

## An NHS leadership team for the future

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November 2015

#clinicalleadership



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## **Reform**

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*The secret message communicated to most young people today by the society around them is that they are not needed, that the society will run itself quite nicely until they – at some distant point in the future – will take over the reigns.*

*Yet the fact is that the society is not running itself nicely... because the rest of us need all the energy, brains, imagination and talent that young people can bring to bear down on our difficulties. For society to attempt to solve its desperate problems without the full participation of even very young people is imbecile.*

Alvin Toffler

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## Forewords

### Sir Bruce Keogh KBE

Strong clinical leadership leads to better patient care. So the best place to start developing leadership skills is early on in a clinical career. The UK is a world leader in the engagement and training of junior doctors in leadership and management but, as this review demonstrates, there remains much to be done if the full potential of this talented group is to be harnessed to address the significant challenges facing the NHS.

Training in leadership and management for junior doctors is increasingly gaining traction in the UK National Health Service with some schemes into their second decade and thousands of alumni. For many years there has been agreement for the UK Medical Leadership Competency Framework to be incorporated into under- and postgraduate curricula. There is a wide range of NHS regional leadership fellowships for junior doctors with an interest in leadership and management. At a national level, significant numbers of the most talented and motivated doctors in training now spend a year working at the top of healthcare-related national organisations on the National Medical Director's Clinical Fellowship Scheme. The recently launched alumnus scheme will reach 100 members in 2015. The success, and promise, of this programme suggests that change is afoot. There is a new generation of clinical leaders who are eager to take up leadership opportunities and act as agents for change. We must now support them.

Beyond training, the NHS has begun to recognise the contribution of junior doctors over and above their clinical input. For example, it has become the norm for junior doctors to be part of the Care Quality Commission national inspection systems following the recommendations in the 2013 Keogh Review into hospitals with elevated mortality.

The UK is one of the few countries to have a professional body for medical leadership, the inter-collegiate Faculty of Medical Leadership and Management. Over 1,000 junior doctors and medical students have enrolled offering a huge potential talent pool both for the present and the future. The first standards of medical leadership have been

published and shortly there will be a certified qualification specifically for doctors in training.

This encouraging backdrop gives no cause for complacency. We face an unprecedented leadership challenge to sustain and progress what the Commonwealth Fund defined as the best healthcare system in the world. The growing body of evidence linking leadership with clinical outcome adds a further critical dimension as does the research which demonstrates the quality advantage for patients of having medical leadership well represented at the top of organisations. The literature is also clear that the days of the solitary hero are gone – the challenges are simply too complex. In recognising the leadership and management potential of junior doctors, the UK is well placed to draw on a major pool of latent and willing talent.

This *magnum opus* is a thorough and timely review of the state of medical leadership through the eyes of the generation who will all too soon inherit the system. Their concerns, passion and observations can be heard clearly and should be listened to and addressed. The review argues cogently that dispersed leadership underpins the way forward and that the system needs to draw on all of the talent – but that talent needs to be identified, nurtured and developed. Whilst there is much activity with many examples given, the report argues legitimately that there is no standard, co-ordinated approach. As others have argued, and Sir Robert Francis called for in his report into events in Mid Staffordshire, leadership needs to be professionalised and respected by all. That respect should extend to junior doctors who have had the foresight to invest time during their training to improve their leadership skills.

Too often aspiring clinical leaders feel unsupported in their pursuit of reforming the way we deliver care. This is in part due to our failure to disseminate evidence that having clinicians in leadership roles is as important to patient care as being a professor in medicine, surgery or primary care. Secondly, although there are many leadership programmes in existence, a system-wide talent management pipeline is required to ensure that we can anticipate and support our leaders of the future.

I welcome this report in supporting my firm belief that our clinical leaders of tomorrow must be developed today. We should count ourselves fortunate to have a generation who are so engaged and advanced in their understanding of both the challenge and potential solutions.

**Sir Bruce Keogh KBE**

National Medical Director, NHS England

## **Sir Hugh Taylor KCB**

The authors of this report are engaged and committed clinicians and students. Just as – perhaps more – important, they are engaged and committed human beings who want to make a difference to the world they see around them. In a sense the issue at the heart of their report is: how can we harness the energy, drive and vision of young people like them to improve health services in this country?

Bookshops – for some reason especially bookshops at airports – have shelves stocked full of helpful, sometimes stimulating books on leadership and management. If nothing else this tsunami of learning and advice should alert us to the fact that leadership and management are not the domain of an exclusive club of discreet professionals at the top of organisations. They are about bringing professionalism to bear to the issue of helping organisations to work and to improve – at all levels and across the whole workforce.

Health organisations are no different, as this report compellingly demonstrates. The best have always recognised the need to draw on the leadership and management skills of all their workforce. In fact clinicians – at all levels – are of course engaged in what the rest of us would call leadership and management every day of the week. A surgical operation is as pure an example of a small team working together to achieve a successful outcome, with differentiated roles and different expertise, as is possible to imagine. In other less elegant terminology, it would be described as a project, with processes, action lists, risk management, decision points, learning points and the rest of the jargon. In the in-patient hospital setting probably the key leadership and managerial role is that of the nurse in charge of the ward: invariably a clinician. In some NHS organisations – including the one I am fortunate enough to work in – doctors, nurses and other healthcare professionals are bringing those same leadership and management skills to bear on wider organisational demands of strategy, innovation, assurance and encouraging staff at all levels to live out their values and the values of the organisation. What marks out the Chief Nurse, the Medical Director, the Clinical Directors at Guy's and St. Thomas' is a restless desire to improve our services for the benefit of the patients and communities we serve.

But for some reason clinicians in our system have, too often, been encouraged to see leadership and management as a separate ‘dark art’ from which they are excluded and, too often, despise. Disengagement has, sometimes disastrously, been the result. I think the authors of this report are right to diagnose a systemic failing in the NHS to break through this barrier. In particular, I strongly welcome and endorse the trenchant call for existing training programmes to deal systematically with change management and improvement methodologies. We need, as they say, to stimulate, develop and benefit from the latent, untapped talent of clinicians to become ‘agents for change’ in our system and to take responsibility for making change happen. Most of them will always be clinicians first and foremost; but they should be encouraged and supported to become clinicians able to champion and lead improvement. Others may go on to develop deeper expertise in operational, finance, information or people management. There will always be subject experts in those areas in the system as well. This is all about releasing the talent, entrepreneurship and energy of a new wave of clinical leaders. That really would get the NHS jumping.

**Sir Hugh Taylor KCB**

Chair, Guy’s and St Thomas’ NHS Foundation Trust

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## Executive summary

All healthcare systems recognise the importance of the clinical workforce in delivering high-quality care. An ageing population, a growing burden of chronic disease and rising costs hasten the need for reform. One year ago, the *Five Year Forward View* set out to address these demographic, financial and quality pressures. It proposed new, integrated models of care with a radical push on efficiency, a better relationship with patients and communities, and a greater emphasis on prevention and public health. Visionary leadership will be essential to realising its aims.

Developing clinicians as the ‘agent for change’ has never been more important. This report seeks to evaluate how the NHS is preparing future clinical leaders for this responsibility. The NHS has access to 50,000 junior doctors who are among the highest performing young people in the country. It is an unparalleled resource in comparison to many corporations and organisations operating in the UK today.

An international body of evidence demonstrates the value of clinical leadership. The Francis Inquiry into failings of care at Mid Staffordshire NHS Foundation Trust highlighted the detrimental impact clinical disengagement can have on the quality of care patients receive.

There is a need for greater clinical engagement and leadership at national and local level. In contrast to healthcare systems internationally, few NHS hospital CEOs have a clinical background. In most trusts 10-20 per cent of consultants are in formal leadership roles. These clinicians are largely responsible for quality and rarely for major budgets.

In order to address this, the NHS must first make leadership an attractive option for clinicians. At present, progression in medical careers continues to undervalue leadership. Creating a culture which values clinical leaders requires changing the language and understanding of what it means to be a leader, centred on a shared commitment to high-quality care.

Secondly, clinicians must be placed at the centre of the ‘value agenda’. Clinicians have significant purchasing power; the NHS currently spends £3 billion on products and consumables selected by

clinicians, but with variation in outcomes and costs. Effective clinical leadership is required to reduce waste and to address the growing challenge of overdiagnosis and overtreatment.

Thirdly, medical schools must accelerate the incorporation of healthcare management into undergraduate curricula to equip future clinicians with leadership acumen. The tradition of healthcare management being restricted to senior clinicians can be reversed, starting with educating medical students and continuing with opportunities for clinicians-in-training.

Lastly, the NHS needs to take a system-wide approach to developing the clinical leaders of the future. High-performing organisations in other sectors have made a unified 'high-potential' talent management programme a priority. In contrast, strategic direction of the development of clinical leaders is divided between a number of national and local leaders. The NHS requires an aligned clinical leadership talent management pipeline, combining clinical practice with leadership experiences and training. This novel approach would allow the NHS to consistently develop clinical leaders and match them with service requirements.

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# 1 Introduction

At the 2004 European Championships Germany failed to win a single game and did not progress beyond the initial group stage. In response, the German Football Association (DFB) directed their efforts to restructuring their youth development programmes to cultivate the next generation of footballers. A decade later, Germany won the World Cup once again.

The DFB decided that developing the technical abilities of young players would be in the nation's best interests. They launched a talent development programme in 2003 with the aim of identifying promising young players and honing their technical skills and tactical knowledge from an early age. Spanning more than 350 German provinces, the initiative accommodates children aged 8 to 14 and is delivered by 1,000 part-time DFB coaches who have a responsibility to scout, as well as train the players. "We have 80 million people in Germany and I think before 2000 nobody noticed a lot of talent," says Robert Dutt, Sporting Director of DFB. "Now we notice everyone."<sup>1</sup>

The NHS has suffered recent high-profile failures in the delivery of quality care to patients. National reviews into substandard performance have identified the lack of clinical leadership and low levels of staff engagement as contributing factors. Despite the NHS having access to a rigorously selected, highly motivated and academically high-achieving cadre of 50,000 junior doctors, there appears to be no coherent system-wide plan to engage these talents and ensure that the next generation of exceptional leaders are embedded at every level of the NHS.

This paper, written by aspiring clinical leaders, sets out ambitions for a systemic approach to clinical leadership development to ensure a highly skilled leadership team is in position and ready to help the NHS meet the complex healthcare demands of the future.

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1 Stuart James, "How Germany Went from Boom to Bust on the Talent Production Line," *The Guardian*, May 23, 2015, <http://www.theguardian.com/football/2013/may/23/germany-bust-boom-talent>.

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# 2

## The case for clinical leadership

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## 2.1 Strong leadership delivers better care

In the face of an ageing population, a growing burden of chronic disease and rising costs, the need for NHS reform is widely acknowledged. The *Five Year Forward View* has put forward a vision of change to address these challenges. The NHS must make rapid progress on the integration and redesign of services, on prevention and public health, and on a system-wide step change in productivity.

Achieving this pace and scale of change will require a pool of skilled and visionary leaders at a local level. All health systems recognise the importance of the workforce to deliver high-quality care to patients. As the King's Fund commission on leadership found: "high-quality leadership and management at all levels is a prerequisite for a National Health Service that delivers both the highest possible quality of care to patients and the best possible deal for the taxpayer."<sup>2</sup>

The best organisations therefore need strong management and leadership. "High performance working practices", such as staff engagement, empowering the front line, highly selective recruitment, staff development and performance-related reward are now increasingly used by high-performing providers. A recent survey of healthcare in seven countries found that improved management practices in hospitals resulted in better patient care and better financial performance. In UK hospitals the study found a one point increase in management quality resulted in a 6.5 per cent reduction in mortality rates, a 33 per cent increase in income per bed and a 20 per cent increase in the likelihood of above average patient satisfaction.<sup>3</sup>

When senior management actively involve staff in their organisation and realising its goals, there is a similarly positive impact on outcomes. Higher employee engagement has been shown to reduce staff absenteeism, increase inpatient satisfaction and improve financial performance. A study by the King's Fund found that on average, an "ordinary" (one standard deviation) increase in engagement correlated with a saving of £150,000 in salary costs, and a 2.4 per cent reduction in mortality rates.<sup>4</sup>

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2 Edwina Rowling, ed., *The Future of Leadership and Management in the NHS: No More Heroes* (The King's Fund, 2011).

3 Stephen Dorgan et al., *Management in Healthcare: Why Good Practice Really Matters* (McKinsey & Company and Centre for Economic Performance, 2010).

4 Michael West and Jeremy Dawson, *Employee Engagement and NHS Performance* (The King's Fund, 2012).

## 2.2 A new kind of leadership: leaving the hero behind

The NHS will require not only strong leadership, but the right kind of leadership. In an integrated NHS, leaders and clinicians will have to look across services and health economies to revolve care around the patient, not the provider. This requires a shift away from “heroic” individual leaders to a model of collective or distributed leadership across organisations and systems.<sup>5</sup> All staff must play a role in driving forward a culture of continuous improvement and a focus on quality of patient care. This means a much larger number of staff adopting leadership roles in various formal and informal ways, and embracing responsibility for delivering safe, effective and compassionate care for patients.

The nature of healthcare and professional bureaucracies means locally driven leadership is the only option. The sustainability of healthcare providers and the quality of care patients receive are determined by a complex and fast moving set of decisions by thousands of people on the front line of the NHS, none more so than doctors. A one-size-fits-all solution from the top cannot provide the right decision in every situation. The *Five Year Forward View* made clear that change would happen through “diverse solutions and local leadership”.<sup>6</sup> Enabling individuals to take decisions on the front line, with accountability for the outcome, is the only sustainable approach.

In this way, as well as having capable leaders at the top, effective hospitals have distributed leadership whereby responsibility and authority is devolved to the front line.<sup>7</sup> This model of leadership ensures better followership among staff.<sup>8</sup> The development of service-line management in NHS hospitals has been most successful where boards have devolved responsibility to the front line, supported the judgement of clinicians and held them to account.<sup>9</sup>

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5 Nicholas Timmins, *The Practice of System Leadership: Being Comfortable with Chaos* (The King's Fund, 2015).

6 NHS England, *Five Year Forward View*, 2014.

7 Rowling, *The Future of Leadership and Management in the NHS: No More Heroes*.

8 Keith Grint and Clare Holt, *Followership in the NHS* (The King's Fund, 2011).

9 Catherine Foot et al., *Service-Line Management: Can It Improve Quality and Efficiency?* (The King's Fund, 2012).

## 2.3 The role of clinical leaders

There is an international body of evidence which demonstrates that strong clinical leadership is an essential component of successful health systems. Within this context, it is increasingly important that there is a high-quality pool of clinical leaders to meet these challenges.

From the highest political level to the lowest level of organisational sub-units, clinical leadership adds value:

- At the highest level, clinicians can ensure policymakers maintain a patient-focused outlook when designing and reforming services.
- Among providers and commissioners, clinicians are best able to navigate the complexity of healthcare systems and the difficulties of operating within a professional bureaucracy. They can align clinical outcomes and financial considerations.
- Within organisational sub-units, patient outcomes are not just determined by the skill of the individual clinician but by the processes within which they operate. Clinical leadership, engagement and teamwork is therefore crucial to better patient care.<sup>10</sup>

For many clinicians, management is the art of improving efficiency and containing cost. In fact, the best kinds of leaders can improve the quality of care patients receive. While medical technology and skill are vital, without well-functioning systems in which to operate they are not sufficient.<sup>11</sup> Teamwork, standardised care processes, process compliance and organisational and team-level culture are all key to achieving good outcomes. As Simon Stevens, Chief Executive of NHS England, said in 2014:

*Let's not undervalue the need for well-run hospitals, community and primary care services. Outpatient departments where the phone is answered and appointments clinics where tests and investigations are all synched up. Accurate waiting list management with PTLs [patient targeted treatment list] as*

<sup>10</sup> Richard Bohmer, *The Instrumental Value of Medical Leadership: Engaging Doctors in Improving Services* (The King's Fund, 2012).

<sup>11</sup> Ibid.

*routine. Patient discharge information in the hands of GPs on the day someone goes home – if not before. We know how to do this, and most places do it well. It makes an enormous difference to patients.*<sup>12</sup>

At the system level, integrated systems in the US show the role which doctors can play in effectively redesigning patient pathways and integrating services. Clinicians have the expertise to implement improvements in healthcare delivery and securing their buy-in is essential to deliver change on the front line.

A recent cross-sectional study of 100 leading US hospitals found that those providers with clinician-CEOs scored approximately 25 per cent higher on an index of hospital quality (IHQ) score. Honour roll hospitals – those with high IHQ scores in at least six specialties – were more likely to be led by physician managers.<sup>13</sup> Below board level, evidence suggests that organisations with clinically qualified managers give them greater autonomy and achieve better results.<sup>14</sup> One study found that high-performing ward managers had 36 per cent lower turnover, 57 per cent lower rates of absenteeism and 40 per cent fewer drug errors.<sup>15</sup> The evidence therefore suggests that better management of the care itself, as well as management of the organisational setting in which the care takes place, leads to better outcomes.

Clinical leadership can help align clinical and financial responsibility. Front-line, seemingly clinical, decisions about treatment and care greatly determine the costs borne by organisations and are the source of enormous variation across providers and systems. By presenting clinicians with the data to accurately assign costs to their actions, the number of unnecessary tests and interventions fall and costs are reduced. A study at Johns Hopkins Hospital, in Baltimore USA, found that physicians ordered fewer laboratory tests when prices were displayed upon ordering. This resulted in the hospital saving more than \$27,000 in a six-month period while still obtaining necessary clinical

12 Simon Stevens, "Full Text of Simon Stevens' Speech, 1 April 2014," 2014, <https://www.england.nhs.uk/2014/04/01/simon-stevens-speech/>.

13 Amanda Goodall, "Physician-Leaders and Hospital Performance: Is There an Association?," *Social Sciences and Medicine* 73, no. 4 (2011): 535–39.

14 Dorgan et al., *Management in Healthcare: Why Good Practice Really Matters*.

15 Hay Group, *Making Clinical Leadership Work: Enabling Clinicians to Deliver Better Health Outcomes*, 2013.

information and maintaining the quality of care.<sup>16</sup> A study of 126 UK hospitals found that those with greater levels of clinical leadership scored approximately 50 per cent higher in lean management (operational effectiveness) and performance management (implementation of clinical-quality and productivity targets) scores. This suggests clinical leaders may improve overall best-practice management.<sup>17</sup>

## 2.4 When leadership fails

While high-performing systems share common management habits, there are a number of prominent factors that have been found to undermine quality. Successive reviews have identified the following organisational traits that contribute to poor quality care:

- poor leadership and ineffective management from board to ward;
- weak communication in the organisation;
- poor measuring, benchmarking and reporting of performance;
- absence of an organisational culture that prioritises patient care and values patient feedback;
- closed cultures, with staff unlikely to come forward to report poor quality;
- lack of understanding in the organisation of what good care looks like and indifference of staff to poor standards of care;
- dismissive attitudes towards process, procedure and patient concerns;
- poor clinical governance, audit and accountability, poor team relationships and multidisciplinary working; and
- failure to reward right behaviour, train staff effectively or ensure staff maintain skills.

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16 Leonard Feldman et al., "Impact of Providing Fee Data on Laboratory Test Ordering: A Controlled Clinical Trial," *JAMA Internal Medicine* 173, no. 10 (2013): 903–8.

17 Pedro Castro, Stephen Dorgan, and Ben Richardson, "A Healthier Health Care System for the United Kingdom," *The McKinsey Quarterly*, February 2008.

Organisational culture and leadership needs to support clinicians to deliver quality care. In his evidence to the Francis Inquiry, Sir Bruce Keogh argued:

*It's not the managers who see the patient. It's not the managers who actually nurse the patient. It's not the managers who diagnose the patients or offer them choice of treatments. Hospitals are an aggregate of different service lines, each of which is serviced by various tribes of clinicians, doctors, nurses, physiotherapists and managers, all of whom are professional in their own right, and actually when I look at this kind of failure, what I see is a failure of clinical leadership and professionalism.<sup>18</sup>*

The Francis Inquiry into failings of care at Mid Staffordshire NHS Foundation Trust has been the most high-profile example in recent years. It laid out extensive criticism regarding the managerial focus on meeting targets without considering the quality of care itself. It also described how senior leaders within the Trust ignored warnings from staff about shortcomings in the quality of care provided. It emphasised how these deficiencies fostered a negative culture, which tolerated poor standards and did not listen to patients.

The report should be compulsory reading for all NHS staff. It highlighted that failures in leadership did not result in abstract consequences; rather they resulted in avoidable deaths and mistreatment of patients. Those who were most vulnerable, who had placed their trust in healthcare professionals were inexcusably failed. Descriptions by patients included:

*They were bullies. They bullied...the other staff and they bullied the patients. There was no word for it. ... particularly during the two weeks that Mum was dying, effectively, they were calling out for the toilet and they would just walk by them.*

*And then very often it would be two people calling at the same time and then you would hear them crying, like shouting "Nurse" louder, and then you would hear them just crying, just*

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18 Bruce Keogh, "Evidence given to the Mid Staffordshire NHS Foundation Trust Public Inquiry," 2011, [http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffpublicinquiry.com/sites/default/files/transcripts/Tuesday\\_20\\_September\\_-\\_Transcript.pdf](http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffpublicinquiry.com/sites/default/files/transcripts/Tuesday_20_September_-_Transcript.pdf).

*sobbing, they would just sob and you just presumed that they had had to wet the bed.*

*He was frightened. He got to the point that he was frightened to get back into bed. He was frightened to mess the bed, and that is why he never asked anybody to get him back in bed.*

Most of all, the report identified “professional disengagement” by senior clinical staff and a lack of support for junior doctors as a key contributing factor to the tolerance of poor-quality care. As Francis wrote, “Consultants at Stafford were not at the forefront of promoting change...The Trust lacked a sufficient sense of collective responsibility or engagement for ensuring that quality care was delivered at every level.”<sup>19</sup>

It is striking that the Keogh Review into mortality at 14 NHS trusts identified a similar failure of leadership, particularly a failure to engage junior doctors. Speaking of junior doctors and student nurses, Keogh found that “too many are not being valued or listened to. Junior doctors in particular were receiving inadequate supervision and support...They often felt disenfranchised. In some trusts we visited junior doctors are not included in mortality and morbidity meetings because they were considered ‘not adult enough to be involved in the conversations’.”<sup>20</sup>

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19 The Mid Staffordshire NHS Foundation Trust Public Inquiry, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary*, 2013.

20 Bruce Keogh, *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England: Overview Report*, 2013.

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# 3

## Progress on clinical leadership

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### 3.1 The policy context

Among policymakers and NHS leaders there is widespread recognition of the value of engaging clinicians in management. Since the 1983 Griffiths Review, it has been widely acknowledged that a key habit of high-performing providers is strong engagement, particularly with the clinical workforce. Lord Darzi's review in 2008 put clinical leadership at the centre of efforts to improve the quality of care. He set out a vision of the hybrid clinician-leader as a practitioner of care, a partner in delivery and a leader of systems. He argued that "quality of care is improved by empowered patients and empowered environments" but "making change actually happen takes leadership. It is central to our expectations of the healthcare professionals of tomorrow."<sup>21</sup>

Recent government policy has shown a clear willingness to place greater decision-making power in the hands of clinicians. The *Health and Social Care Act 2012* saw the introduction of GP-led Clinical Commissioning Groups (CCGs), putting two-thirds of the NHS budget in the hands of clinicians, alongside strategic clinical networks and clinical senates to guide and support service delivery and redesign.<sup>22</sup> Doctors are now tasked with taking an active role in the delivery of health services, whether at a local, regional or national level.<sup>23</sup> The *Five Year Forward View* clearly stated that change will not be centrally imposed; instead NHS England and others "will back diverse solutions and local leadership."<sup>24</sup>

Traditionally, however, efforts to bring clinicians into leadership roles have largely been locally driven. Financial pressure for providers has led to renewed interest in medical engagement in management, such as the development of service-line management. The most powerful driver of the renewed focus on a culture of clinical engagement and leadership has been the emphasis on collective responsibility for driving quality improvement following a series of reviews on failings of care.<sup>25</sup>

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21 Department of Health, *High Quality Care For All: NHS Next Stage Review Final Report* (Department of Health, 2008).

22 Department of Health, "Health and Social Care Act 2012: Fact Sheet Series," 2012, <https://www.gov.uk/government/publications/health-and-social-care-act-2012-fact-sheets>.

23 NHS Leadership Academy, "Clinical Leadership Competency Framework," 2011.

24 NHS England, *Five Year Forward View*.

25 Department of Health, *A Promise to Learn – A Commitment to Act*, 2013; Keogh, *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England: Overview Report*.

**Table 1: Key publications on clinical leadership**

<b>Year</b>	<b>Key reports</b>	<b>Headline findings</b>
<b>1966</b>	Salmon Report	Recommended a new hospital nursing structure under the direction of a Chief Nursing Officer as part of the management team.
<b>1967</b>	Cogwheel Report	Called for more involvement of clinicians in management, with clinical divisions taking more responsibility for the management of resources.
<b>1967</b>	Institute of Hospitals Administrators and King's Fund Joint Working Party	Proposed a clear chain of command in hospital management with a general manager supported by medical and nursing directors as well as a director of finance and a director of general services.
<b>1972</b>	The Grey Book	Recommended a system of consensus management by multi-disciplinary management teams including administrators as well as doctors and nurses.
<b>1983</b>	Griffiths Report	Concluded that "if Florence Nightingale were carrying her lamp through the NHS today, she would be searching for the people in charge". Introduced general managers but the report also saw a central role for doctors in management as chief executives and as the critical managers of resources within clinical directorates.
<b>1989/ 1990</b>	Working for Patients/ NHS and Community Care Act	GPs given the option of becoming fundholders, purchasing some services on behalf of their patients following the creation of an internal market in the NHS.
<b>1999</b>	Health Act	GPs and other primary care staff were brought into the commissioning of care through Primary Care Groups (subsequently known as Primary Care Trusts). Introduced practice-based commissioning by GPs.

<b>Year</b>	<b>Key reports</b>	<b>Headline findings</b>
<b>2008</b>	Lord Darzi's Next Stage Review	Emphasised clinicians as practitioners, partners in service improvement and leaders of organisations and teams. Made the case for greater front-line accountability and staff engagement as well as more clinicians in formal leadership roles. Set up the National Leadership Council led by the NHS Chief Executive and reformed the Clinical Excellence Awards to make reward contingent on clinical activity and quality indicators.
<b>2011</b>	Clinical leadership competency framework	Set out the leadership capabilities clinicians will need to adopt to drive "radical service redesign and improvement", including teamwork, managing resources, and facilitating service transformation.
<b>2012</b>	Health and Social Care Act	Unprecedented shift of power and accountability within the NHS by replacing Primary Care Trusts and Strategic Health Authorities with GP-led CCGs in control of two-thirds of the budget. CCGs supported by clinical networks and clinical senates, draw medical experts into the commissioning of care.
<b>2013</b>	Francis Inquiry	Review into failings of care at Mid Staffordshire NHS Foundation Trust identified a lack of leadership and "professional disengagement" as a key contributing factor to poor quality care.
<b>2013</b>	Keogh Review	Review into the quality of care and treatment provided by 14 trusts identified as outliers on mortality indicators. Key recommendation around staff engagement in quality improvement and harnessing junior doctors not just "as clinical leaders of tomorrow, but clinical leaders of today."

Year	Key reports	Headline findings
2013	Berwick Review	Review into patient safety in the NHS, identifying building a culture of quality and safety as the cornerstone of high performing providers. It argued leaders at all levels should strive to contribute to a shared quality improvement agenda.
2013	Shape of training	The Greenaway Review into clinical training recommended a renewed focus on general competencies as well as medical specialities, including leadership and management, as a core part of the training curricula. Doctors should be given an optional year to spend in leadership or management work.
2013	Raising standards, putting patients first	Care Quality Commission (CQC) introduced new inspection regime in the wake of reviews into failures of care.
2013	Future hospital: Caring for medical patients	The Commission established by the Royal College of Physicians called for consultants to assume clinical leadership for safety, clinical outcomes and patient experience. This includes responsibility to raise questions and take action when there are concerns about care standards, and collaborate with other teams and professions to make sure that patients receive effective care throughout the hospital and wider health and care system.
2014	Five Year Forward View	<p><i>The Five Year Forward View</i> set out a vision of change for the health service. This will not be centrally imposed but delivered by local leaders on the ground who can look beyond their own individual organisation to system development across health economies.</p> <p>Committed to invest in leadership by reviewing and refocusing the work of the NHS Leadership Academy and NHS Improving Quality.</p> <p>Committed to a more diverse leadership team.</p>

## 3.2 Addressing failures of quality: building the right culture

While a number of measures of clinical outcomes and patient experience have improved in recent years, several high-profile reviews in the last Parliament highlighted instances of poor-quality care and the failures of leadership behind them.<sup>26</sup> The Francis Review into Mid Staffordshire NHS Foundation Trust and the Berwick Review into safety in the NHS called for organisational leaders to build a culture of quality and safety of patient care as a matter of urgency. They argued this cannot simply be a priority at national or board level, but on the front line as well. Clinical engagement and leadership was therefore a key route to building a culture of compassionate and safe care. As Don Berwick wrote, “The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS.”<sup>27</sup>

Sir Bruce Keogh, in his review of 14 trusts with poor clinical outcomes, identified a similar professional disengagement within NHS organisations, not just at senior levels but among junior doctors as well. The review recommended that providers find new ways to “tap into the latent energy of junior doctors who move between organisations and are potentially our most powerful agents for change” and for student nurses to “become ambassadors for their hospital and for promoting innovative nursing practice.”<sup>28</sup> This should mean for instance, that junior doctors are involved and engaged in mortality and morbidity meetings within their trust. In this way, “junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but clinical leaders of today. The NHS will join the best organisations in the world by harnessing the energy and creativity of its 50,000 young doctors.”<sup>29</sup>

Don Berwick in his review of patient safety issued a similar warning regarding the dangers of ignoring the development of the next generation of leaders. He called for all doctors to engage in developing future leaders by providing support and work experience to enable others to improve their leadership capability.

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26 NHS England, *Five Year Forward View*.

27 Department of Health, *A Promise to Learn – A Commitment to Act*.

28 Keogh, *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England: Overview Report*.

29 Ibid.

The effect of these reviews has been to create new momentum behind the agenda to invest in leaders, especially those from clinical backgrounds, and engage them in the drive to create the right culture for a safer, more compassionate, patient-centred NHS.

**Table 2: Shortcomings in leadership and recommendations as prescribed in the Francis Inquiry, Berwick Review and Keogh Review**

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**The Francis Inquiry**

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**Findings at Mid Staffordshire**

- The Trust maintained a negative culture which tolerated poor standards and a disengagement from managerial and leadership responsibilities.
- Lack of focus on standards of service.
- Leaders were expected to focus on financial issues.
- Leaders paid insufficient attention to the risks in relation to the quality of service this entailed.
- Failure of the leadership to give sufficient explicit priority to the protection of patients and to ensuring that patient safety and quality standards were being observed.

**Recommendations**

- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare.
  - The Department of Health should ensure senior clinical involvement in all decisions that may impact upon patients' safety and wellbeing.
  - The healthcare system needs leaders who can adopt and promote the common values of the NHS and have the competence and skills for the complex task of delivering health services to the public with the required standards and within the allocated resource.
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**The Berwick Review**


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**Poor leadership behaviours**

- > Failure to focus on the patient (often signalling instead that targets and costs are “centre stage”).
- > Failure to listen to staff.
- > Offer no systematic support for improvement capability.
- > Lead by rules and procedures alone in a disengaged way.
- > Ignore the development of the next generation of leaders.

**Good leadership behaviours**

- > Constantly and consistently assert the primacy of safely meeting patients’ and carers’ needs.
  - > Seek out and listen to colleagues and staff.
  - > Give help to learn, master and apply modern improvement methods.
  - > Lead by example, through commitment, encouragement, compassion and a learning approach.
  - > Help develop the leadership pipeline by providing support and work experiences to enable others to improve their own leadership capability.
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## The Keogh Review

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### Concerns in underperforming trusts:

- Board and clinical leaders were not “effectively driving quality improvement.”
  - Medical directors and/or directors had poor strategies for quality improvement.
  - Poor articulation of the strategy for improving quality by medical directors and/or directors.
  - A significant disconnect between what the clinical leadership said were the key risks and issues and what was actually happening in wards and departments around the hospitals.
  - In some cases, the non-executive directors and chairs of the trusts were not providing appropriate critical challenge to the management team.
  - With regard to medical directors, most trusts reviewed were either struggling without a strong clinical leader or experienced a capability gap in the recent past.
  - A lack of focus on providing high quality supervision, mentoring and pastoral support for junior doctors.
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## 3.3 Training and professional development

Alongside efforts to create greater incentives and opportunities for clinical leadership to emerge, there has been a shift in the training and development of clinicians from the earliest stages of their career. All General Medical Council (GMC) registered doctors are required to possess leadership skills as stipulated in *Good Medical Practice* and *Management for Doctors*. In 2012 the GMC published *Leadership and Management for all Doctors* reaffirming the need for all doctors to recognise their responsibility for leadership in the clinical environment. There is similar guidance on core competencies for nurses and midwives issued by the Nursing and Midwifery Council (NMC).<sup>30</sup>

The development of competence in leadership has been a requirement for doctors since the Medical Leadership Competency Framework (MLCF) was incorporated into both undergraduate and postgraduate

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<sup>30</sup> Nursing and Midwifery Council, *Standards for Pre-Registration Nursing Education*, 2010.

curricula in 2009 and 2010 respectively. The MLCF is based on the concept of shared leadership, where leadership is the responsibility of everyone, and it sets out the leadership competencies that doctors need to become more actively involved in the planning, delivery and transformation of health services. In 2011 the Faculty of Medical Leadership and Management was established to take forward this agenda.

Recent reviews, however, have highlighted the need for further emphasis on leadership and general capabilities in training alongside traditional medical competencies and specialities. Professor David Greenaway's 2013 review into the future of medical training acknowledged the need for training to reflect the changing responsibilities of clinicians. It emphasised that alongside speciality training, organisations will need to introduce a generic capabilities framework to "allow them to gain wider experiences that will help them become more rounded professionals."<sup>31</sup> The report suggests that during postgraduate medical training doctors should develop these broader capabilities, such as patient safety, communication with patients, teamwork, and management and leadership. These skills were recognised as "complementary to doctors' clinical skills" but "integral to professional practice." Greenaway recommended that doctors should be given the option of a year in leadership or management work as part of their training.<sup>32</sup>

The Royal College of Physicians, in their 2012 Future Hospital Commission, set out a vision of consultants as clinical leaders as "stewards of quality, and not simply passive responders to prevailing circumstances."<sup>33</sup> It called for consultants to assume clinical leadership for safety, clinical outcomes and patient experience. This was to include a duty to raise concerns and act when care standards were called into question. It would mean clinicians collaborating with other teams and with other professions to ensure patients receive effective care throughout the hospital and steward them through the wider health and care system. The report called for a culture shift "away from outmoded notions of mastery, autonomy, privilege and

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31 David Greenaway, *Securing the Future of Excellent Patient Care: Final Report of the Independent Review*, 2013.

32 Ibid.

33 Future Hospital Commission, *Future Hospital: Caring for Medical Patients* (Royal College of Physicians, 2013).

self-regulation. Consequently, doctors must commit to leadership in health in order to accelerate improvement in health outcomes.”<sup>34</sup>

### **Brief overview of postgraduate medical education training**<sup>35</sup>

Final year undergraduate medical students apply to Foundation programmes: a two-year training programme managed by Foundation schools in association with medical schools, deaneries and healthcare providers. UK graduates enter the first year of the Foundation programme (F1) as provisionally registered doctors and apply for full registration with the GMC in the second year of the programme (F2). Developed by the Academy of Medical Royal Colleges and approved by the GMC, the curriculum for the Foundation programme provides trainee doctors with a range of experience and allows them to undertake supervised responsibility for patient care before choosing a field of medicine in which to specialise.

Following successful completion of the Foundation programme, trainee doctors may apply to GP or specialist training programmes. The former involves a three-year programme leading up to Membership of the Royal College of General Practitioners (MRCGP) exams. The length and nature of specialty training depends on the chosen specialty and can be anywhere between three and eight years. Some specialty training programmes have trainees recruited for the full duration of the programme whereas some entail Core Training in the first three years after which they must apply again for their chosen sub-specialty and continue training. Training is supported by postgraduate deaneries and curricula are developed by the respective Royal Colleges. Doctors are awarded a Certificate of Completion of Training (CCT) upon successful completion of training and become eligible for entry to the GMC’s Specialist or GP Register.

<sup>34</sup> Ibid.

<sup>35</sup> General Medical Council, “Medical Career Structure,” n.d., [http://www.gmc-uk.org/Medical\\_career\\_structure\\_\\_\\_doctors\\_in\\_training.pdf\\_25417075.pdf](http://www.gmc-uk.org/Medical_career_structure___doctors_in_training.pdf_25417075.pdf).

### 3.4 Opportunities for future leaders

Attempts have been made to provide a common and consistent approach to leadership development in recent years. To lead this drive for NHS leadership, the NHS Leadership Council, now called the NHS Leadership Academy, was set up in the wake of Lord Darzi's review. The Academy aimed to:

- deliver national leadership programmes to develop leaders, including clinical leaders, to improve outcomes, patient experience and value for money;
- provide an evidence base for leadership development and access to expertise;
- help create a talent pipeline for senior leadership positions;
- set high standards for leadership development at a national level and challenge inappropriate leadership behaviours; and
- promote the leadership values required to uphold the NHS Constitution.

The Academy oversaw the creation of the Clinical Leadership Competency Framework emphasising five leadership domains: demonstrating personal qualities; working with others; managing services; improving services; and setting direction. The NHS Leadership Academy invests £16.1 million in professional development programmes.<sup>36</sup> The organisation currently works via ten Local Delivery Partners (LDPs) and offers a number of leadership programmes. The majority involve a combination of online modules, lectures, mentoring, residential placements and, in some cases, placements outside the NHS. Some programmes have input from business schools with modules in subjects such as finance and management that are completed alongside quality improvement projects.

Table 3 highlights some of the opportunities, fellowships and schemes available; it is important to note that this is not an exhaustive list. There is considerable appetite for leadership and management schemes. The NHS Leadership Academy website estimates that 26,000 people

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36 NHS Leadership Academy, *NHS Leadership Academy: An Overview*, 2014.

have used some form of their leadership programmes and predicts this number will increase by 10,000 over the coming year.<sup>37</sup> As well as the schemes described in Table 3 there are further opportunities advertised and organised at a local trust level. These are often stand-alone posts where a clinician takes a sabbatical year out of their training and works with a trust in a leadership or management capacity. Often these posts have distinct objectives and involve clinicians working closely with a trust's management team.

**Table 3: Overview of current leadership options for clinicians-in-training**

<b>Scheme</b>	<b>Regional or national</b>	<b>Description</b>
<b>Fellowship in Clinical Leadership ('Darzi' Fellowship)<sup>38</sup></b>	Regional – Based in London	London 'Darzi Fellows' are engaged in a 12-month 'out of programme experience' in acute, foundation, mental health and primary care settings. The Fellows will work on a major project or a number of smaller projects. Mentored by their medical director (or nominated deputy), fellows lead on a variety of priority service change projects within their trusts. Fellows also participate in a bespoke leadership development programme.
<b>NIHR CLAHRC Fellowship<sup>39</sup></b>	Regional – North West London	The Improvement Leadership Fellowship sets out to develop a range of future leaders in innovation, improvement and research. Applicants are from all sectors and are supported by the CLAHRC team with a NIHR bursary. Participants are expected to commit the equivalent of one day a week to the programme but this can be adjusted according to the local organisation. Each applicant has a mentor and there is teaching/training on quality improvement throughout the 12 months. Fellows are expected to undertake service improvement projects and improve their leadership skills.

37 NHS Leadership Academy, "NHS Leadership Academy – Our Two Year Story," 2014, [https://www.youtube.com/watch?v=9zQqq\\_1xVd4#t=182](https://www.youtube.com/watch?v=9zQqq_1xVd4#t=182).

38 NHS London Leadership Academy, "'Darzi' Fellowships in Clinical Leadership: Programme Information," 2014.

39 Collaboration for Leadership in Applied Health Research and Care Northwest London, "Fellowship," n.d., <http://clahrc-northwestlondon.nihr.ac.uk/what-we-do/learning-and-development/fellowship>.

<b>Number of clinicians per year</b>	<b>Years established</b>	<b>Follow-on opportunities once back in clinical practice</b>
40-60	5	Focus in recent years has been on primary care and the expectation is that there are system-wide benefits once fellows return to clinical practice in integrating and developing cross-disciplinary learning.
7-13	5	Many fellows continue to work in their own organisations while some go on to undertake further studies including PhDs.

<b>Scheme</b>	<b>Regional or national</b>	<b>Description</b>
<b>NHS Medical Director's Clinical Fellow Scheme (Faculty of Medical Leadership &amp; Management)<sup>40</sup></b>	National	<p>The NHS Medical Director's Clinical Fellow Scheme gives doctors in training the opportunity to spend time in a dedicated out-of-programme experience to develop their skills in leadership, management and health policy. Participating doctors work within a host organisation in roles that typically include policy work, analysis, strategy and project management.</p> <p>The scheme runs for 12 months and fellows are attached to a participating national organisation (e.g. NHS England, GMC, CQC, and Health Education England). There is an emphasis on experiential learning with fellows getting involved at the highest levels of their host organisations.</p>
<b>NHS Leadership Academy<sup>41</sup></b>	National	<p>The Academy provides a suite of resources and programmes (12 programmes in total) for all levels of healthcare professionals. There are multiple programmes with varying intensity from the Fast Track Executive programme to online self-directed learning. More specifically there are two programmes for clinicians in training.</p>
<b>London Deanery: Paired Learning<sup>42</sup></b>	Regional – London	<p>This is a work based peer-learning programme which centres on bringing clinicians and managers together. The paired clinician and manager will shadow each other, undertake improvement workshops and complete a joint service improvement project. The paired learning model has provided excellent learning opportunities and there are plans to expand it with the help of bursaries.</p>

40 Faculty of Medical Leadership and Management, "National Medical Director's Clinical Fellow Scheme," n.d., <https://www.fmlm.ac.uk/professional-development/national-medical-directors-clinical-fellow-scheme>.

41 NHS Leadership Academy, "Programmes for Every Level of Leadership Responsibility," n.d., <http://www.leadershipacademy.nhs.uk/programmes/>.

42 NHS London Leadership Academy, "Paired Learning," n.d., <http://www.londonleadingforhealth.nhs.uk/programmes/paired-learning>.

<b>Number of clinicians per year</b>	<b>Years established</b>	<b>Follow-on opportunities once back in clinical practice</b>
25-30	10 (started in 2005 under a different name: Clinical Advisor Scheme)	Fellows re-enter clinical training on completion of their 12 months with an expectation that they will use the skills and knowledge gained to influence change. There is no formal continuation process.
Not defined	Launched in 2012	Dependent on programme.
Dependent on local organisation	2-3	Not defined

Scheme	Regional or national	Description
<b>Medical Leadership Programme (MLP)</b> <sup>43</sup>	Regional – North West Region	This is a flexible integrated programme for doctors. Recommended level of entry: GP ST3, or ST4 and above. The programme involves spending 50 per cent of time gaining leadership competencies and as a result clinical training is extended by one year. The programme runs over two years. There is an academic component which aligns with the NHS Leadership Academy Elizabeth Garrett Anderson programme and results in an MSc in Healthcare Leadership. There is also a vocational component which involves trainee led work based projects. Projects involve improving training, service design, service improvement and meeting standards.
<b>Clinicians in Management</b> <sup>44</sup>	Regional – Northern Deanery	This is a course organised for specialist registrars close to becoming consultants to equip them with leadership and management knowledge which they will need in their roles. It comprises of different modules over a two or three day period. The course involves practical examples with relevant material for the candidates.
<b>Commonwealth Harkness Fellowship</b> <sup>45</sup>	National	The Harkness Fellowship is an international scheme open to healthcare professionals from a number of countries. It is supported in the UK by the Nuffield Trust and National Institute for Health Research (NIHR). The scheme gives the opportunity for clinicians, managers, academics and researchers to spend up to 12 months in the USA as a fellow of healthcare policy and practice. The fellows are placed with mentors and experts from leading organisations such as Harvard University, Kaiser Permanente and the Institute for Healthcare Improvement.

43 Health Education North West, “Medical Leadership Programme: Recruitment Information,” n.d., <https://www.nwpgmd.nhs.uk/medical-leadership-programme>.

44 Northern Deanery, “Clinicians in Management Programme,” n.d., <http://www.northerndeans.nhs.uk/NorthernDeanery/faculty-education/clinicians-in-management-programme>.

45 “Harkness Fellowships in Health Care Policy and Practice” (The Commonwealth Fund, n.d.), [http://www.commonwealthfund.org/~media/files/fellowships/harkness/harkness\\_fellows\\_201617\\_april2015\\_v9.pdf?la=en](http://www.commonwealthfund.org/~media/files/fellowships/harkness/harkness_fellows_201617_april2015_v9.pdf?la=en).

<b>Number of clinicians per year</b>	<b>Years established</b>	<b>Follow-on opportunities once back in clinical practice</b>
12 per year	4	Not defined
Not defined	Not defined	Not defined
Not defined	Harkness Fellowship has been limited to healthcare since 2001. It has been supported in the UK by Nuffield Trust since 2009	On a case-by-case basis

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# 4

## Barriers to clinical leadership

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Evidence suggests that medical engagement and leadership improves system and organisational performance. Policymakers from Sir Roy Griffiths to Lord Darzi have made the case for clinical leadership to no longer be optional but at the centre of raising the quality of patient care. Despite this, progress on the ground has been limited. There remain relatively few doctors filling CEO positions versus managers in the UK. In contrast, the best performing hospitals in the US have physicians as CEOs who have spent decades in their respective organisations.<sup>46</sup>

A review of clinical leadership in the NHS found that most trusts had just 10-20 per cent of medical consultants in formal leadership roles, with those leaders largely responsible for quality and rarely for large budgets. It was estimated that no more than 5 per cent of consultants' time, who are not clinical directors, is allocated to leadership roles.<sup>47</sup> While CCGs had the potential to create clinically-led commissioning, evidence so far suggests limited improvement in medical engagement.<sup>48</sup>

This extends from board level down to the newest generation of clinicians. Reports have begun to argue that junior doctors being left out of decisions and more informal types of leadership is a missed opportunity for patient care and for service improvement.<sup>49</sup> Junior doctors feel hospitals and senior doctors fail to make full use of their skills. One survey found 77 per cent of junior doctors felt "not valued at all" or only "sometimes valued" by their hospital. Despite a desire to contribute to improving services, the junior medical workforce "feel that the environment in which they work is not sufficiently receptive to their skills."<sup>50</sup>

The King's Fund commission on leadership and management concluded that "one of the biggest weaknesses of the NHS has been its failure to engage clinicians – particularly, but not only, doctors – in a

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46 Amanda Goodall, *Physician-Leaders and Hospital Performance: Is There an Association?* (Institute for the Study of Labour, 2011).

47 Helen Dickinson et al., *Are We There yet? Models of Medical Leadership and Their Effectiveness* (National Institute for Health Research, 2013).

48 Chris Naylor et al., *Clinical Commissioning Groups: Supporting Improvement in General Practice?* (The King's Fund and Nuffield Trust, 2013).

49 Keogh, *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England: Overview Report*.

50 Alexandra Gilbert et al., "Perceptions of Junior Doctors in the NHS about Their Training: Results of a Regional Questionnaire," *BMJ Quality & Safety*, 2012.

sustained way in management and leadership.”<sup>51</sup> This section seeks to explore the barriers which exist to realising the potential of clinicians as leaders in the NHS.

## 4.1 Attitudes to leadership

Despite the well-established need for stronger leadership, clinicians have often proved reluctant to take on leadership roles.<sup>52</sup> Traditionally clinicians have perceived leadership and management as driven by the need to cut costs and at odds with their duty of care.<sup>53</sup> In part this stems from an ambiguous view of the study of leadership and management from the early years of medical careers.<sup>54</sup> For some it is the emphasis on central targets by management and a culture of naming and shaming when they are not met that has created a ‘them and us’ attitude to managers. The lack of role models for young clinicians interested in leadership is also likely to be a contributing factor.

Those clinicians who do progress into leadership roles often face suspicion from medical colleagues as having ‘gone over to the dark side’ and, as a result, are left with poor support structures and low morale. Surveys of junior doctors in leadership programmes identify apathy and lack of interest in leadership skills from senior staff as key obstacles to progress in leadership development.<sup>55</sup> Some still hold the view that clinical practice is being compromised when junior doctors partake in non-clinical activities. This is consistent with studies which demonstrate that, despite evidence of improved outcomes, adoption of non-technical skills, such as checklists and process standardisation, is often met with cultural resistance by medical staff.<sup>56</sup>

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51 Rowling, *The Future of Leadership and Management in the NHS: No More Heroes*.

52 Bohmer, *The Instrumental Value of Medical Leadership: Engaging Doctors in Improving Services*.

53 Ibid.; Huw Davies and Stephen Harrison, “Trends in Doctor-Manager Relationships,” *BMJ*, no. 326 (2003).

54 James Mountford and Caroline Webb, “When Clinicians Lead,” *The McKinsey Quarterly*, February 2009.

55 Pippa Bagnall, *Facilitators and Barriers to Leadership and Quality Improvement: The King’s Fund Junior Doctor Project* (The King’s Fund, 2012).

56 Peter McCulloch et al., “The Effects of Aviation-Style Non-Technical Skills Training on Technical Performance and Outcome in the Operating Theatre,” *Quality and Safety in Health Care* 18, no. 2 (2009): 109–15.

## 4.2 The wrong incentives

Cultural scepticism towards management is one way in which leadership is made unattractive to clinicians. Entry into and promotion within the NHS generally does not take leadership potential into consideration. Rather, clinical and academic recognition in the form of research publications are key to securing top positions and salaries, with leadership and managerial acumen remaining peripheral, if considered at all.<sup>57</sup> The overall career path for a clinical leader remains poorly defined and it is unclear how clinicians could move in and out of management roles.

Clinicians are often expected to balance existing clinical duties with management responsibilities in the limited time available. Frequently, junior doctors undertake audit or service improvement projects as box-ticking exercises in between multiple rotations. They are expected to carry out these projects outside of working hours with limited structural, IT or administrative support and can be overwhelmed by manual data collection. Rotas are set without consideration for non-clinical activities, hence a doctor willing to pursue these would have to work around an already busy schedule of long hours and night shifts. This reinforces the perception that leadership skills are a ‘nice to have’ rather than a ‘must have’.

## 4.3 A diverse leadership team

The NHS requires a leadership team which facilitates engagement and inclusiveness. It is widely recognised that a more diverse management team can play a key part.<sup>58</sup> While a third of all NHS employees originate from BME backgrounds, only 2.5 per cent of BME staff hold chief executive or chair positions. White Caucasian staff are three times more likely to occupy senior manager or higher roles compared to BME staff.<sup>59</sup> Similar parallels exist in the US, where few doctors from

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57 Mountford and Webb, “When Clinicians Lead.”

58 Denis Campbell, “NHS Boss Simon Stevens Criticises Lack of Diversity in Management,” *The Guardian*, May 21, 2014, <http://www.theguardian.com/society/2014/may/21/nhs-boss-simon-stevens-criticises-lack-diversity-management>.

59 Roger Kline, *The “Snowy White Peaks” of the NHS: A Survey of Discrimination in Governance and Leadership and the Potential Impact on Patient Care in London and England* (Middlesex University London, 2014); Aneez Esmail, Virinder Kalra, and Peter Abel, *A Critical Review of Leadership Interventions Aimed at People from Black and Minority Ethnic Groups* (The Health Foundation, 2005).

BME backgrounds are awarded the title of professor in medical schools (the most common indicator of leadership).<sup>60</sup>

A lack of mentorship, exclusion from leadership networks, and discrimination all contribute to this lack of BME representation within the NHS.<sup>61</sup> The “Breaking Through Programme” and the BME Network have aimed to support BME clinicians into leadership roles. In 2014 it was announced that NHS trusts which fail to meet new race equality standards for senior management will face punitive measures.<sup>62</sup> Yet while these initiatives have been important, their impact so far has been limited. Headline trends in the numbers of NHS leaders from BME backgrounds continue to show a gradual decline year-on-year.<sup>63</sup>

#### 4.4 A lack of strategic direction

Development of clinical leadership opportunities and training is split across several different agencies and schemes at both national and regional level. Clinical training is managed by Health Education England (HEE) and the various Royal Colleges while leadership development is provided by multiple organisations, making alignment difficult. Schemes such as the Darzi Fellowships are widely acclaimed, although their limited scale means they hold a largely totemic role: showing what clinicians in the early part of their career can do without achieving the scale of change necessary.<sup>64</sup> As Lord Darzi’s review identified, while the NHS invests in leadership development programmes, “these can be variable in their scope and standard”.<sup>65</sup>

60 Brian Smedley, Adrienne Butler, and Lonnie Bristow, eds., *In the Nation’s Compelling Interest: Ensuring Diversity in the Health-Care Workforce* (Washington DC: The National Academies Press, n.d.); Sandra Daley et al., “A Conceptual Model for Faculty Development in Academic Medicine: The Underrepresented Minority Faculty Experience,” *Journal of the National Medical Association* 103, no. 9–10 (2011): 816–21.

61 Virinder Kalra, Peter Abel, and Aneez Esmail, “Developing Leadership Interventions for Black and Minority Ethnic Staff: A Case Study of the National Health Service (NHS) in the UK,” *Journal of Health Organization and Management* 23, no. 1 (2009): 103–18.

62 Shaun Lintern, “Exclusive: NHS Race Equality Standard Unveiled,” *Health Service Journal*, July 31, 2014, <http://www.hsj.co.uk/news/exclusive-nhs-race-equality-standard-unveiled/5073479.article#VjDOPLfBaQ>.

63 Kline, *The “Snowy White Peaks” of the NHS: A Survey of Discrimination in Governance and Leadership and the Potential Impact on Patient Care in London and England*.

64 Vayra Shaw, “How the ‘Darzi’ Fellowship Boosts Clinical Commissioning,” *Health Service Journal*, April 9, 2013, <http://www.hsj.co.uk/leadership/how-the-darzi-fellowship-boosts-clinical-commissioning/5056853.article#VjDO-7fhBaQ>.

65 Department of Health, *High Quality Care For All: NHS Next Stage Review Final Report*.

The result of this fragmented leadership landscape is that it has become difficult for the NHS to anticipate where the next generation of clinical leaders are being created, the depth of their leadership training and how best they can be supported. Aspiring clinical leaders may leave clinical posts for a prestigious year-long sabbatical at a national organisation. On their return to clinical practice at their 'parent' trust, however, they often find themselves unable to share their learning due to lack of co-ordination between national bodies and local provider organisations. Clinicians that have completed leadership fellowships share a mutual feeling of lack of stewardship once back in clinical training.

High-performing organisations such as Unilever and PepsiCo have established "high-potential" talent management programmes to cultivate potential leaders from the outset. In contrast, the NHS is not dissimilar to the example of the German Football Association described above: unable to identify talent early and support its development.

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# 5

## Building a clinical leadership team for the future

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At the heart of better healthcare is the ability to realise the full potential of doctors, nurses and allied health professionals. Harnessing clinicians as an agent of improvement and change has never been more important. The NHS has access to 50,000 junior doctors who are among the highest performing young people in the country – an unparalleled resource in comparison to many corporations and organisations operating in the UK today. How can the NHS realise their potential more fully?

## 5.1 Making leadership a priority

It is essential that there is a clear focus for leadership not just at a national level but in every NHS organisation from board to ward. Strengthening and supporting clinical leadership should be an integral part of every provider's strategy for improvement. As Simon Stevens has argued:

*It is not just funding that will shape the future success of the NHS. As important will be our capacity for improvement and change...As NHS managers we're not just in the business of performance; as NHS leaders we're in the business of change. As the legendary Peter Drucker put it: 'There is nothing so useless as doing efficiently that which should not be done at all.' That means constantly asking: why are we doing it like this? Is there a better way?'*<sup>66</sup>

As the new models of care programme sees organisations join up in new ways across health economies, developing clinical leaders must be a key pillar of efforts to build up capacity for change. In this emerging landscape, clinicians at all stages of their career can act as 'agents of change' and 'system architects' as they collaborate across different organisations.<sup>67</sup> Clinical leaders are not a 'nice to have' but an absolute essential if the NHS is to achieve the historic scale of change set out by the *Five Year Forward View*.

66 Simon Stevens, "Speech by Simon Stevens to the King's Fund Annual Leadership Summit," 14 May, <https://www.england.nhs.uk/2014/05/21/simonstevens-kf-speech/>.

67 Keogh, *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England: Overview Report*; Department of Health, *Examining New Options and Opportunities for Providers of NHS Care: The Dalton Review*, 2014.

## 5.2 Leadership for the many, not the few

Leadership both empowers front-line staff and holds staff to account. As well as having capable leaders at the top, the most effective hospitals have distributed leadership where responsibility and authority is devolved to the front line.<sup>68</sup> If clinicians are to be held to account for the quality of care they deliver then they should have the power to set the direction for services and make decisions about resourcing which affects those quality outcomes.<sup>69</sup> This model of leadership also ensures better “followership” among staff.<sup>70</sup> The development of service-line management in NHS hospitals has been most successful where boards have devolved responsibility to the front line, supported the judgement of clinicians and held them to account.<sup>71</sup> Clinicians will need access to real-time information to enable local benchmarking, monitoring of performance and cost, and the identification of variations and opportunities for service improvement.

A shift towards collective leadership means that leadership should not be restricted to the most senior of doctors. The nature of medical training means that junior doctors rotate through multiple hospitals. As such, they may have a better understanding of the inner workings of different hospitals and approaches to clinical care. There is evidence that while a significant cohort of junior doctors have the appetite to contribute to leadership and system change, many feel disengaged and marginalised. A survey of junior doctors within the Oxford Deanery found that 85 per cent of respondents had seen better ways of working in a previous job or hospital, including better clinical ways of working (71 per cent), rota design (58 per cent) and time management (35 per cent). 65 per cent of the junior doctors said they had tried to use their experience to improve their current job, however the reception of these ideas was mixed with the majority met by indifference, or polite interest with no follow up action. The biggest reason for not raising new ideas was the perception that they would not be listened to.<sup>72</sup>

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68 Rowling, *The Future of Leadership and Management in the NHS: No More Heroes*.

69 Department of Health, *High Quality Care For All: NHS Next Stage Review Final Report*.

70 Grint and Holt, *Followership in the NHS*.

71 Foot et al., *Service-Line Management: Can It Improve Quality and Efficiency?*.

72 Thomas Duncan and Jonathan Fielden, “Junior Doctors and Change,” *BMJ Careers*, 2011.

Having both formal and informal channels by which ideas can be communicated to supervisors may result in much greater involvement of junior doctors in management. Some of the suggestions from junior doctors regarding how to achieve this included open access to departmental meetings, introducing some junior doctor representatives onto managerial committees, and a questionnaire for new starters about what did and did not work well in previous roles. Senior clinicians and managers in NHS organisations should harness junior doctors as ambassadors for innovative ways of working.

### 5.3 Leadership as a core part of clinical training

Building a generation of leaders with clinical experience and management training must begin at the stage of undergraduate medical education. Medicine selects the brightest students in the country and almost all medical students excel in multiple domains. On entry to medicine it appears that this diverse repertoire is not harnessed. Students undergo a process of “institutionalisation” where additional interests are lost due to the feeling of these skills being superfluous. Nevertheless, there remains enthusiasm for leadership and management education in the undergraduate curriculum.<sup>73</sup>

The tradition of healthcare management being reserved for senior clinicians should be reversed, starting with educating medical students and continuing with opportunities for clinicians-in-training.<sup>74</sup> Medical schools nationwide should accelerate implementation of healthcare management options into undergraduate curricula. With a better understanding of value in healthcare and development of managerial and leadership acumen, students stand in good stead for becoming clinicians that seek out and lead service improvement.

In order to truly engage clinicians, we must appeal to their goal-centred motivation. Don Berwick has described how a successful clinical leadership programme should have a combination of general training as well as specific goals, linking the overarching aims of reform

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73 Thelma Quince et al., “Leadership and Management in the Undergraduate Medical Curriculum: A Qualitative Study of Students’ Attitudes and Opinions at One UK Medical School,” *BMJ Open* 4, no. 6 (2014).

74 National Center for Healthcare Leadership, *Physician Leadership Development Programs: Best Practices in Healthcare Organizations*, 2014.

to specific changes in practice.<sup>75</sup> The integrated nature of the Darzi Fellowships is an example of this, allowing clinicians to translate high-level policy into institutional change. It is essential that other programmes not only develop transferable leadership skills, but also engage participants in projects with specific, measurable outcomes.

## 5.4 Value-based healthcare: achieving the best outcomes at the lowest cost

Discussions of value in healthcare needs to move from boardrooms into wards and classrooms so that doctors, and those training to be doctors, are better placed to manage and improve the quality of services. This should be understood not as cost-cutting but as the pursuit of value in healthcare; that is better outcomes at the lowest cost.<sup>76</sup> This will become particularly important as the NHS seeks to reduce waste and unnecessary interventions. A report from the Academy of Medical Royal Colleges found that the NHS wastes £2.3 billion a year on procedures and processes that could be delivered more efficiently or not at all.<sup>77</sup> The Carter Review reported that the NHS spends £3 billion on products and consumables selected by clinicians for patients.<sup>78</sup> Research by Professor Tim Briggs, uncovered extensive variation in the selection and costs of orthopaedic prostheses across the NHS. Improving procurement of hip and knee prostheses could save £200 million over the next five years.<sup>79</sup> It has been predicted that hospital supply chain costs will exceed workforce costs by 2020.<sup>80</sup> Clinical leadership is required to ensure that patients' best interests are served by reducing waste, standardising care and preventing inappropriate treatments. Disengaged clinicians may lead to fear of rationing and hamper any efforts to improve efficiency.

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75 Department of Health, *A Promise to Learn – A Commitment to Act*.

76 Michael Porter and Thomas Lee, "The Strategy That Will Fix Health Care," *Harvard Business Review*, October 2013, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

77 Academy of Medical Royal Colleges, *Protecting Resources, Promoting Value: A Doctor's Guide to Cutting Waste in Clinical Care*, 2014.

78 Department of Health, *Review of Operational Productivity in NHS Providers: Interim Report*, 2015.

79 Tim Briggs, *A National Review of Adult Elective Orthopaedic Services in England* (British Orthopaedic Association, 2015).

80 Material Handling and Logistics, "Healthcare Companies Using Supply Chain to Stay Competitive," 2015, <http://mhlnews.com/global-supply-chain/healthcare-companies-using-supply-chain-stay-competitive>.

## 5.5 Giving clinicians the skills and support to lead

A significant problem cited by clinicians is the challenge of finding the time to lead change and improvement whilst simultaneously fulfilling patient care duties. Trusts must ensure medical leaders have sufficient time to do the job, particularly clinical directors and others expected to retain substantial clinical commitments. The importance of these roles must be reflected in consultants' job plans and the time allocated to leadership activities.

Mentoring is a valuable tool that is incorporated into many of the high-quality leadership programmes which can help give clinicians the support and encouragement to pursue such roles. Leading health thinker, Professor Atul Gawande, has written about his positive experience of hiring an experienced surgeon as a coach, providing support and helping improve surgical performance.<sup>81</sup> Nevertheless, junior doctors post-leadership opportunity are left alone to overcome subsequent challenges including unsupportive environments, and often lack ongoing leadership development.

The NHS needs more role models to inspire their peers and demonstrate to doctors-in-training that becoming a leader is an attractive and rewarding option. This means involving more clinicians in leadership roles through mentoring, tailored support, training and financial reward. It will also enable medical leaders to resume full-time clinical commitments if they wish to. Within the NHS, the use of Educational and Clinical supervisors is well established. Their role, under the supervision of HEE, is to ensure clinicians-in-training achieve their clinical milestones. A network of experienced clinical leaders serving as independent coaches within HEE and its regional infrastructure may be more appropriate to guide aspiring clinical leaders.

## 5.6 Building a culture of clinical leadership

For clinicians to be able to shape the future of patient care, there needs to be a shift in attitudes towards leadership and management

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81 Atul Gawande, "Personal Best," *The New Yorker*, October 2011, <http://www.newyorker.com/magazine/2011/10/03/personal-best>.

within the medical community. This change cannot be achieved in isolation or via formal changes to job descriptions. Instead, it relies on changing clinicians' professional identity and sense of accountability.<sup>82</sup> Celebrating high-performing clinical leaders, both within local healthcare systems as well as at a national level, and highlighting their achievements is a step in the right direction. This will help to build a credible evidence base for the benefits of clinical leadership for other staff and patients. In turn, it will foster an environment in which other doctors are inspired to excel in leading successful teams.

A culture of clinical leadership also relies on the relationship between leaders at all levels and the goals they work towards. It depends on a collective commitment to improving the quality of patient care. High-performing providers use statements such as "the needs of the patient come first" to align leaders around a common purpose.<sup>83</sup> These statements orientate leaders around a common goal, focused on patients, committed to improvement and done through teamwork not individuals. As Thomas Lee and Toby Cosgrove have argued: "Discussions with physicians about reorganising care cannot begin with talk of contracts and compensation but most focus instead on the stakes for patients."<sup>84</sup>

## 5.7 An integrated pipeline for aspiring clinical leaders

At the system level, it is essential that there is a well-defined strategy within workforce planning to meet the need for clinical leaders across the NHS. The *Five Year Forward View* emphasised the importance of greater alignment in the work of strategic clinical networks, clinical senates, NHS Improving Quality, the NHS Leadership Academy and the Academic Health Science Centres and Networks. The number of organisations involved in the training of aspiring clinical leaders needs to be rationalised. The sheer number of leadership development programmes and programme providers has left the NHS unable to deploy the graduates of these schemes effectively. The formation of

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82 Mountford and Webb, "When Clinicians Lead."

83 Mayo Clinic, "Mayo Clinic Mission and Values," n.d., <http://www.mayoclinic.org/about-mayo-clinic/mission-values>.

84 Thomas Lee and Toby Cosgrove, "Engaging Doctors in the Health Care Revolution," *Harvard Business Review*, June 2014, <https://hbr.org/2014/06/engaging-doctors-in-the-health-care-revolution>.

NHS Improvement presents an opportunity for a nationally co-ordinated process to train and place emerging clinical leaders to support quality improvement within provider organisations.

There is a need for a single NHS clinical leadership talent management pipeline. By combining clinical practice with leadership experiences, leaders across the health service can undergo intensive management training in parallel with their clinical specialties. The closest model to this currently is the Darzi Fellowship scheme, which is delivered through the London Leadership Academy and Centre for Innovation in Health Management. Since its launch in 2009, it has aimed to develop the leadership skills of junior doctors through opportunities to work on supervised service delivery products in primary and secondary care settings. It has since received positive feedback regarding its structured and practical approach to leadership development.<sup>85</sup> The precise content for such a leadership development programme requires further discussion.

## 5.8 An integrated career path for clinical leaders

The career path for clinicians with leadership aspirations is often unclear. If leadership programmes are to be effective, they must support those participating in them to identify the best way to pursue a career that develops their interests. Physicians have traditionally followed a structured pathway to develop a clinical career with interests in research or education. Similar pathways, however, do not exist for those wishing to pursue careers with a leadership or management focus which can be off-putting for those with leadership potential. In the US, physicians who have these interests often complete MBA/MPH programmes and are then able to pursue hospital roles at board level. Similar structures do not exist within the NHS, which can lead to those with these interests moving to the private sector. Management consulting, for example, is a popular choice for clinicians who choose to leave medical practice, in part due to clearly defined pathways for career progression. We must ensure that for those interested, completion of a leadership programme will result in clear career progression together with job security.

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85 Karim Shazid, "The Darzi Fellowship: Leading the Way," *InnovAiT* 5, no. 2 (February 2012): 122–23.

The NHS has already proven able to adapt in the face of changing workforce and population needs. The academic clinical career pathway was established to address the lack of academic clinicians within the NHS.<sup>86</sup> Similarly, aspiring academic clinicians described a lack of clear entry route and a transparent career structure, lack of flexibility in the balance of clinical and academic training and a shortage of properly structured and supported posts upon completion of training. Much like the integrated clinical academic career pathway, a clinical leadership pathway could be integrated into postgraduate medical education. A three-month rotation in clinical leadership over three years could provide an invaluable means of recruiting and producing clinical leaders. Instead of taking on research projects, quality improvement projects could be undertaken at selected hospitals under the guidance of a senior NHS leader. Trainees could receive a postgraduate certificate, or an MBA equivalent, from a business school. This would combine experiential learning with an understanding of the science of management and leadership. In the same way that academic fellows complete their training and take up clinical lectureship or consultant posts, leadership graduates could go on to assist trust executives, as associate medical directors or quality improvement officers.

## 5.9 A representative leadership team

There is a need for clinical leaders to be representative of the communities they serve. As Simon Stevens has said: “Diversity in leadership is associated with more patient-centred care, greater innovation, higher staff morale, and access to a wider talent pool.”<sup>87</sup> The *Five Year Forward View* emphasised that the NHS should “provide supportive and non-discriminatory ladders of opportunity for all its staff, including those from black and minority ethnic backgrounds”.<sup>88</sup> This will not only help to attract those with ability but will also ensure that talented individuals who complete these programmes remain engaged within the health service. Ensuring that board-level positions are available to all of those with talent will ensure that those individuals will not feel the need to look elsewhere to further their career.

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86 *Medically- and Dentally-Qualified Academic Staff: Recommendations for Training the Researchers and Educators of the Future* (Modernising Medical Careers, 2005).

87 Stevens, “Speech by Simon Stevens to the King’s Fund Annual Leadership Summit.”

88 NHS England, *Five Year Forward View*.

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# Annex 1: Expert commentaries

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## **Annex 1.1**

### **Manfred F. R. Kets de Vries**

In taking on my role as a leadership specialist (and recalling to memory my numerous patient experiences in hospitals), there have been many times when I have been appalled by the quality of patient care – including a number of mistakes that were (almost) deadly. What troubled me even more was that so little was needed to bring about significant change to patient care. Already, the basic principles of Management 101 would have yielded noticeable improvements.

I am not suggesting that poor patient experience is intentional. Most likely, the reasons for my miserable experiences were plain ignorance of the basics of management and leadership. It didn't require a whiz kid to see how the hospital's personnel was hanging on to outdated, extremely hierarchical practices. Participative management was an unknown word. Many senior doctors had no idea how to run teams effectively. They didn't know how to communicate. The term "organisational culture" and its critical role in hospital care was not known to them. Furthermore, in their efforts to manage their own anxieties – after all, people suffer and die in hospitals – they have turned their patients into 'part-objects'. Thus, instead of a holistic approach to patient care, the patient becomes the cancer in room A, the broken spine in room B, or the hospital infection in room C. The basics of how to manage the various units effectively; how to get the best out of people, were direly missing. And as we know, the hospitals of the NHS are no exception. They have had their share of failures in the delivery of quality care to patients.

Thinking about my personal experiences makes this report so true to form. It couldn't have been timelier. I admire the authors for their passion, honesty and their concerns about the delivery of quality care to patients in the NHS. And very appropriately, they have identified failures in clinical leadership as a key contributing factor. As the report stresses, strong clinical leadership is an essential component for effective healthcare systems. Unfortunately, as far as key decision makers are concerned, this is not top of mind. Education for future leadership is not built into the curriculum of aspiring doctors. There isn't an overall plan to teach junior doctors – very important leaders in the making – the basics of management and leadership. Of course,

we all learn on the job, but as experience has taught us, we can accelerate such learning by putting into place well thought through leadership development programs.

Unfortunately, management and medicine can be seen as ships passing in the night. Many, especially those in positions of leadership fail to realise the communalities that hospitals have with more traditional organisations, and the benefits that may be reaped through a higher degree of professionalism. Like it or not, when medical professionals become more senior, they will be put into leadership positions. Thus, is it much better to learn the basics of management as early as possible.

The report points out the many barriers health professionals face. Most obvious is the stereotypical view of executives as being predominantly obsessed by cost control, standardisation and time management, at the expense of patient concerns and quality care. Of course, this assumption is far from the truth. The less obvious reason preventing convergence may be concerns about identity. Many health professionals may ask themselves whether they can be both medical doctor and managers? Are these roles contradictory? Will assuming one imply a loss of identity in the other? Again, I don't think this needs to be the case. It's not a zero-sum game. On the contrary. As the present troubles in the health service suggests, the NHS would do well to make the development of high quality clinical leaders a priority.

I can say (again from personal experience) that I have tried to help transform many senior clinicians into leaders. But while doing so, I have often asked myself, how much more effective I could have been, if such interventions had come at a much earlier stage in their career trajectory. If that had been the case, if it would have prevented many, now deeply ingrained bad habits. Again, the report makes a salient point, saying that "the tradition of healthcare management being reserved to senior clinicians should be reversed, starting with educating medical students and continuing with opportunities for clinicians-in-training." Leadership development should be embedded in early training as a medical doctor.

This need is more relevant than ever. Healthcare is now facing challenges at a rate unprecedented to previous times, having to

operate on a global level, keeping up with shifting competition bases, increased accountability from stakeholders, and the need for innovation and reinvention in order to stay ahead of the game. To be effective under these circumstances requires creative and adaptive leadership. It necessitates new ways of operating. From early onward, medical doctors need to create the kinds of organisational cultures that allow people to collaborate and work more interdependently, to build important relationships across boundaries, to lead with a more flexible style, and to be open and adaptable to change and to new ideas.

The challenge for leaders in the healthcare business will be to make their organisations work – to create employee and client-centered organisations. Many of us have very good ideas, but the question is how to transform these ideas into action? One critical competency to bring about client-centric organisations is seamless teamwork – a scarce commodity in many hospitals. Drawing on my personal experience I have found the team coaching method that I have developed a highly effective way to put vision into collective action. It has a very good track record in creating effective, highly diverse virtual teams; it has proven to be very successful in breaking down silo-like behaviour; and it makes for true knowledge management, implying real exchange of information. But without the institutionalisation of a team-oriented culture, it is very likely that healthcare professionals will do things their own way, often resulting in uncoordinated, even conflicting decisions and actions.

Let me end with a few thoughts about leadership in general – including the development of junior doctors. As a start, to be effective in whatever leadership position one happens to be in, healthcare professionals need to instill in the people they are responsible for with a *sense of purpose*. From early onwards in their careers, they need to know how to create and articulate a vision for the future of the organisation (big or small) that they are responsible for – a vision fleshed out with vivid descriptions of the healthcare provider's fundamental purpose and culture, its values and beliefs. This description of the organisation's future – if imbued with sufficient meaning – will have a connecting value and thus contribute to a group identity.

Also, leaders at whatever level (and I am a great believer in distributed leadership) need to create the conditions that foster a *sense of*

*competence*. This goal is reached when each person in the organisation has a feeling of ongoing personal growth, development and engagement. To prevent stagnation, *continuous learning* will be essential. On-the-job growth and development offer a strategy for reaffirming the self and preserving personal equilibrium.

Furthermore (very different from what is presently the case in hospital settings) healthcare providers need to create a greater *sense of self-determination* among the people that work there. It's time to break strict, hierarchical boundaries. For the sake of their organisation's mental health, it is essential that the people who work there have a feeling of having some control over their lives. The conditions should be created whereby healthcare personnel see themselves not as mere peons in the larger scheme of things but as capable masters of their own lives.

Finally, leaders at all levels of the organisation need to create a *sense of impact* among their people. In other words, each organisational member must be convinced that his or her actions make a difference, affecting organisational performance. Believing that each member of the organisation has a voice is what empowerment is all about. It helps to create a sense of collective responsibility.

If leadership training is embedded in healthcare organisations, if (from the start of their careers), when doctors learn from early onwards how to take on a leadership role, it will be more likely that the institutions they work for become better places to work and provide the best possible patient care. The creation of an identity that unites the roles of being a good doctor and a good leader (roles that are not contradictory but complimentary) will be beneficial to all.

**Manfred F. R. Kets de Vries**

Distinguished Clinical Professor of Leadership Development and Organisational Change, INSEAD, France, Singapore & Abu Dhabi

## **Annex 1.2**

### **Amir Dan Rubin**

Healthcare delivery is changing with the rise of electronic records, precision medicine, consumerism, population health, and value-based imperatives. These factors are impacting workflows of caregivers, composition of care teams, and settings of care. They are driving organisations to improve efficiency, access, patient experience, and population health. To successfully navigate these changes and positively impact care delivery, leadership is needed. Where are these leaders to be found? They are within our healthcare systems – in the form of our physicians, nurses, clinicians, staff, managers and administrators. To support this leadership challenge, we need to equip our team members with leadership and performance improvement tools.

The leadership challenge facing the NHS is likely similar to the leadership journey we face at Stanford Health Care, the academic health system affiliated with Stanford University and the Stanford School of Medicine in Stanford, California. Across our organisation, we have been advancing the leadership and performance improvement skills of our team through a variety of programmes. We allocate protected and compensated time to these activities, and hire experts to facilitate these initiatives, as we believe they provide valuable returns.

All physicians, managers, and staff participate in orientation sessions and on-line training in our Lean performance improvement and patient experience approaches. Departmental leaders participate in supervisory training programs on key areas of Lean and customer service, including team problem solving, leading daily huddle meetings, mapping out value streams to identify improvements, and conducting observational coaching rounds. Our advanced medical leadership program invites a physician cohort to further dive into Lean and customer service approaches, project management, team building, influence, change, strategic thinking, accounting, and time management. Additionally, we offer all team members access to an array of workshops on managing difficult conversations, leading and managing change, setting and managing expectations, and coaching team members.

At Stanford Health Care we believe our investment in leadership development has delivered great returns. Our patient experience scores have risen to top levels in the US, our quality metrics are at benchmark levels, our clinic wait times have been halved, our inpatient throughput has increased, and our employee engagement scores have reached new organisational highs. By developing the leadership and performance improvement capabilities of our team members, we not only believe we can address key external factors of change, we believe we can help shape and lead the future of healthcare.

**Amir Dan Rubin**

President and CEO, Stanford Health Care, Stanford University

## **Annex 1.3**

### **Dr Amanda Goodall**

In the past, hospitals were routinely led by doctors. Yet in the UK today most hospital CEOs are professional managers. That the pendulum has swung so far towards managers and away from clinicians has not gone unnoticed; many academic papers and practitioner reports have questioned whether this is a mistake. But the evidence to support these arguments has mostly been absent. The question about how leadership links to organisational performance had previously not been answered. However, there is now growing evidence that hospitals perform better when they are led by doctors instead of non-medically trained managers. This is also being shown at board level; the best hospital trusts have more directors who are doctors. Interesting to me is that some find the idea of experts as leaders to be counterintuitive. In fact a leader's technical competence – or 'expert knowledge' – is empirically associated with organisational performance. It is also the single strongest predictor of workers' wellbeing, and there is growing evidence that 'happier' workers are more productive.

My research colleagues and I have examined leaders in a number of settings and found: outstanding hospitals in the US are more likely to be led by doctors not managers; there is evidence that the best universities in the UK are in the top ranks because they have been led by outstanding researchers; academic departments improve when they are led by more cited scholars; basketball teams win more when

their coach is a former basketball star; Formula 1 Championships are won more often by a team principal who is a former racing driver; and before you ask – football teams in the English league are typically managed by former players with an average of 16 professional years in the game. Indeed, even the most commercial IT company in the world, Google, has a leadership and Board replete with engineers and other scientists including two US university presidents.

Surely *this* is the intuitive story. It goes without saying, that leaders need to know the nuts and bolts of how to manage and lead; but, we also want them to have in-depth expert knowledge about the core business of the organisations they are to head. In new research with the Faculty of Medical Leadership and Management (FMLM) my colleagues and I are asking ‘why might it matter to other doctors if they are led by someone who is ‘one of them’?’ This informative report assesses a vast body of research and makes helpful recommendations towards designing a future for clinical leadership.

**Dr Amanda Goodall**

Senior Lecturer in Management, Cass Business School, City University London

**Annex 1.4**  
**Michael Macdonnell**

Leadership is like charisma: difficult to define precisely, but you can be sure when you’re in its presence. Like charisma, it is also rare – strong clinical leadership all the more so. That’s why it’s both heartening and insightful to read *An NHS leadership team for the future*, written by six aspiring clinical leaders who already exhibit this uncommon skill.

You can also be sure when clinical leadership is absent. Mid Staffordshire hospital was a tragic and prominent case. But the absence of strong clinical leaders was also a marked trait of Sir Bruce Keogh’s Mortality Review in 14 hospitals as well as many that have subsequently been put into special measures. The CQC rates providers on whether they are ‘well-led’ including hospitals, care homes to GP practices, confirming how important clinical leadership is to high-quality care.

So we are going to have to take decisive steps in the coming years to

build a larger, more diverse and higher-powered cadre of clinical leaders – from medical students to chief medical officers. The authors of the paper make several important suggestions such as improving training and development opportunities and challenging the cultural divide that separates clinicians from managers.

Perhaps the most important is to set out structured opportunities for clinical leaders, reinforced with the right incentives, and building on schemes like the Fellowships in Clinical Leadership (better known as Darzi fellows) and the clinical fellowships sponsored by the National Medical Director, Bruce Keogh, each year.

But we could be more systematic, designing career paths that enable aspiring leaders to blend their clinical practice with opportunities to lead care model redesign locally, commission services, and shape investment patterns as well as national policy. These should begin early, whilst recognising that the priority for clinicians should be their training. For consultants, GPs, senior nurses and equivalent positions, we should develop options for attractive and rewarding portfolio careers. As *An NHS leadership team for the future* demonstrates, there is plenty of energy and appetite amongst young clinicians. We now need to unlock it.

**Michael Macdonnell**

Director of Strategy, NHS England

**Annex 1.5**  
**Robert Pearl MD**

Healthcare in the 21st century requires leadership, vision and training. To be successful, organisations like the NHS need to recognise physician leadership talent early, invest in these individuals and encourage them to expand their expertise beyond their clinical practice. Providing superior quality and personalised service in the most efficient and effective ways possible requires increased collaboration and cooperation across specialties, advanced information technology systems and an understanding of the change process. Leaders create a vision, align people around it and motivate them to move forward. Learning these skills allows patients to receive better healthcare outcomes through redesign of systems, innovative

solutions and group excellence. Developing the skills of a broad range of clinical leaders will be in the best interest of the British people and the Government.

In Kaiser Permanente we have used this approach to train emerging leaders and new chiefs of service. Through the commitment and dedication of our physician leaders and the improvements they have accomplished, we have lowered the chances of our patients dying from heart disease by 30 per cent, from stroke by 40 per cent and from sepsis by close to half compared to patients cared for by others across our nation. I encourage people to read and learn from this report which highlights what is possible through leadership education and development.

**Robert Pearl MD**

Executive Director and CEO, The Permanente Medical Group, Kaiser Permanente

**Annex 1.6  
Nigel Edwards**

*Physicians, as a rule, have less appreciation of the value of organisation than the members of other professions*  
William Osler

There is a plausible case that the growth of lay management in healthcare is a response to the failure of clinicians to take on the challenge of management, or to respond to demands for accountability and responsiveness from societies with a limited willingness to pay but high expectations.

Initially the deal was that management would provide support, negotiate resources and leave well alone. But, as the finances got tighter, and the public more demanding, the scope of management grew.

There has been some resistance from clinicians to get involved in leadership and management. There has been reluctance to accept that clinical decisions are about resource allocation with significant consequences – not least for patients not yet treated. There has also been a strong tendency to downplay the contribution of high quality

leadership and management. Administration and management have often been seen very negatively and those responsible for it dismissed as bureaucrats who add little value.

The quality and safety movement, the realisation that creating more systemic approaches saves money, improves quality and enhances working lives and the idea that professionals should step up and take responsibility for the systems in which they work has created a significant shift. The idea that clinicians could become managers and leaders without learning new skills and approaches just because of their clinical background has been replaced by a strong desire to acquire methodologies, techniques and knowledge. More challenging is the change in mind set that is required to take on these roles. For example, thinking about populations and organisations is not the same as a focus on an individual patient.

The strong case for more clinical leadership that is made here is part of a wider argument about the need for better leadership and management more generally. Clinicians bring the insights that come from actually knowing the business being managed and speaking the language of those they are leading. To be effective they will need staff who understand the importance of leadership and management and strong systems at the front line to translate their leadership into reliable delivery. This call for change from the next generation of medics is a reminder that we have been talking about this for too long and while there has been action there needs to be more and it needs to go quicker.

**Nigel Edwards**

Chief Executive, The Nuffield Trust

## **Annex 1.7**

### **Huw Jennings**

Prior to joining Fulham Football Club, I was Youth Development Manager for the Premier League, and Southampton FC's Academy Director. I am proud to have helped develop some of the exciting prospects in football including Gareth Bale, Theo Walcott, Alex Oxlade-Chamberlain and Adam Lallana.

I had spent 12 years as a teacher in two comprehensive schools, and left Southampton in 2006 to join the Premier League and then on to Fulham in 2008. The Chief Executive, Alastair Mackintosh, brought me in to focus on developing the youth infrastructure and a youth development programme, something Fulham had not paid much attention to in the past.

The most important element of developing a winning team for the future is getting recruitment right. At Fulham, I am supported by an excellent and experienced recruitment team but have also made it my business to know every single player from the under nines upwards. At Southampton, despite our location on the coast, we benefitted from a satellite training academy in Bath ensuring we were constantly connected and developing top talent with the same ethos and standards.

Once a player has been identified, we create a structured development plan that aligns with the player's needs. Take Cauley Woodrow for example, who is now in the first team. We scouted him at Luton Town when he was 16, having previously been released by Tottenham. We nurtured him in the U18 and U21 teams before he joined the first team. We spotted his potential and then supported him through a structured development plan that culminated in a first team outing and now he has just signed a new contract.

We've moved on from a culture of getting the youngsters to shine the pros' boots to encouraging the first team players to act as mentors. We've found that the youth team players have greatly benefitted from learning from their experiences and approaches to challenges in football.

Every football club is now investing in developing its youth

development programmes with a view to capture talent early on and nurture it with the hope that one day they will break into the first team. This report outlines the importance of developing leadership early on; I hope that the example of our success in football can act as an inspiration. Fulham's youth teams have now won two Premier Academy League titles, the prestigious Dallas Cup and Runners Up in the FA Youth Cup. Twenty nine of our academy players have now graduated to play for the first team since 2008.

**Huw Jennings**

Director, Fulham Football Club Academy

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