INSIGHT

NHS underinvests in leaders at its peril

With the Healthcare Commission's annual health check putting the spotlight once again on the performance of NHS leaders, King's Fund director of leadership development Karen Lynas warns the health service against underinvesting in its leaders.

The government is under considerable pressure to decide whether the reported £500 million underspend in the NHS should be declared as such when it is estimated that the backlog of maintenance is around £4 billion. The distinction between capital and revenue commitments tends to be lost on front-line staff battling to provide high-quality services with below-par equipment and buildings.

Just as underinvestment in physical stock can increasingly blight the otherwise improving performances of many organisations, so too can underinvestment in leaders and the structure within which they work.

This underinvestment in senior leadership is being addressed by the NHS this year. NHS Chief Executive David Nicholson's personal commitment to raise the quality of leadership is backed by considerable support from strategic health authorities, while Director General of Commissioning Mark Britnell has cited NHS leadership as the key factor in delivering world-class commissioning.

However, almost since the time Roy Griffiths introduced the notion of general management into the NHS, we have seen numerous initiatives to improve management, leadership, clinical leadership and clinical engagement. How can we ensure that this investment will be different and will have a sustained impact on the quality of leadership across the NHS?

These previous initiatives have been crucial, and many senior leaders can point to a particular development programme that had made a powerful and important contribution to the kind of leader they are today. However, although development programmes can provide invaluable insight into different ways of doing things or offer different perspectives, they cannot replace the expertise developed through experience and practice and the learning that comes from the job.

In the USA successful businesses often refer to their leadership 'bench strength' – a pool of talented leaders who are ready to take on more challenging roles. Bench strength in the NHS is not what it could be, particularly at middle-management level. Successive reorganisations have depleted the pool of talent and created an environment in which experienced leaders appear to underperform – in roles and within systems that have hardly had time to establish themselves – and then leave. There is then a rush to promote more junior staff; they too are destabilised by the reorganisations and have had less time to develop their experience.

This cyclical pattern reinforces the problem – we change the structures partly because of an apparent deficit in quality leadership, moving those who are just gaining expertise into roles where they need to start learning all over again, not building on ability but constantly undermining its progress.

The problem is that not only have successive development initiatives rarely been built upon (often being implemented as if nothing has ever gone before) but the environment in which effective leaders grow has been made unstable by successive restructuring and changing roles for leaders.

The latest Healthcare Commission annual health check cited poor management as a key contributor to poor outcomes. We have been here before: the public inquiry into children's heart surgery at the Bristol Royal Infirmary was clear about the lack of effective management and poor clinical engagement, while a very similar assessment was delivered recently following the *Clostridium difficile* outbreak at Maidstone and Tunbridge Wells NHS Trust.

The Healthcare Commission report is particularly damning about the performance of PCTs – the weakest part of the NHS structure and the most recently reorganised. Indeed, the organisations that fared well were those that had escaped restructure.

Outside the NHS, organisations with vibrant and effective talent management programmes for their leaders are much less tolerant than the NHS has been about poor performance and lack of productivity – for example, they would not create exit packages for poorly performing leaders. Instead they provide performance management discipline in a system that is extremely clear about what constitutes good performance and they allow leaders time to develop confidently in each successive role.

An alternative solution – routinely used in FTSE 500 companies – would be to employ talent managers to secure and manage the senior talent of their organisations. The NHS has tried this before and not succeeded through lack of systems, commitment or engagement.

A business of the size and importance of the NHS, and one which has declared leadership as a key need in securing its future, should not shy away from deciding how to manage this key resource.

Surely it is as important to have a sustainable, consistent and well-funded policy for maintaining leadership talent in the NHS as it is to develop sustainable investment strategies for physical stock?

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