Many clinicians are moving into roles that are bigger and broader than ever before and are on a steep learning curve. With the reforms moving at pace, getting clinical leadership working fast is a critical challenge for the NHS. In the past, clinical leaders have often been thrown in at the deep end to ‘muddle through’. Given the context, this seems like an increasingly risky option.

Developing doctors’ leadership skills is not enough. Broader organisational change is required, with roles, behaviours, culture and governance structures aligned in a way that enables clinicians to deliver better health outcomes.

How then can you ensure that clinical leaders are both prepared and enabled to be successful? We draw on our work with hundreds of clinical leaders from Provider organisations and CCGs to explore this question asking: how are clinical leaders’ roles changing? What are the implications for development? And what needs to change at an organisational level to support them to be successful?
Getting clinical leadership roles right

Most agree that the effectiveness of clinical leadership will be critical to the success of NHS reforms. However, what is meant by clinical leadership is a little less clear. Get it right – and clinical leaders can add enormous value. Get it wrong – and you face costly duplication as managers step in to pick up where things are not working, and clinicians decide that the roles are ‘not worth the trouble’.

In practice roles are shifting and growing and many clinical leaders are increasingly finding themselves with far more direct accountability for managing people and resources, leading services and setting direction. This reflects a change in emphasis for many (see fig. 1).

Many organisations are still working through what this means in practice for their clinical leadership roles. Common teething problems include: roles too broadly or ill defined, unclear divisions between managers, clinical leaders and matrons and a lack of realistic consideration of the time needed to deliver accountabilities. This can result in conflict, confusion, upwards delegation – and ultimately, undoable jobs.

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I was catapulted into a senior clinical leadership role at a time of crisis and substantial change for my trust. There was little time for reflection about how I would carry out that role, and a great many operational decisions to be made. It was exhilarating, challenging, but also left me with an uncomfortable feeling that I was at times making it up as I went along; and while experiential learning through the consequences of the errors that I made might be a brutally effective way to learn lessons, it is not an approach I would wish to continue with in the longer term.

Clinical leader
What can be done?

With time for leadership roles often limited, it is crucial to think carefully about where clinical leaders focus time and energy. Getting it right means some careful thinking and communication about accountabilities and focus.

When defining roles, ask these questions.

- Where is the emphasis of your strategy and what does this mean in terms of prioritising your clinical leaders’ limited and expensive time?
- What are managers best placed to do, and what can only clinical leaders do?
- Who do you have among your clinical leaders, and what are their strengths and motivations? How do you make best use of these given the work you need to get done?
- Are the jobs doable, both in terms of time and range of areas that are covered? What is most important for them to deliver?
- How will they link with other roles – in particular management? Does everyone understand this? Is everyone clear about where accountability and authority lies?

In order to really get the most from your clinical leaders – build clarity for clinical and non-clinical leaders alike about what is required of them, the inter-dependencies between them and what good performance looks like.

Developing clinical leaders

Changing roles mean new skills and behaviours – even for experienced clinical leaders. Putting individuals into these challenging posts with no previous leadership development is an increasingly risky option. A more structured approach to developing clinical leadership will be pivotal in equipping people for these posts both now and for the future.

Many clinical leaders are moving into a totally new field in taking on leadership roles, and lack the benchmarks and role models that help them to understand what good clinical leaders look like. As for most professional groups, the shift from individual professional to leader is a significant one which requires a shift in self-image and values, alongside new skills and behaviours.

At the same time the leadership community in the NHS is focusing on how they ‘do things differently’ recognising the dominant styles of the past will not serve them well in the new world. It is hoped that clinical leadership will bring some of that ‘difference’.

We have analysed strengths and development areas across hundreds of clinical leaders applying for new CCG roles, medical directors already identified as ‘Top Leaders’ and clinical leaders at all levels in provider organisations. Our analysis can help you to focus development where it counts by exploring two key questions.

1 What does good look like, what are the best doing?
2 Where do clinical leaders need support?
Learning from the best

Many clinical leaders are working through what good looks like in their context. Our analysis showed that clinical leaders, like their non-clinical counterparts, have the best impact when they have a diverse range of leadership styles and approaches.

Likewise, as clinical leaders’ leadership range increases, they:

- move away from solely using those styles associated with getting tasks done and telling people what to do (Directive and Pacesetting)
- are most likely to focus on providing common direction, facilitating others to give their views and building relationships (Visionary, Affiliative and Participative leadership styles).

In other words, in roles that often rely on engaging and influencing experienced professionals over whom they have limited authority – the ability to create a common vision, work collaboratively and build relationships is critical to get things done.

But in reality, do clinical leaders bring any of the ‘difference’ that the reforms hope for? We explored the composite results of our work assessing all those who applied for the new CCG posts. These tend to be newer and less experienced leaders than those we work with in Provider organisations or as part of the Top Leaders programme. Therefore, they are less likely to reflect broader patterns of leadership behaviours. At their best these leaders did bring a couple of things that are different from their more experienced colleagues.

1 These leaders were notably more entrepreneurial in approach and challenged conventional wisdom.
2 While clinical leaders in general bring a strong patient focus, these leaders appear more adept at using real patient stories and experiences to engage their colleagues and others.

It is important that the difference brought by new perspectives is not lost, while new skills and behaviours are developed.

33 per cent of medical directors creating a high performing climate for their team used three or more leadership styles, versus 17 per cent who created a de-motivating climate.
Developing clinical leaders – where to focus

Given the challenges in new roles and relatively low levels of experience for many, where do clinical leaders typically need support? From our experience, clinical leaders bring strong intellect, resilience, and a clear patient focus. However, they need support to understand the move from individual operator to leader, and the corresponding shift in self-image and values. Alongside this shift, common gaps include the following.

- Understanding the processes and practice by which organisations ‘get things done’. This ranges from an understanding of how to run effective meetings and set objectives at a more junior level, to managing organisational performance and dealing with financial processes at a more senior level.

- Focusing on leading rather than doing. Leading by doing (or Pacesetting – the most common leadership style), means clinical leaders need help to consider how they engage and lead through others. They need to understand how to get the best from others, how to engage around a common purpose and build teams and partnership.

- Asserting authority. Many clinical leaders struggle with having difficult conversations or holding others to account. Clinical leaders often manage peers and more senior colleagues, and these relationships are important. This makes managing performance a challenge, particularly for more junior staff.

- Setting direction. For many the need to set direction for others is new and often clinical leaders do not recognise their role in creating clarity for others.

- Influence. Doctors grow up in their profession using logic to persuade. Clinical leadership roles demand both greater focus on influencing and more thought to how to get different stakeholders on board. This means increasing understanding of internal and external politics and agendas, and developing more sophisticated influencing techniques.

I’m starting to move away from thinking of myself as a clinician who does leadership on the side, to a leader who does clinical work on the side, but it’s been a long journey.
Developing clinically led organisations

Development of individual clinical leaders is only the first step. To achieve genuinely clinically led organisations, the organisation itself will need to do things differently too. In practice, clinical leadership roles are introduced often without the corresponding changes in culture, governance structures and relationships with managerial and nursing colleagues. In this context there is a risk that clinical leaders find themselves with accountability, but without the authority to deliver and managers struggle to let go of the reins.

While many CCGs are being formed with clinical leadership at their heart, provider organisations face the challenge of unpicking existing traditions of clinical leadership, both with their own employees and in their engagement with their CCG colleagues.

Common problems can include the following.

- Unclear responsibilities and complex reporting structures – which leads to poor relationships between nursing, clinical and managerial staff. As one clinical leader said: “My managerial counterpart always finds out about things first, I get copied in several emails down the chain when someone remembers”.

- Explicit accountabilities given to clinical leaders that are not backed up by formal and informal governance and decision making structures.

- An organisational reluctance to challenge clinical staff – which leads to a lack of support or back up for clinical leaders when tackling issues with consultant peers and colleagues. The temporary nature of many clinical leadership roles makes this very difficult for them to do without this support.

Given the challenging nature of these roles, without organisational support it will be all too easy for clinical leaders to step away from leading and return to their day job.
To create truly clinically led organisations, a holistic view of how the organisation needs to change is critical. Senior leaders need to not only ‘train’ their leaders, but align their own behaviours, processes and structures to enable those leaders to thrive. This means lining up formal accountability and informal decision-making structures.

Ask these questions.

**Governance:** Are governance structures aligned with clinical leadership accountabilities?

**Authority:** Do clinical leaders have the authority to deliver, as well as the accountability and capability?

**Relationships:** Is there clarity about the inter-relationships between nursing leaders, general managers and clinical leaders?

**Senior behaviours:** Do senior leaders’ own behaviours, processes and ways of working enable clinical leaders to thrive? Do they support clinical leaders to deliver organisational messages? Does the top team help clinical leaders to lead across complex reporting lines?

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The clinical director is the key individual and tier in the organisation that you have to get right. They reconcile on a daily basis the irreconcilable imperatives of quality, value and finance. It is in these day-to-day decisions that these conflicts become tangible and their decisions are what make a difference between success and failure.

Roger Stedman, Medical director
Sandwell and West Birmingham Hospital’s NHS Trust
Conclusion

Health organisations are at different stages in their journey to clinical leadership, but there are common challenges that they all have to confront if they are to become genuinely clinically led. It is important to recognise that clinical authority relies on influence, relationships and engagement, as much as formal leadership. Clinical leaders need to be strong at reading people and context, excellent influencers, and able to build trust and engage others around a vision.

But developing doctors’ leadership skills is not enough. They also need the formal governance structures, culture, behaviours and senior leaders of the organisation to back them up. Only then will clinicians be able to lead in a way that successfully delivers better health outcomes.

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About Hay Group

Hay Group works with leaders to transform strategy into reality. We develop talent, organise people to be more effective and motivate them to perform at their best. Our focus is on making change happen and helping people and organisations realise their potential.

Our clients are from the private, public and not-for-profit sectors, and represent diverse business challenges. For 70 years, we have been renowned for the quality of our research and the intellectual rigour of our work. We give our clients breakthrough perspectives on their organisation, and we do it in a way which delivers results and real value. For more information please visit www.haygroup-bigsqueeze.co.uk