Leadership in the NHS
Roger Kline

INCLUSION: ESSENTIAL LEADERSHIP PREREQUISITE OR OPTIONAL EXTRA?

In healthcare, leadership is decisive in influencing the quality of care and the performance of hospitals. How staff are treated significantly influences care provision and organisational performance so understanding how leaders can help ensure staff are cared for, valued, supported and respected is important. Research suggests ‘inclusion’ is a critical part of the answer.

Inclusion may be regarded as the extent to which staff believe they are a valued member of the work group, in which they receive fair and equitable treatment, and believe they are encouraged to contribute to the effectiveness of that group. Inclusive workplaces and teams value the diversity and uniqueness that staff bring and seek to create a sense of belonging, with equitable access to resources, opportunities and outcomes for all, regardless of demographic differences. Inclusive organisations are more likely to be ‘psychologically safe’ workplaces where staff feel confident in expressing their true selves, raising concerns and admitting mistakes without fear of being unfairly judged.

In hospital settings, managing staff with respect and compassion correlates with improved patient satisfaction, infection and mortality rates, Care Quality Commission (CQC) ratings and financial performance as well as lower turnover and absenteeism. By contrast, ‘disrespect’ in medicine is a threat to patient safety because ‘it inhibits collegiality and cooperation essential to teamwork, cuts off communication, undermines morale and inhibits compliance with and implementation of new practices’. Yet, 24% of NHS staff in England report that they are subject to bullying, harassment or abuse by fellow workers and managers, impacting on increased intentions to leave, job satisfaction, organisational commitment, absenteeism, presenteeism, productivity and the effectiveness of teams, costing the NHS at least £2.28 billion annually.

The NHS has an extraordinarily diverse workforce, but workforce and NHS staff survey data show many staff experience systematic discrimination in many aspects of their NHS working lives notably in recruitment, development, disciplinary action and through bullying which are likely to adversely impact on patient care and safety.

The NHS is a complex archipelago of national and local bodies, networks, commissioners, regulators and providers. Though the Health and Social Care Act 2012 changed the relationship between Ministers and Arm’s Length Bodies, it made little change to how the NHS workforce was managed and led with a continuing stream of expectations, requirements, targets, inspections and funding decisions which fundamentally influence workplace culture and leadership. The dominant cultures within those national bodies deeply influence behaviours and priorities at local level. Robert Francis blamed the failings of Mid Staffordshire Foundation Trust on an institutional culture which put the ‘business of the system ahead of patients’. Evidence to his Public Inquiry concluded there was a ‘pervasive culture of fear in the NHS and certain elements of the Department for Health. The NHS has developed a widespread culture more of fear and compliance, than of learning, innovation and enthusiastic participation in improvement’. Top-down management, exacerbated by government policies, contributed to widespread poor treatment of staff. There was a failure to mitigate that poor treatment.

WHY?

The first reason was denial. In his Public Inquiry report, Francis concluded that ‘there lurks within the system an institutional instinct which, under pressure, will prefer concealment, formulaic responses and ‘avoidance of public criticism’ and ‘an institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern’. The pressure to send ‘comfort seeking’ rather than ‘difficult’ information upwards is strong. Example: 2 years after the Francis Report, when presenting a Trust Board with their own (dreadful) data on race equality, one Non-Executive Director asked where ‘my’ data came from. I explained it was from the Trust’s own web site. The Board had not been told.

The second, linked, reason is that we often struggle to have honest conversations when ‘mistakes’ or poor behaviour occur, whether about bullying or racism or in appraisals or feedback. We may prefer (in society, in workplaces, in teams) to live in false harmony since any type of change creates conflict even though sustained efforts to address conflict can pay dividends for staff and care. The result can be doubly challenging—staff who are unable to share their concerns and managers anxious about even seeking them or having honest informal conversations as ‘protective hesitancy’ is triggered, since both may not feel it is ‘psychologically safe’ to have such discussions. Without trust, people may just ‘shut down’ leaving no capacity to have honest conversations or be vulnerable, critical in examining options in, for example, clinical decision-making.

The third reason is the mismatch between demand and resources. Two decades of ‘control totals’, ‘savings targets’ and staff shortages have left local leaderships under immense pressures, often fearful of blame and knowing senior leader turnover is astonishing. Example: the Mid Staffordshire
Hospitals NHS Trust Board agreed in January 2005 that 180
posts had to go because ‘the trust had a statutory requirement to
break even at the end of the financial year’, yet, when I trawled
through Trust Committee minutes between 2005 and 2008, I
found no mention of the countervailing duty of care to patients
(or indeed staff). Such tensions continue to exist today.

The fourth (crucial) reason is a fundamentally flawed human
resources (HR) paradigm which, until recently, has dominated
much NHS practice on tackling discrimination, bullying, whis-
tleblowing and disciplinary action. ‘Policies, procedures and
training’ have been seen as key to safe, effective means whereby
individual staff can raise concerns about bullying, discrimina-
tion, unfair disciplinary action and unsafe practice. But research
suggests this approach is fundamentally flawed as a means of
improving organisational culture. Such ‘methodological indi-
vidualism’ is underpinned by the individualistic nature of UK
employment law and has dominated the treatment of NHS staff.
A response to bullying that is focused on individualism may also
treat toxic leadership behaviours as the exception whereas data
and research suggests they are widespread. Example: the NHS
Employers guidance on bullying at work (2006–2016) stated
‘employers can only address cases of bullying and harassment
that are brought to their attention’, yet, employers had (and
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that are brought to their attention’, yet, employers had (and
have) a wealth of local data on prevalence which could have
enabled them to be proactive and preventative.

This HR paradigm has also driven the Ministerial response
to whistleblowing, much of which has focused on (unsuccess-
fully) protecting those individuals raising concerns rather than
changing the organisational climate in which such concerns are
ignored or rejected. Similarly, until recently, tackling discrimi-
nation largely relied on individuals raising concerns despite the
likelihood that legitimate complaints would not be upheld and
would certainly not change institutional discrimination. Progress
on the ‘compassionate and inclusive’ treatment of staff may be
seen as too difficult for many teams and organisations, especially
if the behaviours of national bodies do not match their exhor-
tations to local bodies. Yet, the evidence is that when sustained
evidenced interventions, applying ‘human factors’ science and
incentivising a learning culture not blame, replace a retributive
culture with a restorative one, there are very substantial gains
for staff and substantial benefits to organisations, saving 2% of
staffing costs in one Trust.

The fifth reason is that, unlike NHS clinical interventions, we have
too rarely asked of HR interventions ‘why do you think
this is likely to work?’ For example, in response to bullying or
discrimination, the default answer has been more ‘training’. Yet,
the largest study of diversity initiatives found that ‘attempts to
reduce managerial bias through diversity training and diversity
evaluations were the least effective methods of increasing the
Proportion of women in management’. Similarly, Unconscious
Bias Training, widely used in the NHS, may be helpful but the
evidence it changes decision-making is limited. It is difficult to
understand why HR directors and Boards did not ask whether
initiatives on diversity, bullying or whistleblowing were eviden-
tially based.

The final reason has been a failure to systematically use the
decisive influence of management and leadership to help create
a culture in which staff (including managers) are valued and
respected. After all, hospitals with more managers achieve better
clinical and financial performance, higher patient satisfaction
and reduced infection rates than those with fewer managers.

Culture, or ‘how we do things round here’, is shaped by formal
organisational values (NHS Constitution and local policies), by
values, behaviours and knowledge that staff learn, and (crucially)
by how an organisation’s leaders behave. What leaders focus on,
talk about, pay attention to, reward and seek to influence, tells
staff what leadership values they should take note of. Yet, the
NHS Long Term Plan (2019) devotes less than two pages to lead-
ership and talent management.

We know that leaders who demonstrate a commitment to high
quality and compassionate care directly affect clinical effective-
ness, patient safety and experience, the health, well-being and
engagement of staff and the extent of innovation. Evidence of
the links between psychological safety, supportiveness, positivity,
empathy, leadership (in aggregate compassionate leadership)
and innovation is deep and convincing. Without such a focus
teams may be more vulnerable to learnt helplessness or outright
bullying.

A lack of psychological safety, unaddressed conflict and
dissonance between financial and performance targets and the
motivations of staff to care can be demoralising. As one Clinical
Director told me recently ‘staff feel ground down by talk of effi-
ciency and throughput because in a time of resource famine this
can take the humanity out of what we came into medicine to do’.
Such concerns are well captured by Unwin’s focus on embed-
ding relational intelligence (kindness, emotional intelligence) as
powerfully as rational intelligence (regulation, measurement and
efficiency). Leaders who regard staff primarily as a cost rather
than an asset and who fail to listen to the most junior cleaner,
talk with the admin clerk, admit mistakes or engage in repeated
acts of kindness and support are not role models for their staff.
Example: I recall being told by one CEO a few years ago, when I
asked why he hardly spoke with staff as we walked around his
hospital, that if he did that he ‘wouldn’t have time to do his job’.

SO WHAT MIGHT NHS LEADERS DO BETTER?

There is an extensive literature on healthcare leadership, but
relatively little conducted to a high academic standard. We do
know, however, that top-down approaches to leadership are the
least effective way of managing healthcare organisations whereas
inclusive and compassionate leadership helps create a psycho-
logically safe workplace where staff are more likely to listen and
support each other resulting in fewer errors, fewer staff inju-
ries, less bullying of staff, reduced absenteeism and (in hospitals)
reduced patient mortality.

Research suggests that in such an inclusive environment team
creativity improves, innovation is more likely, information is
processed more carefully, risk awareness improves, produc-
tivity improves, turnover declines and where organisational
leadership better represents the diversity of staff, there is more
trust, stronger perceptions of fairness and overall better morale
of staff. Inclusive leadership is more likely to encourage the
patient and carer involvement associated with higher levels
of innovation and improvement, and to promote higher staff
engagement—itself a good predictor of patient satisfaction,
patient mortality, quality of care and staff well-being is higher
and also helps create inclusion.

However, command and control are deeply embedded in
senior NHS leadership behaviours. Status and funding are used
to either support or, in effect, beat up local leaders, confusing
bullying with accountability. The behaviours of national bodies
largely shape what local leaders do or don’t do. Where NHS
trusts are highlighted as being particularly innovative, effective
and safe employers, it is unclear how many of them became so
because of top-down support.

Dixon-Woods et al found that six key elements were neces-
sary for sustaining cultures of high quality compassionate care
for patients: inspiring visions operationalised at every level by leaders; leaders ensuring clear aligned objectives for all teams, departments and individual staff; supportive and enabling people management; high levels of staff engagement; leaders focused on ensuring learning, innovation and quality improvement in the practice of all staff and effective team working. Inclusive leaders help achieve such cultures by providing a limited number of challenging but manageable priorities.

**SOME PRACTICAL STEPS**

**Individuals**

Individual inclusive leaders challenge the status quo and make diversity and inclusion a personal priority. Such leaders do not leave it to those subjected to poor behaviours to challenge them. Such leaders will want to be aware of, and understand, the perspectives and experiences of staff who are ‘outsiders’, facing discrimination, bullying, struggling with unsafe workloads or other pressures. For such leaders, placing themselves ‘in other’s shoes’ can help understand what life is really like in their organisation, department or team.

Such leaders are modest about their own capabilities, admit mistakes, and create the space for others to contribute. They show awareness of personal blind spots as well as flaws in the system and work hard to ensure fairness in all they do. They listen, show deep curiosity, demonstrate kindness and seek to understand those they work with.

**Teams**

Bullying and discrimination create uncertainty, erode self-confidence and undermine the fair and consistent treatment of team members which is crucial to the trust which underpins effective team working. Recognition of the deep human need to belong, and the anxiety everyone may feel when speaking up or sharing ideas in front of others for fear of saying something that may appear stupid or wrong, can help create effective teams.**25** Teams are more inclusive (and effective) when they are clear about their purpose, have a small number of agreed team objectives with regular feedback, clear roles, good information-sharing and a strong commitment to quality improvement and innovation. In such teams, inclusive leaders enable and facilitate discussion and shared decision-making and, however, intense the pressures, ensure teams take time out to reflect on their work such as a Schwarz Round or a postoperative theatre debrief.

**Organisations**

Inclusive leaders apply a similar approach to improving staff treatment as to any other factor impeding good patient care. They listen to staff and patients, understand relevant research, find other organisations successfully tackling similar issues and adapt or adopt evidenced approaches using real-time data from staff surveys, workforce reports, patient feedback, clinical risk indicators and soft informal staff intelligence that may be direct or proxy measures of culture. For such leaders, budget pressures are not simply counter posed to caring for and supporting staff since that approach prevents either being achieved.

A majority of NHS line managers are staff at Band 7 or below. Most managers have both managerial and clinical roles. Many clinicians may not identify as ‘leaders’ but they lead teams. All lead in some way and all need support to learn how best to bring about what can be complex, time consuming and personally daunting challenges. The recent NHS leadership development strategy makes inclusion central to progress and is helpful.**26**

Inclusive leaders understand that while demographic diversity is crucial, inclusion is what helps leverage that diversity. When interventions to improve behaviours and culture are proposed, inclusive leaders ask why they are likely to work, since research suggests many are simply not evidenced. Tackling cultures of fear should be seen as means of improvement not just of statutory compliance. Improvement methodologies can create small but continuous learning and gains, though it remains unclear how much quality improvement initiatives improve quality.**27**

Inclusive leaders adopt a ‘public health’ approach to changing organisational climates and institutional barriers, ending the excessive reliance on responding to individual grievances (policies, procedures and training) and instead are proactive and preventative.

Above all, inclusive leaders understand the decisive importance of their own role and behaviours. Values are central to good leadership. Boards that demand changed behaviours from their managers without modelling those themselves will fail. Example: I remember meeting a past Secretary of State for Health who banged the table as he announced he would ‘stamp out’ bullying. I thought ‘well, that won’t work’. It didn’t.

Leaders have to respond to problems for which there may be well-developed technical responses (eg, managing shift patterns and on call) as well more unpredictable and disruptive challenges (such as a sudden loss of a major contract or a serious outbreak of infection).**28** When resolving the latter type of challenge inclusive leaders draw on diverse knowledge and experience; instead of staff being presented with a predetermined solution cooked up in a dark room, they create a space for collaborative discussion in which diverse staff bring a range of ideas and potential solutions into discussion.

Creating safe spaces, where staff can share concerns in the knowledge they will be listened to and respected for doing so, are essential as NHS leaders grapple with even more complex cross-disciplinary, cross-organisational challenges. The leaders’ primary role is to enable such discussions. The most important person in the room is the one who knows what to do, which may well not be the most senior person present. Effective leaders recognise that all members of the organisation/team play leadership roles at various times in their work. Inclusive teams will also be more likely to recognise that among the most valuable sources of information are the reports and voices of patients, carers and staff. Such teams will be more likely to enable staff to counter pose their professional duty of care to countervailing pressures. Good leaders are effective ‘story tellers’ but such stories best emerge alongside, and often arise from, collaborative listening, including from patients and carers. They understand that ‘the art of leadership lies in polishing and liberating and enabling the gifts of others’.**29**

The evidence that caring better for staff has multiple benefits has grown as service pressures have increased. The 2019 NHS Long Term Plan acknowledges the crucial importance of caring for staff to improve patient care. That will only happen if NHS leaders at all levels speak truth to power and act on the evidence that understanding and enabling inclusion is an essential prerequisite for success, not an optional extra.

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ORCID ID
Roger Kline http://orcid.org/0000-0002-5896-8802

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