

Are We There Yet? Models of Medical Leadership and their effectiveness: An Exploratory Study

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Helen Dickinson was involved in the design of the study, the collection of data in phase one and two, data analysis and contributing to the final report writing.

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Glossary of terms/abbreviations

AHP – Allied Health Professional
AMD – Associate Medical Director
BAMM – British Association of Medical Managers
BMA – British Medical Association
BPR – Business Process Reengineering
CAMHS – Child and Adolescent Mental Health Services
CEO – Chief Executive Officer
CH – Chris Ham (member of research team)
CQC – Care Quality Commission
DSS – Department of Social Security
FT – Foundation Trust
GMC – General Medical Council
GP – General Practitioner
HCC – Health Care Commission
HD – Helen Dickinson (member of research team)
HR – Human Resources
MD – Medical Director
MES – Medical Engagement Scale
NHS – National Health Service
NRES – National Research Ethics Service
PA – Programme Activities
PCT – Primary Care Trust
PS – Peter Spurgeon (member of research team)
SDO – Service Delivery Organisation
SHA – Strategic Health Authority
SMR – Standardised Mortality Rate
SPA – Supporting Programme Activities
TCS – Transforming Community Services
T&O – Trauma and Orthopaedics

TQM – Total Quality Management

UCLH – University College London Hospitals

UK – United Kingdom

US – United States

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Executive Summary

Background

Medical leadership in the NHS has attracted increasing attention among politicians of all parties. Previous studies have analysed the evolution of medical leadership, particularly since the Griffiths report of 1983, but there is no comprehensive and up to date picture of how doctors are currently involved in leadership roles. This study therefore fills a gap in knowledge in an important area of health policy.

Aims

The main aims of the study are to provide an up to date picture of the nature and range of medical leadership structures in NHS trusts in England; to analyse how different structures operate in practice and the processes at work within these structures, for example between doctors, nurses and managers; and to relate evidence on structures and processes to available data on organisational performance.

Methods

The study uses a mixed method approach involving a questionnaire survey of NHS trusts in England; case studies of nine NHS trusts that responded to the survey; and the use of the Medical Engagement Scale in these case studies to establish the extent to which doctors feel engaged in the work of their organisations. The results of the Medical Engagement Scale are related to available data on organisational performance.

Results

A wide variety of structures are identified including divisions, directorates and service line approaches, sometimes in combination. Most of the case study sites report themselves to be medically or clinically led with doctors holding leadership roles at three or four levels. Triumvirates exist on paper in most sites but in reality the duality of medical leader and general manager is perceived to be more important. An engagement gap between medical leaders and their colleagues is commonly reported, though this is seen to be part of the journey trusts are on. There are variations both between and within trusts in the extent to which doctors feel engaged in the work of their organisations. Trusts with high levels of engagement perform better on available measures of organisational performance than trusts with low levels of engagement.

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Conclusions

Progress has been made in involving doctors in leadership roles in NHS trusts but the journey that started with the Griffiths report of 1983 is by no means complete. Recognising the existence of variations between trusts, it is clear that medical leaders face many challenges and occupy a relatively precarious middle ground between senior managers and their medical colleagues. There are many barriers to involving doctors effectively in leadership roles, and in most organisations a step change is needed to overcome these barriers. This includes increasing the time commitment of medical leaders and the proportion of doctors in formal leadership roles and developing the culture of engagement we found in those trusts that had progressed furthest on this journey. Further research is needed in trusts that are recognised to be at the leading edge of performance, as well as to understand the perspective of doctors who are not in leadership roles.

1 Policy context

1.1 Introduction

The aim of this chapter is to describe the policy context which provides the backcloth for our research into models of medical leadership and their effectiveness. The main points made in the chapter are:

- There have been substantial improvements in patient care in the last decade as a result of investment and reform.
- The three main elements of reform have been targets and terror, competition and choice, and clinical leadership of quality improvement.
- NHS trusts have been affected by continuing organisational changes including the establishment of NHS Foundation Trusts and the Transforming Community Services policy.
- Politicians and senior managers have been the main agents of change with medical and patient leaders much less involved.
- Regulation of doctors has been reformed in response to well publicised failures in the quality of care.
- Regulation of health care organisations has been strengthened and a more systematic approach to improving quality of care adopted.
- The Coalition Government elected in 2010 has introduced further radical changes and has emphasised the need to empower doctors and other front line staff.
- Successive governments have not been prescriptive about models of medical leadership in NHS trusts, and the models adopted have been a matter for local decision.
- The return of financial pressures has led to renewed interest in medical leadership in NHS trusts, as seen in the development of service line management.
- Compared with the 1980s, there is now a much stronger focus on medical leaders improving the quality of care and not simply controlling budgets.

1.2 Investment and reform

The study reported here has taken place at a time of unprecedented change in the NHS. NHS spending in England increased from £43.9 billion in 2000 to nearly £102 billion in 2010 - a real rise of over 80 per cent - and this increased investment was accompanied by wave after wave of reform.

The result of investment and reform was measurable and in some cases dramatic improvements in patient care (1). Waiting times for treatment in all services fell to levels never seen before; cancer and cardiac services saw major increases in spending and staffing linked to improvements in outcomes; and public confidence in the NHS reached an all time high. While not all areas of care benefited to the same extent, by the end of the decade surveys showed that on many indicators the performance of the NHS was as good as and often better than that of a number of other comparable countries (2).

These improvements in patient care resulted from a series of interlocking and overlapping reforms. Initially, the emphasis was placed on tying investment to the delivery of targets such as those contained in the *NHS Plan* published in 2000 (3). Implementation of these targets was supported by a performance management regime that left NHS managers in no doubt what was expected of them. The regime of 'targets and terror' (as it was described by Carol Propper and colleagues (4)) was responsible for much of the progress that occurred during the decade but the limits of such an approach were also increasingly recognised.

Partly for this reason, increased attention was given to competition and choice as the Labour government reversed its stated opposition to the use of market principles in the NHS and went much further in applying these principles than its Conservative predecessors (5). Beginning with the framework set out in *Delivering the NHS Plan* published in 2002 (6), the government introduced NHS Foundation Trusts, Independent Sector Treatment Centres, Payment by Results, Practice based Commissioning, World Class Commissioning, and changes to the regulatory regime. At the same time the choices available to patients were progressively increased in pursuit of the aim of creating a 'self improving' NHS in which the drive for improvement would come from within rather than being imposed through targets and terror.

Towards the end of the decade, a third set of changes were introduced on top of those already described. These changes stemmed from the *NHS Next Stage Review* (7) led by Lord Darzi which placed the emphasis on improving the quality of care to patients through measurement of performance and transparent reporting of the results. Lord Darzi, a doctor himself, also emphasised the need for there to be much greater clinical leadership of service and quality improvement. The proposals in the NHS Next Stage Review were informed by three independent reports commissioned by the government which highlighted weaknesses in previous approaches to

reform and the need to engage doctors and other clinicians more effectively in bringing about further improvements in care (7).

The other point to note about the NHS in the last decade is the continuing process of organisational change affecting both commissioners and more importantly from the point of view of our study providers. The establishment of NHS Foundation Trusts and the Transforming Community Services policy meant that many providers committed substantial time and effort to the creation of new organisations and mergers with others. For Foundation Trusts this included strengthening their leadership at all levels and their financial performance in order to become Foundation Trusts and meet the requirements of the regulator. For providers affected by Transforming Community Services, it entailed integrating new services into their organisations and making attendant changes to their management arrangements.

As this overview illustrates, the main agents of reform throughout this period were politicians supported by senior managers, almost all of whom came from general management backgrounds. To be sure, medical leaders played some part in the reforms, most notably through the national clinical directors or tsars who were appointed to take forward the development and implementation of national services frameworks such as those for cardiac and cancer care, but they did so at the behest of politicians and relied on senior managers to secure implementation of their plans. It might be added that representatives of patients were even less well represented in the corridors of power than medical leaders notwithstanding the political rhetoric around choice and patient centred care.

In making this point, it should be emphasised that doctors retained considerable influence within the NHS by virtue of their expertise and training. The role of politicians and managers in driving reform should not therefore be confused with these agents of change controlling decision making and resource allocation on a day to day basis. One of the characteristics of professional service organisations like the NHS is the autonomy enjoyed by the front line teams delivering care to patients, and this continued to be a major factor in how the NHS was run throughout this period, even if it did not always appear to be so to the teams concerned.

1.3 Reforms to the regulation of doctors and health care providers

Yet if clinical autonomy remained an important influence on decision making and resource allocation within the NHS, there was increased questioning of the means used to regulate standards both of the health professions and of the organisations in which they practised. Reforms to the regulation of doctors derived from long standing concerns about the adequacy of existing forms of professionally dominated regulation, illustrated by well publicised failures such as those affecting children undergoing heart surgery at Bristol

Royal Infirmary and the patients of Harold Shipman, a GP in the north of England. Shipman was convicted of murdering over 200 of his patients and his case highlighted graphically and tragically the need for more effective forms of scrutiny of medical practice and assurance that doctors were fit to practise.

Reform of medical regulation entailed a series of changes including proposals to introduce revalidation and recertification of doctors, changes to the membership of the General Medical Council (GMC) to create a smaller council with an equal number of medical and lay members, and reform of the fitness for practise regime to create greater confidence in its role within the GMC. In parallel, changes were made to the processes for addressing concerns about the performance of doctors. These changes included setting up an Adjudicator to decide whether individual health professionals should remain in practise, with responsible officers being appointed at a local level to oversee the conduct and performance of doctors.

The regulation of health care organisations was strengthened through the establishment of a quality regulator, currently the Care Quality Commission, to oversee and report on the performance of these organisations. The forerunner of the Care Quality Commission, the Healthcare Commission, published an Annual Health Check setting out the results of its assessments, and we draw on the results of the Annual Health Check in our research (see chapter 6). Currently the Care Quality Commission is involved in registering health care providers, undertaking visits to assess standards, and publishing reports based on its work.

The establishment of the quality regulator was part of a series of initiatives to improve the quality of care set out in a policy document entitled *A First Class Service, Quality in the new NHS* published in 1998 (8). This document foreshadowed the creation of the National Institute for Clinical Excellence to set standards for the use of drugs and other technologies and develop evidence based guidelines on the provision of services; the development of national service frameworks to support improvements in care in areas of clinical priority; and the introduction of clinical governance to ensure the delivery of standards and improvements in quality at a local level. Chief executives of NHS trusts were placed under a duty of clinical governance to signify that their responsibilities in relation to the quality of care were as important as their responsibilities in relation to other aspects of performance. Subsequently the National Patient Safety Agency was set up to run a national reporting system to log errors, failures and mistakes and learn the lessons for the NHS.

The other relevant development during this period was the introduction of a new contract for hospital consultants in 2003. In return for a substantial increase in pay, consultants were required to agree job plans with their employers setting out a consultant's duties and responsibilities based on 10 programmed activities per week. The purpose of job plans is to be clear what is expected of each consultant in relation to the provision of clinical

care, supporting professional activities, additional NHS responsibilities and external duties. Studies of the impact of the new contract reported mixed results and little evidence that the benefits for patients were commensurate with the additional expenditure involved.

1.4 The Coalition Government

To bring the story up to date, at the end of the decade a new Coalition Government was elected and its programme included further radical changes to the NHS. These changes were to be implemented in a period of unprecedented financial constraint as the new government brought a halt to the rapid growth of public spending in order to address the financial problems caused by the banking crisis of 2008 and the subsequent downturn in the economy. The importance of the government's plans in relation to the study reported here is that they explicitly emphasised the need to empower doctors and other front line staff and to reduce reliance on targets and terror.

In pursuance of this objective, Ministers announced plans to cut management costs and make a large number of managers redundant. This was to be achieved in large part by abolishing strategic health authorities and primary care trusts and handing over responsibility for commissioning health care to clinical commissioning groups led by GPs. The government's plans had much less to say about the greater involvement of doctors and other clinicians in the provision of care, other than through the promise to free clinicians from the burden of centrally determined targets thereby allowing them greater opportunity to decide how best to improve patient care.

The absence of plans to reform the involvement of doctors in the running of NHS trusts is a notable example of this government (and others) standing back when almost every other area of NHS activity seemed to be the subject of a politically driven initiative. For our purposes, this meant that NHS trusts were able to decide for themselves how best to involve doctors in management and leadership roles unconstrained by central guidance. Other bodies like Monitor, the regulator of NHS Foundation Trusts, did take the initiative in encouraging the use of service line management (see below) to strengthen the role of doctors in leadership, but take up of this approach remained discretionary. In these circumstances, it might be expected that a variety of medical leadership arrangements would emerge reflecting local histories and preferences, and as we shall see this was indeed the case.

1.5 Service line management

The ending of the period of sustained and high levels of investment in the NHS led to renewed interest in NHS trusts in engaging doctors and other clinicians in finding the substantial efficiency savings (estimated to be

£20bn by the NHS chief executive) required in the period 2011-15. This interest stemmed from recognition, as the Griffiths report had observed as far back as 1983 (9), of the key role played by doctors in committing resources through their clinical decisions. Variations in these decisions meant there were opportunities to both improve the quality of care and release resources but this could only be done if doctors themselves were fully involved in managing services and budgets. It was therefore not surprising that some of the most experienced chief executives redoubled their efforts to strengthen medical leadership in their organisations through the adoption of service line management and related approaches (10).

It should be emphasised that an important difference between the 1980s and current efforts to engage doctors and other clinicians in management and leadership roles is the explicit focus today on quality of care as well as finance. This shift has occurred because of increased awareness of variations in quality of care and the development of policies, such as those described above, to strengthen the regulation of doctors and health care providers. Lord Darzi's *NHS Next Stage Review* may have been the first major policy document to place the emphasis on quality improvement but it was foreshadowed by *A First Class Service* a decade earlier and by a series of other initiatives in the same vein. As the *NHS Next Stage Review* contended, the rationale behind doctors taking on a more significant role in leadership lay in part in evidence from high performing health care organisations of the key role of medical leaders in improving the quality of care.

The need to focus on improving the quality of care was underlined by failures in patient care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009. These failures were analysed in detail in the independent inquiry led by Robert Francis QC which reported in February 2013. The serious and deep seated nature of these failures led the Coalition Government elected in May 2010 to establish a public inquiry into the role of commissioning, supervisory and regulatory bodies in the monitoring of care at Mid Staffordshire NHS Foundation Trust. Among other issues, the public inquiry investigated the role of trust leaders and organisational culture in the NHS, including the role of medical leaders in maintaining high standards of patient care. The failures that occurred at Mid Staffordshire, and the need to hold two inquiries into these failures, was an indication that systems for improving the quality of care remained under developed.

1.6 In summary

This brief and inevitably superficial account of policy developments in the NHS in England in the last decade provides context for our research. It illustrates the complex nature of power and influence in the NHS with politicians and senior managers in the lead in taking forward successive waves of reforms to the organisation of the NHS, and doctors and clinical teams retaining considerable autonomy in relation to day to day decision

making and resource allocation. The interest in models of medical leadership stems from this complexity and attempts to find more effective ways of linking clinical decisions with decisions about the strategic direction of NHS organisations. The fact that this remains work in progress contains some clues to the story that unfolds in the pages that follow.

2 Literature review

2.1 Introduction

In this chapter we summarise and review the literature on medical leadership in the NHS and more generally to provide context for our research and the empirical findings from this research. The main points made in this chapter are:

- Doctors have enjoyed a large measure of autonomy since the inception of the NHS, and only in the 1980s was this autonomy challenged.
- The Griffiths Report of 1983 led to the introduction of general management and attempts to involve hospital doctors in management as clinical directors.
- Evidence on the impact of general management found a more active management style resulted in which managers were increasingly involved in questioning medical priorities.
- The extent to which this led to a shift in the frontier of control between managers and doctors is disputed with the balance of evidence maintaining that change was limited and doctors retained significant influence.
- The persistence of clinical autonomy reflects the nature of health care organisations as professional bureaucracies in which front line staff have a large measure of control over the content of work by virtue of their training and specialist knowledge.
- In professional bureaucracies, professionals play key leadership roles, leadership is distributed and collective in nature, and followers exercise significant influence.
- Organisational theorists have posited the emergence of new organisational forms such as the managed professional business and the quasi market hospital archetype, but evidence for the ascendancy of these new forms is weak.
- More recent empirical research into medical leadership in the NHS has underlined the challenge of changing deeply entrenched relationships.
- While there are variations in the way in which clinical directorates operate within hospitals, professional bureaucracy continues to provide an appropriate description of how hospitals function.

- Doctors who move into leadership roles occupy hybrid positions and face considerable ambiguity in discharging their functions.
- Tribal relationships between doctors, nurses and managers persist and are reflected in different conceptions of clinical work.
- The rationale for involving doctors in leadership roles, despite the difficulties in doing so, is underlined by evidence from quality improvement programmes showing the link between medical leadership and organisational performance.
- Experience in other countries points to examples of systems that have made more progress than the UK in the development of medical leadership, such as Denmark and some integrated systems in the US.

2.2 The NHS Context

Doctors have enjoyed a large measure of freedom to practise in the way they consider appropriate for much of the history of the NHS. As the Department of Health put it in 1978:

'At the inception of the NHS, the Government made clear that its intention was to provide a framework within which the health professions could provide treatment and care for patients according to their own independent professional judgement of the patients' needs. This independence has continued to be a central feature of the organisation and management of health services. Thus hospital consultants have clinical autonomy and are fully responsible for the treatment they prescribe for their patients. They are required to act within broad limits of acceptable medical practice and within policy for the use of the resources, but they are not held accountable to NHS authorities for their clinical judgements'. (DSS evidence to the Normansfield Report: 11: pg. 424-5)

Clinical autonomy was based on the negotiations that took place at the formation of the NHS and the concessions the government made to the British Medical Association to secure the support of the medical profession. Klein has described the deal that was struck in the following way:

'Implicit in the structure of the NHS was a bargain between the State and the medical profession. While central government controlled the budget, doctors controlled what happened within that budget. Financial power was concentrated at the centre; clinical power was concentrated at the periphery. Politicians in Cabinet made the decisions about how much to spend; doctors made the decisions about which patient should get what kind of treatment' (12: pg. 61).

Strong and Robinson argue that as a result of this deal the NHS was 'fundamentally syndicalist in nature' (13: pg. 15) in that the medical profession was able to control and regulate its own activities without interference from politicians or managers. Harrison and Pollitt go further in maintaining that the role of the manager until 1982 was to act as a diplomat, appointed 'to provide and organise the facilities and resources for professionals to get on with their work' (14: pg. 36).

As Klein has emphasised, the bargain struck at the inception of the NHS was a temporary truce rather than a final settlement. The truce came under strain in the 1980s in the face of the financial pressures facing the NHS. This led to a fundamental reappraisal of the relationship between managers on the one hand, and doctors and the other health professions on the other. These issues came to a head with the publication of the report of the Griffiths inquiry into NHS management which argued for a system of general management to be introduced in place of consensus management. The Griffiths report contended that general management was needed to provide the NHS with effective leadership and to ensure clear accountability for decision making. The report also argued that hospital doctors 'must accept the management responsibility which goes with clinical freedom' (9: pg. 18).

To this end, a number of demonstration projects were set up to test out what was termed 'management budgeting' and in 1986 this was superseded by the resource management initiative. Building on these efforts, most NHS hospitals implemented a system of medical management centred on the appointment of senior doctors as clinical directors responsible for leading the work of different services within the hospital. Clinical directors combined their management and leadership roles with continuing but reduced clinical duties. They usually worked with a nurse manager and a business manager in a directorate management team known as a triumvirate. Clinical directors often came together as a group with the medical director and chief executive to advise on developments across the hospital as a whole. The involvement of hospital doctors in management was influenced not only by the Griffiths report but also by developments at Guy's Hospital which pioneered this approach, drawing on the experience of Johns Hopkins Hospital in the United States (15).

Evidence on the impact of general management found that a more active management style resulted in which managers were increasingly involved in questioning medical priorities (16). The extent to which this led to a shift in the frontier of control between managers and doctors is disputed with the balance of evidence maintaining that change was limited and that doctors retained significant autonomy and influence (13;14;17). As Harrison summarised the evidence:

'...although managers are more clearly agents of government than before, and although the frontier of control between government and doctors has shifted a little, in favour of the former, there is as yet little

evidence that managers have secured greater control over doctors' (17: pg. 122).

Likewise, research into organisational change concluded that many of the transformational changes that had been initiated were not well embedded, and the dominance of the medical profession remained largely intact (18). These findings are reinforced by the review of events leading up to the failures in paediatric heart surgery at Bristol in the 1990s which described a hospital in which the chief executive (himself a doctor) delegated a large measure of responsibility to individual doctors and clinical directors, and a culture that emphasised the importance of clinical autonomy (19).

This brief summary of the evidence highlights the robustness of established relationships of power and influence in the NHS. It also underlines the strength of 'tribalism', in the face of attempts to make the NHS more businesslike and to bridge the divide between managers and doctors. As Strong and Robinson concluded in their ethnographic study of the impact of general management, the Griffiths report threw down a radical challenge to the NHS, in particular a 'challenge to the syndicalist notion that the clinical trades knew best' (13: pg. 97), but it was only a partial break with the past. From this perspective, the changes initiated by the Griffiths report are best seen as the start of a long term process of renegotiating the role of the medical profession in the NHS. This process was to continue into the introduction of the internal market into the NHS in the 1990s and beyond, and was therefore more akin to a permanent revolution than a sudden coup (13: pg. 100).

To help interpret the findings of research into general management, we now draw on the literature on health care organisations as professional bureaucracies, as this literature provides important insights into the challenges involved in leadership in hospitals. Having highlighted the way in which organisational theory can help in understanding the role of doctors and managers in health care organisations, we will then return to NHS experience and focus more specifically on research into the role of clinical directorates and medical leadership.

In the NHS, a distinction is sometimes drawn between the role of doctors and other clinicians in providing leadership of services and the role of managers in supporting clinical leaders in this work. This formulation draws attention to leadership as the task of setting direction, determining priorities and goals, and engaging people to deliver these goals. Management by contrast is the means by which resources are deployed to enable goals to be implemented. While in practice there is often overlap between leadership and management, we have used this distinction in this research.

2.3 Health care organisations as professional bureaucracies

In the language of organisational theorists such as Henry Mintzberg, health care organisations are professional bureaucracies rather than machine bureaucracies (20). One of the characteristics of professional bureaucracies is that front line staff have a large measure of control over the content of work by virtue of their training and specialist knowledge. Consequently, hierarchical directives issued by those nominally in control often have limited impact, and indeed may be resisted by front line staff.

In this respect, as in others, professional bureaucracies are different from machine bureaucracies (such as government departments). More specifically, they have an inverted power structure in which staff at the bottom of the organisation generally have greater influence over decision making on a day to day basis than staff in formal positions of authority. It follows that organisational leaders have to negotiate rather than impose new policies and practices, working in a way that is sensitive to the culture of these organisations. The following observation from a study of the impact of business process reengineering in an English hospital summarises the challenge in this way:

'Significant change in clinical domains cannot be achieved without the co-operation and support of clinicians. . . . Clinical support is associated with process redesign that resonates with clinical agendas related to patient care, services development and professional development. . . . To a large degree interesting doctors in re-engineering involves persuasion that is often informal, one consultant at a time, and interactive over time . . . clinical commitment to change, ownership of change and support for change constantly need to be checked, reinforced and worked upon' (21: pg. 66-67).

Control in professional bureaucracies is achieved primarily through horizontal rather than vertical processes. These processes are driven by professionals themselves who use collegial influences to secure co-ordination of work. In health care organisations, professional networks play an important role in ensuring control and co-ordination, both within and between organisations, alongside peer review and peer pressure. Collegial influences depend critically on the credibility of the professionals at their core, rather than simply the power of people in formal positions of authority.

An important feature of professional bureaucracies in Mintzberg's view is that they are oriented to stability rather than change. Not only this, but also they are characterised by tribalism and turf wars between professionals who often identify more strongly with 'their' part of the organisation, than with the organisation as a whole. Put another way, professional bureaucracies are made up of collections of 'microsystems', to adapt the language used by

Batalden and colleagues at Dartmouth, comprising multi-professional teams responsible for day to day work (22).

Three implications for leadership follow. First, **in professional bureaucracies, professionals play key leadership roles**, both informally and where they are appointed to formal positions. Much more so than in machine bureaucracies, the background of leaders and their standing among peers have a major bearing on their ability to exercise effective leadership, and to bring about change.

Second, **professional bureaucracies are characterised by dispersed or distributed leadership**. In health care organisations, clinical microsystems are a particularly important focus for leadership. It follows that in professional bureaucracies there is a need for large numbers of leaders from clinical backgrounds at different levels. A focus on leadership only at the top or most senior levels risks missing a central feature of these bureaucracies.

Third, much of **the evidence highlights the importance of collective leadership in health care organisations**. Collective leadership has two dimensions: first, it refers to the role of leadership teams rather than charismatic individuals; and second, it draws attention to the need to bring together constellations of leaders at different levels when major change programmes are undertaken, as demonstrated by empirical research into leadership in Canadian hospitals undertaken by Denis and his colleagues (23).

The large measure of control that front line staff have over the content of work can result in professional bureaucracies becoming disconnected hierarchies or even organised anarchies. Appointing respected and experienced professionals to leadership roles is often advocated as the response to this challenge. Chantler is one of the foremost advocates of this approach, arguing that in Guy's Hospital:

'By giving significant responsibility for the organisation to those who actually delivered the service, we aimed to reduce the disconnection that occurs in hospitals, as pointed out by Mintzberg, between those at the top who organise the strategy and those at the service end who deliver care to patients' (15: pg. 1179).

However, in itself this may not be sufficient to address the need for control, co-ordination and innovation. As well, health care organisations have increasingly recognised the requirement to strengthen the role of all staff as followers, Silversin and Kornacki (24) emphasise this in their work on medical leadership in the United States by investing in organisational development and not just leadership development. In view of the importance of influence and persuasion, alongside formal authority, appointing doctors as clinical directors is unlikely to be sufficient to enable hospitals and other health care organisations to undertake transformational change. This conclusion is underlined in a recent review by Baker and Denis

who argue that initiatives that focus only on individual capacities and competencies will have limited impact (25). Consistent with the evidence summarised here, they emphasise the importance of collective and distributed leadership in health care organisations and the need therefore to adopt a systemic approach to change and improvement.

As a final comment on the organisational theory literature, it is worth noting the argument that professional bureaucracies have been superseded by newer organisational forms. Archetype theory has been used to characterise and compare professional organisations with very different aims and objectives and analyse the ways in which decision-making and control operate within these settings. Greenwood and Hinings (26: Pg. 1052) define an organisational archetype as 'a set of structures and systems that reflect a single interpretive system'. Greenwood *et al* (27) chart how between the 1960s and the 1990s there was a consistent picture of the classical professional organisation where professional experts retained power and managers administered facilities and supported professionals. This classical professional archetype is known in the literature as P² and, much as in Mintzberg's professional bureaucracy, is characterised by little hierarchy and relatively high vertical and horizontal differentiation.

Cooper *et al* (28) argue that due to pressure induced by competitive markets, and the need to adopt more corporate and managerial modes of operation in order to increase efficiency, professional organisations have shifted from the P² archetype to the Managed Professional Business (MPB). The MPB retains some aspects of the P² form, but with a superimposition of managerial structures or business values. It is claimed that the ascendancy of the MPB form has undermined the effectiveness of 'traditional' modes of professional organisation that may no longer fit this changing and more dynamic environment.

In relation to health care, two archetype forms have been described, namely the managed professional business (28) and the quasi market hospital archetype (29). In both forms, it is argued that management structures and business values have been superimposed on professional bureaucracies and changed their nature. As we show in the next section, the evidence for the ascendancy of new kinds of professional organisations is weak, and it is for this reason that we have emphasised the continuing importance of Mintzberg's writings in understanding leadership and relationships in health care organisations.

Part of the explanation of the persistence of professional bureaucracies can be found in the work of Friedson (30) who contends that professional (and especially medical) dominance in health care has been maintained by internal differentiation of roles. This entails a distinction between 'rank and file' doctors providing patient care, a 'knowledge elite' of doctors involved in education and research and an 'administrative elite' of doctors in leadership roles in hospitals and other health care organisations. Members of the administrative elite occupy the hybrid roles referred to above and identify

as much with the organisations they work in as the profession in which they trained. The point we would add is that the size and role of the administrative elite varies between health care systems and organisations within these systems.

2.4 The Role of Medical Leaders in the NHS

In our summary of the impact of the Griffiths report, we emphasised the importance of seeing the report as the start of a long term process of renegotiating the role of the medical profession in the NHS. Subsequent research in this area has underlined the challenges of changing deeply entrenched relationships. While some hospitals have made progress in using clinical directorates to engage doctors in leadership roles and to achieve improvements in performance, others have experienced difficulties. These difficulties are starkly illustrated in a detailed study of leadership in an NHS hospital in the 1990s undertaken by Bate (31).

In this hospital, consultants did not accept the legitimacy of management, and as a result were able to undermine managerial power. The hospital was characterised by sub-cultures centred on microsystems that were isolated from each other. This was problematic when change was attempted involving more than one microsystem, as it led to tensions and often gridlock. Doctors held power and managers became afraid to challenge doctors lest they should face a vote of no confidence. Progress only became possible when doctors and managers agreed to establish a 'network community' (pg. 504) in place of the system of clinical directorates which was seen to have been 'a failed experiment' (pg. 509).

A more mixed picture emerged from a survey of clinical directorates in Scotland conducted by McKee and colleagues (32). This survey found wide variations in the way directorates were constructed and conducted their business. Three major directorate types were identified. The dominant type was described as '**traditionalist**' and this was characterised by a strong focus on operational issues and limited scope for innovation and change. Relationships between clinical directors and clinical colleagues remained embedded in a collegiate clinical network and were based on consensus building and facilitation.

The second type was described as '**managerialist**' and was characterised by a business oriented approach more in line with the philosophy of the Griffiths report. Clinical directors in managerialist directorates had direct links with top managers in the hospital and were better placed to influence overall strategy and direction than those in traditionalist directorates. The third type was described as '**power-sharing**' and involved clinical directors working across established specialty boundaries and operating as a team with the business manager and nurse manager.

McKee and colleagues note that the variability between clinical directorates shows the ability of doctors to adapt managerial initiatives. More

importantly, they emphasise the overwhelming sense of continuity rather than change, and *'few examples of trusts creating a new climate in which clinical directors of the future were being spotted, nurtured or sustained'* (p. 110). Furthermore, clinical management was very thinly resourced, with many directorates run on a shoestring. The minority of directorates that were not traditionalist held out the prospect that clinicians could be developed into innovative leaders, but for this to happen:

'More, and more senior, doctors will have to be given the incentive to get involved, the relevance of management will have to be actively marketed and the clinical legitimacy of doctor-managers will have to be safeguarded' (pg. 112).

This study reaffirmed evidence from the organisational theory literature relating to the tendency of professional bureaucracies to be oriented to stability rather than change, while also underlining the limited progress in moving from professional bureaucracies to managed professional businesses. A similar conclusion was reached by Marnoch in his study of clinical directorates:

'The means of controlling the operational performance of hospital doctors have advanced somewhat since the introduction of general management in the 1980s. Nevertheless, the Griffiths-inspired drive to push resource-consuming decisions down to the level where they could best be made is far from complete. A traditional centralized style of management has been used to make the internal market work. This form of control remains constrained in its influence over clinical behaviour. At worst, medical directors and clinical directors will be used as go-betweens in a familiar book-balancing exercise that involves closing wards periodically, not filling vacancies and cancelling operations. At best they are the basis for a new strategically led style of corporate management in the NHS' (33: pg. 61)

Further confirmation of the persistence of established relationships comes from Kitchener's study of the impact of quasi-market reforms on NHS hospitals (29). Drawing on Mintzberg's writings, Kitchener hypothesises that the NHS reforms are an attempt to replace the professional bureaucracy with the quasi-market hospital archetype. In this new archetype, the hospital is based around clinical directorates and medical cost centres, and a more businesslike approach to management is adopted, centred on medical cost centres and using enhanced management information systems. Kitchener found that in practice the impact of this new archetype was limited and warns that:

'The fact that some hospital doctors have accepted medical-manager roles within a more integrated formal structure should not...be conflated with either a loss of their professional autonomy or a replacement of key elements of the PB (professional bureaucracy) interpretive scheme' (pg. 197).

He concludes that the notion of the professional bureaucracy continues to provide an appropriate basis for understanding the nature of hospitals as organisations.

Kitchener's argument is supported in a different context by the work of Kirkpatrick and Ackroyd (34) who take issue with those who argue that new organisational archetypes are replacing traditional forms such as professional bureaucracies in public services. Drawing on a study of the restructuring in social services departments in the 1990s, they emphasise the persistence of older professional values and working practices. Kirkpatrick and Ackroyd argue that the exclusion of organisations representing social workers in policy development resulted in a perception that change was being done to staff rather than with them. This resulted in restructuring having less impact in practice than envisaged by policy makers. These authors note that 'despite strong forces for change, radical shifts in orientation had not occurred', adding that there was 'a very strong tendency to defend the status quo among professional staff and a resistance to many of the core tenets of new managerialism' (pg. 526).

Primary care was largely bypassed by the changes that flowed from the Griffiths report, and only recently have there been moves to strengthen management and leadership in primary care. Work by Sheaff and colleagues (35) has described the impact of these moves in primary care groups and trusts in England. Lacking any formal, hierarchical authority over GPs, primary care groups and trusts worked through GPs who took on the role of clinical governance leads, and managers exercised influence by proxy through these leads. Sheaff and his co-authors argue that clinical governance leads used a range of informal techniques to implement clinical governance in primary care, and they use the terms 'soft governance' and 'soft bureaucracy' to describe the relationships and organisations they studied.

2.5 Role Ambiguity Among Medical Leaders

The challenges facing clinical directors in taking on leadership roles were highlighted in a survey of doctor-manager relationships in Great Britain by Davies and colleagues (36). This survey found that senior managers such as chief executives and medical directors were more positive about these relationships than managers at directorate level. Among all the groups surveyed, clinical directors were the least impressed with management and the most dissatisfied with the role and influence of clinicians. Davies and colleagues argued that unless the divergence of views they found were addressed then it would be difficult to engage medical leaders in the government's modernisation agenda (36).

This conclusion echoes other work which concluded that clinical directors and other doctors in leadership roles occupied a 'no man's land' between the managerial and clinical communities (37). It is also consistent with the research of Degeling and colleagues (38) which has described the

differences that exist among staff groups in relation to individualist versus systematised conceptions of clinical work, and in terms of conceptions of the financial and accountability aspects of clinical work. Degeling and colleagues show that:

- General managers hold strongly systematised conceptions of clinical work and financial realism and transparent accountability.
- Medical managers tend to hold individualist conceptions of clinical work and to support financial realism and transparent accountability.
- Medical clinicians hold strongly individualist conceptions of clinical work and are equivocal about financial realism and transparent accountability.

The existence of these differences confirms the persistence of tribal relationships in hospitals and the difficulties facing staff like doctors who go into management roles in bridging different cultures.

On a more positive note, one of the most comprehensive studies of medical managers noted evidence that clinical leaders can play an influential role as promoters of change. However, Fitzgerald and colleagues observed that, notwithstanding the proliferation of clinical director and medical director roles, and the establishment of the British Association of Medical Managers (BAMM) as a professional association, clinical managers lacked a coherent identify and accepted knowledge base. They commented that:

'Externally, there is no recognition of clinical management as a specialty, with limited opportunities or credentials – and an unwillingness to undertake major training. Other medical professionals do not consider clinical management to represent a medical specialty – rather clinical managers uncomfortably span the managerial/clinical divide and are not full or influential members of either occupational group' (39: pg. 170).

In its work, BAMM has reviewed the development of medical management roles in the NHS, and has set out a proposed career structure for medical managers such as medical directors, clinical directors and associate medical directors (40). BAMM's proposals emphasise the need to properly reward and recognise the part played by medical management, and to make it an attractive career option for skilled and motivated doctors. These recommendations underline the need to link the development of medical leadership to appropriate incentives and career structures. As BAMM has argued:

'It is essential that medical management is rewarded and supported in a way that will attract the strongest applicants to the posts. Currently there are a number of major deterrents – for example the relative difficulties in describing and defining management activities. These activities can be more difficult to define as coherent sessions than is

the case for clinical work. The lack of a clear concept of where a medical management career move will take the individual also proves to be a major barrier' (40: pg. 24).

BAMM's conclusions were echoed in a study of doctors who became chief executives in the NHS (41). The study found that there was little structured support for doctors going into leadership roles and many deterrents to them doing so. These deterrents included the insecurity associated with being a chief executive, pay differentials, the absence of career planning and career pathways, and the lack of practical support in the form of coaches and mentors. While the doctors included in the study were positive about the opportunities available to them to make a bigger difference than in a clinical role, they referred to themselves as 'keen amateurs' who had learnt on their job. They also reflected on the change in professional identity entailed in making the transition from clinician to medical leader and ultimately chief executive. Medical chief executives reported ambiguity in their roles and the assumption of dual (and in some cases multiple) identities as they progressed through different roles.

The findings of this study illustrate the challenges in strengthening medical leadership in the NHS along the lines advocated by Lord Darzi in his report for the last government on the reform of the NHS (7). Darzi contended that the NHS needed to build on improvements in care such as shorter waiting times for treatment by focusing on quality of care in the next stage of reform. Drawing on a series of papers commissioned from experts in quality improvement from the United States, he argued that renewed efforts were needed to involve doctors in leadership roles in order to give greater priority to the quality of care.

One way in which this has been done is through the application of service line management and service line reporting in NHS Foundation Trusts. In essence, service line management has evolved from clinical directorates and involves medical leaders working with other clinical leaders and managers in taking control of budgets and assuming responsibility for the development of services in different areas of clinical care. While there have been promising early reports from the NHS Foundation Trusts that have pioneered service line management, a recent review of experience in seven organisations highlighted the tensions and challenges of going down this route (10).

To support more doctors to become medical leaders, the Academy of Medical Royal Colleges and the NHS Institute have developed the medical leadership competency framework. First published in 2008, the framework applies to doctors at all stages in their careers and sets out the competences they need as leaders. It draws on experience in other countries and is part of a broader programme designed to raise the profile of medical leadership in the UK. The recent establishment of a Faculty of Medical Leadership and Management is another step in the same direction and is in part a response to the argument advanced by Fitzgerald and

colleagues about the lack of recognition of clinical management as a specialty. Montgomery's work in the United States underlines the importance of these initiatives in enabling medical leadership to become seen as a specialty in its own right (42).

2.6 Evidence from quality improvement programmes

While engaging doctors in leadership may be important in itself, it is usually seen as a means to improving the quality of health care. Evidence from a number of studies shows a link between medical leadership and organisational performance. For example, an evaluation of the introduction of total quality management (TQM) into the NHS by Joss and Kogan found that the impact of TQM varied across the pilot sites. In explaining variations in impact, the study concluded that the application of TQM to the NHS had to be done in a way that made sense to staff and that engaged doctors fully in its implementation (43).

These findings were echoed in a detailed analysis of the impact of business process reengineering (BPR) at the Leicester Royal Infirmary by McNulty and Ferlie (44). As in the evaluation of TQM, this analysis showed that BPR had variable impact in the hospital, with the authors emphasising the difficulty of implementing a programme of this kind in professional bureaucracies. Despite the fact that there was top management support for BPR, this was insufficient for widespread organisational change. Of critical importance was the power of consultants in the hospital and their ability to promote or inhibit change. Implementation of BPR had to be sensitive to the nature of medical work, and the importance of negotiating change with consultants.

Similar conclusions were reached by Ham and colleagues in a study of the implementation of the national booked admissions programme in 24 pilot sites. The study found substantial variation in progress between the sites. Some areas were more receptive to change than others and the most successful pilots were those with a combination of a chief executive who made it clear that booking was a high priority for the organisation and medical champions who were willing to lead by example and exert peer pressure on reluctant colleagues (45).

Evidence from outside the UK confirms these findings and also emphasises the range of factors that affect the impact of quality improvement programmes. Blumenthal and Scheck reported on the application of total quality management to hospitals in the United States, drawing on the work of various researchers to highlight the potential contribution of TQM while also acknowledging the challenges of engaging physicians in so doing (46). Walston and Kimberley's review of reengineering in United States hospitals summarised the facilitators of change as: establishing and maintaining a consistent vision; preparing and training for change; planning smooth transitions in re-engineering efforts; establishing multiple communication channels; ensuring strong support and involvement; creating mechanisms

to measure progress; establishing new authority relationships; and involving physicians (47).

In another review, Ferlie and Shortell (48) conclude that medical leadership is an important but not exclusive contribution to the effort to lead quality improvement in health care. They emphasise also the influence of what they term core properties such as organisational culture, team and microsystem development and information technology. As Ferlie and Shortell argue, system wide quality improvement hinges on action at a number of different levels – the individual, microsystem, organisational and larger system – and is likely to result in pockets of innovation and change unless action at these levels and in relation to core properties is co-ordinated.

2.7 Experience in Other Countries

These findings can be contrasted with evidence from other countries where there are organisations in which doctors play a much more significant and effective role in leadership, often in partnership with experienced managers. Kaiser Permanente and Mayo Clinic are well known and extensively studied examples from the United States (49). Both organisations have well developed systems of medical leadership in which there is an expectation that doctors should take responsibility with managers for providing services and managing budgets and improving the quality of care. Doctors are supported to take on leadership roles by training and development programmes that begin on appointment and continue throughout their careers. The role of medical leaders is recognised and valued and is facilitated by organisational cultures in which the importance of followership is also acknowledged.

Closer to home, Denmark was identified in a comparative study as the country that appeared to have made more progress than a group of others in developing medical leadership across a whole system of care (50). Kirkpatrick and colleagues (51) have compared Denmark and the UK to understand the reasons behind the differences in medical leadership in these countries. They show that doctors have been much more reluctant to engage in leadership roles in the UK than in Denmark, and they seek to explain this in terms of differences in the historic relationship between the medical profession and the state, as well as differences in the policy making process.

More specifically, the medical profession in the UK focused on maintaining its traditional independence from the state whereas in Denmark the profession sought to increase its power and status through collaboration with state institutions. In relation to policy making, the consensual and corporatist approach adopted in Denmark stood in contrast to that in the UK where a Conservative Government in the 1980s and 1990s promulgated reforms with little or no consultation with the medical profession. The consequence is that medical leadership has developed further in Denmark

than in the UK through the incorporation of doctors into formal leadership roles in health care organisations.

In contrast to the positive experience of Denmark and some organisations in the United States, evidence from Australia echoes findings from the NHS. Braithwaite and colleagues (52) have studied the introduction of clinical directorates in hospitals extensively and concluded that not all directorates operate in the same way and that taking the benefits of directorates for granted is premature. They found that doctors were very negative about clinical directorates and although allied health staff and nurses were more positive than doctors, they were still more negative than positive about clinical directorates. These organisational forms were perceived to push difficult decisions to staff and only a small number of those who took part in the research believed that patient care had improved as a result of clinical directorates. Ultimately Braithwaite and colleagues conclude that governments need to think carefully about what structural reforms can be expected to achieve.

2.8 In summary

In summary, research into medical leadership in the NHS since the Griffiths report highlights the challenges involved in developing the role of medical leaders. While progress has been made in appointing doctors as clinical directors and in establishing clinical directorates within hospitals, the effectiveness of these arrangements is variable. If in some organisations there appears to be much greater potential for involving doctors in leading change, in most there remain difficulties in changing established ways of doing things and in supporting medical leaders to play an effective part in bridging the divide between doctors and managers.

Also important is the continuing influence of informal leaders and networks operating alongside formal management structures. Tribalism remains strongly ingrained in the NHS and staff who occupy hybrid roles, like doctors who become clinical directors, face the challenge of bridging different cultures. Research into the impact of clinical directors highlights the difficulties of introducing new ways of working into the NHS, the strength of traditional relationships, and the orientation to stability rather than change. The evidence also suggests that medical leadership has often been under resourced and the incentives for doctors to become involved in management have been weak.

The findings from empirical research confirm the persistence of hospitals as professional bureaucracies in which front line staff have a large measure of control by virtue of their training and specialist knowledge. Control and co-ordination are achieved primarily through professional networks and collegial processes. In these bureaucracies, professionals themselves play key leadership roles, both informally and where they are appointed to formal positions; leadership is dispersed and distributed; and collective leadership is critically important. In the absence of hierarchical control,

followership is also important in enabling leaders to function effectively, as is the role of doctors who are leaders by virtue of their personal credibility.

In summary, there is little evidence that professional bureaucracies have been superseded by newer organisational forms such as the managed professional business and the quasi market hospital archetype. As Greener and colleagues (53) have noted in a review commissioned by the SDO programme, 'it has been noticeable that the dynamics of doctor, nurse and manager relationships in secondary care have remained remarkably unchanged through all the reforms in the NHS during the last twenty years' (p. 60). In their view, 'Full-time managers often regard doctor-managers with suspicion...Clinicians tend to view managers as driven by political and financial imperatives...Doctor-managers regard the managerial aspects of their role as part-time and temporary and having little authority over their peers who often do not regard doctor-manager roles with respect' (ibid.)

2.9 Our research

Against this background, we now go on to report the results of our research into current approaches to medical leadership and engagement in NHS trusts in England. The main aims of the research were to provide an up to date picture of the nature and range of structures of medical leadership through a questionnaire survey and case studies of a number of organisations with different structures. In the case studies we focused particularly on finding out how different structures worked in practice by examining the processes at work within these structures. More experimentally, we sought to relate the evidence gathered on structures and processes to available data on organisational performance.

Throughout the research, we were interested in understanding how far the clinical directorate model had evolved and the extent to which more recent structures, such as service line management, had been adopted. We were also interested through the case studies in understanding roles and relationships of leaders from different backgrounds. Specifically, we investigated the existence or otherwise of the traditional triumvirate of clinical director, nurse manager and general manager; whether there was evidence of clinical directors and other medical leaders playing a bigger part in leadership roles than revealed in previous studies; and variations in practices between the organisations selected as case studies.

In so doing, our aim was to relate the data we collected to the literature summarised in this chapter. Key questions here included: has there been a shift from the dominant form of professional bureaucracy to new organisational archetypes? To what extent are the traditionalist, managerialist and power sharing types of clinical directorates described by McKee and colleagues still evident? And how are NHS organisations supporting and development doctors to take on leadership roles?

Equally important was our concern to draw out lessons from our research for NHS leaders about the practical steps that are needed if the aim is to find more effective ways of engaging doctors in leadership roles in the future. In the final chapter of this report we therefore go beyond discussion of the theory of medical leadership and the implications of our work for the literature to explore its relevance for those in senior leadership roles. Our research is designed to contribute both to knowledge about models of medical leadership in the English NHS, and to use this knowledge to influence policy and practice in this area.

3 Methods

In this chapter we provide an account of the methods employed in the research. It explains the three different phases of the research process and how we analysed the data generated in each phase. We encountered a number of challenges throughout the process of data collection and this has implications in terms of the volumes of data collected and the types of claims that we are able to make about our findings.

3.1 Mixed Methods

A mixed method approach was adopted using both quantitative and qualitative data in order to investigate models of medical leadership and their effectiveness. As Tashakkori and Teddlie (54) suggest:

'A major advantage of mixed methods research is that it enables the researcher to simultaneously answer confirmatory and exploratory questions, and therefore verify and generate theory in the same study' (pg. 15).

In our case, the main methods employed were a questionnaire survey of NHS Trusts in England, case studies of a sample the Trusts who responded to the survey, and the use of the Medical Engagement Scale to understand how engaged doctors felt in the case study sites. As Tashakkori and Teddlie (54) argue, mixed methods have often been used by researchers with a practical orientation and this is very much the case in relation to this research where we have sought to draw out implications for policy and practice.

The research comprised three inter-related phases: the national questionnaire survey; in-depth case studies of nine NHS Trusts; and analysis of the relationship between the engagement of doctors in the case study sites and various measures of organisational performance.

3.1.1 Phase One: the National Survey

Based on an extensive literature search concerning the involvement of doctors and other professionals in management and leadership roles, a questionnaire was designed by the research team that sought to investigate the types of medical leadership structures in place in NHS Trusts in England (Appendix 1). It was intended that the questionnaire would give a national snapshot of the structures of medical leadership and also provide the basis for developing a typology which would be used to investigate different types of medical leadership arrangements in the second phase of research. As outlined in chapter 2, previous research into structures has typically either been of single organisations or of a relatively small sample. Existing research moreover is now fairly dated with much of this being conducted in

the 1980s and 1990s, and the survey was therefore designed to update the literature and also to fill a gap in knowledge.

The initial draft questionnaire was shared with the project's advisory group which comprises chief executives and clinical directors of NHS Trusts across England, a researcher and a patient representative. This group commented on the length and format of the questionnaire and also on the specific questions. Following these comments the questionnaire was revised and then piloted in a sample of 12 NHS Trusts to ensure its validity. Following these responses the questionnaire was further amended, before a final version was agreed upon.

Ethical approval for the research was obtained (REC reference number 09/H1203/65) and the project was awarded NIHR Clinical Research Network Portfolio status. The research sought to investigate the medical leadership structures in NHS Trusts across England (excluding Ambulance Trusts) meaning that 245 sites would be included in the sample and would require local research governance approval. The documentation for research governance approval was sent out to all sites in December 2009 and once this had been gained a questionnaire and participant information pack was sent to the chief executive of Trusts. Questionnaires were distributed and responses received back between March and December 2010 with a series of reminders being sent to those trusts we had not heard back from.

Questionnaires were staggered in their sending out, as they were sent to Trusts once research governance approval had been granted. On return, data were entered into an Excel spreadsheet for analysis. In all research approval was gained for 179 sites out of the 245 approached (73%). Two sites declined to be involved in the research (0.1%) and 64 did not respond to our request for research governance approval (26%). Map one reveals the locations of trusts that granted our study research approval and shows the sites for which no approval was received.

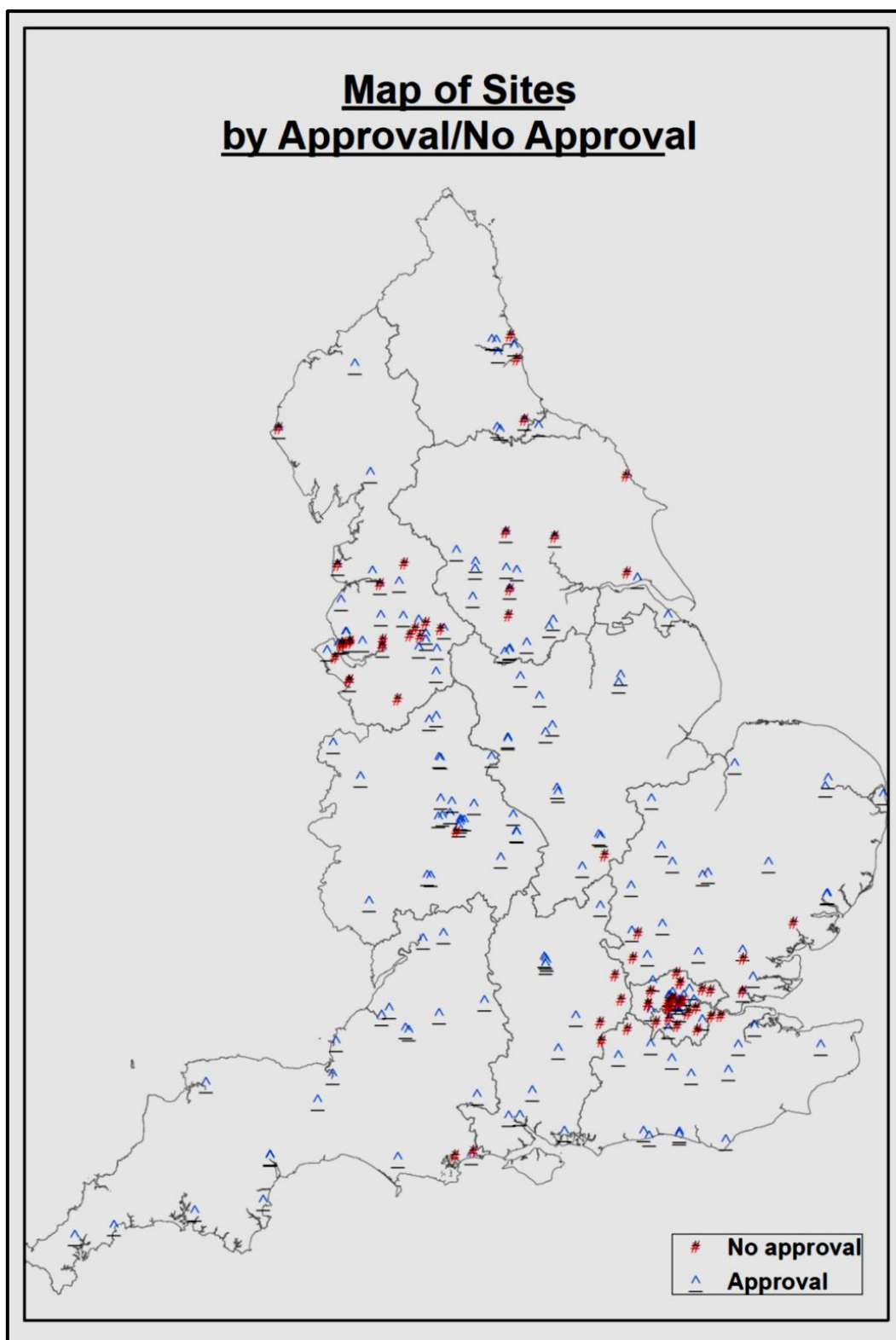


Figure 1. Map of Sites by Approval/No Approval

Data generated by the survey were transferred to an Excel database and coded. Those answers that generated numerical answers were afforded categories depending on the magnitude of their answers and the free text was coded according to the types of themes that it generated. As this data collection exercise was intended to be descriptive, simple statistical tests were run on the data in order to generate a snapshot of the major features of the trusts that responded to the survey and their principal organisational units. For example, data relating to structures, staff size, budgets, number of organisational units were correlated against one another and graphs produced to illustrate the responses gained from questions.

3.1.2 Phase Two: Case Studies

The second phase of the research involved the in-depth exploration of 9 case study sites which were selected from those who had responded to the survey. We say more in chapter 5 about how we sampled the trusts for this phase of this research but essentially we employed a purposive sampling approach (55). Such an approach aimed to select sites with a range of different principal organisational structures across a range of criteria such as size, geography, trust type and budget.

A spreadsheet was created from the survey data which set out the responding trusts by their principal organisational units along with the trust type and an indication of whether the trust budget and staff size was located in the top, middle or bottom third of the overall sample. Alongside this was an indication of whether or not the trust self-rated as effective in terms of medical engagement. Nine sites were selected in agreement with the advisory group to cover the full range of structural types and other criteria. An overview of the key features of the case study sites can be found in Table 1.

Table 1. Overview of key features of case study sites

Case Study	Trust Type	Foundation Trust or non-Foundation Trust	SHA Region	Total Budget (£ million)	Total Number of staff (total head count, not FTE)	Number of Medical consultants	Number of doctors on Trust Board of Directors	Number of doctors on Trust's Management Board	Principal Organisational Structure	Number of principal organisational units
A	Acute	FT	South West	193	3300	140	1	5	Directorate	5 Directorates
B	Acute	FT	North East	450	6582	358	1	12	Division	36 Directorates
C	Acute	Non-FT	Yorkshire and Humber	950	13000	714	1	1	All	5 Divisions
D	Acute	Non-FT	South Coast	507	8743	504	2	8	All	5 Divisions
E	Acute	FT	Yorkshire and Humber	178	4300	223	1	14	Directorate	12 Directorates
F	Specialist	Non-FT	London	323	3594	249	3	6	Division	5 Divisions
G	Mental Health	FT	East of England	150	2000	70	2	5	Division	5 Divisions
H	Mental Health	Non-FT	West Midlands	140	3200	64	3	5	Service Line	5 Directorates
I	Mental Health	FT	North West	131.5	2808	86	2	5	Service Line	4 Service Units

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Although the first phase of the project had been deemed research by NRES, the case studies were defined as service evaluation by the same body, meaning no additional ethical approval needed to be sought for the second phase of the research. Contact was made with the research offices in each of the sites and information was provided where required.

For each of the case study sites, contact was made with the chief executive to discuss the research and to gain access. When this had been agreed, the first part of the fieldwork involved interviewing board members. Approximately five members of the executive board were interviewed at each site (n=46). These interviews were tape recorded and notes were also taken during the course of the interviews. The interviews were used to check out the survey responses that we had received from that site and whether there had been any changes to this since completion and to gain more information about key areas.

The aim of these interviews was to gain a high-level insight into the structures of the trust, how doctors were selected, prepared and developed for leadership roles, how effectively management structures operated on a daily basis, and the strengths and weaknesses of medical leadership within the trust as perceived by interviewees. As part of this initial round of interviews we asked interviewees to identify clinical units or sub-groups which we could do more in-depth work with in order to complement the board perspective with those closely involved with the delivery of patient care. We asked interviewees to identify clinical units that in their view illustrated the full range of engagement levels of doctors from those that had well-engaged doctors to those which were perceived to be less well engaged.

In so doing, we were interested in exploring how and why engagement levels varied within trusts as well as across trusts and asking board members for their perceptions of different levels of engagement was the starting point for so doing. It is important to note that we did not verify board members' perceptions at this stage. Only subsequently through the use of the Medical Engagement Scale (see below) did we collect data on the degree to which doctors in the units concerned reported that they were or were not engaged.

Within the units identified, we conducted approximately five interviews (see Table 2) among a range of different professionals. We aimed to involve a mix of doctors, nurses and managers in each of the units, although the precise mix of individuals varied from unit to unit depending on their particular personnel and characteristics. Most of these interviews were conducted on-site at the Trust, with follow up telephone interviews where individuals were not available in person.

In total 105 interviews were conducted as part of this stage. Again all interviews were recorded and notes taken. Following the interview the researcher sent a summary of the interview to the interviewee for

verification and also to invite any additional comments which had arisen after a period of reflection.

Table 2. Individuals interviewed in principal organisational units

Case study site	Number of individuals interviewed	
A	Doctors	6
	Managers	5
	Nurses	3
B	Doctors	5
	Managers	4
	Nurses	3
C	Doctors	3
	Managers	3
	Nurses	5
D	Doctors	9
	Managers	3
	Nurses	2
E	Doctors	3
	Managers	2
	Nurses	4
F	Doctors	1
	Managers	2
	Nurses	1
G	Doctors	6
	Managers	4
	Nurses	2
	Psychologists	2
H	Doctors	8
	Managers	3
	Nurses	3
I	Doctors	5
	Managers	4
	Nurses	3
	Psychologists	1

Data from the sites were analysed according to three meta-themes of structures, processes and outcomes. The extended notes of each interview were coded into these three meta-themes and sub-themes were inductively generated for each of the individual sites. The thematic analysis for each of the sites was then verified with key respondents at the sites to check their validity and our understanding of these. A local report was produced for each site and comments were invited from chief executives or medical directors to check for accuracy and interpretation.

Data across the nine sites was then aggregated and the sub-themes cross-compared to analyse the degree of overlap between the sites. A final set of sub-themes was agreed and data generated according to these were compiled to compare different perspectives on these issues across the sites. The write up of these themes were shared amongst the research team to check their validity and interpretation.

The process of arranging interviews and access to all those that we wished to speak to was more complex than anticipated. On the whole we found it relatively straightforward to obtain access to executive board members and to set up interviews. However, once units within the trusts had been identified from the board interviews, we struggled in some places to engage all the doctors, managers and nurses that we wanted to.

At several of the sites many attempts were made to chase contacts to try and secure interviews with them and on many occasions interviews were cancelled and rearranged for later dates due to issues with availability. As Table 2 demonstrates at some sites we were not successful in securing all of the interviews we had planned but in practice we pursued as many interviews as possible right up to the cut off date for data collection.

The research team met regularly over the course of the project to discuss emerging findings. This was particularly important in terms of the case study component of the process where different researchers took the lead for different case study sites so that we could ensure we had consistency over the data collection and the kinds of findings emerging from the sites. We also fed back the major themes of the research to the advisory board in order to check our understanding, interpretation and presentation of the data.

3.1.3 Phase Three: Medical Engagement and Organisational Performance

The final phase of the research focused on the relationship between medical engagement and organisational performance. This built on previous studies indicating that organisations in which doctors were in leadership roles or where doctors reported that they felt engaged in the work of these organisations appeared to deliver better results than organisations lacking these characteristics.

In our study we used data on organisational performance from two sources: the self-assessments provided in the questionnaire survey undertaken in phase one; and routinely available data collected by the NHS through the Healthcare Commission and Monitor. A major challenge in the use of routinely available data is accessing a data set that applies across the range of Trusts selected as case studies. These Trusts encompassed Foundation Trusts and Trusts yet to become Foundation Trusts as well as organisations providing different services (acute, mental health and specialist services). In chapter 6 we discuss how we addressed this challenge.

Data on medical engagement was obtained through the use of the Medical Engagement Scale (MES). The background to the MES and its development and design is discussed further in chapter 6. In brief, it comprises a series of meta scales relating to working in an open culture; having purpose and direction; and feeling valued and empowered. Each of these Meta scales is then further made up by two sub-scales, one of which relates to individual aspects of engagement and another scale relating to organisational conditions. The MES provides an overall index of medical engagement together with an engagement score on the three component meta-scales. The MES has been used in a large number of different NHS Trusts and is validated as measure of engagement.

In the context of this research we used the MES in conjunction with the qualitative research into the case study sites. The MES was sent out to all doctors in the units on which we focused within the case studies and these doctors were asked to report on how engaged they were using the questions included in the MES. Our aim was to understand how levels of engagement varied between units within each site as well as (through aggregating the results) how it varied between sites.

While we hoped to relate medical engagement at the unit level to measures of unit performance, this proved difficult in practice because of the lack of accepted and comparable measures of performance for the diverse range of services encompassed by the units we investigated. We therefore focused mainly on relating the MES results for the case study sites with data on organisational performance drawn from the two sources described above. Variations in response rates to the MES between sites meant that this was not possible for all of the case studies and we focus on reporting and analysing the results for those sites where higher response rates were achieved.

3.1.4 Bringing data sources together

In making use of data from different phases of the research, we relied on data triangulation as a way of demonstrating that our findings are valid and are corroborated across the different methodological techniques (56). In doing so we are aware of the challenges of mixed methods approaches not least the degree to which interpretations of 'validity' fit with one another in

terms of qualitative and quantitative research (57). As such, we have followed Lather (58) in attempting to 'consciously utilise designs which seek counter patterns as well as convergence if data are to be credible' (pg. 67).

As we have explained above, the first phase of the research was intended to map out the types of organisational structures that English trusts use. The responses generated from the survey were then purposively sampled to generate the nine case studies that we would investigate in the second phase of the research. Data generated from the survey was also presented to interviewees in the case study research to assess the degree to which they agreed with both the organisational arrangements presented and also the self-ratings of organisational performance. Finally data relating to the self-rating of performance gathered through the questionnaire survey were used as one component of the performance dataset.

The qualitative data from the case studies were used to understand in more detail perceptions of the structures, processes and outcomes of medical engagement within the case study sites. Building on the data generated through the questionnaire survey we delved into these issues in more detail to understand how a range of stakeholders from different backgrounds felt about these issues in practice. The research team used its regular meetings to compare and contrast the emerging findings and to relate them back to the existing literature. These meetings were themselves an important part of the research process and a productive way of making sense of data from different sources and settings.

In the final phase of the research quantitative data was brought together from the survey, routinely available data about the performance of the trusts and the data generated from the MES. The self-assessment data from the questionnaire survey was correlated with the national performance data and the MES data to see if we could identify any links between self-rated performance, routine data and the MES scale which measures the degree of medical engagement within trusts. Analysis of the resulting patterns was further aided through the use of the case study data in order to help explain why some of the results we were seeing may have been produced.

3.2 Limitations

As we have indicated throughout this chapter the collection of research data did not always go smoothly and the project was beset by a number of challenges.

The most important in the initial stages was the need to secure ethical approval for the first phase of the work i.e. the questionnaire survey. This meant that significant delays were added to the mapping component of the work as we had to apply to each individual trust in England for research governance approval. This process also added a lot more work to the research than had originally been envisaged. Given that not all of the sites

granted us approval, it also meant that we did not have a complete sample to send questionnaires to. This in turn has implications for the sorts of claims that we can make about the data and the conclusions that we can reach.

The problems encountered in obtaining ethical approval for the questionnaire survey can be contrasted with our ability to approach the case study sites in the second phase without needing ethical approval because NRES deemed the work involved to be service evaluation. In view of the fact that the case studies involved face to face interviews with key informants whereas the questionnaire survey did not, it is difficult to understand why ethical approval was needed for the first phase and not for the second. The work and delay that resulted required us to request an extension of our deadline for completing the work but much more importantly it meant that our ability to undertake the work we had hoped to conduct in the third phase was compromised.

During the research process we also encountered some difficulties in securing access to case study sites and individual staff members within these. At some sites we found it more difficult to recruit key informants to interview than others. Although strenuous efforts were made to undertake the full number of interviews at each site, this was not possible at all and so a cut-off date had to be applied after which we could collect no further data. In practice this means that some trusts are better represented in the sample than others.

As noted already access to performance data was a challenge for the sample of case studies given that we incorporated a range of different trust types. This component of the research was always intended to be exploratory in nature, especially in relation to the performance of clinical units within trusts and it underlines the difficulties in comparing performance across trust types as well as within trusts. We reflect more on this in the chapter on performance data (chapter 6).

Similarly, as we describe in chapter 6, some sites were more responsive to the MES than others. While at some sites we were able to garner an extensive picture of the nature of medical engagement across the trust, at others doctors did not return the survey and therefore we were not able to obtain an adequate understanding of engagement in the trusts concerned. This phase of the research was most affected by the delays and work that resulted from us having to seek ethical approval for the use of the questionnaire survey in the first phase.

Among other things, these delays meant that we ran out of time to analyse in detail how data collected in the case study phase might help explain findings from the work on medical engagement and organisational performance. To be more specific, we had intended to interrogate the case study data for clues as to what factors might explain varying levels of medical engagement in the case study sites.

Often the limited response to the MES and requests for interviews appeared to be related to the work pressures faced by medical leaders and senior managers. While not unexpected, this has implications for other research commissioned by the SDO programme that requires access to people in similar roles. The well publicised financial and service challenges facing the NHS in England are likely to increase the pressures on medical leaders and senior managers in future and therefore accentuate the difficulties of data gathering in studies such as this.

3.3 In summary

In this chapter we have described the mixed-method approach adopted in the research. These methods included a national questionnaire survey of NHS trusts in England to gather data on structures of medical leadership, and views on the effectiveness of these structures; in depth case studies in nine trusts designed to understand the processes at work in these organisations, and the relationship between doctors, nurses and managers; and analysis of medical engagement through the MES and how engagement is related with performance in the case study sites.

As we have described, the process of data collection was not always straightforward and delays in the process due to the need for ethical and research governance approval for phase one of the research in particular caused significant delays. Despite these delays, all three phases of the research were completed, although we experienced difficulties in interviewing the number of key informants we had planned to and the response to the MES was variable. Work pressures on medical leaders and senior managers undoubtedly contributed to these difficulties in data collection.

4 Survey Results

In this chapter, we present the findings from phase one of our research, involving a questionnaire survey of NHS Trusts in England. The aim of the survey was to gather a range of information about these Trusts and the medical leadership structures in place. The survey also asked respondents to assess the effectiveness of these structures. The main points made in this chapter are:

- Trust budgets varied from £55mill to £950mill, with the majority of trusts reporting budgets in the range of £100-£199 million per year. The budget range was much greater for non-Foundation Trusts than for Foundation Trusts. Analysing budgets by Trust types shows that mental health/ partnership Trusts had smaller budgets than acute Trusts.
- The number of staff employed within Trusts ranged from 600 to 13000 (head count rather than full time employees) with the majority reporting in the range 2000-3999. Organisations with large numbers of staff (defined here as 6,000 or more) were all NHS trusts rather than Foundation Trusts. Analysing the number of staff by Trust type shows that organisations with large numbers of staff are all acute Trusts.
- The number of medical consultants employed ranged from 30 to 714 with the majority employing between 50 and 199 consultants. Reflecting their size, NHS Trusts typically have more consultants than Foundation Trusts, and mental health/partnership trusts have the fewest
- The survey asked about the involvement of doctors in leadership roles. The number of doctors on the boards of trusts ranged from 1 to 4 with most having only 1. There was little variation in the number of doctors on boards when the data were analysed by trust type and whether or not they were Foundation Trusts.
- The number of doctors on the trust management board ranged from 1 to 17, the most common number being 1 followed by 8. There was little variation in the number of doctors on management board when the data were analysed by whether or not they were Foundation Trusts. Mental health/partnership trusts had fewer doctors on the management board than either acute or specialist trusts
- Doctors are represented on a wide range of committees with Quality and Patient Safety, Clinical Governance, and Research and Development being most frequently mentioned

- There was a wide variation in how trusts were organised. Respondents reported the use of directorate, divisional and service line structures, sometimes in combination.
- When asked to identify the *principal* organisational units adopted, the most common responses were directorates and divisions, with service line being much less frequently mentioned. There was little variation according to Trust type and whether or not respondents were Foundation Trusts
- The number of principal organisational units varied from 2 to 23 with most falling in the range of 3 to 6. There was a tendency for larger trusts to make greater use of divisions
- Most trusts reported that between 10 and 20% of medical consultants were involved in formal leadership roles. This showed little variance by trust type or foundation trust status. There was a tendency for a high proportion of doctors to be involved in leadership roles in organisations that used service lines
- When asked to identify the accountable officer within the principal organisational units, most trusts reported that this was a clinical director/doctor/clinical lead, followed by a general manager and a clinician and manager jointly. Only a very small proportion reported that the triumvirate took on this role
- Most trusts reported the existence of development programmes for medical leaders and these were delivered both in-house and by external providers. In free text responses, respondents reflected on the difficulties of developing medical leaders, the lack of proper career structures and some of the financial barriers that existed
- In response to a series of self-rated questions about various aspects of performance, respondents reported doctors feeling a strong sense of responsibility for quality, but far less so for finance. There was little variation in relation to the principal organisational unit adopted
- Respondents were mostly positive about the effectiveness of medical leadership arrangements in their trusts. There was little variation in self assessments of performance when analysed by the principal organisational unit adopted
- Free text responses highlighted the challenges facing medical leaders including lack of support from general managers and variations in the willingness of doctors to deal with difficult issues. These responses also drew attention to examples of medical leaders making a positive

difference and the likely impact of the next generation of medical leaders

4.1 Response rate

The questionnaire was sent out to 179 sites and 73 were returned. One questionnaire was returned uncompleted meaning we had 72 completed responses (40%). The data summarised here are drawn from the 72 completed questionnaires, although not all Trusts completed every question. For each of the questions analysed, data are provided on the number of responses received. Percentage values are reported to the nearest whole number and so in some cases the total percentage figure may not seem to add to 100% and this is due to the rounding of figures.

In terms of who completed the questionnaire, this was predominantly either the Chief Executive (28) or the Medical Director (35), with a small number (3) of other organisational respondents and in 6 cases it was not clear who completed the questionnaire.

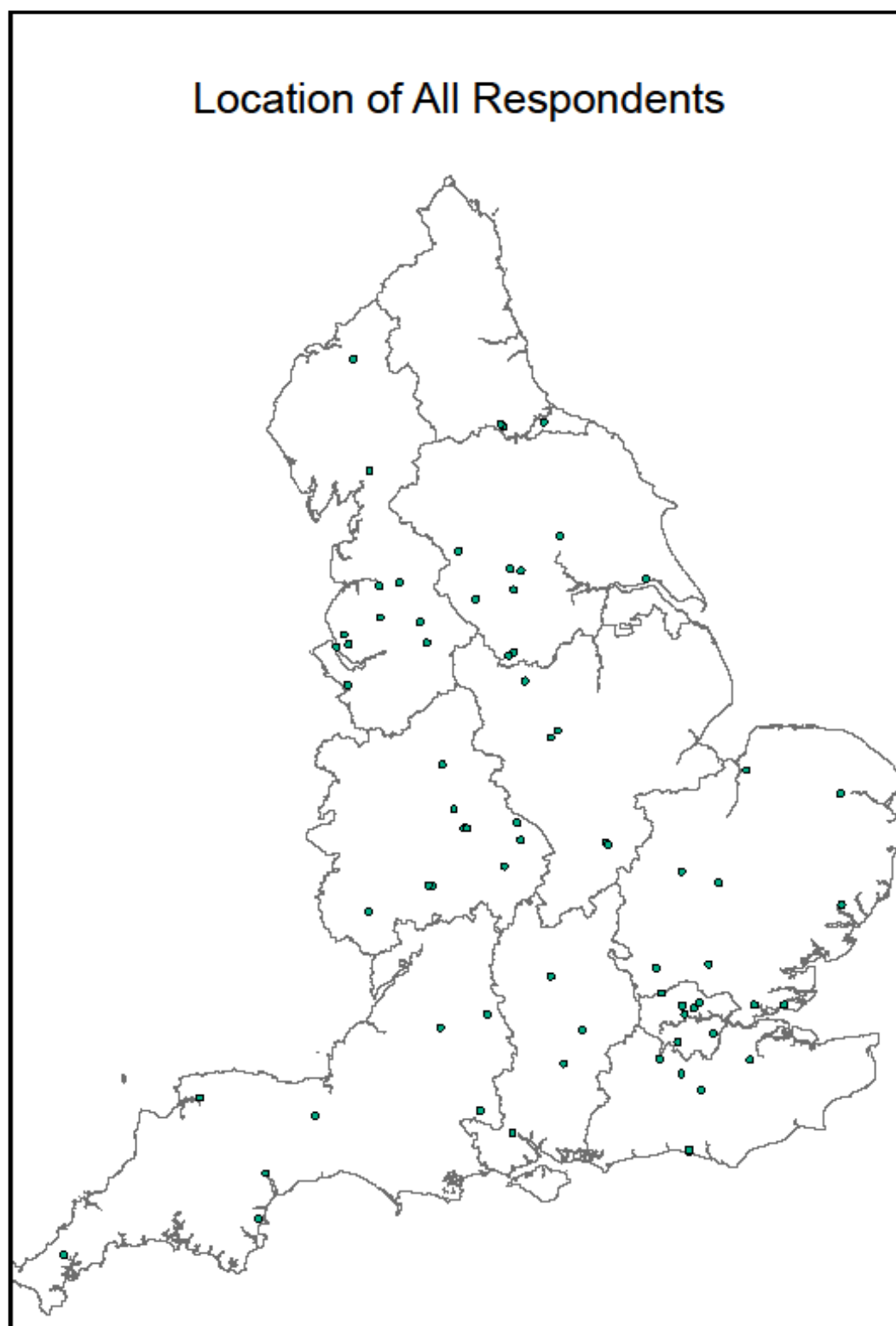
4.1.1 Responses by Region

Table 3 shows the responses received by region and shows that East of England and the North West provided the highest number and proportion of responses and the North East and South East Coast the lowest number and proportion of responses. Map Two illustrates these completed responses by area.

Table 3. Responses by Strategic Health Authority Area

SHA	Number of responses
East of England	11
North West	11
Yorkshire and the Humber	9
South West	9
West Midlands	8
London	7
South Central	5
East Midlands	5
South East Coast	4
North East	3
TOTAL	72

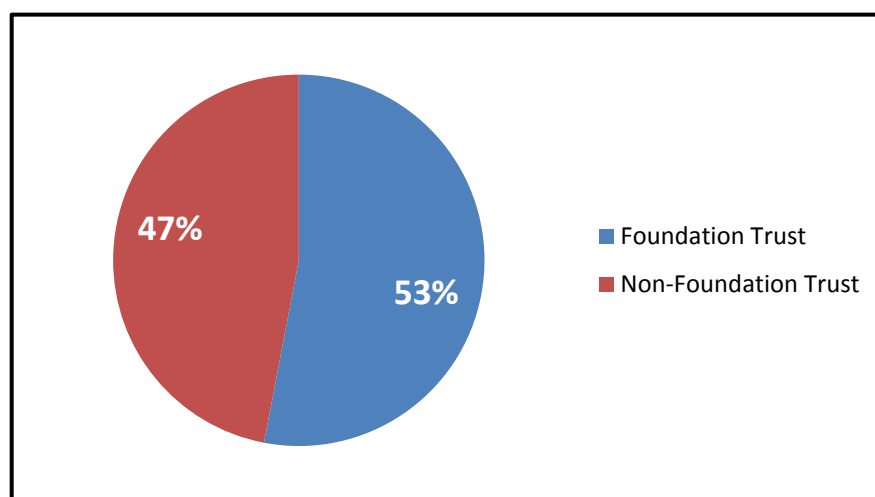
Figure 2. Map Two: Locations of trusts who completed and returned questionnaire.



4.1.2 Responses by Foundation Trust Status

Of the responses gained, 38 were from Foundation Trusts (53%) and 34 were from non-Foundation Trusts (47%). These responses are illustrated in Figure 3. Nationally there are 134 Foundation Trusts in existence at the time of writing (discounting the 2 ambulance trusts) which means that this response rate is broadly consistent with the national picture (55% Foundation Trust nationally).

Figure 3. Percentage of Foundation and non-Foundation Trust responses



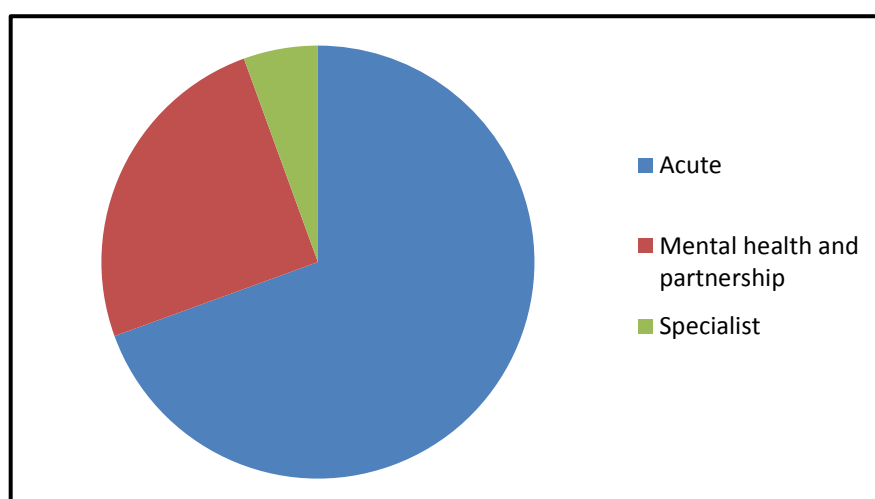
4.1.3 Responses by Trust Type

Responses were analysed according to the type of trust based on three categories: Acute, Mental Health/Partnership and Specialist trusts. Table 4 illustrates that the majority of responses are from acute trusts, with just over a quarter of responses from mental health/partnership trusts and a small number from specialist trusts. These are also illustrated in Figure 4. In terms of how representative this sample is of Trusts nationally, there is a slight over-representation of mental health and partnership trusts, specialist trust responses are low although representative and acute trusts are slightly under-represented.

Table 4. Questionnaire Responses by Trust type

Trust Type	Number of responses	% of total responses	% of national trusts
Acute	50	69	74
Mental health and partnership	18	25	15
Specialist	4	6	5
TOTAL	72		

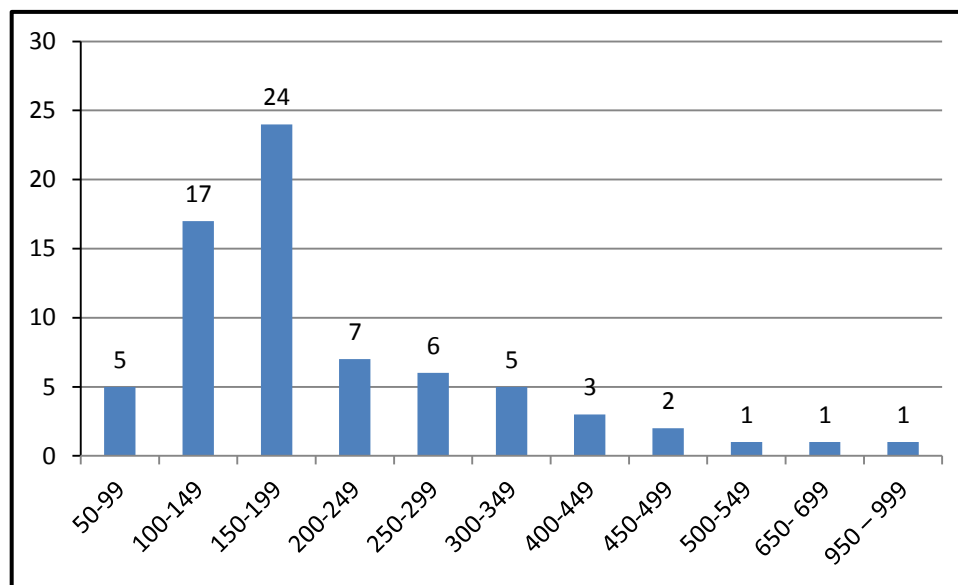
Figure 4. Questionnaire responses by Trust type



4.1.4 Responses by Size of Budgets

Figure 5 illustrates the responses by the size of the budgets controlled by trusts. While the budgets varied from £55mill to £950mill, the majority of trusts have budgets in the range of £100-£199 million per year.

Figure 5. Questionnaire responses by budget size

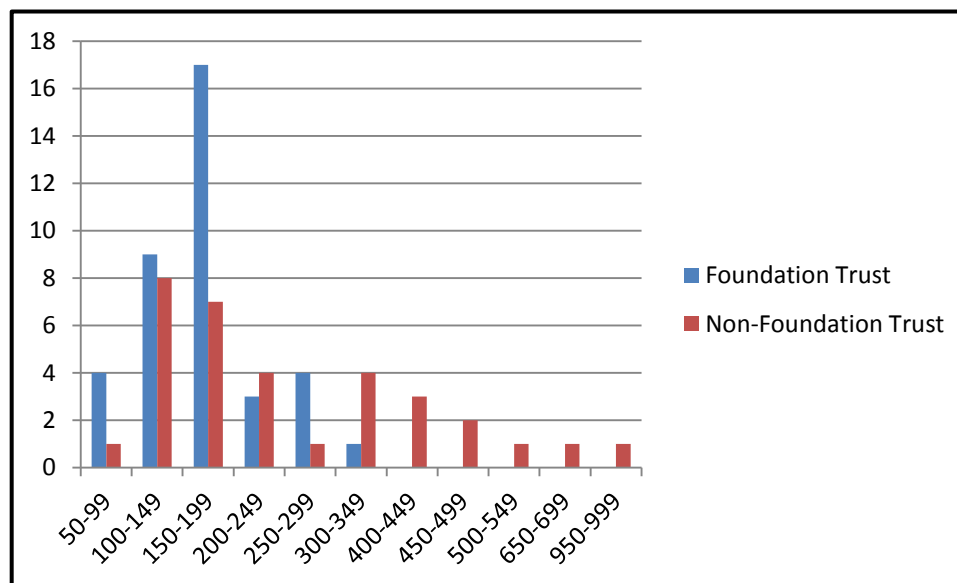


Analysis of budget size on the basis of whether respondents were NHS trust or Foundation trusts shows that the budget range was much greater for non-Foundation Trusts (Table 5). No Foundation Trusts reported a budget over £320 mill, whilst 8 NHS Trusts reported budgets over this amount. However, for both types of trust the mode lies between £100-£200 million.

Table 5. Budget by Foundation and non-Foundation Trust type

Trust Type	Budget Millions Pounds										
	50-99	100-149	150-199	200-249	250-299	300-349	400-449	450-499	500-549	650-699	950-999
Foundation Trust	4	9	17	3	4	1	0	0	0	0	0
Non-Foundation Trust	1	8	7	4	1	4	3	2	1	1	1

Figure 6. Budget by Foundation or non-Foundation

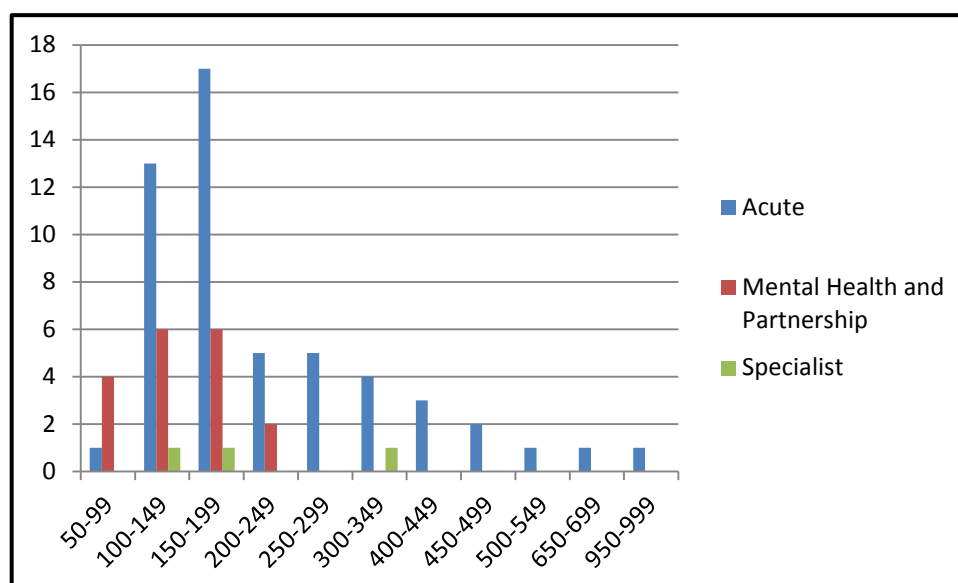


Analysing budgets by Trust types shows that mental health/ partnership Trusts have smaller budgets than acute Trusts (Table 6). There are only a small number of Specialist Trusts in the sample and their budgets are also usually small.

Table 6. Budget by Trust Type

Trust Type	Budget Millions Pounds										
	50-99	100-149	150-199	200-249	250-299	300-349	400-449	450-499	500-549	650-699	950-999
Acute	1	13	17	5	5	4	3	2	1	1	1
Mental Health and Partnership	4	6	6	2	0	0	0	0	0	0	0
Specialist	0	1	1	0	0	1	0	0	0	0	0

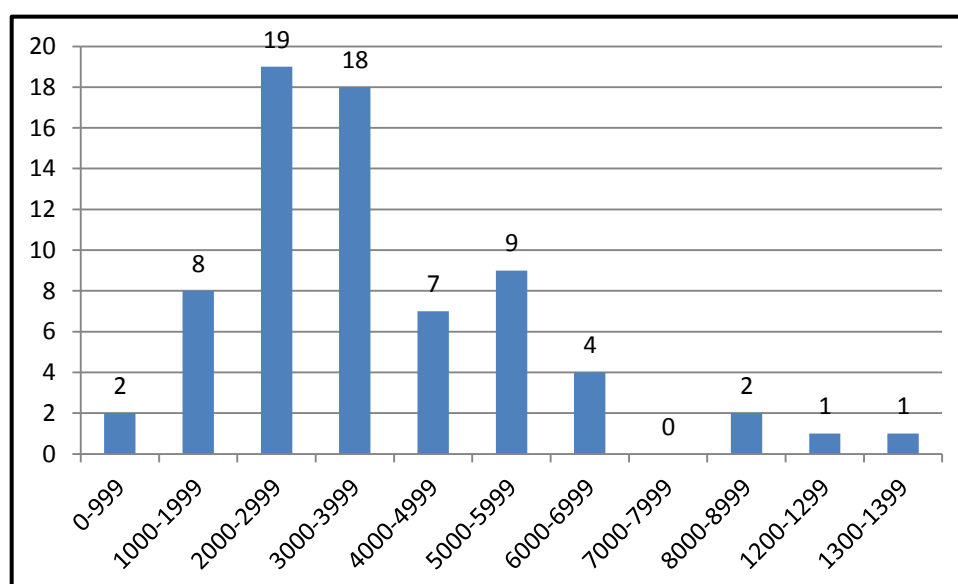
Figure 7. Budget by Trust



4.1.5 Responses by number of staff employed

Looking at the responses by the number of staff employed within Trusts, there is a range of between 600 and 13000 total staff members (head count rather than full time employees). As Figure 8 shows, the majority have in the range 2000-3999 staff members.

Figure 8. Responses by number of staff

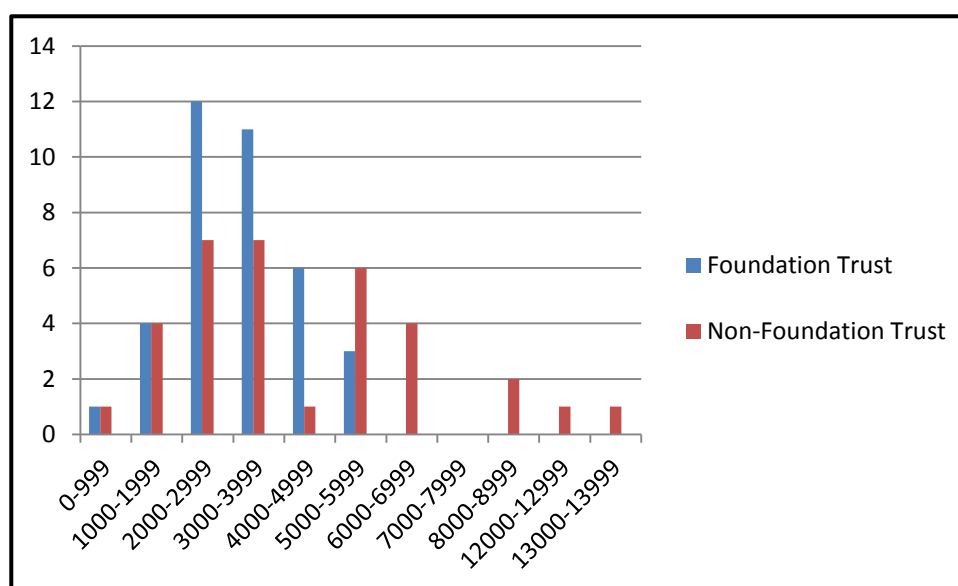


Analysing the number of staff employed on the basis of whether respondents were NHS trusts or Foundation trusts shows that organisations with large numbers of staff (defined here as 6,000 or more) were all NHS trusts, and this is consistent with our findings on the size of budgets controlled by respondents (Table 7 and Figure 9).

Table 7. Number of Staff employed by Foundation/non-Foundation Trust

Number of Employees	0-999	1000-1999	2000-2999	3000-3999	4000-4999	5000-5999	6000-6999	7000-7999	8000-8999	12000-12999	13000-13999
Foundation Trust	1	4	12	11	6	3	0	0	0	0	0
Non-Foundation Trust	1	4	7	7	1	6	4	0	2	1	1

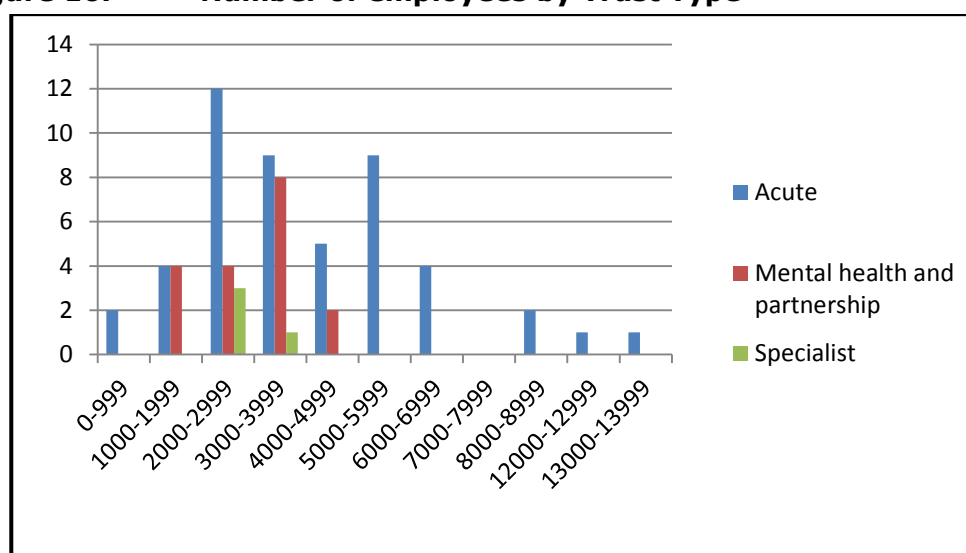
Figure 9. Number of staff employed by Foundation/non-Foundation Trust



Analysing the number of staff by Trust type shows that organisations with large numbers of staff (defined here as 6,000 and over) are all acute Trusts (Table 8).

Table 8. Number of employees by Trust type

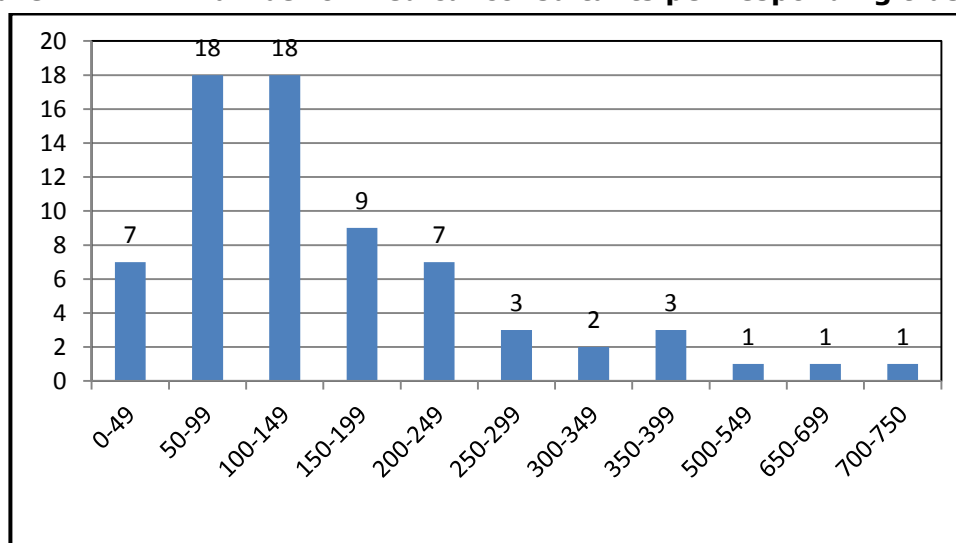
Number of Employees	0-999	1000-1999	2000-2999	3000-3999	4000-4999	5000-5999	6000-6999	7000-7999	8000-8999	12000-12999	13000-13999
Acute	2	4	12	9	5	9	4	0	2	1	1
Mental health and partnership	0	4	4	8	2	0	0	0	0	0	0
Specialist	0	0	3	1	0	0	0	0	0	0	0

Figure 10. Number of employees by Trust Type

4.1.6 Responses by number of consultants employed

Analysis of responses by the number of consultants employed revealed a range of 30-714 medical consultants per Trust. Most trusts employ between 50 and 149 consultants.

Figure 11. Number of medical consultants per responding trust

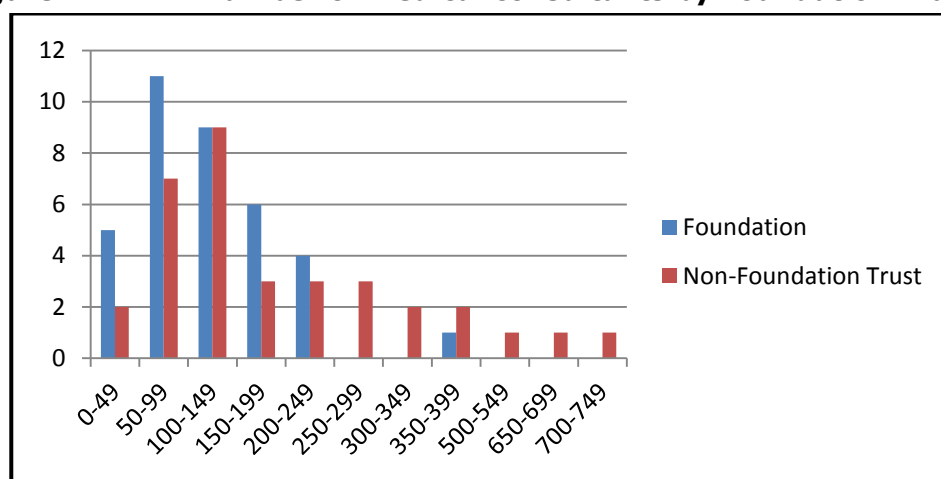


Analysis of the responses by Foundation Trust status (Table 9 and Figure 12) shows that NHS Trusts typically have more consultants than Foundation Trusts.

Table 9. Number of medical consultants by Foundation Trust status

	0-49	50-99	100-149	150-199	200-249	250-299	300-349	350-399	500-549	650-699	700-749
Foundation	5	11	9	6	4	0	0	1	0	0	0
Non-Foundation Trust	2	7	9	3	3	3	2	2	1	1	1

Figure 12. Number of medical consultants by Foundation Trust status

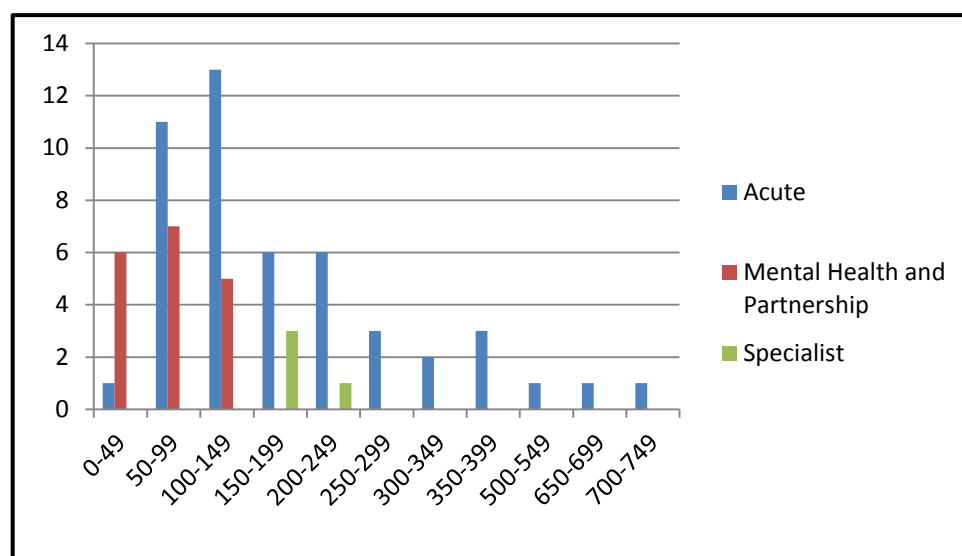


Analysis of responses by type of trust shows that mental health/partnership trusts tend to have fewest medical consultants and acute trusts the most (Table 10).

Table 10. Number of medical consultants per Trust type

	0-49	50-99	100-149	150-199	200-249	250-299	300-349	350-399	500-549	650-699	700-749
Acute	1	11	13	6	6	3	2	3	1	1	1
Mental Health and Partnership	6	7	5	0	0	0	0	0	0	0	0
Specialist	0	0	0	3	1	0	0	0	0	0	0

Figure 13. Number of medical consultants per Trust type



4.2 Structures

Having set out some basic details about the response rate analysed by different types of Trust, we move on in this section to look at the structures of Trusts that responded to the questionnaire.

4.2.1 Medical Leaders on the Trust's Board of Directors

Analysis of response by the number of doctors on the Trust's Board of Directors (i.e. the Board led by the Trust Chair), revealed a range of 1 to 4 (Table 11 and Figure 14). 71% had just one doctor and an additional 22% had 2. All of the Trusts have a Medical Director on the Board and where Trusts had more than one doctor on their board they often had two Medical Directors. The other types of roles for doctors on boards cited include:

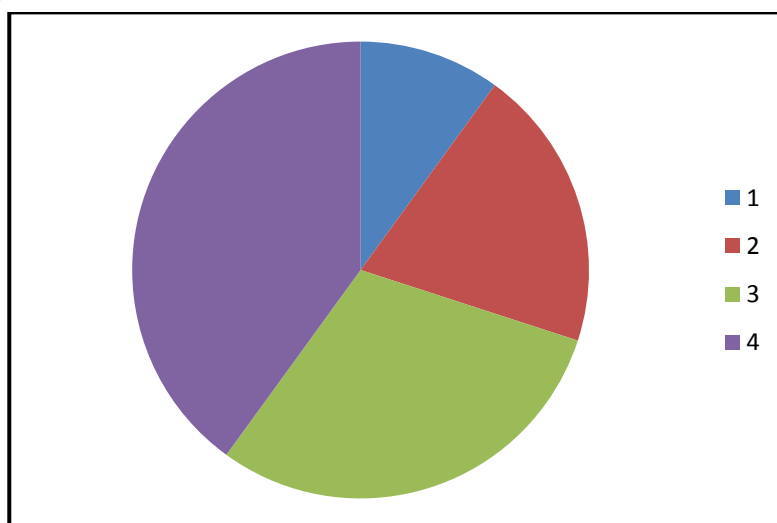
- Non-Executive Director
- Chief Executive
- Director of Research and Development
- Director of Children's Services
- Director of Strategy
- University appointed non-executive director
- Executive Director of Quality and Medical Leadership
- Director of Forensic Services

- Director of Medical Development
- Director of Strategy and Business Development

Table 11. Numbers of doctors on Trust Board of Directors

Number of doctors on Trust Board of Directors	Responses	%
1	51	71
2	16	22
3	4	6
4	1	1
Total	72	100

Figure 14. Numbers of doctors on Trust Board of Directors

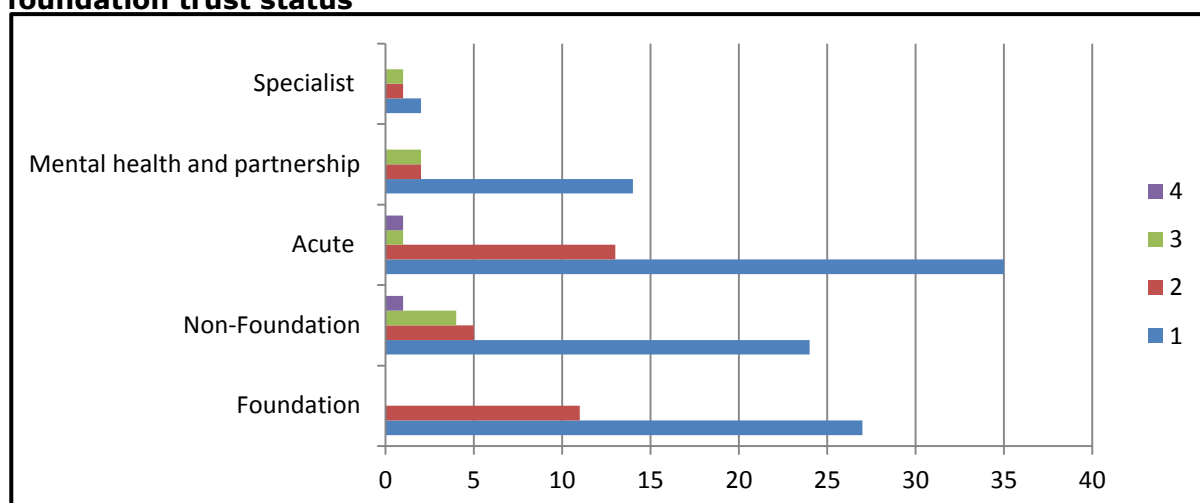


Analysis of numbers of doctors on the board of Directors by different Trust types and Foundation status (Table 12 and Figure 15) reveals similar patterns.

Table 12. Number of doctors on board of directors by trust type and foundation trust status

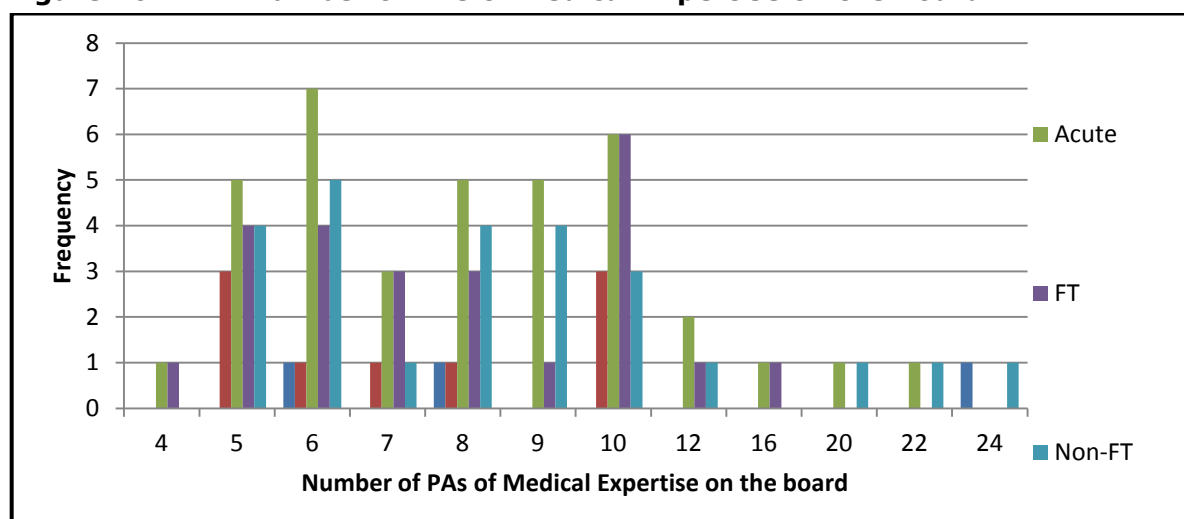
	1	2	3	4
Foundation	27	11	0	0
Non-Foundation	24	5	4	1
Acute	35	13	1	1
Mental health and partnership	14	2	2	0
Specialist	2	1	1	0

Figure 15. Number of doctors on board of directors by trust type and foundation trust status



In terms of what support Doctors on these boards receive, there is an average of 8.5 PAs of medical time dedicated to each Trust Board, although the range varies from 4-24 PAs (Figure 16).

Figure 16. Number of PAs of Medical Expertise on the Board



4.2.2 Medical Leaders on the Trust's Management Board

Analysis of the numbers of doctors on the Trust's management board (i.e. the board led by the Trust CEO), shows more doctors present than on the Board of Directors with a range of 1-17 (Table 13). Where additional doctors beyond the Medical director sit on the board, these are typically the Clinical Directors from across the various specialty areas within the Trust, but also include:

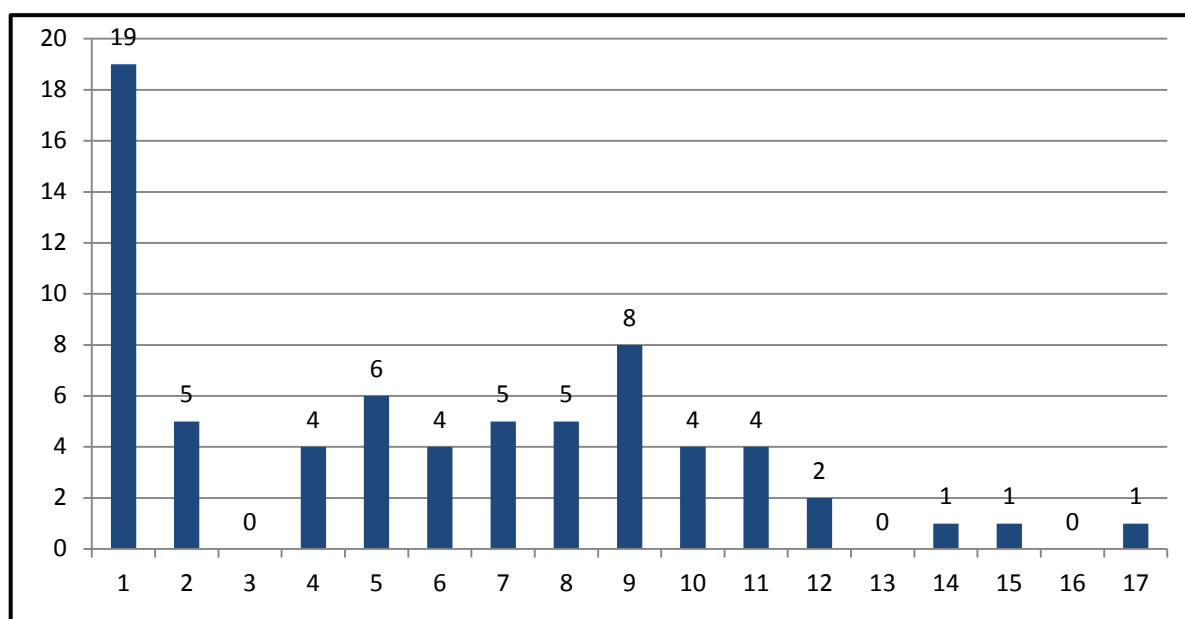
- Deputy medical directors
- Lead consultants for Research & education
- Divisional Directors
- Clinical Lead for Clinical Governance
- Lead Physician
- Director of Strategy
- Director of Audit and Research
- Clinical tutors
- Director of infection Prevention and Control
- Director of Education
- Reps from Medical Staff Committee
- Clinical Site Leads

- Lead Cancer Clinician
- Clinical Pathway Leads

Table 13. Number of doctors on Trust Management Board

Number of doctors on Trust management Board	Number of responses	%
1	19	28
2	5	7
4	4	6
5	6	9
6	4	6
7	5	7
8	5	7
9	8	12
10	4	6
11	4	6
12	2	3
14	1	1
15	1	1
17	1	1
TOTAL	69	

Figure 17. Number of doctors on Trust Management Board

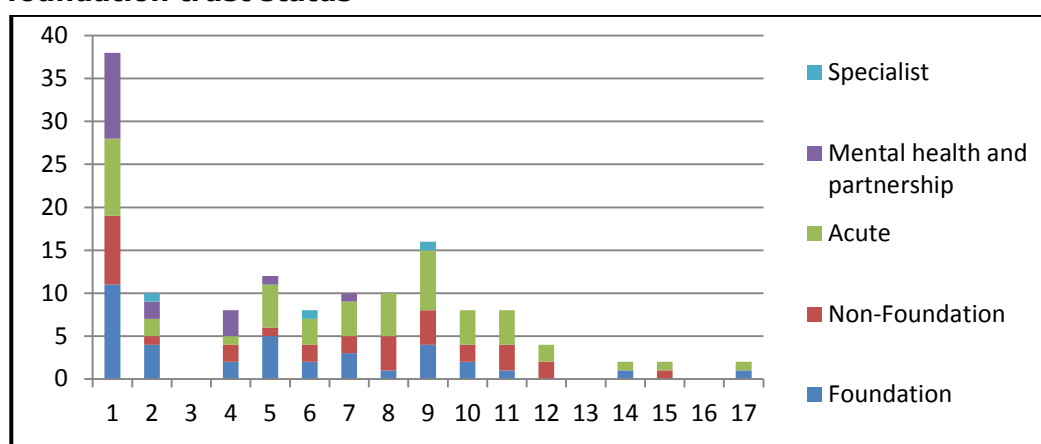


Analysis by Trust type and Foundation status again shows similar patterns, although mental health/partnership trusts often have fewer doctors on their board than acute trusts.

Table 14. Number of doctors on the management Board by trust type and foundation trust status

	Foundation	Non-Foundation	Acute	Mental health and partnership	Specialist
1	11	8	9	10	0
2	4	1	2	2	1
3	0	0	0	0	0
4	2	2	1	3	0
5	5	1	5	1	0
6	2	2	3	0	1
7	3	2	4	1	0
8	1	4	5	0	0
9	4	4	7	0	1
10	2	2	4	0	0
11	1	3	4	0	0
12	0	2	2	0	0
13	0	0	0	0	0
14	1	0	1	0	0
15	0	1	1	0	0
16	0	0	0	0	0
17	1	0	1	0	0

Figure 18. Number of doctors on board of directors by trust type and foundation trust status



4.2.3 Doctor involvement in multi-disciplinary committees

In Table 15 the committees that doctors are involved in across the Trust are presented, ranked by the frequency they were cited by respondents. With the exception of Information Governance and Finance and Performance, the top ten are predominantly medical and quality focused, which is a trend that continues down the list. This table illustrates the wide range of different committees that doctors are engaged with.

Table 15. Committees that doctors are involved with across Trusts

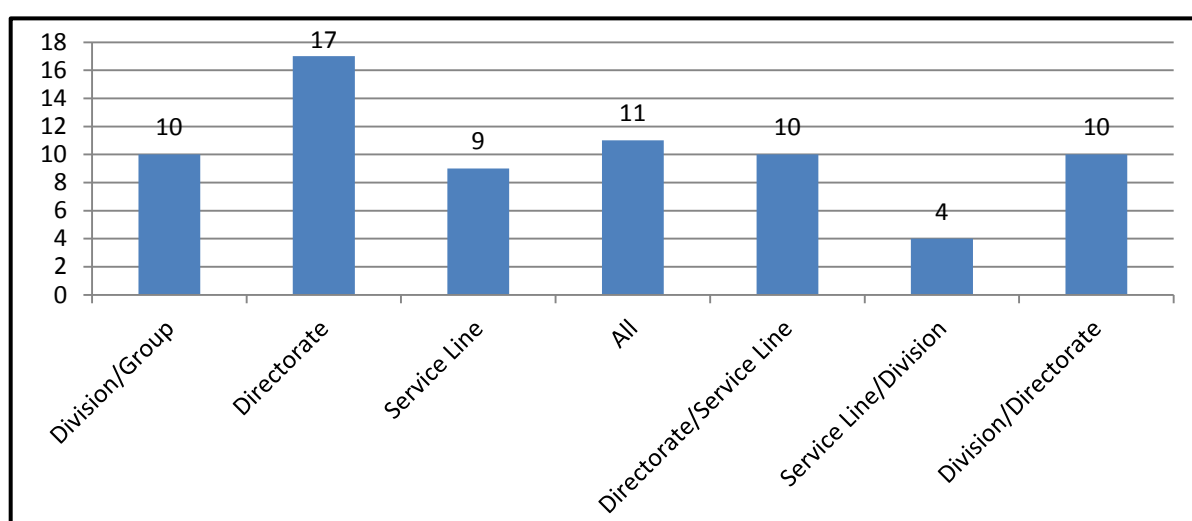
Rank	Committee	Frequency	%
1	Quality and Patient safety	44	61
2	Clinical Governance (Occasionally integrated with Social Governance)	38	53
3	Research & Development	35	49
4	Medical Education, learning advisory	33	46
5	Clinical Effectiveness and Audit	24	33
6	Risk + SUI	24	33
7	Medicines Management, Drugs, Therapies	23	32
8	Information Governance, IM&T, Caldicott	18	25
9	Infection	15	21
10	Finance and performance	12	17
11	Clinical standards / advisory group	12	17
12	Clinical Management Board / operational board	11	15
13	Divisional meetings	8	11
14	Mental health act	8	11
15	Executive Board	7	10

Other committees include: Patient experience, Mortality review, Service transformation, Medical Devices, Workforce, Blood transfusion, Professional advisory group, Staff side, Diagnostic & Treatment, Resuscitation, Safeguarding/ Child protection, Postgraduate medical education Board, Capital Investment, Charitable funds, Foundation Trust status steering group, Human Resources Group, Cancer Group, Network wide meetings, Medical Staffing Committee, Medical Triage Committee, Joint academic committee, 18 week, New hospital planning, Vacancy control, Preventions and Control, Clinical Excellence, Emergency planning, Patient Flow, Outpatient Improvement, Staff engagement, Nutrition, Radiation, Equality & Diversity and Ethics.

4.2.4 Organisation of the Trust beneath the Trust's Management Board

Analysis of how the work of Trusts is organised beneath the Management Board (i.e. the board led by the Trust's CEO) shows a spread across different types of structures. Respondents were presented with the list of options set out in Figure 19 and were asked to select that which best reflected arrangements in their Trust. Directorate is the most frequently selected choice. Just under half of responses (35) indicated a mix of the structures of division, directorate or service line suggesting these are not "pure" organisational forms.

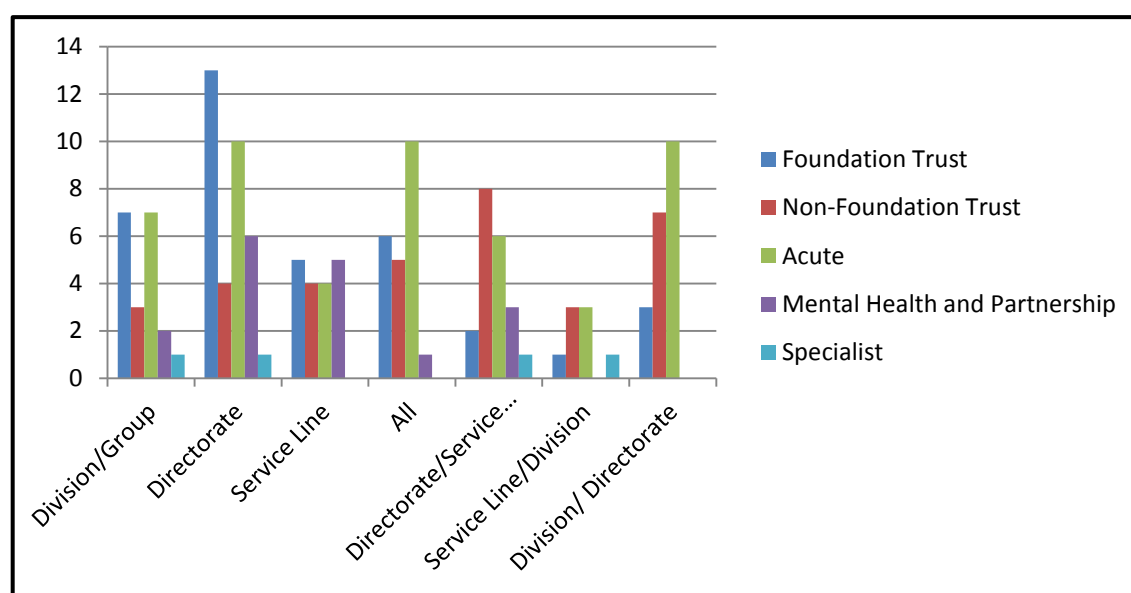
Figure 19. Trust structures



Analysing these structures by Trust type (Table 16 and Figure 20), shows a similar spread across each of the different Trust types and foundation trust status.

Table 16. Trust structures by Trust types and foundation status

	Division/ Group	Directorate	Service Line	All	Directorate/ Service Line	Service Line/Division	Division/ Directorate
Foundation Trust	7	13	5	6	2	1	3
Non- Foundation Trust	3	4	4	5	8	3	7
Acute	7	10	4	10	6	3	10
Mental Health and Partnership	2	6	5	1	3	0	0
Specialist	1	1	0	0	1	1	0

Figure 20. Trust organising structures by Trust types and foundation status

4.2.5 Principal Organisational Unit

Where respondents reported the use of more than one type of structure, they were asked to indicate which was the principal one in terms of responsibility for leadership and the management of services. We defined this as the principal organisational unit.

Analysing the results by principal organisational unit shows equal numbers of respondents indicating directorate or division, whilst service line was only selected in just over a tenth of cases (Figure 21). However, where Trusts checked the “other” option typically they indicated some combination of service line and another type of structure in response to the previous question.

Figure 21. Principal organisational Structure

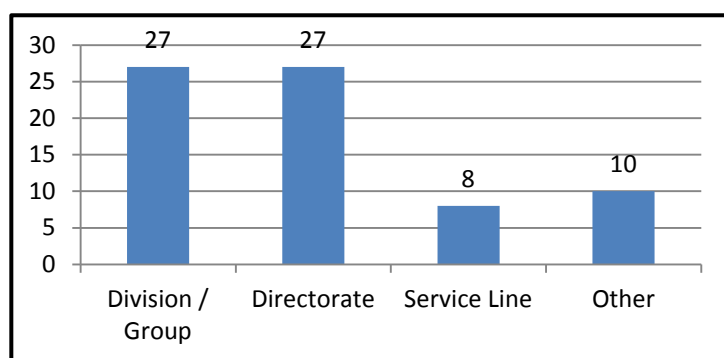
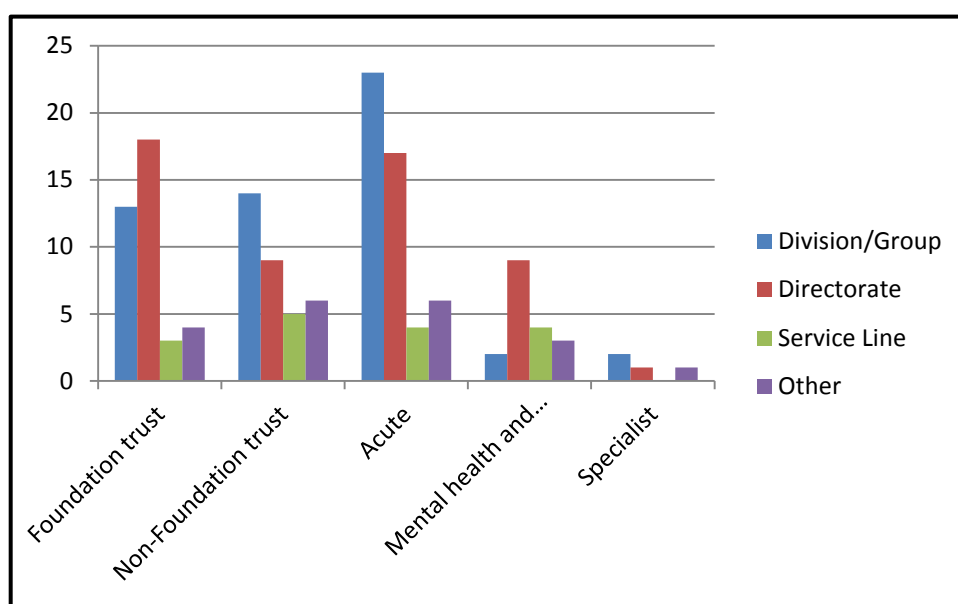


Table 17 and Figure 22 show the results by Trust type and whether or not they were Foundation Trusts.

Table 17. Principal organisational Structure by Trust type and foundation status

	Division/ Group	Directorate	Service Line	Other
Foundation trust	13	18	3	4
Non-Foundation trust	14	9	5	6
Acute	23	17	4	6
Mental health and partnership	2	9	4	3
Specialist	2	1	0	1

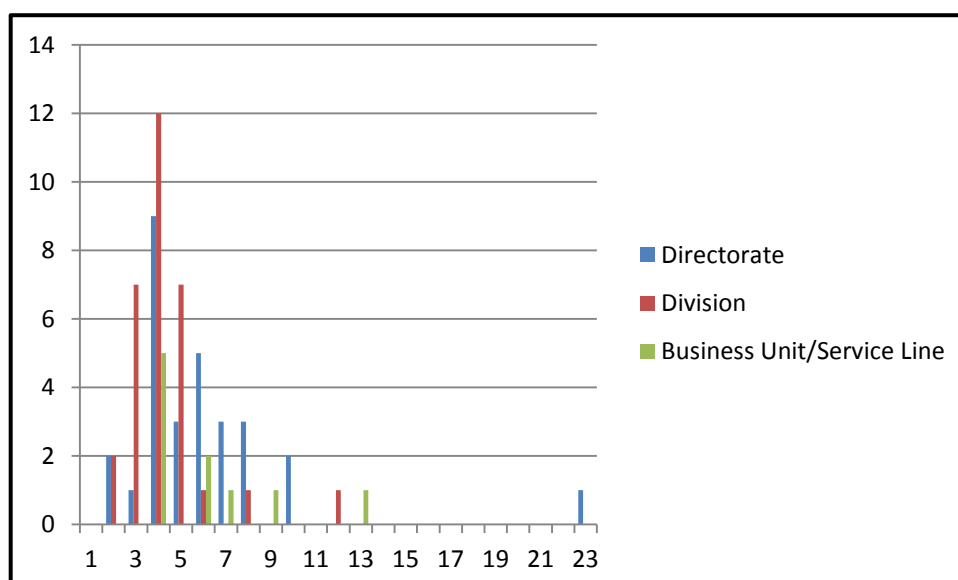
Figure 22. Principal organisational Structure by Trust type and foundation status



4.2.6 Number of units

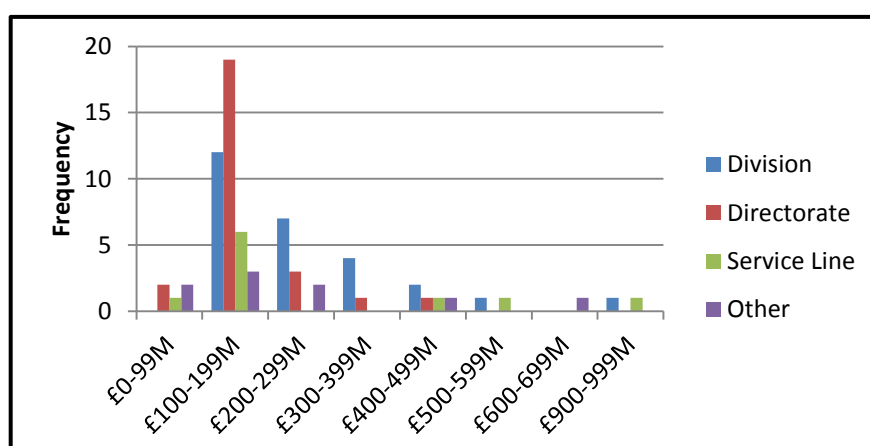
The survey asked respondents how many units there were for each type of organisational unit. The results are shown in Figure 23 and show a range of 2 to 23 with most falling in the range of 3 to 6. Units were typically described as organised by clinical specialty areas.

Figure 23. Number of units for each structural type



Analysis comparing trust financial size and structural type shows a slight preference for larger trusts to make use of divisions (Figure 24).

Figure 24. Size of budgets and structural type

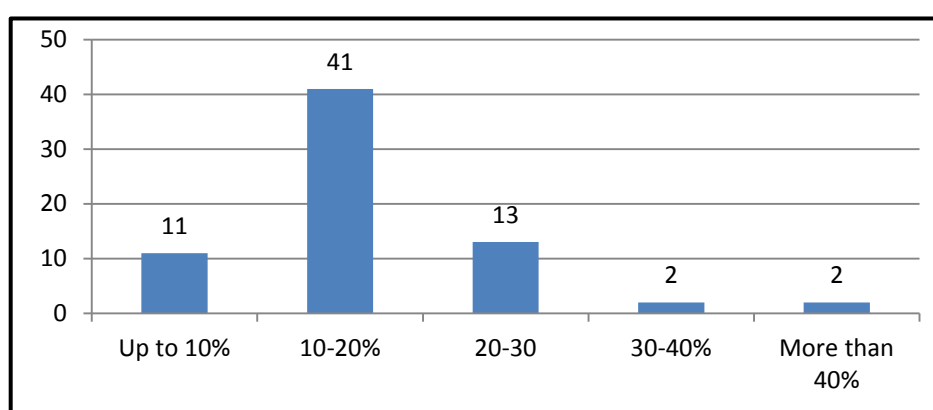


4.3 Processes

4.3.1 Percentage of medical consultants involved in formal leadership roles

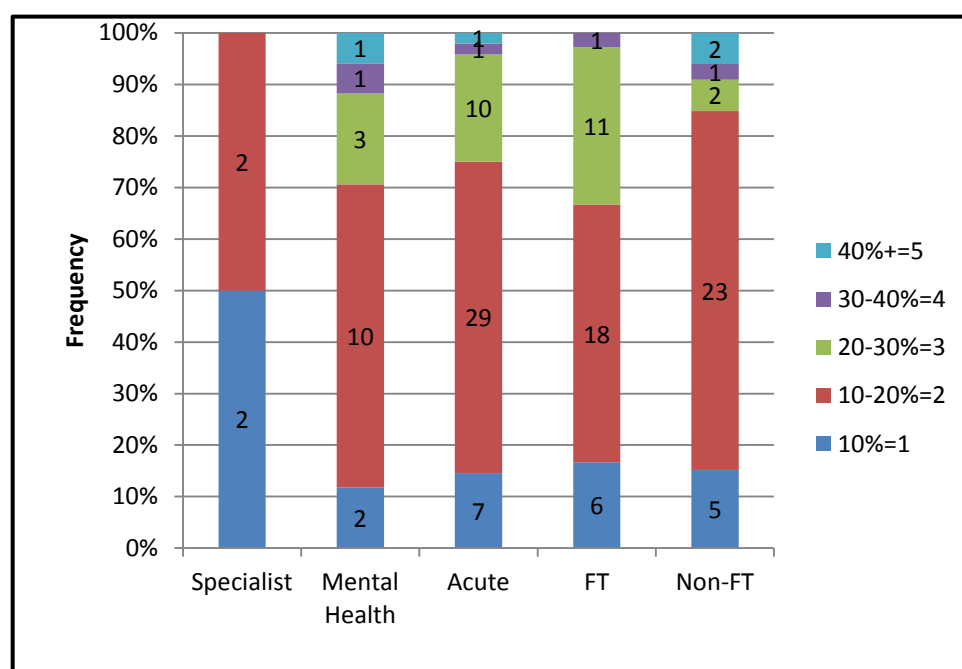
Analysis of the percentage of medical consultants involved in formal leadership roles shows a mode of 10-20% (Figure 25) with almost all responses being under 30%.

Figure 25. Percentage of medical consultants involved in formal leadership roles



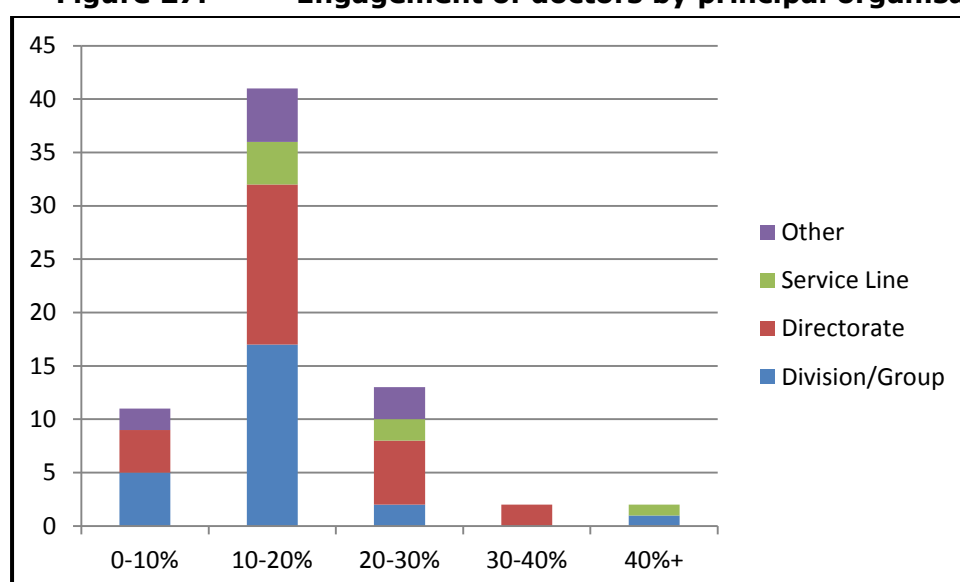
Analysing these figures by trust type and foundation status shows little variance in terms of responses (Figure 26).

Figure 26. Percentage of doctors involved in formal leadership roles by Trust type



Analysing these figures by principal organisational structure shows broadly the same patterns in terms of levels of engagement of doctors across different types.

Figure 27. Engagement of doctors by principal organisational structure



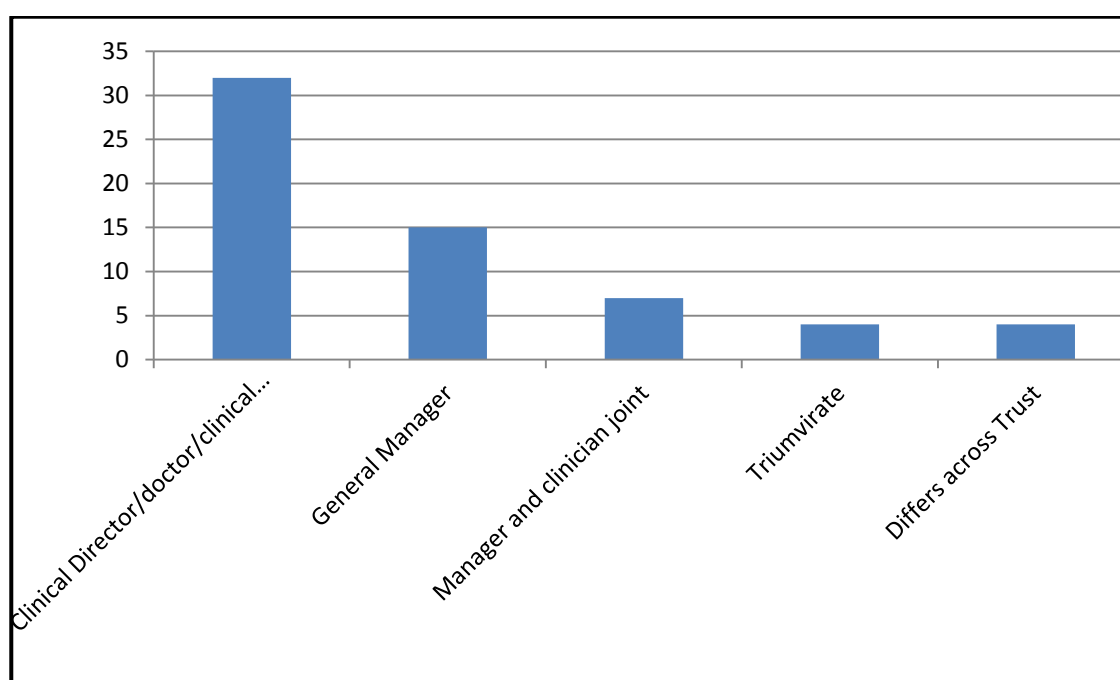
4.3.2 Accountable officer for principal organisational units

Analysis of who is the accountable officer within the units that make up the principal organisational structure shows that this is most frequently a clinician (Table 18 and Figure 28) followed by general managers and a joint arrangement between clinician and manager. In only a small proportion of cases is the accountable officer the triumvirate.

Table 18. Accountable officer within principal organisational units

Responsible Officer	Frequency	Percentage
Clinical Director/doctor/clinical lead	32	52
General Manager	15	24
Manager and clinician joint	7	11
Triumvirate	4	6
Differs across Trust	4	6
Total	62	

Figure 28. Responsible officer within principal organisational units



4.3.3 Programmes for development of medical leaders

74 % (n=53) of respondents stated that their Trust has development programmes for medical leaders. These were a mixture of uni- and multi-disciplinary programmes. Trusts also made use of a range of other external medical leadership programmes such as those run by:

- BAMB
- King's Fund
- NHS Institute
- SHA programmes
- Warwick University
- Keele University

In relation to developmental issues, in the free-text sections some respondents reflected the difficulties in developing medical leaders. One respondent suggests that what is needed is:

"A proper career structure, entrance and exit, can be seen as high risk, difficulties maintaining two fields of interest i.e. clinical and managerial, difficulties of managing colleagues, mounting bureaucracy, and part of usual aspirations for trainees, time

burdensome are stressful. I think greater clarity as regards the role is also needed”.

What this respondent is reflecting is the lack of a clear career progression for medical leaders and some of the difficulties in taking on these types of roles, particularly where there is not always sufficient clarity surrounding these. Another respondent added that:

“There are some potential complex tax/pension interface issues which can make it difficult to recruit the best doctors without leading to them being financially disadvantaged ... Whilst we now have a new leadership framework the people we need now (as opposed to in 5 years) have not benefitted from this and are certainly too busy to do lengthy training”.

Respondents drew attention to the perceived ease with which doctors might revert to clinical roles when times are difficult. One respondent suggested that; *“Doctors are 'involved' in leadership & can easily revert to their clinical role when the going gets tough - managers are 'committed' (if they fail, that can lose their livelihood)”*. In terms of what could be done to overcome these difficulties, one respondent suggested that roles could be made *“prestigious to warrant consistent bilateral investment”* but there is potentially a danger in this given that as one respondent highlights, *“medical salaries are higher and reluctance to find a secondment/appointment”*.

4.3.4 Effectiveness of Arrangements

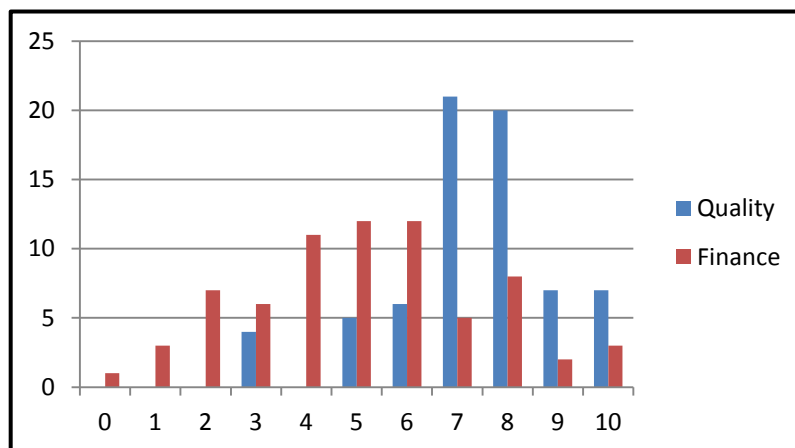
This final section of data reporting reflects on the self-rated effectiveness of medical leadership arrangements. In this section we generally used Likert-type scales to assess perceptions of various aspects of performance and also included space for free text responses.

In looking at the effectiveness of these arrangements it is important to consider that these arrangements have often changed in recent years: 77 % of trusts (54/70) reported having made changes to their structures in the past 3 years. This shift primarily relates to a transition towards service line/business units on gaining foundation trusts status. In a minority of cases, some sites report a transition from Divisions to Directorates, with just a single trust moving to a divisional structure.

4.3.5 Service quality and financial performance

The questionnaire explored respondent perspectives of the degree of accountability doctors felt in terms of service quality and financial performance. Respondents were asked to rate their answer on a Likert scale of 0-10 (where 0 equates to a negative perspective and 10 positive). Figure 29 sets out this data which shows that whilst respondents are positive in general in relation to both factors, the responsibility doctors feel for quality was rated by respondents more highly than finance.

Figure 29. Self-rating of doctor responsibility for quality and finance



All structural types illustrate a wide degree of variation in relation to the self rating aspects of performance as illustrated in Tables 19 and 20.

Table 19. Perceptions of quality in relation to principal organisational structure

Structure Type	Quality		
	Lower Range	Upper Range	Mode
Division (n=26)	3	10	7
Directorate (n=26)	3	10	8
Service Line (N=9)	3	9	7
Other (n=4)	7	8	8
Overall (n=65)	3	10	7

Table 20. Perceptions of finance in relation to principal organisational structure

Structure Type	Finance		
	Lower Range	Upper Range	Mode
Division (n=26)	1	10	4
Directorate (n=26)	1	10	4
Service Line (N=9)	2	7	2
Other (n=4)	4	8	5
Overall (n=65)	1	10	5

In free text responses respondents were clear that doctors see issues of quality and safety as being intimately linked with their roles. For example, one respondent comments that: *"Clinicians largely wedded to the idea of promoting quality"*. Quality and safety were suggested to be *"everyone's responsibility"* and a large number of Trusts reported that they had done a lot of work in recent years to ensure that doctors are involved in service management and design and supervision of other clinicians as a way of enhancing these factors. Finance was described as much less of a central consideration for doctors, although this is becoming increasingly encouraged. As one respondent described:

"Strong responsibility for Quality - placed in job description - Lead for Clinical Governance. Less so for finance but encouraged - this is improving".

Some respondents spoke of a perceived conflict between the agendas of financial accountability and quality; *"Clinicians still struggle to accept responsibility/accountability for finance - feeling of conflict with patient safety/quality but not really justified"*. Others attributed this to clinicians simply not feeling that finance should be an issue that they are concerned with, *"Finance - most believe that's the manager's job"*. Whilst clinicians are happy to take ownership of quality and safety agendas, respondents suggest that they do not feel that they should be responsible for financial issues and this should be the role of others:

"Doctors (are) mostly aware of their influence and accountability for clinical quality, but not all fully aware of their contribution of financial performance including income and expenditure balance and cost savings".

Some respondents suggested that it is not a matter of clinicians not wanting to take responsibility for budgets, but not being allowed to. For example, one respondent told us:

"Only medical managers are interested in finance but most are not allowed to hold budgets by the general managers".

4.3.6 Effectiveness of medical leadership arrangements

Perceptions of the effectiveness of medical leadership arrangements were also tested on a Likert scale (Figure 30) again with space for free text comments. These self reported ratings are generally positive in terms of medical leadership arrangements, albeit within a wide range.

Where respondents were negative about the effectiveness of these types of arrangements they often stressed difficulties in working relationships and clinicians not being "allowed" to lead. The following two quotes exemplify this well:

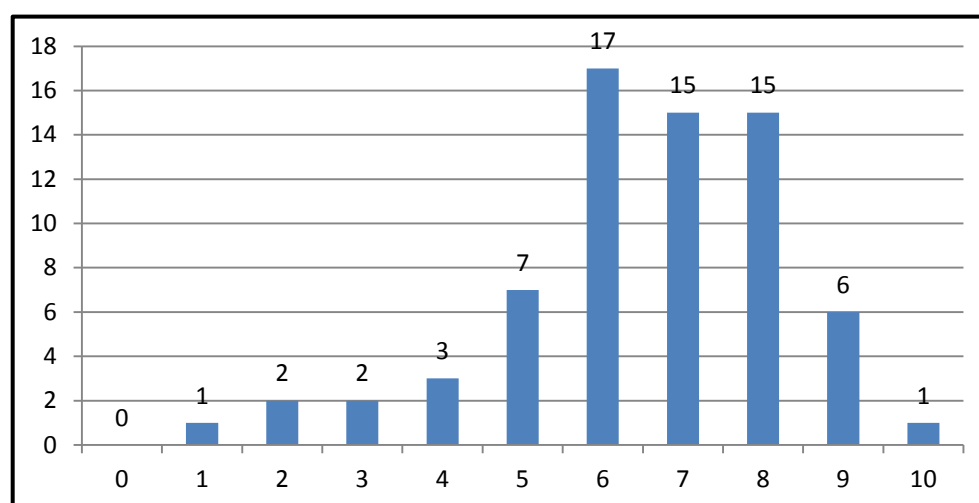
"Managerial engagement at middle management level - business managers and equivalent that have developed a culture of blocking clinicians from doing anything outside of their basic clinical role - a 'no can do' attitude. In my experience, problems with 'clinical engagement' stems from being actively discouraged from engagement in the past, e.g. by being ignored".

"Finding a way to allow capable doctors to actually lead. General managers & other professions find it difficult to accept medical leadership when the medical manager is capable. Good medical leaders tend to be undermined and under developed".

Respondents suggested that the willingness and ability of clinicians to lead is variable. Whilst some clinicians were seen as being willing to engage with some strategic and service issues, they were often portrayed as being unwilling to become involved in some of the more "difficult issues". One respondent outlined that:

"Doctors are often reluctant to 'manage' difficult colleagues even with HR/Gen Manager support. They see their role as being in service development etc but less keen to performance manage their 'immediate' colleagues".

Figure 30. Self-rated responses on how well medical leadership arrangements work



4.3.7 Contribution of medical leadership to Trust performance and patient experience

In terms of the link between medical leadership, Trust performance and patient experience, the responses to this Likert-scaled question are set out in Figure 31. As these demonstrate, responses were far more positive about relationships between medical leadership and trust performance and patient experience than the relationship between medical leadership and quality and finance (as shown in figures 29 and 31).

In free text responses individuals took the opportunity to explain the ways in which the activities of clinical leaders led to improvements in patient experience and trust performance. For example, one respondent explained that:

"Our trust's performance has improved in tandem with better clinical engagement. Our first patient survey in 2006 gave poor(ish) results on some aspects of communication between doctors & patients. This has improved significantly since then".

Whilst another reports that:

"A couple of remarkable improvements demonstrate that recent changes to clinical leadership have had this effect. Firstly, our infection rates have decreased hugely over the last year - a notable change. Secondly, our Healthcare Commission ratings have moved from 'weak' to a position where we have just been registered with no Conditions. Thirdly, our patient surveys demonstrate (most recently) that patients are happy and satisfied with the services we offer. Finally - the recent introduction of a patient recounting his/her story at Trust Board meetings has helped focus attention on areas where we could

do better - and this is already yielding positive results through demonstrable clinical leadership”.

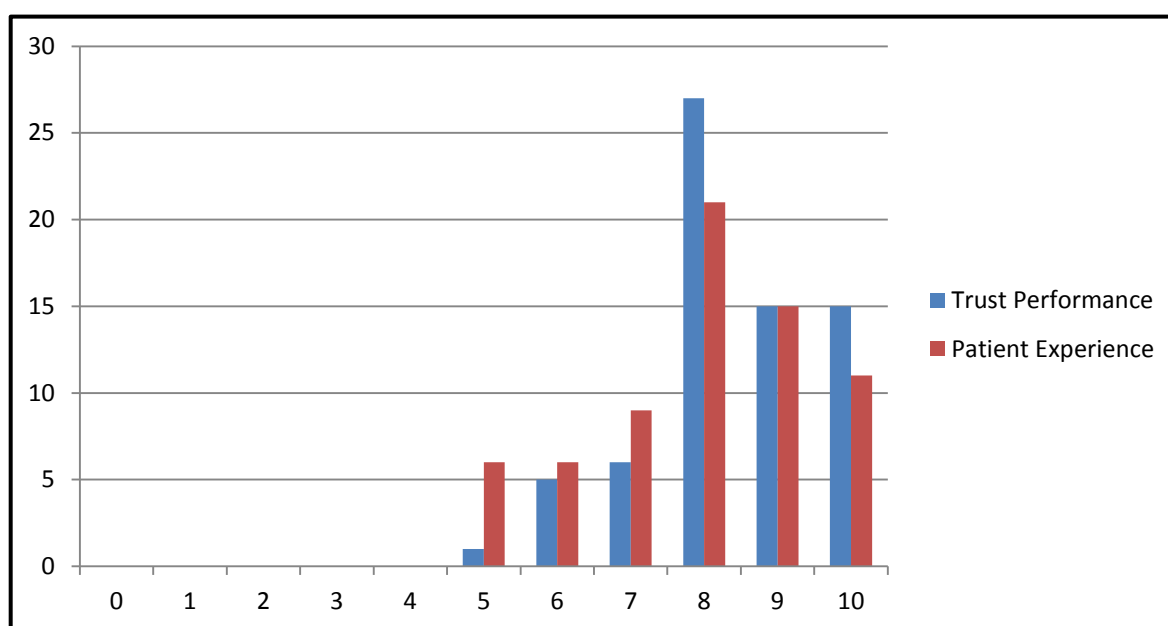
In these examples the respondents clearly attribute changes in performance of their Trust and patient experience to the actions of clinical leaders. However, others were more circumspect suggesting that although clinical leaders are helpful in informing service development, *“patient experience is harder to attribute directly to doctors since to some extent this is still seen as a nurse responsibility”*. In a number of the free text responses there was a more general sense that by just having clinical leaders we might not see improved outcomes occur – the individuals in these roles need to be active in creating the right conditions. For example; *“those directorates with active leaders (medical) have been the most successful ones both financially, performance related and patient safety/quality initiatives”*. Some spoke of the importance of having doctors and managers who recognised the need to work together and both take action to achieve this. As one respondent articulates, if clinical leaders are to have an impact they must have a clear role and this must include responsibility for different facets of that role and they must also want to assume this role and not simply take it on because it is their turn to do so:

“CDs [Clinical Directors] have, in many areas, seen the role as 'buggins turn' rather than a managerial appointment with clear Responsibility for resources and quality. These issues have now been embedded in the CD job description and the role is evolving. We will need clinicians who want to lead their departments rather than assume the role because it is their turn”.

Several respondents alluded to a generational issue in relation to the willingness to engage with leadership roles, suggesting those that are coming through now are more likely to work with different groups and really get to grips with these sorts of leadership roles:

“We have I suspect a generation of managers who worked around rather than with doctors, and a generation of doctors who accepted this. The newer recruits are key to changing the culture, and so helping senior trainees become consultants who enjoy working with all other staff groups, especially managers, is the biggest challenge I think. It will take a few years but is likely to create sustainable medical engagement”.

Figure 31. Self-rated responses to medical leadership and relationship with trust performance and patient experience



Analysing these data by the principal organisational unit shows little variation across the different structural types. Typically those who self reported highly in terms of quality and financial performance also reported highly against trust performance and patient experience.

Table 21. Perceptions of trust performance in relation to principal organisational unit

Principal organisational unit	Trust Performance		
	Lower Range	Upper Range	Mode
Division (n=26)	6	10	8
Directorate (n=26)	6	10	8
Service Line (N=9)	5	9	9
Other (n=4)	8	10	9
Overall (n=65)	5	10	8

Table 22. Perceptions of patient experience in relation to principal organisational unit

Principal organisational unit	Patient Experience		
	Lower Range	Upper Range	Mode
Division (n=26)	5	10	7
Directorate (n=26)	5	10	8
Service Line (N=9)	6	10	8
Other (n=4)	8	10	8
Overall (n=65)	5	10	8

4.4 In summary

In this chapter we have reported and analysed the results of the national questionnaire survey of NHS trusts in England. The picture we have painted is of a wide variety of arrangements for involving doctors in leadership roles encompassing the number of doctors on boards of directors and management boards and involvement in trust committees. There were also variations in how trusts were organised encompassing the use of divisions, directorates and service lines, often in combination.

Most trusts in our survey reported that between 10 and 20% of medical consultants were involved in formal leadership roles and that doctors were usually the responsible officers within these units. Respondents reported that their medical leadership structures were effective and noted that doctors felt a strong responsibility for quality, although less so for finance. The survey also highlighted the challenges facing medical leaders including lack of support from general managers, and variations in the willingness of doctors to deal with difficult issues.

5 Case study thematic analysis

The aim of this chapter is to report and analyse the data gathered in the second phase of the research which focused on nine case studies. The chapter starts by describing how the sites were selected and outlines their main features. The influence of context is then discussed, including the impact of organisational and leadership changes.

The main part of the chapter is based on analysis of the qualitative data collected from interviews in relation to the themes we were investigating. A key focus here is the processes at work in the case study sites. This includes analysing the roles of doctors, nurses and managers and the relationships between them.

We then move on to consider the ways in which triumvirate and duality relationships operate in practice. Following this we discuss the time allocated to leadership roles and the training and development opportunities offered to doctors taking on these roles. The degree to which there is competition for medical leadership roles is then discussed as is the process for appointing medical leaders.

One of the challenges facing doctors who take on leadership roles is their relationship with medical colleagues. We present findings from our research on these challenges including evidence on engagement and followership and the consequences for speed of decision making.

The main points made in the chapter are:

- The context of the case study sites varied in relation to the size of the Trusts, the stability of their organisational structures, the impact of mergers and related organisational changes, the process of becoming Foundation Trusts, and the wider financial context of the NHS.
- Sites varied in relation to whether they were medically led, clinically led, managerially led or had aligned structures in which leadership was shared by doctors and managers.
- Doctors typically held leadership roles at three or four levels within Trusts with the middle or meso levels usually being seen as the most important; doctors also held leadership roles in horizontal structures that cut across directorates and divisions.
- Triumvirates existed on paper in most sites but the duality of medical leader and general manager was perceived to be more important in practice.
- Nurses were seen to be less prominent members of the triumvirate except in mental health/partnership trusts where general managers often came from nursing backgrounds.

- In a number of sites the duality expanded to a wider leadership group encompassing nurse managers, finance and HR colleagues when needed.
- Stability in structures and key personnel were perceived to be helpful in supporting the effective operation of the arrangements that were in place, although in some cases long service of senior staff was reported to have drawbacks.
- Medical directors usually committed at least half of their time to leadership roles and clinical directors committed around 2 PAs (equivalent to 20 per cent of their time) to these roles; in some cases both medical directors and clinical directors reported giving more time to their leadership roles than allowed for in their contracts.
- The need for medical leaders to retain some clinical commitments in order to retain credibility with their colleagues was an important factor influencing the time they spent on leadership roles.
- Medical leaders were usually appointed after a number of years experience as consultants and initially served a term of 2-3 years, often being reappointed for a further term.
- In all sites the training and development of doctors for leadership roles was receiving increasing attention with some Trusts running their own programmes and others accessing programmes run by strategic health authorities, deaneries and others.
- Some of these programmes were for doctors only and others were for staff from different clinical and managerial backgrounds.
- The sites supported doctors to become leaders in other ways including enabling them to deputise for colleagues, take on leadership roles across the Trust, and providing peer support, coaching and mentoring.
- The appointment of medical leaders in many sites was reported as having become more formalised, although competition for leadership roles was often limited and in some cases non-existent.
- The need for medical leaders to have clinical credibility with their colleagues and to think and act corporately were seen to be important attributes.
- An 'engagement gap' between medical leaders and their colleagues was commonly reported, especially in large Trusts and those covering

a wide area; this was not seen to present major challenges and was often described as part of the journey they were on.

- Medical leaders faced many challenges in taking on their roles, both in balancing clinical and leadership commitments, and in engaging followers; the qualities of the individuals in these roles was seen to be critical to how effectively they were performed.
- It was recognised that one of the consequences of involving doctors was to slow down decision making but this was perceived to be a price worth paying in relation to the ownership that was gained as a result.

5.1 Overview of the features of the case study sites

As we suggested in the previous chapter we were not able to easily define a typology of structures for medical engagement given the complexity of the results produced. However, we did identify a range of variation in terms of structural type, trust type, geography, size of trusts and budgets, self-reported ratings of efficacy of medical leadership arrangements and the types of impacts that these have on a wide range of different factors (e.g. quality, finance, patient experience). These criteria were used in selecting case study sites for this phase of the research.

Table 23 outlines the major features of the case study sites. As can be seen from this table, trusts have been selected from different areas of the country and they vary in size from site I having a budget of £131 million and around 2800 staff, to site C which has a budget of £950 million and approximately 13000 staff. Two of the sites report a directorate structure (A and E), three a divisional structure (B, F and G), two service line arrangements (H and I) and two report making use of all of these structural forms (C and D).

In this table, the principal organisational unit refers to the main type of structure employed at this trust (directorate/division/service line or a mixture of these). Regardless of the terminology used or the size of the trust, there are similar numbers of principal organisational units across the case studies with seven of the nine sites having four or five units. Only two sites (B with 36 and E with 12) are outliers.

Where service line was being used in trusts, this was reported as being mapped onto existing structures rather than being cause for redefining operational units around new service lines. Within our sample there was nervousness about moving quickly towards service line management even where medical leadership was reported to be well developed. This was because of concern that greater devolution to service lines might entail a reduction in the ability to manage across the trust as a whole.

Where service line reporting was in place, information developed through this approach was being used more at the corporate level than in

directorates and divisions. Our interviews revealed a tension between the view that service line reporting and management is a powerful way to engage doctors and other clinicians in leadership and management, and the argument that medical leadership needs to be well developed before decision making is fully devolved to service lines.

Table 23. Overview of key features of case study sites

Case Study	Trust Type	Foundation Trust or non-Foundation Trust	SHA Region	Total Budget (£ million)	Total Number of staff (total head count, not FTE)	Number of Medical consultants	Number of doctors on Trust Board of Directors	Number of doctors on Trust's Management Board	Principal Organisational Structure	Number of principal organisational units
A	Acute	FT	South West	193	3300	140	1	5	Directorate	5 Directorates
B	Acute	FT	North East	450	6582	358	1	12	Division	36 Directorates
C	Acute	Non-FT	Yorkshire and Humber	950	13000	714	1	1	All	5 Divisions
D	Acute	Non-FT	South Coast	507	8743	504	2	8	All	5 Divisions
E	Acute	FT	Yorkshire and Humber	178	4300	223	1	14	Directorate	12 Directorates
F	Specialist	Non-FT	London	323	3594	249	3	6	Division	5 Divisions
G	Mental Health	FT	East of England	150	2000	70	2	5	Division	5 Divisions
H	Mental Health	Non-FT	West Midlands	140	3200	64	3	5	Service Line	5 Directorates
I	Mental Health	FT	North West	131.5	2808	86	2	5	Service Line	4 Service Units

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5.1.1 Context of Case Studies

Having outlined the main features of the case study sites and the types of structures adopted, in this section we focus on how the contexts of the nine NHS trusts included in the research varied. We also discuss the impact of different contexts on the medical leadership structures that were adopted.

As outlined in Table 23, there is wide variation in the size of the case study sites. Large trusts reported that they faced a challenge in developing and maintaining effective relationships between leaders at a corporate level and those in divisions and directorates. This was most apparent in site C with a budget of £950 million and around 13,000 staff and was expressed in relation to the difficulties for those in front-line operational roles to feed back to the senior management and for the board to be visible within the organisation.

Size was also an issue for two of the mental health trusts in our sample, sites G and H, which covered large geographical areas and operated across a number of sites. This posed difficulties as it meant that a limited number of formalised leadership roles were spread across a large area. In practice, it was reported to be difficult for board members to have a visibility and presence throughout the organisation.

Size was not seen as so much of an issue at site I (also a mental health trust) as the directorates were described as operating in much more of a self-contained manner. In this trust, directorates tended to have a stronger relationship with commissioners and wider partners than they did with other directorates in the organisation. Accordingly, relationships with executive directors were seen as less salient than in some of our other sites.

The degree of stability in structures was cited as a factor having an impact on the operation of medical leadership. Whilst some sites had well established structures and relationships (e.g. sites A, E and B), others had either relatively new structures or had gone through significant changes in recent years that impacted on the arrangements in place (e.g. H, I and G). Yet others anticipated that there would be changes in the near future.

Stable structures were seen as very valuable in those sites where they existed as they were described as allowing professionals to form relationships with one another and to develop effective clinical and medical engagement. As one interviewee explained:

"this structure has been in place since 1991, so we've been doing clinicians in leadership and having serious discussions about medical and clinical participation in leadership for over 20 years now"
(Director, Site B).

Acute trusts tended to have the benefit of being more stable than mental health trusts as in our sample as the latter were more likely to have been

formed through mergers. Where acute sites had changed their medical leadership structures, it had often been to move to larger divisional (or directorate) structures as a way of maximising the talent available in medical leadership roles (e.g. site D) rather than resulting primarily from mergers.

Where structures were relatively recently established, the experience of the trust was often described as being on somewhat of a "journey".

Respondents were unable to articulate entirely what the end point would look like but recognised that they were not yet at the final point of this process:

"Ultimately at some point we want to be as multi-disciplinary, single line management as we possibly can be and we're on a journey there, but quite where we'll end up we still haven't fully articulated yet"
(Director, Site H).

Another contextual factor was a change in top leadership. In three of the sites, structures had undergone significant reorganisation following the appointment of a new chief executive. In another site an interim chief executive was in place. Board members here indicated that they expected the appointment of a substantive chief executive would bring with it some alteration to the existing structure.

In other sites the impact of the Transforming Community Services (TCS) programme, which concluded part way into our period of qualitative data collection, were being felt. The importance of TCS for the structures of some of the trusts involved in our research was that they were acquiring aspects of community services provision which had formerly fallen under the remit of their local PCT. Sites A, E and H had all been through this process and were involved in discussions regarding how they would incorporate these new services into existing structures. Those organisations acquiring community services tended to manage these (in the first instance at least) through an addition to the existing structure, for example through the creation of a new directorate.

Far greater challenges were anticipated where acute hospitals merged, especially where this entailed bringing together hospitals on different sites. These challenges were shown in one of the case studies (site E) by a Foundation Trust planning to merge with an NHS Trust in what was effectively a takeover. The medical director of this site explained:

"The big challenge for the structure is how we relate to [the other hospital] and community services. We have always functioned as a single site before. We haven't finished the full process.... the language is around acquisition rather than merger. To begin with the language was probably a little bit softer, but now the clarity is helpful for clinicians at [both sites] as it removes ambiguity. On the whole clinicians at [the other site] were happy with 'acquisition' language, because they recognised that the alternatives were unpalatable, and

the hospital was in an untenable position. We have a number of clinical engagement meetings where there have been a number of reservations from both sides, but the engagement has been very good”.

In some cases changes to structures had been prompted by external factors. The most prominent of these factors was that of the wider financial context of the NHS. The constrained budgets that many NHS organisations are presently experiencing were keenly felt by many of the sites and in some cases had prompted a reduction in the number of principal organisational units in a bid to become more efficient, or to reduce the dedicated management support available through ‘sharing’ of some posts.

This same financial climate was reported as having a positive impact on the engagement of doctors in other sites. The need to save money was leading to processes of service redesign which were described as requiring medical leadership. For example at site E, a Clinical Director whose Directorate had to save 20% over three years was taking responsibility for considering reducing the bed complement by a quarter:

“.. [the financial position] makes me think a lot about what we can do differently to stop people coming into those beds or getting people out of the beds quicker so we don’t need so many beds, and that’s some of the work we are developing as a department to try and do that.”

Sites A, G and I were all conscious of the growing importance of general practitioners as commissioners of services and felt that the medical leadership they had in place had been helpful in facilitating discussions with GPs. Site I was particularly focused on this issue and saw the role of the clinical director as being important in terms of leadership not just within the trust but beyond. The clinical director was described as crucial in establishing the clinical credibility of the trust with GPs and also other partners such as schools and social services.

Similarly at site E a clinical director was acting as an arbitrator between the local PCT which had introduced restrictions on the provision of some services. There was some concern that a ‘management view’ might be strong in the PCT and the role of the clinical director was seen:

“To represent clinical views, see both sides, and bring both sides [Consultants and commissioners] together”.

This example points to the role of medical leaders outside their organisations as well as within.

The final contextual factor of relevance to our study is the process of becoming a Foundation Trust. Four of the sites involved in the research are FTs, one became an FT during the research process and four are in the process of formulating bids to become FTs. Those who were applying for FT status had in some case made changes to their structures in order to

meet the requirements of Monitor (the regulator of NHS Foundation Trusts). The expectation that all trusts should become FTs by 2014 means that further changes in structures are likely in order to satisfy the regulator and demonstrate that the organisations concerned have effective medical leadership in place.

5.1.2 Structures as medically or managerially-led

One of the issues that we spent time exploring was how structures were perceived to operate in practice and specifically whether they were felt to be medically or managerially led. Most often the conclusions about the nature of the trusts were reached by interviewees on the basis of where formal accountabilities lie within structures. So, for example, if the doctor holds the formal accountability within the principal organisational unit then it was seen as being a medically-led structure. However, this relationship between formal accountability and the description of the Trust does not necessarily hold in all cases, as we discuss further below in the section on triumvirate arrangements.

Five of the sites described themselves as being strongly medically-led (A, B, D, E, and F). Another (G) felt similarly strongly about being led by health professionals, describing itself as clinically-led. This reflected the nature of the professional make up of the Trust. Only one site described itself as a managerially-led organisation (C) and two were described as having an aligned structure in which leadership was shared by doctors and managers (H and I).

Table 24 sets out the variety of names that are given to the formalised roles that doctors play within the structures of the trusts and also an indication of who is the responsible individual within principal organisational units. As this table illustrates, although the size of trusts ranges significantly within our sample, there is less variation in the number of levels that doctors hold roles at. Regardless of the size of the Trust, there tend to be either three or sometimes four 'formal layers' where doctors hold leadership roles.

In investigating how structures worked in practice, we found that most trusts identified the middle or meso-layer of the organisation as being the most important in terms of medical leadership, with the top layer representing the formal executive and the lower level being the specialty level. However, this was not the case across all trusts with site B describing its clinical directorates as the key operational units, with the divisions seen as "*a creature of the organisation's convenience*" as one director explained. The point to emphasise here is the variability in how structures work in practice notwithstanding apparent similarities in structures across the sites.

Table 24. Formalised structural roles that doctors hold and responsible officers within principals organisational units

Case Study	Number of levels doctors hold formalised structural roles and roles	Responsible officer within principal organisational unit
A	3 – Medical Director, Associate Medical Director, Specialty Leads	Associate Medical Director
B	4 – Medical Director, Chief of Service (Division level), Clinical director, Lead clinicians	Clinical Director
C	4 – Medical Director and Deputy Medical Directors, Divisional Medical Managers, Clinical Directors, Lead Clinicians.	General Manager
D	4- Medical Director, Clinical Director, Director of Education and Director of Research	Divisional Clinical Director
E	3 – Medical Director, Clinical Director, Lead Clinicians	Clinical Director
F	3 – Medical director, Divisional Director, Specialty Leads	Divisional director
G	3- Medical Director, Clinical Director, Associate Clinical Director	Clinical Director
H	3 - Medical Director, Associate Medical Director, Medical Leads.	General Manager
I	3 – Medical Director, Clinical Directors (at 2 different levels)	'Jointly and Severally'

Those trusts that described themselves as medically, or clinically, led stated that this had been a deliberate decision on the basis that medical leadership is a “key to success” (respondent, B). Site A was keen to be clear that it is explicitly medically-led on the basis that this should help fully engage doctors in decision-making processes and not have doctors in leadership roles simply as representatives. As a director at site A stated:

“the AMDs [Associate Medical Directors] are not some figureheads we wheel out when we need a doctor. They are genuinely the managers of that directorate and the general managers are junior to them. We could have made them equal, or we could have –like some hospitals do – the general managers in charge and the doctors feeding in sideways. We were quite clear that we wanted the most senior person in the directorate to be a doctor”.

Site G described itself as clinically-led:

"We made the conscious decision that in order to get effective clinical engagement we needed to have a clinically-led organisation in particular devolving authority and decision-making down to the front line".

That this site was described as clinically-led rather than medically-led was explained as being due to it being a mental health trust and therefore having fewer doctors and more clinical professionals such as clinical psychologists.

Site F was also described as having a medically-led structure. This is the only specialist trust in our case study sample and many of the sub-specialties provide services on a national basis. Although doctors at the divisional level had a full range of responsibilities, medical leaders at the specialty level had a much clearer clinical orientation, with variable interest and engagement on issues which may have been regarded as 'managerial'.

Two of the trusts (H and I) described themselves as having an aligned structure where managers and doctors worked together in partnership. Both of these are mental health trusts. Although the formal accountability in site H resides with the general managers, the structure was reported as being an attempt to:

"Match the medical structure with the operational management structure".

As one director explained:

"We did this to make sure that we had a doctor who was the contact point for the operational managers. So the AMDs match directly to the operational manager and then below them as far as possible we've tried to match in with whatever structures they've got. We did this to try and get doctors involved in decisions about their services and to make sure that any particular operational manager knew who to talk to and don't have to ask several".

In trust I accountability was held 'jointly and severally' at the operational units, between the general managers and the clinical directors.

Outside of the main 'vertical' medical leadership structures, many of the sites also had a series of 'horizontal' structures which were medically or clinically-led and which developed strategy for clinical issues, for example cancer services or planned care, or addressed specific issues such as updating mortality reporting. These horizontal structures cut across the vertical clinical directorate structure in an attempt to give some consistency in terms of strategic and operational issues. They were also seen as vehicles for including a wider range of clinical representation.

As an example, site E included doctors who were not clinical directors in these arrangements as a way of maintaining the interest and expertise of former clinical directors and to provide opportunities and experience for doctors who might be interested in a more formal role in the future.

Although it was recognised that these horizontal structures complicated management arrangements, they reflected the complexity of managing NHS organisations and the importance of focusing on issues that cut across directorates, divisions and service lines. As a director commented on these arrangements:

"There is no confusion about specific accountability for delivery and the wider participation around strategic direction, it's difficult to write down formally, but it seems like it works. It gives us different ways of engaging with the wider body of consultants".

In Site B, a group of unpaid Associate Medical Directors, working to the Medical Director, took on a range of projects. The group includes Consultants who may wish to become Clinical Directors, as well as former Clinical Directors, and individually they led on specific projects. The Medical Director explained:

"I have met them individually to discuss how [the project] should be done, and then I have largely left them alone to do it, reporting back from time to time. We meet regularly as a group and informally as well, and we discuss where we are, the barriers and challenges and what is going well."

5.1.3 The operation of triumvirates and dualities

As we outlined in the literature review, healthcare organisations are often characterised as operating triumvirates where a doctor will come together with a manager and a senior nurse to lead clinical directorates and divisions in different service areas. Although most trusts in our sample had a lead doctor, lead nurse and a general manager in place in their principal organisational units, often interviewees did not recognise the term 'triumvirate'. Where they did recognise this concept they would report that although it may exist on paper in practice it did not operate as such. What we more often found was that there is a 'duality' of the doctor and manager in place to the exclusion of nursing partners who on the whole are perceived as more junior.

What this meant was that the effectiveness or otherwise of medical leadership structures was critically dependent on how the duality functioned. As a Director at site G described:

"The structure completely relies on the clinical director and general manager relationship working well. If we got a pairing who couldn't work together then this would be unworkable. All our pairings work, although some work much better than others. Where it works well the individuals have worked out which are their roles and responsibilities".

The mental health trusts in the sample (sites G, H and I) often reported that they do not operate a triumvirate as "mental health trusts are

different" (Director, H). The rationale offered for this is that in mental health trusts there are a broader range of professionals present in these organisations (AHPs, psychologists, social workers etc) who might feel that they have an equal right to have a voice in terms of how services are led and provided. Some suggested that it was therefore easier to limit the crucial relationship to the lead clinician and the manager. Although this would exclude others from this relationship, it was a way of not valuing nurses above other relevant professionals.

Many of the managers that we interviewed in mental health trusts had nursing backgrounds but told us that in order to progress further they were required to go into management roles. Therefore, although nurses may not be formally involved in a triumvirate, a nursing perspective is fed in through general managers. This was not always perceived positively by other nurses within these units who felt that managers were sometimes overstepping the parameters of their roles.

Outside of the mental health trusts, the duality of medical leader and general manager was described as really driving the organisation. Although notionally triumvirates are present, the degree to which they operate as such in practice was less certain. In one case this is because there are actually two matrons at the directorate level which means there are two lead nurses rather than one (site C). Site C also has designated finance and HR at the divisional level which effectively widens the leadership team to at least five individuals.

The one exception to this is site D which operates a triumvirate throughout each of its care groups where a doctor, a nurse (or equivalent allied health role) and a business manager meet regularly to discuss operational and strategic issues. Where difficulties are encountered they are brought to the next meeting of the triumvirate (usually weekly in this trust). This was seen by those involved as an effective way of working, although the downside is that this process can sometimes cause delays in resolving issues.

The leadership 'duality' was usually described as a partnership. Even where the formal accountability of the general manager to the clinical director was clear, the partnership was widely seen as being crucial to the effective operation of the units concerned. A deputy director at site B explained:

"The relationship between Chief of Service and Divisional Manager is key, and the Divisional Manager gives a lot of managerial support to the Chief. Formally the Chief of Service is the boss, but sometimes it is the other way round. In terms of who does what within the duality there was a common distinction that general managers would lead on the practicalities of whatever issue they were facing whilst for clinical directors their role related to coordinating with the medical workforce and 'selling' messages to them."

Clinical directors occasionally expressed some frustration at the processes of management when introducing or suggesting change, and whether the

leadership role should be mainly directed at doctors or at all staff. For example at site E a clinical director said:

"I'm not sure whether I should lead all the staff directly, or through the management hierarchy. There is a lack of a structure when you want something, but when you want to make changes a structure gets in your way. It [a specific proposed change] could happen in a single e-mail, but there are barriers to change".

We previously noted that changes in senior management (particularly chief executive level) might lead to associated structural change. The executive directors at two sites (B and E) had been in post for some time and this was seen as crucial in developing relationships with senior clinical leaders which was perceived to lead to effective medical engagement. However, stability and long service among executive directors was not always viewed as positive.

The chief executive at site E acknowledged that although:

"The longevity of senior leadership is a key feature in best practice sites. I recognise though that longevity can become a constraint in different ways".

By this he meant a tendency to manage through personal relationships rather than through clear structures and accountabilities. In the same trust there was also a suggestion by a clinical director that longevity was over-valued in some management positions, in that promotions were influenced by how long someone had been at the Trust.

At the operational level the importance of the 'duality' was also emphasised in patterns of communication between the general manager and the clinical director. Regular, relatively informal communications were widely reported, usually face to face, and these were facilitated through offices being located close to each other. Where offices were not co-located, regular communication through e-mail and telephone was reported.

Meetings between general managers and clinical directors, with the exception of appraisal meetings, were not regarded as 'formal'. Often the formal management team involved a range of colleagues outside the duality or triumvirate in the operational meeting, including clinical leads, senior nurses, and managers responsible for specific functions or services. Although clinical directors acknowledged their role as leader of the whole directorate, there was an emphasis on them managing the medical workforce, and contributing to the development of strategy.

In thinking about the role of doctors in the leadership and management of the principal organisational units a distinction between management and leadership was often raised. One director (site B) said of clinical leaders:

"They are not managers. They are clinical leaders. I don't expect them to go to a 50 page budget report and show the overspending on sutures. I expect them to be conceptually thinking about the future and making sure the present is appropriately managed, with a team. I am expecting leadership skills not management skills".

Having made this point, clinical directors had different styles and some had a greater interest in getting involved with tasks like detailed budget management that might be traditionally considered more managerial.

At site F, for example, a general manager commented in the context of considering how the detailed accountability worked with a clinical director with a 'hands-on' style:

"Partly it is what you feel responsible for. My clinical director has a good grasp of detail and is involved in operational detail. I think that's quite unusual. I'm not sure whether him being on top of the detail helps or hinders. It might make me feel less responsible for things I should be responsible for".

This suggests that whatever structure is adopted, individual responsibilities are negotiated, explicitly or implicitly, within the working of the partnership between clinical directors and general managers.

The extent to which this partnership extends to nurse managers, in a line management relationship with general managers, was more variable. Nurse managers reported a strong line of accountability to the director of nursing, which was formal in the sense of professional accountability, but extended to operational and strategic matters which cannot easily be separated from professional issues. General managers in the main had a strong relationship with an executive director (director of operations or equivalent) which was regularly described as 'informal'.

In most cases this relationship was seen as positive and clear, and supporting the relationship between the general manager and the clinical director rather than undermining it. In one case however, a general manager felt that this informal relationship introduced a lack of clarity, particularly around priorities. The relationship and interaction between the general manager and the nurse manager often took place separately to the relationship between the general manager and clinical director, or alternatively within the context of a wider operational management team, which included a range of other managers.

This suggests a downgrading of the nursing role from the idea of a triumvirate, which seems to be mitigated by three factors: the existence of good relationships between medical leaders, nurse managers and general managers, the strong professional line of accountability to executive nurse positions, and general managers often being nurses by background. The clinical background of general managers in acute trusts was considered more important in establishing credibility in discussing issues with clinicians than in managing the nursing workforce. It was also argued that this

accountability enabled nurse managers to see themselves as being part of a profession, led professionally across the organisation, rather than being dominated by medicine or management.

There was a further partnership which also appeared to be important in terms of the operation of medical leadership across the trusts and this was the relationship between clinical directors (or associated positions) and the board. Even where there was a strong view that an organisation was devolved and medically led, there was recognition that in some instances individual clinical directors might need support in the certain circumstances. In trust B this support was seen by the board as either accepting that some things might not be possible or that board level intervention might be necessary.

As one director explained:

"When your clinical leaders are struggling with something, you need to think how you enable them to get there. Or if they don't get there entirely, what you are prepared to put up with.What I say to clinical leaders is that occasionally they have to step back and let me go in and call the tune because it is not acceptable for them to say difficult things to their colleagues. It doesn't happen very often. But this is a reality".

Operational accountability through doctors is therefore not always absolute even where the trust is medically-led and it is recognised that there needs to be appropriate support from a range of different sources in order that it might be successful.

5.1.4 Time commitment of medical leaders

Doctors in management and leadership positions within the Trusts are all allocated programme activities (PAs) to support their roles. In some cases 'responsibility payments' are paid as an alternative where doctors are given additional money for the role rather than time within their job plan. As Table 25 illustrates there is some variation in the amount of time that is allotted to these roles.

What this table illustrates is that Medical Directors typically have somewhere in the region of half to the whole of their programme activities dedicated to their leadership role, whereas at the clinical director level (or equivalent) this reduces to approximately 2 with specialty leads receiving 1 PA if anything at all. In some trusts there is some flexibility in relation to programme activities at the clinical director level depending on the size and the scope of the trust, but typically the allocation to this level is relatively marginal.

Table 25. Time doctors dedicate to leadership roles

Case Study	Programme Activities dedicated to leadership roles
A	Medical Director 8 Associate Medical Director 2 Specialty Leads 1
B	Medical Director 12 Chief of Service 2 Clinical Director 1
C	Medical Director 10 and Deputy Medical Directors 8 Divisional Medical Managers 5 Clinical Directors 1 (and 1 local discretion) Lead Clinicians 0.5
D	Medical Director 8 Lead Clinician 1 to 2 Divisional Clinical Directors 4 P
E	Medical Director 8 Clinical Director 2
F	Medical director 12 (6 each for 2 posts). Clinical Unit Chair – 2 (responsibility payment) Specialty Leads – 1
G	Medical Director 6 Clinical Director 2-4 depending on size and scale of division Associate Clinical Director 1
H	Medical Director 7 Associate Medical Director 2 Medical Leads 1
I	Medical Directors 10 (5 each for 2 posts) Clinical Directors – 2 (responsibility payment)

Across all sites there was a strong sense that medical leadership roles are challenging and tend to take a good deal of time to do well. Many of those in these roles suggested that it is difficult to be precise about how much commitment these roles take in practice as it is not easy to separate this out from other responsibilities because many management and leadership activities take place “in the margins” of the job. As one doctor described:

“The role spills into everything else – my clinical work and my home life” (site A).

We interviewed more than one doctor who had formerly had a medical leadership role but had resigned as it overshadowed his clinical role. Where additional PAs were given for a clinical leadership role, often these were added to a job plan rather than substituting for other activities, particularly clinical activities. As an example, a 10 PA job (the standard full-time contract) might become a 12 PA job plan, which clearly suggests that leadership roles are undertaken in addition to a full workload.

Often medical leaders talked about structuring their roles so that they could “borrow” from other activities and thereby supplement their allocation for leadership roles. Consultant job plans now include Supporting Programme

Activities (SPAs) which allocate time for activities which are not directly related to patient activity, but are necessary to support it. This might include professional development, research, audit, quality improvement, etc. In many sites there was an expectation that leadership roles, particularly at 'lower' levels, such as specialty leads, would be undertaken in these SPA sessions.

How much time is allocated to these posts was described as being a decision that goes beyond simply determining how much time such a role might involve. For example, some of the Board of Directors at Site G were clear that they believed that if the leadership element of a doctor's role goes beyond six PAs a week then there is a risk that they will lose clinical contact and clinical credibility in the eyes of their colleagues. If this is the case then simply allocating more time to these roles might not be helpful. In this case the answer then lies in how these medical leaders are supported and the relationships they have with their clinical and managerial colleagues so that they are able to delegate aspects of their roles to others.

Even where time allocations are made to medical leaders, particularly at the lower levels (e.g. specialty leads, lead clinicians), doctors reported not always being able to give up part of their clinical duties or caseloads to make the time to do these roles. In terms of why doctors cannot give up aspects of their clinical duties to make time for these roles, sometimes this was described as doctors simply not wanting to give up these duties. However, in others where there are small teams or very specialist areas of clinical practice doctors reported being unable to give up aspects of their duties even where they did want to. In some cases a 'responsibility payment' was given to a clinical director role rather than allocated PAs, and although clinical directors were encouraged to reduce their hours there was a marked reluctance to do so.

A further aspect to the commitment to these roles is the length of time that doctors take on medical leadership roles for. Often these sorts of roles are time limited in the sense that they are appointed for 2-3 years with the opportunity of carrying on in that term if the doctor and senior management are happy with this arrangement and its performance. A Director at site I illustrated this suggesting,

"The intention is that people take on the roles only as long as they want to and as long as they are being effective".

Some sites suggested that if you are new to a leadership role then there is often a significant learning curve that doctors have to take on. As such, if appointments are only made for 2-3 years then just as the doctor has settled into the role it might be time to recruit a new person. If these sorts of short term appointments are the norm then what also might happen is that doctors are unwilling to challenge the behaviour of their colleagues in a significant way as they fear they may "burn bridges" which could cause difficulties when they step down from the role:

"People aren't really encouraged to challenge behaviours because they are going to be working with people for a long time and this person might become their manager" (Manager, Site C).

5.1.5 Training and development for medical leaders

Training and development of medical leaders was an important issue for the sites, with all recognising that effective training and development is essential if they are to have able medical leaders in place. All of the trusts were taking steps in terms of talent management and succession planning to ensure that they had strong medical leaders now and in the future. Training and development of medical leaders was seen as a critical part of moving away from *"amateur clinical leads"* to more professionalised medical leaders. As a director at site A explained:

"We will get more out of it if people really engage with these roles".

In terms of formal leadership programmes, five of the sites (A, B, C, E and I) reported that they had established programmes within their trusts specifically for doctors in leadership roles. Typically these had been run either in conjunction with a local university or a management consultancy. A number of trusts (B, E, and F) had development programmes for all consultants, with a view to engaging a wider consultant body. These trusts tended to have a longer history of clinical engagement, so that clinical leaders had emerged from a workforce already relatively highly engaged, rather than needing to be trained for a managerial role.

Others did not have specific internal programmes but offered doctors places on training and development programmes through relationships with their Strategic Health Authorities (SHA) or Deaneries (Sites D, G and H). There was some variation within these programmes as to whether they were specifically provided for doctors taking on leadership roles or more general leadership programmes open usually to more senior management tiers. Site D had developed its own leadership academy where it offered training in improvement methodologies.

One of the sites (A) felt that medical leaders cannot be developed on their own and that it is important that they take part in learning processes along with other managers and leaders. Site H was in the process of commissioning a leadership development programme which will be structured around their triumvirate arrangements in order to improve teamwork. As one Director told us:

"Working on medical leadership by itself I don't think is the best way to develop leadership. I think what we need to do is think about collective leadership and how we work together better across our organisation to deliver more effective care. Just focusing on medical leadership perpetuates these silos".

Similarly at other sites it was reported that more "joined-up" training would be helpful to professionals better understanding each other and their roles.

In some cases, particularly where sites had accessed SHA training programmes and doctors had trained alongside other professionals, this was seen as being a helpful by-product of the process. In addition to these more programme-based development opportunities all of the sites had a variety of local programmes relating to various aspects of leadership and management roles which are accessed as required as part of an individual's development programme.

At the more informal end of the scale many of the Trust reported how they used opportunities of deputising for existing medical leaders at meetings or through projects to give doctors experience of these roles so that they fully understand what these entail and the skills that are required to effectively undertake these. As well as deputising opportunities, trusts identified a number of roles as important for development of future clinical leaders. These roles might include safety or service improvement leads, specialty leads, representation on committees, some of which like a drugs and therapeutic committee were clinically and managerially significant but may be difficult to recruit to.

Many trusts highlighted the importance of informal peer support and coaching and mentoring. At Trust I the cohort of medical leaders who had undertaken a development programme some years previously maintained a close peer support network. Development support from general managers, even where they were in a formal line manager relationship with the clinical director, was also acknowledged as helpful. This underlines the importance of relationships particularly between the clinical director and general manager.

5.1.6 Competition for medical leadership roles

As part of the process of moving from "amateur" status of doctors in leadership roles, all of the sites had recently gone through a process whereby if they did not have a formalised process for the appointment of medical leaders previously they had implemented one. These more formalised processes typically involved an advert going out to all doctors along with a job description and interested doctors are then invited to apply for these roles. Those considered suitable are interviewed by members of the executive team and in one case a service user (Site I) before selecting the individual who will take on this role.

Site D reported having assessment centres for medical leadership roles based on the Medical Leadership Competency Framework. This process is suggested to stand in contrast to previous approaches whereby medical leaders would "emerge" from the consultant body as the "natural" people to take on this role. This was seen as problematic as it did not engender competition for medical leadership roles and therefore either these might go to the same 'usual suspects' or emerge through an opaque process. The sorts of names that might emerge through this process could come with varying levels of personal enthusiasm and competence.

Formalisation of the appointment process in most of the trusts had not in practice generated huge competition for medical leadership roles. As one Director described, doctors are not necessarily *"queuing up for these roles"*. For the most part trusts were trying hard to make sure that they did manage to generate more competition in future and they were being *"ruthless in getting the right people"* (Director, Site D). However, some of the directors at site A, for example, were less concerned about a fiercely competitive process and suggested that their lack of contest could be due to the fact that their talent management processes are so effective rather than doctors not being interested in these roles.

At site C similarly medical leadership positions are often uncontested at the clinical director level. The consultants in directorates often came together and decided which of their colleagues they would like to be put forward for these roles and then once agreed this individual would apply for the role. This meant that although a formalised structure was in place in theory, in practice the consultants in that service area appointed the individual. The doctors concerned were reported to be happy about this as they believed it was a helpful way of determining the most appropriate person for the job. A counter view was that this kind of informality could be perceived as an "old boys" network that sought to exclude the views of the rest of the team.

In some trusts where there was either little contest for posts or no willing applicant for them, doctors from different specialty areas were appointed to these roles. This typically only happened at associate medical director or clinical director level (i.e. one management level below the medical director) and those in the lower levels of medical leadership roles were seen to require the specialist knowledge of that clinical area. This was seen as unproblematic because at this level what was being sought in these individuals was their leadership and management skills, rather than necessarily their specialist knowledge of this particular clinical area. Arrangements of this kind were reported to be a helpful way to allow medical leaders to be more objective in their leadership as they would not be swayed by their interest in that specialty. They were also seen as a way of allowing medical leaders to challenge behaviours without worrying that they would damage relations with their colleagues and this is particularly helpful in those areas that are more challenged.

Alongside these formalised processes there are various informal processes of talent spotting whereby individuals who are seen to be suitable for medical leadership roles are noted and are allocated project based activities so that they can try out these kinds of roles. Site C in particular reported doing a lot of work with newly appointed consultants who meet on an individual basis with the chair, chief executive and the medical director. As the medical director described to us:

"Getting to younger consultants is really important, they've got another 25-30 years here so we need to get them engaged now".

In terms of what trusts are looking for in terms of medical leaders, rather unsurprisingly clinical credibility was seen as an important factor. Typically this might mean that candidates for medical leadership roles would need 5-10 years experience in a consultant role before they were seen as having sufficient "clout" with their colleagues so that they could be successful in these roles. For those applying for clinical director or associate medical director type roles there was normally an expectation that an individual had undertaken some sort of clinical lead work or other project-based work in the trust before which would have given them experience of management and leadership.

Aside from clinical credibility another major factor across all of the trusts is an ability to think and act in a "corporate manner", beyond the doctor's immediate specialty area. As one director explained:

"The doctor traditionally represented the consultants at management and that has changed now. It is now representing a clinical position in the tough choices that need to be made. And then if tough decisions need to be made then explaining that to your colleagues. It's not a trade union representative on the board and most people get that" (site A).

This was echoed by a Director at site H who commented that:

"We don't want people whose primary aim is to be the doctors' advocate. We want people whose primary aim is to improve the quality of the service and understand that that might mean they have to say or do things their colleagues might not like".

Beyond these factors, interviewees found it difficult to identify what it was precisely that they looked for in medical leaders. For many they "*knew it when they saw it*" but couldn't quite articulate what the important factors are. Many suggested that they are quite similar to those sorts of characteristics that make good leaders in a more general sense, so things like the ability to communicate well at a number of levels, being engaging, having the ability to think strategically and being able to make decisions.

These leadership qualities are quite different from management competencies though, as an interviewee at site B noted:

"They [chiefs of service and clinical director] are not managers. They are clinical leaders. I don't expect them to go to a 50 page budget report and show the overspending on sutures. I expect them to be conceptually thinking about the future and making sure the present is appropriately managed with a team. I am expecting leadership skills, not management skills".

5.1.7 Medical leaders and their followers

As indicated in the previous section, one of the important factors that is looked for in medical leaders is that they can think in a corporate manner and not just act as a *“trade union representative”*.

In many of the sites there was a distinction made in levels of engagement in terms of those doctors that are in formal medical leadership roles and the “rank and file” consultant body who are seen as less engaged in the business of the trust as a whole. Those in medical leadership roles at a range of levels made sure that they attended regular trust update meetings but the wider consultant body were less engaged and are often less positive about change or initiatives within their trusts. This was described in interviews as something of an “engagement gap”.

The engagement gap was compounded in the larger trusts where size or geographical area covered could increase the distance between leaders and followers. One trust reported much less of this type of gap (site E) because of the range of different opportunities there were for consultants to lead in other types of roles within the trust’s ‘horizontal’ structure and through specific project roles. In another trust (site B) there were reported to be many opportunities for consultants to meet and discuss issues within the directorate, and these meetings were said to be typically well attended and lively. Bridging the “engagement gap” through medical leaders was seen as a more effective strategy than direct engagement with general managers. As we discuss in the next chapter, sites B and E have particularly high levels of medical engagement as measured by the Medical Engagement Scale.

Even trusts which believed that they had high engagement of consultant staff acknowledged that there was a group of consultants that were not engaged in the corporate affairs of the trust, perhaps because they had interests in teaching or research, or in professional bodies. What seemed to be important was that the trust maintained opportunities for engagement, so non-engagement was a choice of the individual consultant rather than a product of the structure or processes of medical leadership. The specialist trust in our sample of case studies (Site F) reported that this was an issue, as there were more opportunities for other clinical activities and other ways of exercising leadership through, for example, specialist commissioning or national specialty bodies.

Some of the executive teams identified the ‘engagement gap’ as an issue but thought of it as a natural part of their journey towards more effective medical engagement. The first phase of this process has been to develop and appoint strong medical leaders and in the next phase to then try and better engage the rest of the consultant body. As one director explained:

“Is every single doctor – all 650 of them – engaged in strategy? No I don’t think so. Have we got the 10-20% we need to start making the shift? Yes I think we probably do” (site C).

Even in trusts where there was a strong history and culture of medical engagement, having engagement from all medical staff was understood as being very difficult. As a director at site B explained:

"If you see clinician engagement as a triangle, we work well with the 13 divisional directors, and probably 80% well with directorates. It is when you get to the bottom of the triangle that there is always a problem, and we are looking at different ways now of trying to engage with those – who I call the backbenchers".

There was a commitment here to using different ways of engaging staff, but also a realisation that complete engagement was unlikely to be possible and may not be desirable.

All the trusts reported that engagement of doctors in general was variable, but as one chief executive (site E) said:

"It is a continuum and on the whole the bulk of doctors are at the engaged end".

5.1.8 Challenges faced by medical leaders

As we have acknowledged in this chapter, across all the trusts the roles of medical leaders was recognised as being challenging. There are a range of reasons for this and as we have already seen the issue of time constraints and fitting aspects of leadership and management roles in alongside existing clinical commitments is difficult. Although in many of the trusts interviewees suggested that the "bad old days" of doctors and managers being permanently at loggerheads seem to be behind them, this does not mean that all is well for medical leaders.

While the case for medical (and clinical) leadership is generally understood across the trusts in our sample, there are still some doctors:

"Who think that getting involved in medical leadership is like going over to the dark side" (doctor, site H).

Indeed, tensions between managerial and clinical aspirations are still very much present in relation to a range of issues. These are compounded given that the NHS is currently facing a huge financial challenge. This means that a large part of the current role for medical leaders involves being involved in finding savings and making efficiencies. As one clinical director reflected:

"it must be lovely to be a clinical director in a period of service development. It's a bit depressing when all you are asked is to save money!" (Site I).

Across the case study sites we saw little evidence of clinically-led service redesign and reconfiguration. On the whole trusts reported getting by through 'salami tactics', or by top slicing the budgets of each part of the trust. The fact that leadership across whole health systems was an often

an under-emphasised trend seems to suggest that many of the trusts were on the verge of major changes, rather than fully engaged in them. How major service reconfigurations or efficiency measures are introduced and led locally is a key challenge for organisations generally and for clinical leaders specifically.

As we have outlined in previous sections, most of the trusts had set up formalised structures, processes and selection and development programmes in order to try and develop more effective processes of medical leadership. However, most of the trusts recognised that these were insufficient in themselves in delivering effective leadership. In practice the success of medical leadership relies on the individuals in these roles and their ability to forge relationships with others.

As such, most trusts reported that there are variations *within* trusts as well as between trusts. As one interviewee described performance across their trust:

"it can be variable because how well it works depends on the relationship of these individuals, how long they have been in post, how mature these relationships are" (site H).

A common theme was that structures and the process of medical leadership worked because of the exceptional personal qualities of particular medical leaders. For example at site F, an executive Director explained:

"The divisional directors are the key people. They are the people that I, and the rest of the organisation, rely on the most. They run the services and to my mind they are the people who keep the organisation going".

Site I reported how it acknowledges these intra-trust differences and plans to use them more through a process of 'earned autonomy'. As one Director explained:

"There is an operating framework which is developing but 'earned autonomy' is not emphasised at clinical unit level. Autonomy of units is developing gradually – clinicians are not given increased powers related to their unit's performance. However, there are aspects being added to the operating framework which indicate that 'earned autonomy' is like as a future direction".

In this case the clinical units are developing at their own pace and the relationship particularly between the clinical director and general manager is crucial in determining the pace at which this development happens.

5.1.9 Disadvantages of engagement

One of the disadvantages of medical leadership cited by trusts is the speed it takes to make decisions. As one interviewee described:

"Once decisions are made, we get somewhere. The only problem is that it sometimes takes an awful long time to get there" (Site, B).

The situation in this trust was presented as a clear trade off between speed, compliance and uniformity, with a *"compliant, not so engaged culture"* on the one hand, and an engaged culture with slower but more committed decision-making, and some difficulties in achieving consistency in all areas.

In those trusts that have more developed medical leadership processes the time it takes to reach decisions was cited as much longer than going through standard management processes, but it was agreed to be worth it due to the additional ownership of strategies that was gained as a result. This 'time issue' also includes an element of there being a lot of discussion and many meetings, which are a heavy use of resource, particularly clinical time.

At several trusts, there were potential difficulties in co-ordinating strategy or operational processes as a result of medical leadership, because medical leaders tend to have greater loyalty to their specialties than to the organisation as a whole. This was being addressed in a number of different ways – through for example the 'horizontal' structures, and *ad hoc* initiatives and groups.

5.1.10 In summary

In this chapter we have set out findings relating to the in-depth qualitative component of the research. Although there is a high degree of variation across the sites in terms of their budgets, staff numbers and locations there is a high degree of commonality in terms of the numbers of 'layers' in the structures of the trusts and the levels at which doctors are engaged in the leadership of the trusts. Regardless of what the different structures are called there seemed to be a high degree of congruity in terms of the sorts of challenges that the trusts faced and the trajectories of their developments in terms of medical leadership.

As this data demonstrates there are a range of factors which are seen to help in terms of achieving engaged medical leadership including; stability in both structures of trusts and relationships between individuals. Regardless of whether trusts described themselves as medically or managerially-led the key relationship in most of the trusts was in terms of the duality relationship between the clinical director and general manager. Few of the trusts operated a triumvirate where doctors, nurses and managers took joint responsibility for the leadership of their trust.

Most trusts had in recent years invested in specific recruitment and training for medical leaders to ensure that they appointed the highest calibre of medical leaders. However, regardless of this it is apparent that medical leadership jobs are challenging and doctors do not always feel sufficiently

developed to take on these roles. Further, despite the investments there is still not always a high degree of competition for medical leadership roles.

What is apparent from the data is that those doctors engaged in leadership at board or clinical director/divisional director level appear to be very engaged in the overall direction of their trusts. These doctors were cited as key individuals in the working of the trusts and seen as crucial factors in the delivery of high quality services. However, there was often an 'engagement gap' between these medical leaders on the one hand and specialty leads and the general consultant body on the other.

6 Medical engagement and organisational performance

In this chapter we report the results of the work we undertook in the third phase of the research on medical engagement and organisational performance. The main part of the chapter sets out the background to the Medical Engagement Scale and discusses how it was used in the case study sites. The results from these sites are presented and this is followed by an analysis of the relationship between these results and data on organisational performance drawn from the questionnaire survey and routinely available data on Trust performance. The main points made in this chapter are:

- the Medical Engagement Scale (MES) is a validated instrument for assessing the degree to which doctors are engaged in the work of NHS Trusts
- previous research has demonstrated a positive relationship between medical engagement and organisational performance in NHS Trusts
- results from the MES in the case study sites in our sample show variations both between trusts and within trusts in the degree to which doctors report that they are engaged
- these results were correlated with the self-assessments of performance reported in the questionnaire survey and with routinely available data on trust performance at the aggregate level
- analysis confirms that there is a relationship between medical engagement and trust performance but the variety of trust types included in our sample means that there are limitations to the analysis
- analysis of the relationship between medical engagement and performance in clinical units and subgroups is much more challenging because of the lack of accepted measures of performance at this level
- nevertheless, analysis did show a relationship between unit performance as perceived by board level and the MES results at this level
- free text responses to the MES highlight a number of challenges in securing effective engagement including lack of time, work pressures and in some cases relationships between medical leaders and managers

6.1 The Medical Engagement Scale

The Medical Engagement Scale (MES) was developed as part of the Enhancing Engagement in Medical Leadership project run jointly by the NHS Institute for Innovation and Improvement and the Academy of Medical Royal Colleges (2005-2011). A detailed account of the development process can be found in Spurgeon et al (59). A brief account of the background and development is provided here as context and explanation to the use of MES data on the Results section of this report.

The essential hypothesis of the engagement model is that higher levels of engagement generate a greater frequency of positive affect such as satisfaction and commitment and that this in turn flows through to enhanced work performance. Schaufeli and Bakker (60) describe engagement as “a persistent, positive affective motivational state of fulfilment in employees that is characterised by vigour, dedication and absorption”. An important aspect of this definition is to illustrate that engagement is not a single concept but is made up of different facets. This is reflected in the process of developing MES as it provides an overall index of engagement as well as sub-scales that measure various components of engagement

6.2 Development Process

The measures of engagement that do exist tend to focus upon the feelings of individual staff and do not simultaneously evaluate the associated cultural conditions of the organisation. Moreover, no assessment tool exists that is designed to focus upon medical engagement with management and leadership in an NHS context – the specific context for the Enhancing Engagement in Medical Leadership project. There were three specific aims to the project work:-

- a) to develop a reliable and valid measure of medical engagement which will be quick and relatively unobtrusive to complete;
- b) to differentiate within the scale and measure of personal engagement at an individual level (the motivation of the individual to perform in appropriate managerial and leadership roles) from the organisational context (which may foster or constrain engagement);
- c) to develop a systematic framework for recommending organisational strategies for enhancing medical engagement and performance at work.

These goals and the process of development were based on three conceptual premises:-

- i. medical engagement is critical to implementing many of the radical changes and improvements sought in the NHS and engagement levels are not universally high;

- ii. that medical engagement cannot be understood from consideration of the individual employee alone. Organisational systems play a crucial role in providing the cultural conditions under which the individual's propensity to engage is either encouraged or inhibited. The measure must therefore simultaneously assess both the individual and cultural components of the engagement equation
- iii. that a distinction is made between competence and performance in the context of work behaviour. Competence may be thought of as what an individual "can do" but this is not the same as what they "will do" – performance.

Applied Research Ltd (a relatively small research and consultancy organisation) had previously developed a Professional Engagement Scale, with data on over 20,000 healthcare professionals. In the timescale of the overall project it was felt that an adaptation of this existing scale to medical engagement was the most effective route. This involved refining the existing scale items to provide a medical engagement focus, piloting the items with an appropriate population and then undertaking relevant psychometric analysis to confirm the reliability and validity of the scales.

The re-analysis of the original data-set (23,782 NHS staff) using factor analysis produced a hierarchical scale structure as presented in Table 26.

Table 26. MES Scales and definitions

MES Scale	Scale Definition <i>[The scale is concerned with the extent to which]</i>
Index: Medical Engagement	...doctors adopt a broad organisational perspective with respect to their clinical responsibilities and accountability
Meta Scale 1: Working in an Open Culture	...doctors have opportunities to authentically discuss issues and problems at work with all staff groups in an open and honest way
Meta Scale 2: Having Purpose and Direction	...Medical staff share a sense of common purpose and agreed direction with others at work particularly with respect to planning, designing and delivering services
Meta Scale 3: Feeling Valued and Empowered	...doctors feel that their contribution is properly appreciated and valued by the organisation and not taken for granted
Sub Scale 1: [O] Climate for Positive Learning	...the working climate for doctors is supportive and in which problems are solved by sharing ideas and joint learning
Sub Scale 2: [I] Good Interpersonal Relationships	...all staff are friendly towards doctors and are sympathetic to their workload and work priorities
Sub Scale 3: [O] Appraisal and Rewards Effectively Aligned	...doctors consider that their work is aligned to the wider organisational goals and mission
Sub Scale 4: [I] Participation in Decision-Making and Change	...doctors consider that they are able to make a positive impact through decision-making about future developments
Sub Scale 5: [O] Development Orientation	...doctors feel that they are encouraged to develop their skills and progress their career
Sub Scale 6: [I] Commitment and Work Satisfaction	...doctors feel satisfied with their working conditions and feel a real sense of attachment and commitment to the organisation

The overall Index of Medical Engagement made up of a series of sub-scales:

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Meta Scale 1 Working in an Open Culture

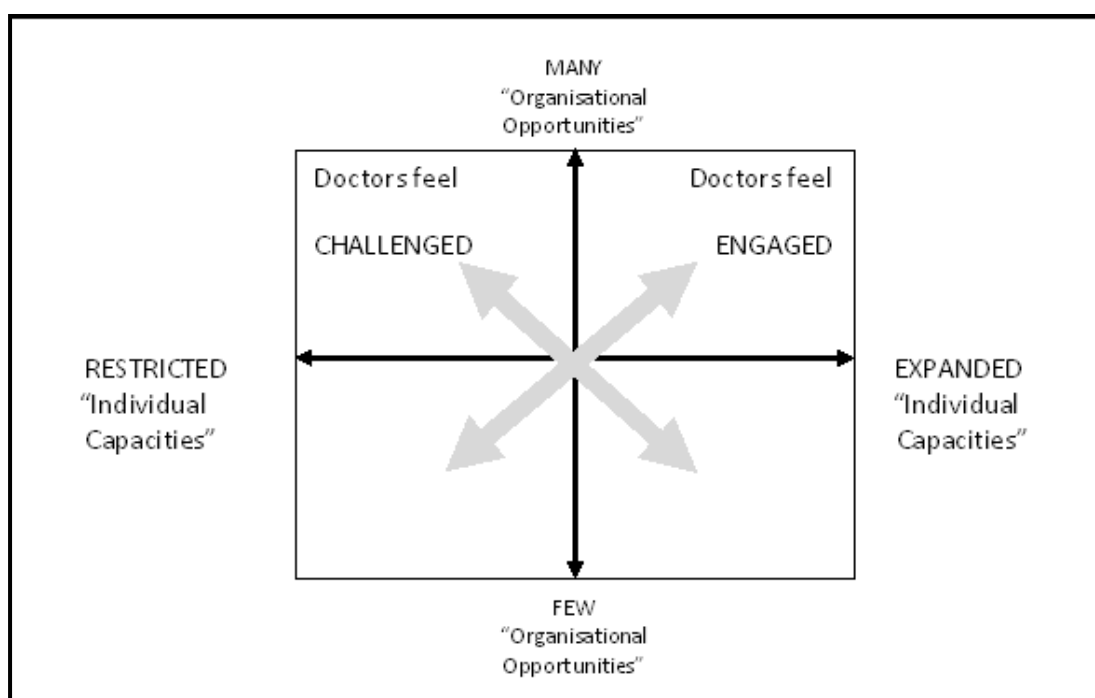
Meta Scale 2 Having Purpose & Direction

Meta Scale 3 Feeling Valued & Empowered

Each of these Meta scales is then further made up by two sub-scales, one of which relates to individual aspects of engagement (notation I) and another scale relating to organisational conditions (notation O).

This framework can also be represented as a dynamic model of Medical Engagement as in Figure 32.

Figure 32. Medical Engagement Model



The dynamic nature of the model can be thought of as seeking to develop the organisation towards the top right hand cell whereby doctors are positive and keen to be involved and the organisation provides a range of opportunities for this involvement to take place. In contrast the lower left cell would equate to a lack of organisational opportunities to be involved and doctors not really feeling that they want to tackle issues, leading to a sense of powerlessness.

The prototype Medical Engagement Scale was piloted with 4 NHS acute trusts. Two of those Trusts had been identified and recognised

independently for their work on engaging clinicians, another trust was in a state of crisis where a new Chief Executive suspected that lack of medical engagement was a significant problem, and a final volunteer trust was unknown in terms of the likely picture of medical engagement. The Medical Engagement Scale was then given to a sample of all doctors in these trusts (56% return rate overall) as well as a smaller sample of senior managers (non-medical) who were asked to estimate the level of medical engagement they thought existed in their trust.

Following this relatively successful pilot stage the Medical Engagement Scale was then applied to a further 30 NHS acute trusts in order:

- a) to establish normative data for patterns of medical engagement, and
- b) to assess the underlying issue relating to medical engagement – how it relates to organisational performance?

An initial set of norms has been established and these enable the extent and nature of medical engagement within any trust to be benchmarked and compared. Almost 5,000 doctors are now represented on the database.

6.3 Medical Engagement and Organisational Performance

The evidence linking leadership, and specifically clinical leadership, to organisational performance is quite limited but important findings are emerging. Smith (61) captures an important aspect of the problem when he suggests that almost all the performance measures have been directed explicitly or implicitly at the managerial community and also at such a high level of generality that they have failed to engage the health professional.

Nonetheless there is emerging evidence of how leadership can positively influence organisational performance. West *et al* (62) reported good human resource management practice (effective appraisals and team working) were linked to patient mortality. Similarly Shipton *et al* (63) conclude that “effective leaders shape organisational outcomes through creating a vision and building the allegiance of individuals and teams” (pg.443).

A subtle shift in presentation has seen a recent focus upon engagement in organisational processes as a proxy for the concept of leadership. Guthrie (64) argues that physician engagement is one of the markers of better-performing hospitals. Toto (65) has also demonstrated that engaged physicians can have a direct day-to-day impact on the financial bottom line of hospitals. Reinertsen *et al* (66) represents the views of the Institute of Healthcare Improvement in suggesting that engagement of clinicians in the management of their organisations is fundamental to effective organisations.

Goodall (67) has provided an intriguing report suggesting that when the performance data relating to large patient care specialties (Cancer, Diagnostic Disorders and Heart and Heart Surgery) are examined in the top

100 U.S. hospitals then a strong positive association is found between the ranked quality of a hospital and whether the CEO is a physician. As she quite properly notes this finding does not, by its correlational nature alone, prove that clinician managers outperform non-clinician managers but it does reinforce the need to understand how engaging clinicians more generally in the wider aims of the organisation may flow through to improved performance.

Further evidence for the benefits of medical engagement is provided in the study undertaken by McKinsey and the Centre for Economic Performance at the London School of Economics (68). Their work examined the performance of around 1,300 hospitals across Europe and the United States. Overall they found that hospitals that are well managed produce higher quality patient care and improved productivity, including significantly lower mortality rates and better financial performance. Importantly, those organisations with clinically qualified managers produced better results and gave managers higher levels of autonomy.

A study in the UK conducted on behalf of the Institute for Innovation and Improvement and the Academy of Medical Royal Colleges and subsequently reported by Spurgeon *et al* (69) found that medical engagement (as assessed by the Medical Engagement Scale) was strongly associated with a range of measures of organisational performance. As part of the project normative data for MES was collected (Table 27 and Table 28) to illustrate patterns of association between medical engagement and organisational performance and hence the use of MES in this current project.

Table 27. Comparison of MES Index (30 secondary care Trusts) to overall Healthcare Commission Ratings

	Trust ID (Trust Name withheld for confidentiality)	Overall Medical Engagement Scale Index (in descending order)	CQC – NHS performance ratings 2008/09				
			Overall Quality Score	Financial Management Score	Core standards score (as a provider of services)	Existing Commitment score (as a provider of services)	National priorities score (as a provider of services)
Top 10 Trusts of Sample	21	65.8	Good	Excellent	Fully Met	Fully Met	Good
	12	65.2	Good	Good	Fully Met		Good
	15	63.4	Excellent	Good	Fully Met	Fully Met	Excellent
	5	62.0	Excellent	Excellent	Fully Met	Fully Met	Excellent
	24	60.8	Good	Excellent	Fully Met		Good
	1	60.4	Excellent	Excellent	Fully Met	Fully Met	Excellent
	10	59.9	Good	Excellent	Almost Met	Fully Met	Good
	16	59.8	Good	Fair	Fully Met	Almost Met	Excellent
	14	59.7	Excellent	Excellent	Fully Met	Fully Met	Excellent
	11	58.8	Excellent	Excellent	Fully Met	Fully Met	Excellent
Bottom 10 Trusts of sample	25	56.8	Fair	Fair	Almost Met	Fully Met	Poor
	4	56.7	Fair	Fair	Almost Met	Fully Met	Fair
	22	55.7	Fair	Fair	Partly Met	Almost Met	Good
	23	55.3	Fair	Good	Almost Met	Partly Met	Excellent
	29	54.4	Good	Excellent	Fully Met	Fully Met	Good
	3	54.3	Fair	Excellent	Fully Met	Fully Met	Poor
	26	53.1	Fair	Fair	Almost Met	Almost Met	Fair
	8	52.7	Good	Good	Fully Met	Almost Met	Good
	18	52.1	Fair	Fair	Fully Met	Partly Met	Good
	20	47.0	Poor	Poor	Almost Met	Not Met	Fair

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Here the top 10 and bottom 10 Trusts on Medical Engagement are compared with the Care Quality Commission ratings 2008/10. It is apparent that the organisations scoring more highly on engagement are independently assessed as superior in performance across a number of areas. Table 28 presents a number of the key performance markers from the Care Quality Commission and their significant correlations with virtually all elements of the Medical Engagement Scale.

Table 28. Comparison of bottom 10 trusts by MES and CQC ratings 2008/10

	Medical Engagement Index	Meta 1: Working in a Collaborative Culture	Meta 2: Having Purpose & Direction	Meta 3: Being Valued and Empowered	Sub 1: Climate for Positive Learning	Sub 2: Good Interpersonal Relationships	Sub 3: Appraisal & Rewards Effectively Aligned	Sub 4: Participation in Decision Making & Change	Sub 5: Development Orientation	Sub 6: Work Satisfaction	n Trusts
The Care Quality Commission - NHS performance ratings 2008/09											
Overall quality score	0.68	0.63	0.70	0.65	0.68	0.46	0.73	0.49	0.62	0.62	
	***	***	***	***	***	**	***	**	***	***	30
08/09 financial management score	0.47	0.48	0.44	0.46	0.50	0.37	0.52	0.24	0.47	0.41	
	**	**	**	**	**	*	**		**	**	30
08/09 core standards score (as a provider of services)	0.34	0.37	0.25	0.36	0.37	0.31	0.31	0.12	0.41	0.28	
	*	*		*	*	*	*		*		30
08/09 existing commitments score (as a provider of services)	0.64	0.59	0.67	0.60	0.64	0.45	0.69	0.53	0.61	0.55	
	***	***	***	***	***	*	***	**	***	**	25
2008/09 NHS performance ratings existing commitments and national priorities indicator scores (frequency of 'achieved')	0.69	0.54	0.75	0.70	0.56	0.44	0.76	0.62	0.66	0.68	
	***	**	***	***	**	*	***	***	***	***	25
Total time in A&E: four hours or less (% level 'achievement')	0.55	0.55	0.47	0.59	0.52	0.53	0.52	0.33	0.70	0.46	
	**	**	*	***	**	**	**		***	*	24
Inpatients waiting longer than the 26 week standard (% level 'underachievement')	-0.57	-0.59	-0.41	-0.64	-0.52	-0.62	-0.44	-0.30	-0.72	-0.52	
	***	***	*	***	**	***	*		***	*	25
All cancers: two month urgent referral to treatment (% level 'achievement')	0.54	0.52	0.42	0.61	0.49	0.50	0.35	0.46	0.60	0.57	
	**	**	*	***	**	**	*	*	***	**	24

¹Attenuated range of performance ratings

Levels of significance; * = p < 0.05, ** = p < 0.01, *** = p < 0.001

This powerful and unique data is evidence of a strong association between levels of Medical Engagement and externally assessed performance parameters in health care providers. This is consistent with much of the earlier literature around engagement reported from other sectors. Therefore it was decided that MES would be an appropriate tool to explore engagement in the Case Study sites.

6.4 Case Study Sites- Organisational Performance Profiles

In a normal application to a whole Trust MES is given to all doctors working in the organisation, from the most senior e.g. Medical and Clinical Directors, to juniors (excluding Foundation Years I and II). Of the 50 Trusts represented in the normative database sample rates range from 40% (lowest) to 78% (highest). However, in the context of this study MES was utilised in the 3 clinical units or sub-groups used to explore the day to day operation of arrangements for medical engagement. Clinical units were identified by asking board level interviewees to nominate three units in their Trust that represented a range of performance.

Some of these units had relatively few doctors and hence the MES returns in some instances are quite small. Nonetheless the large number of doctors on the MES database (5000+) enabled any individual doctor to be located against a percentile ranking. This allows the relative standing of an individual or small group to be positioned in terms of the overall sample.

A perfectly average score would have a percentile rank of 50, whilst a percentile rank of 85 would mean that the individual (or group) was more engaged on the MES data than 85% of their peers. In practice the following percentile scores have been put into bands to facilitate a quick and easily interpreted set of scores.

60 and above= high relative engagement; marked green

50-60 = medium relative engagement; marked yellow

50 or less= low relative engagement; marked red

Two sites (D and A) were successful in undertaking MES and their data is presented below in whole Case Study reports. There is some repetition in the description of MES in these two but this is done to maintain the holistic nature of them as Case Studies. Five further sites are reported in a similar format but with limited samples (sites B, C, E, H and I). Two further sites (G and F) were unable to participate and so no MES data is reported for these sites.

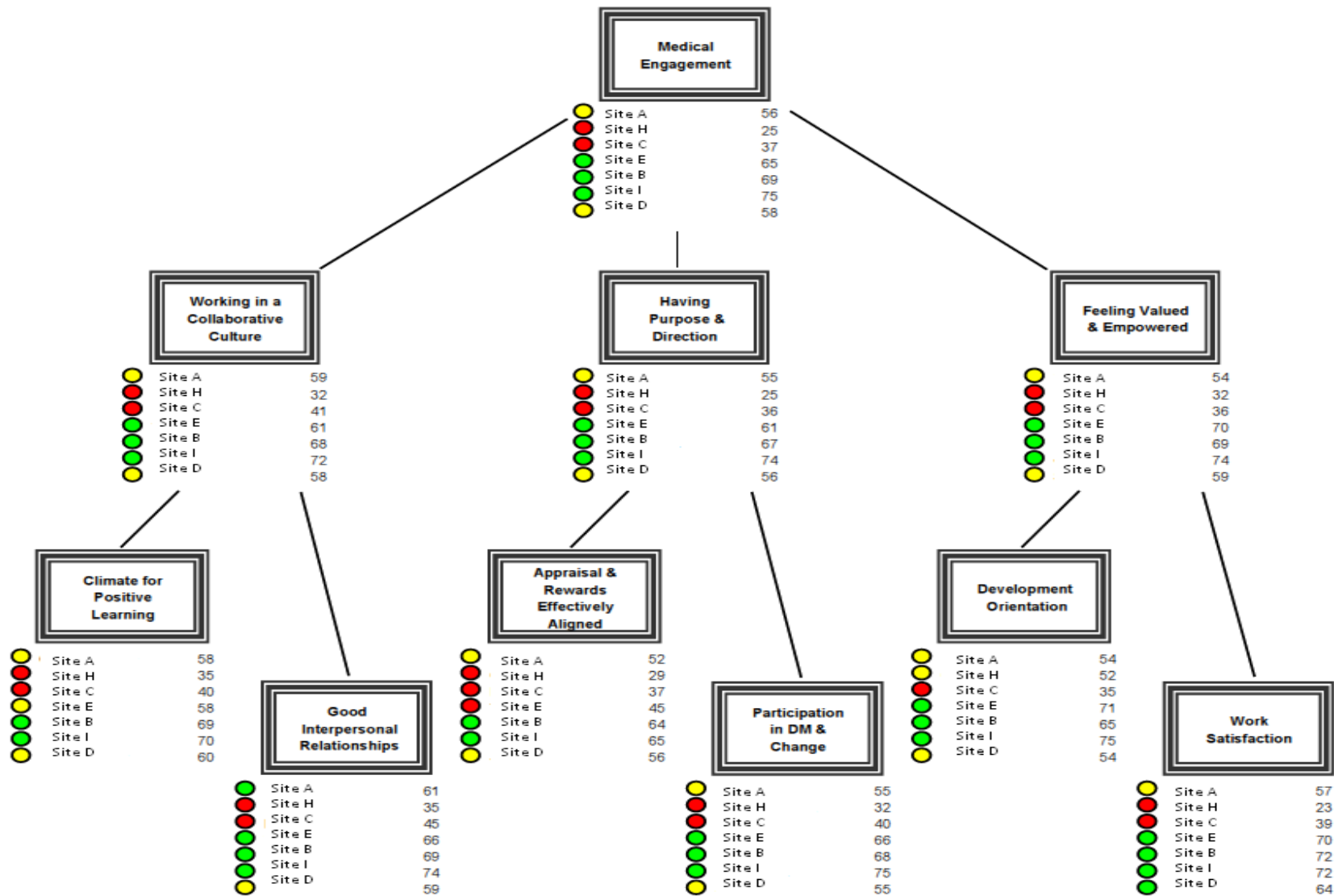
6.5 Overall MES Summary

MES returns from each site are drawn together in the following summary (see table below). Although there are minor movements in the

subscales, the overall Medical Engagement Index suggests from the 7 returning sites that 3 have good levels of engagement (Sites B, E and I), 2 have medium levels (Sites D and A) and two have low levels (Sites H and C).

Although the sample size in some instances is small and therefore to be interpreted with caution it is apparent that the percentile based data does enable sub-groups of clinicians to be described in terms of the level (or culture) of engagement that exists in their part of the organisation. The data has great potential to unlock a key performance variable in the NHS given two future conditions a) a satisfactory data sample if MES returns and b) an appropriate level of performance data relevant and specific to this level of sub-group.

Figure 33. MES results for 9 case study sites



g contract

6.6 Full Case Study: Site A (N=31)

6.6.1 The Medical Engagement Scale (MES) – Scale Structure

The instrument has a hierarchical structure and provides an overall index of medical engagement together with an engagement score on three reliable meta-scales with each of these three meta-scales itself comprising two reliable sub-scales (see scale titles and definitions in Figure 34 and Table 29).

Figure 34. Scales of MES

Meta-Scale 1: Working in a collaborative culture

- Sub-Scale 1: Climate for positive learning
- Sub-Scale 2: Good interpersonal relationships

Meta-Scale 2: Having purpose and direction

- Sub-Scale 3: Appraisal and rewards effectively aligned
- Sub-Scale 4: Participation in decision-making and change

Meta-Scale 3: Feeling valued and empowered

- Sub-Scale 5: Development orientation
- Sub-Scale 6: Work satisfaction

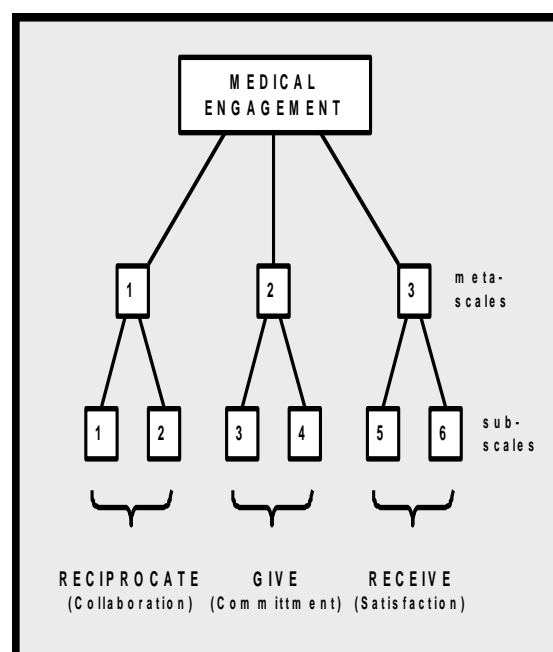


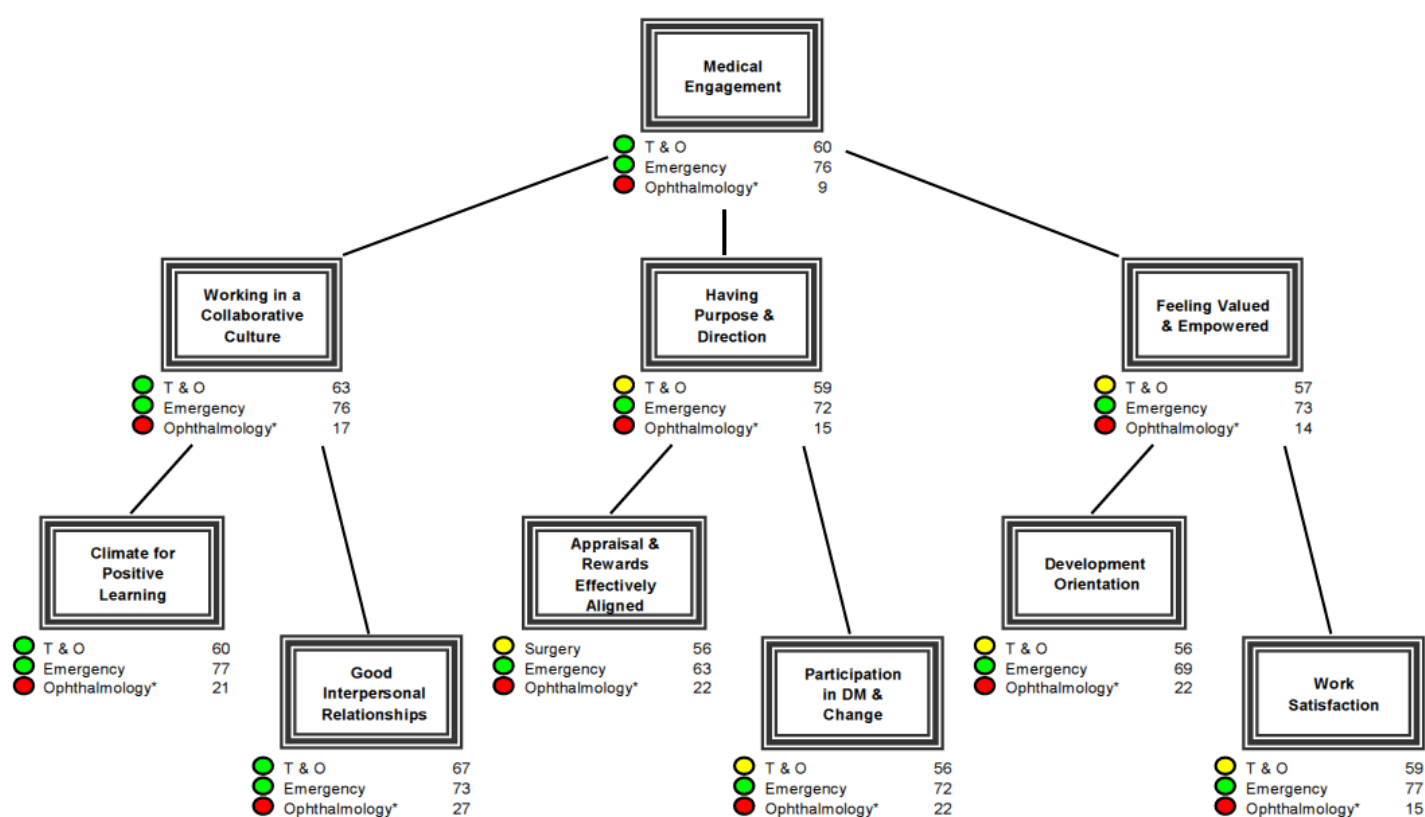
Table 29. Definitions of MES scales

MES Scale		Scale Definition (the scale is concerned with the extent to which....)
Index:	Medical Engagement	...doctors adopt a broad organisational perspective with respect to their clinical responsibilities and accountability
Meta Scale 1:	Working in a Collaborative Culture	...doctors have opportunities to authentically discuss issues and problems at work with all staff groups in an open and honest way
Meta Scale 2:	Having Purpose and Direction	...medical staff share a sense of common purpose and agreed direction with others at work particularly with respect to planning, designing and delivering services
Meta Scale 3:	Feeling Values and Empowered	...doctors feel that their contribution is properly appreciated and valued by the organisation and not taken for granted
Sub Scale 1:(0)	Climate for Positive Learning	...the working climate for doctors is supportive and in which problems are solved by sharing ideas and joint learning
Sub Scale 2:(I)	Good Interpersonal Relationships	...all staff are friendly towards doctors and are sympathetic to their workload and work priorities.
Sub Scale 3:(0)	Appraisal and Rewards Effectively Aligned	...doctors consider that their work is aligned to the wider organisational goals and mission
Sub Scale 4:(I)	Participation in Decision-Making and Change	...doctors consider that they are able to make a positive impact through decision-making about future developments
Sub Scale 5:(0)	Development Orientation	...doctors feel that they are encouraged to develop their skills and progress their career
Sub Scale 6:(I)	Work Satisfaction	...doctors feel satisfied with their working conditions and feel a real sense of attachment and commitment to the organisation

6.6.2 The Medical Engagement Scale (MES) – Percentile Scores

Percentiles have been used with the MES scales because they divide the scores on each of the ten scales into 100 equal parts and are a useful way of determining *the relative standing or position* of an individual doctor or a sample of doctors compared to the norm (i.e. all other doctors who have completed the MES to date). Figure 35 shows where medical staff groups within this particular Trust fell with respect to the normative database.

Figure 35. MES results case study site A

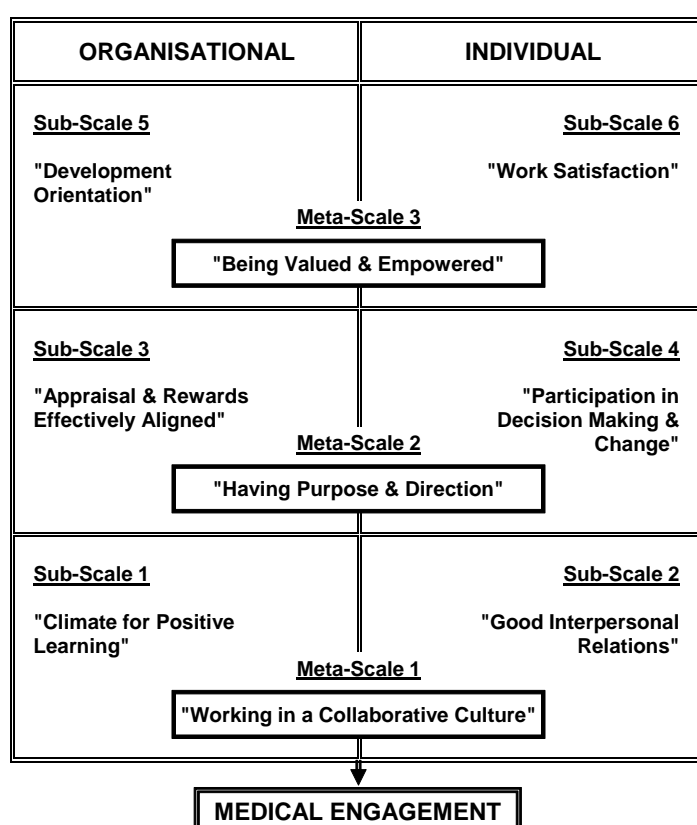


6.6.3 Organisational and Individual Influences

The 6 MES sub-scales are of two types (three **organisational** sub-scales and three **individual** subscales). The MES model also emphasises the interaction between the individual doctor and the organisation. Opportunities and capacities

- Three **ORGANISATIONAL** sub-scales (1, 3 and 5) which reflect the cultural conditions which facilitate or inhibit medical staff to be more actively involved in leadership and management
- Three **INDIVIDUAL** sub-scales (2, 4 and 6) which reflect medical motivation, empowerment and confidence to tackle new management and leadership challenges

Figure 36. MES Model



The relative influence of the number and type of organisational opportunities interact with the individual motivation and capacities of the doctor and the combined impact of these two factors are crucial in shaping the extent to which doctors are both willing and able to become engaged in managerial activities at work. Figure 37 details the relative percentile endorsements of both influences at the overall engagement level and also within its three meta-scale components.

It can be seen that the relative levels of medical endorsement of the organisational and individual components of the three meta-scales are broadly aligned for all three organisational sub-samples. However, unlike

the other two sub-samples, the endorsement levels for medical staff from ophthalmology are low on both the organisational and the individual component. The meaning of these joint ratings is explored in more detail in the next section.

Figure 37. Overall medical engagement scale results

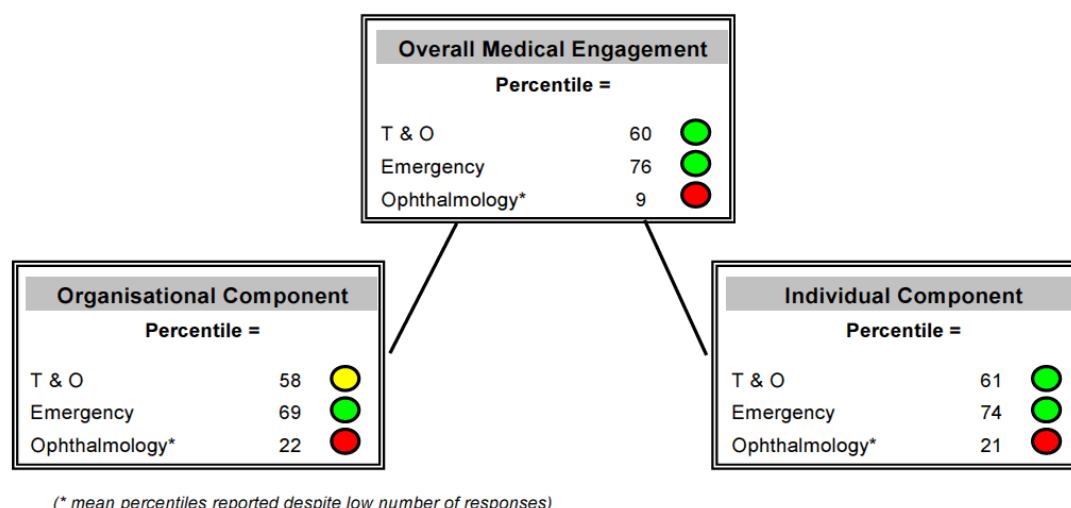


Figure 38. Meta scale 1

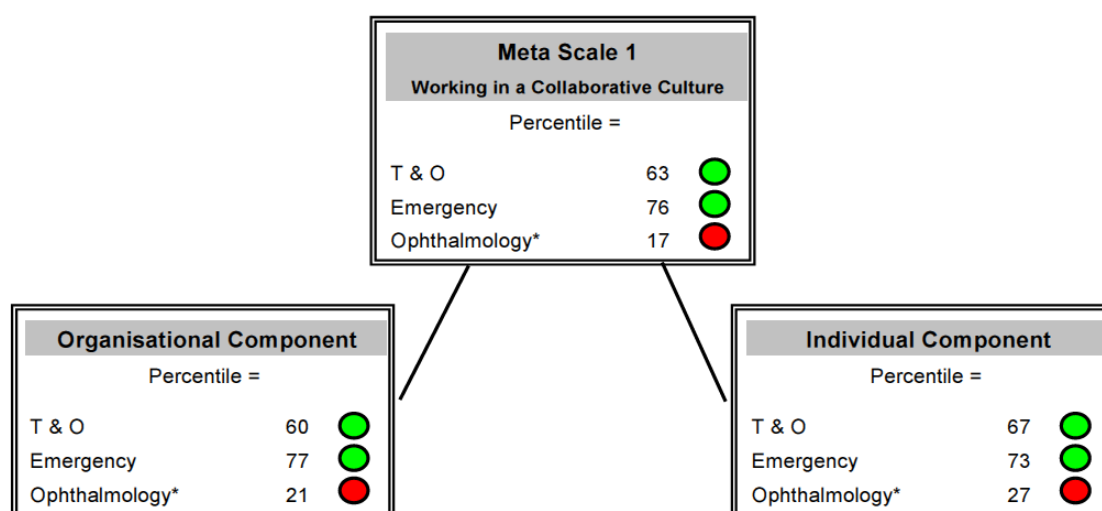


Figure 39. Meta Scale 2

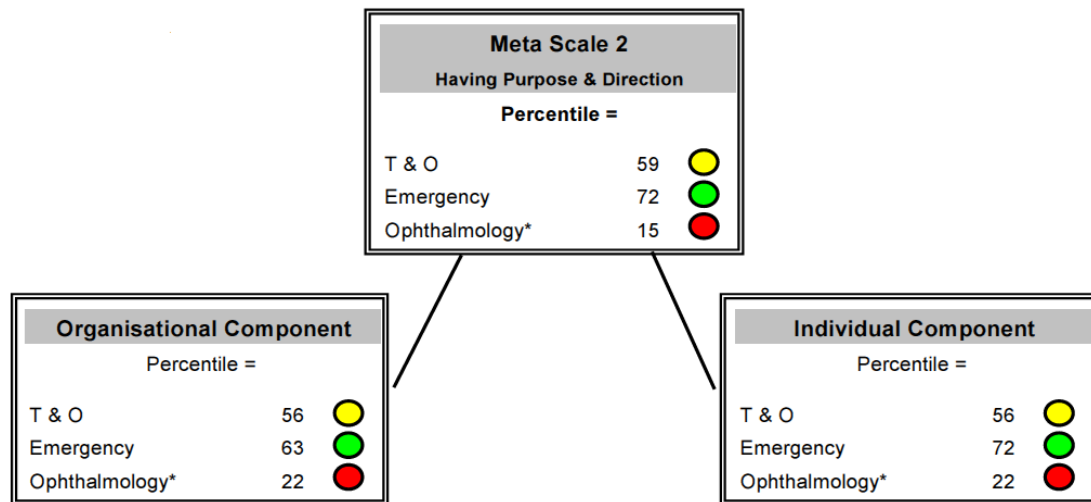
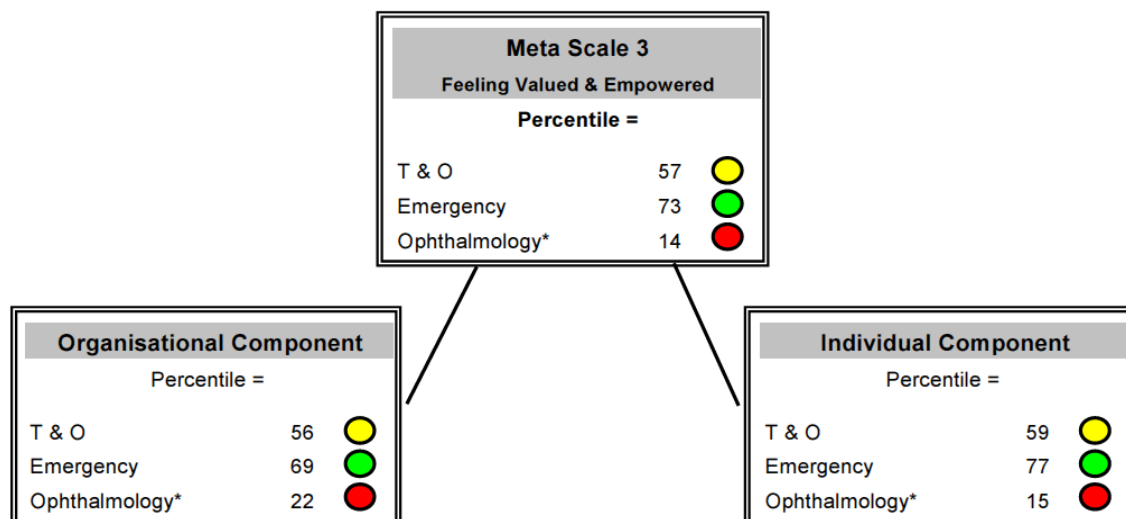


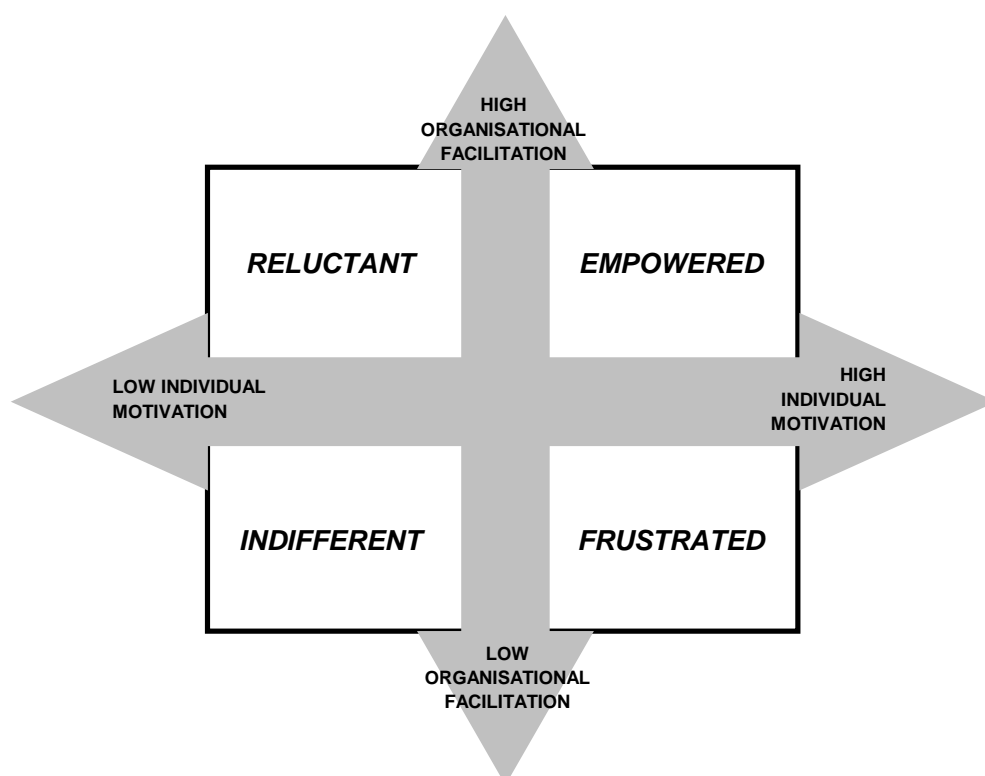
Figure 40. Meta Scale 3



6.6.4 The Medical Engagement Scale (MES) – Percentile Mapping

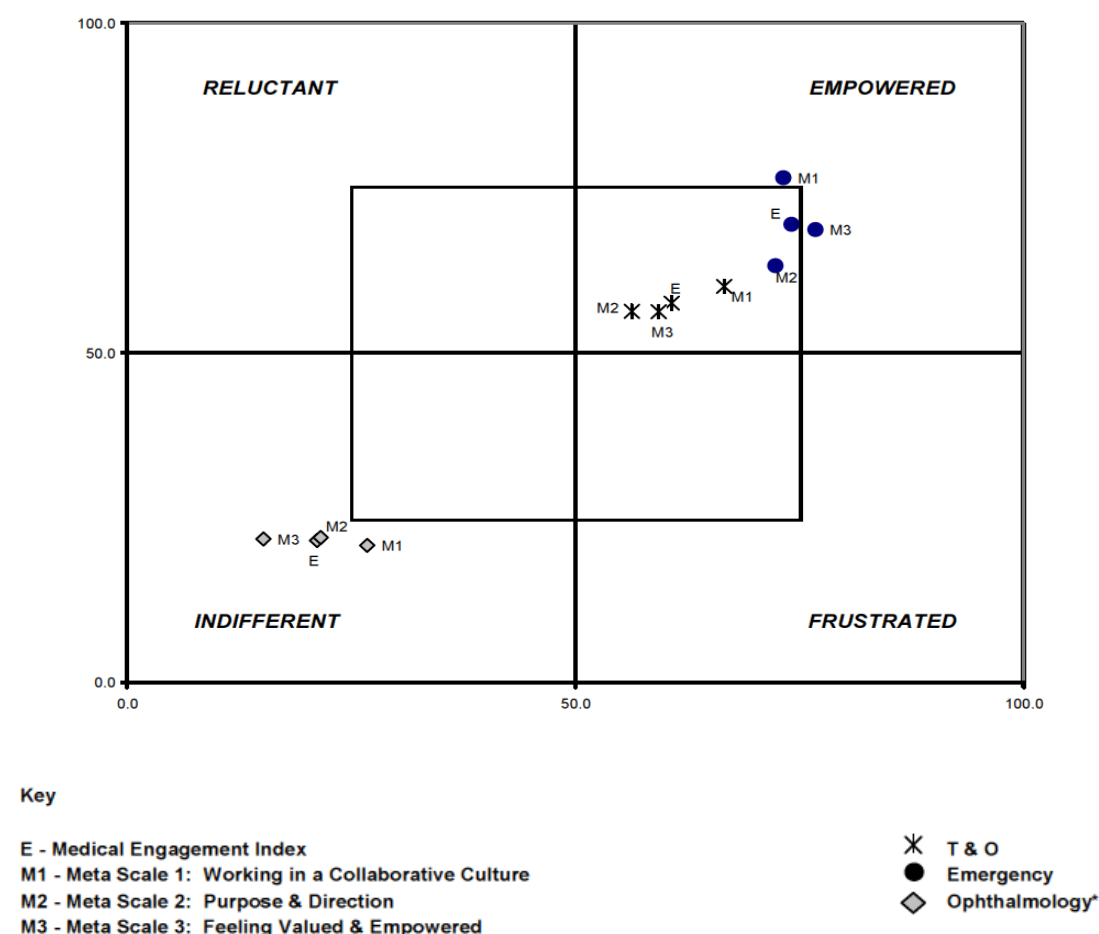
The figure below illustrates the four basic 'types' of engagement that becomes apparent when group percentile scores based on medical staff sub-samples are mapped onto the MES grid. Clearly, those medical staff who are highly personally motivated to become engaged in the managerial agenda and who are actively encouraged by the organisation to do so will be placed within the '**empowered**' quadrant of the grid. This is the quadrant that defines a culture of highly active and positive medical engagement whereas the remaining three quadrants define three less desirable states of compromised engagement cultures. Members of medical staff tend to become '**frustrated**' when they have high levels of individual motivation but are not encouraged by the organisation to apply this desire to become involved to any meaningful leadership agenda. Conversely, in some circumstances the organisation may provide many opportunities and may actively attempt to encourage greater involvement, but members of medical staff show little enthusiasm and remain '**reluctant**' and sometimes antagonistic to becoming further involved in taking effective leadership roles. In the worst scenario, when both individual concern and organisational interest is low, then members of medical staff tend to disengage from the leadership process and become '**indifferent**'.

Figure 41. Engagement Typology



The figure below presents the mapping of medical sub-samples from this Trust.

Figure 42. Engagement Typology Results (Case Study A)



It is apparent that the ratings of members of medical staff from both **'Emergency'** and **'T&O'** mean that they both fall within the **'Empowered'** quadrant of the grid, with **'Emergency'** being the more positive of the two sub-samples. In contrast, the rating of medical staff from **'Ophthalmology'** means that this sub-sample falls within the **'Indifferent'** quadrant of the MES grid. In the selection of these subgroups some concern was suggested around the Ophthalmology group and the MES data confirms this, underlining the potential importance of engagement to effective performance.

6.6.5 Additional Questions

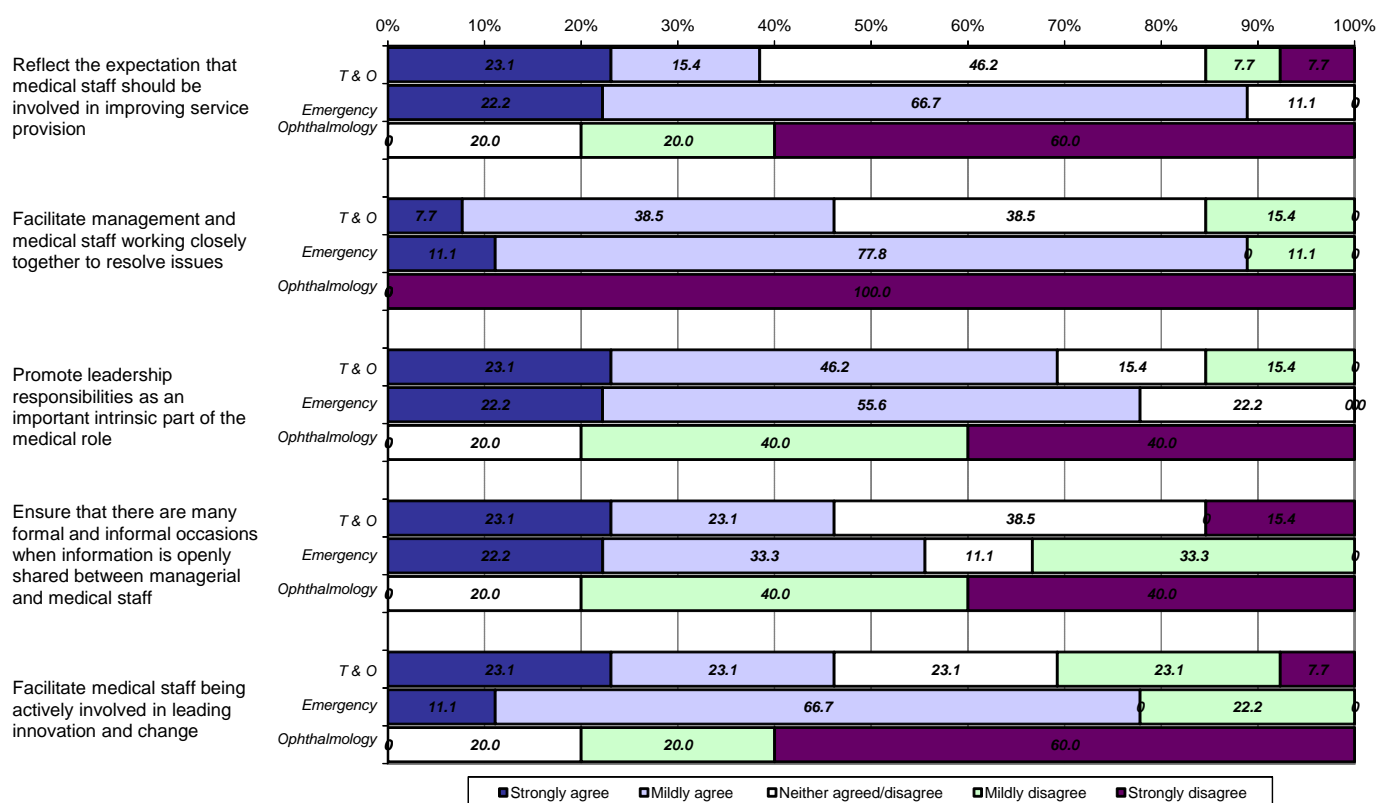
Section B of the MES questionnaire comprised five questions which related to the organisational structure and working arrangements in the Trust. An examination of the figure below indicates that medical staff from Ophthalmology rated particularly negatively. In contrast over 70% of

medical staff from Emergency rated four of the five items as either 'mildly agree' or 'strongly agree'.

Figure 43. Perceptions of Effectiveness of Organisational Structures

Section B: Percentage of Respondents Endorsing Rating Categories

The organisational structure & working arrangements in this Trust.....



It is notable that most medical staff in Ophthalmology disagreed (i.e. mildly disagree or strongly disagree) with the following:-

The organisational structure & working arrangements in this Trust.....

Q1 Reflect the expectation that medical staff should be involved in improving service provision

[80%]

Q2 Facilitate management and medical staff working closely together to resolve issues

[100%]

Q3 Promote leadership responsibilities as an important intrinsic part of the medical role

[80%]

Q4 Ensure that there are many formal and informal occasions when information is openly shared between managerial and medical staff

[80%]

Q5 Facilitate medical staff being actively involved in leading innovation and change

[80%]

6.6.6 Open Comments

Finally in this Case Study respondents were invited to comment on two broad questions

- a) What are the main barriers to engaging doctors in your Trust in leadership roles?
- b) What would help facilitate more effective engagement of doctors in your Trust?

A selection of comments for each question is presented below

Question A

- *"Too busy trying to fulfil clinical commitments!"*
- *"Lack of communication between managers and doctors, while suggestions to change organisation accepted, changes are not."*
- *"Time - there is a huge clinical burden which leaves little time for leadership roles."*
- *"Disregard for information given to them by consultant staff."*
- *"Lack of communication between management and clinical teams."*
- *"Work related pressures- service provision demands are high not much time for other tasks."*
- *"Total lack of appreciation by management of the 'Clinical' issues and a tendency to exclude doctors from decision making process other*

than those clinicians who put themselves forward for managerial roles and, who, in my opinion, are the least representative of the profession."

- *"NHS managerial imperatives conflict with clinical priorities"*
- *"I think there are no real barriers."*
- *"There are opportunities but long working hours and heavy rotas preclude doctors from taking more active roles in leadership roles."*

Question B

- *"Being more involved in organisational decisions. Being able to achieve professional goals"*
- *"More understanding that doctors can, sometimes, help solve problems and are not the cause all of the problems."*
- *"Openness about issues and increasing trust between executives and doctors."*
- *"Management willing to listen to facts rather than rely on it's own opinion"*
- *"Engagement of clinicians in important decisions"*
- *"More honesty and transparency by management about clinically important issues. Their role should be to facilitate the Doctors' ability to provide high quality health care. They do not."*
- *"Respect for clinical decisions and priorities of care."*
- *"Having inspirational role models in medical management."*

6.6.7 Conclusions

The results demonstrate that the MES is able to differentially describe the levels of engagement within the sub-samples of medical staff selected from this Trust. Clearly, medical staff from 'Ophthalmology' are less like to be positively engaged in a leadership agenda and consider that the organisational structure and working arrangements within the Trust are not conducive to adopting this change in role.

6.7 Full Case Study: Site D (N= 61)

6.7.1 The Medical Engagement Scale (MES) – Scale Structure

The instrument has a hierarchical structure and provides an overall index of medical engagement together with an engagement score on three reliable meta-scales with each of these three meta-scales itself comprising two reliable sub-scales (see scale titles and definitions below).

Figure 44. Scales of MES

Meta-Scale 1: Working in a collaborative culture

- Sub-Scale 1: Climate for positive learning
- Sub-Scale 2: Good interpersonal relationships

Meta-Scale 2: Having purpose and direction

- Sub-Scale 3: Appraisal and rewards effectively aligned
- Sub-Scale 4: Participation in decision-making and change

Meta-Scale 3: Feeling valued and empowered

- Sub-Scale 5: Development orientation
- Sub-Scale 6: Work satisfaction

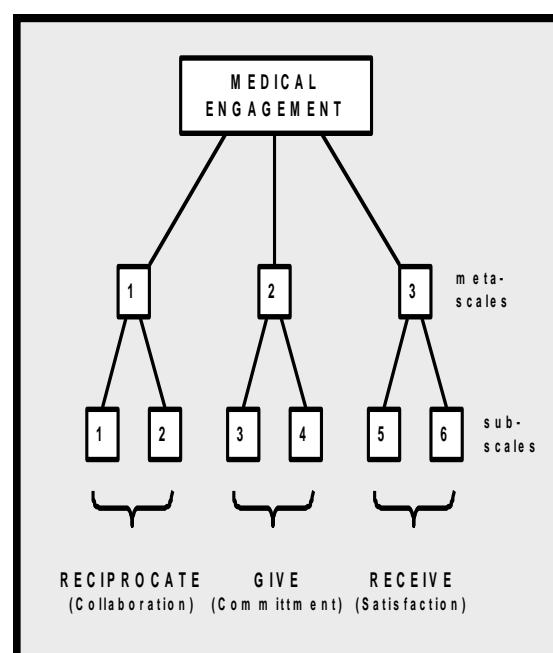


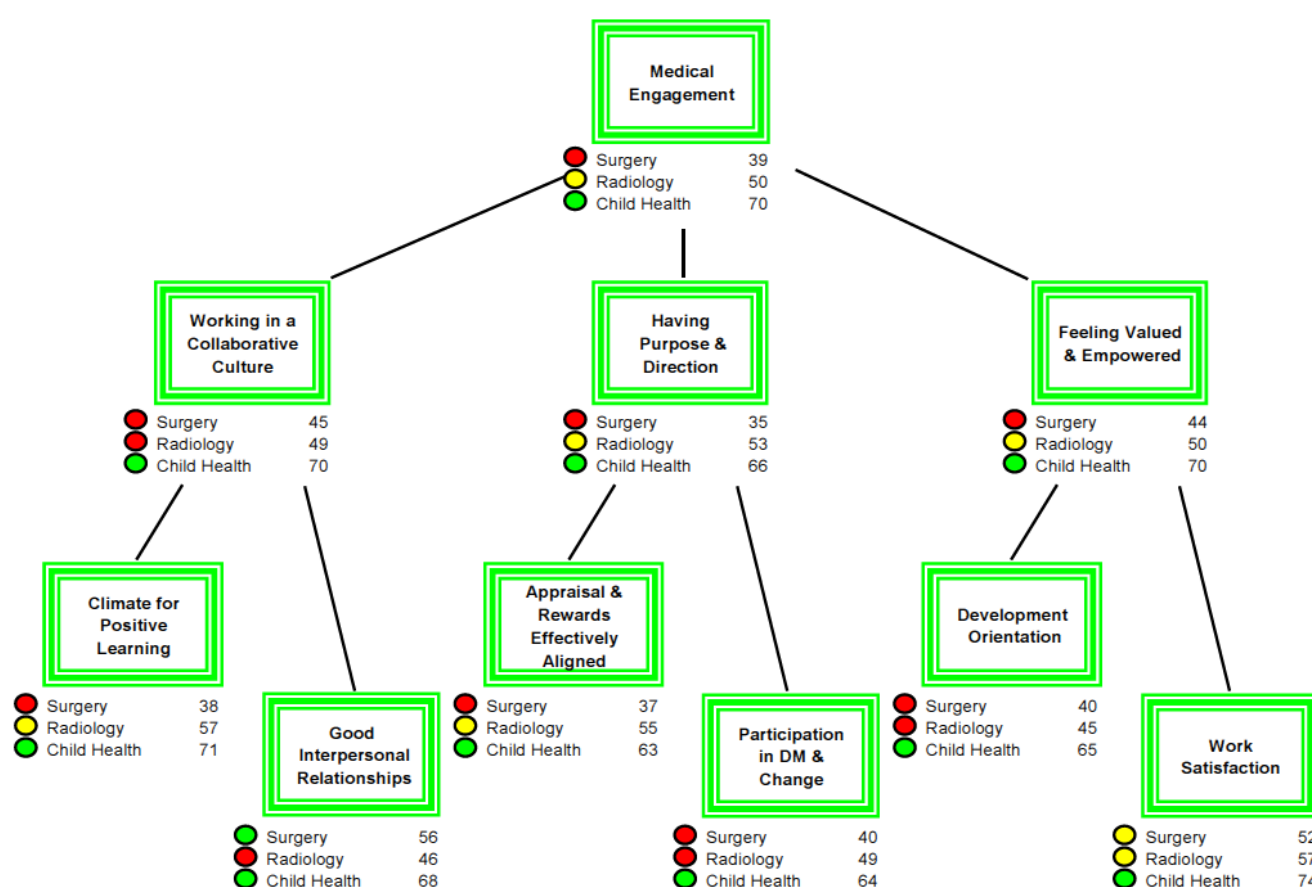
Table 30. Definitions of MES Scales

MES Scale		Scale Definition (the scale is concerned with the extent to which....)
Index:	Medical Engagement	...doctors adopt a broad organisational perspective with respect to their clinical responsibilities and accountability
Meta Scale 1:	Working in a Collaborative Culture	...doctors have opportunities to authentically discuss issues and problems at work with all staff groups in an open and honest way
Meta Scale 2:	Having Purpose and Direction	...medical staff share a sense of common purpose and agreed direction with others at work particularly with respect to planning, designing and delivering services
Meta Scale 3:	Feeling Values and Empowered	...doctors feel that their contribution is properly appreciated and valued by the organisation and not taken for granted
Sub Scale 1:(0)	Climate for Positive Learning	...the working climate for doctors is supportive and in which problems are solved by sharing ideas and joint learning
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6.7.2 The Medical Engagement Scale (MES) – Percentile Scores

Percentiles have been used with the MES scales because they divide the scores on each of the ten scales into 100 equal parts and are a useful way of determining ***the relative standing or position*** of an individual doctor or a sample of doctors compared to the norm (i.e. all other doctors who have completed the MES to date). The coloured hierarchical figure below shows where medical staff groups within this particular Trust fell with respect to the normative database.

Figure 45. MES Results Case Study D

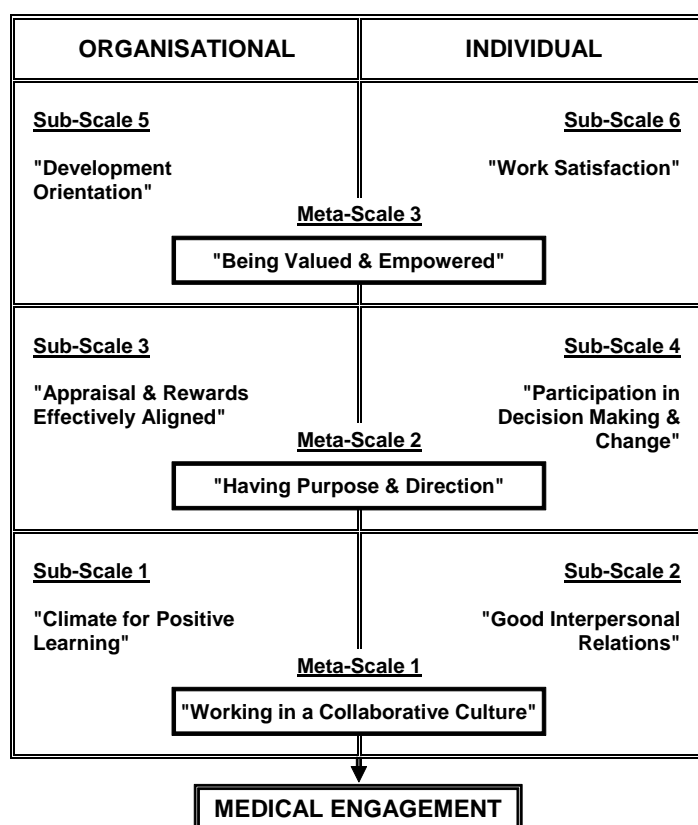


6.7.3 Organisational and Individual Influences

The 6 MES sub-scales are of two types (three **organisational** sub-scales and three **individual** subscales). Although satisfaction and commitment clearly interact within the individual doctor at work, the MES model also emphasises the interaction between the individual doctor and the organisation. Opportunities and capacities

- Three ORGANISATIONAL sub-scales (1, 3 and 5) which reflect the cultural conditions which facilitate or inhibit medical staff to be more actively involved in leadership and management
- Three INDIVIDUAL sub-scales (2, 4 and 6) which reflect medical motivation, empowerment and confidence to tackle new management and leadership challenges

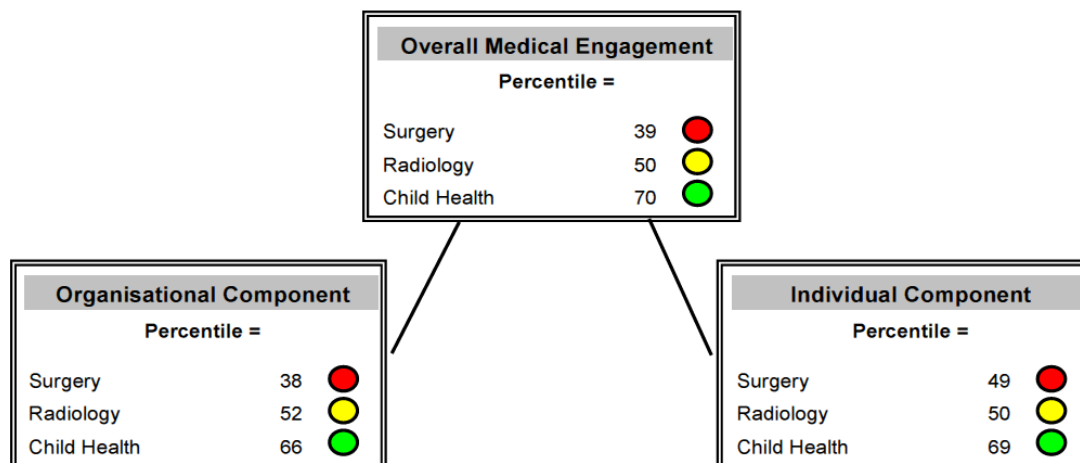
Figure 46. MES Model



The relative influence of the number and type of organisational opportunities interact with the individual motivation and capacities of the doctor and the combined impact of these two factors are crucial in shaping

the extent to which doctors are both willing and able to become engaged in managerial activities at work. The figure below details the relative percentile endorsements of both influences at the overall engagement level and also within its three meta-scale components.

Figure 47. Overall Medical Engagement Results (Case Study D)



(* mean percentiles reported despite low number of responses)

Figure 48. Meta Scale 1

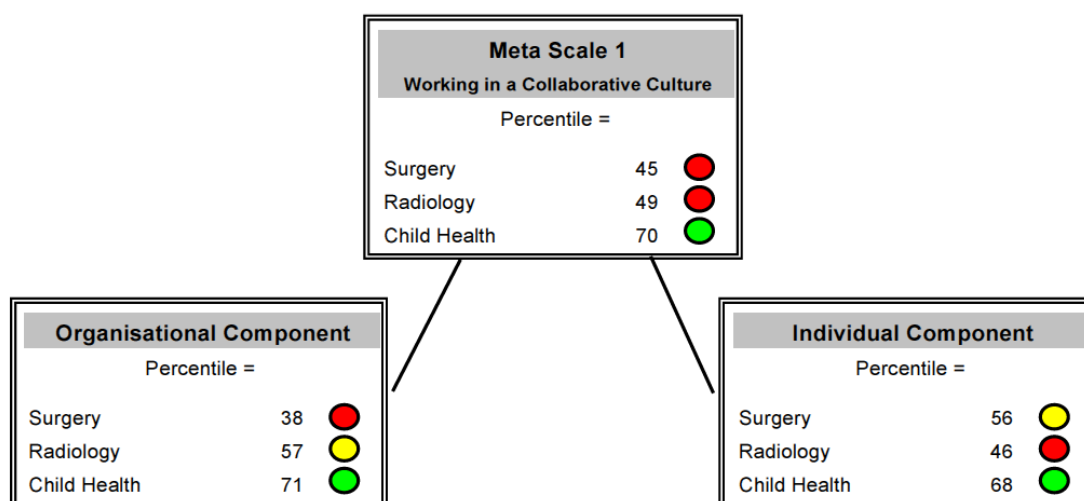


Figure 49. Meta Scale 2

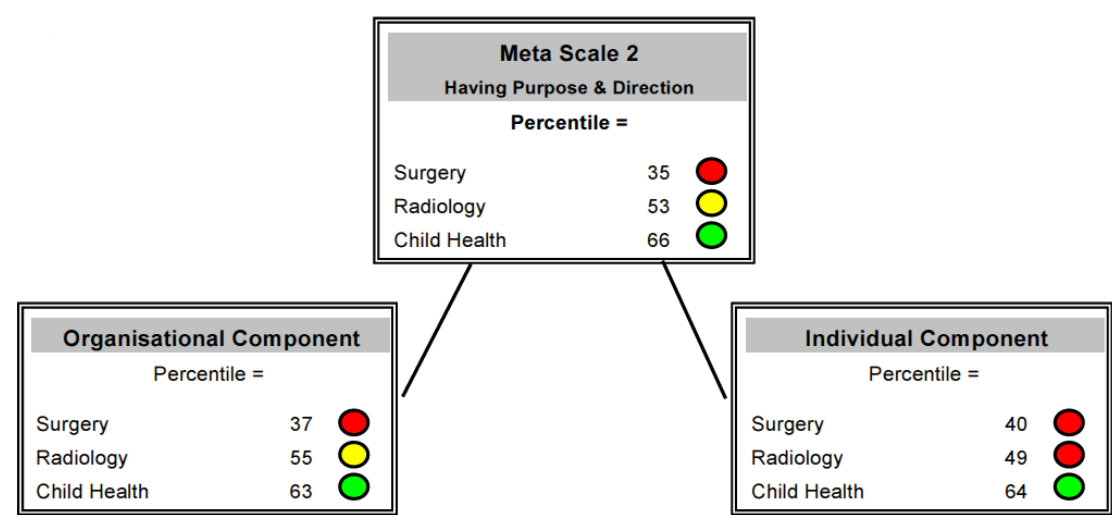
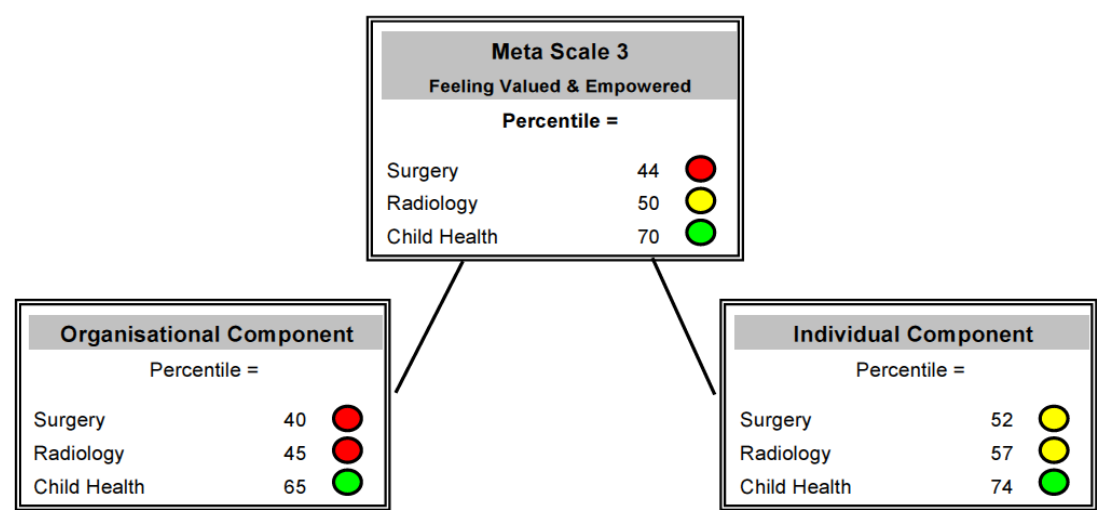


Figure 50. Meta Scale 3



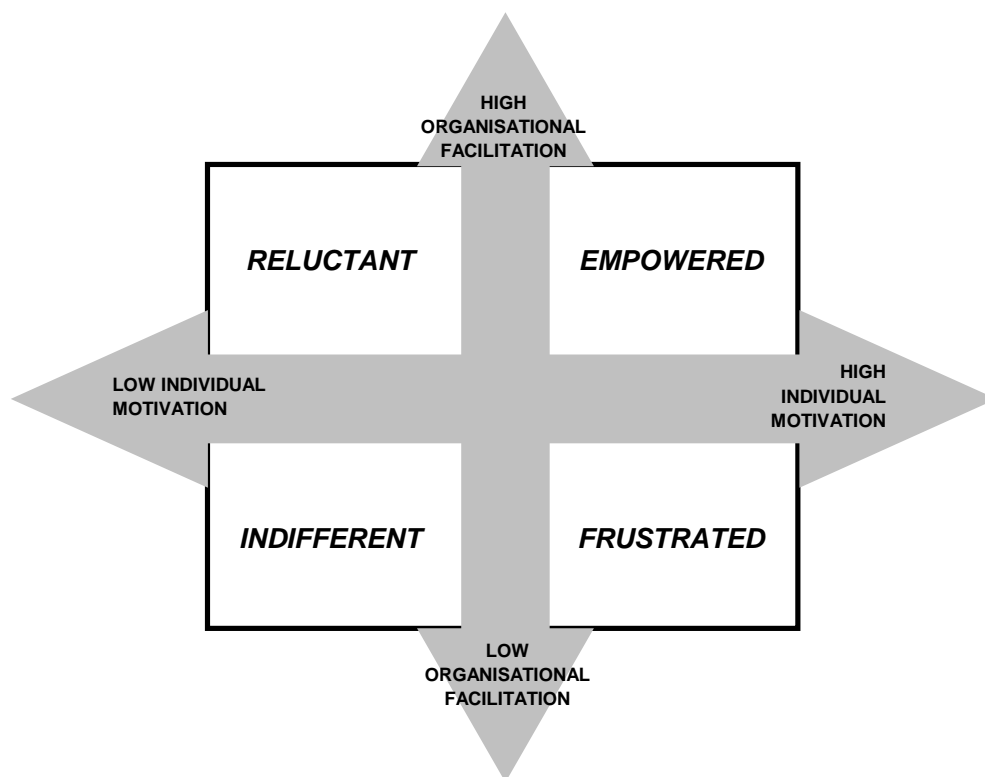
An examination of the first of the 4 figures above shows the relative levels of medical endorsement of the organisational and individual components of the MES are broadly aligned for Radiology and Child Health care groups. For Surgery, medical ratings for the individual component are higher than the organisational component indicating that this sub-sample of medical

staff tend to consider that they are relatively more individually motivated and relatively less organisationally encouraged to be engaged. An inspection of the remaining 3 figures detail where medical ratings are more or less aligned.

6.7.4 The Medical Engagement Scale (MES) – Percentile Mapping

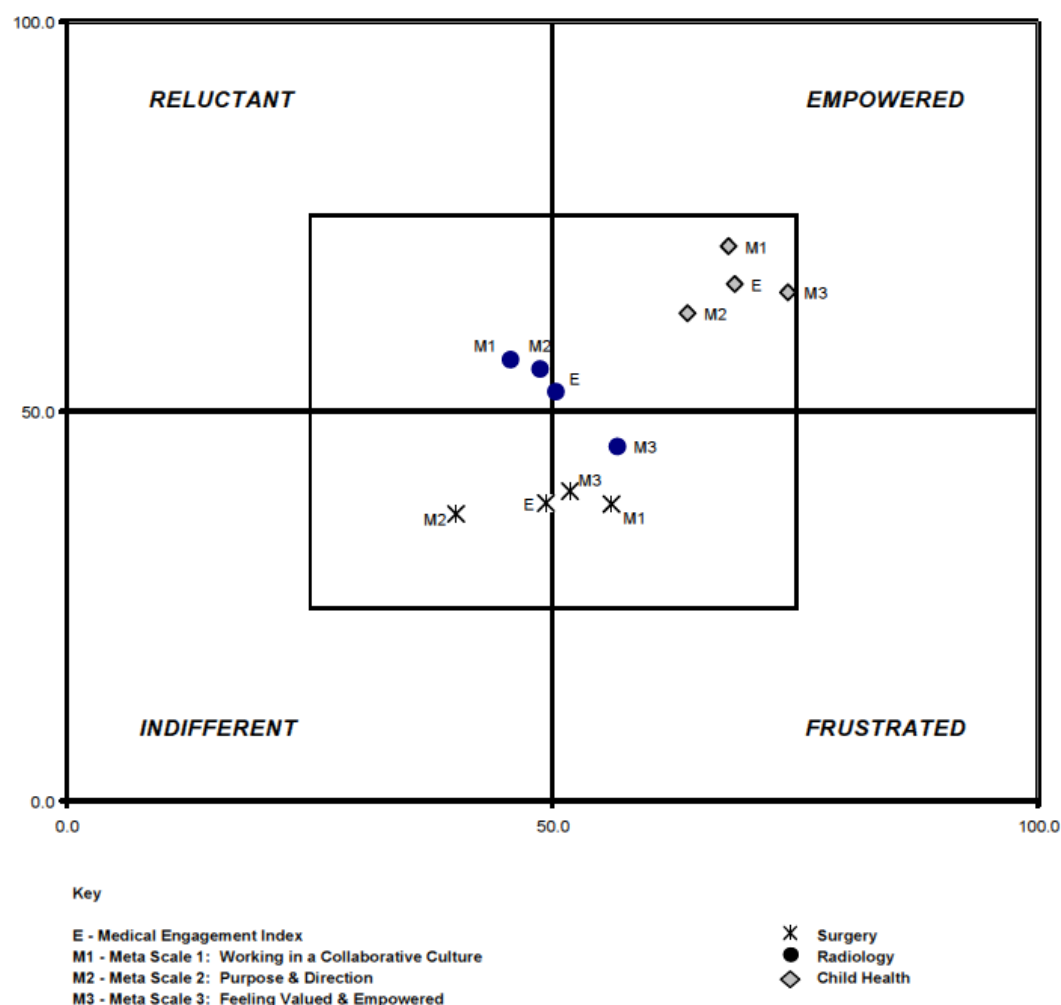
The figure below illustrates the four basic 'types' of engagement that becomes apparent when group percentile scores based on medical staff sub-samples are mapped onto the MES grid. Clearly, those medical staff who are highly personally motivated to become engaged in the managerial agenda and who are actively encouraged by the organisation to do so will be placed within the 'empowered' quadrant of the grid. This is the quadrant that defines a culture of highly active and positive medical engagement whereas the remaining three quadrants define three less desirable states of compromised engagement cultures. Members of medical staff tend to become '**frustrated**' when they have high levels of individual motivation but are not encouraged by the organisation to apply this desire to become involved to any meaningful leadership agenda. Conversely, in some circumstances the organisation may provide many opportunities and may actively attempt to encourage greater involvement, but members of medical staff show little enthusiasm and remain '**reluctant**' to become further involved in taking effective leadership roles. In the worst scenario, when both individual concern and organisational interest is low, then members of medical staff tend to disengage from the leadership process and become '**indifferent**'.

Figure 51. Engagement Typology



The figure overleaf presents the mapping of medical sub-samples from this Trust.

Figure 52. Engagement Typology Results (Case Study D)



It is apparent from the figure above that generally medical staff from **'Child Health'** fall within the **'empowered'** quadrant of the grid with respect to overall engagement index and to its 3 component meta-scales. For medical staff from **'Radiology'** the ratings for the overall Engagement Index tended to fall very near the mid-point of the MES grid. However, on **'Meta-Scale 3: Feeling valued and empowered'** this staff group's scores fell within the **'frustrated'** quadrant of the grid. For **'Surgery'** the figure shows that **'Meta-Scale 2: Having purpose and direction'** is mapped within the **'indifferent'** quadrant, whereas **'Meta-Scale 1: Working in a collaborative culture'** and **'Meta-Scale 3: Feeling valued and empowered'** are mapped within the **'frustrated'** quadrant.

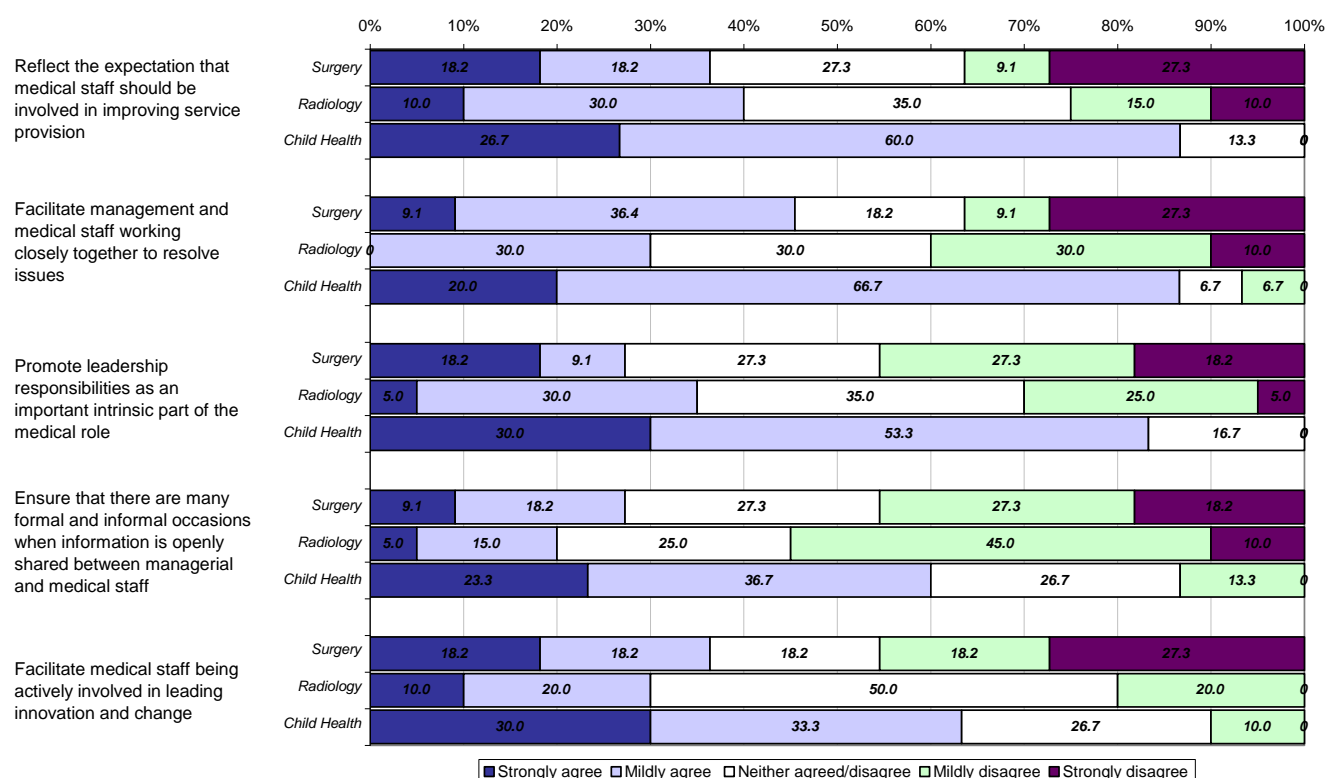
6.7.5 Additional Questions

Section B of the MES questionnaire comprised five questions which related to the organisational structure and working arrangements in the Trust. An examination of the figure below indicates that none of the questions were ringingly endorsed. Generally, medical staff from Child Care tended to be the most positive and medical staff from Radiology tended to be the least positive.

Figure 53. Perceptions of Effectiveness of Organisational Structures

Section B: Percentage of Respondents Endorsing Rating Categories

The organisational structure & working arrangements in this Trust.....



It is notable that over a third of medical staff disagreed (i.e. mildly disagree or strongly disagree) with the following:

The organisational structure & working arrangements in this Trust.....

Q1 Reflect the expectation that medical staff should be involved in improving service provision

[36% from Surgery]

Q2 Facilitate management and medical staff working closely together to resolve issues

[36% from Surgery, 40% from Radiology]

Q3 Promote leadership responsibilities as an important intrinsic part of the medical role

[46% from Surgery]

Q4 Ensure that there are many formal and informal occasions when information is openly shared between managerial and medical staff

[46% from Surgery, 55% from Radiology]

Q5 Facilitate medical staff being actively involved in leading innovation and change

[46% from Surgery]

6.7.6 Open Comments

Finally in this Case Study respondents were invited to comment on two broad questions

- a) What are the main barriers to engaging doctors in your Trust in leadership roles?
- b) What would help facilitate more effective engagement of doctors in your Trust?

A selection of comments for each question is presented below

Question A

- *"Pressure of clinical work."*
- *"The role of doctors as clinical leaders is very poorly defined. As such limited involvement of doctors in management. Chief executive is great very open but middle managers not so!"*
- *"The focus on financial management has a much higher priority than the systems management of the trust. Clinical work is so heavy that*

many people have no-one to fill in when they are not there. In order to get involved your clinical practice needs to be sacrificed."

- *"Doctors distrust of management. Lack of time due to clinical commitments."*
- *"Conflicting pressures for service commitments."*
- *"Insufficient time. Those involved in these roles frequently do not have enough time allocated in their job plans. Also the interface between non-managerial and managerial staff is increasingly adversarial."*
- *"It feels as though there is an expectation that involvement in new leadership activities is taken on within existing job plans which is often difficult to achieve. I have been asked to take on leadership activities which I am keen to do but this is not possible within my current 10PA job plan consisting of 9.5DCC."*
- *"Management is seen as more stressful and constraining than clinical work. Having to manage colleagues is always stressful - rewards are not sufficient and then difficult reintegrating once time is up."*
- *"The pressure to increase Consultant Lead clinical service at the detriment of service development. In short there is not enough time in the working day to see & clinically manage all the patients as well as be involved in leadership roles"*
- *"Lack of communication between managerial and medical staff, lack of engagement with junior medical staff."*
- *"Lack of real managerial engagement - the medical staff are either ignored or side-lined if we have an opinion which does not fit the party line."*

Question B

- *"More open discussion on finance & even medical responsibility for this."*
- *"More regular meetings with top managers. It would be good if the forthcoming annual meeting could take place twice a year."*
- *"An atmosphere of mutual respect."*

- *"Some feeling of ownership - I think doctors feel increasingly powerless to influence change. All consultants need some leadership and team playing training - of course those most in need often don't realise it."*
- *"I'm not sure I have the answer, but sending out emails with long attachments which never get read or using acronyms without explaining what they stand for certainly does not help."*
- *"The belief that their opinions are listened to, taken seriously and acted upon."*
- *"The ability to action a decision quickly and decisively, without being de-railed by intransigence at middle levels (both medical and non-medical management). The encouragement of good staff and supporting them with a reasonable work load, not punishing them by getting them to cover for the less able staff."*
- *"If the Trust management ever listened to what the consultant body as a group felt strongly about then they would gain our respect. We occasionally are informed about planned changes. Clearly the decision has already been made and no amount of collective reasoning by the consultant body ever changes any of these management decisions. It is therefore much simpler to ignore the management and get on providing the best clinical service we can without management interference."*

6.7.7 Conclusions

The results demonstrate that the MES is able to differentially describe the levels of engagement within the sub-samples of medical staff selected from this Trust. Clearly, medical staff from 'Child Health' have a positive perception of their leadership roles whereas medical staff from 'Surgery' consider that they are not sufficiently encouraged to take leadership roles on board. In contrast, medical staff from 'Radiology' are more mixed in their perceptions.

6.7.8 Case Study Comment

It is clear that MES data is able to differentiate sub-groups of clinicians and that distinct cultures of engagement exist across various parts of the NHS. Engagement levels are not necessarily therefore common across an organisation and units of analysis to understand how medical engagement operates must be at this sub-culture level.

6.8 Remaining Five Case Studies

A selection of results from the remaining sites completing MES are presented here but must be interpreted with caution due to the low returns. In some instances only two clinical sub-groupings were involved.

Figure 54. MES Results Site E (n=11, 2 sub groups only)

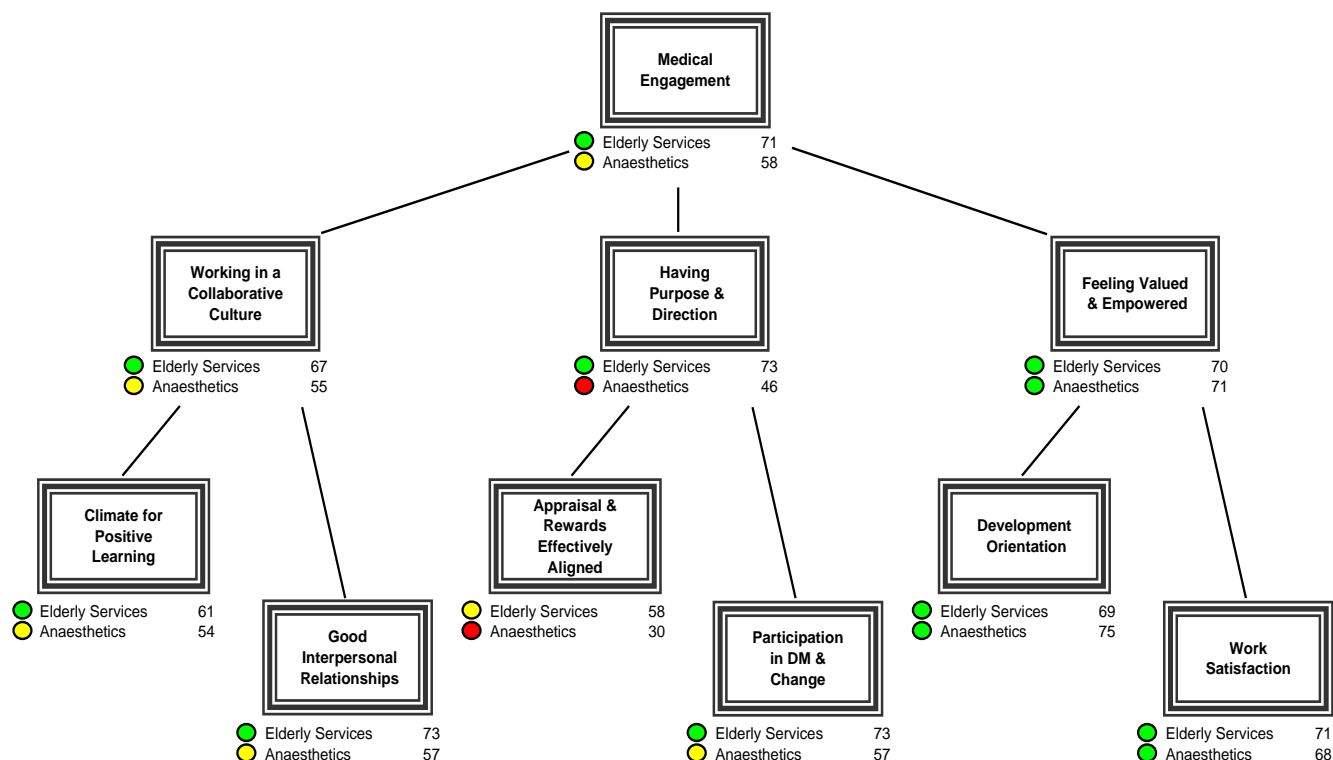


Figure 55. MES Scales

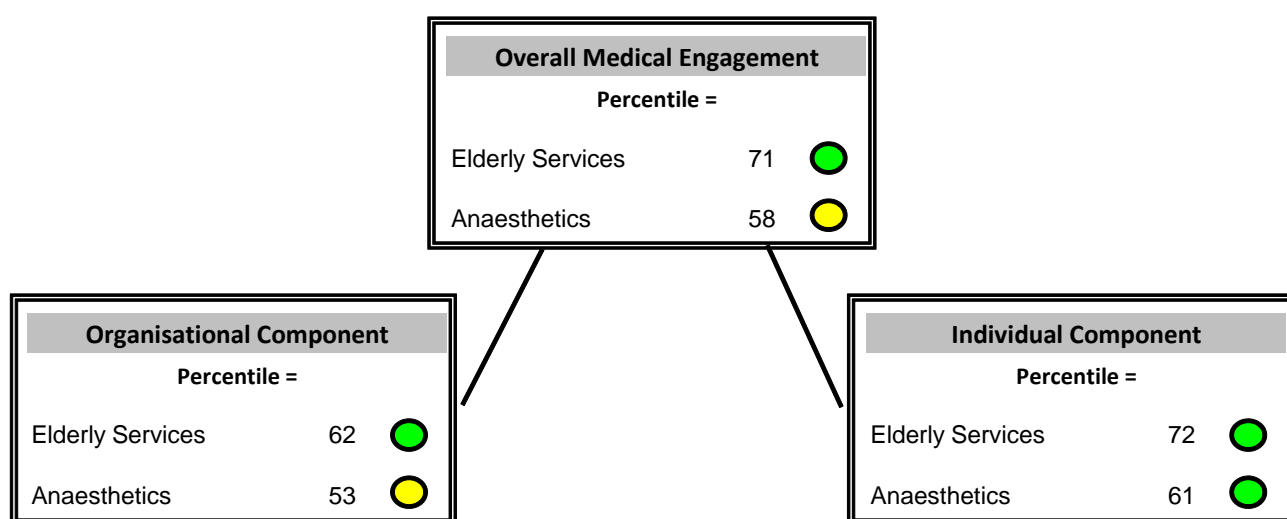


Figure 56. Meta Scale 1

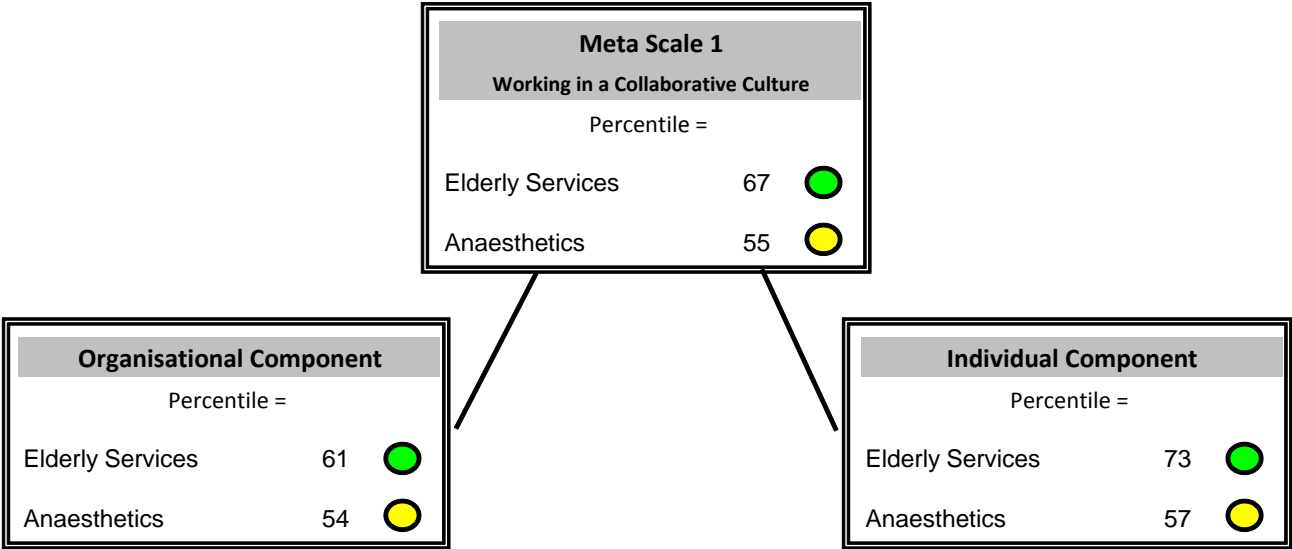


Figure 57. Meta Scale 2

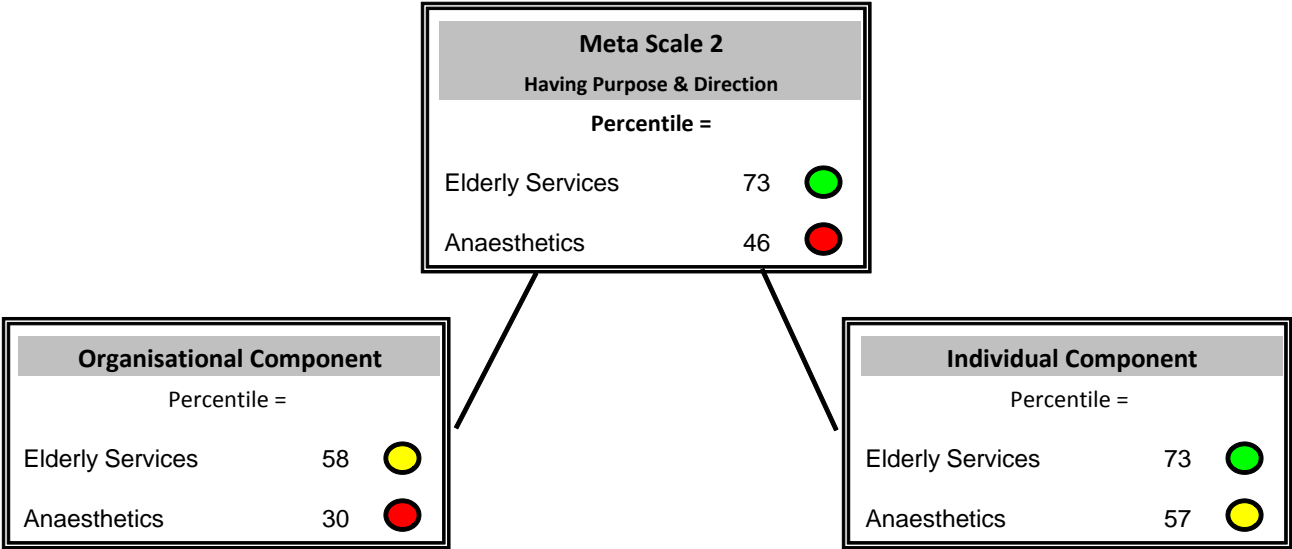
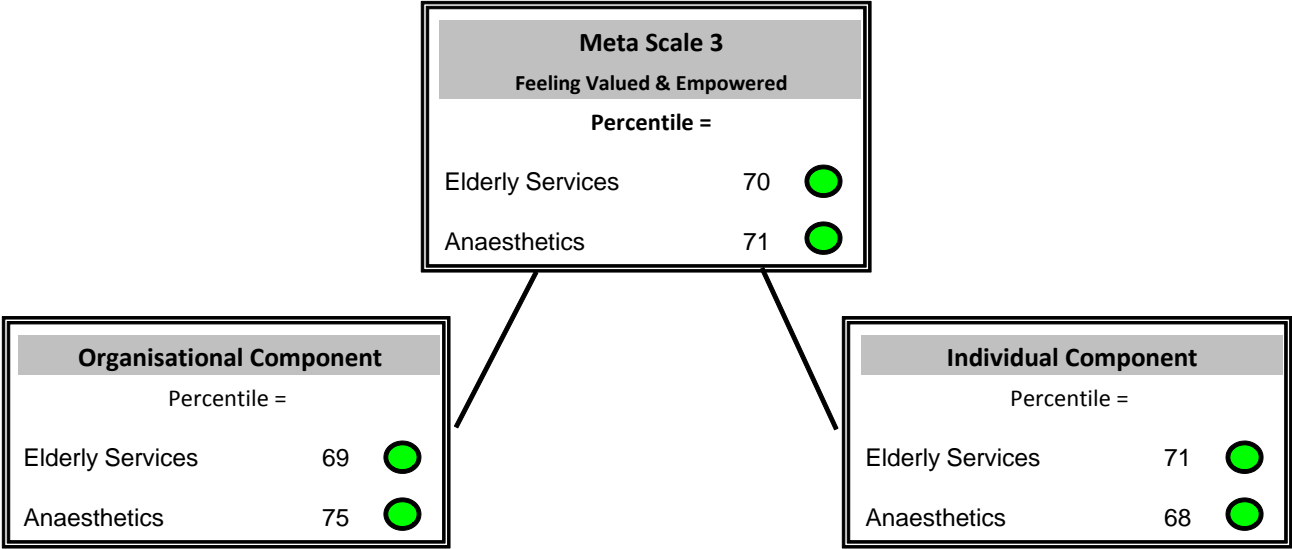


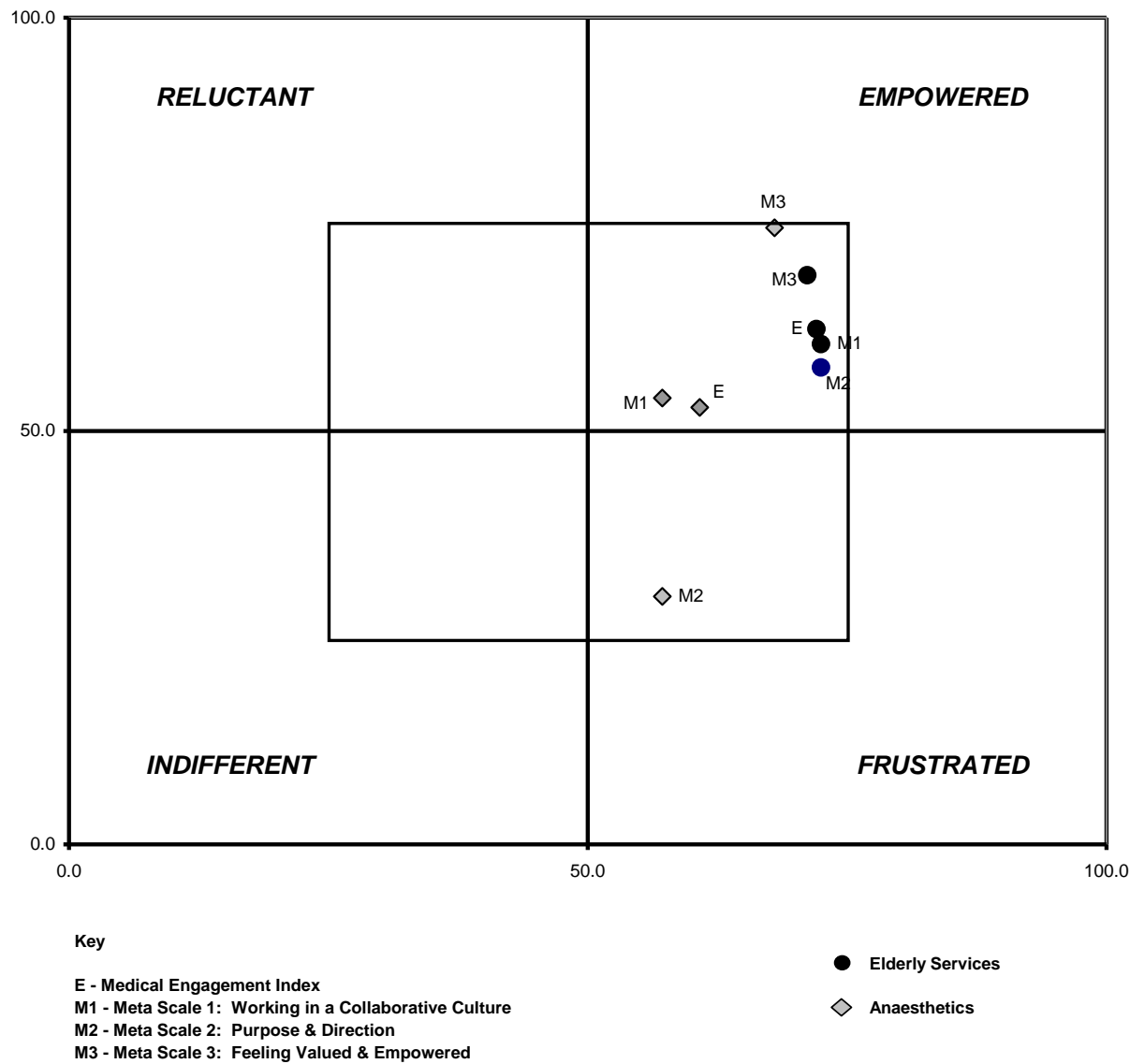
Figure 58. Meta Scale 3



It can be seen that the relative levels of medical endorsement of the organisational and individual components of the three meta-scales are different for these two organisational sub-samples. Medical staff from **'Elderly Services'** are associated with high levels of relative engagement across the board whereas the ratings of medical staff from **'Anaesthetics'** present a more mixed picture.

Figure 59 presents the mapping of medical sub-samples from this Trust.

Figure 59. Engagement Typology Results (Site E)



An examination of the MES grid above shows that generally medical staff from '**Elderly Services**' are more engaged than medical staff from '**Anaesthetics**'. Although it is clear that most ratings fell within the '**Empowered**' quadrant of the MES grid, one rating fell within the '**Frustrated**' quadrant. This was the case for medical staff from '**Anaesthetics**' for **Meta-Scale 2: Purpose and Direction**.

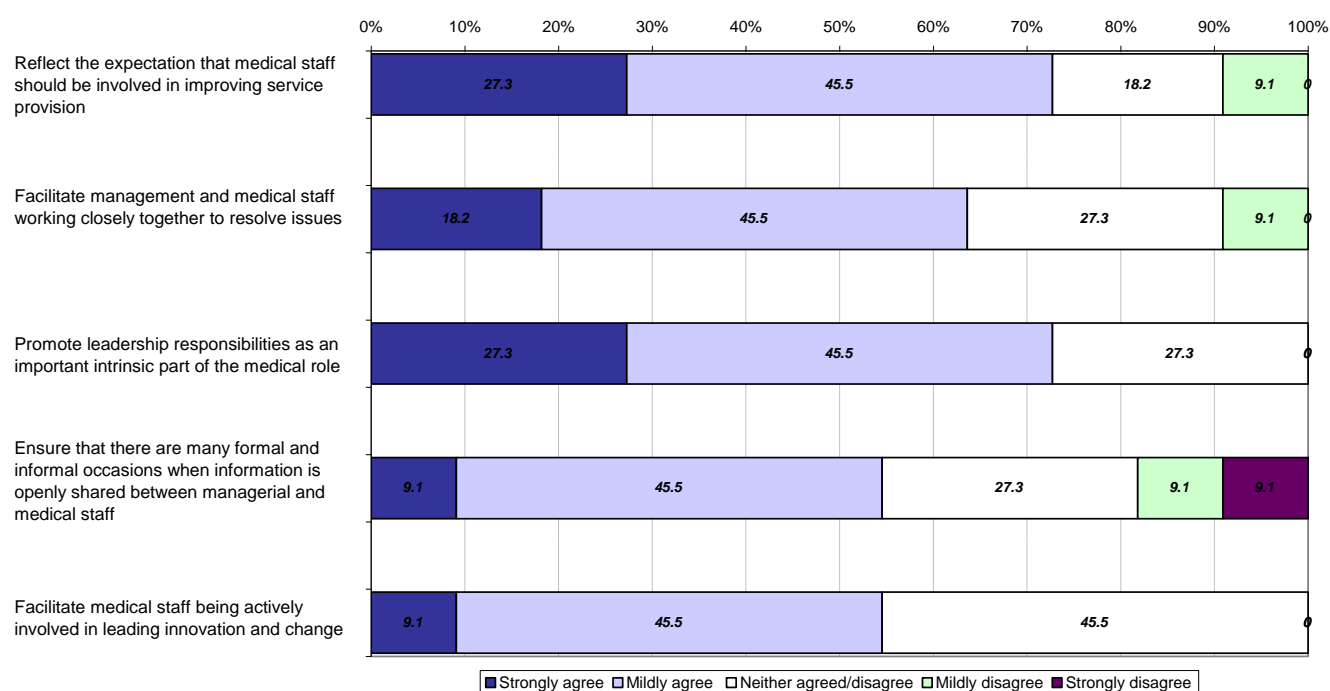
6.8.1 Additional Questions

Section B of the MES questionnaire comprised five questions which related to the organisational structure and working arrangements in the Trust. An examination of the figure below indicates that most medical staff in this small sample tended to be fairly positive

Figure 60. Perceptions of Effectiveness of Organisational Structures (Site E)

Section B: Percentage of Respondents Endorsing Rating Categories

The organisational structure & working arrangements in this Trust.....



6.8.2 Conclusions

The results demonstrate that levels of engagement within this small sample of members of medical staff was generally relatively high particularly for those staff from **'Elderly Services'**. However, there were areas of relatively lower engagement associated with medical staff from **'Anaesthetics'**.

Figure 61. MES results Site B (n=18)

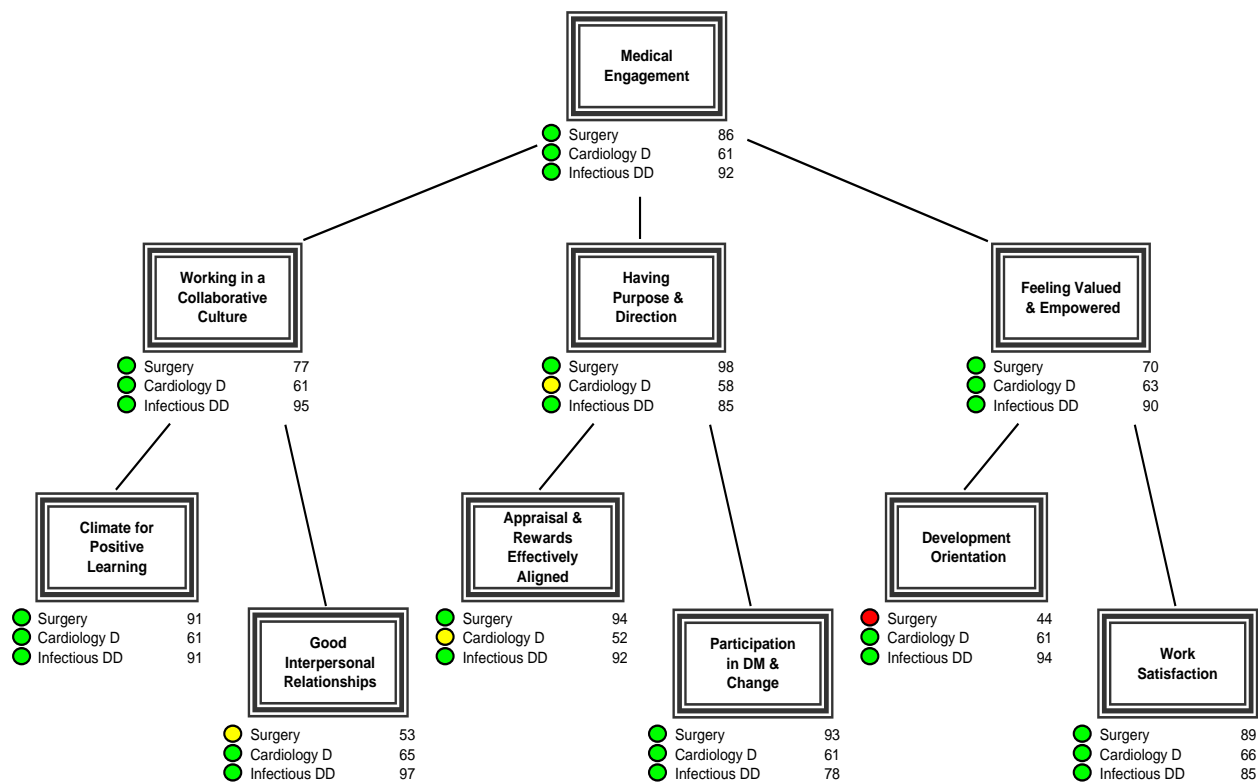


Figure 62. MES Scales

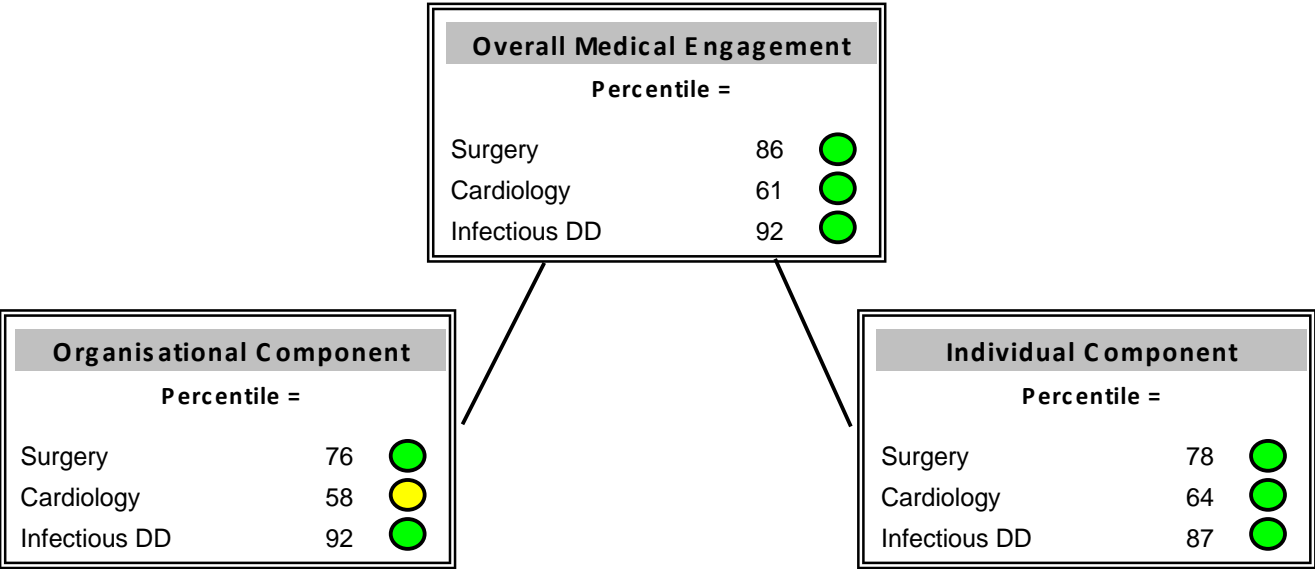


Figure 63. Meta Scale 1

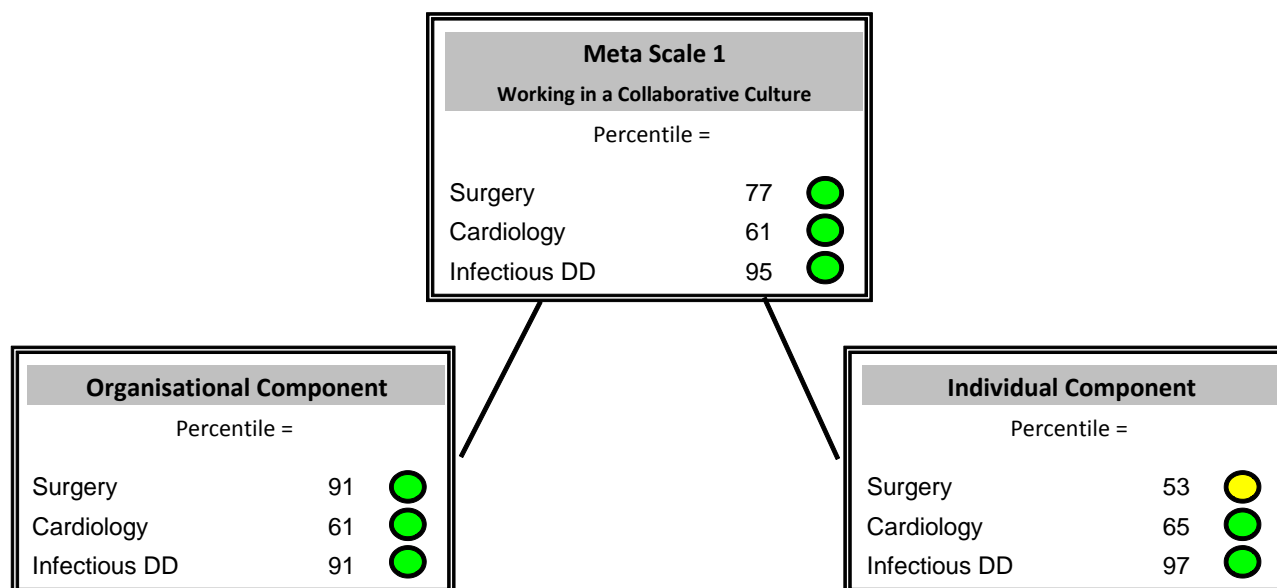


Figure 64. Meta Scale 2

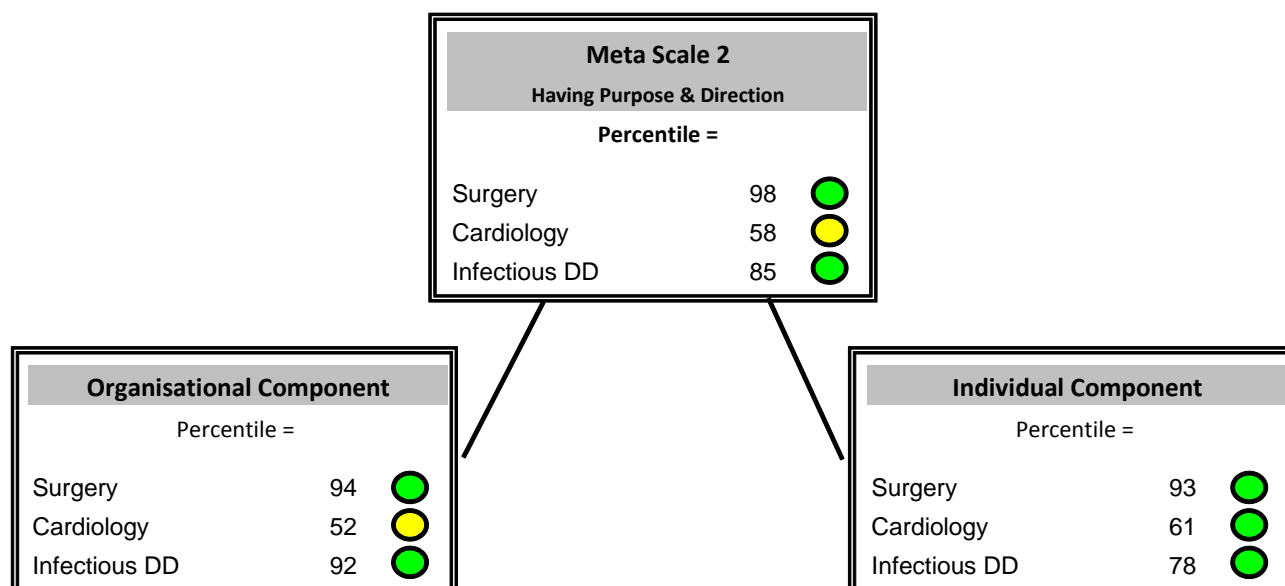
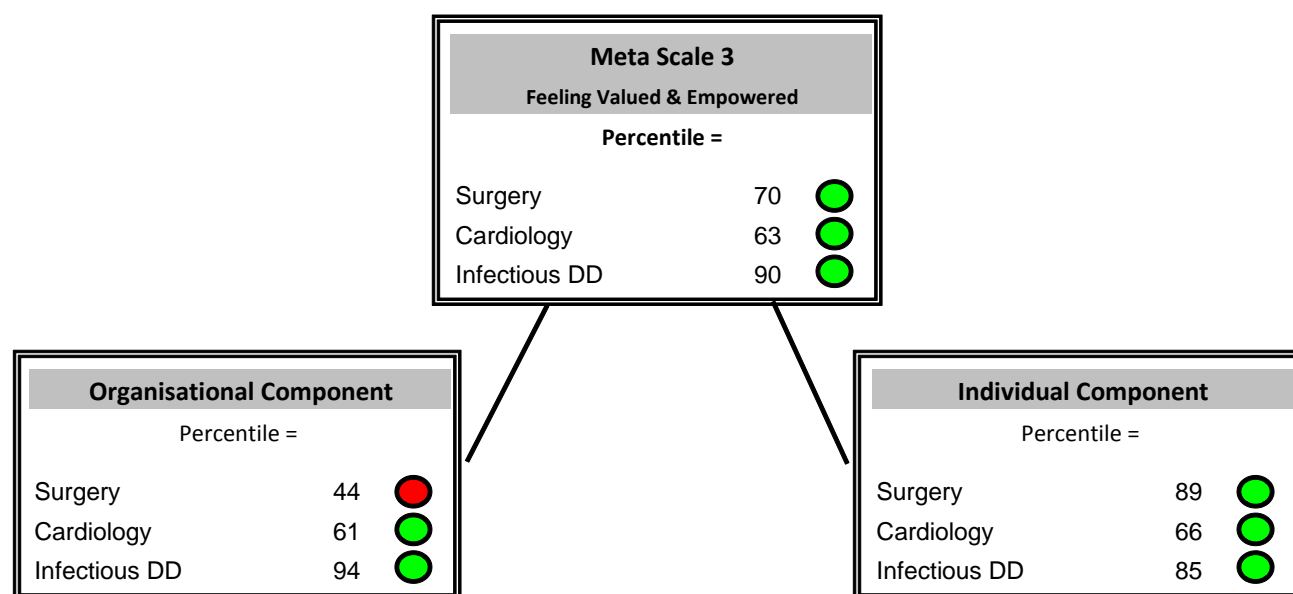


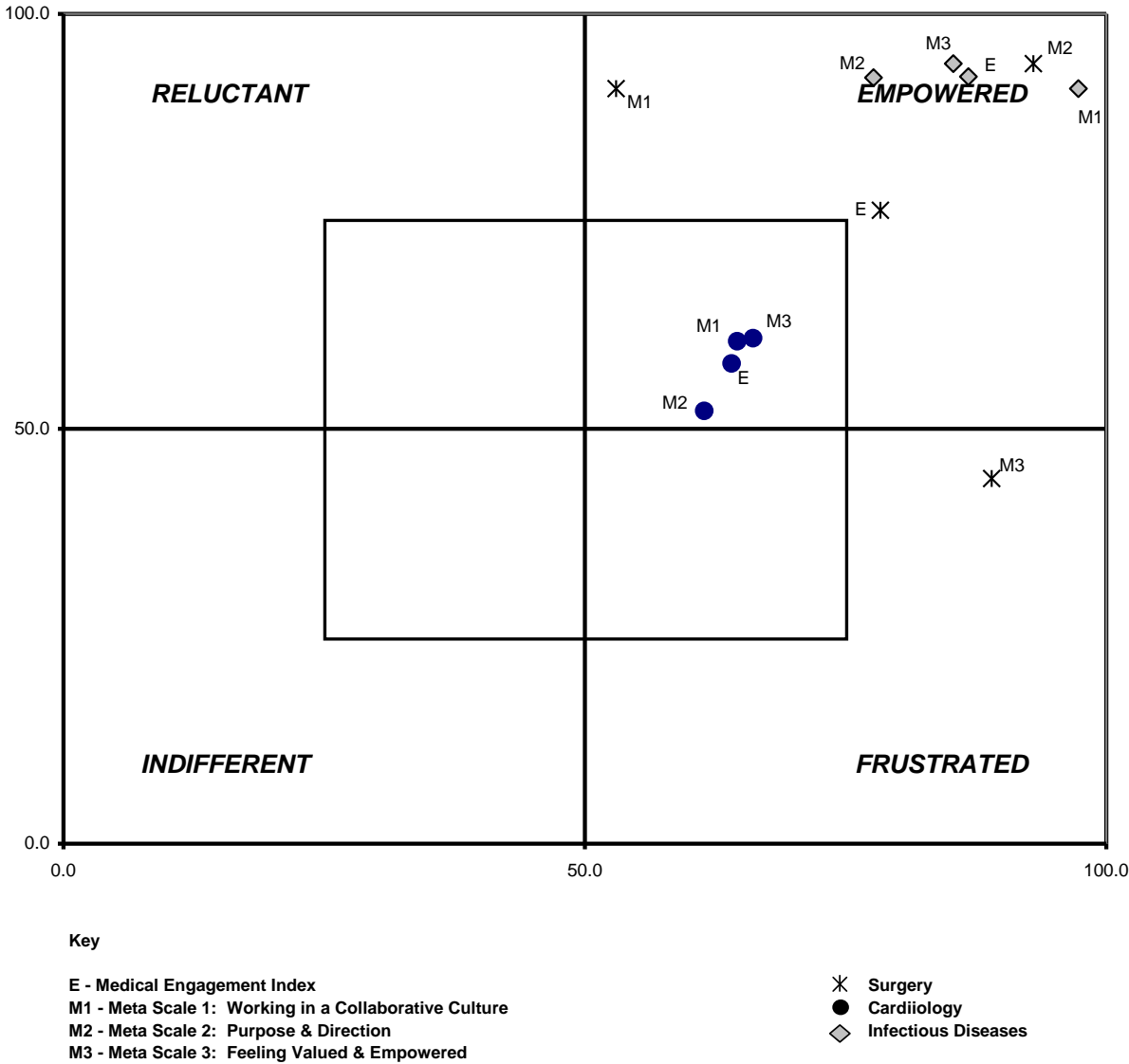
Figure 65. Meta Scale 3



It can be seen that the relative levels of medical endorsement of the organisational and individual components of the three meta-scales tend to be relatively good and broadly aligned for all three organisational sub-samples. However, one area of relatively low medical engagement is apparent for medical staff from '**Surgery**' with respect to the organisational component of **Meta-Scale 3: Feeling Valued and Empowered**. The meaning of these joint ratings is explored in more detail in the next section.

Figure 66 presents the mapping of medical sub-samples from this Trust.

Figure 66. Engagement Typology Results (Site B)



It is apparent that the ratings of members of medical staff from both **'Surgery'** and **'Infectious Diseases'** mean that they both generally fall within the **'Empowered'** quadrant of the grid, with the sole exception of medical staff from **'Surgery'** ratings of **Meta-Scale 3: Being Valued and Empowered**. In contrast, although the ratings of medical staff **'Cardiology'** also fell within the **'Empowered'** quadrant of the grid, they are less engaged than their colleagues in the other two sub-samples.

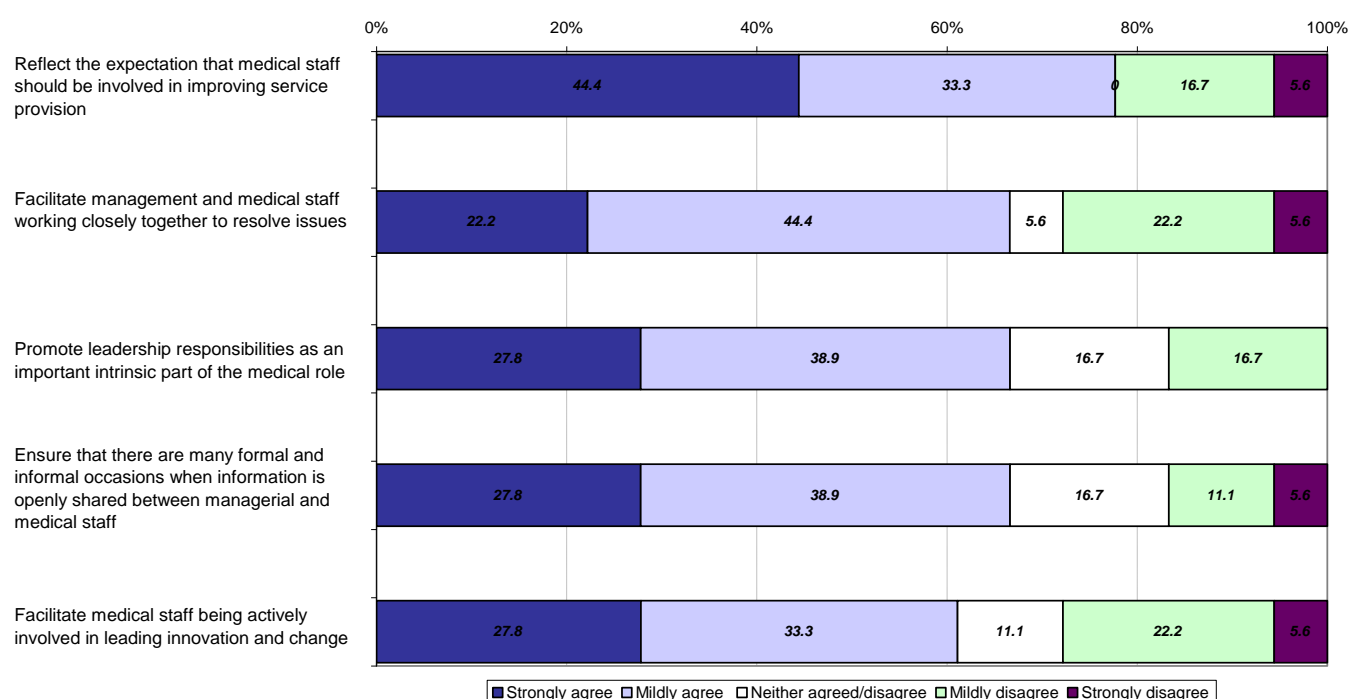
6.8.3 Additional Questions

Section B of the MES questionnaire comprised five questions which related to the organisational structure and working arrangements in the Trust. An examination of the figure below indicates that overall this small sample of medical staff tended to be fairly positive about all five items.

Figure 67. Perceptions of Effectiveness of Organisational Structures (Site B)

Section B: Percentage of Respondents Endorsing Rating Categories

The organisational structure & working arrangements in this Trust.....



6.8.4 Conclusions

The results demonstrate that relative levels of medical engagement are high although medical staff from '**Surgery**' are associated with a relatively low level of engagement with respect to **Sub-Scale 5: Development Orientation** indicating that these medical staff would welcome more training and development opportunities.

Figure 68. MES results for site C (n=14)

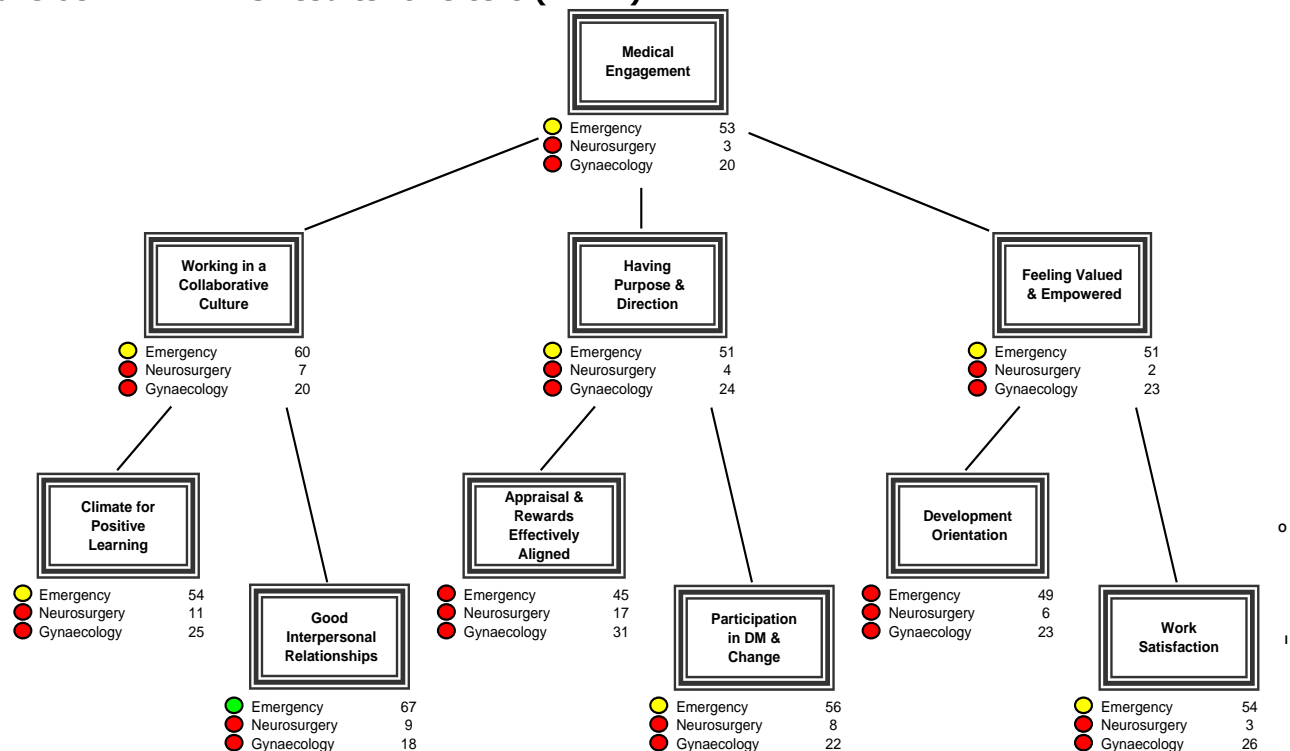


Figure 69. MES Scales

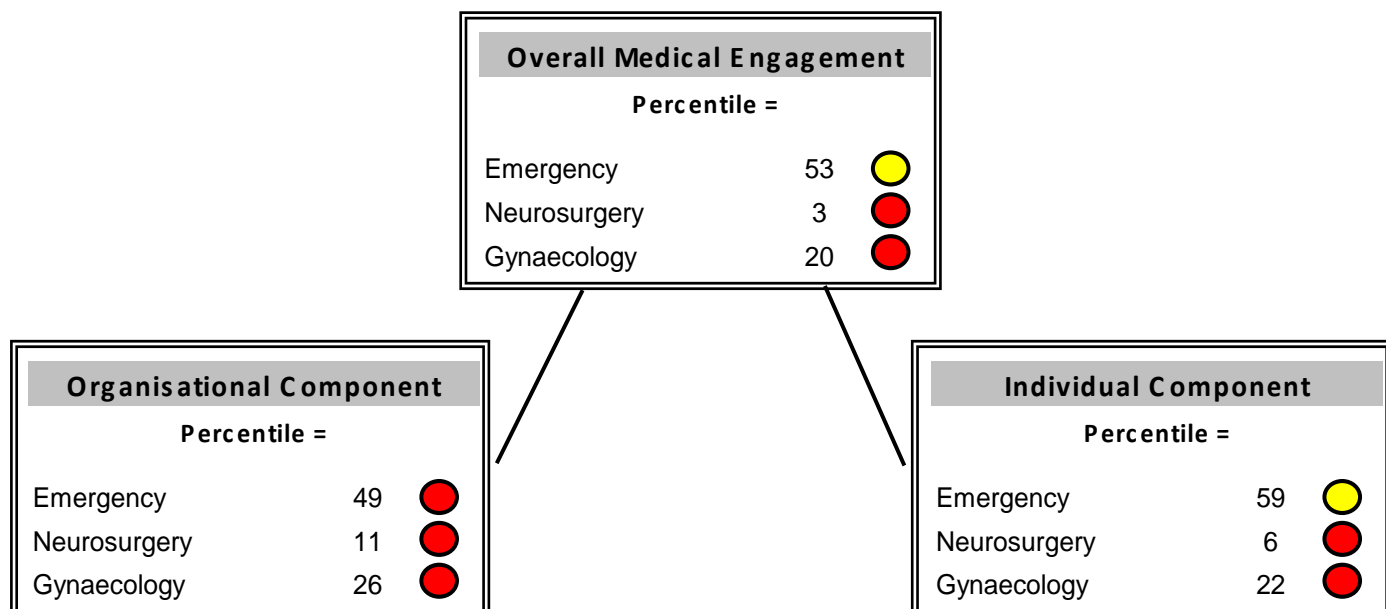


Figure 70. Meta Scale 1

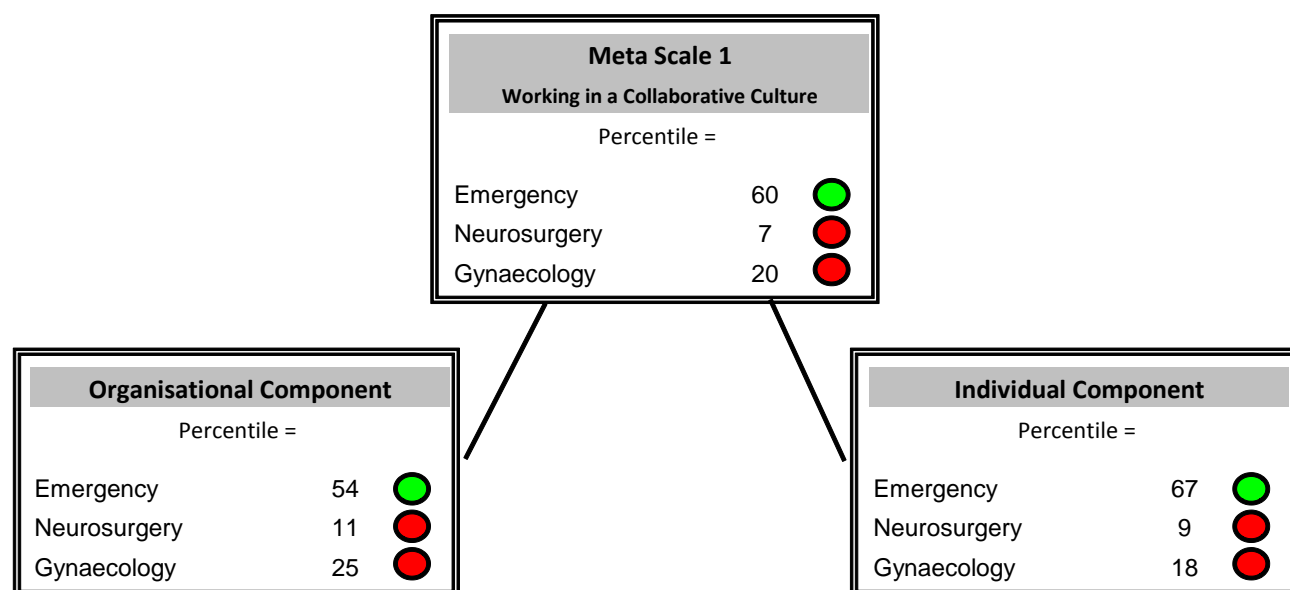


Figure 71. Meta Scale 2

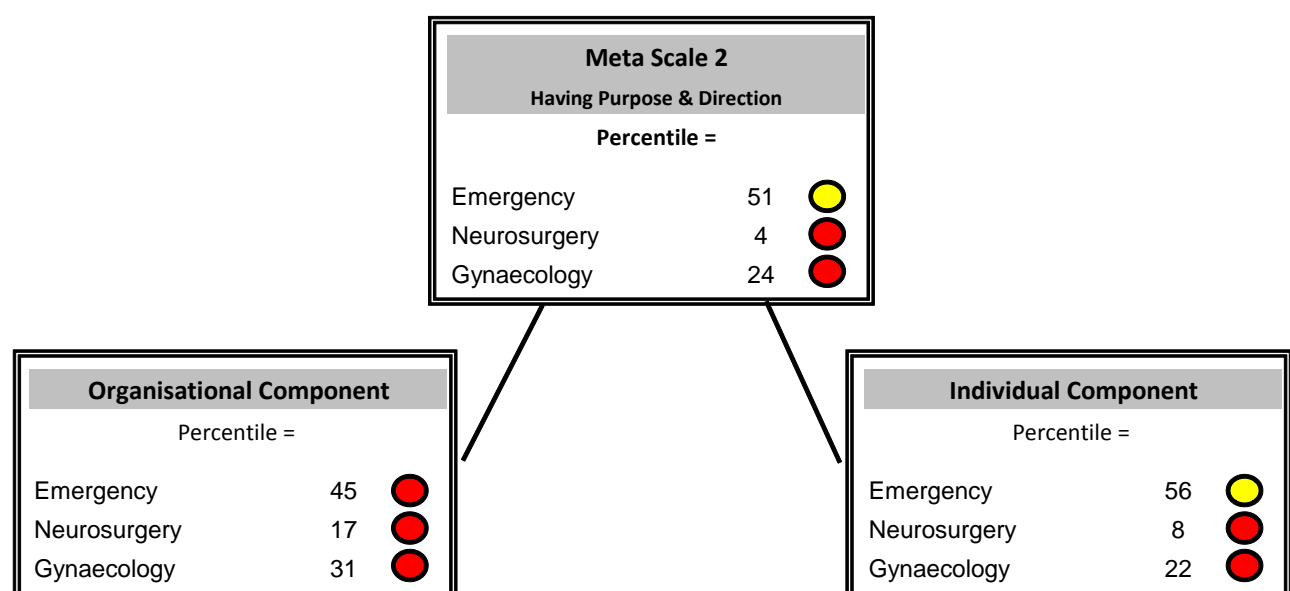
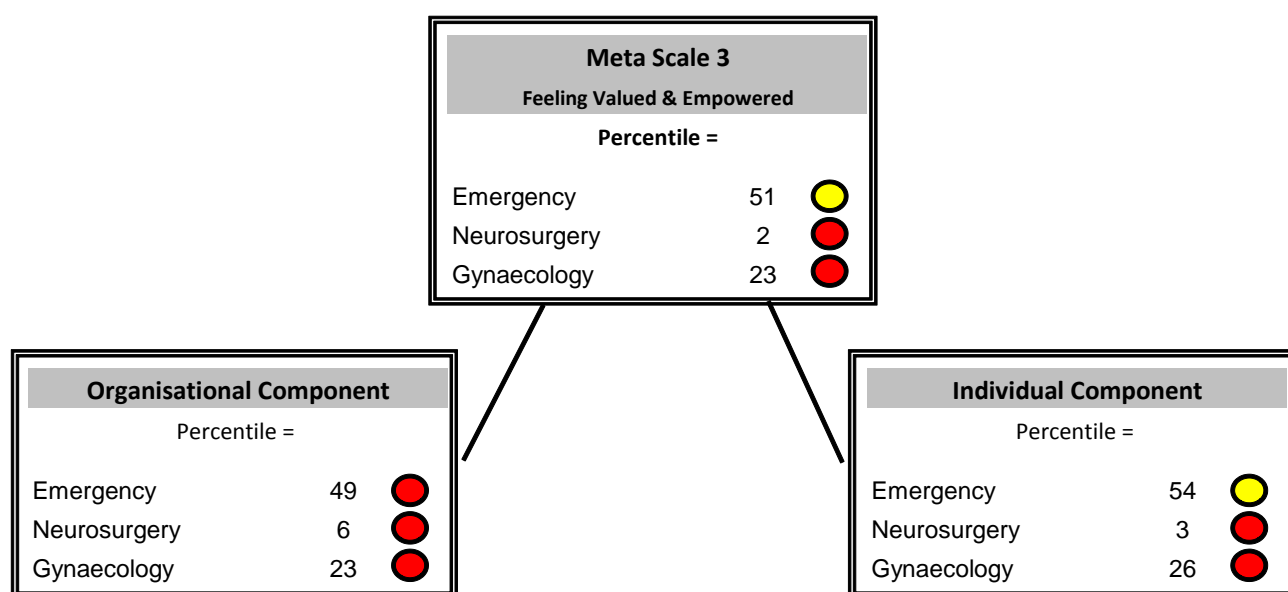


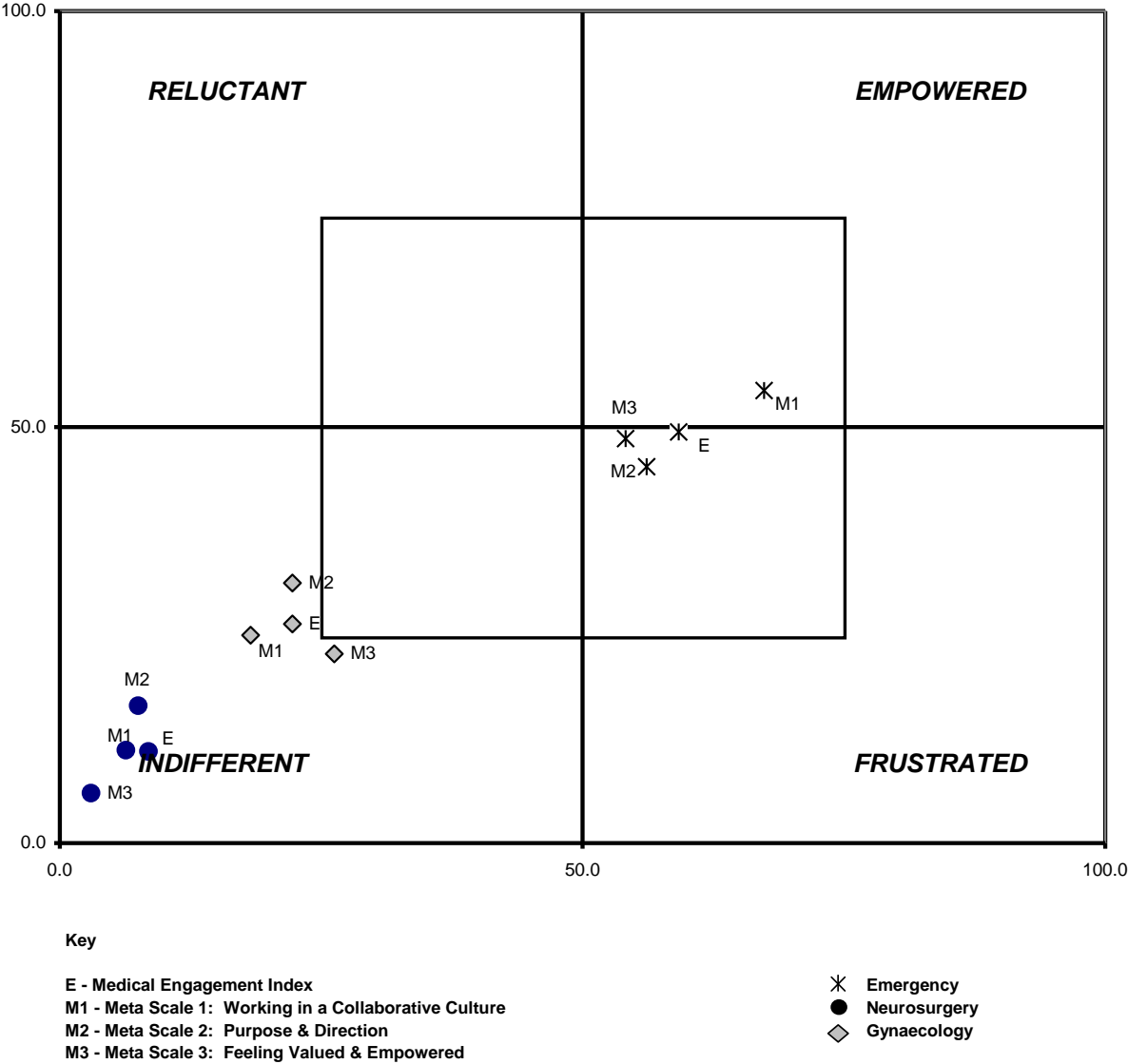
Figure 72. Meta Scale 3



It can be seen that the relative levels of medical endorsement of the organisational and individual components of the three meta-scales are broadly aligned for two of the three organisational sub-samples. It can be seen that medical staff from both the '**Neurosurgery**' and '**Gynaecology**' sub-samples are associated with low levels of relative engagement. However, unlike the other two sub-samples, the endorsement levels for medical staff from '**Emergency**' tend to be higher particularly with respect to **Meta-Scale1: Working in a Collaborative Culture**. The meaning of these joint ratings is explored in more detail in the next section.

Figure 73 presents the mapping of medical sub-samples from this Trust.

Figure 73. Engagement Typology Results (Site C)



An inspection of the figure above reveals that the three sub-samples fall within three well-defined clusters with medical staff from '**Neurosurgery**' being the most disengaged and falling within the outer area of the '**Indifferent**' quadrant of the MES grid. The ratings of medical staff from '**Gynaecology**' were not quite so disengaged but they were still placed within the outer area of the '**Indifferent**' quadrant of the MES grid. In contrast the ratings of medical staff from '**Emergency**' were more positive although greater individual motivation and organisational facilitation would

be required to move these ratings unambiguously within the **'Empowered'** quadrant.

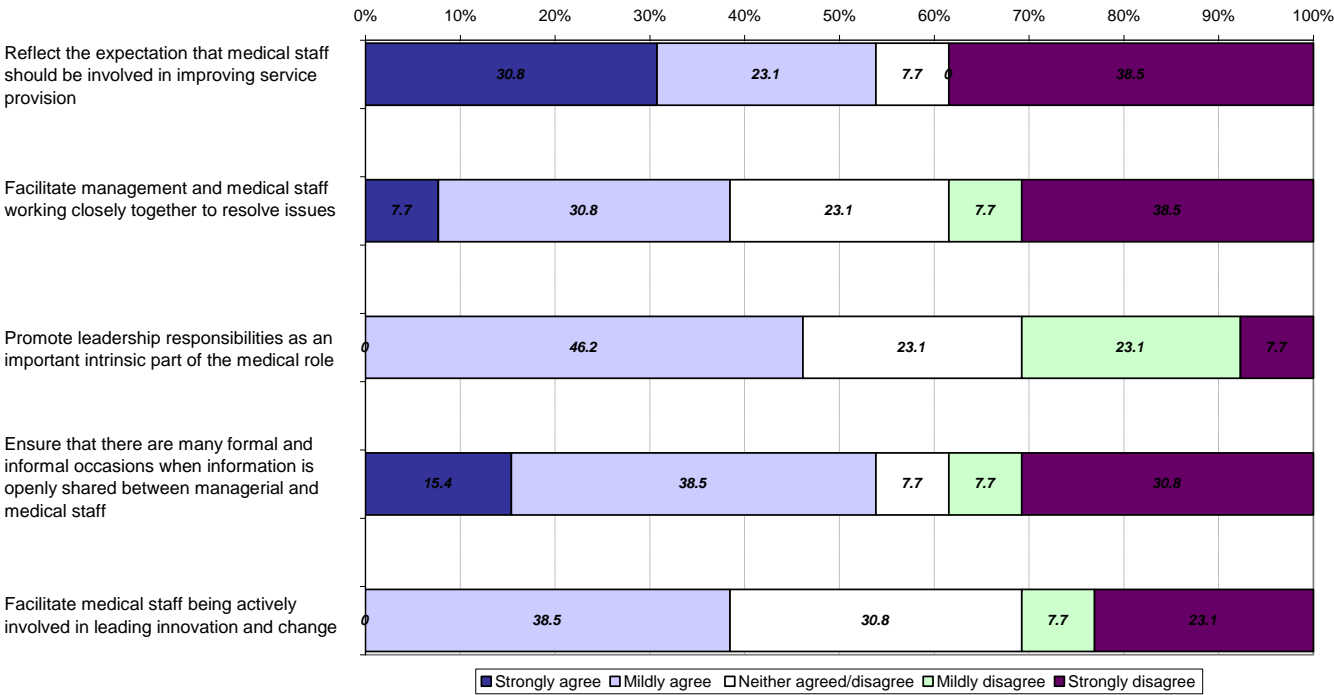
6.8.5 Additional Questions

Section B of the MES questionnaire comprised five questions which related to the organisational structure and working arrangements in the Trust. An examination of the figure below indicates that the ratings of medical staff from this Trust tended to reflect the full spectrum of opinion.

Figure 74. Perceptions of Effectiveness of Organisational Studies (Site B)

Section B: Percentage of Respondents Endorsing Rating Categories

The organisational structure & working arrangements in this Trust....



6.8.6 Conclusions

The results demonstrate that the MES is able to differentially describe the levels of engagement within the three sub-samples of medical staff selected from this Trust. Clearly, medical staff from **'Emergency'** appear more likely to become positively engaged in a leadership agenda than those from either **'Neurosurgery'** or **'Gynaecology'** who were less engaged.

Figure 75. MES Results Case Study I (n=12, two clinical units only)

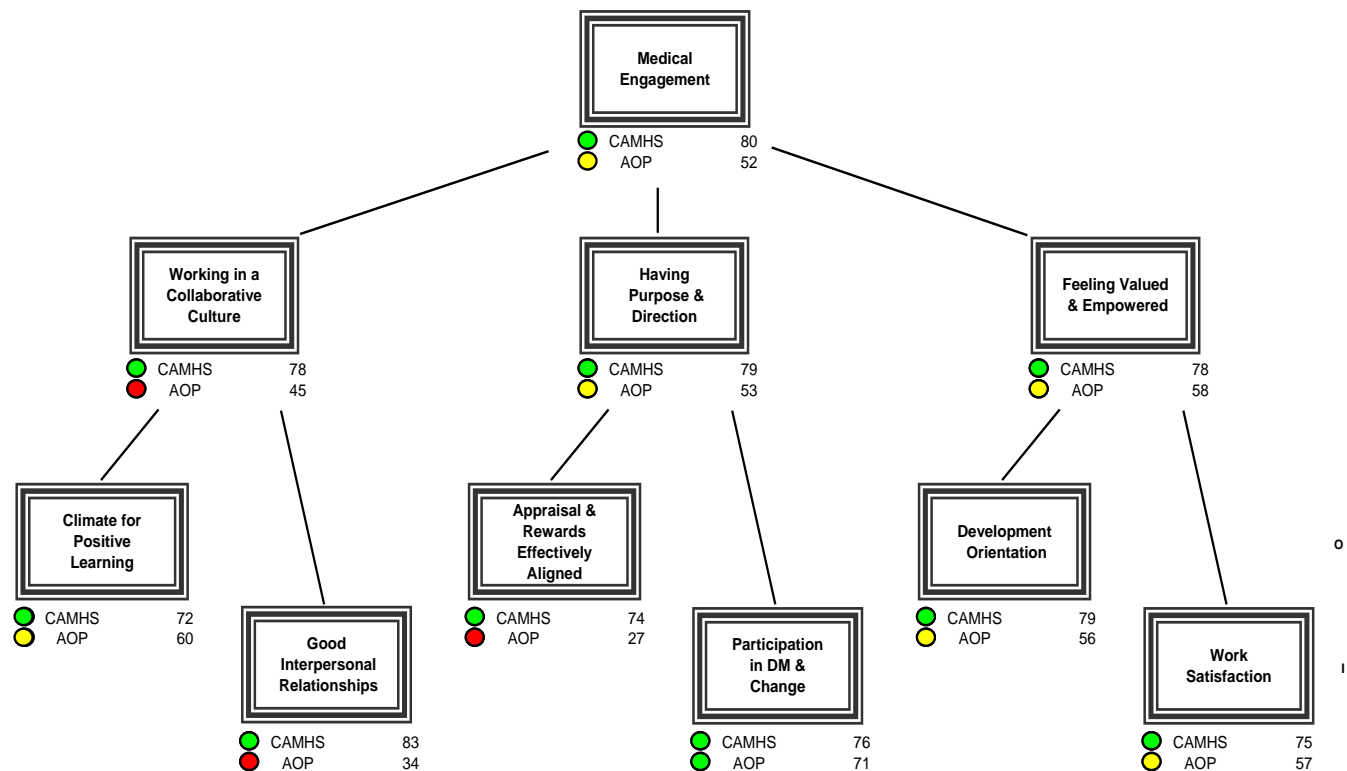


Figure 76. MES Scales

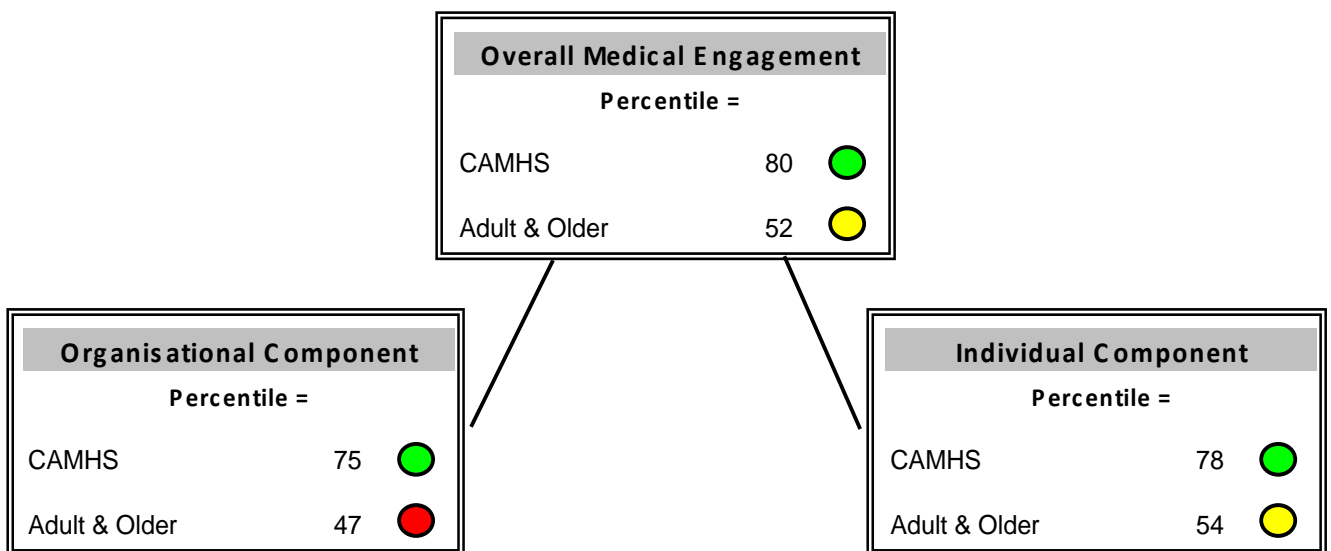


Figure 77. Meta Scale 1

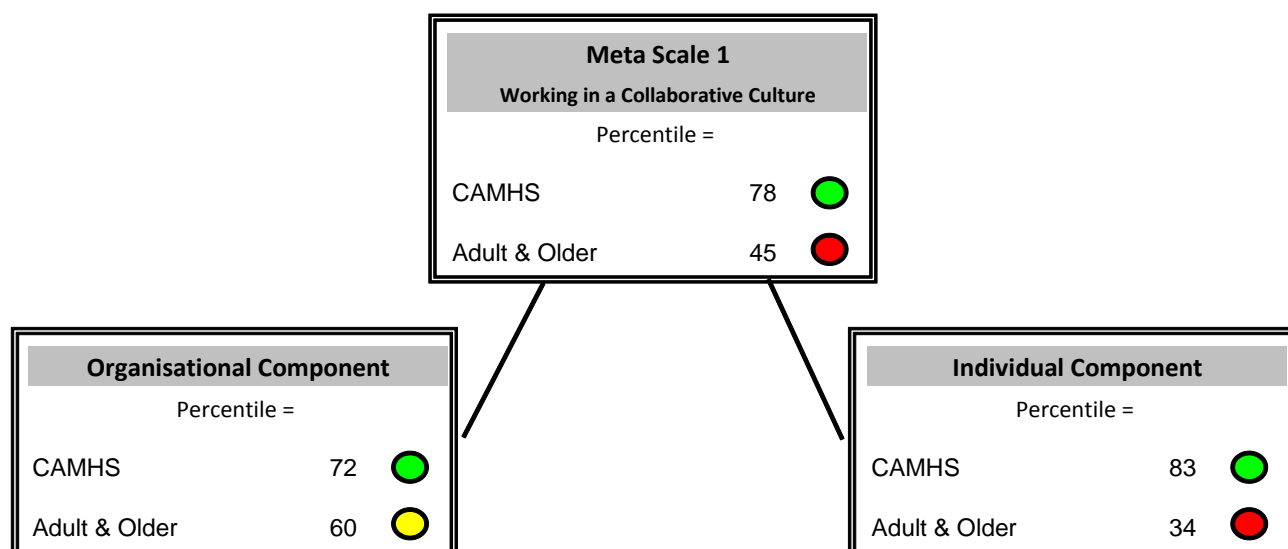


Figure 78. Meta Scale 2

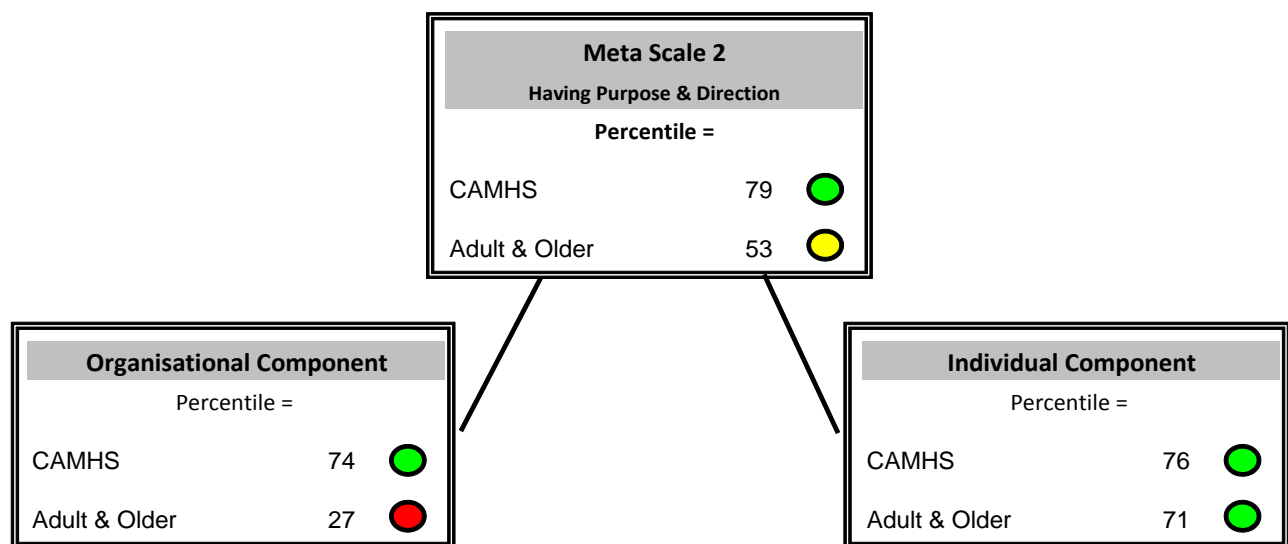
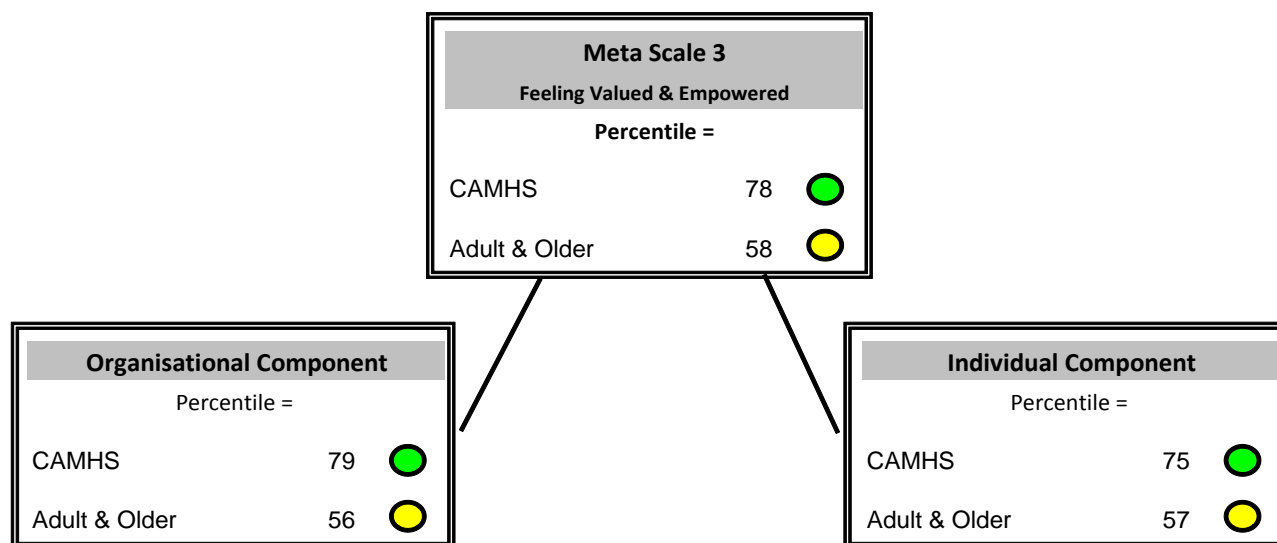


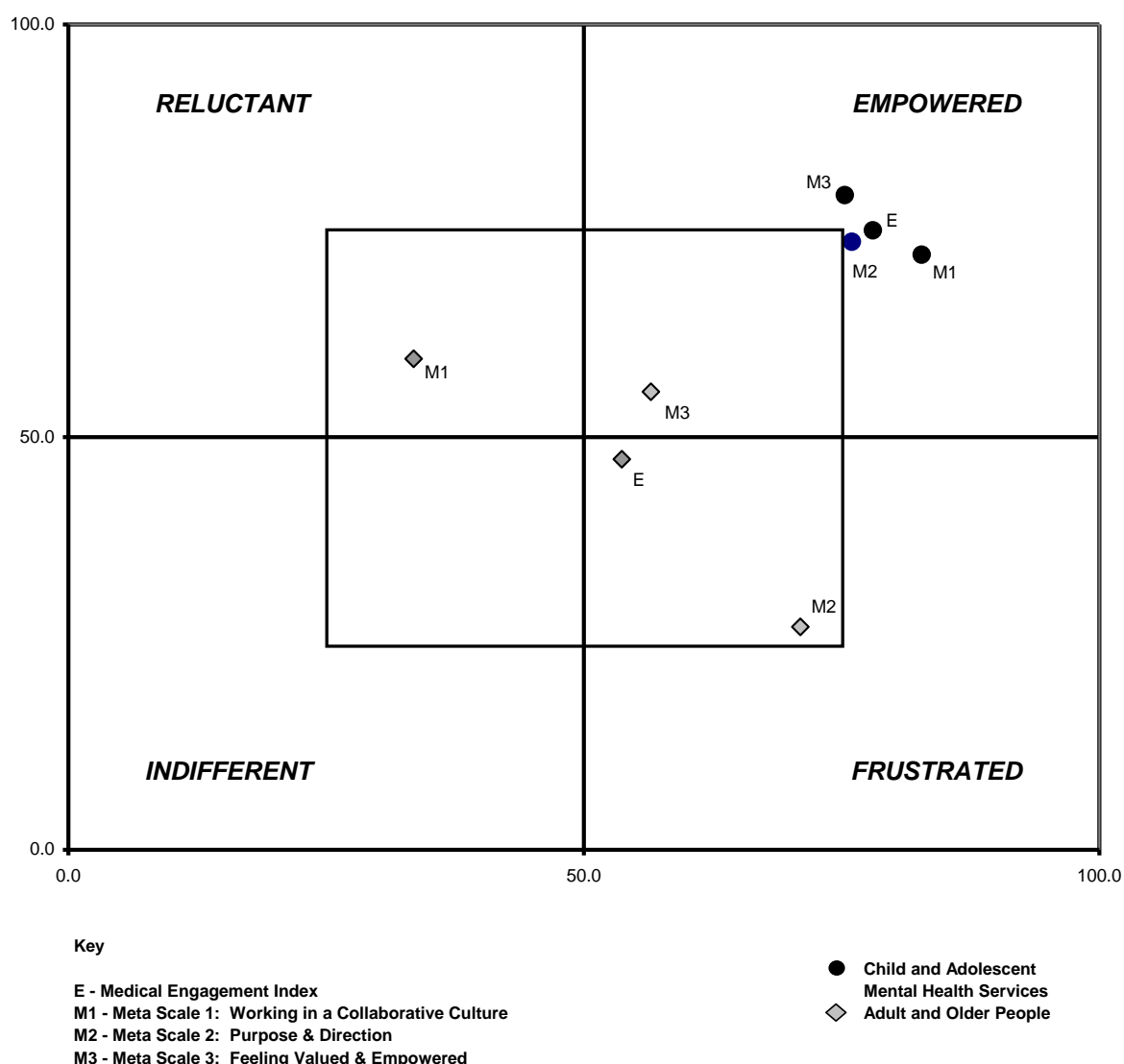
Figure 79. Meta Scale 3



It can be seen that the relative levels of medical endorsement of the organisational and individual components of the three meta-scales differ for the two organisational sub-samples. The level of medical engagement for medical staff from '**CAMHS**' is relatively high across all components whereas the level of medical engagement for medical staff from '**Adult and Older**' varies across the MES components. The meaning of these joint ratings is explored in more detail in the next section.

Figure 80 presents the mapping of medical sub-samples from this Trust.

Figure 80. Engagement Typology Results (Site I)



The MES grid clearly identifies the two sub-samples as distinct clusters. Whereas all of the ratings for medical staff from '**Adult and Older People**' fell within the inner area of the grid, all of the ratings for medical staff from '**CAMHS**' fell within the outer area of the '**Empowered**' quadrant of the MES grid indicating that this latter sub-sample are more engaged.

6.8.7 Additional Questions

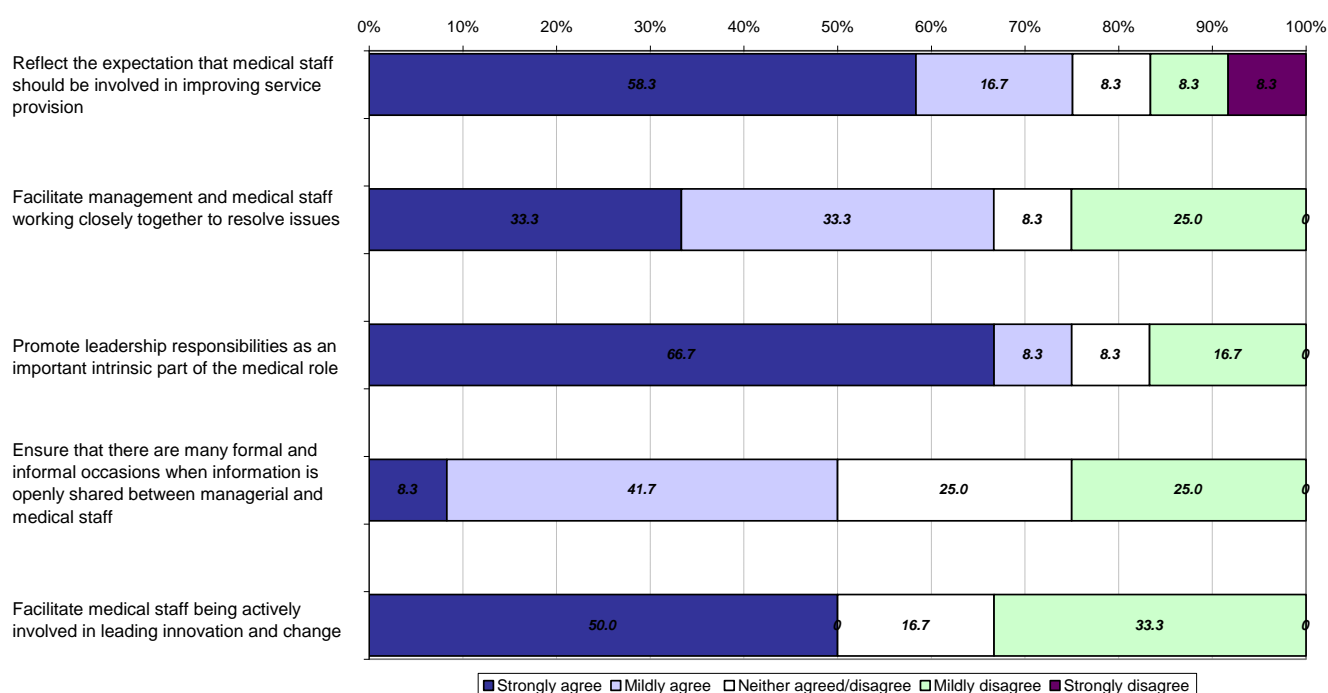
Section B of the MES questionnaire comprised five questions which related to the organisational structure and working arrangements in the Trust. An

examination of the figure below indicates that over half of this small sample of medical staff were generally fairly positive although 8% strongly disagreed that the Trust structure reflects the expectation that medical staff should be involved in improving service provision.

Figure 81. **Perceptions of Effectiveness of Organisational Studies (Site I)**

Section B: Percentage of Respondents Endorsing Rating Categories

The organisational structure & working arrangements in this Trust.....



6.8.8 Conclusions

The results demonstrate that the MES is able to differentially describe the levels of engagement within the two sub-samples of medical staff selected from this Trust. Clearly, medical staff from '**Adults and Older People**' whereas some medical staff from '**CAMHS**' are less likely to become positively engaged in a leadership agenda.

Figure 82. MES results for Site H (n=6, 2clinical units only)

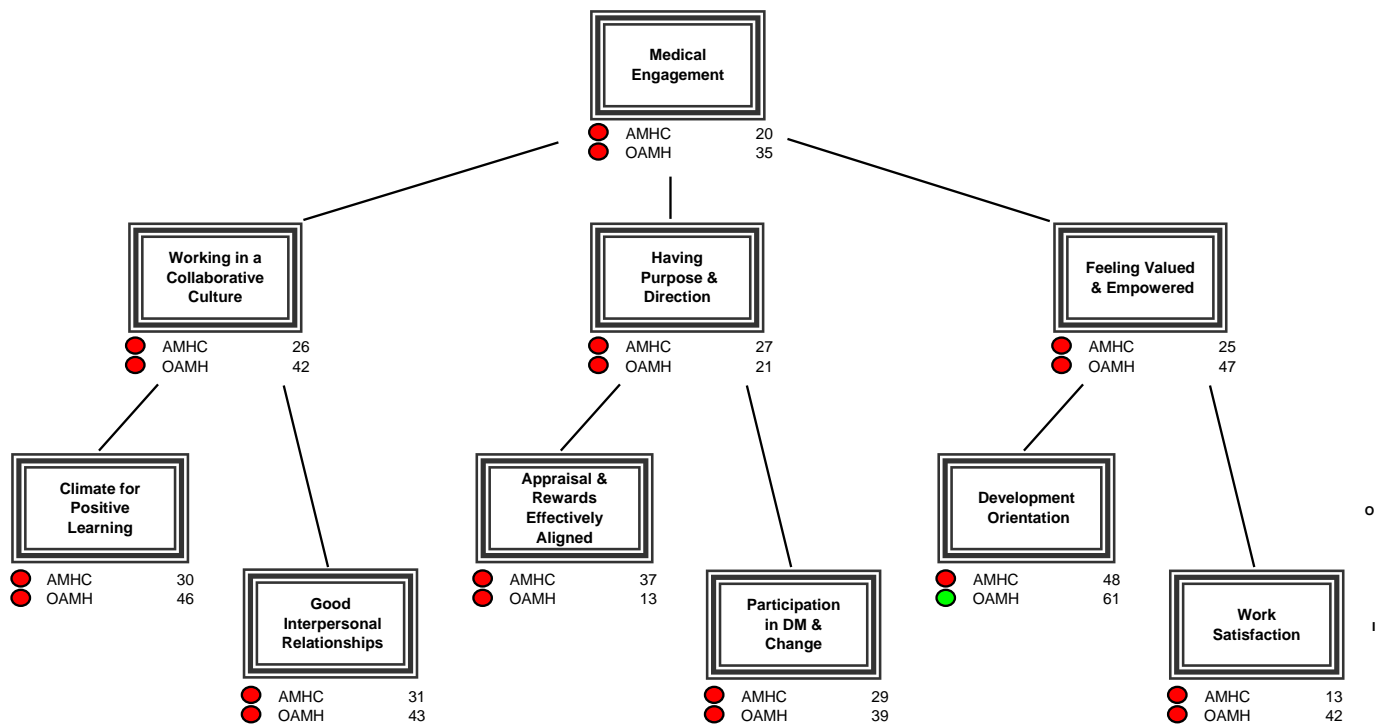


Figure 83. MES Scales

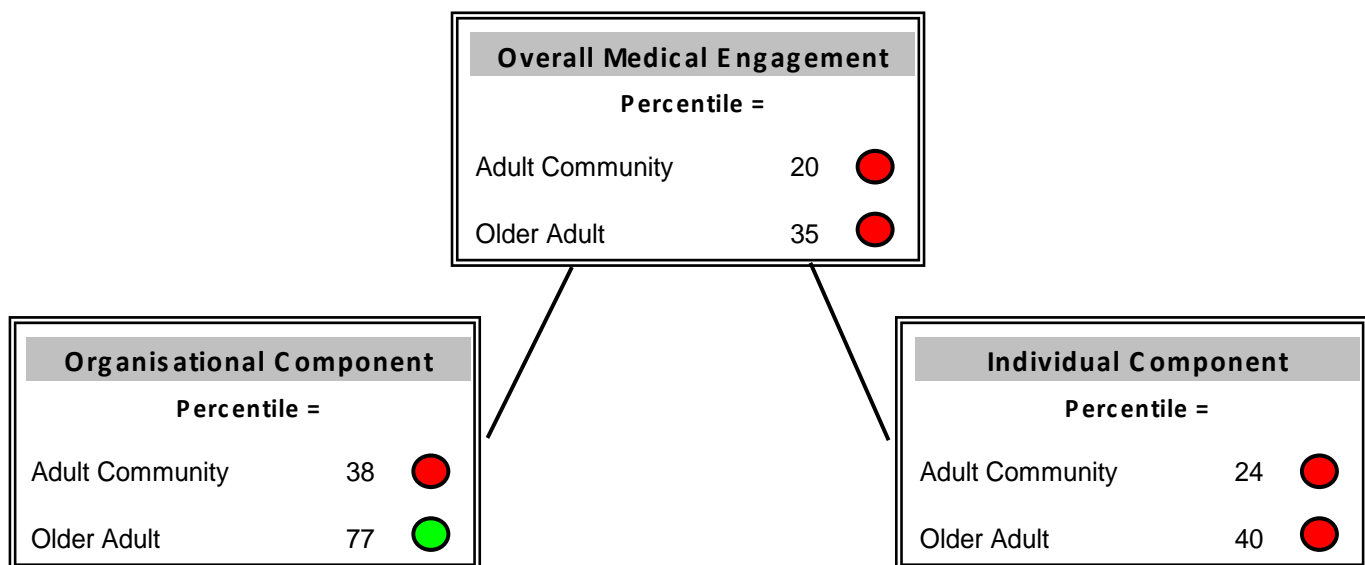


Figure 84. Meta Scale 1

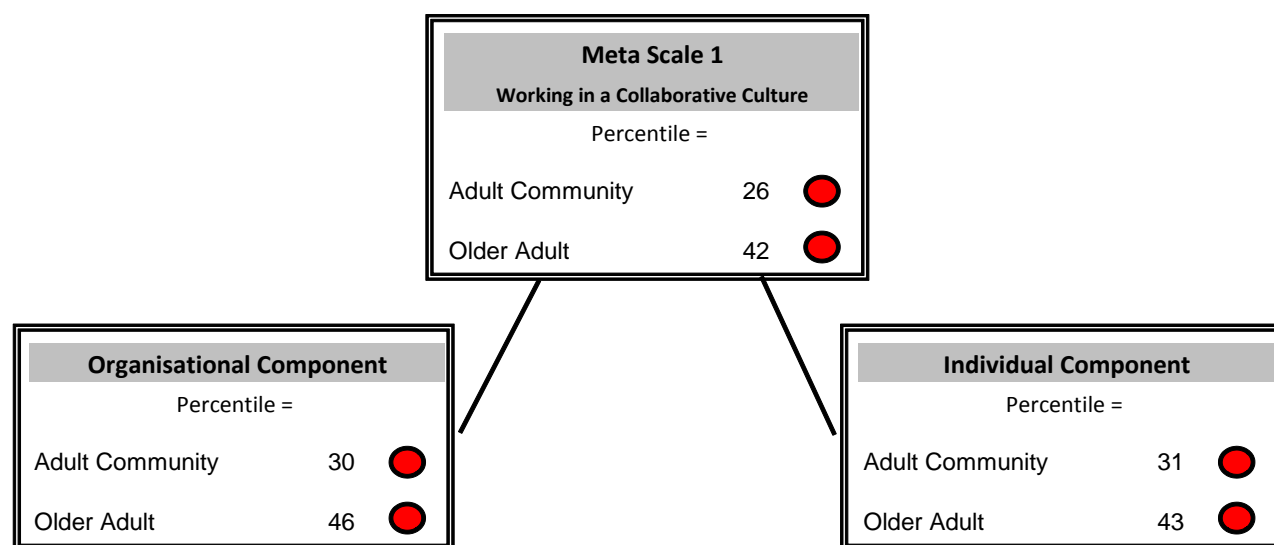


Figure 85. Meta Scale 2

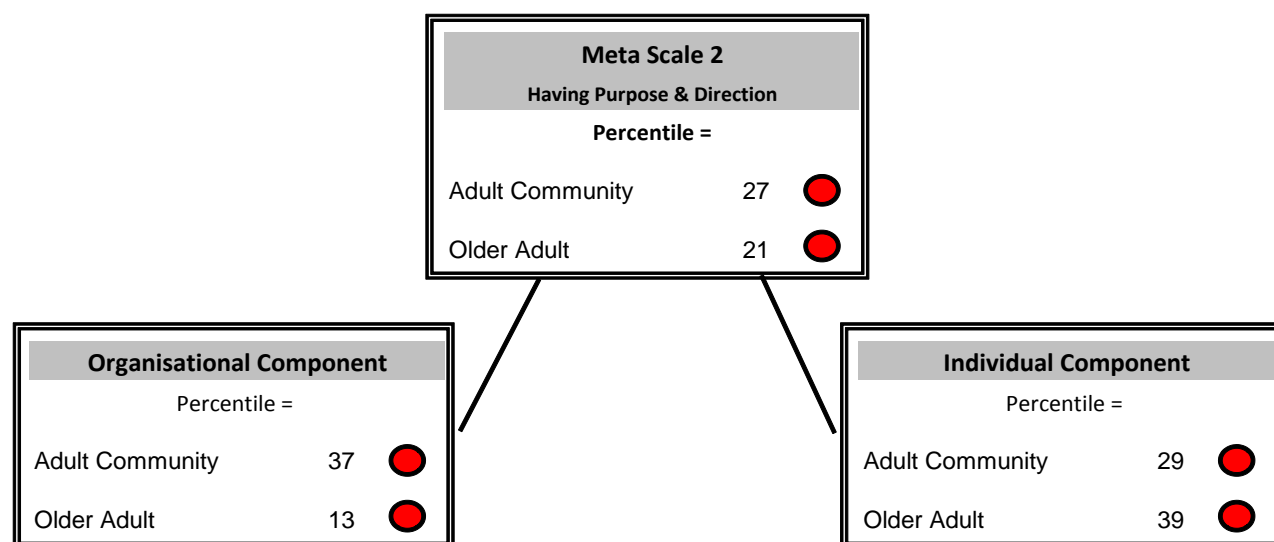
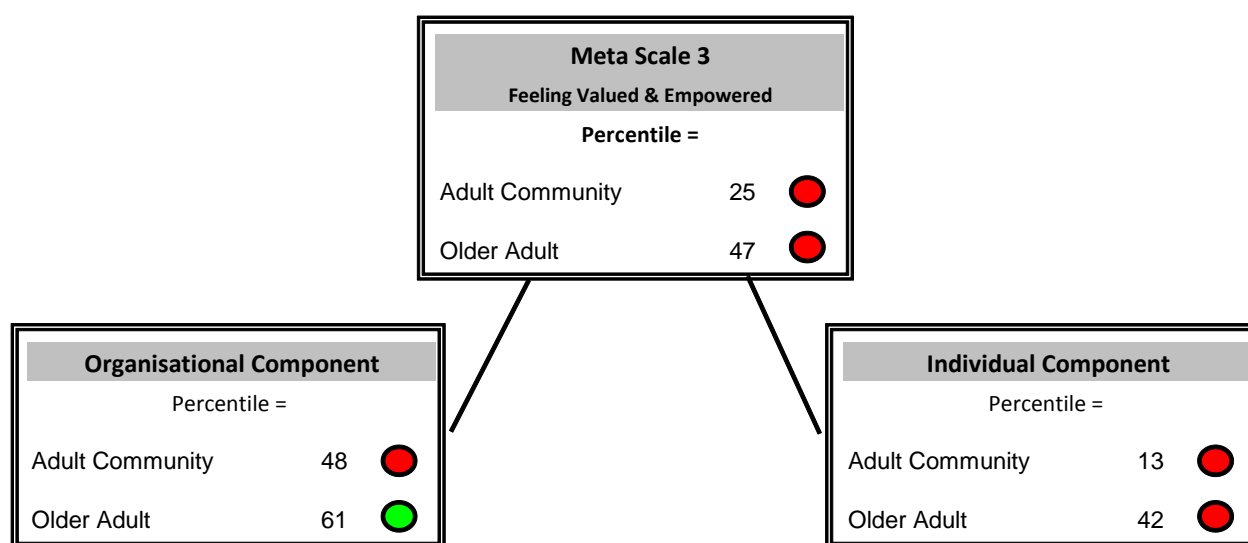


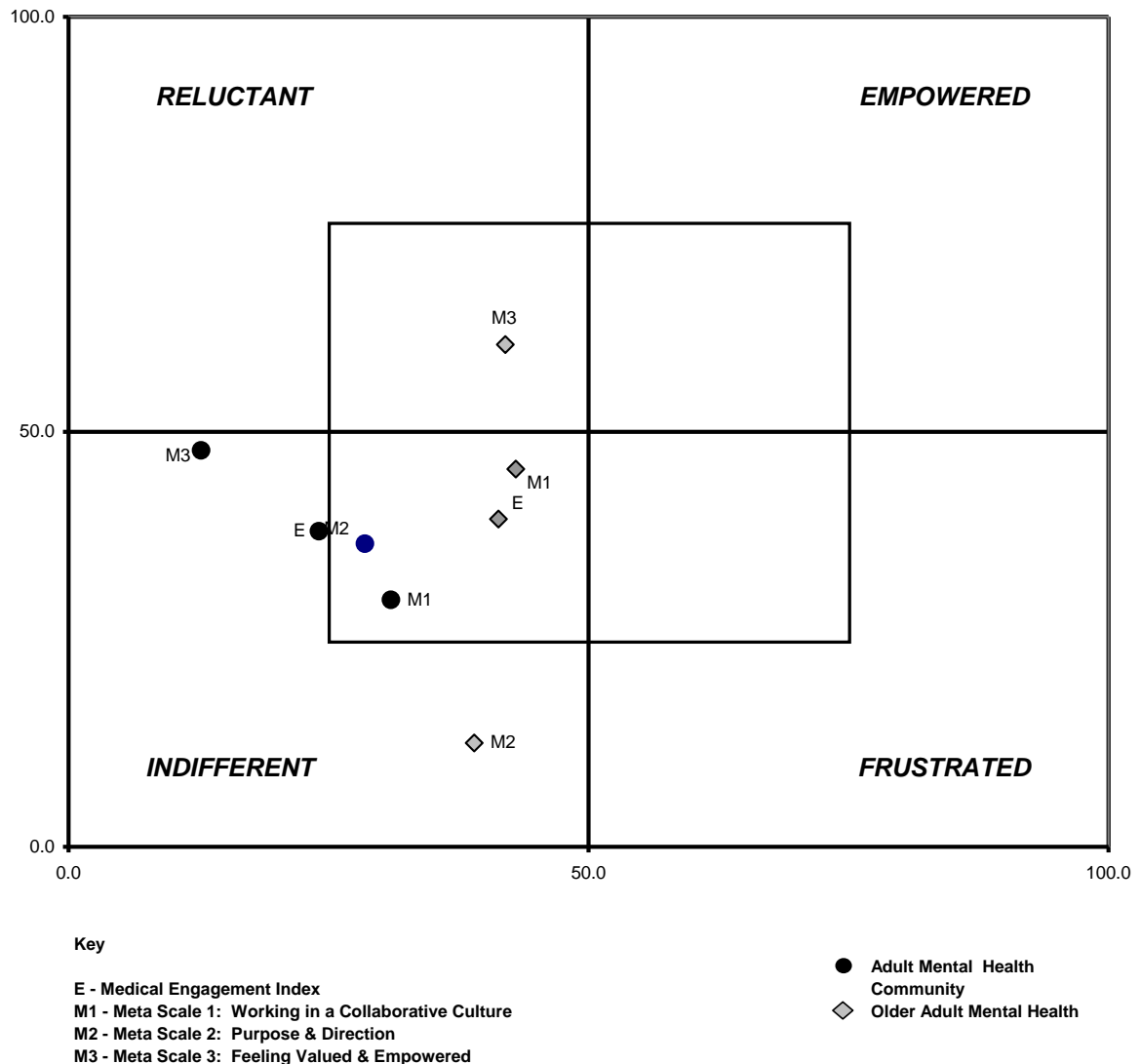
Figure 86. Meta Scale 3



It can be seen that the relative levels of medical endorsement of the organisational and individual components of the three meta-scales are broadly aligned for both organisational sub-samples. However for Meta-Scale 2, the endorsement levels for medical staff from '**Older Adult Mental Health**' are higher on the organisational component but not on the individual component. The meaning of these joint ratings is explored in more detail in the next section.

Figure 87 shows the mapping of medical sub-samples from this Trust.

Figure 87. Engagement Typology Results (Site H)



Although forming two distinct clusters, it is apparent that most of the ratings of members of medical staff from both '**Adult Mental Health Community**' and '**Older Adult Mental Health**' fell within the '**Indifferent**' quadrant of the grid. In contrast, one rating of medical staff (i.e. those medical staff from '**Older Adult Mental Health**' on **Meta-scale 3: 'Feeling Valued and Empowered'**) means that this sub-sample fell within the '**Reluctant**' quadrant of the MES grid.

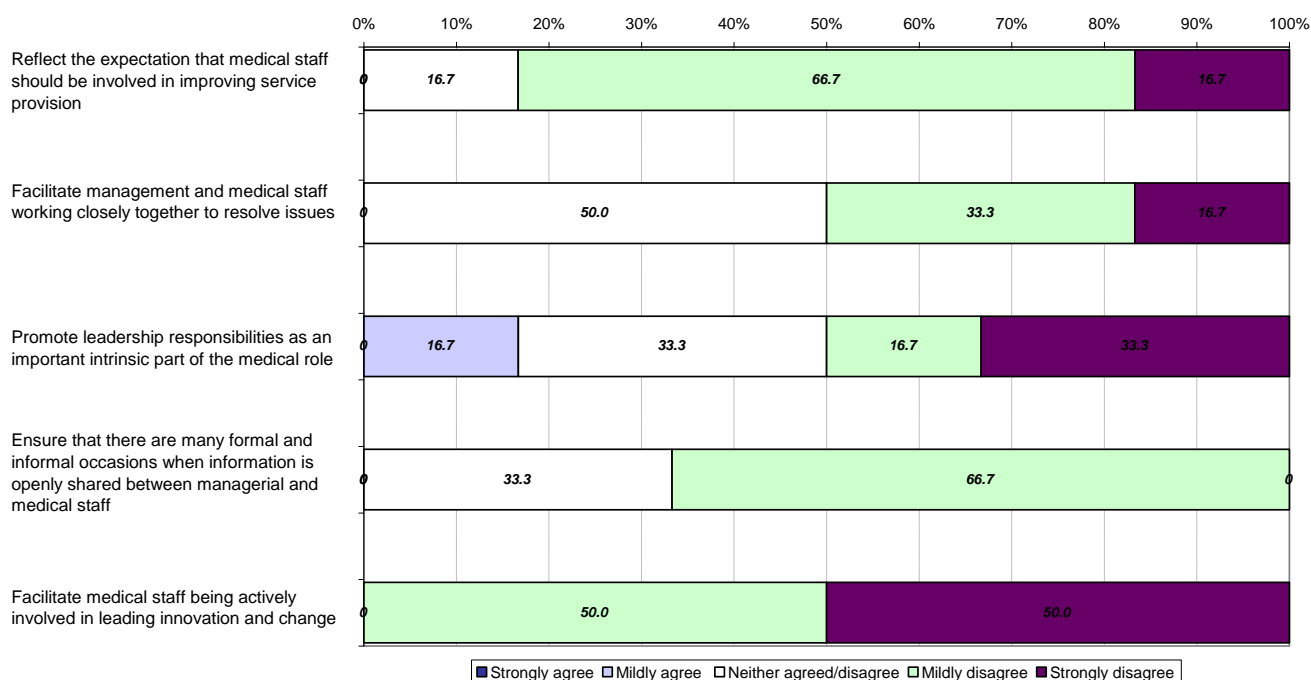
6.8.9 Additional Questions

Section B of the MES questionnaire comprised five questions which related to the organisational structure and working arrangements in the Trust. An examination of the figure below shows that only one of the five questions received any level of positive endorsement. Specifically, 17 % of respondents mildly agreed that the organisational structure and working arrangements in the Trust promote leadership responsibilities as an important part of the medical role. In contrast all respondents (100%) either mildly disagreed or strongly disagreed with the Trust structure facilitating medical staff being actively involved in leading innovation and change.

Figure 88. Perceptions of Effectiveness of Organisational Studies (Site H)

Section B: Percentage of Respondents Endorsing Rating Categories

The organisational structure & working arrangements in this Trust....



6.8.10 Conclusions

Even with this small sample, the results indicate that the MES is able to differentially identify the levels of engagement within the sub-samples of medical staff selected from this Trust. Clearly, medical staff from both '**Adult Mental Health Community**' and '**Older Adult Mental Health**' appear to be disengaged from the leadership process and the organisation does not appear to be actively promoting a leadership agenda.

6.9 Organisational performance data

Two sources of data were used on organisational performance. These were the self-assessments provided by the Trusts in their responses to the questionnaire survey undertaken in phase one, and routinely available data on performance collected by the Healthcare Commission and Monitor.

As part of the national survey undertaken in Phase I of this project each Trust was invited to complete a self-rating of how effective they felt arrangements for clinical leadership were in their organisation with respect to Quality, Financial Management, Overall Trust Performance and Patient Experience. This was on a rating scale of 1-10 with 10 representing most effective. Therefore for each Case Study site four rating figures between 1-10 for each of the areas listed above are an initial source of self-report data.

Table 31 presents these ratings for each site with the type of Trust sub-headed for ease of comparison.

Table 31. Trust Self- Report Ratings

Sites	Quality	Financial Management	Overall Performance	Patient Experience
Acute Sites				
A	10	10	10	10
B	10	10	8	8
C	7	2	6	6
D	7	6	10	10
E	8	8	8	8
Mental Health and Learning Disability				
G	8	8	9.5	9.5
I	7	7	9	9
H	7	2	5	8
Specialist				
F	10	10	10	10

It is worth reiterating that the data in Table 31 is self-reported and informed the choice of sites as case studies. On the whole the ratings are uniformly high with only 3 individual ratings out of a total of 36 falling below 6. Nearly all Trusts therefore self-report their arrangements for involving doctors in leadership roles working well and affecting most aspects of the Trust positively. Particular exceptions are to be found in Sites C and H where Financial Management, with ratings of 2, is an area clearly not seen to be well served by current arrangements. It may well be that this area of functioning has a pervasive effect as both these sites also rate Overall Trust performance as 6 and 5 respectively. In the wider context of performance data the value of such self-ratings is to be seen in terms of how the ratings match with other sources of independent data.

A senior researcher based at Kings Fund (location of Principal Investigator) was asked to determine what performance data might be accessible with respect to the nine sites. This was a challenging task with three of the sites being Mental Health Trusts and one a specialist Trust and therefore not necessarily subject to the standard data sets for NHS Acute Trusts. In addition some sites were Foundation Trusts while others were not.

The following seven data sources therefore apply variably across the full set of sites. The data obtained was:

1. Monitor Foundation Trusts Financial Assessment- 1 = highest risk to 5 (lowest risk)2010/11
2. CQC Annual Health Check- weak/ fair/ good/ excellent. 2008/09
3. Dr Foster hospital guide; Standardised Mortality Ratio (100=average), sites coded above average, average, below average.
4. 2011 NHS Inpatient Survey- worse than average, average and better than average. 2010
5. Inpatient and Outpatient NHS Surveys and A&E Survey. Consistency in performance across the three surveys on the basis of 6 domains (Dignity and Respect, Provisions of Information on care, Cleanliness, Confidence in Staff, Consistency in Communication, Involvement in decisions about care)- above average, below average and mixed performance. 2011
6. Mental Health Survey for community services- worse than average, average, better than average. 2011
7. NHS Staff Survey- highest 20%, above average, average, below average, lowest 20%. 2011

Although sound data it must be recognised that the information applies on a Trust wide basis only. The following table summarises the results by different types of Trust.

Table 32. National Performance Data

Sites	Financial Management	Financial Risk	Quality of Services	SMR	Overall Inpatient Experience	Consistency of Performance Across Patient Surveys	Overall Staff Engagement	Job Satisfaction
Acute								
C	Fair	N/A	Fair	Below Average	Average	Mixed	Lowest 20%	Lowest 20%
E	Excellent	3	Good	Above Average	Average	Above Average	Above Average	Above Average
A	Good	3	Good	Below Average	Average	Mixed	Above Average	Highest 20%
D	Good	N/A	Fair	Above Average	Average	Mixed	Above Average	Highest 20%
B	Good	3	Excellent	Below Average	Average	Above Average	Above Average	Highest 20%
Mental Health and Learning Disability					Overall Experience of Mental Health			
G	Excellent	3	Good	N/A	Average	N/A	Below Average	Above Average
I	Excellent	4	Good	N/A	Better than Average	N/A	Above Average	Highest 20%
H	Good	N/A	Weak	N/A	Average	N/A	Below Average	Lowest 20%
Specialist								
F	Good	N/A	Fair	N/A	N/A	N/A	Average	Average

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From this sample of Acute Trusts it would seem that financial aspects are reasonably well managed with site E being rated as Excellent, the others good, apart from Site C which is Fair. In terms of Financial Risk (applicable only to Foundation Trusts) all three sites are rated 3 which is average in a 1-5 scale. In terms of quality of services (HCC rating and SMR) Site C is rated only Fair on Quality of Services but 'below average on SMR'- which is the better end for this scale. Sites E and A are both rated 'Good' on Quality of Services but one (Site E) is 'Above Average on SMR', whilst the other (Site A) is below. It is not clear how 'Good' Quality of Service relates to an "Above Average" SMR.

Irrespective of the minor variability in the measures discussed to date, all sites are rated as 'Average' on Overall Inpatient Experience. The consistency of patient survey data across years may be a better measure and hence two sites (E and B) are Above Average. Both of these sites are Good and Excellent on Quality of Services, although one of them (E) is Above Average on SMR. It is interesting to note that the two sites (A and D) who self-rated 10 on Patient Experience achieve 'Average' or 'Mixed' in terms of independent data.

In terms of the staff measures, one site (C) is in the Lowest 20% for both Overall Staff Engagement and Job Satisfaction. It is rated 'Fair' on Quality of Services but Average for Overall Inpatient Experience. The four remaining Acute sites are all 'Above Average' on Overall Staff Engagement and three (A, B and D) are in the highest 20% for Job Satisfaction. However, as they have variable performance data on the previous measures discussed it is not easy to suggest how high scores here relate to other aspects of performance.

In summary there is one site (B) where there is a consistent and largely strong set of performance data- good financial management, excellent Quality of Services, Below Average on SMR, Above Average on survey data over time, Above Average on Staff Engagement and in the top 20% for Job Satisfaction.

6.9.1 Specialist Trust (site F)

As a specialist care Trust much of the previous data set does not apply. In fact only four of the nine possible items can be obtained for Trusts of this type. The scores suggest a 'Good' rating on Financial Management, and 'Fair' on Quality of Services. On Overall Staff Engagement and Job Satisfaction this site is rated as Average. It is virtually impossible to draw any conclusions from this data.

6.9.2 Mental Health and Learning Disability Sites

There are five data sources, one of which 'Overall Experience of Mental Health and Community Services' replaces the two inpatient experience and patient surveys. In terms of Financial Management these sites are rated- Excellent (sites G and I) and Good (H). The two Mental Health Trusts that are Foundation Trusts are also rated 3 (Site G) and 4 (Site I) respectively. So this appears to be quite a strong area of performance.

Two sites (G and I) are rated Good for Quality of Services, whilst one (H) is rated 'Weak'. However, this site is rated as Average on the Overall Experience of Mental Health and Community Services, along with another site (G) although this is rated Good for Quality of Services (G) The remaining site (I) is rated 'Above Average' on Overall Experience of Mental Health and Community Services. In fact Site I seems to have the strongest overall profile of the Mental Health Trusts.

In terms of Overall Staff Engagement two sites (G and H) are rated 'Below Average' and one (Site I) Above Average. This last site is also in the Highest 20% for Job Satisfaction. Site G is Above Average on Job Satisfaction despite the 'Below Average' score on Overall Staff Engagement. The final site H- Below Average on Overall Staff Engagement - is rated in the Lowest 20% on Job Satisfaction.

Overall, despite the more limited data there is a little more internal consistency here with one site (H) having quite a poor profile- weak on Quality of Services, Below Average on Overall Staff Engagement and Lowest 20% on Job Satisfaction. Site H is thought about average in terms of Overall Experience of Mental Health and Community Services. In contrast site I has a strong profile- Excellent on Financial Management and 4 on Financial Risk, Good on Quality of Services, Above Average on Overall Experience of Mental Health and Community Services, Above Average on Overall Staff Engagement and Highest 20% for Job Satisfaction.

6.10 *Exploring Performance Data Relationships*

The various performance data sets were intended to explore the issue of whether arrangements for involving doctors in leadership roles might have some detectable impact upon performance. Although each data source is relatively self-contained there is value in examining the linkages between the different sources to see whether patterns emerge. This must though be seen in the context of the limitations of the data sources and with some data being from different years depending on the latest set available.

As reported earlier in this chapter, MES data has been strongly linked to a range of independently collected performance data. In this study, MES data has been successfully collected in 7 of the 9 sites and particularly effectively in two sites (A and D) allowing full Case Study reports to be prepared. The

identification of performance differences within the clinical sub-groups in these two sites has confirmed previously reported data MES scores are associated with the better performing clinical sub-groups (in our research as assessed by board level interviewees) (69).

MES data was collected from a further 5 sites, albeit with less satisfactory samples. Using the 7 sets of MES data it is possible to examine how far the other two sources of independent data (Self- Report and National Performance Data) relate to MES profiles. High levels of medical engagement were observed in sites B, E and I- the last of these being a Mental Health Trust.

On the Self-Rating measure sites B and E are rated highest on Quality, Finance, Overall Performance and Patient Experience, whilst I (Mental Health) is rated highest on the two applicable measures (Overall Experience of Mental Health Services and Patient Experience). In direct contrast sites H and C are the lowest sites on MES and are also the two sites in the Self-Ratings that receive 2 on Finance and 5 and 6 respectively for overall performance (the lowest Self- Ratings). Within the limitations of Self-Rating data the MES scores map across well to this particular source.

The highest scoring MES sites (B, E and I) have a number of particularly striking positive performance data on some key markers. For example two are Excellent and one Good on Financial Management, two are Good and one Excellent on Quality of Services, all are Above Average on Overall Staff Engagement and on Job Satisfaction one is Above Average and two in the Highest 20%. In direct contrast the two lowest MES scorers (Sites H and C) have distinctly different profiles with, for example, Fair and Weak on Quality of Services; Below Average and Lowest 20% on Overall Staff Engagement and Lowest 20% for both on Job Satisfaction. They are both Average on Overall Patient Experience.

Despite the variability within the performance data it is possible to discern the highest rated MES sites (B, E and I) as well performing Trusts and the lowest MES sites (H and C) as relatively poor. A key interest area within the whole research project was the structural arrangements made by Trusts in respect to how medical leadership functioned. It is clear from the earlier discussion of the Phase I questionnaire and subsequent case studies that descriptive classifications of Directorate, Divisional and Service Line are not entirely precise or mutually exclusive, with a number of sites having a mixed profile. However, if we revert to the initial classification of sites it is relevant to ask how the better Trusts (B, E and I) and the poorer Trusts (H and C) are organised structurally.

Perhaps a key finding and somewhat undermining one in terms of the influence alone of structures is that of the three better sites, one is a Directorate (E), one is Divisional (B) and one is Service Line (H). Again of the poorer performing sites one is Service Line (H), and one is a

combination of all (C). It would appear as ever that relationships trump structures, such that "it aint what you do, it's the way that you do it".

Data gathered in the interviews conducted as part of the case studies shed light on the factors within two of these trusts (B and E) that contributed to the high level of medical engagement and organisational performance. These factors included the importance attached to relationships rather than structures, the fact that these relationships had been built up over time, and the relative stability of structures and leaders compared with other case study sites. Managerial leaders in these two trusts were also clear that doctors in leadership roles were leaders rather than managers and they were pragmatic about the extent to which doctors could be expected to be fully committed to the organisations in which they worked, as illustrated by the following quotations from interviews:

"We haven't got clinicians who have swallowed the gospel according to the trust. You don't get that with clinicians. Sometime people ask: why aren't the doctors more corporate? Doctors just won't put the trust at the top of their hierarchy of values. They just won't do it" Director at Site B

"...if we are honest the shape of our services are determined by the nature and qualities of our consultants in the main. Therefore our job as a corporate team is to harness these qualities to take us forward. If there was a fracture between the clinical perspective and mine, it would be my responsibility to do something about it. You belittle consultants and treat them as another employee at your peril." Director at Site E

Both trusts had developed what might be described as 'a culture of engagement' in which managerial leaders developed a way of working that placed the emphasis on the role of medical leaders and explicitly acknowledged the underlying tension between professional and organisational values.

The overall data here support the previously reported work (69) that medical engagement seems to be a crucial underpinning element to organisational performance, even where only partial MES data was available. It is also clear that levels of medical engagement can vary between different clinical units within the same Trust suggesting that distinct cultures (as described by MES) can co-exist in one organisation and also that MES is capable of distinguishing between these cultures. Our analysis showed a relationship between unit performance as perceived by board level interviewees and the MES results at this level.

Further work to explore these issues in clinical units in different trusts where there accepted measures of unit performance would be of value as we discuss further in the next chapter.

6.11 *In summary*

This chapter has reported and analysed the findings from the third phase of the research. It has illustrated variations in medical engagement both between and within trusts, and related these variations to trust performance using the self-assessments in the questionnaire survey and routinely available data. Notwithstanding difficulties in achieving high response rates in the case study sites, and the lack of sufficient responses in two, the chapter confirms the existence of a relationship between medical engagement using the MES and trust performance at the Trust level.

It has been more difficult to explore this relationship in relation to clinical units or sub-groups because of the absence of accepted measures of performance at this level. Nevertheless, there is a relationship between unit performance as perceived by board level interviewees and the MES results at this level.

Free text responses to the MES highlighted a number of challenges in securing effective engagement. Many of these challenges echo the findings reported in the previous chapter and include pressures of clinical commitments and lack of time, and variable relationships between medical leaders and managers. These responses also identified factors that could facilitate engagement including greater openness, improved communication and mutual respect between doctors and managers.

7 Discussion and conclusions

In this final chapter we summarise the main findings of our research and analyse these findings in relation to what is already known about medical leadership in the NHS. In doing so we draw on the existing literature on the subject to understand changing roles and relationships and whether the frontier of control between doctors and managers has shifted. We also draw out the implications for the NHS from our research in a context in which renewed efforts are being made to involve doctors in leadership roles. As the NHS enters what may turn out to be a decade of austerity, and when efforts to engage clinicians including doctors in efforts to reduce waste and increase efficiency are gaining renewed momentum, what lessons can be taken from our findings to support these efforts, and to make a reality of the aspiration that the NHS should increasingly be clinically led?

In the first part of the chapter we summarise our findings in relation to the policy context, the literature review, our questionnaire survey of NHS trusts, the case studies we undertook, and our exploratory analysis of the relationship between medical leadership and engagement on the one hand and organisational performance on the other. This leads into an analysis of how the findings can be interpreted making use of existing literature on the subject. In the final part of the chapter we turn to the implications for the NHS and seek to identify a number of lessons that leaders at both the national and local levels may find helpful in seeking to strengthen medical leadership in future.

7.1 *The policy context*

Our research was conducted against a background of a decade of investment and reform that resulted in substantial improvements in patient care. Reform comprised three main elements: targets and terror, competition and choice, and clinical leadership of quality improvement. During this period, NHS trusts were affected by continuing organisational changes, including the establishment of NHS Foundation Trusts, and the Transforming Community Services policy. Politicians and managers were the main agents of change in the process of reform with medical and patient leaders much less involved.

Failures in the quality of patient care in some parts of the NHS in this period were instrumental in leading to the reform of the regulation of the medical profession. In parallel, regulation of health care organisations was strengthened through the establishment of regulators like the Care Quality Commission and the Labour Government adopted a more systematic approach to improving the quality of care, for example by introducing a duty of clinical governance on NHS organisations. The Coalition Government

elected in 2010 is implementing further radical changes to the NHS and has emphasised the need to empower doctors and other front line staff in order to further improve patient care.

As far as medical leadership is concerned, successive governments have not been prescriptive about models of medical leadership in NHS trusts. This means that the models adopted have been a matter for local decision. The return of financial pressures had led to renewed interest in medical leadership as in the interest shown in service line management. Compared to the 1980s and 1990s, there is now a much stronger focus on medical leaders improving the quality of care and not simply controlling budgets. The report of the Francis Inquiry into Mid Staffordshire NHS Foundation Trust has again put medical leadership and the quality of care firmly back on to the policy agenda.

7.2 What is already known about medical leadership

Previous research has described how doctors have enjoyed a large measure of autonomy since the inception of the NHS, and only with the Griffiths Report of 1983 (9) did this autonomy begin to be challenged (e.g. 12;13) . The Griffiths Report led to the introduction of general management and attempts to involve hospital doctors in management as clinical directors. This resulted in a more active management style in which managers were increasingly involved in questioning medical priorities, although evidence from research carried out in the 1980s and 1990s indicates that doctors retained significant influence.

The persistence of medical autonomy reflects the nature of health care organisations as professional bureaucracies in which front line staff have a large measure of control over the content of work by virtue of their training and specialist knowledge. In professional bureaucracies, professionals play key leadership roles, leadership is distributed and collective in nature, and followers exercise significant influence (20). Evidence for the emergence of new organisational forms such as the managed professional business is weak (32;37) . Studies have shown a link between medical leadership and organisational performance (e.g. 43;44) .

More recent empirical research into medical leadership in the NHS has underlined the challenges of changing deeply entrenched relationships (53). Doctors who occupy hybrid positions as medical directors and clinical directors face considerable ambiguity in discharging their functions. Tribal relationships between doctors, nurses and managers persist and are reflected in different conceptions of clinical work. Evidence from other countries points to examples of organisations that have made more progress than the UK in the development of medical leadership (46;47;70).

7.3 Results of the questionnaire survey of NHS trusts

Our survey of NHS Trusts found that the number of doctors on the boards of trusts ranged from one to four with most having only one. The number of doctors on the management board of trusts ranged from one to seventeen, the most common number being one followed by eight. Doctors were represented on a wide range of trust committees with Quality and Patient Safety, Clinical Governance and Research and Development being most frequently mentioned.

There was wide variation in how trusts were structured. Our survey found that directorates, divisions and service lines were all in use, sometimes in combination. The principal organisational structures were reported to be directorates and divisions with service lines being much less frequently mentioned. The number of units for each type varied from two to 23 with most falling in the range of three to six.

Most trusts reported that between 10 and 20 per cent of medical consultants were involved in formal leadership roles. Within the principal organisational units, the clinical director/doctor/clinical lead was identified most frequently as the accountable officer, followed by a general manager and a clinician and manager jointly. Only a very small proportion reported that the triumvirate of medical leader, general manager and nurse manager took on this role.

Trusts reported using a variety of development programmes for medical leaders and reflected on the challenges facing these leaders, including lack of career structures and financial incentives. Other challenges included lack of support from general managers and variations in the willingness of medical leaders to deal with difficult issues. At the same time, the survey found examples of medical leaders making a real difference to their organisations. Respondents were mostly positive about the effectiveness of medical leadership arrangements in their trusts.

7.4 Findings from the case studies

Medical leadership arrangements in the case study sites were influenced by the different contexts of trusts. Key variables were the size of the trusts, the stability of their organisational structures, the impact of mergers and related organisational changes, the process of becoming Foundation Trusts and the wider financial context of the NHS.

Sites varied in relation to whether they reported themselves to be medically led, clinically led, managerially led or had aligned structures with most having medically or clinically led structures. Doctors usually held leadership roles at three or four levels with the middle level being seen as the most important. Doctors also held leadership roles in horizontal structures that cut across directorates and divisions.

Triumvirates existed on paper in most sites but in reality the duality of medical leader and general manager was perceived to be more important. In a number of sites the duality expanded to encompass nurse managers, finance and HR colleagues when needed. In mental health/partnership trusts general managers often came from nursing backgrounds.

Medical directors usually committed at least half of their time to leadership roles and clinical directors committed around 20 per cent of their time. In some cases both medical directors and clinical directors reported giving more time to their leadership roles than allowed for in their contracts. The need for medical leaders to retain some clinical commitments in order to be credible with their clinical colleagues was an important factor influencing how much time they spent on leadership roles.

Medical leaders at different levels were usually appointed after a number of years experience as consultants and in the case of clinical directors initially served a term of 2-3 years, often being reappointed for a further term. Training and development for doctors in leadership was receiving increasing attention in all sites with some trusts running their own programmes and others accessing external support from strategic health authorities, deaneries and others. Some programmes were for doctors only and others were for staff from different clinical and managerial backgrounds.

In many sites the appointment of medical leaders was reported as having become more formalised. Despite this, competition for leadership roles was often limited and in some cases non-existent. In appointing medical leaders, trusts reported that having clinical credibility with their colleagues and thinking and acting corporately were important attributes.

An engagement gap between medical leaders and their colleagues was commonly reported, although this was seen to be part of the journey on which trusts were on and did not present major challenges. For medical leaders themselves, the main challenges were balancing clinical and leadership commitments and engaging followers. The quality of the individuals in these roles was seen to be critical in how effectively they were performed.

7.5 Medical engagement and organisational performance

Our analysis of medical engagement, based on the use of the Medical Engagement Scale (MES), found variations in levels of engagement both between and within the trusts selected as case studies. The free text responses highlighted a number of barriers to effective engagement including pressures of clinical commitments and lack of time, and variable relationships between medical leaders and managers. These responses also identified factors that could facilitate engagement including greater

openness, improved communication and mutual respect between doctors and managers.

Data on organisational performance were derived from the self-assessments provided in the questionnaire survey and routinely available data used by the Healthcare Commission and Monitor. Self-assessments covered quality of care, financial management, patient experience and overall performance and were overwhelmingly positive, with the exception of financial management in two of the trusts. Routinely available data painted a more mixed picture and analysis of these data was challenging because of differences in data between trust types i.e. acute, mental health/partnership and specialist.

Despite this, those sites that reported high levels of engagement on the MES also performed well on many of the key indicators of performance used by the Healthcare Commission and Monitor. It was more difficult to explore the association between medical engagement and performance within trusts because of the absence of accepted measures of performance for clinical units within trusts and the wide range of services covered by these units in our study. There was, however, a relationship between the perceptions of board level interviewees about unit performance and the MES results at this level.

7.6 Interpreting the results

The picture that emerges from our research is of variations in the structures and processes of medical leadership in the NHS trusts we studied.

Notwithstanding these variations, there are some common themes and many similarities in the challenges trusts face in making their chosen arrangements work effectively. We now go on to analyse how the findings can be interpreted making use of existing literature on the subject and the policy context in which our fieldwork was undertaken.

As we noted in chapter 1, successive governments have not been prescriptive about models of medical leadership in the NHS, even though politicians of all parties have emphasised the importance of doctors and other clinicians being involved in leadership roles. In this context, it is not surprising that a variety of structures have been adopted, nor indeed that these structures should be changed from time to time. The arrangements that exist reflect the decisions of local NHS leaders on what is needed in their organisations, leading to the various permutations we have described.

Our case studies reveal that whatever the structure adopted, roles and relationships vary between directorates, divisions and service lines. There are also variations in the perceived effectiveness of medical leadership at this critical middle level of the organisation. There are variations too in the

engagement of doctors at this level and in the performance of the services concerned.

The literature we reviewed in chapter 2 would see these variations as a natural consequence of health care organisations being professional bureaucracies. To use the language of Paul Batalden and colleagues (e.g. 71;72;73), health care organisations comprise a collection of clinical microsystems which form the basic building blocks of care delivery. To borrow a nautical metaphor, these organisations are much more like an armada than an aircraft carrier, underlining the critical importance of distributed leadership in clinical microsystems as well as strategic leadership at the level of the organisation itself.

If this is the case, then much hinges on the quality of microsystem leaders and the roles and relationships at this level. Again as we emphasised in chapter 2, leadership in professional bureaucracies needs to be collective as well as distributed, a property of teams and not individuals. The importance of collective leadership is recognised and reflected in the findings of our research, particularly in the evidence we have gathered about the key role of the duality of medical leader and general manager supplemented by other sources of expertise when required. It appears that this duality has superseded the triumvirate as the effective focus of leadership in trusts even though the triumvirate still exists on paper.

In our fieldwork, we heard time and again that the impact of medical leaders depended critically on their personal credibility and their ability to lead peers who were often highly skilled and autonomous professionals. It was for this reason that trust leaders focused on developing doctors as leaders and introducing greater formality and professionalism into the process. To return to Friedson's typology (30), the 'administrative elite' of doctors in leadership roles has resulted in increasing differentiation between these doctors and the 'rank and file' whose main focus is their clinical work, leading to the engagement gap we noted above.

A common theme in our findings is that the journey that began with the Griffiths Report of 1983 (9) and its argument that doctors should play a bigger part in the management of services and budgets has continued but is by no means at an end. The challenges faced by Trusts and their medical leaders, as summarised above, remain significant, including how leaders can engage followers and how more doctors can be supported to become leaders. Also, based on the evidence we have gathered, there is no reason to suggest that new organisational archetypes have supplanted the professional bureaucracy as the dominant form in the NHS, notwithstanding the emphasis on managerialism and market based reforms.

To be sure, service line management structures have been adopted in some NHS trusts and they bear many of the hallmarks of the managed professional business and quasi market hospital archetypes described in the

literature. These structures are often used in combination with clinical directorates and divisions. Our own exposure to organisations that have pioneered service line management, beyond the case studies reported here, offers some basis for arguing that they may in time evolve into new organisational archetypes, and as we discuss below this is a fertile area for further research. But the fieldwork we carried out and the results of our questionnaire survey indicate that this time is some way off for the organisations we studied.

Returning to the typology outlined by McKee and colleagues (32) in their study of clinical directorates in Scotland in the 1990s, the research reported here points to a move away from 'traditionalist' and 'managerialist' structures to 'power sharing' arrangements in the current English NHS. We base this claim on the fact that most of the case study sites described themselves as medically or clinically led or having aligned structures in which doctors shared power with managers, rather than being managerially led. The sites also provided some evidence of their structures and processes leading to innovation and service change of a different order to that described by McKee et al in their account of how 'traditionalist' directorates functioned.

Yet although roles and relationships have moved on, there is no reason to question fundamentally the argument of Greener and colleagues (53) about the persistence of established relationships and dynamics between doctors, nurses and managers. To be sure, progress has been made on the journey of involving doctors in leadership roles that started with the Griffiths Report in 1983 but the organisations we studied are not yet at the point that Griffiths advocated in his prescription for the NHS. We would also endorse the analysis of Greener and colleagues and that of others that medical leaders in hybrid roles (the administrative elite in Friedson's (30) language) continue to occupy a relatively precarious middle ground. Hybrid roles do not have the same status as that attaching to medical leaders who are committed to clinical, research and educational activities, and it is therefore not surprising that our research found that competition for these roles is often limited.

To make this point is to underline the challenges of changing an NHS culture in which doctors who go into leadership roles in NHS trusts are sometimes perceived by their colleagues to have gone over to the dark side (74). Our findings also echo other work that has drawn attention to the lack of clear career structures for doctors taking on these roles, the financial disincentives that may exist, and historically at least the absence of appropriate training, development and support (41). Changing cultures is of course much more difficult than putting in place new structures and processes and yet it is fundamental if the aspirations of politicians to strengthen medical leadership are to be translated into practice.

7.7 Implications for the NHS

In undertaking the research reported here, our aim was to contribute to the practical development of medical leadership in the NHS as well as the literature and evidence base on medical leadership in the NHS. In this final part of the chapter we therefore draw out the lessons for the NHS and discuss the steps that are needed if the aim is to find more effective ways of engaging doctors in leadership roles in future. We have framed our discussion in the knowledge that the thirtieth anniversary of the Griffiths Report is approaching, making this an appropriate time to be identifying next steps in the continuing journey of medical engagement and leadership.

The arguments set out in the Griffiths Report for medical leadership have been reiterated recently in Lord Darzi's NHS Next Stage Review and by the Coalition Government in its plans to reform the NHS. As the Darzi Review noted:

'Clinicians are expected to offer leadership and, where they have appropriate skills, take senior leadership and management posts in research, education and service delivery. Formal leadership positions will be at a variety of levels from the clinical team, to service lines, to departments, to organisations and ultimately the whole NHS. It requires a new obligation to step up, work with other leaders, both clinical and managerial, and change the system where it would benefit patients' (7: pg. 60).

The Review continued:

'The NHS Medical Director and National Clinical Directors will also work with senior clinicians to ensure that clinical leadership becomes a stronger force within the NHS. Compared to healthcare organisations in the US, such as Kaiser Permanente, the NHS has very few clinicians in formal leadership roles' (pg. 67).

A similar commitment to clinical leadership was made in the Coalition Government's white paper, *Equity and Excellence: Liberating the NHS* (75), which stated that the government's reforms 'will empower professionals and providers, giving them more autonomy and, in return, making them more accountable for the results they achieve' (pg. 4). Both the white paper and the NHS Next Stage Review emphasised the role of clinical leaders in improving the quality of care and outcomes. What then does our study have to say about the current state of medical leadership in the context of these aspirations?

The evidence we have gathered suggests some progress has been made in involving doctors in leadership roles but much remains to be done. Alongside positive reports from our case study sites, and the responses to the questionnaire survey, we also heard of the many challenges and barriers that exist. The free text responses to the Medical Engagement

Scale enumerated several of these challenges including pressures of work and time on doctors in leadership roles and organisational cultures that inhibit effective participation.

Our findings are echoed in a recent study by the BMA (76) of doctors' perspectives on clinical leadership. The study is based on focus groups with BMA members in the autumn of 2011 and it identifies, among other things, a number of barriers and enablers of medical leadership. Interestingly the study found far more barriers than enablers of leadership, the authors commenting: 'This in part may reflect a feeling of lack of empowerment among doctors in addition to deeply embedded views on the factors they perceive limit their professional influence' (p. 16).

The main barriers identified were pressures on time resulting from clinical commitments; the autonomy of doctors and the difficulty of leading them; and the availability of leadership opportunities. The last of these barriers included the absence of a well defined career structure. Another barrier was relationships with managers, including 'notable hostility towards managers in some cases' (p. 20). This included negative perceptions of doctors who go over to the dark side when they take on management and leadership roles. The principal enablers were the support of colleagues and the length and breadth of experience of doctors going into leadership roles. Also important was the financial climate within the NHS which was seen to require greater clinical input in order to bring about the necessary changes in services.

These findings are consistent with research undertaken by three of the authors (CH, HD and PS) into the experience of doctors who become chief executives in the NHS conducted in 2009 (41). The study found that only around 4 per cent of all NHS chief executives at the time came from medical backgrounds and it reported an absence of structured support for those wanting to take on leadership roles. Many of those interviewed felt it important to retain clinical commitments in order to be credible with their peers, although this became increasingly difficult as doctors moved into more senior positions. Doctors who became chief executives experienced a shift in their professional identities, enhancing their original clinical identity when they took on leadership responsibilities while also experiencing some ambiguity in the process.

In this study, the barriers to doctors becoming chief executives included the insecurity associated with these roles, pay differentials between senior doctors and chief executives, and the lack of career structures. All recognised that they had learnt how to become leaders on the job and were therefore best described as 'keen amateurs'. It was acknowledged that the pressures on chief executives and the intense scrutiny of performance required a different approach in future. This approach entailed a much greater degree of professionalism, including organised training and

development, as well as attention to pay differentials. Also important was the need to value doctors going into leadership roles and to raise their status, for example through the establishment of a faculty of medical or clinical leadership.

Since this study was completed, the Faculty of Medical Leadership and Management has been established by the Medical Royal Colleges and is endorsed by the Academy of Medical Royal Colleges. Part of the rationale of having a body like this is to raise the profile of medical leadership and to provide a focus for doctors who go into leadership roles. Specifically it has been set up to:

- Determine and establish the standards and competences for medical leadership, management and quality improvement required for all medical students, doctors and secondary-care dentists at all levels, and to translate these into educational curricula and revalidation where appropriate.
- Develop and maintain the good practice of medical leadership and management by ensuring the highest professional standards of competence and ethical integrity.
- Promote medical leadership and management.
- Act as an authoritative body for the purpose of consultation and advocacy in matters of educational or public interest concerning medical leadership and management.
- Promote the advancement of research, education and knowledge in the field of medical leadership and management.
- Provide a voice for emerging and existing medical managers and leaders through a properly constituted membership structure.
- Advance medical management and leadership as a profession.

In carrying out these functions, the Faculty aims to improve the quality of patient care.

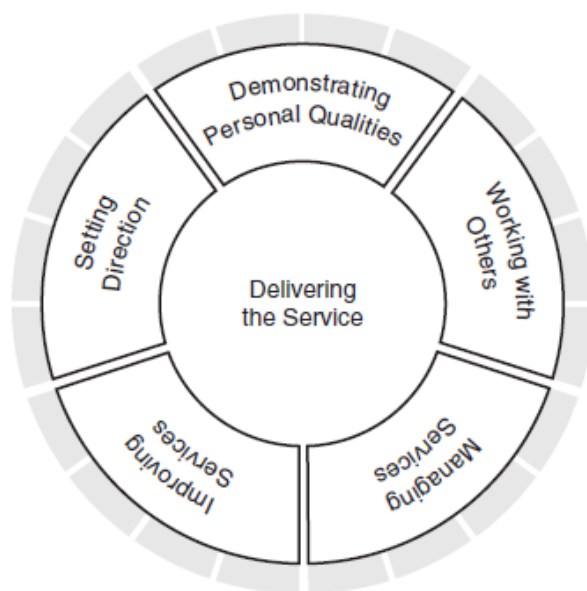
Montgomery's (42) work on medical leadership in the United States has argued that a professional association like the Faculty can play an important part in enabling medical leaders to achieve recognition, affiliate with their peers and establish legitimacy. It also has the potential to address the many barriers facing doctors going into leadership roles including the absence of organised training and development and defined career structures. As we have argued, taken together these initiatives may help in

making the shift from medical leaders who are keen amateurs to those who are skilled professionals (41).

One of the roles of the Faculty will be to build on the work done to develop the Medical Leadership Competency Framework, first published in 2008 and subsequently refined. The framework describes the competences doctors need to become more actively involved in the planning, delivery and transformation of health services. The framework has five domains (see accompanying figure) and it outlines what needs to be done at the undergraduate, postgraduate and continuing practice stages of medical careers. The newly established NHS Leadership Academy has a potentially important part to play in building on the framework and establishing more systematic training and development opportunities to support doctors to become more effective leaders.

The demise of BAMB in 2010 is an indication of the difficulties of sustaining an organisation set up to advance the cause of medical leadership. The reliance of BAMB on soft funding sources and the commitment of a small number of key staff reinforces our argument that medical leadership needs to be supported and resourced more effectively in future.

Figure 89. Medical Leadership Competency Framework (NHS Institute for Innovation and Improvement, Academy of Medical Royal Colleges, 2012, p.6)



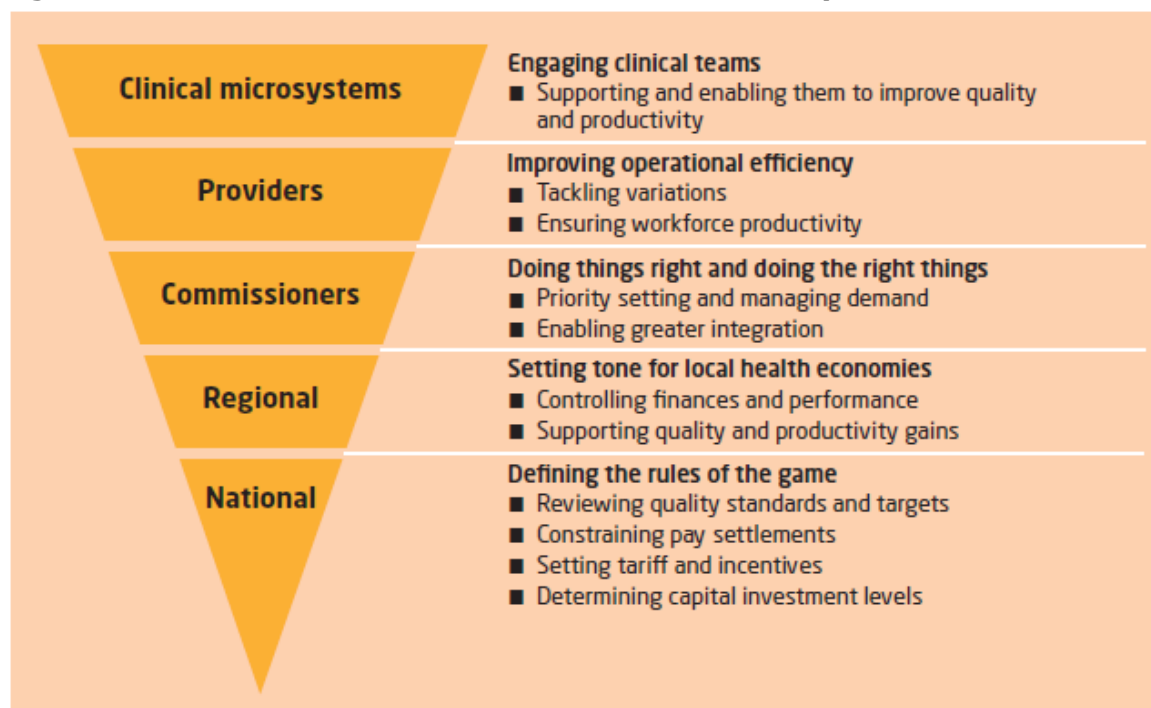
Important as these initiatives are, they are unlikely to be sufficient. A greater degree of professionalism in medical leadership also requires every NHS organisation to review and redouble its efforts, learning from best

practice in other systems where more progress has been made. As our work has shown, medical leaders in clinical directorates, divisions and service lines typically commit around 20% of their time to their roles, while medical directors commit upwards of 50% of their time. Our findings also indicate that between 10% and 20% of consultants are involved in leadership roles, meaning that this remains a minority activity.

We believe that the NHS will only make the step change that is needed if the time commitment of medical leaders increases substantially and if the proportion of doctors in formal leadership roles also increases. Equally important is the need to attract more doctors into leadership positions who are credible with their peers and for them to become role models for their colleagues. In organisations like Mayo Clinic and Kaiser Permanente it is common for around one quarter of doctors to hold formal leadership roles and for the majority of their time to be committed to these roles (49). This is especially important at the clinical directorate/divisional/service line level where a 20% commitment is unlikely to be sufficient as the financial and service pressures on the NHS increase.

In work with other colleagues, one of us (CH) has analysed the opportunities available to the NHS to make the savings needed to deliver the Nicholson challenge of reducing waste and inefficiency by £20bn over four years (77). The accompanying figure illustrates that action is needed at all levels and it emphasises in particular the role of engaged clinical teams in clinical microsystems in improving quality and productivity. The reason for placing the emphasis on clinical teams is that the decisions of these teams on how to treat patients commit the bulk of the resources used in the NHS. Reducing waste and inefficiency therefore hinges on teams working differently and in many cases this can only be achieved if clinical leaders work closely with managers in rising to the Nicholson challenge.

Figure 90. Role of clinical teams in clinical Microsystems



Source: (77)

The argument for a step change in approach is underlined by research into the relationship between medical engagement and leadership and organisational performance summarised in chapters 2 and 6. There is clear and consistent evidence from a variety of sources that medical leadership is one of a number of factors that is associated with quality and service improvements. Our own data drawing on the Medical Engagement Scale confirms a relationship between organisational performance and medical engagement and reaffirms the argument that the journey that started with the Griffiths Report should continue. Work currently going on to develop service line management in NHS Foundation Trusts is the latest manifestation of this (78).

In drawing lessons from other health care systems, two other points need to be made. First, doctors may be more willing to go into leadership roles if they know that training and support are available to enable them to return to clinical work if they decide to do so. Denmark does this by offering one month of retraining for every year of service in a leadership role. In the NHS this will become increasingly important as revalidation of doctors is implemented.

Second, the experience of other systems illustrates the value of medical leaders working with experienced managers. The dualities we have found in our research indicate that this approach is already in place in the NHS and it can be supported in future through a stronger commitment to joint training

and development of future medical leaders and managers. Current examples of joint training include a programmes in the North West of England, the West Midlands and Kent, Surrey and Sussex, and London as well as multidisciplinary programmes run by NHS Trusts for their own staff.

The more general point here is that high performing health care organisations that have well developed systems of medical and clinical leadership, such as Mayo Clinic and Kaiser Permanente, have learned the importance of focusing on a range of factors, including:

- prioritising education and development in the skills needed by doctors to be effective leaders and team players
- developing career structures that enable doctors to move into and out of leadership roles, and to combine leadership and clinical responsibilities
- valuing medical leadership roles not only in financial terms but also in how the organisation sees the roles and recognises the individuals who take them on
- nurturing an organisational culture that creates an expectation that doctors will take on leadership roles and that their colleagues will serve as followers
- creating an expectation that doctors are leaders and are found at all levels in the organisation rather than being a minority interest.

One final reflection on the implications for the NHS is that the issues we have discussed are likely to receive renewed attention following the publication of the Francis Inquiry into Mid Staffordshire NHS Foundation Trust. The failures in patient care that occurred at Mid Staffordshire had many causes and these included weaknesses in leadership within the trust both at board level and in the front line teams delivering care to patients. The argument for supporting clinicians, including doctors, to be more effective leaders of these teams seem certain to be rehearsed yet again, making our findings timely and relevant in the next stage of reform. This includes recognising the role of clinical leaders in improving outcomes as well as managing budgets.

7.7.1 Implications for future research

The final question to address is what are the implications for future research of the work reported here? In our view there are four main areas that merit further exploration in the following order of priority.

The first relates to NHS trusts that are perceived to be high performing organisations and the factors that contribute to their performance. Expert judgement supported by routine data on organisational performance could be used to identify a small number of NHS trusts that are perceived to fall into this category. The reasons for their high performance could then be investigated enabling the role of medical engagement and leadership to be considered alongside other factors. A study of this kind would be complementary to the research reported here which has focused on a cross section of trusts rather than those at the leading edge.

There would be particular value in focusing on trusts that have pioneered the use of service line approaches in such a study. We are aware from our own work that organisations like University College London Hospitals (UCLH) NHS Foundation Trust has focused particularly on service line management and it is acknowledged to be one of the highest performing trusts in England. An analysis of a small number of trusts like UCLH (other examples would include Newcastle and Addenbrookes in Cambridge) would also throw light on the argument that new organisational archetypes are supplanting established forms like professional bureaucracies.

The second area relates to doctors who are not in formal leadership roles and their perspectives on medical leadership. Research in this area would help illuminate the engagement gap we have identified and the factors that impinge on the role of doctors as followers and not just as leaders. Given that leadership by definition entails a relationship between leaders and followers, understanding medical leadership structures from the point of view of those being led would offer important learning about what more needs to be done to involve doctors in leadership and overcome the barriers to further progress.

The third area relates to nurse leaders and their role in NHS trusts. Our research indicates that the duality between medical leaders and general managers has become more salient with triumvirates much less in evidence than in previous research. It would be fruitful to understand what factors are at work in the apparent downgrading of the role of nurse leaders, not least because the report of the Francis Inquiry drew attention to their contribution in promoting high standards of patient care.

The fourth area concerns analysis of medical engagement and performance in clinical units and sub-groups. Our own research has found this a particularly challenging area to investigate and with the benefit of hindsight this was always going to be a difficult area to research given the diversity of services encompassed in sub-groups and the absence of established measures of performance at this level. One way forward would be to select clinical units where accepted measures do exist (surgical specialties would be a good starting point) and conduct an analysis of medical engagement in a number of such units in different trusts

7.7.2 Conclusion

This chapter has provided a summary of our research and has drawn out the implications for research, policy and practice. It is clear that the answer to the question that forms the title of this report is 'no, not yet'. The NHS has undoubtedly made considerable progress in involving doctors in leadership roles but the evidence presented here suggests that there is some way to go before the journey is complete.

The findings from our research shed light on why this is the case. The nature of health care organisations as professional bureaucracies, the persistence of tribal relationships between doctors, nurses and managers, and the still fragile nature of leaders occupying hybrid roles present formidable obstacles to the further development of medical leadership. Making progress hinges on overcoming these obstacles and requires a step change in action at all levels.

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Appendix 1 – Questionnaire

Models of Medical Leadership Survey

Name Of Organisation:

Completed By:

***** Please kindly attach an organisational chart to your survey response *****

1. Please detail the following basic statistics about your Trust

Total Budget

Total Numbers of Staff (total head count, not FTEs)

Total Numbers of Medical Consultants (total head count, not FTEs)

2a. How many doctors are there on the Trust's Board of Directors (i.e. the board led by the Trust Chair)?

- What are their job titles? & How many programme activities does each dedicate to his or her leadership role?

2b. How many doctors are there on the Trust's Management Board (i.e. the board led by the Trust CEO)?

- What are their job titles? & How many programme activities does each dedicate to his or her leadership role?

3a. Are doctors involved in multi-disciplinary committees across the Trust? (e.g. for Quality, Clinical Governance, Finance, R&D and Education)

Yes ☐ No ☐

- If Yes, please give details of forums

3b. Are doctors involved in dedicated uni-professional committees across the Trust where they can collectively contribute to discussions on Trust strategy and management (e.g. Medical advisory / Medical executive committee)?

Yes ☐ No ☐

➤ If Yes, please give details of forums

4a. How is the work of the Trust organised beneath the Trust's Management Board (i.e. the board led by the Trust's CEO)?

Please tick as many as applicable

- ☐ Divisions/Groups
- ☐ Directorate Structures
- ☐ Service Line / Business Unit
- ☐ Other

Please Specify

➤ Please remember to attach an organisational chart

4b. If there is more than one type of organisational unit beneath the Trust's Management Board (i.e the board led by the Trust's CEO), which is the principal one in terms of responsibility for leadership and management of services?

Please tick one box only

- ☐ Divisions/Groups
- ☐ Directorate Structures
- ☐ Service Line / Business Unit
- ☐ Other

Please Specify

➤ Please give reason for your selection

5. For each type of organisational unit identified in Q4a, please state:

- *How many units are there?*

- *How are these 'units' arranged e.g. according to specialty, patient pathway or by other means?*

- *What is the range of budgets controlled by these units and the average for each type?*

6. What formal leadership roles do doctors play at each level (detailed in Q4a)?

- *What are their job titles?*

- *Is there agreed time in job plans to dedicate to these formal leadership roles (if so please give both average and range)?*

- *Do the doctors in these roles receive an additional managerial allowance (if so please give both average and range)?*

7. What percentage of medical consultants in the Trust is involved in formal leadership roles?

Please tick one box only

- ☐ Up to 10% ☐ 10-20% ☐ 20-30% ☐ 30-40% ☐ 40%+

➤ **Does the Trust board deem this percentage sufficient?**

8. In the principal organisational units within the Trust (detailed in Q4b), do medical leaders in their managerial roles work in conjunction with.....

Please tick as applicable

- ☐ Non-clinical/General Managers only
☐ Nurse Managers only
☐ Triumvirate of Non-clinical/General and Nurse Managers
☐ Other e.g Finance, HR Please Specify

➤ **Who would be seen as the responsible officer of these organisational units?**

9. Do you have any internal Trust programmes for developing medical leaders?

Yes ☐ No ☐

➤ **If yes, is this uni-disciplinary or multi-disciplinary? What job grades of medical staff are included in the programme?**

➤ **If no, does the Trust make use of other external medical leadership development programmes?please provide detail**

10. Has the organisation of the Trust changed within the last 3 years or are there plans to change it in future?

Yes ☐ No ☐

➤ *If yes, what have been the principal changes?*

➤ *Why have these changes been made?*

➤ *Are there any examples within the Trust of innovative organisational arrangements that involve medical leaders?*

11. To what extent do doctors in your organisation feel they have responsibility and accountability for both 'service quality' and 'financial performance'?

Quality

Please tick one box only

NOT AT ALL 0 1 2 3 4 5 6 7 8 9 10 COMPLETELY

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Finance

Please tick one box only

NOT AT ALL 0 1 2 3 4 5 6 7 8 9 10 COMPLETELY

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

➤ *Please kindly give explanations for your selections*

12. From the point of view of medical leadership, how well in your view are the current organisational arrangements working:

Please tick one box only

NOT AT ALL WELL 0 1 2 3 4 5 6 7 8 9 10 EXTREMELY WELL

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

➤ Please kindly give explanations for your selection

13. Do you feel that medical leadership in your organisation directly improves Trust performance and patient experience?

Trust Performance

Please tick one box only

NOT AT ALL 0 1 2 3 4 5 6 7 8 9 10 TO A LARGE EXTENT

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Patient Experience

Please tick one box only

NOT AT ALL 0 1 2 3 4 5 6 7 8 9 10 TO A LARGE EXTENT

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

➤ Please kindly give explanations and/or case studies to illustrate your selections

14. In your opinion what is the single biggest challenge faced by your Trust in developing medical leadership in the future?

Thank you for taking the time to complete this Survey

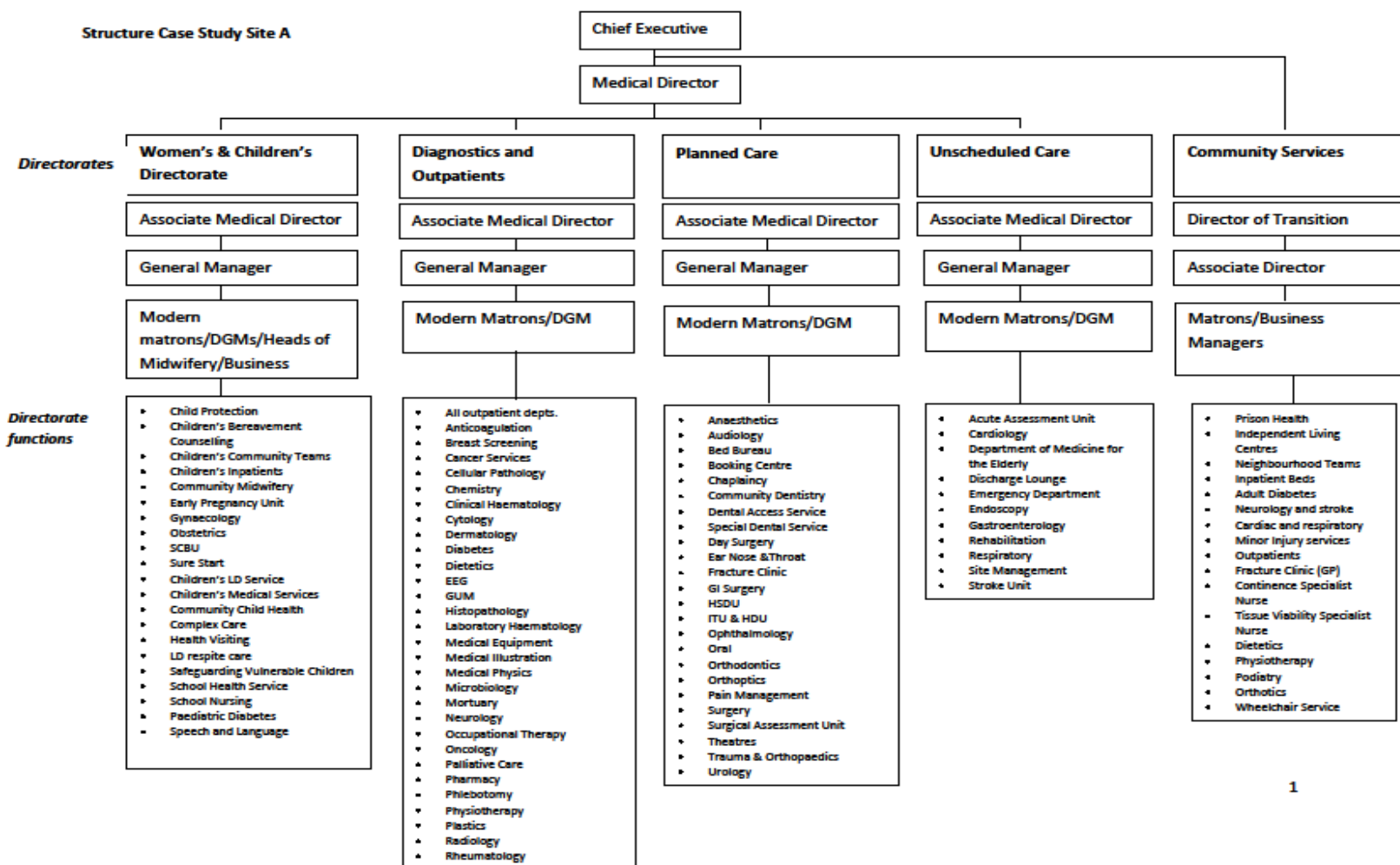
***** Please kindly attach an organisational chart to your survey response *****

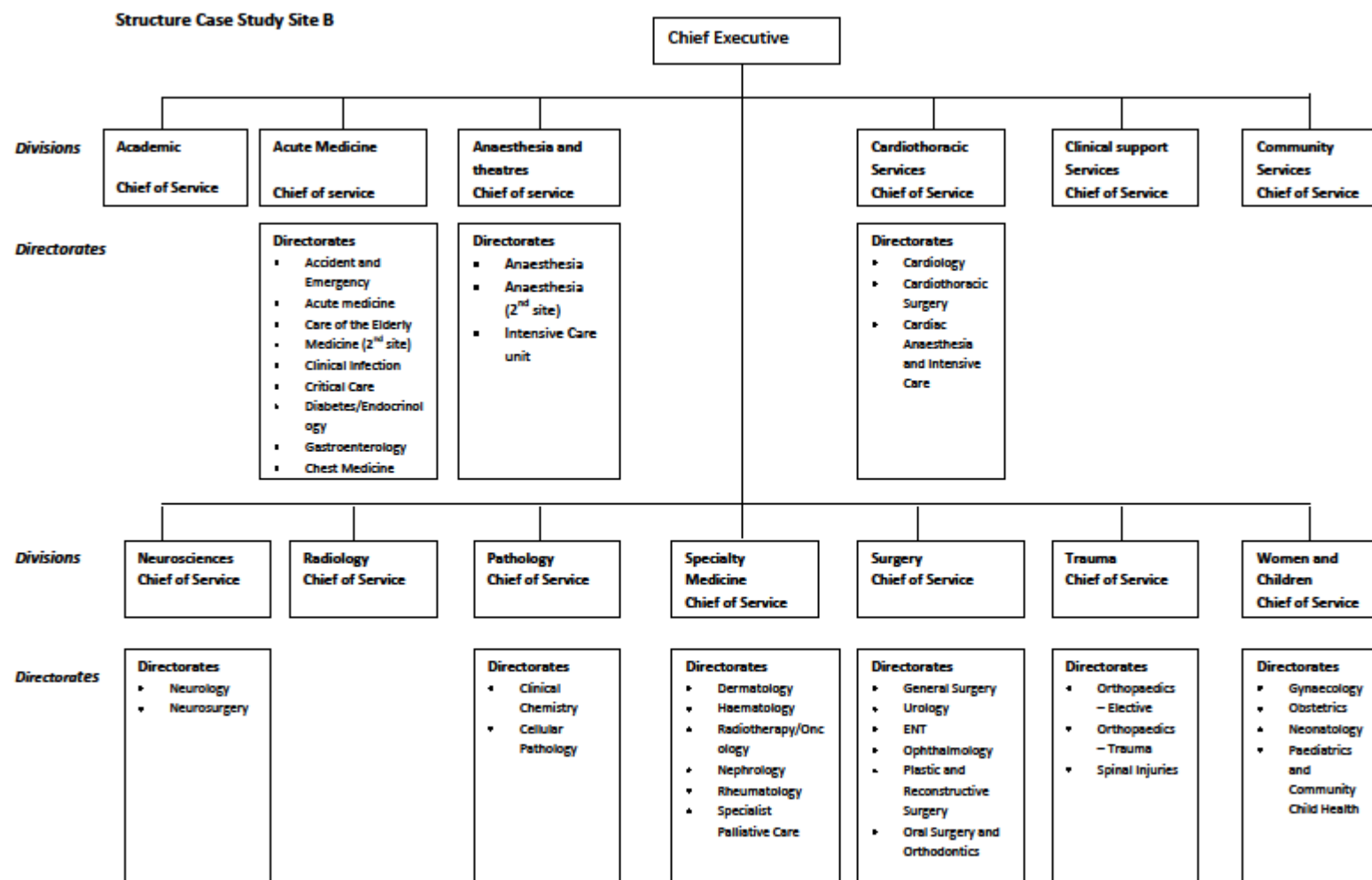
Kind Regards

Professor Chris Ham
Professor Peter Spurgeon

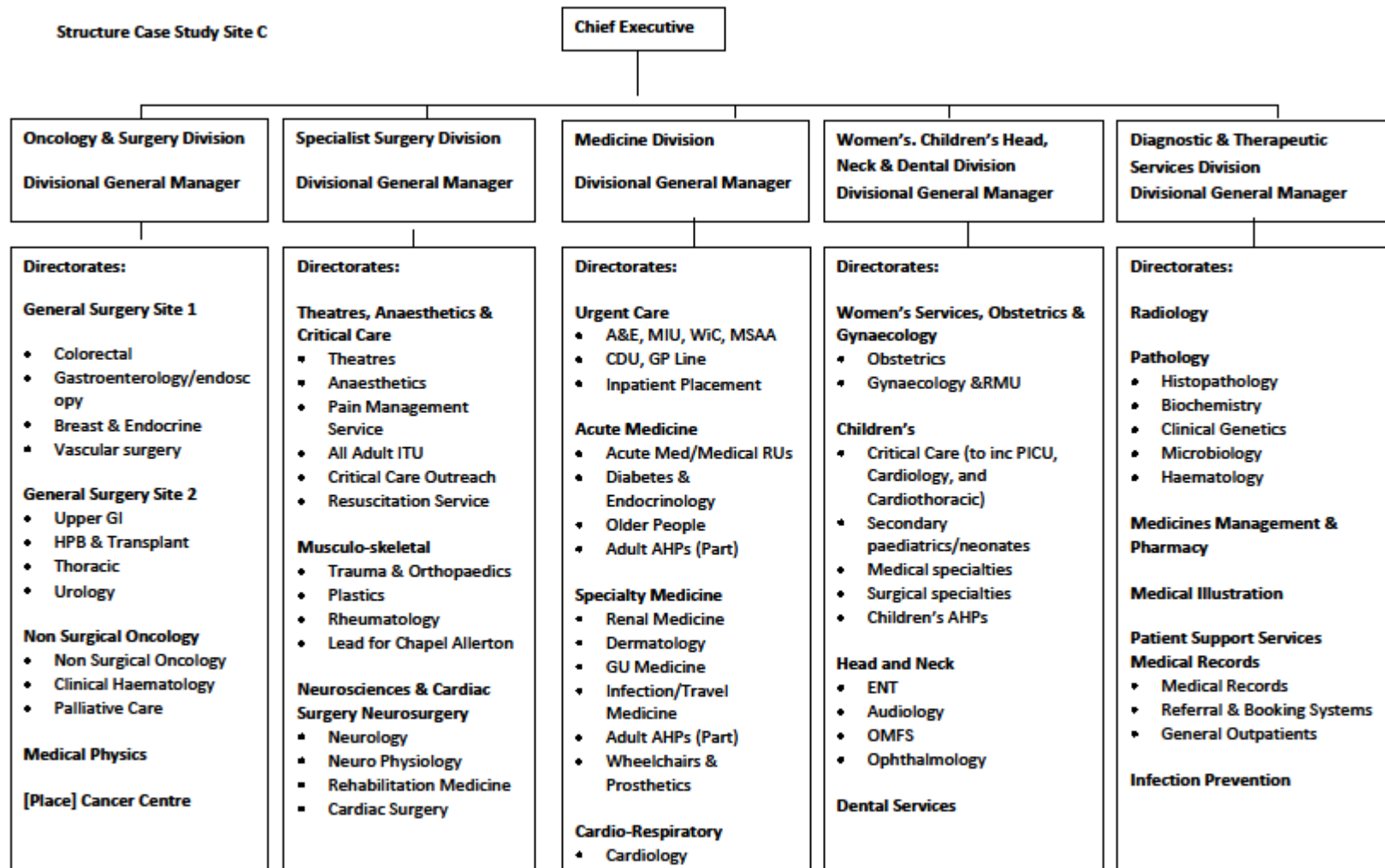
*HSMC, University of Birmingham
Medical School, University of Warwick*

Appendix 2 - Organagrams

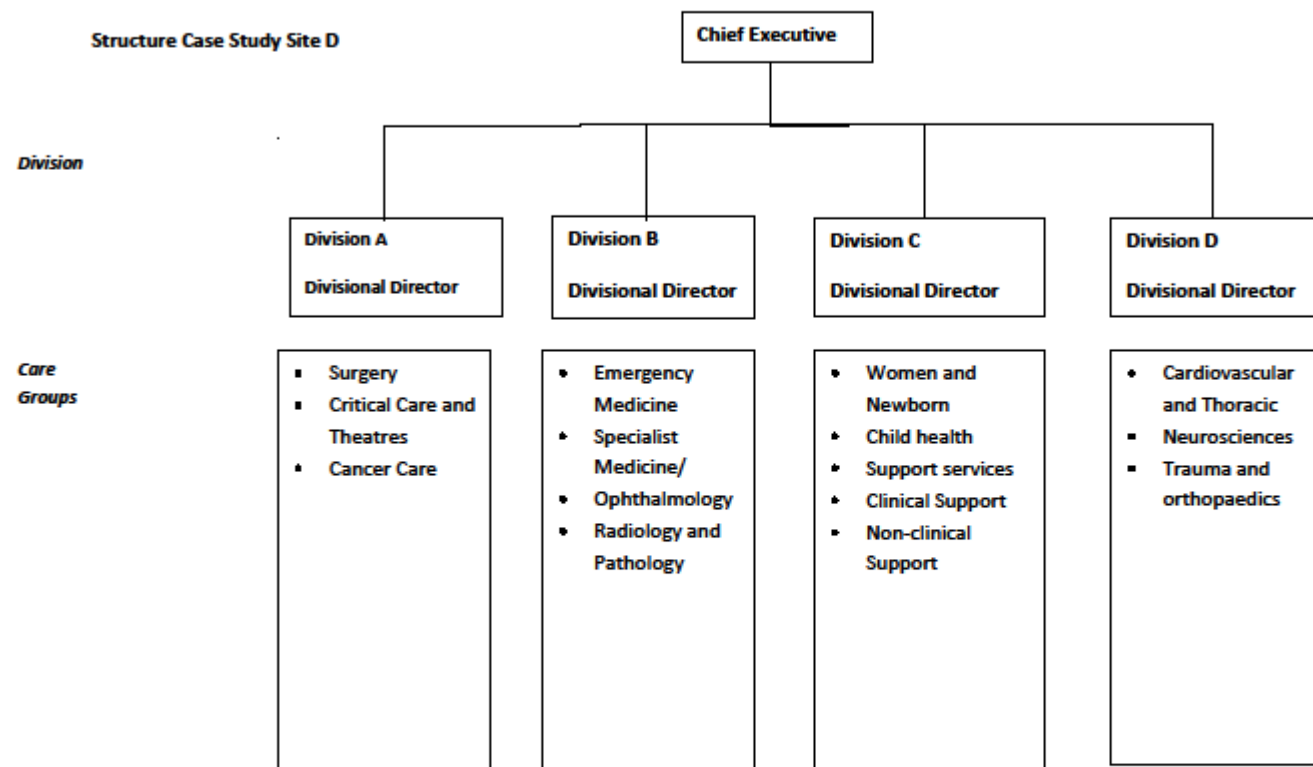




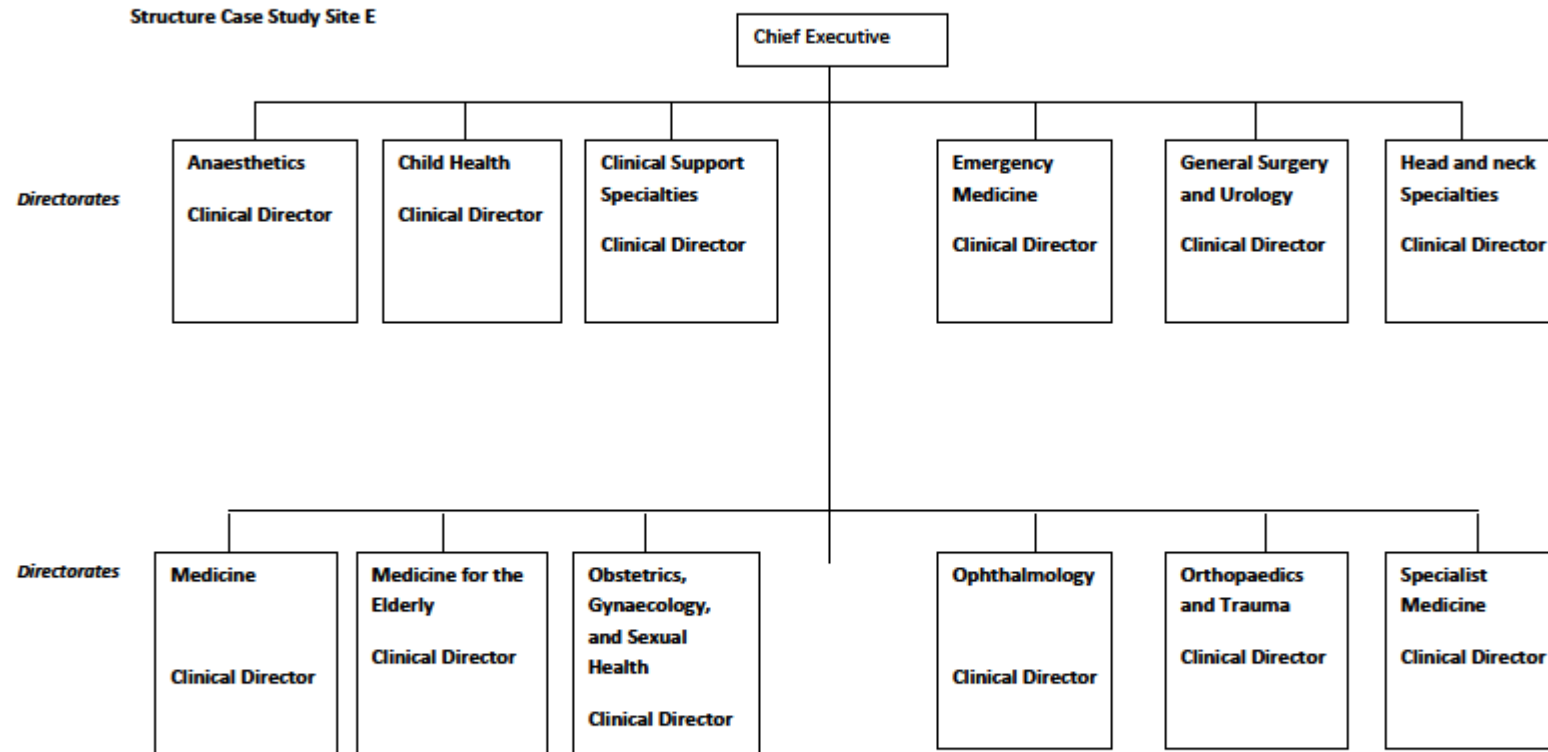
2



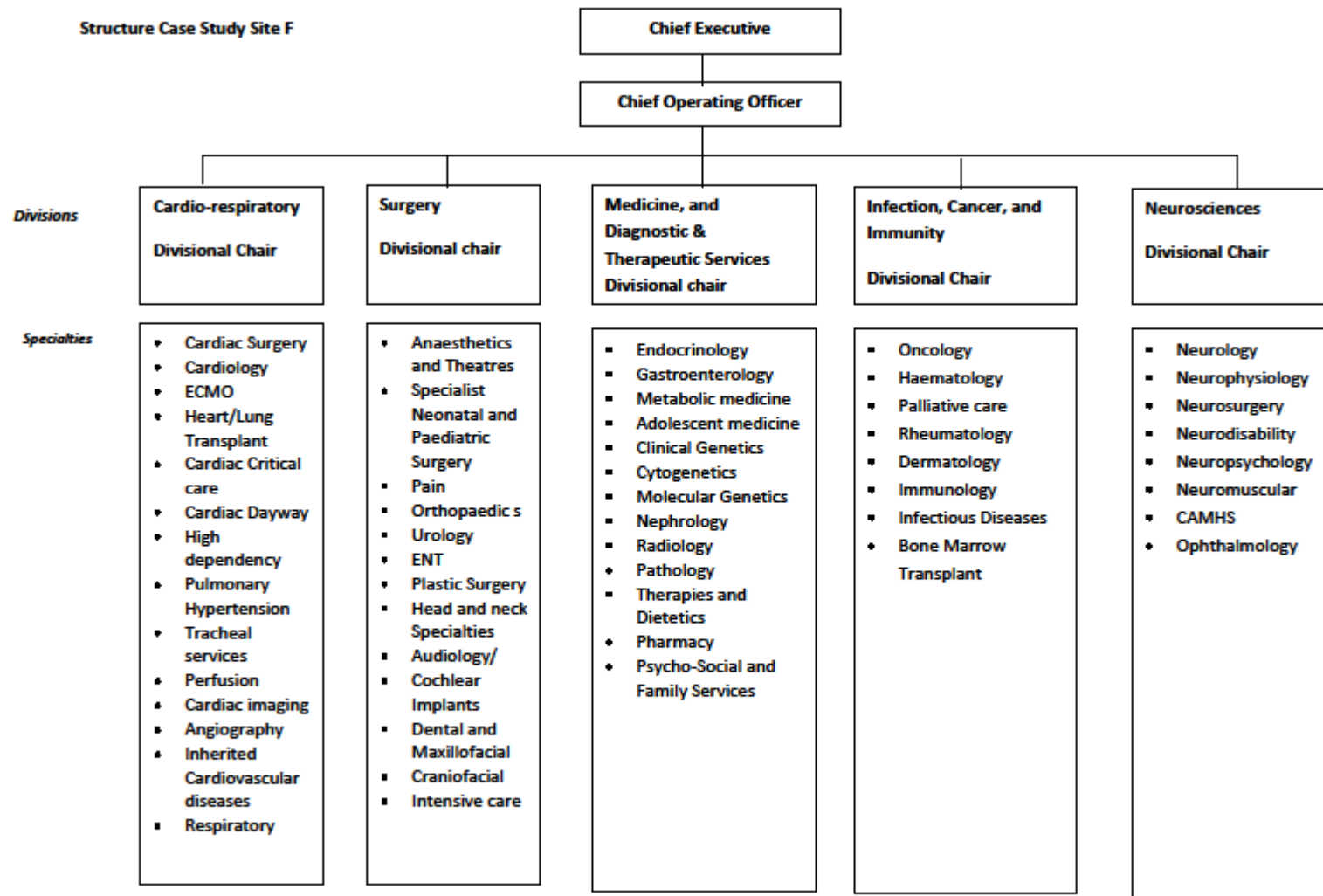
Structure Case Study Site D



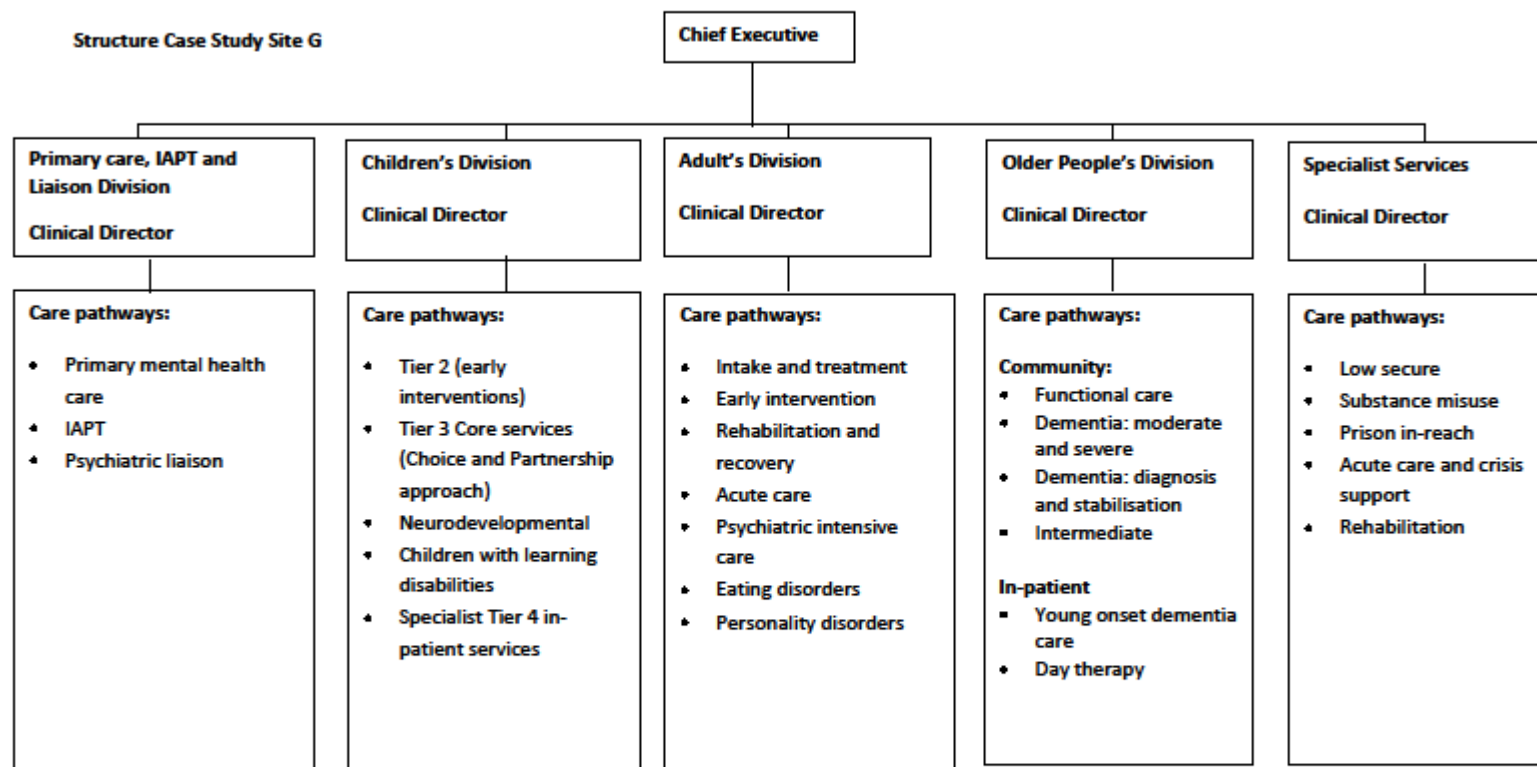
Structure Case Study Site E



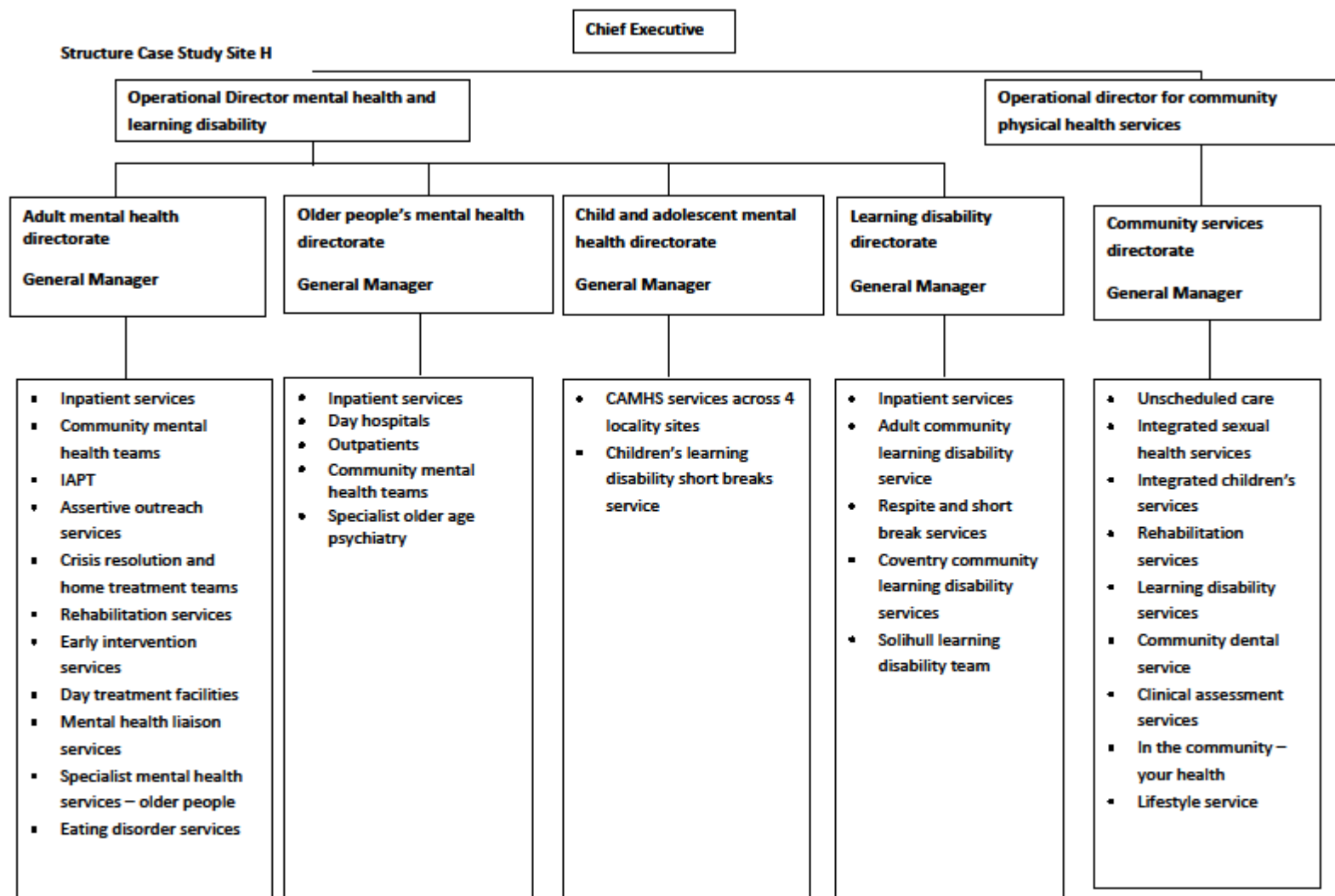
Structure Case Study Site F



6



□



8

