A picture of health?

Examining the state of leadership and management in healthcare

Richard Hyde
Niamh O Regan

SMF Social Market Foundation

A picture of health?

Examining the state of leadership and management in healthcare

Richard Hyde
Niamh O Regan

In partnership with

FIRST PUBLISHED BY

The Social Market Foundation, July 2023
Third Floor, 5-6 St Matthew Street, London, SW1P 2JT

THE SOCIAL MARKET FOUNDATION

The Foundation's main activity is to commission and publish original papers by independent academics and other experts on key topics in the economic and social fields, with a view to stimulating public discussion on the performance of markets and the social framework within which they operate. The Foundation is a registered charity (1000971) and a company limited by guarantee. It is independent of any political party or group and is funded predominantly through sponsorship of research and public policy debates. The views expressed in this publication are those of the authors, and these do not necessarily reflect the views of the Social Market Foundation.

CONTENTS

ACKNOWLEDGEMENTS 4

ABOUT THE AUTHORS 5

ABOUT THIS REPORT 6

FOREWORD 7

EXECUTIVE SUMMARY 8

CHAPTER ONE – INTRODUCTION 11

CHAPTER TWO – THE PROVISION OF HEALTHCARE IN THE UK 13

CHAPTER THREE – THE PERFORMANCE OF ENGLISH NHS HOSPITALS AND GP PRACTICES 16

CHAPTER FOUR – THE IMPORTANCE OF LEADERSHIP AND MANAGEMENT TO THE PERFORMANCE OF HEALTHCARE ORGANISATIONS AND OUTCOMES 19

CHAPTER FIVE – LEADERSHIP IN HEALTHCARE ORGANISATIONS IN THE UK 25

CASE STUDY: NHS LEADERSHIP AND MANAGEMENT IN ACUTE SERVICES PROVISION – TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST 34

CHAPTER SIX – MANAGEMENT PRACTICES IN THE PROVISION OF HEALTHCARE IN THE UK 43

CASE STUDY: LEADERSHIP AND MANAGEMENT IN ACUTE HEALTHCARE SERVICES – LEEDS TEACHING HOSPITALS NHS TRUST 53

CHAPTER SEVEN – OBSTACLES TO IMPLEMENTING EFFECTIVE LEADERSHIP AND MANAGEMENT PRACTICES IN THE NHS 61

CASE STUDY: LEADERSHIP AND MANAGEMENT IN A PRIMARY CARE SETTING – OAKWOOD SURGERY 67

CHAPTER EIGHT – POLICY RECOMMENDATIONS 72

ANNEX I: THE DIFFERENCES BETWEEN LEADERSHIP AND MANAGEMENT 77

ANNEX II: THE NHS WORKFORCE IN ENGLAND 78

ANNEX III: FURTHER SURVEY SAMPLE DETAILS 81

ENDNOTES 82

ACKNOWLEDGEMENTS

This report would not have been possible without the partnership of the Chartered Management Institute (CMI). The CMI is the professional body for managers and leaders, with a membership community of over 200,000 aspiring and practising managers. More than 150,000 people are currently studying on a CMI management and leadership programme. The CMI's Royal Charter defines its charitable mission as increasing the number and standard of professionally qualified managers and leaders.

In addition, SMF would like to thank:

- Karen James OBE (Chief Executive of Tameside and Glossop Integrated Care NHS Foundation Trust) and Kathryn Gaskell do Carmo (Divisional Director of Nursing and Interim Divisional Director of Operations Medicine and Urgent Care) for giving us some of their time, sharing with us their leadership and management in healthcare expertise and telling us about their experiences of being senior leaders at Tameside and Glossop Integrated Care NHS Foundation Trust.
- Professor Philip Wood (Chief Executive at Leeds Teaching Hospitals NHS Trust) and Clare Smith (Chief Operating Officer) for giving us some of their time, sharing with us their leadership and management in healthcare expertise and telling us about their experiences of being senior leaders at Leeds Teaching Hospitals NHS Trust.
- Dr Dean Eggitt (Managing Partner at Oakwood Surgery) for giving us some of his time, sharing his expertise in healthcare leadership and management and telling us about his experiences of leading Oakwood Surgery.
- the seven experts who participated in the leadership and management in healthcare roundtable, in March 2023.
- the 292 healthcare respondents who took part in the survey about leadership and management in the public sector.
- Adam Drummond, Oliver White and Calum Weir at Opinium for their help in designing the survey, managing it in the field and providing the SMF with the data and various data tables.
- the six public sector management experts that spoke with the SMF early on in this project to help identify some of the key issues of concern and summarise the most salient thinking in the current literature about the quality of public sector leadership and management.
- Zeki Dolen and Richa Kapoor, SMF's Events and Communications Intern and Impact Officer respectively, for their proofreading of the drafts of the report and for designing and formatting the final report.

This report could not have been researched, produced and published without their contributions to the process.

ABOUT THE AUTHORS

Richard Hyde

Richard joined the SMF in August 2019 as Senior Researcher. Before joining he was a Senior Policy Advisor at FSB (Federation of Small Businesses) with responsibility for a diverse range of small business policy issues, including the small business regulatory environment, data and cyber security, crime and civil justice. Prior to FSB, Richard was a Policy Officer at the Law Society of England and Wales. He has also held policy and research roles at Which? and the Small Business Research Centre (SBRC) at Kingston University.

Richard holds an LLM in Law from the University of London and an MA in Global Political Economy from the University of Hull.

Niamh O Regan

Niamh joined the SMF research team in August 2021, with previous roles in higher education and research on nuclear issues. Niamh holds an MA in Intelligence and International Security from King's College London, and a BA in Politics, International Relations and Irish from University College Dublin.

ABOUT THIS REPORT

This report uses evidence from a range of sources. These include the content of a SMF-convened expert roundtable on leadership and management in healthcare and the results of a survey of public sector leaders and managers across the UK. Opinium was commissioned to poll 1,000 leaders and managers in the public sector. Among survey respondents was a sub-sample of 292 leaders and managers in healthcare. It is the answers from these respondents that are presented in this report.[i]

In addition, qualitative and desk research was undertaken into three specific healthcare organisations in England where leadership and management has made a notable difference to their performance. This is presented in the three case studies in this report.

Finally, the primary research was supported by broader desk research into the existing stock of literature on the influence of leadership and management on healthcare quality.

[i] For more detail on the sample please see Annex III.

FOREWORD

If there was ever a doubt about the importance of the NHS to our lives then the pandemic quashed it. And yet we know that considerable change is needed if it is to continue to meet our growing needs. This is not to detract from the amazing work that goes on in the service every minute of every day. Still, the need for major change, symbolised by the emergence of record waiting lists, is both apparent and acute.

As things stand, patient outcomes and waiting times are worse than in comparable countries. Dated IT infrastructure, growing demand for services, workforce shortages, and burnout are taking a worrying toll on frontline staff. The continually vexed question of how we integrate treatment with care, public and community health as well as other forms of fragmentation across services remains unresolved.

The Chartered Management Institute, as the chartered professional body for management and leadership, with thousands of members across the NHS and care sectors, was enthusiastic to partner with the Social Market Foundation to explore what role the best in clinical and healthcare management has in enabling the service to reform and evolve, meeting public expectations as a result.

None of this is to suggest that resources, skills, technology, structures and policy are irrelevant to meeting the needs of the future. Rather we want to support those needs by helping to fill any gaps in NHS management and leadership.

We sought evidence to better understand existing deficits – and the potential – of effective management. According to this research, over one in four NHS managers and leaders (27%) said senior leadership in their healthcare organisations was "ineffective" at ensuring their organisation was successful. Most of the NHS staff surveyed also reported that management-related issues are blocking them from effectively recruiting staff and are leading to poor organisational culture.

In truth, across the UK, leadership and management skills are not taken seriously enough as a driver of improved healthcare. In the media, managers are often portrayed as a burden. This couldn't be further from the truth. Yet skilled managers in the NHS make a critical difference to our health. Examples in this report, including the Teaching Hospitals Trust in Leeds and Tameside and Glossop Integrated Care NHS Foundation Trust in Greater Manchester, demonstrate how investing in management led to better care for patients.

The NHS will need to focus on quality of management in order to lean into the challenges it is facing. We hope this work with the Social Market Foundation galvanises the critical reform needed to support NHS leaders, frontline staff, and patients who rely so heavily on this treasured service.

Anthony Painter, Director of Policy and External Affairs, CMI

June 2023

EXECUTIVE SUMMARY

Healthcare delivery in the UK

UK healthcare provision lags behind that in many other comparable countries

- Prior to the COVID-19 pandemic, the UK was performing comparatively poorly in international healthcare rankings relative to other similar countries. For example, comparative OECD data from 2019 suggested that the UK ranked 17th out of 19 countries for life expectancy, 15th out of 18 countries for breast cancer survival five years after diagnosis, and 17th out of 18 counties for survival from lung and stomach cancer. The aftermath of the COVID-19 pandemic has made the situation worse, with waiting times, for example, lengthening considerably compared to pre-pandemic.

The overall picture is nuanced, with the NHS experiencing some aggregate improvements in performance as well as being home to many underperforming providers

- The comparatively poor international position is in part driven by a large minority of under-performing healthcare organisations. In 2022 for example, 25% of inspected organisations were rated as "require improvement" or "inadequate".
- Nevertheless, pre-COVID-19, the National Health Service (NHS) had shown some signs of slow improvement in recent decades. For example, in one study the UK experienced the fifth largest reduction (out of 11 countries) in avoidable mortality between 2009 and 2019.
- The positive aggregate trend is reflected in the proportion (74%) of acute services providers (typically hospital trusts) and GP practices (96%) achieving a "good" or "outstanding" rating in their Care Quality Commission (CQC) inspections.

The two key healthcare challenges for politicians, policymakers and the NHS

Lifting up the tail of under-performers

- The most important challenge for politicians, policymakers and the NHS is improving poorly performing acute services providers.
- Leadership and management are key influences on the efficacy of organisations. There is a growing body of evidence showing the importance of both in driving up healthcare outcomes. Therefore, efforts to boost leadership of and the management in these laggard providers will be key to improving them.
- The two hospital trust case studies in this report are testament to the centrality of good-quality leadership and management to the process of improving trust ratings from "inadequate" or "require improvements" to "good".

Creating more "outstanding" healthcare providers through continuous improvement

- The second challenge for politicians, policymakers and the NHS is to turn many of the "good" healthcare providers into "outstanding" organisations. For the UK to match the best healthcare systems in the world, it is imperative that the performance of those already doing well is enhanced further.
- The scale of the opportunity for further improvement is clear in the CQC inspection data, which shows that less than one in 10 GP practices and acute service providers are rated "outstanding". Among GP practices in particular, the proportion achieving "good" ratings has remained broadly stagnant for a long time.
- There is a clear link between leadership management quality and better organisational performance, their deployment of best management practices and better organisational performance and health outcomes. This indicates that leaders and managers have a vital role to play in delivering on the ambition of continuous improvement by those already doing well.

Leadership and management landscape in the NHS has the potential to help improve on the current healthcare situation

There is growing evidence that leadership and management can improve the performance of healthcare providers

- More and more research is demonstrating the link between leadership and management quality and better organisational performance among healthcare providers. The corollary of this is that leaders and managers have a vital role to play in tackling the two big healthcare challenges and getting the UK closer to the international "frontier" on health outcomes.

The state of leadership and management across healthcare

- Original survey data from healthcare leaders and managers means this report is able to present a picture of the state of leadership and management in the NHS.
- Survey results broadly reflect the mixed picture captured by the CQC's inspection activity. Most respondents (65%) report that their organisation has effective leadership that displays many of the characteristics associated with good leadership practice.
- However, there is a significant minority who reported a more negative picture. Some 27% of leaders and managers surveyed, for example, reported that senior leadership in their healthcare organisations was "ineffective" at ensuring the organisation succeeded. Amongst respondents in junior management roles this proportion was even higher, at 36%.
- A similarly large minority of participants reported negative experiences when asked about the deployment of good leadership practices by their organisation's leaders.

- Some 32% of respondents agreed that the leaders in their healthcare organisations were "poor" at motivating staff, while 4% said their leadership did not attempt to motivate staff at all. Another 25% said that their senior leaders were not easily available to colleagues, and just under one in five (19%) stated that their leaders were "poor" at setting a clear direction and long-term goals for the organisation.

Leadership and management succeeds most in the right environment

- Good leadership and management is essential but context is important to delivering improvements at scale. Policymakers therefore need to consider the wider healthcare operating environment and how policy can support it to perform at its best.
- Some 62% of leaders and managers said that they face obstacles that hinder their ability to do their job effectively. Of those, 46% cited human resourcing problems (e.g. recruitment and retention), 46% highlighted organisational challenges and 20% reported process issues (e.g. red tape) as barriers.

Ensuring best leadership and management practices are embedded across all of the NHS

The role for policy in maximising leadership and management efficacy in healthcare

Bringing the UK's healthcare performance up to the international frontier will require a more thorough policy response than has been the case to date. Specifically, efforts are needed to maximise the contribution of leadership and management to turning underperforming providers around and improving further those organisations that are already doing well.

Doing so will require putting in place measures that ensure that best leadership and management practices are universal across the NHS and sustainable over the long term. More particularly, this will require building up a picture of and effectively monitoring the quality of leadership and management across the NHS, and ensuring there are mechanisms for driving improvements in leadership and management where required through universalising best practices so that the whole of the NHS benefits from them. To deliver on these objectives, the Government needs to take steps to:

- broaden the CQC's "well-led" category for inspections so that it includes a detailed review of the management practices, training and leadership pipelines of the organisations it inspects
- establish a set of benchmarks for judging good leadership and management that the CQC can use in its assessment of whether or not an organisation is "well-led"
- mandate in-work leadership and management training requirements across the NHS and primary care for managers and leaders
- mandate NHS England to establish a compulsory national excellence framework for the minimum in-work leadership and management training requirements
- pilot workplace democracy methods (giving all staff an opportunity to feed in to decision making processes) modelled on those used by Leeds Teaching Hosptials NHS Trust in under-performing NHS Trusts.

CHAPTER ONE – INTRODUCTION

There is significant room for improvement in UK healthcare provision

For some time, healthcare in the UK has been widely seen as under-performing compared to other similar countries. The NHS has been particularly badly hit by the fallout from the COVID-19 pandemic too, which has exacerbated existing, long-running problems with the public provision of healthcare in Britain.

As a result, politicians, policymakers and healthcare providers in the UK, face two challenges:

- recovering from the dislocation to the NHS caused by the aftermath of COVID-19
- tackling the deeper-seated and persistent problems associated with comparative under-performance in healthcare delivery in the UK in general, and England in particular.

The importance of leadership and management

Performance problems are, at least in part, linked to insufficient amounts of good-quality leadership and management across some parts of the NHS. Further, where there is currently good performance, there is often scope for continuous improvement, which the right leadership and management can help drive forward.

For a long time, there has been a good deal of awareness among politicians, policymakers and the NHS of the importance of high-quality leadership and management to the success of individual healthcare providers and, in turn, the healthcare system as a whole. This awareness has been evident in the numerous inquiries and reviews into these topics in recent years. While there has been progress in improving leadership and management in the NHS, this report shows that there is not a universally high standard of leadership and management and suggests that this is a key contributing factor both to:

- the large minority of underperforming acute care providers
- the small proportion of healthcare organisations achieving an “outstanding” rating from the Care Quality Commission (CQC).

This report suggests that improving the standard of leadership and management in the NHS can tackle both of these challenges. Ultimately, reducing the tail of underperforming entities and further boosting the performance of those already doing well can help deliver even better health outcomes for the UK. This would see Britain at the frontier of quality public healthcare, in contrast to its lacklustre standing at the moment.

This report

This report looks to build a picture of the current state of NHS leadership and management, including providing a sense of how widespread good practices are. In particular, through three case studies, it will show how the deployment of effective leadership and management practices can deliver improvements in healthcare organisation performance.

It will also highlight areas where there still seems to be room for improvement, and finally will make recommendations for reforms to help tackle some of the deficiencies the report identifies, which politicians and policymakers may want to consider.

CHAPTER TWO – THE PROVISION OF HEALTHCARE IN THE UK

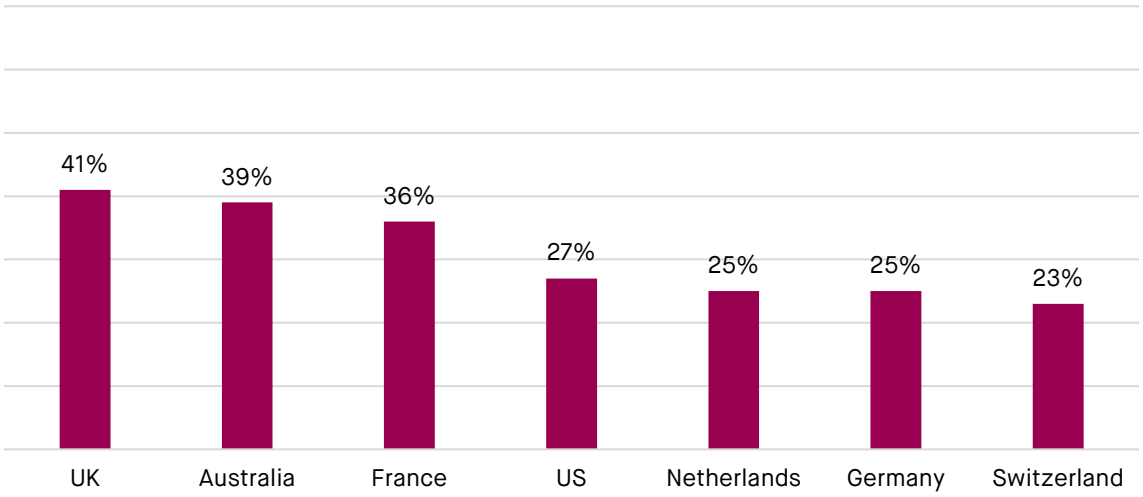
The pre and post-COVID-19 pandemic healthcare delivery picture

The NHS's comparative performance before the COVID-19 pandemic

Healthcare in Britain has underperformed compared to many of the UK's peers for a long time. Prior to the pandemic, comparative OECD data from 2019 suggested that the UK ranked 17th out of 19 countries for life expectancy, 15th out of 18 countries for breast cancer survival five years after diagnosis, and 17th out of 18 counties for survival from lung and stomach cancer.[1] The British Medical Journal (BMJ) highlighted research in 2019 showing that the UK had below average (compared to other industrialised countries) survival rates across cervical, colon and rectal cancer.[2] For stroke and heart attack survival rates, the UK ranked ninth out of nine countries according to the OECD.[3] Analysis published by the BMJ stated that the 30-day mortality rate for people suffering heart attacks in the UK was 7.1% compared to the average among peer countries of 5.5%. For strokes, the rate was 9.6%, three percentage points higher than the mean across comparable nations.[4]

Waiting times are seen as proxies for the overall efficacy of a healthcare system,[ii] and on this metric, 2018 data shows that the UK also compared poorly with numerous other industrialised countries (see Figure 1).

Figure 1: Proportion of people waiting one month or more for a specialist appointment in selected countries, 2018



Source: OECD

[ii] Waiting times are linked to difficulties in accessing healthcare and therefore heath inequalities and poorer health outcomes. While a far from perfect comparative metric, waiting times are as good as most others at being a proxy for the efficacy of different healthcare systems. Source: Waiting Times for Health Services : Next in Line | OECD iLibrary (oecd-ilibrary.org)

The fallout from the pandemic has seen waiting times across England, Wales and Scotland grow

The COVID-19 pandemic and its aftermath have compounded existing problems in the NHS.[5] The UK continues to lag behind other similar countries in healthcare outcomes. Analysis by The Commonwealth Fund saw the UK ranked ninth out of 11 peer healthcare systems for "outcomes" in 2021.[6] [iii].

Some of the most obvious impacts can be seen in key healthcare metrics, such as waiting times for appointments and treatments. Pre-COVID efforts to reduce and maintain short waiting times for appointments, referrals and treatments have gone into reverse across England, Wales and Scotland.

Table 1: Key NHS waiting time performance metrics in England, Scotland and Wales, 2023

Nation	Metric	Performance
England	Median waiting time for planned care	14 weeks in March 2023 (nearly double pre-pandemic level of 7.5 weeks)[7]
	Proportion of cases of suspected cancer referrals happening within two weeks of the referral	79.4% in March 2023 (92% in 2018-19)[8]
	Waiting less than four hours after presenting at A&E to be admitted, transferred or discharged	74.6% admitted, discharged within four hours of arriving in April 2023[9]
Scotland	Outpatient appointments within 12 weeks of a referral from a GP	62.9% within 12 weeks of a referral in March 2023[10]
	62-day standard for suspicion of cancer to the first treatment	71% of cases meeting the standard at the end of 2022 (down from 84.7% in March 2020)[11]
	Waiting less than four hours after presenting at A&E to be admitted, transferred or discharged	In March 2023 68% of attendances at A&E services were being seen within four hours, with 11% waiting for eight hours and 4.9% more than 12 hours waiting[12]

[iii] "Outcomes" included factors such as infant and maternal mortality

Wales	Median waiting time for outpatient appointments	20 weeks in March 2023 (11 weeks in March 2019)[13]
	62-day standard for suspicion of cancer to the first treatment	55.3% began treatment within 62 days of the disease being suspected, in March 2023[14]
	Waiting less than four hours after presenting at A&E to be admitted, transferred or discharged.	In March 2023, 70.2% of attendances at A&E services were being seen within four hours[15]

Healthcare in the UK has improved relative to where it was a decade earlier

Despite the negative international situation, the aggregate picture of healthcare delivery in England before the pandemic was one of broad improvement, relative to where domestic standards were in previous decades. This was evident in the decline in preventable mortality in the UK between 2009 and 2019. The UK experienced the fifth largest decline among 11 industrialised countries.[16]

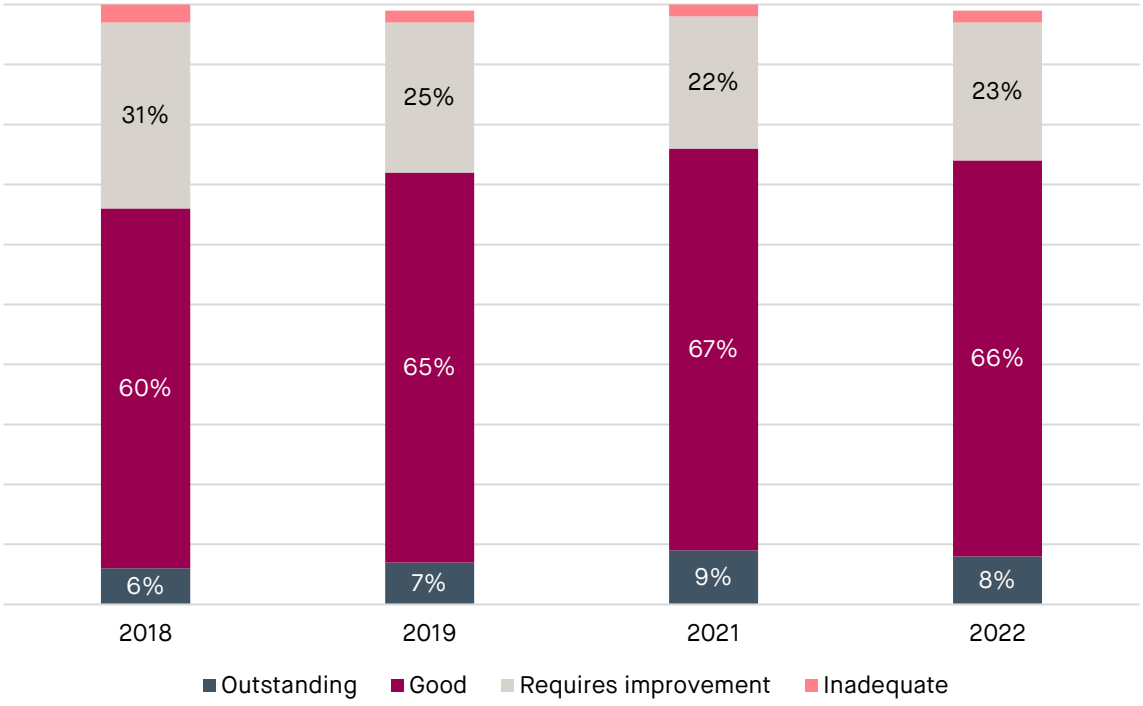
CHAPTER THREE – THE PERFORMANCE OF ENGLISH NHS HOSPITALS AND GP PRACTICES

Inspection evidence on the performance of English acute care providers and GP practices

The inspection evidence indicates that around a quarter of hospital trusts are in need of considerable improvement and that there is scope for many to do better

Figure 2 illustrates the aggregated ratings of the CQC inspections of NHS acute care services providers (typically hospitals) between July 2018 and July 2022 (excluding the main COVID year of 2020).[17] [iv]

Figure 2: Aggregate ratings achieved by NHS acute services providers in CQC inspections, 2018 - 2022



Source: CQC State of Care 2021/22

[iv] The data presented in Figures 2 and 3 represent only a sample of the total number of acute services trusts and GP practices in England, as only a portion of them are inspected in any given year.

Analysis from the BBC suggested that there were 140 acute services trusts in England in 2021.[18] [v] The data presented in Figure 2, if replicated across the whole population of foundation trusts providing acute services providing , would suggest that, in 2022, there were approximately 11 "outstanding" trusts in England, 93 rated as "good", 32 that "require improvement" and three that were "inadequate". In 2021-22 there were 19.6 million Finished Consultant Episodes (FCE) across the NHS.[vi] If trusts were more equal in their size and the population of England more evenly distributed, the data on the proportion of poorly performing trusts presented in Figure 2 would imply that in 2022 around 4.9 million FCEs could have been provided under the auspices of poorly performing trusts.[vii] A similar exercise with emergency admissions (inpatients) data would imply that in 2022, as many as 1.4 million such incidents could have been in trusts that the CQC rated as underperforming.

CQC inspection evidence suggest that the vast majority of GP practices are doing well but few are "outstanding"

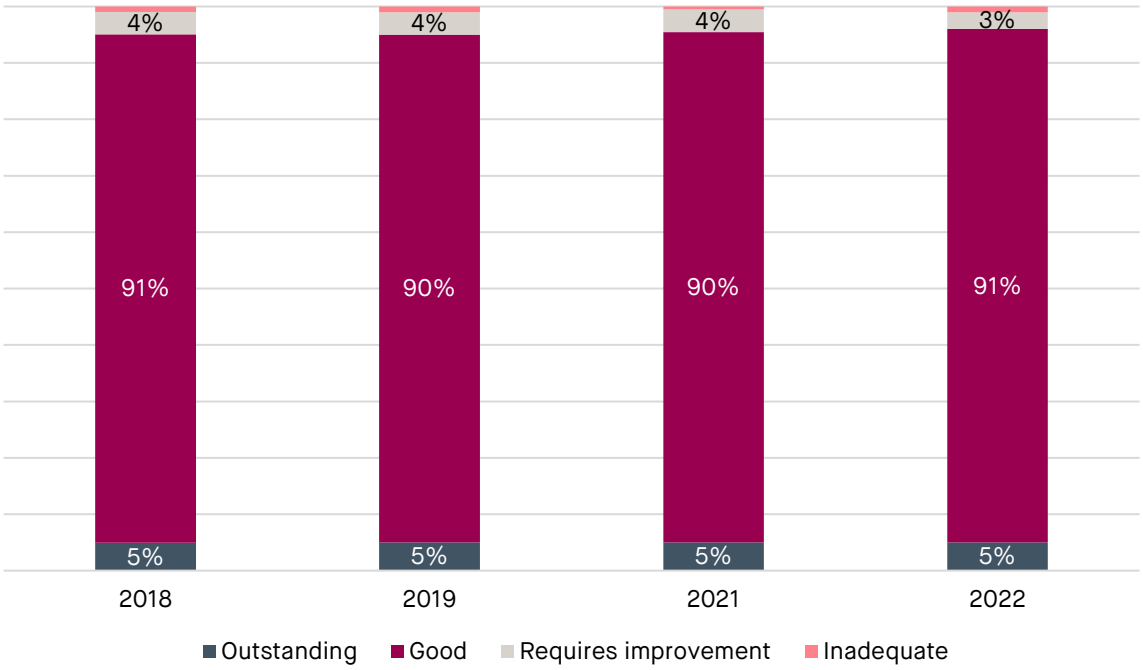
According to the NHS's GP Quality and Outcomes Framework, there were more than 6,720 GP practices in England in 2019-20. If the 2022 findings outlined in Figure 3 were replicated across the whole GP practice population, this would suggest that approximately 336 were "outstanding", 6,115 were rated as "good", 201 were deemed to "require improvement" and 67 that were "inadequate".

[v] There are many more hospitals than trusts, because many trusts run more than one hospital. Further, 10 of the total number of trusts are ambulance trusts. Source: Key facts and figures about the NHS | The King's Fund (kingsfund.org.uk)

[vi] A FCE describes the period of time that a patient is under the continuous care of one consultant at one healthcare provider. FCEs are counted in the year the patient concerned ceases to be under the care of the relevant consultant. The number of FCEs a year are not necessarily representative of the number of patients seen in that year because a patient can be under different consultants for more than one problem. Source: Latest hospital admission data published - NDRS (digital.nhs.uk)

[vii] Trusts vary in size. Some are a single hospitals, others are made up of several. Some include other services provided outside of hospital settings. The geographical spread of trusts and the distribution of the English population creates considerable variability in the size of the patient populations covered by different trusts. Therefore, this calculation should be seen as illustrative only, as it relies on a considerable simplification of the actual situation.

Figure 3: Aggregate ratings achieved by GP practices in CQC inspections, 2018 – 2022



Source: CQC State of Care 2021/22

The relative consistency of these results over the past five years could be viewed positively. However, the absence of an increase in the proportion of GP practices rated "outstanding" suggests that there has been some stagnation in primary care quality. This indicates there is likely to be scope for enhancement by focusing upon continuous improvement, to maximise the contribution of all the factors under the influence of individual practices towards optimising delivery.[19] Leaders and managers will be indispensable in this process.[20] The Leeds Teaching Hospital Trust case study in this report offers a clear idea of how continuous improvement can be done in practice and therefore, what kinds of changes other organisations could adopt to become continuous improvers.

CHAPTER FOUR – THE IMPORTANCE OF LEADERSHIP AND MANAGEMENT TO THE PERFORMANCE OF HEALTHCARE ORGANISATIONS AND OUTCOMES

Evidence suggests that leadership and management are linked to better public services outcomes

The importance of leadership and management to organisational success has been observed in both the private and public sector for some time. A growing body of healthcare-specific evidence indicates how important leadership and management are to quality healthcare delivery in particular.[21] [viii]

Debate over the number of NHS managers can obscure the issue of quality

The public debate about NHS management is often seen through the prism of numbers. Some argue there are too many "bureaucrats" taking resources from "frontline services". Others highlight research suggesting that the NHS is under-managed, and that this results in NHS under-performance.[22]

[viii] For more on the differences between "leadership" and "management" and "leaders" and "managers", please see Annex I.

Box 1: The debate over the number of NHS managers

Management roles in the NHS have grown in recent decades, following the widespread introduction of professional management into the NHS in the 1980s. The best estimates suggest that NHS England now has 25,294 managers and 13,596 senior managers, just under 3% of the total NHS England workforce.[23][ix] Compared to the wider economy, the English NHS appears to be under-managed. For example, one analysis revealed that the proportion of manages in the UK workforce as a whole is 6.5 percentage points higher than in the NHS workforce.[24]

One study highlighting under-management as a problem estimated that an increase in the proportion of managers from 2% to 3% of the workforce was linked to a 15% reduction in infection rates and 5% increase in efficiency.[25] Another found that reductions in "administrative intensity" through steps such as having more managers in place helped improve efficiency in English NHS hospitals.[26]

Other research has suggested it is he quality rather than quantity of managers that makes the difference.[27] Analysing seven years of NHS Staff Survey data, hospital accounts and Hospital Episode Statistics (HES), the results of one study indicated that better management *quality* can be associated with better hospital performance, with positive effects on financial performance, elective treatment and A&E waiting times. Increased *numbers* of managers, however, was not found to have any notable impact on performance. The study does note that the considerable constraints faced by NHS managers (e.g. lack of autonomy) may hinder the extent to which management numbers can impact performance.[28]

The balance of evidence suggests that the NHS is not over-managed,[29] though the answer to whether it is under-managed is more ambiguous.[30]

While the debate over the *quantity* of managers remains unresolved, as indicated in Box 1, Box 2 shows that the link between the *quality* of leadership and management practices and performance is much clearer.

[ix] It should be noted that these are likely underestimates because no measure captures all clinical staff with at least some management responsibilities.

Box 2: The impact of better leadership and management practices on healthcare performance

Research is increasingly demonstrating the positive link between management practices and the quality of healthcare. One study found that 43% of hospitals scoring above average in management practices[x] achieved "high quality" outcomes,[xi] compared to 14% of those below average.[31] This positive relationship was found across all the key domains of management practice (operations, monitoring, targets, human resources) as well as overall. Ultimately the study judged that a single standard-deviation increase in the overall management score of a hospital raised the probability of that same institution being rated as "high quality" by around a fifth.[32]

A 2010 analysis identified that the utilisation of best practice management methods (as measured by the World Management Survey's (WMS) management scorecard) was associated with a significantly lower emergency admission heart attack mortality rate.[33] More specifically, a standard deviation increase in management scores for a hospital was linked to a 4% reduction of the average mortality rate of 17.1%. The same work found that better-quality management in hospitals was associated with fewer deaths from all emergency surgery, shorter waiting lists and substantially lower MRSA infection rates.

Another study of the link between emergency admissions heart attack survival and management practices in hospitals found that a move from the bottom third to the top third on the WMS's hospital management scoring system led to 36 fewer heart attack deaths a year at the average hospital.[34] A similar piece of research also identified that a one-point improvement in a hospital's management score in the WMS index is associated with a 6% reduction in the heart attack mortality rate.[35]

Other data has found that proxies for good leadership and management practices[xii] such as high staff morale, motivation and satisfaction, as recorded in surveys such as the NHS Staff Survey, are associated with better performing healthcare institutions, whether that performance is judged through CQC ratings or patient experience data.[36]

[x] The source of this was the World Management Survey's cross-country research into hospitals and those in the US and UK in particular.

[xi] "Quality" in the study was derived from two sources. For US hospitals the researchers calculated an overall score for an organisation based upon 19 practices across three health clinical conditions (heart attack, heart failure and pneumonia) using the methodology of the Hospital Quality Alliance (HQA). For English hospitals the relevant metric was the "Overall Quality of Services" score awarded by the CQC. Those scoring "excellent" were categorised as "high quality". Source: Hospital Board And Management Practices Are Strongly Related To Hospital Performance On Clinical Quality Metrics | Health Affairs

[xii] These kinds of factors are in large part the result of the presence of good quality leadership and management in a healthcare organisation.

There have been efforts to improve leadership and management

Politicians, policymakers and the NHS have been alive to the scope for better leadership and management to make a difference in the quality of healthcare for a long time. This is evident in:

- the establishment of institutions focused on healthcare leadership and management, focused such as the NHS Graduate Management Training Scheme (GMTS)[37] [xiii] and NHS Leadership Academy[38][xiv]
- the NHS's own Patient Experience Improvement Framework, providing guidance on how to turnaround failing healthcare providers, where leadership and management are central[39]
- the recognition of the need to do more on management in important NHS planning documents[40]
- the repeated commissioning of reviews and reports into various aspects of leadership and management in the NHS (see Table 2) by politicians.

Table 2: Recent reviews of NHS leadership and management

Author	Report	Year
Sir Gordon Messenger and Dame Linda Pollard	Leadership for a collaborative and inclusive future[41]	2022
Sir Ron Kerr	Empowering NHS leaders to lead	2018
Lord Rose	Better leadership for tomorrow NHS Leadership Review	2015
Ed Smith	Review of centrally funded improvement and leadership development functions	2015
Sir David Dalton	Examining new options and opportunities for providers of NHS care	2014
National Advisory Group on the Safety of Patients in England	A promise to learn – a commitment to act: Improving the Safety of Patients in England	2013
Robert Francis QC	Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry	2013

[xiii] Established in the 1950s to give people the skills and experience they needed for senior management roles in the NHS. It now takes the form of a two-year non-clinical leadership development scheme, with the opportunity to specialise in particular areas of healthcare management. (Source: NHS Graduate Management Training Scheme)

[xiv] Set up to help improve the quality of leadership. The academy provides continuous development opportunities for all levels of leadership and management. Opportunities can be part of structured programmes as well as self-guided courses. (source: NHS Leadership Academy)

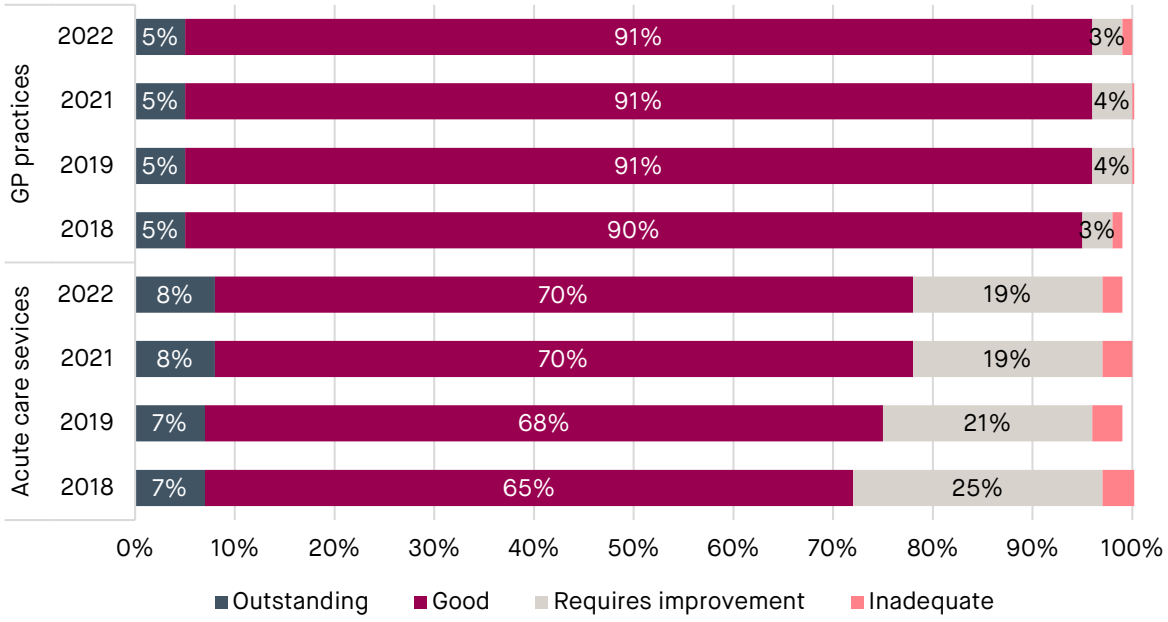
The leadership and management challenges facing politicians, policymakers and the NHS

While there has been some reduction of under-performing acute service providers, a significant minority of poor-quality providers remain

The creation of leadership and management-focused institutions and the plethora of reviews and inquiries have, no doubt, helped to bring about some improvements in NHS leadership and management. The three case studies in this report help reinforce that fact. Further, five percentage point increase in the proportion of trusts being rated "good" in the "well-led" inspection category (see Figure 4 between 2018 and 202,2 is also an indication of this.

However, as Figure 4 also reflects, there is a sizable tail (21%) of providers scoring poorly in the specific category of leadership. The proportion of poorly led acute services providers in particular, almost mirrors the proportion of provides that are rated as underperforming (25%) by the CQC (see Figure 2).

Figure 4: CQC leadership ratings for acute care services providers, 2018 - 2022



Sources: CQC. (2022). State of care 2021/22 and CQC (2019), State of care 2018/19.

Similar to Figures 2 and 3, Figure 4 also shows that less than one in 10 GP practices (5%) and acute services providers (8%) are rated as "outstanding" by the CQC, for leadership quality.

Improving the tail of under-performing acute services providers

The data presented in Figure 2 indicates that the biggest challenges for politicians and policymakers that want to improve health outcomes are to be found amongst acute care providers. Approximately a quarter are falling short of being rated as "good" or higher and around a fifth are not rated "good" or higher for their leadership. When applied on a national scale, the 21% of poorly led trusts highlighted in Figure 4 equates to about 30 of the 140 acute trusts in England. Given the centrality of leadership and management to better performance by healthcare organisations, this provides clear evidence of instances where organisational improvement could likely be achieved through enhancing the quality of the leadership.

The findings from our sub-sample of healthcare leaders and managers, drawn from the wider survey of public sector leaders and managers, found that just over a quarter (27%) of the respondents said the leadership in their healthcare organisation was "ineffective" (see Figure 6). As we will discuss further in Chapter Seven, 11% of manages listed the leadership in their organisation as an explicit obstacle to them doing their job.

The challenge of moving more "good" healthcare providers into being "outstanding"

Improving the country's comparative international healthcare performance and equalling that of the leading industrialised countries will require more than just bringing the tail of hospitals up to a higher performance standard. It will also need more of the "good" rated GP practices and hospitals to move into the CQC's "outstanding" category. Such a shift will require further improvements to leadership and management practices in some NHS healthcare providers.[42]

However, bringing about performance improvements through the refinement and enhancement of leadership approaches and management methods when an organisation is already performing comparatively effectively has its own challenges. It is likely that the opportunities for further changes with significant returns are fewer. This is in no small part because a competently performing organisation has to work hard to remain a good performer.[43] Many organisations fall prey to regression.[44] Therefore, achieving further improvement means not only staving off decline but marshalling limited resources (such as time, people, skills, finance, equipment, etc) towards continuous improvement.[45] [xv]

[xv] This ambition is also recognised by the CQC in its current strategy, as a priority. Consequently, in the strategy it set out a number of ways in which it aims to provide hospital leaders, managers and clinicians with the information and support needed for further improvement. Source: "A New Strategy for the Changing World of Health and Social Care" (Care Quality Commission, 2021).

CHAPTER FIVE – LEADERSHIP IN HEALTHCARE ORGANISATIONS IN THE UK

Factors associated with successful public sector leadership in general are also applicable to healthcare

The evidence from the leadership literature suggests there are several leadership characteristics and techniques that can make positive differences to the performance of a public sector organisation.[46] Roundtable attendees highlighted additional elements such as the importance of collaboration within and across institutions as well as the collection of good-quality data and its effective use:

> *"It's really interesting to look at high performing organisations, the depth and the extensiveness of those connections between managers between leaders, incredible sort of reciprocal relationships, information is being exchanged."*

In our survey, we sought to build up a picture of the efficacy of senior leadership in the NHS.[xvi] The information collected indicates the extent to which NHS leaders are employing good leadership practices and, consequently, where there might be room for improvement.

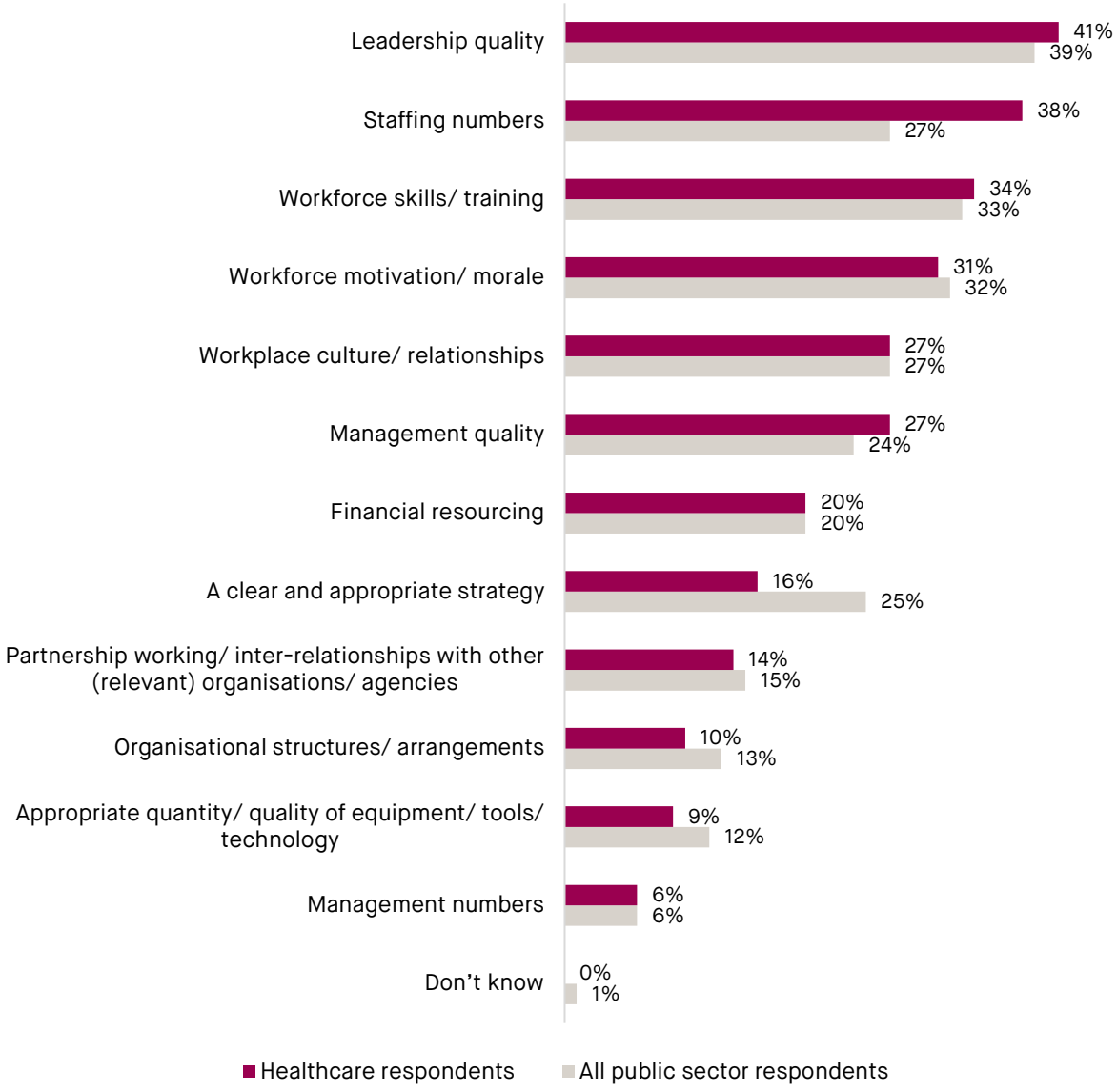
Healthcare managers see leadership quality as important, but question the effectiveness of it in their own organisations

Public sector managers see leadership quality as key to success

As evidenced in Figure 5, leadership quality is viewed as the most important factor for helping public sector organisations to succeed. This pattern in the wider public sector was broadly reflected in responses from healthcare managers. Two in five (41%) healthcare managers see leadership quality as being one of the three most important factors for helping organisations in the public sector succeed, compared to 39% of all public sector managers.

[xvi] We sought to examine managers' evaluations of their leaders, typically against the methods and techniques that are widely seen as best practice.

Figure 5: Factors that are important for an organisation to succeed in the public sector, for public sector managers as a whole and for healthcare sector managers specifically

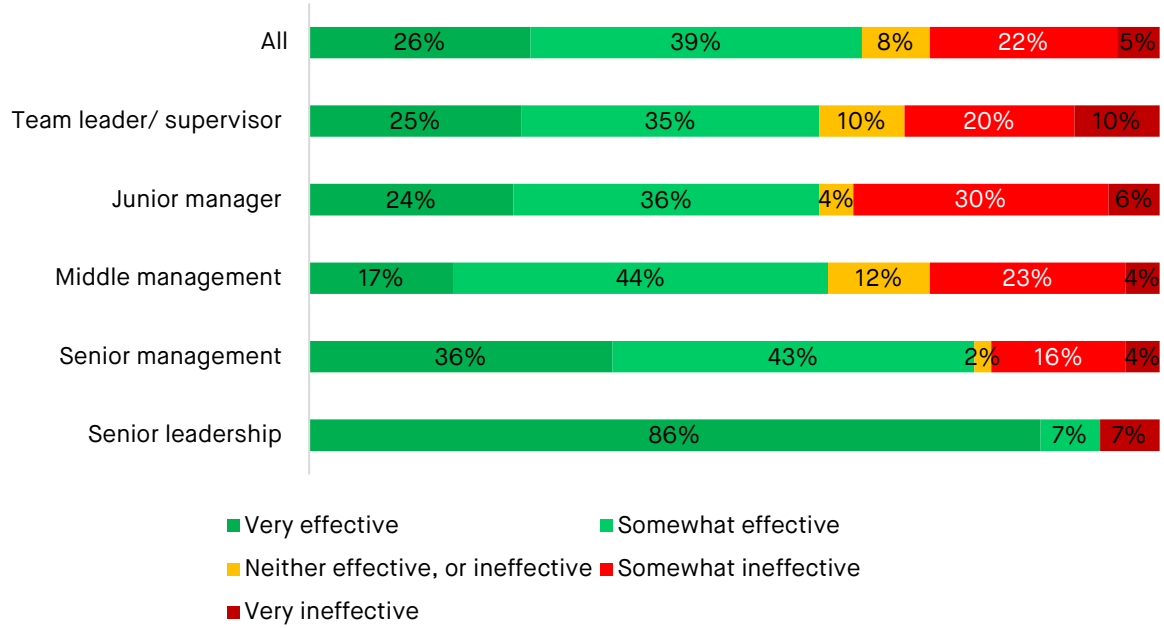


Source: SMF Opinium Survey March-April 2023

Managers think their senior leadership is effective, but this does differ by managerial level

Leadership quality is difficult to measure, but a good proxy can be how effective managers in the same organisation believe the leadership is. In aggregate, as Figure 6 shows, a relatively high proportion of healthcare managers view their senior leadership as effective (65%). However, more than a quarter of all respondents think their senior leadership is ineffective. Further, Table 11 in Chapter Seven illustrates that, when leaders and managers were asked about explicit constraints on their ability to lead and manage effectively, 17% of those who said they faced obstacles cited the senior leadership of their organisation as one of them.

Figure 6: Healthcare managers at all levels rating the effectiveness of senior leadership at ensuring the organisation succeeds



Source: SMF Opinium Survey March-April 2023

When broken down across different management levels, the picture of effectiveness is more varied. A comparatively low 60% of team leaders and junior managers rated their senior leadership as effective. Some 27% of middle managers rated their senior leadership as ineffective, as did 30% of team leaders and 36% of junior managers. This disconnect between managers and those they supervise has been seen before. A 2022 report looking at how managers were responding to the early stages of the pandemic found that, while managers at all levels felt they were communicating more, their direct reports did not feel there was a difference.[47]

Most senior leaders are good at setting clear mission-related goals, but are slightly less effective at communicating them

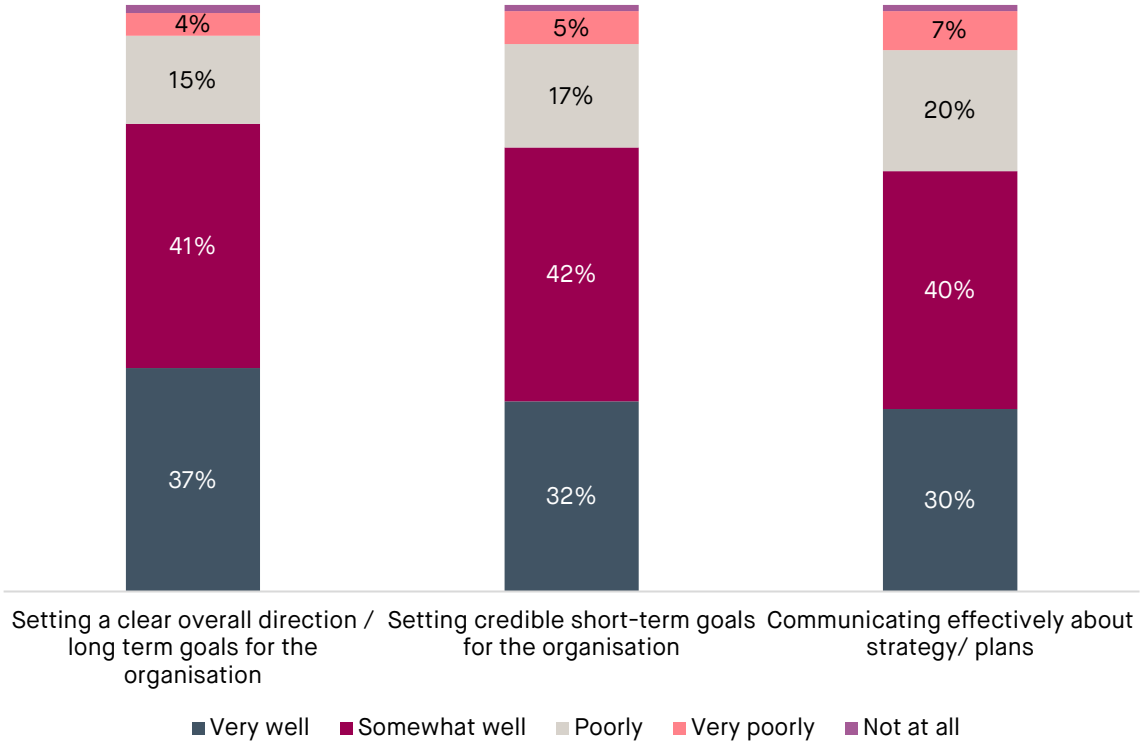
An important factor in successful leadership is setting high-level objectives based upon a clear mission that, while difficult, is feasible.[48] Successful leadership is also buoyed by that leadership having and sharing a public service vision of the organisation, which helps staff to see the social value of their work.[49] A strategic plan determines what should be prioritised in the context of the vision. The importance of strategic clarity for successful healthcare organisations was noted by one contributor to the expert roundtable, who pointed out that:

> *"Successful organisations [are] very good [at] thinking about…[the]…thicket of priorities that they face…they think about the interdependencies. And they focus very relentlessly on where they need to…[where]…to invest that kind of resources and strategic attention." (healthcare researcher)*

Figure 7 highlights that managers in UK healthcare organisations considered the senior leadership to perform well at setting credible short-term goals (74%) and a clear overall long-term direction (76%), with 19% and 26% respectively reporting that leaders in their organisation were poor with regards to these facets of leadership. An absence of clear goals is widely seen as tending to have negative impacts on important performance factors such as staff motivation.

Senior leaders were found to communicate their organisation's strategy or plans well by 70% of respondents, with 27% reporting that they did this poorly and 1% indicating their leaders did not communicate at all. Sharing the strategy and communicating plans are important leadership best practice methods.[50] Failure to deploy and embed these is likely to hinder an organisation's ability to succeed.

Figure 7: Performance of senior leadership in setting a long-term direction, short-term goals and communicating them effectively.



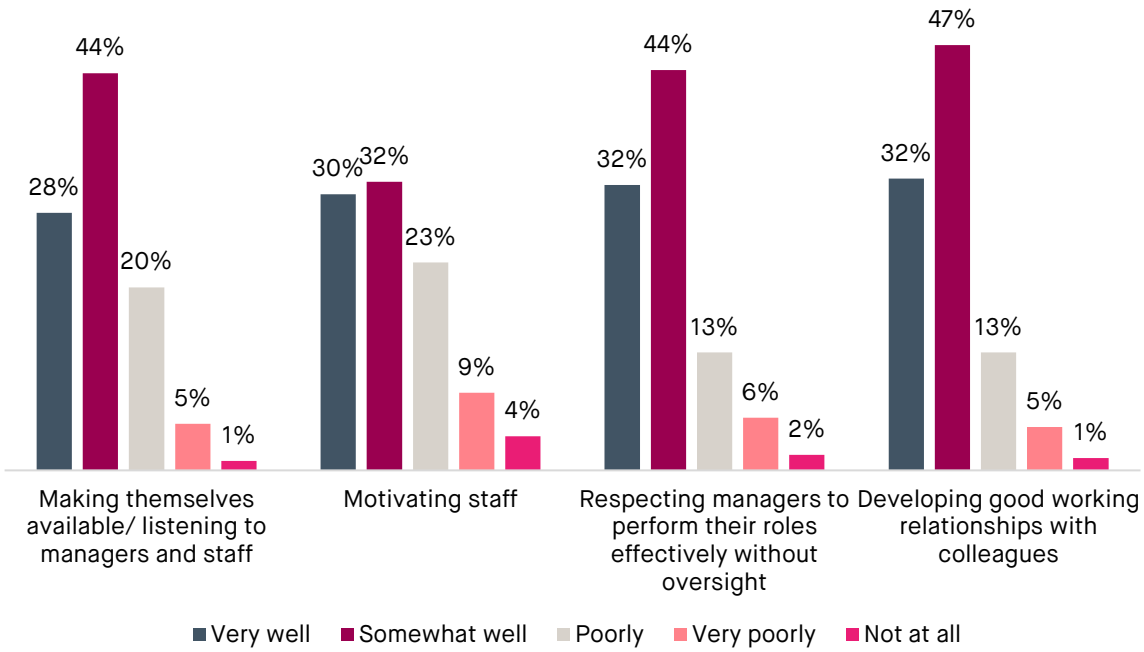
Source: SMF Opinium Survey March-April 2023

Most senior leaders are effective at building the key components of a high trust workplace

As the case studies later in this report attest, organisations where there is a strong relationship between leaders and their colleagues and an inclusive approach to decision making, fostered by strong relationships and an open communication culture, are places of high trust. That leads to motivated workforces with high morale, which generally perform more effectively. [51]

Relationship building by senior leaders was viewed positively by most managers (79%). In contrast, 18% reported that they do not do this well and 1% that they do not do this at all.

Figure 8: Performance of senior leadership in healthcare organisations across a range of "soft skills"



Source: SMF Opinium Survey March-April 2023

Nearly 75% agreed that the senior leaders in their organisations were good at making themselves available to staff and listened to managers and staff about issues. However, 25% reported that their senior leaders did this poorly, with 1% saying that their leaders did display this behaviour at all.

Most managers feel their senior leaders avoid command and control approaches and that they lead by example

High-trust workplaces avoid command and control approaches to leadership. These often damage morale and motivation and, in the end, performance. [52] Examples of a trusting approach include respecting staff enough to get on with their work and deliver on agreed objectives, and giving managers autonomy to perform their roles and solve problems when they arise.

As Figure 8 shows, 76% of respondents to the survey agreed that the senior leadership in their healthcare organisation did respect the autonomy of managers such that they could be described as doing it well. However, 19% reported that their senior leadership did not do this well.

Senior leadership are more likely than managers to have formal management and leadership qualifications

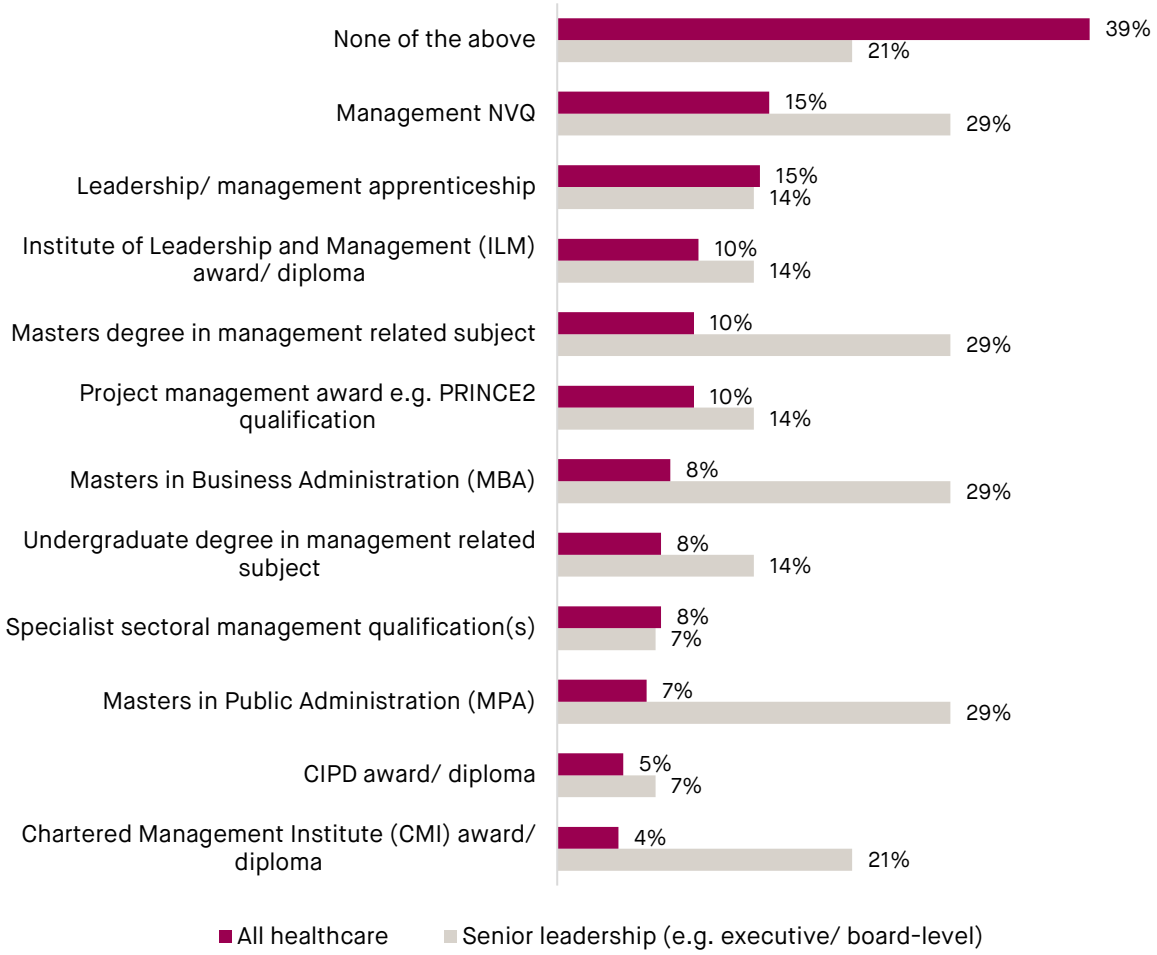
The importance of training

Good-quality leadership training is an important channel through which potential leaders can acquire the competences needed to be a good leader and existing leaders can improve their effectiveness.[53] Training can be formally accredited, leading to recognised qualifications,[54] or more informal and unaccredited. Continued access to and participation in training helps leaders to maintain and upgrade their skills over time.

There is a variety of formally accredited skills among leaders and managers in the NHS

Leadership and management qualifications are common among NHS leaders and managers. 80% of senior leaders have a formal qualification and 60% of all managers do. However, there are greater differences in which qualifications are held. Master's degrees are most common among senior leadership and senior leaders are more likely to have a variety of qualifications. This is unsurprising, as they have had more time in leadership and management posts to build up a history of accredited training.

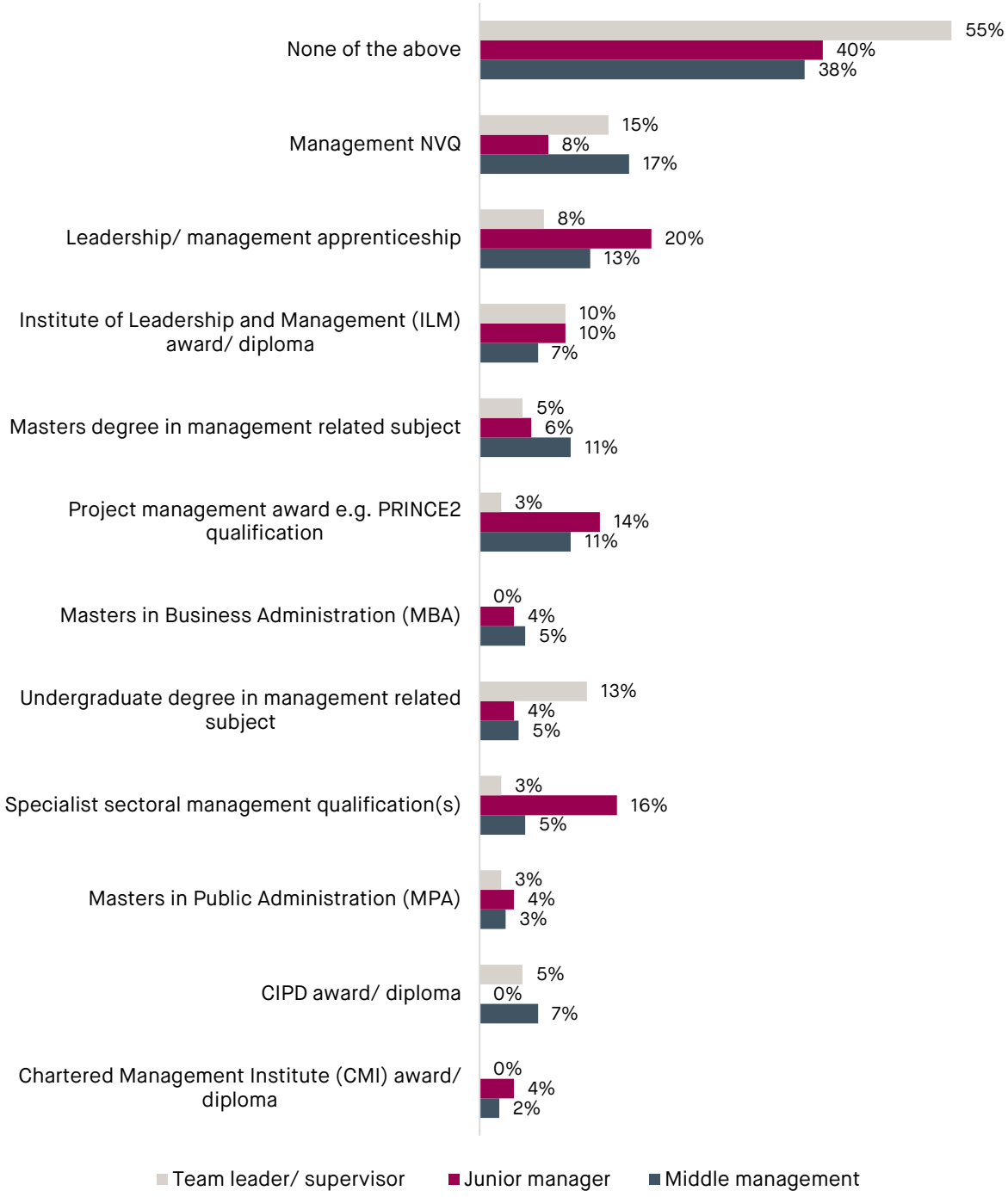
Figure 9: Leadership or management qualifications among senior leaders in healthcare organisations



Source: SMF Opinium Survey March-April 2023

Notable in Figure 9 is that nearly four in 10 (39%) leaders and managers in healthcare do not have an accredited leadership or management qualification. In contrast, one in five (21%) senior leaders do not have an accredited leadership or management qualification.

Figure 10: Leadership or management qualifications among junior and middle managers in healthcare organisations



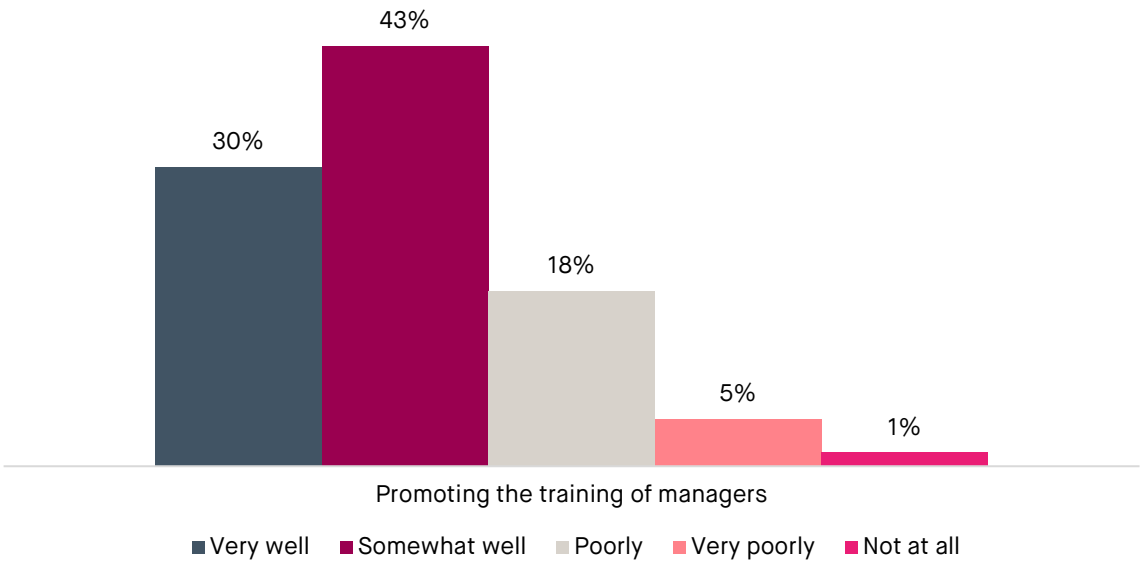
Source: SMF Opinium Survey March-April 2023

Figure 10 shows the qualification differentials in greater granularity. Team leaders/supervisors (55%) are the most likely to say they have no formal management and leadership qualifications. This figure lowers as positions become more senior, to 40% of junior managers and 38% of middle managers. If junior managers do not add to their qualifications as they rise through the system, there may be a future shortfall in appropriately trained senior leaders.

Managers feel that their senior leaders are relatively good at promoting management training

Our survey indicated that most senior leaders do effectively promote leadership or management training. Three-quarters (76%) of respondents reported this was the case. The effectiveness of this training is discussed in Chapter Six.

Figure 11: The extent to which senior leaders promote management training for their manager colleagues.



Source: SMF Opinium Survey March-April 2023

CASE STUDY: NHS LEADERSHIP AND MANAGEMENT IN ACUTE SERVICES PROVISION – TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST

Tameside and Glossop Integrated Care Trust

Box 3 provides an overview of Tameside and Glossop Integrated Care NHS Foundation Trust and the patient catchment area that it serves.

Box 3: Tameside and Glossop Integrated Care NHS Foundation Trust

Tameside and Glossop Integrated Care NHS Foundation Trust serves a population of around 250,000 living over an area of 40 sq miles. The population is both urban and rural, covering Tameside Metropolitan Borough, part of Greater Manchester, and Glossop, a market town in north-west Derbyshire.

The Trust employed approximately 4,300 staff in 2021-22, had 524 beds across 28 wards and departments and an annual turnover in the region of £209 million.

The Trust also operates Community Healthcare Services across five neighbourhoods in Tameside and Glossop. These are delivered in both community locations and to people in their homes.

Sources: CQC (2019) and Tameside and Glossop Integrated Care NHS Foundation Trust Annual Report 2021-22

For this case study Karen James (Tameside and Glossop Integrated Care NHS Foundation Trust CEO) and Kathryn Gaskell do Carmo (Divisional Director of Nursing and Interim Divisional Director of Operations Medicine and Urgent Care at Tameside) were interviewed in depth about Tameside's story.

A failing Trust

As far back as 2002, there were concerns about Tameside's performance.[55] During 2010, Tameside hospital was identified by the then NHS financial regulator, Monitor, as being in need of substantial improvement.[56] Tameside was one of the 14 failing trusts examined by Sir Bruce Keogh in his 2013 review.[57] In his statement to Parliament, then Secretary of State for Health Jeremy Hunt described:[58]

> *"Tameside Hospital NHS Foundation Trust, where patients spoke of being left on unmonitored trolleys for excessive periods and where the panel found a general culture of "accepting sub-optimal care"."*

Karen James, outlined the situation she faced when she took over in 2014:

> *"The community themselves were…talking about how poor the organisation was, they were…walking up and down with placards…it was terrible…it was called 'Shame-side'…the quality of the performance through the organisation and patient care was appalling."*

Reflecting this situation, between 2010 and 2015, Tameside was inspected 11 times by the CQC. Table 3 and 4 illustrate the recent inspection history of Tameside and Glossop, which demonstrates the extent of the ongoing turnaround that has already taken place. As it shows, in 2014, the year that James became CEO at Tameside, the Trust was in a difficult situation.

Table 3: CQC ratings for Tameside and Glossop Integrated Care Trust 2014-2019

	2014	2015	2016	2019
Overall rating	Inadequate	Requires improvement	Good	Good
Safety	Inadequate	Requires improvement	Requires improvement	Good
Effective	Requires improvement	Requires improvement	Requires improvement	Good
Caring	Good	Good	Good	Good
Responsive	Inadequate	Requires improvement	Good	Good
Well-led	Requires improvement	Good	Good	Good
Resources used-productively	-	-	-	Requires improvement

Sources: Care Quality Commission (2014), (2015), (2017) and (2019)

Additional signs of Tameside's improvement trajectory

The improvement trajectory that Tameside was on before the pandemic was also evident in other metrics beyond its CQC ratings. For example, between 2014 and 2019, the overall rating given to Tameside in the NHS Patient's Survey has steadily risen – see Table 4.

Table 4: Inpatient "overall experience" rating for Tameside and Glossop Integrated Care NHS Foundation Trust, various years

Year of patient survey	Trust score	Lowest in England	Highest in England	Difference between Trust score and highest in England
2014	7.6	7.2	9.2	-1.6
2018	7.8	7.3	9.1	-1.3
2019	8.1	7.4	9.2	-1.1
2020	8.2	7.5	9.5	-1.3

Sources: Survey of adult inpatients, Tameside and Glossop Integrated Care NHS Foundation Trust, (2014), (2018), (2019) and (2020)

Table 5: A & E patient "overall experience" rating for Tameside and Glossop Integrated Care NHS Foundation Trust, various years

Year of patient survey	Trust score	Lowest in England	Highest in England	Difference between Trust score and highest in England
2016	7.7	7.5	8.9	-1.2
2018	7.8	7.0	8.7	-0.9
2020	8.1	7.5	8.9	-0.8

Sources: NHS A&E patient survey, Tameside and Glossop Integrated Care NHS Foundation Trust, (2016), (2018) and (2020)

With the worst of the COVID-19 pandemic over, the situation for the NHS remains challenging. Nevertheless, there is evidence that Tameside is at least sustaining its pre-pandemic quality, with (marginally) higher than average scores across a range of areas relevant to good leadership and management practices, as Table 6 demonstrates.

Table 6: Tameside and Glossop scores in selected categories in the NHS staff survey compared to the benchmark average, 2022

	Recognised and rewarded	A voice that counts	Always learning	Work flexibly	A team	Engagement	Morale	Average score
Tameside and Glossop	5.9	6.7	5.4	6.2	6.7	6.8	5.8	**6.2**
Benchmark average	5.7	6.6	5.4	6.0	6.6	6.8	5.7	**6.1**

Source: Tameside and Glossop Integrated Care NHS Foundation Trust, NHS Staff Survey Benchmark Report, 2022

The improvement in the Trust's performance was palpable for Gaskell do Carmo, who had been at Tameside since the late 90s. This change was typified by what had happened in the areas that she knew best. She noted that retention rates (a notable reflection of workplace culture, staff morale and motivation) had significantly increased. Vacancies, Gaskell do Carmo noted, were no longer a problem:

> *"We've got no nurse vacancies in the whole of medicine and urgent care. Which is really rare... I know when I was in theatres, we had 20 gaps, and nurse vacancies...I think it comes from Karen's leadership, and then to the others that work for Karen."*

Turnaround

As Tables 3 and 4 illustrate, under the new leadership, the Trust was "turning around" by 2016. At the most recent inspection in 2019, the Trust had maintained its "good" overall rating. To demonstrate the degree of positive change between 2014 and 2019, in its most recent inspection, the CQC stated:[59]

> *"The board demonstrated high levels of skill, knowledge and integrity…There was a stable and experienced executive team….delivering good operational performance as well as being focused on the development of the local integrated care system…There were 26 transformation schemes in place or in progress to support the strategic plan and there was early indication of the positive impact. There was a culture to support the delivery of high-quality, sustainable care. Staff across the organisation spoke positively about the culture of the organisation…[and]…indicated they felt…proud to work at the Trust…[adding]…that they felt the Trust had changed completely, for the better, over the past few years."*

The role of leadership and management in turning Tameside and Glossop around

It was clear from the testimonies of James and Gaskell do Carmo that improving the leadership and consequent changes to management have been essential ingredients in the move onto an improving trajectory. The steps taken by James and her team broadly reflect what the existing evidence base suggests should be considered as effective leadership and management practices.

Prioritising problems and tackling them in sequence

At the strategic level, James moved quickly to put priorities in place, to boost confidence that an improvement process was beginning and that it would ultimately make a difference:

> *"You've got to build a rapport…[and be]…clear about your assessment".*

James added the next step was to:

> *"stabilise, and…[swiftly]…deliver confidence to those…[such as]…regulators that we have to report to…to [show]…actually, improvements are happening…that was my…priority."*

Building confidence through increasing the levels of trust within the organisation

Changing the organisation's culture

James was clear about the kinds of steps it took to get the failing trust out of its difficulties. She described that transformation required everyone to be on board with efforts to improve the situation and believe that it could be done. This would first require her to earn the trust of the staff at Tameside:

> *"It [required] galvanising the whole workforce to drive…improvements, and they needed to trust you."*

Understanding the problems

James noted that this involved showing that she understood the problems and taking the time to build relationships, from which trust would emerge in time:

> *"They needed to understand that you understood what the issues were."*

> *"I had to go out and talk to all the clinical teams, because they…just think management are people that pass through the organisation, and they're there for life. So you've got to build a rapport with them."*

> *"Trust will emerge [if you]…develop those relationships and that trust. And if you don't have that trust or those relationships, you're not going to achieve. And that's at every level."*

Being visible, open and accessible to all staff at Tameside and Glossop

One technique, among others, that James deployed was to make herself visible and available to her colleagues:

> *"I could walk along the corridor now and have a…conversation…you have to be out there being visible, talking to staff, be understanding of their operating model, their contexts, the challenges, and celebrating when the…teams and individuals do a great job, and acknowledging that and involving them in decisions."*

The openness of James was in stark contrast to her predecessors at the Trust. Those on the front line noticed a difference very quickly and appreciated the change, as Gaskell do Carmo attested:

> *"The change…in the leadership…very different, very approachable….[the]…door is literally open. And that's not a cliche, you can go in and speak to any members of the exec team."*

A clear perspective on the problems

James cited the importance of being honest with her new colleagues about the situation and being clear about the direction she wanted to go in:

> *"[you] have to be clear about your assessment of the organisation…[and]…being clear…to everybody what needed to be done."*

Rebuilding a team ethic around the right values, behaviours, aims and objectives

Starting at the top

Rebuilding a team mentality was another essential ingredient in bringing about recovery. This had to be encouraged from the top, with the leadership setting out a vision and displaying the behaviours that they expected everyone else to also live out at work:

> *"I've got a great executive team…very supportive of one another, they have the right values…"*

> *"It's…being clear about the values and behaviours you expect for the organisation, and making sure you're demonstrating those values and behaviours as well, in terms of having that leadership role…you will only get the benefits, particularly in terms of the public sector by working with others. And that has to happen at every level."*

Clear goals to aim for

In addition to setting the right tone and demonstrating the behaviours that leaders want to see from everyone in organisation, having the right goals to work towards and ensuring everyone bought into them was also vital for bringing about change:

> *"[we have]…to be clear about…the outcomes…expect[ed]… they are very broad…we have about five…of them …I'm clear about the outcomes I want…them to deliver"*

> *"Those [goals] are high level…[and] allow us to achieve our…strategies"*

Linking the overall goals with the specific objectives for the workforce and trusting teams to deliver

James described how it was vital that the objectives of everyone in the organisation should link up to the organisation's goals:

> *"[they're]…a golden thread throughout the organisation…So everybody knows…how they can contribute to…delivering."*

Gaskell do Carmo praised the high levels of trust that the new leadership under James had in the staff at Tameside. Autonomy for teams to be able deliver in the ways the professionals considered best was central to the improved approach at Tameside and stood in stark contrast to the previous regime:

> *"It's about being given the space to be able to develop your team. But it's also about not only being listened to, but it's about having the autonomy to make the changes…"*

Securing buy-in from middle management

Creating a single team mentality requires everyone at each level to buy into the concept and the goals. The centrality of middle managers as conduits for inculcating such an ethos was emphasised by James, and she therefore spent a lot of time taking steps to win them over to her vision:

> *"You have to spend a long time with…middle managers, because they…are so important…You spend time developing those individuals, getting them on board…Because you know, when things go wrong, often it's that middle tier. So of course…we're visible, we're out about…[to]…get a feel of what's going on…you've got to make sure…you're working with that middle tier very closely, they understand what the issues are"*

James's view of middle management and its importance is consistent with the existing literature.[60] In less successful organisations, it is only when there are problems that the importance of the quality of middle management becomes clear.[61]

Identifying and targeting some "early wins" to build momentum around improvement

It was important to build-up momentum through early wins, to show that change was possible. To deliver those wins, areas where a service improvement team could be sent in to work with the operational teams were identified:

> *"There were some easy wins....so we targeted those...with...our own service improvement team, who worked with the operational teams to make...changes and immediately you could start seeing some improvements happening...it was steadying the ship"*

Strengthening relationships with outside organisations

After the initial work laying the internal foundations for a high-trust, team-centric organisation that key external parties could see was undergoing improvement, James looked to engage and build good working relationships with key local bodies, which were indispensable partners for effectively delivering healthcare services:

> *"[along with the]... confidence... [of]... regulators... to... say... improvements... are happening... At the same time... talking to the local authority, making sure they knew we were competent, that I knew what the issues were, and how I wanted to work with them going forward."*

The alchemy of talent and training

Having the right people in place

The recruitment of effective people was a vital component of the efforts to turnaround Tameside. The leadership team is at least, if not more, important than the CEO:

> *"I'm only as good as my team...my success has been spotting the talent and developing...those people that...are able to function at this level...[those]...with the right. personal attributes... I know... my strengths and weaknesses. But I've got people that complement my weaknesses."*

The difficulty of recruiting for lower and middle management was highlighted by James, with a recognition that internal promotions have been difficult at Tameside because of a lack of management skills among those in line for promotions:

> *"It's really difficult to recruit into those posts...you may be good as a clinician...all of a sudden, because you're great at what you do, you're promoted to a management role or a clinical director role...And...[they]...haven't developed...different skill sets."*

The other side to the recruitment of effective managers is removing persistently under-performing ones, after attempts to work with those who were not able to deliver. As she tried to transform Tameside, James reported having to lay off a number of middle managers, so she could replace them with better performers:

> *"We moved quite a few people on...[there were colleagues who didn't]...have the right skills set to drive the organisation forward....so there were some difficult conversations, but then that middle tier is absolutely key...And where...I've got one or two issues...in one or two departments...that is about their middle management and that team. And so you've really got to make sure you've got the right people in those posts."*

Possessing the appropriate skills is vital

James strongly supported the notion that leaders and managers need to be properly trained to deliver an improvement programme like the one that is being implemented at Tameside. James herself deliberately sought out and nurtured talent with training and mentoring, because she understood the importance to organisational success of building and maintaining a pipeline of able people:

> *"I…want great people…I can spot talent, bring them on, even within the organisation…And those individuals over the years have done various jobs, have… become directors…and aspiring chief execs…But, it's got to be the right kind of…people who've got the ability to engage individuals…and they've got the academic side as well, the ability to progress."*

James had had to be proactive on nurturing talent in house, as she felt that the wider official system for leadership and management training was not working as well as it might:

> *"The management training program has changed somewhat, and you don't get the same numbers coming through. And so you really have to grow your own."*

However, James also acknowledged that this was difficult because, where talented individuals were identified, they often did not have the time to undertake the training and acquire the appropriate experience that would then enable them to progress and become the capable managers and leaders of the future:

> *"Those individuals haven't got the headroom to do those things…there aren't development programs…you try and ensure they do progress…but you just haven't got the headroom to do it."*

Introducing a new pro-training culture

Divisional Director of Nursing Gaskell do Carmo described how James and her team had brought about a sea change in the approach to learning, with upskilling of staff now a top priority:

> *"It's a culture thing…we're really encouraged to go…on…courses…we have a training allowance… the culture is definitely one of supporting staff to develop."*

Gaskell do Carmo offered up an example from early in James' tenure:

> *"We asked Edge Hill University to come and do…bespoke training…We've…never done it before….The Trust funded it, they came in and…taught 15 nurses an anaesthetic qualification….[these are the]…type of things that the Trust will do…it was something we asked for as a nursing team."*

Gaskell do Carmo herself was completing a post-graduate qualification in healthcare leadership to reflect her move up the healthcare hierarchy. Further, Gaskell do Carmo noted that what she had learnt through her post-graduate learning had been very valuable to her job:

> *"What I've learned…especially now I'm in this role…I've found it really useful…the different modules that I've done…[whether that was]…about…leadership and your leadership style, etc…or things like…project management."*

The characteristics, experience and training of the CEO

James's background fits with findings in the wider literature on healthcare leadership that suggest the most effective leaders are often those with clinical backgrounds.[62] She was a clinician and combined this with formal postgraduate management training, acquired as she moved up the management hierarchy. James felt her clinician background combined with a long time spent in lower levels of management in the NHS were invaluable prerequisites for enabling her to lead the kind of change at Tameside, that she has delivered:

> *"I understand, I've managed all the departments that I'm asking others to manage. I know…the professional issues as well…, I know, there's the way you talk to surgeons, as opposed to physicians…you have to understand…their contexts, how you can get the best from them, and you need to understand where they're coming from, and the…different beasts…having that exposure and having a clinical background, but also…having managed all those different departments, or teams, then you really get an understanding of how…the system and processes work."*

Structural changes complemented the "softer" attitudinal and cultural changes

Also important for Tameside's transformation have been structural reforms to how the Trust is organised. These have facilitated the changes in the leadership approach and culture. Gaskell do Carmo described them as involving the creation of four divisions, which make regular interaction, the spreading of new and better ideas and the resolution of problems more easily :

> *"There are only four divisional directors….because there's only four of us…there are…small teams who are literally meeting daily…that's where we share good practice, …and[say] that's working and that one isn't…there is…trust in the fact that everybody knows everybody."*

The reorganisation at Tameside also involved a reformulation of middle management at the Trust, to create more "dense networks" of effective middle managers that a participant at the roundtable noted were important for successful organisations (see Chapter Five):

> *"The extra positions that have been put in have been…really beneficial…we never used to have a Head of Nursing…we had a gap from a Matron's post right away up to…Deputy Chief Nurse, and nobody in between, which was a…a real concern, really, to get that voice from [the team] from one to the other."*

In line with the existing evidence on management in the NHS,[63] Gaskell do Carmo acknowledged that the utility to the delivery of health services of these new roles was dependent on the quality of the people that filled them:

> *"It's probably, not so much about the layers, it's about the quality in…those layers…"*

CHAPTER SIX – MANAGEMENT PRACTICES IN THE PROVISION OF HEALTHCARE IN THE UK

Better management is linked to improved public sector performance

It is not leadership alone that helps drive up public service performance levels. Without good management, it is almost impossible to implement the measures needed to achieve an organisation's vision and the goals that its leadership has set out.

Middle management in particular is an important layer in delivering changes, implementing evidence-based best practice and improving performance. [64] Middle managers have a unique bridge position in an organisation's structure that allows them to learn from both sides, [65]and therefore know how best to implement innovative practices that suit their teams.[66] The centrality of middle management was reiterated at the SMF-convened expert roundtable, where one contributor articulated how:

> *"Middle managers…provide the conduit of information from top to the bottom of the organisation, and also horizontally, they are the glue that holds organisations together, they provide that information flow…we know that good organisations, and good managers make that possible." (management researcher at health policy think tank)*

The management practices associated with better performing public organisations

When public sector leaders and managers were surveyed about the most important ingredients in organisational success, management quality ranked sixth, with 27% citing it (see Figure 5). Nevertheless, factors such as workforce skills and training (31%) that management often have considerable influence over, were seen by more leaders and managers as important.

This suggests a degree of disconnect between the views of many healthcare leaders and managers about the importance of management and the variety of workplace factors that they can and do influence, which in turn help determine the performance of an organisation.

Ensuring there are competent managers is an important starting point for improving organisational performance

Central to effective management is having enough competent managers. Of those we surveyed, most managers (39%) worked in large organisations with 2,500 people or more, and 55% reported that they led or managed between six and 49 people. This number rose with seniority, as we would expect. Ensuring there is competence amongst mangers can be done through training, as well as ensuring there is accountability for underperformance.

The data collected from healthcare leaders and managers suggests that UK healthcare organisations deploy a number of techniques to try to improve manager performance. When asked in the survey to describe the steps that are taken in their organisation to manage underperforming managers, as Table 7 shows, there was no measure that was overwhelmingly common at any stage of the performance management process.

Table 7: Steps taken when addressing underperformance of managers

	First instance	Second instance	Third instance
Most common action	Informally encourage improvement (26%)	Provide additional (relevant) training (28%)	Pass onto HR to deal with (18%)
Second most common action	Provide additional (relevant) training (20%)	Formally put under a performance management programme (20%)	Mentoring from another colleague (17%) Formally put under a performance management programme (17%)
Third most common action	Formally put under a performance management programme (12%) Mentoring from another colleague (12%)	Mentoring from another colleague (13%)	Provide additional (relevant) training (15%)

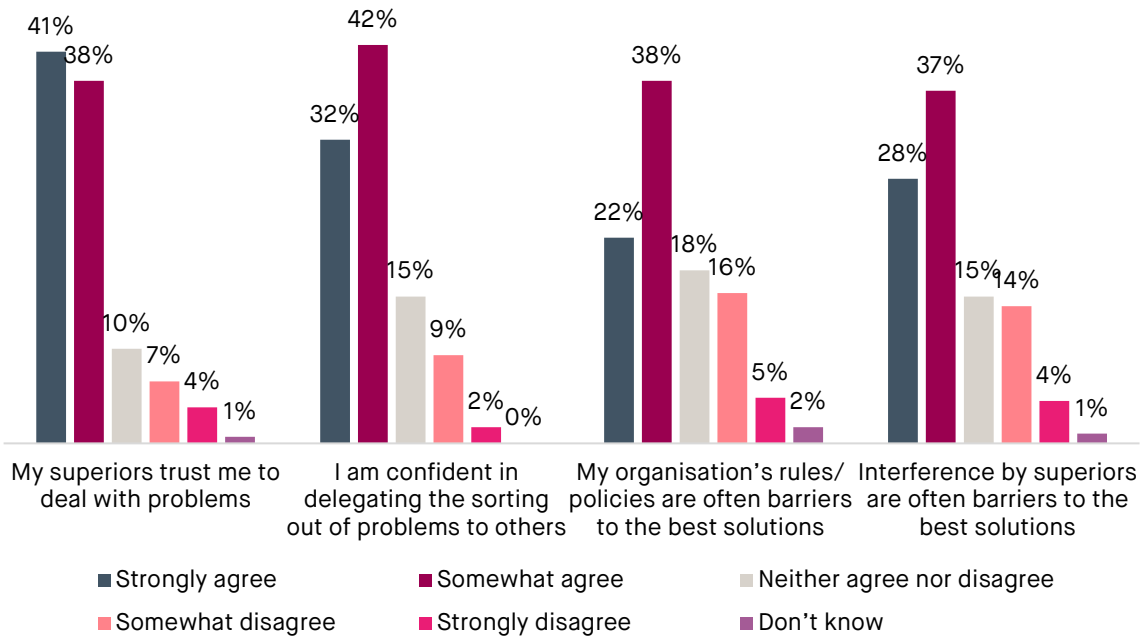
Source: SMF Opinium Survey March-April 2023

Actions such as letting someone go, passing underperformers onto a more senior colleague or moving them to another role were uncommon, indicating a widespread interest in retaining managers and a belief that they can improve their performance when given the right support.

Autonomy is an important component of facilitating good management

Almost 80% of healthcare managers reported that their superiors trusted them to deal with problems, and 74% were confident in delegating the sorting out of problems to others, as Figure 12 illustrates.

Figure 12: Extent to which managers have the autonomy to solve problems that they come up against within healthcare organisations



Source: SMF Opinium Survey March-April 2023

Nevertheless, the involvement of other staff and organisational "red tape" were still issues for many, with 60% stating that internal policies or rules, and 65% that interference by superiors, were barriers to the identifying and implementing the best solutions to problems.

More about the role of internal constraints on leaders and managers emerged when survey respondents were asked about the nature of the obstacles they face to being effective leaders and managers. Table 11 in Chapter Seven shows that, among those leaders and managers who said obstacles hindered their ability to do their job as effectively as they might otherwise, 20% raised internal processes and associated bureaucracy. Typical complaints from survey participants, included:

> *"Being restricted by new policies and procedures as the company gets bigger." (middle manager, community care service/ network)*

> *"Too much red tape, such as needing approval for the smallest of things, usually the people providing approval have no idea themselves so never reply." (middle manager, hospital)*

As the Tameside and Leeds case studies in this report illustrate, the freedom of managers to manage is an important ingredient in improving performance. However, the above findings suggest that many healthcare institutions are falling short in this regard.

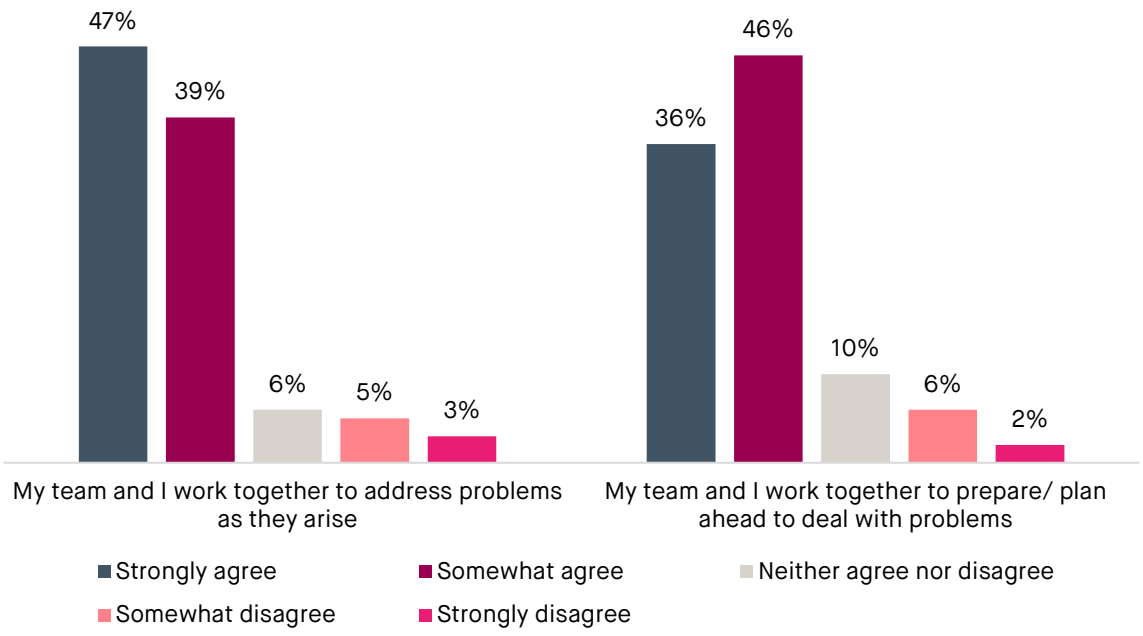
A good culture appears to be present in many healthcare settings, although there is room for improvement

A good work culture has many aspects to it, such as a positive working environment, team working and a focus on staff development. Levels of motivation, morale, recruitment and retention are all indicative of good culture.

There is a prevalence of collaboration and team working, however this may be limited to problem solving

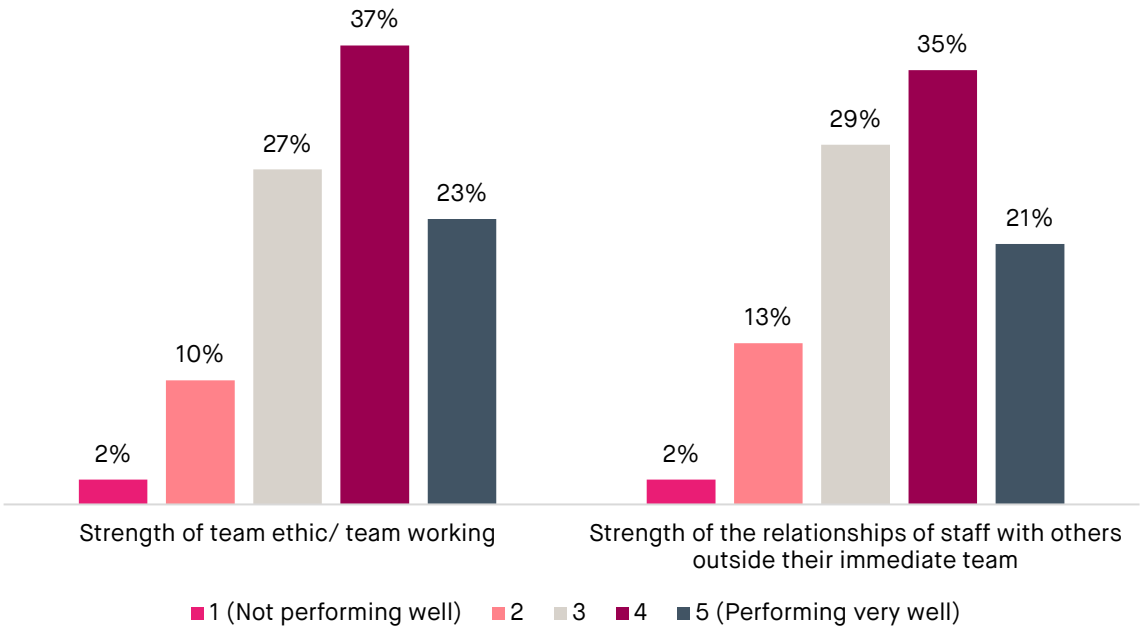
The survey results indicate that team working is prevalent within healthcare organisations in the UK (see Figure 13). Some 86% of healthcare respondents say they work together to address problems and 82% say they do so to plan ahead to tackle issues. However, there was a notable drop in the proportion of respondents saying that their workplace has a strong team ethic (60%) and describing their organisation as performing well on the strength of relationships outside their immediate team (56%) (Figure 14).

Figure 13: Strength of relationships between managers' staff and those in the rest of the organisation and the team ethic, as ranked on a scale of 1-5, with 1 being the lowest



Source: SMF Opinium Survey March-April 2023

Figure 14: How well healthcare respondents feel their organisation is performing on the following areas



Source: SMF Opinium Survey March-April 2023

Workforce motivation and morale are key to organisational success yet both are areas where a sizeable minority fall short

Motivation and morale are two important factors that help determine whether a workplace is a high-performing one or not, as they correlate with metrics such as levels of patient satisfaction.[67] However, just over half (52%) of respondents reported that their organisation performed well on staff motivation levels. Under half (49%) reported that their organisation was doing well with staff morale.[xvii] This implies that only around half of healthcare providers (and their leaders and managers) in the UK are maximising their efforts to ensure good levels of motivation and high morale among their staff.

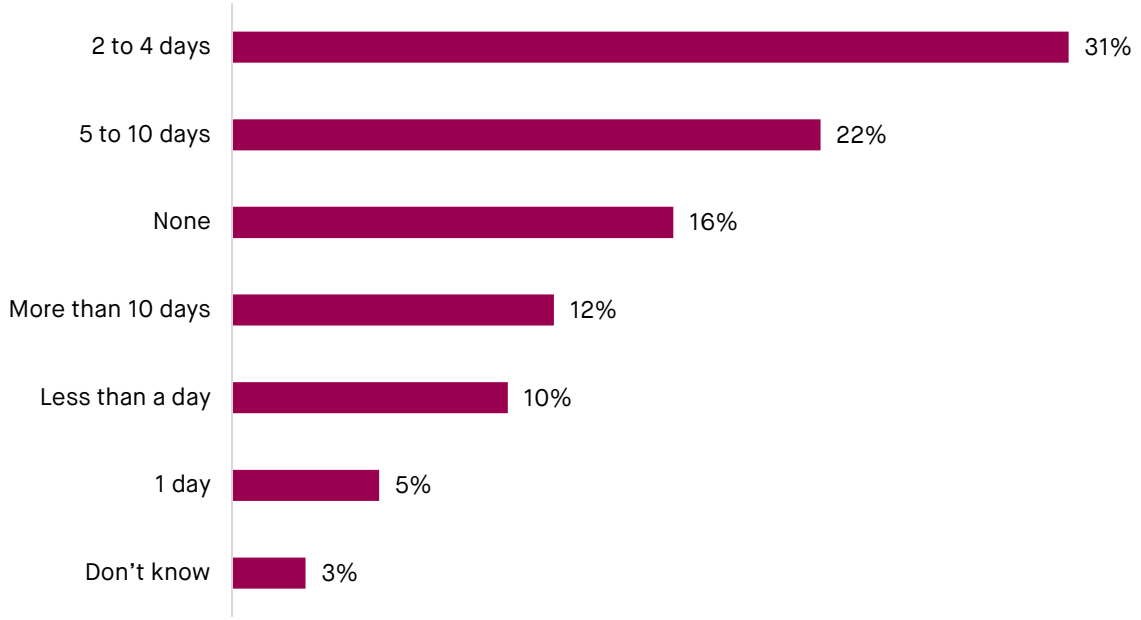
Consequently, bringing about substantial improvements in these areas should be a priority for leaders and managers in healthcare organisations looking to improve performance. Where leaders and managers are not identifying and deploying the best methods to achieve these ends, support through training or other means should be provided to enable them to do so.

[xvii] We should note, that at the time the survey was in the field, strikes were taking place across the healthcare sector, which may have had some impact on morale. However, when reflecting on 2022, 43% said that maintaining morale had improved.

Training is essential for good-quality management and a degree of it is common in healthcare

As Chapter Five described, senior leadership was generally considered to be performing well when it came to promoting manager training. Reflecting this, 81% of all healthcare managers surveyed reported having participated in at least some leadership or management training in 2022. Over half of respondents participated in between two and 10 days of training. This is broadly in line with the wider public sector picture.

Figure 15: Days of leadership or management training and development undertaken in 2022

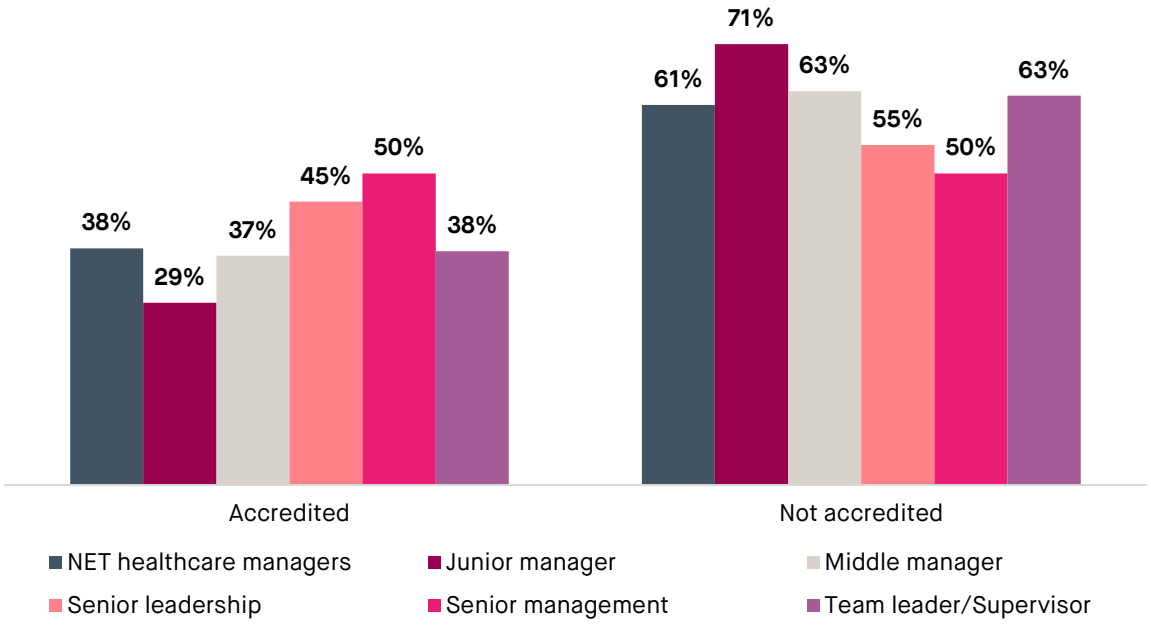


Source: SMF Opinium Survey March-April 2023

There are problems with management training for more junior managers in the NHS

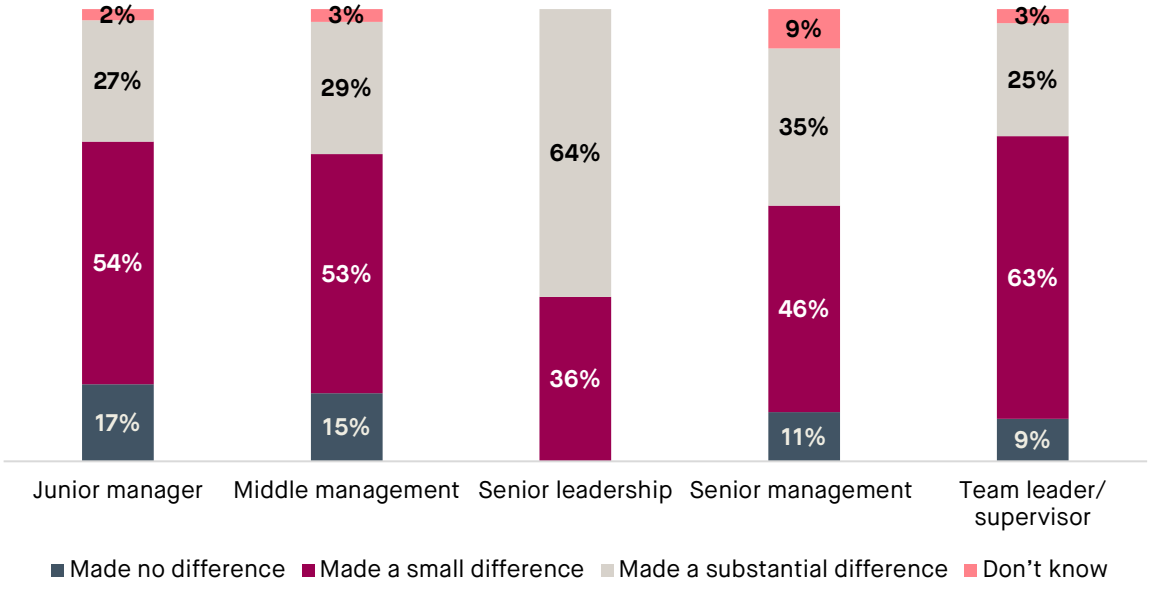
Most training taking place is unaccredited. As Figure 16 shows, this is particularly noticeable at lower management levels, with 63% of team leaders and 71% of supervisors reporting that, in 2022, little to none of their training was accredited. Senior managers (50%), closely followed by senior leaders (45%) were the two groups most likely to have had accredited training. Most managers said that the training they undertook made a difference to their effectiveness as a leader or manager, but that the benefit was small (see Figure 17).

Figure 16: Proportion of training that was accredited



Source: SMF Opinium Survey March-April 2023

Figure 17: Whether leadership and management training made a difference



Source: SMF Opinium Survey March-April 2023

The apparent under-serving of more junior managers as exemplified by the lower levels of leadership and management qualifications noted earlier mirror the experiences described at the SMF's expert roundtable. Several participants echoed this description by one attendee:

> *"Relatively new...clinical staff who are coming through...[who are]...showing signs that they're suitable for promotion and so on...they'll have received no leadership training whatsoever. " (healthcare management professional)*

He added:

> *"This is first level…beginners…into the superstructure of management and leadership. And it's barren…they've had nothing to prepare them for what's coming." (healthcare management professional)*

For GP practice managers, the situation was considered equally inadequate with one roundtable participant stating that:

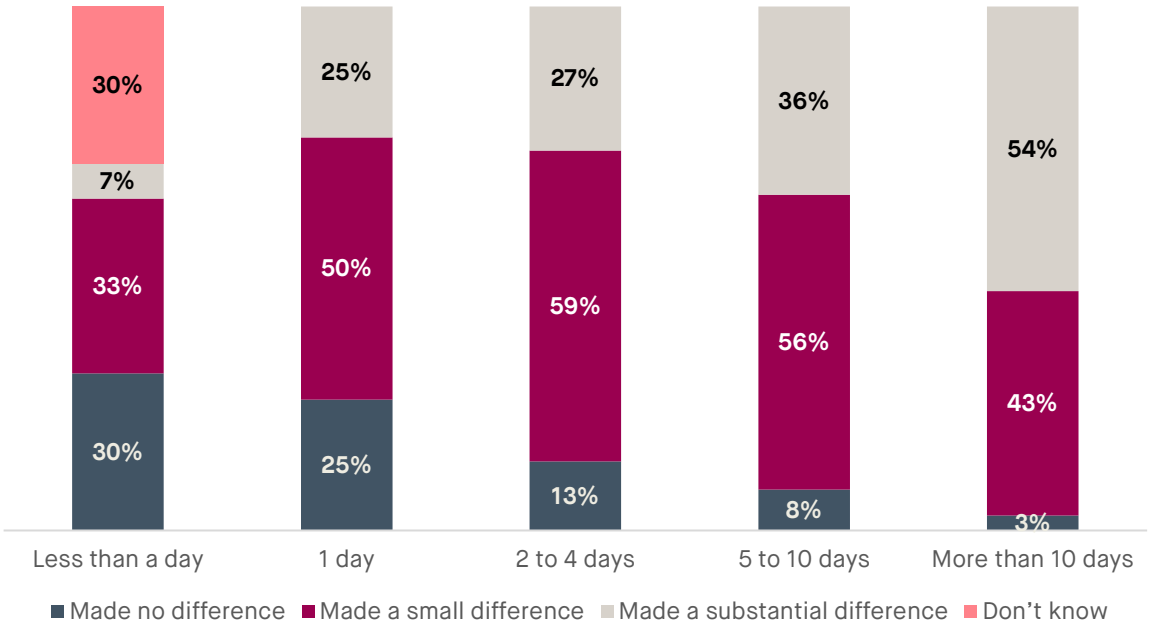
> *"There is not a lot of training and development available for practice managers across the country. It's quite sporadic and patchy in places. So it is quite a difficult role to carry out in isolation….A lot of our GP partners are not trained to be managers or employers." (GP Practice Manager)*

The recent Messenger review made similar observations about the NHS management training situation:[68]

> *"[there is an] absence of accepted standards and structures for the managerial cohort within the NHS…it has long been a profession that compares unfavourably to the clinical careers in the way it is trained, structured and perceived…greater professional status and more consistent, accredited training and development are required. This training must be aligned to professional skills required in the future."*

Longer training and training that is accredited were largely viewed by respondents as more valuable than shorter, unaccredited training. The more training respondents undertook, the more likely they were to say it made a substantial difference to their leadership and management capabilities: 54% of people who did more than 10 days of training said it made a substantial difference, with a further 43% saying it made a small difference. This was in contrast to those who did five to 10days, 36% of whom said it made a substantial difference.

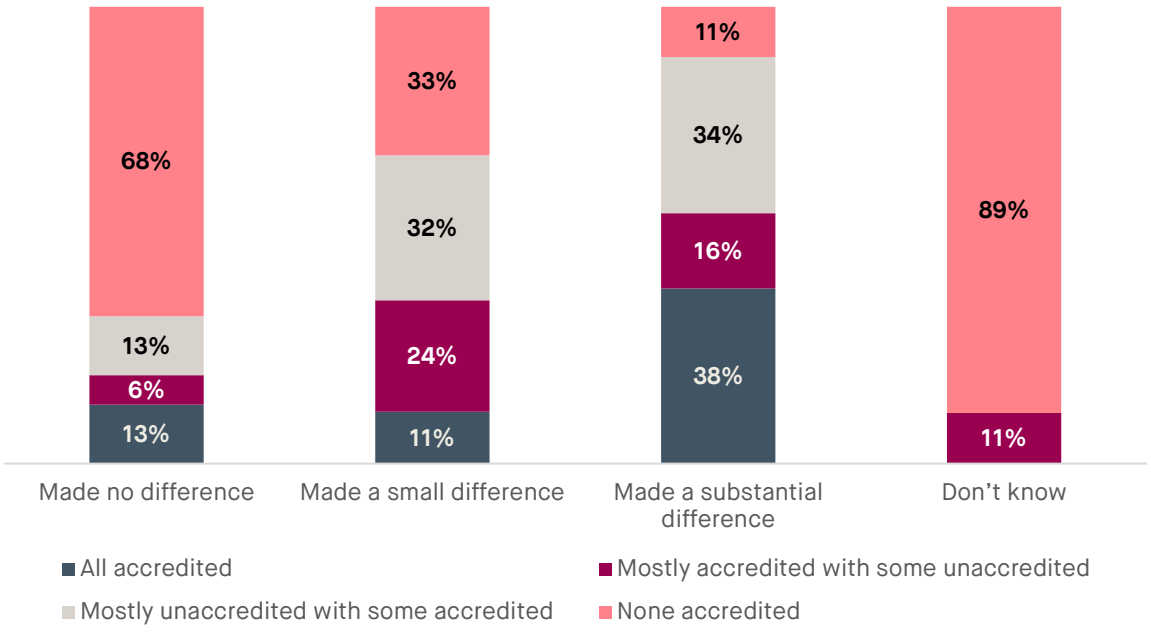
Figure 18: Whether training made a difference by number of days training undertaken



Source: SMF Opinium Survey March-April 2023

Those with accredited training were also more likely to feel it had made a positive difference. Of those who felt their training made a substantial difference, 38% had done all accredited training, a further 16% had done mostly accredited training, with some unaccredited.

Figure 19: Whether training made a difference by whether training was accredited



Source: SMF Opinium Survey March-April 2023

However, it should be noted that 34% of those who had done mostly unaccredited training also felt it had made a substantial difference. On the one hand, the small proportion of accredited training they had could have made a larger and more lasting impact, with the unaccredited training that was done provided in house and more informally. The latter can vary widely in quality, from a one-off session of only a couple of hours duration on a topic to something more intense and likely beneficial, such as mentoring from a more senior colleague.

Performance targets are common at all levels, although some areas receive more attention than others

Achieving an organisation's overarching goals depends on all the different parts of the organisation working towards those goals. To ensure this, many teams will have their own performance targets. Best practice dictates that these ultimately align with and help achieve the wider goals of the organisation. Where relevant to their role, most managers (81%) surveyed had internal or team focused targets in place. As shown in Table 8, just under two-thirds (62%) of those who had targets in place felt that they were aligned with the goals of the organisation.

Table 8: Proportion of leaders and managers with targets in place and the proportion that have targets that are aligned with organisation-wide goals

With targets in place	Without targets in place no	Whether targets are aligned with goals of organisation
81%	19%	62%

Source: SMF Opinium Survey March-April 2023

The fact that one in five leaders and managers across healthcare organisations do not have targets and, in more than a third of cases where there are targets these are not aligned with the goals of the organisation, suggests there is a failure in a large minority of healthcare providers to implement this basic management best practice measure.

CASE STUDY: LEADERSHIP AND MANAGEMENT IN ACUTE HEALTHCARE SERVICES – LEEDS TEACHING HOSPITALS NHS TRUST

Leeds Teaching Hospitals Trust

Box 4: Leeds Teaching Hospitals Trust

Leeds Teaching Hospitals Trust (LTHT) is one of the largest acute hospital trusts in the UK. Formed in 1998, it provides healthcare and specialist services for people across the city of Leeds, the Yorkshire and Humber region and further afield. The Trust is currently made up of seven hospitals across five sites and is one of the largest providers of specialist hospital services in the UK.

The Trust has a budget of £1.4 billion and employs more than 21,000 staff. In 2022 it treated more than 1.7 million patients.[69]

As well as providing care to the surrounding areas, the Trust provides education and training to medicine, nursing and dentistry students at the University of Leeds. The Trust also is active in clinical research, and is the highest-ranked NHS Acute Trust in health research recruitment and fourth overall.[70]

Moving to a higher standard

In October 2014, a CQC intelligent monitoring report found that Leeds Teaching Hospitals Trust had an "elevated risk" across three areas, and a "risk" in eight areas, including "never events"[xviii].[71] The Trust was placed as a "band 1" risk by the CQC - the highest possible risk category.[72] A few months later, this was downgraded to band 4, in part due to a change in staff survey responses. A full inspection report from March 2014 acknowledged that while some of the care provided was outstanding, there were too many areas of concern and the Trust received an overall grade of "requires improvement".

At this time a new chief executive, Julian Hartley, had been appointed. The change that Hartley began and the trajectory of improvement LTHT went on is demonstrated in the Trust's performance ratings improving at each subsequent inspection. Table 9 shows, for example, that in its next full inspection in 2016, the Trust was upgraded to "good" overall with "requires improvement" in fewer areas. It maintained its overall "good" rating at its most recent inspection in 2018.

The upgrade in LTHT's CQC rating positively correlates with an improved patient survey score, rising from 7.9 at the time of the review to 8.1 in 2021.

[xviii] Never events are serious incidents that are completely preventable due to guidance or safety recommendations provided at national level, which should have been implemented by all healthcare providers.

Table 9: CQC ratings for Leeds Teaching Hospitals Trust, 2014 - 2018

	2014	2016	2018
Overall rating	Requires improvement	Good	Good
Safety	Requires improvement	Requires improvement	Requires improvement
Effective	Good	Good	Good
Caring	Good	Good	Good
Responsive	Requires improvement	Good	Good
Well-led	Requires improvement	Good	Good
Resources used productively	n/a	n/a	Outstanding

Sources: CQC (2014), (2016) and (2018)

Table 10: Inpatient "overall experience" rating for Leeds Teaching Hospitals Trust, various years

Year of patient survey	Trust score	Lowest in England	Highest in England	Difference between Trust score and highest in England
2014	7.9	7.2	9.2	-1.3
2018	8.1	7.3	9.1	-1
2019	8.2	7.4	9.2	-1
2021	8.1	7.4	9.4	-1.3

Sources: NHS Inpatient survey (2014), (2018), (2019) and (2021)

The role of leadership and management in maintaining a "good" Trust

Speaking to current CEO Professor Philip Wood, and current COO Clare Smith, adopting a new approach to leadership and making changes to how the Trust was managed played key roles in the improvements that have been seen.

The process of building "The Leeds Way"

Inclusive decision making

Shortly after arriving at LTHT, Julian Hartley developed the "The Leeds Way". Wood was Clinical Director of Pathology and subsequently Oncology at the time of the leadership change. He felt that there were some challenges around behaviour and leadership at the Trust and described how "the Leeds Way" came into being:

> *"What came to be known as the Leeds Way, was a kind of crowd sourced approach to asking our staff what they wanted to see in terms of how we provided services for patients and how we interacted with each other."*

Smith, who joined the Trust shortly after Hartley's appointment described the situation the Trust was in when she arrived as one where management was distrusted:

> *"They [new leadership] had clear vision about what they wanted to do, and really good engagement with the organisation. But there was an absolute undercurrent, and you could still feel it when I joined…[of]…distrust of management."*

The Leeds Way came about through initial conversations with staff about the challenges they felt the Trust faced, through staff engagement events. These were followed up with an approach that through crowdsourcing technology, enabled all staff to give their opinions on what the values of the Trust should be. Staff could see each other's comments and vote on the topics and issues that they felt were important. This helped to develop a codified set of values and behaviours that the organisation works by:[73]

> *"The key thing was…that…inclusive approach to…Because…it was about what values are important, as much to the porter as to the professor of surgery."*

These values articulated in the development of the Leeds Way remain embedded in the Trust. Over the past 10 years there has been a consistent policy which has staff buy in, that feeds into all decisions.

Refreshing the values

It is important, Wood noted, to ensure that the values remain consistent with the staff's outlook. Therefore, in 2022 staff were once again asked to feed into a consultation about what they felt the values should be. The Trust's values were updated in line with the conclusions of that exercise. The core values themselves still resonated strongly with staff, with the aftermath of the COVID-19 pandemic highlighting the importance of health and wellbeing within the staff group, in addition to remaining focused on the highest-quality patient care.

Values informed goals and personal contribution

The Leeds Way helps ensure that LTHT's mission and goals are driven by the values:

> *"We focus on care quality, because that's what people engage with. And that's what people are interested in"*

One of the advantages of the inclusive approach to organisational value formation was that it helped to secure workforce buy-in to the organisation's goals. Clear goals, and a focused group of annual commitments, underpinned by those values help all staff to understand their personal contribution to achieving those goals.

> *"I've been very passionate about making sure that…if you're the domestic who's cleaning the wards, you're contributing to the quality of the care we provide for our patients. And your personal contribution to that is as valuable as the person who's doing that complex operation…if wards are dirty, people get infections,. So we've really tried to focus down on things that everybody can feel they are contributing to."*

A common purpose and commitment to public service was something which Smith also felt very strongly about. Emphasising the need for respectful and collaborative relationships across the Trust was considered crucial, if it was to deliver for its patients. The values help prioritise issues such as workforce wellbeing, which, in turn, is crucial to getting the best out of staff.

Professor Wood spoke about how this sense of mission helps to prioritise staff wellbeing and is a crucial part of maintaining morale and motivation among hospital staff. He noted that this has been particularly important in recent years with multiple cost of living crises:

> *"Keeping people feeling that they are valued in the health service is actually really critical. Whatever anybody's long term workforce plan is, we need to keep the skills that we've already got."*

The impact of the wellbeing measures on staff morale appears evident in the results of the NHS Staff Survey. The 2018 CQC inspection reported on this improved morale[74]

> *"Overwhelmingly staff were positive about and proud to work in the organisation. In the last 3 years, the Trust had moved from the bottom 20% of Trusts to the top 20% in the NHS staff survey." (CQC 2018 Inspection report)*

Leadership visibility and leading by example are fundamental to the values becoming embedded

To ensure that values were "lived" rather than imposed, Professor Wood explained how it was important that the executive team is both visible and seen to be acting on the values:

> *"All of us on the executive team will be out and about a lot having conversations with staff..... a lot of it is around exemplifying our own behaviours, because I think that that reinforces that for the staff as well."*

> *"Leadership is around a set of behaviours and encouraging people to follow you rather than a title that says I'm in a particular role."*

This was echoed by Smith, who spoke of the importance of consistency and visibility of senior leadership in applying the values . She also highlighted the importance of holding leaders to account on the values, and calling them out when they are not applied. This was particularly important at the start of the turnaround in helping to build trust with those who had been at the Trust the longest and were used to a different style of leadership.

A flat structure that encourages collaboration

Professor Wood spoke of how Leeds had a more decentralised management structure, which eschewed a very top-down, command and control approach.

> *"That whole parent child, bit of leadership is what we've spent a decade moving away for arms."*

> *"We've been very focused on being…collaborative and empowering our staff right at the front line to be leaders in their own right. So we've taken a very inclusive and permissive view of leadership."*

Rather than a pyramid structure, leadership at the hospital is relatively flat, with 19 unit, reporting to an executive team. Leeds instead encourages dialogue and working across different parts of the Trust:

> *"Our Clinical Directors will get together, our general managers get together, the heads of nursing, get together, and we do encourage a lot of informal dialogue between teams."*

Wood noted that, occasionally, encouragement to find joint solutions may be needed but this is light touch:

> *"If you need to bring four or five teams together, because actually, you need a collective solution…. So sometimes you need a convener or a facilitator or, just the glue that will actually bring them together to thrash your solution out….it is there to facilitate and support the conversation not to tell people what to do."*

Strong interpersonal relationships that foster good communication

The flat structure has helped to build strong relationships between senior leadership and those that report to them. The good relationships that have formed mean that any issues that arise are noticed promptly and can be dealt with sooner, in a respectful way. It also means that staff wellbeing is kept in mind.

> *"If you're going to have a good relationship with somebody, that relationship has to be built on honesty, the good and the bad. And, and I think that is why that is what I work really hard on doing."*

> *"These are hard jobs, and when people get themselves into a negative spiral, it's really difficult for them to get back out there. Making sure that those meetings are a balanced… let's talk about the difficult stuff, but let's also recognise the things that you're doing really well."*

A culture of continuous improvement

The impact of the Virginia Mason Institute partnership

The values and ways of working developed through the Leeds Way set the Trust up well for its partnership with the Virginia Mason Institute. The emphasis was on helping to develop a "lean-based improvement capability" through improving efficiency and reducing waste. By adapting the lessons learnt in this partnership to their own setting, the Trust developed the "Leeds Improvement Method", which promotes a culture of continuous improvement. The evidence of the effectiveness of this method can be seen in the most recent report on the hospital, which found them to be "outstanding" in the area of "resources being used productively":

> *"The kinds of things that the Virginia Mason work has really helped us with..[are]…connecting our frontline teams to the idea [of] what adds value and quality to the patient journey… and what doesn't…and what doesn't can be an opportunity to make your care more efficient."*

Autonomy to achieve outcomes

The work with the Virginia Mason Institute and development of the Leeds Improvement Method has meant that managers have been prepared with tools and processes they can use to achieve their objectives. Having these tools, within the flat structure at LTHT, allows managers greater autonomy to deliver in ways that best suit them. Professor Wood commented that:

> *"We've been very focused on…empowering our staff right at the front line to be leaders in their own right."*

> *"58Our local leaders felt very much that we were giving them permission to achieve…there were a set of parameters, but…delivery…was very much…based on their own volition."*

Autonomy is granted within a framework reflecting local and national ambitions

There is some structure to this autonomy. Plans and strategy are scrutinised, but the approach to how change should take place is bottom-up:

> *"One of our Leeds Way values is accountability…so we will want to have an accountability conversation about how you are delivering on…commitments. But beyond that…you have the permission to deliver that how you wish."*

This autonomy applies to not only the internal goals of the Trust, but also for achieving larger national goals.

> *"If you're [government] asking us to achieve X, how we do that needs to be something that we locally generate…[government]…telling us how to do it isn't actually going to make it happen any faster and our staff will not feel committed and connected to it."*

The corollary of autonomy is a culture of fearlessness about failure

The Trust also takes an approach to accountability that focuses more on why some areas of the Trust may not be succeeding and what support they need to achieve, rather than promoting a culture of blame.

> *"We've got some of our units that are absolutely motoring along… we've got others who are really struggling to deliver…because…there are some real challenges around…and they need more support…the key is that we still do that in the same supportive facilitative and collaborative way, rather than…coming down on them in a heavy-handed way."*

As Professor Wood noted, this approach applies to issues of progression as well:

> *"We…have to give people the opportunity to fail, because that's important for their own growth and development…. they might think they will want to do a management role and do one for two or three years and actually realise that it isn't really what they do want to do. And we have to…be okay with that."*

A focus on human capital and identifying and developing talent is important to success at LTHT

Leading a large team is very different to a small team and clinicians need to be trained for it

Professor Wood spoke of the leadership training that he himself received and how instrumental it was for coping with managing larger groups of people. Providing clinical leaders with sufficient leadership training was central to the vision of his predecessor, so that those in leadership roles were equipped to lead:

> *"As Clinical Directors, in those early years... we did get a lot of support, we got coaching, development sessions.... And I think that's really important for anybody going into leadership...because...you're leading larger groups of staff, so...[the]...traditional team leadership model can't work, ...Clinical Directors are leading units of several- hundred, staff size...this is not something doctors get any training in. Doctors mostly work in teams of maybe up to 20 people."*

Ensuring talent is spotted and supported with appropriate training is vital to performance

Training is not just for senior staff at LTHT. The Trust makes an effort to ensure that there is good leadership and management at every level. Managers at Leeds engage in a variety of formal training and development programmes, as well as encouraging mentorship within the Trust.

This focus on development extends to identifying future managers and leaders at the Trust at all levels. Rather than a formal process that creates a definitive pipeline of leaders and managers, leadership is encouraged to lookout for those interested in progressing to management roles:

> *"At all levels people are noticed, as it were."*

Smith spoke about her own experience with managerial progression, taking note of upcoming managers among those that report to her and developing them.

> *"I've got quite a few direct reports... And there are, they're all at different stages of their careers. So they all have different needs and requirements. Some of it can be dealt with, and supported through shadowing, those sorts of things. And others actually need some specific support...as part of the ongoing conversation with them, in their one to ones will identify any needs that they may have. And then I will try and support them to get access to that whether or not it's formal coaching, or whether or not it's more informal"*

Training and further development also does not end with senior leadership. Smith spoke of her own training both prior to her board level position and her continued development, such as through coaching and reciprocal mentoring.

> *"A really beneficial thing for me was we did a shadow board in the organisation. And I found that hugely beneficial in terms of understanding. I was sub-board at that point, and understanding the roles and responsibilities of our of our boards, but also then allowing me to have a good understanding for when I took that transition."*

> *"One of the people I'm mentoring is through the reciprocal mentoring program, which, which I have found hugely beneficial for my own development as well as they have"*

Getting everyone in the right job optimises organisational performance

The philosophy of LTHT is to support people in having a go, even if eventually it does not work out. Having this awareness of people's skills also means that if roles do not work out for them, there is an understanding that they might thrive in an area that suits that suits them better. In other words, LTHT sees a central function of management as ensuring people are in the right role for them, as this is best for the organisation's performance:

> "*We've certainly had people who've worked in operational roles, where clearly that doesn't really speak to their skill sets. And actually, they're better in a policy or a strategic role. And we will try to facilitate that... we've tried to look at people's skill sets and their talent and have that kind of level of career coaching that might help them think about what it is they find fulfilling."*

Leadership experience of the senior team

One of the consistent messages from the existing evidence base around medical leadership is the value of a CEO with a clinical background. Julian Hartley, who pioneered the change in the organisational culture at Leeds, did not have a clinical background, but did have extensive experience in supporting clinical leadership and was a graduate of the NHS Leadership Academy. Current CEO Philip Wood, however, noted that Hartley was committed to clinical leadership and developing the leadership capacity of clinicians. That said, Wood indicated that there can be benefits to clinical experience in a senior leader:

> *"There are some hugely effective chief executives from a non-clinical background ... you certainly wouldn't make the ... assumption ... [that] ... everyone from a clinical background would be suited to these kinds of roles....But I do think that there's a benefit to having a degree of ... professional understanding of the challenges of delivering health care, and never more so than ... [when facing] ... the complexities of ... the 21st Century"*

Smith highlighted the value of having a senior leadership team with mixed experience, to draw on the clinical side but also on those without clinical experience. In some areas, she pointed out, leaders did not have to depend on clinical experience to know there was an issue and that it should be addressed.

> *"You work collaboratively to be able to make the best effect for patients... When you're having a conversation around, why would it be the right thing to do to have a patient on a corridor for four hours verses having 30 patients bedded in the ED? I don't think you need to be a nurse or a doctor to have that conversation."*

CHAPTER SEVEN – OBSTACLES TO IMPLEMENTING EFFECTIVE LEADERSHIP AND MANAGEMENT PRACTICES IN THE NHS

The constraints on leaders and managers within the NHS

The context in which healthcare is delivered is a complex one. There are many elements to the environment in which a hospital or a GP practice operates and, by extension, the leaders and managers of such organisations find themselves. A key part of that environment is the nature of the healthcare model that predominates in a country and how the different parts of that model interact over time.[75] In the English context for example, as Messenger noted, particular characteristics of the NHS model that have become prominent often impede leaders and managers:[76]

> *"Very public external and internal pressures combine to generate stress in the workplace…constant demands from above, including from politicians, creates an institutional instinct…to look upwards to furnish the needs of the hierarchy rather than downwards to…the service-user. These pressures inevitably have an impact."*

Politicians, policymakers and the NHS senior leadership need to be aware of the salience of the environment in which leaders and managers operate. It should not be seen as a separate sphere to leadership and management; both are closely interconnected with their context. Consequently, the environment and all its many elements will have a bearing on the extent to which leadership and management can make a difference to individual organisations.

Human resource constraints are the most common obstacles to leading and managing as effectively as possible in the NHS

Some of the obstacles that hinder the ability of leaders and managers to do their jobs as effectively as possible can be very specific to organisations; others can be more systemic. In our survey, respondents were asked to give feedback on areas where they faced obstacles to being able to lead and manage effectively. Just over a quarter (28%) of respondents said that there were either no obstacles or that they weren't sure of what they were. Another 10% declared they would prefer not to say. Across the remaining 62%, there were 38 different types of obstacles were reported. We have grouped the majority of these into six broad themes, which are listed in Table 11. Individual types with significant numbers of responses are also listed in the same table.

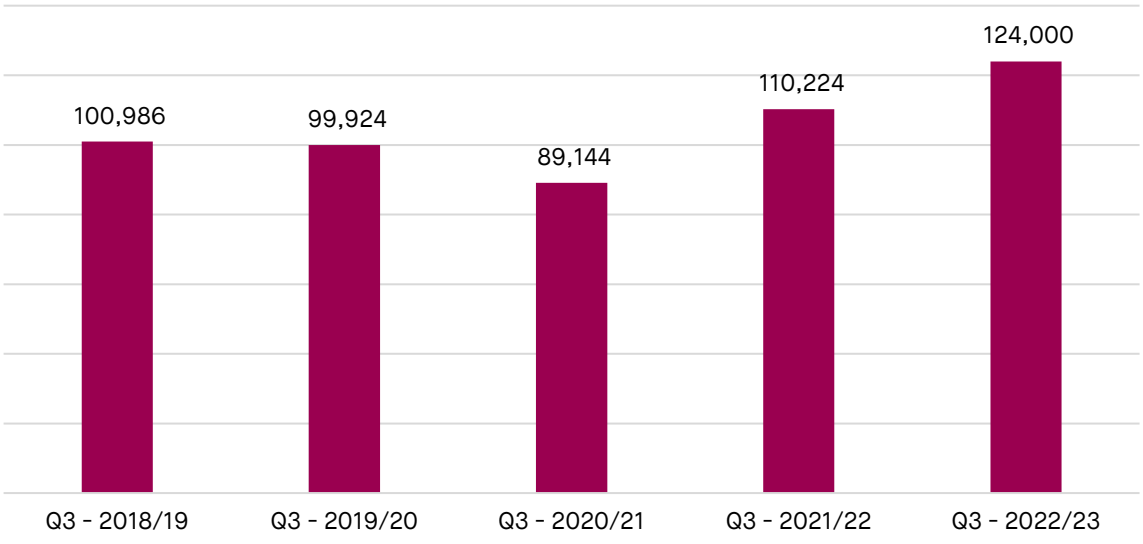
Table 11: Themes of obstacles towards good leadership and management

Obstacle theme	% of total respondents	% of all respondents who described obstacles
Human resourcing	30%	46%
Organisational culture	27%	46%
Staffing/ workload	23%	37%
Budgets/ funding	18%	29%
Internal process[xix]	12%	20%
Senior leadership[xx]	11%	17%
Inadequate/ insufficient tools	8%	13%
Structural/ organisational	6%	10%
External (to the NHS) factors	4%	5%

Recruitment and retention are the most significant obstacles to effective leadership and management

At the end of 2022, the NHS had around 124,000 vacancies.[77] This included 8,700 medical professionals and 43,600 nursing staff. That is a vacancy rate of just under 10% of the total NHS workforce in England. Lightcast data also indicates that NHS vacancies are taking longer to fill. In 2022, almost 700,000 NHS jobs were posted across the UK, and on average each job had to be posted six times before it was filled, compared to the overall average of two times.

Figure 20: NHS vacancy levels in the third quarter of the NHS financial year, 2018 - 2023



Source: NHS Digital

[xix] There is more on this topic in Chapter Six.

[xx] There is more on this topic in Chapter Four.

Issues relating to recruitment and retention were some of the most commonly cited obstacles by healthcare leaders and managers. Of those that identified obstacles, 37% felt a lack of staff, excessive workload and insufficient time affected their ability to manage effectively. Some survey respondents gave us brief statements on how staffing was affecting their managerial or leadership capacity, with one describing the impact of staff under-resourcing:

> *"Staff resourcing. Every day is firefighting as [we] do not have enough staff to cover all the positions required." (senior manager, hospital)*

For some, the lack of sufficient numbers of staff had implications for their own workloads, with knock-on effects on management training, as staff were needed first and foremost to look after patients:

> *"Cancelling training at the last minute for staffing problems." (team leader/supervisor, community health clinic/ centre)*

Insufficient staffing (i.e. recruitment and retention) and work overload can have a knock on effect onto staff morale and motivation, with such staff more likely to be overworked:

> *"As well as managing our team, we are responsible for the day-to-day shift management. The workload is often so massive that there is not enough time to effectively support staff on our team." (middle manager, ambulance service/ trust)*

Financial constraints inhibit the implementation of effective leadership and management practices

An attendee at the expert roundtable raised central government micro-management of financial decisions as a key constraint on healthcare leaders and managers being able to do a good job:

> *"Treasury rules are a fundamental obstacle to good management in the NHS…[using Integrated Care Boards as an example]…if we overspend, it gets taken off us next year, and if we underspend it gets taken off us this year. So the only incentive…is to exactly balance the budget. That is a mad way of basically accounting for money…Financial discipline is a key part of good management, but the rules mitigate against operating in a sensible financial environment." (representative of an Integrated Care Board)*

Finance and funding-related issues were the second most common obstacle cited by survey respondents. Some 29% found budget cuts a key obstacle in being able to manage effectively. One channel through which such cuts impact managers is the impact on the ability to obtain better equipment:

> *"Each year our budget is reduced despite demand rising year on year." (middle manager)*

> *"Financial barriers [are a factor] not having ability to purchase certain products." (senior manager, hospital)*

> *"Lack of funding for replacement equipment."(middle manager, hospital)*

> *"Finance [is a barrier] to successfully recruit to safe staffing numbers." (middle manager, community care service/ network)*

> *"Lack of funding for sufficient staffing levels." (middle manager, hospital)*

NHS reorganisations and the current trust model have created difficulties for leaders and managers

The organisation of the NHS was raised, as a barrier to effective leadership and management, multiple times by numerous participants in SMF's expert roundtable. One contributor highlighted the constraining role of regular reorganisations of the NHS:

> *"There are issues around how managers cope with reorganisations, repeated reorganisations." (academic with health management focus)*

Another concurred, saying that regular changes in structures were a disincentive to leaders and managers to doing the things that politicians and policymakers want them to do:

> *"What are the signals within the wider system … that has been given to organisations and to managers [are] to be autonomous, to take some risks, to innovate, when they're within a system that is [regularly] … changing." (academic with health management focus)*

In addition to the disruption caused by the process of reorganisation, the nature of some of the changes that have been put in place were described as creating their own obstacles to the delivery of better healthcare. In particular, one participant noted that the reforms of the past two decades had created incentives against cooperation between leaders of healthcare providers and by extension their organisations:

> *"There is a real tension between individual institutions perhaps being well run, but at the expense of the whole rather than contributing to the, the whole." (representative of an Integrated Care Board)*

At the heart of the structural tension described at the roundtable was the foundation trust model. The latter has been central to NHS reform for a long time and is emblematic of the new public management (NPM) approach to public services. One attendee felt that the new integrated care system (ICS) was its death knell:

> *"The Foundation Trust experiment…is…running into the sand. And it was just last week that…[it was being]…talked about whether foundation trusts were viable in an ICS environment." (academic with health management focus)*

Box 5: Integrated care systems (ICS)

The latest reorganisation of the NHS in England is around the concept of integrated care systems (ICS). These were introduced in the Health and Social Care Act 2022.[78] The ICS approach emphasises principles of collaboration and coordination. Consequently, it appears to be a step towards copying at least some of the underlying approaches of the Scottish system, where there has been less application of market principles to healthcare delivery.[79]

The Hewitt review into how the ICS will work in practice identified six operating principles: collaboration; a limited number of shared priorities; giving local leaders space and time to lead; providing systems with the right support; balancing freedom with accountability; enabling timely, relevant, high-quality and transparent data.[80]

The introduction of the ICS model raises a number of questions for many of the leaders and managers in the NHS in England. Prior to its introduction, the dominant elements determining the health care delivery environment that leaders and managers had to work within were the highly autonomous foundation trust model, the purchaser-provider split and the consequent quasi-market in public sector healthcare provision. These questions include:

- How might the requirements of working within the contours of the new ICS model impact the approaches to leadership that many senior leaders of trusts and primary care providers have been used to?
- How can the adjustment from a quasi-competition to a more collaborative approach to healthcare delivery be navigated successfully?

In addition, there are questions as to how:

- The leadership and management of this new layer of NHS organisation might develop?
- What best practice looks like for leaders and managers of the integrated care system and how can be shared and embedded across the whole network?[81]

These will all remain open questions for some time. What seems clear is that, for senior leaders in trusts and primary care providers, there will need to be an even stronger external focus on building and maintaining good relationships with external organisations in the ICS, to maximise the benefits of collaboration.

There are some early signs that leaders and managers will be able to adapt to the cooperative requirements of the ICS model. Drawing on their experience of the benefits of primary care networks (PCN) one attendee at the expert roundtable described their nascent experience of cooperative fora as positive:

> *"Where PCN have come in in England, and with the establishment of the ICS, is giving us more opportunities to work at scale and share best practice." (General Practice manager)*

This has been broadly reflected in analysis by the NHS Confederation. It reported that ICSs were helping to mitigate workforce pressures, improve collaborative working and local decision making.[82]

However, there is a way to go before the ICS model is fully embedded and a full evaluation of its effectiveness in improving healthcare delivery can be made. Nevertheless, at this early stage, one obvious mistake that politicians, policymakers, NHS senior leadership and the ICSs themselves must strive to avoid is failing to pay enough attention to the importance of the leadership and the management of each ICS. It is essential to be vigilant against replicating some of the problems in NHS leadership and management at the ICS level. Another is not helping leaders of trusts who developed their skills sets and approaches to leadership among the old arrangements, to adapt as swiftly and painlessly as possible to the new dispensation. An early focus, therefore, on these issues would seem to be appropriate.

CASE STUDY: LEADERSHIP AND MANAGEMENT IN A PRIMARY CARE SETTING – OAKWOOD SURGERY

Oakwood Surgery

Box 6: Oakwood Surgery

The Oakwood Surgery is situated within the town of Doncaster in South Yorkshire. It is a member of Doncaster's Clinical Commissioning Group (CCG). In 2019-20, the surgery had 5,619 patients on its list.[83]

At the surgery there are two GP partners. They are the owners. Consequently, they are the strategic decision makers. In addition, there are two non-partner GPs. The surgery also employs a physician associate, a clinical pharmacist and two nurses.

On the management and administration side, the surgery has a practice manager who runs the practice day-to-day, including managing most of the staff. There is also a secretary and eight reception, administration and allied staff.

As a practice, it has a particular focus on helping train medical and nursing students, and encouraging young people to consider careers in healthcare.

Sources: CQC (2015) and (2019), Oakwood Surgery website and NHS Quality and Outcomes Framework, 2019-20

For this case study, in addition to looking at publicly available information, managing partner Dr Dean Eggitt was interviewed in depth about Oakwood Surgery's story.

An effective practice delivering good-quality care

Oakwood Surgery is a consistently good performer in CQC inspections. In both its 2015 and 2019 inspections it scored an overall rating of "good", which was underpinned by a "good" rating across the various areas CQC inspects. Further, some areas of outstanding practice were noted in the two inspection reports, e.g. taking a proactive approach to helping patients live healthier lives and leading innovation efforts among local practices with multidisciplinary education sessions on child safeguarding.[84]

Table 12: Oakwood Surgery, CQC ratings

	2015	2019
Overall rating	Good	Good
Safety	Good	Good
Effective	Good	Good
Caring	Good	Good
Responsive	Good	Good
Well-led	Good	Good

Sources: CQC (2015) and (2019)

To underline its consistently effective performance, Oakwood is a practice with expansion ambitions. It is currently in the process of merging with a less successful practice in its locality. This follows a joint working venture partnership that Oakwood Surgery had been involved in for a number of years with the Mayflower Medical Practice.[85]

The "good" performance of Oakwood Surgery is reflected in the practice receiving a higher proportion of patients in the last annual national GP Patient Survey, reporting their experience of the surgery as "good" (77%) which was five percentage points higher than the national benchmark (72%) and six more than the other practices within the same ICS (71%).[86]

The quality of the practice's performance is also reflected in its 2018-19 and 2019-20 scores under the NHS's Quality and Outcomes Framework. In the latest, Oakwood Surgery scored close to the maximum.

Table 13: Oakwood Surgery's NHS Quality and Outcomes Framework scores, 2018 – 2020

	2018-19	2019-20
Overall achievement score (max 559)	547.61	555.71
Average across the country	539.22	533.88
Overall achievement (% of maximum score)	97.96%	99.41%
Average across the country	96.6%	95.51%

Source: NHS Quality and Outcomes Framework, 2019-20

Leadership and management at Oakwood surgery

The comparative success of Oakwood surgery is the result of a number of factors. One of those is its leadership. The CQC described leadership and management at Oakwood Surgery in the following way:

> *"The way the practice was led and managed promoted the delivery of high-quality, person-centred care."*

As was uncovered in the interview with GP partner Dean Eggitt, the practice has utilised good leadership and management practices to achieve their success. The elements of this approach are explored in more detail below.

Focusing on the right goals is key to high performance

A high-performing organisation has to be focused upon achieving clear goals. Dr Eggitt argued that this was often hard to achieve because the wider structures and culture of the NHS:

> *"There are forms … and it was important … the forms were completed. There didn't seem to be any rational reason why … all it seemed to do was implement delay for the clinician … I realised a lot of the reasons … why we do that, it's not necessarily because of evidence, it's not necessarily because it's best practice. It's because it's somebody's job. So we created this process for no other good reason."*

> *"People weren't really thinking about what the right thing to do was or the wider impact."*

Nevertheless, despite Dr Eggitt's concerns about systemic problems with the NHS, the focus set by Dr Eggitt and his partner for the Oakwood Surgery workforce was to forget those wider issues and deliver on achievable goals:

> *"We're…provid[ing] gold standard care on a faded bronze budget… I say to them [my team] very regularly in the morning, what I ask of you guys is to not worry about capacity, capacity isn't your problem, your problem is quality. You're brilliant…the patients love you… it's your role to provide quality care when a patient contacts you, keep doing that"*

Good relationships and communication are the bedrock of a collaborative workplace culture and should be a focus of good leadership

Dr Eggitt described how, since becoming a partner, he had developed his approach to leadership, not only through running his practice but also because of involvement in wider local and national healthcare structures. He argued that good leadership:

> *"is 99.99%, about communication and relationships."*

Communication and relationships are central to Eggitt and his partner's approach. They are foundational to a collaborative workplace culture. The latter both relies upon and helps nurture effective communication and strong workplace relationships, where:

> *"They'll challenge me, and I'll challenge them back."*

> *"This is about the mindset, this is about the culture and about the roles that people adopt."*

For this collaborative workplace culture to work, it was vital for leaders to be able to accept criticism and be willing to adapt in the face of it. Eggitt contrasted the culture in his practice with what he considered to be the mainstream culture within the NHS, which rejected an open, high communication culture if, for example, such communication transgressed rigid, pre-determined forms of delivery:

> *"You have to learn to be able to…absorb and change and listen … the feedback that you might receive can be utterly brutal… That doesn't make it invalid."*

> *"The leader..[has]…to go through that translation and interpretation, and realise whether or not to do something with that, to take it onboard…whereas …at the NHS, as soon as it's said in a way that it shouldn't be said, it doesn't exist, We're not going to listen to that"*

In addition to the opportunity that an open feedback culture has created for better information flow, Eggitt observed that the latter has most impact when it is utilised effectively:

> *"Part of being a leader is learning how to interpret that information and do something positive with it."*

Operating as "one team" is essential to organisational success

The benefit of the strongly relational and collaborative approach Eggitt described has been a better understanding between him, his practice partner and their practice colleagues, which has facilitated team efficacy:

> *"It helps you to understand, when…you think in a different mindset to get that problem solved. Rather than just clashing as before, because you're from [a] different mindset, you can adopt the mindset of somebody else and say, I need this because I recognise your barrier is this and is there a way that we can work around that."*

As Eggitt noted, over and above everything else, the "single team" ethic is at the core of Eggitt and his partner's vision for the practice and how best to deliver healthcare,:

> *"We do not work in anything close to a silo here, we just have a team where we recognise each other's strengths and weaknesses."*

A positive culture ultimately helps drive higher performance

The culture that has been cultivated at Oakwood Surgery has helped generate a strong team ethic, which has ultimately fed into an effectively performing practice, as Dr Eggitt described:

> *"It means that my front of house team…are incredibly flexible. They're incredibly wide ranging in their thinking and can solve most of the problems before they even get to me, because they understand the rest of the system and how to 'speak' to the rest of the system."*

The right structural and management practices support an effective workplace culture

A number of structural and practice changes were made at Oakwood, which helped entrench the open culture at the surgery. In the interview with Dr Eggitt, he described that creating a flat structure to the surgery was an important step in this process:

> *"It is very flat…when I started at this practice…it wasn't like that at all…Bit by bit, we've chipped away at it."*

The introduction of the flatter structure had a substantial positive impact on morale among the team at the surgery, according to Eggitt:

> *"I think morale…picked up from that. Because we can share the problems as a team, and we can continue to make sure that we're delivering quality."*

Specific additional practices that have been employed to complement the flat management structure, and which helped embed the more collaborative leadership style and culture of openness, have included:

> *"We have a brief every single morning, when we meet before we open the doors. When we get together as a team. When everyone is in a room, we ask how everyone is. We ask what the theme was from yesterday, if there's anything that we need to be aware of and challenges… [we] ask anybody to raise any issues that they think might cause a hiccup, and we solve it as a team. We talk about how to tackle the challenge for the day."*

Having the right people in place is central to having the right culture and best practices in place

An important factor in embedding the changes Eggitt and his partner introduced was older members of staff (who were imbibed with a different approach) being replaced by newer staff, who were able to more easily slot into the surgery's culture:

> *"It's been an evolutionary process … as staff members have naturally wasted, retired, moved on and the new staff members have been inducted into a different way of thinking. So we've developed this flat team structure … It hasn't been an overnight thing … and it couldn't have been because of old ways of thinking, old ways of working … new members are turning up … they hit the ground running."*

As with the other case studies in this report, the right personnel (and by extension the right recruitment and retention practices) seem to be an important element in developing and sustaining a high-performing organisation.

CHAPTER EIGHT – POLICY RECOMMENDATIONS

The comparative international evidence and the CQC inspection ratings indicate that there is room for improvement in the provision of healthcare in the UK in general, and in England more specifically. That is despite healthcare quality before the COVID-19 pandemic being on a slow but broadly improving trajectory overall.

The existing evidence suggests that leadership and management both have a key role to play in bringing about any future performance improvements in healthcare delivery. The case studies presented in this report show the kind of positive impact that high-quality leadership and the deployment of best management practices can have on an organisation like an underperforming hospital trust.

To make the NHS one of the leading healthcare systems in the world, best leadership and management practices need to spread and embed across the whole NHS

The survey results presented in this report, along with the CQC inspection evidence, suggest that leadership and management across much of the NHS (including GP practices) is functioning well, at least compared to where the NHS was in previous decades. However, the evidence also shows this overall picture needs some substantial caveats adding to it. Among acute services providers there is a sizeable tail of under-performing providers who are delivering care to millions of patients. Additionally, while there are many "good"-rated GP practices and acute services providers, there are few (less than one in 10 in both categories) that achieve an "outstanding" rating. This implies there is an issue with achieving continuous improvement in many of the organisations delivering healthcare.

High-performing entities tend to score particularly well on leadership, human and workplace cultural factors (which are linked to factors such as motivation and morale), and the use of tools like targets to help align workforces' activities with wider organisational goals. Therefore, some of the most notable areas where improvement in leadership and management practices seems possible include:

- the 27% of healthcare leaders that are considered to be ineffective by their leadership and management colleagues (Chapter Four)
- the 65% of survey participants that said interference from superiors hindered problem solving by them and their team
- the 51% of leaders and managers who felt unable to say that their organisation did well at staff motivation
- the 49% of respondents that were not able to agree that morale was good in their organisation
- the one in five managers that said they had no targets, and the additional third whose targets were not aligned with wider organisational goals (Chapter Six).

Part of improving leadership and management is good-quality training for those in such positions or who have ambitions to move into them. The survey found a number of gaps in the training of leaders and managers in the NHS, especially but not exclusively at the more junior levels. Some 21% of senior leaders, and 39% of leaders and managers in the healthcare sector as a whole, did not have any leadership or management qualifications. The picture is worse among more junior managers. Many respondents reported that, while leadership and management training took place in their organisations, much of it was short and unaccredited, again particularly so for those in more junior roles.

Laying the foundations for a leadership and management training overhaul across the NHS

Measures that ensure the universalisation of best leadership and management practices and their sustainability over the long term are essential. This will require building up a picture of and effectively monitoring the quality of leadership and management across the NHS and ensuring there are robust mechanisms in place for driving improvements in leadership and management in order to universalise best practice. The best tools for the latter two would be to improve the training offer and encourage trusts to adopt tried and tested reforms to incentivise the development of good organisational cultures .

Any transformation of the current leadership and management training landscape will require suitable resourcing. This, in particular, implies adequate staffing levels, which can absorb people taking time out to train. Any serious NHS workforce plan will need to recognise these challenges.

Recommendation One – broaden the CQC's "well-led" category for inspections so that it includes a detailed review of the management practices, training and the leadership pipelines of the organiaitons it inspects

Many factors contribute to a healthcare organisation being "well-led". When assessing providers on whether they are "well-led", the CQC tends to look primarily at the state of leadership and governance of an organisation.

Given the numerous factors that are associated with good leadership and management, we would like to see a fuller range included in the inspectorate's analysis of whether an organisation is "well-led". The aim should be to build up a detailed (and public) record of leadership and management practices across the NHS, and at all levels within an organisation.

As part of this expanded focus, attention should be paid to the prevalence, appropriateness and quality of management and leadership training. In cases where the result is less than "outstanding", the CQC should develop functions to actively help organisations improve. This could build on the recognition by the CQC in their current strategy that they have a role in accelerating improvement.[87]

Recommendation Two – establish a set of benchmarks for judging good leadership and management that the CQC can use in their assessment of whether or not an organisation is "well-led"

CQC inspection teams usually contain "specialist professional advisors" such as nurses, doctors or GPs relevant to the provider. Where assessments are made of whether an NHS trust is "well-led" at the trust level, inspection teams might also include "specialist professional advisors" who have experience in organisational leadership and governance.[88]

To support the more extensive evaluation of management proposed in Recommendation One, NHS England should create a series of benchmarks for what "good leadership" and "good management" look like. Benchmarks should be informed by national and international evidence on what works and should be publicly available and accessible to all managers and leaders. Such a tool, known as the Gatsby benchmarks, is in use for careers information, advice and guidance provision in schools and colleges in England. Not only do the benchmarks set out what good career guidance looks like, they also give inspectors a frame of reference for their evaluation.

Recommendation Three – mandate in-work leadership and management training requirements across the NHS and primary care for managers and leaders

The provision and take-up of leadership or management training in the NHS is inadequate. The lack of a high-quality universal minimum of training among all leaders and managers helps contribute to many of the deficiencies in leadership and management highlighted in this report.

The current approach leaves much up to individual healthcare organisations, line managers or members of staff. There is little evidence of an institutionalised pipeline for bringing through new leadership and management talent, or maintaining and updating the skills of the existing stock of leaders and managers.

To address this patchy picture, accredited management training should be compulsory. The training required should be commensurate with the management level, with minimum requirements in place for the types of training needed from a team leader up to executive board members.

Training should not just be focused on developing hard managerial skills. Softer skills such as communication and relationships are key parts of good leadership and management. The training would not have to be in the form of academic qualifications such as a master's degree in leadership.

Recommendation Four –mandate NHS England to establish a compulsory national excellence framework for the minimum in-work leadership and management training requirements

To ensure the leadership and management training requirements proposed in Recommendation Three result in leaders and managers receiving high-quality training, NHS England and its partners across the rest of the UK should establish National Training Excellence Frameworks for healthcare leadership and management. These would establish minimum competence requirements for each level.

The framework should look to consolidate the best from existing frameworks and build upon them where necessary. These include the General Management Competencies of the GMTS, the Clinical Leadership Competency Framework model, the NHS Leadership Academy's Healthcare Leadership Model and the Edward Jenner Programme.

The framework would need to reflect the variety of leadership and management roles and challenges in the NHS. Leading a small GP practice is different in many ways from being a middle manager in a large hospital trust. Further, leaders and managers operating the new ICS structure will also require appropriate training. However, the framework should aim to recognise equivalence where possible. If, for instance, someone moves from primary care to tertiary care, it should be possible for them to understand where their existing training fits into the framework for the other.

The structure and detail of the framework should be developed in partnership with NHS staff, healthcare institutions, the professional medical bodies, chartered professional bodies, existing providers of healthcare leadership and the wider academic and professional management training firmament. Under this new approach, providers of leadership and management training should be accredited by NHS England, to ensure quality and consistency.

Recommendation Five – pilot workplace democracy in the NHS in under-performing trusts

Staff motivation and morale are important parts of a successful healthcare organisation. Having an overall strategy or a vision for the organisation can go some way to motivating staff, but the vision has to be something that staff can believe in and get behind. As the Leeds University Hospital Trust example illustrates, a proven means of ensuring this is putting in place a system of workplace democracy. In Leeds the process has helped secure staff buy-in to the goals of the Trust and has improved the motivation and morale of the staff.

This style of decision making should be piloted with other healthcare providers, starting with a sample of trusts in NHS England's Recovery Support Programme,[89] to help them replicate the improvement journey that Leeds University Hospital Trust itself went on.

ANNEX I: THE DIFFERENCES BETWEEN LEADERSHIP AND MANAGEMENT

Box 6: The differences between leadership and management

Leaders are figureheads, typically the most senior people in an organisation. They are usually in charge of strategising and endowed with ultimate authority over the people in and the operations of the organisation they lead. Some have suggested that leadership is not necessarily tied to a specific function in a hierarchy, but is rather a set of skills and behaviours. These include being an effective communicator, motivating people and being able to identify a vision (and goals) underpinned by effective strategy development.[90]

Leadership is widely seen as a distinct function to management.[91] [92] Management is a more routine and technical exercise, focused upon organising resources towards achieving intermediate objectives and the ultimate ends that those leading an organisation have identified. Consequently, a manager is typically a technician, an administrator and problem solver.[93]

In most organisations leaders often have some management responsibilities and many managers have to display some leadership qualities. Managing a team is not just a technical exercise but requires, among other factors, communication skills and the ability to motivate staff.

In the most successful organisations, leaders and managers recognise the co-dependence of their roles and the links between leadership and management.[94] Consequently, leaders and managers, and leadership and management, are best seen as complementary to one another.

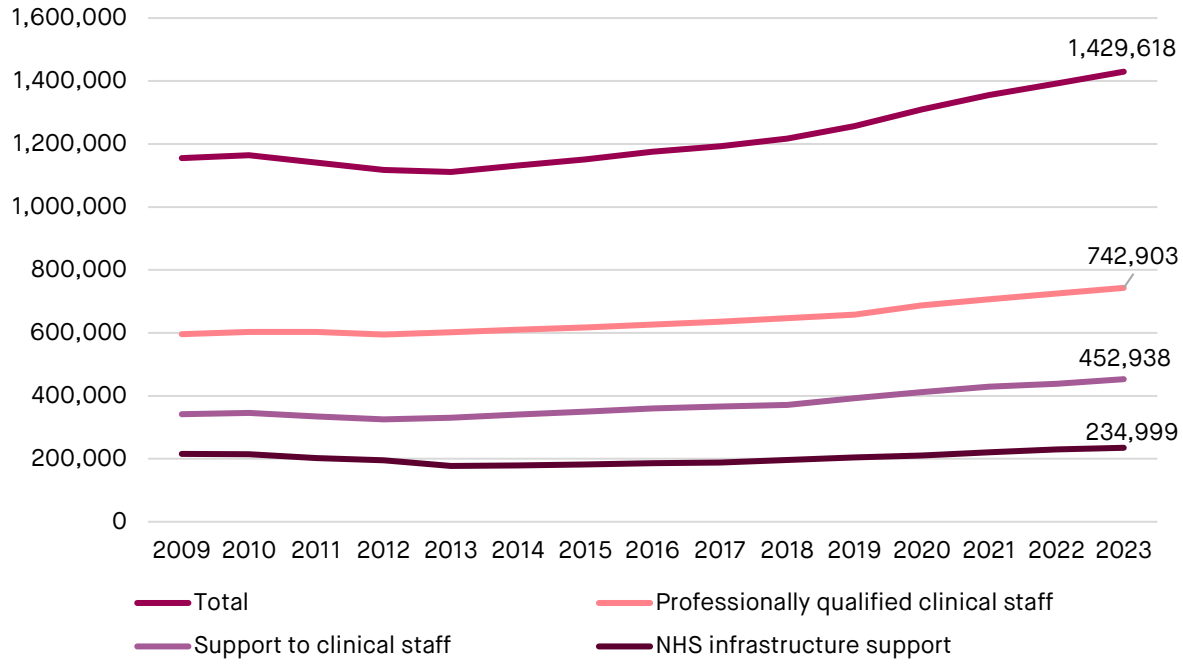
ANNEX II: THE NHS WORKFORCE IN ENGLAND

Composition of the public sector healthcare workforce in England

Make-up of the hospital and community healthcare workforce in England

By February 2023, the NHS had more than 1.4 million people working in its hospitals and community health services (HCHS) – see Figure 21. This included more than 742,000 clinical professionals.

Figure 21: Workforce composition of NHS hospitals and community health services, 2009 - 2023

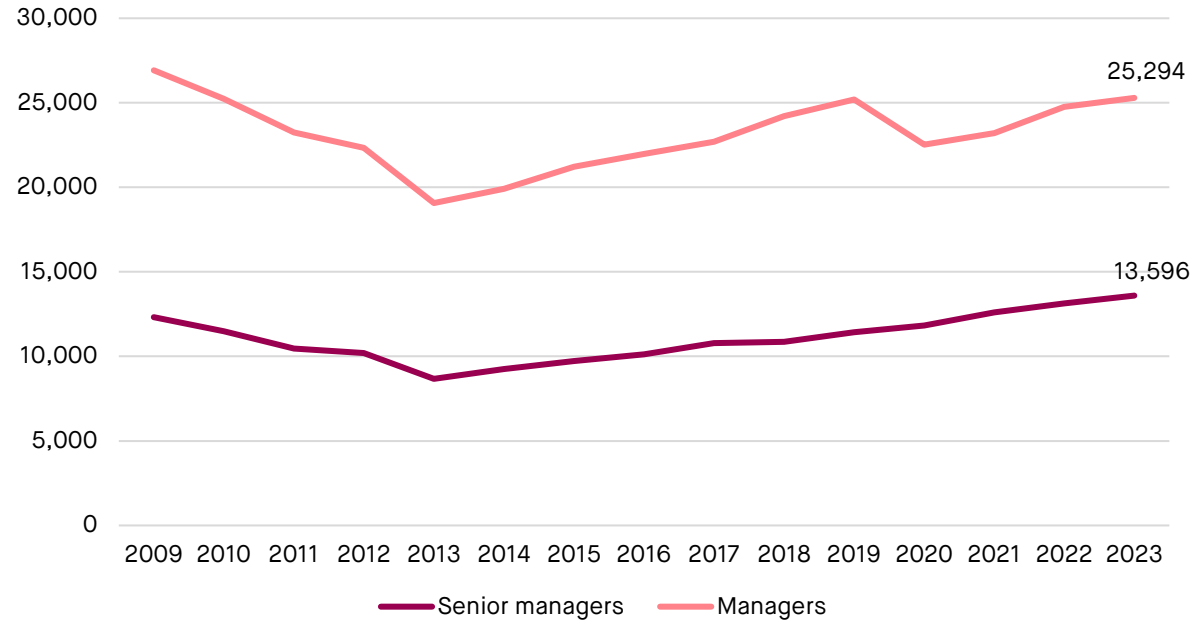


Source: NHS England

Managers in the English hospital and community healthcare workforce

Between 2009 and February 2023, the number of NHS staff in HCHS managerial roles had risen to 38,890, from 37,555 (see Figure 22), a 3.5% increase. Managers accounted for around 3% of the HCHS workforce in February 2023, lower than in 2009, when they accounted for 3.7% of the workforce. The composition of the management strata has altered slightly over the 2009-2023 period. Senior managers accounted for 35% of HCHS managers in February 2023, compared to 31% in 2009.

Figure 22: NHS management in hospitals and community health services, 2009 - 2023

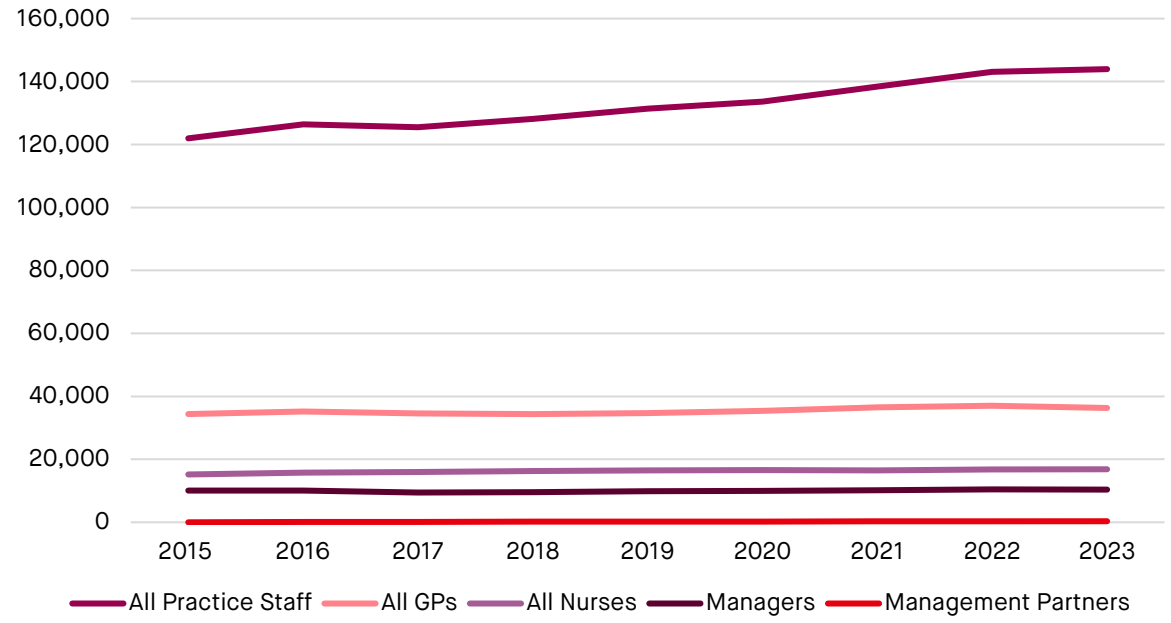


Source: NHS England

Composition of the general medical practice workforce in England

According to NHS England, in April 2023 there were 143,948 people working in general medical practice (GMP). This total included 36,358 GPs, 16,845 nurses and 74,484 non-clinical staff. Within the latter 10,419 were managers and 336 partner managers.[95]

Figure 23: General Medical Practice in England: all staff, GPs, nurses and managers, 2015-2023



Source: NHS England

Excluding GPs, who may have management roles within a practice, managers accounted for around 7% of the GMP workforce in England. Over the period 2015 to 2023 GPM managers grew by 3.5%.

A small proportion of the healthcare workforce in England are in leadership and management roles

Across both the HCHS and GMP, in the first quarter of 2023, the proportion of the total healthcare workforce in England accounted for by managers of various kinds was around 3%.

The above estimates need to be caveated by the fact that the situation on the ground is often less clear-cut than the classifications in the official data suggest. This point was noted by one contributor to the expert roundtable convened by SMF to discuss leadership and management in healthcare:

> *"it is so very difficult to find a reliable numbers…if you look at a medical division, for instance, you might find that there are a group of 'pure plays', and they are dwarfed by the number of clinicians with some kind of management responsibilities. So…[they] really do need to understand how much management is taking place, who's doing what" (healthcare management researcher)*

ANNEX III: FURTHER SURVEY SAMPLE DETAILS

The survey sample consisted of 40 team leaders/supervisors, 50 junior managers, 132 middle managers, 56 senior managers and 14 people in senior leadership positions. The total number of managers in the NHS, and how these are spread across different managerial levels is unclear (see Annex II), and so it is difficult to say how representative the sample is of the distribution of people across the levels of management in the NHS as a whole. However, it seems reasonable to believe that the sample somewhat over-indexed on middle managers and under-indexed on team leaders/ supervisors.

The largest portion of respondents worked in hospitals (43%), followed by community care services (13%) and GP practises. 93% had worked in leadership or management roles for a year or more, and the single largest group had worked in management for one to five years (49%).

The survey was in the field across March and early April 2023. At the time the survey was conducted, therefore, some strikes had already taken place across the NHS, and there were discussions of further industrial action.

ENDNOTES

[1] Tim Knox, "International Health Care Outcomes Index 2022," 2022, https://www.civitas.org.uk/content/files/International-Health-Care-Outcomes-Index-FINAL.pdf.

[2] Irene Papanicolas et al., "Performance of UK National Health Service Compared with Other High Income Countries: Observational Study," *BMJ* 367 (November 27, 2019): l6326, https://doi.org/10.1136/bmj.l6326.

[3] Knox, "International Health Care Outcomes Index 2022."

[4] Papanicolas et al., "Performance of UK National Health Service Compared with Other High Income Countries."

[5] Saoirse Mallorie, "What Caused the UK's Elective Care Backlog, and How Can We Tackle It?," *The King's Fund* (blog), February 24, 2023, https://www.kingsfund.org.uk/blog/2023/02/what-caused-uks-elective-care-backlog-how-can-we-tackle-it.

[6] Eric C. Schneider et al., "Mirror, Mirror 2021: Reflecting Poorly," August 4, 2021, https://doi.org/10.26099/01dv-h208.

[7] "NHS Performance Tracker" (Nuffield Trust), accessed June 22, 2023, https://www.nuffieldtrust.org.uk/qualitywatch/nhs-performance-summary.

[8] "Cancer waiting times" (NHS England, 2023)

[9] NHS England, "Statistics » A&E Attendances and Emergency Admissions 2023-24," 2023, https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2023-24/.

[10] Public Health Scotland, "Stage of Treatment Waiting Times - Inpatients, Day Cases and New Outpatients 30 May 2023 -" (Public Health Scotland, May 2023), https://publichealthscotland.scot/publications/nhs-waiting-times-stage-of-treatment/stage-of-treatment-waiting-times-inpatients-day-cases-and-new-outpatients-30-may-2023/.

[11] Public Health Scotland, "Cancer Waiting Times - 1 October to 31 December 2022," April 2023, https://publichealthscotland.scot/publications/cancer-waiting-times/cancer-waiting-times-1-october-to-31-december-2022/.

[12] Public Health Scotland, "A&E Activity and Waiting Times - Month Ending 31 March 2023" (Public Health Scotland, May 2023), https://publichealthscotland.scot/publications/ae-activity-and-waiting-times/ae-activity-and-waiting-times-month-ending-31-march-2023/.

[13] Ryan Pike "NHS activity and performance summary, February and March 2023" (Welsh Government April 2023)

[14] Mark Dayan and Sophie Flinders, "How Well Is the NHS in Wales Performing?" (Nuffield Trust, June 2022), https://www.nuffieldtrust.org.uk/news-item/how-well-is-the-nhs-in-wales-performing.

[15] Steve Duffy, "NHS Wales Waiting Times: Thousands Still Waiting Two Years," *BBC News*, May 18, 2023, sec. Wales, https://www.bbc.com/news/uk-wales-65616395.

[16] Schneider et al., "Mirror, Mirror 2021."

[17] "State of Care 2021/22 Appendix: Ratings Charts - Care Quality Commission" (Care Quality Commission, October 2022), https://www.cqc.org.uk/publication/state-care-202122/appendix.

[18] Rob England, "Covid-19: Critical Care Wards Full in Hospitals across England," *BBC News*, January 16, 2021, sec. England, https://www.bbc.com/news/uk-england-55672901.

[19] "NHS Delivery and continuous improvement review: recommendations" (NHS England, April 2023)

[20] "Creating a culture of excellence: How healthcare leaders and build and sustain continuous improvement" (KPMG, 2019)

[21] Bryan Jones, Tim Horton, and Joe Home, "Strengthening NHS Management and Leadership: Priorities for Reform" (The Health Foundation, 2022).

[22] "Myth Four: The NHS Has Too Many Managers," *The King's Fund* (blog), 2011, https://www.kingsfund.org.uk/projects/health-and-social-care-bill/mythbusters/nhs-managers.

[23] NHS Digital, "NHS Workforce Statistics - February 2023" (NHS Digital, n.d.), https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/february-2023.

[24] Ian Kirkpatrick and Becky Malby, "Is the NHS Overmanaged?" (NHS Confederation, January 2022), https://www.nhsconfed.org/long-reads/nhs-overmanaged.

[25] Ian Kirkpatrick, "What the NHS Needs Is More Managers," Warwick Business School, December 17, 2018, https://www.wbs.ac.uk/news/what-the-nhs-needs-is-more-managers/www.wbs.ac.uk/news/what-the-nhs-needs-is-more-managers.

[26] Kirkpatrick.

[27] Miqdad Asaria, Alistair McGuire, and Andrew Street, "The Impact of Management on Hospital Performance," *Fiscal Studies* 43, no. 1 (2022): 79–95.

[28] Asaria, McGuire, and Street.

[29] Kirkpatrick, "What the NHS Needs Is More Managers."

[30] Asaria, McGuire, and Street, "The Impact of Management on Hospital Performance."

[31] Thomas C Tsai et al., "Hospital Board and Management Practices Are Strongly Related to Hospital Performance on Clinical Quality Metrics," *Health Affairs* 34, no. 8 (2015): 1304–11.

[32] Tsai et al.

[33] Nicholas Bloom et al., "The Impact of Competition on Management Quality: Evidence from Public Hospitals," *The Review of Economic Studies* 82, no. 2 (2015): 457–89.

[34] Nicholas Bloom, Raffaella Sadun, and John Van Reenen, "Does Management Matter in Healthcare?" (London School of Economics, November 2013).

[35] John Van Reenen et al., "Why Good Practices Really Matter in Healthcare," *CEPR* (blog), December 17, 2010, https://cepr.org/voxeu/columns/why-good-practices-really-matter-healthcare.

[36] Martin Powell, Jeremy Dawson, Anna Topakas, Joan Durose, and Chris Fewtrell, "Staff satisfaction and organisational performance: evidence from a longitudinal secondary analysis of the NHS staff survey and outcome data" *Health Services and Delivery Research* No. 2.50 2014; Jeremy Dawson, "Links between NHS staff experience and patient satisfaction: Analysis of surveys from 2014 and 2015" (NHS England, 2018) ; Michael West, Jeremy Dawson, Lul Admasachew and Anna Topakas, "NHS Staff Management and Health Service Quality Results from the NHS Staff Survey and Related Data" (Department of Health and Social Care)

[37] "Graduate Management Training Scheme," accessed March 23, 2023, https://graduates.nhs.uk/.

[38] "Leadership Academy – Better Leaders, Better Care, Brighter Future," accessed March 23, 2023, https://www.leadershipacademy.nhs.uk/.

[39] "Patient Experience Improvement Framework" (NHS England, June 2018)

[40] NHS England, "We Are the NHS People Plan for 2020/2021 - Action for Us All" (NHS England, July 2020).

[41] Gordon Messenger and Linda Pollard, "Leadership for a Collaborative and Inclusive Future" (Department for Health and Social Care, June 8, 2022), https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future/leadership-for-a-collaborative-and-inclusive-future.

[42] Tsai et al., "Hospital Board and Management Practices Are Strongly Related to Hospital Performance on Clinical Quality Metrics."

[43] Ted Baker "Sustaining improvement", *Care Quality Commission* (blog) 5 March 2020 https://carequalitycomm.medium.com/sustaining-improvement-the-story-of-four-nhs-trusts-1c3203b56f96

[44] Jane Hendy and Danielle A Tucker Public Sector Public Sector Organizational failure: A Study of Collective Denial in the UK National Health Service *Journal of Business Ethics* 172 (2021): 691-706 ; Pauline Jas and Chris Skelcher "Performance Decline and Turnaround in Public Organizations: A Theoretical and Empirical Analysis", *British Journal of Management*, 16 no. 2 (2005):195-210

[45] Andreas Bernecker, Julia Klier, Sebastian Stern, and Lea Thiel "Sustaining high performance beyond public-sector pilot projects", (McKinsey, September 2018)

[46] Richard Hyde, "Managing it Better" (Social Market Foundation, 2023)

[47] "Management Transformed: Managing in a Marathon Crisis" (Chartered Management Institute, November 19, 2020), https://issuu.com/cmi_/docs/management_transformed.

[48] Andersen et al. (2018) cited in ; Luu (2015) cited in Hameduddin and Engbers.

[49] Hyde, "Managing it Better".

[50] Andersen et al. (2018) cited in Hameduddin and Engbers.

[51] Andersen et al. (2018) cited in Hameduddin and Engbers. ; Schwarz et al (2016) cited in Hameduddin and Engbers.

[52] Caillier (2020) and Luu (2018) cited in Hameduddin and Engbers.

[53] Luu (2015) cited in Hameduddin and Engbers.; Camilleri and Van Der Heijden (2007) cited in Hameduddin and Engbers.

[54] Nicholas Bloom, Renata Lemos, Raffaella Sadun & John Van Reenen (2017). "Healthy Business? Managerial Education and Management in Health Care". https://www.nber.org/system/files/working_papers/w23880/w23880.pdf

[55] "Standardised Mortality Rates at Tameside General Hospital" (Tameside Personal and Health Services Scrutiny Panel, 2011).

[56] Amanda Crook, "Tameside Hospital Bosses Slammed in New Report," *Manchester Evening News*, June 30, 2010, sec. Health, http://www.manchestereveningnews.co.uk/news/health/tameside-hospital-bosses-slammed-in-new-893079.

[57] "Tameside Hospital Slammed In Death Rate Probe," *Sky News*, July 2013, https://news.sky.com/story/tameside-hospital-slammed-in-death-rate-probe-10440127.

[58] Jeremy Hunt, "Oral Statement - Sir Bruce Keogh Review," Oral Statement, July 16, 2013, https://www.gov.uk/government/speeches/oral-statement-sir-bruce-keogh-review.

[59] "Tameside and Glossop Integrated Care NHS Foundation Trust" (Care Quality Commission, April 2019).

[60]

Sarah Birken et al., "Middle Managers' Role in Implementing Evidence-Based Practices in Healthcare: A Systematic Review," *Implementation Science* 13, no. 1 (December 12, 2018): 149, https://doi.org/10.1186/s13012-018-0843-5; Jennifer Gutberg and Whitney Berta, "Understanding Middle Managers' Influence in Implementing Patient Safety Culture," *BMC Health Services Research* 17, no. 1 (August 22, 2017): 582, https://doi.org/10.1186/s12913-017-2533-4; Ryann L. Engle et al., "What Roles Do Middle Managers Play in Implementation of Innovative Practices?," *Health Care Management Review* 42, no. 1 (January 2017): 14–27, https://doi.org/10.1097/HMR.0000000000000090.

[61] DA Buchanan et al., "How Do They Manage? A Qualitative Study of the Realities of Middle and Front-Line Management Work in Health Care," *Health Services and Delivery Research* 1, no. 4 (June 2013): 1–248, https://doi.org/10.3310/hsdr01040.

[62] Amanda Goodall and James K Stoller, "The future of clinical leadership: evidence for physician leadership and educational pathway for new leaders", 2017.

[63] Asaria, McGuire, and Street, "The Impact of Management on Hospital Performance."

[64] Birken et al., "Middle Managers' Role in Implementing Evidence-Based Practices in Healthcare."

[65] Gutberg and Berta, "Understanding Middle Managers' Influence in Implementing Patient Safety Culture."

[66] Engle et al., "What Roles Do Middle Managers Play in Implementation of Innovative Practices?"

[67] Jeremy Dawson, "Links between NHS staff experience and patient satisfaction: Analysis of surveys between 2014 and 2015" (NHS England, 2018)

[68] Messenger and Pollard, "Leadership for a collaborative and inclusive future"

[69] About Us, The Leeds Teaching Hospitals NHS Trust, Accessed 22 June 2023 https://www.leedsth.nhs.uk/about-us/

[70] Our Research, The Leeds Teaching Hospitals Trust, Accessed 22 June 2023 https://www.leedsth.nhs.uk/research/our-research/

[71] "Leeds Teaching Hospitals Trust, Intelligent Monitoring: Report on 21 October 2013" (Care and Quality Commission, 2013) ; "Never events policy and framework",(NHS Improvement January 2018)

[72]"NHS Trusts put in risk categories - full list"", The Independent 24 October https://web.archive.org/web/20131102002900/http://www.independent.co.uk/life-style/health-and-families/health-news/nhs-trusts-put-in-risk-categories--full-list-8900971.h[73] N. Burgess, G. Currie, B. Crump, A. Dawson, Leading change across a healthcare system: How to build improvement capability and foster a culture of continuous improvement, Report of the Evaluation of the NHS-VMI partnership (Warwick Business School, 2022).

[74] "Leeds Teaching Hospital NHS Trust, Inspection Report" , (Care Quality Commission, 2019).

[75] Ana Belén Espinosa-González, Brendan C Delaney, Joachim Marti & Ara Darzi, "The impact of governance in primary health care delivery: a systems thinking approach with a European panel." *Health Research Policy and Systems* 17, 65 (2019).

[76] Messenger and Pollard.

[77] "NHS Vacancy Statistics England, April 2015 - March 2023, Experimental Statistics" NHS Digital, 25 May 2023, https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---march-2023-experimental-statistics

[78] "Health and Care Act 2022" (Department of Health and Social Care, 2022).

[79] Chris Ham, Deirdre Heenan, Marcus Longley, David R Steel, "Integrated care in Northern Ireland, Scotland and Wales, Lessons for England" (The King's Fund, 2013).

[80] Annie Bliss, "Hewitt review: what you need to know" (NHS Confederation, 2023).

[81] Nicholas Timmins, "Leading for Integrated Care",(The King's Fund November 2019).

[82] William Pett and Annie Bliss, The State of Integrated Care Systems 2021/22",(NHS Confederation, February 2022).

[83] "Quality and Outcomes Framework, 2019-20" (NHS Digital, 2020)

[84] Drs Phillips,Harding and Eggitt, Inspection Report, (Care Quality Commission, 2019)

[85] The Newsroom " One Doncaster GP merger plan ditched as three others move forward" Doncaster Free Press, 8 March 2018.

[86] Analysis Tool, GP Patient Survey, Accessed 22 June 2023 https://gp-patient.co.uk/analysistool?trend=1&practicecode=C86012

[87] "A New Strategy for the Changing World of Health and Social Care" .

[88] Care Quality Commission, "The Inspection Team: NHS Trusts," n.d., https://www.cqc.org.uk/guidance-providers/nhs-trusts/inspection-team-nhs-trusts.

[89] HS Oversight "Recovery Support Programme" (NHS England, Accessed 22 June 2023 https://www.england.nhs.uk/system-and-organisational-oversight/national-recovery-support-programme/

[90] Buchanan, D A and Huczynski A A. (2019). Organisational Behaviour: 10th edition.

[91] Leslie Doyle, "Leadership vs. Management: What's the Difference?," *Northwestern University Bachelor's Degree Completion* (blog), June 28, 2019, https://bachelors-completion.northeastern.edu/news/leadership-vs-management/.

[92] Ali Algahtani, "Are Leadership and Management Different? A Review," *Journal of Management Policies and Practices* 2, no. 3 (2014): 71–82.

[93] Buchanan, D A and Huczynski A A. (2019). Organisational Behaviour: 10th edition.

[94] David Barrett, "Leadership and Management: Are They Different (and Does It Matter)?," *The University of Hull Online* (blog), May 7, 2021, https://online.hull.ac.uk/blog/leadership-and-management-are-they-different.

[95] "General Practice Workforce 31st May 2023" (NHS Digital, June 2023).