The King's Fund

Ideas that change health care

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August 2010

Leadership needs of medical directors and clinical directors

Summary

The National Health Service (NHS) is facing one of the toughest financial periods of its history during which it will need to maintain the quality of care. Clinical leadership will be critical as the service faces this challenge. The King's Fund has a wealth of experience in developing the skills of leaders in the NHS, and is constantly adjusting its approach to meet the needs of those leaders. With this in mind, we conducted a survey of clinical and medical directors to find out what skills they believed they need to face these challenging times.

Major findings include the following.

- Both medical and clinical directors embrace the quality agenda articulated by Lord Darzi in *High Quality Care for All* (Darzi 2008), and are committed to preserving it.
- Both medical and clinical directors are eager to work with their managerial colleagues as equal partners to maintain clinical quality, ensure patient safety and improve patients' experience in the face of reduced resources. They see an urgent need for clinicians and managers to share a single mindset on maintaining quality efficiently.
- Clinical directors believe that they are largely cut off from the decision-making and planning processes, and view this as a critical challenge that must be overcome.
- Clinical directors and medical directors have high levels of confidence in their influencing, negotiation and communication leadership skills, and in their ability to use resources to maintain the quality of care.

Introduction

The National Health Service is facing one of the toughest financial periods of its history, during which it will need to maintain the quality of care. It will be essential for the service to engage clinicians if the decisions taken to increase productivity and to release savings are to be made without damaging clinical care.

In *High Quality Care for All*, Lord Darzi (2008) placed clinical leadership at the centre of efforts to improve both the quality of care and patients'

experience. Clinical leadership will be critical in maintaining quality as the NHS is put under financial stress that will last until 2017 (Appleby *et al* 2009). The challenge facing clinical leaders is to maintain clinical quality, patient safety and the quality of patients' experience in the face of reduced resources – and the scale of the task can appear to be overwhelming.

Given these circumstances, it is important that clinical leaders in the NHS have the support they need to lead change that maintains clinical quality. Are clinical leadership skills being sufficiently developed to address the challenges of a cold economic climate? Do they have the resources they need? Are they part of the decision-making process? Without the support clinical leaders need to maintain quality, the advances in clinical quality, safety and patient experience that have been made over the past few years might be jeopardised.

The King's Fund has a wealth of experience in developing the skills of leaders in the NHS and is constantly adjusting its approach to meet the needs of those leaders. We therefore conducted a survey plus a series of in-depth interviews asking medical and clinical directors to identify the leadership capacities, skills and levels of support that they believed would help them face the challenges. (S*ee* Appendix A on p 11 for more details on the methodology.)

What qualities do clinicians need to lead?

The critical questions facing the NHS are how to provide consistently excellent clinical quality and what the right organisational arrangements are to enable this.

In the past, the answers were straightforward: clinicians looked after patients; managers looked after the organisation. This no longer holds true (Mountford 2010, p 160). The complex nature of a modern NHS – which faces diverse and changing needs, rising patient expectations and the high cost of new treatments – requires clinicians to consider the needs of the wider patient population, and to take decisions that not only make the best use of resources, but also deliver clinical quality.

This focus on quality is bridging the traditional divide between managers and clinicians. Indeed, empirical research demonstrates that service improvements are likely to succeed when they are clinically led (Mountford 2010, p 162). Moreover, the chances for organisational learning that sustains improvement over time are enhanced by collaboration between managers and clinicians (Rushmer *et al* 2004a).

Research suggests that leadership involves building new structures and relationships, and motivating, inspiring and gaining commitment from others (Bennis 1989). It is not enough simply to use technical managerial techniques (such as financial and service planning tools) to effect change, because these alone do not engender shared values, bring along staff when difficult decisions need to be made, or help a clinician to develop an effective personal leadership style.

What Newman *et al* (2009) call 'affective leadership skills' are often needed to empower and motivate individuals, and to communicate and collaborate across organisational, disciplinary and functional boundaries. These skills include self-knowledge, knowing how one's behaviour and beliefs affect others (particularly those who work outside one's own functional area or discipline), an ability to tolerate debate and disagreement, a capacity to understand the values and beliefs of others, excellent communication skills, and powers of persuasion and negotiation (*see* Goleman 1998).

At the same time, organisational development requires managerial skills to build structures and systems of support, evaluation and quality assurance (*see* Rushmer *et al* 2007). Bohmer and Lee (2009) have suggested that clinicians will be increasingly required to be 'outcomes oriented' and to play two roles – one that calls on their clinical skills, and

another that calls on their managerial capabilities. Together, this will enable clinicians to 'design, oversee, and improve innovative systems of care' that deliver excellent and efficient clinical outcomes. Clinical leaders will therefore rely on a seamless set of skills, behaviours and outlooks to be used as the context warrants, and will have the ability to move between clinical, managerial and leadership roles.

In this regard, a medical director described to us his transition from being a 'medic' to being a broader leader.

> *What I've had to do is redefine myself as a corporate director. Representing medics is a small part of my job. It's thinking corporately and being a full member of the team. Then you have to translate ideas to and from the team. You are now looking at the company, not just clinical sciences. You have to help people understand the challenges, and to help and motivate clinicians to meet them.*

Findings

Maintaining quality in a cold climate

Maintaining and improving clinical quality, safety and positive patient experience in the face of reduced funding is at the top of respondents' leadership agenda. As one medical director put it: 'It's easy to talk the quality game when you have money. But how will you be able to do this when you don't?'

The interviews with and open-ended comments from respondents to our survey suggested that they see a direct link between clinical leadership and improved clinical outcomes. One medical leader who suggested that quality has become part of the day-to-day work of clinicians credited Lord Darzi: 'Darzi was an honest doctor, he was still a practitioner; and having a doctor in that role, pushing the quality agenda, really said something to me and others like me.'

By putting quality firmly on the agenda, Lord Darzi has, in the words of one medical director, 'let the quality genie out of the bottle; there's no going back'. Respondents to the survey believed that the public now expects that quality will be maintained and improved, no matter what happens to the NHS budget. One argued:

> *This isn't the late 1980s when you could cut services and everyone accepted it. The public now see what a high-quality service looks like, and they expect that it will remain at the same level of quality even if we have to make do with 15 per cent less.*

Moreover, the quality agenda will be driven, in part, by a public that has access to information on the internet, enabling many to make informed choices. As one clinical director explained: 'The days of the uninformed patient are long gone. The public know what's available, and they expect it.'

Both medical and clinical directors argue that clinicians are best placed to maintain quality because it is they who are ultimately responsible for patient care, and they know which resources and processes are crucial to quality care. All suggested that clinicians are well positioned to make financial and resource decisions that will help to preserve quality, but they did not believe that they should make such decisions alone. There was little in the responses to suggest a divide between clinicians and managers. Instead, clinicians responding to the survey generally wanted to work alongside financial managers 'as equals' in maintaining quality in the face of reduced resources. Many voiced an urgent need to create a common mindset. One medical director said:

> *There is a widespread realisation of the financial issue, how serious it is, and that this will hit us fast and hit us hard. People see this reality, and we are co-operating. People are not advocating for their space only. This is a time for clinicians and managers to work together, and to come to a common understanding. We have a way to go, but we have to get there.*

Another medical director said: 'The state of finances is dire. But we can't move into a defensive position, and we don't want to get into a clinical huddle.'

Others suggested that reduced funding might have the effect of focusing minds closely on quality. One respondent said:

> *The Darzi agenda can be read both ways in tough financial times. Yes, there could be cuts to meet financial targets that have a negative effect on quality. But tough financial times may further it by creating more incentives to simplify what we do. Simplicity and efficiency is in everyone's interest and to everyone's benefit.*

Current and future support

Both medical and clinical directors understand the scale of the resource challenges ahead of them, and the potential effects that these will have on clinical quality and patients' experience. There seems to be a mismatch, however, between, on the one hand, the support that both medical and clinical directors believe they need to maintain quality in the face of a cold economic climate, and, on the other, what they actually receive. Although some initiatives, such as budgeting workshops, are under way, most activities reported in the survey centred on information-sharing and getting to grips with the magnitude of the impending financial problems. Proactive efforts to equip leaders with the necessary skills to maintain quality with reduced resources appear to be largely absent.

We asked respondents what type of support they had received to meet the challenges of a future of reduced NHS funding (*see* Table 1 below). Responses from both medical and clinical directors suggested that current support largely takes the form of discussions with the chief executive and the medical director, and team briefings. Responses from our follow-up telephone interviews indicated that these discussions focus on planning resources, along with helping teams to grasp the gravity of the impending financial situation. One respondent said that high-level discussions had allowed clinicians and managers to get together to form 'a common understanding of what we're facing', and

Table 1 Types of support being received

	Medical director	Clinical director	Number of responses	Responses (percentage)
Benchmarking workshop	10	8	18	17.1
Budgeting workshop	17	13	30	28.6
Coaching	8	7	15	14.3
Contingency planning	17	7	24	22.9
Discussions with CEO	42	33	75	71.4
Discussions with medical director	13	28	41	39.0
Mentoring	1	5	6	5.7
Networks	16	8	24	22.9
Scenario planning	16	8	24	22.9
Simulations	5	1	6	5.7
Stakeholder planning	19	2	21	20.0
Team briefings	32	32	64	61.0
None	0	11	11	10.5
Other (please specify)			21	
		Answered question	**105**	
		Skipped question	**3**	

that 'people are now seeing the reality of the situation'. There is no evidence in this survey to suggest that respondents are avoiding the issue.

There are differences between medical and clinical directors in the level of support they currently receive. Medical directors receive support, in addition to that mentioned above, in the form of budgeting workshops, stakeholder planning and contingency planning. Clinical directors, on the other hand, reported very low levels of professional development in the use of financial and service improvement planning tools such as stakeholder planning or scenario planning. In fact, more clinical directors reported that they had received no professional development support at all except in budgeting workshops. This might suggest that, while discussions on financial pressures are taking place, concrete steps to improve capacity, particularly among clinical directors, are not yet being taken. It further suggests that decisions, as opposed to discussions and information-sharing, on how to address reduced resources (and maintaining clinical quality) are taking place with relatively little or no participation by clinical directors.

Comments made in the free text of the survey suggested that many clinical directors see their separation from decision-making as a lost opportunity because they believe that they are best placed to understand how to bring about improvements in both clinical quality and patient experience. They assert that they are closest to patients and operational environments, understand the opportunities and constraints of their local *in situ* work settings, and, as one said, 'know how things really work'.

We asked respondents to identify the support that could be useful in helping them to meet the challenges of reduced funding, but that they were not already receiving (*see* Table 2 below). Both medical and clinical directors identified planning and budgeting tools as being absent. Medical directors identified scenario planning, contingency planning, simulations and stakeholder planning as particularly important. Clinical directors identified the same areas, but with benchmarking and budgeting workshops as well. Interestingly, neither coaching nor mentoring were seen by both medical and clinical directors to be as important as workshops in budgeting, contingency planning, and other financial and service planning tools and activities.

Table 2 Support that could be useful but that is not already being received

	Medical director	Clinical director	Number of responses	Responses (percentage)
Benchmarking workshop	12	24	36	37.9
Budgeting workshop	7	29	36	37.9
Coaching	11	13	24	25.3
Contingency planning	15	24	39	41.1
Discussions with CEO	2	8	10	10.5
Discussions with medical director	1	6	7	7.4
Mentoring	11	13	24	25.3
Networks	11	18	29	30.5
Scenario planning	14	23	37	38.9
Simulations	13	21	34	35.8
Stakeholder planning	14	25	39	41.1
Team briefings	3	3	6	6.3
Other (please specify)			7	
		Answered question	**95**	
		Skipped question	**13**	

Leadership and management needs

We asked respondents to rate the confidence they have in their managerial skills (their ability to create budgets, use evidence to inform decisions, etc) and leadership capacities (such as their powers of persuasion, ability to set an example, engender shared values, and work across functional and disciplinary boundaries). The list was drawn from the NHS Institute for Innovation and Improvement's Medical Leadership Competency Framework, and from the Institute for Healthcare Improvement. We asked respondents to rate their level of confidence with these skills on a six-point scale from 'strongly agree' to 'strongly disagree'.

Table 3 (below) and Table 4 (opposite) show the ranking and strength of self-reported confidence in both managerial competencies and affective leadership skills. The results suggest that both medical and clinical directors, on average, have confidence in their people-oriented, affective leadership skills. Moreover, both groups are confident in their abilities to manage resources in support of patient care. For example, virtually all medical directors are confident in their ability to use quantitative data to improve patient outcomes. Among clinical directors, however, there is some lack of confidence about using financial data. For example, only 35 per cent said that they were confident in using financial data to inform decisions.

In the follow-up telephone interviews, we were interested to know what respondents believed to be the right mix of skills for medical and clinical directors, or whether they thought that managerial skills were not really needed by them at all. For example, do medical directors really need to know how to use financial data, or do they need only to understand financial intricacies well enough to work effectively with a manager who has a specialist skill in that area?

Table 3 Survey respondents' confidence in their own managerial skill

Medical directors (n=44)			Clinical directors (n=63)		
	Number	Percentage		Number	Percentage
I am confident in my ability to use quantitative information to improve clinical outcomes	40	90.91	I use benchmarking and best practices to improve safety	43	68.25
I am confident in my ability to manage resources	36	81.82	I am confident in my ability to use quantitative information to improve clinical outcomes	39	61.90
I use benchmarking and best practices to improve safety	35	79.55	I can identify methods to reduce costs	35	55.56
I can identify methods to reduce costs	30	68.18	I am confident in my ability to manage resources	33	52.38
I track and measure patient safety performance data over time	27	61.36	I know how to design systems to improve safety	32	50.79
I can align systemwide activities to improve safety	25	56.82	I can draft persuasive business plans	29	46.03
I know how to design systems to improve safety	24	54.55	I track and measure patient safety performance data over time	28	44.44
I have a firm understanding of how to use financial data to inform decisions	22	50.00	I have a clear idea of our budget position 1+ years from now	25	39.68
I have a clear idea of our budget position 1+ years from now	22	50.00	I can align systemwide activities to improve safety	23	36.51
I can draft persuasive business plans	19	43.18	I have a firm understanding of how to use financial data to inform decisions	22	34.92
Average		**63.64**			**49.05**

Table 4 Survey respondents' confidence in their own affective leadership skills

Medical directors (n=44)			Clinical directors (n=63)		
	Number	Percentage		Number	Percentage
I am confident in my ability to share values around patients' experience	40	90.91	I am confident in my ability to lead by example around patients' experience	58	93.55
I am confident in my ability to lead by example around patients' experience	39	88.64	I am confident in my ability to communicate effectively in non-clinical settings	51	82.26
I am confident in my ability to develop shared values around patient safety	38	86.36	I am confident in my ability to develop shared values around patient safety	50	80.65
I am confident in my ability to communicate effectively in non-clinical settings	34	77.27	I am confident in my ability to motivate others around patients' experience	50	80.65
I am confident in my ability to motivate others around patients' experience	33	75.00	I am confident in my ability to share values around patients' experience	49	79.03
I am confident in my negotiation skills	30	68.18	I am confident in my negotiation skills	42	67.74
Average		**81.06**			**80.65**

All respondents who answered the question believed that the basic affective leadership skills, such as self-awareness, persuasion and communication, are at the core of a leader's skill set. One medical director said: 'This is the basic stuff that every leader has to know.' A clinical director said:

> *My skills of persuasion are critical in getting other clinicians to work in a multidisciplinary fashion. I'll need to depend on my skills to communicate because times are going to be tough, and we need transparency with the staff, the senior team, and we have to engage with the staff to set clear, agreed, and measurable goals. You can't assume that people on the shopfloor understand what needs to be done, and you have to motivate, inspire, and empower them.*

Although there was agreement among respondents that leaders need affective leadership skills, there was less agreement about whether clinicians need to master the tools often used by managers. For example, one clinical director said that he needed both affective leadership and managerial skills (such as using financial data) so that he could look at problems analytically and make reasoned and informed decisions: 'These are skills that are learnable by clinicians.' A medical director amplified this by arguing that analytical thinking and leadership are 'not unlike clinical medicine – you are making decisions on incomplete information in times of uncertainty. We're accustomed to being in that role. To manage and lead well, you need to use a set of high-calibre tools, and you need the skills to bring people along with you.'

Not all respondents agreed, however, that clinical leaders must embed managerial skills into their day-to-day working practice. Instead, they should appreciate and be able to work with others who have such skills. One said: 'I might be wrong or naïve, but I don't have these skills, and I don't believe that I need them. I need to know who has the requisite skills, and how to get people, teams, to do things for me. My role is to implement that change.'

Another argued that clinical leaders should know enough about budgeting and planning to ensure that the service is led by those 'who put the quality of care at the centre of planning, and who don't make random cuts as part of some financially driven performance management exercise.'

The results appear to reinforce the view expressed by both medical and clinical directors that they want to work collaboratively with senior managers to maintain quality within constrained resources. To do this, they do not necessarily have to have the same set of skills as senior managers, but they see a need to understand how managers think – how they make decisions. This does not necessarily imply that clinicians need to have the same set of skills as, say, finance directors. Instead, they need the ability to move from clinical work and engage with a finance director to make decisions collaboratively. For this, their affective leadership skills are central.

What needs to change?

We asked clinical and medical directors in the closed surveys and in the telephone interviews what, in their view, was the most important change that would improve their leadership effectiveness. The two factors that stood out were:

- increased time for the job
- increased participation in decision-making.

Increased time for the job

By a wide margin, time was identified as by far the most important resource that would help respondents improve their clinical leadership performance. Indeed, time was identified more than all other factors combined. It would be easy to suggest that everyone says that they need more time to do a good job, and that this could be addressed by a simple staff-development module in time-management.

However, the follow-up interviews and open-ended survey responses indicated a complex picture, suggesting that medical leaders value reflective practice and learning, which take time. Indeed, as Rushmer *et al* (2004b) point out, protected time is one of the most important factors in fostering organisational learning in clinical practice. One clinical director said:

> *Like so many doctors, we find ourselves in management positions because we're 'good chaps'. We're not ready to transform things in ways that are needed. You get appointed without sufficient training, and you need to know and have the right skills. We don't get appointed as part of a package, and we need time to develop the right set of skills. But we're driven between our clinical practice and our management responsibilities, and we don't have time to develop.*

Of those respondents who reported a need for time to learn, one highlighted learning from others outside his place of work: 'I feel isolated from the rest of the medical world. I would like to go a day a month to other places to see how others do things – to learn from others. But time doesn't allow this.'

One reason why time on the job is needed for clinicians to develop is that many believe that their medical training did not prepare them for leadership roles, nor are there embedded structures and processes to help clinicians move to leadership positions and then back into full-time clinical work. For example, one medical director said during an interview:

> *In truth, my organisation gets clinical leadership on the cheap. In Scandinavia, for example, they have leader and clinical jobs that are well defined. The best is Sweden. The psyche of the clinician there is that this is my obligation to be a manger at this stage in my career, and then move back into clinical medicine at a later stage. In England there is no structure that says: 'This is how you step out, this is what you'll do as a manager and here's the support you'll get, and this is how you'll step back in to your clinical role when you're ready.'*[1]

1 In an international study of leadership education and support for doctors before and after registration, Denmark stands out. See Ham and Dickinson 2008, pp 25–7).

Many responses strongly suggest that clinicians are torn between their busy clinical workloads and the time they can, or are willing to, devote to management and leadership. Part of this split is possibly explained by their professional identity as clinicians. One clinical director wrote: 'I could ask for more time but that would remove me from clinical practice, which is the activity which energises me, gives me a clinical feel for the organisation, as well as the opportunities to meet colleagues.'

Another suggested that medical and clinical directors are not given clear guidance on how much time to devote to different parts of their workload: 'From the organisational point of view there isn't a clear distinction between the clinical management workload, with real time allocated, and real expectations of commitment between the two. Time seems to be entirely voluntary.'

Increased participation in decision-making

Lack of inclusiveness in decision-making was a particular concern of clinical directors. Clinical directors identified their lack of engagement with both executive staff and the board as the second most important factor affecting their effectiveness as leaders in their organisations. When we examined closely the open-ended responses to the closed survey questions, respondents suggested that there is a lack of engagement between senior management and clinical directors, not that there is a material lack of support that undermines their clinical director role.

The responses suggest that many clinical directors feel removed from the places where decisions are made. One wrote:

> *At present, most interactions between [clinical directors] and the executive board are via the divisional general managers. These managers are under severe stress and it is really difficult for them to get their heads round all the issues. I am not confident that they understand the issues or that they represent our directorates accurately. More direct contact between the executive team and the [clinical directors] is needed.*

Some respondents, however, believe that there is little support in their organisations for clinical opinion, and that policies are directed *at* clinical directors by the executive board and the chief executive officer (CEO), and that this undermines innovation. One clinical director wrote:

> *The freedom of divisions is tightly controlled by the executive directors, and there is a cultural gap between clinical leaders who feel they can deliver solutions, and executive[s] who by their control give the impression that they don't trust the clinicians with managerial responsibility – so the change would be to give clinical leads greater freedom to innovate and implement solutions.*

Discussion and conclusion

The results of this survey show a picture of clinical and medical directors who are critically concerned with maintaining quality in the face of reduced budgets. Most respondents are seeking ways to work with management as equals in making resource decisions. The results also suggest that, although there is a wide recognition that the financial situation for the NHS will become materially worse over the coming years, the main response to this so far has largely been limited to high-level discussions and team briefings, with little use of financial and service improvement tools (such as scenario planning or contingency planning) among clinicians, particularly clinical directors.

Both medical and clinical directors have high levels of confidence in their affective leadership skills, and in their resource planning tools with respect to patient care. Some believe that a knowledge of budgeting and management skills, combined with core affective leadership skills, are an essential combination if clinicians are to take leadership

roles that protect clinical quality in a time of reduced resources. However, there is no clear agreement on this. Most do not necessarily believe that they need to embed strong financial management skills, rather that they need to know enough about budgeting and resource planning so that they can work 'as equals' with finance directors and senior managers to maintain quality. Clinicians want to avoid cuts which affect clinical quality that are the result of a performance-management exercise driven solely by financial considerations.

There is a manifest need among both medical and clinical directors for reflective practice and learning. They identify the lack of time to develop their skills and to reflect on their leadership practice as a serious problem that encumbers their potential as clinical leaders. This is not simply a time-management problem, but instead goes to the heart of organisational learning – time to reflect, learn and improve skills. The unstated, but altogether clear, implication is that, without protected time, medical directors, clinical directors and others of all stripes could become reactive. They might become less inventive at precisely the time when inventiveness and innovation are required.

How can it be, then, that respondents identified a need for reflective practice and learning, but did not see a need for coaching and mentoring? It might be reasonable to assume that the press of constrained resources has led respondents to underestimate their need for coaching and mentoring. Their immediate problems appear to be financial, and clinicians might believe that they have to understand the financial situation before they can make evidence-based decisions. But when clinicians are thrust into taking difficult decisions, they will need to persuade others to understand, accept and act upon those decisions, and they must manage the conflicts that will inevitably arise from those with whom they have close and long-standing working and personal relationships.

For both junior and senior clinicians, these persuasive and conflict-resolution skills can never be thoroughly developed through training programmes, but are instead instilled via interactions and consultations with others who have already developed relevant, tacit knowledge gained through hard-won experience. Mentoring can reduce the job-related stress that accompanies conflict, and have a positive impact on the transformational change needed to maintain clinical quality when resources are reduced (Fagenson 1989; Sosik and Godshalk 2000).

The survey suggests that the leadership capabilities of both medical and clinical directors are built around a core of affective personal leadership skills that build motivation, values and empowerment among all clinicians, and that enable clinical leaders to work effectively across functional and disciplinary boundaries. Clinicians believe that collaborative decision-making between senior managers and clinical leaders will become increasingly important in maintaining clinical quality. Although clinical directors believe that they are willing to play a role in strategic decision-making, they feel excluded from the process. They believe that innovative solutions to difficult problems are more likely to be found if decision-making is both more inclusive and devolved than it seems to be at present. As one clinical director said: 'Our future isn't performance management. This is about skills for vision and innovation.'

In conclusion, we can see that the effects of Lord Darzi's emphasis on clinical leadership resonate with the respondents to this survey. They are committed to maintaining clinical quality in the face of reduced resources, accept the pressure to maintain quality, are eager to develop professionally on the job around quality issues, and are willing to work alongside managers. The responses hint that high-quality clinical care is bound up with the respondents' professional values.

Professional tribalism or a divide between managers and clinicians does not characterise the responses of this group. Perhaps because the financial crisis happened very quickly, and is widely seen as being caused by others in the international financial community,

clinicians are eager to pull together with managers to face the challenges to keep clinical quality, safety and patient experience at the core.

But there is a strong suggestion that the support that clinicians need to work effectively with senior managers is lacking, and this is especially true in the case of clinical directors who have received no support to develop their financial and planning skills to take evidence-based decisions, who seem to lack clear lines of communication with senior management, and who believe that they are marginalised in the decision-making structure.

Given the empirical and academic evidence suggesting that high-performing clinical practice is characterised by close relationships between managers and clinicians, and open communication between CEOs and clinicians (Mountford 2010, p 162), it is difficult to understand how effective clinical leadership in difficult economic conditions can take place without clinical directors' direct involvement. The survey did not address the reasons for this, but from the responses we can hazard a hypothesis, namely that although much effort has gone into developing clinical leaders, there appears to be a lag in transforming the organisational and communication structures to make best use of them.

The coming years will put great strain on the NHS, and clinically led innovation will be the key to maintaining clinical quality. Clinicians in this survey embraced the leadership roles they can play; it remains to be seen whether the organisational and communications structures can evolve to take advantage of them at a time when their expertise will be most sorely needed.

Appendix A: survey methods

In November 2009, an online survey was sent via email to medical and clinical directors in England who were particularly interested in commenting on their leadership development needs and experiences. The survey can be described as a straw poll; it is not a representative sample, and we do not claim that the results represent the views of the wider medical and clinical director communities. However, the consistency of respondents' responses to the questions suggests that the survey might provide valuable insights into the leadership development needs of this group.

We received valid, completed surveys from 108 clinical and medical directors representing all strategic health authorities. Clinical directors comprised 57 per cent of the respondents, and medical directors the remaining 43 per cent. (In England, according to a commercial database of medical and clinical directors, the proportion of clinical and medical directors is 78 per cent and 22 per cent, respectively.)

About 80 per cent of responses come from medical and clinical directors working in acute trusts, which roughly represents their proportion across all medical and clinical directors in the NHS, and there were responses from directors working in primary care trusts, mental health trusts, and an ambulance trust.

The survey consisted of 16 closed questions, along with free text where respondents could elaborate on their answers. We also conducted follow-up telephone interviews with eight medical and clinical directors selected at random. The interviews focused on areas that respondents believed would be their greatest challenge in the coming years, and the capacities that they believed to be necessary to meet them.

The telephone interviews lasted from 20 minutes to almost an hour. Descriptive statistics were computed from the closed survey questions, and themes were identified from both the free text survey responses and telephone interviews.

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ISBN 978-1-85717-599-8

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Registered charity: 207401

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