

## CHIEF EXECUTIVE'S OFFICE

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The Scottish Parliament  
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Via email: [papls.committee@parliament.scot](mailto:papls.committee@parliament.scot)

10 December 2020

Dear Mr Sarwar

### **Leadership and workforce challenges: health and social care sectors**

Thank you for your letter of 30<sup>th</sup> October 2020 in which you request a further contribution to the Committee's work in the above area by 11<sup>th</sup> December 2020.

For clarity, I should state at the outset that my response (as with my contribution on 5<sup>th</sup> March 2020) is based upon my personal experience at senior leadership level within Scotland's Public Services. It does not carry any corporate endorsement or formal representative status within the health and care sector. I hope that the Committee will nevertheless find these additional thoughts helpful.

As you may recall, when I appeared as a witness on 5<sup>th</sup> March 2020, I focused my contribution on the issue of leadership, leaving the topic of wider workforce challenges to those witnesses who were better placed to speak as experts. I shall maintain that focus in this response also.

In your letter, you pose three questions and I have used these questions to shape this response:

#### **1. How has the pandemic impacted on your views on leadership and workforce challenges in the health and social care sectors?**

- In the Committee's earlier work, the Auditor General's published insights into the nature of the sector's leadership challenges were highlighted. The Committee specifically noted the following extract from the joint Auditor General and Accounts Commission report <https://www.audit-scotland.gov.uk/report/health-and-social-care-integration-update-on-progress>. The report states that "*top down leadership, which focuses on the goals of a single organisation*" cannot work in the context of Integration. It goes on to highlight the need for system leaders who have an ability to bring a perspective from the wider system and who "*recognise that it is necessary to*

- *distribute leadership responsibilities to bring about change in a complex interdependent environment*". I start here because these insights have application beyond Integration and have also been clearly demonstrated by the sector's response to the pandemic. The health and care sector's response to the pandemic has been most effective where it has been system-wide in its scope and collaborative in its delivery. **A core role for leaders in the future will be to preserve and nurture these two key characteristics.**
- In my verbal contribution to the committee on 5<sup>th</sup> March 2020, I drew a distinction between the apparent shortage of candidates choosing to seek promotion to the top tiers of Health and Social Care leadership and a leadership capability deficit within the workforce. I advised against conflating these two issues and offered a view that Scotland had a challenge with the former, not the latter. On the evidence of the strong contribution from that cohort of colleagues over the last nine months, I remain convinced that we are not dealing with a capability deficit here. **The leadership challenge was, and remains, how to render these senior leadership roles more attractive to this talent pool.** See below.
- At the evidence session on 5<sup>th</sup> March, I suggested that without stronger evidence of system reform, some senior leadership roles may appear "undoable" and therefore unattractive. Over the last nine months, a significant level of system reform has in fact taken place, largely necessitated by the pandemic. **If this reform is sustained and built upon after the pandemic, it will help to make these senior leadership roles more attractive to potential candidates.**

## 2. What lessons can be learned from this experience?

- This experience has shown us that our health and care system is capable of moving at speed; of uniting in response to extreme challenges; of working effectively across boundaries; of leading and delivering collaboratively for a sustained period. **Crucially, these collective endeavours have been focused on a small number of shared goals.**
- These goals have typically been articulated in terms of crosscutting population health and wellbeing outcomes. In other words, the pandemic provided a catalyst for our health and care system – and the people in it – to behave in a way more in keeping with the spirit and aspirations of the National Performance Framework. This resonates strongly with the Auditor General observation quoted above on the inadequacy of top down management focused on the goals of a single organisation. There is much food for thought in this point as we consider how to remobilise our systems and reset frameworks for accountability in a post pandemic world. For example, existing accountability frameworks typically include numerous targets, set at the level of a single institution or sector. **Is there an appetite to reframe these to incentivise and track progress towards a smaller number of collaborative goals that may ultimately be of greater value to the people of Scotland?**
- As an indirect consequence of the pandemic, we have learned to recognise when something is "good enough" and to run with that in order to achieve rapid implementation. We have done so whilst moving flexibly towards learning and improvement thereafter. Such agility (of mind set, as well as of delivery mechanisms) does not generally characterise large, complex public service operations, but these

more agile characteristics have been apparent throughout our response to the pandemic. This is a feature that should be retained in our post-pandemic return to business as usual. If this is to happen, we must first of all develop a shared understanding of the conditions that have enabled such rapidity of service design and implementation. For example, such a shared understanding is likely to identify the desirability of an environment that maximises the level of “subsidiarity” of decision-taking. **Agreement on a fundamental design principle of this nature would in turn allow us to define the leadership behaviours and performance frameworks necessary to achieve this.**

### 3. How can we move forward?

- I have indicated in the course of my response to Questions 1 and 2 above, those aspects of pandemic-related learning and practice that merit being retained and built upon in the future.
- Beyond this, I would strongly advise that a structured evaluation is scoped and commissioned across the health and care sector. The purpose of this would be to identify, understand and agree the system and leadership learning that should inform our planning and delivery in a post pandemic world. There is undoubtedly much rich learning to be had and a proactive approach to its distillation and dissemination will be essential if its true benefit is to be fully realised.
- Lastly, I enclose a link to a Carnegie Foundation report published this week; [\*The courage to be kind: Reflecting on the role of kindness in the healthcare response to COVID-19\*](#). The report describes some individual experiences of working in the NHS in Scotland during the pandemic and offers some extremely thoughtful observations about what these experiences might mean for Health and Social Care Renewal. It offers a powerful reminder of the human dimensions of leadership and of individual and organisational performance. I hope it will enrich the committee’s consideration of these important issues.

I am grateful for the opportunity to contribute to this work and thank the Committee again for the invitation to do so.

Yours sincerely



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