Ten Minutes with Professor Matt Makin; Medical Director at North Manchester General Hospital, part of Manchester University NHS Foundation Trust

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Abstract

In late 2019, Professor Matt Makin was facing the significant challenge of leading North Manchester General Hospital through a complex disaggregation process, as it left Pennine Acute NHS Trust and joined Manchester University NHS Foundation Trust. This period of uncertainty was made yet more testing as the hospital had been earmarked as one of six hospitals destined for a complete rebuild and redevelopment, thus leading to significant management and leadership capacity being absorbed by strategic project planning.

Moving into 2020, it soon became clear that a further challenge would require the full attention of leaders and managers across the health service. As the organisation with the regional centre for Infectious Diseases, North Manchester was looked to from the onset of the pandemic to provide support and advice to other acute providers across the region. In this short piece Professor Makin describes some of the lessons learnt during this challenging time and describes how he dealt with the extraordinary pressures facing North Manchester services.

Interview

1. **What are the key leadership messages you want to get out to the BMJ Leader readership?**

The main messages were not to underestimate the virus, but also not to underestimate the ability of teams to innovate and develop solutions if given the space, autonomy, and authority to do so. What was clear was the depth and breadth of clinical leadership, at all grades and some of the best examples of clinicians challenging, driving change, supporting and inspiring, was demonstrated by clinicians not necessarily in recognised ‘leadership roles’. This included doctors-in-training, and staff, specialist and local employed doctors.

At times, when the situation was changing rapidly it was also important that there was real clarity on the purpose and priority of what we were doing collectively, particularly when there were huge amounts of information to assimilate. There was a key leadership task in setting priorities and communicating these.

There also needs to be a sense of hope to keep people going, and a connection with the leadership team. This isn't easy and needs to be done in a purposeful way as it is not uncommon for large parts of the working week being occupied by back-to-back meetings on MS-Teams, risking a disconnect between board and ward.

Core messaging about failure was crucial, and the recognition that because things were changing quickly, and because staff at times felt overwhelmed, mistakes happened, and when this happened it should be met with compassion. The approach to dealing with mistakes was critical. Strong messaging about using them as an opportunity to learn, rather than blame, was imperative.

The pressures felt during the pandemic permeated the whole hospital, from portering and catering staff, Intensive Care and Emergency Department teams, to Booking and Scheduling clerks. It is hugely important to have a clear narrative of hope, with strong themes to support a cohesive approach:

- **Stay Current** - Our junior doctors developed an online resource, accessible by QR-code for all staff to have accessible up-to-date information on organisational changes
- **Defer to Experts** – *Escalate don't speculate*, we have highly skilled people let's use knowledge as strength
- **Coordinate** – Don't confuse!
- **Keep calm** - You are not alone, this is new to all of us, you're stronger than you think
- **Stay Kind** - A smile, a thank you, and positive feedback can mean a lot

2. **Tell us a little bit about your leadership role and how it is changing as a result of the pandemic?**

I was involved in the early stages of the pandemic in January 2020, in my role as chair of the infection prevention control committee. In those early months before the worst of the pandemic hit, the task was largely preparatory, ensuring that we had the necessary estate, PPE and workforce to ensure the hospital could face the storm that was gathering. At the same time, our hospital, North Manchester General Hospital, was being acquired by Manchester University NHS Foundation Trust (MFT) and leaving the Pennine Acute NHS Trust (PAT). Thus, I faced a big decision, whether to remain as Medical Director of PAT, or whether to stay with North Manchester. I chose to stay with North Manchester, and it very much felt like the right decision, having been based here for five years and it being the hospital where I do my clinical work in palliative care medicine. There were some significant changes in the leadership team as a consequence of both the pandemic and acquisition, and so part of my role was to provide continuity and organisational memory. The words of an old (now sadly deceased) mentor came to me many times. Aiden Halligan told me: "*you're judged in your NHS leadership role by how you respond under pressure, get to know how you respond under pressure*". I determined to be as visible as I could be during the early part of the pandemic through the morning and evening briefing meetings, although due to the multiple planning meetings much of my clinical work was sacrificed and my colleague Dr Iain Lawrie and the Palliative Care Nursing Team provided an exceptional service right across the hospital with daily visits to wards and departments where they focussed as much on the wellbeing of staff as our patients. Dusting off my postgraduate ethics contribution, I was part of the regional clinical ethics team considering the many moral dilemmas associated with the pandemic. Although there were the technical aspects of the pandemic response associated with oxygen supply, changes in Public Health England advice and testing and treatment regimes. The main change to me was the confirmation that much, if not all of what we were able to do at North Manchester was based upon relationships and maintaining these relationships. It is these relationships that connect staff to the leadership team and ensure that issues and concerns are raised early; our narrative was very much "**bring us your concerns**" and we were able to have a frank discussion about what we could fix and what we couldn't. It also meant we could have authentic conversations about wellbeing and ensuring teams were able to support each other and access additional expertise if necessary. As the pandemic stretched over months into its second year, it felt

that the leadership role required a much less hierarchical approach to one that more about listening, learning, and coordinating. The revelation during the pandemic was tapping into the expertise that sat within the group of junior doctors, and it was through them that "junior doctor leaders"[1] came to the fore and really turbocharged several changes that were crucial to the pandemic response. This included the formation of a unified on-call team: "*the clinical response team*", a complete restructure of junior doctor handover and the development of the doctors' mess facility as a hub for wellbeing. These projects were all identified, designed, and delivered by junior doctors, showcasing them as a cohort of individuals with skills not limited to their clinical backgrounds. We were fortunate at this time to have Dr Joe Home working with us a Leadership Fellow and Joe was instrumental in much of this change working with the Director of Postgraduate Medical Education, Dr Leann Johnson.[2]

While all this was happening, we were working on a tight timescale to draw up a business case to completely rebuild the hospital, disaggregate from Pennine Acute Hospitals NHS Trust, integrate into Manchester University NHS Foundation Trust. The expectation that we will be adopting a whole new electronic patient record system is also asking much of our already fatigued clinicians in terms of engagement. It's a veritable herculean "multi-task" and has only been possible because of the commitment of a hugely talented and committed clinical leadership team.

3. **What events in your past experience are most informing your leadership in this pandemic?**

Working with the emergency planning and response teams, we recognised the importance of looking at the weeks, months and years following system response. I learnt this following the tragic circumstances of the Manchester Arena bombing, where the response to the incident persisted for months afterwards, particularly in relation to staff wellbeing, and the importance of not only recognising good practice, individual and team contribution but also acknowledging failure as a route to learning and improvement. I was also mindful that the trauma and intensity of experience that staff were exposed to, would not always be immediately apparent, and could take months or years to process.

During the early part of my career at PAT the focus was improvement, via improvement science and improvement methodologies. Central to this was the narrative from my colleague and Director of Nursing: "***failure is your friend***", and it has been this perspective that has been most valuable, recognising the simple solutions aren't always the right ones, that trying and failing was a necessity, and that generally we hate admitting mistakes even more than we hate making them. Admitting mistakes is tough, but it's the only way to prevent making even worse ones. If you can start by admitting mistakes to yourself, you're one step ahead, if you can share it to demonstrate a degree of vulnerability, it can generate trust and encourage learning.

4. **What are you finding the biggest challenges?**

Looking forward, my biggest concern is the for staff who keep our services going. We continue to see sustained intensity over months and years with limited respites and with-it exhaustion and fatigue. The burden on all staff has been incredibly difficult as there are entire support networks and staff groups who are experiencing symptoms of burnout. Additionally, dissonance seen in the media narrative and public perception regarding the real pressures on services leads to a landscape that does not recognise the challenges faced by our staff and patients.

In terms of services themselves, we continue to see all-pervading disruption and delay in urgent and elective systems. This is compounded by high levels of staff absence due to sickness, self-isolation or catching up with annual leave. This is compounded by pressure to catch up with backlog of elective cases, and the narrative in the public space that "we're out of the woods". This is particularly felt in the increasing frustration expressed by the public to delays in accessing care and the narrative in some segments of the national press that the NHS has either let down or abandoned groups of patients.

Keeping going is the biggest challenge, maintaining hope, which for us at NMGH largely centres on a full hospital rebuild, and ensuring amongst the multitude of competing demands that we can be clear on what the priorities are.

5. **Any particular surprises?**

What I would refer to as the *silent leaders*; individuals whose contributions had (pre-pandemic) been less visible, making significant contributions through their determined and resolute contribution.

How some staff groups have met challenges head on, with a “can do” attitude. Notable at North Manchester have been the theatre staff deployed to ICU and the junior doctors taking on leadership roles and influencing board decisions,[3] providing that real-time feedback and strengthening the crucial board-to-ward relationships, leading to the organisation being shortlisted for a national Health Service Journal award.

This collaborative approach also extended beyond organisational silos with an approach to inter-organisational working with colleagues in community care, primary care, secondary care and social care working toward a common goal. An approach which I hope will continue beyond the current pressures.

6. **Are you seeing any behaviours from colleagues that encourage or inspire you?**

For all of the challenges in the last two years, what has really come to the fore has been superb leadership in the face of huge adversity. In my career so far, I have seen many times health services have been required to rise to the challenge, but in this period health workers and teams have truly risen above it.

The manner in which colleagues have done this has perhaps been the most inspiring; Intensivist Dr Tracy Duncan with her quiet determined leadership in critical care, or Emergency Medicine Consultant Mr John Bachelor, ever present, ever flexible and solid as a rock in our emergency department. Additionally, teams such as our catering colleagues who’s emphasis on safety in our dining areas, whilst still ensuring mealtimes are always met with a smile, a chat, and the famous NMGH cheese and onion pie on a Wednesday.

7. **How are you maintaining kindness and compassion?**

Having a genuine and determined effort to maintain a work-life balance, part of which is recognising I can't do everything. Ensuring I savour moments more, enjoy music and reading, search out humour and spend mindful moments in the kitchen and around the table enjoying good food and having a daft laugh.

8. **Are there any ideas or readings that you find helpful, for inspiration and support, which you would recommend to others?**

As a clinician it is often relatively clear how and where to look, to maintain clinical competence and build knowledge. The same cannot be said as a medical leader, with sometimes unhelpful assumptions that clinical training and knowledge makes me a good leader by default. In looking to build my knowledge in medical leadership I found Patrick Lencioni's work on team (dys)functionality insightful, as well as Kotter's change management principles.

Healthcare remains a challenging sector to work within, and Viktor E. Frankl's book '*Man's Search For Meaning'* has helped me remain grounded and objective in difficult periods. Lastly, Bob Mortimer's autobiographical '*And Away…*' is on my recommended read list for the way it serves as a reminder that that behind every patient is a human story.

9. **What are you looking for from your leaders?**

To challenge; no one is immune to their own biases and the more we submit to groupthink the higher risk of falling through holes in the swiss cheese. To share vulnerability; no-one is infallible, and we need to move away from heroic styles of leadership to ones that build collaboration and trust. To work together toward shared goals for the collective rather than

the individual good; the health business is a people business and the best ideas that have made it through the complexities of NHS decision-making are those who prioritise relationships over results. Finally, I want my leaders not to lose sight of our mission, we are all patients and we must do everything we can to ensure kindness toward our fellow people pervades everything we do.

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