Welcome to the Launch Event of the Centre for Healthcare Innovation Research!

Embedding Innovation in Healthcare

Chair: Dr Amanda Goodall, Cass Business School

30 October 2019
Introducing: The interdisciplinary Centre for Healthcare Innovation Research (CHIR)

Created in January 2019 by Cass Business School and School of Health Sciences at City, University of London
Brings together our health-related innovation research

On applied vision, food policy, health service provision, language communication sciences, maternal and child health, and mental health.

On health technology & digital innovation, strategy and change processes in healthcare systems, clinical and medical leadership, health insurance and health analytics.
18:00-18:05 Introduction to the Launch Event
Dr Amanda Goodall, Cass Business School, City, University of London

18:05-18:10 Welcome Address
Professor Andrew Jones, Vice-President (Research & Enterprise), City, University of London

18:10-18:30 Introducing CHIR - A New Interdisciplinary Approach
Dr Charitini Stavropoulou & Professor Harry Scarbrough, Co-Directors of the Centre for Healthcare Innovation Research (CHIR), City, University of London

18:30-18:55 The Challenges of Embedding Healthcare Innovation at Scale
Professor Trish Greenhalgh, Professor of Primary Care Health Sciences, University of Oxford

18:55-19:20 Leading Healthcare Innovation
Professor Marcel Levi, Chief Executive, University College London Hospitals & Professor of Medicine, University College London

19:20-19:30 Concluding Remarks
Professor Zoe Radnor, Vice-President (Strategy & Planning), City, University of London

19:30-20:30 Reception & Networking
Welcome & join in!

The Centre for Healthcare Innovation Research (CHIR) is funded by City, University of London.

- [email] city.ac.uk/chir
- [email] CHIR@city.ac.uk
- [LinkedIn] CHIR LinkedIn Group
- [Twitter] @CHIR_City
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Introducing CHIR
A New Interdisciplinary Approach

Prof Harry Scarbrough, Cass Business School
Dr Charitini Stavropoulou, School of Health Sciences
CHIR Co-Directors

CHIR Launch Event, 30th October 2019
Why CHIR?
The challenge of embedding innovation

In practice, transferring even simple innovations from one NHS organisation to another is a complex process requiring adaptation, testing and re-evaluation.

King’s Fund, 2018

Almost everything in the NHS long-term Plan is already being implemented successfully somewhere in the NHS. Now the challenge is how we get it implemented everywhere.

Tim Horton, Health Foundation, 2018

Innovative companies in the private sector (Apple, GE Healthcare…) typically spend 2-3 times as much on disseminating innovations than their development.

In the NHS it is the reverse: £1.2 billion for R&D, £50m for adopting/spreading innovations.

Nuffield Trust, 2018 & King’s Fund 2018
What do we mean by Innovation?

- Technologies
- Medication
- Treatments
- Service users
- Organisation and management
- Service delivery models
- Professional roles
What do we mean by *Embedding Innovation*?

- Development
- Research
- Implementation in healthcare practice
- Population-wide spread
- Sustainable Implementation
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What do we mean by *Embedding Innovation*?
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**Diagram:**

- **Spread**
  - HIGH
  - LOW

- **Implementation**
  - LOW
  - HIGH

**Top-down innovations**

**EMBEDDING INNOVATIONS**

**Innovation**

**Pilotitis**
What do we mean by *Embedding Innovation*?
The need for an interdisciplinary approach

Embedding innovations is an interdisciplinary problem - involves an understanding of the innovation and implementation processes, how organisations work, professional disciplinary perspectives, a ecological/system’s perspective.
What is CHIR?
What is CHIR?

CHIR

Education

Research

Community
What is CHIR?

CHIR
Core Team
What is CHIR?
Research: systematic reviews

- Conceptualisation of diffusion and spread of healthcare innovations
- Conceptualisation of successful and sustainable implementation of healthcare innovations
- Developing an external implementation context framework
- Role of service user and public involvement in different healthcare innovation stages
Research - Empirical projects

Learning from the AHSN’s experience to successfully spread innovations in the NHS

*Key partners:* NHS Accelerated Access Collaborative, UCL Partners

The challenges of translating Artificial Intelligence innovations into front-line practice in radiology

*Key partners:* The Royal Marsden NHS Foundation Trust, Boston University and HEC Montreal, Canada
Research - Empirical projects

The role of patients and the public in embedding innovation in healthcare

*Key partners:* National Voices, NHS England & Improvement

Embedding system-level innovation in China – Medical Alliance

*Key partners:* University of York, Huazhong University of Science and Technology, China, Zhongnan University of Economics and Law, China, University of Alberta
What is CHIR?
Community

CHIR Collaborative
- Includes City scholars interested in innovation research
- Virtual collaboration platform, academic workshops during term time

CHIR Partners
a wider community of stakeholder organisations and research partners including academic institutions, professional groups, service users, companies and policymakers
Community: Advisory Board

Prof Rifat Atun, Harvard University, USA
Dr Amanda Begley, UCLPartners & National Innovation Accelerator
Dr John Craig, Care City
Prof Michel Goldman, II3h Institute, Belgium
Dr Tim Horton, Health Foundation

Prof Marcel Levi, University College London Hospitals
Prof Graham Martin, THIS Institute
Prof. Eivor Oborn, Warwick University
Janice Preston, Macmillan Cancer Support
Shani Shamah, Service user representative
Prof Paul Wallace, Health Innovation Network & DigitalHealth.London
What is CHIR?
Education

MSc Health Management
School of Health Sciences

Executive Masters in Medical Leadership
Cass Business School

We offer: internships, dissertation supervision, projects
How can YOU get involved?
Get involved!

City Scholars
If you are interested in innovation and implementation research, join the CHIR Collaborative!

External researchers, practitioners, policymakers, companies…
- Work with us on collaborative research projects & grant applications
- Help us organise or sponsor roundtables with key stakeholders (funders, service users, practitioners, policymakers)

Students
Contact us if you are interested
- in writing your MSc/PhD dissertation project with us
- in doing a research internship with us
Upcoming events

28 November 2019
5th CHIR Collaborative Workshop
at School of Health Sciences

12 December 2019
Healthcare Management & Services Research Incubator
By Cass Business School & Warwick Business School

4 December 2019
1st CHIR Advisory Board Meeting
at Cass Business School
Keep in touch!

city.ac.uk/chir

CHIR@city.ac.uk (for mailing list)

CHIR LinkedIn Group

@CHIR_City
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Centre for Healthcare Innovation Research Launch event, 30th October 2019

The Challenges of Embedding Healthcare Innovation at Scale

© Professor Trisha Greenhalgh   Funding: Wellcome Trust, NIHR, MRC
EDITORIAL

Studying complexity in health services research: desperately seeking an overdue paradigm shift

Trisha Greenhalgh1,2 and Chrysanthi Papoutsi1,3

How to improve success of technology projects in health and social care

Trisha Greenhalgh4,5

4 Nuffield Department of Primary Care Health Sciences, University of Oxford, UK
5 Corresponding author: www.phc.ox.ac.uk/team/trisha.greenhalgh

ANALYSIS

Infrastructure revisited: ethnographic case study and (re)theorization of the ‘installed base’ of healthcare IT

Trisha Greenhalgh6
Joseph Wherton PhD
Sara Shaw PhD (Acad)
Chrysanthi Papoutsi
Shanti Vijayaraghavan
Rob Stones PhD (PhD)

Development and empirical testing of the NASSS-CAT tools for supporting technology projects in health and social care: co-design and action research study

Trisha Greenhalgh FMedSci (Professor)1
Harvey Maylor PhD (Professor)2

QUALITY IMPROVEMENT

Spreading and scaling up innovation and improvement

Disseminating innovation across the healthcare system is challenging but potentially achievable through different logics: mechanistic, ecological, and social, say Trisha Greenhalgh and Chrysanthi Papoutsi

Trisha Greenhalgh professor, Chrysanthi Papoutsi postdoctoral researcher
An anecdote from Australia

“Trish, you came here 10 years ago and gave us 10 tips for implementing a national e-healthy programme.

Sadly, our government ignored those tips, and that’s why we are now in a mess.”

Comment from audience member at Health Informatics Society of Australia, 2018
Ten insights from my early case study research on NHS IT

1. The bigger and more interconnected the system, the greater will be the interdependencies – and the implementation effort
Ten insights from my early case study research on NHS IT

2. Different stakeholders have different goals, values and priorities. They define ‘success’ and ‘failure’ differently. They need to talk to each other and learn about each other!
Ten insights from my early case study research on NHS IT

3. A. complex system has tensions and paradoxes that are impossible to resolve. These include:
   • national standards versus local contingency
   • ‘rip and replace’ versus ‘much-loved local system’
   • protecting privacy versus making data accessible
Ten insights from my early case study research on NHS IT

4. Knowledge is tacit (personal and informal) as well as explicit (objective and formal)
Ten insights from my early case study research on NHS IT

5. The preferred change model is ‘organic’ rather than mechanistic
6. The programme should therefore include:

- leaders who understand the complexities
- a ‘rolling vision’ and story of what we are doing
- space for learning and reflecting
- competent project management
- reliable performance data fed back locally
- budgets for addressing local contingencies

Ten insights from my early case study research on NHS IT
7. Technical development should be
   • ‘co-creation’ rather than ‘engineering’
   • alert to the subtle and unpredictable nature of clinical work
   • linked to organisational and team development
Ten insights from my early case study research on NHS IT

8. Font-line staff usually want to do their job well. They bring beliefs, values, motives and meaning-systems
9. It is important to engage (and listen to) clinicians. Clinical engagement is an ongoing process, not a one-off.
Ten insights from my early case study research on NHS IT

10. My advice to government is...
   • there is no ‘tipping point’ for big IT projects
   • don’t impose ‘political’ milestones
Complexity
Simple [or complicated] phenomena
- are [more or less] predictable
- are [more or less] solvable by logical means
- can be split up into work packages

Complex phenomena
- are unpredictable
- are inherently unsolvable
- are full of interdependencies
NASSS framework (shown left)

Series of co-design workshops with technology designers, professionals, patients, policymakers

NASSS-CAT tools (shown on next slide)

1. CONDITION
   - Nature of condition or illness
   - Comorbidities
   - Sociocultural factors

2. TECHNOLOGY
   - Material properties
   - Knowledge to use it
   - Knowledge generated by it
   - Supply model
   - Who owns the intellectual property?

3. VALUE PROPOSITION
   - Supply-side value (to developer)
   - Demand-side value (to patient)

4. ADOPTERS
   - Staff (role, identity)
   - Patient (passive vs active input)
   - Carers (available, type of input)

5. ORGANISATION(S)
   - Capacity to innovate in general
   - Readiness for this technology
   - Nature of adoption and/or funding decision
   - Extent of change needed to organisational routines
   - Work needed to plan, implement, and monitor change

6. WIDER SYSTEM
   - Political/policy context
   - Regulatory/legal issues
   - Professional bodies
   - Sociocultural context
   - Interorganisational networking

7. EMBEDDING AND ADAPTATION OVER TIME
   - Scope for adaptation over time
   - Organisational resilience

7. Continuous embedding and adaptation over time

5. Health/care organisation(s)
   Implementation work, adaptations, tinkering

4. Adopter system
   Staff, patients, carers

3. Value proposition

6. Wider system
THE NASSS-CAT (COMPLEXITY ASSESSMENT TOOL)

UNDERSTAND COMPLEXITY
• Tease out uncertainties and interdependencies using narrative as a synthesising and sensemaking device

REDUCE COMPLEXITY e.g.
• Limit scale / scope / interdependencies / pace
• Control programme growth e.g. limit scope creep

RESPOND TO COMPLEXITY e.g.
• Strengthen leadership; build relationships
• Co-develop a vision through collective sensemaking
• Develop adaptive capacity in individuals and resource their creative action
• Harness conflict productively to generate multifaceted solutions
3 versions of NASSS-CAT

<table>
<thead>
<tr>
<th>Short</th>
<th>Long</th>
<th>Supplementary</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-page ‘taster’ version</td>
<td>16-page complexity assessment tool</td>
<td>4-page project monitoring tool</td>
</tr>
<tr>
<td>(semi-quantitative)</td>
<td>(qualitative + quantitative)</td>
<td>(quantitative)</td>
</tr>
</tbody>
</table>

**NASSS-CAT SHORT**

**NASSS-CAT LONG**

**NASSS-CAT PROJECT**

---

**3 versions of NASSS-CAT**

- **NASSS-CAT SHORT**
  - 3-page ‘taster’ version
  - (semi-quantitative)

- **NASSS-CAT LONG**
  - 16-page complexity assessment tool
  - (qualitative + quantitative)

- **NASSS-CAT PROJECT**
  - 4-page project monitoring tool
  - (quantitative)
# NASSS-CAT SHORT – example of domain (illness)

## 1. THE CONDITION

Think about the illness or other condition that the technology is designed for – and what sort of person has that condition.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Disagree</th>
<th>Not applicable or don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are significant uncertainties about the condition e.g. poorly-defined, variable manifestations, uncertain course</td>
<td>![Select Agree]</td>
<td>![Select Disagree]</td>
<td>![Select Not Applicable]</td>
</tr>
<tr>
<td>Many people with the condition have other co-existing illnesses or impairments that could affect their ability to benefit from this solution</td>
<td>![Select Agree]</td>
<td>![Select Disagree]</td>
<td>![Select Not Applicable]</td>
</tr>
<tr>
<td>Many people with the condition have social or cultural factors that could affect their ability to benefit from the technology or service</td>
<td>![Select Agree]</td>
<td>![Select Disagree]</td>
<td>![Select Not Applicable]</td>
</tr>
<tr>
<td>The population with the condition, and/or how the condition is treated, is likely to change significantly over the next 3-5 years</td>
<td>![Select Agree]</td>
<td>![Select Disagree]</td>
<td>![Select Not Applicable]</td>
</tr>
<tr>
<td>SUMMARY: The condition has significant complexity which is likely to affect the project’s success</td>
<td>![Select Yes]</td>
<td>![Select No]</td>
<td>![Select Not Applicable]</td>
</tr>
</tbody>
</table>
3. **THE VALUE PROPOSITION**

*Think about what kind of value the technology might generate for different groups of people. (‘Value’ can be financial, such as profit, or non-financial, such as control of symptoms)*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Disagree</th>
<th>Not applicable or don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>The commercial value of the technology is uncertain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The value to the intended users (e.g. patients, clinicians) is uncertain</td>
<td></td>
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<tr>
<td>The value to the healthcare system (e.g. from efficacy and cost-</td>
<td></td>
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</tr>
<tr>
<td>effectiveness studies) is uncertain</td>
<td></td>
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</tr>
<tr>
<td>The value to this particular healthcare organisation, given the current</td>
<td></td>
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<tr>
<td>situation locally, is uncertain</td>
<td></td>
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</tr>
<tr>
<td>The technology could generate a negative value (costs are likely to</td>
<td></td>
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<tr>
<td>outweigh benefits) for some stakeholders</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>The value proposition is likely to change significantly over the next 3-5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUMMARY: The value proposition has significant complexity which is</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>likely to affect the project’s success</td>
<td>Yes</td>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>
SUMMARY: USES OF THE NASSS-CAT TOOLS

NASSS-CAT SHORT
- Explaining what the tool can offer; trying it out

NASSS-CAT LONG
- Due diligence: deciding whether to invest in tech (e.g. for boards)
- Planning and monitoring a project (e.g. for project managers)
- Supporting a project (e.g. for facilitators / consultants)

NASSS-CAT PROJECT
- Monitoring how subjective complexity changes over time

NASSS-CAT INTERVIEW
- Semi-structured interview guide based on NASSS-CAT LONG
Principles of innovation/improvement under conditions of complexity

- **Acknowledge unpredictability**: Contemplate multiple possible futures
- **Recognise self-organisation**: Expect local teams to tinker and adapt
- **Facilitate interdependencies**: Assess strength of interdependencies; facilitate new ones
- **Encourage sensemaking**: Encourage teams to admit ignorance, explore paradoxes, reflect collectively

**Develop adaptive capability in staff**: Ability to make judgements when faced with incomplete data

**Attend to human relationships**: Teams work together to solve problems using give-and-take

**Harness conflict productively**: Multifaceted solutions born of ‘conflicting’ views
Infrastructure
Infrastructure consists of

- A **material scaffolding** (hardware, software, buildings, rooms, transport links), which we don’t notice until it breaks down
- A **network of relationships** and practices
- We learn it **collectively**, though shared use
- **Patchworked** (new bits are added every year) and **path-dependent** (e.g. constrained by contracts signed in the past)
- Institutionally supported and sustained (e.g. through **standards** and **professional expectations**)

“**Infrastructure is what other things run on**” – Susan Leigh Star
This beautiful, modern,’ simple’ wearable technology for the child with epilepsy....

... must somehow interface with this patchworked, over-regulated and slow-to-change infrastructure
Principles for addressing infrastructural challenges when scaling up:

1. Attend to **material things** (e.g. expect bugs and breakdowns, and prioritize basic dependability over advanced functionality).
2. Take a **system and relational** (as opposed to isolated tool or function) view of the technology.
3. Train teams on the job; bring clinicians and technologists together; and nurture **communities of practice**.
4. Innovate **incrementally** (i.e. in small steps), paying attention to technological and socio-cultural legacies.
5. Take note of **standards** – and ask where these standards have come from and whether there is flexibility to adapt them to local conditions.
SUMMARY

Technology projects are characterized by various kinds of complexity.

Complex systems operate to a different logic: they are inherently unpredictable and their paradoxes cannot be resolved.

The best way to study technology projects is via rich, in-depth case studies.

In addition to studying exciting new technologies, we need to study old, boring things like infrastructure.

The NASSS-CAT tools will help implementation teams and researchers to understand and respond to complexity.
Thank you for your attention

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Leading healthcare innovation

Marcel Levi, MD PhD FRCP
Chief Executive UCLH/ Prof. of Medicine UCL
Consultant Acute Medicine & Haematology
‘... Never has the outlook for the profession been brighter. Everywhere the physician is better trained and better equipped than he was 25 years ago. Disease is understood more thoroughly, studied more carefully, and treated more skilfully…’

William Osler, 1909
Biomedical knowledge

Science 2015
The golden age of medicine
explosieve groei (bio)medische kennis
• What does this mean for our patients?
• Are we sufficiently organized for healthcare in the 21st century?
• Who will be in the lead?
Comorbidity of 10 common conditions among UK primary care patients

BMJ 2012;345:e6341 doi: 10.1136/bmj.e6341
(Published 4 October 2012)
Number of chronic disorders by age-group

The whole is greater than the sum of the parts.
A **subspecialist** knows a lot of his/her specific area of expertise.

**subspecialist** or **superspecialist**?

A **super** specialist has not lost his/her interest in the areas beyond the subspecialty.
**Scope of Roles and Assignments**

- **Specialist**
  - Deep Skills
  - Narrow Scope
  - Peer-Recognized
  - Unknown Outside Domain

- **Generalist**
  - Broad Scope
  - Shallow Skills
  - Quick Response
  - Others Lack Confidence

- **Versatilist**
  - Deep Skills
  - Wide Scope of Roles
  - Broad Experience
  - Recognized in Other Domains

**Depth of Skill**
organisation of hospitals
Hospital volume and mortality

- Colectomy
- Gastrectomy
- Esophagectomy
- Pancreatic resection
- Lobectomy
- Pneumonectomy
- Cystectomy
- Prostatectomy
- Valve replacement
- Liver surgery
- Transplantation
- Short bowel resection
- Spine surgery
- Vitrectomy
- Splenectomy
- Nefrectomy
- .................
re-organisation of hospitals
Effects of Centralizing Acute Stroke Services on Stroke Care Provision in Two Large Metropolitan Areas in England

Angus I.G. Ramsay, PhD; Stephen Morris, PhD; Alex Hoffman, MSc; Rachael M. Hunter, MSc; Ruth Boaden, PhD; Christopher McKevitt, PhD; Catherine Perry, PhD; Nanik Pursani, MA; Anthony G. Rudd, MB, BChir; Simon J. Turner, PhD; Pippa J. Tyrrell, MD; Charles D.A. Wolfe, MD; Naomi J. Fulop, PhD

*Stroke. 2015;46:2244-2251*
Hospital volume and stroke outcome
Does it matter?

Neurology 2017; 69: 1147-56
Leading innovation at UCLH

We want to transform ourselves from a hospital conducting a lot of research into a real research hospital that focuses on gathering new knowledge, creating innovation and improvement, and implementing evidence-driven changes to medicine, healthcare delivery and organisation.

- Translating novel biomedical discoveries into patient care
- Optimising operations
  - Operational processes and clinical service delivery pathways
  - Clinical decision support
- Clinical trial optimisation
- Automated analysis of digital images and digital pathology
- Bringing advanced analytical methods into hospital operations
Who is going to lead this?
A Time for Revolutions — The Role of Clinicians in Health Care Reform

Ara Darzi, M.D.

Feature

Doctors as leaders

BMJ 2009; 338 doi: 10.1136/bmj.b1555 (Published 21 April 2009)

Cite this as: BMJ 2009;338:bmj.b1555

Candace Imison, deputy director of policy, The King’s Fund, Richard W Giordano, senior consultant, Developing Leaders, The King’s Fund
knowledge & responsibility

• Medical care is increasingly complex, so why not leave managerial decisions to the experts

• Decisions are driven by contents, other factors are less prominent

• Professionals are co-responsible for (eg. financial) consequences
Short report

Physician-leaders and hospital performance: Is there an association?

Amanda H. Goodall$^{a,b,c,*}$

Social Science & Medicine 73 (2011) 535–539
2: professionals know the organization better than anyone

- What is going well and what is going wrong?
- How is the atmosphere in the institution and the morale of the staff?
3. Managerial language is not understood by professionals

- Production
- Governance
- Business case
- Transparantie
- Human resources
- Dashboard
- Balanced score
- Management tool
- Business unit
In some institutions the best students are carefully schooled to avoid leadership responsibilities. . . . The plain fact is that all over this country today trouble is brewing and social evils accumulating while our patterns of social and professional organization keep able and gifted potential leaders on the sidelines.\(^1\)

Lessons in management are just what the doctor ordered

Demographic and economic shifts in global healthcare systems present business schools with vast opportunities, writes Sarah Murray.

Seismic demographic, political and economic shifts are demanding radical changes in global healthcare systems.

With administrators under pressure to cut costs, physicians being pushed to work more collaboratively and new technologies on the need of commercialisation, the skills acquired on an MBA look increasingly relevant. For business at a time of increasing demand for healthcare means NHS leaders need to do more with less.

"The current decade is presenting those leading healthcare with the biggest challenges we've seen since the establishment of the NHS," says Chris Ham, chief executive of the King's Fund, a leading healthcare think-tank.

Meanwhile, emerging markets - many of which are still combating infectious diseases and infant mortality - face an additional burden in the rising incidence of conditions such as cancer and diabetes.

Perhaps the most radical changes are taking place in the US. Healthcare in the country - public and private - is now 17.9 per cent of GDP, against
What did I learn about being a professional in the lead?
Learning points

• There is nothing wrong with accidental leadership
• Motivated by a desire to improve the care for my patients and the conditions in which I and my colleagues were working
• It is not rocket science, many previously acquired skills are applicable
• There is a lot of learning on the job
• Some formal education is certainly helpful
• And:
1. It is not about being the boss.
2. It is about enabling your team, taking the lead and responsibility
3. Keep it simple!

\[ 1+1 = \left[ \frac{27}{3} / 3 \right] - 1 \]
4. Authenticity

Be yourself, everyone else is already taken.
5. It is fun to be a leader!

“Some people want it to happen, some wish it would happen, others make it happen.”

-Michael Jordan
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Dr Charitini Stavropoulou & Professor Harry Scarbrough, Co-Directors of the Centre for Healthcare Innovation Research (CHIR), City, University of London

18:30-18:55 The Challenges of Embedding Healthcare Innovation at Scale
Professor Trish Greenhalgh, Professor of Primary Care Health Sciences, University of Oxford

18:55-19:20 Leading Healthcare Innovation
Professor Marcel Levi, Chief Executive, University College London Hospitals & Professor of Medicine, University College London

19:20-19:30 Concluding Remarks
Professor Zoe Radnor, Vice-President (Strategy & Planning), City, University of London

19:30-20:30 Reception & Networking
Keep in touch!

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