What sort of leadership do we need in the NHS?

Few years ago (2005) when I came to work in Manchester the contrast struck me – the City had the lowest life expectancy for men and fourth lowest for women, wide inequalities and ranked second in the deprivation league table nationally. Yet, it had many highly acclaimed health institutions and some of the nationally and internationally renowned health leaders. It reminded me of Engels, who in his 'The Condition of the Working Class in England' had said:

"One day I walked with one of these middle-class gentlemen into Manchester. I spoke to him about the disgraceful unhealthy slums and drew his attention to the disgusting condition of that part of town in which factory workers lived. I declared that I had never seen so badly built a town in my life. He listened patiently and at the corner of the street at which we parted company he remarked: "And yet there is a great deal of money made here. Good morning, Sir".

It seemed to me that Manchester was still rich pickings for people, except for its own residents. I was fascinated by this and with the late John Pickstone and Stephanie Snow we then published the book on history of public health: "The Quest for Public Health in Manchester, The Industrial city, the NHS and the recent history". I was keen to learn from history and understand how we could leverage the strengths in Manchester and make a difference locally (and not just export our ideas out).

I subsequently tried to start the DREAM *for* Manchester initiative- Delivering Research and Education to Advance Medicine for (not in) Manchester- and which was about making a difference locally. I had some interesting discussions including about whether there really was anywhere in the world where research had been translated into practice locally (researchers publish and move on to more research and service providers never get to catch up) and whether it really was possible to bring research, education and practice together for local benefit? Despite serious effort to make it work, which made me unpopular, the DREAM became a nightmare and was abandoned.

Recognising that the system was bigger than me and it was hard to change things I also got on with the daily grind, and focussed on whatever I could do but it has always left me wondering whether we have the right incentives and leadership in the NHS.

The reason for revisiting this issue now is the recent discussion I have seen on another forum and basically three examples have been mentioned:

1. Dr Mark Porter, the BMA leader, who denied any 'specialist' knowledge of the case of Dr Mattu, and works in one of the unsafest hospitals:

   http://medicalharm.org/uncategorized/dr-mark-porter-in-parliament-the-whole-truth-and-nothing-but-the-bmas-truth/

2. Dr Clare Gerada, the ex-Chair of RCGP, who has been given the job of transforming GP care and who 'runs one of the worst surgeries'

http://www.standard.co.uk/news/health/doctor-given-job-of-transforming-gp-care-runs-one-of-the-worst-surgeries-9367409.html

3. And the new NHS England Chief Executive, Mr Simon Stevens, who worked in the US, and a system which has been ranked worst in the developed world

http://time.com/2888403/u-s-health-care-ranked-worst-in-the-developed-world/

My point is not to be cynical and make sniggering comments of the "so, the NHS is in very good hands" variety. I have very little personal knowledge of all three in terms of what they did, or are doing, to address these challenges, and it will be wrong of me to judge them. Perhaps they tried their best – after all to have tried and failed is much better than not doing anything. And maybe they are the right people to lead since they know the traps and what not to do. Indeed, it can be argued that we need to put our best people in the worst places, and it does take time to change cultures.

But maybe there is another side here? May be we have bought into the spin too much – those who can, do and those who cannot, advise scenario? Who should we believe, and reward in the NHS – talkers or doers? Putting one's own house in order is lot tougher than advising others. May be some leaders are wilfully blind, lack insight, ready to blame others or are indeed benefitting from the status quo. We all know of consultants keeping long waiting lists to boost private practice or the case of the CEO in Raj Mattu's case who wanted 5 in 4 policy to continue so that he could get more funds (as told by Dr Mattu). Going back to my DREAM story, one very senior academic told me he had no interest in or responsibility for the local area and his audience was international, and was trying to get his next merit award.

So, what should we do? There is a fine balance between giving benefit of doubt and a second chance/s and tackling poor performance/behaviours; ultimately senior figures are role models for the next generation and have to walk the talk. With seniority comes responsibility. There are no easy answers, but it is important to learn some lessons, find out the leader's track record, stop rewarding failure, link reward to transparent and validated performance, and put some accountability in place. This needs to happen before the NHS can move on from its present state, but it would take real courage to set up the equivalent of the Truth and Conciliation Commission, heal the NHS and make it fit for the 21st century. We are at the cross roads (the famous cross roads of the NHS!), and we can either keep investing in reviews or regulation which are taking us nowhere, or draw a line. We also have a choice – we can either make or break the man who has been given the responsibility, despite his BTA (Been To America): we work with him or oppose him. On my part I am going to give him the benefit of doubt- not out of sycophancy but out of necessity and respect. You can make your own minds, but think hard and choose well, and do the best you can wherever you can- every little bit counts.

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NOTE: My friend, who provided advice (but has no responsibility for the content) thought this piece could be seen as a thinly veiled attack. If it does then I have failed- my interest is in the bigger issue. And I (re) quote an advice I was given long time ago- You must say what you see and feel and if you get it wrong then apologise, and it is in this spirit I have written this piece. I will add Dr Gerada to the tweet, but do not have twitter names for Dr Porter and Mr Stevens and will email this to them, as part of my being open, and will be happy to post their responses.