DIGITAL HUMANITY IN HEALTH AND CARE

#02 LEADERSHIP

**THE VISION OF THE FUTURE**

**EDUCATION**

CHANGE MINDSETS

- Tech = helpful
- Patient need = expert
- All voices heard & build shared consensus

CHANGE CULTURE -> CHANGE SYSTEM

- A person experience = valid => stats
- Empower patients to make own choices
- Offer choices
- Educate / signpost
- Patient perceptions

- Transform not improve HC system
- Involve everyone / reduce system "red tape" / transparency / accountability / admin / paper work

- Capture data & share learning / journal
- Tell patient stories / legacy
- Improve role for digital (efficient = time)
- Stop doing things if doesn’t work

**LEADERSHIP**

- Patient co-design / patient / person centered
- Patient knows best
- Search for unmet need

**CHANGING MINDSETS AT ALL LEVELS**

- Clinical leadership
- System of care
- Patient
- Community

**BETTER USE OF DATA**

- In thinking about using digital health...
- First we need to think of "who serves, and serves whom?"
The Digital Humanity in Health and Care seminar series held its second event on Tuesday 25th July. The collaboration between mHabitat (Dr Victoria Betton) and the School of Media and Communication (Dr Helen Thornham) explores contemporary dilemmas around ethics, morals and humanity in a digital age. The workshops bring together people across the spectrum of those accessing health and care services, practitioners, policy makers, digital designers, tech organisations and regular people.

The overarching questions threading through the series are these:

- What does digital humanity look like? And what does it look like in relation to health and care and in relation to the axes below of policy, leadership and citizenship?
- Where is digital humanity in health and care? Is it, and could it be in systems? If it is in the human, then is this enough in a changing landscape?
- How can we be digitally humane? What everyday, digital, connective or community actions or reflections can we make or do?

SPEAKERS:

**Alan Taylor, PhD, MSc, FHEA**

Alan is a Senior Lecturer in Leadership, Management and Service Development, School of Nursing, Midwifery and Health, Coventry University. He is passionate about person-centred health and social care. Alan’s aim is to help health and social care professionals overcome the barriers which prevent them really attending to people’s needs, and thus radically transform the care they deliver. [@alndix](https://twitter.com/alndix)

**Kate Allat**

Kate is a marketeer, campaigner, mum and former 70 mile a week fell runner. She suffered a brainstem stroke & locked in syndrome (LIS) when her children were 5, 8 & 10 years old. Her book ‘[Running Free – breaking out of locked in syndrome](https://www.amazon.co.uk/Running-Free-breaking-locked-syndrome/dp/1780819598)’ reflects on her experiences. She won Extraordinary Woman in 2011 and founded and ran her registered digital charity in 2011 – just 3 months after leaving hospital. She campaigns to transform our healthcare & inspire improved outcomes after stroke especially brainstem strokes, which develop locked in syndrome.

[@kateallat](https://twitter.com/kateallat) LIS.

**Mike Chitty**

Head of Applied Leadership, NHS Leadership Academy [@mikechitty](https://twitter.com/mikechitty)

The NHS Leadership Academy has worked for the last 4 years to improve the quality and impact of leadership in health and care. The Academy develops people to provide compassionate and inclusive care in line with the values and principles of the NHS constitution. To develop the leader is to develop the human being.
At our second workshop, we looked specifically at issues relating to LEADERSHIP, and we started with the provocation from Alan Taylor that, contrary to popular conceptions of leadership as the behaviour of individual towards another person or persons, leadership is better thought of as located in the relational spaces between people. To a certain extent, Taylor’s provocation is in keeping with the Kings Fund white paper (2017) which talks about the need for the NHS to move away from competition and towards collaboration. The idea of collaboration promoted in this white paper also emphasises the space between people in terms of long term and ‘bigger picture’ collaboration, developing a shared vision, and focusing on relationships not transactions. Mike Chitty expanded on Taylor’s idea in his talk, when he suggested that leadership should be thought about as a property of a social system, something that was fluid and changeable, that was always becoming, even as it is contextually felt and lived. Both Chitty and Taylor were trying to move the idea of leadership away from something akin to an owned skill or action of an individual, where it has often been aligned with ‘management’, ‘PR’ or ‘communication’, where it can be measured through action points, quality improvement and metrics. As Taylor argued, these latter understandings of leadership feed the idea that leadership is about getting ‘more’ out of people – by ‘releasing capacity’, squeezing more out of technologies to make ‘incremental gains’ within existing systems to become more efficient or cost effective. The problem with these notions of leadership is that they feed into, without questioning (as Alan Taylor argued), existing power relations within the NHS (and other institutions).

Set against these ideas of leadership, our workshop participants considered the core principles of emotional labour, experience, and dialogue as guiding forces for thinking about leadership. Mark Chitty argued very strongly, for example, that we should return to the core principles of the NHS as a starting point, rather than trying to work within an already problematic and highly political system. At the same time, he acknowledged that these two starting points (the core principles of the NHS, and the NHS as an organisation) are actually dialectic if not oppositional. The latter is increasingly run on values of competitiveness and efficiency, the former on experience, dialogue and care. The turn to digital solutions – which quite often favours transactions over relationships and speed over labour – might well be a chimera that is actually blindsiding us. Regardless of our starting point, the current experience of the NHS – as Allat poignantly articulated – is one where the patient can be dehumanised, looked over and even dismissed. Her provocation – her demand – to look people in the eye – was a clear response to the lived impact of ‘efficient’ systems and leadership on patients today in an increasingly challenging environment. That Allat called for this simple gesture, reminds us of the very real and lived consequences of not thinking carefully about leadership.
1. LEADERSHIP IS ABOUT CHANGING MINDSETS – BUT WE ALSO NEED TO CHANGE OUR MIND SET ABOUT WHAT LEADERSHIP IS PER SE

The first argument to emerge from our workshop was that leadership may be about changing mind sets, but in order for that to happen, we need to change our own mind set about what leadership might be. The provocations provided by the speakers – which at one end of the spectrum outlined what leadership should be, and at the other end of the spectrum detailed the lived effects of leadership within the existing system – gave us clear parameters through which to work. But imagining leadership differently is a difficult task not least because it requires a culture change. In the end, we were only able to suggest some steps that might take us towards the culture change needed to radically rethink leadership. All of our steps – such as starting with care and humanity, returning to the core principles of the NHS, prioritising dialogue over efficiency and supporting the expertise of healthcare professionals in decision making – are important as both first steps and an ideal to work towards. Taken together, what they highlighted perhaps most of all, was the constraints of existing systems which generate low morality, feelings of disempowerment, anxiety and distrust. This, in and of itself, was a power reminder of the need to take action.

2. LEADERSHIP IS LOCATED IN RELATIONAL SPACES BETWEEN PEOPLE AND WITHIN SYSTEMS

Both Taylor and Chitty talked about the need to try and shift how we think of leadership away from a particular individual and think of it as the consequence of shared dialogue and decision making. In many respects, these arguments develop and go one step further than the suggestions in the Kings Fund white paper (2017) which argues for the importance of:

1. Developing a shared purpose and vision
2. Frequent dialogue in the form of personal contact
3. Actively discussing tensions and conflicts
4. Behaving altruistically towards each other
5. Working together for the long term.

The white paper is concerned with enabling a culture change and in many senses they outline the conditions through which leadership can emerge. Thinking of the two arguments together then offers us a number of steps to generate a culture change in order to better enable leadership as something that can be and should be located in the relational spaces between people and within systems.
3. LEADERSHIP NEEDS TO CHANGE THE CONDITIONS OF THE PRESENT TO IMAGINE THE FUTURE DIFFERENTLY

The final argument made by Mike Chitty was that the first two issues go hand in hand. One of the central problems in discussing leadership is that (as we found out in our workshop) imagining something differently is very difficult to do. Chitty argued that in many respects we can’t imagine the future – or leadership – differently precisely because of the conditions in which and through which we are asked to imagine. His example was the current experiences of digital take up within the NHS, which provokes a second layer of administration and labour if the implementation is not smooth, resulting in a frustrating and distrustful experience for health and care practitioners. The community nurse, for example, has a tablet for school and home visits. Yet schools are firewalled, so wifi is often impossible, or the community nurse feels s/he is spending too much time inputting data and not enough time talking and listening to patients. So the community nurse hand writes notes to upload later, adding a second layer of labour for a task s/he is doubly responsible for. The overall effect is that the community nurse experiences digital ‘innovation’ as a mostly negative practice: how could s/he then imagine a positive future of digital leadership? As Chitty argued, creating positive experiences – as Allat also detailed through her use of social media – can create an environment where thinking differently can be possible.

These are big and complex issues – and part of the challenge of the workshop was to think about the big and the small together: in order to think of leadership as something different, we need to imagine it differently. In order to imagine it differently, we need to create the conditions through which this might be possible. In order to create different conditions, we need to have different priorities around healthcare which reject the discourse of efficiency and transactional system thinking, and prioritise dialogue, long term discussion, care and humanity: we need to return to the core values of the NHS and build them into the systems in which we work.