



# Everyday Leadership

Final Report

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# Acknowledgements

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## Executive Summary

### Background

Doctors who have completed their specialty training – consultants and general practitioners – undertake many roles and activities outside their patient-facing clinical practice. This includes clinical administration, alongside other non-clinical activities including management, education and research. Some will also be in formally defined management roles such as clinical directors or medical directors, or have roles with other organisations. By virtue of these doctors' seniority, their roles will tend to involve an element of leadership.

Awareness of medical leadership has developed in recent decades, as the range of formal leadership roles undertaken by doctors has increased. Consequently, a need for support and development of doctors in these roles, and for the leadership responsibilities embedded in their day-to-day work, has been recognised.

This project set out to examine the experiences of consultants and GPs in relation to the work they do, including their taking on of additional roles and responsibilities. Research questions encompassed the roles and activities undertaken by senior doctors, the changes in those roles and perceptions of why they have changed, the impact of change, and the extent to which they had been trained or prepared for those roles.

### Methods

Semi-structured telephone interviews were carried out with 22 consultants (10 male, 12 female) and 10 GPs (4 male, 6 female) across the UK, identified by 'snowball' sampling through professional networks. Consultants represented a range of clinical specialties. Participants had been in consultant or GP posts for periods ranging between 1 and 30 years.

Interviews covered the content of participants' work, their perceptions of leadership, how they felt about different aspects of work, and their future plans. Inductive thematic analysis was carried out on the interview transcripts.

### Findings

Analysis found that the composition and structure of participants' work is complex, and that changes in those roles are idiosyncratic.

### *Perceptions of leadership*

Perceptions of the nature of leadership were varied, with some describing it as an intrinsic quality and others as a skill, but there were common elements. These included leaders having a 'vision', expressed as being able to identify desired changes in a service or system, or solutions to discrete problems. Having the skills to deliver those changes or solutions, or being able to delegate appropriately to those with the necessary skills, was also important. Collaborative working, and having the communication skills to persuade colleagues at all levels and across professional groups, were felt to be essential.

### *Embedded and explicit leadership*

Participants' roles evolved to encompass 'embedded' leadership roles and activities, which were part of their day-to-day clinical jobs, and included service management and improvement, and governance activities. Others had 'explicit' leadership roles, with the same employer or different organisations. Progression into these roles was haphazard, and often unplanned. Often individuals were approached to apply for roles, rather than seeking them out.

### *How doctors' roles are changing*

Participants' work in clinical, embedded and explicit leadership capacities was shaped by a number of different factors. Changes in clinical work due to increased workload – increased volume and increased complexity – was the most notable of these, with effects more severe in primary care, but also noted in secondary care. This workload adds time pressure, which has consequences for doctors' ability to take on additional leadership roles, and can have adverse effects on their wellbeing.

Technology also changed the practice of medicine for some, through increased availability of imaging and diagnostic technologies, telemedicine, and rapid communication with colleagues. Counterintuitively, the increased efficiency enabled by these technologies could add workload and time pressure.

Changes in governance, including clinical and professional governance processes, added further workload, and were also felt to challenge the professional autonomy of doctors. Even though clinical governance at least was seen to have value, the scrutiny involved was felt to damage a sense of trust.

Workforce challenges, in the form of staffing gaps among training grades, and attrition of senior doctors to retirement, also added further strain. This was ameliorated, in part, through increases in non-medical clinicians and trained administrative staff, but there could be adverse consequences if this redistribution of work increased the intensity of doctors' patient contact, even if overall volume was reduced.

### *Supporting changing roles*

The development of participants' roles could be supported by employers through providing time, and additional staffing to allow doctors to identify more time for non-patient-facing work. Where activities were included in job plans in secondary care, this allocation was often not enough.

Organisational culture was also key. While in part a function of resources, this was also experienced at an interpersonal level, with medical, non-medical and non-clinical staff all providing support in different ways. Senior management can provide support by being available, visible and 'listening'.

### *Benefits of changing roles*

Participants described intrinsic rewards of additional roles which benefited individual doctors and made their delivery of more effective. Echoing motivations that had led them into roles, many spoke of the way in which multiple roles gave them freedom and balance, and would leave them refreshed for their core clinical work.

### *Sustainability of leadership roles*

Finally, we identified elements relating to the sustainability of medical leadership roles through recruitment of newer consultants and GPs into senior roles, and the retention of those more established doctors who may be considering shedding roles as they approach retirement. At both ends, work-life balance is an issue.

### **Conclusions and implications**

The findings lead us to four main conclusions, with associated implications for policy and practice.

Firstly, **doctors' roles change as part of a complex system of policy and practice**. The interdependence and feedback between clinical work (and its socioeconomic determinants and technological facilitators), the availability of staff and resources, changes in governance and regulation, and the motivation and capacity of individual doctors mean that simple effects cannot be easily isolated.

Articulating leadership roles as part of a system, and identifying the systemic effects which shape and maintain those roles may provide a means of understanding, and so modifying, how leadership functions in the NHS.

Secondly, **organisations may support doctors in changing roles by improving the culture of leadership at all levels**. While individual leadership may depend on effective communication, organisational leadership may depend on effective listening, and enabling leaders to lead. Part of this is recognising leadership in all its forms, from embedded to explicit management roles, and providing support for individual transitions

into leadership roles. This may aid doctors' wellbeing by providing support to avoid or mitigate pressures, and make roles more attractive, and so sustainable.

Thirdly, while cultural support is important, it must also be reflected in **material support to ensure capacity for leadership**. In secondary care, this will be primarily in the realistic representation of work in job plans, and the resources to do that work. In primary care, partners have ostensibly more flexibility and autonomy in how they allocate their time, but not all practices have income to employ salaried GPs to free that time, and as noted above may be under other systematic pressures. Some areas of practice will require more attention, and resources, than others – whether because of staffing issues or headline clinical load – and so equity may not be achieved through equal investment, but rather investment where appropriate.

Finally, as doctors' roles, and the health service around them, continue to change, there is a **question of sustainability**. People need to be aware of the full range of leadership roles within medicine, and in order to be sustainable, access to those roles must be equitable to capitalise on the motivation that doctors bring to their post-training work. At present, opportunity is often linked to being in the right place at the right time, and while this may be effective, there are risks for individuals or roles being under-served, and implications for equality, diversity and inclusivity. We did not hear any examples of negative experiences, but even benign patronage is at risk of unconscious bias. There are also questions about whether leadership roles can be more open to a wider constituency, such as SAS doctors and salaried GPs.

We heard from doctors approaching retirement, or even post-retirement, who were still keen to keep going with clinical or non-clinical work. The extended careers of older doctors, as retirement ages advance, may provide a means of redistributing work, and 'recycling' that enthusiasm and skill for younger generations who may have different training experiences, and personal priorities, but there will still be doctors with skills and motivation to capitalise upon.

## Conclusion

We have found that doctors' leadership activities, embedded in their daily work, are under pressure from a number of directions. While explicit roles separated from their clinical jobs can be beneficial, the same pressures act as a deterrent to their taking on and remaining in those roles. However, the motivation and enthusiasm expressed by doctors in our study, to make positive changes, not just to their patients' lives, but also to those of their fellow doctors, and the wider healthcare system, is something to be capitalised upon.

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# 1 Introduction

The work of doctors has always involved activity additional to the practice of clinical medicine and associated administration. Clinical governance, education and management functions are all part of doctors' work, and are formally encompassed in the contract of employment for NHS consultants<sup>1</sup> (see Appendix A). In general practice, additional activities are not specified as GPs' work, but the General Medical Services Contract includes governance and administration that will often be done by GPs themselves, especially in small practices. All of these roles include elements of leadership, and our definition of 'doctors who lead' implicitly encompasses all consultants and GPs.

## 1.1 The centrality of medical leadership

Medical leadership has been defined as 'physicians with formal managerial roles or physicians who act as informal 'leaders' in daily practices'.<sup>2, p1</sup> Leadership can include management of resources, decision making, recruitment, and implementation of change,<sup>3</sup> functions which will involve the management of relationships within and between organisations.<sup>4</sup> Medical leadership also includes staff management, team building and delegation. For GPs, the leadership role encompasses all of these, but also extends to all aspects of running a business, including bringing in income.<sup>5</sup>

Leadership can therefore be seen as an integral part of all doctors' work, meaning that medical leaders may need to find a balance between leadership roles and responsibilities and their medical practice. While there is often a distinction made between 'leadership' and 'management',<sup>6</sup> we do not explore this or other theoretical issues in this report, and treat all senior functions as expressions of leadership.

The need for doctors to be leaders and take on management roles derives in part from the complexities that characterise modern health care.<sup>4</sup> Doctors are ideally placed to both understand and influence the functioning of health care, and so the presence and importance of leadership in all elements of doctors' work has become increasingly recognised. The Academy of Medical Royal Colleges, with NHS Improvement, published the Leadership Competency Framework in 2008<sup>7</sup> and the GMC explicitly stated in its 2012 guidance on management and leadership that it applies to all doctors whether they have a formal management role or not.<sup>8</sup> These formal management roles, which constitute distinct jobs from doctors' clinical appointments, have multiplied and grown in complexity<sup>9</sup> as efforts are made to engage physicians as a way of bridging the gap between clinicians and managers.

In the UK, government initiatives since the 1980s have focused on ways of introducing managerial responsibility and authority into doctors' work.<sup>10</sup> Doctors were initially made more responsible and accountable through budgetary experiments, then encouraged to take on formal managerial roles as part of their work, first as hospital general managers and then as clinical directors (managers of their own

directorates or specialty). Numbers of these medical managers were such that the British Medical Association (BMA) established a subcommittee to represent this group in 1994.<sup>11</sup> Today, clinical directors and clinical leads have responsibility for particular clinical areas (directorates in most NHS organisations), and report through a medical director to the organisational board. The effectiveness of individuals occupying posts such as these is therefore crucial for the effective functioning of the organisation.<sup>10</sup>

## 1.2 Benefits of effective clinical leaders

Effective clinical leadership has been shown in the literature to be a driver of positive organisational culture (ie which are supportive, open, and honest),<sup>12</sup> and that such a culture can often have benefits for patient care.<sup>13</sup>

Recent work commissioned by the GMC has shown that much of medical leadership is geared towards being compassionate and inclusive – fostering positive cultures that will, in turn, promote staff wellbeing and motivation.<sup>14</sup> While that study considered leadership as responsive to and influential on culture, our study has a broader remit in considering the entirety of leadership-related work undertaken by consultants and GPs.

Clinicians who take on leadership and managerial roles are likely to be motivated by a desire to influence the form of care provided and, in some cases, to improve on the way in which decisions have been taken in the past.<sup>15</sup> To perform these leadership roles effectively, one study identified that credibility among medical peers was the most important factor, followed by knowledge, skills and attitudes.<sup>2</sup> Collective and compassionate leadership are thought to have the biggest impact on care quality improvements.

## 1.3 Challenges in taking on leadership roles

The literature has found that new consultants are under-prepared for non-clinical leadership elements of their work compared to clinical elements, and that leadership is under-represented in training programmes.<sup>16,17</sup> Gaps have been identified within generic aspects of consultant work, including leadership, teaching and management skills; time management skills; change management skills; and understanding the system and how to operate within it (including financial skills).<sup>16, 18</sup>

There is little literature considering the development of senior roles once doctors have completed training. One recent study examined how consultants are involved in management structures in NHS Trusts in England and identified lack of time and career opportunities among barriers to their engagement.<sup>19</sup> The fast pace of change, the growing importance of increasingly complex organisations, and increasing cost pressures are a few challenges facing the modern medical leader.<sup>9</sup> The NHS system is under pressure, especially when staff shortages and rota gaps are changing the way doctors work. Work

commissioned by the GMC in 2018 elaborated some of these pressures experienced by doctors, finding a high proportion – especially in GP – are considering leaving medicine.<sup>20</sup>

Doctors who take on managerial roles are also confronted with questions about their identity and therefore may choose to reassert the primacy of their identities as clinicians, rather than focus on their role as a manager.<sup>21, 22, 23</sup> Taking on part-time managerial roles can be both stressful and isolating.<sup>23, 24</sup>

#### 1.4 Challenges for medical leadership

The types and nature of roles undertaken by doctors have been subject to changes in the organisation and delivery of healthcare arising from regulatory and political policy changes (such as changes in contracts and pensions, and the introduction of revalidation). Others may arise from clinical changes, as medical science and technology, including developments in telemedicine, change practice. Changes in the workforce, with new models of care and the expansion of non-medical practitioner roles, are also shaping the clinical environment. These may not *directly* change the roles that doctors undertake, but in changing the professional and clinical context, they have potential to influence what doctors do, and how they do it.

In a climate of central control exercised through standards and targets, there seems to be little encouragement and opportunity to lead change.<sup>4</sup> Recent NHS reforms have aimed to increase GP control through the creation of clinical commissioning groups (CCG). However, these act at a distance from surgeries and ‘hands-on’ patient care. GP engagement in managerial work may potentially ‘take GPs away from patient care, may alienate them from peers, and may, in time, make them unpopular with patients’.<sup>21, p10</sup> Further developments set out in the NHS England Long Term Plan<sup>25</sup> include the creation of Primary Care Networks which bring practices together to provide primary care at scale. The target for their introduction was July 2019, and they may further change leadership in primary care.

A key challenge identified in the literature is that the current approach to leadership development is based more on *individual* rather than *collective* leadership. Collective leadership means ‘everyone takes responsibility for the success of the organisation as a whole – not just for their own jobs or work area’.<sup>26, p4</sup> This collaborative style of leadership includes continual learning, with a focus on patient care, and requires high levels of communication, debate and discussion to achieve shared understanding about issues and solutions. Embedding the development of leaders within the context of the organisation is essential to unlocking cultural change throughout the NHS and will likely have a positive impact on both staff and patient care.<sup>26</sup>

#### 1.5 Developing medical leaders

It has been argued that there ‘needs to be a relentless, systematic drive to identify, support and develop good medical leaders’.<sup>27, p210</sup> It often falls to individual organisational leaders to create leadership

opportunities for working doctors within their organisations.<sup>4</sup> The most recent statement of the GMC's *Outcomes for Graduates* specifies that new doctors must have understanding of leadership principles and be able to demonstrate leadership skills.<sup>28</sup> However, there are likely to be associated challenges around the teaching and assessment of leadership.<sup>29</sup>

Individuals have a responsibility to apply the same standards to their leadership career as they do to their clinical career. Barriers to taking on these roles include competing rationalities, role ambiguity and a lack of time and support.<sup>2</sup> In order to overcome these barriers, it has been proposed that leadership development should be an essential component of the education of all medical staff.<sup>30</sup> Doctors must begin early in their careers to develop a set of knowledge, skills and behaviours that will enable them to engage and lead in highly complex, rapidly changing environments.

Mentoring relationships with established leaders, strong professional networks and experiential learning are suggested as excellent ways for future medical leaders to start developing the requisite skills and experience, but research has also highlighted the positive impact of leadership training programmes.<sup>31</sup> Participation in management programmes has always been thought to empower doctors to develop their role in management and to change what they do.<sup>5</sup> However, despite initiatives such as the development of the Faculty of Medical Leadership and Management (FMLM), doctors may continue to be unprepared for additional leadership roles.<sup>4</sup>

A lack of diversity is also limiting the clinical leadership potential within the NHS. Women and doctors of Black and Minority Ethnic (BME) background are underrepresented in leadership positions.<sup>32,33</sup> There is also a lack of engagement with doctors-in-training and GPs as clinical leaders.<sup>34</sup> Data from 2018 highlights an increase in the proportion of white doctors at consultant level, whilst BME doctors are a minority and still dropping.<sup>33</sup>

## 1.6 The current study

This study is concerned with how doctors perceive and demonstrate leadership in their varied roles. Recognising that leadership is a complex concept, we did not specify what leadership constitutes, but left it open to participants' interpretation. We set out to examine the roles undertaken by consultants and GPs, how those roles have changed, and what influences the taking on and delivery of those roles. The project examined five research questions, exploring the past, present and future work undertaken by senior doctors.

1. How do senior doctors describe their roles and activities in the organisation?
2. In what ways have these roles changed over time, and have they developed as doctors expected?
3. What factors are felt to influence the changing of roles?

4. What is the impact of these changes on senior doctors (such as well-being, perceptions of medicine and career plans)?
5. How have doctors' training and development equipped them to undertake leadership tasks and responsibilities beyond their clinical practice?

Our focus is on the experiences of individual doctors, but with the goal of informing understanding of the policy and organisational contexts which shape those experiences in a changing NHS.

## 2 Method

This was a cross-sectional interview study. Data was collected through one-to-one telephone interviews with participants across the UK.

### 2.1 Sampling

We used a 'snowball' sampling approach, whereby participants are sought through the suggestions of initial contacts (who may or may not choose to participate themselves). While initial invitations did not specify any restrictions, in later stages contacts were asked to suggest participants with particular characteristics to ensure a range of demographic or professional groups were included in the sample.

Participants were consultants, and GPs in salaried or partner roles. Sampling sought to capture new and established doctors in these roles. These were not fixed thresholds but we defined 'new' as being up to five years after completion of training, and 'established' as being over 15 years. We were content though to recruit across a range of ages and experience. Sampling also reflected differing workplace contexts, including size of organisation, clinical specialty and workforce composition (for example, specialties or practices where advanced practitioners may be involved in service delivery). Clinical specialties were categorised as 'craft' (included general surgery, surgical subspecialties, obstetrics & gynaecology), 'emergency' (included emergency medicine, intensive care, trauma and orthopaedics), 'medicine' (included general internal medicine, medical subspecialties and paediatrics), 'psychiatry' (including adult and child and adolescent mental health services) and radiology.

We wanted our sample to reflect a range of experience, from those who have relatively recently become consultants or GPs, to those who are well established, and beginning to look towards retirement. This is necessary not only because roles will develop through a medical career, but because the shape of medical careers has changed rapidly in recent decades. In particular, the 'modernising medical careers' (MMC) initiative involved a fundamental change starting with the introduction of the Foundation Programme in 2005, from an apprenticeship model of training whereby trainees worked closely with a consultant as part of their 'firm', to an outcomes based model where training and progression reflected standardised curricula. Secondly, in 2012 junior doctors' work came within the scope of the Working Time Regulations (2009), a restriction on working time which may have limited exposure to, and capacity to take on, non-clinical activity.

We are not setting out to examine whether these changes or other changes have had effects on doctors' careers and the leadership roles they undertake, but highlight them here as background to the different types of experience they may have had in training. In our sample, seven of 32 participants qualified since the introduction of the Foundation Programme.

## 2.2 Respondents

Thirty-two participants took part. These were drawn from different geographical areas across the four nations of the UK, and contained a mix of ages, genders and clinical specialties. Table 1 summarises the groups represented, and anonymised details of individual participants are included in Appendix B. In order to maintain anonymity, we provide only participants' gender, and how long they have been a consultant or GP with any illustrative quotes. To anonymise the part of the UK in which participants work, we use the term 'employer' generically to refer to the NHS Trust or Health Board in which a secondary care consultant primarily works, and 'regional/national roles' to refer to roles which have a wider remit across an English region (eg Health Education England local office) or a constituent nation of the UK (eg NHS England, Health Education and Improvement Wales, Departments of Health). We use the term 'UK-wide' if roles relate to whole nation (eg Royal Colleges, NICE).

**Table 1. Geographical, demographic and clinical breakdown of interview participants**

	Consultants (n=22)	GPs (n=10)
Time as consultant or GP *	Range = 1-31 years Median = 13 years 'New' ( $\leq 5$ years) n = 7	Range = 1-30 years Median= 9 years 'New' ( $\leq 5$ years) n = 3
Specialty	5 'craft' ** 3 emergency/trauma 11 medicine 2 psychiatry 1 radiology	
Country	8 England 3 Northern Ireland 7 Scotland 4 Wales	7 England 1 Northern Ireland 2 Scotland
Gender	12 female 10 male	6 female 4 male
Ethnicity and country of origin	4 BME, 3 IMG ***	

\* Where this was not obtained during the interview, it is estimated from the year of entry to the specialist or GP register displayed on searching the online register at [www.gmc-uk.org](http://www.gmc-uk.org)

\*\* 'Craft' includes general surgery, surgical subspecialties, obstetrics & gynaecology;

\*\*\* BME=Black & Minority Ethnic groups; IMG=International Medical Graduate

## 2.3 Interview guide

A semi-structured interview guide was used, illustrated in Box 1. All interviews covered the main topic areas, although specific question wording varied with individual interview dynamics (such as participants' areas of experience) and time available.

### Box 1. Main topic areas and example questions from interview guide

#### Current work, and changes

To begin with, tell me about what your work involves?

Since you became a consultant/GP, how have your clinical / non-clinical role(s) changed?

#### Why has work changed?

Why have those changes occurred?

Are there any elements of working environment that you think have influenced changes (eg technology)?

#### Feelings about work

How do you feel about different aspects of your role?

Has anything been lost/gained from your role as a clinician when becoming a leader?

#### Leadership

What do you think leadership is?

How do leadership requirements/skills in clinical and non-clinical areas compare?

#### Expectations

Are there any elements of your current work that you did not anticipate earlier in your career?

How much of your clinical work is at the level or of the type you expected? If not, why may that be?

Have things been different to what you observed as a trainee?

#### Preparedness

How prepared have you been [do you feel] for different roles – that you're doing now/may do in the future?

What prepared you to do those roles (eg specific training, role modelling, support, mentoring)?

#### Looking ahead

Thinking about your future career, how do you see your role or roles changing?

Do you think the shape of your work and clinical/non-clinical demands will change?

## 2.4 Analysis

Interview transcripts were analysed using inductive thematic analysis.<sup>35</sup> Sample transcripts were first reviewed to identify initial codes. These were applied to another set of transcripts, allowing development of codes and definitions to be refined and agreed. All transcripts were then coded, with ongoing discussion among the researchers, as needed, to ensure consistency. Sorted codes were reviewed to identify descriptive and cross-cutting themes. These were developed into narratives that were structured to address the research questions.

## 2.5 Ethical considerations

The proposal was subject to the Newcastle University Faculty of Medical Sciences Research Ethics process. Preliminary review established that full ethical review was not necessary. In order to ensure participants had the opportunity to provide full informed consent, a study information sheet and consent form for the recording and use of interview data was sent to participants in advance of interviews. Informed consent was established verbally at the outset of each interview.

## 3 Findings

### 3.1 Overview

In considering the changing roles of doctors who lead, we explored how, and why, participants' roles have changed over time. We also considered their perceptions of leadership, and how they identify or experience it in their work. The findings are structured as follow:

**Perceptions of leadership:** What leadership means to participants.

**How doctors' roles change:** How roles evolve, and how participants access additional leadership roles and responsibilities.

**How the context of work is changing:** Aspects of practice which change the nature or experience of participants' work.

**Factors shaping change:** Local factors which have supported or inhibited participants in changing or developing their roles.

**Rewards:** How participants describe personal and professional benefits of leadership roles

**Future changes:** How doctors' roles may change in the future, both for individual participants, and for the medical workforce in the longer term.

We considered findings from all participants together, and analysis did not distinguish a priori between consultants' and GPs' responses. However, we do note that there are some differences between primary and secondary care.

### 3.2 Perceptions of leadership

#### 3.2.1 *How is leadership defined?*

Participants described leadership in different ways – some indicating it is an individual attribute or personal quality, others that it is a skill. The implied distinction of these two views is that the latter is more inherently learnable and trainable, while the former is more stable and innate. However, those who made references to being 'natural' leaders or managers did not necessarily preclude it as being something which can be developed.

The skills of leadership encompassed abstract and practice skills, generally defined in terms of vision and communication, respectively. Vision was regarded as the ability to identify a need for, and a pathway to,

change. This required understanding of systems, and problem-solving ability. However, that alone was not sufficient, and the vision must be translated into 'doing', and effectively communicated to others. The core of this was effective communication with others, but also an understanding of the practicalities of practical 'management' skills, such as staffing issues and finance. Effective leadership did not necessarily require these to be done by the clinician (and indeed we heard examples of how non-medical managers helped support these skills in a GP surgery or hospital department), but doctors should understand them sufficiently so that they can be delegated. It was clear that leadership does not just mean having an idea, but also seeing it to fruition.

*'Doctors are great at coming up with ideas. They're absolutely fantastic at generating a vision. They're innovative, creative people. What they are absolutely rubbish at, almost to man and woman, is being able to see that through and break it down and manage it as a project through to completion.'* (Female consultant for 15 years)

The approach to communication was important, and an engaging, rather than a 'dictatorial' approach was preferred, as indicated by 'willingly' in the following quote. Communication also needs to be adaptive and flexible, recognising that different approaches may be necessary for different professional groups and individuals – such as other doctors, managers or nurses.

*'It's trying to have a vision and get everybody around you to work willingly towards that vision, I think. And willingly in the sense of taking them on board, convince them it is the right way and then go ahead with it.'* (Male consultant for 1 year)

The reward of leadership was illustrated by some participants who cited an element of lasting change and legacy arising from their activities, suggesting strategic, rather than just operational, vision: *'I wanted the world to be better than it was'* (male consultant for 14 years). This may be through education and training roles, through which they may shape the experience of trainees and so future practice in their specialty, but could also be related to developments in the service or changes that support the local community.

This sense of a personal investment in 'others' was illustrated by two GPs, both of whom were committed to sharing and passing on their drive and success to colleagues and patients in the local community.

*'I also really enjoy it if I can get some infectious energy across to somebody else in my team that will then run with a project to help improve things, that is one of the most satisfying things that I could ever do.'* (Female GP for 6 years)

### 3.2.2 *Explicit versus embedded leadership*

Regardless of how leadership was understood, there was a practical distinction in how it is recognised in work. This distinction was between 'explicit' leadership roles, associated with the formalised, named roles (such as

clinical lead, clinical director, medical director), and ‘embedded’ leadership in the day-to-day work of a consultant or GP.

Some explicit roles were completely separate from participants’ clinical jobs, either as an additional role with the same employer (e.g. clinical director), or with a different organisation (e.g. a deanery role such as training programme director). These tended to have dedicated time, and in theory provided a clear separation of time and/or place between jobs, albeit with a ‘*big mental switch*’ (as described a male GP of 12 years, who worked seven sessions as a GP partner, and three in a role with regional/national responsibility). However, these roles could penetrate other areas of clinical work, and may stretch leadership skills in having to deal with a broader range of people, from senior non-clinical management to the media. For example, a hospital-wide lead for patient safety described having to liaise with people from a patient’s relatives to the coroner to their Trust’s media office in the event of a serious untoward incident. The responsibilities of explicit leadership roles may still not always be clearly defined – ‘*nebulous*’ as one clinical lead put it.

Despite these challenges, there appeared to be more control or flexibility in time management for these explicit roles, compared to the embedded leadership responsibilities described by all participants. Indeed, the additional explicit role could have some advantage in encouraging personal time-management or in ‘*working for somebody else*’ (female consultant for 17 years) protecting against one’s own time being used for unpaid clinical work.

*‘I have to be very restrictive in the clinical work I can’t just let it roll on to the evening because I know that I’ve got other stuff that I need to do.’ (Female GP for 4 years)*

Embedded leadership responsibilities encompassed day-to-day clinical activities, as illustrated in this description of a ward round given by a newly appointed consultant.

*‘So, [for] example if you are doing a ward round that in itself is a kind of leadership role. So you walk to the ward you announce you’ve arrived and then you are the one who is essentially leading on it. So, you decide how to go around it in terms of deciding whether you’re planning to see sick patients first, new patients first and then at a very basic level you are delegating work as well as making sure everyone is on board and make sure the ward round goes smoothly.’ (Male consultant for 1 year)*

Supervision of trainees and other non-medical staff similarly incorporates responsibility and direction that echoes other aspects of leadership, and was accepted as an essential aspect of practice. There were also more strategic elements to embedded leadership in the development of services and focus on improving patient care. These may involve writing business cases or guidelines, research, audit and quality improvement projects.

Responsibility is perhaps the key common element of all these embedded activities: *'the buck stops with you'* (male consultant for 1 year).

As suggested above, embedded leadership was not always recognised by individuals. One GP described how they had identified an issue with the appointment system in their practice, designed a solution and introduced it to the other partners, yet only during the interview conceded *'I suppose that is leadership'* (female GP for 7 years).

Embedded leadership may also be a function of workplace systems, meaning that GPs and consultants developed their leadership roles because it is what was expected of them. For example, one participant described how they were alerted to errors which they were responsible for investigating, despite not being aware of it beforehand. This is illustrative of how consultants may have additional responsibilities imposed on them by the system, rather than being their choice.

*'Datix [web-based incident reporting and risk management software] then decides that you are going to be an investigator for something and you'll probably get an email saying you are an investigator for some incident usually which you've never had anything to do with. I've never agreed to do this. I don't actually have the time to do this and most of these Datix's are to be frank, stupidity.'* (Male consultant for 30 years)

There were mixed opinions on how transferable leadership skills are between clinical and non-clinical activity. Most suggested that the communication skills involved in particular were useful in clinical and non-clinical areas of work. However, some indicated that the nature of the problems faced in leadership and management roles was distinct: *'being a leader is a very different set of skills and doing that within a health service that is challenged financially and logistically and all sorts of levels is actually really difficult'* (male consultant for 5 years). These views are not necessarily contradictory, but suggest different people have a different focus on the skills or the content of leadership roles.

Leadership can be a wide-ranging activity, as indicated in Case 1.

### Case 1: An example of leadership

An example of the scope of leadership in primary care came from an established GP in a remote rural practice.

He described how he had moved to the practice after 15 years as a partner elsewhere, with the specific aim of turning it around.

This involved changing and updating elements of its clinical practice, such as introducing up to date chronic disease management pathways (diabetes, COPD, hypertension), providing the practice manager with development opportunities, introducing undergraduate and postgraduate training and developing new premises.

There was an element of opportunity acknowledged, in that the Private Finance Initiative at the time provided capital investment for new premises, allowing a multi-disciplinary team to be co-located rather than distributed across several older premises. Changes to the GP services contract in 2004, meaning that GPs were no longer responsible for providing out of hours care also made the move to the practice realistic, as well as desirable.

Collaboration with the local ambulance trust on providing a community paramedic service following the closure of an ambulance station also involved public consultation to address concerns from the local population.

This example illustrates the breadth of activities involved in effective leadership. It also illustrates the capacity, and indeed desire, for a well-established doctor to seek a change of direction and a new challenge.

### 3.3 How individual doctors' roles change

In the course of their post-training careers, participants' roles changed and developed in complex and idiosyncratic ways, and there was no single route through practice and career development. Embedded leadership *evolved* with experience and seniority, and while some consultants and GPs were content with those embedded elements, others were attracted to formal, explicit leadership roles.

Although there were examples of deliberate pursuit of, and progression into, these roles via intermediate positions (such as associate medical director *en route* to medical director), there did not appear to be a transparent career path. Participants in explicit leadership roles often described their progression into these roles as being 'opportunistic' and 'random'. Opportunities for new roles often came *ad hoc* from invitations or suggestions from senior colleagues. Some of these were a function of simply being in the right place at the right time, but others also contained an element of being the right person, and could be a more deliberate, or even strategic decision on the part of the proposer. There was a political undercurrent to this, with references to being encouraged to apply in order to avoid another (implicitly less suitable) candidate getting the role.

*'I suppose it interested me but probably I was flattered to be asked by the person who asked me and I'm under no illusion it was to avoid somebody else getting the job but it was then voted on so clearly other people supported me.'* (Female consultant for 14 years)

Opportunities also varied with organisational or geographical context. Small and remote communities may limit awareness of additional roles, but conversely could mean they are taken on by default because there are fewer possible candidates.

Participants often felt underprepared for leadership elements of their work in embedded and explicit roles, such as chairing meetings, writing a business case or managing poor performance of staff. These responsibilities are generally not part of specialty training curricula, where clinical skill development is the priority.

*'Actually though then [as a senior trainee] most of us focused on being an excellent or trying to be an excellent clinician and looking after patients.'* (Male consultant for 5 years)

Several participants had undertaken leadership courses during the latter stages of their training programme, although one noted it would have been more useful had she done it once she had experience of working as a consultant. Another felt that some consultants were rushed into explicit leadership roles, and felt fortunate that they had worked for a year, consolidating their position as a consultant, before taking on anything additional.

Notably no participants referred to any education or training in leadership or management *before* specialty training. Skills and knowledge evolved mostly through learning in practice, when already in a leadership role.

### 3.4 How doctors' work is changing

While doctors' roles change naturally through progression in their careers, other changes arise from wider contextual factors. Participants described a number of ways in which their work is shaped and changed by societal and political factors, including the content of that clinical work, changing governance requirements, changing technology, and changes to the workforce.

#### 3.4.1 Content of clinical work

**Firstly, the volume and content of clinical work has changed, and continues changing. This was experienced universally by consultants as well as GPs.**

While the fundamentals of clinical practice, and the essence of the doctor-patient consultation has remained constant, participants indicated that the volume and type of clinical cases, has changed. This

was more explicit, and leading to greater apparent strain, in primary care, but there were also examples in secondary care. These changes were distinct from the natural taking on of more complex cases as doctors progressed in seniority and experience.

In primary care, increased clinical workload was identified in two main ways. Firstly, there were increased numbers of patients. Patients additionally often had greater awareness of health issues and higher, sometimes unrealistic, expectations of access to a doctor. This may be driven by policy emphasising swiftness of access rather than appropriate access to healthcare.

*'There is a bit of a dial-a-doctor kind of norm where you know something happens medically and you instantly pick up the phone and call the doctor because we're very accessible ... when actually you could've gone to the pharmacist.'* (Female GP for 4 years)

Secondly, while some patients attended for ostensibly trivial clinical concerns that did not require a GP's attention (*'threadworms, head lice'*; female GP for 4 years), there were also more patients with increasingly complex multi-morbidities, including dementia, associated with an ageing population. There was also an increase in palliative care work in the community because of lack of space in hospices. Some GPs working in socioeconomically deprived areas also identified increased numbers of complex socio-medical problems associated with poverty, including homelessness, mental health problems and substance abuse.

Furthermore, these patient-driven presentations were in the context of a policy-driven shift to primary care, with GPs having to become more specialised in managing these complex cases. However, the challenging, and distressing, nature of many of these presentations, with little respite, was itself a challenge for GPs (see Case 2). Some spoke of the benefits of having simpler cases to break up their day.

In secondary care, participants similarly reported an increased pace of work and complexity of patients. Medical therapeutics and surgical techniques were also changing and becoming increasingly specialised. There was an expectation for consultants to be on the *'shop floor'* (female consultant for 10 years), which could be physically draining for some at an older age.

*'So, for example you're up and you're in. I was on call at the weekend started just on Saturday, started Saturday at 9 and I finished at half past ten and back in again the next morning at 7 o'clock and I'm working till 4 o'clock yesterday and I'm working full time today and to the end of the week. So as you get older that's a lot harder to do.'* (Female consultant 19 years)

## Case 2: Changing clinical demands in primary care

Two GPs in different parts of the country described how the experience of work in general practice is changing and adding pressure on them.

One described a former single-handed practice which had developed problems of management and effectively become a practice targeted by patients with drug dependencies: *'that cohort of patients had gravitated towards it'*. The practice had developed a reputation among GPs, making it undesirable for salaried GPs, and the sole partner had been supplemented by short-term locums.

This was symptomatic of a deprived socioeconomic area, with problems relating to poverty and release from prison, as well as alcohol and drug dependency. Attention to safeguarding (to avoid over-prescribing) complicated consultations, and there would often be multi-agency follow up not required elsewhere. The participant contrasted this with the experience of working in a more affluent adjacent area.

The practice had received investment from a local network, including nurse practitioners and a community psychiatric nurse. Although this took the pressure off, *'the nurse practitioners took away the quick'*, leaving a burden of complex cases left for GPs, and *'we broke a couple of doctors in the process just because they couldn't manage the workload'*. A move to 15 minute appointments mitigated this, but there remained pressure and the effects on this individual were striking.

*'..it was probably the closest to burnout I've ever been last year with everything that was going on. The only thing that kept me going was knowing I was going to be off on maternity leave and it was going to end. There was an endpoint that I just had to get to.'*

The second example described the changing relationship between primary care and other areas of healthcare – secondary care and other community practices such as dentists and optometrists. They felt that increasingly general practice is seen as the *'dustbin specialty'* and were passed a host of different problems, some of which may be outside the appropriate expertise of a GP. This informal referral could lead to increase and unrealistic patient expectations: *'I get somebody coming in with something they have been led to believe that I will solve and I simply don't have the skills or the training to do that'*.

Secondary care participants reported that pressures to discharge patients, linked to bed shortages and clinical targets, added stress to their workload. This however also compounded the pressure felt by GPs as patients were referred back to them at an early stage.

*'If people are admitted the chances of them being followed up in clinic are next to none... You know that used to be the norm that someone would at least get one appointment [in outpatients, now] people have a heart attack and they just get discharged.'* (Female GP for 4 years)

These changes mean that doctors have less time to undertake additional roles. Patient-facing clinical work was participants' priority, with associated administration being done in their own time where necessary.

As a result, 'optional' additional explicit roles may be expendable, while much essential embedded leadership is squeezed into Supporting Professional Activity (SPA) time and doctors' own time.

### 3.4.2 Governance

**Work has also been shaped by changes in clinical and professional governance – adding discrete elements of work, and changing how other activities are done.**

As part of governance, we include any administrative work requiring data to be collated or returned for the purposes of establishing or ensuring quality. Within this we include clinical governance, focused on clinical practice and patient outcomes, and professional governance, focused on the development and performance of the individual doctor. These changes have been shaped by national policy and regulatory changes, and had the effect of influencing participants' perceptions of the culture they are working in, and indeed the social status of medicine.

*'The work itself hasn't changed it just takes twice as long to do everything sometimes. Because there is so much, for example patient reflection notes that kind of thing, the other stuff you have to do now that is not directly clinical but satisfies someone else for other reasons that aren't clinical, like things they can measure or that kind of thing which are important for trusts maybe but not important for patients.'* (Male consultant for 17 years)

Clinical governance has placed added leadership responsibilities on all clinicians by requiring the collation and return of clinical outcomes. There were also some aspects of clinical governance that created explicit roles. For example, one participant chaired a 'new procedures committee', which had oversight of any new surgical procedure before it could be carried out in a hospital.

Aspects associated with professional governance mainly referred to education, appraisal and revalidation. Some participants referred to the administrative requirements of these processes as being paperwork that is '*frustrating*' and '*doesn't mean anything*' (female consultant for 17 years). However, they also presented more fundamental challenges in a perceived threat to the professionalism of doctors in the increased 'scrutiny' they represent. Participants referred to feeling a loss of autonomy and a perceived lack of trust. The detailed focus of job planning was also a related issue, as an aspect of organisational monitoring which was unwelcome ('*infantilising*' in the words of a male consultant of 17 years), as well as being of dubious practical value.

*'It's just the feeling about the whole thing is different because you were trusted before, or it felt as if you were trusted to do the best for the patient, and now you have to actually prove you are doing the best for the patient. We know that is good for the patients but it has changed the feel of how we do the work quite a lot. You were autonomous before and now you are being scrutinised while you're doing that. There's a difference, it's subtle, actually now that is a difference in how you do your work.'* (Male consultant for 31 years)

While the validity and usefulness of governance was questioned by some, the benefits of clinical governance at least were generally recognised and acknowledged. However, even then there was a sense of there being a fundamental challenge to what it means to be a doctor.

*'It's the head and the heart. My head is completely okay with that but my heart its 'don't you trust me anymore?''* (Male consultant for 31 years)

### 3.4.3 Technology

**Developments in technology have changed aspects of medicine. Some of these changes are associated with direct clinical care, others with administrative aspects.**

New technologies have the potential to make work more efficient, but there was evidence that they could in fact add to work by increasing the information doctors have to deal with.

This included online communication – whether electronic records (such as the 'Paperlite' system) or the ubiquity of email. These systems facilitated ease and reliability of access, but could also add to workload. Use of 'Paperlite' could slow patient clerking, whereas email added to the volume of clinical administration.

*'You can't, you know, write a letter send it and sit back and wait for the response. You like to get a response in three minutes and then that generates the next thing for you to do and the next. So everything you do you do much more quickly.'* (Female consultant for 19 years)

In patient-facing clinical work the increased availability and precision of diagnostic and therapeutic technologies could have a similar effect. For example, in radiology the increased availability of sophisticated imaging has changed how some diagnostic images are used (see Case 3). In medicine, continuous glucose monitoring data provides more insight into diabetes, but requires additional expertise (and so training) to interpret, and changes the way in which investigations are handled. Both of these examples had the potential to increase the workload of consultants by providing them with more data to consider.

### Case 3: How technology is changing a medical specialty

The clearest examples of how technology can change practice within a specialty came from a consultant radiologist. The expansion of technology in radiology is understandable as digital imaging is well established, but some of the points here may be transferable to other areas where technology is emerging.

Two main changes were described. The first relating to the ease and accessibility of imaging with the increased availability of multi-detector CT (computerised tomography) equipment which provides high quality images. This is used routinely as an acute investigation, substituting for other investigations (example, an intravenous urogram), or even clinical skills and decision-making. Previously CT scans were limited to serious medical cases only.

CT scans are also indicated by NICE guidelines as a routine investigation in case of falls in older patients. The ease of gaining such images enables emergency departments to more quickly admit or discharge patients within the four hour target period. Such changes do not mean investigations are unnecessary or inappropriate, but they do increase the quantity of images to be reported.

Our participant also noted that the availability of such detailed diagnostic images may be leading less experienced doctors to not develop the same skills of clinical reasoning within their own practice as more established colleagues.

The second change, in part, mitigates the additional workload noted above, and reflects the relative ease of storing and accessing digital images. This allows both remote viewing and reporting by off-site radiologists, and review of historical images of a patient.

Telemedicine, which can be broadly defined as the use of technology to facilitate healthcare remotely, is another example where technology has had an impact. This can mitigate workload, for example, in the use of electronic systems to allow remote reporting of radiographic images – in one case overnight by radiologists ‘on call’ in Australia. However, in that example it required a local radiologist to be available as a failsafe should there be problems with the technology.

Telemedicine can also take the form of remote consultations. We heard examples of telephone triage (meaning patients do not have to attend a GP practice but can be screened by a GP or other professional), and remote patient consultations. The latter may be of particular benefit for patients in remote and rural communities, and may enable patients to see specialists elsewhere more easily. However, it may not reduce workload if, as well as the remote specialist, a second clinician is still required to be physically present with a patient.

#### 3.4.4 Workforce changes

Doctors' work is also directly affected by changes in the healthcare workforce, encompassing both medical and non-medical staff.

The medical workforce is under strain. There are many elements to this, but those identified by participants related largely to underfilled posts in specialty training, and the loss of senior doctors through retirement. These changes can place additional strain on consultants and GPs, and again limit their time to carry out non-patient-facing activities. One participant described how they provide a resident out-of-hours service due to persistent rota gaps, a rota which had a direct effect on time for other work due to rest days following night shifts.

Such formal rostered changes, or the need to informally step in to cover service, could lead to consultants acting outside their normal roles or 'acting down' in doing things normally done by trainees.

*'It's almost par for the course that you check the rota to see what gaps there are, that then impacts on your ability to deliver the care. Whereas we used to be able to get locums, now you just can't, either because you can only get them for break-glass ceiling rates or because they just don't exist out there anymore.'* (Male GP for 30 years)

Acting down was also evident in some examples of procedures conducted by the consultant because their recent trainees had had inadequate experience. The more common expectation of a consultant being on the 'shop floor' to supervise trainees could imply acting down, though this was not necessarily problematic.

*'In my experience acting down is only acting down if you let it be. So of course I'm not keen to allow myself to become a clerking machine. I'm not letting myself become someone who just chases blood results & does all the fundamental administrative tasks. So when a lot of people think about acting down they mainly concentrate on providing hands on clinical cover as 1 of the first doctors to see the patient, so that can be combined with your supervisory activity.'* (Male consultant for 14 years)

Gaps in the consultant workforce were also described as being due to perceived under-investment. Consultant gaps may be filled by SAS doctors who have undertaken the Certificate of Equivalence for Specialist Registration (CESR), but one participant noted that this compounded problems in the short term, as the SAS doctors had to leave rotas in order to gain experience for the CESR.

In general practice, workforce problems were notable more through the loss of GPs to retirement, and difficulties in recruiting new partners, or salaried doctors. Locums can provide a short-term solution, but

are costly and may be difficult to recruit. Also, they may not fulfil all elements of the clinical role, which one GP felt limited their usefulness.

Non-medical staff, including nurses, allied health professionals, physician associates and administrative staff were all referred to as having a role in changing doctors' work. Largely these changes were positive, and several participants spoke highly of the role of non-medical clinicians in providing care, and non-clinical staff taking on work to free time for additional roles. In general practice non-medical clinicians can triage and see patients, with advantages for patient access.

*'We do use emergency care practitioners for doing visits, they are part of the district nursing community services and you have to choose, you can't just send them to any visit they're there for people who could potentially be kept at home with a little bit of extra input rather than going to hospital, and they're very good. They're very good and they don't create extra work normally which is good.'* (Female GP for 7 years)

One participant noted a practice's negative experience with nurse practitioners who referred most things back to GPs, which suggests training and appropriate processes are necessary to ensure the benefits of such staff are achieved.

However, there were other potential changes in primary care, linked to the changing mix of patient presentations. Some felt that with advanced nurse practitioners taking on minor problems, the intensity of GPs' work increased, with risks for wellbeing. On the other hand, other GPs' welcomes a similar change, with complex cases being more rewarding.

Other examples of non-medical roles in primary care that were identified as key to freeing time included a 'link worker' employed to support patients with social problems, clinical coders who review discharge correspondence from hospitals and code diagnoses correctly, and prescribing technicians who can provide a range of support, from preparing repeat prescriptions to conducting prescribing audits. Those participants who had these additional staff in surgeries appreciated the time and flexibility it gave them to undertake other roles (whether embedded or explicit).

### **3.4.5 Organisational models**

In primary care particularly, the multi-professional workforce was often associated with changes in the organisation of work. In Scotland, a new Scotland-only GP contract was introduced in 2018, linked to the establishment of geographical 'clusters' of practices.<sup>36</sup> In England, Primary Care Networks were formulated as collectives of GP practices working at scale in the 2018 NHS England Long Term Plan,<sup>25</sup> and several of our participants referred to these being in place or in development. (Similar approaches have

been specified in Wales and Northern Ireland, but we did not hear about these directly from participants<sup>37, 38</sup>).

Practices' working collaboratively in such ways allows distribution of roles, leading to economies of scale in the shared employment of support staff, and centralisation of expertise. For example, one consortium of several practices had human resources and payroll functions held by a Foundation Trust, removing the need for practice staff to take on these jobs, and freeing GPs from some of their management roles. This model employed most GPs on salaried terms rather than as partners – which gave flexibility to take on non-clinical responsibilities. One respondent felt this was a benefit as the business responsibilities and risks of partnership were removed, while providing the benefits of a leadership role.

*'[The idea] is that the clinicians are freed up to focus on providing clinical care. So you can take on additional roles as I have done with a new organisation but that's not mandatory and if you want to just see patients you absolutely can.'* (Female GP for 4 years)

We also heard from a collective of small practices in a rural community. This offers economies of scale in employing administrative staff who would otherwise not be cost effective in a single practice – or involve low hours that would be hard to recruit to appealing to the staff member.

### 3.5 What supports or inhibits change?

The previous section described changes in doctors' work arising from changes that are happening at a societal, regulatory or policy level. While these are shaped locally, with clinical demands, workforce, and appraisal systems all varying by setting – they have effects across the profession. There are also more proximal effects on the work of individual doctors, which may support or inhibit their ability or inclination to take on more-than-clinical work.

#### 3.5.1 Time

The first of these was the time available to perform different activities in addition to patient-facing clinical work. Some of the causes of time pressure have been discussed in the previous section. This is an endemic problem, with participants often talking of time being 'squeezed', or 'ducking and diving' and using their own time in order to be able to deliver all aspects of their work.

This squeezed time also limited, and was a deterrent to taking on, additional leadership roles. Some spoke positively about using their time flexibly and efficiently between roles, but for others the need to be responsive, and the intrusion of work into their own time had implications for work-life balance.

*'I've got 3 young children as well... time with them I should not be looking at my phone and checking emails and stuff.'* (Female GP for 3 years)

Allowing more time for doctors to undertake all elements of their work, including additional explicit leadership roles, may improve the accessibility of these roles and reduce workload pressures. For consultants, the management of their time is largely down to their job plan agreed locally with their primary NHS employer. Local solutions allowing consultants to drop clinical sessions without service delivery suffering, or to come off on-call rotas, did not seem to be common.

*'It can be difficult to blend the two and get the balance right and there's a lot of pressure from the hospital to make sure you're delivering your clinical work.'* (Male consultant for 5 years)

GP partners ostensibly have more control over the number of clinical sessions they work, but clinical demands can be more intense, and the non-clinical aspects of practice management are a more intrinsic part of their working week. While they have autonomy to employ salaried or locum doctors to ease clinical pressure, this is not always financially possible, and some practices due to geography or patient population are less popular than others.

### **3.5.2 Organisational culture**

As well as practical support, a positive and open culture can facilitate doctors' undertaking additional roles. Such a culture was described in terms of access to senior management, and support for flexible arrangements to allow other roles to be taken on. While communication is an important element of leadership, the organisation must be able to 'listen' for that communication to be effective. The tone and engagement of senior management changes how consultants approach their leadership roles (see Case 4).

*'I have to compromise and I have to do some general [clinical] commitments. But they've been very understanding that they know it's not my first love and so I don't do an onerous amount of it, I do a very reasonable amount. But that took time and compromise from the department and I have to remember, and I do remember, that my department is my first loyalty as it were. I'm very lucky that we have an engaged department.'* (Female consultant for 5 years)

There are also other local cultural factors. For smaller communities, organisational and social culture may be interrelated, and participants from these areas indicated that the social and geographical context of their work had a direct impact on why they took on leading service change for benefit of the local community.

*'The culture is the most important part of that and I think that's a culture that is not necessarily throughout general practice on the mainland, particularly in urban areas that are struggling to recruit GP's.'* (Female GP for 20 years)

#### **Case 4: How organisational culture can facilitate leadership**

Two consultants in different parts of the country described how organisational culture impacted on their perception of leadership roles.

One described how different hospital senior management styles changed how they approached their role. They contrasted a negative management style experienced as a trainee, with a more positive and inclusive attitude latterly: *"the medical director said in the induction... 'hopefully this is the only time you'll see me... because if you see me again it's probably because you're in trouble'... the new guy came in from another trust who was a complete breath of fresh air, very engaged, working with people, very open, very contactable".*

The more open senior management approach continued into the participant's consultant role. The change did not necessarily have a material effect on the consultant role, but shaped the atmosphere of their work *"It is very common to see the senior management team on the ward in ED [emergency department], and not just at times of crisis, but also whenever things have gone well. Business as usual. So, there is that visibility at different times and not just when there is crisis."*

Elsewhere, a consultant described tension between clinical and non-clinical senior management, and an apparent lack of engagement, and even antagonism between the two groups. They described pressure and expectation without consultation, or resources, from senior management, with a previous clinical director having felt a *'messenger boy'*. This attitude led to the participant declining the opportunity to apply for the clinical director role.

### **3.6 Perceived benefits of leadership**

Doctors' careers described benefits from having leadership roles. Some of these benefits were anticipated, and formed part of doctors' motivation to take on roles. Others were incidental, but affected desire to remain in roles.

Participants described explicit benefits for their personal wellbeing in undertaking multiple roles. This was truer of those in explicit leadership roles which constituted discrete and distinct jobs. While participants' clinical areas varied, all spoke of the enjoyment they still gained from patient contact and the practice of clinical medicine, but they also often spoke of the satisfaction and enjoyment of their non-clinical roles, including the greater imagination and creativity possible in non-clinical roles.

*'I think actually what I really like about it is it allows me space to be creative, innovative and put my own stamp on things that you don't always get in the clinical environment.'* (Female consultant for 19 years)

There was intrinsic satisfaction from having multiple roles, and the freedom to explore interests. Several spoke of variety providing a break from clinical work and so 'keeping fresh', and retaining interest in the clinical side of work. Implicitly, this benefit for wellbeing may protect against burnout or simple boredom.

For some, there was clear positive impact from a mutual benefit or synergy between their multiple roles – with personal and professional benefit. Consequently, it was important to maintain clinical work, and 'understand what's happening on the ground' in order to be able to do the non-clinical work effectively.

*'Then I found that actually doing the things I enjoy which is education actually gives me more energy when it comes to doing the clinical job and I have to be very restrictive in the clinical work I can't just let it roll on to the evening because I know that I've got other stuff that I need to do.'* (Female consultant for 17 years)

Having a 'foot in both camps' in this way may help serve as an interface between clinical and management worlds.

One participant went further and stated that in order to be an effective clinical leader it was essential to be an effective clinician, and have the respect of clinical peers.

*'You know, but am I really going to listen to somebody telling me they want me to do a b and c, if I think, you know, 'You kind of can't cut your way out of a wet paper bag. Well, why would I listen to you?'* (Male consultant for 18 years)

This credibility may be, in part, predicated on a practical understanding of clinical practice, but also appears to be a more abstract credibility.

There were some negatives identified from being involved in management roles. Leadership was identified by some in senior management roles as 'thankless', and lacking the closure or tangible reward of clinical work. There were also suggestions of adverse effects on interpersonal relationships, when situations required the clinician to exert authority over colleagues.

*'There is hardly ever an end point in the managerial role, while clinical I stick your arm in a cast and you come back 6 weeks later and the cast has healed it, I take it off and off you go back to your previous life and I don't see you again.'* (Male consultant for 31 years)

Overall, participants reported a benefit of having additional roles, with some GPs actively planning a portfolio career in order to capitalise on this.

*'So I would describe myself as a portfolio GP. In my opinion that's the only way to survive in primary care at the moment, which is not to do it purely full-time GP.'* (Female GP for 6 years)

Furthermore, while it was apparent that clinical and manager roles were separate roles and identities, we found no apparent conflict or threat arising from dual roles, but rather a complementarity. Any challenges came from logistics and time, rather than having multiple roles. These challenges could be serious, such as the perceived risk of deskilling if clinical time was too restricted, but were practical in nature. The perceived risk of deskilling, and associated consequences for taking on additional roles, was felt to be higher in craft specialties than in medicine.

*'If I was to go back to being a full time Anaesthetist I would need to have some quite comprehensive support to re-skill.'* (Female consultant for 15 years)

However, as long as this support is available, re-entry to wider clinical practice is possible.

### 3.7 Future changes in the roles of doctors who lead

We considered how the roles of doctors will change in the future, and implications for leadership roles, given the changes experienced by our participants. Analysis examined participants anticipated changes in their own careers – whether they saw themselves taking on additional roles – and also for the next generation of consultants and GPs coming through training into a different system. There are two elements here – recruitment of new leaders from those in early stage of their career, and retention of established leaders.

These questions are integral to the sustainability and future planning of the senior medical workforce. Issues of retention and recruitment to additional roles will be more important in future, given the changing context of work.

#### 3.7.1 Recruitment

There was a perception that doctors coming through training and entering the consultant and GP workforce differ from their more established colleagues and will have a different perspective on taking on additional embedded and explicit leadership roles.

While perceptions of generational difference are endemic in each generation, and often overstated, the differences identified can be linked to specific changes in systems of postgraduate medical education. The Foundation Programme and consequent changes in specialty training were initiated in the Modernising Medical Careers programme in 2005, meaning that the first cohort of GPs to follow this pathway will only have completed training in 2010. Some secondary care specialties will not have completed training until 2016, or even later if they have taken time out of programme.

These changes, designed to streamline medical training amongst other things, will have led to a different experience of having time to choose a career and gain experience before entering specialty training compared to earlier generations. At the same time, changes in doctors working hours, mainly associated with the Working Time Regulations (1998) which have applied to doctors in training since 2009, have been perceived as limiting clinical exposure. The changes in workload, workforce and governance described earlier have also been part of these newer doctors' environment during training.

Therefore, while individual motivation and opportunity may stay essentially the same, there are important differences in the experiences of today's trainees, which may be reflected in a perceived different attitude by more established doctors. This was felt by early career consultants and GPs, and not just those more established. These perceptions were not necessarily pejorative, but suggested that their approach to work is different, perhaps influenced by organisational priorities around time and being told by Trusts not to work beyond rostered hours. The consequences for this may be a reluctance to take on additional roles, or, more positively, to engage with them differently and more assertively for their own wellbeing.

*'I think you'll find that people will still do them but they will do them on their own terms.'*  
(Male consultant for 2 years)

Contractual issues may compound this. Newly appointed consultants in at least one location were routinely appointed on contracts with just one Supporting Professional Activity (SPA) session, in which to fit all their educational roles and CPD, compared to the two available to their more established colleagues. Taking on further non-job planned roles will be far more challenging for them.

*'There is absolutely no room for their personal development taking that forward without having to fight for extra SPA time. I think these extra roles are vital but not properly valued [by employers].'* (Female consultant for 10 years)

Some younger participants, facing later retirement than those in their 50s or 60s, felt that compared to older generations their career plans may be more fluid. There was a sense that change and renewal are desirable, perhaps reflecting their motivation to take on these roles in the first place, and the associated desire expressed by some to have varied roles.

*'So, I don't expect my roles to be the same. I would expect it to evolve and change... I haven't got bored yet but I think inertia and boredom will be the death of many a career.'*  
(Female consultant for 6 years)

There are also practical constraints to recruitment. The sustainability of the population of medical leaders, at all levels, is subject to policy and resources.

In general practice, the personal and financial investment in running a business may dissuade clinicians from taking on other roles or responsibilities. This was identified by one newer GP as being a factor in resistance to organisational change and joining a practice network, despite it potentially being more beneficial in the long term. This element of sunk cost was also apparent at an individual level, if personal time had been invested in developing leadership skills – it would be a waste not to use these.

*'I think I only started my leadership training in 2012 when I took up the role, so one of the things with sticking with it is I spent a lot of time learning and developing over the last 7 to 8 years so it feels difficult to walk away from that.'* (Female consultant, 17 years)

### 3.7.2 Retention

Participants' perspectives on their own future varied. Many were content with their current working lives and felt their roles would not change much in the future, for personal or professional reasons. Others, at similar stages of their careers, had aspirations to progress further, either to specific roles (generally educational, rather than medical managers), or as a more generic aim.

However, some more established participants were considering the end of their careers, and many indicated they would limit their hours as they approached retirement. While few were intending to stop work completely, most indicated they were likely to retain clinical work, as it is the most intrinsically rewarding, and that leadership roles were more expendable.

Although most do not wish to leave the workforce completely, work-life balance was important for these more established doctors. Many spoke of spending time with family, and enjoying retirement.

*'I suspect I won't retire from one day working and the next day nothing, I suspect I will scale down .... So, I don't think I will stop working for quite some time still, but whether that will be in a managerial type of role or in a clinical role I'm not sure.'* (Male consultant for 31 years)

On the other hand, there were drivers out of medicine, with frustrations often linked to the perceived extra bureaucracy of professional governance, which were making staying in medicine less appealing.

*'I think that I find the amount of, just the whole revalidation and all the staff and all the paperwork it doesn't mean anything and I just find that all frustrating. I have one more revalidation and then I don't imagine I will work beyond that. I just think I'll have had enough of it all.'* (Female consultant for 17 years)

For this reason, some were clear they would not want to over-commit and would decline roles that they felt would jeopardise the quality of the care they provide to their patients.

*'The first aim was to fit into the new role, second one, and will continue to be, patient safety because you are now responsible for them so I don't want to take too much on board and compromise on, for example, dictation time so your letters are getting delayed and stuff like that.'* (Male consultant for 1 year)

The pressures of work and perceived adverse effects on wellbeing were particularly notable in primary care, with clear indications this may be leading to increased attrition.

*'So it was incredibly stressful and in the world that I live in where there are not enough GPs and the ones that we do have are retiring early because they can't cope with the stress and resigning.'* (Female GP for 7 years)

The changes to taxation of pensions were also cited by several participants as deterrents to taking on additional roles, or continuing in them. These changes appeared to be a definite disincentive for some to take on additional roles, or indeed to stay in the NHS.

*'The pensions thing is perhaps the single biggest thing that has made me decide that I will leave, well certainly the NHS pension scheme and probably the NHS itself, at the earliest opportunity really. I think that's it's been a catastrophe.'* (Male consultant for 17 years)

Overall, there is a mature workforce for whom a change in role later in their career may provide personal and professional benefits. Retention of these doctors in the workforce, even in different roles, may provide a benefit.

## 4 Discussion

The project set out to examine five research questions. Brief answers to these are given below, however this under-represents complexity. The remainder of this section considers the synthesis of findings across the four main research areas, with implications for policy, practice and further research.

### **RQ1: How do senior doctors describe their roles and activities?**

The roles undertaken by consultants and GPs are varied and complex. Patient-facing care is central to their work, with other activities, including clinical administration and leadership roles, fitting around it. All consultants and GPs have leadership roles that are embedded, and implicit in their day-to-day clinical roles. These roles include managing clinics, ward rounds and surgeries, supervision of trainees and other team members, and aspects of clinical governance. Some also have explicit leadership roles which tend to involve responsibility for larger and deeper areas of their organisation (such as a clinical director or medical director), or national or regional responsibility in a different organisation (such as their deanery).

### **RQ2: In what ways have these roles changed over time, and have they developed as doctors expected?**

### **RQ3: What factors are felt to influence the changing of roles?**

Roles change naturally with career progression as doctors take on additional activities and responsibilities. Movement into explicit leadership roles is often opportunistic, and there are no clear career paths into leadership, and as such no clear expectations to be fulfilled or subverted. Their work is shaped by a number of factors, such as changes in the volume and intensity of clinical work, including patient' expectations, the growth of clinical and professional governance, and technological changes.

### **RQ4: What is the impact of these changes on senior doctors (such as, well-being, perceptions of medicine and career plans)?**

Changes in clinical workload bring challenges, particularly in primary care. Increasing numbers and complexity of clinical work can put pressure on other embedded roles, leading to stress. However, the impact on individual doctors of having distinct, explicit leadership roles is largely positive. These roles can fulfil motivation for change and self-fulfilment, while variety can maintain interest in clinical work, and potentially protect against 'burnout'.

### **RQ5: How have doctors' training and development equipped them to undertake leadership tasks and responsibilities beyond their clinical practice?**

Doctors are largely unprepared for embedded and explicit leadership roles, with much being learned on the job, albeit with some prior role modelling. Access to training in management and

leadership skills appears to be very variable, with some receiving it routinely through local courses during specialty training, and others seeking it themselves. The timing of leadership and management training is important, as it must be salient and linked to their current practice.

#### 4.1 Understanding changing roles in a changing healthcare system

Our findings show that doctors' changing roles are part of a complex system of policy and practice. Things which affects one aspect of a doctor's work may have direct and indirect effects on others. Similarly, what affects one individual doctor, or group of doctors, may have an effect on other doctors. This should come as no surprise, but while some of the features of that system are directly and proximally related to the work that doctors do (such as clinical workload and job planning), others are more removed (such as societal inequality and pensions changes).

Below we consider effects of the culture and capacity of organisations in relation to changing roles, how doctors move into explicit leadership roles, and considerations for the future sustainability of leadership in medicine. These are not independent elements of the system, and there are direct and indirect feedback effects between them.

First among the system effects is the content of clinical work. Increasing volume and complexity of work limits time for non-clinical work. Itself subject to other complex factors, the largest change in clinical work appeared to be in primary care, with a variable sociocultural context shaping the clinical demands on GPs. At its most extreme, GPs in deprived areas can have a very high load of distressing and stressful cases, who cannot be 'treated' *per se* but rather whose health concerns are functions of wider socioeconomic problems. This places pressure on individual GPs in managing this complexity in short consultations, and greater numbers of consultations. This may be compounded by such practices being unattractive to locums or salaried GPs. Even in less extreme contexts, the increase of comorbidities in an ageing population increases the numbers of complex cases, adding pressure.

These changes in immediate patient demand are compounded by policy changes which aim to move more healthcare provision from secondary to primary care. Meanwhile changes in secondary care, aiming to minimise hospital stays, place pressure on consultants to minimise admissions and speed up discharges, and in turn put pressure back on general practice. The net result of this may be good for patients, but the strain experienced by doctors is a challenge to the system.

Clinical practice is also changing with technology. Telemedicine in its varied forms may distribute work, potentially worldwide, but this does not necessarily mean that work is shared, or reduced. Rather the increased speed and accessibility of electronic information sharing, and diagnostic investigations may

multiply workload. Remote consultations may provide welcome flexibility for patients, but the expectations placed on medical staff may not be clearly recognised.

Secondly, wider changes in governance requirements have changed the content, and the context of doctors' work. Clinical governance, appraisal and revalidation, and the increased bureaucracy associated with these processes can be seen as integral to the leadership elements of doctor's work.<sup>4</sup> As they change, so does the way in which those roles are seen. The increased scrutiny associated with governance has implications for doctors' perceived autonomy, and may indicate a perceived de-professionalisation of medicine. While these initiatives are intended to improve quality of care or training, they may have adverse consequences on doctors' self-perception and so their attitude towards elements of their work.

Finally, changes in organisational structures, and the wider healthcare economy, frame the work that doctors do. Workforce issues, including the fluctuation in trainee numbers and significant under-filling of rotas in some specialties and areas, mean that more work is spread among fewer doctors. This has implications for both clinical work (although we did not hear of 'acting down' as a particular problem), and for management challenges. Moves to consultant-delivered services, where consultants are present or immediately available at all times<sup>39</sup> may benefit patients and more junior trainees, but may limit the time consultants have for additional leadership roles.

The introduction of collective approaches to primary care, such as Primary Care Networks in England, geographical clusters in Scotland and Wales, and federations in Northern Ireland may change how leadership is viewed and performed in general practice, with explicit collaboration now to the fore. Changes to GP contracts allow for expansion of non-medical staff which will change the structure of GPs' practice and work, but incur risks that GPs will become more overwhelmed with the stressful, complex cases as minor cases are triaged onto non-medical practitioners. New professional roles and structures have the potential to reduce pressure on doctors, but this is by no means guaranteed.

***Articulating leadership roles as part of a system, and identifying the systemic effects which shape and maintain those roles may provide a means of understanding, and so modifying, how leadership functions in the NHS.***

## 4.2 Supporting doctors in changing roles

Organisations can provide support to doctors as their roles develop and change. Time is the key factor in adding pressure to doctors, and the main practical barrier to their taking on, and retaining, additional roles. This echoes the literature.<sup>2</sup>

In secondary care, time should be addressed within job planning. However, while technically the consultant contract provides for the full range of activities through SPAs, additional NHS activities and

external activities, in practice it seems job plans are very limited. In particular, SPA time has become a container for many activities, and the reality is that much work is done in doctors' own time. (We have heard this in another recent GMC-commissioned project relating to recognition of trainers).<sup>40</sup> Available support and flexibility in the workforce will enable doctors to adapt their time and working pattern to take on different roles. In primary care, partners have more flexibility in how they allocate their time, but not all practices have income to employ salaried GPs to free that time, or indeed are able to appeal to salaried or locum doctors.

***Organisations have an important role in ensuring individuals are not over-burdened, which will afford feasibility of explicit leadership roles. Some areas of practice will require more attention, and resource, than others – whether because of staffing issues or headline clinical load – and so equity may not be achieved through equal investment, but rather investment where appropriate.***

Individuals' capacity and inclination to take on roles are also influenced by the available training, development and support for leadership roles. Those who are entering senior roles must either have prior training, or be supported and developed once in post.<sup>5,30</sup> The latter approach may be preferable to avoid interfering with clinical training, but also because the salience of leadership issues may be better understood in practice. In a similar way to shadowing and induction for more junior roles, programmed support may be useful, with formal and informal mentoring and support networks encouraged in order to provide longitudinal support.

Support is also apparent in the organisational culture, and particularly the relationship between senior management and doctors. Just as individual doctors must be able to communicate and make their visions heard and seen by others, so the organisation at all levels must be able to listen and ensure that those visions can be heard. Part of this is recognising leadership in all its forms, from embedded to formal management roles. This resonates with the findings of the recent GMC-commissioned study of leadership and culture, which noted that culture can be 'background' or 'role derived'.<sup>14</sup> Our study did not foreground culture as an a priori interest, but has found that leadership is a function, or indeed a component, of organisational culture.

***A supportive and listening culture of leadership at all levels may help the performance of leadership roles by improving preparedness and competence. It may aid doctors' wellbeing by providing support that avoids or mitigates pressures, and makes roles more attractive and so sustainable.***<sup>26,27</sup>

### **4.3 Promoting sustainability through equitable access and retention of expertise**

Doctors' roles continue to change. Doctors at all stages of their careers are facing new clinical and political challenges, which raise a question of sustainability for leadership roles. Those roles will need to be done,

but the question is how to make them sustainable for the health service without undermining the performance or wellbeing of doctors. Increasing capacity through recruitment and retention of more doctors into those roles will be essential.

We have found that doctors remain highly motivated to carry out not just their clinical work (for which they retain notable commitment and passion), but also to take on additional roles as part of, or in addition to, their main clinical jobs. This motivation can be active, and stem from interest in an area of work, or a desire and perceived aptitude to address problems, or reactive, as a desire to dilute more stressful aspects of their work. The latter motivation is perhaps more prevalent in primary care, where we heard more evidence of negative consequences of clinical work. Capitalising on this motivation may enhance the experience of those in, or considering, leadership roles. Identifying and supporting attractions and benefits of portfolio careers – in which individuals undertake multiple roles concurrently – may provide a means of attracting more doctors to those roles.

However, doctors must have the opportunity to take on additional roles. At present, opportunity is often rooted in being in the right place at the right time, and an individual's potential being recognised by others who are aware of opportunities themselves. While this may be effective, there is a risk that some people are overlooked, or that some roles or functions are not filled because there is no-one to identify or take advantage of opportunities. There are also implications for equality, diversity and inclusivity – we did not hear any examples of negative experiences, but even benign patronage is at risk of unconscious bias.

There are also questions about whether leadership roles can be open to a wider constituency. In secondary care, we limited our sample to consultants. We know that non-consultant SAS doctors have even more limited time than consultants, as they tend to be employed for clinical sessions only, but those who seek career advancement may be a pool for leadership development. In primary care, we spoke mostly to partners, although some salaried GPs in a new model consortium were included. In the traditional partnership model, salaried doctors are employed only for clinical sessions. In new models however, they may take on additional explicit leadership roles as part of their sessional employment.

We heard from doctors approaching, or even post-retirement who were still working, demonstrating their ongoing motivation and enthusiasm. While we also heard from those who were planning an exit from the NHS, the extended careers of older doctors (as retirement ages advance) may provide a means of redistributing work, and 'recycling' that enthusiasm and skills. Some doctors are doing this themselves, but a systematic approach may extend benefits to others. We heard of generational differences with trainees coming through with new skillsets, but also different attitudes to work, and here the practical expertise and experience of established leaders may help foster and shape keen 'beginners'.

A third element of this wider system was apparent in the effects of pensions reform on NHS staff. While this has no direct effect on doctors' current work, it raises an issue of work being valued by the wider system, and having value for the individual doctor. Established doctors feeling that they are doing more for less long-term benefit is potentially damaging to morale, and the sustainability of their leadership roles.

***Overall, the sustainability of the leadership activity currently undertaken by consultants and GPs may be better served by increasing the accessibility of those roles to all doctors, while also considering how to mitigate attrition and capitalise on the motivation and enthusiasm of those approaching retirement.***

#### 4.4 Conclusion

We have found that doctors' roles change in ad hoc and complex ways as they progress through their careers. Leadership activities embedded in their daily work are under pressure from changes in clinical workload, patient expectations and policy changes. While explicit roles separated from their clinical jobs can be beneficial, the same pressures act as a deterrent to their taking on and remaining in those roles.

Our findings develop those of a recent study of NHS Trusts across England,<sup>19</sup> which indicated that the primary barriers to engaging consultants in formal leadership positions were 'feasibility' and time in particular. The key question is how employers and other stakeholders can enhance capacity so that the strain identified in the 2018 State of Medical education and Practice report (GMC 2018) does not become unsustainable.

The motivation and enthusiasm expressed by doctors in our study, to make positive changes not just to their patients' lives, but also to those of their fellow doctors, and the wider healthcare system, is something to be capitalised upon.

## References

- <sup>1</sup> NHS Employers. Terms and Conditions – Consultants (England) 2003 version 9 (2013). London: NHS Employers, 2013
- <sup>2</sup> Berghout MA, Fabbriotti IN, Buljac-Samardžić M, Hilders CG. Medical leaders or masters?—A systematic review of medical leadership in hospital settings. *PloS One*, 2017; 12(9): e0184522.
- <sup>3</sup> Chadi N. Medical leadership: doctors at the helm of change. *McGill Journal of Medicine*, 2009; 12: 52.
- <sup>4</sup> Bohmer R. The instrumental value of medical leadership. *Engaging doctors in improving services*. London: The Kings Fund, 2012
- <sup>5</sup> Allen D. Doctors in management or the revenge of the conquered: The role of management development for doctors. *Journal of Management in Medicine*, 1995; 9: 44-50
- <sup>6</sup> Swanwick T, McKimm J. What is clinical leadership...and why is it important? *The Clinical Teacher*, 2011; 8: 22–26
- <sup>7</sup> AoMRC. Medical Leadership Competency Framework. London: NHS Institute of Innovation and Improvement, 2008
- <sup>8</sup> GMC. Leadership and management for all doctors. London:GMC, 2012
- <sup>9</sup> Carsen S, Xia C. The physician as leader. *McGill Journal of Medicine*, 2006; 9: 1
- <sup>10</sup> Willcocks S. The Clinical Director in the NHS: Utilizing a Role-theory Perspective, *Journal of Management in Medicine*, 1994; 8: 68-76
- <sup>11</sup> BMA. Guidance on the role of the Clinical and Divisional Director. London: British Medical Association, 2009
- <sup>12</sup> Willis CD, Saul J, Bevan H, et al. Sustaining organizational culture change in health systems. *Journal of Health Organization and Management*, 2016; 30: 2-30.
- <sup>13</sup> Braithwaite J, Herkes J, Ludlow K, Testa L, Lamprell G. Association between organisational and workplace cultures, and patient outcomes: systematic review. *BMJ Open*, 2017; 7: e017708.
- <sup>14</sup> Shale S. How doctors in senior leadership roles establish and maintain a positive patient-centred culture. Research Report for the General Medical Council, 2019
- <sup>15</sup> Fitzgerald L. Moving clinicians into management: a professional challenge or threat? *Journal of Management in Medicine*, 1994; 8: 32-44
- <sup>16</sup> Balderson S, MacFadyen U. Management training for doctors: An in-house approach. *Journal of Management in Medicine*, 1994; 8: 17-19
- <sup>17</sup> Morrow G, Burford B, Redfern N, Briel R, Illing J. Does specialty training prepare doctors for senior roles? A questionnaire study of new UK consultants. *Postgraduate Medical Journal*, 2012; 88:558-565
- <sup>18</sup> Higgins R, Gallen D, Whiteman S. Meeting the non-clinical education and training needs of new consultants. *Postgraduate Medical Journal*, 2005: 81: 519-523
- <sup>19</sup> Dickinson H, Ham C, Snelling I, Spurgeon P. Are We There Yet? Models of Medical Leadership and their effectiveness: An Exploratory Study. Final report. NIHR Service Delivery and Organisation programme; 2013.
- <sup>20</sup> GMC. The State of Medical Education and Practice 2018. London: GMC, 2018
- <sup>21</sup> Segar J, Checkland K, Coleman A., et al. Changing the ties that bind? The emerging roles and identities of general practitioners and managers in the new clinical commissioning groups in the English NHS. *SAGE Open*, 2014; 4: 2158244014554203
- <sup>22</sup> Hallier J, Forbes T. The role of social identity in doctors’ experiences of clinical managing. *Employee Relations*, 2005; 27: 47-70
- <sup>23</sup> Fitzgerald L. Moving clinicians into management: a professional challenge or threat? *Journal of Management in Medicine*, 1994; 8: 32-44
- <sup>24</sup> Gordon L., Jindal-Snape D, Morrison J, Muldoon J, Needham G, Siebert S, Rees C. Multiple and multidimensional transitions from trainee to trained doctor: a qualitative longitudinal study in the UK. *BMJ Open*, 2017; 7: e018583
- <sup>25</sup> NHS England. The NHS Long Term Plan. London: NHS England, 2019
- <sup>26</sup> West MA, Eckert R, Steward K, Pasmore WA. Developing collective leadership for health care. London: King’s Fund, 2014
- <sup>27</sup> Lees P. Professionalising medical leadership. *Future hospital journal*, 2015; 2: 208-210.
- <sup>28</sup> GMC. Outcomes for Graduates. London: GMC, 2018
- <sup>29</sup> Webb AMB, Tsipis NE, McClellan TR, et al. (2014). A first step toward understanding best practices in leadership training in undergraduate medical education: a systematic review. *Academic Medicine*, 2014; 89: 1563-1570

- <sup>30</sup> Warren OJ, Carnall R. Medical leadership: why it's important, what is required, and how we develop it. *Postgraduate Medical Journal*, 2011; 87: 27-32
- <sup>31</sup> Straus SE, Soobiah C, Levinson W. The impact of leadership training programs on physicians in academic medical centers: a systematic review. *Academic Medicine*, 2013; 88: 710-723
- <sup>32</sup> Nath V. Are opportunities still limited for black and minority ethnic staff in health care leadership? London, The King's Fund, 2016
- <sup>33</sup> NHS workforce figure 2018. Available at <https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest#by-ethnicity-and-grade-medical-staff>
- <sup>34</sup> Darnton, R., Pearson, N., Morris, C., Preston-Shoot, M. (2015). Where will our Future GP Leaders Come From? *BMJ Careers*, 2015; 6
- <sup>35</sup> Braun V., Clarke V., Hayfield N., Terry G. Thematic Analysis. In: Liamputtong P. (eds) *Handbook of Research Methods in Health Social Sciences*. Springer, Singapore, 2019
- <sup>36</sup> Scottish Government. *Improving Together: A National Framework for Quality and GP Clusters in Scotland*. Scottish Government, January 2017
- <sup>37</sup> NHS Wales. What Are Clusters? [<http://www.primarycareone.wales.nhs.uk/primary-care-clusters> accessed 6 September 2019]
- <sup>38</sup> Health and Social Care Board. GP Federations. [<http://www.hscboard.hscni.net/our-work/integrated-care/gps/gp-federations/> accessed 6 September 2019]
- <sup>39</sup> AoMRC (2012). *The Benefits of Consultant Delivered Care*. London: Academy of Medical Royal Colleges
- <sup>40</sup> Burford B, Vance G, Rothwell C, Scott J, Jones S. A qualitative evaluation of the GMC's trainer recognition framework. Report for the GMC, July 2019.

## Appendices

### Appendix A: The NHS Consultant Contract

The NHS consultant contract (2003) describes additional activities in three categories: ‘Supporting Professional Activities’ (SPAs) which may be undertaken by all consultants (including participation in training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities); ‘Additional NHS Activities’ undertaken only by some (including being a medical director, clinical director or lead clinician, director of public health, or acting as a Caldicott guardian, clinical audit lead, clinical governance lead, undergraduate dean, postgraduate dean, clinical tutor or regional education adviser), and ‘External Duties’, which may include work for Royal Colleges, government departments or the General Medical Council.

### Appendix B: Details of participants

Number	Gender	Country	Years post CCT	Specialty	Other
1	M	England	1	Medicine	IMG; BME
2	F	England	2	Craft	surgery
3	M	NI	2	Medicine	
4	M	NI	12	GP	
5	F	England	4	GP	salaried
6	F	England	4	Medicine	paediatrics
7	F	England	4	Craft	O&G; IMG; BME
8	M	England	5	Medicine	
9	F	England	6	GP	salaried
10	F	England	7	GP	
11	M	Wales	9	Emergency	BME
12	F	Scotland	10	Medicine	
13	F	England	10	Emergency	
14	M	England	11	GP	
15	M	Scotland	12	Emergency	
16	F	NI	17	Radiology	
17	F	Scotland	20	GP	
18	F	Scotland	20	GP	
19	M	England	30	GP	
20	F	NI	5	Medicine	anaesthetics
21	F	Wales	14	Craft	surgery
22	F	Scotland	17	Psychiatry	
23	F	Wales	15	Medicine	anaesthetics
24	M	England	17	Psychiatry	
25	M	England	18	Craft	surgery
26	F	Scotland	19	Medicine	
27	F	Scotland	19	Medicine	IMG
28	M	Scotland	31	Craft	Surgery; IMG
29	M	Scotland	30	Medicine	
30	M	Wales	14	Medicine	paediatrics
31	M	England	1	GP	salaried
32	F	England	3	GP	

## Appendix C: Sessions and job plans

The unit of working time in medicine is the 'session', also referred to as Programmed Activity (PA) in secondary care. These are usually four-hour periods, such that a five-day working week comprises ten sessions. In secondary care under the standard consultant contract, these sessions are divided between direct clinical care (DCC) and supporting professional activities (SPAs), with time allocated and accounted for in a formal job plan. The 2003 consultant contract indicated 7.5 DCC and 2.5 SPA sessions, but often this is 8:2 or for new consultants 9:1. Details of PAs are negotiated at a local level. Other roles provided for in the contract (Additional NHS Activities and External Roles) can be allocated PAs on an individual basis.

In primary care, the distribution of work is managed within a practice. Partners, who are contractors, have discretion as to the number and arrangement of sessions they work. A full-time week is 37.5 hours. Salaried GPs are employed under the new General Medical Services contract 2014, where a whole-time week is 37.5 hours, and a session is 4 hours 10 minutes. This contract includes a Continuous Professional Development [CPD] entitlement of one session or 4 hours per week on an annualised basis for full-time and pro rata for part-time practitioners.