Leading the Way 13:
Leading change
Transcript of podcast
Jonathan Darling and Nadeem Moghal

(Music starts)

Jonathan Darling:

Hello, I'm Jonathan Darling, and I'm host for the Leading the Way RCPCH podcast about leadership in paediatrics and child health. I'm really delighted to introduce our guest today, Dr. Nadeem Moghal. Nadeem's been an NHS paediatrician and senior leader across several roles and NHS organizations for thirty years, and a few of these include consultant paediatric nephrologist, director of strategy, medical director, non-executive me- director roles, and now leadership in a private healthcare sector organization.

And he's going to tell us more about these as we talk. So welcome, Nadeem.

Nadeem Moghal:

Thank you, Jonathan. Good to meet you. Remember that you and I were once in the same building in Jimmy's many years ago.

Jonathan Darling:

That's right. We go back a while. So it's great to have the chance to talk. So let's start off with a bit about y- your career, just as an overview.

And when we were talking earlier, you, you said it's been quite an atypical career. Can you just tell me a bit more about what makes it atypical and some of the choices or things that happened for you along the way?

Nadeem Moghal:

I think, it was, first of all, it was very typical in that I did the classic pre-common for those that remember it, postgraduate training, and then ended up as a consultant in Newcastle, and felt that was it then, wasn't it?

I'm settled now and this is where I'm going to be for the next next decades. And then fundamentally, I guess the real mind shift happened when I became a service lead, and I began to realize there was something much more interesting

about people, about how you organize things, how you start to use resources and make decisions that sometimes are very difficult.

And that started to make me do things to my career, if you like. I started to do things like an MBA and other more interesting things that took me out of the building. As a result of which I think my idea of atypical isn't so much that I did the work to become better at being a leader, but also, more interestingly, I left the building to which I might have stayed for till retirement, trying to pursue some sort of leadership career.

I went to different NHS buildings across the country to do interesting things that were really very challenging, and therefore, I progressed the idea of leadership capability by doing things with the Black Country and the Midlands and ul- ultimately East London. Then, of course, once I retired out, I started to do things in other organizations as opportunities arose.

So it's really atypical. I didn't, as often happens, stay in one building and progress up the ladder within one building. And there are lots of reasons why that happens. In one sense, perhaps the opportunity was never there in Newcastle for me, and therefore, I maybe felt I had to go and pursue them elsewhere.

Jonathan Darling:

You said that when you became a service leader, it started you off on looking for ways to improve how you could do that and that took you to doing the MBA and other things. So when you initially became service leader, what took you in that direction?

Nadeem Moghal:

The thing that kind of made me want to become service lead was the experience up to that point.

I have to say it wasn't the best experience up to that point in terms of being part of a team. It was really quite challenging, and I felt that this wasn't what I felt was a good way of doing stuff. And as time went on, it was like I had to start to make some choices, really difficult choices.

But I stuck with staying in the team and in the organization. And when the opportunity arose, I took on the lead responsibility, and I began to realize that there was something here that was really interesting because you could really focus more strategically about the service rather than just about the day-to-day stuff.

There was something more than just doing clinics and doing needle biopsies. There was something about how you organize resources and how you can actually improve the quality of care without actually having to spend a vast amount or any money, in fact. And all that experience made me think that this is fascinating because there are some really interesting ways of doing things.

And I then said maybe I can learn something outside the NHS that might make me even better at what I'm supposed to be trying to do," right? So I self-selected and was supported to go and do the MBA whilst I was a full-time service lead, full-time consultant on call, effectively one in three. So it was quite challenging, but I was quite determined to go through that so that I could actually potentially become better at what I was trying to be, which is, I suppose a good lead, good at making difficult decisions, but taking a wider and wider perspective on what I was trying to do

Jonathan Darling:

And just while we're on the MBA, is it something you would recommend?

And k- I know it's difficult to sum up anything, but are there some key lessons that you took from that sort of stayed with you through your onward leadership?

Nadeem Moghal:

The thing that struck me whilst I was doing it and afterwards, I came across people who'd done the MBA and did nothing with it, right?

I know people that spent a fortune on MBAs and actually just went back to the day-day job. And I was going some people just to collect badges perhaps, I don't know." But we just want to do that. I felt that if I was going to do it, I was going to extract value from it, which I think I did.

I think some of it was interesting. I think I-- one of the best bits of the whole experience was meeting people from a vast, diverse range of industries, right? I was the only medic in the group. I had people from the mining industry, from the civil service, from the military. It was just fantastic because these were people that brought a worldview that also challenged my worldview, right? So I began to learn things about the idea of trust in the military, for example, and then said, "Okay, what does that mean in healthcare?" So that was, for me, probably one of the most valuable parts of the MBA, which was meeting people from diverse industries, learning from them.

Yes, the MBA program was interesting and actually really quite very good, but fundamentally, it was the whole thing that kind of made me then say, "No, I can't waste this. I need to use this." And I guess I did.

Jonathan Darling:

You've done quite a lot of work then around leadership in organizations and system change, and one of the things you've said is that paediatric services can be often termed fragile.

I think I've got that right. So can you tell me a bit more about what you mean when you talk about fragile paediatric services?

Nadeem Moghal:

Yeah. I think the word fragile in healthcare, particularly in the NHS, is almost always referred to as the challenge of workforce, right? So can't find the workforce, can't fill the rotas, relying on expensive locums.

There are lots of services that are in that difficult space. And particularly with the work I've been doing with the current organization, with Strasitz, we end up reviewing group models, collaboratives of trusts trying to work together, ICB focus around systems. Certainly from a paediatric perspective, we've come across more and more what we call fragile services, and Paediatrics is almost always a fragile service in these settings.

But we define fragile not just based on workforce, it's also the performance of the service, the quality being provided to the population, as well as the workforce challenge. So what we've began to understand is that a lot of effort over many years has been to try and sustain individual units across the country, which which is proving more and more difficult.

And because Paediatrics is Paediatrics, it's not the dominant conversation. It's always what's happening with the elderly and that demographic and very little focus on children's services. So there's a lot of money thrown at paediatric services to sustain units that are proving very difficult to sustain.

And our view and my view is that actually we've got to begin to look at, take a system view of paediatric units. So you can look at an ICB landscape. You could look at Norfolk and Waveney, which is a new gr- new group with three paediatric services. What is, what do we learn about those three services, and how might they be shaped for future sustainability, providing good quality care for the population?

Remember, we're in the context also of a declining child population, right? So maternity units are under stress. Paediatric services are also under stress. The nature of disease has changed, the demographic is shifting and yet we still think that a model of many decades in the making is still the right model, and I think that's no longer the case.

It can't be. You could say, "Oh, it's a money thing," or, "We just need more money." No, we can't even find the workforce, right? So that's a problem. And the work I did, for example, in North Warwickshire, without referencing anything that I knew ex- I didn't know existed at the time, I, the Royal College 2012 policy paper, which describes really well, small units, i.e.,

less than 1,500 admissions, of which there were 35 at the time, and less than two and a half thousand admissions, of which there were 75 at the time, which, were defined as really units in trouble because of workforce.

Jonathan Darling:

That's the Facing the Future paper, is that right?

Nadeem Moghal:

2012, yes. Which you're referring to and the question is what's happened since? And we, I've done some work looking at that and looked f- to where we are now and to the future. And, the work I did in North Warwickshire to really redesign Paediatrics between two trusts who actually didn't like each other and actually were in opposition to each other, and it was really tough work, and I'm sure it shortened my life, has ended up providing, I would argue, a model that still works at more than a decade later, where 95% of services for the children of Nuneaton are getting really good care, and the admission bit, ward bit, is somewhere else, which it works very well for them.

Now, geography is destiny in one sense, so it worked for them because of the nature of work we did and the change that I led. Earlier on you talked about leadership. I like to talk about leading change, 'cause fundamentally, leadership is not just about the badge. It's about what are you doing with the idea of leadership?

What are you changing? What decisions are you making? And what, and why is it so difficult? Because it's got to be hard work to do this, otherwise, everybody would be at it, and they're not.

Jonathan Darling:

Yes I like that, leading change, not just leadership. Maybe we need to change the name of the podcast.

So just going back to your thinking about how a system can work, you mentioned ICB landscape, and just for those listeners that don't know about ICBs, would you say a bit about what, why that landscape might be different? What is an ICB, and why, and it might be relevant to Paediatrics?

Nadeem Moghal:

So integrated care boards, this was a reform that resulted in something like 40-plus ICBs across the country, and then as a result of the work of the current administration, there was a, there's been a radical reshaping to fewer ICBs, integrated care boards across the country.

So they, each one is covering a larger portion of a region that encompasses acute trusts particularly, and community services, et cetera, and of course general practice. And I believe, and we've written a paper on this, it's available on our website, the Trust's website. It's about the future of paediatric services.

We look at the past, the present, and the future. And fundamentally again, back to it, I referenced the 2012 policy document from Royal College 'cause I think it's a really good policy document. I think it's worth going back to that to really understand what the College is saying and wh-where are we today.

Now, I believe the ICB reform or the reform the shape of the ICBs is a really good moment to take advantage of. Because what we now have is a commissioning structure, arguably, of the right scale that would allow for people that determine how money is spent to really say, "Look, we need to take a network view of paediatric services."

We can't just try and support every single paediatric unit i-in our landscape. We've gotta say what can we do across an ICB patch?" I'll go back to Norfolk and Waveney, or I can go to Lancashire and South Cumbria, or I could look at West Yorkshire, where are, there are three acute trusts, right? All three are working really hard, Bradford, Airedale and Calderdale, for example.

Now, the question is, and I know nothing about Airedale and Calderdale, right? I know a little bit about Bradford. Is what is the opportunity to really make sustainable paediatric services in West Yorkshire that is not about supporting them just by money, but actually, if you look at the North Warwickshire model, if you look at the hospital at home model at Bradford, has really matured.

A child comes in with bronchiolitis, doesn't automatically mean admission in Bradford. They've got really clever and matured hospital at home systems that send the kids straight back home with the right support. So suddenly, the things that I used to admit as a SHO routinely doesn't happen anymore, right?

So wha-what are the things that we now do and can do that don't, and also don't need inventing, which includes ways of working. Okay, technology always comes into the conversation, but actually consultant capabilities, who are the people that carry the risk? Remember, consultants get the money because they carry the risk.

They've learnt how to assess risk, they've learnt how to manage risk, and they also ultimately carry the risk. So they're the right people to make these difficult decisions about, "No, you can go home, right? And we'll look after you at home." If an SHO makes that sees that child, they'll say, "Oh, you need to come in.

Somebody's going to have, 'cause I can't make that decision or don't feel safe enough." So there are things that we've evolved over, over many years that could actually suddenly say, in West Yorkshire, there's a different model for children's services that still provides high quality care, actually probably better quality care ultimately, 'cause we're using our resources more appropriately.

So that's where I think the space of focus needs to be from a policy point of view, because the ICBs are now the right size to be able to commission these sort of network conversations. And we've done things as paediatricians and as units that have evolved capabilities like hospital at home. Look at the work that was also tried at anticipatory work by a colleague in Bradford, Eduardo Moya.

Eduardo Moya did a really fantastic experiment on anticipatory work for complex children at home, trying to predict a deterioration and prevent a deterioration resulting in admission, right? Really proved it, but money didn't come because it wasn't commissioned through the right structures. All right, so the money runs out and s- the experiment stops.

Matthew Mathai, who did the hospital at home work in Bradford, has been really clever about this because he's built a education structure to support nurses who do the work at home. So he's now made it sustainable, and people across the country are rushing to learn how to do this. So he's scaled it through that.

But he-- the challenge he's described is, but why aren't other paediatric units doing this thing? And the answer is, nobody's commissioning this work through an ICB approach because that's the way you scale it up

Jonathan Darling:

Yeah, and that paper, just to mention is called Securing the Future of NHS Paediatric Services.

So we'll put-- try and put a link in our notes. But you'll be able to find that online. But I think it's a very nice discussion of some of these challenges. One of the things you did that I found quite helpful, and it was about thinking of the shape of your paediatric population and the conditions and health issues they bring, and how you have to then build your service around that shape.

Jonathan Darling:

Can you just say a bit more, more about that?

Nadeem Moghal:

Yes. So the work I now do, which actually I have to say, I always say it, it gives me hope is that what I've learned through the organization I'm now part of now for some years, is that the way you start looking about services is you don't start with services.

That's a mistake. It's an old model, right? What we typically do in NHS, we say, "Okay, what's the policy? What's the compliance or regulation? What's the finance? Actually, what do we have as services, and what's the money and workforce to meet the, this population thing called demand?" That's a classic, what we call classic way of thinking, but the way we think, the way we work with organizations is we start with population needs, right?

That's not the same as population health or public health. It's population needs. So we u- we, we use data, we look at how people are us- accessing service, why are they accessing service, how they move through the system. And we do a really I call it clever analytics, 'cause I've got-- I work with much cleverer people than me around this stuff.

And we then kinda conclude something really interesting about the population. Now we use the word consumers. Consumer needs, what do they look like? And then we then say are these consumers all the same? Can we consider them in consumer segments?" I-I'm not talking about allergies now, so you know, it's not cardiac disease or respiratory disease or neuro disease.

It's actually what are your common needs. So really successful organization in the priva-private sector spend a fortune and a huge amount of time to understand their customer, right? If you think about that, they work hard to understand their customer because then they can provide the products and services that the customer needs and wants, and then the organization survives and thrives.

That's how it works in a commercial world, right? What we've done in healthcare, and we'll keep to the NHS frame, is we've built something over, I would argue, more than seventy years that is professionally determined. We've determined the shape of services. We've built more and more specialisms and allergies and now that.

And we say, "Look, here's what we offer. Now come and use them. And y-you need them." We don't worry as much. We do a bit now, more and more, about whether you're bouncing through fifteen services to get to the right place. What we are saying is, if you started with consumer needs, population needs, you'll begin to understand that when you try and map up to what we offer based on what their needs, there's a mismatch And therefore, we then start talking about new models of care.

We now need new models of care that meet the needs of the population, right? So still not talking about -ology, not talking about nephrology, not talking about cardiology, the common needs of the populations through consumer segments. That forces us to think about new ways of working across these -ologies fundamentally.

But under-underneath that, and this is something that now begins to sound like not medical, but it is fundamental about how we organize re- resources, is business models, right? You need to understand that the way we run our organizations, it has to be founded on what we call a business model. And in, in the hospital, we're effectively, without realizing it, running a Michelin-star restaurant next to a McDonald's offer constantly, right?

You wouldn't do that, would you? You wouldn't say, "I'm now going to offer you a restaurant that does McDonald's, Kentucky Fried, and some Michelin-star offers, and come in, and, let's see how it works with the workforce," and it's a mess. There's a lot of what we call friction that gets generated as a result, and that's waste, and that's your frustrations as consultants and as clinicians and staff.

So if you understand the business models that you really need to separate out to run the models of care, suddenly we begin to understand there's a way of not spending two hundred and twenty billion as badly as we do, which we do, a huge amount. The NHS budget went from a hundred and twenty billion in twenty sixteen to two hundred and twenty billion in twenty four, twenty five, right?

Now, some people say some of that's national insurance. Yeah, but actually, what are we getting as value for an additional a hundred billion for the population? It's a good question, right? And what we're doing, and the work I'm now involved in, is to really question the fundamentals of needs set against models of care, set, set against business models that are really required to run healthcare properly, so

look, in Leeds, you have really clever people doing bone marrow transplant stuff for children, right? That's precision medicine. That's really complex, very expensive stuff, right? Next to what I would call high volume work, just standard stuff that keeps coming in, that needs admitting and needs doing. We call that standard work, right?

And then you've got this other consumer segment, which is typically comes in, but actually shouldn't have to come in. The frail, elderly, and dying patient who's coming through the front door, the vast majority should not come into hospitals because they should be cared for in other places more effectively, and we're spending a fortune doing what we shouldn't be doing.

I can talk about more than Paediatrics 'cause the nature of the work I do, although I'm really focused on children and maternity services in our organization, I've done a lot of work across the whole population in Leeds.

RCPCH:

We'll be right back after this short message.

(Music starts)

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Jonathan Darling:

Going back to the theme of leading change, you've obviously been involved in that process in, in, in quite a number of settings. So can you tell me a bit more about how you view leading change, how you, how to do it well, and what are some of the challenges and how to surmount them?

Nadeem Moghal:

Gosh. That's a podcast series in itself, Jonathan.

I remember somebody once accused me of being too academic in the work I was doing, right? Leading change. This was a manager. And I went and spoke to Professor Samuel Gray about this. He's a doyen of all sorts of great things at the

edges. And he said, "You should never ever be embarrassed about working academically by practicing academically."

In other words if you've done the work to understand some of the fundamentals, you understand some of the theories, and you understand what is the art of the possible, then you have to then use that to then test the systems that you're working in real life. And that's-- So the first thing to say is it's important to have some sort of foundation that helps you think as a reference point.

And over, over the years, that nature of that foundation has kept, has continually changed for me for different reasons over time. So I've kept refer-referring back to what's out there I need to read, who do I need to talk to, what do I need to listen to that helps me understand the challenges that we're facing.

So that's really key to being able to lead change as well as you can. The second is you kinda need to want to do it, right? If you don't want to do it, then don't do it, 'cause you'll do it really badly, right? You really want to do it, but you also have to want to know, you have to know that it's going to be really hard work.

It's going to age you, it's going to shorten your life, and you're not going to make friends. You can't want to do this work and think you're going to make friends. You are going to lose people along the way, right? So there's a lot of theory about you have to communicate, and you have to bring the people with you, and otherwise you will.

But you can't always expect to take everybody with you, and you will lose some people on the way. And I have lost people on the way of some of, any of the things that I've led. But I've considered that. I used to think that was a failure, and then I realised actually it's just the cost of leading change, right?

It meant that what was being tried was achieved, but there was a price to pay leading up to that change. And as much as I would not want it to happen, it happens, right? So because of the human condition and human resistance to change or this isn't going to work for me, I need to leave. Okay. I can't do anything about it. So you have to accept that. You have to accept a good foundation that changes over time. Read. Talk to people. Know you have to want to do it, and you have to accept that you're going to potentially lose people on the way. You're not there to make friends. And the final thing I would say is you really and I've not always done this well, is you need good wing cover for the work you do, right?

And that's typically the levels of work I did, was the executive and the board because some of these changes were quite significant. And that's quite

Jonathan Darling:

What do you mean by, just say what you mean by wing cover there.

Nadeem Moghal:

Yes. So you need to keep the... You need to make sure that the people that are going to support you in the changes you're doing are either people above you- Recognize what you're doing, why you're doing it, how you're doing it, and you're keeping them abreast of what's happening, and you're making sure that they don't get surprised about anything, right?

Leaders hate surprises. Board people hate to be surprised about anything. So you've got to work really hard politically to keep people abreast of change, what's happening and why it's happening, and why something's not going to work so then they're not surprised. That's really hard work. That's a lot of work 'cause these people are also typically extremely busy.

They've got a thousand other things to think about, and not just what you're doing in the organization. And you've got to be able to do that, and it's really tough work

Jonathan Darling:

That's great. Coming back to that second one you've got to want to. Does that come out of the first one, which is to really understand the foundation of what's going on?

Or is it something else? For you, what made you step up to do these really some of these difficult tasks and roles? What was your motivation?

Nadeem Moghal:

So it's obvious, right? That the kidney didn't hold my attention long enough, right? So it was paediatric nephrologist. I I really enjoyed being a paediatric nephrologist.

I enjoyed the challenge and, becoming a good paediatric nephrologist takes a lot of effort 'cause the buck stops with you at 2:00 in the morning when a DGH consultant calls you and goes, "What do I do with this idea?" And so that's You gotta get good at that. And I'm not sure I was the very best at it, but I was getting better and better at it.

But I began to realize through my leadership experience and how the organ- the department was working and how could, should have worked, I said, "I think I want to figure out what this means and see if I can do a better job." So the desire to understand people grew rapidly. I was like, "I need to understand people.

I need to understand how people work together. Why aren't people working? What's the collaboration challenge?" What's the idea? How do we define medical professionalism, right? So I began to think really seriously about the idea of medical professionalism quite early in my leadership quest, right?

Remember earlier on I said I hate the word journey, 'cause I didn't set off with an idea of I'm going to get to point B or C or D. It was just like, "Let's see what happens." So it's been a quest. And medical professionalism is really import- interesting for me 'cause it is about us as human beings, how we express our ability to be good at what we do.

And in there is the idea of conduct, how we behave, which is really important, right? One of the def- defining fundamentals. And some of the things that really fail are because of the way people behave, right? And trying to understand that is really quite key. I was leading change in a service not in Newcastle, which was a failing service 'cause the people in the team hated the organization, hated some people, just hated stuff, right?

So I had a really tough job of how do we how do I fix this? And it wasn't easy, but you begin to have to understand individuals, how they collaborate, why people are doing what they're doing. For me, that was much more interesting. Successful organizations are constantly trying to figure out how to remain successful or how to become even better.

It won't be about resources and digital stuff. It'll be about the humans. If you go back to... I will go back to Peter Drucker, all right? Peter Drucker was one of the earliest thinkers of the idea of management in corporations and business, right? He's the one who actually made me think about leading and leadership and leading change early in my career.

It was one of the first few books that I bought and started to read and went, "Oh, this is really interesting." And I didn't really un- I was enjoying what he was writing and you look at his background, right? He-- Vienny from-- he's Austrian. He leaves, he goes to Germany. He leaves Germany in the '30s when he realizes that actually this was not going to be a safe place for him to be because the way people were organizing themselves through fascism was going to be a problem.

He then moved on to Britain and then went on to the US, and he ba- basically started to focus, having qualified in law and in other interesting topic like

philosophy, he said, "I'm interested in people." And through that lens, started to talk about how you make organizations successful. So it's a people thing, right?

And I'm not saying I was always great with people, but I wanted to learn more about how this thing works. So the idea of ethical professionalism, people, and organizing assets and resources, which include, which includes workforce. And,

Jonathan Darling:

Just to go to some nitty-gritty there you've mentioned this situation, people really not getting on or even hating each other or the organization. Can you just give a little insight on what do you actually do? Or, because even if you understand people, you've got to do something.

Nadeem Moghal:

Yes. Some of the decisions, not just in any-- not just one organization, but in more than one organisation, sometimes... Look I wrote a piece, which I thought was, it was a reflection in 2019 about sex, lies, and the deliberately difficult doctor, right?

So we have, we know the concept of the difficult doctor, right? We all know the concept of the difficult doctor. And I've, as my experience over the years, realized there are two types. Those that kind of are accidentally difficult. They don't want to be difficult, they just have found themselves in that space for lots of reasons.

Health, family resources, lots of things that kind of just happen to them, and they just fall into-- And then people treat them as difficult, but they're not wanting to be difficult. They just get treated like that. And then suddenly there's a sort of cognitive dissonance, and then there's a separate-- And people start building stories around individuals, and it's not fair, and it's not correct, and it needs to be fixed, right?

And there's a tiny number who are deliberately difficult. Th-re- they do exist, I'm afraid. There are a small number in every building, in every hospital in this country, and they know who they are, and they know what they're doing, and they know why they're doing it. And they're the ones the medical director should be shit scared about, excuse my language.

They should be really scared about, right? Because they're the ones that are manipulative. They're the ones that have got personality issues that are fundamentally damaging people around them. They're destroying teams. And there's a-- That these people have survived their careers and retire out, have been leaving a wave of pain and destruction along the way.

You occasionally hear about them because they hit the news. Paterson, the breast surgeon. You-- He surfaced because he was, he got caught doing terrible things. But there are lots, there, there are others who got away with it. Now, they're the ones you need to be scared of. They're the ones you need to do s-t-stuff with.

So the first thing is get the diagnosis right, is what I say. Don't assume everybody's the same, right? The accidentally difficult needs a different set of solutions to lift them out of that difficulty, and then they get on with life. They want to get on with life. The deliberately difficult need a whole different approach, and that's a really tough bit.

And when you identify them, that's where your energy starts getting sapped to make these difficult decisions, which sometimes is, sacking the individual that is causing the pain. But not-- And what often happens in the end, just tragically, is they just move on to some other place to cause destruction.

GMC knows this, NHS Resolution knows this. Boards are tragically often silent or don't even know this is going on, and part of my experience has been that I made errors in not getting the wink of it to do some of this really difficult work. Sometimes it worked, sometimes it didn't work, and it definitely shortened my life

Jonathan Darling:

So you're, if I get this right, you're saying part of it is the right diagnosis, understanding why, and then being willing to step up and do what's needed with the right buy-in from your board or the, those that support- Yeah

you in the organization. And sometimes tough things have to be done and that can be quite painful for long term, but worth it because you get a better organization, you deliver better care for patients.

Nadeem Moghal:

Absolutely right. Remember, this is the thing that is the result of how you appointed people, how you managed people, how the organization governs itself, how the board is or isn't engaged, right?

So it's a whole system at the end of which somebody who's deliberately difficult can get away with what they're getting away with. So you're having to deal with the consequence of a lot of decisions over time, and non-decisions over time, and neglect, that suddenly becomes a hard decision. So my-- one of my perspectives is we need to rethink how we appoint, we rethink how we govern.

I didn't use the word manage here, remember, I used the word govern. The most important workforce in a hospital, the consultants, and I have a thing on that. They'll say, "Oh, but what about nurses?" I don't know. The most important workforce, I'm afraid in a hospital, whether you like it or not, are the consultants.

How do we govern them so that we-- they are the best they can be? How do we govern them so we identify those that are accidentally difficult and get them out quickly? How do we govern them so we can identify those that have slipped through and are deliberately difficult? So I go back to there are things we need to learn to do right at the beginning rather than having to deal with the difficult bit at the end.

Jonathan Darling:

Like what at the beginning?

Nadeem Moghal:

How you appoint people and how you develop people, how you govern people, how you ensure medical professionalism is a real thing in a hospital building rather than just assumed as a thing that exists because, the Hippocratic Oath or because you're a doctor, you've got, you've got all the right values.

Don't always assume that, right?

Jonathan Darling:

I'd love to explore that a lot more, but I think we should move on for now. You are in this current role in an organization, as you mentioned, called Strasys and that was part of the paper we referred to earlier. Just say a bit more about what took you into that and what it means for you to be doing that work.

Nadeem Moghal:

So like all these sort of things I joined them by accident, by somebody introducing me to the founder, Naeem Younis, during COVID. He wanted to talk to a medical brain about something. I ended up talking to him about my ideas of medical professionalism. We began to realize that what I was doing was fundamentally developing a model of decision intelligence.

So what we are fundamentally is a decision intelligence organization. We're really clever folk and they really are some really clever folk and really experienced folk from different disciplines, I go back to that point who come together and look at

healthcare through data analytics and evidence in terms of what is it we're doing and how are we starting to think about organizations.

So we, as I said earlier on, start with population needs as the starting point of really beginning to question, challenge, and support boards. So we work with boards around reimagining how workforce resources are allocated optimally to meet population needs. So part of that might include undertaking a service review to fundamentally understand the challenges in a service so that resources are better used and better allocated.

And I genuinely I'm saying this, the work that I am now doing with Strasys has given me hope back into healthcare. Look, I've had cancer as a patient, and my experience was terrible. It was, it was a horrific year, and accidents and errors happened in my care. I'm not sure why we're surprised about that.

But I came away from that and then came away from my experience through leading changes. There's something not working with the way we're running the NHS. Not that I can solve the problems of the NHS, but there are ways now of thinking differently about the NHS that need to be brought to the front, to the fore, because we've, we, the models that we've built, and to be honest, they were built by the professions for the professions from the '40s, right?

The, Yes, the ologies have become more, more dominant. Great, because we can do much more now than we could in the '60s. But the but the way we're organizing ourselves is the critical problem now. It isn't the innovation and the invention that's the problem. Who leads those? The medics, the consultants. Who generates them? They do. Who brings them into the buildings? The doctors do. So we forget the most important workforce, but we also forget the idea of doing things in the building. Look here's a point which might be interesting in what sense. The person that brought together the idea of the district general hospital and every population of about 100,000 needing a hospital was Enoch Powell, as health minister. And so he started the first new hospital building program, right? He was the first that shut down mental health institutions, asylums, as they were called then, because he was so shocked at the care of these folk in these buildings. So he did the first community shift. Think about that, right?

He forced that, and it's continued from when-- after he left, after three years as health minister. But we're stuck now with a DGH model that worked in the '60s. Now, think about medicine in the '60s. What could you do in the '60s compared to what we can do today? Yet the same DGH model is now doing everything for everybody all at the same time, right?

And we then wonder why it's so difficult to sustain some of these things. Just doesn't work. So that's where I'm quite interested in the work we do. The DGH model is part of the problem

Jonathan Darling:

Thanks. And I think you've written about some of what you just referred to there in your... You've got a blog on LinkedIn, is that right?

Nadeem Moghal:

I don't know what to call it because I feel like the blog is a decades-old term now. But, so I write a thing called The Fish and Chip Paper which I drop into my LinkedIn profile. I wrote 53 pieces at a straight go with a few short pieces because, I was on holiday or something.

But I've written about all sorts of things from the junior doctor strikes. Sorry, you can't call them junior doctor strikes. They are resident doctor strikes now. I wrote about that, what we've learned, what we should be learning through to the maternity challenges. So I wrote a, it's health-focused.

I took a long break, and now I've just written something about my experience in Sweden and why benchmarking in the NHS is an exercise in futility. So I do write about healthcare, I do write about the way I think based on some of the work we do, some of the thinking that we do, and it's open to everybody

Jonathan Darling:

Yeah. I think it's a great resource. As we're coming towards the close I'm just interested if you can recommend resources or approaches for people interested in leadership, leading change. What's helped you?

Nadeem Moghal:

So what's helped me? So I think you've gotta be really curious, right?

Curiosity is really important, and the curiosity should lead you to wanting to read stuff to get some sort of context, some sort of foundation of understanding. So as I mentioned earlier on, Peter Drucker and his books, are really worth reading. I think if you're really interested in quality improvement, but also the idea of an engineer understanding the human condition as well as data, Deming is really important, so you can read Deming.

Don't just accept the consulting frameworks that foundation Deming, but read Deming, actually read Deming. Read Henry Mintzberg. More recently, I've been really interested in the idea of a learning organization. Hospitals, if they were genuinely learning organizations, would organize themselves differently.

So Peter Senge's work and The Fifth Discipline is a really interesting b- resource. The thing that also kept me hooked was the work of Ivan Illich, another Austrian philosopher actually a priest. He wrote about medicine as well as other things, and what he wrote all those decades ago is really pertinent today and is actually happening today as he predicted all those decades ago.

So definitely worth going back to him. And then I always argue that you need to read about people, right? And there's a thing apparently is true that men, when they turn 50, they stop reading fiction. Apparently, it's pretty universal. I didn't know that. Maybe I made that up. Maybe I'm listening to the wrong people.

But we apparently stop reading fiction, and I think if I reflect, it happened to me for sure. But I go back to wanting to read fiction because you begin to-- because fiction is a really clever way of articulating in one book a huge amount of the complexity of the human condition. And so therefore, I would always go back and explore some of that to understand people.

One of my favorites is V.S. Naipaul but also other things. Maybe the generations that we're also perhaps targeting or listening, the younger generations Might want to read this Korean German philosopher Byung-Chul Han. I struggle to pronounce that name. That's my ignorance. He's written really excellent little books that are philosophical treats, if you like, about things.

And I first came across him when he wrote about the idea of rituals and the importance of rituals in day-to-day life. And I began to reflect on actually, what do we do in work that gives you the idea of rituals? And then from there has come the idea of what do we mean by community, right? And I'm-- Some of the work I've done is focused on the idea of community.

The whole thing about neighborhood health is a big thing. I go what is neighborhood health? What do you mean by that?" And yet, when you look at the work that the Brazilians have proven in terms of value, it's not about health, but actually the idea of building the ideas of communities back, and people are working to the ideas of supporting people in a way that makes health a better outcome rather than health the focus.

So he made me think about the idea of communities and the idea of ritual. Again, diverse reading is important. Yeah. Meeting people from different disciplines is really important and being curious all the time is really important.

Jonathan Darling:

That's a fabulous reading list that we'll try and put in our notes so that people can refer to it.

And you have mentioned the crucial sort of stages of our careers, particularly becoming a consultant. And is there-- we've talked about what the system should be doing in that process. But what if you're an individual just at that transition, is there anything you can recommend that helps you off to a really good start in that role?

Nadeem Moghal:

Yes. I think so, in my time and in your time, it was a very different model of becoming a consultant. You went to a senior registrar role, which at least in my experience, was, this was going back quite some time. On reflection, I thought that was a really good model of training you to become a consultant, right?

And y- over time, you began to feel a little bit more autonomy, right? And you felt okay, this is training me to become a consultant. That model's gone, right? So you're an ST7, eight or you go to a fellowship 'cause you're wanting to build expertise in something else, and then you're suddenly landed into a consultant job, right?

And I have spoken to a few folk in that sort of space. I don't think there is the right shape of things in place to, to develop you into the idea of what it is to become a consultant. And I think that consultant job is the thing that people are chasing, right? And you get it. And then you got to understand what is it that actually means.

Yeah, the buck stops with you. Okay. If the buck stops with you, what does that actually mean? You're going to have to get really good at what you're supposed to be delivering as a consultant. So the tendency for this generation is to rush off and want to do tech stuff or consulting work or-- And I would say, okay that's something I never had when I was training, and it's great you have the diversity of options, but actually get really good at what you're supposed to be good at.

Build your credibility at, in the thing you're supposed to have been appointed in. And then from there, you begin, you'll begin to see the opportunities that could be more better founded for what you're trying to do. But to become a consultant is to also understand it is the most important job in the hospital, okay?

Now, I'm not saying that so that you can go and play power games with people. People need to understand what I mean by that is, and it's the term I use a lot, is

the consultant controls and directs the means of production. That's it, right? In a building of 6,000 people, may have 300 consultants. The 300 consultants direct and control the means of production, and they affect every decision from board to basement, right?

So what is the inventory coming into the basement? The consultant's determining that, right? I need these drugs. I need this kit. I need this machine. I... that, right? And then, of course, the board is fundamentally trying to govern this organization of 6,000 people. But why do people come into that building?

To do what? It's because of those 300 people. Now, if we really understand that, then you begin to understand your role as a consultant. How do you then become a good citizen of the organization? That's a really important bit, isn't it?

It isn't a power thing, it's a good citizen of the organization. A really critical point I make in one of the seminars I deliver, which I recently did at Bayes Business School, where they run a superb-- I have said, having been exposed to lots of development programs, they run an executive master's in medical leadership just targeting medics, right?

I think it's fantastic. I think it's a really brilliant program, because Bayes believes that organizations led by subject matter experts do really well, right? So engineers should run engineering firms, lawyers, lawyer firms, right? There's a reason why there isn't an MBA in media running a football team. There's a reason why that doesn't happen, right? So medics should now begin to understand that they should be more and more interested in leading stuff and leading change, rather than just being passive acceptors of this thing of being a consultant. So you have to develop yourself. And if we could begin to understand that role and the importance of the role, what are we doing to prepare people to get into that role so that they now understand what that role means and how they optimise that role for the benefit of the population and for the people that work with you.

They say the boards determine the culture of an organization. They probably say that in Leeds, right? A board is really important for determining the culture of the organization. To a point, that's true. But what they mean by that is when things go wrong, they have a duty to correct it or to challenge it, or keep putting up these posters of values.

Oh my God, don't even get me to that. The people that determine the climate and culture of a hospital are the consultants. How they behave, what they say in corridors, in wards, in therapy rooms, in theaters. They have all these folk around them that they are basically activating to get things done. How they behave determines the culture, right?

So the board isn't really determining the day-to-day culture, the consultants are. Now, okay a nurse that behaves poorly, part of the problem with culture, for sure. The maternity challenge is quite complex, but actually good professionalism, good medical professionalism that really understands the role of the consultant would lead to far fewer of these challenges. Far fewer.

Jonathan Darling:

There's a big challenge in that for everyone, I think, given what you've just said. So we need to be drawing to a close. That we could go on for quite a long time here, I think. But just as we finish, can you give us a few takeaways, some sort of key points, key messages, particularly around leadership, leading a change that, that you feel you'd like to leave with people?

Nadeem Moghal:

We've covered some of this stuff, right? Curiosity is really important. Building a good foundation of understanding that is both mental models and theory is really important. Talking to people and listening to people, particularly listening to people to understand their what they're experiencing is really important.

But you really have to want to do this thing called leading change. You have to really be honest about what you're facing up to and what the challenges are going to be. And you have to have the courage to, to deal with the really difficult stuff. You have to have tenacity to keep going, right? There was a change that I was leading that was relied entirely on not giving up, because everybody was working against me, not for it to happen, because it was not to their wants, right?

And with the right conditions that I'd set up, I just kept going. So tenacity is really important. And you have to want to un- unlearn stuff. You need to want to unlearn stuff. You need to want to then learn how to think differently. But really importantly, you just want to do it and then step back and see what have I achieved, and then you'll you're likely going to have to want to move on.

That's what happened to me. I did stuff and I felt I need to move on. I've done what I came to do. I need to move on. That's very atypical, by the way. Very atypical

Jonathan Darling:

Thank you, Nadeem. That's been great, and we'll finish there.

Nadeem Moghal:

Thank you, Jonathan

(Music starts)

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