The Manager’s Code – background

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February 2010.

This paper provides some of the thinking behind The Manager’s Code

Introduction – wellbeing and performance in the NHS

Organisations are controlled communities. They are constructed and disbanded regularly, and can be as fleeting as a dinner party, a bus queue or as permanent as the Department of Health. They exist to overcome the limitations of individual action. The extent and manner to which each organisation is controlled in relation to its purpose often determines whether or not the organisation is successful in its aims. Queuing for a ferry in Dover is a different experience to queuing for a ferry in Piraeus. The ferries at Dover tend to leave on time. Queuing in Piraeus tends to be more fun.

Control is one of the classic purposes of managers and management – the others are providing direction and facilitating coordination.

Managers are responsible for the means to achieve specified ends. Too often, it appears, the ends are solely specified in terms of products and services for which an organisation is created to deliver. Rarely is the building and sustaining of a finely tuned, dynamic, sleek and healthy workforce specified as an end that will produce the high quality end product. Managers should be, and for some are, the means to a hugely successful organisation producing hugely successful end products.

Organisations are constructed of people. Successful organisations are constructed of people with a passion and energy to work together to a common aim that they cannot achieve on their own. If, for any reason, the organisation itself does not assist individuals within it to achieve what they expect, the individuals will disengage with the organisation and become diverted towards other activities and actions. Their personal performance will drop off, and by extension, so will that of the organisation.

There has been a growing interest and concern within sections of the NHS and the public about managers’ ability to manage people effectively so that they produce the high quality end product we all expect. This has major implications for the achievement of the prime purpose of the NHS – the delivery of high standards and quality of health care, much of which depends on the unencumbered focus of high level skills on the issues and challenges that patients present.

Unencumbered focus requires people to feel well. People perform better if they feel well. Wellbeing has a direct link to performance. Wellbeing is idiosyncratic and determined largely by one’s own perception of feeling well. People diagnosed with an illness can still feel well; people
without a diagnosis of ill health can feel unwell. Performance is about eliminating deviation, hesitation and repetition in personal performance linked to appropriateness, efficacy, effectiveness and efficiency in the services that are delivered. Psychological distress at work, and at home, is a significant inhibitor to personal performance, with the knock-on effect on the performance of the organisation and high quality and standards of health care.

There is a general consensus in the research literature that levels of psychological distress have a direct impact on the quality of care. Stress is at the wrong end of a continuum that starts with pressure (a work stimulant), moves through a period of strain (diversion from concentration) and, if untreated, leads to stress (work impairment).

It appears that an NHS culture exists that seemingly encourages transactional management behaviours tinged with negative coercive undertones, judging by comments on web based social networks, web site forum and staff surveys; that discourages talented managers from seeking senior positions, as illustrated by the number of vacancies and few applicants; that condones an atmosphere of bullying and harassment, judging by the numbers of complaints about this; that fails to bridge the gap in trust between some managers and staff as illustrated by staff surveys; that abandons protection and acknowledgement of what whistleblowers have to say, according to the numbers of staff making this observation on web based social networks and web based forum.

The costs of the generally negative culture are enormous. In the UK as a whole one third of working people suffer diagnosable (for example anxiety and depression) and non-diagnosable (worry and bereavement) mental ill health at any one time. These cause about 40% of all sickness absence from work, but their impact is greater as the average period of absence is around 21 days. It has been calculated that people who come to work feeling unwell costs the country about £15.1 billion per year, or 58% of the total cost of sickness absence, staff turnover and presenteeism. (Mental Health and Work. Royal College of Psychiatrists. March 2008)

The ethics that condone the continuation of negative culture taint the traditional values of a health service established to restore the nation to good health.

Stress affecting staff, however caused, but often cited as caused by ‘the boss’, can result in disengagement, poor concentration, low motivation, lethargy, lack of sleep, loss of commitment, and the cause of errors. Stress if often manifested as anxiety and depression. Stress can result in poor interaction between people, which, in turn, may result in a lack of interest, attentiveness and concern between one person for another, for example a clinician for a patient. If left untreated, stress causes serious and life threatening physical conditions.

The behaviour of managers and their capacity to manage people and resolve routine daily problems in a manner that promotes trust and commitment leading to engagement has a fundamental impact on the levels of psychological distress amongst people at work - ‘the starting point for addressing poor mental health at work is good people management....’ CIPD 2008.

Not only does negativity have a direct influence on healthcare it has an influence on career development. There is hesitancy amongst talented middle ranking managers moving to top management. Fewer talented managers are wishing to be exposed to the adverse events and
lack of support provided to top managers. The numbers of candidates for Chief Executive posts, in some cases, are so small that a genuine competition for the ‘best’ candidate is impossible. The number of vacancies for senior nurse managers is alarmingly high. In a biological sense, the paucity of candidates coming forward would render the ‘species’ of chief executive potentially extinct. The average ‘life expectancy’ of a Chief Executive is now calculated to be about three years, with publically expressed concerns over a failure to nurture future generations of senior staff despite an ever increasing number of leadership development programmes and other forms of encouragement. The cascading effect of this gives rise to serious concerns for future management at every level of service delivery.

These observations, alongside observations about the levels of sickness absence, staff turnover, incidence of presenteeism and levels of mental ill health amongst staff, are different to the background to current discussions concerning accreditation of senior managers. Those discussions were triggered by the apparent failures of a small group of top managers and the need to raise standards of managers at Board level by possibly introducing processes of accreditation, licensing and regulation. The main thrust, however, is on developing a Code of Conduct that sets out the standards that managers are expected to apply to their work.

The key issue is more profound. It is about a defensive culture that does not currently connect wellbeing with performance; that does not overtly value the staff it employs (apart from celebratory showcase national events); that relies on systems and services to patch up deficiencies; that doesn’t tackle root causes to prevent threats to wellbeing and performance from arising in the first place.

The impact of culture is not cited in the work on accreditation nor by the various reviews and reports into the health and wellbeing of staff that have been published since early 2008. Instead there have been glancing observations about the role of management in promoting health and wellbeing, but little that is substantial. The reviews and reports recognise a major challenge but only ‘Organisation Health: a new perspective on performance improvement’ April 2009 NHS Institute - and the recent report ‘Improving People Management – Building Productive Public Sector Workplaces’ January 2010, CIPD – sets out to address issues of organisation and personal wellbeing at work.

The HSE/CIPD report on ‘Manager competencies for preventing and reducing stress at work’ in 2008 and The MacLeod Review – ‘Engaging for Success – enhancing performance through employee engagement’ 2009 – come close to addressing the fundamental issues relating to the causes of psychological distress, and therefore, under performance at work. Most, if not all, the other reviews and reports are reactive in tone – seeking to put in place services for people who suffer psychological distress, accidents and physical ill health. Early intervention is advocated as a form of prevention, but essentially this is preventing deterioration in situations that have already occurred.

Since early 2008 the following selection of reports has been published in relation to mental health at work, and health and wellbeing. They have mainly been addressing how to keep people at work, and, for those absent due to sickness, how to ensure their return to work. Their relevance to this paper is the lack of ideas and proposals to prevent people from suffering psychological distress in the first place, thereby preventing people from becoming absent, or
being present when ill, or preventing people from under performing at great cost to the taxpayer.

- *Staff Engagement in the NHS. Briefing no. 50 November, 2008. NHS Employers.*
- *Improving working lives in the NHS. July 2009. DoH.*
- *NHS Mutual. Engaging staff and aligning incentives to achieve higher levels of performance. 2009. The Nuffield Trust*
- *Promoting Mental Health through productive and healthy working conditions. November 2009. NICE.*
- *New Horizons in Mental Health. November 2009. DoH*

Changing the NHS into a Positive Work Culture, based on a wellbeing and performance agenda involving trust and commitment leading to engagement, would rapidly reduce anticipated budget deficits and release funds for more direct patient care. The MacLeod Review 2009 reports that staff turnover can be reduced by 87%, sickness absence reduce to around 2.7% and financial surpluses be raised by 19% through staff engagement, a cornerstone of a Positive Work Culture. The input costs of making a change are tiny; the main challenge is understanding the issues and developing the resilience and determination amongst leaders and managers to make a positive change.

With seemingly little concern from top management for the widespread damage that a negative culture causes, an initiative by Professor Derek Mowbray in 2008, supported by the Institute of Healthcare Management (IHM), brought together the most senior people in the Institute of Healthcare Management, the Royal College of Nursing, the British Medical Association, The Health and Safety Executive, the British Psychological Society with Dame Carol Black, Director of Health and Work at the DoH/DWP, to discuss the concerns and seek a remedy that might bring a change to the culture of the NHS that would inspire managers from all professions. At the same time a positive cultural environment would address the problems of wasted resources due to high levels of presenteeism, sickness absence and staff turnover. One outcome of this Symposium was a proposal to formulate a ‘new’ Code of Conduct.

In October 2009 a similar but expanded group including the Welsh Assembly Government, the Health Foundation and the Royal College of General Practitioners, convened to review the draft Code and its supporting papers on Engagement, Ethical Leadership and Effective Management. It was agreed to progress the work to a conclusion in May 2010 at which point the process of implementation would commence.

The intention, in late 2008, was that the revised Code would focus on building and sustaining a Positive Work Culture based on wellbeing and performance. To achieve this, leader and manager behaviours would need to promote commitment and trust leading to engagement between managers and the staff they manage, this being evidenced as having the most significant impact.
on psychological distress, the performance of people, their organisations and the delivery of high standards and quality of services.

**The complexity of healthcare leadership and management**

Healthcare leadership and management is a complex business. At its simplest, the NHS is an organisation where some conflicts of interest may always exist. Amongst the strongest is the conflicting ideologies between ‘the professionals and the bureaucracy’ where the professional has the interest of the individual as the prime focus, whilst the bureaucracy has the interests of all patients as the prime focus. This can lead to the conflict of individual accountability whilst encouraging creativity and participation to flourish which can be, sometimes, difficult to justify.

Still further, the quality and efficiency relationship can give rise to tension, where an approach to quality depends on the time and resources that efficiency does not allow. These tensions have to be managed, and the behaviours needed to manage them have to mitigate the risks of further tensions being created.

A framework for understanding the required skills, knowledge and experience of leaders and managers is below.

**Level A** – The behaviours everyone requires to build and sustain trust and commitment. Leaders and managers require the skills to achieve specified aims by mobilising the skills, knowledge and experience of others – the raison d’être of an organisation – without causing psychological distress in the process. This is best achieved by building trust and commitment. Anyone with psychological distress is disengaged, and less able to contribute to the achievement of a specified aim.

**Level B** – the skills needed to apply theories, principles and systems that can be described by protocol or procedure. This is the bulk of management practice, the basis on which most managers control others – the application of systems to targets, financial procedures, efficiency, planning processes and a whole range of policy, procedures, regulation, legislation and activities that are described in writing. The application of these protocols and procedures resemble transactions, where managers transact with staff to complete the application of a specific protocol.

Transactional skill stems from the view that leaders and managers have power over followers and use the power to achieve objectives and goals. Transactional style tends to focus on the ‘here and now’, on problems, daily routines and mistakes.

**Level C** – the eclectic skills, knowledge and experience, that is used to manage and lead people in every situation, whether in encouraging innovation, imagination, entrepreneurial activities, or in mergers, acquisitions and ‘seeing the future’. Level C skills are needed to solve complex problems, for dealing with the broad range of judges of managers and leaders, for negotiating solutions amongst competing interests, for development of partnerships. Level C skills rely on the power of argument and personality and skill of persuasion. Working at this level requires managers to be credible, to possess psychological status, to be able to think on their feet, and to
be able to bring people along with them. This level most closely resembles transformational or adaptive style of leadership and management.

Transformational and adaptive styles look for ways to motivate others with a view to engaging them intimately in the processes of work – thereby achieving performance beyond expectation. Transformational styles also have the interest of building something new out of something old – of moving forward and moving ahead from an existing situation. An application of transformational style is adaptive style, a process of engaging followers in the resolution of challenges faced by an organisation. The emphasis in adaptive style is on flexibility – to be able to re-think approaches to challenges by embracing the skills, knowledge and experience of followers in the process of challenge resolution. This is a powerful style in securing engagement and commitment leading to a Positive Work Culture, as it draws followers closer to a sense of ‘ownership’ of challenges and their resolution.

Most managers use level B skills and may not have acquired level A and C skills. There is a massive industry around policies, procedures, systems and protocols which are being applied to routine management practice. The degree of focus on these devices and techniques appears to have squeezed out manager ability to behave towards staff in ways that persuade and encourage, relying more on following protocols than on personal attributes and skill. This makes it difficult for managers to acquire level A and C skills, knowledge and experience, so essential in building commitment and trust. It is potentially more difficult to ‘test’ for levels A and C, although the use of Assessment and Development Centres is one way of assessing individual abilities at all three levels.

Level B skills are also more closely allied to the ‘quick fix’ management style, and strategies of imposition that are prevalent, whilst levels A and C are more closely allied to strategies of conviction which take longer to achieve results, but the results are more effective and longer lasting.

Levels of manager skill do not always equate with level of management in organisations. They are linked to the type of work the manager is expected to perform. The issue is whether those managers expected to work with level C skills have the opportunity to develop the skills, knowledge and experience to be effective, or whether there is too much emphasis on acquiring level B skills.

For managers to be successful at levels B and C they require the skills, knowledge and experience of level A to interact effectively with the people they manage. Level B skills are needed to structure actions to achieve specified aims. Level C skills are required to persuade people to undertake relatively unstructured actions they might otherwise not take.

The NHS as a complex organisation

Healthcare services in the UK have their origins in organisations of ‘virtuous intent’ for the common good. This idea persists as a public service, provided by dedicated healthcare practitioners to an increasingly informed, sceptical and challenging public. Public service may no longer be held in the high esteem of years past; it may now be tainted by reported activities of politicians, and the general shift in government departments and agencies towards mediocrity in
service, increasingly complex administrative processes and challenges to individual independence of thought and action. Public confidence in public service may have reached an all time low.

If the delivery of healthcare can be described as foreground, and the bureaucracy as background, there is a significant foreground/background tension. In contrast to highly successful organisations where the purpose of the background is the delivery of highly successful foreground activities, the NHS might be characterised as the foreground having to support the background with justifications and information, an approach which diverts attention away from the prime purpose of foreground activities – patients and their care. The deluge of media reports are often about background activities, reflecting, perhaps, the massive numbers of people employed in background work, who are, effectively, dislocated from the foreground, yet offering reports and commentary about the activities in the foreground. Behaviours of Chief Executives and other managers in this context are likely to be ambiguous, seeking to look two ways at once – either ‘feeding the bureaucratic beast’ with reports, data, and meetings to defend themselves, or developing and directly supporting staff delivering the highest possible standards and quality of care to patients. In a publically accountable organisation, a balance has to be struck, just as a balance has to be struck in organisations governed by the Companies Acts and Charity Commission. Some would argue that the balance favours the resources invested in regulation, the background bureaucracy and the time, effort and energy used to justify the activities of foreground services with little benefit being shown for the investment.

The processes involved in delivering services to patients are often described as chaos, a term used to illustrate the unpredictable elements of organisation and services, unlike, for example, a retail organisation that may be managed as a smooth series of inter-locking steps. In a chaotic organisation those that deliver services to patients have to be adaptive to the situation they confront; they need strong self-efficacy and strong self-organisation. Individual responsibility is paramount, and this often requires exercising individual discretion.

The background services are organisations within the NHS that have little or no direct contact with patients or clients, and have little managerial responsibility in relation to different health and other professional groups. The management of background services is more akin with bureaucratic organisations, with little individual discretion being required or expected.

Still more complex is the managed commercialism of the NHS that is conducted in a context of a mixture of ‘free’ enterprise, bureaucratic constraint, centralist micro-management tendencies with ‘independent’ regulation. It can be observed that this heady mix of constraints results in self interest amongst healthcare organisations as a means of creating resilience against threats, bullying and challenges to survival. The notion of ‘virtuous intent’ appears to have given way to self interest, a basic threat to the idea of a comprehensive healthcare system offering equal opportunity of access to people with equal need.

The gap between the ambiguous purposes of a national health service funded by taxes, and the clarity of purpose of commercial organisations, some partly funded by taxes and partly by insurance and personal income, is growing wider with commercial organisations attracting increasing numbers of patients. Both the public and private health services appear to have self interest in common as a means of survival and growth. Mergers, take-overs and franchises are now common in the public as well as private services, and demonstrate a shift towards a
dependency on the market as a tool for regulating the distribution of healthcare provision. This shift is also seen in the growth of social enterprise organisations that essentially have to survive and prosper in the same way as any other company. In the absence of additional resources to meet the expanding needs from demographic and technological change, a way of moderating demand is to reduce or keep static the supply of services and rely on other sources of provision, for example from the charitable, voluntary, other public agencies and carer sectors, to meet the shortfall.

The ability to survive and prosper in this complex environment is further constrained by regular changes in the purpose, structure and rules of parts of the NHS, presumably seeking to find the balance between encouraging responsiveness to individual needs combined with a requirement to account for taxpayer’s money, in an environment of changing and increasingly demanding demography and reducing resources.

The brief description of contemporary healthcare in the UK serves to illustrate the complexity that faces managers. They are expected to have vision, but need to know when not to use it; they are expected to know when to focus on balls in the air many of which don’t have ‘healthcare’ written on them; when to be active in pushing forward, and passive in raising concerns, and know how to interact effectively with an audience of patients, relatives, friends, staff, the media, local politicians, national politicians, Board members, peers, civil servants, hierarchically superior and inferior NHS staff, managers of public, private, charitable, voluntary, educational agencies, and their own family.

**The Leader – a complex array of interactions**

Leaders and managers face an array of interactions with different categories and groups of the public and the workforce.

Amongst these interactions a constructive and mutually beneficial relationship between managers and clinically focused professionals is the essential component of a successful and high quality healthcare system. Over the years there have been many initiatives to draw the professionals and managers closer together in understanding roles and responsibilities that each has in a healthcare system with finite resources. Understanding each other’s challenges goes a long way to developing mutually beneficial working relationships.

The conflicting ideologies of clinicians and managers are only one set of relationships that need managing. Others abound under the headings of ‘the building blocks for leadership’ that are set out below.

The research into leadership is substantial. Distilling the salient points is bound to omit elements that some will regard as critically important. The following are some of the influences and challenges facing leaders at any level of health services.

**The person** – the personality, gender and life experiences of the leader have an effect on the way in which he/she acts out their role.
The context – people act according to the situation they find themselves. Therefore, leaders need to be able to ‘read’ a situation and respond to it in the most appropriate way to achieve a ‘successful’ outcome.

Leadership – there are many styles of leadership. The most common descriptions are transactional and transformational leadership styles. Others include ‘leader as servant’; ‘leader as agent’; ‘leaders as regulator’; adaptive leadership, autocratic; benevolent; and laissey-faire. The style that leaders adopt should reflect the situation they are in and the style that will yield a ‘successful’ interaction without causing psychological distress.

The emerging leader – the people who think they can do a better job than the designated leader. This can be turned on its head and become the leader nurturing future leaders to do a better job than themselves.

The followers – the people the leader needs to undertake activities. Individuals, teams, constituencies are the main followers. They each need to be understood, and the approach to each needs to be considered in terms of appropriate style to produce a ‘successful’ interaction. Beware of Groupthink, those teams that reach decisions quickly, normally following the views of the leader, without taking in information from outside the team.

The judges – leaders are judged by a range of people with potentially different interests and agendas, for example, the followers, the patients, the Board members, the public, the politicians, the media, the regulators and the leader him/herself.

These features of leadership and leaders provide a complex mix of influences on a leader, each of which requires management. The judgements that have to be made when interacting with the emerging leaders, followers and judges are potentially difficult to reach without considerable experience and personal skills. How the leaders make judgements will be partly determined by the cultural context within which decisions are made. Dealing with emerging leaders, for example, can be perceived as a threat in a highly competitive, blame or defensive culture, whilst in a psychologically healthy environment emerging leaders are people to be nurtured, and personal pride can be derived by seeing the emerging leader succeed in a leadership role.

The glue that binds these features is the behaviour that the leader acquires at level A and shows in each and every interaction between him/herself and someone else. Successful leaders will adopt behaviours that promote engagement, whilst unsuccessful leaders will be less attentive to their behaviour and may disengage followers. Whilst each situation and interaction is different, there are some common behaviours that can be applied with the aim of building and sustaining commitment and trust leading to engagement and onwards to improving wellbeing and performance.

The manager – a pivotal role in a chaotic environment
In a multi-professional organisation where the responsibility for the care of individual patients is vested in clinicians, the role of the manager is to enable clinicians to discharge their responsibilities effectively. This is made complex by Codes of Professional Conduct that reinforce clinician’s own responsibility towards individual patients, a possible source of tension between
clinicians and managers who have no such Professional Conduct Codes and who may be seen to be interfering rather than enabling. As several clinicians may be engaged in the care and treatment of a single patient suggests that there is a polyarchy at work – where leadership in patient care is distributed amongst many, each contributing their own special skill, not an oligarchy where it is done by the few. In this context the role of manager needs to reflect the polyarchy context to be effective, in other words, to facilitate everyone’s contribution to patient care.

The purpose of the manager, therefore, becomes more focused on ensuring that all the professional groups are able to discharge their responsibilities towards their patients effectively. In generic management terms, the manager will need to adopt an inclusive style in discharging direction, co-ordination and control, simply because to adopt any other style will clash with the responsibilities of those being managed, and will be ineffective. In the past this has been described as ‘the negotiated order’ – an approach to drawing everyone into the decision making processes relating to the management of healthcare organisations. Adopting any other style may be easily misconstrued as hostile, give rise to conflicts leading to stress, presenteeism, sickness absence, and staff turnover.

In the complex world of healthcare the attributes of professional groups are characterised by their self-efficacy, and self-organisation capabilities. As the processes involved in healthcare delivery are shaped around individual variations in behaviour and illness/accident, the mosaic of interactions between people delivering services to an individual patient resembles chaos. In this environment, there is a ‘natural’ tendency for independently acting people to look for and focus on ‘attractors’ – those who attract the attention in chaotic situations because of their personal attributes and are perceived as steady and not chaotic in their actions and behaviours. Whilst the patient may be a principal focus, he or she is unlikely to resemble the stability that chaotic situations demand – they are part of the problem of chaos, not part of the solution.

It is, therefore, reasonable to observe that the purpose of the manager is to facilitate the provision of co-ordination, direction and control in a chaotic environment, and to have the purpose of ‘attractor’ – the natural focus for those caught up in chaotic situations and who makes order from the chaos. For the ‘attractor’ to function with credibility and stability, he/she needs to command trust and commitment that leads to staff engagement.

However, in those organisations in healthcare that have no direct contact with patients or professional groups, where the organisational dynamics are less chaotic, the purpose of management is co-ordination, direction and control, but the style of delivery might be more transactional than adaptive, encouraging participation but not ownership.

**Styles of management**

In order for an organisation to ‘give out’ the characteristics of being healthy, individuals need to act on their own initiative knowing that what they do and what they decide is within a framework that is lending support to their actions. In a multi-professional organisation individual initiative is to be expected, but in the NHS, not always encouraged.

Whilst it might be expected that a substantial number of professional staff have personal goals that coincide with the goals of the NHS, and, therefore, act to achieve these goals, not all staff
are in this situation. There are groups whose personal goals are different to those of the NHS, who come to work in order to earn money for personal purposes, without having a strong interest in the work they perform and its purpose in relation to high standards and quality of healthcare. There are, also, those who joined the NHS with shared goals, but who have become disengaged from it having been prevented from acting in ways they expected would be supported, but found were blocked.

Insofar as it is possible, an aim is to ensure that all staff are conscious of the purposes of the NHS, and that they play an important part in its delivery. This is more likely to be achieved if the culture of each of the organisations that constitute the NHS is based on the purposes, values and principles of the NHS as a whole. However, some of the organisations that form the NHS do not have any contact with the ultimate prime purpose – the prevention, diagnosis, treatment and care of people. Such organisations, whilst playing a part in the successful functioning of the NHS, might believe their purpose is different – for example, to ensure that processes are followed regardless of their impact on quality and standards. Clearly it is hoped that all processes have a positive impact on quality and standards, although the evidence for this might be questioned. A difficulty is that those organisations that are removed from the ultimate purpose tend to be organisations that assume a hierarchical superiority to the organisations that deliver healthcare to patients.

The issue for consideration is whether different groups of staff in the NHS require different leadership and management behaviours for effective management, or is there an overall approach to behaviour that is appropriate for everyone?

**Ethical leadership and management in the face of complexity**

The number of influences and challenges that leaders face on a daily basis will test the judgment of anyone. In a public service, especially, leaders and managers (as well as staff) need to be above reproach, and to be beacons of decency and stability in an otherwise chaotic and complex environment. Choosing to adopt ethical principles and behaviours is an approach that leaders and managers may find helpful at times when their own values might be challenged.

There are four parts to this ethical framework – status, staff, service, and society.

**The 4s Model of Ethical Leadership™**

**Status** – the profile of an ethical person that shines through into leadership and convinces followers of his or her common sense, wisdom and effectiveness as a leader.

**Staff** – the behaviours and decisions of leaders that lead to the engagement, trust and commitment of the workforce in their work and their organisation.

**Service** – the behaviours and decisions of leaders that produce the highest quality and standard of service.

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1 Otherwise known as ‘the Mowbray Model of Ethical Leadership’
2 Psychological status refers to individuals who attract attention by virtue of their personality, wisdom, depth, decisions and behaviours towards others.
Society – the behaviours and decisions of leaders that demonstrate a concern to prevent harm to, and promote wellbeing in, society at large.

Status – the profile of an ethical leader and manager

The profile of an ethical leader and manager is built on the personal characteristics and motivations of the individual.

Characteristics

An ethical leader and manager will be concerned about building and maintaining trust and about acting correctly in relation to others. The following personal characteristics are found in ethical leaders and managers:

- Attentiveness (genuine attentiveness to others produces an automatic response of attentiveness back – it shows a genuine interest in others; anything less, such as a hint of superficial interest, automatically switches people off from the interaction and gains nothing)
- Being able to offer direction with committed ambition (determination)
- Someone who attracts psychological status (status that people with wisdom attract)
- Someone who possesses intelligence with humour (the ability to make people smile and chuckle combined with intellectual flexibility)
- Assertiveness (being clear about what is required)
- Someone who can create stress and deflate it (deflating stress before it passes from pressure to strain to stress – for example, expressing anger and then controlling and using the anger for positive effect)
- Someone who addresses individual need

Motivations

In addition, an ethical person has the motivation to be:

- Competent
- Emotionally intelligent
- Intellectually flexible
- Attentive
- Non-prejudicial
- Non-discriminatory
- Respectful of others
- Honest (Probity)
- Transparent
- Sound (Integrity)
- Reliable
- Selfless (without self interest)
- Humble

Profile

In addition, other features contribute to the profile of an ethical leader and manager:

- The ability of the ethical person to shine through to leadership and management.
• The adoption of a leadership style that lends itself to ethical considerations, for example transformational and adaptive styles – both of which engage followers in the decision making processes.
• The motivation to prevent harm to anyone.
• The motivation to ensure a safe place of work for staff and patients.
• The respect for the law and regulations
• The motivation to maintain and develop skills, knowledge and experience in oneself and others
• The motivation to be objective, fair and reasonable
• Taking responsibility for own as well as others actions
• The motivation to act with conviction
• The motivation to provide a clear direction
• The motivation to communicate effectively
• The discharge of a Duty of Care to patients, relatives and staff.

Staff – Wellbeing and performance in the workforce
The key behaviours of ethical leaders, in their interaction with others, are those that promote engagement, trust, commitment, resilience and tolerance at work. Ethical leaders should be motivated to (be):

1) Attentive
demonstrate genuine attentiveness to the contents of an interaction by demonstrating listening, responsiveness and reaction.

   Polite
   be polite in any interaction

   Courteous
   place the other person (people) at the forefront of an interaction

   Communicate personally
   communicate personally wherever possible; understanding the limitations of electronic communication.

   Use Body language
   use body movements and expressions to show attentiveness.

   Address needs
   respond positively to individual needs, even in circumstances when the needs cannot be met, given all the circumstances.

   Empathise
   demonstrate an understanding of the other person’s issues, ideas, thoughts and experiences

2) Intellectually flexible
think on one’s feet and respond with credible choices, alternatives and ideas

   Emotionally intelligent
   be self aware, self regulate, motivate, show empathy and be socially adept

   Negotiate
   negotiate a successful outcome in an interaction.

   Share
   share with others one’s own thoughts and ideas

3) Reliable
do what one says
Honest
be open in an interaction
Clear
be clearly understood in an interaction
Fair
be fair to anyone in an interaction, taking account of all the circumstances, and to explain clearly the position that is taken and the reasons
Humble
acknowledge mistakes, misunderstandings, errors and faults, and to apologise where necessary.

4) Resolve conflicts
the ability to resolve conflicts at the time of the dispute.

5) Encourage contribution
the ability to motivate and encourage others to make a contribution in interactions

Service - Leading the service through ambiguity and uncertainty
There are a range of ambiguities related to the purpose of healthcare services. Included amongst them is the purpose of hospitals; the purpose of health services in improving the health of populations; the nature of partnerships between different organisations delivering health services; the definition of service provision; and the concept of ‘free’ healthcare at the point of delivery.

Under these circumstances, leaders need to provide degrees of certainty that people can attach themselves to as ‘anchors in a stormy sea’. Leaders have to be able to generate commitment, trust and engagement between themselves, their followers and the organisations they work in or communities they are attached to. A principal approach to gaining the confidence and conviction of followers is to act ethically. Trust in people comes with an outward demonstration of ethical decision making and actions, the kind of decisions and actions that people believe to be right, fair and appropriate.

Society - Concern for society
Ethical leaders will be motivated to assess the impact of their own organisation, decisions and actions on society at large.

Below are determinants of health that impact on society. They provide a framework within which ethical leaders can consider the impact. The dominant consideration is to attenuate the possibility of harm arising.

- Poverty and deprivation
The impact on health and wellbeing of poverty and deprivation is now well established. In the UK there are pockets of poverty and deprivation relative to the standards of the UK. Healthcare organisations are in a position to support individuals suffering poverty and deprivation with positive health and wellbeing activities and services.

- Crime
Crime may, also, be a consequence of poverty, deprivation and unemployment. In the UK, as elsewhere, there are effective projects that cut the rate of crime using a variety of health focused activities, in particular exercise. As healthcare organisations are often a dominant employer with
visible buildings and services, there may be projects that can help reduce the levels of crime by using the skills, expertise and facilities of healthcare resources.

- **Lifestyle**
  Behaviour is one of the principal influences on health and wellbeing. There is much to be achieved in effective health and wellbeing promotional activities, not least an eventual reduced demand on healthcare services as well as the achievement of improving the health of people.

- **Environment**
  The impact we have on the environment is now generally understood and acknowledged as a serious concern. Ethical leaders will be motivated to reduce waste, reduce carbon emissions and take any other actions that reduce the ‘footprint’ of healthcare organisations on the environment. There is, also, the internal environment – the working environment – that has an impact on patients and staff. Ethical leaders will be motivated to prevent harm from arising from any aspect of healthcare provision.

- **Scientific knowledge and advance**
  The rate at which new developments come into practice is very fast, although, for some in urgent need of new treatments, not fast enough. The processes involved in discovery, testing and application will place people at risk, simply by virtue of the time required to complete the processes. The ethical leader will be motivated to prevent harm to people as a result of developments in science and its application.

- **Technology**
  The healthcare industry is at the front of technological development. However, some applications of technology cause risks and concerns for people – centralised databases and the possibility of identity theft, for example. Whilst technology is invaluable to all of us, nevertheless, the ethical leader will be motivated to ensure that no harm comes to anyone as a result of the application of technology to healthcare.

- **Public expectations**
  There is a danger that public expectations of the effectiveness of healthcare services are exaggerated. It is the nature of healthcare that there is a darker element to the services where individuals do not achieve the expected outcome that they had hoped. Transparency and lack of exaggeration are key to keeping the public abreast of what is possible within healthcare. The motivation of the ethical leader is to ensure that public expectations are not falsely raised.

- **Disease**
  Healthcare services exist to treat disease. However, new diseases and variants of existing ones arise all the time. Sometimes these can defeat the most powerful interventions. The ethical leader is motivated to be transparent in communication about the risks to people of newly identified diseases, and how they can be treated.

- **Globalisation**
  This phenomenon makes it easier for diseases to transfer across the world. It, also, results in skilled people working away from their home country, and technology exchanges taking place. The ethical leader will be motivated to learn from experiences globally, and motivated to support other healthcare systems, in particular by not extracting healthcare resources, but by offering development and training opportunities.

- **Demographics**
  The changing structure of the population, combined with the changing mix of races and culture are challenges for public and private healthcare services. The ethical leader will be motivated to ensure that all patients are cared for equally and with equal effectiveness.
**Codes of Conduct – Purpose**

A Code has the purpose of being the central guide and reference for users in day to day decision making. The Code is meant to reflect the organisation’s purpose, mission, values and principles, and linking these to the standards of professional conduct. The conduct of individuals, therefore, should clearly reflect what the organisation ‘stands for’ and how the organisation wishes to see itself projected to the outside world.

The Code is an open and public disclosure of how the organisation operates.

A Code can fulfil other functions. It can become a tool that encourages discussion around ethical dilemmas, prejudices and grey areas that can arise during everyday working; it can provide the opportunity to create a positive public identity for the organisation that can raise levels of public confidence and trust.

**Existing Codes**

There are a number of Codes in existence. A selection of headlines is reproduced here for interest.

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<td>Openness</td>
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<td>Probity</td>
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<td>Respect</td>
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<td>Environment</td>
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<td>Team work</td>
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<td>Learning and development</td>
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<td>Competence</td>
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<td>Responsibility</td>
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<td>Selflessness</td>
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<td>Leadership</td>
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<td>Objectivity</td>
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These headline codes conceal a range of expected behaviours to achieve the headline. There is a mixture of codes looking outwards (environment, society), looking inwards (care, safety) and personal attributes and behaviour (integrity, honesty, openness, probity, team work) and
managerial imperatives (accountability, performance, learning and development, objectivity, competence, responsibility, leadership). They all add up to what should be expected from a well managed organisation.

The Manager’s Code - Where to start?
The Manager’s Code has been prepared to support managers in stepping outside the stereotypes and appealing to personal values and concern for the wellbeing of others as a means to the end of achieving high performance combined with high levels and standards of quality and service.

The involvement of influential professional, trade union and development groups in supporting this Code emphasises the professional focus for the Code, compared, for example, with the bureaucratic origins of the 2002 Code of Conduct and the current discussions on accreditation of senior managers.

Manager behaviour does not take place in isolation. It takes place within a cultural context. People adopt the roles expected of them, and, if the expectation is rigid application of systems, procedures and targets, this will be reflected in manager behaviour. If the expectation is that staff are the most valuable resource available to the organisation, and that staff need to perform at their optimum and beyond, then nurturing, encouragement, support and continual development, will be reflected in manager behaviour.

NHS Culture – promoting wellbeing and performance
In the approach to creating a Manager’s Code the view is taken that the cultural foundations of the NHS are unhelpful, despite the legalising of the NHS Constitution. The cultural foundations need to be based on a Positive Work Culture that promotes wellbeing and performance. The behaviours and competencies of managers would be expected to display these cultural foundations by building trust and commitment leading to engagement between themselves and the people they manage. In other words – putting people first.

People act. People act according to the context in which they find themselves, and the meaning the context has for them. People also act in ways to create an expected response. Managers, therefore, act according to the context in which they manage. The context is normally determined by the cultural foundations of the organisation within which managers manage other people; cultural foundations often reflect the values that drive the organisation.

The NHS Constitution
The NHS Constitution, published in January 2009, provides the cultural foundations within which managers and others are expected to behave. The key elements of the Constitution are reproduced below:

The Principles are:
1. The NHS provides a comprehensive service, available to all.
2. Access to NHS services is based on clinical need, not individual’s ability to pay.
3. The NHS aspires to the highest standards of excellence and professionalism.
4. The NHS works across organisational boundaries and in partnership with other organisations in the interests of Patients, local communities and the wider population.

5. The NHS is committed to providing best value for taxpayer's money and the most effective, fair and sustainable use of finite resources.

6. The NHS is accountable to the public, communities and patients that it serves.

**The Values** are:

1. Respect and dignity
2. Commitment to quality of care
3. Compassion
4. Improving lives
5. Working together for patients
6. Everyone counts.

The Constitution sets out the rights of patients and staff together with responsibilities. The parts of the rights and responsibilities that require certain behaviours are these:

   a) Unlawful discrimination
   b) Decisions in a clear and transparent way so that they are understood
   c) Patients to be treated with dignity and respect
   d) Patients involvement in discussions and decisions about healthcare
   e) Patients are treated with courtesy, and appropriate support in handling a complaint
   f) Acknowledgement of mistakes, apologies and explanation. Patients should treat staff and other patients with respect.
   g) Patients should provide feedback.
   h) Staff should have rewarding and worthwhile jobs; confidence to act in the interest of patients; treated with respect; listened to; good working environment; flexible working opportunities; free from harassment and bullying or violence; free from discrimination; personal development; clear roles and responsibilities; maintenance of health and wellbeing; engagement in decision making about themselves; honesty; involvement in improving services; openness with patients and families; create a climate where truth can be heard; and errors are reported and lessons learnt.

Some might argue that the Constitution doesn’t provide a clear enough picture of what the NHS should look like; that the words do not convey the depth of meaning required for greater understanding of what is intended by the Constitution, other than a series of rights and wrongs.

The Constitution contains some characteristics that define a healthy organisation. Others are presented below.

**The characteristics of a psychologically healthy organisation**

The following description of a healthy organisation is derived from research into the most globally successful public, private and voluntary sector organisations.

The characteristics of a psychologically healthy organisation are:
• a clear, unambiguous purpose, expressed as a simple ‘big idea’, an idea which all the staff relate to closely, and are proud to discuss with friends and colleagues.

• an atmosphere of confidence, where all the staff are interested in each other, support each other, and project this confidence towards clients and customers.

• staff who behave respectfully towards each other, value each other’s views and opinions, work in teams which are places of mutual support, where anything is debated without a hint of humiliation, where the critique of individual and team work is welcomed, discussed and where lessons are learnt and implemented.

• staff who ‘go the extra mile’ by providing unsolicited ideas, thoughts, stimulus to each other, and where their interest in their customers offers something more than is expected, beyond courtesy, and beyond service, offering attentiveness and personal interest.

• challenges for their staff, that provide opportunities for personal development through new experiences, and which treat everyone with fairness and understanding.

• staff who are personally driven towards organisation and personal success - intellectually, financially, socially and emotionally.


There are some key words that provide a steer towards the behaviours that are needed to produce organisations with the above characteristics:

- Unambiguous purpose
- Pride
- Confidence
- Interest
- Support
- Teams
- Respectful
- Critique
- Learning
- Unsolicited ideas
- Courtesy
- Attentiveness
- Personal interest
- Challenges
- Personal development
- Fairness
- Understanding
- Intellectual success
- Financial success
- Social success
- Emotional success

The description above contains many of the ingredients for building staff engagement with their organisation and their work.

**Engagement**

Engagement is a relatively recent interest for researchers and is characterised by energetic and effective connection with work. Engagement has been described as ‘a positive, fulfilling, work-related state of mind that is characterised by vigour, dedication and absorption’. Vigour is characterised by ‘high levels of energy and mental resilience whilst working, and willingness to invest effort in one’s work, and persistence in the face of difficulties’. Dedication refers ‘to be strongly involved in one’s work and experiencing a sense of significance, enthusiasm, inspiration, pride, and challenge’. Absorption is characterised by being ‘fully concentrated and happily
engrossed in one's work, whereby time passes quickly and one has difficulties with detaching oneself from work'.

People who are engaged in their work and with their organisation are more likely to focus on their work and produce high performance. In addition, engagement is known to have a significant impact on the levels of psychological distress, and on the levels of sickness absence, staff turnover and presenteeism.

Engagement is achieved by building a Positive Work Culture based on trust and commitment between employees and their organisation as represented by their managers.

**Components of a Positive Work Culture**
The key components of a Positive Work Culture fall into four categories – purpose, architecture, rules and behaviour.

**Clarity of purpose**
- The ability to make clear and unambiguous the purpose of the organisation in ways that are simply expressed, and in ways that employees and the public can understand and relate to.

**The structures (architecture)**
- The ability to structure organisations in ways that enable employees to be engaged in decisions about themselves and their work.

**The ‘rules’**
- The ability to recruit managers based on the convergence of clear and unambiguous expectations of the skills, knowledge and experience needed for the job and those of the applicant, together with the personal characteristics set out in this Code.
- The ability to ensure that training and development (the acquisition of skills, knowledge and experience) meets the needs of the organisation and those of the trainee; that training is based on sound learning experiences, and that the training is applied in practice.
- The ability to provide employees with challenges in their work.
- The ability to create and maintain teams of people who are sufficiently trusting of each other that they can critique each other’s work without fear of humiliation or retribution, and in the knowledge that lessons can be learnt and applied.
- The ability to communicate – the process of interpreting messages, conveying them intelligibly, seeking responses, and reacting positively to the responses.
- The ability to engage employees and clients in the processes and critical decisions that affect them.
- The ability to performance appraise employees regularly and routinely as part of the bloodstream of management, together with the ability to provide appropriate supporting resources to raise performance where needed.
The ability to nurture employees by providing opportunities to gain wider skills, knowledge and experience, and the ability to use these in practice in career development.

The ability to safeguard the opportunity to complete tasks, projects and assignments undertaken by employees.

The ability to encourage employees in their work, and to encourage limited risks in their contribution to the work of the organisation.

The ability to respond positively to employee domestic crisis.

The ability to create and maintain openness (transparency) in the management of the organisation.

Managing people

Behaviour

Within a context of a Positive Work Culture managers will be expected to behave according to the cultural foundations of the organisation. Some of the behavioural characteristics that reduce the risks of psychological distress have been identified from research conducted on behalf the CIPD and HSE.

The HSE/CIPD approach

The Health and Safety Executive and the Charted Institute of Personnel and Development jointly funded research into the behaviours that aim to prevent and reduce stress at work. The behaviours are directly linked to the HSE Management Standards.

The behaviours include:

- Being aware of team member’s ability
- Trusting employees to do their work
- Giving employees responsibility
- Steering employees in a direction rather than imposing a direction
- Provide opportunities to air views
- Prepared to listen to employees
- Knows when to consult employees
- Helps employees develop in roles
- Communicating that employees can talk to them at any time
- Making time to talk to employees at their desks
- Praising good work
- Acknowledging employee's efforts
- Operating a no blame culture; passing positive feedback about the team to senior management.
- Regularly asks ‘how are you?’
- Listening objectively to both sides of a conflict
- Dealing with conflict head on
- Having a positive approach
- Acting calmly when under pressure
- Walking away when feeling unable to control emotion
- Apologising for poor behaviour
- Admit mistakes
- Treats employees with the same importance
- Willing to have a laugh and a joke
- Socialises with the team
- Regularly has informal chats with employees
- Keeps team informed of what is happening in the organisation
- Communicates clear goals and objectives
- Explains exactly what is required
- Communicating ‘the buck stops with me’.
- Able to put themselves in employees shoes
• Takes an interest in employees personal lives
• Notices when a team member is behaving out of character

Defining the behaviours in carrying out the role of manager

The existing Codes and the Qualities Framework encourage team working, openness, partnerships, empowering others – all of which show hints of approaches to management that might produce the desired outcome of quality and effective management.

Approaches to carrying out the role of manager (headlines)

<table>
<thead>
<tr>
<th>Behaviours</th>
<th>NHS Leadership and Qualities Framework</th>
<th>Code of Conduct for NHS Managers</th>
<th>IHM Management Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transformational</td>
<td>Empowering others</td>
<td>Working as a team member</td>
<td>Lead by example</td>
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<tr>
<td></td>
<td>Leading change through people</td>
<td></td>
<td>Openness in decisions and actions</td>
</tr>
<tr>
<td>Adaptive</td>
<td>Empowering others</td>
<td>Working as a team member</td>
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<tr>
<td>Transactional</td>
<td>Holding to account</td>
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Managers need to interact effectively with their staff to acquire information, make informed decisions, and initiate effective action subsequent to the decision. At the same time managers need to ensure that their interaction enhances psychological wellbeing, and doesn’t produce psychological distress. Psychological distress will result in a fractured psychological contract, disengagement, failed action and worse.

Among the many purposes for successful interactions are those that promote trust, commitment and engagement between staff and the manager and the organisation. There are several aspects to this, amongst them:

• The implementation of structures and processes that lead to trust, commitment and engagement
• The reinforcement of these by the behaviours manifested in managers towards their staff.

The structures and processes that facilitate trust, commitment and engagement include the following:

• Encouraging training and development amongst staff
• Providing challenges to staff in their work
• Engaging in team work
• Effective two way communication that seeks responses
• Encouraging involvement in the activities of the workplace
• Undertaking continuous performance appraisal
• Providing opportunities for career development
• Securing the ability for staff to complete projects and tasks
• Continuous encouragement
• Responding positively to domestic crisis
• Ensuring openness and transparency in all activities
Managers that promote these activities and encourage them to become part of the bloodstream of management will acquire the role of ‘attractor’ in the chaotic world of healthcare delivery. Staff will respond positively to the structures and processes if they attenuate the stresses incurred through the normal delivery processes of healthcare. This requires judgement. Too much of any of the items above, and staff will become disengaged. Too little and the same will happen. Only by discussing and engaging with staff on all the issues above will the manager move closer to adaptive behaviour that is appropriate to the chaos of healthcare delivery.

Effective healthcare managers will need to demonstrate an awareness and understanding of the range and differences of the multi-professional and multi-ethnic groups they interact with. They will need to understand the causes and effects of different cultures and standards that exist within multi-professional and multi-ethnic services.

In particular, as the healthcare services are essentially constructed with ‘virtuous intent’, healthcare managers will need to be sensitive to the range, variations and interests of the populations served and the staff serving them.

As healthcare is based on innovation, technological advance and scientific research, healthcare managers will need to be aware of and understand the complexities around the application of research into practice. They may wish to become engaged in research, by identifying researchable topics, applying research findings into practice or using action research methods to bring change to the organisation.

The behaviours that reinforce the effectiveness of structures and processes are acted out in interaction between the manager and another or other people.

An effective interaction is one that concludes with action taking place without any sense of psychological distress being experienced either by the manager or the member of staff.

**Managing the service – promoting wellbeing and performance**

**Defining the personal characteristics of an effective manager**

The Codes of Conduct and the NHS Leadership Qualities Framework include personal characteristics expected in a healthcare manager. They are listed below.

<table>
<thead>
<tr>
<th>Personal characteristics</th>
<th>NHS Leadership Qualities Framework</th>
<th>NHS Code of Conduct</th>
<th>IHM Management Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self belief</td>
<td>Respect for others</td>
<td>Respect for others</td>
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<tr>
<td>Self awareness</td>
<td>Honesty</td>
<td>Honesty</td>
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<td>Self management</td>
<td>Integrity</td>
<td>Openness</td>
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<tr>
<td>Drive for improvement</td>
<td>Take personal responsibility for self development</td>
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<tr>
<td>Drive for results</td>
<td>Value other people</td>
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<td>Personal integrity</td>
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<tr>
<td>Intellectual flexibility</td>
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</table>
Research has identified the personal characteristics that persuade others to take actions they might not otherwise take within a framework that promotes wellbeing and performance.

They are - the ability to demonstrate:

- *competence in life skills*
- *genuine attentiveness to others*
- *trustworthiness, probity, selflessness*
- *wisdom*
- *assertiveness*
- *intelligence and intellectual flexibility*
- *a sense of humour*
- *a passion for the work of his/her organisation*
- *addressing individual needs*
- *nurturing others*
- *direction with committed ambition*
- *emotional intelligence*

Defining the skills, knowledge and experience of an effective manager

Without going into detail, the core skills, knowledge and experience required for effective management are those that produce effective decisions and actions linked to the purpose of management - co-ordination, direction and control at the strategic, administrative and executive levels of organisations. In addition, managers who manage specialised services may acquire additional skills in relation to the specialised areas. For example, practice management may require different specialist skills to hospital management.

Below are the headline topics that relate to effective management skills, knowledge and experience found in existing Codes and Quality Framework:

**Skills, knowledge and experience (headlines)**

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<tbody>
<tr>
<td>Leading change through others</td>
<td>Care and safety of patients</td>
<td>Respecting the impact of one's own actions on society</td>
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<td>Political astuteness</td>
<td>Performance management</td>
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<td>Effective use of resources</td>
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<td>Safe working environment</td>
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<td></td>
<td>Reasonable and fair treatment of those with concerns</td>
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<tr>
<td>Achieving the potential of others</td>
<td>Support the Accountable Officer in discharging his/her responsibilities.</td>
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<tr>
<td>Knowledge</td>
<td>Best interests of public, patients and clients are upheld in decision making</td>
<td>Awareness of energy and environment conservation</td>
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<tr>
<td>Experience</td>
<td>Judgements about colleagues are consistent, fair and unbiased</td>
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</table>

The possible range of appropriate skills, knowledge and experience for effective management is very broad. Below are headline topics that would be expected as the core skills and knowledge to be acquired and used as a manager. These amount to levels A, B and C skills.
Accountancy B
Action learning C
Action research C
Acquiring skills C
Assessments B
Attentiveness A
Absence management B
Appraisals B
  Staff appraisals
  Option appraisals
  Architecture (structure)
Application of research C
Assertiveness B
Behaviour at work A
Breaking Bad News A
Body language A
Bullying and Harassment A
Career development B
Change C
  Organisation change
  Coping with change
  Change strategies
Challenging conversations A
Citizenship A
Co-ordination A
Commitment and Trust A
Communications A
Coaching C
Conflict resolution B
Control B
Creative thinking C
Culture C
Customer relations A
Delegation A
Decision making B C
Direction C
 Disability B
Diversity and equality B
Discrimination B
Dismissal B
Difficult people B
Emotional Intelligence A
Employee engagement A
Ethics A
Empowerment A
Governance B

Engagement A
Evaluation B
Facilitation C
Feedback C
Growth and expansion C
Gender issues B
Harnessing experience C
Handling leavers B
Health and Safety B
Humour A
Iceberg Effect A
Interviewing C
Intuitive thinking C
Leadership C
Learning A
  Single loop
  Double loop
  Triple loop
Learning organisation C
Learning sets C
Listening skills A
Manager-employee relationships A
Management encouragement A
Management performance A
Management development C
Marketing B
Mediation B
Mergers B
Mental health and wellbeing A
Mental resilience A
Mentoring C
Mind mapping B
Motivation A
Negotiation C
Networking C
Organisation purpose C
Organisation design C
Organisation development C
Organisation citizenship A
Performance management B
Politics C
Presentations C
Project management B
Problem solving B C
Public relations C
Psychometric testing B  
Psychological contract A  
Quality assurance B  
Recruitment B  
Redundancy B  
Report writing B  
Research methods B  
Resilience B  
Responsibility B  
Risk management B  
Ripple effect A  
Roles B  
Rules B  

Staff turnover B  
Staff retention B  
Strategic thinking C  
Strategic planning C  
Stress management A  
Team working and development A  
Training and development B  
Time management B  
Trust at work A  
Values A  
Work life balance C  
Wellbeing at work A  

A= level A; B= level B; C= level C

Level A skills can be taught in specific training programmes. Level B skills can be taught in specific programmes. Level C skills are acquired through the role models that managers experience in their formative years, which is why ‘Buddy Schemes’ are so important for the development of effective managers. Experience of different types of organisation and service will be, clearly, invaluable to the committed and interested manager, which is why attachments and secondments are important in manager development.

The Manager's Code - Who's Code is it anyway?
The NHS is a complex organisation where there can be confusion over the roles and responsibilities of different levels of management leading to considerable uncertainty for managers (Chairmen, Executive and Non-Executive Board members, Chief Executives and managers) facing the need to make decisions. Politicians, Regulators, Civil Servants, staff in various organisational levels, as well as the general public, all seem to have the ability to make their views known when events occur that may not result in a positive outcome, and may seek to intervene in situations about which they have no direct knowledge or understanding. The 2002 Code, widely adopted, has not necessarily resulted in building a cultural context that fosters enthusiasm for talented people to achieve the highest managerial positions, yet its content is reasonable and had widespread support. Like other Codes the 2002 Code is used as the benchmark against which the actions of managers are judged. It, therefore, represents a default position, rather than an enabling code for encouraging good practice. It has become a regulation that managers know is in the background, but which is avoided until such time as someone raises a complaint. It has not become embedded into the bloodstream of the NHS as a representation of its values and principles.

The question arises – who's Code is it anyway? This review is intended to seek a consensus Code across the principal professional organisations, and to focus the content on the managerial behaviours that will lead to high standards and quality of care. The aim is for individual managers to want to abide by the Code because it makes sense, and because it leads to high quality healthcare and a fulfilling working life.
Implementation

Consensus across professional groups
The NHS is made up of groups of professional staff, each with their various professional bodies, interest groups, Trade Unions and traditions. The nature of the delivery of healthcare means that some professional staff find themselves working alone with their patients, whilst the majority are working in the company of others, each contributing their own skills within a team context. Whatever the mode of healthcare delivery, a prime aim of the NHS is to provide consistently high quality healthcare wherever it is delivered. For this reason the management of health services needs to be consistent across all the professional groups, with all the managers of different services adopting the same approach to managerial behaviour.

The changing background of managers, from professional general managers to general managers with prior professional expertise in, say, a clinical field, opens up opportunities from a much larger pool of managerial expertise from which managers can be selected.

Each professional body has its own Code for various purposes. The aim is to gain a consensus across the professional bodies for a common Manager’s Code.

Words and deeds
A challenge for all written statements is their validity. There is scepticism surrounding the issuing of Mission Statements, for example, because they sometimes have little face validity, but appear as excellent aspirations for an organisation. The choosing of words that are supported by valid actions is an essential component of a Code, particularly one that has the aim of bringing change to an organisation’s culture.

Training and development
Implementation will require training and development of staff in how to conduct themselves according to the Code. This Code is focusing on behaviours that create a Positive Work Culture that has many advantages relating to the achievement of high quality healthcare services. The return on investing in training and development will exceed the expectations placed on the provision of support services, such as Occupational Health Services, for example, because the aim of the Code is to promote an environment that prevents psychological distress from occurring in the first place, and a culture that promotes engagement.

Legality and enforcement
The extent to which a Code becomes enforceable depends on the decisions to include the Code as part of contracts of employment.

There are other ways of cementing a Code into the bloodstream of an organisation – through the training of staff; the adoption of a concept of organisation citizenship; the development of policies and their implementation concerning issues of dignity; and the linkages a Code could have with existing policies and regulations relating to discrimination, equality and diversity, bullying and harassment and conduct. Normally such policies and regulations rely on a default position, whilst this Code is meant to project a positive and active stance that promotes
management actions that lead to trust, commitment and engagement between managers and the people they manage.

There may be a case for organisations to review their policies and procedures in the light of this Code, and for these to emphasise trust, commitment and engagement as a central feature.

**Conclusion**

In the light of developments in the NHS there appears to be a growing level of negativity that is hindering efforts to achieve high standards and quality of healthcare. This situation carries a huge cost in terms of sickness absence, staff turnover and presenteeism. In addition, this is having an impact on the numbers of talented manager seeking the highest positions.

In an effort to improve the culture and management practices a Manager’s Code has been prepared to act as a benchmark for manager action and behaviours. The focus for the Code is to build and sustain a Positive Work Culture that leads to wellbeing and performance for staff and for their organisation. This will have the impact of reducing levels of psychological distress, and increasing commitment, trust and engagement by staff in their work.

February 2010.
Purpose of a Code
A Code has the purpose of being the central guide and reference for users in day to day decision making. The Code is meant to reflect the organisation’s purpose, mission, values and principles, and linking these to the standards of professional conduct. The conduct of individuals, therefore, should clearly reflect what the organisation ‘stands for’ and how the organisation wishes to see itself projected to the outside world.

The Code is an open and public disclosure of how the organisation operates.

A Code can fulfil other functions. It can become a tool that encourages discussion around ethical dilemmas, prejudices and grey areas that can arise during everyday working; it can provide the opportunity to create a positive public identity for the organisation that can raise levels of public confidence and trust.

The aim
The aim of the Manager’s Code is to build and sustain workplaces with a Positive Work Culture that mirror the description below. Such organisations achieve great success in producing high performance combined with high quality services.

• a clear, unambiguous purpose, expressed as a simple ‘big idea’, an idea which all the staff relate to closely, and are proud to discuss with friends and colleagues.
  • an atmosphere of confidence, where all the staff are interested in each other, support each other, and project this confidence towards clients and customers.
  • staff who behave respectfully towards each other, value each other’s views and opinions, work in teams which are places of mutual support, where anything is debated without a hint of humiliation, where the critique of individual and team work is welcomed, discussed and where lessons are learnt and implemented.
  • staff who ‘go the extra mile’ by providing unsolicited ideas, thoughts, stimulus to each other, and where their interest in their customers offers something more than is expected, beyond courtesy, and beyond service, offering attentiveness and personal interest.
  • challenges for their staff, that provide opportunities for personal development through new experiences, and which treat everyone with fairness and understanding.
  • staff who are personally driven towards organisation and personal success - intellectually, financially, socially and emotionally.
Outline
The Manager’s Code focuses on three areas:

- Managing the organisation – to build and sustain a Positive Work Culture
- Managing people – to build and sustain commitment, trust and engagement
- Managing the service – to build, sustain and deliver high quality health services

➢ Code 1 - Managing the organisation

To build and sustain a Positive Work Culture as the context in which staff thrive, perform at their optimum, are engaged with their organisation, are energised to contribute, and derive personal and professional fulfilment.

Managers are expected to demonstrate:

Clarity of purpose
- clarity of purpose of the organisation and its sub divisions in ways that are simply expressed, that staff and the public can understand and relate to.

The structures
- structures of their organisations that enable staff to be engaged in decisions about themselves and their work.

The ‘rules’

Recruitment
- recruitment of managers based on the convergence of clear and unambiguous expectations of the skills, knowledge and experience needed for the job and those of the applicant.
Training and development

- training and development (the acquisition of skills, knowledge and experience) of all staff based on meeting the needs of the organisation and those of the trainee; that training is based on sound learning principles, and that the training is applied in practice.

Challenge

- that staff are stimulated with personal challenges in their work.

Teams

- building and sustaining teams with people who are sufficiently trusting of each other that they can critique each other’s work without fear of humiliation or retribution, and in the knowledge that lessons can be learnt and applied.

Communication

- excellent communication – the process of interpreting messages, conveying them intelligibly, seeking responses, and reacting to them positively.

Involvement

- engagement of all staff, other organisations and the relevant sections of the public in the processes and critical decisions that affect them.

Performance appraisal

- regular and routine performance appraisal of staff as part of the bloodstream of management, together with providing appropriate supporting resources to raise performance where needed.

Career development

- nurturing and development of staff by providing opportunities to gain wider skills, knowledge and experience, and to use these in practice in career development.

Security

- continuation of already started activities to enable staff to complete tasks, projects and assignments.

Encouragement

- encouragement of staff in their work, and encouragement of calculated risks in their contribution to the work of the organisation.

Work life balance

- responsiveness to employee domestic crisis.
Openness

- building and sustaining openness (transparency) in the management of the organisation.

[Code 2 - Managing people]

To build and sustain trust, commitment and engagement between managers and who they manage.

Status
Managers are expected to show:

Competence as a person, as a manager and as a leader

- emotional intelligence
- intellectual flexibility

Attentiveness in every interaction

- non-prejudicial, and non-discriminatory attentiveness
- attentiveness to diverse interests and people

Honesty and trustworthiness

- transparency in all actions
- application of soundness, integrity and reliability in judgments

Selflessness

- humility

Staff and the public
Managers are expected to show:

Attentiveness

- genuine attentiveness to the contents of an interaction by demonstrating listening, responsiveness and reaction.
**Politeness**
- politeness in any interaction

**Courtesy**
- placing the other person (people) at the forefront of an interaction

**Personal communication**
- personal communication wherever possible; understanding the limitations of electronic communication.

**Use of Body language**
- the use of body movements and expressions to show attentiveness.

**Address needs**
- positive responsiveness to individual needs, even in circumstances when the needs cannot be met, given all the circumstances.

**Empathy**
- an understanding of the other person’s issues, ideas, thoughts and experiences

**Intellectual flexibility**
- being able to think on ones feet and respond with credible choices, alternatives and ideas

**Emotional intelligence**
- being self aware, self regulating, motivated, showing empathy and being socially adept

**Negotiation**
- being able to negotiate a successful outcome in an interaction.

**Sharing**
- sharing with others one’s own thoughts and ideas

**Reliability**
- doing what one says

**Honesty**
- being open in an interaction
Clarity

- being clearly understood in an interaction

Fairness

- being fair to anyone in an interaction, taking account of all the circumstances, and to explain clearly the position that is taken and the reasons

Humility

- acknowledging mistakes, misunderstandings, errors and faults, and to apologise where necessary.

Resolve conflicts

- being able to confront a conflict at the time of conflict and to try and resolve any dispute at the time of the dispute.

Encourage contribution

- being able to motivate and encourage others in interactions.

Code 3 - Managing the service

To build, sustain and deliver high quality health services

Effective managers are expected to demonstrate:

Decision making

- justification for decisions based on appropriateness, evidence, experience, timeliness and feasibility.

Direction

- providing direction based on analysis and with committed ambition

Co-ordination

- efficient integration of the mosaic of available resources to achieve a declared aim.

Control

- reaching an agreed goal within agreed boundaries of time and resources.
keeping resources at his/her disposal within agreed boundaries.

ensuring that proper governance of resources is applied always

**Service**

**Appropriate interventions**

- appropriateness of interventions in meeting individual, community and corporate need.

**Intervention effectiveness**

- effectiveness of interventions in producing positive outcomes.

**Value and efficiency**

- guaranteed efficient delivery of services within the prescribed resources that also represent genuine ‘value’.

**Patient satisfaction**

- satisfaction of patients (and their relatives and friends) receiving healthcare services they need and have been prescribed.

**Society**

**Impact on society**

- being aware of, and, where necessary, moderating the impact on society of healthcare organisations and the services they deliver

**Promotion of health and wellbeing**

- participating with others in promoting health and wellbeing activities

**Preventing harm**

- taking appropriate actions to prevent or limit the risks of harm in society arising from any healthcare activity
- making judgements about the use of sensitive and confidential information in the public and society interest

January 2010

[www.ihm.org.uk](http://www.ihm.org.uk)
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