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Leadership in the NHS

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bmjleader.bmj.com**INCLUSION: ESSENTIAL LEADERSHIP PREREQUISITE OR OPTIONAL EXTRA?**

In healthcare, leadership is decisive in influencing the quality of care¹ and the performance of hospitals.² 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 difference 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.³

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 performance⁴ 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'.⁵ 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.⁶ 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 workforce 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'.⁷ 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'.⁸ 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.⁹ 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'¹⁰ 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



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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).¹¹ 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, whistleblowing and disciplinary action. ‘Policies, procedures and training’ have been seen as key to safe, effective means whereby individual staff can raise concerns about bullying, discrimination, unfair disciplinary action and unsafe practice. But research suggests this approach is fundamentally flawed as a means of improving organisational culture.¹² Such ‘methodological individualism’ 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.¹³ 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’,¹⁴ 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 (unsuccessfully) protecting those individuals raising concerns rather than changing the organisational climate in which such concerns are ignored or rejected.¹⁵ Similarly, until recently, tackling discrimination 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 exhortations 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.¹⁶

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’.¹⁷ Similarly, Unconscious Bias Training, widely used in the NHS, may be helpful but the evidence it changes decision-making is limited.¹⁸ It is difficult to understand why HR directors and Boards did not ask whether initiatives on diversity, bullying or whistleblowing were evidentially 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.¹⁹

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.²⁰ Yet, the NHS Long Term Plan (2019) devotes less than two pages to leadership and talent management.

We know that leaders who demonstrate a commitment to high quality and compassionate care directly affect clinical effectiveness, 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.²⁰ 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 efficiency 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 embedding relational intelligence (kindness, emotional intelligence) as powerfully as rational intelligence (regulation, measurement and efficiency)²¹ 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.²² 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 psychologically safe workplace where staff are more likely to listen and support each other resulting in fewer errors, fewer staff injuries, less bullying of staff, reduced absenteeism and (in hospitals) reduced patient mortality.²³

Research suggests that in such an inclusive environment team creativity improves, innovation is more likely, information is processed more carefully, risk awareness improves, productivity 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.²⁴ 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—itsself 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 leaderships 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*⁴ found that six key elements were necessary 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 a 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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REFERENCES

- 1 Firth-Cozens J, Mowbray D. Leadership and the quality of care. *Qual Saf Health Care* 2001;10(Supplement 2):ii3–7.
- 2 Shipton H, Armstrong C, West M, et al. The impact of leadership and quality climate on hospital performance. *Int J Qual Health Care* 2008;20:439–45.
- 3 Shore LM, Cleveland JN, Sanchez D. Inclusive workplaces: a review and model. *Hum Resour Manag Rev* 2018;28:176–89.
- 4 Dixon-Woods M, Baker R, Charles K, et al. Culture and behaviour in the English National health service: overview of lessons from a large multimethod study. *BMJ Qual Saf* 2014;23:106–15.
- 5 Leape LL, Shore M, Dienstag J, et al. A culture of respect, part 1 the nature and causes of disrespectful behavior by physicians. *Acad Med* 2012;87:845–52.
- 6 Kline R, Lewis D. The price of fear: estimating the financial cost of bullying and harassment to the NHS in England. *Public Money Manag* 2019;39:166–74.
- 7 Joint Commission International. Quality Oversight in England - Findings, Observations and recommendation for a new model Submission to the DoH; 2008.
- 8 Francis R. Report of the Mid Staffordshire NHS Foundation. Executive summary. Trust Public Inquiry, 2013. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf [Accessed 30 May 2019].
- 9 Latrielle P, Saundry R. *Towards a system of conflict management? An evaluation of the impact of workplace mediation at Northumbria healthcare NHS Foundation trust*. London: Acas, 2015.
- 10 Thomas DA. The truth about mentoring minorities. Race matters. *Harv Bus Rev* 2001;79:98–107.
- 11 Carter B, Kline R. The crisis of public sector trade unionism: evidence from the mid Staffordshire Hospital crisis. *Capital & Class* 2017;41:217–37.
- 12 Evesson J, Oxenbridge S, Taylor D. Seeking better solutions: tackling bullying and ill-treatment in Britain's workplaces. ACAS, 2015. Available: <http://m.acas.org.uk/media/pdf/e/b/Seeking-better-solutions-tackling-bullying-and-ill-treatment-in-Britains-workplaces.pdf> [Accessed 29 May 2019].
- 13 Aasland MS, Skogstad A, Notelaers G, et al. The prevalence of destructive leadership behaviour. *Br J Manag* 2009;15.
- 14 NHS Employers. Guidance: bullying and harassment. 2006 patient safety concerns in intensive care units. *Soc Sci Med* 2017;193.
- 15 Tarrant C, Leslie M, Bion J, et al. A qualitative study of speaking out about patient safety concerns in intensive care units. *Soc Sci Med* 2017;193:8–15.
- 16 Kaur M, De Boer RJ, Oates A, et al. Restorative just culture: a study of the practical and economic effects of implementing restorative justice in an NHS trust. *MATEC Web Conf* 2019;273:01007.
- 17 Kalev A, Dobbin F, Kelly E. Best practices or best Guesses? assessing the efficacy of corporate affirmative action and diversity policies. *Am Sociol Rev* 2006;71:589–617.
- 18 Atewologun D, Cornish T, Tresh F. Equality and human rights Commission research report 113 unconscious bias training: an assessment of the evidence for effectiveness. EHRC, 2018. Available: https://warwick.ac.uk/services/ldc/researchers/resource_bank/unconscious_bias/sub_an_assessment_of_evidence_for_effectiveness.pdf [Accessed 29 May 2019].
- 19 Veronesi G, Kirkpatrick I, Altanlar A. Are public sector managers a "bureaucratic burden"? The case of english public hospitals. *J Public Admin Res Theory* 2019;29:193–209.
- 20 West M, Eckert R, Collins R. Caring to change. How compassionate leadership can stimulate innovation in health care. Kings Fund, 2017. Available: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Carin_g_to_change_Kings_Fund_May_2017.pdf [Accessed 1 June 2019].
- 21 Unwin J. *Kindness, emotions and human relationships: the blind spot in public policy*. London: Carnegie, 2018.
- 22 West M, Armit K, Lowenthal L, et al. Leadership and leadership development in health care: the evidence base, 2015. Available: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/leadership-leadership-development-health-care-feb-2015.pdf [Accessed 22 May 2019].
- 23 Carter M, West M, Dawson J. Developing team-based working in NHS trusts. Report prepared for the Department of health; 2008 (accessed 19 July 2019).
- 24 Kline R. Diversity and inclusion are not optional extras if the NHS wishes to improve. *Health Service Journal*, 2018. Available: <https://www.hsj.co.uk/equality-and-diversity/diversity-and-inclusion-are-notoptional-extras-if-the-nhs-wishes-to-improve/7023599.article> [Accessed 19 July 2019].
- 25 Edmondson A. Psychological safety and learning behavior in work teams. *Adm Sci Q* 1999;44:350–83.
- 26 Developing people: improving care. National improvement and leadership development board, 2016. Available: https://improvement.nhs.uk/documents/542/Developing_People-Improving_Care-010216.pdf [Accessed 1 June 2019].
- 27 Dixon-Woods M, Martin GP. Does quality improvement improve quality? *Future Hosp J* 2016;3:191–4.
- 28 Heifetz R, Linsky M, Grashow M. *The practice of adaptive leadership: tools and tactics for changing your organization and the world Harvard business review books*, 2009.
- 29 Depree M. *Leadership is an art*. New York: Doubleday, 1989.