Where is this all leading?

Author: 'Prospector'

OVERVIEW

The Future Hospital Commission acknowledges that the principal challenge for healthcare organisations and professionals is to accept the fundamental requirement that patients must be treated with compassion, kindness and respect while having their physical and emotional needs met at all times. The recognition that clinical outcomes alone are an insufficient guide to the adequacy of health service provision demands cultural, organisational and individual change. In the Future Hospital Forum we scan the world literature for papers on systems of care that might best ensure these principles are delivered, and to critically evaluate their potential impact. The theme in this edition is leadership.

In a shallow attempt to grab your attention before the conclusion of this edition of the Journal, *Prospector* contends that there is too much leadership. Certainly not from those tasked with effecting health service change, but for the purpose of this review most definitely in published literature. In previous editions of the *Future Hospital Forum* he has struggled to unearth gems from a dearth of articles pertaining to the theme of the Journal. On this occasion the problem is not one of famine but of feast. There's a wealth of reading available for those seeking pearls of leadership enlightenment and the volume of work he's been presented with even after an abbreviated search has left him disorientated. Leadership traits, leadership strategy, leadership meaning, leadership styles and more, all covered in depth and with clarity, not only in this edition of the Journal but also in many other august international publications. It's unsurprising that those individuals doing the leading are motivated to write and in a position to be given a platform. While many readers will have held leadership roles and may have contributed to this body of work, others, the leaders of the future in fact, may wonder where to start and how to continue. *Prospector* will begin with recent opinion and then move towards a particular destination yet to be revealed.

His embarkation point is *Leadership: an overview* a personal reflection by Ronald J Vender, a clinical and academic leader at Yale School of Medicine.[1] The author rejects several succinct definitions of leadership used by earlier noteworthies and substitutes his own more substantial synthesis. For Vender leadership is 'a combination of position, responsibilities, attitude, skills, and behaviours that allows someone to bring out the best in others, and the best in their organization, in a sustainable manner.' He briefly mentions leadership styles and theory which thinking, though potentially educational, he discards as less helpful to those leading who he advises to remain true to themselves and to avoid trying to fit too closely to any particular archetype. By contrast, Vender contends that an understanding of the various practical responsibilities of leadership is essential. Among these he numbers articulating vision, creating culture, strategic planning, establishing a decision-making process and managing the boss. Although all are familiar, the piece is broad ranging and thoughtful, recognising that we are all leaders in a variety of formal and informal roles but including of our patients healthcare and ultimately of our own lives. In this context leadership is an acceptance of the responsibility to develop oneself sufficiently to meet the challenges and trials of working with multiple overlapping and interacting teams both in and outside of work. This leaves *Prospector* with slight uncertainty, perhaps shared and revealed by Vender in his opening line 'We are regularly exposed to leadership; yet it remains poorly understood by most of us'. While the leadership theories discussed represent a guide to practice, is leadership ability in fact primarily consequent on innate personal traits rather than learning? Vender concludes 'Although character and integrity are not sufficient to guarantee effectiveness as a leader, they are absolutely essential for success'.

This personal essence of leadership represents a potential difficulty for those hoping to convert theory into practice. Is it possible to determine those elements of leadership which not only make a difference but which are also transferable? Before starting this month, *Prospector* wondered whether the published literature would consist not of empirical evidence but of academic theory, personal opinion and or directive from leaders themselves. Nevertheless, his hope while contributing to the *Forum* is that he can reveal an evidence base to guide the realisation of the Future Hospital. He shouldn't have worried. On this occasion, at least in part, his work has been done for him. Kirsten Armit, in the current edition of the Journal summarises an extensive review of published evidence in support of effective leadership in healthcare organisations. A considerable body of work outlined in *Leadership and leadership development in healthcare: the evidence base* published by the Kings Fund demonstrates that the climate and culture created by leaders within healthcare organisations indeed influences the quality of healthcare.[2]

If the evidence for leadership has already been reviewed, where now for this review? Where now for leadership? Others here have written about how the NHS has responded to the challenge of training the leaders of the future. Further,

national leadership has outlined a strategy for meeting the challenges inherent in radically changing the way that care is delivered in the coming decade.[3,4] The *Five year forward view* represents a leadership blueprint for creating a service dedicated to providing excellent and safe health and social care integrated between hospital and the community. *Prospector* with a much lowlier perspective, in harmony with Vender's conception of leadership as a more personal journey, wonders how those of us leading smaller teams should calibrate our sights. What change should we be trying to bring about? He has two answers to that, the first, a technical response to how we might manage our teams and then second, a consideration of impending cultural change.

Therefore, he next recommends to you a paper which describes how the adoption of management strategies based on those widely used in the manufacturing and technology sectors is associated with improved healthcare outcomes.[5] Investigators surveying practice in 597 US cardiac units scored 18 management practice dimensions in four areas (standardising care/lean operations, performance measurement, targets and employee incentives). First, the authors demonstrate that there was wide distribution in management practices, with fewer than 20% of hospitals scoring a 4 or 5 (best practice) on more than 9 measures. Second, in multivariate analyses, management practices were significantly correlated with 30-day mortality ($p=0.01$) and all six process measures used to assess the quality of care for patients admitted with an acute myocardial infarction ($p=0.05$). There will no doubt be sceptics who maintain that good medicine often if not always occurs independently of management structures. As an exercise *Prospector* suggests that you score your own institution or unit against the table of 18 management practices highlighted. He recognises that this is but one more set of criteria against many others which may be used to judge performance, but notes that, not only is it evidence based, but also that the criteria themselves are highly relevant independent measures of quality of care, and patient and staff experience.

Such specific targets for leaders are no doubt essential if we are to change our collective practice for the better. By contrast, *Prospector* has found himself, in several editions of the *Forum*, repeating leadership calls for more a more nebulous cultural change. While easy to call for, the term in fact implies a coordinated change in thinking and behaviour not only system wide, but also at an individual level. More quickly said than done! Surveying the various potentially beneficial cultural changes suggested for our collective improvement, *Prospector* has been most recently arrested by the concept of value in healthcare. Berwick *et al* have described the triple aim, a simple reduction which can be used as a yardstick against which to evaluate healthcare system performance, but which can also be used to understand the ideal functions of any health system change.[6] The triple aim is explicitly: the best care (patient experience) and the greatest population health for the lowest per capita cost. This is an effective triangulation allowing healthcare leaders in the US to understand that while their care is the most expensive it is in population terms the least effective of the developed nations and therefore provides the worst value.[7] While this allows US commentators to argue for greater equity in healthcare distribution, the same model can be used to assess change in the opposite direction. While the UK enjoys a more equitable system, how will change in the NHS affect the triple aim of our healthcare? Will integrated care result in lower per capita cost? Will the private provision of services adversely affect population health or improve patient care? Both systems seem to be demonstrating a convergent evolution, arriving at a similar point from very different beginnings. Regardless of location or system level all healthcare leaders who are prepared to accept the triple aim as a guiding principle will be obliged to recognise that we should prioritise value. In the NHS in particular, this will require cultural change. Though our system may be extremely efficient, it allows individual practitioners to operate with only limited awareness of the costs of their care. The converse, cost-conscious care is a relatively recent formulation.[8,9] It has been recognised for several decades that not only omission, but also overuse and misuse of medical interventions, contribute to poor-quality care by exposing patients to harm while also increasing costs.[10]

More recently, a drive to improve the quality and value of care by reducing unnecessary interventions has prompted the American Board of Internal Medicine Foundation to lead the Choosing wisely initiative. The specific aims of which are:

> *to promote conversations between clinicians and patients by helping patients choose care that is: supported by evidence, not duplicative of tests or procedures already received, free from harm and truly necessary.*[11]

National organisations representing individual specialities have been asked to provide evidence-based lists of interventions which are frequently overused. Importantly, educational material for patients is provided so that they may also participate. Since 2012, the initiative has also been adopted first by Canada and then other countries.[12] Already there is some evidence that simple interventions designed to reduce overuse may improve care. The required reading for this edition of the *Future Hospital Forum* is therefore the UK response to the initiative by the Academy of Medical Royal Colleges.[13] *Prospector* leads you to this paper not because of the important potential of the initiative to reduce harm, but because it represents a large-scale introduction, perhaps for the first time for some UK practitioners, to concepts of cost-conscious care and value. It has been suggested that those seeking to be the eyes and ears of quality improvement, the trainee staff responsible for ordering the majority of investigations, might be best placed to lead this initiative.[9,14] *Prospector* wonders whether such bottom-up leadership will be able to flourish but is certain that such growth and development is the only way in which true cultural change can be achieved. ■

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