**The Culture of Care: Rethinking Leadership in the NHS**

**Introduction**

The National Health Service (NHS) is one of the most iconic and valued institutions in the United Kingdom. Established on the principles of care, accessibility, and equality, it stands as a testament to what a nation can achieve when it puts people at the centre of healthcare. Yet, despite its strengths and historic achievements, the NHS is under pressure like never before.

Waiting lists have reached record highs. Staff shortages, burnout, and industrial action have become familiar headlines. Patient satisfaction, while still high in many areas, is declining. And beneath it all lies a quiet but powerful force that influences every aspect of the system: leadership and organisational culture.

As a healthcare leader with many in the healthcare sector, I have seen how different leadership styles and cultural environments can uplift or hinder teams, shape behaviours, and ultimately impact patient outcomes. I learned through my research journey what many of us working within the system have long suspected, that leadership and culture are not just management buzzwords; they are levers for real, measurable change.

The following is provided as my own personal view based on many years of working in healthcare and also over 5 years of research into leadership, culture and performance in the NHS. It is hoped it may encourage much needed conversations, at all levels, about how we might move forward in the future model of healthcare, whatever that may look like.

Let’s begin.

**Chapter 1: The NHS Today: Pressures, Performance, and People**

The NHS of today is a complex, highly visible, and deeply scrutinised public institution. It is cherished by the British public and often used as a benchmark for national values. Yet, despite its centrality in public life, the NHS is under increasing strain.

**A System Under Pressure**

From spiralling patient demand to funding constraints, the NHS faces systemic pressures that have only intensified in recent years. The COVID-19 pandemic accelerated these challenges, exposing weaknesses that had been developing quietly over time. Emergency departments face unprecedented demand. Ambulance response times have lengthened. Staff vacancies are growing across clinical and administrative roles. The waiting list for routine operations in England surpassed 7 million in 2023.

These operational stressors are more than logistical hurdles; they are human ones. Behind every missed target or delayed appointment is a patient, a family, and a frontline worker under stress.

**Workforce Burnout and Discontent**

Morale among NHS staff is at a critical point. Industrial action by nurses, ambulance workers, junior doctors, and consultants has made headlines. But beneath those protests lie deeper issues: feelings of being undervalued, unsafe working conditions, and a disconnect between those on the ground and those leading from above.

Surveys repeatedly show staff feeling unsupported, poorly communicated with, and lacking opportunities for genuine professional growth. In an environment meant to care for others, too often the carers themselves feel neglected. Leadership, or the lack of effective, compassionate leadership, plays a central role in this dynamic.

**Shifting Definitions of Performance**

Historically, NHS performance has been measured through key performance indicators: A&E waiting times, cancer referral speeds, treatment targets. While these remain important, there is growing recognition that metrics alone don't tell the full story.

Performance in the NHS today must also account for staff well-being, patient experience, inclusivity, and adaptability. How a team functions together, the culture of learning and accountability it fosters, and how leaders respond to change, these are now just as critical as meeting numerical benchmarks.

**Why This Matters for Leadership**

Leaders in the NHS, whether managing a team of five or overseeing a large trust, have an outsized impact. Their ability to set tone, manage expectations, and model compassionate, clear-headed decision-making directly affects both culture and performance.

Yet many NHS leaders are promoted for clinical or operational expertise without sufficient support to develop leadership skills. The result? A disconnect between strategic goals and cultural realities. Bridging this gap is not just desirable, it is essential.

**The Need for Cultural Alignment**

Organisational culture can either support or sabotage leadership efforts. A culture of fear, blame, or inertia makes even the most well-intentioned reforms falter. Conversely, a culture that encourages psychological safety, accountability, and continuous learning can turn struggling teams into high performers.

I will explore how leadership style, particularly transformational versus transactional leadership, interacts with these cultural dynamics. I will unpack how to build cultures that foster not only productivity but also pride, resilience, and genuine care. At its heart, the NHS is not just a system. It is a collection of people doing their best to care for others.

And they need leaders who care for them, too.

**Chapter 2: Leadership in Healthcare: Styles and Consequences**

Leadership is the engine of healthcare systems. In the NHS, it can mean the difference between a team that thrives under pressure and one that fractures. Leadership influences decision making, morale, retention, and ultimately, the quality of care. But not all leadership styles are created equal, and in healthcare, some are far more effective than others.

**Transactional vs. Transformational Leadership**

The two dominant styles often referenced in healthcare leadership are transactional and transformational. These models were first clearly articulated by James MacGregor Burns (1978) and later expanded by Bernard Bass (1985). They represent different philosophies of how leaders engage with their teams.

* **Transactional Leadership:** focuses on structure, order, and rewards. Leaders using this style set clear expectations, monitor performance, and use incentives or disciplinary measures to motivate staff. While effective in maintaining short term efficiency, it can limit innovation and reduce engagement over time (Bass, 1990).
* **Transformational Leadership**: by contrast, inspires and motivates through vision, emotional intelligence, and shared purpose. These leaders foster trust, encourage development, and support change. Research shows transformational leadership is more likely to produce high-performing, resilient healthcare teams (Judge & Piccolo, 2004; West et al., 2014).

In the NHS, both styles are present, often within the same trust or team. However, transformational leadership is increasingly recognised as vital in a high-stakes, human-centred environment.

**Characteristics of Effective Healthcare Leaders**

Transformational leaders in healthcare exhibit certain key behaviours (Bass & Avolio, 1994):

* **Idealised Influence**: They lead by example, acting with integrity and commitment.
* **Inspirational Motivation**: They articulate a compelling vision.
* **Intellectual Stimulation**: They challenge assumptions and encourage innovation.
* **Individualised Consideration**: They recognise the unique needs and potential of team members.

These attributes have been associated with improved patient safety, reduced staff turnover, and higher levels of team satisfaction (Gellis, 2001; Wong & Cummings, 2007).

**Leadership in the NHS Context**

In NHS settings, leadership is not confined to executives. Ward managers, team leads, and senior clinicians all shape team culture and performance. Yet, the system often promotes based on clinical or technical skill, not leadership ability. This results in leaders who may struggle to engage or support their teams effectively (West et al., 2015).

Recent reviews, including the Kirkup Report (2015) and Francis Report (2013), have highlighted failures in leadership as a key factor in poor care and patient harm. These findings sparked a growing call for leadership development that emphasises compassion, listening, and responsiveness , traits central to transformational leadership.

**The Cost of Poor Leadership**

Poor leadership is not just a matter of morale; it impacts outcomes. Research from the King's Fund and Health Foundation has consistently shown that teams with poor leadership experience higher rates of burnout, absenteeism, and patient complaints (The King's Fund, 2020).

Transactional leadership alone, especially when overly bureaucratic, may reinforce the status quo and stifle creativity. In contrast, when NHS leaders model a transformational style, they promote cultures of learning, shared accountability, and staff empowerment (Daly et al., 2014).

**Leadership is Everyone’s Business**

Leadership in healthcare is not restricted to those with formal titles. Anyone who influences, motivates, or supports others has the potential to lead. This distributed view of leadership aligns with the NHS People Plan (2020), which encourages inclusive, compassionate leadership at every level. To lead effectively in today’s NHS, we must move beyond authority-driven models and embrace approaches rooted in empathy, communication, and shared purpose.

**Chapter 3: Culture: The Unseen Driver of Performance**

Culture is the invisible force that shapes how things get done in an organisation. In the NHS, where thousands of staff interact with patients and colleagues every day, culture has a powerful impact on morale, performance, safety, and innovation. Understanding and influencing culture is essential to improving outcomes.

**Defining Organisational Culture**

Organisational culture can be understood as the shared values, beliefs, and behaviours that influence how people work together (Schein, 2010). It determines whether staff feel safe to speak up, whether they take initiative, and how they respond to change.

In healthcare, culture affects not just internal dynamics but patient care. A positive culture fosters teamwork, learning, and compassion. A toxic culture leads to disengagement, conflict, and even patient harm (Francis, 2013).

**Schein’s Model of Organisational Culture**

One of the most influential frameworks for understanding culture is Edgar Schein’s three-level model:

1. **Artifacts**: visible elements such as dress codes, layout, and observed behaviours.
2. **Espoused Values:** the stated values and strategies (e.g. mission statements).
3. **Basic Assumptions:** unconscious beliefs, perceptions, and feelings that truly drive behaviour.

Schein argues that to change culture, leaders must first uncover and understand these deep-seated assumptions (Schein, 2010).

**Hofstede’s Dimensions of Culture**

Another well-known framework, particularly useful for understanding multicultural teams, is Geert Hofstede’s model. It describes national and organisational culture across dimensions such as:

* **Power Distance** (acceptance of hierarchy)
* **Individualism vs. Collectivism**
* **Uncertainty Avoidance**
* **Masculinity vs. Femininity**
* **Long-term Orientation**

While originally focused on national culture, these dimensions help leaders reflect on workplace dynamics and differences in values across teams (Hofstede, 2001).

**Culture in the NHS Context**

The NHS has historically struggled with elements of its culture. Reports from Mid Staffordshire (Francis, 2013), Morecambe Bay (Kirkup, 2015), and Shrewsbury and Telford (Ockenden, 2022) exposed cultures where fear, hierarchy, and silence led to compromised care.

Conversely, trusts that have embraced open communication, staff empowerment, and continuous learning have shown improved performance and resilience (West et al., 2017).

**Changing Culture: A Leadership Responsibility**

Culture change is not about posters or slogans. It requires consistent action, especially from leaders. Key enablers include:

* Psychological safety (Edmondson, 2019)
* Role modelling (Bass & Avolio, 1994)
* Inclusion and shared purpose (NHS People Plan, 2020)

Changing culture also takes time and must be aligned with systems, processes, and incentives that reinforce desired behaviours.

**Why Culture Matters Now More Than Ever**

As the NHS navigates workforce shortages, growing demand, and a need for innovation, its ability to sustain a healthy culture will define its success. Leaders must understand not only how to improve structures, but how to shape the unwritten rules that guide behaviour.

A strong, positive culture is a force multiplier, it amplifies good leadership and absorbs pressure during crises. Might I also suggest that leadership does not drive performance directly. Culture does. Leadership shapes culture, and culture shapes performance.

**Chapter 4: Research Insights: What the Data Tells Us About Leadership, Culture, and Performance**

To understand the real impact of leadership style and organisational culture on NHS performance, we should turn to data. Quantitative research, drawn from surveys and statistical analysis, provides a grounded and objective picture of the relationships at play. This chapter presents insights derived from my own doctoral research conducted across NHS organisations, focusing on how transformational and transactional leadership, along with cultural awareness, influence organisational outcomes.

**Methodology Snapshot**

The small study used a quantitative design, distributing a survey instrument based on validated leadership and culture models to over 250 NHS staff across clinical and non-clinical roles. Statistical analysis was conducted using SPSS (v.21.0), applying Pearson correlation, regression analysis, t-tests, and one-way ANOVA to test the strength of relationships between leadership style, culture, and perceived organisational performance.

Key variables:

* **Independent variables**: Transactional and transformational leadership; organisational culture.
* **Dependent variable**: Performance (measured through staff perceptions aligned with NHS outcomes).
* **Moderating variables**: Age, role, education, length of service, and pay banding.

**Headline Findings**

1. **Transformational Leadership and Performance** There was a strong, statistically significant positive correlation between awareness of transformational leadership and perceived performance (r = 0.803, p < 0.05). This aligns with the literature asserting that transformational leadership improves motivation, innovation, and collaboration (Bass & Avolio, 1994; Judge & Piccolo, 2004).
2. **Organisational Culture and Performance** Culture also showed a strong positive correlation with performance (r = 0.747, p < 0.05), confirming that environments with clear values, supportive behaviours, and psychological safety perform better (Schein, 2010; West et al., 2017).
3. **Transactional Leadership and Performance** Transactional leadership demonstrated a moderate but significant correlation with performance (r = 0.542, p < 0.05). This suggests that structure and order are important but insufficient alone for long-term performance (Bass, 1990).
4. **Moderating Factors** Demographics impacted perceptions:
* **Age** positively influenced perception of transactional leadership effectiveness.
* **Role** had little to no impact.
* **Education and pay banding** showed moderate relationships with awareness of leadership and culture, indicating a need for tailored development programmes.

**Interpretation of Results**

The results strongly support the hypothesis that leadership style and organisational culture significantly influence NHS organisational performance. The data reinforces the view that transformational leadership creates the conditions for better communication, psychological safety, and engagement, all vital for patient care (Wong & Cummings, 2007; Francis, 2013).

The findings also challenge the over-reliance on hierarchy and compliance-based models. While necessary in high-risk environments, these must be complemented by values-driven leadership that connects with the human side of healthcare.

**Implications for Practice**

* **Leadership development programmes** must integrate emotional intelligence, self-awareness, and coaching skills, not just policy and governance.
* **Culture audits** should be conducted regularly to uncover and address hidden barriers to performance.
* **Performance frameworks** should expand to include wellbeing, team cohesion, and communication as critical indicators.
* **Diversity in leadership** must be supported, as different demographics bring different perspectives on culture and leadership.

**Research Limitations and Future Directions**

As with any research, there are limitations:

* Self-reported data may reflect perceptions rather than objective performance.
* A larger sample size across more trusts would allow for greater generalisation.
* Further qualitative work could deepen understanding of the “why” behind the data trends.

Nonetheless, the findings offer powerful evidence that culture and leadership are not abstract concepts, they are measurable, impactful, and essential to the NHS’s future.

**Chapter 5: Case Study Snapshots: Real Stories from the Front Line**

While statistics tell one part of the story, real-life experiences breathe life into data. This chapter highlights snapshots from national case studies that formed part of my research, stories that reflect the daily reality of NHS professionals and how leadership and culture play out on the ground.

**1: The Power of Transformational Leadership in a High-Pressure A&E**

In a busy urban hospital, a matron well known for her collaborative approach turned around one of the most underperforming A&E departments in the trust. Staff surveys had previously shown low morale, high stress, and friction between clinical and administrative teams.

After introducing daily huddles, encouraging feedback at every level, and advocating for staff wellbeing, the department saw a 22% improvement in staff satisfaction and significant reduction in sick leave over 6 months (Inkpen, 2023).

Colleagues described her as “present, approachable, and empowering”, all hallmarks of transformational leadership (Bass & Riggio, 2006).

**2: Culture of Silence in a Maternity Unit**

In contrast, a rural trust’s maternity unit experienced persistent complaints, high turnover, and risk incidents. Junior staff reported feeling afraid to raise concerns, and several described a “culture of silence” that prioritised reputation over learning.

This echoed findings from the Ockenden Review (2022), which linked failures in maternity care to toxic cultures, lack of psychological safety, and ineffective leadership.

Once an interim leadership team was brought in, including a director of midwifery with a track record in transparent communication, cultural audits were performed, team training introduced, and staff forums established. Within a year, CQC assessments noted improvements in team communication and openness.

**3: Role Clarity and Transactional Stability**

A surgical unit in a major teaching hospital showed how transactional leadership, when used effectively, can provide clarity and stability. The theatre manager, a former military nurse, was described as “firm but fair.” She ensured protocols were followed rigorously, roles were clearly defined, and feedback was immediate.

Although her style was not emotionally engaging, the team appreciated the reliability and structure, especially junior staff new to the environment. However, staff engagement scores were modest, suggesting this style might benefit from being complemented by more inclusive practices (Wong & Cummings, 2007).

**4: A Hybrid Approach in Community Mental Health**

Perhaps the most successful model came from a community mental health team led by a clinical psychologist with leadership experience and appropriate advanced training. Combining transformational principles with operational discipline, this leader fostered innovation and staff autonomy while ensuring accountability.

The team piloted a peer-support model for service users, cut missed appointment rates by 18%, and improved cross-functional collaboration. This leader modelled Schein’s principle of surfacing underlying assumptions by actively listening to frontline workers and revising outdated practices (Schein, 2010).

**Cross-Case Themes**

Several recurring themes emerged from these stories:

* Psychological safety, when prioritised, led to stronger performance.
* Leaders who blended vision with operational control were more successful.
* Silence, blame, and rigidity consistently undermined outcomes.
* Engagement improved when staff felt heard, valued, and trusted.

**Real Lives, Real Lessons**

These examples highlight the tangible effects leadership and culture have in practice. They also reinforce my central argument; that care for patients begins with care for people, and that starts with how we lead and the cultures we create.

As Michael West (2014) noted, “the culture of any organisation is shaped by the worst behaviour the leader is willing to tolerate.” It is also shaped by the best behaviour they choose to model.

**Chapter 6: Reflections: Personal Lessons on Change and Compassion**

Leadership is often described in abstract terms, as a theory, a competency, or a skillset. But for those of us who have lived it day in and day out in the NHS, leadership is also profoundly personal. It is shaped by difficult choices, human connections, and moments that challenge us to be better.

In this chapter, I share some of my most meaningful reflections from my years of working in healthcare leadership roles, also informed by my academic research.

**1: Leading Through Uncertainty**

One of the defining features of NHS leadership is managing ambiguity. Whether responding to a policy shift, an emergency, or resource constraints, the only constant is change.

During the early days of the COVID-19 pandemic, uncertainty was overwhelming. Staff looked to leaders not for answers, but for clarity, reassurance, and honesty. Transparent communication, even when we didn’t have all the facts, was more valued than perfect solutions (West et al., 2020). This reinforced the importance of psychological safety, as described by Edmondson (2019), where staff felt able to speak up, admit concerns, and share ideas without fear.

**2: Compassion Is a Leadership Strategy**

There is a growing body of evidence that compassion isn’t just a virtue, it’s a leadership imperative. Studies by West and Chowla (2017) show that compassionate leadership improves morale, engagement, and patient outcomes.

In one trust I worked in, we introduced a ‘compassionate conversations’ framework. Line managers received training in active listening and empathetic questioning. Over time, staff feedback scores improved, absenteeism declined, and teams reported feeling “seen and heard.”

Compassion must extend to oneself too. NHS leaders are often so focused on caring for others that they neglect their own wellbeing. Sustaining compassion requires boundaries, self-awareness, and reflective space.

**3: Change Happens at the Speed of Trust**

Top down initiatives often fail not because they are ill-conceived, but because staff don’t trust those leading them. Trust is built in small moments, consistency, follow through, and fairness.

I recall a situation where a service redesign faced resistance. By creating co-design workshops where staff and patients shaped the new pathway, resistance softened. The process took longer, but the implementation was smoother and more sustainable. Trust was the lever that enabled change (Covey, 2006).

**4: Leadership Isn’t About Being the Expert**

In complex environments like the NHS, no one person can know everything. One of the hardest lessons for me after leaving the military after 22 years was learning to let go of control and really empower others. Adaptive leadership, as described by Heifetz et al. (2009), involves mobilising others to tackle tough challenges, not solving every problem yourself.

When I started leading with questions instead of answers, I noticed a shift in team dynamics. People stepped up, offered ideas, and took ownership. That shift was only possible when I embraced vulnerability, as advocated by Brown (2018), and allowed myself to not have all the answers.

**5: Culture Is Everyone’s Responsibility, but leaders set the tone**

Throughout my career, I’ve seen how one leader can shape an entire team’s culture, for better or worse. When leaders model openness, fairness, and care, those values cascade. When they tolerate bullying, exclusion, or complacency, those behaviours also take root (Schein, 2010).

Changing culture takes time, but every small act of integrity matters. Holding a difficult conversation, calling out unprofessionalism, or simply saying thank you, this is leadership in action.

**A Personal Commitment**

Whilst writing this I have reminded myself why I intensely study leadership and culture: to make a difference. Not just to policies or performance metrics, but to people, the nurses, doctors, porters, managers, and patients who make up the NHS community.

As we move forward, I believe the most effective leaders will be those who bring their whole selves to their role: their intellect and emotional intelligence, their strength and vulnerability, their strategy and compassion.

Because leading well in the NHS is not about command and control. It’s about care and connection.

**Chapter 7: Recommendations: Action Steps for Leaders, Teams, and Policymakers**

Having explored the challenges, evidence, and lived experiences of leadership in the NHS, we now turn to action. This chapter outlines practical recommendations for different audiences: NHS leaders, frontline teams, and policymakers. Each action is grounded in research and informed by the findings and reflections shared throughout this publication.

**For NHS Leaders**

1. **Adopt a Transformational Style Where Possible** Leaders should strive to embody transformational behaviours, such as articulating vision, modelling integrity, and recognising individual contributions (Bass & Avolio, 1994). These approaches are consistently linked with improved performance and morale (West et al., 2014).
2. **Develop Compassionate Leadership Competencies** Invest in leadership development that emphasises empathy, active listening, and relationship building (West & Chowla, 2017). Compassionate leadership is not only ethically important, it drives retention, wellbeing, and care quality.
3. **Build Psychological Safety in Teams** Foster environments where staff feel safe to speak up, challenge, and innovate without fear of punishment (Edmondson, 2019). This is foundational to learning cultures.
4. **Lead by Example in Cultural Change** Leaders shape organisational culture through their everyday behaviour. Be visible, transparent, and consistent. Address toxic behaviours promptly and model the values you want to see (Schein, 2010).
5. **Embrace Reflective Practice and Vulnerability** Use structured reflection (e.g., Schwartz Rounds, peer dialogue) to process challenges. As Brown (2018) notes, vulnerability builds trust and authenticity, key leadership traits.

**For NHS Teams**

1. **Promote Peer Support and Team Dialogue** Create time and space for teams to talk about what matters, not just tasks. Peer support improves emotional resilience and teamwork (West et al., 2017).
2. **Co-create Local Values and Norms** Engage teams in identifying shared values and how they want to work together. This promotes ownership and alignment.
3. **Use Feedback to Improve Culture** Regularly gather feedback through anonymous surveys or facilitated sessions. Turn this into tangible action and share progress transparently.
4. **Celebrate Successes and Acts of Kindness** Recognising the everyday wins boosts morale and reinforces positive culture. Kindness, when modelled and acknowledged, multiplies.

**For Policymakers and System Leaders**

1. **Incentivise Leadership Development and Retention** Provide protected time, funding, and progression pathways for aspiring leaders. Effective leadership should always be a strategic workforce priority (NHS People Plan, 2020).
2. **Invest in Culture Transformation Programmes** Support initiatives like Just Culture, Civility Saves Lives, and culture audits that help organisations understand and improve their internal environments.
3. **Broaden the Definition of Performance** Embed staff experience, team learning, and psychological safety into performance frameworks alongside operational targets (NHS England, 2023).
4. **Support Inclusive Leadership Pipelines** Tackle structural barriers that prevent diverse talent from reaching leadership positions. Diversity in leadership leads to better decision-making and more equitable care (West et al., 2015).

**Final Thought**

Sustained transformation of the NHS won’t come from policy alone, nor from any single leader. It will come from a collective commitment to lead with care, align culture with values, and prioritise people alongside performance.

As I stated at the start, this is my personal view and it is up to you whether you agree or not but until we get it on the table we can’t discuss openly and move forward into a new world where we understand leadership and culture and actively seek new ways to improve where and how we work, as ultimately we work to deliver first rate care to those that need it. As the evidence shows, compassionate, values-driven leadership isn’t a soft option, it’s the strongest foundation we have for a thriving NHS.

**Chapter 8: The Future of NHS Leadership and Culture: A Vision for What’s Possible**

The future of the NHS depends not only on funding or technology, but on how we lead and the cultures we cultivate. This chapter outlines a forward-looking vision for NHS leadership and organisational culture, one that is inclusive, adaptive, and grounded in compassion.

**Reimagining Leadership in the NHS**

Future leaders will need to be more than managers. They must be catalysts for trust, learning, and innovation. The NHS Leadership Academy (2023) highlights a growing emphasis on systems leadership, emotional intelligence, and resilience.

Leadership will no longer be confined to roles at the top. Instead, it must be distributed across the system, empowering clinicians, administrators, and allied health professionals to lead change at all levels (West et al., 2017).

**Embracing Adaptive and Inclusive Approaches**

The complexities of healthcare require adaptive leadership,the ability to diagnose systemic issues and mobilise others to co-create solutions (Heifetz et al., 2009). This involves embracing uncertainty and experimentation rather than seeking quick fixes.

Inclusive leadership is also essential. The NHS Workforce Race Equality Standard (WRES, 2023) and NHS England (2022) data show that staff from minority backgrounds often experience exclusion and discrimination. Leaders must create environments where everyone feels seen, valued, and heard, a proven contributor to engagement and performance (Kline, 2020).

**Embedding Learning Cultures**

In high-performing NHS organisations, continuous learning is embedded at every level. Learning cultures depend on psychological safety, constructive feedback, and a tolerance for intelligent risk-taking (Edmondson, 2019).

Trusts should embrace systems like:

* **Learning from Excellence**: to replicate success
* **Just Culture**: to balance accountability with fairness
* **Schwartz Rounds**: to reflect on the emotional dimensions of care

These initiatives promote well-being, cohesion, and professional development (West et al., 2020).

**Human-Centred Technology and Innovation**

While digital innovation is vital, it must be human-centred. Leaders must ensure that AI, data systems, and digital tools enhance, not erode, the human connections that define care. Co-design with staff and patients is key to meaningful adoption (Topol Review, 2019).

**A Vision of Possibility**

Imagine an NHS where:

* Leadership is inclusive, empathetic, and skilled in systems thinking.
* Culture is shaped by values, voice, and collaboration, not fear or compliance.
* Learning is routine, feedback is welcomed, and innovation is continuous.
* Patients experience joined-up care from empowered teams who feel supported and inspired.

This future is possible, but only if leadership and culture are treated not as side projects, but as central strategies for sustainability and excellence.

**Final Words**

The NHS is more than a health system. It is a community of care. The next era of its evolution will be defined by how courageously we lead and how deliberately we shape the cultures that care for those who care for others.

As West et al. (2017) wrote, “The NHS has always been about people. Its future depends on how bravely and compassionately we lead them.”

**Chapter 9: Resources & Tools: Frameworks, Checklists, and Further Reading**

This chapter provides practical tools, models, and further reading to support leaders, educators, and teams in applying the principles explored in this doucument. Each resource has been selected based on evidence and relevance to NHS settings.

**Frameworks and Models:**

1. **Schein’s Model of Organisational Culture**
	* Use to assess visible behaviours, stated values, and underlying assumptions (Schein, 2010).
2. **Transformational Leadership Framework** (Bass & Avolio, 1994)
	* Apply the four I’s: Idealised Influence, Inspirational Motivation, Intellectual Stimulation, and Individualised Consideration.
3. **Edmondson’s Psychological Safety Framework**
	* Diagnose team environments and build cultures where people feel safe to speak up (Edmondson, 2019).
4. **Adaptive Leadership Model** (Heifetz et al., 2009)
	* Guide teams through complex change by engaging them in problem-solving and shared learning.
5. **West’s Compassionate Leadership Model** (West et al., 2017)
	* Emphasise attending, understanding, empathising, and helping — core behaviours of effective leaders in healthcare.

**Checklists for Leaders and Teams:**

**Compassionate Leadership Self-Check**:

* Do I listen without interrupting?
* Do I follow up on concerns?
* Do my actions align with my stated values?
* Do I support others to grow and lead?

**Culture Diagnostic Questions**:

* What behaviours are rewarded here?
* What is not spoken about?
* How do we treat people who make mistakes?
* Who feels included, and who doesn’t?

**Team Learning Environment Checklist**:

* Do we debrief regularly and honestly?
* Are mistakes treated as learning opportunities?
* Is feedback welcomed from all levels?
* Are cross-boundary collaborations encouraged?

**Programmes and Initiatives**

* **NHS Leadership Academy** – for nationally recognised leadership development (NHS Leadership Academy, 2023).
* **Just Culture Guide** – supports fair and consistent decision-making (NHS Improvement, 2019).
* **Learning from Excellence** – positive reporting to reinforce best practice (Kelly et al., 2016).
* **Civility Saves Lives** – campaign to improve workplace culture and reduce incivility (Porath & Pearson, 2013).
* **Schwartz Rounds** – reflective practice for emotional and relational aspects of care (Goodrich, 2012).

**Further Reading**

* Brown, B. (2018). *Dare to Lead: Brave Work. Tough Conversations. Whole Hearts.*
* Covey, S. (2006). *The Speed of Trust.*
* Heifetz, R., Grashow, A., & Linsky, M. (2009). *The Practice of Adaptive Leadership.*
* Schein, E. H. (2010). *Organizational Culture and Leadership.*
* Edmondson, A. (2019). *The Fearless Organization.*
* West, M. (2021). *Compassionate Leadership: Sustaining Wisdom, Humanity and Presence in Health and Social Care.*
* NHS Leadership Academy and FMLM publications

These resources can be used individually or integrated into team development programmes. They are not a substitute for leadership, but they are powerful tools to support it.

**Chapter 10: Conclusion: Culture Is Care, and Leadership Is the Lever**

The evidence and experiences shared in this document point to a single, powerful truth: how we lead, and the cultures we create, define the NHS’s capacity to care. From boardrooms to wards, every interaction is shaped by the tone, trust, and values embedded in leadership and culture.

As the NHS continues to face evolving challenges, from workforce pressures to digital transformation and societal health inequalities, the human dimension of healthcare leadership must remain central. Technical solutions matter, but they cannot substitute for compassion, connection, and trust (West et al., 2017; Edmondson, 2019).

We have seen that transformational leadership is not just a management strategy but a catalyst for performance, engagement, and healing. We’ve explored how organisational culture can either enable excellence or inhibit it. And we've examined data, stories, and practical tools that make these concepts real and actionable.

The journey to a more resilient and responsive NHS will not be linear. It will require courage to lead differently, to listen more deeply, and to act with both head and heart. As Heifetz et al. (2009) remind us, adaptive leadership calls us to mobilise collective wisdom, not impose top-down solutions.

Leaders at every level have a choice: to default to status quo or to actively shape environments where people flourish.

Let us choose the latter.

Because in the NHS, culture is not a backdrop, it is the care. And leadership is not a title, it is the lever for change.

Let’s lead well, together.

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