Faculty of Medical Leadership and Management

Barriers and enablers for clinicians moving into senior leadership roles

Review report

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About the Faculty of Medical Leadership and Management

Established in 2011 by all the UK medical royal colleges and faculties, the Faculty of Medical Leadership and Management (FMLM) is the professional home for medical leadership. FMLM's fundamental objective is to improve patient care through better medical leadership. This is under-pinned by the evidence linking leadership and team-working with improved quality of patient care and better outcomes including reduced mortality. We believe that all practising doctors need leadership and management skills commensurate with the level at which they work. Accordingly, FMLM has defined and published the 'Leadership and management standards for medical professionals', and offers a bespoke 360-degree feedback tool at four levels based on the standards. A certification process at three levels of seniority (Fellowship of FMLM) was launched in August 2016 to allow individual doctors and organisations to benchmark performance in medical leadership and management.

We are extremely grateful to the many groups, individuals and administrative teams who contributed so willingly to this project, against the constant pressures of time and their day-jobs.

Executive Summary

This report sets out the findings of a review carried out by the Faculty of Medical Leadership and Management (FMLM) and commissioned by the Department of Health and Social Care (DHSC) at the instruction of Secretary of State for Health, the Rt Hon Jeremy Hunt, MP. This followed a speech by the Secretary of State in November 2016 that broadly asked the question: how can we increase the numbers of clinical professionals taking up the most senior leadership roles in the NHS? Leading on from this, was a further query as to whether professional regulation is a factor in this area.

To inform the review, FMLM established a steering group with representatives from the main regulatory bodies and senior NHS clinicians. It then commissioned a high-level review of relevant literature and spoke to a wide range of senior and some less senior clinicians from professions from across the UK including medicine, nursing, allied health professions, biomedical science and pharmacy. These discussions covered five core questions:

- What do you think are the benefits of clinicians taking up senior leadership roles?
- What are the main barriers to this?
- What are the main enablers of this?
- What part does regulation play?
- What changes would you suggest to encourage more clinicians into senior leadership?

To enrich the contributions further, FMLM also interviewed several current chief executives from a clinical background, to draw any lessons from their career experiences.

Findings

While some common themes emerged between the professions, fundamental differences were also evident. Most people highlighted progression to senior leadership was rarely promoted as a legitimate career pathway as part of training programmes and even where programmes exist, such as the National Medical Director's Clinical Fellowship scheme, these are not recognised as part of specialty training. Most felt the skills and competences for senior leadership, especially chief executive, are not always clear and there is a need to identify and develop leadership talent in a more structured way than is currently the case. In general, there is a lack of data about the backgrounds and qualifications of senior leaders in the NHS.

The different career structures of the professions were highlighted as providing significant variations in the levels of grounding and development opportunity in leadership and management skills. For example, a nurse can be leading a ward in their mid-twenties with 50-100 staff and a budget in the hundreds of thousands, compared to a doctor at the same age who would still be in foundation training focusing solely on developing their clinical specialty expertise. It was suggested that at the other end of the seniority scale, this leaves clinical and medical directors with a steeper learning curve to negotiate than their nursing colleagues. The other professions feel strongly that board structures (which require a nurse director and a medical director, but not other professions) constrain their opportunities to develop and demonstrate senior leadership potential, leading to under-exploitation of that talent pool.

The cultural issues within professions that lead to negative attitudes towards those showing an interest in management and leadership, were still felt to be at play. This suggests the continuing need to highlight and promote the value and importance of clinical professionals taking on senior leadership roles. In addition to this, the ‘emotional hurdle’ of relinquishing clinical status was highlighted as a factor people find challenging and this was accentuated by the perception of most, though not all, that becoming a chief executive is a one-way, permanent move away from being a clinician.

The chief executives all felt their professional background enhanced the delivery of their role, but also emphasised that having been a clinician was no guarantee of success as a chief executive. What is needed are people with the right skills and attributes as leaders and it would be important to identify and support these at an early stage. Some had benefited from being picked up by regional leadership development programmes early in their careers, but all had been given exposure to a wide range of complex management and leadership challenges either as projects or part of portfolio roles. The importance of sponsorship by one or more senior colleagues as they developed in their careers was mentioned universally, as was the need for ongoing support once in their role. Despite the challenges of the roles, all referred to what they see as the privilege they feel to be leaders in such a socially important industry.

Regulation, and specifically the potential ‘double jeopardy’ of being accountable as a senior leader and a registered professional, was generally not thought to be a significant factor that would discourage clinicians from moving into senior leadership roles. On the contrary, regulation was highlighted as a beneficial factor in strengthening the position of senior leaders in certain situations. Regulation is an important part of the landscape for senior clinicians when moving into senior leadership, but there were mixed views about how sustainable it was to retain registration, especially as a chief executive. This suggests a continuing need for regulators to proactively communicate how their schemes interact with professionals in senior leadership roles. Where regulators are developing standards or guidance, it was felt to be important that they take account of leadership roles undertaken or held by clinicians.

The culture and climate currently surrounding NHS chief executive roles was mentioned consistently by the chief executives and all other groups spoken to, as a factor that will discourage clinical professionals from taking them on. The perceived insecurity and challenge of the roles was a recurring message from participants. For doctors, this was especially the case when set alongside the potential rewards and recognition associated with clinical practice compared to senior leadership.

Conclusions

The focus of this review was widely welcomed as timely and a valid question to explore. Having reviewed the relevant literature and discussed the issues with a wide range of clinical leaders, it is evident that increasing the numbers of clinical professionals moving into senior leadership will not happen spontaneously and requires a concerted strategy. This will need to encompass training and development processes for the different professions, as well as structured talent management.

While regulation is not seen as a significant barrier, regulators can help by taking account in their policies, procedures and processes of the circumstances and roles of senior leaders who are also clinical professionals.

The culture and climate surrounding chief executive roles would seem to be significant inhibiting factors for clinicians considering moving into the most senior leadership roles in the NHS and addressing this should be a priority.

It is recognised that significant work is already underway across the system in the realms of leadership and talent development. It is hoped the findings of this review will provide a helpful perspective for this work. The recommendations set out below are intended to complement and build on these efforts.

Recommendations

System-wide strategy

1. DHSC should work with the relevant national agencies and professional bodies to develop a focused, multi-faceted system-wide strategy for driving up the numbers of clinicians entering the most senior NHS leadership roles. The strategy should build on existing initiatives and cover the following domains:

Workforce intelligence

2. NHS Leadership Academy in partnership with NHS Improvement should create and maintain an accessible, simple database setting out the career history and professional qualifications of senior leaders in the system.

Culture and climate and role design

3. DHSC and the relevant national agencies should establish and deliver a concerted campaign to shift the adverse culture and climate currently surrounding NHS chief executive roles. This campaign should include engaging current clinician chief executives in communicating the realities of balancing professional and business values.

4. NHS Improvement should work with relevant professional bodies to develop guidance for chairs on how to structure and support chief executive roles to make them more amenable to clinicians taking them on while maintaining their registration/licence to practise – perhaps with a view to ultimate return to more clinically oriented roles.

Identifying, supporting and developing talent

5. HEE should work with the relevant training bodies, faculties and colleges to establish a national programme for identifying, tracking, supporting and developing leadership and management talent from the clinical ranks. This programme should have multiple entry levels and be largely provided in context.

6. Training bodies should review their programmes to ensure they provide adequate flexibility and recognition for the growing number of clinicians showing an interest in leadership and management early in their careers.

7. FMLM should work with the medical Royal Colleges to produce a document setting out senior leadership as a legitimate and valued career-path for doctors.

Balancing incentives

8. DHSC in partnership with NHS Employers should develop terms and conditions strategies, with associated templates, for removing adverse differentials for clinical professionals moving into senior leadership roles. Recognition awards should be reviewed to ensure they reward excellence in leadership.

Career planning and opportunity

9. The NHS Leadership Academy should develop a resource setting out the career options and potential pathways for clinician professionals considering a move into senior leadership.

10. The relevant professional bodies (for example the Faculty of Medical Leadership and Management) should develop a career-planning and development advisory service that supports clinicians towards senior leadership roles and thereafter – including where appropriate, return to clinical practice or leadership.

11. NHS Improvement should develop guidance for trust boards on how to ensure a wider spectrum of clinical professionals other than just doctors and nurses have the opportunity to engage in organisation leadership by removing unnecessary barriers to participation. This work should include exploring the potential benefits, as highlighted by research, of increasing the numbers of non-executive roles for clinicians on trust boards.

12. NHS England in partnership with NHS Improvement should write to the Sustainability and Transformation Plans (STP) leads asking that they put in place procedures to ensure the STP process draws on the contribution of leadership across all relevant clinical professions including Allied Health Professionals (AHPs), biomedical scientists and pharmacists.

Regulation

13. The professional regulators should collaborate to proactively communicate how their functions apply for registrants in the most senior roles and in particular how senior leaders can maintain their registration/licence to practise where appropriate. They should explicitly consider the circumstances of senior leaders who are clinical professionals in any new policy, standards or guidance they develop.

Background

In a speech to the NHS Providers conference on 30 November 2016, the Rt. Hon. Jeremy Hunt MP, Secretary of State for Health made several policy announcements aimed at addressing a range of leadership and workforce-related issues.

In his speech, the Secretary of State noted that only 54% of NHS hospital managers have a clinical background – compared to 74% in Canada and the US, and 94% in Sweden. At the top, only a third of chief executives are clinicians (of which roughly two-thirds are nurses, just under a third are doctors and a small number are AHPs). He added that more needs to be done to tap into the skills of women and those from BME backgrounds, with only 46% of chief executives or directors being female compared to 75% of the healthcare workforce; while 2% of chief executives are from BME backgrounds compared to 17% of the healthcare workforce. He linked this issue to the fact that 1 in 10 chief executive posts are filled by interims or on a fixed term contract basis.

The Secretary of State went on to announce a package of measures to encourage more clinicians into management roles, setting an ambition to see a greater proportion of clinician chief executives in the next decade, allow space for an outstanding new generation of leaders from both clinical and non-clinical backgrounds and at the same time, better utilise the talents of the female and BME workforce.

These measures included:

- Asking the FMLM to work with the General Medical Council (GMC), Nursing and Midwifery Council (NMC) and Health and Care Professions Council (HCPC) to ensure that their policies, procedures and processes encourage and enable more clinicians to transition into management roles. Specifically, this work was to explore whether clinical professionals feel more exposed because their actions as CEO fall under their professional regulator and whether the risk of taking on management roles can be reduced by making it easier for doctors, nurses and AHP’s who have had a spell in management return to clinical practice.

- Every year the NHS Leadership Academy will send 30 students to a world-leading university (this year it will be Yale) as part of a new fast track development programme designed to support outstanding clinicians interested in moving into senior management positions with the knowledge, skills, attitudes and behaviours they will need. This scheme will ensure those clinicians who want to move into senior management positions are able to do so with tailored support from both the Academy and from world-class business and management schools.

- The GMC was asked to work with HEE to examine how clinical leadership can be incorporated as a core component of all specialty training and consider whether this should be established as a specialty or sub-specialty in its own right.

- A partnership with some of the best universities to offer an NHS Masters Business Administration (MBA) for senior professionals working in the NHS, with the first students enrolling in September 2017. These will be available to do part time so clinical professionals can work towards their MBA alongside clinical practice.

- From 2018, HEE will double the number of places available on the NHS graduate management training scheme to 200, as part of an intention to make the system truly sustainable by increasing the numbers to 1,000 places each year.

This report is the culmination of the DHSC commissioned work carried out by the FMLM relating to the first of the above announcements.

Review approach

In his speech, the Secretary of State set the expectation that this work would be concluded by the end of March 2017. With commissioning and set-up taking place immediately before Christmas 2016, this gave three months for the project duration.

Scope

The prime focus of this project was clinical leaders in the English NHS and their perceptions of:

- the opportunities presented by senior operational management roles to clinicians working in the NHS
- the barriers which might prevent them from moving into senior management (by senior manager we mean board level appointments such as chief executive or senior operational roles such as chief operating officer, nurse director, medical director.). Including whether professional regulation (as conducted by the General Medical Council, Nursing and Midwifery Council and Health and Care Professions Council) impacts on a clinician's decision to move in to management.

As far as possible within the project timescale, corresponding perceptions were to be explored among clinicians in the UK devolved jurisdictions.

Aims of the project

The aims of this project were to:

- Develop a more detailed understanding of the views of clinical professionals about barriers or enablers, including regulation, to becoming a senior manager;
- Explore the experiences of clinicians who have successfully moved into senior management roles and capture any generalisable enabling factors;
- Develop a consensus view among clinical and regulatory colleagues (including the GMC, NMC, HCPC and Professional Standards Authority) about any recommendations for improvement; and
- Present recommendations for improvement to the Health Secretary.

Method

Our fieldwork obtained, through workshops, roundtable/teleconference discussions and one-to-one interviews, the views of a sample of clinical professionals from a range of practice settings, locations and career-stages about the issues raised by the review. The views of 11 substantive, acting or recently retired chief executives with clinical backgrounds were also obtained via semi-structured interview, to learn from their experiences, explore how real or perceived the barriers are for clinicians and to identify enabling factors in their career journeys. Where needed, the group discussions were augmented by one-to-one interviews with individuals with a specific perspective of relevance. To inform the project we commissioned a brief overview of the relevant published academic literature, grey literature, and trade press.

As part of the communication plan for the project, briefings were sent to NHS England's Chief Allied Health Professions Officer, the Chief Scientific Officer and the Chief Pharmaceutical Officer. This led to telephone discussions or face-to-face meetings with each of their deputies and further engagement with senior clinical professionals. The General Pharmaceutical Council were also added to the regulators contributing to the project.

A table setting out all interactions of the project team is at Appendix 1.

In each of our interactions, the questions covered were broadly the same, namely:

- What do you think are the benefits of clinicians taking up senior leadership roles?
- What are the main barriers to this?
- What are the main enablers of this?
- What part does regulation play?
- What changes would you suggest to encourage more clinicians into senior leadership?

The project was designed to be delivered in four broad phases:

1. Discovery – to gain greater definition about the nature and scope of clinical professional perceptions about barriers and enablers
2. Validation – to explore initial findings with clinical professionals in the NHS in England and with the other UK devolved jurisdictions to establish corresponding or differing experiences for these groups

3. Situation review – to explore findings in relation to regulatory processes and their impact in practice

4. Recommendation development

In practice, phases 1 and 2 were merged into a single process, as were phases 3 and 4. This was a pragmatic response to the time constraints, availability of participants and timing of key meetings.

Caveats to the approach

As with any research approach there are caveats to be borne in mind when drawing conclusions from the findings. There was no general call for evidence from the sector to inform the review. However, we compensated for this by commissioning a review of relevant literature and also engaged with all four UK Chief Nursing Officers (CNO), the NHS England Medical Director, and the three devolved-nation Chief Medical Officers (CMO), as well as those highlighted above. Several stakeholders drew attention to literature and reports of relevance to the review.

We only spoke to those groups or individuals that were available within the timeframe of the review, so we were highly flexible about the format of our engagement approach. That said, we made purposeful approaches to increase the number and type of informants as much as possible and obtained good coverage between the professions and across the UK. The numbers spoken to were not statistically representative and so caution needs to be exercised in generalising the findings. The approach was qualitative exploring the perceptions of participants - we did not go behind what we were told to independently verify or triangulate it. However, there were strong recurring themes that also chimed well with the literature, suggesting validity in the findings.

Finally, although we had a breadth of input from various settings and types of clinician, the review design did not expressly ensure coverage between different sectors (e.g. mental health) and no specific measures were taken to address equality and diversity issues or ensure balance between protected characteristics of participants. These should be considered for any further work in this area.

Governance and quality assurance

FMLM convened a steering group with nominees from the GMC, NMC, HCPC, NHS England and the DHSC to oversee the conduct of the project, facilitate access to participants and steer any necessary internal approval pathways. The steering group membership was as follows:

- Jon Billings, Associate Director – FMLM (Project Lead)
- Kirsten Armit, COO – FMLM
- Mary Agnew – GMC
- Marc Seale – HCPC
- Peter Thompson – NMC
- Christine Braithwaite – PSA
- Celia Ingham-Clark – NHS England
- Susan Aitkenhead – NHS England
- Joseph Smith - DHSC

FMLM provided project delivery and quality assurance scrutiny through its chief executive and medical director, Peter Lees, and sign-off for the final report was via the FMLM Chair, Professor Sir Neil Douglas.

Findings

Overview of literature and previous work

To inform the project we undertook an overview of relevant literature. The literature review included a commissioned database search by the King's Fund, literature gathered from FMLM's previous research in this area and suggested references from steering group members. The literature includes peer-reviewed articles, grey literature, and trade press. This section summarises the key messages from the review. The full review is at Appendix 2.

In 2016, the Professional Standards Authority conducted a literature review aimed at highlighting the factors that drive and influence professional identity among the health professions. They found the literature suggests several factors interplay in shaping professional identity. These include regulation, education, professional bodies and wider societal attitudes. Notably, the review found that hybrid roles can cause a blurring of boundaries and give rise to anxiety about identity. This was noted especially when clinicians take on management roles.

The barriers and enablers for clinicians moving into senior leadership roles have been explored previously. Ham et al (2010) interviewed 22 medical chief executives in the NHS to better understand the barriers and enablers in their career progress. In summary, they found:

Barriers	**Enablers**
Little structured support to taking up leadership roles	Advice and guidance from senior colleagues
Training variable and mostly learning on the job rather than formal development	Ability to retain some clinical commitments while assuming increasing leadership responsibilities
Shift in professional identity	Enhancing of original clinical identity by taking on leadership responsibilities
Insecurity compared with clinical work	Motivation: the opportunity to make a bigger difference than is possible by clinical work
Short tenure of chief executives in the NHS	
Pay differentials between chief executives and senior doctors	
Lack of recognition of leadership roles in clinical excellence awards	

Recommendations from the report were to:

- strengthen career planning, training and development, including the use of professional coaches and action learning sets
- develop clearer career pathways 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.

Similar findings emerge from a subsequent King's Fund report – 'Patient-centred leadership: rediscovering our purpose' (2013). This includes commentary on the culture and climate of leadership roles as perceived by doctors, concluding: "many doctors have been reluctant to take on leadership roles, alienated by centrally mandated targets and corporate efficiency objectives. Some are deterred by the risk of a failed career move, the lack of financial reward, and a reluctance to give up clinical work." The same report suggests that: "nurses may be deterred [from leadership roles] by the pressures of caring for an ever-more demanding patient caseload, rising public expectations, and static resources."

Blakemore (2015) describes the challenges being faced by nurse directors:

- Conflict between their responsibilities for the quality of care and the demands of making cuts at a time of financial constraint
- Keeping up with the demands of regulatory bodies, dealing with complaints and major incidents, feelings of personal vulnerability and accountability
- Volume of emails
- Demands for data from quality-monitoring bodies such as NHS England and Monitor.

Blakemore goes on to highlight some of the factors that support and build resilience among nurse directors including:

- Being part of a team with shared goals and ownership
- Trusting relationships with board member colleagues
- Good peer support networks
- Preparation before stepping into the role and ongoing support.

For AHPs, the literature search revealed little specifically addressing transition into senior leadership roles, however a Centre for Workforce Intelligence report (2013) acknowledges some of the specific challenges of this group noting that: “[by taking a] competence-based approach to leadership, AHPs will have more transparent opportunities to move into leadership roles, thereby removing some of the current barriers from the system and releasing diverse leadership talent”. Petchey et al (2013) also notes for this group echoes of the cultural factors identified for others, namely: “the variable and complex relationship between the managerial and the clinical on the front line that requires significant ‘bridging’ to maintain credibility with staff, other professionals and managers”.

These reports highlighted in our review of the literature are notable in that many of the findings resonate closely with those of this review, suggesting that for clinicians contemplating senior leadership, little has changed in the meantime. This will be explored further in the Conclusions section.

This section now goes on to summarise the findings from our fieldwork. For presentation purposes, the findings are grouped according to the professional groupings except for findings relevant to regulation which are reported under a separate heading.

Medical leaders

During our fieldwork, we had discussions with well over 100 medical leaders from across the country including medical directors, clinical directors, regional and national specialty/topic leads and post-graduate deans. Sectors spanned providers and commissioners. Overall there was significant consistency in the issues raised, though the possible emerging difference between generations in terms of opportunity and ambition were mentioned more than once – this may bear further exploration in any future work. The issues identified by medical leaders are set out below.

Education and training programmes do not routinely identify management or leadership as a viable career objective and there is no recognised pathway for working towards

becoming a senior leader. Programmes are very much oriented to developing expertise in a specialty and producing consultant or GP expert in their field.

One consequence of this is that **medical career structures** do not routinely expose doctors to leadership or operational management until they are deep into their careers, especially when compared to other professions such as nursing. Even as clinical and medical directors, it was suggested that doctors can remain relatively 'sheltered' from the 'hard yards' of managing performance and resources. This means they do not get the opportunity to develop or demonstrate the wider leadership and management skills as they progress in their careers. More than one contributor described how they felt quite exposed by a lack of knowledge in key areas, such as finance and governance, when they first assumed a board-level position and it was highlighted that doctors are trained to be experts in their field and may feel reluctant to step out of this 'comfort zone'. Some observed this can lead to a tendency for medical directors to adopt what was referred to as the role of 'sage advisor', rather than developing and delivering solutions. To counter this, others pointed out that doctors can be very skilled at formulating views based on incomplete or conflicting information – as they do in their clinical roles – which can be particularly relevant to what is needed in leadership roles.

Reflecting on this issue of exposure to opportunity, one participant suggested that many doctors don't think of what they do as leadership or management, but are demonstrating these skills routinely through work in education, research and quality improvement. It was suggested that connecting these groups in some way may be a step towards identifying doctors for further development who are already exhibiting the inherent skills and competencies of senior leaders.

The **cultural barriers** within the profession associated with clinicians taking on a management or leadership role were felt to still be at play in some settings – 'going to the dark side' was a phrase summoned more than once, which implies disapproval from within the profession of those taking on management or leadership roles. But some felt this may be lessening and highlighted potential emerging generational differences. This view is perhaps given weight by the experiences of the clinical fellows, set out below, who had negative reactions and a lack of value placed in their leadership work among their consultants. Nonetheless, the **emotional and practical hurdles** of stepping back from clinical work are very real for doctors who feel torn between maintaining credibility with peers, doing what's best for patients and making a success of their leadership role. In general practice, this was seen as having an additional tension with the practical requirements for maintaining inclusion on the performers list. This dilemma was felt to have been brought into further focus by revalidation and most saw the move into senior leadership, especially at chief executive level as a 'one-way street' permanent move away from clinical practice. Even for medical directors there was a sense of uncertainty about next career steps once leaving the role.

Although often described as an issue no-one wants to talk about, **rewards and recognition** were identified regularly as a significant barrier for attracting doctors into senior leadership (especially chief executive) roles. In fact, the incentive of earnings potential - including through recognition awards (which are not widely perceived to acknowledge leadership achievement) and private practice, professional and social status all create a strong pull towards clinical practice when compared to senior leadership. These factors have further implications that may undermine the potential for chief executives to come from this group, for example by creating disincentives for geographic or sector mobility.

Finally, the most commonly mentioned factor that may discourage doctors from considering moving into chief executive roles (particularly in light of the previous point) is the perceived challenge and insecurity of the roles as currently designed. There is no doubt that the **culture and climate** surrounding these roles is seen as extremely difficult and many doctors said that the career-impact of failure as a medical CEO were believed to be greater than for other professions (though this same view was expressed by nurses about their position). The phrase: ‘why on Earth would you put yourself in that position’ came up repeatedly and it was notable that the consequences of failure featured prominently in the discourse rather than the opportunities of success. This perspective was echoed by the other groups we spoke to and would seem to present a significant barrier to increasing the numbers of clinicians taking on these roles.

Clinical fellows

In order to obtain the perspectives of doctors at different stages in their careers, we ran a roundtable discussion about the issues raised by the review with a selection of current participants in the National Medical Director Clinical Fellow Scheme.

Perhaps not surprisingly they were positive about the clinical fellows scheme itself and similar structured leadership development programmes. The exposure to diverse experiences and the opportunity to work at close quarters with senior role models were regarded as highly beneficial, as was the attendant access to mentorship.

However, they did express reservations about a sense that there is a lack of acknowledgement of the roles in some settings because they are not legitimised in training programmes. This was sometimes reinforced by the culture among consultants which doesn’t always value the leadership experience gained by fellows, as opposed to their clinical skills. This added to a concern from some that stepping off the ‘standard’ medical career path can feel risky.

While this group has an inherent interest in leadership and the wider system issues, there was a lack of understanding and clarity about the possible routes or career-paths that would be necessary to pursue a career as a senior leader. This was a point highlighted

further by one medical chief executive we interviewed who spoke of a ‘steady stream’ of junior doctors asking for advice on this.

Nurse leaders

We held discussions with a wide range of senior nurse leaders across England, Wales and Northern Ireland. These included national and regional chief nurses, directors and assistant directors of nursing, specialty commissioners, quality managers and educationalists.

A recurring view came across that nurse training and career structures provide a **strong grounding in leadership and operational management** much earlier in their careers than other professions, particularly doctors. The contrast was drawn between a ward manager who from their mid-twenties may be leading 50-100 people and managing a budget in the hundreds of thousands and a doctor, still in the foundation programme, who may not become involved in such issues until they are much deeper into their careers, if at all. This meant there was no surprise among those we spoke to that of the current clinically qualified chief executives, more are from nursing backgrounds. It was felt nurses also tend to gravitate towards more general management oriented roles as their careers progress, continuing this development trajectory. Consequently, divisional nurses or directors of nursing generally tend to have significantly greater operational and leadership experience than their medical counterparts. It was reported this lends nurse directors to being regarded as the ‘doers’ around the boardroom table.

Despite this, there was a view expressed that not all clinical groups are valued equally and it was said that ‘often when people say clinical, they mean medical’, suggesting there may be a need to ensure the leadership potential of all professional groups is recognised. There was also some concern that, particularly in the current financial climate, chairs making chief executive appointments may tend to ‘play safe’ and appoint candidates from finance or turnaround consultant backgrounds rather than clinicians. This point was also made by some of the chief executives we interviewed, and perhaps reinforced by the experience of one senior nurse who, when enquiring recently about a chief executive vacancy, had been told they were not looking for a ‘nurse-type’ appointee.

The fact that **undergraduate training does not promote senior leadership** as a potential career path was highlighted, although the point was also made that nurses tend to put themselves forward for leadership development more frequently than other professional groups.

As with other groups we spoke to, the **challenging nature of chief executive roles** and the culture and climate within which they operate were highlighted as discouraging factors for some. However, this was allied to a repeatedly expressed view that the **values of the profession may conflict with those required of a chief executive**. This was described

as ‘having to put your professional hat to one side’ as a chief executive, the implication being that decisions taken may be at odds with the requirements of professional registration, especially ‘when it comes to balancing the books’. This point was strongly countered by the chief executives we spoke to, but it highlights, both the way chief executive roles are regarded, and the need for a continued discourse about how best to reconcile the principles of professional conduct with those of being a successful board director including chief executive.

AHPs, biomedical scientists and pharmacists

Engaging with leaders within in this group was less straightforward than the other groups because the regional and sub-regional structures are either not there or are less well defined. Nonetheless, by a combination of speaking with national leaders, a selection of frontline leaders and professional representative bodies, we developed a reasonable picture of the issues. Whilst our initial focus was AHPs, we did speak to members of other professions including from clinical science and pharmacy, and although the context of their practice is very different, some common themes emerged, hence we have grouped them for the purposes of this report.

Our discussions with this group repeatedly raised the view that the **big frontiers of change and challenge in healthcare are in areas relevant to the expertise of AHPs, scientists and pharmacists** and the system should be drawing more on leadership from within these groups. Despite this, we heard that services provided by these professions can be a ‘blind-spot’ in some organisations and it was reported that they can ‘struggle to get round the table’, for example in the current STP process in England.

There was a strongly held view that there are structural barriers arising from the way boards are constituted in the English system, where they are mandated to have a nurse director and a medical director but no other clinical professions. This can work against these professions when it comes to gaining access to opportunities for developing and demonstrating board-level skills. There was a view expressed that this can lead some organisations to unnecessarily limit candidate eligibility for certain roles to the nursing profession. This is less the case in Wales where, since 2009, boards must include an officer responsible for therapies and health sciences (The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009).

Despite the attitudinal and structural barriers described, it was acknowledged by some we spoke to that in some cases the professions ‘can be their own worst enemies’ by taking a siloed perspective, and that professionals ‘taking a strategic system-wide view and coming with solutions’ will be listened to and can progress. This suggests the professions themselves may have more to do to promote participation in leadership activity.

A similar point to those of other groups was made about the fact that training programmes do not highlight senior leadership as career pathway. This was reinforced by the senior leaders we spoke to who had not set out to become senior leaders, but had followed self-directed, opportunistic pathways.

Overall, there was a perception that the leadership potential of these professional groups could be better utilised than it is now.

Chief executives

As well as exploring the perspectives of senior clinicians yet to make the transition to chief executive, our approach included obtaining the views and experiences of current chief executives who have successfully navigated that path. This included individuals from medical, nursing and AHP backgrounds holding chief executive roles in the NHS in England (x8), Wales (x1) and a national body in Wales (x1).

Perhaps not surprisingly, all those we spoke to welcomed the focus on this issue and saw having a clinical background as a chief executive as a **significant benefit when it comes to engaging with and understanding sometimes subtle clinical issues**. Some saw their professional background and values as intrinsic to their role as chief executive, especially when making finely-balanced decisions; while others highlighted the beneficial symbolism for frontline staff of having someone at the helm of the organisation who has ‘been in the trenches’ and knows what it is like for them. It was also felt that as clinical professionals, they have ‘one less barrier to overcome’ when it comes to speaking to politicians or the public about (for example) proposed service changes.

The point was made strongly, however, that simply having been a clinician does not equip someone to be a good chief executive. Building on this, it was also emphasised that having the **right skills and attributes for leadership** were most important for these roles and identifying, then supporting people with these to develop the right experience. One went further, suggesting that anyone taking on leadership of such large and complex businesses should hold formal business qualifications before doing that. While all saw the benefits of a clinical background in their roles, the hope was also expressed that the importance of diversity of experience among chief executives was also recognised as important. Leading on from this, it was suggested that development opportunities need to draw people from across the spectrum of experience and ‘the last thing we need’ is cohorts of clinicians being put together to develop as senior leaders.

In terms of enablers in their professional journey, some highlighted participation in a structured regional leadership development programme early in their careers as having given them an initial grounding in the principles of leadership; but all placed huge importance on having been **exposed to a range of challenging and complex issues** through projects or holding a broad portfolio of responsibilities. There was a general view

that there is a need for a more structured approach to identifying and supporting talent to develop the senior leaders of the future. It was suggested that this would be more effective if this were designed and organised regionally to take account of regional issues and priorities.

All spoke of how pivotal the **support and sponsorship of one or more senior colleagues** had been for them in first inspiring them to realise they could aspire to become chief executives and then supporting them to develop with the sense that someone was watching out for them in the system. They went on to say that there was a **need for ongoing support** after appointment as a chief executive and most had in place or were contemplating establishing a support network to provide mutual emotional and well as intellectual and practical support. It would seem important that these aspects are built into any talent management approach.

While all the NHS chief executives spoke of having very supportive chairs, some suggested that, particularly in a time of financial constraint, there may be a tendency for chairs to ‘play safe’ and go for chief executives from a finance or turnaround director background. While it was acknowledged, there may be times when this is completely appropriate, those advising chairs about appointments should be encouraged to support them to make innovative appointments as well, including people from clinical backgrounds. Leading on from this, some suggested there may be a ‘received wisdom’ about the typical career path and duration that prepares people for chief executive appointments, but that a competency-based approach to selecting candidates is more important.

There were mixed views about whether professional registration was sustainable once in the role of chief executive, and some either planned to relinquish this, or had done so already citing the difficulty of maintaining revalidation requirements among other things. Others were determined to keep their registration and spoke of how important this remained in how they approached their role as a chief executive.

In line with all other groups we spoke to, the challenging nature of chief executive roles in terms of the culture and climate that surrounds them, was highlighted as a factor that would not make the roles widely attractive to clinical professionals. Most said they try to model and promote a culture of supporting staff to do a good job in their organisations and that it is important for this approach to be reinforced throughout the health system, even when it is under pressure. To reinforce this point, one said that ‘assurance and grip are important, but they are not what motivates thousands of people to do a good job everyday’.

Finally, it is worth emphasising that, despite the challenges that go with it, all the chief executives interviewed alluded to what they see as the great privilege they feel in having the role and the opportunity it gives them to serve their communities. As one put it: ‘why would you not want to lead a business that literally saves people’s lives?’.

Regulation

In looking at the barriers and enablers for clinicians moving into senior leadership roles, we were asked to explore whether regulation was a potential factor to discourage clinicians from considering taking on senior leadership roles. We engaged with five regulatory bodies as part of this process:

- Professional Standards Authority
- General Medical Council
- Nursing and Midwifery Council
- Health and Care Professions Council
- General Pharmaceutical Council

Taken together these bodies oversee or regulate well over one million health and care professionals. Their remits are mainly UK-wide and a précis of the roles and functions of each regulator is set out at Appendix 3.

In all our meetings and interviews we specifically asked views about the role of regulation for clinicians either in or contemplating senior leadership roles. This section now summarises the findings.

We asked participants about the potential scenario of a chief executive who is also on a professional register, being subject to an **additional layer of scrutiny** compared to general manager colleagues. This so-called ‘double jeopardy’, has been suggested from time to time as a possible concern on the basis that clinical leaders who run into difficulty could face not only losing their job, but their livelihood if subject to erasure from their professional register because of fitness to practise proceedings. Across all the professions we spoke to, while this was acknowledged as a potential scenario, this was **not generally regarded as an issue** that could put people off taking on senior roles. This is supported by the position of the Professional Standards Authority summarised below. On the contrary, many highlighted the **positive influence of professional registration** as ‘adding weight’ to their role as a senior leader. One chief executive we spoke to said they were conscious of the ‘additional pressure’ of being on a professional register, but portrayed this as a positive thing that made them even more vigilant in the conduct of their role.

One aspect of fitness to practise (FtP) procedures that did come up in our discussions, especially among medical directors, was the phenomenon described as **‘tactical’ counter-referral to FtP** of a medical director, (for example by a doctor subject to a local performance or disciplinary process), as a way of undermining the authority of the medical

director. We spoke to the General Medical Council, which pointed out that the Medical Act mandates them to investigate any allegation of impaired fitness to practise. Nonetheless, they also understand concerns about counter-referrals. Their process is designed to ensure that allegations are scrutinised at the outset before an investigation is opened. The GMC now carries out more provisional enquiries at the initial assessment stage to ensure that full investigations are only opened where necessary. If there was concern about a counter-referral that process could, where appropriate, lead to enquiries at triage to check the basis for the referral and, where those enquiries confirm there is no allegation of impairment, closing cases quickly without a full investigation. Some doctors we spoke to suggested the GMC could communicate these issues more explicitly, including being clear about the potential consequences for doctors raising malicious or vexatious concerns about colleagues.

A small minority we spoke to suggested the FtP processes of some professional regulators may have a more negative impact on people referred than others, ‘even if they are exonerated’. This appeared to arise from the length of time they can take to conclude and the reputational consequences. The evidence available to the PSA, as summarised below, does not support the view that sanctions are applied differently, but regulators should be aware of the perceptions held about their processes.

We heard mixed views from chief executives about whether they could or would maintain their professional registration as CEOs. Some regarded it as impossible to meet the **ongoing requirements of registration** (especially revalidation) whereas others saw no difficulty and indeed regarded it as core to how they conducted their role as chief executive. This was linked to a view expressed by some that the step into a chief executive role represented a ‘one-way street’, meaning that it implied an **irreversible move away** from being a clinician. As highlighted earlier, a recurring view among senior nurses we spoke to was the perception of a theoretical tension between the values and principles linked to maintaining professional registration and those that may be necessary as a chief executive. All the above points suggest an **ongoing need for clarification** about how the requirements of professional registration play out for professionals in very senior leadership roles.

We discussed with participants and the regulators how their wider functions might support a policy of increasing numbers of clinicians taking on senior leadership roles. From this came the suggestion that where they are developing or reviewing standards for education or practice, they should consider how these could promote the importance of developing and exhibiting leadership skills. One immediate opportunity highlighted is the ongoing work being led by the GMC to develop a generic competence framework for doctors in training which has a significant leadership component.

Each regulator has provided a short commentary on how their functions support leadership and what further they might do to ensure their policies, procedures and processes can encourage clinicians to move into senior leadership as follows:

Professional Standards Authority

- **Fitness to practise**: Each regulator has a 'fitness to practise' process for handling complaints about health and care professionals. The most serious cases are referred to formal hearings in front of fitness to practise committees. The number of cases referred to regulators' fitness to practise committees is small - about 0.27% of 1.5 million registrants.

- **Managers that are registered professionals**: Relevant case law suggests that where being a registered health professional is relevant to the managerial post or is relied upon in carrying out the responsibilities of the post it may be of relevance to the regulator and could be the subject of fitness to practise complaints.

- **Sanctions**: We do not have any evidence that sanctions are applied more heavily by one regulator compared to another. They tend to be case specific and the majority fall within the range of reasonableness.

- **Overall conclusion**: We do not see evidence that regulators are being disproportionate in their use of their powers in respect of registrants who hold managerial positions. The numbers of fitness to practise cases is small and those involving registrants as managers smaller still. Research carried out by the Authority suggest that the influence of regulators on registrants' behaviour in such matters is likely to be over-estimated. We do not consider that regulation is an obstacle to registrants transferring into management positions.

General Medical Council

- **Registration and revalidation**: Doctors in chief executive and other senior leadership positions can – and have – revalidated. We designed our revalidation principles and processes purposefully to be flexible to allow supporting information from any scope of practice, including from leadership and management roles, to be reviewed at appraisal and reflected upon. Any doctor in a chief executive role should think carefully about whether they need to be registered or licensed. It's relatively easy for them to relinquish and restore their registration and/or licence to practise (subject to continued fitness to practise). Relinquishing a licence to practise releases any doctor from their legal obligation to participate in revalidation. However, while on the register, they remain subject to fitness to practise requirements.

- **Guidance**: In January 2017, we responded to Sir Keith Pearson's independent review of revalidation. Sir Keith recommended that the GMC 'should continue its work with partners to update guidance on the supporting information required for appraisal for revalidation to make clear what is mandatory (and why), what is sufficient, and where flexibility exists. They should also ensure consistency and compatibility across different sources of guidance'. As we take forward the work to implement this recommendation, we will explore: how our guidance can better support the revalidation process for senior doctors; and how we can improve our messaging for senior doctors to make it easier for them to decide whether they need to hold their licence to practise. Our guidance for doctors in management roles sets out how Good medical practice applies for doctors in management positions.

- **Generic professional capabilities**: More focus in postgraduate training will be on the generic professional capabilities expected of all doctors, which will introduce a common core to all curricula. New standards for postgraduate curricula, the generic professional capabilities framework and a refined approvals process will be launched in May 2017. Through the generic professional capabilities framework, we will expect all postgraduate curricula to reflect the essential generic professional capabilities crucial to safe and effective patient care – leadership and team working form one of the nine domains in this framework. All doctors, regardless of their specialty, will have to demonstrate they have achieved these capabilities by the time they complete training.

Nursing and Midwifery Council

- **Education standards**: We are developing new education standards for the future registered nurse and midwife. These are the standards for competency that all nursing and midwifery students must meet before they can come on to the register. An increased focus on leadership, management skills and political awareness is included in the standards, which will be out for consultation in summer 2017.

- **Revalidation** was introduced in 2016 and is the process that all nurses and midwives in the UK need to follow to maintain their registration with the NMC. All nurses and midwives need to demonstrate that they have completed a number of different requirements as well as reflecting on their practice. For nurses and midwives in a leadership role this would mean reflecting on examples of how their leadership had met the standards and behaviours set out in the Code. Revalidation has been designed to be sufficiently flexible to enable nurses and midwives from a diverse range of practice areas to revalidate. For example, our guidance on the practice hours requirement explains that the hours that count towards this requirement are those in which a registrant relies on their skills, knowledge and experience as a registered

nurse or midwife. This may include providing direct care to patients but can also include managing teams, teaching others and helping to shape or run a care service.

- **Fitness to practise (FtP)**: Our new legislation, which will come into effect in the summer of 2017, will give Case Examiners greater powers to manage FtP cases more effectively and quickly, improve the way we're able to schedule and hear cases and speed up and simplify our processes to protect the public and increase efficiency. The changes will mean a better use of our resources, a fairer process for our registrants, and ultimately, better public protection.

Health and Care Professions Council

- **'Practising your profession' requirements**: We say that our registrants should be practising in order to remain registered. But we define practising broadly as drawing on your professional skills and experience in the course of your work. This specifically ensures that it is possible to retain your registration, even if you are a CEO.

- **Continuing Professional Development (CPD) / continuing fitness to practise requirements**: We have tried to develop our CPD requirements in a way that means that those who are in leadership or other roles and who do not undertake frontline or clinical practice are still able to retain their registration. Our CPD standards mean that the registrants have to reflect on the benefits of their CPD to their current or future practice – which means CPD need not be focused solely on clinical aspects of practice, and could be exclusively about developing and maintaining skills relevant to leadership roles.

- **Return to practice**: Our returners to practice requirements are articulated in terms which means that someone can undertake updating in their area of practice – which can include management, leadership, education or other types of practice, and not just solely clinical work.

- **Education**: Regulators' focus is on pre-registration and speciality training which impacts on the Register. Influenced by the work to develop the NHS clinical leadership framework, our standards of proficiency now include a standard which means that graduates from pre-registration programmes in all the professions have to be able to 'understand the concept of leadership and its application to practice' at entry (e.g. occupational therapists standards of proficiency, standard 13.12).

- **Communication**: There is an ongoing role for regulators generally in communicating with registrants, perhaps we should as a sector be better at communicating what regulation means for those who are moving or who want to move into leadership positions – to provide reassurance.

General Pharmaceutical Council

- **Revalidation**: Our proposed model is bespoke for pharmacy professionals and flexible enough to account for the huge diversity in roles across both the professions we regulate.

- **Leadership**: Over the course of our development programme we have considered pharmacists and pharmacy technicians in leadership roles to make sure that they are able to participate and also that activities we are asking them to undertake benefit their development as well as assuring continuing fitness to practise. Our evidence suggests that our model supports development of pharmacy leaders.

- **Evidence**: Our model allows for a variety of evidence types to be submitted to us and our research has borne out that people in leadership roles are equally able to engage as other pharmacy professionals and to derive benefit from the reflective practice our model encourages.

- **Peer discussion**: Pharmacy leaders are more likely to engage in our proposed peer discussion with someone in another leadership role and therefore they are more likely to seek out someone who is not a pharmacist, or even a health professional, in order benefit from reflection with someone who understands the demands of leadership. Our draft guidance for revalidation, which will be subject to consultation over the summer of 2017, explicitly covers this point.

Conclusions

In exploring issues raised by this project, we have spoken to a wide spectrum of senior and less senior clinicians at national, regional and local levels from across the professions and across the UK. We have also interviewed several ‘clinician’ chief executives in a range of healthcare organisations and national bodies. We think the findings represent a reliable ‘temperature check’ of attitudes and perceptions about the challenges and opportunities of increasing the numbers of clinicians moving into senior leadership roles.

The first point to make is that **the focus on this question was widely welcomed** as very timely by the people we spoke to. The project has highlighted a raft of important issues, not least the current **weakness of data** about the professional backgrounds of current chief executives and the wider executive and leadership cadre of the NHS. Improving this position should be a priority.

It is worth noting that many of the issues we explored have arisen in previous work in the same area and previous recommendations have also been made in this field. This includes emerging evidence of the benefits for performance of involving clinicians in the leadership of organisations (e.g. Veronesi G et al. Clinical leadership and the changing governance of public hospitals: implications for patient experience. Public Administration. 2015; 93(4):1031–1048). Both the Francis (2013) and Kirkup (2015) reports had clear calls for professionalising leadership and developing standards for clinical leaders. Our findings also have echoes in those of the Rose Report (2015) as regards the need for coordination and clear objectives for leadership development. The overview of the literature also highlighted other relevant work that has framed recommendations not dissimilar those in this report.

Based on our findings, it is evident that increasing the percentage of clinicians in senior leadership won’t happen spontaneously, and demands a **concerted strategy** to drive change alongside any wider programme to identify and develop NHS leaders of the future. As part of this, there is a continuing need for the case for system benefits of more clinical leaders to be reinforced and more research is needed in this area. The suggested areas of focus for such a strategy are summarised in Figure 1 at the end of this section.

Looking at the different professions, there are common issues that need cross-sector solutions such as the lack of profile of senior leadership as a defined career aspiration. However, our work suggests many of the barriers and enablers for the different professions are distinct for professions and will need **tailored solutions**.

We gained the impression of low awareness among clinical professionals about the skills and attributes required of senior leaders and the steps they should take to equip themselves for these roles. As an example, FMLM has published the Leadership and Management Standards for Medical Professionals and more recently launched formal

certification against those standards, because doctors largely enter the professions to treat or care for patients, not run organisations. Therefore, it was felt that, in parallel with clinical practice, guidance and a system of benchmarking was necessary. Furthermore, this suggests that if moving into senior leadership is not an instinctive aspiration of clinicians, there is even more reason for **creating and signposting the career options for clinicians, identifying people with the core competencies and then putting in place the development pathways** necessary to move into senior leadership. This might be termed a talent management programme and there are initiatives already underway of this type in England, which need to take account of this report's findings.

Even where structured leadership development opportunities exist, for example, the national clinical fellows programme for medical trainees, on the one hand people participating felt they were taking a risk by stepping off the recognised clinical training pathway, on the other, these concerns were reinforced on the ground by at best, indifference and at worst hostility from consultants. This suggests **education and training programmes need to be much more flexible** and to properly recognise and **value** leadership and management development as a core part of training.

Regulation has not come out as presenting a significant barrier when it comes to clinicians moving into senior leadership roles; indeed, many drew on it as a strength. However, it is part of the landscape and the reality for clinicians, and the regulators could help by explicitly **considering across all their functions the challenge of clinicians in senior roles** who want to retain their professional status and may want to return to clinical practice at some point. Drawing attention to or strengthening existing guidance would be helpful in this regard, as would thinking about the potential expectations for clinicians as senior leaders when developing standards for education or practice.

Perhaps the most significant barrier to clinicians moving into senior leadership roles, however, arises from the nature of the roles themselves and how they are regarded. The **culture and climate** surrounding chief executive roles in particular, came out repeatedly and such that many clinicians will think twice before taking them on. For doctors, this perspective is also set against a reward and recognition equation that does not balance in favour of senior leadership as opposed to continued clinical practice. Without resolving these issues, we believe the numbers of clinicians putting themselves forward for senior leadership will remain low and driven by local circumstances rather than as part of a policy drive.

In pursuing this discussion, however, it is notable that the discourse has tended to be about how do we mould our clinicians to have the skills, knowledge, resilience, etc, needed to take on our chief executive roles as they are currently conceived? We feel it is worth asking the question: how could we design chief executive and other board-level roles to **make them more amenable to senior clinicians** taking them on as part of a wider career trajectory – perhaps for a defined 'tour of duty'? Examples are beginning to

emerge of this more creative approach to senior roles being taken – for example, at University College London Hospitals NHS Foundation Trust - it will be important to learn from those as they progress.

It is recognised that there is a wider drive to improve leadership and management within the health system with various initiatives underway - for example, 'Leading Change, Adding Value: a framework for nursing, midwifery and care staff', co-produced by nursing and midwifery leaders across the health and care sectors and launched by Professor Jane Cummings, Chief Nursing Officer for NHS England, or the multi-agency 'Developing People - Improving Care' framework published in December 2016. The main point to highlight is implementation of similar strategies should take account of the issues highlighted by our project, and acknowledge the specific needs of diverse clinical professionals in accessing leadership development. The emerging commitment to **compassionate leadership** fits well with addressing our observations about the need for the culture and climate surrounding the most senior roles to change. Also, the focus on **talent management** aligns well with our findings, but will need to be tailored to account for the different challenges identified for the clinical professions.

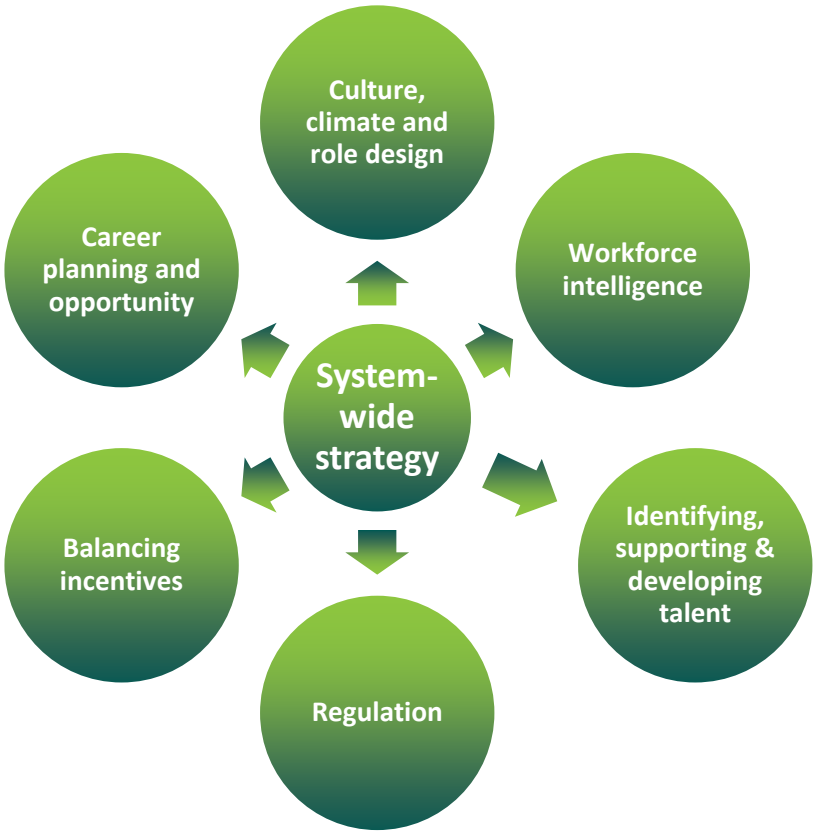
Finally, it is notable that very consistent messages came back from professional groups across the UK countries where this was acknowledged as an important issue to explore – as evidenced by their willingness to participate.

Recommendations

Drawing on the ambition set out by the Secretary of State in his 30 November speech to increase the numbers of chief executives from clinical backgrounds, this section sets out the recommendations of this review.

System-wide strategy

1. DHSC should work with the relevant national agencies and professional bodies to develop a focused, multi-faceted system-wide strategy for driving up the numbers of clinicians entering the most senior NHS leadership roles. The strategy should build on existing initiatives and cover the following domains:



Workforce intelligence

2. NHS Leadership Academy, in partnership with NHS Improvement, should create and maintain an accessible, simple database setting out the career history and professional qualifications of senior leaders in the system.

Culture, climate and role design

3. DHSC and the relevant national agencies should establish and deliver a concerted campaign to shift the adverse culture and climate currently surrounding NHS chief executive roles. This campaign should include engaging current clinician chief executives in communicating the realities of balancing professional and business values.

4. NHS Improvement should work with relevant professional bodies to develop guidance for chairs in how to structure and support chief executive roles to make them more amenable to clinicians taking them on while maintaining their registration/licence to practise – perhaps, ultimately, with a view to return to more clinically oriented roles.

Identifying, supporting and developing talent

5. HEE should work with the relevant training bodies, faculties and colleges to establish a national programme for identifying, tracking, supporting and developing leadership and management talent from the clinical ranks. This programme should have multiple entry levels and be largely provided in context.

6. Training bodies should review their programmes to ensure they provide adequate flexibility and recognition for the growing number of clinicians showing an interest in leadership and management early in their careers.

7. FMLM should work with the medical Royal Colleges to produce a document setting out senior leadership as a legitimate and valued career-path for doctors.

Balancing incentives

8. DHSC, in partnership with NHS Employers, should develop terms and conditions and strategies, with associated templates, for removing adverse differentials for clinical professionals moving into senior leadership roles. Recognition awards should be reviewed to ensure they reward excellence in leadership.

Career planning and opportunity

9. The NHS Leadership Academy should develop a resource setting out the career options and potential pathways for clinicians considering a move into senior leadership.

10. The relevant professional bodies (for example the FMLM) should develop a career-planning and development advisory service that supports clinicians towards senior leadership roles and thereafter – including, where appropriate, return to clinical practice or leadership.

11. NHS Improvement should develop guidance for trust boards on how to ensure a wider spectrum of clinical professionals than just doctors and nurses have the opportunity to engage in organisation leadership by removing unnecessary barriers to participation. This work should include exploring the potential benefits, as highlighted by research, of increasing the numbers of non-executive roles for clinicians on trust boards.

12. NHS England in partnership with NHS Improvement should write to the Sustainability and Transformation Plans (STP) leads asking that they put in place procedures to ensure the STP process draws on the contribution of leadership across all relevant clinical professions including Allied Health Professionals (AHPs), biomedical scientists and pharmacists.

Regulation

13. The professional regulators should collaborate to proactively communicate how their functions apply for registrants in the most senior roles, and in particular how senior leaders can maintain their registration/licence to practise where appropriate. They should explicitly consider the circumstances of senior leaders who are clinical professionals in any new policy, standards or guidance they develop.

Appendix 1

Interactions held by the project team during the project

Meeting attended	Est. numbers	Profession
NHS South meeting, Taunton	45	Medicine
NHS England medical directors meeting	30	Medicine
Welsh Medical Directors	12	Medicine
FMLM Northern Ireland conference	70	Medicine
FMLM Scotland conference	40	Medicine
Clinical Fellow roundtable	6	Medicine
BMA medical managers committee	12	Medicine
Medical leaders' forum, Northern Ireland	12	Medicine
Shelford Group Nurse Directors	4	Nursing
All Wales Executive Nurse Director's Group, Cardiff	13	Nursing
Central Nursing and Midwifery Advisory meeting, Belfast	20	Nursing
Midland and East DoNs Network	10	Nursing
Nurse Federation Forum, RCN	10	Nursing
AHP leadership forum	4	AHP
AHP Federation	10	AHP

Interviewed or spoken to

Name	Role
Adrian Bull	Chief Executive, East Sussex Hospitals NHS Foundation Trust
Tracey Batten	Chief Executive, Imperial College Hospital NHS Foundation Trust
Fiona Carragher	Deputy Chief Scientific Officer, NHS England
Brendan Cooper	President, Academy for Healthcare Science
Tracey Cooper	Chief Executive, Public Health Wales (former NHS medical director)
Stephen Dalton	Interim CEO, NHS Confederation
Shane DeGaris	Chief Executive, Hillingdon Hospitals NHS Trust
Vinod Diwakar	Regional Medical Director, NHS England (London Region)
Amanda Doyle	Accountable Officer, Blackpool CCG
Berne Ferry	Incoming Head of the National School for Healthcare Science
Carmel Lloyd	Head of Education and Learning, Royal College of Midwives
Helen McConville	Commissioning Lead, Lancashire North CCG
Simon McKenzie	Acting CEO St George's Hospital NHS Trust
Jane Melton	Director of Engagement and Integration
Peter Miller	Chief Executive, Leicestershire Partnership NHS Trust
Jane Milligan	Chief Officer, Tower Hamlets CCG
Shelagh Morris	Deputy Chief AHP Officer, NHS England
Sara Munro	Chief Executive, Leeds and York Partnership Trust

Andrew Nwosu	Regional AHP lead, NHS England - London
Steve Ryan	Strategic Lead, CAMHS Transformation, Healthy London Partnership
Carol Shillabeer	Chief Executive, Powys Health Board
Heather Tierney-Moore	Chief Executive, Lancashire Care Trust
Ros Tolcher	Chief Executive, Harrogate and District NHS Foundation Trust
Bruce Warner	Deputy Chief Pharmaceutical Officer, NHS England

Appendix 2

Literature Overview

1.1 Introduction

The purpose of this literature review is to better understand what is currently published about the barriers and facilitators for clinical professionals aspiring to or in clinical leadership roles, including whether professional regulation has an impact.

The focus of the research commissioned by the DHSC focuses on three regulatory bodies – the GMC, NMC and HCPC. Therefore, the literature review has largely been focused on the professions for which these regulators are responsible.

The literature review will be used to inform the design and questions used in semi-structured interviews and focus group discussions in February and March 2017. To accommodate agreed timeframes this has been a rapid review and FMLM cannot guarantee its comprehensiveness.

The literature review has involved a commissioned database search from the King's Fund, literature l gathered from FMLM's previous research in this area and suggested references from steering group members. The literature includes trade press, grey literature and peer-reviewed articles. Details about the databases searched and search terms used are in the appendix.

1.2 Role of the professional regulators regarding leadership

The Health Foundation report, 'Fit for purpose? Workforce policy in the English NHS' explains that the professional regulators, whilst independent of government and employers, naturally have a role to play in leadership of their respective professions but also in developing and supporting their registrants as leaders (The Health Foundation 2016, p. 5). They describe "The system of professional regulation centres around ensuring certain health professions are only practiced by individuals with particular qualifications. However, the regulators also have a diverse set of functions, including:

- Setting standards of education and training for the professions that they regulate
- Maintaining a register of those who demonstrate they meet these standards by securing appropriate qualifications

- Inspecting and assuring the quality of education and training providers and qualifications (with statutory powers to shut down courses and withdraw trainees from training hospitals)

- Setting standards of conduct, ethics and competence required to remain on the relevant professional register

- Investigating concerns about registered professionals who are taking appropriate action where individuals might present a risk to the public

- Taking action against those falsely claiming to be a registered professional (a relatively rare occurrence)" (The Health Foundation 2016, p. 5)

The report states that the regulators "sit at the centre of a statutory system that works with other key professional groups and institutions to shape, adapt – and occasionally enforce – what are accepted as the norms of reasonable professional attitudes, proper professional behaviour and professional competence. As such, they leave a mark on their registrants and have an important reach into the quality of individual interactions between hundreds of thousands of patients and professionals every day". (The Health Foundation 2016, p. 19)

The report goes further to suggest that "a strategic priority for the NHS should be to ensure that the education and training of doctors:

- Shapes a professional culture that engages constructively with properly evidenced change in the interest of patients

- Grows doctors who lead change themselves in the name of improved patient care

- Shapes a profession in which colleagues who step up to the leadership mark are valued and willingly followed." (The Health Foundation 2016, p. 43)

From an initial review in 2017 of its database of fitness to practise decisions, the Professional Standards Authority reported that:

> "We do not see evidence that regulators are being disproportionate in their use of their powers in respect of registrants who hold managerial positions. As the case law demonstrates, where registrants' fitness to practise either as a clinician, as a manager employed for their clinical knowledge and skills or who uses or should use their knowledge to protect and care for patients, it is proper that regulators hold them to account. The numbers of fitness to practise cases is small and those involving registrants as managers smaller still. Two pieces of research carried out by the Authority suggest that the influence of regulators on registrants'

behaviour in such matters is likely to be over-estimated. Our literature review on the effects of regulation on behaviour and our recent paper on professional identity both suggest that other factors have a stronger bearing on professionals and their behaviour [Quick 2011; Professional Standards Authority 2016]. We do not consider therefore that regulation is an obstacle to registrants transferring into management positions."

1.3 Professional identity and regulation

In 2016, the Professional Standards Authority conducted a literature review to better understand how professional identities are acquired and developed amongst health and social care professions and the impact and effect of regulation on professional behaviour. Their findings reinforce the important role of professional regulation as outlined in 2 (above). The following summarises findings from the report pertinent to this study on barriers and facilitators to clinical leadership:

- Regulators hold an important role in setting standards and acting as a compass to guide members of a profession
- Regulators help describe what is distinct about a profession (this can include role names and titles) and clarity regarding scope of practice
- Regulation may help individuals value their profession as well as feel and act in a professional way and support self-efficacy, confidence, resilience to role pressures and demands.
- Perceptions within society can have an effect on professional identity i.e. when society thinks well of a group, the self-esteem, self-image and self-presentation of a group will increase accordingly
- Regulation can help improve professional status to the wider public
- If a regulator does not hold the same role title as those regulated there can be adverse effects
- Education – through reflection, relationships and resilience – can develop professional identity and qualifications from education can be used to affirm professional identity
- Professional bodies also support professional identity by representing the interests of their members, protecting the integrity of their relevant professions and raise the standards of their members' work

- Hybrid roles can cause a blurring of boundaries and give rise to anxieties about identity. This is noted particularly when clinicians take on management roles and identify themselves as a clinician first and manager second. This crossover can force people to confront their own perceptions of individuals in the management sphere a delegitimising their superiority over managers.

The Clinical Leadership Competency Framework, NHS Leadership Academy (2011) also articulated the role of the regulators in supporting leadership:

> "The statutory responsibility for regulation of the clinical professions is vested in the Health and Care Professions Council (HCPC), the Nursing and Midwifery Council (NMC), the General Optical Council (GOC), the General Dental Council (GDC), the General Pharmaceutical Council (GPhC), the General Medical Council (GMC), the General Osteopathic Council (GOsC) and the General Chiropractic Council (GCC). All of these regulators have the lead role in ensuring practitioners are fit for practise and able to be registered.
>
> Behaviours that all clinicians must demonstrate are described in the various policy, guidance, standards of proficiency, standards of education, codes of conduct and ethical behaviour set down by these regulators. Each of these bodies maintains and publishes a register of practitioners that meet these standards and are legally able to practise in the United Kingdom.
>
> While the primary focus of regulation for clinicians is on their professional practice, all clinicians, registered or otherwise, work in systems and most within organisations. It is vitally important that clinicians have an influence on these wider organisational systems and thereby improve the patient experience and outcome.
>
> Clinicians have an intrinsic leadership role within health and care services and have a responsibility to contribute to the effective running of the organisation in which they work and to its future direction. Therefore the development of leadership capability as an integral part of a clinician's training will be a critical factor." (NHS Leadership Academy 2011, p. 6)

1.4 The medical profession

There are numerous articles and papers written about encouraging doctors into leadership and management. Of those, there are three pieces of research of particular note:

- Veronesi, Kirkpatrick, and Vallascas (2012) examined strategic governance in NHS hospital trusts by gathering data such as annual reports, trust performance

statistics, patient outcomes, mortality rates and national patient survey data. They found that the proportion of clinicians on governing boards was low compared with international rates, but that higher representation appeared to be associated with better performance, patient satisfaction and morbidity rates.

- Goodall (2001) assessed the impact of clinical leadership on hospital rankings in the US, finding a strong relationship with the US News and World Report ranking. The authors caution that the research is correlational and may merely indicate that top performing hospitals seek doctors as leaders.

- Dickinson, Ham, Snelling and Spurgeon (2013) found that organisations with high levels of medical engagement performed better on available measures of organisational performance than others.

In looking at the barriers and facilitators for doctors going into senior roles, there were two studies of note in the UK and Australia:

1.4.1 The UK

Ham, Clark, Spurgeon, Dickinson and Armit (2010) conducted a review of 22 medical chief executives in the NHS (about 5% of the population) to better understand the facilitators and barriers to their career progress. Interviewees reported the following barriers and facilitators:

Barriers	**Facilitators**
Little structured support to taking up leadership roles	Advice and guidance from senior colleagues
Training variable and mostly learning on the job rather than formal development	Ability to retain some clinical commitments while assuming increasing leadership responsibilities
Shift in professional identity	Enhancing of original clinical identity by taking on leadership responsibilities
Insecurity compared with clinical work	Motivation: the opportunity to make a bigger difference than is possible with clinical work
Short tenure of chief executives in the NHS	
Pay differentials between chief executives and senior doctors	
Lack of recognition of leadership roles in clinical excellence awards	

Recommendations from the report were to:

- Strengthen career planning, training and development, including the use of professional coaches and action 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 (Ham, Clark, Spurgeon, Dickinson and Armit 2010, p. 5)

Many of these findings and recommendations are echoed in results from a survey of medical directors in England commissioned by Monitor and the Trust Development Authority (2014) to understand more about the demands of the medical director role. Those surveyed described the challenges of the role included driving cultural change, leading the profession and quality governance, delivering on quality and the financial challenge. Many reported enjoying the role as it provided an opportunity to drive improvements on a larger scale, ensure a strong clinical voice on the board, across organisations and local health economies. A small number of those surveyed were interested in moving into chief executive roles but reported career progression after the medical director role as unclear.

To better support those in or transitioning into the role, respondents suggested it would be useful to have:

- Greater role clarity
- Clearer training and career pathways
- Organisational and peer support – from above, below and alongside More acknowledgement of the strategic as well as the operational aspects of the role

- A means of identifying the medical directors of the future and making it clearer career option that more people will consider (Monitor and the Trust Development Authority 2014, p. 4)

Respondents to the survey suggested mentoring, induction, networking, coaching, and Board support would be helpful for those in the medical director role.

1.4.2 Australia

Dickinson, Bismark, Phelps, Loh, Morris and Thomas (2015) conducted a review of current medical leaders in the Australian healthcare system to seek their views of the opportunities, motivating factors, barriers and supporters to leadership through semi-structured interviews. A summary of these is provided below:

Barriers	**Facilitators**
No consistent or recognised career path	Intrinsic motivation to make an impact for a wider population
Lack of specific training or development	Clear description of the benefits of senior leaders with clinical backgrounds
Culture and/or views of colleagues (going over to the 'dark side')	Organisational support to do the job or flexibility to allow continuing clinical work
Difficult nature and security of executive roles	Mentorship or role models
Financial reward comparison - lower earning potential	Training and development
'Emotional hurdle' of stopping clinical practice or relinquishing registration/licence to practise	Structured talent management
Regulation (licensing/registration, fitness to practise, revalidation/competence assurance, education standards, return to practise processes)	Professional recognition and belonging to a group e.g. RACMA
Possible lack of transparency in recruitment and appointment of processes	

The study also identified that there was a diverse array of opportunities to engage in leadership and management, both informal and formal. They identified a few factors affecting such opportunities:

- If individuals are good clinically they get to ‘run something’

- There are a wide range of different leadership and management job titles

- The variation in roles available means some allow for combining leadership and management with clinical practice as well as those that more or less require giving up clinical practice
- Acting or temporary roles can provide exposure and opportunity to ‘get a taste’
- Increasing range of formalised education processes, from inclusion of leadership and management at medical school to postgraduate education such as MBAs and more specialised Masters e.g. public health
- Opportunities may be impacted by locality – rural vs urban
- Currently there may be limited competition for roles – either through lack of interest or levels of competence
- In-house training aligned to the values of culture of the locality can be helpful to develop leadership and management skills
- The value of mentoring support
- Involvement in committees provides exposure to leadership and management skills and challenges
- The value of clinical experience and how this aligns with getting experience in leadership and management

1.4.3 Doctors in training

While doctors in training are not the focus of this literature review or the work commissioned by the Secretary of State, their experience of leadership and management is worth noting as the above studies in the UK and Australia highlight the importance of education, training and opportunities for their development as leaders. One study looked at the impact of leadership development programmes for trainees. Bagnall (2012) identified the following facilitators and barriers for junior doctor engagement in leadership:

Barriers	**Facilitators**
Lack of interest and insight from consultants and managers	Commitment to leadership development - people who have the insight to invest resources, time and encouragement
Insufficient support from senior leaders	Visionary leaders and role models
Constraints e.g. regular rotations, time to attend meetings, insufficient support beyond strict education and training programme	Mentors and coaches
Development happening in isolation	Time out from clinical practice
History and tradition - inflexible and	Action learning sets

restricting	
Lack of protected time for non-clinical activities	Integrated quality improvement
Leadership skills and capabilities not being valued	Working across specialties and disciplines
When development doesn't link to the organisation	Junior doctors themselves

1.4.4 Healthcare media

In recent years, healthcare media has also taken an interest in the barriers for doctors stepping into leadership roles.

- In a series of interviews with senior medical leaders, Limb (2014) describes the following barriers:
- The way in which management culture is regarded i.e. top down, target driven and harsh
- Lack of defined career paths
- Differences in remuneration with medical salaries
- Giving up more lucrative parts of their work
- Leadership and management seen as:
    - a ‘burden to be borne rather than prize to be won’
    - ‘all the responsibility, no autonomy and no training’
    - considered a ‘second career’ as opposed to primary move or valid choice

Limb (2014) also refers to a BMA study on 'Doctors’ perspectives on clinical leadership' (2012) which suggested:

- A perceived gap between leadership and medical practice, suggesting more should be done to explain the relevance of leadership to doctors
- Lack of leadership possibilities at the top of the medical profession
- Obstacles to leadership included time pressures and importance of retaining clinical credibility.

Through interviews with current and past senior medical leaders, Vize (2015) further describes the risks to those in or considering (senior) leadership and management roles:

- Reputational damage when things go wrong including scapegoating when given impossible job, public humiliation and sacking

- The average survival time of the trust chief executive is c700 days (‘Russian roulette’)

- Double-jeopardy of being brought before the GMC – doctors can face sanctions for errors and misconduct for which they are directly responsible clinically; medical senior managers can face a GMC inquiry for events of which they may have had little knowledge. The GMC guidance makes it clear that doctors are accountable for their actions “even when in roles that could be performed by someone without medical training” (Vize 2015). Despite this, Vize (2015) says there is no evidence of reluctance to take up leadership roles solely for this reason

- The issue of losing clinical skills and lack of path back

- Money doesn’t compensate for risk – consultants don’t run risk of losing excellence awards

The individuals Vize (2015) interviews described other frustrations of the role:

- Limited power to tackle underlying problems from one part of the system e.g. chronic shortages of GPs

- Keeping up a clinical role is challenging given the need to keep up to date with current practice and CPD

- NHS managerial style (harsh and bullying) and culture

- Conflicted positions affected by short term or political imperatives

- Isolation of the role

1.4.5 Think Tanks

Numerous reports from the King’s Fund highlight the importance of medical leadership. 'Patient-centred leadership: rediscovering our purpose' (2013) reinforces the findings from research and articles described above i.e. many doctors have been reluctant to take on leadership roles, alienated by centrally mandated targets and corporate efficiency objectives. Some are deterred by the risk of a failed career move, the lack of financial reward, and a reluctance to give up clinical work (The King’s Fund 2013, p. 13).

This same report proposes that it is particularly important to change the culture in which doctors who become leaders are perceived by their peers to be going over to ‘the dark side’. It is equally important to develop career paths that make it easier for doctors to

assume greater levels of responsibility as leaders, with appropriate mentoring and support (The King's Fund 2013, p. 14). The report also highlights the importance of revalidation and appraisal in altering the culture of how doctors operate as individuals, in teams, and in organisations and offering a chance for medical leaders to renew workforce values and strengthen competence and professionalism' (The King's Fund 2013, p. 14).

1.4.6 The General Medical Council

The GMC has recognised leadership as a key part of doctors' professional work and integrated leadership into various forms of standards and guidance over the decade, including:

- Good Medical Practice (2013)
- Tomorrow's Doctors (2009)
- Leadership and management for doctors (2012)

In 'The state of medical education and practice in the UK' (2011) the GMC indicates the importance of medical leadership and the regulators role in supporting this. The following statements from the report highlight this:

> Professionalism and leadership are crucial to good medical practice. Revalidation, when introduced, will help by bringing every conversation about a doctor's practice back to the standards set out in Good Medical Practice. We have also set up a new team to help employers ensure medical leadership is supported in the workplace. (General Medical Council 2011, p. 7)

> The GMC also recognises the changing way in which doctors work, and the shift from independent practice to team working "demands that all doctors possess and foster team based skills, including working effectively with colleagues and the ability to judge individual performance within a team setting. In many cases, doctors also need to take on more complex leadership roles. Thus, more than ever, doctors are working within systems and their professionalism and ability to adapt to new responsibilities is central to how well those systems perform." (General Medical Council 2011, p. 10)

> For all doctors the pace of change in system organisation and design, and the moves to multidisciplinary team working mean there is an increasing need for on-going professional development in the areas of leadership and management. (General Medical Council 2011,p. 56)

> So it is vital that doctors, and particularly clinical and educational supervisors, demonstrate effective leadership skills and act as positive role models from which medical students and trainees can learn. This is crucial to ensure that tomorrow's doctors possess the professionalism and leadership they will need. (General Medical Council 2011, p. 59)

> The challenge to medicine is to adapt to a world of higher expectations and wider responsibilities. Doctors will more than ever be expected to exercise leadership, understand how the systems in which they work operate, and contribute to, and where appropriate lead, multiprofessional teams. To do this, the doctors of tomorrow need structured, consistent and protected training that fosters the principles of Good Medical Practice. We and others need to support doctors through education and on-going training that cover all aspects of what makes a good doctor, in a context that is appropriate to them and to patients. (General Medical Council 2011, p. 62)

In 2012, when revalidation was launched those occupying senior medical leadership positions were the first to revalidate. FMLM was identified as the Designated Body who would take on responsibility for the most senior medical leaders in the country.

In more recent developments, the GMC consulted on a set of Generic Professional Capabilities (GPCs) which includes leadership, teamwork and communication. The outcome of the consultation was published in 2016 and the GMC is now working with the Academy of Medical Royal Colleges (AoMRC) on guidance to help medical colleges and faculties embed GPCs into all postgraduate medical curricula in 2017.

1.5 The nursing and midwifery profession

There was little found in the literature search which indicated specific facilitators and barriers for nurses and midwives entering senior leadership roles. Apart from one article (Moore, 2016) describing one individual's preparation for a Board level position, other literature indicated an assumption that nurses will move into leadership and management so the focus was on preparing for those roles and support required in undertaking them. Some of the issues covered in the literature were:

1.5.1 Effectively managing the pressures of the job

1.5.1.1 The challenges

The King's Fund report on 'Patient-centred: rediscovering our purpose' (2013) proposes that "nurses may be deterred [from leadership roles] by the pressures of caring for an

ever-more demanding patient caseload, rising public expectations, and static resources." (The King's Fund 2013, p. 13)

Blakemore (2015) describes the challenges being faced by nurse directors:

- Conflict between their responsibilities for the quality of care and the demands of making cuts at a time of financial constraint
- Keeping up with the demands of regulatory bodies, dealing with complaints and major incidents, feelings of personal vulnerability and accountability
- Volume of emails
- Demands for data from quality-monitoring bodies such as NHS England and Monitor

In an article about the ward sister role, Fenton and Phillips (2013) identified several factors affecting one's ability to effectively do the role:

- Increasing complexity of healthcare organisations
- Large and often far-removed corporate services make it difficult to resolve day to day issues.
- Burden of audit and paperwork
- Demands of managing a budget, ward resources and large team of nursing staff
- Culture of traditionally hierarchical and bureaucratic organisations is enshrined in the structure of corporate services and a surveillance culture
- Role complexity, lack of role clarity, inadequate preparation

1.5.1.2 Building support

Blakemore (2015) described factors which were seen to support and build resilience of nurse directors included:

- Being part of a team that is united, striving towards the same goal and with shared ownership and responsibility around finances and quality of care
- Building trusting relationships with board-member colleagues and the chief executive as well as front line nurses through regular visits to clinical areas

- Establishing good peer support networks in external, local and national organisations for brainstorming and debriefing
- Having a mentor
- Maintaining a good work-life balance
- Preparation before stepping into the role and support in post to ensure they have the resilience to fulfil a high-pressure job

Maben and colleagues (2012), cited in 'Patient-centred leadership: rediscovering our purpose' (2013) advises NHS organisations to support nurse leaders by:

- "Systematically measuring job demands in different care environments and limiting them (where possible) to minimise employees' exhaustion
- Investing in unit-level leadership and supervisor support to ensure that team leaders can promote good team working and support peer relations
- Investing more in how teams function and perform, encouraging co-worker support and a sense of 'family at work'
- Freeing up clinical staff to recruit and manage their own teams, ensuring that they have the necessary skills to do so." (p16)

1.5.2 Preparation for leadership roles

Fenton and Phillips (2013) propose that more time must be spent preparing future nurse leaders. Several authors described the barriers to preparation and transition along with suggestions for improving this:

Barriers	**Suggestions for better preparation**
Succession planning for the senior nurse role appears to be informal and more reliant on seeking out people who will make a difference (influencers/challengers) affecting opportunities for development at junior levels (Cerinus, 2016)	Making managerial or leadership experiences more available to junior staff (Cerinus, 2016)
Making the move to general management may make it harder for nurses to remain on the Nursing and Midwifery Council's register (Moore, 2016) **	Supported learning from the perspective or a senior nurse (Cerinus, 2016 and Cohen, 2013)
Lack of clarity regarding the skills and behaviours required of these individuals (Cerinus, 2016)	Induction/orientation period (Cerinus, 2016, Cohen, 2013 and Rankin, McGuire and Matthews, 2016)
	Formal supervision (Cerinus, 2016)

	Clarity in the form of role modelling, understanding expectations across their patch, have good communication skills, commitment to ongoing learning and development, knowledge and skills appropriate to the role e.g. presenting, managing emails and diaries, report writing, HR management (Cerinus, 2016)
	Mentoring (Moore, 2016 and Cohen, 2013) and coaching (Rankin, McGuire and Matthews, 2016)
	Courses or programmes (Moore, 2016 and Cohen, 2013) can improve confidence, particularly in skills such as managing staff, managing change, handling conflict, taking projects forward. It also improved understanding of organisational contexts and service constrains in organisations (Castillo and James, 2013, p19, Rankin, McGuire and Matthews, 2016) **
	Experience e.g. of working in another sector or different part of the NHS, in an operational role, or as director of nursing (Moore, 2016)
	Postgraduate qualifications e.g. MBAs (Moore, 2016)
	Identifying areas where expertise was lacking e.g. finance – which is important as a senior nurse leader will be responsible for much of the workforce and part of the corporate board responsible for making financial decisions. (Moore, 2016)
	Subscribing to literature, automated email quick tips (Cohen, 2013)

*A range of programmes were referred to in the literature, from local initiatives to national programmes such as the Royal College of Nursing Clinical Leadership Programme (Large et al 2005), Leading Better Care (The Scottish Government 2008), Empowering Ward Sister/Charge Nurse (Welsh Assembly Government 2008) and the NHS Leadership Academy Frontline Nursing and Midwifery Programme.

**Note: the article did not further explain the reasons for this.

1.5.3 Perceptions of leadership roles

Through the search two articles stood out in highlighting the negative or skewed perceptions of nurse leadership roles. Carlin and Duffy (2013) found that the leadership

role of the Senior Charge Nurse “appears to be unattractive to newly qualified staff, who cite responsibility, lack of trust and negative feedback as the most off-putting factors.”

A study by Haycock-Stuart, Baggaley and Kean (2010) of community nurses in Scotland found that the leader’s visibility was particularly important as a leadership quality. They found team leaders were particularly noted for their visibility and clinical leadership, however strategic and professional leadership was less evident. The authors suggest this was a barrier to the development of the profession.

1.5.4 Importance of professional identity

Professional identity is still clearly important for nurses moving into leadership roles. Cerinus (2016) described “Professional credibility and being valued as an inspirational leader and excellent role model […] was of utmost importance, emphasizing the need for dedicated clinical time to actively support […] to deliver effectively.” (p22)

A study by Divall (2015) looking at midwifery leaders sense of identity found two central themes:

1. the importance of professional identity despite many no longer undertaking a clinical role and

2. ‘between a rock and a hard place’ in the face of group and organisational discourses. The study concluded the importance of the support of their professional group and organisational structures if midwives are to maintain a positive self and social identity.

1.5.5 The NMC and RCN

The Royal College of Nursing’s 'Response to the Review of Leadership in the NHS' (2009) explicitly states “there should be great investment made in developing nurses to fulfil NHS leadership positions, including Chief Executive roles.”

The Nursing and Midwifery Council’s 'The Code Professional standards of practice and behaviour for nurses and midwives' (2015) highlights that leadership is a core part of all nurse and midwives roles as professionals.

1.6 The allied health professions

Little was found in the search about barriers and facilitators to allied health professionals taking on senior leadership roles and specifically leadership positions. The following summarises the key areas the available literature did cover:

1.6.1 Education and training to support AHPs

Education and training was considered helpful in the development of leadership and management skills, however this tended to focus on team level leadership development rather than preparation for strategic level leadership. For example, the Department of Health produced 'National Allied Health Professional Leadership Challenge Toolkit' (2011) to raise the visibility of the contribution AHPs can and do make to leading service improvement and innovation. This was seen as a facilitator in raising the confidence of AHPs to go back to their organisations and lead change to improve outcomes for patients and increase productivity.

A Centre for Workforce Intelligence report in 2013, states that taking a “competence-based approach to leadership, AHPs will have more transparent opportunities to move into leadership roles, thereby removing some of the current barriers from the system and releasing diverse leadership talent.” (p9) At the time of the report, clinical commissioning groups, senates and networks were being established and identified as opportunities for AHPs. The report highlights the importance of a collective voice from AHPs rather than uni-professional representation. The report also suggests there should be a move away from traditional programmes of delivery to more coaching, mentoring and action learning approaches supported by talent management systems to support succession planning.

There were few studies of specific professional groups in relation to leadership training:

- A study of physiotherapists in Ireland (McGowan, Martin and Stokes, 2016) found that those who identified as leaders tended to be linked with “time since graduation, highest qualification attained, and leadership training. Leadership training was also associated with placing greater importance on achieving a leadership position.”

- Mercer, Haddon and Loughlin (2016) found that paramedics view leadership as necessary to competency for clinical practice. The authors argue that leadership development of paramedics must begin during their formal education and training as part of the core curriculum.

- Probst and Griffiths (2009) identified the “development of appropriate leadership qualities in those within supervisory roles” as one factor which would be important in helping to design retention strategies of therapy radiographers in the UK.

1.6.2 Leadership as part of professional identity

Possibly the most relevant study found in the search was that conducted by Petchey, Hughes, Pinder and City University (2013) of allied health professionals and management. This NIHR SDO study involved interviews with a variety of AHP clinician managers in a range of organisational types and settings. The findings from the study, relevant to leadership and management were:

- “The problematic nature of clinical manager identity: differentiating from other professions within and outside of the ‘allied health’ description

- The variability of clinician management: the shape of their managerial work and autonomy is affected by national policy imperatives, local context, a complex web of inter-professional relationships of clinician-managers, change in focus from management to leadership

- The variable and complex relationship between the managerial and the clinical on the front line: management takes place on the front line so the clinical and managerial are inseparably intertwined. This requires significant ‘bridging’ to maintain credibility with staff, other professionals and managers

- Clinician management as a problem to be managed:

    - Ensuring managerial work is contained and separate to clinical sessions; considering it an optional ‘add on’

    - Keeping management within bounds by downplaying their managerial achievements but in doing so positioned themselves as disempowered compared to senior management while at the same time trying to empower their staff

    - Not recognising the behaviours they were describing as leadership

- The significance of emotional labour in clinician management: where clinical values spill over to the managerial arena

- The problematic transition from clinician management to clinical leadership: leadership featured rarely in discussions with a greater use of clinical and managerial terminology. This was in spite of leadership clearly acknowledged as being important. A traditional model of leadership dominated – heroic leaders occupying positions of authority - diverging from the distributed leadership advocated at the time.”

Petchey, Hughes, Pinder and City University (2013) described four findings from their study which may have implications for policy and practice on clinical leadership:

- “The inherently politicised nature of clinician-management and the unequal distribution of opportunities to exercise leadership

- The continuing potency of the traditional model of leadership, which associates leadership with heroic exceptional individuals in positions of formal authority

- The existence of multiple styles of management, which appear to be associated with gender and professional values

- The importance of emotional labour in management."

The authors went on to explain that these complexities may limit the take-up of current initiatives to promote a universal model of distributed, post-heroic leadership throughout the NHS. The authors also suggest their findings have "implications for the design and delivery of education and training of AHPs in management/leadership at pre-and post-registration levels." They suggest that an approach to AHP leadership education and training that acknowledges the diversity of professional cultures, and builds on their existing leadership and management achievements, may be more likely to be productive.

1.6.3 The Health and Care Professions Council

The HCPC issued a position statement on the Clinical Leadership Competency Framework in December 2012, stating: "We are supportive of the CLCF with its emphasis on the shared responsibility and accountability of all registered professionals at all levels in contributing towards good quality services and improved outcomes for service users. We consider that it is a helpful and important resource for registrants, commissioners and education providers across the breadth of the different professions we regulate."

1.6.4 Summary

An attempt to surmise the barriers and facilitators for AHPs entering leadership roles is below, although the limited research available makes this difficult to generalise:

Barriers	**Facilitators**
Challenge of working with national policy imperatives, local context, complex web of inter-professional relationships of clinician-managers	Competency-based approach to development
Maintaining credibility with staff, other professionals and managers	Coaching, mentoring and action learning approaches
Professional identity and values	Talent management systems to support succession planning
Emotional labour of management	Acknowledging the diversity of professional cultures
Perceived value given to management vs clinical roles	Building on existing leadership/management achievements
Traditional view of leadership (heroic)	Leadership training – within curriculum and to support those in supervisory or

	leadership roles

1.7 Conclusion

All the professions and their regulators acknowledge the importance of leadership and leadership development. The facilitators and barriers to achieving leadership roles are clearly better articulated for the medical profession, possibly due to the increasing interest and research in the last decade demonstrating the link between medical leadership and engagement and organisational performance.

While there is limited literature indicating regulation as a barrier to leadership, The Health Foundation and Professional Standards Authority reports indicate that regulators clearly have an important role in supporting and developing leaders and leadership.

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Appendix 3

Summary of the role and functions provided by the regulatory bodies

Professional Standards Authority

- The Professional Standards Authority for Health and Social Care promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and registration of people working in health and care. We are an independent body, accountable to the UK Parliament.
- We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.
- We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.
- To encourage improvement we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation. We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake some international commissions to extend our understanding of regulation and to promote safety in the mobility of the health and care workforce.

General Medical Council

- We are an independent organisation that helps to protect patients and improve medical education and practice across the UK.
- We decide which doctors are qualified to work here and we oversee UK medical education and training.
- We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.

- We take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

- Every patient should receive a high standard of care. Our role is to help achieve that by working closely with doctors, their employers and patients, to make sure that the trust patients have in their doctors is fully justified.

Nursing and Midwifery Council

- We regulate nurses and midwives in England, Wales, Scotland and Northern Ireland. We exist to protect the public. We set standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare throughout their careers.

- We make sure that nurses and midwives keep their skills and knowledge up to date and uphold our professional standards. We have clear and transparent processes to investigate nurses and midwives who fall short of our standards. We maintain a register of nurses and midwives allowed to practise in the UK.

Health and Care Professions Council

- The Health and Care Professions Council (HCPC) is the statutory regulator of 16 health and care professions including biomedical scientists, occupational therapists and practitioner psychologists.

- All the professions are regulated on UK wide basis with the exception of social workers who are regulated in England only. The organisation sets standards for education, entry to the Register and conduct; quality assures education and training programmes against those standards; maintains a register; and holds registrants to its standards through Continuing Professional Development (CPD) audits and its fitness to practise process.

- In 2015-2016, it handled 2,127 fitness to practise cases and held 320 final hearings. As at February 2017, there were 347,556 registrants on the HCPC Register.

General Pharmaceutical Council

- The General Pharmaceutical Council is the independent regulator for pharmacists, pharmacy technicians and pharmacy premises in Great Britain. It is our job to protect, promote and maintain the health, safety and wellbeing of members of the public by upholding standards and public trust in pharmacy.

- Our principal functions include:
    - Approving qualifications for pharmacists and pharmacy technicians and accrediting education and training providers
    - Maintaining a register of pharmacists, pharmacy technicians and pharmacy premises
    - Setting standards for conduct, ethics, proficiency, education and training and continuing professional development (CPD)
    - Establishing and promoting standards for the safe and effective practice of pharmacy at registered pharmacies
    - Establishing fitness to practise requirements, monitoring pharmacy professionals' fitness to practise and dealing fairly and proportionately with complaints and concerns.