Leadership in a matrix
A personal view from Ciarán Devane, commissioned by the NHS Confederation
The voice of NHS leadership

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Foreword

The need for exemplary leadership in the NHS is greater than ever. The NHS faces its biggest ever challenge of a £20 billion productivity requirement, the huge pressures facing the social care system and the need to drive up quality of care and health outcomes, all set amidst a time of immense change, which will see a new system in place from April 2013.

In response to this significant challenge, it is clear that there is a desire from leaders across the system to work closely together to build a shared leadership approach, using and developing a variety of leadership skills.

This paper is the first in a series which will explore in detail the needs of healthcare leaders in the new system. We have asked respected and influential leaders from the NHS, public sector, voluntary and private sectors to share their personal insights into leadership throughout the run up to the 2013 NHS Confederation annual conference and exhibition. The series aims to stimulate discussion about the importance of leaders being able to adapt to working in the new system by developing new skills, building trust, leading through influence and acting courageously. We will also discuss what steps will need to be taken to ensure these skills are developed for the future.

This paper was authored by Ciarán Devane, who has served as Chief Executive of Macmillan Cancer Support since May 2007. He also serves as a member of the Cancer Outcomes Strategy Advisory Board and the National Stakeholder Forum of the NHS. Ciarán co-chairs the National Cancer Survivorship Initiative, sits on the board of the National Council for Voluntary Organisations and is a trustee of the Makaton Charity. In January 2012, Ciarán Devane was appointed as a non-executive director of the NHS Commissioning Board Authority.
What is a matrix organisation?

Matrix organisations are grid-like organisational structures, commonly used in the management of large projects and product development processes, drawing employees from different functional disciplines for assignment to a team, without removing them from their respective positions. Emerging from the aerospace industry of the 1960s, where government contracts required a project-based system linked to top management, the model has since been adopted by many organisations, including several multinationals. It is credited with allowing these companies to address multiple business dimensions such as function, product and geography, using multiple command structures.

The main reasons given for organisations adopting the matrix model are:

- it allows companies to establish economies of scale
- it allows companies to focus on multiple business goals
- it facilitates the management of information
- it speeds up the response to environmental demands.

The matrix can take many forms, but the balanced matrix is often described as the classic model by which the matrix is known. It features employees who are members of two organisational dimensions and who report to two managers. Project managers take responsibility for defining what needs to be accomplished, while functional managers define personnel staffing and how tasks will be accomplished.

Leadership in a matrix

Moving from hierarchies to a matrix system

The NHS has long been a hierarchical place. Edicts developed by ministers were passed to Quarry House in Leeds. The headquarters of the NHS passed on the instructions to the strategic health authorities (SHAs), who passed them on to primary care trusts (PCTs), who told the trusts and practices. Depending on some combination of ‘grip’, capability and willingness to comply, things happened.

The new world is not like that. In a world of matrix organisations operating in a system in which there is no ultimate authority, you can be accountable for delivery, but not own the resources to do so. You might be told some task is the top priority for your organisation, but find you are working with a colleague from a different component of the system, without whom nothing will happen, but who does not have the vaguest reference to it in their objectives. And you have no ability to instruct. Leadership is through influence, not authority. It is leadership across boundaries, not only without authority, but without visibility.

Moving from one world to another can be unsettling. One former NHS chief executive, finding himself in a matrix organisation, declared that, “the problem with our matrix is it is not clear which arm of the matrix dominates.” Which precisely misses the point.

Moving out of an organisation Henry Ford would approve of, what support should an effective leader be given to operate in a literally anarchic world with no higher authority to mandate the solution?

Learning from others

Fortunately, matrix working is a well trodden path. Multinational companies are the most common three dimensional matrix. National managers, product managers and functional managers have to reconcile their competing objectives to determine the corporate plan, which integrates disparate, but equally legitimate, views.

Simon Dingemans, chief financial officer of the pharmaceutical firm GlaxoSmithKline, a multinational company which uses the matrix organisation structure, has outlined the key success factors critical to driving greater value for their business.

The multinational – lessons from GlaxoSmithKline (GSK)

Simon Dingemans explains: ‘There are three simple principles that we employ consistently across the organisation. Firstly, there must be clear organisational goals, then clear and stated alignment to those goals by the functions within the matrix. This ensures that the organisation is focused on delivering the right things. Secondly, teams must be empowered to allow decision-making at the right levels to enable slick and efficient delivery to the stated goals. Finally, established networks must be created to enable matrix leaders to engage with the right people at the right times; this is what gets the job done.

‘Leadership is through influence not authority. It is leadership across boundaries, not only without authority but without visibility’
“As leaders, we need to invest time to ensure that the organisation is set up in the right way to take advantage of the matrix model. It is important to ensure that responsibilities aren’t blurred, that accountability is clear and that teams are empowered and supported from the top to drive outstanding results. This is becoming increasingly important to us as the drug development and regulatory landscape becomes more complex.”

Matrix working is deployed extensively across GSK and is regarded as having a very positive impact on project teams. Kathy Rouan, a medicines development leader at GSK, outlines the benefits, opportunities and challenges that matrix working brings for her.

“Rather than teams being beholden to multiple layers of decision-making, we have put trusted and accountable leaders in charge of small teams. We have given them budget and influence over who sits on their teams, and empowered them to make the decisions necessary to progress an asset through the development lifecycle. Only at major investment decision and value inflection points do we need to seek committee approvals.

“I have real support from the top to achieve my goals. Projects are very important at GSK; this is a clear statement in our strategy and now a robust organisation is set up behind each project. Every project is run by a talented individual who is empowered to deliver. While vision, strategy and alignment are essential to ensure that everybody is working towards the same goals, it is also critical to have the right behaviours in your matrix team to deliver on those goals.

“The desire to collaborate and communicate, confidence in making decisions autonomously and an ability to genuinely work as part of a team are vital attributes. We are a small, focused team working towards the same goals, committed to the success of our project.

‘Truly empowered people are at the heart of an organisation of the calibre of GSK. The matrix environment allows them the flexibility and the autonomy to deliver results’

“As a matrix leader, none of my team reports directly to me, but I still view myself as a developer of their talent; you have to embrace some of the elements of a line manager to ensure people continue to grow and develop.

“There are of course challenges. Scalability is the most profound test of the model. Developing drugs across multiple countries, involving a growing number of specialisms, is becoming much more complex. As the size of the portfolio grows, you have to put greater trust in your teams – when you’re dealing with 30 to 40 projects it can be a challenge to resource them all at the same time with people at the right level. This is where strong line management plays a key role in supporting the matrix.”

Simon Dingemans’ conclusion is that the three factors critical to driving greater value for the business are:

• alignment with a clear goal
• the autonomy to make decisions
• a managed process of engagement.

He concludes that: “It may sound like a cliché, but truly empowered people are at the heart of an organisation of the calibre of GSK. The matrix environment allows them the flexibility and the autonomy to deliver results. Ultimately, allowing our people to give their best is what delivers the medicines which improve the quality of patients’ lives.”
The key insight
As Simon Dingemans describes, the better multinationals have made an important leap in understanding by realising that you do not create good matrix working by providing increasingly clear guidance as to the relative roles, rights or decision-making powers of the actors in the drama. The variability in geography, products and priorities, but above all in people, makes that futile. Furthermore, his conclusion implies that those matrix organisations which do not empower their people are the least effective, because how to make a decision is difficult to work out.

The boards of the companies who do this well achieve two things. First, they make sure each individual is clear about their overall goals, and the individual understands that they are themselves responsible for deciding the method for accomplishing these goals, within the confines of the law, ethics and brand. But the critical step is the recognition that competing points of view will not reconcile themselves and what is required is a consciously designed conflict resolution process, usually positioned as a planning process which is able to integrate the different points of view. This process can best be explained by giving an example of a typical planning process.

Conflict resolution in practice
Imagine we are dealing with a fertiliser company. At one point in the year, the common data set on which decisions will be made is agreed. How many acres of wheat will be sown in Canada? What will the price of raw materials be next year? Will Russia be in the market? Will China be shifting lots of rice at low cost?

The first step of the process then is to agree the data on which later decisions will be made. The second, later intervention is to agree the decision criteria and non-negotiable priorities.

Countries which have growing future demand for fertiliser will get the first call. Every country will launch the new super fertiliser the lab invented.

Only as a third, separate and facilitated step, is the debate held to develop the holistic plan. The rule is that collective judgement can only be made using the agreed data and agreed criteria.

The advantages are obvious. Separating the steps and agreeing the uncontroversial up-front bounds the debate, builds relationships and focuses on the critical. The implication for an organisation’s leadership is profound. The biggest barons do not get their way. It is those most skilled at conflict resolution. And the true power is with the person who facilitates the process. As Mike Standing of the Monitor Company suggests, reducing complexity is important, but without the process to integrate and the skills to do so, success is unlikely.

Principles for building matrix organisations
Mike Standing, the senior partner in Europe of the Monitor Company, gives a more theoretical view of matrix management, in the context of NHS reform. He suggests that matrix structures are critical to organisations which need to build specialist capabilities and then integrate these skills and points of view to achieve their objectives. He highlights three principles reflecting the experiences of professional service firms operating matrix organisations. Although transferring best practice from one sector to another can be problematic, one can see that there are important parallels between the challenges facing these organisations, the solutions they have adopted and the issues facing the NHS.
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Lessons from the professional services industry

**Build the matrix structure around only two axes**
The discipline to limit the number of axes in a matrix structure is challenging because in many organisations, such as professional service firms, there are often more than two dimensions of the organisation which need to work together. In these firms, regions or countries are responsible for managing people, content units develop new products and account managers address the needs of customers. As a result, occasionally these firms attempt to build matrix structures with three axes which can increase management complexity, cause poor decision-making and increase overhead costs. Limiting the number of axes requires real choices, and a clear understanding of where value is created.

All professional service firms require content, but today the critical issue is either applying content to meet the client needs (the role of the account manager) or maintaining capabilities and managing the deployment of professional staff (best performed by regional management). As a result, most professional service firms are structured around two axes: clients and regions. Content development is integrated into one of the other axis and does not have the same influence.

One thing to be very wary of is the relative power of the arms of the matrix. In a professional services firm, one can legitimately say most value is driven by using one’s people well, or alternatively by servicing clients single-mindedly. One arm of the matrix is paramount. But where the matrix exists not so much to manage a capability, but to represent points of view, to have one arm dominate is to negate the reason for having a matrix in the first place. In this case, the integration of the matrix is the defining requirement.

‘If there is a robust process, then developing a good plan is not dependent on having uniformly enlightened leaders who instinctively do ‘the right thing’’

**Focus on building processes to support the integration of the two axes of a matrix structure**
Successful matrix organisations clearly define the roles, responsibilities and decision rights of managers in the two axes, which they reinforce through supporting metrics. This helps to ensure everyone has an understanding of how their activities fit into the broader purpose and how they connect to other tasks.

More importantly, they also recognise that different teams have different behaviours and can have divergent views. As a result, in addition to implementing clear decision rights, they also invest in team alignment and joint problem solving skills. Only through the combination of clearly designed roles and the development of effective teams at the intersection of the matrix can matrix organisations work effectively.

**Build leadership skills to manage and integrate the axes of the matrix organisation**
In professional service firms, senior executives are expected to have experience in managing both axes of the matrix – client management and regional management – prior to being appointed to a senior role. Criteria for promotion place emphasis on the ability to work collaboratively across different parts of the organisation. Building these skills is critical both to ensuring that the senior executive can make decisions which maximise the effectiveness of the matrix, but also to making sure they are seen as credible leaders across the whole organisation.
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The new architecture of the NHS

Which leads us to the new NHS architecture in England. Consider how this looks locally. Rather than national managers, product managers and functional managers, we now have clinical commissioning groups (CCGs), health and wellbeing boards (HWBs), and commission board areas (CBAs). The first has a legitimate clinical view, the second a legitimate local one, the last has a legitimate duty to drive outcomes. Add in providers, voluntary organisations and regulators, and the art of multi-party negotiation becomes a core competence each organisation needs to develop.

The new NHS architecture needs to develop the equivalent to our multinational’s planning process – one in which there is a shared understanding of outcomes and population data, where decision criteria and priorities are developed, and the disparate views are formed into a plan.

The importance of this process cannot be overstated. First, a plan which incorporated the views of the CCG, HWB and NHS Commissioning Board is likely to be a good one. More importantly, if there is a robust process, then developing a good plan is not dependent on having uniformly enlightened leaders who instinctively do ‘the right thing’. If the process is good, you can get away with having a bad national or product manager in the odd place and still have a good plan. With an NHS of about 211 CCGs, 150 HWBs, 27 CBAs and several hundred providers, Nigel Edwards, the policy expert, would remind us we must not demand a system which relies on every leader being above average.

Investment in leaders

Having said we must not create a system dependent on having exclusively great leaders, it would be quite good to have as many as possible. We need to invest in helping the already good leadership in health to adapt to the new world in which authority is replaced by influence. To some degree, this is about shades of skill. No NHS leader ever relies entirely on their right to instruct or to demand. But the option is there if one is in the management line. If you are not in the management line, that option is never there, and you can legitimately be ignored. That will be an uncomfortable feeling for those who are used to authoritative roles.

The voluntary organisation – leadership through influence

My own organisation, Macmillan Cancer Support, is a good example of leadership through influence. In size, we are one 60th of the cancer budget, so while we aspire to do a lot directly, much of what we do is to use our £100 million of charitable expenditure to help shape the use of the £6 billion of public money spent on cancer. We talk about being a force for change as well as being a source of support.

In our influencing, we apply some mental models to our work. Management theory talks about the rational, emotional and political aspects of leadership. Within Macmillan, as in all leadership roles, my team and I will move constantly between all three aspects.

‘The new NHS architecture needs to develop the equivalent to our multinational’s planning process – one in which there is a shared understanding of outcomes and population data, where decision criteria and priorities are developed, and the disparate views are formed into a plan’
But we do notice how we are different outside. Internally, we like to believe we are broadly rational. We use evidence, point to precedent and align with our strategy ‘route map’. On the other hand, at the end of the day we can cut the conversation, make a decision and tell people to get on with it.

Outside Macmillan, we cannot tell anyone to do anything. So our evidence needs to be empathetic and our insights new to the people we are talking to, so that they learn something which could change their perception. Our rational ‘leadership’ needs to be really robust. We speak of thought-leadership as an enabler of trust, since that trust is created through the credibility that insight gives you, as well as intimacy through being known, and through a record of success which addresses perceived risk.

In the absence of ‘political’ authority, we deliberately work with others to establish communities of influence, the best recent example being the Richmond Group of leading health charities. The community of influence model underlying the Richmond Group is underpinned by the work of Donaldson, Lank and Maher, with its talk of actively planning the ‘social life’ of the document a group produces, making the invisible examples of good practice visible, and bringing people of different characters together for the long haul.

The Richmond Group came together to drive change through a communications plan expressing dissatisfaction with the present, in which we felt there was a lack of parity of esteem for the patient voice in NHS reforms, and presenting an attractive vision with a consensus definition of high-quality, patient-centred, cost-effective care and a commitment to support the NHS through the pain of transition. In management words, our communications plan deliberately mimicked Beckhard’s ‘change equation’.

Beckhard’s change equation

The Formula for Change, which was simplified by Kathleen Dannemiller to \((D \times V \times F > R)\), was originally devised by Richard Beckhard and David Gleicher to provide a model to assess the relative strengths which will affect the likely success or failure of organisational change. The revised formula expresses the notion that in order for meaningful organisational change to take place, then the product of Dissatisfaction \((D)\) with the status quo, multiplied by the vision \((V)\) of what is possible, multiplied by the first \((F)\) concrete steps that can be taken, must be greater than the resistance \((R)\) to change. If any one of these components \((D,V\text{ or } F)\) is absent or low, then the overall product will not be capable of overcoming the resistance to change and change will not be possible.

Therefore, in its influencing role, Macmillan seeks to create and talk about exemplar services for their own sake, shape the £6 billion of cancer spend, and influence the larger £122 billion of UK health expenditure. And without the authority to dictate, we need to do this by consciously managing how we interact with the other components of the ‘system’.

In praise of anarchy

The major distinction between this external engagement of Macmillan and the internal matrix organisational issues identified by Simon Dingemans and Mike Standing, is that in the system there is no higher authority, no ultimate boss who will arbitrate or dictate, no rulebook which can be used by a referee. This is the literal definition of anarchy. The upside is freedom from people telling you what to do. The downside is the inability to get things done without the acquiescence or support of others.
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If one skill needed in the complex world of the new NHS is conflict resolution, the other is multi-party diplomacy – the skill of not only resolving issues through an agreed process to come to the common solution, but doing so when the process itself has to be negotiated, when several legitimate views are at the table and when there is no reason to believe everyone actually wants an agreement.

**Political theory**
The masters of maintaining order in the face of anarchy are of course our politicians – local, national and international. Convincing us all to believe in the law, have confidence in the pound, or accept shutting the hospital ward, is a political skill. How conflict is resolved in an anarchic system is the subject of three competing theories and, in practice, all three play a part.

**Realism** at a basic understanding would say that all organisations will behave the same way in a given situation and that relative power determines the result. So, someone might have a nice idea but if they haven’t got any money while someone else does, then the latter person’s idea will win. Realists believe in large armies and London teaching hospitals.

**Institutionalism** says organisations will pool ideas and sovereignty for the greater good if a credible institution exists where complex trade-offs are made and what they lose today will be made up in the future. Institutionalists believe in the United Nations and clinical networks.

**Constructivism** believes we are a product of our past and what happens depends on who is in charge and where they came from. Constructivists believe in history, culture and organisational development programmes from the NHS Leadership Academy.

The reality, of course, is that all three models apply in politics as they will in the new NHS.

‘NHS leaders will need to be adept at building cross-boundary teams, at inspiring people to follow them based on their thought leadership, clarity of vision and credibility’

Three competing world views co-exist, and success requires accepting the truth in each. The skill will be to know when to apply each one or, more precisely, how to manage the interplay of all three. This poses several questions, such as: How do you draw a large foundation trust into a negotiation, balance their presumed power and enforce compliance? How will a network earn the confidence of the health economy to reconfigure a pathway? How will ingrained ‘tribal’ behaviour be managed?

**Building the capabilities of NHS leaders**
Holding the complexities of an anarchic system in one’s head has not been a requirement of a typical NHS leader. But it is the experience of your average local authority chief executive. Dealing with a multi-party council with a cabinet structure, trading off the school, the housing association, the police and leisure service, is their bread and butter. It is reasonable to expect the council chief executive to be good at the health and wellbeing board process and at the Joint Strategic Needs Assessment (JSNA). NHS managers may not think in terms of the theory of political relations but others around the table will.

Equally, NHS leaders will need to be adept at building cross-boundary teams, at inspiring people to follow them based on their thought leadership, clarity of vision and credibility. This is not new to any of us, but it is different in degree. Being insensitive to those differences will risk failure – failure in one’s new role and also failure of the new system.
System regulation and system values

There are forces which bind systems together. Regulation is one, and health is a heavily regulated sector. Despite Harry Cayton, the regulator’s regulator, wishing for ‘right-touch regulation’, we seem to either have too much regulation, as in multiple regulators visiting the same provider, or too little, as in the failure of self-regulation by some professions.

The best regulation must be a mix: self-regulation as a way of ensuring professional standards, peer review as a learning vehicle for sharing good practice, minimum standards and essential rules enforced by interventionist external regulators.

On top of any system is contract law, which says: “I want you to do this, it is in the contract and I can enforce it.” In health, this applies to commissioning frameworks, data capture and waiting times. Failure to comply with these means sanctions, publicity and professional disapproval.

Yet the health system, as much as the free market system, actually does not rely that much on law or regulation. If you fall back on either of these, you are already in trouble. Just as a matrix organisation operates on influence not authority, a complex system operates on trust not enforcement of rules. The test is whether you trust the individual or organisation to act correctly, not because they are regulated, but because you believe they will still act correctly when no one is looking. This is also the real lesson of Mid Staffordshire. Frontline supervision should be expected and trusted to behave well, and leadership should act to promote that.

Rules, instinct and behaviour creates trust

Ed Smith, formerly senior partner at accountants PwC and now a non-executive director of the NHS Commissioning Board, as well as Pro-Chancellor of the University of Birmingham, points to a Work Foundation document he and Richard Reeves, formerly director of the Intelligence Agency, produced in which they consider whole-sector leadership and regulation.

Organisations need to be trusted to succeed and many organisations are losing that trust. Real trust is delivered by self-regulation and by peer regulation. While external regulation has its place, it risks over-emphasis on the technical rules and crowds out what are essentially moral principles.

Ed points out that trust is awarded to organisations which trust themselves, which are seen to have processes, especially regarding people, which are trusted internally. External reputation and internal people processes are manifestations of the same thing. Culture, which does include rules, but also instinct and behaviours, drives this trust. Focus too much on the rules and organisational integrity loses out because the application of the organisational ‘conscience’ is compromised. Sadly, when something untoward happens and we all demand that ‘something be done’, the default is more rules and often the wrong regulation.

The right answer is harder to deploy. As a leader, the rational rules need to be complemented by your work on organisational...
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instinct and behaviours. If your diary were analysed, would it demonstrate a balance and show that you and your senior team were spending sufficient time on people strategies? Would your own behaviours pass scrutiny, and are they truly consistent with the espoused behaviours of the organisation, i.e. your espoused behaviours as a leader? Moreover, would someone who is not your appointee, acolyte or accomplice say the same? The final test is whether you can show you are driving everything from customer service to patient experience to innovation to efficiency by putting people and behaviours at the heart of how you do it.

Ultimately, Ed Smith says the future is about real trust. It is about knowing you are dealing with Kant’s honest shopkeeper who, even when they could short change you without you noticing, does not. Without that trust, systems do not work and the new NHS architecture won’t either.

‘The final test is whether you can show you are driving everything from customer service to patient experience to innovation to efficiency by putting people and behaviours at the heart of how you do it’

Conclusion

So, where does this romp through matrix organisations, anarchic systems and sector values get us?

For me, three implications stand out. The first is the need for the ‘system’ to build the capability to operate in the new way. An organisational development intervention which is well structured, available to all and consistent over time is required. It is right for the NHS Leadership Academy to host this for the broader NHS.

Secondly, individual leaders should ensure they have read around the topic of matrix management and system leadership. Core skills in the new world, such as conflict resolution and multi-party negotiation skills, will be essential, as competencies in these skills will define who will succeed and who will not. A reading list is below.

Finally, effective system leaders will need to truly understand the different parts of the system. Experience as a provider and as a commissioner should be a requirement of promotion in the major system players. All will need to build trust, which will include building trust in themselves, in their organisations and in the ‘brand’, which is the NHS system. Wide experience will facilitate that trust.

How to deliver this agenda is a topic for another discussion on another day, but having the debate should be an urgent priority.

It may be an exaggeration to say the world will be wildly different, but as the chief executive of a matrix organisation, operating in a system where we influence without authority, I know that many of those joining Macmillan from hierarchical organisations failed to thrive in their roles if they did not develop the new
skills. The difference is real and is potentially damaging to people and careers.

NHS leaders of the future – managerial, patient and clinical – will be working across systems and organisational boundaries. Patient outcomes will not be delivered by only working well within our own organisations, be it a CCG or a trust. The duty of care as an employer applies and all of us have a duty to staff to help them succeed. This is never more true than now, as thousands of our NHS colleagues seek new roles. Let us hope all parts of the new English NHS invest accordingly.

Ciarán Devane, November 2012

**Contributors**

Ciarán Devane – Chief Executive, Macmillan Cancer Support

Simon Dingemans – Chief Financial Officer, GlaxoSmithKline

Ed Smith – Pro-Chancellor, University of Birmingham

Mike Standing – Senior Partner, the Monitor Company
Top ten learning points

1. The success of a matrix organisation is not necessarily based on defining the roles, rights or decision powers of the actors in the matrix. Instead, it is about ensuring that people are absolutely clear about their own objectives and ensuring that they have the autonomy to decide how to meet those objectives themselves.

2. There should be a focus on building processes to support the integration of the axes of a matrix structure. This ensures that everyone in the matrix understands how their activities fit into the broader objectives. Furthermore, it means that the different teams can understand the differing views and behaviors of the other teams.

3. The new NHS architecture needs to develop the equivalent to a multinational’s planning process – one in which there is a shared understanding of outcomes and population data, where decision criteria and priorities are developed, and the disparate views are formed into a plan.

4. Investment is needed to help the already good leadership in health adapt to the new world in which authority is replaced by influence. Leaders will need to get used to not being able to use their rights to instruct or demand. Instead, they will require the skills to lead through influence.

5. NHS leaders will need to be skilled at multi-party diplomacy, which not only involves coming to solutions, but which will often involve having to negotiate the process itself.

6. NHS Leaders will need to be adept at building cross-boundary teams, inspiring people to follow them based on thought leadership, clarity of vision and credibility.

7. A complex system like the new NHS will operate on trust rather than enforcement of regulations or contract law. Frontline staff should be expected and trusted to act well, and leadership should act to promote that.

8. Leaders need to put people and behaviours at the heart of what they do, because it is these factors which drive trust. Without that trust, systems do not work and the new NHS architecture won’t either.

9. Effective leadership requires real understanding of the different parts of the system. Experience as a provider and as a commissioner should be a requirement of promotion in the major system players.

10. All the new players in the NHS will need to build trust in themselves as leaders, in their organisation and in the ‘brand’, which is the NHS.
Useful resources


The NHS is facing its biggest ever challenge, with the £20 billion productivity requirement alongside the huge pressures facing the social care system and the need to continue to drive up quality of care and health outcomes. In response to this significant challenge, it is clear that there is a desire from leaders across the system to work closely together to build a shared leadership approach, using and developing a variety of leadership skills. The need for exemplary leadership in the NHS is therefore greater than ever.

This paper, the first in a series which will explore in detail the needs of future healthcare leaders in the new system, is written by Ciarán Devane. He calls on NHS leaders to build a different set of core skills, covering conflict resolution and multi-party negotiation in order to lead through influence.