



What Works

The trillion dollar quest

How the world's best healthcare organizations develop managers and leaders

KPMG International

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Introduction

Healthcare is one of the largest sectors on the planet with an estimated value of US\$9 trillion (and rising) each year. Recently, the KPMG report 'Value Walks' analyzed healthcare organizations with the best workforce and management systems and concluded that they could deliver up to 15 percent productivity gains.



“One thing we know for sure is that effective leadership and management are linked with strong organizational performance, greater staff satisfaction, and better patient reported outcomes.”

John McDonough
Professor of Public Health Practice, Harvard TH Chan School of Public Health

To claim their share of this potential US\$1 trillion prize, it is essential for organizations to grow the right capabilities and culture. Leadership and management development is pivotal to their pursuit, so it was perplexing that so little evidence-based research exists to say what works.

As part of this study, colleagues from the Harvard School of Public Health reviewed the literature on the return on investment for management and leadership development initiatives in health. Out of more than 1,000 articles reviewed, just 30 gave clear answers. They point to benefits such as improved confidence to tackle bigger challenges, better functioning teams, improved patient satisfaction and increased likelihood of adopting transformational, rather than transactional behaviors.

This thin evidence base prompted us to look to those organizations around the world that demonstrably had effective leadership and management systems in place, or had embarked on approaches we felt others could learn from. Of course, there is no single optimal development approach — if there was it would have been found by now — but we believe the case studies in this report exemplify some of the best practice principles in action. This includes Kaiser Permanente’s ‘rebranding’ of the management role, Discovery’s ongoing, floor-to-board ecosystem, and the NHS Leadership

Academy — perhaps the largest scheme of this kind anywhere in the world.

From speaking to these organizations and many other management development professionals, we found six rules that differentiate successful approaches from those with limited benefit. While some are intuitive, few organizations around the world have adopted them systematically and sustainably. Old habits die hard, and organizations continually feel drawn to outdated modes of learning — classroom based courses in professional and institutional silos which abstract learning away from the real life problems of staff and patients.

Fads and fashions come and go, but we believe that by carefully considering the lessons from the case studies in this report you will be able to take your organization’s management and leadership development approach to the next level. The truth underlying all these lessons is that this is necessarily a long-term endeavor with no quick fixes. The DNA of all good approaches — building relationships and camaraderie, using the ‘live ammunition’ of the organization’s pressing problems, redesigning roles to bring out the changes sought — must be sustained for years after the exciting phase of a new program has passed. Like all transformation, success is a mix of inspiration and perspiration.

The six rules of healthcare management and leadership development

1. Make managers matter
2. Reach every rung on the ladder
3. For low cost, look inwards
4. Blend personal and organizational development
5. Match the scale of the solution to the problem
6. Ground design in reality



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Healthcare is changing, so must managers and leaders

Leadership and management have always adapted to reflect changes in the societies in which they are rooted. Organizations today are flatter, less hierarchical and more informal than they used to be — a reflection of the gradual erosion of deference to professional groups, and the increasing informality that characterizes many modern societies. Much of this change is driven by technology and social media, as staff and consumers increasingly inhabit a world of instant information.

In the healthcare sector, medical discoveries, demographic pressures and new models of care are rapidly changing the environment in which services must be delivered. Leaders and managers are increasingly having to operate in multi-organizational systems with responsibilities across whole pathways of care and patients who demand not just treatments but integrated support to live longer, independent lives.

These changes are prompting a fundamental shift in the types of managers and leaders that healthcare organizations say they need.^{1,2} Terms like 'distributed leadership', 'systems thinking' and 'sense making' are increasingly being used, but this is rarely associated with a corresponding shift in

the way that such roles are developed or incentivized. Instead, many modern healthcare managers and leaders are left to fend for themselves in this new environment, using out of date tools to tackle systemic challenges far more complex than those seen a decade ago.

At the same time, the platforms by which development is done are themselves undergoing a revolution. The fundamentals of peer learning and challenge through trusted relationships remain, but can now be supplemented by new opportunities. These include micro-learning that can be condensed into a nurse's eight-minute break, or multi-media simulations that require staff to interactively solve problems for themselves. The management course isn't dead, but is undergoing a rebirth.

The goal of this study is to explore what some of the best and most innovative healthcare organizations are doing to adapt to this new world, and what really works to improve the quality of managers and leaders. The report showcases six rules that leading organizations and professionals have told us drive successful approaches to leadership and management development, each with a case study of how this has worked in practice. To begin, we ask the important question of what value management and leadership development can really demonstrate, and what evidence exists for a return on investment.



Methodology



The findings of this study were generated through triangulation of three parallel research methods:

- A systematic review of the academic literature on management and leadership development to identify the strength of evidence for payback. 1049 articles were initially reviewed, of which 32 looked in detail at the question of return on investment from healthcare management development, the key messages from which are summarized in the following chapter.
- Expert insights from people with significant expertise running multiple or large scale management and leadership development programs in healthcare. This included interviews with 22 organizational leaders and KPMG development professionals. A half day workshop was also held with 12 faculty members from the Harvard TH Chan School of Public Health and two large tertiary/quaternary healthcare providers (see Acknowledgements).
- A global search for innovative and successful case studies of management and leadership development in the health industry. A two-way selection process was followed: to contact organizations that were regarded as industry-leading and ask about their development programs, and a 'bottom up' process whereby experts were asked to identify organizations whose approaches they saw as 'world leading'.

Data and lessons from the three streams were analyzed through a thematic synthesis process, with key conclusions summarized in the following chapters.

“The core principles of good management and leadership don't change — creating a shared vision, building relationships, raising aspiration and holding people to clear objectives. But the context in which these have to be applied in healthcare is changing beyond recognition.”

Dr Neil Goodwin
Healthcare Board Chair and
Leadership Academic



Management and leadership development in healthcare:

**Sound investment or
money down the drain?**

KPMG's experience from working with healthcare providers and payers in more than 40 countries is that a typical organization can become around 15 percent more efficient purely through operational, administrative and workforce improvements.³ Scaled up to a global level, this suggests that the prize of better managed healthcare services may be in the order of one trillion dollars. For such a potential payback, it is a wonder that so little research has been done on the impact of different attempts to improve leadership and management on organizations' quality, efficiency and outcomes.

Investing in managers and leaders is a key part of achieving these improvements. Our systematic review identified four areas where returns are clearest:

1. Benefits to the wider workforce:

These benefits include better teamwork and collaboration^{4 5 6}, increased clarity of communication to staff⁷, improved morale⁸ and an increase in 'enabling others to act'⁹. For example, after the implementation of a leadership and management development program at several aged care sites in the US, staff reported an increase in transformational (as opposed to transactional) leadership behaviors, as well as a decrease in "passive avoidant" management styles.¹⁰

2. Improvements in patient experience and satisfaction:

Several studies found improved patient satisfaction scores, with better scores for metrics such as "how well pain was controlled"; "nurses took time to listen," and general satisfaction with services.^{11 12} Studies also found that various programs were associated with a reduction in patient complaints; improved communication between staff and patients; and improved continuity of care.^{4 7}

3. Direct benefits from developmental projects:

Many management and leadership programs involve participants completing real-world improvement projects in their organization. These

are often themed, such as action-learning initiatives on patient safety, or innovation. Such projects can generate direct benefits to the employing organization, and help to target improvement efforts where they are most needed.¹³ For example, the Management Academy for Public Health in the United States focused on training public health managers to generate entrepreneurial ideas within their organizations and involved an action-learning project. Of 73 teams who took part in the program between 2000 and 2002, 28 (38 percent) had projects that had generated revenue by 2007 (a total US\$4 million across all projects).¹⁴

4. Increased confidence and use of management/leadership skills:

A number of studies identified measurable improvements in good management and leadership behaviors, for example inspiring a shared vision and proactively facilitating others.⁴ Self-reported impact evaluations also consistently found improvements in the confidence of participants to cope with the demands of their roles.^{15 16 17}

No studies were found showing substantial, quantifiable benefits in terms of health outcomes, financial performance or staff turnover. However, this was more due to few or no studies asking these specific questions rather than a lack of effect. Most of the interventions measured were too small in scale to realistically affect cross-organizational indicators on finance or quality.

What we do know is that when organizations are 'well managed' this can make a substantial difference to their performance: accounting for up to one third of profitability in all sectors¹⁸, and linked to better staff satisfaction and patient reported outcomes in health.¹⁹

Conversely, in depth investigations into large-scale failures in care routinely locate root causes in poor leadership, narrow management-by-objectives, disconnect between board-and bedside and a host of poor procedural, operational and administrative behaviors.²⁰

“For too long we have only invested in healthcare leadership development at times of relative 'plenty'. As long as we continue to regard this as a 'nice to have' and not a prerequisite to high quality, highly effective, compassionate care we will continue to operate with a sub-optimal management and leadership workforce.”

Karen Lynas

KPMG Associate and former Managing Director, NHS Leadership Academy

The Six rules

There remains an urgent need for better quality evaluation of management and leadership development approaches. Yet these roles are too important as a foundation for safe, efficient care to allow backward and ineffective programs to remain in place until hard formal evidence arises to displace them. To discern what really works, we must look to organizations with high levels of management and leadership competence, adaptability and a track record of having out-performed their peers, and see how this has been developed and sustained over time.

Like good customer service, often you know good management and leadership development when you see it — the following six rules try to distill lessons from organizations around the world where we think it can be seen.



Rule 1: Make managers matter

Perhaps the most widely overlooked element of all in healthcare management development is that of the jobs themselves. Very often organizations will invest in programs to train more dynamic, transformational and entrepreneurial managers only to place them back into roles that are narrow, restrictive and hierarchical. Disruptive change is welcomed in theory, but quashed once it arrives in person.

Organizations with weak management cultures often have a symbiotically low view of their contribution — one feeds the other. Administrative and operational skills are devalued and managers are seen as overpaid and out of touch with clinical realities. The reaction to this is a greater reliance on force to make staff comply, and a fear based culture is created.

Changing this negative cultural pattern is as much about giving managers real autonomy and authority in their jobs as it is teaching new skills. This means any leadership and management development strategy should carefully consider the universal lessons that contribute to creating successful organizational design, for example:

- Structure: Can hierarchies be flattened to devolve greater power to managers and leaders at middle and lower grades?
- Incentives: Do the systems of reward, remuneration and promotion encourage the behaviors you want to spread, or focus on the same old narrow targets and transactional goals?
- Reputation: Healthcare management jobs are rich in pace and complexity, but often enjoy a 'second tier' status in the eyes of staff and patients. They need to be visibly valued.

— Talent management: Is there an ongoing rigorous process for identifying and supporting potential leadership and managerial talent across all disciplines?

The presence of physicians in positions of senior management is both an important catalyst and litmus test for the quality of managers' roles. While doctors by no means make better managers necessarily, organizations that struggle to recruit clinicians into administrative roles often find themselves in a damaging spiral of tribal divisions with frontline staff and lower value attached the contribution of management professionals.

Having doctors view management as a legitimate second career (in the same way they do research, education or private practice) is an important statement about the status of these roles. In weak or toxic management cultures there is often a divisive atmosphere among clinicians that 'our job is to look after patients and the manager's job is to look after the money'.

As Kaiser Permanente's story below shows, rebranding the role of management and leadership is possible but is no overnight task, taking years or even decades to produce results. It requires more than warm words, but an unwavering strategy of praise, role redesign, and revised incentives.

“The passion and quality of clinicians' leadership is so important. Yes, it involves giving up some of your professional identity, but you also get to fix some of the things that have frustrated you over the years.”

Dr Bob Bell

Deputy Minister of Health and Long-Term Care, Ontario

Symptoms of failure:

- Few or no doctors in senior non-clinical management roles.
- Attrition of those in whom the organization has invested in in the past.
- Low job satisfaction among managers and a low opinion of them among other staff.



Key action for boards:

Survey management staff and ask them if they feel they have the authority to make real improvements in care.

List the ways in which your organization systematically and publicly is making managers feel valued on a regular basis (e.g. awards, recognition, named praise). Ask yourself if you could be doing more.



Rule 1:

CASE STUDY

Changing the brand of management and leadership: Kaiser Permanente's Physician Executive strategy (USA)



"25 years ago physicians would look with disdain upon colleagues who took up leadership roles," says Dr Sharon Levine, a senior executive with The Permanente Medical Group, an independent multi-specialty group practice of more than 9,000 physicians serving almost four million Kaiser Health Plan members in Northern California. "Now we have multiple applicants for every leadership vacancy."

Kaiser Permanente's seven regions/business units are each multi-billion dollar enterprises, with active leadership of medical professionals at every level. Personal and professional authority has been key to this success, as has a long-term strategy of skills development.

"Strategy is running the culture; tactics are running the institution" explains Levine, and focusing on this represents a significant 'new specialty' for most physicians. Indeed, it marks a transition of identity, and takes some internal readjustment, "finding the ability to step back and trust that you don't have to do everything, that your job is to provide the tools, the resources and encouragement." Once you have gone through the rigors of training to be a physician, you never lose that identity.

Kaiser Permanente has learned that as much as leadership is additive, rather than a replacement, for the clinical identity, there is always some loss. "You are chosen because of your excellence in your medical specialty, a preeminence which you will no longer be able to maintain easily as you take on this new role." No wonder many feel ambivalent about these roles, which is why for over 20 years Kaiser has made a definite case that leadership is valued, with awards, financial stipends, and top-level recognition — making it clear that this is not an 'off ramp' from your career. The CEO never misses an opportunity to express gratitude to those who serve in this way.

Importantly it must be easy for physicians to step out of these roles, as well as into them. For example, once a Department Chair has completed their five year term they have the opportunity to return to the clinical workforce — and fulfil an important role model function. "Good leaders make good followers."

Rule 2: Reach every rung on the ladder

One of the clearest lessons from health organizations that have maintained a consistent focus on improving their management and leadership is that very little can be changed by focusing only on the top-tier. Failure to invest properly in mid-lower management grades was the most common weakness in healthcare organizations' strategies noted by interviewees.

This is an astonishing gap considering that a 'mid-ranking' hospital manager might routinely be responsible for a department of US\$50 million turnover or more — the size of a medium-sized company.

Management and leadership are increasingly seen as collective endeavors, and those that reserve development initiatives for executive positions quickly encounter a number of serious limitations:

- The organization becomes strong on strategy but weak on implementation. A layer of 'corporate concrete' forms which prevents corporate plans filtering down or innovation bubbling up.
- Development is done in isolation from the real business, culture and operations of the organization.
- Resources are focused on those that have already had the opportunities to develop these skills, rather than those that could benefit most. In many cases executives will have attended similar programs before anyway.

— Staff morale, recruitment and retention, along with organizational performance and reputation, suffer as a result.

Instead, the best organizations develop comprehensive, lifecycle programs that instill a consistent and sustainable set of management and leadership behaviors spanning every level of the hierarchy. This means that change can be hardwired over a decade or more of employees' careers rather than expecting transformational effects from one-off interventions. It also communicates to staff across the organization that everyone has a role in the management and leadership of the organization, whatever their grade.

If this comprehensive approach sounds expensive and daunting, it needn't be. Organizations like Discovery (see page 14) show that some of this management development 'ecosystem' can be almost free to implement, by drawing on the resources and opportunities already in the business.

“If one person in an organization has a rich experience, it's so much less valuable and sustainable than if a whole team have that experience, likewise with one professional group and the whole organization.”

Dr Kevin Smith
President and CEO,
St Joseph's Health System,
Hamilton

Symptoms of failure:

- Organization is strong on strategy, but weak on implementation.
- Few senior leaders have risen up through more than three tiers of the hierarchy.
- Low ambition and morale among middle managers.



Key action for boards:

Map your existing development activity against your organizational matrix — are resources being rationally distributed or are there major gaps?



Rule 2:

CASE STUDY

A comprehensive, ecosystem approach, Discovery Health (South Africa)

Health insurers are not usually known for dynamic and innovative management practices, but then Discovery is no ordinary health insurer. The South African payer is one of the fastest growing in its sector globally, with a track record of innovative spin-offs, regular new product launches and rapid international expansion from its current base of 2.6 million members in South Africa to operations in more than nine countries over the past three years.

A comprehensive ecosystem of management and leadership development is an essential component in Discovery's mission to become 'the world's best insurance organization and a powerful force for social good'. The philosophy behind this approach has seven important tenets:

1. Invest in all levels of staff in the organization.
2. Development should begin at onboarding stage and continue throughout an employee's career.
3. Participation should be driven by demand from individual staff members, not mandated upon them.
4. A rich mix of formal and informal development, to suit a broad palate of learning styles.
5. All training is consistent with a single ideal — 'The Discovery Person' — who is optimistic, entrepreneurial, results driven, honest, has low ego and high intellect.

6. An organizational rhythm of continuous opportunities to improve and put skills into practice, including biannual product launches and 90 day challenges.
7. Regular contact time with the senior leadership team, so that staff can see these behaviors modelled in practice.





At the heart of Discovery's ecosystem is the leadership development 'starfish', composed of more than 30 interventions for staff to choose from at varying points in their career. Among these is the 'Inspiring Excellence' program, whereby staff can present organizational, operational or product improvements directly to senior leadership. Staff that are accepted get direct support to develop themselves and their idea, including mentorship by a Discovery executive throughout the process.

For newly-promoted senior managers, an immersion program puts into practice the notion of thinking outside of departmental silos towards the whole organization. Their first three months are spent moving around all different parts of the business from front line services to back office functions. These are more than quick walkthroughs: they are required to spend substantial time engaging with the challenges of each area, and to be in a position to comment critically and appreciatively on their priorities and plans. Then they begin to focus on a project in which they will identify and analyze specific improvements across business units. As they work at this, they compile a personal learning log and portfolio of evidence to support their arguments. At the end of the three months, they present recommendations to the Executive Committee — so accountability and performance are a hard-edged requirement too.

For leaders with the potential to rise to the very top of the organization, Discovery's Executive and Operational Committees have up to two rotating secondment positions each lasting six months. This is to give the most promising leaders a chance to see behaviors modelled at the most senior level and have all-important contact time with the executive teams.

The results of this developmental activity are plain to see throughout the organization, including at the very top. The organization's COO Karren Sanderson, for example, started with Discovery in 1997 as a call center agent, working her way up through the hierarchy and drawing on many of the opportunities in the starfish.

“I like to think of it as the University of Discovery, where you learn things no text book can teach, in the format that suits you best, whenever you are ready.”

Karren Sanderson
Chief Operating Officer,
Discovery Health

Rule 3: For low cost, look inwards

Full-scale, multi-program development ecosystems like Discovery might be beyond the means of many local health organizations, but that doesn't mean that an effective management development strategy is out of reach.

While business schools and leadership experts have much to contribute, organizations should never overlook the resources that exist internally — often at low or no cost — to develop their management and leadership cadres. Examples of this include drawing on patient volunteers as experts-by-experience, senior managers as mentors and asking frontline staff to define how they would like to be managed.

Not only are these resources very often free, they also add valuable real-world insight to an intervention and ground content in the daily realities of the organization, as opposed to management theory. So even when externally-run programs can be afforded, it makes sense to think carefully about how to supplement their design using human resources from within.

Everything an effective manager does is sandwiched between action on the ground and reflection in the mind. Stretching practical experiences followed by reflection are the foundation of many of the best development approaches and neither necessarily require buying external support.

Local bodies with links to the organization can also be a well of low-cost resources for management and leadership development. Many healthcare providers have formed 'buddying' relationships together to bring in new perspectives and support greater collaboration and system leadership. Some have come together to jointly sponsor programs, while others have formed partnerships with successful non-health businesses nearby to bring in new management expertise and development opportunities.

“There's no doubt that external management and leadership experts have something to add. But there is also so much to be learned just from listening to patients, listening to staff, listening to partners in the health system, your competitors even.”

Gary Belfield

Partner, KPMG in Australia

Symptoms of failure:

- Internal resistance to management development due to perceptions of low value.
- Participants that rate development programs highly at first, but the effects are short-lived.
- A feeling of disconnect between layers of the organization.



Key action for boards:

List your current development activities against a grid of patients, staff, senior leaders and professional trainers. Are the resources you are using to deliver them balanced?



Rule 3:

CASE STUDY

Community-led public health:
Institute of Urban Indigenous
Health (Brisbane, Australia)

Is the patient the problem? Often, public health targets are missed because apparently recalcitrant patients don't make use of the services offered them. But who wants to keep asking for care when one is forever being blamed? So how can beneficiaries take hold of the reins in public health, to work with clinicians and other professionals in a constructive way? The Institute for Urban Indigenous Health (IUIH) in Brisbane, Australia, has found a way to bring Aboriginal leadership effectively to the center of public health provision.

The IUIH was founded in Brisbane in 2009 by four Aboriginal Community Controlled Health Services, with a mandate to expand service delivery to the 60,000 people identifying as either Aboriginal or Torres Strait Islander. In the beginning IUIH only had five staff members and now employs over 400 people engaged in public health driven programs and clinical service delivery. Critical to the rapid growth and expansion of IUIH was an existing Aboriginal Senior Executive team who resolved that IUIH should enculturate a 'bottom up', peer-based approach to leadership development that valued the insights and cultural knowledges of Aboriginal and Torres Strait Islander staff members. The existing leadership also recognized that the development of a culturally reflective and responsive non-Aboriginal workforce necessitated far more than a 'tick-a-box' approach to cultural competency.

Guided by consultant Monica Redden, they adopted CoachingOurselves, a peer-learning approach engaging small groups in structured conversations on pressing topics. Clinical Director Renée Blackman describes it as integral to her leadership of four local clinics: it is a great way for people to conceptualize their managerial predicaments, to hear each others' perspectives, and to embody a kind of leadership that sets agendas and trusts colleagues to take responsibility for the work that needs doing. As Redden says "The learning curve for the workforce on some of the practical application of management in particular has been very steep; they are leaping from entry as registered nurse to clinic

manager to regional manager within the span of two years. Generally I think CO has helped the middle managers and emerging leaders to understand the significance of structured and focused conversation on the management of IUIH. CO has been a powerful scaffolding tool for them to learn and continue to learn."

CoachingOurselves is a proven approach with 20,000 managers around the world, but uniquely, IUIH has taken this on as a way to work with client-expert relations. Under the heading of a Cultural Integrity Investment Program, Renée Brown and Alison Nelson (responsible for workforce development at IUIH) recognized the great fit between Coaching Ourselves and conversation-oriented or *yarn** based learning modeled within Aboriginal cultures. Brown and Nelson developed *Yarnin' Up*, with a focus on the socialization of staff and reminding clinical experts that their personal and professional identities are provisional, socially constructed and limited in scope. Like CoachingOurselves, *Yarnin' Up* will extend to further topics on societal values, privilege, trans-generational grief and loss, family values and legitimacy. The *Yarnin' Up* approach has already proved its ability to raise and facilitate profound discussions. Some staff have even taken *Yarnin' Up* topics home to use with their own families; and now there is the possibility that *Yarnin' Up* will be used beyond IUIH.

IUIH employs a lot of newly graduated health professionals, and values the way that *Yarnin' Up*, like CoachingOurselves provides a scaffolded learning approach. By staff bringing their own story to their connections with others, they can draw on more than their professional identities.

Even if *Yarnin' Up* remains specific to its context, Monica Redden is convinced that the original CoachingOurselves approach can be widely applied where shared understanding is necessary to ensure the continued — and properly contested — legitimacy of leadership.

* Yarn is a contemporary Aboriginal English term which is similarly defined as a conversation or chat.

Rule 4: Blend personal and organizational development

A great irony of leadership development initiatives is that when times are tough they are among the first programs to be cut, when this is actually the best possible time for them to happen. What better context to develop people than when they have 'live ammunition' to develop their skills with?

The most sophisticated leadership and management schemes are seen as indistinguishable from organizational development, rather than a branch of human resources. Training programs are integrated with existing corporate priorities and strategic improvement projects.

Jonathan Gosling, Emeritus Professor of Leadership at Exeter University, calls this *"use work, don't make work"*. In other words, practical improvement projects — a vital part of any successful management and leadership development program — are not directed at made-up or marginal

problems but pressing challenges that the organization has already identified as needing to overcome.

One of the key trends in this regard is the movement towards training team members together. The link between team functioning and high quality care is becoming ever clearer.²¹ As a result, the traditional model for management and leadership development programs, where individuals are the focus and training is separated from their normal work context and colleagues, is changing. Courses aimed at just one profession or one cadre of workers are becoming less common, replaced by interventions designed to boost collective leadership — often by training doctors, nurses and managers together.

“When I hear ‘training program’ it always makes me nervous because if you sit people down classroom style, you only have about 20 minutes of their attention. Instead, we do all the teaching through the work itself — observing and coaching them along the way. Learning by doing is the only way that really works.”

Dr John Toussaint
CEO, ThedaCare Centre for
Healthcare Value

Symptoms of failure:

- Leadership development is absent from the organization's major strategic plans.
- Most training is done in professional silos.
- The board is not being kept aware of the content of improvement projects underway as part of development programs.



Key action for boards:

Integrate training efforts to develop staff teams together. Ensure that action learning projects are focused on the pressing problems of the organization.



Rule 4:**CASE STUDY**

Forging system leadership through peer exchanges: Halton's leadership exchange (Canada)



Collaboration across health and social service agencies is a core part of any modern, sustainable system. However, in the Health Department of Halton (a district of around half a million people across four municipalities west of Toronto) it sometimes seemed easier to collaborate with external organizations than other internal departments and services in the local system.

In an attempt to improve intra-organizational collaboration, a 'leadership exchange program' trained pairs of management staff from different areas of health and social services to act as action-researchers in each other's workplaces. The program focused on how leadership and collaboration are accomplished (or hindered) in real-time and in context; and as a by-product enabled participants to appreciate each other's leadership strengths and challenges. Outcomes included ideas to reduce barriers and normalize a culture of collaboration.

The aim of the program was twofold: to assist middle managers in developing their leadership in a meaningful way and to tackle low intra-organizational collaboration to improve the local healthcare system's ability to be flexible and innovative. The resulting

exchange involved managers from emergency care, public health, mental health, housing and child services.

There were three phases to the exchange process: a two-day pre-exchange workshop for all of the managers involved, two-day exchanges in each direction, and a post-exchange phase consisting of individual interviews and a half-day group debrief/workshop.

Participants all felt the exchange helped them gain a new perspective on their own leadership style and a chance to improve their listening skills and 'systems-awareness'. It also allowed them to develop relationships with other managers, who they otherwise would not have worked with, which have persisted long after the exchange.

Lynne Hanna, manager of the School Years Program, said "I have over 20 years of experience as a manager, but the exchange allowed for a view into another part of the sector which I'd not previously had a lot of insight into — in particular seeing areas like labor relations, organizational design and role diversity within management."

Rule 5: Match the scale of the solution to the problem

One of the most common causes of ‘failed’ management or leadership development interventions is a mismatch between the scale of the problem and the solution. Organizations can be susceptible to wild optimism about what is likely to be achieved by very modest investments in development schemes, resulting in disappointment when the anticipated transformation either never arrives or fizzles out.

Attempting to fix huge institutional and cultural problems with a few away days, ‘sheep-dip’ training or course scholarships is clearly not going to work. However, this doesn’t mean that management and leadership is not the

right solution — just that the dosage may need to be increased or sustained over a longer period than many leaders’ attention spans.

Evidence from outside the health sector shows organizational behaviors and cultures require effort and time to change and this is rarely initiated by a single person who has been sent away for training.²² Real change takes perspiration, repetition and an intervention of significant enough scale to overcome the problem to be solved.

One health system that has matched a large-scale, transformational ambition to an equally large-scale solution is the

English NHS. It saw a need for system-wide improvement in the quality of its managers and leaders, as similar patterns of missing competencies were observed across all health services around the country. Rather than leave each organization to address the problem itself, a national academy was founded to train thousands of managers and leaders every year. Over time, this will create a substantial cadre of NHS Leadership Academy graduates with consistent approaches. By training staff at multiple levels, the program also helps to create a supportive environment and network for change in each organization.

Symptoms of failure:

- Uncoordinated, approaches to management and leadership development, with heavy use of individually-focused external programs.
- Goals of development programs consist of broad aspirations that cannot be measured.



Key action for boards:

List the specific behaviors that your management development strategy is designed to change. Ask yourself if the scale of activity and investment is really likely to produce these effects, or is underpowered.



Rule 5:**CASE STUDY**

A whole system effort for whole system impact: NHS Leadership Academy (England)



In 2012, the NHS in England was facing a national crisis of confidence over quality of care following the “culture of blame” and “acceptance of poor standards” reported by the Francis Inquiry — a review into care failures and excess deaths at Mid Staffordshire Hospitals.²³

“Leadership which was unable to command confidence” was laid at the heart of the “appalling suffering” of many patients, and the report called for a “fundamental culture change” across the entire English health system, including higher standards of professionalism and skill among managers and leaders.

Fixing a problem of this scale required a substantial policy response, and so one of the largest healthcare management and leadership development programs in the world was initiated. By mid-2016, the NHS Leadership Academy had trained over 45,000 people through the tiered strategy of full-time, part-time and spare-time programs described overleaf.

By operating at such scale, the Academy was able to design tailored programs targeted at the specific priorities and context of the NHS. Some of the distinctive features of the programs that resulted were:

- Embedding the patient voice at every level, including having teams of patient volunteers participate in discussions and shape course materials.
- A consistent focus on making immediate and lasting change in participants’ own places of work.

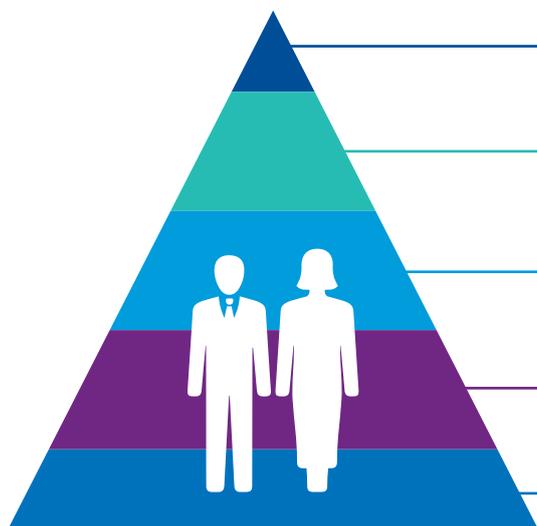
- Cutting edge learning technologies, including a custom-made ‘virtual campus’ that supported simulations in a fictional local healthcare system, interactive scenarios, professionally produced video presentations, and engagement with other participants and tutors through group forums. This allowed participants to learn anytime, anywhere.
- A global perspective that broadened participants’ outlook towards truly world-class examples of great care, rather than what was best in the UK.

While the intensity and style of the different tiers varies, each is founded on four consistent aims: to professionalize leadership skills across the system, to broaden leadership styles, to make leadership roles more inclusive and to create a climate in which innovation can flourish.

As for outcomes, the Academy was always geared towards long-term change, but has ended up occurring during the most challenging financial environment in the history of the NHS. Narratives collected from participants have documented a library of examples of the skills and confidence developed throughout the programs in action, from savings, to more engaged staff to patient-led service redesign. In 2016 the Leadership Academy won the European Foundation for Management Development ‘Gold Award’ for excellence in practice.

Rule 5:

CASE STUDY Contd.



Executive Fast Track Program

A 10-month, full-time, structured course for **50** outstanding clinicians and business leaders, designed to attract new skills and experience into the highest level positions in the system. Included a five week residential program at Harvard, an elective of up to four weeks in the NHS or industry, an executive placement working closely with an NHS CEO and intensive inductions into NHS structures, politics and ways of working. EFTP was run as a one off pilot and is now being considered as a longer-term program.

Nye Bevan Program

Aimed at those preparing for board-level roles, this one year, part-time program is helping to prepare **900** of the NHS's next generation of executives to enable radical service redesign and meet the challenges of modern NHS leadership. Peer feedback is at the heart of the program's ethos, with participants coaching, holding to account, and assessing each other's performance.

Elizabeth Garrett Anderson Program

For mid-level managers aspiring to senior roles, over **2,000** staff are on, enrolled on or have completed this two year-long program, which includes an MSc in Healthcare Leadership. The program aims to build up the confidence to drive immediate and lasting change in their place of work. Participants are grouped into cohorts of 48 who develop together, share experience and create bonds that will span the system and last throughout their careers.

Mary Seacole Program

For those facing their first leadership position in the NHS, this six month, part-time program builds the foundations of learning to lead in healthcare for over **4,000** staff. With an emphasis on developing resilience, empathy and awareness of participants' personal leadership style the program blends residential, online and practical learning, all guided by a personal tutor.

Edward Jenner Program

The Jenner program is open to all NHS staff that wish to develop their management and leadership competencies, regardless of their role or grade. **39,000** staff have now accessed and completed various modules of the course, with 3,500 completing all components. The program is structured as a series of 20 interactive online modules that teach the basics of people management, quality improvement, patient safety, teamwork and facilitating change.

Rule 6: Ground design in reality

An in-depth, sober understanding of the experience of staff and patients is the essential foundation for all successful development programs. There is no shortcutting this step and no development program should commence without a detailed diagnostic of the everyday context in which leadership and management are experienced.

Organizations that fail to properly analyze their own culture and operational realities before investing in management and leadership programs encounter a number of serious problems. The most common is designing a development scheme to fix issues that, they eventually realize, have nothing to do with management and leadership skills.

Misdiagnosis is most likely to result from confusing competencies with context. So investment goes into people development when in reality structural issues are the root cause, such as responsibility being divorced from autonomy, insufficient data to make decisions, a target-driven culture, or an environment of strategic chaos and churn.

There are many helpful organizational diagnostics available to cut through these complex questions of culture. Some of the key lessons noted by interviewees that have used them repeatedly include:

- Use an approach that captures multiple levels of context. ‘How we do things around here’ can change dramatically from one level of an organization or system to the next, so don’t confine your analysis just to one layer. There is little point investing in services leadership if the problems lie at the systems level, and likewise in organizational leadership for frontline improvement if the lines of control over operations are impaired.

- Invest in an independent set of eyes, as purely internal assessments can produce biased results. Some organizations even bring in professional anthropologists to spend time observing working cultures at various levels.
- If external management tutors or leadership consultants are to be used at any stage of the program, engage them in this ‘grounding’ process. Allow time for them to shadow the teams that they will be working with to understand the day to day feel and workings of the organization.

Finally, it is often forgotten that development activities should also be fun. We have all sat in abstract learning sessions and had our minds never really leave the in-tray piling up back at work. What engages participants is practical learning focused on the real challenges they face in their jobs, as well as a sense of camaraderie with colleagues. The US Military Health Service is a particularly marked example of these principles in practice.

“Leadership development should exist in relation to an organization’s management model. However very often you find that leaders haven’t spent sufficient time reflecting on the nature of their organization and how they really work, and can’t articulate exactly what that management model is.”

Richard Bohmer
Senior Fellow, Nuffield Trust

Symptoms of failure:

- No ongoing input into leadership development strategy by staff, patients and care givers.
- External trainers have never spent time shadowing staff.
- Goals of development programs that would be better achieved through role and structural redesign.



Key action for boards:

Commission a comprehensive internal study to understand management and leadership cultures in the organization. This could mean inviting an organizational anthropologist to shadow teams, or a tailored survey.



Rule 6:

CASE STUDY

Simulating stretching challenges for the US Military Health Service (USA)



After an initial term of service in the military, many health professionals leave for a civilian career. Those who stay form the talent pool for the next generation of leaders, taking the military's health services into an unpredictable and demanding future. Commanders — heads of the military's medical treatment centers around the world — need to be prepared for many intensely pressured short and long-term challenges, where failure is both likely and costly.

These roles require more than head knowledge — in particular practical experience of the contexts they will face when crises and critical challenges emerge. As one would expect from the military, therefore, development leans heavily on preparation for the real-world experience of leading. Since 2015, the service's top-level development program for new Commanders uses a set of live scenarios based on recent real-life examples. These are designed both to develop and test this next generation of leaders under conditions as close as possible to those they might face in the field.

Readings in advance of the program provide content and concepts, leaving time during the course to work through the varied scenarios. Stage by stage, each of these scenarios unfolds, and participants are called to communicate with patients, appear before the media, brief legal advisors and so forth. Next time round there are plans to make them even more immersive, using a computer assisted war-gaming center.

It's an effective approach to leadership development, but demanding to run. These scenarios took a team of 12 to develop and manage, and will need annual renewal. But they are part of a consistent plan to move away from 'sage on the stage' presentations, making more use of participants' own experience in preparing them for the true context of leadership in the field.

Conclusion



We should remember that the overwhelming majority of patients will rarely be interested in organizations' grand plans and strategies, being more concerned about the day-to-day running of the services they use. In an increasingly complex world, however, meeting these demands for efficient and effective care grows ever more challenging. Consequently, the field of leadership and management in healthcare grows ever tougher.

While the underlying principles of good leadership and management remain the same, how these must be applied, and developed is changing rapidly. Though the case studies in this report span four continents and organizations of widely varying size and history, they all display a number of shared features that are universally applicable.

The importance of rooting development in organizational context is an important theme in the case studies. The challenge here is to ensure that the problem to be fixed is properly understood before embarking on a solution. Organizations must also make an effort to stimulate, engage and entertain through development, and nothing maintains interest more than feeling

that the scheme is actually helping them address their current operational and strategic challenges.

Relationship building, coaching and the use of colleagues for support and mentoring is also an important approach for the organizations in the case studies. This reflects the fact that at its root management and leadership are interpersonal.

Each of the organizations demonstrate a visible, long term commitment to developing their people. Leadership development rarely offers a quick fix, requiring sustained organizational and personal effort over time: perspiration as well as inspiration. This is especially true if many of the underlying challenges are

systemic, such as recruitment difficulties or a tight economic environment.

The good news is that leadership can be practiced. Healthcare managers and leaders will continually find themselves in situations where they are having to have difficult conversations, respond to a crisis or lead a change project. Far from distractions to development — these are the ideal times to do it. Repetition and guided reflection are the bedrock of almost all behavioral change. No modern healthcare organization is short on opportunities to drive improvement through their daily work and to enhance their skills. What differentiates the best is that this isn't left to chance, but is supported and directed.

Is your organization following the rules?

Maturity Level				
	0	1	2	3
1. Make managers matter	'Transformational' management behaviors are encouraged on paper but punished in practice	Staff reward and remuneration are based on the same goals as the development program	In addition to reward and remuneration, roles are restructured to empower managers and align authority & responsibility	There is no perceived '2 nd class status' to management — incl. for doctors. Managers and leaders are judged on transformational behaviors.
2. Reach every rung on the ladder	Executive-level programs only	Programs at multiple layers but without a coordinating strategy	Coordinated programs at multiple layers, but a narrow range of learning styles	Coordinated programs at all tiers with content to suit a broad range of learning styles, including improvement opportunities
3. For low cost, look inwards	Programs are delivered entirely by external partners	Program content is shaped by patients and staff, but delivered externally	Patients and some staff are actively involved in program content and delivery	Patients and staff from the executive, frontline and the local system are involved in shaping and delivering the program
4. Blend personal and organizational development	Program learning is largely didactic, and not experiential or project based	Project work is a core part of the program, but is an individual responsibility	Project work is core, but conducted in teams that work together on a daily basis	Project work is core, with teams working together around projects aligned to the programs and organization's overall goals
5. Match the scale of the solution to the problem	Bursary system which staff can apply to for external programs of their choice	Short-term institutional programs, with short-term expected results	Longer term, one-off programs, with longer term expected results	A long term strategy of ongoing support, with long-term expected results
6. Ground design in reality	Program goals are defined from the top down, are numerous, with no evaluation	Program goals are defined by an internal organizational diagnostic, with no evaluation	Program goals are defined by a detailed analysis that results in a clear vision on the type of person to be developed, and evaluated formally	Program goals are defined by internal and external analysis, with a clear 'person' outcome, and evaluated formally. External trainers shadow staff before the program starts

How KPMG can help

KPMG's professionals are helping healthcare systems at national, regional and local levels transform services through management and leadership development.

KPMG's professionals are helping healthcare systems at national, regional and local levels transform services through management and leadership development. Our experience includes leading a consortium in the design and delivery of two programs featured in this report — the Elizabeth Garrett Anderson and Nye Bevan components of the NHS Leadership Academy.

We are also implementing management and leadership improvement programs in countless individual organizations around the world. Our teams equip healthcare managers and leaders to drive real service change and help boards to rethink and reform governance to meet the demands of modern healthcare.

Alongside partners from world leading technology companies and universities, our approach puts improved quality of care for patients at the centre of everything, and draws on the rules described in this report at every stage. We offer complete progressive leadership programs or self-contained modules — whatever best fits the needs of the individual system.

KPMG has an exclusive contract with the English NHS to enable the materials developed for the NHS Leadership Academy to be used globally in part or in their entirety or to be further developed and/or adapted to the local context.

If you would like more information about how we can help your organization or system enhance management and leadership capabilities, please contact the KPMG Head of Healthcare in your local region.

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References

- ¹ Addressing the leadership gap in healthcare, Centre for Creative Leadership (2015).
- ² West M et al, Developing collective leadership for healthcare, King's Fund (2014).
- ³ Value walks: Successful habits for improving workforce motivation and productivity, KPMG International (2013)
- ⁴ Boomer CAM, B. Creating the conditions for growth: a collaborative practice development programme for clinical nurse leaders. *Journal of nursing management*. 2010;18(6):633-644.
- ⁵ Tumerman MC, L. M. Increasing medical team cohesion and leadership behaviors using a 360-degree evaluation process. *WMJ: official publication of the State Medical Society of Wisconsin*. 2012;111(1):33-37.
- ⁶ Singer SJ, Hayes J, Cooper JB, et al. A case for safety leadership team training of hospital managers. *Health care management review*. 2011;36(2):188-200.
- ⁷ Dierckx de Casterle BW, A.; Verschueren, M.; Milisen, K. Impact of clinical leadership development on the clinical leader, nursing team and care-giving process: a case study. *Journal of nursing management*. 2008;16(6):753-763.
- ⁸ Haseman BCC, M. P. Phillips, J. N. Stafford, P. J. Practising inspired leadership: the use of applied theatre "prophetic" in the executive Leadership Development Program for Queensland Health. *Australian health review : a publication of the Australian Hospital Association*. 2009;33(3):377-381.
- ⁹ Duygulu SK, G. Transformational leadership training programme for charge nurses. *Journal of advanced nursing*. 2011;67(3):633-642.
- ¹⁰ Jeon YHS, J. M.; Li, Z.; Cunich, M. M.; Thomas, T. H.; Chenoweth, L.; Kendig, H. L. Cluster Randomized Controlled Trial of An Aged Care Specific Leadership and Management Program to Improve Work Environment, Staff Turnover, and Care Quality. *Journal of the American Medical Directors Association*. 2015;16(7):629.e619-628.
- ¹¹ Hultman CSH, E. G.; Kaye, D.; Helgans, R.; Meyers, M. O.; Rowland, P. A.; Meyer, A. A. Sometimes you can't make it on your own: the impact of a professionalism curriculum on the attitudes, knowledge, and behaviors of an academic plastic surgery practice. *The Journal of surgical research*. 2013;180(1):8-14.
- ¹² Assessment Tool Helps Hospital Conquer Challenges. T + D. 2006;60(6):68-69.
- ¹³ Singer SJ, Hayes JE, Gray GC, Kiang MV. Making time for learning-oriented leadership in multidisciplinary hospital management groups. *Health care management review*. 2015;40(4):300-312.
- ¹⁴ Orton SU, K.; Zelt, S.; Porter, J.; Johnson, J. Management academy for public health: creating entrepreneurial managers. *American journal of public health*. 2007;97(4):601-605.
- ¹⁵ Porter JJ, J.; Upshaw, V. M.; Orton, S.; Deal, K. M.; Umble, K. The Management Academy for Public Health: a new paradigm for public health management development. *Journal of public health management and practice: JPHMP*. 2002;8(2):66-78.
- ¹⁶ Saleh SSW, Dwight; Balougan, Modinat. Evaluating the effectiveness of public health leadership training: the NEPHLI experience. *American journal of public health*. 2004;94(7):1245-1249.
- ¹⁷ Dannels SAY, H.; McDade, S. A.; Chuang, Y. C.; Gleason, K. A.; McLaughlin, J. M.; Richman, R. C.; Morahan, P. S. Evaluating a leadership program: a comparative, longitudinal study to assess the impact of the Executive Leadership in Academic Medicine (ELAM) Program for Women. *Academic medicine: journal of the Association of American Medical Colleges*. 2008;83(5):488-495.
- ¹⁸ McGahan AM, Porter ME. What do we know about variance in accounting profitability? *Management Science*. 2002;48(7):834-851.
- ¹⁹ Dawson et al, NHS staff management and health service quality: Results from the NHS Staff Survey and related data, Department of Health (2011).
- ²⁰ Walshe K & Shortell S, When things go wrong: How healthcare organizations deal with major failures, *Health Affairs* 23:3 p103-111 (2004).
- ²¹ Faculty of Medical Leadership and Management & The King's Fund; Leadership and leadership development in healthcare: The evidence base (2015).
- ²² Mintzberg H. Managers not MBAs: A hard Look at the Soft Practice of Management and Management Development. Berrett-Koehler Publishers (2005).
- ²³ Mid-Staffordshire NHS Foundation Trust Public Inquiry, Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry, Stationary Office (2013).

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