See sweet to C-suite: Imran Rahman

BY DAVID LOCKINGTON

In this three-part conversation series, Co-editor David Lockington speaks with highly influential individuals about their journey to the top, with advice for the next generation of leaders. Part Two: David speaks with Imran Rahman, CEO of CHEC.

Imran Rahman

Rather than this being some major thesis on how to be a businessman, I want to get to know the real you. Can you give us a bit of your background – how you ended up in medicine, how you ended up in ophthalmology, and how did you branch out from there?

There's always a role model that influences us at a young age, but reflecting back it's actually the profession that really draws you to medicine. The ability to have a career based around something you enjoy doing on a day-to-day basis. The interaction with people in many different walks of life that medicine is unique in exposing us to.

When I graduated from UCH in 97, I spent a couple of years in London in house jobs. I was in colorectal surgery for a short while, at which point I needed to make a career decision: medicine or surgery. It was really clear to me. I wanted to be a surgeon.

I wanted to do clean surgery, things that would make an instant difference. I don't particularly have the attention span for a three- to four-hour operation, so I had to find a career for myself that held the surgical aspect but did not involve long operations. Ophthalmology suited that really well.

I wasn't getting shortlisted initially. I had undertaken my Part 1 already and I visited a consultant for career advice and he said something that really chimed to me at the time about my name being the reason for not getting shortlisted. I thanked him for being honest as sometimes you don't know what's going on the background. That was a turning point for me, and my goal was to pursue a career in ophthalmology more vigorously.

My first ophthalmology role was in Plymouth and then ST training in Manchester with my corneal fellowship resulted in my placement in Nottingham for a year. The final stage in my clinical career was as the Lead for Cornea and Cataract Surgery in Blackpool. I was there for nine years.

The NHS is a great institution, but cannot be changed easily. This is not finger pointing at any one person, but as an institution it's very, very difficult to change, which I am sure many colleagues will agree with. I found this really testing for eight or nine years.

I found that my skills as a consultant ophthalmologist weren't always being used to the optimum effect. As well as at times having to manage waiting lists – not something that was in my training or skill set – I might also find myself completing 'low-risk' work that could have been better allocated to others. However, the NHS approach is to see as many patients as possible rather than considering the complexity of the patients seen. I was quite lucky in Blackpool. We had a progressive unit when I first arrived there. The consultant body worked with one voice.

After years of trying and making small gains, the change in my mindset came when I realised that I could not change anything tangibly in the NHS. As with many people who have been consultants in the NHS for many years, we have never really been taught anything to do with business or financial governance. They've never really been taught anything other than how the NHS works.

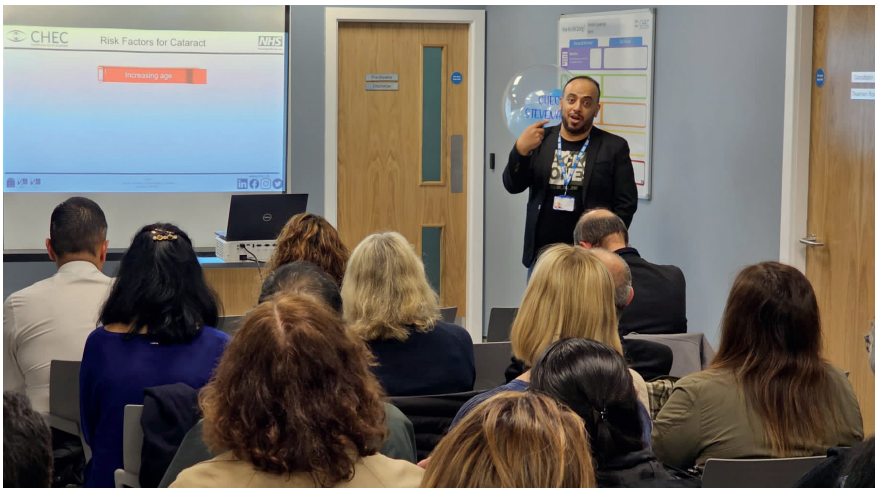
So, as a consultant, private practice started creeping in. I had to work my way around how the private practice market worked and that was a bit of a minefield – an enjoyable minefield because you could do the things that you wanted to do without the constraints of the NHS.

What I realised was I didn't want to do private practice. That wasn't my niche, and I reflected on that. I just thought to myself,

the biggest bottleneck in ophthalmology is outpatient work, the work that nobody wants to do – the glaucoma, the dry eyes, that kind of thing.

What we [at CHEC] did well for five or six years was community ophthalmology. CHEC soon became the largest provider of community ophthalmology in the UK. We had to build our infrastructure from scratch, and when I reflect on how the NHS fundamentally works, I have seen the change in our model.

The NHS is designed for essentially a doctor to consult with a patient and management are there to support that interaction. At Community Health and Eyecare (CHEC) we have flipped this and say, "Our Consultants have to follow our pathways from day one which are evidence based and largely without individualised variations." This means if we have a certain way of working, clinicians follow it. Any doctor around the country can go into any of our units and follow the same methodology, and the same pathway. The result is consistency and an approach where we can benchmark clinicians' outcomes and complication rates.



It seems like you started CHEC yourself from scratch, so on day one you were the CEO. Did you have training? How did you develop that skill set?

Honestly, David, I don't think I know what a CEO is. If I went into a Fortune 100 business, would I be a good CEO? I probably wouldn't as they are professional businesspeople and I am a trained consultant ophthalmologist. What I do know about myself is that I have a very clear vision about what I want to do, and I need to achieve that. And what I have noticed over the years is that if I recruit the best people, then the best people recruit others that are the best in class.

Unsuccessful hires are not good for the organisation. I've learned quickly that I need to spend the right amount of time to recruit the right people, in the right way, to make sure they (1) fit the culture and (2) that they've got the skill set to do the job. As a CEO, I would say I am a strategist and a recruiter of talent.This is something I've learned in the last four years. I'm not shy about looking at people and saying, "You probably don't fit what we want to do." If you get the right people, the right people run the business for you.

I stopped clinical work about two years ago. I still do bits and pieces of outpatient work but my sole job now is to understand how the parameters of the business can vary and grow legs, becoming things we don't want them to. If we have bad results, it impacts patients and impacts the organisation. My job is to make sure that we've got enough data and monitoring to ensure we are best in class with clinical results. We've got a good clinical team to analyse that data monthly. They present outcome data benchmarked to national standards, engendering a continuous learning mentality with lessons from when things go wrong. It's a proactive way of working.

It's interesting that conferences like ESCRS and UKISCRS are adding more business leadership and innovation branches to their programmes. What does your study leave look like? Do you go to traditional conferences or other avenues to develop business skills?

I think it's by default; the skillset of being very clear in my thinking and because of that, I've got my senior team clear in their thinking as well. We've got a strategy that we stick to. We have board meetings on a monthly basis where we actually have tangible debates on what we do well, what pain points we have, and we work as a team to rectify those problems. That's commonplace, and what I've found is that I learn a lot more from my team than going to a conference. I think you go to a course and refine your thinking, but you can't go to a course and start your own business.

As an observer looking in, you've had the chance to set something up from scratch. If I was playing devil's advocate – you know you are going to be accused of cherry picking, that you are taking staff away. How do you respond to that?

I like to think in facts rather than accusations. Facts are facts and I use that phrase quite a lot. It's black and white. I can tell you from a CHEC / organisation point of view, we don't influence which patients are referred to us, so we have the same referral mechanism – optometrists and GPs refer a patient. We assess the patient. Is the bigger question, why are patients choosing not to go to an acute trust? People vote with their feet in every industry. If a patient can have treatment within three weeks, spend less than 30 minutes in a hospital, and have free unrestricted parking and free transport, why would they choose an alternative? Referrals are received without the referrer knowing deeply the intricacies of what patients will need surgically, so I have never understood 'cherry-picking' as we have no influence on the patients' comorbidities on referral.

If independent service providers (ISPs) cherry pick, you would intuitively think that a large percentage of the patients that have been referred to ISPs will get referred to secondary care. Our onward referral rate is less than 1%, so less than 1 in 100 patients are referred to secondary care after they're seen in CHEC hospitals. I wouldn't imagine one in 100 patients is cherry picking. Onward referrals would be more in line for patient safety because of the need for say, general anaesthetic. I believe the perception of cherry picking is solely as the majority of cataracts are undertaken by ISPs in England and the numbers seen internally are from specialist clinics with extensive co-morbidities, rather than new referrals. It really is a misperception of case distribution.

And staff?

Again, facts are facts. Less than 3% of CHEC are from the NHS. We employ over 600 staff now. In our experience, colleagues coming from the NHS can find the move to the independent sector challenging. What we do find, though, is that staff move within the independent sector. I can only talk for CHEC, but what I would say is that if staff are moving to ISPs, why is that?

That's really interesting.You have a very successful business – what are the biggest challenges of your work as a CEO?

Clinicians are ultimately risk takers because that's what we do when we operate. There's always a risk element – we're used to that – the risk to a CEO is very different. We must maintain governance over the whole team, the infrastructure, and ultimately the buck stops with me. I then need to be on the ball and make sure I have the processes, the people and the data coming to me so I can analyse it and be reassured against benchmarks, whether financial or clinical.

Trust, to me, has been the biggest changing point in the last three or four years; trusting my team, trusting them to deliver, trusting them to monitor, analyse and implement good practice. If they have problems, I've got an open door – they come, and we all discuss it – and sometimes we can't decide and we have to get external opinions on how to do things. We do have data analysts externally, we have coders externally, we have education strategists externally to advise us, so we bring in the resource as we need it.

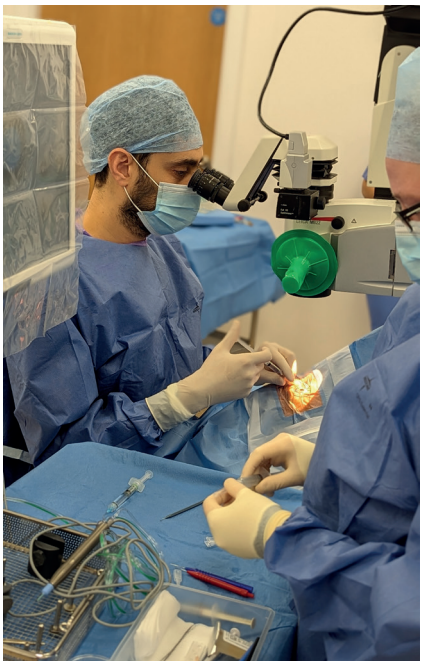
Thinking about the corporate responsibility stuff – does that fill you with dread, or does that inspire you to just be as safe as possible and be better?

That doesn't frighten me at all. I think the team that we've built around us runs the show and I wouldn't be able to manage the business unless I had complete conviction and confidence in their abilities as leaders within their field.

I wonder if that's the reason people are reluctant to either dip their toe into private practise or go out beyond that because the NHS, for all its faults, is still a bit of a life jacket.

When I left the NHS in 2017 I had exactly the same anxiety – what's going to happen if it doesn't succeed? What are people going to think about me? What do I do in these situations? And what I found was actually nothing is that much of a problem if you're a decision maker. You will make a decision. The worst thing you can do is not make a decision in business.

Now, not all doctors are clear decision makers on non-clinical grounds and that's why you have medical directors. That's why you have people moving into senior corporate positions because they're more than just a medical decision maker. And I think I'm more than just a medical decision maker. I can see things differently aside from clinical aspects.



I do think you are right in that the corporate risk is a scary thing, but if you've got the right team around you, the right skill set, you'll be absolutely fine because they ultimately make a decision for you, and they know that they have to make safe decisions as well. And that's not just clinical, that's financial, HR, IT, etc.

We hired a chief technology officer a year ago because we want to automate as much as we can. I'll give you an example of this, and this is where I think the NHS not necessarily fails but fails to achieve the goal that they want to achieve due to the size of the organisation. We had a problem a few years ago after Covid-19 staff left the bookings team, so we had about a four- or five-week wait for patients booking in. We just didn't have the staff, and I knew that if things were going expand for us, we would need a different way of working, so we developed within about four months our booking app and that now undertakes 70% of all our bookings.

We, at the time, undertook about 180,000 bookings per year with 43 staff booking patients. We now have 40 staff booking 500,000 patients, who wait less than three days for contact. It just shows the power with which technology can really drive your business efficiency. We want to divest away from people and that's not to say that we don't want people in the business, but we want the right people in the business. We don't want people undertaking manual tasks that they don't need to do.

If you're a Jack of all trades, you're master of none, and the NHS is very good at getting you to do everything apart from what only you can do. We've talked about the stress, so how does Imran, the CEO, switch off and relax?

Honestly, a CEO doesn't relax and I'm on call 24 hours a day, seven days a week, 365 days a year. It doesn't matter where I am in the world, I'm always contactable and that's the culture I've instilled in the business' senior team. They're always available because we can't do without our HR director, our CFO or our medical director at any point. It's not just the CEO, the team want support from other people in the business.

The C-suite will come to me with problems, but the rest of the business will go to the C-suite with problems. I don't think anybody of seniority ever switches off in the business and I think that's the right thing to do. We operate seven days a week across the country. We need our estates up and running – if there's a leak or worse, it needs to be dealt with by somebody.

I accept that, but surely you must be on call from a golf course or a beach, or you must do something in your holidays?

I've got family. I go abroad. We go skiing. But what I try and do is align with CHEC's working day no matter where I am in the world, so CHEC staff do not even realise I am abroad. As an example, my family go to North America skiing on the basis that there's a big time difference. So, if I want to do three or four hours of skiing, I can do that and then I'm back to work when everybody in the UK else is back to work. You can work and have a holiday at the same time.

I think that's really valuable advice, because I often tell my trainees, "Phone me early." I don't want to not know about something for ages, and then it's a catastrophe. Tell me early and we can sort it out. What advice would you give a younger version of yourself, if you can go back to that doctor who wasn't getting on the training schemes?

I would say that the NHS is the best institution that you can learn the good and bad things from, and that might be from a purely clinical perspective, or it might be from a business perspective. And that there are always frustrations. CHEC doesn't run without frustrations – there will be frustrations on a daily basis, but if people can change their mindset and how they deliver services, how they engage with people and how they bring people on board, they will do far better than trying to change the structure of how they've been delivering

the service because ultimately, David, any service that anyone delivers, whether its NHS, independent sector, private work, it's dependent on the people that are delivering that service.

I totally agree, and I think the beauty of what you have is you've been able to build it from the bottom up rather than having to avoid all the detours. Do you wish that you had taken the leap of faith earlier, or do you think your circumstances conspired to that perfect moment when you said, "Right, enough. I'm going to do this"?

I think one of the failings of training is that they don't train us on the other options out there. They don't give you the skill set of understanding how businesses actually run and the infrastructure needed.

Professor Dua used to say to me, "Always look after the patient and everything else will follow." And he's absolutely right. If you do the right thing, everything else falls into place and I don't think the training scheme teaches you anything other than the clinical side. Yes, they send you on leadership courses and business courses, but that isn't really how business works. You can't set up a business by going on the course. I do think now that the independent sector is training junior doctors, those doctors are going to see things differently. They'll see what the rest of the world is like, and that will bring good things back to the NHS.

The agility of the independent sector, especially CHEC and other providers, is that if we've got national estate, we can make changes within two or three days that permeate across the whole business and everybody changes the way they work, and that doesn't happen in the NHS, which is a frustration.

I don't think there's a right or wrong answer in how new trainees will see the independent sector or the NHS. I think it will be an evolution. I think we've just started that evolution, and it will take a few years before people start to realise there's other ways of working and that can only be good for patients all across the NHS.

I agree, Imran. Thank you so much for your time and your insights. I find that fascinating and thank you for being so open and sharing.

INTERVIEWED BY

David Lockington,

Cataract and Cornea Ophthalmic Surgeon, Tennent Institute of Ophthalmology, Gartnavel General Hospital, Glasgow, UK.

Declaration of competing interests: Consultant grants, advisory boards, lectures for Alcon, Bausch & Lomb, MST, Santen, Scope, Théa Pharmaceuticals.