



# Clinical leadership



**Effective clinical leadership**

is important in shaping positive cultures



Leadership is one of our priorities.

We have an opportunity

and responsibility to help shape effective clinical leadership that supports positive workplace cultures

**Progression into formal roles can be haphazard and often unplanned. Doctors rarely undertake specific leadership training, leaving some feeling unprepared**

Clinical leadership includes **formal leadership** roles and **everyday leadership** where doctors lead in their day-to-day practice

**Everyday leadership** can be difficult to define, and doctors don't always recognise leadership in their own clinical and professional behaviours

**Formal leadership** roles have both personal and professional benefits for doctors. But they're sometimes seen as expendable and the first thing to be dropped over other clinical priorities



**Workplace cultures that are inclusive and compassionate have a positive impact on staff wellbeing and safe patient care**

## Leadership and workplace cultures

Effective and compassionate clinical leadership has the power to alleviate some of the challenges within the healthcare system and create positive change.

### Clinical leadership is complex and multifaceted

Clinical leadership has two elements:

- doctors in formal leadership roles, also known as clinical or medical management
- the informal leadership activities that doctors carry out as part of their everyday practice.

These two elements are not mutually exclusive. We recognise all doctors as leaders in their daily practice and publish guidance to this effect.<sup>46</sup> Many doctors will also have some form of additional formal leadership or management role.

In the recently published *Caring for doctors Caring for patients*<sup>5</sup> review of doctors' and medical students' mental health and wellbeing, Professor Michael West reported compassionate leadership as the single biggest driver of positive culture in healthcare. Positive cultures improve workforce morale, motivation, mental health and wellbeing, as well as having a positive impact on the quality of patient care.

The importance of effective leadership in shaping positive cultures is highlighted in four independent research projects we commissioned in 2019.

- *How doctors in senior leadership roles establish and maintain a positive patient-centred culture*<sup>47</sup> – Dr Suzanne Shale, a medical ethicist, explored the lived experiences of doctors in senior leadership roles. The research

looked at doctors' leadership journeys, the everyday challenges they face and how they view their role in shaping their organisation's culture.

- *Everyday leadership*<sup>26</sup> – Newcastle University carried out this UK-wide research, which examined consultants' and GPs' experiences of leadership in relation to their own work, including taking on additional roles and responsibilities.
- *Fair to refer?*<sup>7</sup> – Dr Doyin Atewologun and Roger Kline carried out this UK-wide research to understand why a disparity exists in the referrals we receive from employers and healthcare providers, and to identify recommendations for us and others to act on. Employers and healthcare providers are more likely to make fitness to practise referrals to

us about doctors who gained their primary medical qualification outside the UK, or who are from a black and minority ethnic background, than they are to refer their UK qualified or white peers. This is important as complaints from employers are more likely to result in an investigation being opened. And more likely to result in a sanction being applied, than complaints from other sources.

- *Caring for doctor Caring for patients*<sup>5</sup> – Dame Denise Coia\* and Professor Michael West chaired a UK-wide review of medical students' and doctors' wellbeing. The review focused on:

the working conditions that cause workplace stresses among doctors; the support currently available in healthcare organisations and medical schools to prevent workplace stresses; and how workplace stress and mental health conditions among doctors compare with other professions, both within and outside healthcare.

We'll work with partners to address the findings from these reports, in particular looking at how we shape our work around leadership in the future. We address some of the ways we plan to do this in chapter 7.

## The benefits of good leadership in shaping healthy workplace cultures

### Doctors are more likely to recognise their formal roles as leadership, but these are often the aspects of their work they feel less prepared for

Doctors at all levels across primary, secondary and acute care carry out a range of formal leadership activities. When consultants and GPs were interviewed about their leadership roles as part of the *Everyday leadership* research, many most naturally talked about their formal roles or activities as opposed to their informal duties.

The research found that many of these formal roles were separate from participants' clinical jobs, as an additional role either with the same employer (eg clinical director) or with a different organisation (eg a deanery role, such as training

programme director). These formal roles tended to have dedicated time, and in theory provided a clear separation of time and/or place between jobs, though participants found the 'big mental switch' a challenge when moving between roles.

However, while these roles are separate, they can merge into other areas of clinical practice – some doctors talked about using the leadership skills they have developed in their formal role as part of their clinical practice.

Participants with formal roles in a different organisation felt protected against clinical work spilling into their own time. The separation of having two employers drew a clear line between clinical and leadership time.

\* Professor Michael West and Dame Denise Coia co-chaired this review until May 2019, when Dame Denise Coia stepped down from her role prior to the production of the report because of health problems. Professor West led on the review until its conclusion, but Dame Denise Coia's views up to that point are fully represented in the report.

## Though time consuming, formal leadership roles seem to have personal and professional benefits for doctors

In the interviews, doctors described benefits of having formal leadership roles. Some of these benefits were anticipated and formed part of a doctor's motivation to take on a leadership role, while others were incidental, affecting their enjoyment of the role and desire to stay in it.

One of the key rewards of having a formal leadership role was having a sense of creating lasting change or building a legacy. For these doctors, leadership was about strategic change, not just operational improvement.

Doctors also described how having multiple roles benefited their wellbeing. While participants' clinical areas varied, all spoke of the enjoyment they still gained from patient contact and practising medicine. Many also spoke of the satisfaction and enjoyment of their formal leadership roles.

Some felt they were able to be more imaginative and creative in their leadership roles than they were with direct patient care. Doctors talked about formal roles giving them the freedom to explore their interests beyond clinical practice. Some spoke of enjoying the variety that formal roles brought into their work. And others simply appreciated the break they offered from the pressures of clinical work – they felt this helped them to 'keep fresh' and maintain their enthusiasm for their clinical work.

Although many participants appreciated the opportunity to take a break from clinical practice, almost all interviewed doctors spoke of how valuable their clinical work was to their

formal roles. They talked of the importance of 'understanding what's happening on the ground' to be the most effective leader. Many felt their roles were mutually reinforcing; having a 'foot in both camps' made them both better leaders and better clinicians.

The research did highlight a few negative aspects associated with doctors taking on additional roles. These were largely based around having enough time to get things done. Some doctors described their formal roles as 'thankless', that there was considerable responsibility without the tangible reward of clinical work. Furthermore some suggested that being a formal leader can be a challenge for team working, as at times they may have to exert authority over a clinical colleague in the course of their formal role.

The overall sense was that, while formal leadership roles had a variety of benefits for wellbeing, these roles were expendable. They would be the first thing that doctors would push aside when time had to be prioritised towards clinical practice.

In the *What it means to be a doctor*<sup>9</sup> research reported in *The state of medical education and practice in the UK: 2018*,<sup>4</sup> almost a quarter of doctors (23%) reported they felt increased leadership requirements had a positive impact on their work. A further fifth (21%) said they felt increased leadership requirements had both a positive and a negative effect. This supports the findings from the *Everyday leadership* research, which found that some doctors felt conflicted about their leadership roles – while the roles could be a strain on their time, they offered benefits to their wellbeing at the same time.

## **Inclusive and compassionate workplace cultures have a positive impact on doctors' wellbeing and, crucially, on the quality of patient care**

The recently published *Caring for doctors Caring for patients*<sup>5</sup> review of doctors' and medical students' wellbeing found that NHS organisations with inclusive and compassionate cultures foster fairness and promote good wellbeing among their staff. The review found that a sense of autonomy, control and belonging, as well as a feeling of competence, were crucial for doctors' wellbeing. By supporting these elements, nurturing cultures enable doctors to provide safe and compassionate care to patients.

Research carried out by Dr Suzanne Shale on senior leadership roles found that there's no single understanding of positive culture among senior clinical leaders. Notions of culture are rich, complex and varied; largely based on individual understandings of organisational culture. Senior clinical leaders tend not to see culture as a 'thing' that they specifically set out to improve. Rather, their everyday leadership activities shape organisational cultures through what is described as cultural housekeeping.

The *Caring for doctors Caring for patients*<sup>5</sup> and the *Fair to Refer?*<sup>7</sup> research both made key recommendations for establishing workplace cultures that are collective and nurturing and that focus on accountability and learning rather than blame. Positive culture is not only good for doctors' wellbeing but facilitates a working environment in which patient care is safe and compassionate.

## **Everyday leadership can be difficult to define and often goes unrecognised by doctors, but it's crucial for shaping positive workplace cultures**

While doctors seem clear about the leadership inherent in their formal roles, everyday leadership appears less tangible and doctors don't always recognise leadership in their own clinical and professional behaviour (figure 45).

The *Everyday leadership* research found that day-to-day leadership activities weren't always recognised by individuals. One GP described how they had identified an issue with the appointment system in their practice, designed a solution and introduced it to the other partners, yet only during the interview conceded 'I suppose that is leadership'.

Day-to-day leadership may be a function of workplace systems, meaning that GPs and consultants developed their leadership roles because it was what was expected of them. For example, one participant described how they were alerted to errors, which they were responsible for investigating, despite not being aware of this responsibility beforehand. This is illustrative of how some doctors may have additional responsibilities imposed on them by the system, rather than it being their choice. Where a role or activity was imposed, participants didn't always recognise this as a leadership responsibility.

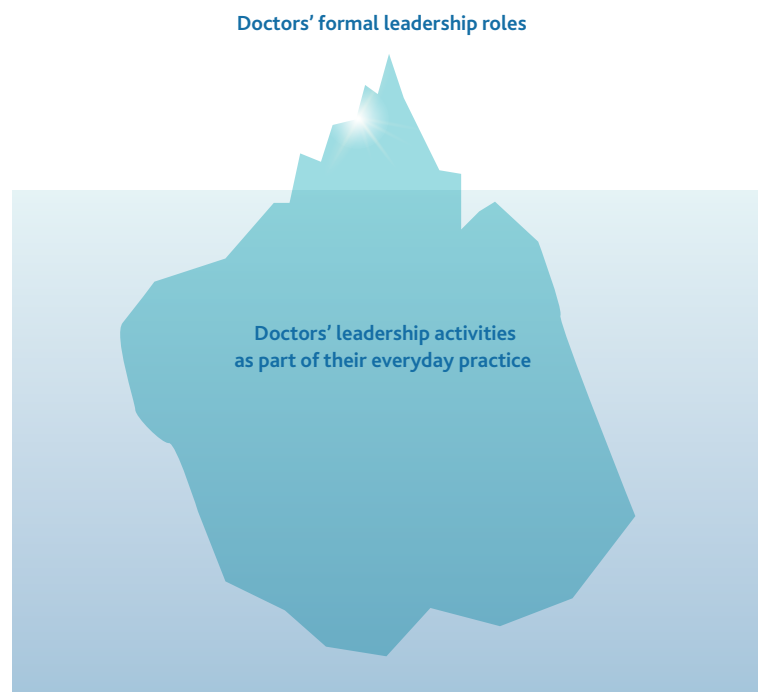
## There are differences in leadership between primary and secondary care

The position of the GP partner is very different from that of a hospital-based consultant. As self-employed contractors, GP partners have significantly more autonomy than consultants in hospitals. It's notable that the consultants who participated in the *Everyday leadership* research identified governance structures as a key barrier to leadership, whereas no GP partners did.

This autonomy makes general practice a fertile ground for innovation. However, particularly in small practices, with greater autonomy can come less leadership capacity.

Across all areas of medical practice, doctors identified a lack of time as the key barrier to leadership. In general practice, GP partners technically have control over the number of clinical sessions they undertake, which should, in theory, allow time for leadership and innovation. However, meeting clinical demand and managing the business side of the practice may eat into this time. Even if the practice has the resources to take on a salaried or locum GP colleague to address some of the time constraints, there's no guarantee that the practice will be able to recruit from an already stretched workforce.

Figure 45: Elements of clinical leadership



## **We must take a multi-professional view of leadership to make sure organisations have inclusive cultures and productivity is maximised**

It's important to have effective leadership from all those working on the frontline of healthcare. By recognising that different professional groups/individuals hold specific knowledge and expertise, it's possible to maximise productivity by making sure that the right skills are brought to the fore with the right people at the right time.

In July 2019, we announced that we'll be regulating physician associates and anaesthesia associates, who, along with other medical associate professionals, make up a crucial part of a multi-professional workforce.

Multi-professional working is becoming increasingly common throughout the health service in all four countries of the UK, particularly with the push for better integrated services in primary and community care.

The *Caring for doctors Caring for patients*<sup>5</sup> report highlights the need for compassionate leadership and effective team working. It also highlighted how beneficial both team working and good colleague relationships can be. However, it stressed that these communities of colleagues must be inclusive of all members of multi-professional teams, or risk isolating some healthcare professionals.

## Current challenges to effective clinical leadership

### Progression into formal leadership roles can be haphazard, and doctors rarely undertake specific leadership training

The *Everyday leadership* research revealed that progression into formal roles is haphazard and often unplanned. In the interviews, doctors discussed being approached to apply for roles, rather than seeking them out. While there were some examples of doctors deliberately pursuing formal leadership progression via intermediate positions (such as progressing from an associate medical director to a medical director) there did not always appear to be a clear career path.

The interviewed doctors in formal leadership roles often described their progression into these roles as being 'opportunistic' and 'random'. Opportunities for new roles often came from ad hoc invitations or suggestions from senior colleagues. Some of these were a function of simply being in the right place at the right time. But others suggested it was about being the right person – a more deliberate, or even strategic, decision on the part of the proposer.

Leadership opportunities vary according to organisational or geographical context. Doctors practising in small and remote communities may have limited awareness of, or very little access to, additional leadership opportunities. But, conversely, it could mean that they have more opportunities available to them because there are fewer possible candidates for the roles.

The interviewed doctors said they often felt underprepared for the leadership elements

of their work, such as chairing meetings, writing a business case, or managing poor staff performance. These responsibilities are generally not part of the specialty training curricula, where clinical skill development is the priority.

Several participants said they had undertaken leadership courses during the latter stages of their training programme, although one noted it would have been more useful had they done it once they had had the experience of working as a consultant. Another felt that some consultants were rushed into formal leadership roles and felt fortunate they had worked as a consultant for a year before taking on a formal role.

Notably, none of the doctors interviewed referred to any education or training in leadership or management before specialty training. Doctors mostly talked about their skills and knowledge evolving through learning in practice once in a leadership role.

### Negative cultures enable unprofessional behaviour, such as bullying, harassment and discrimination, with consequences for doctors' wellbeing

*Caring for doctors Caring for patients*<sup>5</sup> reported the impact of system pressures on negative cultures, with the endemic strain from high workloads contributing to higher levels of bullying, harassment and discrimination. The doctors who participated in the review identified a lack of fair or transparent procedures around bullying and discrimination as a key element of negative workplace cultures.



In a survey carried out in 2018, the BMA found that two-fifths of doctors felt bullying and harassment were a problem in their workplace.<sup>48</sup> In the 2017 NHS England staff survey, a fifth of doctors reported experiencing bullying or harassment in the preceding 12 months. When looking at NHS staff overall, around half of those who had experienced bullying or harassment had reported the issue, compared with only one out of three doctors who did so.<sup>49</sup>

In research to better understand bullying and harassment in the medical profession, the BMA asked doctors why they felt bullying and harassment were an issue in their workplace. The two most common responses were:

- people are under pressure (65%)
- it's difficult to challenge behaviour that comes from the top (58%).<sup>50</sup>

These examples highlight the critical role that system pressures and culture play in enabling unprofessional behaviours. Both the *Caring for doctors Caring for patients*<sup>5</sup> review, and the *Fair to Refer?*<sup>7</sup> research raised the need for compassionate and inclusive leadership, to create more positive cultures that don't validate such behaviours.

When quality-assuring medical training environments, we check that effective leadership and good workplace culture are in place. If we think standards in this area are not being met, and that local action is not adequately addressing the issues, we can use our enhanced monitoring to help drive improvements. Departments under enhanced monitoring are expected to put clear plans in place to show how they will make changes to achieve the specific standards we have flagged up as not currently being achieved. And across the UK we work closely with education and improvement bodies, and deaneries to drive improvements in the departments we have concerns about.

## Systemic opportunities to improve leadership

### Organisations can support doctors in leadership roles by improving the culture of leadership at all levels

Good organisational leadership depends on formal leaders who are effective communicators and who can listen well. In turn, this can help enable staff at all levels to lead effectively.

Part of this is recognising leadership in all its forms – from day-to-day leadership, to formal management roles. And providing support for individual doctors to transition into leadership roles. Providing support to avoid or mitigate pressures associated with transitioning into a leadership role can help doctors' wellbeing and make roles more attractive, and, more sustainable.

While improving leadership culture is important, there must also be guidance and appropriate materials to enable capacity for leadership. In secondary care, this could be the realistic representation of leadership responsibilities in job plans. In primary care, partners have more flexibility and autonomy in how they allocate their time, but not all practices have income to employ salaried GPs to make use of that time. Some areas of practice will require more attention, and resources, than others – whether because of staffing issues or clinical workload – and so equity may not be achieved through equal investment, but rather investment where appropriate.

All doctors need to be aware of the full range of formal and informal leadership roles within medicine. And to be sustainable, access to

those roles must be equal, to capitalise on the motivation that doctors bring to their work. At present, opportunity is often linked to being in the right place at the right time, and while this may be effective, there are risks for individuals or roles being under-served, as well as implications for equality, diversity and inclusivity. There are also questions about whether leadership roles can be more open to a wider constituency, such as SAS and LE doctors and salaried GPs.

### We're committed to taking forward the wealth of recommendations from the research and reviews we've commissioned, ultimately to support doctors

As the reviews and research projects that have contributed to the evidence base for our work around *Supporting a profession under pressure* draw to a close, we are working hard to shape our response to the recommendations made. Culture and leadership have emerged as key themes. It's crucial to recognise the vital role that leaders across the health service play in creating the nurturing cultures that protect wellbeing and enable high-quality patient care.

We believe that our position and regulatory levers – particularly in education and training – afford us a unique opportunity and responsibility to act. In 2020, we will focus on our strategic partnerships with others in the system. In particular we'll work with the Care Quality Commission and NHS Improvement in England on the *Well-led* programme,\* and we'll continue to work with the Faculty of Medical Leadership and Management.

\* *Well-led* is a national leadership development programme for managers of adult social care services working in the private, public or third sectors.