Medical Chief Executives in the NHS:

Facilitators and Barriers to Their Career Progress

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Foreword

The quality of leadership and management define the difference between excellence and mediocrity and success and failure for all organisations.

In my view good leaders inspire others and are able to align them towards a common goal. Good managers, on the other hand, simplify and streamline the way organisations work to achieve the organisational goals and maximise potential. These two are quite different functions. Not all leaders are good managers but most effective managers are also good leaders.

In provider organisations the quality of clinical leadership always underpins the difference between exceptional and adequate clinical services which in aggregate determine the overall effectiveness, safety and reputation of every hospital. Similarly, effective clinical leadership in commissioning organisations brings perspective and challenge which in turn drives up clinical quality for the whole health economy. So, good clinical leadership is not an end in itself, it is a means to achieving high performing healthcare systems.

Our NHS employs over 1.4 million people in a federal system of multiple heterogeneous organisations working in a semi-autonomous, semi-competitive environment. To add to the complexity, the 750,000 clinicians who deliver the service have individual professional identities and consequently allegiances with professional bodies outside their employing organisation. These facts inflict a very special and complex leadership hierarchy on the NHS and its constituent organisations.

Young doctors are inspired by good clinicians, those who are intellectually adept, who bring forensic scrutiny to their diagnostic and therapeutic routines, who are kind to their patients and exhibit a comprehensive mixture of compassion and professionalism. Such doctors may have no managerial inclination, yet they are highly influential and essential leaders if our NHS is to flourish.

Doctors also seek leadership from medical royal colleges and the specialist associations with whom they identify on matters of clinical quality, standards of care and training of the next generation.

Therefore, clinical leadership across the NHS may take many forms ranging from frontline leaders who provide excellent service through a spectrum of clinical innovators and academics, to those who provide leadership through their professional bodies or through managerial involvement at various levels in their employing institution.

Successful medical leaders are usually, but not always, experienced clinicians with good people skills, who look outside the boundaries of their own specialty, who exhibit passion through positivity and perseverance and are prepared to take reasonable risks to achieve their goals.

There are plenty of doctors who have these characteristics so why are there so few doctors in senior managerial roles?

It may be that selection in to medicine may seek different attributes, but this study indicates that Incentives are not structured to attract clinicians in to managerial roles because there are more traditional, respected avenues to pursue.

More specifically, the system in which we work has historically inhibited the development of senior medical managers. The career path to medical director or chief executive has been hampered by poor job security and no well defined training or career path. At a personal level the professional and financial opportunity costs of migrating from a clinical to a managerial career are very high for our most influential doctors.

As the National Leadership Council begins to address this question this study provides a timely analysis of the issues faced by medical chief executives along with some positive recommendations to alter our approach to encourage more doctors to aspire to chief executive roles in the NHS.

Professor Sir Bruce Keogh
NHS Medical Director

Executive summary

This paper reports on the experience of 22 medical chief executives in England (around 5 per cent of the total chief executive community).

The career paths of medical chief executives are highly variable with some becoming chief executives relatively early in their careers and others being appointed much later.

Most of the medical chief executives in this study (13/22) were in their first posts; the most experienced had held six chief executive roles during his career.

There has been little if any structured support for doctors who wish to take on leadership roles within the NHS. Some of those interviewed for this study reported that, in the absence of structured support, they had benefited from advice and guidance from senior colleagues.

The training received by medical chief executives is highly variable and often involves learning on the job rather than more formal development.

An important consideration for doctors going into leadership roles is the ability to retain some clinical commitments while assuming increasing leadership responsibilities.

Most of the medical chief executives in this study (17/22) gave up clinical commitments on becoming chief executives, either out of choice or because it was impossible to continue with these commitments.

Doctors who become chief executives experience a shift in their professional identities as they assume hybrid roles. These hybrid roles usually enable doctors to enhance their original clinical identity by taking on leadership responsibilities.

An important motivation for becoming a chief executive is the opportunity to make a bigger difference than is possible in clinical work.

The chief executives interviewed for this study reported that their experience was generally positive.

There are also many challenges in being a medical chief executive and considerable insecurity when compared with clinical work.

The short tenure of many chief executives in the NHS was felt to be a major deterrent to more medical leaders putting themselves forward to become chief executives.

Pay differentials between chief executives and senior doctors were also considered to be relevant to the number of doctors wishing to become chief executives, as was lack of recognition of leadership roles in clinical excellence awards.

At a time when greater attention is being paid to medical leadership in the NHS, this study has important implications for the future. To support doctors to become chief executives in future, there is a need to:

- strengthen career planning, training and development, including the use of coaches and learning sets

- develop clearer career paths that enable doctors to see how they can gain experience in different roles on the way to becoming chief executives

- use existing medical and non-medical chief executives as role models, mentors and advisers

- review pay differentials and use clinical excellence awards to recognise the contribution of medical leadership where appropriate

- consider the establishment of a faculty of medical or clinical leadership to address the question of professional identity and to promote high standards of practice

- develop a framework for continuing education and professional development that defines the competences and skills needed by medical leaders

- enable medical chief executives to undertake clinical retraining as happens in Denmark, should they wish to return to clinical work.

A clear message from this study is that the time has come to adopt a more structured and systematic approach to medical leadership in the NHS. The days of the 'keen amateurs', to borrow a phrase used by one of our interviewees, are numbered and the NHS will only be able to rise to the challenges that lie ahead by ensuring that the work being developed by the National Leadership Council is translated into a practical programme of support for the future.

This paper presents the results of a study of doctors who have become chief executives of primary care trusts, NHS trusts (including Foundation Trusts) and strategic health authorities in England. The study was commissioned by the NHS Institute for Innovation and Improvement (hereafter referred to as the NHS Institute) and the Academy of Medical Royal Colleges (hereafter referred to as the Academy) from the Universities of Birmingham and Warwick with the aim of learning about the career paths taken by medical chief executives. The NHS Institute and the Academy wanted to understand the facilitators and barriers facing doctors in becoming chief executives in the NHS in order to inform ways in which this transition might be supported. The work summarised in this paper helps to explain why there are few medical chief executives at present and outlines what can be done to encourage more doctors to take on leadership roles in future.

The study was undertaken in the context of the final report of the NHS Next Stage Review, *High Quality Care for All*, which emphasised the need for NHS reform to be locally led with the full engagement of clinicians, including doctors. The argument for greater clinical engagement and medical leadership derives from evidence about the positive impact that this can have on organisational performance (Ham and Dickinson, 2008) and on the experience of high performing health care organisations outside the United Kingdom (Ham, 2009). Both evidence and experience underline the importance of doctors taking on leadership roles, including becoming chief executives. This has been reinforced by David Nicholson, Chief Executive of the NHS, and Bruce Keogh, NHS Medical Director, who have argued that there should be more doctors on shortlists for NHS chief executive positions.

While this paper focuses specifically on medical chief executives, it is important to emphasise that many factors contribute to organisational performance in the NHS. These factors include having a clear and consistent vision to guide improvements in performance, providing training and support to staff, communicating the reasons for change, developing leadership at all levels to support improvement programmes, setting clear goals for improvement and measuring progress towards these goals, ensuring effective implementation of improvement programmes, and using information and IT in support of these programmes. Also important is encouraging clinicians other than doctors to take on leadership roles. Increasing the number of medical chief executives in the NHS may assist the ambition of enabling the NHS to move from good to great, but many other actions need to be taken in parallel.

Methods

In carrying out the study, we compiled a list of medical chief executives in primary care trusts, NHS trusts and strategic health authorities using our own knowledge of the chief executive community and advice received from strategic health authorities. The emerging list was then cross checked against the Binleys NHS Directory and in all 22 medical chief executives were identified (around 5 per cent of the total chief executive community).

We approached these individuals with a request to undertake an interview and in the event 20 interviews were conducted between June and December 2009. In addition, we interviewed two former medical chief executives, one of whom has since returned to the NHS. One of the chief executives we interviewed turned out to be a dentist and information gathered from this interview has been included in our analysis. Summary information about those interviewed is displayed in the appendix. This information shows that age on first appointment varied from 36 to 64 for the 21 chief executives who supplied this information with the average age being 48. Six of the 22 chief executives interviewed were women.

Most interviews took place in the office of the chief executives (with a small number conducted by phone) and lasted between one and two hours. A semi-structured questionnaire was used, designed to understand the career paths taken and the facilitators and barriers encountered along the way. Interviews were conducted on a confidential basis and on the understanding that they would be used to identify the main themes relevant to the study rather than to disclose details of individual careers. The notes of interviews were sent to each interviewee to be checked for accuracy and to ensure confidentiality. A draft of this paper was then circulated to all interviewees for comment, and the draft was discussed with almost half of those interviewed at a seminar held in early February 2010. The final version of this paper incorporates comments made on the previous draft and issues raised at the seminar.

Alongside the interviews, we carried out a review of the literature and contacted experts in a number of other countries to seek information about relevant studies of which they were aware. Our contacts in other countries confirmed that little if any work had been carried out on medical chief executives. Similarly, there is a limited literature directly relevant to our work. The main value of the literature review was in highlighting the challenges facing clinician managers occupying hybrid roles, and in helping us to interpret the results in relation to the changing professional identity of doctors who become chief executives.

The organisation of this paper

This paper is organised around the main issues discussed during the interviews. In writing up the results, a major challenge has been to do justice to the variety of experiences of those we interviewed and at the same time to distil from this variety the themes of wider relevance to the NHS in supporting doctors to become chief executives where they wish to do so. We have responded to this challenge by organising this paper on a thematic basis, illustrating these themes with anonymised examples drawn from the interviews. We have also summarised the career paths for five individuals schematically in flow charts displayed in the paper.

Limitations of this study

In interpreting the results of our study, it is important to emphasise that while a very high response rate was achieved, the paper is based on a small number of interviews. Equally important is to recognise that the individuals who were interviewed, by virtue of being relatively unusual in having made the transition to chief executive positions, may not be representative of either medical leaders in other roles or doctors who have maintained full time clinical commitments. In view of this, caution is needed in drawing out implications for doctors thinking of taking on leadership roles in future.

The paper has been written primarily as a descriptive account of the experiences of the chief executives who were interviewed, with the aim of drawing out the implications for doctors who wish to take on leadership roles in future. It was not within the scope of this study to evaluate the effectiveness of medical chief executives, although a number of interviewees commented on this issue. Two of the paper's authors (CH and HD) are involved in a service delivery and organisation (SDO) funded research project examining models of medical leadership in the NHS, and this project will be exploring the relationship between organisational performance and the involvement of doctors in leadership roles.

Acknowledgements

The Findings

Choosing medicine

Interviewees reported various motives for choosing medicine. In a small number of cases, there was a history of medicine or dentistry in the family. More often, having studied science subjects at school, and having achieved good results, medicine was selected following careers advice or discussion with parents. One interviewee who studied arts subjects for 'A' level decided to switch to medicine at a late stage and was able to do so following advice from a family friend who was a surgeon.

Early influences also played a part, as in the case of one interviewee who set his mind on medicine after the experience of having undergone surgery at the age of 4. Another interviewee explained that she had set her heart on becoming a doctor at an early age and became even more determined to do so when her aunt suggested she might train as a nurse first. A third interviewee reported that she had gone into medicine in part because of family pressure and support.

These influences can be contrasted with others who decided relatively late in the day to pursue medicine as a career, exemplified by one interviewee who studied medicine as a mature student having taken a first degree in psychology. Another interviewee observed that in choosing medicine he was 'the odd one out' in his family where other occupations were the law, journalism and film.

Experiencing leadership

While some interviewees gained experience in leadership roles at school and university, this was by no means universal. Alongside those who were head boys or girls, captains of sports teams, and who had roles in student unions, there were at least as many whose involvement in leadership emerged only later in their careers.

There was also variability in how interviewees described their attitudes to people in positions of authority during their training. While there were a few self confessed 'rebels' who were willing to question and challenge the status quo, many others reported a conventional and uneventful career path.

Deciding to specialise

Interviewees included doctors who had pursued a career in general practice, public health, psychiatry, learning disability, and various areas of acute care. Some interviewees had experience in a number of these areas (see appendix for a breakdown). Deciding on the area of medicine in which to specialise came easier and earlier to some than to others. Role models encountered at medical school played some part in this but also important were concerns to avoid careers that lacked the variety or stimulation that were felt to be important.

In one case this led to a decision to undertake medical training in the armed forces and in another to the abandonment of general practice training in favour of a post as a doctor in the civil service. The latter decision was also strongly influenced by the experience of serious illness (a cancer diagnosis) that 'changed me quite a lot' and prompted a 'massive rethink' of career direction.

The career paths taken by interviewees varied considerably. In some cases, the route from graduation through training to appointment as general practitioner or consultant appears relatively smooth and seamless. In others, the route was longer and less direct, reflecting uncertainties about career choices as well as other decisions e.g. to travel and work in other countries. Later career choices displayed similar variety with some interviewees working in the same organisation for many years and others moving frequently. Five interviewees had worked in the private sector for part of their careers.

A recurring theme in our interviews was the value attached to work experience in other countries, especially early in the career path. This experience was important in revealing weaknesses in NHS practices and services and in so doing had underpinned the motivation to make a difference by bringing about improvements in care. One interviewee used his NHS experience to apply successfully for a chief executive post in the health care system of another country.

Becoming a leader

The transition from being a full time doctor to becoming involved in management and leadership roles took place at different stages. In many cases, this transition occurred when interviewees became leaders of their teams or took on interests outside their clinical work e.g. general practitioners who became involved in fundholding, or consultants who were asked to become clinical directors in the hospital setting. A commonly expressed reason for moving in this direction was a concern to make a bigger impact than was possible in clinical work.

Also important was a perception that it was possible to provide more effective leadership than others had done. As one interviewee expressed the point, 'seeing others buggering it up' persuaded him to take on a leadership role in his trust when the opportunity came along. A second decided to become a chief executive when he experienced frustration in 'being number 2'. A third was asked to take on the chief executive role after his predecessor was dismissed, and reported that he accepted because he felt 'I couldn't do any worse'. Most of those interviewed came over as willing leaders for whom the possibility of being a chief executive was a positive decision.

However, in a few cases interviewees communicated a sense of being reluctant leaders who had not set out to go down this path but who having made this choice then availed themselves of further opportunities as they arose and over time came to see themselves as medical leaders. In this sense, 'luck and circumstances' shaped what happened next rather than conscious planning. By being in the right place at the right time, these individuals were able to make the move from medical director (and similar positions) to become chief executives, usually in the same organisation.

The process of becoming a medical chief executive can be contrasted with the experience of general managers, many of whom start their careers on the graduate management training scheme and have a chief executive role in their sights from an early stage. The career progression of general managers is designed to provide these individuals with experience in a range of roles in order to equip them to become chief executives in mid career. Doctors moving into leadership positions and seeking to become chief executives typically do not have the same structured opportunities.

Becoming a chief executive

The paths that were taken subsequently were many and varied as demonstrated by the accompanying examples (pp12-16). The most straightforward involved progression from clinical director to medical director and then chief executive. This often included additional experience in one or more senior leadership roles before appointment as chief executive e.g. in leading work on service reconfiguration or taking on an operational management role to obtain more rounded experience. One interviewee reflected that for him becoming a chief executive was a natural progression, and was based on an early decision that a lifelong career in clinical work was likely to be unattractive.

Medical School
1980 - 1985

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GP Training
1988 - 1991

↓

GP Partner
1991

↓

GP Lead on Fundholding and Total Purchasing
1991 - 2000

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Part-time role with National Patients Access Team (NPAT)
1991 - 2000

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Care Trust CE
2002 - 2006

↓

PCT CE
2006 - current

Career path example 2

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┌─────────────────────────────────┐
│          Medical School         │
│           1981 - 1987           │
└─────────────────────────────────┘
                 ↓
┌─────────────────────────────────┐
│        Specialist Training      │
│           1990 - 1997           │
└─────────────────────────────────┘
                 ↓
┌─────────────────────────────────┐
│            Consultant           │
│           1997 - 2003           │
└─────────────────────────────────┘
                 ↓
┌─────────────────────────────────┐
│         Clinical Director       │
│              2003               │
└─────────────────────────────────┘
                 ↓
┌─────────────────────────────────┐
│         Medical Director        │
│              2004               │
└─────────────────────────────────┘
                 ↓
┌─────────────────────────────────┐
│ Medical Director and Strategy Director │
│              2007               │
└─────────────────────────────────┘
                 ↓
┌─────────────────────────────────┐
│ Medical Director and SHA Clinical Director │
│              2008               │
└─────────────────────────────────┘
                 ↓
┌─────────────────────────────────┐
│   Interim and then substantive CE   │
│          2008 - current         │
└─────────────────────────────────┘
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Medical School
1984 - 1989

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Public Health Training
1989 - 1993

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Consultant in Public Health
1993 - 1995

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Director of Public Health
1995 - 1999

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Clinical Services Director, NHS Trust
1999

↓

Regional Office Role on Cancer Services
2000

↓

CE Workforce Development Confederation
2000 - 2002

↓

Director of Strategy and Workforce, SHA
2002 - 2004

↓

Acting and then substantive CE, NHS Trust
2004 - current

Career path example 4

Medical School
1976 - 1981

↓

Specialist training
1981 - 1990

↓

GP Practice
1990 - 1991

↓

Career break
1991 - 1994

↓

Public Health Training
1994 - 1997

↓

Overseas study and travel fellowship
1997

↓

Civil servant, DH
1998 - 2000

↓

Medical Director
2000 - 2004

↓

1st CE Post
2004 - 2008

↓

2nd CE Post
2008 - current

Medical School
1976 - 1982

⬇

House Jobs and GP Training
1982 - 1987

⬇

Public Health Training
1987 - 1991

⬇

Overseas study and travel fellowship
1991 - 1992

⬇

Public Health Consultant
1992 - 1998

⬇

Civil servant, DH
1998 - 2002

⬇

Joint Director of Public Health
2002 -2008

⬇

PCT CE and Joint Director of Public Health
2008 - current

Interviewees who trained in general practice and public health used experience as primary care leaders or directors of public health as stepping stones to chief executive positions. Again, it was common for these interviewees to have spent time in other leadership roles along the way, both in the NHS and in other settings e.g. the civil service and the private sector. Most chief executives who came up through general p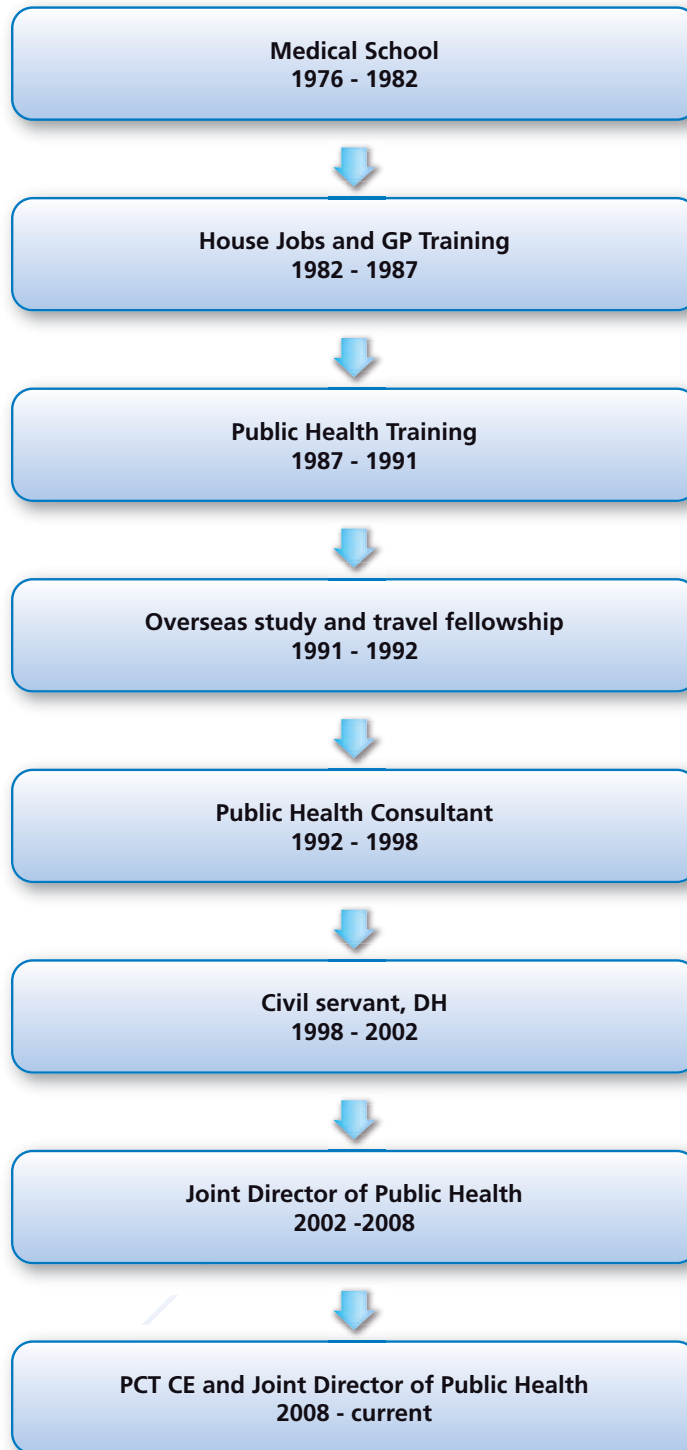ractice and public health were to be found in primary care trusts although two held posts in acute trusts and one was in a mental health trust.

A distinction can be drawn between interviewees who moved quickly into a chief executive role when they decided that this was the path they wished to take and those who took longer to make the transition. Among the latter, becoming a chief executive often involved unsuccessful applications on one or more occasions and the disappointment that ensued before they achieved their goal. The reflections of interviewees with experience of this kind underlined the value of advice received from senior NHS colleagues (see below) and the importance of personal resilience in the face of rejection. The transition to chief executive was often smoother for those appointed to this role within the organisations in which they already worked than for those who became chief executives in other organisations.

A small number of interviewees described much more varied careers involving experience of working in different systems and in the public and private sectors. This included one individual who had held a series of chief executive posts (six in total) in the NHS and elsewhere. Another interviewee pursued a career mainly as a clinical academic. This included experience as dean of two medical schools before appointment as chief executive. Most of those interviewed had work experience in other countries (though only exceptionally as chief executives) and often reflected on the influence this had on them.

The majority of those included in our study (13/22) were either in their first chief executive roles at the time of interview or had stepped down from these roles having only held one such post (see the appendix for a detailed breakdown). Among this majority, a distinction can be drawn between those for whom appointment as chief executive came relatively late in their careers (typically in their 50s) following a number of years of experience in other medical leadership roles, and those who became chief executives in mid career (either late 30s or 40s). Most interviewees fell into the latter category and many anticipated moving on to other chief executive roles as opportunities arose. Some had already done so and had taken on progressively greater responsibilities in the process. The appendix shows that the age of chief executives on their first appointment ranged from 36 to 64, the average age being 48.

As already mentioned, five interviewees had worked in the private sector for part of their careers. Their experience outside the NHS was mixed with one leaving an NHS chief executive role for a senior post in the private sector for a short time and returning to the NHS as a chief executive when this did not work out. Others reported more positive experiences and valued the stimulation and variety of working in other sectors. One of these interviewees had in fact pursued a career mainly in the private sector and eventually returned to the NHS as a chief executive (in the process taking a considerable drop in pay) because of the attractions this opportunity held.

Retaining clinical commitments

A major consideration for many interviewees (public health doctors being the exception) was the impact on their clinical work of taking on leadership roles. This became particularly important as they progressed from involvement as clinical directors and primary care leads to take on more significant responsibilities e.g. as medical directors. A small minority of those interviewed did not express concern on this score, mainly because they had already decided to pursue careers beyond clinical work and felt that it was impossible to combine the two.

For the majority, the dilemma was how to ensure sufficient contact with patients to maintain their clinical skills, and to provide a safety net (see below) if they ran into difficulties in their leadership roles. One way of resolving this dilemma was to arrange to continue with clinical commitments on a limited basis, even on appointment as a chief executive.

The reported benefits of doing so included retaining credibility among clinical colleagues and maintaining the stimulation of seeing patients. As more than one commented, continuing contact with patients provided a reality check and a relative oasis of calm and predictability compared with the responsibilities of being a chief executive.

There were marked differences of opinion on how much time chief executives should commit to clinical work: one chief executive spent two days a week seeing patients whereas others took the view that being a chief executive should be a full time occupation leaving no time for clinical commitments. The time commitment depended in part on the specialty concerned, the nature of the work involved (e.g. outpatient and inpatient) and other considerations. In some cases it was feasible for chief executives who maintained clinical commitments to fit these into defined periods of the working week without this adversely affecting their chief executive responsibilities, but in others this was much more challenging or simply impossible. This led all but five of the chief executives who were interviewed to relinquish their clinical commitments, albeit reluctantly in many cases.

All recognised that the new arrangements for revalidation of doctors would have a bearing on this in future and might make it increasingly difficult for chief executives to combine clinical work with their leadership roles. Some went further to argue that it was not appropriate to retain clinical commitments given the demands of the role and the risk of being seen to be partisan in relation to the specialty or service in which the chief executive continued to practice. From this point of view, medical chief executives who retained part time clinical activities reinforced the perception of people in this role being keen amateurs. In some cases, this was linked to the argument that a faculty of medical or clinical leadership should be set up to provide a focus for doctors and other clinicians taking on leadership roles and to help in professionalising the work involved. It was suggested that this might have the added benefit of helping to raise standards of practice among medical leaders.

Redefining professional identities

The bigger question this gives rise to is the professional identity of doctors who go into leadership roles and then become chief executives. When asked this question, interviewees offered a range of responses. One described himself as 'an established chief executive' who could compete for leadership roles in any sector, not just health care. Another felt he was 'a general manager first and a doctor second'. In both cases, interviewees had given up clinical work a long time previously and had therefore 'burnt their bridges', although they argued that being a doctor was still advantageous.

A more common response was for interviewees to describe themselves as leaders who combined clinical and managerial experience. A number of interviewees acknowledged there had been a sense of loss when they moved into leadership roles, with some seeing themselves as first and foremost doctors who also happened to be chief executives. A newly appointed chief executive reported that when asked what he does he describes himself as a doctor and does not talk about being a chief executive unless it is appropriate to do so.

Other interviewees argued that medical chief executives had an important role to play in overcoming the tribalism that is endemic in the NHS because they are boundary spanners who bridge the worlds of management and medicine. The acknowledgement in the final report of the NHS Next Stage Review, *High Quality Care for All*, of the need to strengthen clinical engagement and medical leadership derives from concern that the

gap between doctors and managers will act as barrier to further progress in improving the performance of the NHS. From this point of view, having a growing cadre of medical chief executives who can serve as role models has obvious attractions.

Having made this point, it is important to understand the perceptions that doctors hold of managers and vice-versa, and the impact this has on professional identity. The cliché that doctors who take on leadership roles risk 'going over to the dark side' was mentioned on more than one occasion as was a concern that becoming a chief executive meant 'leaving the professional family'. At the same time, there was recognition of the danger of being seen by fellow doctors as 'one of us' and by implication likely to be supportive of the views of medical staff rather than being willing to challenge those views when appropriate. It was argued that medical chief executives who had been medical directors needed to be clear that this was no longer their role.

Interviewees reflected on the disadvantages of being a medical chief executive as well as the benefits. A key theme here was the importance of recognising gaps in competence and experience that needed to be filled by others. This had often resulted in the appointment of experienced colleagues as chief operating officers, medical directors and other roles to ensure that appropriate support was available. Being able to rely on one or more senior colleagues was important not least to enable chief executives to retain some clinical commitments where they wished to do so. It was also essential that medical chief executives should be willing to fill gaps in their knowledge through appropriate training and development.

Developing hybrid roles

Some interviewees felt that the impact on professional identity of becoming a chief executive was underestimated and not well understood. The broader point here is the challenge faced by clinician managers occupying what have been described as hybrid roles within the NHS. Fitzgerald and colleagues (2006) have highlighted this challenge in a study of change management in the NHS, noting:

'The hybrid group does not yet have a coherent work identity or credentialised knowledge base…there is no recognition of clinical management as a specialty, with limited educational opportunities or credentials – and an unwillingness to undertake major training. Other medical professionals do not consider clinical management to represent a medical specialty – rather clinical managers uncomfortably span the managerial/clinical divide and are not full or influential members of either occupational group' (p170).

Montgomery's work on medical management in the United States has discussed the processes by which clinical management can become recognised as a specialty in its own right. These processes include 'discovering colleagueship' and 'establishing legitimacy' e.g. by forging a nucleus of people involved in these roles, forming a professional association and developing training programmes and an agreed curriculum (Montgomery, 1990). While some progress has been made on these issues in the NHS, for example through the work of the British Association of Medical Managers (BAMM), our work suggests that the role of clinical managers, including medical chief executives, is still not well recognised. In some quarters, this has given rise to proposals to establish a faculty of medical or clinical leadership to raise the profile of this kind of work and to raise standards of practice.

In a later paper, Montgomery (2001) argues that physician executives in the United States are typically drawn into leadership roles by the attractions they see in these roles. Both she and Hoff (1998 and 2001) suggest that physician executives develop a dual identity in which becoming a leader enlarges and enhances rather than replaces their original clinical identity. Our data, admittedly from a small sample, lend support to the dual identity thesis, albeit with the caveat that the cultural divide between doctors and

managers appears to affect the willingness of some medical chief executives to relinquish medicine as their principal identity. The still embryonic nature of medical management as a hybrid role may help to explain this reluctance.

A number of interviewees argued that in practice they felt they had several identities, combining the roles of doctor, leader, spouse, parent etc. In this sense, plural identity may be a more accurate description of the lived experiences of medical chief executives than dual identity. We would add that medical chief executives also appear to have shifting and to some degree fluid identities that derive from the sometimes uncertain and insecure positions they occupy.

Receiving advice and guidance

In making the transition from clinician to clinical leader and ultimately to chief executive, some interviewees reported receiving advice and guidance from senior colleagues. An example was a GP leader who reported that at a critical stage in her career she received the backing of a health authority chief executive who was willing to take a risk in appointing her to her first chief executive post despite her relative inexperience. However, this was by no means universal and a recurring theme in our work was the extent to which many of those interviewed felt there was a lack of career planning and support for leaders in the NHS. Even those who reported the value of advice received from chairs or chief executives they had worked with emphasised that this advice had to be actively sought.

Only in a handful of cases were there examples of active mentoring and support to allow interviewees to fill gaps in their experience, thereby enabling them to compete successfully for chief executive positions. One of the best examples concerned a consultant who had assumed increasing leadership responsibilities and whose chief executive arranged for him to fill gaps in his experience in an operational management role to enable him to progress eventually to become a chief executive in another organisation. Another involved a consultant

being supported by a strategic health authority to take on a regional clinical leadership role to complement his experience at trust level as a stepping stone to his first chief executive appointment.

Notwithstanding these positive examples, a strong message from most of those involved in this study was the lack of interest shown by 'the NHS' in their careers. Indeed, many volunteered that taking part in our work was the first time they had been asked to reflect on the journeys they had taken. There were some indications that this was beginning to change with the recent renewal of interest in leadership development and succession planning. Yet even in this context, existing chief executives reported that it was not easy to know whom to turn to in thinking about future career moves, other than senior and respected colleagues (who were often to be found in other organisations).

Monitor has not taken on this role in the case of NHS Foundation Trusts and strategic health authorities have focused more on aspiring chief executives and directors than those already in chief executive roles. Chief executives with experienced chairs reported that chairs were a valuable source of advice and had often been important in their decisions to seek chief executive roles. It was much less clear that chairs could provide counsel and guidance on future career moves, and in some cases chief executives turned to personal coaches to fill the gap.

Undertaking training and development

Various sources of training and development were used by interviewees to enable them to become effective leaders.

A number emphasised the value they placed on learning 'on the job', and receiving support from a coach. Often this included reflecting on learning they had gained from working with chief executives before taking on this role themselves. In some cases, interviewees reported learning about leadership styles and approaches to avoid, and in

others they spoke positively about role models whose example they sought to emulate and adapt. In this sense, they compared learning to be a leader with the medical training they had undertaken in which doctors were expected to 'see one, do one and teach one'.

Some interviewees had benefited from more formal training in leadership. In one case, an experienced chief executive who had held a series of leadership roles in different countries reported undertaking a professional qualification in leadership, leading to the award of a Masters degree. In his view, it was important to put much more emphasis on leadership development for doctors wishing to become chief executives. A newly appointed chief executive took a similar view but emphasised the challenges he had faced of finding the time to study for a higher degree while maintaining clinical commitments and taking on more senior leadership responsibilities.

Chief executives who trained in public health reported that part of their training included content on management and leadership and understanding the importance of systems. Some of those who had gone down this route had gone on to study for MBAs and executive programmes run by business schools (one or two others had done the same) or had taken up other opportunities e.g. a Harkness Fellowship in the United States. More often, interviewees reported attending leadership development programmes run by the King's Fund and similar organisations (BAMM was another of those mentioned).

A small number had been nominated to take part in the Cabinet Office's top management programme and those who had done so testified to its value. Two interviewees had been appointed as chief executives after taking part in programmes for aspiring chief executives organised by strategic health authorities. A number of benefits of undertaking training and development in management and leadership were identified. These benefits included filling gaps in knowledge and skills and helping in the development of softer skills like negotiating with colleagues. In the words

of one interviewee, the critical consideration was to be able to demonstrate a 'portfolio of achievement' and competences that could be applied in practice, rather than simply paper qualifications.

Almost all interviewees had availed themselves of coaches and felt this had been valuable. Even with thorough preparation and comprehensive training and development, becoming a chief executive was often 'a shock' and required rapid adjustment. Coaches were felt to be especially important at this point in the leadership journey, alongside more informal forms of support from experienced chief executive colleagues.

As these findings suggest, the training and development accessed by medical chief executives is highly variable and in a few cases extremely limited. Reflecting on their careers, a number of interviewees emphasised that there was a need to move beyond medical leaders who were 'keen amateurs' who learnt mainly on the job. These interviewees argued that in both primary care and secondary care the responsibilities of medical leaders for services and budgets demanded a much more professional and systematic approach than they had experienced in their own careers. The question this raises is what should be the nature and content of the training and development undertaken by doctors who wish to become chief executives and we return to this below.

Making a difference

In reflecting on their experience, interviewees spoke about the opportunities and challenges of being a chief executive. The principal opportunities were the ability to make a difference for populations and not just patients and to tackle weaknesses in existing services. The drive and ambition which lay behind the decision to study medicine and to pursue a clinical career were in this way directed at organisational and service improvement on a bigger scale than was possible in clinical work.

Interviewees felt there were clear benefits in being a chief executive from a medical background. These benefits included having credibility with

clinical colleagues and being able to challenge them. Also important was the fact that medical chief executives 'speak the same language' as their medical colleagues and have experience at the clinical front line in the early hours of the morning. One interviewee expressed concern that if doctors in future move into leadership roles without having the benefit of a successful clinical career behind them, they may lack the credibility and experience needed to be successful chief executives.
The training and 'intellect' of doctors was seen as another advantage by some.

On being appointed as chief executives, many interviewees reported that they had had doubts about their ability to do the job, even with support and encouragement from others. These doubts were reinforced by not always understanding the jargon and language of career NHS managers who became chief executives. Medical chief executives felt they often lacked the networks and support systems that other chief executives had developed, and this could be a hindrance, although they benefited from contacts and knowledge that other chief executives often lacked.

Another reflection was that chief executives were more constrained and exposed in their roles than medical directors because of the accountability they carried (see below). Despite this, none expressed regret at the decision to become a chief executive. Indeed, a strong message from our study is of the excitement and stimulation involved in the role and the opportunity it offers to contribute to the development of the NHS – 'the best job I've ever done' in the words of one interviewee.

'It can be a very satisfying job', in the words of another, 'because you are doing what you want to do'. A third commented that she 'really loves what I do', notwithstanding the constant challenges involved. In discussions with some interviewees of an earlier draft of this report, being a medical chief executive was likened to the journey of Icarus involving the excitement of taking big risks and requiring the judgement to know how to manage these without falling to earth with serious consequences.

Rising to the challenges

The challenges of being a chief executive related to what one interviewee described as the 'white water' ride of leadership and the wide range of problems and issues that chief executives were expected to address. This gave rise to 'stomach churning moments' and involved 'a steep learning curve'. One interviewee reflected that some medical chief executives were 'adrenaline junkies' who thrived on chaos and unpredictability, notwithstanding the constant pressures they encountered.

In some cases, interviewees discovered major problems in the organisations they had been appointed to lead, including among their senior colleagues, and it had taken time and effort to resolve these problems. For the chief executives of NHS Foundation Trusts/Trusts, there was pressure resulting from leading a group of autonomous professionals, even with a shared background with these professionals. One interviewee went so far as to wonder if being an NHS chief executive was 'impossible because of the dysfunctionality of the system'.

Two PCT chief executives reported that they had experienced huge pressure from SHAs in relation to the performance of their organisations and this had made life extremely uncomfortable.
These interviewees and others acknowledged the ever present insecurities associated with being a chief executive in the NHS, and the personal and careers risks that ensued. Those who held this view argued that the management culture in the NHS often felt punitive rather than supportive, and they felt this was an important consideration for medical leaders who were considering becoming chief executives.

It is worth noting in this context that in the period during which we undertook this study (June 2009-February 2010), four of the 19 chief executives currently working in the NHS changed roles. One moved to a chief executive role in another health care system, a second moved to a chief executive role elsewhere in the NHS, a third was removed

from his post and a fourth resigned. In the opposite direction, a chief executive who had left to work in the private sector returned to take on an NHS role.

Coping with the insecurity

Perhaps not surprisingly, the insecurities associated with being a chief executive were a recurring theme in our interviews, including the short tenure of many appointed to this role. Inevitably, this prompted comparisons with the position of doctors who pursued clinical careers or who combined clinical careers with leadership roles.

The fact that medical chief executives are in a small minority in the NHS was felt to be due in no small part to the risks associated with giving up a secure and predictable career path for the uncertainties of being a chief executive. This helps to explain why some of those interviewed retained a small clinical workload in order to keep open the option of a return to a clinical career in the event of failure. It also accounts for the decision of some interviewees to delay seeking a chief executive role until late in their careers when the consequences of failure would be easier to deal with.

A minority of those interviewed took a different view of these issues, expressing the opinion that to contemplate failure on appointment as chief executive was to adopt the wrong mindset. Those who held this view recognised the insecurities associated with being a chief executive but emphasised that those who failed often found their way back into another chief executive role after a period of time. It was also possible to return to clinical work with support and retraining if necessary.

The most experienced of those interviewed (in terms of the number of chief executive posts held during his career) argued that doctors choosing to pursue a leadership career at an early stage should expect to move on from time to time as long term tenure as a chief executive was the exception rather than the rule. Along with some other interviewees, he maintained that attitude to risk was fundamental and that those who wanted stability and security were probably not best suited to

becoming chief executives. This interviewee and others were self confessed 'adrenaline junkies' for whom insecurity was an attraction rather than a deterrent. From this perspective, it was suggested that doctors interested in leadership roles who were risk averse may be better advised to take on positions as clinical directors, medical directors and PEC chairs (described by one interviewee as a 'half way house') rather than chief executive positions.

Against this, even some of the interviewees who described themselves as risk takers argued that the level of vulnerability of NHS chief executives was too great in that one mistake in an otherwise successful role could result in termination of contract. The concern here is that the dominant management culture in the NHS is one in which failure is not tolerated and leaders are often in fear of their jobs if their organisations do not achieve the performance targets they are set. This culture is fuelled by intense media interest in the NHS, especially when things go wrong, and the expectation that politicians will intervene to take remedial action to reassure and protect the public. The consequences include a tendency for many chief executives to avoid risk and lower their ambition. It was argued that this issue has to be addressed if more doctors were to come forward as chief executives, especially if the current cohort is not representative of doctors as a whole in terms of psychometric profile and related factors.

One interviewee explained that he had handled the risk in his first chief executive appointment by negotiating the option of returning to clinical work if being a chief executive did not work out. This was possible because he was taking up this role in the organisation in which he had worked for several years and he recognised that a 'parachute' of this kind would not have been on offer had he been appointed in another organisation. In the event, he moved on to a second chief executive role after four years and did so understanding that he no longer needed the security of knowing that a clinical post was still available to him.

A number of interviewees reflected on difficulties they had experienced at different stages of their

careers and how these had been handled. One argued that failure is often less important (because it is likely to happen from time to time) than how chief executives respond to failure, including the help they seek in so doing. Others mentioned the importance of support they had received in dealing with difficulties, including opportunities that they had been offered to take on other roles to enable them to rescue or revive their careers as leaders. Linked to this, one interviewee argued that there should be a sense of there being 'life after being a chief executive' – underlining the importance of better career planning in the NHS.

Being a chief executive was described by one as 'a lonely job' and it was therefore essential to put in place forms of support like coaches and mentors. A small number of interviewees also referred to the impact on their family lives of being a chief executive and the importance of the support they received from partners. There was recognition of the pressure that partners could feel in some circumstances, especially when chief executives found themselves in challenging circumstances.

Dealing with pay differences

Related to perceived insecurities was the pay differential between chief executives and senior doctors in clinical roles.

This differential has become less important as compensation for chief executives has increased but it was recognised that it could be a deterrent for some, especially experienced secondary care doctors who take on roles such as clinical director and medical director and who may also have significant supplementary sources of income from private practice and other activities. A number of interviewees reported that they were not the most highly paid individuals within their trusts, and they questioned whether this was appropriate.

Some of those interviewed said that pay was not the most important consideration in their career choices and they had been willing to trade off additional income or accept a cut in pay for the stimulation they experienced as chief executives.

On the other hand, they argued that if more doctors were to be attracted into chief executive roles, then pay differentials would need to be addressed e.g. through clinical excellence awards for doctors who still held clinical contracts and other means. Some interviewees reported that they had negotiated retention of their clinical salaries when they became chief executives to deal with this issue.

Drawing out the lessons

Discussion of pay differentials and job insecurities led into consideration of what might be done to enable more doctors to become chief executives in future. There was a clear view among interviewees that while having more medical chief executives was desirable, it was unrealistic to expect a substantial increase even over a 5-10 year period. There was also a view that, given the demanding nature of the role, the best people should be appointed as chief executives regardless of their training or background. As we argued at the outset, the appointment of more medical chief executives must not be seen as a magic bullet as many other factors are important in contributing to further improvements in NHS performance.

Alongside the specific proposals (see below) put forward during the course of our work, it is important to acknowledge the continuing influence of some deep seated factors that have a bearing on the willingness of doctors to become chief executives. These factors include the still fragile nature of hybrid roles within the NHS, and the importance of professional identities. While some other countries have made more progress in engaging doctors in leadership roles (see Kirkpatrick and colleagues, 2009, in their interesting comparison of the United Kingdom and Denmark), it remains uncertain how far their experience can be adapted in the NHS because of differences in history and culture. At the time of writing, establishing medical leadership and particularly medical chief executive roles as attractive options in the NHS remains a work in progress. Much remains to be done to build on the experience of the pioneers whose experience is summarised in this paper if chief executives from medical backgrounds are ever to form more than a small minority.

Equally important is the NHS management culture and the insecurities this gives rise to. At a time when there is continuing pressure to improve performance and an intolerance of failure, it is perhaps not surprising that doctors who have successful clinical careers, including those who combine clinical work with leadership roles, are reluctant to become chief executives. Providing more structured support and opportunities for training and development may well help more doctors to make the transition in future but other changes are also needed. These changes include finding ways of helping chief executives who get into difficulty and enabling them to return to clinical work or move on to other leadership roles in the event that they lose their posts. It might be added that similar support is needed for chief executives who are not doctors.

Specific ideas put forward for enabling more doctors who wished to become chief executives to do so were:

- providing more opportunities, like the Prepare to Lead programme in London, to support future leaders through mentoring, shadowing and networking

- developing both unidisciplinary and multidisciplinary leadership development programmes for new medical leaders

- offering training and development in management and leadership for doctors taking on leadership roles in mid career, building on the best of current provision e.g. the aspiring chief executives programmes run by a number of strategic health authorities

- allocating funds to sponsor experienced medical leaders to undertake appropriate further training to equip them to become chief executives (e.g. MBAs and the Cabinet Office Top Management Programme)

- establishing learning sets for experienced medical leaders to enable them to become chief executives

- using existing medical and non-medical chief executives and senior leaders as role models and making their expertise available to prospective medical chief executives as mentors and advisers

- offering support from coaches to medical leaders and for newly appointed medical chief executives

- requiring doctors to attain an agreed set of leadership competences in future e.g. through the emerging Leadership Quality Certificate (LQC) currently being developed by the National Leadership Council which would potentially make

the Medical Leadership Competency Framework mandatory as level 1 of the LQC, and should help to create a cadre of people equipped to take on leadership roles

- strengthening career planning to ensure that the NHS takes a much closer interest in leadership development, talent management and succession planning at all stages

- developing clearer career paths that enable doctors to see how they can gain experience in different roles on the way to becoming chief executives, including roles that offer doctors the opportunity to become full time leaders e.g. as medical directors or the equivalent in primary care

- using clinical excellence awards to more explicitly reward doctors to combine clinical and leadership roles, and reviewing pay differentials to remove barriers to doctors becoming chief executives

- establishing a college or faculty of medical leadership (or a more broadly based faculty of clinical leadership) to help address the question of the professional identity of people occupying hybrid roles and to raise standards of practice

- developing a framework for continuing education and professional development, including determining the nature and the content of the training needed by medical leaders, and the competences and skills required

- enabling medical chief executives opportunities to undertake clinical retraining, as is the case in Denmark where one month of retraining is made available for every year of service

- supporting chief executives who get into difficulty and enabling them to move on to other leadership roles in the event that they lose their posts.

While we have framed these ideas in relation to medical chief executives, it is worth noting that many are equally relevant to doctors going into other leadership roles e.g. as medical directors, and they echo suggestions put forward by the NHS Confederation (2009) in a recent briefing on this topic.

A key question for the future is whether to encourage continuing experimentation in the approach that is taken to these issues or to move towards greater consistency across the NHS. It is clear from our work that every NHS organisation now needs to give greater priority to the development of medical leadership, including support for doctors to move into chief executive roles where they wish to do so, through in-house development programmes and other forms of support. The work of the National Leadership Council and of strategic health authorities will provide a range of resources to support action within the NHS, including identifying and spreading good practice in leadership development and funding programmes that are best undertaken across a number of organisations.

The purpose of these proposals is to move beyond reliance on 'keen amateurs', to use the words of one of our interviewees, and to recognise that medical leadership and its development needs to be taken seriously.

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CE Number	Medical training						Number of CE posts held	Year of 1st CE appointment	Age at 1st appointment
	GP	Public Health	Secondary care (Mental Health)	Secondary care (Learning Disability)	Secondary care (Acute)	Dentistry			
1					X		1	2007	47
2			X				1	2006	58
3		X					6	1989	42
4		X			X		2	2004	39
5	X						3	2002	40
6					X		1	2007	56
7					X		1	2008	45
8			X				1	2007	47
9	X						2	2000	44
10	X						2	2001	40
11					X		1	2008	57
12					X		2	1996	51
13					X		1	2001	46
14					X		1	2008	64
15						X	1	2004	46
16				X			1	2008	56
17	X	X					1	2007	49
18		X					1	2008	51
19	X	X					3	2001	43
20	X	X					3	2001	36
21	X	X			X		2	2004	46
22					X		1	2000	n/a

Information about the Enhancing Engagement in Medical Leadership project

This UK-wide project has promoted medical leadership and helped to create organisational cultures where doctors seek to be more engaged in management and leadership of health services and non-medical leaders genuinely seek their involvement to improve services for patients across the UK. The project team has worked closely with the medical professional, regulatory and education bodies and health service organisations in promoting these goals.

Medical Leadership Competency Framework [NHSIMLCF3]

The Medical Leadership Competency Framework (MLCF) describes the leadership competences doctors need in order to become more actively involved in the planning, delivery and transformation of health services.

The MLCF applies to all medical students and doctors throughout their training and career. The competences are included in the General Medical Council's (GMC) publication, *Tomorrow's Doctors* (2009). The project team has developed **Guidance for Undergraduate Medical Education: Medical Leadership Competency Framework** [NHSIUgrad] which is a resource to support the development of leadership and management curriculum design within medical schools. The guidance within the document details the leadership and management knowledge, skills, attitudes and behaviours to be developed and assessed through the undergraduate medical curriculum, as a first step in the career continuum of a doctor.

A **Medical Leadership Curriculum**, which is the first shared curriculum of all medical royal colleges, has also been developed and scrutinised by PMETB. As a result, the competences have been integrated into the 56 Speciality Specific Curricula that have been approved by PMETB. It addresses the basic expectations relating to leadership, pertinent to all doctors during their specialist training period, enabling them to join with colleagues and other staff to provide effective healthcare services for patients and the public.

The MLCF is also being used in NHS organisations to inform the design of development programmes, appraisal and recruitment and it can assist doctors with personal development planning and career progression. The project team are working with the GMC, Academy of Medical Royal Colleges (AoMRC), NHS Revalidation Support Team, NHS and the Department of Health on revalidation to ensure the inclusion of leadership competence as a requirement for all doctors.

Medical Engagement and Organisational Performance

In the NHS, the need for greater medical engagement and leadership in the planning, commissioning and development of services is now widely recognised. Increasingly, medical engagement is seen as crucial in ensuring that service changes are properly planned and effectively implemented. Research has shown that medical engagement is one of the key factors influencing organisational performance[1],[2].

Engaging Doctors: Can doctors influence organisational performance? [NHSIDRORG] is a report that shares findings from research into a link between organisational performance and medical engagement. The report provides real examples of good practice in medical engagement, as well as a set of behaviours and approaches emerging from the research that should lead to a more positive and effective way of engaging doctors in management and leadership.

A Medical Engagement Scale (MES) has been developed for NHS trusts to offer a greater insight to the level of engagement of doctors in their organisation and ways in which this engagement might be improved. The MES is designed to assess

medical engagement in management and leadership in NHS organisations. It has been designed to differentiate between the individual's personal desire to be engaged and the organisation's encouragement of involvement. Further information on the MES is available from Applied Research Ltd. at research@perform.gotadsl.co.uk or 0121 434 3511.

In 2010, publications will be available on further research undertaken to a) better understand what high performing organisations do to achieve high levels of engagement and b) to compare medical engagement data from the MES with organisation performance data from Dr Foster, the National Patient Safety Agency and the Care Quality Commission.

Engaging Doctors: What can we learn from international experience and research evidence? [NHSIengagingdocs] is a systematic and research based overview of the evolution of medical leadership and the reasons why a concerted focus on the training and support for doctors who are taking on leadership roles is needed.

Further information about the project is available at www.institute.nhs.uk/medicalleadership, or by contacting us at medicalleadership@institute.nhs.uk or +44 (0) 207 271 0306.

Copies of most of our publications are available from New Audience, quoting the reference given above in brackets. Please contact them at institute@newaudience.co.uk or +44 (0)1922 742555.

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