before starting to embed them into the organisation.

As for vision, Farrar insists this is the only way to engage staff. "A good leader is someone that is visionary and can energise the organisation to move forward and develop ideas. They will enable teams to work together to make a positive contribution. It's also about filling the gaps and putting in place a team that has a mixture of skills and talents."

The Health Foundation's Stephen Thornton brings this back to the role of the leader. "Exemplary top leadership in healthcare is about ensuring you have the right team in place, then backing your clinical leaders to transform care themselves," he says. He adds that University College London Hospitals' chief executive, Sir Robert Naylor, "displays this in spades".

Tony Spotswood is chief executive of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, a previous *HSJ* Acute Organisation of the Year award winner. He has made distributed leadership a priority. "One of the things I focus on is enabling others to have scope, power and resource to get on and make changes," he says.

Stephen Ramsden, former chief executive of Luton and Dunstable Hospital NHS Foundation Trust, sees distributed leadership as critical, and believes that good leaders use a vision to engage and empower staff.

"Distributed leadership is crucial. You need to be systematic and get the message across," he says. "For me it is about having a compelling mission, owned with passion and authenticity. Gandhi said you need 'to be the change you want to see', and that has been a big influence on me."

This point of view is supported by Sue Hodgetts, chief executive of The Institute of Healthcare Management. She says: "When I come across a good leader, I expect to find someone who is authentic and who is able to get across a consistent and coherent message. There is also a degree of humility and I would expect them to talk about the organisation before they talk about themselves."

The King's Fund's Leadership Commission defines leadership as: "The art of motivating a group of people to achieve a common goal." It says this demands a mix of analytical and personal skills in order to set out a clear vision of the future and define a strategy to get there. This must be communicated to others and the skills must be assembled to achieve it.

Communicating this vision is something in which Ramsden invested heavily while at Luton. Telling the transformational story became a major part of his life and he believes it was a key

CASE STUDY 4
Getting the vision right: Derby Hospitals NHS Foundation Trust

Derby Hospitals NHS Foundation Trust serves a population of more than 600,000 people in and around southern Derbyshire. It has developed a vision that has reached into every part of the trust and is at the forefront of staff and patient engagement. The trust's vision is based on five objectives, which are represented by the word PRIDE, which stands for: Putting patients first; Right first time; Investing our resources wisely; Developing our people; and Ensuring value from partnerships.

Chief executive Sue James, who joined the trust in January this year, says: "PRIDE was a way of using a mnemonic that encapsulated our strategy for the organisation. It has been very

valuable for me in terms of how I have begun to engage with the organisation."

James says that PRIDE has also helped to engage staff and has provided a vehicle for explaining the trust's future plans. Its annual plan uses PRIDE as a starting point and helps to explain where the organisation is heading in a straightforward way.

After she joined, James set up a 150-strong leadership community within the trust – clinical leaders and senior management at grade 8A or above. She worked with this leadership community to create a podcast explaining the annual plan, and the financial challenges facing the trust. Members of the leadership community

then held roll-out events with their own teams, to which executive directors were invited.

"The events were designed to help staff understand where they felt they could contribute to the corporate objectives and what initiatives they could come up with to help us meet our financial challenges," she says.

"We were delighted with the response and managed to reach 2,500 members of staff within six weeks. We are now going through more than 1,000 cost-reduction suggestions that we received. We will then work with the members of staff on selected suggestions to support and train them so they can bring about the change they envisaged."

contributor to the successful patient safety transformation."I spent two years telling the same story to 3,000 staff. It's about changing beliefs and behaviours. It has to be cascaded throughout the organisation systematically," he says.

Some argue that a good leader has to go beyond empowering clinical and other staff; patients should also be given responsibility and the power to influence decisions. Conflict in most trusts has focused on the line between managers and clinicians but there is evidence to show that this conflict can be resolved if patients are put first and power is shared with them. Leading trusts are starting to ask how patients can be involved in the design of care pathways.

Ramsden acknowledges that progress is slow on this front. "Most leaders pay lip service to it and I don't think we've yet seen it happen by and large. Patients are starting to be given more control in decision making but power is a two-way thing – leaders need to be truly influenced by patient stories and clinicians need to cede power to their patients."

His own father's death helped Ramsden see how patients and relatives struggle to navigate the system. "It's a different matter when it happens to your loved ones. We have to personalise care and get staff listening to patient stories and then feel they are in a position to do something about it. If a patient asks 'who is in charge of my healthcare?', the answer should be the patient."

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Patients are starting to be given more control in decision making but power is a two-way thing – leaders need to be truly influenced by patient stories and clinicians need to cede power to their patients
Stephen Ramsden, Transforming Health

CASE STUDY 5

Changing the narrative in a failing organisation

Jan Filochowski, chief executive at West Hertfordshire Hospitals NHS Trust, has first-hand experience of what it feels like to work in an organisation where there is either no narrative, or one that has become negative.

"When I came to West Herts, not only was the narrative missing but we had a string of missed performance targets. The financial situation was dire and we had poor morale with no coherence around staff and patient engagement.

"In fact there was a destructive narrative, which you can completely understand."

Filochowski says the new narrative that had been developed around failure was about how unreasonable and unfair the situation had become. Turning this on its head meant altering the sense of ownership and accountability. He points out that in a failing organisation, it is often the case that individuals simply opt out and retreat into their own corners, minimising their responsibility.

"When I've gone into these organisations, the first thing I've done is talk to staff to get an informed view about what needs to change. People will have their own bias but you have to see beyond that. The next step is to test this out and gather support and build confidence. But in every failing organisation, the leader has to be proactive in shaping the narrative. It is important to have a narrative about how we want patients to see the organisation and how we want staff to engage with them."

Investment in development

The *HSJ* Acute Organisation of the Year award judges have always found that the best leaders make sure there is good staff development in their organisations. This has also been true of the trusts that have regularly appeared in the annual CHKS Top Hospitals Programme 40Top awards. Two examples are Calderdale and Huddersfield NHS Foundation Trust, where all staff are encouraged to have at least NVQ levels 1-4, and Aintree University Hospitals NHS Foundation Trust, which has developed an executive leadership programme including talent management and succession planning (see case study 6). A common factor among commended trusts was that every staff member is put through learning programmes, so all feel valued.

The Institute of Healthcare Management's Sue Hodgetts says: "Great organisations have great leaders at all levels. Successful organisations seek to build leadership capacity widely and give people the opportunity to develop it."

Training and development should also feed into the staff appraisal system, which in turn can be linked to an organisation's value and mission statements. High performing organisations express these values in a number of different ways – some even put them on staff ID cards.

However, making a commitment to training and development can be tough, especially when budgets are constrained. Professor Chris Ham, of the King's Fund, believes that the NHS as whole is still not doing enough for leaders of the future. "We have made some progress with the National Leadership Council and The Gateway to Leadership Programme. These are welcome but we must not slacken the pace. There is a real risk that, as the money gets tight, funding for this type of support will run out," he warns.

Stephen Ramsden, of Transforming Health, is concerned that many NHS leaders show a degree of 'learned helplessness'. He describes this as a situation where chief executives and other local leaders have become so used to being told what to do that they are often simply the outpost of NHS Headquarters and spend most of their time on external requirements rather than on what may be more important for their organisations. The notion of succession planning through the development of talent is not a natural fit under such circumstances.

Hodgetts is pragmatic about the challenges facing trusts. "This isn't the time to send people away for weeks at a time. Trusts need to find something inspirational and effective. At the same time, if you slash your learning and development budget you really are on a hiding to nothing."

CASE STUDY 6

Building an executive leadership programme

Aintree University Hospitals NHS Foundation Trust has developed an executive leadership programme that includes talent management and succession planning. The five-stage, 12-month programme is designed to build on the existing strengths of the executive team. However, it is also designed simultaneously to address Aintree's future leadership needs by incorporating a talent management approach for those at the next layer down. Ray Pendleton, director of organisational development at the trust, says: "This will future-proof Aintree's leadership needs and help retain the talent we have by visibly nurturing and investing in it. The programme also offers a blended learning approach, tailored to the unique challenges Aintree faces.

"This will mean more emphasis on 'live learning' – supported learning in the workplace – rather than relying on the learner to translate complex classroom theory and methodology back into the workplace alone."

The totality of the approach

One common theme that is evident across all top performing trusts is that effective leaders make decisions that reflect the trust's overall direction of travel while having the ability to take complex challenges and make them easy to understand. In short, they take the totality of the organisation's activities and condense them into a simple approach to which staff and patients can all subscribe.

The Institute of Healthcare Management's Sue Hodgetts believes that leaders in the NHS face a set of challenges that does not exist in other areas of business. "There is something unique about the NHS which has arisen because its values have been expressed through a political process and defined by legislation. This means NHS leaders in turn have to deal with political process, reform and highly sensitive issues. Good leaders are able to make sense of this and the day-to-day operational issues by looking upwards to government, outwards to the community and inwards to their own integrity."

Helen Bevan, director of service transformation at the NHS Institute for Innovation and Improvement, agrees, saying this is precisely why the role of NHS leaders is critical. "Leaders translate the reform agenda into local goals, design and implement change processes and create meaning and context for individuals."

Bevan distinguishes between those leaders who have a 'first-order' change mindset and those with a 'second-order' change mindset. "Many NHS leaders, locked into the daily struggle of achieving activity levels and quality standards within financial constraints, operate with a first-order change mindset; the future is viewed as 'more of' or 'less of' what currently exists."

Successful organisations, on the other hand, are led by those who have a second-order mindset, she suggests. "From my experience, the leaders who will be most successful in the new world NHS are those who think and operate in a second-order way. The role models for this

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> Having a leader who paints a picture of a radically different future leads to staff who are more positive. They create an appetite for change and build the capacity of their organisation to anticipate, heighten and deliver its positive potential
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> **Helen Bevan, NHS Institute for Innovation and Improvement**

leadership approach are already there in our system. The leaders who stand out have a greater level of optimism about the future and about what they and their organisations can achieve."

Bevan believes these leaders share the ability to create a compelling picture of the future. This enables the people who work in their organisations to see their own situation in a different light and more readily embrace change on a personal level.

The fact that there is a significant difference in the way that organisations implement specific system-wide changes backs up her assertion. Bevan says: "The extent to which a senior leader has a positive, future-focused perspective is in turn reflected in the operating model and strategy the leader adopted. You often find this model is associated with the extent to which other people in their organisations are optimistic and personally committed to building a different future."

"Put more simply: having a leader who paints a picture of a radically different future leads to staff who are more positive and more ready for change. They typically don't focus on mistakes and shortcomings of individuals but on strengths and potential. They create an appetite for radical change and build the capacity of their organisation or system to anticipate, heighten and deliver its positive potential," she says.

Bevan laments the fact that this type of leader is in a minority in the NHS but says where they do exist, they are associated with top performing trusts. A culture characterised by optimism and hope is associated with better performance, greater perseverance in the face of challenge and a better mood at work. There are two suggested reasons for these outcomes. First, such a culture has an amplifying effect; it leads to positive emotions and higher-quality relationships, and encourages individuals to behave in ways that benefit others. Second, it buffers organisations, enabling them to absorb misfortune and maintain momentum at difficult times.

CASE STUDY 7

Tony Spotswood, chief executive, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust provides healthcare for the residents of Bournemouth, Christchurch, east Dorset and part of the New Forest, with a total population of around 550,000. Some specialist services cover a wider catchment area, including Poole, the Purbecks and south Wiltshire. The trust gained foundation status in 2005.

Tony Spotswood is used to simplifying complex messages and in doing so has successfully transformed the trust into an organisation that is very different from the one he first joined in 2000. "We have been able fundamentally to change the way the trust works," he says. "We had a trust with 900 beds, which has now been reduced by 200 beds with the support of our doctors and other clinicians, who were all involved in looking at different pathways of care. This has meant reducing length of stay and providing rehabilitation in the community."

The trust has introduced NHS dentistry and is looking to put in place a nursing home. In short, Spotswood says, it has "fundamentally changed how the hospital is regarded by the community".

Spotswood's role as leader throughout this process has been pivotal and he says that he led and "fronted up" the public consultation, as well as dealing with external stakeholders such as local GPs. "It took a lot of time and effort but the benefits are significant. You have to put in the hours and the hard yards," he says.

Support for future leaders

The Institute of Healthcare Management (IHM) is the professional organisation for managers and leaders in the UK health and social care sector. Chief executive Sue Hodgetts says the institute's accredited manager programme was initiated in response to the unique challenges faced by NHS managers. This programme has been developed to provide a robust and explicit way of demonstrating a manager's individual competence and fitness for purpose across '11 behaviours of quality management' within the ever-changing context of health and social care.

Hodgetts says: "Effective leadership is hard. We should never underestimate the amount of effort and energy required or the skills and knowledge required. True leadership is evident through the behaviour of an individual. Good leaders will be measuring themselves, and a robust way to do this is to look at the 11 behaviours that make up the IHM accredited manager award."

Hodgetts asserts that the award is not just for executive and senior managers, but is also available for middle and frontline managers. It provides a career framework for managers that requires reaccreditation every three years. "This is about continuous professional development, ensuring currency and competence for all managers," she says.

The 11 behaviours are as follows:
- Contextual leadership
- Managing the political and stakeholder environment
- Putting safety first
- Building winning teams
- Communication and relationship management
- Improvement and innovation
- Integrating equalities and diversity
- Reflection
- Governance

Julie Hyde, the institute's director of education and professional development, says: "The programme is not a taught course. Candidates enter the programme at the level of their experience and they achieve the outcomes via reflection on their activity against the 11 behaviours. It is well documented that if managers do go away on 'a course or degree' learning about the theory, there is no impact on the workplace, and the learning may never be applied." Hyde says it is the reflection on behaviour that aims to develop and enhance leadership.

The NHS Institute for Innovation and Improvement has developed a learning programme for leaders, which is part of a focus on leadership for improvement: inspiring senior leadership in order to transform quality of care. This is part of its wider support for organisations, teams and individuals to achieve transformation through quality, innovation, productivity and prevention.

The NHS Board Development Tool (BDT) is a facilitated diagnostic tool that provides a framework for reviewing and improving the effectiveness of boards in NHS organisations. Based on robust research, the BDT draws on evidence from the NHS, as well as the public and private sectors, to measure the characteristics of high performing boards. Boards are challenged to consider how they operate as a corporate entity, in order to find ways to enhance their effectiveness. There are several versions of the BDT, tailored to the type of organisations undergoing review, including foundation trusts.

Resources

Provider	Type of support	Links	Contact
NHS Institute for Innovation and Improvement	A range of interventions to help build leadership capability and capacity across the NHS	www.institute.nhs.uk/ building_capability/general/ leadership_home.html	leadership@institute.nhs.uk
National Leadership Council	Supports and strengthens outstanding leadership within the NHS	www.nhsleadership.org/ about.asp	leadershipcouncil@dh.gsi.gov.uk
NHS Gateway to Leadership programme	Takes talented senior managers, already leaders in their field, and gives them the opportunity to use their skills and experience to make a difference	www.nhsgatewaytoleadership. co.uk/	gateway@lead.institute.nhs.uk
Institute of Healthcare Management accredited manager programme	Provides a robust and explicit way to demonstrate a manager's competence and fitness for purpose	www.ihm.org.uk/education/ accredited_manager_ programme/	education@ihm.org.uk
The King's Fund	Development programmes for individuals and boards	www.kingsfund.org.uk/ leadership/	leadership@kingsfund.org.uk

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It is well documented that if managers do go away on 'a course or degree' learning about the theory, there is no impact on the workplace, and the learning may never be applied

Julie Hyde, Institute of Healthcare Management

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