The King's Fund>

Ideas that change
health care

Patient-centred leadership
Rediscovering our purpose

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Acknowledgements

Key messages

- A transformation of systems, leadership and organisational culture is needed throughout the NHS if the lessons of the Francis Inquiry into the shocking failings of care at Mid Staffordshire are to be learned and acted on.

- The leadership of the NHS at a national level needs to create the conditions in which high standards of care are delivered consistently, setting clear goals and standards for improving quality and patient safety, and providing the means for staff to deliver these goals within available resources.

- The quality of care provided by NHS organisations is first and foremost a corporate responsibility under the leadership of boards. As such, boards must demonstrate that they give sufficient priority to quality and patient safety – for example, by seeking and acting on patient feedback, hearing patient stories, reviewing and learning from complaints, taking time to listen to patients and their relatives, and acting on the results of staff surveys.

- Clinical teams perform best when their leaders value and support staff, enable them to work as a team, ensure that the main focus is on patient care, and create time to care.

- Team leaders are most effective when they work in a group that emphasises shared and collective leadership and when they establish well-structured teams.

- It is essential that leadership in clinical teams, NHS boards and national organisations is aligned around meeting the needs of patients, and quality and safety of care. In particular, boards need to remove barriers related to limited time and inadequate resources, which staff surveyed for this report felt were the biggest barriers to improving the quality of care.

- The leadership of the NHS at a national level has a responsibility to reorient the organisational culture of the NHS as a whole to one in which quality of care is the organising principle.

- Likewise, local NHS organisations must develop their own culture in which patients' needs come first and where undue emphasis on financial performance and other considerations does not compromise care quality.

- The NHS, nationally and locally, must develop a culture that promotes openness and honesty, and encourages staff to raise concerns about quality and safety without fear of retribution.

■ NHS leaders should encourage and nurture patient leaders to help build collaborative relationships and develop genuine co-production as a way of improving services.

■ Every organisation must take responsibility for investing in and building its organisational development and change implementation capacity. This should include an appropriately resourced organisational development plan that will inform its approach to leadership development.

■ Leadership development is essential in promulgating an organisational culture in which patients' needs come first and the values of patient-centred care are communicated and understood at all levels, from the board to the ward.

■ It is the responsibility of every NHS organisation to give priority to developing its leaders – clinicians and managers – rather than expecting others to do it.

■ Leadership development is likely to have the greatest impact when it supports the development of individuals and teams in the organisations and contexts in which they work.

■ Board members and staff should be required to undertake training to ensure that they understand the values of patient-centred care and their personal responsibility to promote safe, high-quality care.

■ Developing excellent team leaders, including ward managers and matrons in hospitals and the community, should be a high priority.

■ It is time for the NHS to rediscover its purpose. The NHS should study and learn from the experience of high-performing health care organisations in other countries that have achieved significant results by focusing on constancy of purpose, organisational and leadership stability, and allowing sufficient time to work on the many other factors that contribute to delivering high-quality care, including developing effective leadership and a culture that puts patients' needs first.

Introduction

The findings of the public inquiry led by Robert Francis QC into the shocking failures of care that occurred at Mid Staffordshire NHS Foundation Trust raise major questions about the leadership and organisational culture that allowed hundreds of patients to be harmed or to die unnecessarily. If used thoughtfully the Francis Inquiry's recommendations could transform the experience of patients and staff by strengthening leadership and changing the culture in which care is provided. This report, *Patient-Centred Leadership: Rediscovering our purpose,* summarises the main findings of the Francis Inquiry in relation to leadership and culture, and sets out what needs to be done to avoid similar failures in future.

This report builds on two previous reports from The King's Fund on leadership and management in the NHS. Our 2011 report, *The Future of Leadership and Management in the NHS: No more heroes,* argued that the NHS should move beyond the outdated model of heroic leadership to recognise the value of a leadership style that is shared, distributed and adaptive (The King's Fund 2011). It emphasised three key points: that general managers and clinical managers alike make important contributions to leadership; that leaders exist at all levels of an organisation (from the board to the ward); and that leadership across systems of care as well as in individual organisations is becoming increasingly important.

Our 2012 report, *Leadership and Engagement for Improvement in the NHS: Together we can*, focused on the role of leaders in engaging staff and other stakeholders to bring about improvements in care (The King's Fund 2012). It provided evidence that organisations in which staff are engaged deliver a better patient experience, better outcomes, and lower absenteeism; at the same time, engaging patients in their own care can ensure that care is more appropriate and can also improve outcomes. It highlighted that the increasing importance of integrated care requires leaders who are able to engage across systems, including outside the NHS, to achieve improvements in outcomes and care for the populations they serve.

These arguments remain relevant to leadership for quality and improvement in a post-Francis NHS. This report draws on a wide range of contributions from within The King's Fund and elsewhere to identify what now needs to be done to ensure that what went wrong at Mid Staffordshire does not happen again. It builds on previous work by the Fund in which we argued that there are three lines of defence against poor-quality care: frontline clinical teams, the boards leading NHS organisations, and national organisations responsible for overseeing the commissioning, regulation and provision of care (Dixon *et al* 2012).

Strengthening leadership is critical in each of these three areas, but we argue that organisations must also develop a culture that puts patients' needs first, and outline what needs to be done to bring about real change for patients and staff. This includes investing in the leadership skills and qualities of clinical and managerial staff and board members, and establishing a cadre of patient leaders to support quality improvement in health care. A sustained effort is needed at all levels to learn the lessons of the Francis Inquiry and to bring about the difficult but essential changes in leadership and culture that are needed to prevent those failures happening again. The journey of improvement and of rediscovering our purpose starts here.

The Francis Inquiry: diagnosis and prescription

What went wrong?

A dangerous culture and weak leadership

The Francis Inquiry identified 'an unhealthy and dangerous culture' as a pervading cause of the failures at Mid Staffordshire NHS Foundation Trust. That culture was characterised by:

- bullying
- target-driven priorities
- disengagement by medical leaders
- discouragement of feedback from trainees
- low staff morale
- isolation
- lack of candour
- acceptance of poor behaviours
- reliance on external assessments
- denial.

As Francis said, 'It is a truism that organisational culture is informed by the nature of its leadership', noting that effective leadership at Mid Staffordshire was 'significantly lacking'. The trust board was inexperienced and over-confident, preoccupied with achieving foundation trust status and meeting financial targets. Non-executives remained aloof from operational concerns even where they constituted a potential risk to patient safety. The trust's clinical leaders either lacked a voice at board level or did not make their concerns heard, while doctors were so disengaged from the trust's management that they failed to pursue their concerns, including those about the standard of patient care.

Shortcomings part of a wider problem in the NHS

Francis also said that this kind of organisational culture, and the shortcomings identified in leadership, are not restricted to Mid Staffordshire: 'It is not possible to say that such deficiencies permeate to all organisations all of the time, but

aspects of this negative culture have emerged throughout the system.' In the wider NHS, the main features of this culture are:

- lack of consideration of risks for patients

- defensiveness

- looking inwards, not outwards

- secrecy

- misplaced assumptions of trust

- acceptance of poor standards

- failure to put the patient first in everything that is done.

According to Francis, these failings – in organisations that are generally staffed by caring and conscientious people – may be the result of mechanisms staff use to cope with the immense difficulties and challenges they encounter in their everyday work.

A top-down, command-and-control leadership style has given rise to a tendency to 'shame and blame'; this not only inhibits managers and staff from owning up to mistakes but also misses an opportunity for others to learn from those mistakes. Moreover, it is inimical to the openness, transparency and candour necessary to safeguard patient safety. As Francis puts it: 'There lurks within the system an institutional instinct which, under pressure, will prefer concealment, formulaic responses and avoidance of public criticism.'

Disengagement between managers, staff and patients

Within this kind of culture, leaders become detached from those on the front line and from the consequences of their decisions – a trend discernible from the Department of Health downwards. As Francis notes: 'DH [Department of Health] officials are at times too remote from the reality of the impact of the service they oversee on patients.' This led to the board and senior managers prioritising and explicitly rewarding the achievement of financial targets while overlooking patient safety and basic care standards – to such an extent that frontline staff began to see finance and targets as ends in themselves. The result, in Francis's words, is 'a culture focused on doing the system's business – not that of the patients'.

How can it be put right?

Francis suggests that an organisational culture based on positive values must take root and grow across the NHS if the failings of care at Mid Staffordshire are to be avoided in future. Such a culture would demand that 'patients are put before

other considerations, fundamental standards are observed, non-compliance is not tolerated, and all commit to full personal engagement in the organisations to which they belong to achieve these ends'.

But this kind of change would not 'just emerge through the good intentions of those working in the system'; it would require strong and stable leadership, mutual support in teams, organisational stability, useful comparable data on outcomes, and greater value placed on openness, transparency and candour. It would need to be accepted by all who are part of it, and continually reinforced by 'training, personal engagement and commitment'.

Francis admits, though, that changing the organisational culture within the NHS is no easy task: 'Quite how the required common culture is delivered is less than easy to discern, given the mixed success met with by previous attempts at cultural change, but it is clearly a co-ordinated combination of factors that must be looked for, rather than some simplistic solution.' In his view, leadership is crucial, and responsibility for leadership needs to be shared at all levels, from the board to the ward. Leaders must exercise 'strong, ethical and patient-centred leadership in every organisation'. To do this, they should:

■ be visible and set an example

■ listen to patients and staff

■ understand their organisations in depth, at both an operational and strategic level

■ think laterally across boundaries

■ share leadership with all staff, and ensure that they feel valued, respected and supported

■ encourage clinical engagement

■ be able and willing to challenge others

■ be ready and able to exercise collective leadership at board level.

In practice, this might mean holding open board meetings, leaders personally listening to complaints (from staff or patients), and being open and honest in cases where a certain service or quality of service cannot be offered. Clinicians would also be more engaged in leadership and management roles – indeed, this is vital if the gulf that has been allowed to open up between clinicians and general managers is to close. Senior NHS leaders would have to demonstrate that their proposals for changes to services would protect or improve patients' wellbeing.

Did Francis get it right?

The King's Fund endorses and supports much of what Robert Francis QC says in his report on the Mid Staffordshire public inquiry. We particularly welcome the emphasis on leadership and culture in explaining what went wrong, and his proposals on how to put things right in these two key areas.

At the same time, it is important to acknowledge that there have been unprecedented improvements in patient care across the NHS during the period covered by the inquiry, partly due to government-led investment and reform and partly as a result of locally led changes in care. Major failures in a small number of NHS organisations – despite their tragic consequences for individual patients and their families – should not obscure these improvements, nor should they detract from broader evidence showing that the NHS performs well on many dimensions of care compared with other national health care systems (Anderson and Markovich 2011).

It is our view that NHS staff are intrinsically motivated to help patients when they are vulnerable, and failures primarily occur when the systems in which staff work let them down. These systems emanate from senior NHS leadership at national level as well as the systems and leadership in place in each and every local NHS organisation. While much of the responsibility for what happened at Mid Staffordshire rests with the staff who were working there at the time, their actions were influenced by the leadership of the wider NHS as well as those leading the foundation trust itself. It follows that nothing less than a transformation of systems, leadership and culture at all levels is needed if the lessons of the Francis Inquiry are to be learned and acted on.

Below, we discuss the changes needed across the NHS to avoid a repetition of the shocking failures of care that occurred at Mid Staffordshire. We begin by discussing the role of senior NHS leaders, moving on to the role of NHS boards, and the critical contributions of frontline clinical teams. We also discuss the challenges involved in changing the organisational culture in a service as large and complex as the NHS. Throughout the report, we draw on evidence about the actions that are most likely to avoid a repetition of Mid Staffordshire and, more importantly, that are most likely to promote an organisational culture that is centred on providing good-quality, patient-centred care. The size and complexity of the NHS means that actions taken to deliver these improvements in leadership and culture must be aligned at different levels – in frontline clinical teams, the boards leading NHS organisations, and the national organisations responsible for overseeing the commissioning, regulation and provision of care – if they are to be effective.

Leading the NHS

At the national level, the NHS leadership must play a crucial role in bringing about much-needed change. The leadership tone and style adopted by politicians and senior civil servants in the Department of Health permeate far into the health service. Through what they say and do, they send important signals about the issues that NHS boards and clinical teams should see as priorities.

Recent improvements in patient care have largely been driven from the top through centrally determined targets and standards, and performance management. While this approach has produced many benefits, it has also had some unintended impacts: aspects of care not covered by the targets and standards were relatively neglected; and a culture was allowed to develop in which local leaders felt they had to comply with priorities identified nationally by ministers and civil servants.

In future, those leading the NHS at the national level must demonstrate that caring and compassion are core values within the service. This means setting clear national goals for improving quality and safety, and supporting staff to deliver them within available resources by removing obstacles and providing staff with the skills and capabilities to provide consistently high standards of care. The actions and behaviours of NHS leaders must be consistent with these values and goals.

Those leading the NHS also need to put much greater emphasis on openness, transparency and candour, as the Francis report recommends, as well as implementing devolved decision-making within a national framework. They should aspire to shift the predominant culture in the NHS from one of compliance with externally imposed standards and targets to one in which NHS leaders and frontline clinical teams are committed to bringing about improvements in care, and work together to access the support they need to do so. A key element of this is providing leaders and teams with the capabilities required to improve the quality of care.

One of the challenges to be addressed is that senior leadership in the NHS has become more fragmented as a result of the government's NHS reforms, which came into full effect in April 2013. A number of national organisations are now involved in setting the leadership tone and style, including the Department of Health, NHS England (previously called the NHS Commissioning Board), Monitor, the Care Quality Commission, and the NHS Trust Development Authority. Unless these organisations demonstrate an uncommon commitment and ability to work together, there is a real risk of NHS staff receiving mixed

messages, with a lack of clarity and direction on what really matters. In this scenario, a repetition of the failures that occurred at Mid Staffordshire is more likely.

In a period of ever-increasing financial and service pressures, it is particularly important that the collective leadership of the NHS does not send out a signal that financial performance and productivity matter more than quality and patient safety. The NHS will, of course, have to use its resources wisely and reduce waste and inefficiency wherever possible. But while continuing to pursue these objectives, it is vital that senior NHS leaders at national level demonstrate, through their words and actions, that patients' needs must come first.

As the government's health and social care reforms come into effect, the NHS is undergoing the biggest structural change in its history. At this juncture, one of the most important things ministers can do is, for a period of time, to place a moratorium on further structural reorganisations, which would be both time-consuming and distracting, diverting NHS leaders from the urgent and core business of improving patient care. As Francis has argued, the priority now should be to focus on changing organisational cultures and ensuring that NHS leaders and frontline clinical teams are able to work together to deliver improvements in care.

As well as maintaining organisational stability, NHS leaders need to reduce the high turnover of chief executives (NHS England Chief Executive, Sir David Nicholson, has calculated the average tenure for a chief executive as 700 days). Stable and consistent leadership is one of the characteristics of high-performing health care organisations in other health care systems (Baker 2011), as well as a notable feature in a significant number of well-performing NHS foundation trusts. With one in ten senior leadership posts in England lying vacant (McLellan 2013) and a significant number of NHS chief executive posts unfilled, the challenge of attracting talented individuals to these roles is both real and urgent.

Leading NHS organisations

The quality of care provided by NHS organisations is first and foremost a corporate responsibility. Boards should be held to account for ensuring that their organisations achieve high standards of patient care, and that serial failures do not occur. They must lead by example, demonstrating through their actions that quality is the organising principle for their organisations, and doing so visibly and purposefully.

Caring and compassion, as core values and behaviours, must be central to NHS organisations – 'the way we do things around here' – not just in relation to patients but in all interactions, including those between staff. For this to happen, boards must be committed to protecting the health and wellbeing of their staff. They must also understand how to promote human wellbeing: for staff to deliver high-quality care, they must be healthy and emotionally resilient themselves, and they must be supported to cope with the demands of their work.

Board members have a collective responsibility to create and maintain positive emotional environments to achieve high-quality care, characterised by optimism, a sense of efficacy, and strong cohesion. Staff who feel valued and are treated well by their organisation will usually reflect this in how they treat their patients. Boards should demonstrate that they appreciate the contribution made by staff; they should set the tone for the broader organisational culture, encouraging leaders at all levels to do the same and make it possible for frontline teams to consistently deliver high-quality care that is patient-centred.

In preparing this report, we conducted a survey of health care professionals to seek their views about what makes a difference to the quality of care. We received more than 900 responses, the results of which are summarised in the appendix (*see* pp 38–40). One of the findings was that boards are seen as having less impact on the quality of care than clinicians, managers and the government. If this finding is representative of the NHS as a whole, then it suggests that boards should be doing much more to exercise clear and visible leadership to improve the quality of care their organisations provide.

How should boards lead?

To lead quality improvement, all board members – but especially the chair – need to frequently communicate the board's values and priorities to staff. They should behave in accordance with these values (especially in tough situations), and do more to understand the patient experience by talking to patients directly (which has not usually been the case in most NHS organisations) (Steward 2012). Quality

and the patient experience should be on the agenda of every board meeting, with significant time devoted to these discussions, preferably early in the meeting rather than towards the end (Ramsay and Fulop 2010).

Some boards now invite patients to tell their stories – positive and negative – at the start of a meeting to focus members' thinking on issues around quality of care. It is important that all board members, including non-executives, have an opportunity to hear directly from patients either during board meetings or on ward walkabouts, or through informal contact. They need to monitor the content as well as the volume of complaints. Although all trusts participate in annual national patient surveys, these do not produce data that are sufficiently detailed or timely to enable boards to interpret them and act on any problems they reveal about the quality of care provided by their organisation. Boards need other ways of obtaining regular and frequent real-time patient feedback (Dixon *et al* 2012).

Boards must learn to actively listen to what they hear – from patients, governors, commissioners and staff – because failing to do so will be a lost opportunity to put things right. Failure to listen can be prompted by lack of trust, or fear of challenge or conflict. If the board is to fulfil its core business, clinical staff and each and every member of the board must feel comfortable about 'bringing bad news'. There should be specific arrangements in place for staff to bring issues of concern to the attention of the board. As the guidance produced by the National Quality Board states: 'Boards should encourage a culture where services are improved by learning from mistakes, and staff and patients are encouraged to identify areas for improvement, and not afraid to speak out' (National Quality Board 2011).

Effective boards are able to respond empathetically to difficult scenarios while maintaining the professional behaviours expected of board members. According to Steward (2012), 'Boards should be able to show an emotional response and not hide behind "performance management speak". If they're not capable of a strong response to bad news, where will the energy come from to change the situation? Like all teams, boards can be guilty of avoidance on a grand scale.'

A successful board is one that understands that it is just as accountable for the organisation's performance on quality as it is for its financial performance. In the high-performing trusts studied by Mannion and colleagues (2005), each senior board member had well-defined responsibilities and formal reporting arrangements. All board members should thoroughly understand patient safety issues and be familiar with measures of quality. The King's Fund provided evidence on how organisations and individuals at board level approach their responsibilities and accountability for the core business of patient care in its 2010 report, *Putting Quality First in the Boardroom*, as part of its Ward to Board programme (Machell *et al* 2010).

Board members should visit teams within the organisation that are striving to improve quality, and support successful staff initiatives. Alimo-Metcalfe (2012) suggests that board members could champion a specific project to raise its profile, signal board support, and improve their own understanding of clinical and organisational issues. The board should regularly invite staff leading quality improvement programmes to report on the progress being made as part of a wider review of such initiatives.

Boards must also be prepared to change organisational systems that hinder high-quality care, whether physical infrastructure, obstacles in patient pathways, unnecessary bureaucracy, delays in the provision of products, services and information, or handover problems. Often, staff cannot initiate the necessary changes independently and need management intervention to do so. Leaders of NHS organisations should work with staff to identify systemic problems and be visible in providing support to address them – again, reinforcing the message that the board is actively listening to staff and working hard to address problems around quality.

The importance of this point is underlined by the responses to our survey (*see* appendix, pp 38–40). Respondents cited appropriate resources and adequate staffing levels as the most important factors in being able to provide quality care; where these factors were not present, they were perceived as the biggest obstacles to providing good-quality care. Authentic leadership and a supportive organisational culture were also seen as key factors.

According to guidance published by the National Leadership Council (Ramsay and Fulop 2010), outward-looking boards, committed to openness and transparency, are more likely to embrace change and innovation while prioritising their organisation's reputation with its patients, the public, and its partners. They are more likely to challenge poor practices and take on difficult issues than inward-looking boards founded on cosy 'clan' cultures. They also tend to show more interest in performance information, management systems, process pathways and other mechanisms that create a more systematic way of working (Edwards and Lewis 2011).

Boards must have access to timely, accurate and relevant information about how their organisations operate, regularly reviewing key quality indicators and standards for measuring the patient experience, as well as external performance ratings. In one US study, 91 per cent of boards in high-performing hospitals regularly reviewed quality data, compared with 62 per cent in low-performing hospitals (Jha and Epstein 2010). Using information as a platform for guiding improvement was a key factor in the success of the high-performing health care systems in Baker's study (2011).

It is often difficult for non-executive board directors to know how they can make an effective contribution. This includes knowing how to strike a balance between challenging executive directors and offering support. The following excerpts from a letter to a non-executive director by Jocelyn Cornwell, of The King's Fund, offer some practical advice.

Letter to a friend, a non-executive director on the board of an NHS foundation trust, from Jocelyn Cornwell of The King's Fund

I know you are really worried about the hospital: about nursing care, about the mortality rate, and whether, before you arrived, people left the trust having signed gagging clauses. Most of all, you are worried about staff and how you can convince them that the board does mean to put 'patients first'…

My advice is to remember that you are the eyes and ears of the outsider, but you have privileged access to the inside of the hospital. That is your value to patients, to the executives and to the board. Use it well but take your time – thoughtful reflection about what can go wrong and why is all too rare, and we need lots more of it at every level of the system…

Commit yourself to a year-long schedule of informal visits to wards, clinics and departments throughout the hospital. Try to visit at different times of day and night and on different days of the week. Introduce yourself to the staff on arrival and then, quietly and unobtrusively, observe what is happening… Introduce yourself to patients and relatives – find out if they know who is in charge of their care and how they can contact that person should they need to. Talk to the staff – find out what they think of their area of work and of the hospital. What would they like to change and why, and what do they feel they can do about it?

Unless you see something that puts patients at risk – in which case you have to report it immediately – don't produce lists of things that need fixing after each visit. That will reinforce the idea that staff are not trusted to get things right on their own. Approach the visits and periods of observation in a spirit of inquiry, not monitoring. Talk to your fellow board members about what you are doing, keep a journal, and find out what lies behind the problems you see and hear about. Be patient, and gradually the workings of the hospital will reveal themselves. Be persistent, and word will spread that the board is seriously interested in the work of caring for patients and the conditions that make it possible.

Remember, cultures change gradually, not overnight. Choose carefully when to act. Be brave, and gradually staff who believe now that Francis's talk of a culture of openness, honesty and no blame is a con, might just be prepared to put their trust in you and to take the first step towards real cultural change.

Leading clinical teams

Nowhere is leadership more crucial to improving care quality than on the front line – in wards, clinics and general practices. Leadership at the front line is often best performed by clinicians (usually doctors or nurses), together with general managers. Clinicians are well placed to take charge of the factors known to affect outcomes – teamwork, inter-professional communication, standardised care processes and process compliance – not least because of the credibility they have with colleagues providing care directly.

However, many doctors have been reluctant to take on leadership roles, alienated by centrally mandated targets and corporate efficiency objectives. Some are deterred by the risk of a failed career move, the lack of financial reward, and a reluctance to give up clinical work. For their part, nurses may be deterred by the pressures of caring for an ever-more demanding patient caseload, rising public expectations, and static resources. Doctors and nurses alike may also be concerned that leadership roles are too far removed from patient care, and feel they do not have the training and management experience required to take on these roles.

Although we recognise these challenges, there is strong evidence that organisations in which doctors are both valued and engaged perform better than those in which this is not the case (The King's Fund 2012). Baker's work on high-performing health care organisations in other health care systems shows that 'effective leadership for improvement requires engaging doctors to participate in redesign efforts and to build support for these activities among their colleagues' (Baker 2011). This finding takes on added importance in view of new evidence that medical leadership in NHS trusts remains variable and often under-developed. (Dickinson *et al* 2013)

Doctors as clinical leaders

Frontline doctors exercise considerable influence over staff and patients. What they say and what they do have a significant impact on those they lead, as they will be taken to be communicating the organisation's priorities and values. As Bohmer (2012) states: 'Speaking clearly, inquiring respectfully, acting decisively, demonstrating humility and fallibility – these are the simple and essential elements of leadership in a clinical setting.' When those in charge admit fallibility, it can help to create a working culture that enables people to speak up about actual or impending failures, and so prevent harm.

One of the challenges facing medical leaders is to identify goals that can unify and engage a team with diverse professional backgrounds while reflecting the organisation's values and priorities. Developing goals from the bottom up conflicts with the NHS's tendency to set goals centrally, but as Bohmer (2012) notes, 'leaders need to inquire and listen more than advocate and push'. Goals must be specific, challenging, measurable and realistic. Improving how the team works with other teams – inside and outside the organisation – should always be a key goal.

Crucially, leaders must give teams feedback based on reliable data about their performance so that they can improve their effectiveness. Where leaders agree goals that may be particularly challenging for a team to achieve, they must recognise that failure, through no fault of the team, should not be a cause for complaint. Making good progress towards the goal should be celebrated.

To achieve all this, clinical leaders need a sophisticated understanding of the complex system in which they work. They must appreciate the roles and perspectives of other professions and stakeholders, and may need to develop their own skills in leading fellow doctors and other clinicians for whom autonomy is often highly valued.

New research into the current state of medical leadership in NHS trusts reveals variable levels of engagement among doctors in management and leadership roles (Dickinson *et al* 2013). Thirty years after the Griffiths report called for doctors to take greater responsibility for budgets and services (Griffiths 1983), much remains to be done both to develop medical leadership and to remove the barriers that get in the way of doctors choosing to take on leadership roles. It is particularly important to change the culture in which doctors who become leaders are perceived by their peers to be going over to 'the dark side'. It is equally important to develop career paths that make it easier for doctors to assume greater levels of responsibility as leaders, with appropriate mentoring and support.

Revalidation will alter the culture of how doctors operate as individuals, in teams, and in organisations. The 'responsible officers' – senior doctors who carry out appraisals of other doctors as part of the revalidation process – will have an opportunity to discuss continuous professional development (CPD) needs and areas for improvement. But one of the most important changes is that doctors will have to present evidence about their interactions with patients.

Revalidation offers a chance for medical leaders to renew workforce values and strengthen competence and professionalism. But they need support to make revalidation a priority and develop the nuanced skills needed to have difficult conversations with other doctors (Nath 2013). More broadly, this highlights the value for all NHS staff of having well-structured appraisals that take the form

of helpful, positive conversations that enable staff to work more effectively, and which are also an opportunity for the organisation to reinforce the message that it values, respects and supports its staff.

Nurses as clinical leaders

The wards in Mid Staffordshire where patients experienced the worst failures of care were those that lacked 'strong, principled and caring leadership'. This led Robert Francis QC to argue that: 'The ward manager's role as leader of a unit caring for patients is universally recognised as absolutely critical.' Yet ward managers now face more challenging circumstances than ever. They have to cope with a high turnover of patients who are often elderly and have complex conditions but stay for a shorter time, making it difficult to establish good relationships; and the boom-and-bust nature of nurse recruitment in the past decade has contributed to high staff turnover.

Maben and colleagues (2012a) carried out a three-year study exploring the links between patient experience, staff motivation and wellbeing. They concluded that ward managers and nursing team leaders played a crucial role in all three areas. To be effective, they advised ward managers and nursing team leaders to adopt the following strategies.

- Building teams by creating space to get to know colleagues and talk about challenges or divisive influences before they become embedded. This includes building a sense of 'family at work', especially in teams that span many different staff grades, professions, or cultural and ethnic backgrounds, for example.

- Facilitating greater staff empowerment – for example, through decentralised forms of job design that give employees more discretion and control over their job.

- Building resilience among staff – by creating support and supervision for staff to reflect on the emotional and physical challenges of caring for people and discussing how to manage 'difficult' patients; Schwartz Center Rounds® (discussed in more detail below) are one way of doing this.

- Developing a supportive local care climate – that is enabling for staff but sets clear expectations, goals and direction for patient care performance.

- Setting a positive emotional 'tone' for the delivery of care – for staff and patients, which reiterates the need for managers and leaders to treat staff as they wish staff to treat patients.

Schippers and colleagues (2013) recommend that teams regularly take time out to reflect on their objectives, effectiveness and team processes, introducing

changes and innovations accordingly. Maben and colleagues (2012a) advise NHS organisations to support nurse leaders by:

■ systematically measuring job demands in different care environments and limiting them (where possible) to minimise employees' exhaustion

■ investing in unit-level leadership and supervisor support to ensure that team leaders can promote good teamworking and support peer relations

■ investing more in how teams function and perform, encouraging co-worker support and a sense of 'family at work'

■ freeing up clinical staff to recruit and manage their own teams, ensuring that they have the necessary skills to do so.

The same principles should apply regardless of the clinical team leader's professional background. What matters is that the critical role of nurse leaders in ensuring care quality and patient safety is recognised, and that they receive adequate support to fulfil their role. Acting on this evidence presents a major challenge in an NHS experiencing increasing pressures in terms of patient demand and constrained budgets. Change will only happen if the leaders of NHS organisations make the necessary time and resources available for teams to learn from their mistakes and provide care to the highest possible standards.

Leadership for culture change

Leadership is key to changing the culture of any organisation. Consciously or unconsciously, leaders set the tone of their organisations through what they say and do. As Robert Francis QC argues, culture and leadership go hand in hand – both are critical to delivering the improvements in patient care that are needed.

The culture of the NHS

An organisation's culture is made up of the basic values, shared beliefs, deep-seated assumptions and working practices that underpin how its staff behave – encapsulated in the phrase 'the way things are done around here'. In fact, there may be more than one culture operating within an organisation, resembling instead an 'interwoven web of subcultures', each associated with different levels of power and influence. The dynamics between these subcultures may change over time (Mannion *et al* 2008).

In the NHS, the prevailing culture was determined by medical staff, but the past 30 years have seen the rise of managerialism (Jarman 2012). As Mannion and colleagues (2008) remarked, 'the NHS is notoriously "tribal"'. To complicate the picture further, the NHS is not a single organisation but a collection of several hundred organisations, each of which has its own culture and subcultures (Mannion *et al* 2005). It is therefore difficult to convey these complexities when talking about 'the culture' of the NHS.

Despite this, many commentators point to certain characteristics of the NHS at the time patients were harmed or died at Mid Staffordshire as having contributed to failures of care. These characteristics were summarised in three reports from experts outside the NHS commissioned by Lord Darzi as part of the NHS review he led in 2007–8 (Institute for Healthcare Improvement 2008; Joint Commission International 2008; McGlynn *et al* 2008). They included:

- a top-down, target-driven approach focused on process measures such as waiting times rather than quality of care and the needs of patients

- a culture of compliance with targets rather than a culture of learning and improvement

- a 'shame and blame' culture that stifled innovation

- chief executives who had a short tenure and constantly feared being sacked

- weak engagement by doctors in management, leadership and quality improvement

- doctors who 'looked the other way'

- disengagement between clinicians and managers.

Taken together, these characteristics describe an NHS culture that contributed to the failures that occurred at Mid Staffordshire. The challenge in responding to the Francis Inquiry is to understand how to develop and sustain a very different kind of culture that supports the delivery of high-quality care and that always puts the patient first (Davies and Mannion 2013). There are undoubtedly lessons that can be learned from other industries with a strong record on quality and safety – for example, the airline industry and the nuclear power industry – and from other national health care systems (Baker 2011).

Putting it simply, the NHS needs to adopt the following characteristics to build the kind of culture that really puts patients first.

- At the national level, NHS leaders must prioritise patients' needs instead of process measures and finances, making it clear to all local-level managers and staff that quality is the organising principle of the NHS.

- NHS organisations must promote a culture of learning and improvement in which staff and managers are supported to enhance quality and safety.

- Organisations must support risk-taking and acceptance of failure where innovations do not succeed.

- Stability of tenure of chief executives and support for NHS leaders who get into difficulty is needed.

- Clinicians must understand the implications of choosing not to raise concerns about quality and safety.

- Doctors and other clinicians need to fully engage in management, leadership and quality improvement.

- Clinicians and managers need to build effective working relationships to address the gap that has developed between them.

The core values identified by Francis, including candour, transparency and openness, should also be at the heart of the NHS culture.

Regulated trust and real trust

In emphasising the importance of culture, we would caution against an overreliance on external regulation as a defence against poor standards of care. Smith and Reeves (2006) made an important distinction between 'regulated trust' and 'real trust' in creating environments that nurture desirable behaviours and

practices. Real trust relies first and foremost on self-regulation and peer review, and is found in organisations which support staff to 'do the right thing'.

Public services like the NHS suffer a surfeit of external regulation, which often crowds out the intrinsic motivation of staff to perform their tasks to the best of their abilities. Regulated trust, secured through intrusive inspection and box-ticking, is not only time-consuming but also risks substituting technical rules for moral principles. By contrast, real trust is cultivated by leaders who embody and express the right instincts, display the right behaviours, and lead by example – valuing and engaging staff and treating them as they would wish staff to treat patients, thus shaping the overall performance of the organisation and its reputation.

In arguing for greater emphasis on real trust, we would also caution against moves to introduce more formal regulation of NHS managers. A better approach would be to strengthen recruitment of managers by focusing on values, attitudes and behaviours. This might include inviting patient representatives to take part in the recruitment process to assess how prospective managers relate to and engage service users. Comprehensive career support for managers is equally important, including ensuring that their appraisals are conducted regularly and effectively, and that underperforming managers are supported to improve in the relevant areas.

Consideration should also be given to adopting the standards for boards developed by the Professional Standards Authority for Health and Social Care (2012). These cover personal behaviour, technical competence and business practice of individual board members. Anticipating Francis's emphasis on the importance of putting patients first, the standards include prominent pledges such as 'I understand that care, compassion and respect for others are central to quality in health care' and 'I understand that I must act in the interests of patients, service users and the community I serve'.

Patient-centred culture

Citing evidence from Sir Donald Irvine, Francis (2013) noted that in an organisation like Mayo Clinic in the United States, all staff, from the chief executive down, focus on clinical quality and patient experience; underperformance and poor practice are not tolerated. High-performing organisations like this have worked hard to create and maintain their culture; the NHS should learn from them and strive to do the same. Openness to learning from others and a readiness to adopt best practice are essential facets of a healthy organisational culture.

Bringing about this cultural change within the NHS will be a slow process, demanding a long-term perspective and a clear, sustained strategy (Baker 2011).

As already noted, organisational stability is a critical backdrop to delivering positive cultural change. The high-performing organisations in Baker's study had all worked hard for a decade or more to develop their capabilities to improve care and spread best practice, and had often benefited from stability of leadership during this transition.

One of the characteristics of high-performing organisations is that they are clear about their values and work relentlessly to ensure that these are known and understood by staff. In Mayo Clinic, this is expressed simply but powerfully in its primary value: 'The needs of the patient come first'. A short and clear statement like this has obvious advantages over the much lengthier and complex commitments contained within the NHS Constitution. In Mayo Clinic, the organisation's values are inculcated during the induction and training of new staff and reinforced at every opportunity with existing staff.

To move beyond pockets of innovation and isolated examples of high-performing organisations, it is critical to engage as many staff as possible by appealing to their values and demonstrating how changes in practice will contribute to improvements in patient care and outcomes. The language used to communicate values and priorities will be critically important, and should avoid jargon and commercial or business terminology that often alienates health care staff. It is equally important to allow sufficient time for new practices to become established and to avoid the temptation to change direction too frequently. The following examples show what some NHS organisations are doing to develop high-quality and safe care, and to engage staff in bringing about improvements.

Patient-focused culture in practice

NHS Quest

NHS Quest is a network of 14 foundation trusts that 'aspire to a level of excellence in quality and safety, for our patients, which is beyond all current expectations'. It rejects command-and-control leadership because such a leadership style does not engender a culture that values staff ideas or supports compassionate care. Instead, it prescribes several 'leadership actions' to help bring about a 'zero-harm culture':

- regularly spending time on wards to be aware of the care being provided
- listening to clinical staff and patients and supporting their ideas for improving services
- acting openly and honestly with patients, the public and staff
- publishing performance data (Dalton 2013).

Listening into Action

Listening into Action (LiA) is a systematic and comprehensive approach to improving patient care that empowers clinicians and other staff to make the changes they want to see. Pioneered by the Sandwell and West Birmingham Hospitals NHS Trust and now being used by several trusts in England, LiA focuses on quality and safety, the patient experience, and working together. Staff decide together what gets in the way of them providing excellent care for patients, and what they will change to improve care quality. The chief executive is expected to lead the LiA process, supported by clinical and operational leaders who oversee its implementation during the first year and beyond until it becomes embedded in the organisation's culture (Listening into Action 2013).

Changing the culture in NHS organisations: what can boards do?

Boards, and particularly chief executives, have a crucial role to play in creating a positive, quality-oriented culture within their organisation. What they pay attention to and talk about matters, as do their messages about why improvement is necessary, whether they really believe in a goal, and their ability to achieve it. They must not only express their organisation's values, but also follow through with the actions necessary to make them a reality (Mannion *et al* 2005).

Chief executives and boards must create a positive and supportive environment for staff. Without that, they are unlikely to achieve high levels of employee engagement. Where staff are engaged, patient satisfaction is significantly higher and mortality lower (West and Dawson 2012). Engagement requires a high level of trust, a positive emotional climate in which staff feel valued, respected and supported, and clear and consistent leadership (West and Dawson 2012). Good leaders will ensure that all staff are clear about their responsibilities, will allow decisions to be devolved, and will communicate effectively, providing feedback that gives credit and recognition where this is due but also holds staff to account.

Work-related stress is a major obstacle to staff engagement, and health care is an inherently stressful occupation. Boards need to put in place measures to counteract work-related stress, yet as Buggins (2013) notes: 'Healthcare organisations are often not very supportive places to work.' She argues that providing staff with 'psychological safety' is key. All team leaders should give staff space to think, review, solve problems and learn from experience, making it more likely that mistakes and failures are detected and addressed early. 'Where leaders really care for staff they are equipped to provide high quality care to patients' (Buggins 2013).

Examining the cultural characteristics of high- and low-performing hospitals, Mannion and colleagues (2005) found that the better performers had devolved power and responsibility to individual directorates for a more participatory and decentralised style of management. The poor-performing organisations had 'an underdeveloped and emasculated tier of middle management', despite service and clinical directors being critical to organisational culture and care safety. Senior managers were seen as a remote and disconnected 'cabal', 'clique' or 'inner circle' whose decisions were divorced from the wider organisation's practical concerns.

The NHS has long neglected investment in middle managers, and rectifying this gap will be crucial to creating a culture of quality improvement. Middle managers and frontline teams need to become a source of solutions. The NHS's traditional command-and-control style, in which solutions are passed down from on high, needs to be replaced with 'two-way trust' (West and Dawson 2012). Leaders need to nurture environments in which innovation by frontline teams can flourish, and develop the 'real trust' that Smith and Reeves (2006) argued for.

Culture and clinical teams

In their study exploring the links between patient experience, staff motivation and wellbeing, Maben and colleagues (2012a) found that while organisational climate (or culture) played a role in staff wellbeing, the local work climate – the ward – was key. Two factors were particularly crucial: ward leadership and co-worker relationships (with the former exerting a significant influence on the latter) (Maben *et al* 2012b). Staff motivation and wellbeing were also closely correlated with patient experience, underlining that clinical teams are the first line of defence in ensuring the provision of high-quality, patient-centred care.

Introducing Schwartz Center Rounds® can be one component of this. Developed in the United States and now being taken up in the NHS, these rounds are a way of bringing together staff from all disciplines monthly to reflect on the non-clinical aspects of their work, giving them a space in which to discuss difficult emotional and social issues arising from day-to-day patient care. Participants have reported less stress, greater appreciation of the importance of empathy, and improved relationships with each other and with patients (Goodrich and Cornwell 2012).

Nurses appreciated ward managers who performed some immediate patient care, had presence in ward areas, and were felt to be accessible. Colleagues saw them as knowledgeable and able to facilitate effective care. By contrast, staff identified autocratic, arrogant and unsupportive leaders as unhelpful and creating a poor environment for staff wellbeing and, therefore, the patient experience.

Ward leaders' freedom to recruit their own staff, and so hand-pick their team, was deemed an important factor. One senior manager reflected on the situation in a ward where this had not been allowed to happen: 'To have lost 80 per cent of her staff and have them replaced and never chosen one of them… it's not surprising there are problems.' Commenting on another ward where the ward sister was allowed to recruit her own staff, the manager said: 'She got the opportunity… to construct a proper team and then do lots of team building work with them. And we do get fewer complaints, fewer incidents, lower sickness, lower turnover, and it is down to good leadership and building your own team.'

Well-structured clinical teams are a powerful means of helping staff develop resilience in the face of frustration as, according to West and colleagues (2011), they can 'reinforce high levels of motivation and morale in a virtuous circle'. They enjoy better health and wellbeing and take less time off work. Poorly structured teams are associated with higher patient mortality, more errors that could harm staff or patients, and higher levels of staff injury. Appraisals make a significant contribution to overall team performance, with evidence indicating that they are most effective when they focus on six or seven clear, measurable and challenging objectives.

Teams should be better co-ordinated, and strive for more effective communication within as well as across teams to ensure that they do not leave patients neglected, exposed, ill-informed and distressed. There are lessons to be learned from effective teamworking in other sectors, as Gawande (2011) has shown in his important analysis of the unlikely but highly relevant examples of Formula 1 pit crews and cowboys herding cattle.

Leadership by patients

Improving the NHS's responsiveness to patients and securing greater patient and public engagement have long been policy priorities, yet the typical NHS experience remains far from patient-centred. A genuine shift in that direction would mean some major departures from traditional ways of working. It would mean, for example: ensuring that care delivery is always responsive to people's physical, emotional, social and cultural needs; ensuring that interactions with staff are informative, empathetic and empowering; ensuring that personal values and preferences are elicited and acted on; ensuring that reliable health information and advice are readily available in a variety of forms; and ensuring that commissioning and provision of services focuses on people rather than diseases (Coulter 2012).

But there are many significant obstacles to achieving this shift in direction and, according to Coulter (2012), resistance to change comes mainly from health professionals rather than patients. Coulter lists the various reasons as: lack of awareness, incentives, knowledge and skills; concerns about time and resource pressures; desire to avoid stress by keeping a distance from patients' emotional problems; and negative attitudes among some clinicians who fear loss of face, power or income. She also notes 'an unwillingness to experiment with new roles or new ways of relating to patients'.

One new concept – patients as leaders – is beginning to gain popularity in the voluntary and community sector. It is perhaps a deliberately provocative notion, the very antithesis of the old-fashioned view of patients as supplicants. The aim is to give 'teeth and meaning' to the often vague concept of public involvement (National Voices 2012), enabling patients to help frontline teams redesign services according to patients' needs.

How can patients lead?

Those who support the idea of patients as leaders argue that patient and public engagement has been 'co-opted by institutional interests as a buffer against change' rather than a mechanism for driving it (Gilbert 2012). They complain that involvement is typically limited to tokenistic consultations, questionnaires, one-off projects or overly bureaucratic structures with a seat for a public representative. NHS organisations are too easily satisfied with 'ticking the box' of public engagement by appointing one or two patient representatives, often covering a dozen committees. Such representatives may feel intimidated by the professional experts they sit alongside, or else while trying to build relationships

they lose their critical faculties and are captured and tamed by the organisation – a reaction occasionally shared by non-executive board members.

As Gilbert and Doughty (2012) point out, patient leaders face a difficult task: 'The patient leader has to shift the dynamic (often unaided) from a child-parent relationship with professionals to a dialogue of equals. On the way they need to develop a nose for where power and decision-making authority lie. They don't need a map of the territory so much as good navigational skills.'

Gilbert (2012) argues that patients' experiences of ill-health often act as 'the crucible within which many have to rethink their lives, reframe and build new identities' – that is, it is both crisis and opportunity. Having to cope with everyday difficulties can release a new capacity for innovation and entrepreneurialism, as well as empathy and a passion to help others. When appraising the NHS, 'they see all too well what needs to improve and could provide innumerable ideas for how things could be better'.

Patient leaders can contribute to an organisation's work in two ways:

- as a community channel – externally facing, keeping in touch with local communities and introducing wider perspectives

- as a 'critical friend' – internally facing, 'flying the patient flag' and offering strategic advice from a non-institutional perspective.

NHS organisations can use patient leaders in a wide range of roles, on patient reference and participation groups, as peer supporters, health champions, foundation trust governors, or as experts by experience. They can help boards, managers and staff to understand the patient experience, improve collaboration, support other patients and families, and hold services to account. To be successful in articulating the patient voice, patient leaders need to be recruited from a diverse range of backgrounds, be clear about their role and expectations, and have access to support and development (National Voices 2012). Although they can rarely represent patients formally in the round, they may still enjoy legitimacy – particularly through using social media effectively (Gilbert and Doughty 2013). National Voices (2012), the coalition of health and social care charities in England, suggests that by addressing questions of recruitment, roles and skills, patient leadership programmes can ensure that patient leaders have legitimacy and impact.

Doughty and Gilbert (2012), drawing on their experience of running patient leader programmes, highlight three key qualities of an effective patient leader:

- capacity for 'self-leadership'

- ability to focus on solutions

■ willingness to value and work with others.

They draw a parallel between strategic leaders, who need a vision but have to address current realities, and people with health conditions, who 'have to do likewise at a personal level'. Patient leaders need planning and project management skills and a 'sophisticated sense of who can help'. They argue that the patient leader model has similar values to professional, community, civic and lay leadership. The intention is that by building collaborative relationships, patient leaders can move beyond 'us and them' attitudes rooted in old-style, command-and-control leadership to true 'co-production' to improve services and the patient experience.

Nurturing patient leaders could become a specific task for NHS leaders. Clinical commissioning groups are obliged to involve patients in commissioning decisions, and how effectively they do so will form part of their annual assessment. If this proves an adequate incentive for them to go beyond traditional 'box-ticking' measures and become genuinely responsive to patients' wishes, they may quickly come to appreciate the value of patients as leaders.

Patient leaders in action

Impressive case studies exist of patient leaders in action and in this section we describe three examples where patient leaders are working to improve the service provided by different health organisations.

The DIMPLE (Diabetes Improvement through Mentoring and Peer-led Education) project

The DIMPLE project in London developed community champions, mentors and educators who were able to reach more people in marginalised communities faster than if the activity had been led solely by professionals. Funded by the North West London Collaboration for Leadership and Applied Health Research and Care, the project emerged because people with diabetes wanted to provide and receive more support outside formal clinical consultations.

DIMPLE's aim was to improve and spread self-care management for people with, or at risk of, type 2 diabetes in four London boroughs. Local volunteers were trained as 'champions' to raise awareness in their communities about diabetes, sharing key health messages to increase knowledge and help change behaviour. The project also trained peer mentors – people already living with diabetes – to take referrals and offer emotional support, in response to evidence that diabetes patients wanted more support and needed more time than was available in primary care consultations. After feedback from people

with diabetes who wanted to be involved in educating and supporting other patients, the project also trained peer educators to motivate and improve self-efficacy among people attending courses to learn about the condition.

In total, the DIMPLE project recruited and trained 51 champions, 30 mentors and 21 peer educators. By 2012, more than 5,000 people had been reached. Service users were active and engaged members of the team co-designing and co-delivering the project, and played a key role in making the project accountable. Those reached by the project had an overwhelmingly positive response to it. The volunteers reported improvements in their own health and self-worth, as well as gaining professional skills (one intends to enter medical school and another hopes to train as a nurse).

Kingston General Hospital, Ontario

Leslee Thompson, Chief Executive of Kingston General Hospital in Ontario, Canada, spoke at a conference on the patient experience organised by The King's Fund in 2012. She told how, a few years ago, the hospital was performing badly in key areas, prompting its leaders to ask: 'What if patients ran our hospital? What would be different?' The answer, she said, was 'Everything.'

The hospital had to introduce an ambitious three-year improvement plan in 2008, when its overspent budget, high infection rates, low staff satisfaction and poor relations between doctors and managers led to government intervention. Four years later, it had reduced infection rates considerably (handwashing compliance rose dramatically from 34 per cent to 94 per cent), raised patient satisfaction, and balanced its books for the first time in 16 years.

A vital part of its improvement programme was the creation of a patient family advisory council, comprising 12 people who had had 'heart-rending' experiences at the hospital. It now has 50 patient advisers throughout the organisation attending all committee meetings that concern patient care. Patient advisers are also involved in recruitment panels for nurses and on committees examining critical incident reviews. The aim is that patients will be present in every decision-making forum that materially affects patient care. 'It starts to change the language,' said Ms Thompson: no one ever refers to 'bed-blockers' now.

Patient experience adviser Anndale McTavish described some of the practical changes patients had suggested. They wanted to be able to find their way around the hospital, with signage respectful rather than 'preaching and negative'. Visitors should be welcomed at point of entry, and again at the service area, within seconds – staff should not delay acknowledging them because of paperwork. All staff should wear name badges. Shift changes

should take place at the bedside wherever possible, with patients and families participating. Families should be welcomed even during difficult procedures at the bedside. Patients and families should be part of every planning process.

One early decision was to do away with restrictions on visiting hours. There were many reasons not to do it, said Ms Thompson. 'But we listened. It made complete sense, and so we did it.' How you make decisions profoundly shapes the organisation's culture and how people work together, she said, but admitted: 'This isn't easy…' Many forces within the organisation were ranged against it, but it was an organic, iterative process that had 'shaped something we never really imagined in the first place'.

Experience-based co-design (EBCD)

The principle of engaging the end user in the design process to improve the product – first applied in the design of housing and the built environment, and technical products – is increasingly common in personal services, reflected in terms such as 'co-production', 'co-creation' and 'co-design'. In health care, experience-based co-design (EBCD), a structured process for bringing patients and staff together to improve service quality, was first developed by Paul Bate and Glenn Robert (Bate and Robert 2006) and has since been applied successfully in settings as diverse as accident and emergency (A&E), recovery services in mental health, and the treatment of cancer, in a range of countries including the United Kingdom, the United States, Australia and New Zealand.

EBCD is a sequential process that starts with mapping the current service experience and the 'touch points' (the moments in the course of the patient experience that are charged with heightened emotion, good and bad) from the perspectives of patients and staff, and then brings patients and staff together into a change management process that involves 'co-design' working groups redesigning the service experience. The involvement of patients and staff on an equal footing challenges individuals in both groups, and needs skilled facilitation. Where it is done well, the process is felt to be deeper and more rewarding and the results more sustainable than those achieved in more conventional 'patient involvement' projects that treat patients as objects of study and leave them out of the improvement work itself. A step-by-step guide to the methodology is available on The King's Fund website (www.kingsfund. org.uk/projects/point-care/ebcd).

Implications for organisational and leadership development

In this penultimate section of the report, we discuss what needs to be done to bring about the changes needed in NHS leadership and culture. We focus on the organisational and leadership development implications of the Francis Inquiry report, drawing on The King's Fund's own expertise as well as the work of other experts and researchers. We begin by exploring the leadership concept that needs to underpin the development of NHS leaders and organisations, and then outline the types of interventions likely to bring the most benefit. We conclude by returning to the three lines of defence we described at the beginning of the report – frontline clinical teams, the boards leading NHS organisations, and national organisations responsible for overseeing the commissioning, regulation and provision of care – and how these can be strengthened to avoid a repetition of the shocking failures that occurred at Mid Staffordshire.

Changing the leadership concept

Every organisation has embedded unconscious assumptions about leadership (Turnbull James 2011), and renewing an organisation's 'leadership concept' is the most important role of leadership development, though it is not easy. As we argued in 2011, and argue more emphatically now, NHS organisations must turn away from the traditional individualistic models of leadership towards leadership that is shared, distributed and adaptive. Leadership development should focus on developing individual performance *in order to* improve the performance of the team, organisation or system.

Leadership development will need to focus on supporting the networks of people practising leadership throughout an organisation – people who may never acquire the label of 'leader'. As Turnbull James argues, 'The NHS needs people to think of themselves as leaders not because they are personally exceptional, senior or inspirational to others, but because they can see what needs doing and work with others to do it.' Another way of expressing this is to say that the NHS needs to focus on developing all of its staff – not just those individuals in formal leadership roles.

It follows that development should tackle organisational relations, connectedness, and changing organisational practices and processes. 'Developing individuals without working with them to simultaneously change the system will not lead to organisation change,' warns Turnbull James, adding that: 'Organisation change

is not achieved by the development of unconnected individuals, no matter how much investment is made in this.' Effective leadership development *in context* provides the means through which the organisation's values, goals and culture are aligned.

Those in positional leadership roles will still need development programmes and interventions such as coaching to help them increase their self-awareness and personal motivation, to have presence and to inspire, and to know and stick to their values. Managers will require personal development and an appropriate skill set, but these should be tailored to their particular context. Leadership development should not be about a generic competence but how skills and behaviours can be honed and applied in the situations in which leaders find themselves, whatever their level within the organisation.

Some programmes may have to help people become more effective leaders, including thinking of themselves as such. According to Turnbull James (2011), the main issues for organisational leadership development include:

- enabling participants to understand how the organisation needs to change to respond to a challenge

- how to adopt the leadership practices that the organisation needs to achieve this change

- clarifying how people play their part to realise change and gain an understanding of how this will be achieved collectively with an outcome of more effective leadership work.

Turnbull James adds that the methods used could be inquiry based, involve action learning and working directly with organisational challenges: 'The key is learning with others, in and for the specific organisational context.'

Baker's work (2011) on high-performing health care organisations underlines the importance of development taking place in context. Examples include Jönköping County Council in Sweden, which has developed its own expertise in developing individuals and teams through the establishment of Qulturum (an in-house learning and quality improvement resource). Similarly, Intermountain Healthcare in the United States has achieved international recognition for the quality and consistency of the care it provides, in no small part due to the Advanced Training Programme developed by Brent James and colleagues over several years. In both of these examples, leadership development supports staff to improve the quality of care in a way that relates to the needs of these organisations and the patients they serve.

The approach needed in the NHS

What are the implications for the NHS? Careful consideration must be given to the approach that is now needed in the NHS and the type of leadership and organisational development interventions likely to bring most benefit, and what this means for clinical teams, NHS boards, and national organisations responsible for overseeing the commissioning, regulation and provision of health care. This is particularly important in view of the chequered history of leadership development in the NHS and the opportunity to use the Francis Inquiry report to ensure that resources are directed where they can have the greatest impact in the context of the establishment of the NHS Leadership Academy and the programmes it has already started to put in place.

We argue that the starting point should be that the principal responsibility for leadership and organisational development rests with every NHS organisation. Leadership development in individual organisations should be informed by an organisational development plan, with implementation led by the board, and must address the specific needs, challenges and culture of the organisation concerned. It is very important that the behaviours of the most senior people in the organisation are consistent with the values and themes set out in any development programme. Without a coherent approach, leadership development will have limited impact on the organisational culture and is unlikely to deliver the changes that are needed to improve the performance of individuals, teams and systems, and the organisation as a whole.

It follows that every NHS organisation needs to have an organisational development plan that is appropriately resourced to ensure its implementation. There is a strong case for boards to include an experienced director of human resources (HR) and organisational development (OD) tasked with leading the implementation of the development plan, as well as getting the basics right. This includes recruitment, induction, appraisal, staff engagement and feedback on staff surveys, and related issues. NHS organisations with sufficient resources are likely to be able to develop their own in-house capacity for leadership and organisational development, whereas others may need to bring in expertise from outside.

As we have emphasised, organisational development plans need to encompass the needs of all staff and not just those in formal leadership positions. We referred earlier to the critical role of middle managers in NHS organisations as one example. Previous approaches to leadership development in the NHS have tended to focus either on those starting their careers or those already in senior leadership positions. This has often resulted in the relative neglect of middle managers and clinicians entering leadership roles in mid-career. Greater support is also needed for newly appointed chief executives to ensure that they have access to help and

support when difficulties arise, thereby tackling the problems arising from short tenure.

It is important to recognise that leadership and organisational development is an ongoing process that extends well beyond individual programmes. Leadership skills need to be constantly developed, practised and nurtured; while ongoing support (in the form of coaching, mentoring and action learning) is important to ensure that individuals are able to drive quality improvement and put patients at the heart of decision-making. The high-performing organisations studied by Baker (2011) recognised this; not only did they make a commitment to quality as a core strategy but they also invested, over many years, in developing the capabilities of their staff to support improvements in care driven from within the organisation.

Many types of leadership and organisational development interventions will be needed, some of which we have already described. They include: developing the personal awareness and skills of individuals; supporting teams and boards to reflect on their behaviours and performance, and how these can be improved; and working across the organisation to engage staff and listen to their views and concerns. As the title of this report suggests, the changes needed in the NHS can be achieved if the importance of *patient-centred* leadership is rediscovered. Leadership and organisational development needs to be reorientated, with greater emphasis on leaders engaging in a meaningful way with patients to improve the patient experience and the quality of care the organisation provides. Experiential learning is particularly important, including providing opportunities for senior leaders to make routine visits to wards so that they can spend time listening to patients, their families, and staff. Interventions like Schwartz Center Rounds® (*see* p 22) are beginning to demonstrate positive results and should be adopted more widely.

Teams, boards and national leaders

Returning to the three lines of defence we have used to frame our thinking about the Francis Inquiry report and its implications, we argue that there should be greater emphasis on interventions to support frontline clinical teams to perform effectively. This requires further investment in the development of doctors, nurses and other clinicians as leaders, through single discipline and multidisciplinary programmes. It also requires much greater clarity about the career paths open to clinical leaders, and the removal of cultural and other barriers that deter some clinicians from going into leadership roles. There is a strong argument for managers and clinicians undertaking joint development programmes to overcome the common disconnect that we described earlier; the practice of

manager/clinician pairing can be an effective initiative to support this (Imperial College Healthcare NHS Trust 2012).

Investing in team development is an equally high priority. West and colleagues' (2011) work has shown the benefits of well-structured teams, identifying four conditions for effective teams:

- having a real team that is bounded, stable and interdependent

- having a clear team purpose

- making the right choices about who should be on the team

- developing the team through regular coaching and self-coaching.

They emphasise that teams are more effective when they routinely take time out to reflect on their objectives, strategies, processes and environments, and make changes accordingly.

Their findings are similar to those of Maben and colleagues, referred to earlier, that team leaders play a critical role in developing and sustaining the culture or climates for effective teamworking and, through this, the delivery of high-quality patient care. It follows that developing team leaders who are able to support and value staff, undertake appraisals effectively, take action to tackle problems that get in the way of delivering high-quality care, and reinforce the values of patient-centred care should be a high priority in future. Many of these leaders will come from clinical backgrounds, reinforcing the importance of clinical leadership development.

Frontline staff are likely to benefit from the kinds of training and development offered in organisations outside health care that have a reputation for providing excellent customer service (including how to meet and greet patients and communicate effectively with them). NHS organisations and the bodies that commission leadership development may find value in forming partnerships with such organisations to learn from their experience.

Board development must also be a high priority to ensure that boards understand their responsibility to promote high-quality, patient-centred care, and feel supported in doing so. One useful strategy is to engage an external facilitator to work with board members individually and as a group to review how they work and their respective roles, including how they identify the problems that get in the way of their organisation delivering quality care. Boards can also benefit from structured programmes covering induction for new members and continuing development for existing members, particularly non-executive directors, who sometimes find it difficult to make good use of the experience and skills they bring.

Supporting boards to understand the patient experience should be a core element of board development. Board members should ask themselves whether they really know what the patients using their services think about them. How much time as a board do they spend discussing quality and the patient experience? Do they invite patients to share their stories (positive and negative) in order to bring quality and depth to these discussions? Board members need to focus on these issues, not just at formal board meetings but during informal contacts and walkabouts. The way board members gather and share information on quality and the patient experience is an important part of their leadership development.

For NHS organisations at the national level, development priorities should include ensuring that the various bodies responsible for overseeing the commissioning, regulation and provision of health care adopt a coherent approach. These bodies also need support to devolve responsibility to local organisations as the NHS shifts from a culture of compliance with externally imposed targets and standards to one in which local organisations and frontline staff take the lead in improving care. The well-known pace-setting style of top NHS leaders is often particularly prevalent among those in national roles; supporting these leaders to adapt their leadership style must also be a priority if the changes needed are to happen.

National leaders must develop an NHS culture that is focused on providing high-quality, patient-centred care. One element of this is ensuring that the values of the NHS are promulgated through staff induction and training, and that this is mandatory – particularly in a context in which care for NHS patients is being delivered by a wider variety of providers. As we argued earlier, focusing on training and supporting NHS staff to deliver high-quality care is preferable to the regulation route if the aspiration is to build real rather than regulated trust.

The boards of national organisations also need to adopt the practices and behaviours we have advocated for NHS boards. These practices include setting aside time to understand the patient experience through hearing patient stories, receiving patients' feedback, and acting on it. The way in which national organisations work should model the behaviour expected of NHS boards, demonstrating leadership by example. To echo Robert Francis QC: 'The common culture and values of the NHS must be applied at all levels of the organisation, but of particular importance is the example set by leaders' (Francis 2013, p 78).

The approach we have outlined will only succeed if there is effective *alignment* between actions taken at each level: in clinical teams, within NHS boards, and within national organisations. This means ensuring that there is relentless communication of the message that quality is the organising principle of the NHS, and that leadership development fully embraces this principle. The NHS should also seriously consider adopting a simple statement such as that used by Mayo Clinic in the United States ('the needs of the patient come first'). This would be a

clear and powerful reminder to everyone – from the Secretary of State for Health to the care assistant on the hospital ward – of what really matters, and why they come into work every day.

The ideas discussed here are not intended to cover all the issues that need to be addressed to develop effective leaders and organisations for the future NHS, but they reflect some of the most pressing priorities, and how we believe these should be approached. Programmes that are put in place need to engage all staff in leadership and quality improvement and provide specific support to those occupying key leadership positions at all levels within the organisation. Developing effective leaders and organisations must be seen as the responsibility of all those engaged in the NHS, starting with NHS organisations themselves.

Conclusion

At the beginning of this report, we argued that if implemented effectively, the recommendations of the Francis Inquiry report on the failings of care at Mid Staffordshire have the potential to transform the experience of NHS patients and staff by introducing changes that will strengthen leadership and enable organisations to develop a more caring culture. For this to happen, all those working in the NHS – not just ministers and the Department of Health – must take responsibility for acting on the report's recommendations. While real change requires NHS leaders at national level to work differently in future, there is much that can and should be done by the leaders of NHS organisations to promote high standards of patient-centred care.

The experiences of the high-performing health care organisations studied by Baker (2011), referred to throughout this report, offer valuable insights into what leaders need to do to achieve change. As Baker shows, the journey to achieving consistently high performance is often lengthy and complex, and cannot be reduced to ticking checklists. What is clear is that leaders must work on several fronts simultaneously to deliver success: seeing quality of care as a core strategy or organising principle; building capabilities and skills for improvement; engaging patients in their care; promoting professional cultures that support teamwork, improvement and patient engagement; and providing consistent leadership themselves.

Acting on these insights is partly a matter of supporting individuals and teams to perform effectively, but it is mainly about creating the systems in which staff are supported to do the right thing. Health care organisations are archetypal complex adaptive systems that cannot be managed easily through a hierarchy and whose performance is the result of the actions of many people at different levels. It is for this reason that leadership in the NHS needs to be seen as shared, distributed and adaptive, and the difficulties of changing leadership and organisational culture must be fully acknowledged (Davies and Mannion 2013).

While recognising the complexities of a system as large as the NHS, we firmly believe that it has its own culture, and that its leaders at local and national level are responsible for shaping and reorienting that culture. If a repetition of the shocking events that occurred at Mid Staffordshire is to be avoided, these leaders need to act now to develop the kind of culture we described earlier (*see* p 18). They must take the first step on the road to creating the systems in which quality and patient safety are seen as the organising principles, and in which the needs of the patient come first (to borrow Mayo Clinic's mantra). The organisational

culture within the NHS also needs to reinforce the message that boards and clinical teams together are responsible for making this happen through effective alignment of actions at all levels.

The King's Fund will be playing its part in supporting the NHS to act on the recommendations of the Francis Inquiry report – not least through its leadership development programmes. While leadership and organisational cultures need to be transformed, leadership development also needs to be redesigned in line with the approach we have described. In future, we will work with NHS organisations and those who lead them to support development in context and to ensure that their investment in development delivers tangible improvements for NHS organisations and, above all, for patients.

This means moving away from generic leadership development provided through large programmes delivered off site to more focused and tailor-made support designed to meet the objectives of organisations and systems in the challenging times that lie ahead. Delivery methods need to be innovative and relevant, and programmes need to capitalise on the imaginative use of web and social media technology. The journey of improvement and of rediscovering our purpose starts here.

Appendix: The King's Fund Leadership Survey 2013

In February and March 2013 we surveyed a range of NHS professionals to understand their views on the factors affecting the quality of patient care and the role of leadership in delivering improvements.

Overall, respondents thought that appropriate resources (including adequate staffing levels), leadership, and a clear focus on patients have the biggest impact on providing high-quality care, while limited resources and organisational cultures were seen as the most significant barriers to improvement.

Generally, respondents were more positive about the quality of leadership and priority given to the quality of care in their service/team than within their wider organisation or the NHS as a whole. However, there were significant differences of opinion between professional groups.

Methodology

The survey was conducted via an electronic questionnaire with a series of closed questions and was targeted specifically at leaders and managers in provider organisations. The survey was promoted in partnership with the Faculty of Medical Leadership and Management, Managers in Partnership, the NHS Confederation, NHS Professionals, the Royal College of General Practitioners (RCGP), the Royal College of Midwives (RCM), the Royal College of Nursing (RCN) and the Royal College of Physicians (RCP).

Respondents were asked to indicate the type of organisation they worked for, their primary role, whether their work was primarily clinical or non-clinical, and whether they had responsibility for managing staff.

Where respondents were asked to rank their responses, we reverse weighted these ranks in order to give a higher value to their preferred response while removing a possible skew from small numbers.

Results

Who responded?

- More than 900 responses were received.

- 62 per cent of respondents worked in an acute setting, followed by mental health (9 per cent), community (7 per cent) and primary care (6 per cent).

- 63 per cent said their work was primarily clinical.

- 87 per cent said they had worked in health care for more than 10 years.

- Nurses were the largest professional group to respond (36 per cent), followed by managers (20 per cent) and senior management (17 per cent) (defined as director or head of service).

What did they say?

Respondents were asked a number of questions.

- *Who do you think has the greatest impact on the quality of care?*
  Respondents ranked their top five from eight options. Clinicians and managers emerged as the most popular choice, followed by government/Department of Health. Boards, however, were ranked only sixth overall.

- *Which of these factors has the biggest impact in creating the right culture in an organisation to deliver high-quality care?*
  Respondents ranked their top 3 from a choice of 10. 'Appropriate resources and adequate staffing levels' were identified as having the biggest impact, followed by 'authentic leadership and setting clear objectives'. This was consistent across roles, with the exception of executive directors and senior managers, who identified 'a clear focus on the perspective of patients' as having the biggest impact in creating the right culture for high-quality care.

- *As a manager, which of the following do you think is the biggest obstacle to you in improving care?*
  In response to this question, 40 per cent of respondents said 'time and/or resources', though this was higher among nurses (51 per cent). 'Organisational culture' was next (28 per cent), though this was identified as the most important factor by executive directors (48 per cent).

- *Do you think enough priority is given to quality of care... [in the NHS, your organisation, service/team, and by your commissioner]?*

  - 73 per cent said they did not think enough priority was given to quality of care in the NHS. This percentage was higher among nurses (80 per cent).

  - Opinion was much more evenly divided when asked about their organisation, with 47 per cent saying 'yes' and 48 per cent 'no'. Executive directors (84 per cent 'yes'). and senior managers (65 per cent 'yes') were particularly positive, while 59 per cent of nurses felt that their organisation did not give enough priority to quality of care.

  - When asked about their own service or team, 78 per cent said 'yes', which was consistent across all roles.

- Finally, 43 per cent said that they did not think enough priority was given to quality of care by their commissioner. However, 38 per cent said that they didn't know reflecting a degree of uncertainty around the emerging commissioning arrangements.

- *What do you think of the quality of leadership... [in the NHS, your organisation, your service/team]?*

  - Just 14 per cent thought the quality of leadership in the NHS was 'good' or 'very good', while 40 per cent thought it was 'poor' or 'very poor'.

  - 36 per cent said the quality of leadership in their organisation was 'good' or 'very good', while 26 per cent said it was 'poor' or 'very poor'.

  - Finally, when asked about the quality of leadership in their service/team, 65 per cent rated it as 'good' or 'very good' while 11 per cent rated it as 'poor' or 'very poor'.

- *Which leadership qualities do you see most regularly in your organisation?* Respondents selected as many as were relevant from eight common leadership characteristics. The three most popular were 'setting a clear purpose, direction and priorities' (40 per cent), 'establishing an improvement culture' (39 per cent) and 'compassion/concern for others' (39 per cent).

Conclusions

While respondents clearly see a role for clinicians and managers in improving the quality of care, they are less clear on the role of boards, suggesting that the boards should be doing much more to exercise clear and visible leadership for quality in their organisations.

Respondents to our survey cited two factors – appropriate resources and adequate staffing levels – as having the biggest impact on quality of care, and where these were lacking, they were cited as the biggest obstacles to providing high-quality care. Similarly, authentic leadership and a supportive organisational culture were seen as key factors.

One of the most interesting findings is that almost three-quarters (73 per cent) of leaders and managers in the NHS do not think that quality of care is given sufficient priority. The leadership of the NHS at a national level must exercise its responsibility for reorienting the organisational culture of the NHS to one in which quality of care is the organising principle. However, just 14 per cent thought the quality of leadership in the NHS was 'good' or 'very good' demonstrating not just the urgency for change, but that change needs to be visible.

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