Chapter Seven: Caring about care – responding differently and uncoupling the circle

If you recall, this book opened with everyone unhappy about the nature of care (and much else besides) and blaming everyone else. Well this is a slight exaggeration but there was a lot of unhappiness, there were a lot of candidates for blame, and blame was pervasive.

I hope that in the course of the last six chapters I have convinced you that we have all, unwittingly, contributed to the impoverishment of the care experience and to its increasing expense. All of us: professionals, managers, policy makers, citizens, as a result of our responses to the five winds have contributed to the vicious circle that these responses fuel. The more positive corollary of this argument is that if this is the case then by changing our own responses we can transform the NHS.

This would mean though that groups of people who currently believe they are behaving well, sensibly, professionally, better than others … must choose to behave differently and in this chapter we consider what this will this look like.

But the argument is more than that: without waiting for anyone else to do things differently we can, if we work in health care, make a difference to our own experiences and those of our patients and colleagues by changing our own individual responses.

In this chapter, then, we begin to look at how members of different groups could behave differently and in so doing change for the better the nature of care, and the reach and value of the NHS.

Professions behaving differently

In Chapter Four we suggested that professions change the way they are interacting with society, so that they use the status and autonomy accorded to them in the interests of society. This will then allow governments to stop wielding blunt instruments of coercion that merely enrage and discourage. We can think in more detail about what this involves by considering how the professions could respond differently to each of the five 'winds' we described in Chapter Two.

Responding to the audit culture

If they are to be able to practice in the way they wish, professionals will need to find ways of accounting to society for what it is they are doing, and while it is straightforward (though not necessarily cheap) to measure transactional aspects of care it is much more difficult to

do so for care that is covenantal. It will be important to find ways of 'accounting' for those aspects of care that cannot be counted.

One important step forward could be for professionals to re-articulate the nature of the care they wish to give and which they perceive us to need, and to articulate it clearly so that it encompassed both aspects of good transactional care and the additional elements that comprise good covenantal care. If they were to do this then we suggest that they would find this valuable, even transformative,[1] transforming their own sense of professionalism, but, more than that, fostering a trust and understanding that will benefit us all.

But the audit culture is about holding people to account through the use of measures and metrics, so if we are talking about means of accounting then perhaps it is helpful before going any further to explore what is meant by the terms 'account' and 'measure'.

The purpose of a measure is to give an indication of performance – whether this is excellent, satisfactory or not good enough – to the practitioner him or herself, to their organisation and to the people purchasing or receiving services from them. This allows the practitioner to reflect on their performance and on any changes they want to make, and allows their organisation to enable, support and challenge them, so that this reflection can involve others, and can be translated into new processes and systems as well as individual action. It also allows commissioners to energise this activity on the part of provider organisations, and to some extent it helps patients to choose between practitioners or services.

Measures enable individuals, professions and services to persuade society that they are conforming with certain aspects of care that people value. They are means by which services and professions are held to account. But they aren't the only means of accounting and when it comes to the covenant of care they are not at all persuasive. Another way of expressing this is to note that the terms accounting and accountability have brought with them from their financial origins a numeric and a hierarchical connotation and that we need to see them more richly and find other ways in which people can give an account of what they are doing, ways which can encompass the things we feel are important even if these are difficult to measure.

For example, as Ananta Giri describes:[2] the term 'accountability' has multiple meanings. It is not merely a question of procedural validation but is intimately linked to the calling of responsibility. It involves '*not only being accountable for what one is expected to do or perform but to one's responsibility beyond legal minimalism to the growth of oneself and the other and thus contributing to the creation of dignified relationships in society*.'

[1] As Jamie Harrison, a member of the learning set, puts it: 'Being able to articulate a sense of professional calling, to something and some people outside my own selfish agenda may offer me hope and direction in a world increasingly worried about motives. To offer reassurance of my own good intentions may prove transformative for all concerned.'

[2] In an inspirational Chapter 6, of Audit Cultures

So the challenge is to find persuasive means of accounting for the actions and performance of individuals, teams and professions when they are exercising Practical Wisdom – all the aspects of care touched on in the right hand column of figure 3.1 in Chapter Three.

Finding ways for many professions to account to society for this kind of care will not be easy and must involve serious reflection on the part of professions themselves. Here is Giri again: 'In order that a unit may be truly autonomous it has to demonstrate on its own its sense of commitment and attitude of servant hood to the wider society. This does not mean subservience to the illogic of a majority but a dialogical creative engagement with the wider society.' 'An autonomous unit has to create self critical space for reflection and interrogation of its basic foundations.' 'Autonomy is not just a pious word to utter but is a value to live for.'

When we think in this way we can see how shallow and unsatisfactory many of our current metrics are. More satisfactory means of accounting are likely to involve methods other than counting, and they are also unlikely to lead to quick and easy verdicts about who is offering 'better' care or which institution is 'safer'.

So we are talking not only about devising new methods of accounting but also developing a more sophisticated understanding of the issues involved on the part of a larger fraction of society, so that the accounting process becomes less a one-sided monitoring and more of a dialogue.

We must not forget that in the search for ways of accounting for covenantal care the transactional aspects are still vital, after all, good covenantal care encompasses good transactional care and the professions will need to recognise that much of care *can* valuably be systematized so that unhelpful or dangerous variation can be eliminated and that here good use of metrics is invaluable. These systems, including reporting and monitoring systems, need to be supported, made as credible and helpful as possible, and used routinely so they consume as little resource (including the emotional energy of professionals) as possible. Part of a new professionalism therefore relies on developing professionals who can see many elements of the audit culture as positive and who thus choose to cooperate with it - while recognising and persuading others of its limitations.

Who might professionals account to, in practice?

We have seen that holding high status professionals to account is not easy. We also know that relations between professional colleagues are an important feature of developing and maintaining good practice. Indeed we could suggest that how professionals treat colleagues is an important factor in their performance and wellbeing. So it is worth considering whether these relations between professionals could be a significant way forward. If we imagined that health care organisations contained within them a critical mass of professionals who really cared about care, (i.e. were prepared to engage in acts of work and

courage to ensure that the care received by patients itself involves acts of work and courage), then we could further imagine them keeping an eye on each other and on their performance, and acting on their observations by giving constructive feedback to each other. This richer kind of peer review could become an important part of holding professionals to account – in its most beneficial sense.[3]

Initially taking place within one profession, we might imagine further that once trust had been established, members of different professions involved with the same patient group or service might review each other's care in a similar way. Of course great care would need to be taken that status differences between professional groups did not skew the discussions, and reflections on this process could themselves yield valuable insights.

Responding to the dominance of reason and of MANAGERIALISM

One of the features of the audit culture is that while policy makers do not wish the audit process to become a game to be played by organisational managers, there is ample evidence that this is what happens. People focus on hitting the target at the expense of the system as a whole rather than improving the system and as a result hitting the target.[4] Indeed this is a particular example of the wider issue of technocratic MANAGERIALISM driving out practical humane management.

Professionals can help keep their organisations honest by refusing to play games and, instead, suggesting ways of improving the system so that targets are met without sacrificing other aspects of value. So as well as keeping an observant eye on colleagues within the professions professionals must take a real and knowledgeable interest in the performance of the organisation as a whole and in the decision making of organisational leaders.

As the highest status profession medicine has the greatest responsibility here and it will be important that doctors do not abrogate this by leaving responsibility for the performance of the organisation to managers alone but instead foster a spirit of clinical stewardship across the organisation, in which clinicians of all sorts take an interest in its performance as a whole, provide advice and guidance, and engage in reflection across disciplines about how care can be nurtured and sustained in ways that are affordable.

Re-energising politics

At the heart of the political task is the reconciling of different interests. While it is clear that this must take place at a national level it is also an inevitable feature of life within organisations, departments and even teams. The different interests to be reconciled include

[3] Please note the constructive way this is described here. We are describing something much richer and more rewarding and valuable than the GMC's insistence on 'whistle blowing'.

[4] It is worth noting that there is an explosion in the number of 'audit experts' wherever and whenever targets and evaluation processes are introduced. While not illegitimate, these experts rarely focus on the underlying systems, paying much more attention to the means of convincing the auditors, helping organisations rehearse their responses and ensure that they score well in the processes used.

those of different patients or client groups and it should be obvious that, for decisions at this level to be properly informed, health care professionals will need to be actively involved. What would this look like in practice? It would involve professionals being prepared to engage in genuine dialogue (that will sometimes be heated and emotional, because it involves much more than logic and reason) about things like the design of a service pathway, how to increase the capacity of a service (perhaps by asking peers to take on different practices), or what services may be funded and which may not. This kind of dialogue will require abilities to work collaboratively to an extent rarely seen to date, and therefore a new set of assumptions, attitudes and behaviours, developed in a new kind of training.

The design of local services clearly needs good input from HCPs most closely involved, but so too does the design of the wider care system. Doctors and others need to be taking an active interest in the nature of our society, how it is governed and the models guiding it; they need to recognise ideology for what it is and not confuse it with inevitability; and to be able to view debates about this through a number of different lenses to develop a rich understanding of a complex reality. They may choose to accept that western liberal democracy founded on capitalism is the best way of organising affairs but they should at least have understood that proposition and considered alternatives and critics. If they (we) do not, how can democracy itself be healthy?

And, we must not forget too, that there are relevant and important ideas that do stem from the economic paradigm. If it is true that the way markets succeed in improving quality and reducing costs is through the 'four Is' (innovation, information, incentives and investment, introduced on page 64) then professionals could look for ways other than a market in which those 'four Is' can be delivered in health care. If debates such as this are left to non-clinicians we must not be surprised if the results are not roadworthy.

Understanding and honouring anxiety

Since anxiety is inherent in the health care task then our HCPs and managers need to be able to respond to it healthily. As so much about health and health care is as yet ill understood, even the most experienced of practitioners will be anxious on occasion. A sense of anxiety is a very valuable reminder of the need to take care and can be seen as an appropriate and healthy to a tricky situation.

Let us remind ourselves of the healthy responses to this:

- noticing an unpleasant feeling of anxiety
- bringing it into awareness
- reflecting on the source of it
- seeking support where we need it
- thinking carefully through the needs and wishes of the other

- reminding ourselves of our sense of purpose.
- bringing together our own concerns with those of the person who has prompted our anxiety
- deciding to embark on a course of 'aware altruism'
- or of meaningful dialogue with the other the outcome of which cannot be anticipated
- seeking support from someone more experienced in a particular procedure or situation.

The new professionals we are describing here will act in these ways themselves - and respond well to others who seek their help when they themselves are anxious.

If we think back to the distinction between transactional and covenantal care we can see that anxiety may well be provoked by the kind of situation in which a patient needs the latter. And when this happens the anxiety can be reduced in three ways: 1. to withdraw both care and compassion and offer bad care, 2. to offer good transactional care, or 3. to offer good transactional care and also to engage in the relational aspects of care. The former two will reduce anxiety levels more quickly but for a shorter period of time. The last will require both courage and work but is the only one that can reduce anxiety levels fundamentally and long term.

We do need to recognise however that choosing (either consciously or subconsciously) one of the first two is a natural human response to anxiety, so when we find people offering care of these kinds it is more valuable to try and find ways of reducing anxiety rather than increasing it further by calling for evermore punitive monitoring and accountability.

Using the opportunities of the digital revolution

The informational world we are moving into in which digital code moves freely (in both senses of the word) in ways that we can only begin to imagine, means that voice will increasingly be exercised by people on their own behalf and not through representative or governance structures, and that we will be able to track real activities in real time and assign reputations to people and organisations based on these, rather than on proxy measures and reputation management exercises.[5]

Souveillance (large numbers of people looking up) will at least accompany and perhaps outperform surveillance (people at the top looking down). In other words 'souveillant masses can replace the surveillant cadre', in a 'dance of millions of people and hundreds of

[5] For example think of Trip Advisor v Michelin or star rating systems by tourist boards.

thousands of organisations leading to meta level patterns'[6] which describe real behaviours and actions from real people in real situations.

This is of course very challenging for professionals and their organisations but may allow more of the covenantal aspects of care to come into the picture – since these are an important part of the overall patient and family experience. So professionals can valuably welcome these sort of initiatives rather than trying to protect against them. Indeed they could encourage them.

Developing our professionals

Since the behaviours just described are radically different from those we see today they will require an equally radical new form of development.

Medicine, and the healthcare professions more widely, have in the past been seen as among the most fantastic jobs in the world, a real privilege to have the opportunity to be entrusted with the health and wellbeing of individuals and society. Somehow, sometime, we lost this sense of privilege and we would all benefit from restoring that, along with a sense of honour, enthusiasm, creativity, and fun. At the same time we could usefully lose the sense of entitlement, resentment, and grievance that characterizes many conversations within professions.

For the professions to engage in the kind of open dialogue described above, and for them to be open to the need to earn their autonomy, and to see autonomy as a value to live for (as Giri describes it, see page 74), will require them to have as their foundation a genuine sense of self worth, and ways of engendering this need to be discussed and developed. A genuine self confidence (that is the very opposite of the arrogance of which some professionals are accused) will be necessary if they are to demonstrate the openness and empathy and responsiveness that covenantal care requires. That same sense of self worth will also be necessary for them to have the courage to engage in the politicalness described above.

If we are to allow and encourage professionals to bring themselves as whole people (and not just their skills), into the care task then we will need to pay more attention in their education and training to developing their understanding of themselves. While curricula have expanded hugely to accommodate new knowledge this has accompanied a focus on what it is that professionals *do*. The kind of *people* they *are* or can *become* has diminished in importance. This is itself a part of the audit culture, a manifestation of transactional rather than covenantal education.

This is an important point. Since education has been as exposed to the five winds as health care has, the educational process through which our young professionals are developed is

[6] Paul Hodgkin, Learning Set paper

now almost wholly transactional in nature. Assessment is driving what is taught and how it is taught. The attention now is almost entirely on competences and on facts. Indeed it is the audit experts' mantra that assessment must drive the curriculum. But this means that essential aspects that are not amenable to objective assessment in the way that meets the needs of auditors cannot now be taught and there are holes in the curriculum that are currently compensated for in the world of practice only by those old enough to have been taught in pre-audit eras[7].

So we must find ways to help those educating our young professionals to loosen the grip of auditors and enter into an educational covenant with their students, so that they can pay attention to who these young people *are*, who they can *be* and how they can behave, and not merely what competences they can demonstrate.

There are many ways of describing aspects of how we want our health professions to behave. Carl Rogers' description of the therapeutic triad (of genuineness, non-possessive warmth and accurate empathy) may be a good starting point for this. 'The therapeutic alliance includes hope, trust, common understanding, and bonding, and is found where there is a supportive, warm, positive attitude on the part of the therapist, who speaks a language the client understands, and is encountered and trusted by that client'.

In the management world too Otto Scharmer talks of 'presencing' and of the 'inner space… the source from which we operate, … the quality of attention and intention we bring to any situation'. In addition concepts such as respectful uncertainty, compassion and 'loving-kindness', deep listening and more, have entered the language from many sources and all of these are surely relevant to the ability to offer covenantal care. So we can picture the kind of outcomes we are trying to achieve in our educational processes and relationships and they all depend on a genuine self confidence on the part of our young professionals.[8] That means their training processes will need to feel, to them, safe as well as challenging.

If we are to achieve this we may need to turn our training programmes (especially for medicine) upside down. Currently the training we offer tends to include a scramble for places, a constant proving of ability to succeed which often leads to an entirely pragmatic focus on what is being assessed, an intolerance of anything else even if it may help them to be better care professionals, and an arrogance in relations with other professions associated with a history of being able to demonstrate superior intellectual skills. We could try a

[7] Jane Macnaughton, GP and Professor of Medical Humanities, University of Durham at the Think About Health Conference 2010. She went on to say 'understanding a subject in a coherent way is diminishing because students don't want to do more than will be assessed and institutions discourage teachers from teaching it' and 'We arrest people's interest in going beyond competence'. We could see this as yet another example of 'efficiency'!

[8] Managers too

different approach. What would we offer instead if we aimed to liberate their potential as much as imbuing facts and testing competences?

Suppose we inducted them into an exciting journey, inculcated a sense of privilege, a sense of purpose and of inquisitiveness: 'go where this takes you as long as you are serving society, oh and first of all have a look at how you are understanding society'?[9] Certainly we would need some kind of net to catch those who aren't capable for reasons to do with effort, intellect or personality, but let us offer an ethos very different from today's competitive, exam based, competency driven production line. We could think of it as educating them in the same way as the way we want to work with them (and they with us and others) in their working lives, in health care organisations. An introduction to the world of good practical humane management.

This is an important point: that we must develop our young professionals to be able to function effectively in the organisations in which they will work. Currently they enter these organisations with no idea of how organisations work. With no understanding of the inevitability of organisational politics, no recognition of organisational hierarchies and decision making processes, no recognition of the need to identify networks of people who can help solve problems, these young professionals are severely handicapped. When they then find that the organisation does not always welcome their ideas for improvements they blame the organisation rather than consider how they could have helped their ideas to succeed, and a pattern of mutual mistrust ensues. If we want to we can change this.

But it is certainly not only the professionals who need to change. Let us think now about managers.

A different style of management

Since the mid 1980s we have made the assumption that there is a method of management (a set of behaviours, analyses and techniques) that can be applied to beneficial effect in any setting, including the NHS. And indeed some of the insights and approaches have, when used wisely and sensitively, been valuable. However it is worth reminding ourselves of the very real differences between health care and other industries and when we have done so we may consider that these differences in context require a difference in the management method that is used. In other words management will be just as necessary in health care as it is anywhere else but the approach and the characteristics of managers themselves should be designed to suit the purpose and dynamics of health care.

We have suggested in Chapter Six that the economic definitions of choice, competition, efficiency and innovation are problematic in health care. In Chapter Four we explored 'disconnected hierarchies' in which groups with professional autonomy cannot be required

[9] Really understanding it, in all its richness (not the collection of self interests the economists and managers and policy makers tell us it is).

to act at the bidding of management. Nor can they be incentivised to do so since nearly all of the incentives (the things professionals care enough about to affect their performance) are not in the gift of managers. In Chapter Four, too, we saw the importance of healthcare organisations fostering and nurturing professional judgement (practical wisdom) for the good of society as a whole, and the importance of enabling and supporting high status professionals in their ability to reflect constructively on their performance while also challenging them to do so if they appear disinclined or unable.

In Chapter Five we considered the role of the manager to include that of enabling their organisations to serve their communities, as well as ensuring their staff and their services are flourishing.[10] We saw too that the way they do this is to undertake acts of work and courage and encourage these throughout their organisation. In Chapter Two we looked at the anxiety experienced by all involved in health care and at the defence mechanisms we all employ as a result.

As a result of all these differences in the context[11] the management method taught in schools of business and management is not merely powerless here, it can become actively malign.

Consider, for example, how management has now, all too often, become (as we saw in Chapter Five) 'performance management', with a very mechanistic model of managing performance. It assumes that we can hold an individual to account for the overall performance of a large and complex system, and indeed often results in the bullying of individuals rather than a proper focus on the system as a whole.

We can think of this kind of bullying as management that is neither good transactionally nor covenantally. It happens as people become disempowered or dis-abled by focusing on particular targets; they both look at the target and not at each other, and they look at each other only insofar as they can help reach the target, they don't *see* the other as a person.[12]

---

[10] Flourishing in the Aristotelian sense of living to your fullness, of realising potential. And yes flourishing will include a proper concern for financial and other resources –after all we are talking about everything realising its potential – financial and physical assets as well as us, the human assets!

[11] Actually we don't believe the differences between health care and other real contexts are so very great. But the differences between health care and the context assumed by economists and business schools are indeed great.

[12] There is interesting evidence from Steven Kelman and John Friedman of Harvard University (An Empirical Examination of Distortionary Impacts of the Emergency Room Wait-Time Target in the English National Health Service) which suggests that:

- Central decision making on priorities is positive, (so choosing cancer, heart disease and suicide was good and drove national benefits)
- Targets change behaviour and deliver results
- Learning doesn't happen; targets are delivered but *no learning on how to run things better and possibly the reverse*
- There is no value infusion. *Nobody* feels good about delivery.

Thus, it feels to many as though the way performance management has been interpreted in the NHS has destroyed or seriously diminished the intrinsic motivation and passion of all concerned.

If we recognised that what we have are a disconnected hierarchy (Chapter Four) and a complex adaptive system in which interventions cannot have predictable outcomes, then we would know that holding individuals to account for a radical change in the **real** performance of that system - and especially within a short time frame - is absurd. Is it any wonder that individuals given such responsibilities do not seek to improve the system (and thereby achieve the target), that instead they focus on the target at the expense of the system?

When so many of the factors that influence improvements in the system are controlled by people (clinicians) who cannot be required or incentivised by the individual whose job is on the line if the target is not met, these key clinical players can simply watch and wait for the next unfortunate incumbent to replace the current one. That they often describe these managers as incompetent when they themselves have refused to accept any corporate responsibility simply adds to the tension between the two camps and makes the context even more profligate, mean spirited and unmanageable.

In this context a language of 'mistakes' and 'fault' predominates, when, more realistically we could talk about 'trying things out 'and 'learning from approaches that haven't yet worked'. Instead individuals are blamed and careers are ruined.

There is one part of the system where the hierarchy *has* been very firmly connected: the management hierarchy running from Department of Health through the chief executives of supposedly autonomous NHS organisations. Here policy is taken from broad statements of purpose and turned, through the various management layers, into detailed guidance. Each layer in the hierarchy adds its own additional detail as the papers cross their desk and they cannot find it in themselves to trust the layer beneath them to enact them wisely. In this way local managers are undermined even further and allowed little room to develop local strategies that make greater sense for their local communities, and opportunities to gain credibility with local clinicians are again reduced.

Another way of describing this cascading of detailed instructions is that it forces local managers to focus on the complicated easy (analyses, reports, ticking boxes, reading the guidance), leaving them little capacity or emotional energy for the simple hard. So they do not spend time on the acts of work and courage that will enable, support, and challenge

---

So while you gain results, you lose intrinsic motivation and a sense of meaning. We all become cogs in the wheel/the means of production. There is also some evidence that persons with high levels of power tend to perceive others as a means to satisfying one's own personal goals rather than as individuals in their own right.

those around them to be creative and energetic in pursuit of goals important to them as individuals and to the organisation and the people it serves.

Instead of engaging in conversations (genuinely interested robust conversations of value to both parties and to the organisation) and relationships and using observation and intuition to pick up signals about how things are going, they rely on 'balanced scorecards' and stars from the regulators.

Having said that, there is usually little in the guidance that forbids this covenantal approach to management (although the irritation caused by the tick boxes discourages it) and we are perhaps short of managers who are good at both transactional and covenantal aspects.

One reason for this is that Business Schools rarely develop the fluency of their students in a language of emotions. So their graduates are not able to identify what they *feel* as they set about their managerial roles, nor share that with others. Neither do they encourage others to identify and express their emotions, nor do they develop the interest or empathy that would enable them to sense these.

If they understood the nature of anxiety, the role it plays in all our lives and the defence mechanisms we display to avoid it, they may refrain from dismantling these willy nilly (by restructuring, de-layering, redeploying, impoverishing skill mix etc etc) and find ways of achieving the same or similar ends without such damaging impact on motivation and meaning.

With an understanding of universal emotional responses they would not be naïve either about initiatives for working collaboratively. They would look out for the inevitable human emotions of envy, sabotage, and 'them and us', realising that to act as if they do not exist or can somehow be ignored is unrealistic, and that in environments characterised by competition they will grow.

Alongside this lack of attention to emotions, apart from some superficial attention to values, vision and missions, Business Schools do not understand (or pay attention to) the more profound sense of meaning that turns a job into a vocation. This lack has allowed people to be seen as machines, as units of production. The enormity of this loss has been left undiscussed and is perhaps now undiscussable.

Of course a transactional approach to management is exacerbated by (as well as a cause of) the increasingly short tenure in senior management positions. In fact while we can feel angry with those at the top of the managerial heap we need to feel sorry for them too. They've had their spirit quashed, either from outside by a more senior spirit quasher, or from inside by a belief in free market economics and the managerial method.

So we need a new kind of manager. One who understands people as well as numbers and has an understanding of some key insights from psychology, sociology, anthropology and

history, moral philosophy and perhaps even theology (not typically the curriculum of an MBA).

Management and the five winds

As managers will be being buffeted by the same five winds as everyone else, we can use these to consider how they could respond in ways that improve and sustain care rather than impoverishing it.

Responding to the audit culture

Just as professions need to earn their autonomy so should organisations and their managers, but instead of earning this organisational autonomy by meeting government targets (as now) organisational leaders would ensure their organisations earn it by placing the organisation at the service of society. We have suggested that professions do this by engaging in creative dialogue with patients, public, and other health and social care organisations and this is also what organisations would need to do. Many would say they are doing so already but we suggest the current efforts are tokenistic and that we need instead a meaningful dialogue.

Similarly, just as professionals will need to find ways to account for covenantal aspects of care so too will organisations. They will find it just as hard and will, again, need to develop innovative ways of doing so. As part of this they must be prepared to challenge the way commissioning is undertaken if it does not take sufficient account of relational and covenantal elements.

This is a point worth emphasizing. If commissioners chose to see their role as working alongside acute sector colleagues to encourage high status clinicians to work constructively on service redesign in pursuit of improved quality and reduced cost, they could play a helpful, indeed vital role. They hold much of the information that is needed if managers and clinicians are to understand the dynamics of their performance. They can help identify comparable services that are better designed. They can encourage managers to care about care, and so on. If they can see their role as helping rather than as fighting there is a chance this will not be a hugely expensive 'industry' of form filling and bean counting, but a genuinely helpful means of energising their acute sector colleagues to address the core issue.

Reducing undue variation in care is an important objective across the system as a whole, and managers will need to work with their HCPs to standardise care where appropriate. They will also need to ensure that this agenda does not interfere with opportunities for good covenantal care. Managers can help HCPs to respond positively to these aspects of the audit culture, by ensuring they are not given disproportionate prominence.

When it comes to meeting organisational targets or undergoing audits, managers too need to insist that there are genuine improvements to the system that *result* in achieving a

satisfactory 'score', rather than a focus on the targets that distorts priorities and impoverishes care. This requires integrity rather than gaming.

At the level of the Board there is a need for reflection on the Board's (and the organisation's) attitude to risk. Boards need to accept that risk is inherent in health care, and that it should be one factor in any decision, *but not the only one*. Organisational leaders must learn to frame questions to, for example, lawyers or control of infection teams in ways that leave the *decisions* to people who are juggling a number of different priorities rather than focusing only on one.

Where there is risk there is litigation and organisations and their leaders must find ways of supporting both the professionals whose actions have had unfortunate consequences and their patients. Some form of litigation-free space where people can be themselves, feel whole again, interact as whole people, then go back into the outside world, could be one way of doing this and something organisational leaders could enable and encourage.

All in all the role of the leaders of organisations will be to help the whole organisation to dance: to be active, alive, creative, present, taking some risk – but not too much – holding the other. This, again, will involve uncertainty and, again, will require courage. We will need organisational leaders, as well as HCPs, who bring *themselves* to work; bringing their values, emotions, and desires to work.

Responses to other aspects of the digital revolution

If professionals are to respond proactively and constructively to digital advances their organisational leaders must encourage and enable this. For example, if *souveillance* (commentary on services by those receiving them using the power of the web) is going to be productive organisational leaders will have to take an interest and encourage their professionals to respond constructively to comments on blogs and other web enabled exchanges.

They could go further than this, they could prompt or support creative thinking across their organisations about how to use the potential of the web to help people flourish.[13]

Re-energising politics

We have discussed the need for HCPs to be prepared to get *involved* in decisions about the nature of services and the allocation of resources, and so too must health care organisations. Organisational leaders must take an active part in decisions about the kind of services to be provided locally, drawing on the rich information they will have and which is needed to inform the debate, and being prepared for these discussions to become heated

[13] And by this we mean understanding the potential of the web and thinking creatively about means of meeting health needs. Really creatively, not just seeing it as a new medium for old thinking

and emotional. This is very different from the kind of inter-organisational relationships that currently characterise the NHS, and will require new skills in dialogue and collaboration.

As part of their service to society, organisational leaders involved in this collaborative dialogue must reflect thoughtfully on the appropriate use of organisational status, recognising the differences in status between organisations and not allowing this to dominate the discussion inappropriately – just as we have discussed in Chapter Four in relation to the status of professions. In this way 'low tech, high touch' services will receive the same attention and concern as 'high tech' specialist care.

Healthy responses to anxiety

If organisational leaders were to support healthy responses to anxiety in all parts of their organisation, recognising anxiety as inherent and not seeing it as weakness, they could help 'contain' anxiety through effective leadership, appropriate structures, and clearly defined roles and role-relationships. They could encourage and support appropriate supervision processes and opportunities for individuals and groups to reflect on the emotional impact of their work.

It needs to be 'okay' to talk about feelings and experiences that disturb us; and we need to develop the capacity to listen and give space to those processing those experiences.

Managers who become aware of their own emotional responses to situations, recognise their own anxiety and attempt to respond in healthy ways themselves will not only be more effective and 'whole' but will also choose to request help when faced with anxious situations and will certainly find ways of supporting others when they request it.

Reclaiming management from the technocrats

We have suggested that the role of managers is to enable others, enable them to realise their potential to help others (ultimately patients) to realise theirs. So we can see that management behaviours have to model the behaviours managers want to see in those they are managing. Every interaction between manager and managed influences the nature of care offered to patients.

Once we can reclaim the concept of management and see it as guiding and influencing the work of others, as helping others to flourish and in turn enhance the flourishing of patients, colleagues and others, we can see once again that most management in health care is undertaken by people who do not describe themselves as managers but as clinicians. Once we have reclaimed the concept we can encourage clinicians to develop their abilities to guide, to influence and enable.[14][15] We need, however, to think about this differently from the way we have approached it over the last twenty years.

[14] We could, if you preferred, call this clinical leadership, but it would be of a very different nature to the kind of clinical leadership being touted currently – which has more in common with Business School models that the one we are describing here.

One solution to the perceived problem of a disconnected hierarchy has been to encourage clinicians to take on managerial responsibilities. Those who do are then often rejected by their clinical colleagues, seen as having rejected the clinical identity in favour of something else. They can be seen as 'going over to the dark side' (!), as dangerous double agents, spies in the camp, to be distrusted. Sometimes this is because people are given jobs they cannot do, either because the jobs are inherently undoable (e.g. persuading their clinical colleagues to do something they don't want to do), or because these individuals are given no training or guidance, or both. Since this is humiliating, and the individual is often unable to say they are out of their depth or under skilled, they then create a range of defensive systems to hide their incompetence. If we take into consideration, too, the fact that managerial roles carry no additional status we can see there is little incentive and considerable risk for clinicians to take on such responsibilities.

There is now even more impetus towards encouraging doctors in to management under the heady title of clinical leadership (largely because it is believed this will connect the hierarchy, that doctors are more likely to follow others if they are also doctors). So there is a move towards high status joint MD MBA programmes or Darzi fellow schemes. Unfortunately these are not answer – indeed they will exacerbate the problem - because they simply spread the MANAGERIALIST method to the medical domain (where it finds very fertile ground). What is needed instead is for those doctors who are practical humanists to find allies wherever they can and transform the management method and managerial landscape in health care. It isn't the medical or MANAGERIALIST knowledge that yields results (not on its own anyway) it is practical wisdom, reflection and review of practical experience, by people using all their wisdom and intuition and not merely their logic.[16]

So, if we want health care that is excellent (or even good enough) in both transactional and covenantal terms we need to think about the role that managers (including in this term most clinicians) can play in achieving this. How they could feel genuine and deserved pride in their contribution. How they can avoid the charge of 'meeting the targets and missing the point'.

Some examples of the kind of management needed can be found in table 7.1.

---

[15] As outlined in Chapter Five and in more detail in my book Really Managing Health Care

[16] In case we have given a different impression we believe that stewardship by doctors is very important – doctors with an understanding of the humanities not management. We really must start educating our doctors and not merely training them.

Table 7.1: Management as an act of work and courage in service of others potential to be of service

Involves	***Does not involve***
High transactional and high covenantal working	Just the transactional
A focus on the simple hard	Focus only on the complicated easy
Relationships and conversations, observation and noticing	Only dashboards and balanced scorecards
Feeling pride in the work of the team	Feeling arrogant about one's own success
Modelling care as acts of work and courage and spreading news about examples of it within their organisation	Passing on the hurt down the 'chain of command'
Being self-aware, having an understanding of group relations, able to recognise and discuss emotions	Ignoring emotions – own and others
Learning as much from what doesn't work as from what does	Talking about failure and finding someone to blame
Using language which fosters and rewards intrinsic motivation	Seeing motivation as needing extrinsic sticks and carrots
Building collective courage	Seeing self as the 'only one'
Sense of being in service to the local community (which may be the community of patients in a specialist area)	Driven by a sense of being in service to the DoH/Monitor
Working with the group dynamics of envy, sabotage; understand their inevitability and work to bring containment to them	Working in ways which reinforce envy, negative protections, high anxiety; providing no containment to these inevitable dynamics
Creating jobs of value and worth	Giving no thought to the value or worth of a role, see it just as a skills mix exercise
Supporting, challenging and enabling people taking up roles to be able to be effective and skilful in them	Putting people in jobs and just hoping they make a decent enough job of it; failing to support them then criticising when they don't do it well

Bringing clinicians and non-clinicians together in productive ways that release energy and motivation; be skilful in facilitating co-creation	Talk about 'herding cats' and comparisons with the private sector where 'staff can be told what to do'.
Seeking, and being open to, hearing feedback; being skilful in giving feedback	Refusing to listen to bad news, shooting the messenger, asking for solutions and not problems
Being emotionally literate; be able to use the language of emotions and be in touch with one's own emotions	Feeling a failure if feel anxious, nervous. Valuing a thick skin and the ability to tolerate other people's pain

Developing organisational leaders

We talked above of the need to find different ways of developing our professionals and, similarly, we must find ways of developing differently our managers. Perhaps more than anything we must reduce the amount of complicated easy in their curricula – this is not the value they add. This can be found elsewhere in the system – in advisory roles – and managers must learn both how to seek advice and not to be bound by it. Making decisions will require of them that they use their Practical Wisdom and draw on their experience, intuition, and judgement, while also being aware of their own emotional responses and those of others involved. This kind of simple hard requires a very different curriculum and a different approach.

And policy makers? We need a new form of policy making and a new form of civic – ness

Changes such as these among professionals and organisational leaders are essential but they are not enough. They will need to be mirrored by changes in the behaviours of those making policy. Policy makers will find it much easier when professions and managers are behaving differently but there are important changes they must make in their own right.

This needs further thought and the ideas below are sketchy. It would benefit from some serious thinking about the distinctive value that politicians and policy makers can genuinely add to the system of care provision. It is not enough to talk of democratic legitimacy (although of course that is crucial) there needs to be dialogue about the value adding nature of the processes of policy making.

Separating policy from administration is a good starting point. So that decisions such as the level of resource and the key priorities are decided by policy makers, along with a few critical features of the system. This is the role that policy makers are equipped for and have the democratic legitimacy to fulfil. Implementation is not their expertise and should be delegated to administrators.

How would policy makers reach decisions about resources and priorities? Not by talking with a few 'experts', health economists, top doctors, senior managers etc; but by tuning in to the vibrant debates happening at local level: debates about how resources are allocated at community level, at hospital level, at service level.

The purpose of their tuning in in this way would not be to intervene in these for party political advantage (as happens now) but to understand the tensions in the system, to encourage the professions and organisational leaders as well as communities and media to find meaningful ways to describe and account to society for aspects of care that are not easily *counted*. They have a crucial role to play here and it will require them to behave with integrity rather than party political point scoring.

Were this to happen, that policy makers understood and took an interest in the practical issues that prompt local debates, then contributing to these local debates could become part of professional, managerial, organisational and community life.

As they became more aware of the realities of local systems policy makers and their administrators would be able to stop believing in big top down initiatives and recognise the importance of small changes devised and introduced locally. And they would find it easier to resist the temptation to set targets just because they *can*. Finally realising that setting targets will inevitably lead to *poorer* services,[17] and that they need to find other ways of energising change.

Perhaps more than any other group policy makers have a responsibility to keep always in mind the aims of a health system: tranquillity, confidence that when care is needed it will be provided in acceptable ways by people who care about patients. It is of course possible to consider reframing these and policymakers have the right to engage in debate about these aims. They do also have a responsibility to engage the public in that debate and in a meaningful way, before they consider changing them.

In general the means of achieving those aims would be the remit of DH administrators but if a major change of approach were instigated by policy makers their role would always be to test the new approach against the aims – and not to become so fixated on any particular means that it becomes an aim in its itself. For example introducing 'general management' (back in the 80s) or 'the market' is not a policy aim it is a means towards an aim and it must be tested against that aim.

Policy makers also need to recognise the role played by anxiety – others' and their own – and choose to respond in the healthy ways described previously. These healthy responses would allow them (liberate them?) to behave with an integrity (a virtue popular with voters) that unhealthy responses do not.

[17] Seddon J [2008] Systems Thinking in the Public Sector

It would be helpful, too, if policy makers were to reclaim as political the issues they have farmed out to 'neutral experts'. Avoiding emotional, difficult unpopular decisions is not a position of integrity and they need to reclaim their difficult, dangerous,[18] role as reconciler of different interests. As much of this will be happening elsewhere in the system as a result of the greater politicalness being developed there, their role can include ensuring the health of those local debates (so that they aren't captured by professionals or managers but genuinely involve views of local people) and taking an interest in the outcomes.

Having separated the making of policy from its implementation we must also consider the role of those administrators charged with the implementation and describe their role as akin to those of the managers we have described above: guiding, influencing, enabling others to realise the potential of their organisations to contribute to the flourishing of their local communities by meeting health needs and seriously addressing health inequalities. So they will need to behave differently too. Fundamentally they will need to understand, really understand, the nature of the system and the impact that policy announcements and changes will have on it, and then leave as much as they can to those closest to the action. To do so they will take an interest in the flourishing of organisational leaders.

Will this require a different set of skills and therefore development process? Almost certainly.

A new civic-ness

As a result of the developments described above we might begin to see a new form of consumerism. Indeed the boundaries between consumer and provider may become less rigid. There is a tendency to promote the assumption that today's society is made up of self interested individuals who perceive their self interest as composed entirely of pursuing their own ends and who will fight for these at the expense of others. Indeed much of the economic paradigm is founded on this belief. And yet this is not the experience of many. People give to charity, they give blood, and they give time to friends and neighbours in need, they sacrifice careers to caring for children and elderly parents.[19] There is a danger that we are teaching people that they *should* only look out for themselves rather than reflecting the reality which is that we want both.

We want to meet our own ends *and* to have good relations with others and help them meet their needs. We will also be fairly sophisticated in our ability to marry the two and we will do so in ways that suit our individual motivations and will not be predicted by economists. A new civic-ness would perhaps start with this debate: does our self interest encompass

[18] Dangerous in that it may require them to court some unpopularity and it will therefore require courage

[19] This is now termed the Hidden Wealth of Nations, (see book by David Halpern, Polity Press) although the only people from whom it this wealth and behaviour has been hidden are economists.

merely goods and services for ourselves and our immediate family or does it also include a sense of the collective, and what does/ could this look like.

Perhaps too we could rediscover our sense of democracy. Democracy can be seen as a process of 'becoming' – as individuals and as communities – in that it achieves the reconciling of different interests, not by the decision of a governing elite but by the active participation of citizens.

This though would require us to develop our 'politicalness', our ability to engage creatively in dialogue with people pursuing different ends, or the same ends by different means. We are most likely to develop these abilities at a very local level among local people discussing decisions that matter to us personally: about buildings, services, planning laws and so on.

This ability, once acquired, can then be applied at a national level. The very fact that local people have developed their political awareness will mean they (we) are able to recognise skill in creative dialogue, and identify it in those seeking our votes. We will reward with power those who show their ability to listen, to gain the confidence of others, and develop options which reconcile as many interests as possible.

This feels very different from the society represented to us by economists (and their friends in the media) - consumerist and selfish - and very much more like the kind of communities many of us do live and work in. So it may not require a major initiative to move us in a new direction so much as a series of nudges to remind us of what we care about and how we can become involved.

Different Responses

Different responses to the five winds – that is what we need. Different behaviours, a different sense of contribution (rooted in a different confidence in the self, a genuine concern for the other and a belief in the importance of *being* as well as *doing),* different roles, especially for managers and policy makers, a distinction between policy making and implementation, means by which citizens can legitimately inform debate, and a clear articulation of what we mean by care.

Together these convey a new sense of what it means to **be** a professional, a manager, a policy maker, a citizen.

New Professionals

There have been recent initiatives under the banner of New Professionalism and they form two strands: that developed within the professions and that originating from government. The former focuses on the wish to use professional judgement and could be seen as a plea to offer individualised care without sufficient emphasis on the transactional aspects. The

latter does the opposite: emphasizing systematizing and standardizing of care and encouraging a move towards a connected hierarchy.

What we are trying to give voice to here is different. We recognise the value of a disconnected hierarchy and do not lament it. We see the need for (and benefit to) the professions of re-establishing a sense of **service** which leads to a genuine concern for good transactional care, much of which can be systematized, *as well* as appropriate use of practical wisdom, with the nature of the care offered being determined by the needs of the patient[20].

New Managers

The management model we are proposing here is different too. While its purpose looks the same (delivering organisational performance that includes good patient care to meet health needs and address health inequalities, within available resources) the METHOD is profoundly different. It is not strident and bullying, nor soft and fluffy: it is challenging, expectant and supportive. Knowledgeably ambitious for services, keen to hear the enthusiasms and concerns of front line clinicians, aware of financial and other constraints: management like this is a covenant between organisation and professionals, organisation and patients, organisation and community. It delivers transactional aspects of care reliably – while it recognises the importance of care as a covenant: this very recognition allowing front line staff to respond with a concern for the transactional that has often been lacking.

We are not advocating any kind of return to a previous world but delivery of genuinely good transactional *and* covenantal care.

New policy making

In our scenario everyone is doing what they do best, applying *their* 'practical wisdom'. We liberate policy makers from policy implementation so they can focus on policy. Policy informed by the active involvement of citizens, professionals, managers in local political debate. Economically literate, socially concerned, and so much more.

Forces for change

Can it happen? It has been societal forces that have driven the changes in the nature of professionalism, management and politics over the last fifty years, and it won't be enough for us simply to declare that we want to change direction, so we need to ask the question: is there sufficient energy in society for a change in direction now? Perhaps:

[20] Without an understanding of the previous chapters this last sentence is likely to drive professionals to anger.

- The financial crisis has undermined faith in markets and so there is much less belief that politics should be left to markets. At the same time it has shaken the belief that risk can be calculated, controlled and managed away – or avoided by taking decisions which diminish people's lives.
- New developments in neuroscience seem to prove conclusively that relationships are an essential element of care. As a result we may soon be able to lose our concern about patients becoming 'dependent' and recognise that in any genuine relationship there is a loss of some autonomy and that this is beneficial rather than dangerous.
- The depth of dissatisfaction on the part of professionals and the public about the nature of care will have an impact.
- Cuts in the public sector should provide pressure to reduce the amount of resource tied up in unnecessary complicated easy activity.

So although we must not underestimate the attraction of the complicated easy, and the determination of those who use logic to the exclusion of everything else to continue to do so (and both of these are amply demonstrated in the current - May June 2011- debate about the precise nature of the coalition government's NHS reforms) we need not feel too dispirited, for two important reasons.

First, although change will be needed in all four groups of people (professionals, managers, patients and public, and policy makers) if the NHS as a whole is to be renewed, and it may feel as though we have to wait for others before making any changes of our own, many of us fall into several of these categories and we will be able to have an impact in all of them simply by changing our own attitudes and behaviours. And the second follows from that: that this kind of renewal will come about as a result of people seeing things differently, choosing to respond differently and behaving differently – none of these require structural change and can start anywhere.