FOR HEALTHCARE LEADERS
HSJ
FUTURE OF
NHS LEADERSHIP

ENDING THE CRISIS IN NHS LEADERSHIP

A PLAN FOR RENEWAL

JUNE 2015

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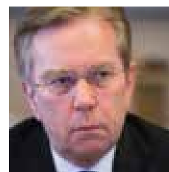
HSJ commissioned this inquiry into the future of NHS leadership in 2013. We asked Sir Robert Naylor, a "child" of the Griffiths reforms and one of the leading health service managers of his generation, to chair it. Together we assembled an inquiry panel containing some of the brightest minds in healthcare.

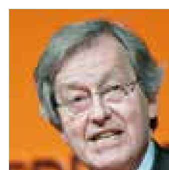
The inquiry held a series of meetings at which members invited leading experts to share their views. Attendees included senior figures from national policy bodies; thought leaders and academics; patient leaders and advocates; clinicians; and leadership experts. The panel also considered the wider evidence gathered through a public call for evidence.

Alastair McLellan, editor, HSJ

Inquiry members



Chair Sir Robert Naylor, *chief executive of University College London Hospitals Foundation Trust*



Stephen Dorrell, *chaired the House of Commons health committee 2010-2014*

Sir Sam Everington, *chair of Tower Hamlets Clinical Commissioning Group*

Richard Lewis, *partner and health leader at management consultants EY*

Dame Gill Morgan, *chair of NHS Providers*

Professor Laura Serrant, *professor of community and public health nursing at Wolverhampton University*

Dr Emma Stanton, *associate chief medical officer at Beacon Health Options and chief executive at Beacon UK*

Full biographies are on page 11

COVER: DELEGATES AT THE 2015 NHS CONFEDERATION ANNUAL CONFERENCE; GUZELIAN

Introduction

Leadership in the NHS is an endlessly debated topic – but discussions rarely go beyond the expression of bland platitudes and well-worn truisms. Only very occasionally do these debates produce actionable conclusions with lasting impact on the management of the NHS.

This report is an attempt to go beyond that uninspiring conversation, to provide real insight into the challenges faced by current and future NHS leaders, and to make some concrete recommendations on how they may be overcome.

Thirty years ago Roy Griffiths produced his landmark report containing the defining phrase that "if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge".

It was, precisely, the right diagnosis for the time. It led to the introduction of general management in the NHS – a form of leadership which replaced the "consensus management" that had arrived with the 1974 reorganisation of the NHS.

Consensus had failed because it effectively gave a veto to any member of the team and too often produced, in Sir Roy's words, "lowest common denominator decisions", if any decision at all.

Today's debate on healthcare leadership, nationally and internationally, is all about integration and system leadership – perhaps a reinvention of consensus management, but this time between organisations rather than within them.

> **Today's debate on healthcare leadership is all about integration and system leadership**

The context

What the NHS needed, Griffiths said, was "the responsibility drawn together in one person, at different levels of the organisation, for planning, implementation and control of performance". That general manager, he said, should be appointed regardless of discipline.

Without the creation of general management, the 1991 reforms, including the introduction of the purchaser/provider split and the creation of NHS trusts, might well not have happened – because there would have been no-one to implement them. In the eyes of the majority, the Griffiths report has shaped the NHS since then and some would argue that it saved the NHS.

It was, however, the last time that a government sponsored inquiry looked comprehensively at leadership in the NHS. *HSJ* decided that it was time to revisit the issue – not least because, as we will spell out, NHS leadership is in many respects in crisis.

Thirty years is a long time, and times change. But before turning to our diagnosis and recommendations it is worth revisiting some of the other themes from Sir Roy's report which still have relevance today. It was not just about the introduction of general management.

Doctors, he said, should not just be eligible to become general managers. They should also take responsibility for their own budgets at hospital level because "their decisions largely dictate the use of all resources, and they must accept the management responsibility which goes with clinical freedom".

It was not, he said, "for the centre to engage in the day to day management of the NHS".

Indeed, he argued that "a small, strong general management body is necessary at the centre (and that is almost all that is necessary at the centre for the management of the NHS)". He judged that the centre then – as might be said now – "is still too much involved in too many of the wrong things and too little involved in some that really matter."

Sir Roy added: "The NHS is in no condition to take another restructuring, and much more can be achieved by making the existing organisation work in practice". This is as true today as it was then, but unfortunately we have inherited a structure that is full of bureaucratic and regulatory obstacles that stifle innovation and limit the extent to which leadership can flourish.

However, significant change to how NHS leaders operate can and must be achieved without the need for another formal restructuring.

The consistent themes we heard during our inquiry were the need for:

- a new generation of clinical leaders across the NHS;
- empowered leadership devolved close to the frontline;
- a commitment from the professional bodies that strong leadership is essential to enabling high quality clinical practice;
- a reduction in bureaucracy and regulation;
- an organic reduction in the number of provider and commissioning organisations to maximise the use of scarce leadership resources.

The evidence for a crisis in leadership

There is no doubt that a crisis in leadership exists, though not quite everywhere in the NHS. There are excellent examples of clinical engagement in some trusts and the introduction of clinical commissioning groups has seen a revival of leadership in general practice. However, general practice is itself under pressure, with recruitment difficulties compounding the fact that more is being demanded of it. Already there is anecdotal evidence that some CCG leaders are becoming disillusioned given the sheer scale and complexity of leading change in the current NHS and social care system.

A survey conducted last year by this inquiry in conjunction with the King's Fund, to which virtually every NHS trust replied, shows that a third of trusts either have vacancies at board level for key leaders, or they have (often highly expensive) interims in post[1]. The largest vacancy rate is for finance directors and chief operating officers – 20 per cent. The figure for directors of nursing was nearly as high. More than one in six trusts have no substantive chief executive and almost one in six have no substantive medical director. The overall position is worst in mental health trusts where 37 per cent have at least one of these posts vacant or filled on a temporary basis, the same being true of a third of acute hospitals.

One in 10 trusts has retained the same chief executive in post for a decade. But the median time in post for a trust CEO was a mere two and a half years, while one in five had been in post for less than a year. This remarkable level of "churn" is just another way of spelling "crisis". A host of academic and anecdotal evidence supports the view of Nigel Edwards, the Nuffield Trust's chief executive, and of Ruth Lewis, previously an associate at the King's Fund, that high executive turnover "has a chilling effect on the willingness of chief executives to take bold initiatives and encourages a passive and responsive culture".

NHS leadership is in crisis in another way. If Roy Griffiths' diagnosis was correct for its time, it is equally true, as the King's Fund remarked recently, that if Florence Nightingale were walking NHS wards today, she would be looking beyond them: out into general practice; into community services; into the private and voluntary sectors; and into social care. She would be looking for the other leaders who would help her make her wards work better[2].

For it has been clear for many years that the NHS cannot provide the best outcomes and experience for patients – and indeed cannot solve its own problems – alone. That message runs like a golden thread through the whole of the Five Year Forward View.

Among those to whom Florence Nightingale would also be looking are patients. And all those on the outside would be looking back at her for exactly the same reasons – given the growing realisation that the whole of health and social care provision should become ever more interdependent if the best results, the best experience and best value for money is to be achieved in an inevitably cash-constrained environment.

The NHS needs high quality leadership within hospitals, mental health and community providers, general practice and commissioning. But, just as critically, it also needs system leadership that works in partnership – across organisations and in places where there is no direct line management control – to construct the services that are needed.

This means the skills required by today's NHS leaders are very different to those in Griffiths' time; different even to those of 10 years ago. "Command and control" and "protectionism" are no longer appropriate in an environment focused on integration. We need leaders capable of building partnerships and operating across institutions and sectors. This report suggests ways in which we can identify and foster such leaders.

Our key conclusion, and the one on which our recommendations are built: *if leadership within the NHS and across health and social care is to be strengthened and successful, then the task must be made more manageable, more attractive and more sustainable.*

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The causes of the crisis

The inquiry received a large quantity of written evidence and oral evidence from a wide range of stakeholders. We discovered that there is:

- A growing burden placed on those doing senior NHS jobs by regulation, inspection, information demands, instant accountability to a growing number of bodies, and performance management – despite the 2012 reforms which, in theory, were meant to dilute central interference.
- A marked tendency to move people or sack them when problems emerge, rather than seeking to understand and address the underlying issues. Despite the rhetoric of a "no blame" culture, blame continues to be heaped on senior leaders for any perceived failure in performance, contributing to the "churn" described above.
- A cadre of people who operate well in second-tier leadership positions but who are reluctant to step into chief executive and other board level posts, in part because of the sheer exposure that comes with the job.
- An increase in the degree of political exposure experienced by senior NHS leaders – which, while always to be expected in a tax funded healthcare system, has now reached unsustainable levels.
- A loss over the years of a "community" of managers, both clinical and non-clinical – the result in part of repeated reorganisations which have seen too many experienced leaders leave. Consequent to that is the dilution of the informal "mentoring" networks that supported younger leaders, again both clinical and non-clinical, as they progressed.
- The impression that the NHS management training scheme remains a good one but that there is far too little continuing support after entrants have, so to speak, graduated.
- A widely held belief the NHS has too many organisations and, as a result, too many chief executive and other board level positions. This means the NHS's available talent is spread too thinly.
- A difficulty in attracting system leaders because of the sheer complexity of engineering service change. Near the end of its tenure, London Strategic Health Authority worked out that the plethora of consultation and assurance processes applicable to service reconfigurations meant the minimum time to achieve one, without a judicial review, was two and a half years. Since then, the position has worsened and created a daunting and dispiriting prospect for many NHS leaders. Those working on the proposed changes in Manchester calculate that there are some 200 assurance and consultation processes that need to be gone through[3].

Despite the rhetoric of a 'no blame' culture, blame continues to be heaped on senior leaders for any perceived failure

Clinical leaders

The inquiry also heard compelling and consistent evidence about the difficulties faced by clinicians entering NHS leadership.

A key characteristic of many of the most successful healthcare organisations the world over is their ability to collapse hierarchies, flatten organisational structures and encourage clinicians to fill key leadership roles.

One of Sir Roy's goals was to see more clinicians take up general management/chief executive posts. One of his proudest accolades was being president of the now defunct British Association of Medical Managers.

Huge progress has been made in medics taking on the role of clinical directors. However, it is proving harder to get them to take the next step of being a medical director and even more difficult to persuade them to move into chief executive posts, especially as doing so may reduce their earnings potential. Equally, while many nurses have entered management roles, too few other clinical staff have made the move into key leadership positions.

We heard frequently that clinicians of all types are still seen by too many staff to have moved "to the dark side" if they take on leadership positions. This problem is not new. As Sir Duncan Nichol, the former NHS chief executive, put it back in 2008: "If you have an MBA in the States and you're a doctor, people think you're a sharp guy. Here they think, well, you're a grubby businessman, a bit of a quisling, and it's beneath you. The medical profession in this country kind of abdicated its leadership role in management to managers, and then bitched about the result."[4]

One reason for a reluctance among clinicians – both doctors and others – to take on the most senior roles is that since the early 2000s they face a "double jeopardy" when things go wrong, or are perceived to have gone wrong. This danger persists even when subsequent investigation proves the clinical leader involved was not to blame.

Not only can such problems put their leadership role at risk, they can face parallel and separate action from the General Medical Council, the Nursing and Midwifery Council or similar professional regulators.

Clinical leaders can suspend their registration if they enter a managerial or leadership role and cease to practise. But that is not possible for medical directors and chief nurses, where it is a condition of the job.

The changing nature of the NHS and its leadership

Autonomous healthcare workers, particularly doctors, respond badly to authoritarian leadership

Leadership means the ability to direct the activities of a group towards a shared goal while coping with change. It concerns the alignment of an organisation's workforce and operating procedures with its vision, values and objectives. Leaders create visions, management is about implementing them.

The essential personal attributes of leaders are IQ, experience and most importantly emotional intelligence. The first two speak for themselves, but emotional intelligence is more ethereal. It can be defined as self awareness (knowing how we feel), self regulation (control of our emotions), empathy (how others feel) and social skills (influencing and inspiring others). Supportive leadership means building relationships with employees to increase positivity and motivation.

The literature is awash with definitions of leadership styles – transformational, collaborative, shared and distributive, to name but a few. Current leaders require skills across all these dimensions to influence attitudes and motivate performance beyond expectations. This is a significant challenge because healthcare systems are as complex as they come.

The NHS contains many powerful professional groups with associated subcultures which are often in conflict. These groups come together in multidisciplinary teams with sometimes multidirectional goals. Autonomous healthcare workers, particularly doctors, respond badly to authoritarian leadership. Leaders need to focus on creating the right environment for professional activity to thrive, within agreed professional standards and guidelines.

Many leadership roles in the NHS rely on personal influence and relationships at a local level. As our health and social care system evolves to have leaders who will sit across multiple, geographically distributed locations, so must their "approach" to leadership style evolve.

For example, while several NHS chief executives are active on Twitter, the potential influence of social media in galvanising the NHS workforce is underpowered. In addition to providing routes for rapidly sharing best practice, online networks also provide a means of connecting otherwise isolated leaders to share their challenges and frustrations. An effective online presence represents position and influence in another dimension – one that is pervasive and growing; one that we believe will be a hallmark of future NHS leadership.

The era of managing single NHS organisations is coming to an end and future managers will need to learn to influence across primary and secondary care, as well as between health and social care in an increasingly complex consumer driven environment. Leaders need to be the first to model collaborative behaviours and nurture interdependency across these traditional boundaries.

The *Five Year Forward View* and the Dalton report both challenge traditional NHS organisational models and could lead to the creation of integrated and accountable care organisations which may fundamentally change the NHS landscape and increase the repertoire of skills needed by leaders.

Recommendations

In the course of our inquiry we heard many suggestions for change. A large number involved culture change – for example, the age-old call for less "politicisation" of the NHS, although there were few concrete suggestions for how that might be achieved. However, it would be welcome if politicians could achieve cross-party agreement on how to avoid becoming too closely involved in the management of the NHS.

Before setting out our recommendations, we should briefly address the propositions put to us that we have rejected.

Patients clearly need to be much more intimately involved in the design of current and future services. But we have rejected the suggestion that a "chief patient officer" or equivalent should be appointed to the board of every NHS organisation. That feels to us tokenistic, and begs the question of which sort of patient. Ticking a box that says "we have a patient representative" will not bring about the close involvement of patients at all levels in service design that is needed.

Equally, we have rejected suggestions for some sort of "royal college" of NHS leadership. Not least because one of our recommendations is that the royal colleges collectively need to embed support for clinical leadership into everything they do. A recently established Faculty for Medical Leadership and Management already exists and should be encouraged in its work. Further separating leadership out as something distinct from the day to day activity of many NHS staff would be a retrograde step.

Our recommendations are presented in three linked groups. Together we believe they would make NHS leadership positions more manageable, attractive and sustainable.

Most of our recommendations focus on developing senior leaders within the NHS – because this is where we believe the most immediate impact can be delivered. However, many of the principles, beliefs and recommendations set out in our report can enhance leadership development at all levels in the service.

> **Appointing a 'chief patient officer' or equivalent to the board of every NHS organisation would be tokenistic**

Making system leadership more manageable

Consultation and assessment of change

Those who seek to make change across health and social care organisations face daunting challenges in the consultation and assurance process. Each reorganisation of the NHS has tended to build new requirements on top of the old. Aside from formal consultation, there are the inequalities and other impact assessments to be done. Different assurance processes are run by NHS England, the Finance and Investment Group, Monitor and the Trust Development Authority. Despite the creation of health and wellbeing boards in which local authorities are key players, reviews by local authority scrutiny committees remain. There are clinical senates and the Independent Reconfiguration Panel. That list is not exhaustive and leaves aside the risk of judicial review. While each of these processes are well meant, cumulatively they create multiple barriers to change. That discourages innovation because of the unnecessary time, cost and effort involved in overcoming them.

1 The new government should urgently institute a complete review of all consultation and assurance processes to produce something much simpler and swifter, while still allowing for proper engagement with staff and the public.

This government review should also introduce a requirement for all relevant bodies involved in appraising specific service change proposals to liaise during their deliberations. NHS England should coordinate this work to a strict timetable so that a decision which has the support of all involved can be reached within six months of the process beginning.

Once an agreed single approach to consultation on, and appraisal of, changes has been reached, any decision referred to the Department of Health should be accepted or rejected within three months to prevent changes being kicked into the long grass for political or other unjustified reasons.

Rationalisation of reporting and regulation

The current confused regulatory and oversight regime has curtailed local autonomy. One prime example concerns foundation trusts. The entire rationale in creating FTs was to grant managerial and financial freedoms to the best led organisations. Yet those liberties have been severely eroded. This trend must be urgently reversed.

There is evidence from all sectors, not just health, that leaders deliver better results when they are trusted and subject to proportionate regulation, inspection and reporting requirements.

In the NHS, the current burden has become too great and, despite improvements, it is still insufficiently risk-based. It is not just the direct costs involved – the Care Quality Commission alone has a budget of some £250m, for example – but the cost in clinical and managerial time to those being inspected which must amount to at least as much again. Failure to tackle the complexities of the current regulatory and oversight regimes will have a continued negative impact on leadership, producing a defensive mindset that discourages innovation.

The *Five Year Forward View* acknowledges the need for greater coordination of regulation and of reporting requirements between the seven arm's-length bodies that currently make up "the top of the NHS": NHS England, Monitor, the Trust Development Authority, the CQC, Public Health England, Health Education England and the National Institute for Health and Care Excellence. We are aware that this work is underway, but it needs to be pursued with greater vigour to rationalise reporting requirements, to better align targets, and to provide the flexibility in regulation that will be needed to achieve some of the system change called for in the Forward View.

2 All seven of the arm's-length bodies together with the Department of Health should set out publicly what information they require from NHS organisations. This should then be reviewed for duplication, and to ensure the requests are proportionate, relevant and necessary. A working group of senior NHS leaders should sign off the final list. If the same data is required by more than one organisation, it must be collected once and then shared.

Inspect system not silos

If system change is to be achieved, then system regulation and inspection is needed – not just inspection of individual silos of care. Again, we are aware that central bodies have begun work on how far it might be possible to inspect a system of care – rather than its component parts, therefore dealing with sometimes conflicting demands that can be placed on organisations. This too needs to pursued at pace.

3 To give leaders clear line of sight, we recommend that NHS system regulation be established by the year 2017-18, with shadow running taking place during 2016-17. The review should also ensure an appropriate and proportionate reduction in the inspection burden placed on individual organisations.

Reducing the number of organisations

It is the inquiry's view that there are too many separate NHS organisations given the talent available to staff them all at board level. There are more than 200 CCG chairs, with a matching number of chief officers. The boards of the 250 provider organisations typically have half a dozen executive directors. To this total of approximately 2,000 leadership posts must be added the significant number of senior positions in the Department of Health and the seven main arm's-length bodies. One is drawn to the irresistible conclusion that we are looking for far too many leaders.

Some CCGs are themselves recognising the problem and moving towards shared leadership arrangements, a development we welcome. On the provider side, however, there has not been an effective failure regime for unsustainable organisations. This must be addressed, with a clear plan put in place for the 80 trusts which have not yet gained foundation trust status. The recommendations of the Dalton review, with its suggestions for chains or franchises – with leading trusts able to take over unsustainable ones – can play a part here. However, we acknowledge the risk of successful trusts spreading their management and leadership talent too thin.

4 By the end of July 2015 the Trust Development Authority should publish its assessment of which NHS trusts are not sustainable in existing form. The TDA, together with NHS England, Monitor, the CQC and Department of Health, should then identify two groups of these "unsustainable" organisations and offer the opportunity for leading NHS organisations to formally take them over, incorporate them into chains or to run them as franchise operations. The resulting new arrangements should be in place no later than April 2016. This initiative should be taken forward in line with the recently announced decision to establish the first four nascent foundation trust chains.

Making leadership more attractive

End the denigration of NHS leadership

It is not acceptable, 30 years after the Griffiths report, that clinicians who enter management and leadership roles can still be seen as having "gone over to the dark side". Many world class hospitals in other healthcare systems take pride in the fact that their most senior leaders are clinicians who recognise that they can do far more for the "community" of patients in these roles. This is a cultural issue that itself requires leadership, chiefly from the medical and other royal colleges, the nursing and other unions and the British Medical Association.

In reality, these organisations all recognise that clinical leadership and high quality management is essential to the delivery of high quality care. But they do not always behave as such nor do they always encourage their members to recognise that. It is as much a responsibility of the leaders in those organisations as it is for politicians to eschew small "p" political and populist attacks on management and managers. Short term headlines often result in irreparable damage to those taking on leadership positions, the organisations they represent and ultimately the patients they serve.

5 We recommend that *HSJ* invites the leadership of all the clinical unions and royal colleges to a workshop to agree a "statement of principles" on how leadership and management in the NHS should be addressed in communications and policy statements. The statement of principles – once agreed – would then be publicised, with *HSJ* and the signatories policing adherence.

Pay the best clinical leaders more

As we have already stated, "clinical leadership" is not synonymous with "medical leadership". Nevertheless, we recognise that there are specific barriers which prevent medics taking on senior leadership roles. The most obvious is remuneration. Someone with a substantial private practice can face a serious loss of income if they become a full-time clinical and managerial leader. It is not ideal that NHS leaders should be paid different rates for the same job, which will be a challenge in tackling this issue, but it is the world in which we live and the issue needs to be addressed.

The number of board vacancies identified by our research will continue to increase and the quality of leadership will degrade if remuneration for the top jobs in the NHS is suppressed. Essentially you get what you pay for and inappropriate restraint on reward will result in fewer people aspiring to leadership positions and poorer candidates for interview, especially clinicians.

6 Attracting more clinicians to take up chief executive positions in the NHS requires a more sensitive benchmark than the prime minister's salary.

A senior group of NHS leaders should be convened by NHS Providers and the NHS Confederation to recommend levels of remuneration for chief executives with clinical backgrounds which reflect career risk, experience and the type of organisation they would lead. We would also encourage them to explore the development of other incentives for developing clinical leaders such as talent management, coaching and mentoring (*see recommendation 11*).

While we are not naive enough to expect formal government backing for this, we would expect it not to attack the proposals and for the BMA and medical royal colleges to offer their support.

7 We also recommend that clinical excellence awards are overhauled to reward leadership excellence as much as clinical excellence. In addition to incentivising medical and clinical director roles, this would serve as a clear acknowledgment that leadership is an integral part of the role of any senior clinician. A separate and similar award should be considered for other clinical staff who show leadership excellence.

End 'double jeopardy' for clinical leaders

"Double jeopardy", in which clinical leaders can face not only disciplinary action by the NHS and potential loss of their leadership role, but also separate and parallel investigation from their professional regulatory body, must be tackled.

8 This is a sensitive and difficult issue. Plainly by their management and leadership actions – refusing to acknowledge problems, burying them, requiring that unacceptable practices continue for financial or other reasons – a clinician can do as much if not more damage to patients as in a strictly clinical role.

When that has clearly happened, action by their registration bodies is justified. But the bar for investigation and action by the General Medical Council, the Nursing and Midwifery Council and the other professional bodies needs to be set at a reasonable height. An independent government-appointed review should be undertaken across the professional bodies to address the issue of double jeopardy. The review should be completed by June 2016.

> **It is not acceptable, 30 years after the Griffiths report, that clinicians who enter management and leadership roles can still be seen as having gone over to the dark side**

Making leadership more sustainable

The NHS has rightly been accused of having a 'snowy white peak' that reflects neither the ethnic mix of society as a whole, nor that of its own workforce

A requirement for management and leadership training

The service's management and leadership training schemes have, like so much of the NHS, been undermined by repeated reorganisation. The NHS Leadership Academy now has a good suite of courses, aimed both at clinical and non-clinical staff, that in some cases lead on to formal qualification. Some organisations, though too few, also offer impressive training and accreditation.

Training needs to emphasise the skills now required of leaders, including emotional intelligence and the ability to connect across organisations. It should draw on the best practice from sectors outside the NHS – in local government and the third sector, for example, both of which have a deep interest in system leadership – while also looking to the private sector where organisations in the developing digital economy have pioneered new non-hierarchical ways of working. These behaviours should be actively used in the appraisal of all NHS leaders, including those with clinical backgrounds.

9 We recommend that the NHS Leadership Academy be allowed to continue its current work but with greater coordination – not a takeover – of the good work being done in trusts.

The Leadership Academy should develop a "minimum requirement" for management and leadership training which all NHS organisations should achieve. This requirement should become part of the judgment that the CQC makes when it decides whether an organisation is "well led". We would also look to the NHS Confederation, NHS Providers and the royal colleges to encourage their members to provide leadership training for all relevant staff.

Although we ask the Leadership Academy to play a significant role, it is just as important that individual NHS organisations be highly proactive in developing leadership at all levels. To create momentum in this area, and to establish best practice, leading NHS organisations should be encouraged and incentivised to offer their leadership and management training programmes to others within their health economy. These should develop into regional centres of excellence within the national framework set by the Leadership Academy.

Identifying and supporting potential leaders

One notable, and in truth downright embarrassing, facet of NHS leadership is its lack of diversity. Partly in terms of gender but most notably in the remarkably few members of the black and minority ethnic communities who occupy senior leadership positions. The NHS has rightly been accused of having a "snowy white peak" that reflects neither the ethnic mix of society as a whole, nor that of its own workforce. If anywhere should be an equal opportunities employer, then it should be the NHS. This is an issue the NHS must tackle.

10 As part of the "minimum requirement" for management and leadership training set out above, NHS organisations should be required to demonstrate active searching for, and encouragement of, black and minority ethnic entrants to management and leadership positions.

Learning by doing

While we believe training is important, the acquisition of leadership skills is also through working alongside those who are already leaders. It should no longer be acceptable for leadership and management training to involve simply being sent on a series of courses. The NHS needs more apprentice leaders.

11 We therefore recommend the Leadership Academy, nationally, and individual NHS organisations working together across local health and care systems, develop a more formal approach to identifying potential leaders; instigating a greater degree of talent management and succession planning than is currently available. Developing leaders should be buddied with contemporaries and provide mentoring from experienced leaders.

Those taking up their first chief executive post should, in particular, be given a well structured and extensive support package during their first few years.

All chief executives and board directors with at least five years' experience in the role should be required as part of their annual appraisal to demonstrate they have provided active mentoring to a less experienced counterpart in their or another organisation.

More on the inquiry and NHS leadership at **hsj.co.uk/future-leadership**

Building leadership into the clinical curriculum

Undergraduate clinical training as it now stands produces individuals with a strong sense of belonging to their profession. This is right and proper and to be encouraged. But the inquiry firmly believes that sense of kinship with a profession must be matched with a sense of belonging to the NHS as an institution comprised of specific organisations. It is rare for a newly qualified clinician to have an understanding of the environment in which he or she will be discharging their duties. It is equally rare for these individuals to have any formal grounding in leadership.

Other sectors would make sure new recruits entered the workplace with a real understanding of the organisation they are working for, its priorities and the context within it operates.

An element of "system knowledge" needs to be built into clinical curriculums in an engaging way, along with an early understanding of what is involved in leadership. This should not simply be a classroom presentation of organisational structures and funding flows.

12 We recommend that Health Education England, the General Medical Council, and all other regulatory bodies for clinical professions come together to ensure that graduates have a grasp of how the NHS functions, and develop an understanding that they will need to lead managerially as well as clinically as their career progresses.

References

1 *Leadership vacancies in the NHS*, The King's Fund and HSJ Future of NHS Leadership Inquiry 2014, www.kingsfund.org.uk/publications/leadership-vacancies-nhs

2 *The Practice of System Leadership: Being Comfortable with Chaos*. The King's Fund 2015, www.kingsfund.org.uk/publications/practice-system-leadership

3 Ruth Carnall in *The Practice of System Leadership: Being Comfortable with Chaos*. The King's Fund 2015, www.kingsfund.org.uk/publications/practice-system-leadership

4 *Rejuvenate or Retire: Views of the NHS at 60*, The Nuffield Trust 2008, www.nuffieldtrust.org.uk/publications/rejuvenate-or-retire-views-nhs-60

Final observation

Our final point is not a recommendation but a deliberately challenging observation. Sir Roy Griffiths' report quite rightly destroyed the consensus management of its day. But paradoxically we need to go back to a different version of that idea. Not one where everyone has a veto, but a version in which we build system leaders who recognise that the best outcome for patients may not always be the one that is in the interests of their own organisation, – or indeed, in the short term, themselves – and then engineer the consensus that allows that to happen. In that sense, we need to go back to the future. It is an enormous challenge. But it is the one that everyone in the NHS who has any claim to leadership has to address. ●

About the panel

Sir Robert Naylor is chief executive of University College Hospitals Foundation Trust, a role he has held since 2000.

Stephen Dorrell is a former health secretary and chaired the House of Commons health select committee in the last parliament. He is now a senior advisor to KPMG, which has been contracted to deliver some of the programmes commissioned by the NHS Leadership Academy.

Sir Sam Everington has been a GP in Tower Hamlets since 1989. He is chair of NHS Tower Hamlets Clinical Commissioning Group and a board member of NHS Clinical Commissioners.

Richard Lewis is partner and health leader at EY. Prior to joining EY, Richard was a senior fellow at the King's Fund and led the health team in the prime minister's delivery unit.

Dame Gill Morgan is chair of NHS Providers. She started her career in healthcare as a doctor, before moving into management. She was permanent secretary of the Welsh Assembly government between May 2008 and August 2012.

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