

Mission command: applying principles of military leadership to the SARS-CoV-2 (COVID-19) crisis: more than just 'mission command'

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The recent paper by Pearce, Naumann and O'Reilly introduces a very important debate about leadership during health crises and the transferability of military leadership attributes into the civilian environment.¹ The enduring tenets of the UK military philosophy of mission command are highly relevant in a fast moving, crisis context. It is noticeable that military medical services personnel are expected to undertake the same leadership training as other members of the Armed Forces and that the military appraisal system for officers and soldiers is based on leadership competencies. The transferable validity of this system is most evident through the success of Defence Medical Services (DMS) Regular and Reserve personnel in working with colleagues across the NHS system.

However, 'mission command' is not the only component of organisational design that delivers a military command and control system that can rapidly respond in crisis situations. It is suggested that this organisational competence is the product of the complete 'command and staff' system. Military doctrine creates a common understanding of how the organisation thinks and operates, education and training delivers this understanding to leaders, and field exercises and evaluation (including the lessons learnt processes) ensure the effectiveness of the system. Most important is the authority

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and responsibility of 'command' and the mechanism to deliver this through a 'staff'. The Staff operate as a unified team within a headquarters to cover all the functional domains necessary to provide an integrated product for decision-making by Commanders and implementation through plans.

It could be argued that the NHS has yet to fully embrace a unified, multiprofessional approach to education for its leaders. The creation of the NHS Leadership Academy and the NHS Staff College are waypoints on this journey. However, there remains a professional separation of leaders with limited, multiprofessional leadership opportunities as part of their undergraduate and postgraduate education. There is no formal 'staff system' nor is there a clear organisational hierarchy and lines of accountability between the Department of Health and Social Care, NHS England's partner organisations, and regional/local delivery.

It will be interesting to observe how the COVID-19 crisis leads to further developments of the NHS 'command and control' system in England and to compare with the three other Devolved Administrations. It will also be important for the DMS to maintain an internal debate about the best routes for education and experience in leadership within military health systems for its own personnel.²⁻⁴ It is probably also important to reflect on the relative lack of access to mid-career and senior leadership education for DMS personnel compared with other professional groups in the Armed Forces.

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