The future of health system leadership

“The eyes of the world are turning to Great Britain. We now have the moral leadership of the world, and before many years are over we shall have people coming here...learning from us in the twentieth century as they learned from us in the seventeenth century.”

Aneurin Bevan, July 5, 1948

As the UK’s National Health Service (NHS) enters its 67th year and a new parliamentary term, eyes are drawn towards its future. The health service has made important strides in the past 15 years—public satisfaction in the NHS has almost doubled, cancer survival is at its highest ever,1 and the service was ranked the highest performing health system by the Commonwealth Fund.2 Simultaneously, the NHS faces the rising pressures of a growing, ageing population with more long-term conditions and increasingly expensive treatments and technologies. Achieving further improvements and sustaining high-quality care will require a cohesive effort by NHS staff, unprecedented leadership, and clear coordination of the 1.3 million NHS workforce.

These challenges are not unique to the NHS. After the recent global economic crisis, health systems faced substantial financial pressures, as well as increasing demand for health services. There are now common goals between nations of achieving the triple aim of improvements in population health, patient outcomes, and cost control, combined with triple integration of mental and physical, primary and specialist, and health and social care services.3,4 These challenges and ambitions forge unity of purpose, but if change is to be achieved a new cadre of leaders is needed.

Traditionally, NHS leaders have developed along a sequential path. Front-line experience has been followed by adoption of larger scale roles. Skills are accumulated and leaders migrate from the periphery to the centre—appreciation of clinical variation, financial matters, and hospital productivity is deepened, and capabilities improved. Such leaders have been clinicians, allied health professionals, or managers who progressively translate their experience from ward to board. However, better integrated and more cost-effective health systems require a new type of leadership.

Current NHS architecture depends on alignment and consensus rather than use of crude levers.5 As we move forwards, leaders are needed with experience not only from ward to board, but also from across system boundaries into social care, local government, the voluntary sector, and industry. Local knowledge needs to be balanced with the ability to empower and enable from national standpoints. The NHS requires leaders with the capacity to engage and collaborate with a broader range of stakeholders across systems of care. Leaders able to maintain peripheral and central roles in parallel, delivering at both the front-line and national level, building skills in both contexts concurrently. Leaders grounded in common values with a broad outlook that is patient centred, population focused, and cost aware. Leaders with experience of innovation, improvement, and implementation at pace, empowered rather than hindered by the system.

If these leaders are to be developed, new opportunities are required. In academia, tracks such as the Walport Academic–Clinical Pathway have been established that facilitate a bench-to-bedside approach with parallel clinical and research training.6 In the context of leadership, greater opportunities to gain experience across the system are needed in national, managerial, local health organisation, social care, or industry roles. Such opportunities could be enabled through more flexible training possibilities. In a way similar to academic–clinical pathways, front-line and system training would need to take place in parallel rather than in sequence, through protected time for such roles, ranging from, for example, 1 to 3 days per week. Individuals

See Online for a podcast interview with Mahiben Maruthappu

Comment

Rethinking and reframing obesity

In 2011, we published The Lancet’s first Series on obesity, which summarised the then available knowledge about its origins, economic and health burden (with projections for the future), and the physiology of weight control and maintenance. The Series concluded with science-based recommendations for action.1–4 In an accompanying Editorial, we called for a concerted response with five urgent messages (panel).5

What has happened since? Unfortunately, little progress has been made beyond acknowledgment that there is a worldwide problem with far-reaching consequences for health and wellbeing. The 2013 Global Burden of Disease Study, published in May, 2014, showed that 37% of men and 38% of women had a body-mass index of 25 kg/m² or greater, a rise of 28% in adults and of 47% in children since 1980.6 An estimated 2·1 billion people are overweight globally.6 And while some developed countries have seen an apparent slowing of the rise in obesity prevalence since 2006, no country has reported significant decreases for three decades.

In addition, the debate is becoming increasingly polarised with false and unhelpful dichotomies: individual blame versus an obesogenic society; obesity as a disease versus sequelae of unrestrained gluttony; obesity as a disability versus the new normal; lack of physical activity as a cause versus overconsumption of unhealthy food and beverages; prevention versus treatment; overnutrition versus undernutrition. “Lack of exercise is twice as deadly as obesity”, ran a headline in the UK’s The Daily Telegraph on Jan 15, 2015, in an attempt to interpret one complex piece of epidemiology.7 When the American Medical Association declared obesity a disease in 2013—against the recommendation of its Council on Science and Public Health—a heated debate ensued. The European Court of Justice in Luxembourg ruled in December, 2014, that if obesity could hinder full and effective participation at work then it could count as a disability. Reactions

Panel: The Lancet’s five messages on obesity in 2011

- The obesity epidemic will not be reversed without government leadership
- Business as usual would be costly in terms of population health, health-care expenses, and loss of productivity
- Assumptions about speed and sustainability of weight loss are wrong
- We need to accurately monitor and evaluate basic population weight data and intervention outcomes
- A systems approach is needed with multiple sectors involved

Published Online February 19, 2015
http://dx.doi.org/10.1016/S0140-6736(15)60153-5
See Series pages 2400, 2410, and 2422
See Online/Series http://dx.doi.org/10.1016/S0140-6736(15)60163-5

From mid-career level onwards could be eligible, and receive appropriate recognition for delivering in these capacities. By gaining experience in both front-line and cross-system positions, professionals with both patient and managerial experience could be developed with a broader appreciation of the health service architecture. The design, costs, and feasibility of such a programme would need to be developed and evaluated.

There is a need for greater plurality in NHS leadership, to ensure it is better aligned with the provision of integrated care, underpinned by improved quality and financial stewardship. The models in the Five Year Forward View present an excellent opportunity for training such leaders.1 Development of a new cadre of leaders will require recognition and unified support at local and national levels. Design and implementation of such programmes could well determine the success of health systems in the UK and elsewhere.

*Mahiben Maruthappu, Bruce Keogh
Chair and Chief Executive’s Office, NHS England, London SE1 6LH, UK
mahiben.maruthappu@nhs.net

MM is Senior Fellow in the Chief Executive’s Office at NHS England. BK is National Medical Director of NHS England. We declare no competing interests.