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Perspectives on clinical leadership: a qualitative study exploring the views of senior healthcare leaders in the UK

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Abstract

Introduction: Clinicians are being asked to play a major role leading the NHS. While much is written on about clinical leadership, little research in the medical literature has examined perceptions of the term or mapped the perceived attributes required for success.

Objective: To capture the views of senior UK healthcare leaders regarding their perception of the term 'clinical leadership' and the cultural backdrop in which it is being espoused.

Setting: UK Healthcare sector

Participants: Senior UK Healthcare leaders

Methods: Twenty senior healthcare leaders including a former Health Minister, NHS Executives, NHS Strategic Health Authority, PCT and Acute Trust chief executives and medical directors, Medical Deans and other key actors in the UK medical leadership arena were interviewed between 2010 and 2011 using a semi-structured interview technique. Using grounded theory, themes were identified and subsequently analysed in an attempt to answer the broad questions posed.

Main outcome measures: Not applicable for a qualitative research project

Results: A number of themes emerged from this qualitative study. First, there was evidence of changing attitudes among doctors, particularly trainees, towards becoming involved in clinical leadership. However, there was unease over the ambiguity of the term 'clinical leadership' and the implications for the future. There was, however, broad agreement as to the perceived attributes and skills required for success in healthcare leadership.

Conclusions: Clinical leadership is often perceived to be doctor centric and 'Healthcare Leadership' may be a more inclusive term. An understanding of the historical medico-political context of the leadership debate is required by all healthcare leaders to fully understand the challenges of changing healthcare culture. Whilst the broad attributes deemed essential for success as a healthcare leaders are not new, significant effort and investment, including a physical Healthcare Academy, are required to best utilise and harmonise the breadth of leadership talent in the NHS.

Keywords

leadership, clinical leadership, healthcare leadership

Introduction

It is widely considered that good clinical leadership is important for optimal patient care. With the current, turbulent, restructuring of the NHS and the requirement to simultaneously meet the £20 billion efficiency savings outlined in the 'Nicholson Challenge'[1] (see Box 1), strong leadership at all levels of the NHS is critically important. Clinicians must ensure clinical services continue to be delivered and redesigned for maximum efficiency while maintaining quality of care. Clinicians, and particularly doctors, are rightly being asked to play a major role in this process. The term 'clinical leadership' has been coined to encapsulate the requirement of all clinical staff. The authors believed the term clinical leadership was intended to be a generic one, applicable to all clinical staff, but were aware of concerns expressed by other healthcare professionals that it had started to be monopolised by the medical profession, to the exclusion of others.

Box 1. The Nicholson Challenge.

Sir David Nicholson is the current leader of the NHS in England. He issued a series of mandates to the whole NHS that collectively add up to a demand for 'efficiency savings' of £20 billion by 2015. Sir David believes that to maintain quality and also cost-effectiveness better (more efficient and innovative), ways of working must be found amid a warning that if his challenge was not met, either more money would be needed or quality of care would inevitably decline.

The clinical leadership agenda has recently been given further momentum following the recent publication of the Francis[2] Report (see Box 2) into the failings of Mid Staffordshire NHS Foundation Trust. The term 'clinical leadership' has become embedded in the NHS lexicon, but there appear to be various opinions as to what the term means.[3–5] While there is much commentary written on the subject of clinical leadership, there remains little robust

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research published in the clinical literature that examines perceptions of the term and maps changing attitudes to engagement in leadership among clinicians, particularly among NHS doctors, in the decades since the 1983 Griffiths Report[6] (see Box 3) highlighted the need for clinicians to become more involved in the management of the NHS.

Box 2. The Francis Report 2013.

Robert Francis QC investigated failings at the Mid Staffordshire NHS Foundation Trust. His report was published in February 2013. Among over 200 recommendations, he included a desire to see a single regulator for financial and quality healthcare, more powers to suspect/prosecute individuals and Boards, a desire to see all staff bound by a duty of candour, the registration of all healthcare workers, specialist healthcare inspectors, the reinstatement of the practice of identifying a senior clinician responsible for a patient's care and general practitioners to be more actively monitoring the care patients receiving care in hospitals or other specialist services.

Box 3. The Griffiths Report 1983.

Sir Ernest Roy Griffiths was deputy chairman of J. Sainsbury plc, a large UK supermarket when he was asked by the then Prime Minister, Margaret Thatcher to produce a report on the management of the NHS. The report identified that the NHS was failing to use its resources effectively and efficiently. Therefore, Sir Roy suggested that the NHS required general managers to be appointed within the NHS structure. According to his report, managers would monitor budgets and cost-effectiveness of the department, motivate staff and lead the department to continually look to improve the service. While he advocated managers and clinicians working together, many clinicians reacted negatively subsequently disengaging from the broader leadership and management of the NHS.

Lord Darzi's[7,8] White Papers (Box 4) supported the vision that clinical leadership was a core part of a safe, high quality and patient-focused system. His reports included recommendations for all healthcare professionals to engage with the delivery of the clinical leadership agenda. He introduced the concept of clinical leaders being tripartite practitioners, partners and leaders, but his reports lacked specific detail or commentary on what he truly meant by this statement or what additional attributes (knowledge, skills and attitudes) were necessary for aspirant or existing medical leaders to successfully deliver his vision.

Box 4. The Darzi Reports.

Lord Ara Darzi, is a UK surgeon and was a junior health minister in Gordon Brown's tenure as UK Prime Minister. His two linked White papers (High Quality Care for All – NHS Next Stage Review Final Report and NHS Next Stage Review: A High Quality Workforce) were published on 30 June 2008. They set out a 10-year vision for a world class NHS that was fair, personal and safe. His papers were published alongside the NHS Constitution. Within his wide-ranging review, he stated that clinican involvement should be strengthened in decision-making at every level of the NHS, with clincians being practioners, partners and leaders within the NHS.

This qualitative research study aimed to collate the views of senior healthcare leaders in the NHS and wider UK healthcare leadership field.

Methods

Design

A series of targeted semi-structured questions were designed to examine the views of senior staff involved in leadership within the UK healthcare sector. The individuals approached were selected as part of a purposive sample, on the basis of their senior positions within the healthcare leadership sector, and recruited on the basis of previous contacts at national leadership events and well-known educational initiatives. Additionally, individuals were selected to try and ensure broad representation of the key UK stakeholders involved in the healthcare leadership agenda. The specific questions asked are shown in Table 1.

Design and development of questions

To ensure questions were appropriate and robust, a focus group was conducted. This group contained a mix of senior leaders in the NHS, external consultants involved in delivering leadership training in the UK and previous participants of leadership programmes.

The focus group revealed no additional changes to the question posed but highlighted potential areas for the interviewer to consider. Additionally, it was felt that the term 'attribute' was most specific and encompassing when discussing knowledge, skills and attitudes required for successful clinical leadership. The questions were deemed to be appropriate and unambiguous. The process highlighted the need for the interviewer to be mindful of leading questions or appearing to give support or credence to responses either directly or in non-verbal prompts.

Table 1. Questions used in focus group and semi-structured interviews.

1. What do you understand by the term 'Clinical Leader'?
2. What do you think Lord Darzi meant by 'Practitioner, Partner and Leader'?
3. What skills do you think are required to be a Partner and Leader in today's NHS?

Sampling and recruitment

Following the focus group, semi-structured interviews were undertaken (between 2010 and 2011) with 20 senior healthcare leaders. A purposive sampling technique was used with individuals selected based on their seniority and to ensure the cohort represented the full spectrum of NHS and leadership agendas, whether political, primary *versus* secondary care, managerial *versus* educational, medically qualified *versus* managerially qualified, etc. Interviews lasted between 60 and 90 min, and the questions were used as a basis for wider discussion.

Data capture

All interviews were recorded and transcribed, while observational notes were taken at the time by the investigator to capture the immediate thoughts and reactions of the interviewer and provide a basis for reflection.

Consent

Written consent of the interviewees was gained immediately preceding the interviews.

Data analysis

Full transcripts from the interviews were analysed according to the principles of grounded theory[9,10] using NVivo (NVivo 8, QSR international) to assist with coding. Coding of interview data continued in parallel with subsequent interviews so that emerging data could inform and be tested in new interviews. Interviews continued until data saturation was reached, and no new ideas were being put forward. One author (EN) carried out all the interviews, developed the themes and grouped them into supra-categories (nodes) which eventually accounted for all the data. A second coder checked for negative instances and agreed that the codes were appropriate.

Results

Demographic information

Twenty senior healthcare leaders were interviewed. The cohort included a former Health Minister, NHS Executives, NHS Strategic Health Authority, PCT and Acute Trust chief executives and medical directors, Medical Deans and other key actors in the medical leadership arena (National Leadership Council, commentators, commercial and charitable providers of health leadership programmes). Fifteen of 20 respondents were men and 17/20 were aged over 50 years, with 18/20 having over 25 years of healthcare experience in the UK. Twelve of 20 respondents were clinically qualified, however not necessarily in current clinical practice. Only two individuals declined the invitation to be interviewed.

Themes identified

From the questions posed in the series of interviews, six major themes were identified: History, culture and changing attitudes towards health leadership; Perceptions of clinical leadership; Attributes required to be a successful healthcare leader; Training and education in health leadership; A national leadership model for healthcare; and Delivery of a national health leadership model. While defined as separate themes, these topics are enmeshed and intertwined with much overlap between them. This manuscript focuses on the first three major themes.

History, culture and changing attitudes towards healthcare leadership

Nearly all participants felt that to have a robust discussion on perspectives and the definition of clinical leadership required historical contextualisation to be meaningful. This was particularly the case for respondents who had spent the majority or the whole of their careers solely in the NHS. Themes that surfaced throughout the discussions included the history of doctors leading in the health service and the introduction of managers into the NHS following the Griffiths Report.[6] Much was made of the subsequent culture and attitude among senior clinicians to this agenda and the subsequent (often negative) role-modelling for aspiring clinical leaders. However, many respondents also commented on the recent, perceptible, change in culture among the younger generation of clinicians and the NHS itself.

There was a widespread belief among interviewees, both clinical and managerial, that following the

Griffiths Report, doctors (particularly consultants) who previously had not had their leadership role questioned or challenged in any meaningful way, reacted negatively to the perceived imposition of managers taking over the leadership of the NHS. This was despite this not being the intention of the reforms. It was felt, in the main, that doctors had subsequently disengaged from the management and leadership of the NHS; to quote: 'We are still in the aftermath of decisions that alienated the medical professions; Doctors in particular, then abrogated their responsibility and said "let managers get on with managing and we will get on with our clinical work"' (Respondent 1).

Many respondents felt that while the negative attitude of doctors towards others leading service development had been tolerated by politicians for a generation, the rise of clinicians (both doctors and other healthcare professionals) delivering high-quality health leadership, particularly in the US, had provided evidence that 'practising clinicians exercising leadership in a variety of ways improves patient outcome'. In addition, an increasing 'recognition that the lack of clinician involvement held back initiatives to improve the NHS' (Respondent 2) had led to an 'acknowledgement that they (the politicians) had lost something' (Respondent 3) and wanted 'consultants and other clinicians back' and, indeed, needed them back to 'raise [their] profile in terms of the way health services are currently being managed, run, designed and shaped' (Respondent 1).

In tandem with the political drivers for a 'clinical leadership' agenda, many interviewees, both in educational and managerial roles, expressed the opinion that the attitudes of doctors were also changing. It was felt this was partly because 'the current generation of junior clinicians have always lived with targets' (Respondent 4) and therefore 'do not automatically rail against them' (Respondent 5), but more broadly was because of a maturing approach to both managers and the corporate agenda, especially by junior doctors.

One stated: 'Specialist Registrars have changed, [they are] far more open to discussion; happy to work in ambiguity; develop a critique as to where they are as medics, even if not able to influence; and some are more politically aware' (Respondent 6), while another said:

> On management courses the response to why individuals are attending is now usually "I need to know the systems. I want to be more aware of finances, Payment by Results (PbR) etc. as I am going to be leading," whereas it used to be "to tick a box". (Respondent 7)

One respondent suggested: this 'generational acceptance of managers [particularly by doctors] will be a big driver to support partnership working' (Respondent 8).

While senior NHS leaders felt the workforce was changing, they additionally highlighted changes in the opportunities available for all clinicians, including doctors, within the NHS to undertake leadership roles as another factor influencing clinicians' engagement with the corporate agenda. Respondents stated that opportunities to cross the clinical, managerial and leadership boundaries had increased, with 'clinicians now being invited to take up posts such as Medical Directorships, for example within SHAs; whilst new jobs with commercial and strategic roles were appearing in Foundation Trusts and were now available to clinicians' (Respondent 4).

Finally, several respondents acknowledged that broader societal change was also playing a role in driving this agenda and underpinning a rapid cultural change within the profession. This was particularly true of the younger cohort and those who had close engagement with junior doctors.

One noted: 'Clinical leadership amongst junior doctors is becoming a social movement; making it socially acceptable and rapidly changing the culture [in medicine]' (Respondent 3).

Furthermore, it was noted that 'portfolio' careers were now often the accepted norm outside the healthcare sector and this was seen to be increasingly permeating the NHS.

Not everyone was universally positive however, and, while the engagement of the current generation of younger doctors with their non-medical colleagues and the wider leadership agenda was widely welcomed, there was also a view, expressed by a few, that caution should be applied. It was felt that, for some individuals, the motivation for engagement with the leadership agenda was predominantly more for personal advancement than an altruistic wish to improve the service.

Several respondents stated that 'individuals must prove their ability in the real world' (Respondent 9) and not just become proficient in leadership and management theory. It was argued that for leadership education and training to be relevant to the wider NHS and to encourage clinicians' engagement, 'Leadership training must be for a purpose; i.e. for quality improvement and improving health for patients' (Respondent 4) and absolutely should be 'for the benefit of the service not just the individual receiving the training' (Respondent 10).

Perceptions of clinical leadership

Asking respondents to discuss the meaning and perception of the term 'clinical leader' generated strong views, both positive and negative. Most acknowledged the importance of developing the next generation of leaders and the main responses about clinical leadership were positive. However, the negative perceptions and overtones were felt to be important, both in terms of individuals' perceptions and also in highlighting the problems with the term 'clinical leadership' and the potential prejudices that it may engender. Importantly, it was felt that these views carried the risk of hindering the wider healthcare leadership agenda within the clinical cadres.

While there was broad support for clinicians, particularly doctors, taking an active leadership role in delivering 21st century healthcare, the perception of the term 'clinical leadership' did generate some strongly negative comments.

The term was variously described as 'exclusive and elitist' (Respondent 8) (particularly when applied to cohorts of junior doctors on leadership programmes), 'semantic and unhelpful' (Respondent 4), 'politically driven' (Respondent 11) and 'not a helpful definition, as it has been conflated with the term medical leadership' (Respondent 8).

There was a real concern expressed by some respondents that the medical profession, while critical to the leadership agenda, should not be seen to exclusively 'own it'.

One respondent similarly expressed the view that 'doctors have taken the ambiguity [of the term] and have highlighted and promoted themselves, in hierarchical terms, into a better position for their profession' (Respondent 8). The risk of these last points was emphasised by several respondents, who felt it ran the potential risk of 'disenfranchising a ''large population'' of other, non-medical, NHS clinical staff' (Respondent 6).

The term 'clinical leadership' was also felt to 'mean too many things to too many people' (Respondent 12) and to be 'ambiguous' (Respondent 11). Additionally, several respondents expressed an opinion that clinical leadership 'was not a panacea for all the NHS' problems and there is a danger if we abuse the term' (Respondent 13) we risk it 'becoming a hackneyed phrased' (Respondent 14) or a 'seven day wonder' (Respondent 9).

Many interviewees acknowledged that not everyone either wanted to be a leader nor necessarily had the skills to lead. However, these same respondents also expressed a view that if individuals did not want to lead, they had a duty to be a responsible follower, while leaders had a responsibility to inform and engage these individuals.

The need for a distinction between 'clinical leadership' as a separate entity, as opposed to leadership delivered by clinicians, was also challenged.

One respondent captured this by stating 'leadership with clinical engagement is the key, not who the leader is' (Respondent 4). It should be 'based on who the best person is, not their background' (Respondent 9).

Ultimately, whether a 'clinical leader', or an individual undertaking clinical leadership, there was a feeling that one should be an 'exemplar to others' (Respondent 13). There was also a requirement to make sure that, if doctors were to become 'clinical leaders', they needed to focus on both the 'soft and hard, non-clinical leadership skills' (Respondent 6), in addition to their clinical ones, to allow them to become successful.

Several respondents felt there was a distinct difference between clinical leadership, i.e. a behaviour that 'occurs at all levels' (Respondent 12) and was 'not associated with a particular title or position' (Respondent 4) and a being a clinical leader. There was disagreement, however, about whether to be a clinical leader required an individual to hold an official leadership role within an organisation or the wider NHS, but most felt that to be a clinical leader one must 'hold a clinical qualification' (Respondent 14). However, there was broad agreement that the two terms were not synonymous and certainly there were individuals in clinical lead roles who did not display good clinical leadership, 'some [of whom] are very narrow minded and too focused' (Respondent 2).

Finally, the term 'healthcare leader' was suggested in several early interviews and subsequent respondents were asked as to their opinions on this alternative term. Subsequent respondents felt that, while to be a clinical leader one needed a clinical qualification, to be a healthcare leader did not; one might come from a non-clinical or clinical background. It was widely felt that the term 'healthcare leadership' was therefore a more inclusive and appropriate term under which the NHS workforce could 'pull together' (Respondent 3).

Attributes required to be a successful healthcare leader

The semantic argument of terminology aside there was broad agreement on the required attributes required to be a successful leader in the healthcare sector. The complete verbatim list of attributes is shown in Table 2, without ranking. The domains were determined from themes developed during

Table 2. Attributes required for successful healthcare leadership.

Domain	Leadership attribute
Relationship skills	Self-awareness
	Emotional intelligence – awareness of self and impact on others
	Personal integrity
	Approachable
	Influential
	Authoritative and affiliative
	Ability to listen
	Humility
	Willingness to acknowledge when wrong
	Motivational
	Ability to align others
	Compassionate
	Humane
Personality	Strategic thinker
	Flexible leadership styles
	Reflective
	Passionate
	Articulate
	Exceptional communication skills
	Team player
	Committed
	Self-belief
	Grounded
	Enthusiastic
	Visionary
	Resilient
	Charismatic
	Aspirational
	Comfort in both clinical and managerial roles
Leadership style	Patient-focused
	Flexible
Technical competence	Credible clinician and manager based largely on experience and delivery
	Financial skills (budgets, accountancy)
	Change management
	Risk management
	In-depth understanding of the organisation and wider healthcare sector
	Negotiation and influencing skills
	Deep corporate knowledge
	Credible business skills
	Ability to balance both clinical and managerial roles
Political awareness	Political insight (Big politics and little politics)

discussion on this topic. The vast majority of attributes deemed to be required are personal and involve relationship skills; however, technical, clinical, political and managerial skills were also imperative along with a flexible leadership style, born from significant experiential learning. High emotional intelligence, intellectual flexibility, relationship skills and a broad, inclusive attitude were universally selected as the most important attributes for healthcare leaders to be successful.

> [Clinical leaders need an] ability to think and analyse the external environment; [have] strategic thinking skills; political and Political awareness, intuition, skill and antennae; think and plan for the future locally and describe it in order to enable others to come, willingly, on that journey. (Respondent 8)

Box 5. Types of healthcare leader (Respondent 2).

In healthcare there are many types of leader:
i. The fine clinician – good diagnosticians, their forensic expertise brought to bear on their medical management and delivered with compassion, the pinnacle of what peers regard as a fine doctor; a professional leader who inspires other doctors;
ii. Academic leaders and thought leaders – those at the cutting edge of academic medicine;
iii. Clinical academics – innovators involved in service redesign, cutting edge technical leaders – i.e. robotic surgery pioneers;
iv. Professional leaders i.e. within professional organisations – they define quality and standards but are not part of the delivery or management process;
v. Educational leadership – those who inspire and teach the next generation, inculcate standards and culture in the younger generation to encourage them to perform to their highest professional standards;
vi. Traditional medical managerial leaders – progression from topic lead, through service lead, divisional lead within specialty, then CD, MD, CE, NHS MD. (Respondent 2)

The NHS leadership frameworks (both past and present) were frequently cited as exemplar documents in this regard, and quoted widely, such as below:

> Three elements in NHS leadership qualities framework sum it up for me: a. Personal qualities and integrity; people can then trust you, you do the right things and do them right and take the tough decisions with integrity. b. have a vision of where you want to go; be able to describe it in a way that people can understand, see where they fit in and what they have to do to contribute. c. Engage and motivate others; to be able to deliver and execute the vision. (Respondent 6)

As well as the variety of attributes required for clinical leadership, it was also acknowledged that there were many types of 'clinical leader' in medicine, most eloquently summed up by the quote in Box 5.

It was felt that differing types of leadership roles would undoubtedly require different emphasis to lead effectively and respondents, although clear that certain generic attributes were required for leadership, acknowledged that these were neither exclusive nor exhaustive and that both role and situation would require flexibility in leadership style. While framed in the context of doctors as clinical leaders, the quotation in Box 5 could be equally applicable to all healthcare professionals.

Discussion

This study challenges the current thinking on clinical leadership in the NHS. It acknowledges a cultural shift within the younger generation of doctors, highlighting a perception that there is a greater engagement among this generation with the wider managerial healthcare agenda. However, this research also challenges the very use of the term 'clinical leadership', suggesting that its use may in itself be perceived as exclusive, due to misuse of the term and misrepresentation that it applies only to doctors, thus having the potential to disengage the wider healthcare community. This research clearly states the belief that medical leadership and clinical leadership should be disambiguated, the former specifically applying the medical staff (doctors) with the latter being applicable to all clinical staff, regardless of profession. Finally, it places strong emphasis on the broad personal attributes and non-clinical skills required to be a successful healthcare leader. High emotional intelligence and corporate outlook appear to be key, coupled with a patient-focused leadership style born from a deep and wide understanding of the political, financial and business skills required to operate organisations successfully in the 21st century. While the latter point may be well rehearsed in the managerial and medical sociology literature, we feel that these results warrant further consideration and reflection in the clinical literature and clinical community at large.

While there is a significant amount written on heath leadership in the management studies, health services research and medical sociology literature, little of this debate or literature permeates into the clinical arena. The wider policy context underpinning a political call to more distributed, clinical leadership is in the NHS is acknowledged and debated in this literature[11] as is the tension between centralised and decentralised control of the NHS.[12] Additionally, the views of NHS Chief Executives on the shift of language from administration to management have been explored,[13] and this manuscript extends on the previous work by looking at both the shift from management to leadership as a cultural and political driver in UK healthcare and it expands the cohort interviewed previously beyond Chief Executives to a wider range of stakeholders.

It is acknowledged that this research was performed prior to the full implementation of the recent seismic changes in the NHS and the increasing different approach to NHS delivery in the devolved regions. However, the cohort of senior interviewees in

this study has lived through a generation of change in the NHS and, as a result, their depth and breadth of NHS experience is immense. They have lived through the changing roles of doctors and other clinicians in the NHS and have seen firsthand the effect of three decades of political reorganisation, including these recent changes. Their views remain particularly relevant, therefore, when trying to put the current 'clinical leadership' debate in context. Engaging clinicians, and particularly doctors, in leading service development and redesign was a central tenet of Lord Darzi's[7,8] White Papers released to much fanfare in 2008. Despite a change in government, there has been no lessening of the emphasis on a professionally led service,[14,15] and the recent report into the organisational and leadership failings at Mid Staffordshire NHS Foundation Trust, by Robert Francis QC, further reiterates the central role of clinical leadership in delivering compassionate, high-quality healthcare.[2] It should be noted that the whole concept of the Griffith's report in 1983 sought for doctors to play a significant role in general management in the NHS[16] so this is not a new modern mantra. However, a recent document published by the BMA suggested that much more is required to engage doctors in clinical leadership,[17] and the poor relationship between doctors and lay managers was cited as one of the key barriers to clinicians engaging in leadership. Other complaints from doctors within the BMA cohort were the lack of leadership opportunities and a feeling that there was no requirement for formal leadership skills to be taught to medical students. This contrasts considerably with many of the perceptions identified in this study, where respondents felt that both opportunity for leadership and attitudes among many clinicians had changed and that there was a groundswell of support for engagement, especially among the younger generation of doctors.[8]

One key point of contention that arose from this series of interviews was the risk that 'clinical leadership' might be used by both individuals and the medical profession as a whole, to further personal[18] and professional agendas. The egocentric, self-fulfilling, personal agenda that is enabled by 'clinical leadership' programmes is not really acknowledged in the current literature, nor widely discussed; however, it was a recurrent theme in this study and, if left unchecked, clearly has the inherent risk of both failing to deliver an improved service and disengaging the wider clinical and lay medical managerial community. However, Bernard Crump[19] points out that this egocentric approach does not necessarily have to be mutually exclusive from concurrent benefit to the service and high performance.

Many of the skills, knowledge and attitudes described as essential in this research are ubiquitous to leadership across all professions. The emphasis on personality and inclusive or affiliative leadership chime with the current re-emergence of the trait and emotional intelligence theories espoused by Goleman[20,21] and implicit in the NHS leadership frameworks produced by the NHS Institute[22,23] and Leadership Academy.[24] While it may suggest that the interviewees were just expressing the current NHS mantra, such senior members of the profession are unlikely to feel inhibited in expressing an alternative view if they felt this to be just the next 'fad'. Other linked concerns included the lack of real experiential leadership development rather than theoretical leadership education and training currently offered to most and the continuation of single specialty leadership training that does little to break down barriers between clinical cadres and managerial staff. While there are programmes that pair managerial and medical staff together,[25] this rarely extends to a whole multidisciplinary team.

While true opportunities for experiential learning is acknowledged as expensive to deliver,[8] many respondents in this study felt that the current focus of 'clinical leadership' education and training did not expose individuals to 'real-world' leadership, where the realities of the workplace often highlight individuals' true challenges. The possibility of 'stretch assignments' within or outwith individual's usual place of work may allow the theoretical knowledge to put into practice. The funding of these individuals could potentially come from savings made by reducing the expenditure on outside management agencies and could theoretically enhance the NHS at the same time.[26]

As with all qualitative research, themes are generated in the light of the researchers' experiences as much as the respondents. Notwithstanding the tendency of all respondents to revise their histories in the light of subsequent events and also the influence of the interviewer in co-constructing the conversation, several common themes were developed. The choices of quotations used in this manuscript were selected as being most representative and illustrative of these themes. By definition, this means that some respondents may be represented more than others; however, this does not detract from the representative nature of the comments. We acknowledge this study has a relatively small sample size; however, the authors are senior NHS professionals and the sample is a purposive sample of individuals at the highest level of UK healthcare. We also acknowledge that the NHS continues to change rapidly and relentlessly; however, the credibility and transferability of our

findings comes from our understanding of the NHS context, the selection of our respondents and the rigour with which we analysed the interview data. The findings, however, remain a function of our interpretation. The dependabilty and relaibility of the work we believe derives from the seniority of the interviewees, our attention to the iterative nature of the research and our search for negative instances.[27] The outcomes, however, are limited to our understanding of the views of these respondents, at this time.

Conclusion

So what should we do as a result of these findings? The term 'clinical leadership' appears to be perceived by many as being synonymous with doctor leadership. The continued use of this term, therefore, runs the risk of disengaging other stakeholders required to deliver leadership within the NHS, not just fellow non-medical clinicians but healthcare managers also. We would propose the term 'healthcare leadership' as a more encompassing, less tribal and less ambiguous term and one that should include all leaders who are leading and shaping healthcare, regardless of professional background.

While all respondents felt it was important to have doctors involved in leading the current changes and service redesign, it was felt there was a critical need for inclusiveness, with all leaders, whether clinically or managerially trained, working together to deliver the required efficiency and productivity demands.

To fully consider the challenges and opportunities for clinicians, and particularly doctors, leading within the health service, one has to have an understanding of both the historical medico-political context in the UK and the wider literature supporting this approach globally. This is an area that is currently not main stream for most clinicians. The need to deliver broader leadership education includes a need for clinicians to more fully understand both managerial and political history and context, while managers must be given an opportunity to develop a greater appreciation of the clinical perspective on healthcare delivery and leadership.

The attributes required to be a successful healthcare leader are myriad but not necessarily new. Our senior leaders suggest that the ability of our current and future leaders to be successful requires them to take an inclusive approach, while understanding the system and themselves will allow them to maximise their chances of success. The requirement to deliver cost efficiencies while also implementing the complex reforms outlined in the Health and Social Care Act will require far more than just 'clinical leadership' from doctors, and, although it remains critically important that clinicians are at the forefront of this process and leading within it, there is a need to recognise the breadth of leadership talent within the NHS and utilise it in a harmonised fashion. Without concerted and joint leadership from all stakeholders, the process of clinical engagement to support the political reforms once again risks failing at the first hurdle. The development of a physical healthcare academy was suggested by Francis to support this agenda, and our research would support the argument for a physical establishment to bring together the myriad of specialists to learn more jointly.

The 'take-home' message from our senior leaders is that we need all 'healthcare leaders' to combine their expertise and work together, regardless of their background. Significant investment will be required to make this a reality, and additional research will be required to assess whether the recent reforms have delivered on this poignant message.

Declarations

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