Health Foundation long read (PDF version)

26 September 2024

Strengthening clinical leadership and management

Lessons from our research in the UK and US

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The Health Foundation

Contents

Key points

- Strengthening clinical leadership and management is an important means of helping the NHS to improve quality outcomes and boost operational productivity and efficiency. Evidence suggests clinical leadership and management are associated with high organisational performance and can bring a variety of benefits for leadership and organisational decision making.
- Policymakers and politicians from all parties see clinical leadership and management as crucial in making more efficient and productive use of service and workforce capacity, without compromising clinical quality or outcomes.
- Our research detected signs that progress is being made in supporting greater clinical leadership and management within the NHS, with more clinicians now likely to consider this as a career path. But challenges remain in improving access to management opportunities across clinical professions and improving the training and development on offer to aspiring clinician leaders and managers.
- Lessons can be learned from the highest performing US medical centres in promoting clinical leadership and management – even without the same level of resources available in the NHS. These include more visible backing for management, parity of esteem for managers from different backgrounds, improved processes for recruitment and talent management, and a better training and development offer.
- Increasing clinical leadership and management shouldn't be seen in isolation as a panacea for performance challenges. Clinical leaders and managers cannot necessarily trump the culture and constraints they work within. Further, given clinician leaders' commitment to collaborative leadership and coalition building, it is likely that they will be most successful in open, learning-focused organisational cultures.
- Greater clinical leadership and management needs to be one component of a multifaceted improvement strategy. Policymakers and providers must ensure that strategies to strengthen clinical leadership and management are integrated with the drive to create organisation and system-wide approaches to improvement, following the recently launched NHS Impact approach.

Introduction

Evidence underlining the association between high organisational performance and the presence of clinicians in senior leadership and management roles is steadily growing. Clinical involvement in organisational leadership has been positively linked to improvements in operational efficiency, such as bed occupancy levels, opening the way to health care productivity gains. Elsewhere, evidence that clinical leaders can positively contribute to information technology adoption in health care organisations suggests that clinical leaders could have an important role in the digital transformation of the NHS.

The profile of clinical leadership and management has also risen markedly in recent years – thanks to the efforts of the Faculty of Medical Leadership and Management, the Royal Colleges and others. The discipline has been strengthened by influential clinician leaders like Lord Ara Darzi, who set up the long-running clinical leadership fellowship programme that bears his name. This championing of clinical leadership and management has had an appreciable impact on the esteem in which it is held in the NHS. Once vilified by doctors, as 'a move to the dark side', a career in management is now increasingly seen as a legitimate career choice – as legitimate as specialising in research or focusing on clinical practice. And there is a burgeoning community of organisational leaders with medical, nursing or allied professional backgrounds who can serve as role models and mentors for aspiring future clinician leaders and managers.

Compared with the health care systems of other major economies, however, research has shown that the NHS lags well behind in the proportion of clinicians on the boards of provider organisations and in management positions. One of these studies found 'a strong relationship between an increase in the number of managers with a clinical degree and an improvement in an organisation's management score' and called for the NHS to do more to 'encourage the movement of clinical staff into management'.

This long read looks at what the NHS will gain from strengthening clinical leadership and management, the challenges involved in doing so and how they might be overcome. It draws on 30 interviews we carried out with hospital-based clinician leaders and managers in the UK and the US in 2022–23 and relevant academic studies. Our US interviewees are based in clinically-led academic medical centres, while our UK interviewees work in large teaching and district general hospital-based NHS trusts that have sought to strengthen their clinical leadership and management.

The long read begins by examining the evidence for the benefits of clinician leadership and management. It then considers the current state of clinician leadership and management across the NHS, before looking at some lessons from US academic medical centres. It concludes by making the case for aligning the push for greater clinician leadership and management with the NHS's organisation and system-wide improvement agenda.

Background and context

Policymakers have recognised the importance of clinical leadership and management

Strengthening clinical leadership and management is seen by policymakers and politicians of all hues as a crucial means of making more efficient and productive use of service and workforce capacity, without compromising clinical quality or outcomes.

Speaking at the NHS Providers' conference in 2023, the Secretary of State for Health and Social Care, Wes Streeting, argued that 'Good clinical leadership is crucial to improve services, quality of care, and transforming health care.' His priority, Streeting said, was to ensure that NHS staff are able 'to work smarter' rather than harder and made it clear he viewed strengthening clinical leadership as key to achieving this goal. To help do so, the new Labour government has pledged to set up a Royal College of Clinical Leadership.

Streeting's commitment to clinical leadership was shared by the previous government. The importance of visible senior clinical leadership in organisations was highlighted in the NHS Long Term Plan and NHS People Plan, while the NHS Long Term Workforce Plan pledges to make it easier for senior clinicians to pursue 'portfolio careers' that combine clinical and leadership responsibilities. NHS England has also argued that clinical leaders are likely to be critical to the ability of integrated care systems to 'tackle unequal access to services, experience and outcomes, and enhance productivity, effectiveness and value for money'.

Barriers to progress remain

Yet there are still many barriers to clinical leadership and management that need to be addressed by policymakers and local leaders. Making the transition from full-time clinical work to a hybrid clinician-manager role can still be challenging, not least due to the dearth of training on offer in many places – a point highlighted in the 2022 Messenger Review. There are also marked variations between clinical professions in the opportunities and incentives to enter management and leadership.

But this is not the only challenge faced in advancing this agenda. The collective enthusiasm for greater clinical leadership and management across the political spectrum, while welcome, may create expectations that are hard to meet, especially if it seen as an instant fix for some of the NHS's performance challenges. As we will argue in this long read, greater clinical leadership and management will bring many benefits, but it is part of the solution, not *the* solution – it cannot single-handedly drive performance improvement or service transformation. Specifically, we argue that a strategy to increase the number of clinician leaders and managers, and improve the training and support they receive, will be most effective when accompanied by broader efforts to create positive, improvement-focused workplace environments, built on a culture of learning, knowledge-sharing and openness. Given many clinician leaders' commitment to

collaboration and consensus building, which we discuss later, we believe that it is in this kind of environment that clinician leaders and managers are most likely to flourish.

Clinical and non-clinical managers matter

Our focus here is on clinical leadership and management, but it is also important to acknowledge the vital and often under-appreciated role played by the NHS's non-clinical managers. A call for greater clinical leadership and management should not be interpreted as a call for restricting the role or number of non-clinical managers. Clinician and non-clinical managers each bring a distinct range of skills and perspectives, and the NHS benefits from this breadth and diversity of expertise and experience. Elsewhere, we have written about the need for visible and sustained support for all managers, and an unequivocal endorsement of the essential contribution that good management makes to effective functioning of the NHS.

Box 1: What are management and leadership and what roles do clinicians perform?

Management involves the control, monitoring or organisation of people, processes and systems in order to achieve specific goals. It has been described as consisting of six key tasks: planning, allocating resources, coordinating the work of others, motivating staff, monitoring output and taking responsibility for the process.

Leadership refers to influencing and inspiring others in pursuit of common goals, setting the tone and direction for a group or organisation, and identifying and framing problems for others to solve. In practice, leadership and management are closely interconnected and health care employees at all levels often have to deploy both leadership and management skills in order to carry out their job effectively.

All clinical and care professions are involved to some extent in the leadership and management of organisations, services, systems and professional groups. However, this long read is primarily focused on leadership and management roles undertaken by clinicians working in large provider organisations like NHS trusts, such as doctors, nurses and allied health professionals. These roles include both those specifically reserved for clinicians, such as medical director, matron and clinical lead positions, and roles open to all staff, such as chief executive, chief operating officer or divisional director, that happen to be held by people who are or used to be practising clinicians.

Understanding the evidence for clinical leadership and management

The value of clinically-trained leaders and managers to health care organisations has been consistently demonstrated in research. Several studies have identified an association between clinical leadership at executive level and high organisational performance. Veronesi, for instance, found a significant and positive association between the percentage of clinicians – especially doctors – on the boards of NHS trusts and their quality ratings. Mannion, meanwhile, has suggested that the presence of strong and empowered clinical leaders is an essential feature of high-performing organisations, while Goldstein has described a positive link between clinical leadership and improved organisational efficiency.

Studies looking at clinical management have reached similar conclusions. In his important study on health care management, Bloom found that management performance was stronger in provider organisations with more clinically-trained managers. He also observed that managers in higher-performing hospitals, who are often clinicians, tended to have more autonomy than in lower-performing ones – highlighting the importance of creating the right culture for clinician managers to flourish.

While a growing number of studies have highlighted an association between clinical leadership and management and high performance, rather less attention has been given to *why* this is the case (Kirkpatrick, Sarto). Nonetheless, some studies have advanced potential explanations centred on the experience, attitudes and behaviours of clinicians. Goodall and Bohmer have argued that the deep knowledge that clinicians have of care planning and delivery – the core business of health care providers – ideally equips them to make decisions at a strategic and operational level. Elsewhere, Sarto suggests that managers with clinical backgrounds are in a privileged position 'to bridge the historical divide between the worlds of cure, care and administration'.

Others have drawn attention to the leadership style of clinicians. By tending to operate as 'ambassadors' (Waring) or as 'facilitators' rather than 'enforcers' (Mannion), and by preferring to use persuasion and consultation rather than rely on positional power (Edmonstone), clinician leaders are well placed to build coalitions and to manage and resolve tensions between professional groups. The respect that clinician leaders enjoy among their clinical peers, especially if they are still practising and are highly regarded in their fields, is also seen as helping to give them legitimacy, credibility and confidence as leaders (Bresnan, Angood, Falcone, Bäker). In fact, the notion that clinicians benefit from taking on other responsibilities such as leadership, teaching and research roles, with each role enhancing the others, has a long tradition in medicine – first being espoused by William Osler, a pioneering clinician-educator-leader in the early 20th century (Hebert).

Another perceived performance benefit of clinical leadership, especially at board and executive level, is that it opens up strategic decision making to a broader range of views and backgrounds, arguably leading to

better or more nuanced decisions. Clay-Williams and Bohmer argue that a strong clinical voice at senior levels can help ensure that strategic decision making is seen through a care quality, safety and experience lens, and is grounded in the lived experience of front-line staff. Edmonstone, meanwhile, suggests that it can bring a way of thinking, geared towards reflective practice that differs from what has been described as the 'technical-rational' perspective of leaders from financial, corporate or professional management backgrounds. He goes on to say that clinicians may also be more comfortable with incremental improvement where this is the right approach, rather than large-scale disruptive change – which can bring a valuable perspective to strategic conversations about delivering and managing change.

Others have argued though that it not enough simply to ensure that there is a strong clinical presence at senior levels. The biggest strategic and performance gains come, they contend, from ensuring that these clinical leaders are from a range of professional and personal backgrounds, and crucially, are 'cognitively diverse'. To make their point, they highlight research suggesting that 'cognitively diverse teams' outperform more homogenous teams when it comes to problem solving and the capacity to innovate, among other things.

The clinician leaders we interviewed have made similar points. One clinician leader, echoing the thoughts of many, argued that clinicians' 'detailed, hands-on and round-the-clock knowledge of how care services work' is invaluable for executive leaders. Clinician leaders also have a strong understanding of the impact on patients of low-quality care, delayed treatment and safety failings, which often leads them to prioritise safety, quality and patient experience once they become leaders. Underpinning their approach is a belief that a more efficient and productive service that is well planned and managed is better for patients and better for staff. As one clinician leader put it: 'If you have ever been in clinic and the clinic has been overbooked every afternoon, and every patient you have seen has been cross with you, you don't want to do that to yourself or your patients ever again.'

Crucially though, many clinician leaders acknowledge the ability to make the most of their experience and knowledge is highly context specific. Most cite instances of when their effectiveness as leaders and managers was constrained by operational, cultural, political or resource factors they were unable to control. This suggests that clinical leadership and management need to be seen as one component among several that drive and sustain high performance – a point we will return to in calling for a multifaceted strategy.

Examining the state of NHS clinical leadership and management

Interest is growing in leadership and management careers but there are practical and cultural barriers to overcome

There are reasons to be optimistic about the future of clinical leadership and management in the NHS. According to one NHS clinician leader we interviewed, 'Junior doctors today are more open to considering leadership than in the past.' They may also be more inclined to see a management role as a fulfilling career choice that is respected by their peers. Access to high-quality training and support for would-be clinician managers is also improving, albeit from a very low base. As well as established national programmes such as those run by the NHS Leadership Academy and the Faculty of Medical Leadership and Management, more employers, especially NHS trusts, have set up in-house programmes that provide a grounding in management and leadership theory and practice.

The clinician managers and leaders we interviewed, however, also point to an array of challenges. While an increasing number of NHS trusts have a well-designed training offer, and ensure that clinician managers have the time to take part in the training and the support to put their skills into practice, many still lag behind. The extent to which this training and development is equipping clinicians to meet the growing range of leadership and management challenges that the NHS faces, such as those related to the digital, data and AI related transformation of services, is also open to question.

Many clinicians still choose to avoid management roles, seeing them as an additional burden that will eat into their spare time, and for which they will receive little support, credit or remuneration. In some services clinical leadership roles, far from being sought after positions, are seen as poisoned chalices that are reluctantly assumed and relinquished with relief. In contexts like these, individual clinicians are often encouraged to take on leadership roles, not because they have shown a particular aptitude for leadership or management, but because it is now 'their turn', and not doing so would be to let down their colleagues.

It is perhaps no surprise therefore that compared with the health systems of other advanced economies, the NHS lags someway behind in terms of the proportion of clinicians in senior leadership roles (Bloom).

Clinicians' motivations for entering leadership and management vary considerably

One study has drawn a distinction between 'willing hybrid' and 'incidental hybrid' clinician managers. The former group see management as a chance to work across professional boundaries, and to use the corporate machinery at their disposal to achieve the best possible service for all patients, not just the ones they see in their practice. This has led them to try to reconcile the potential tensions between their clinical and managerial identities and adopt a professional identity that integrates the two. The latter group, who may be reluctant managers, see themselves first and foremost as clinicians, justifying time away from their

core clinical duties as something that allows them to defend the interests of their profession and co-opt the management apparatus available to them for this purpose.

There are also marked differences between and within clinical professions in terms of the attractiveness of and access to a management career. While many doctors may be ambivalent about management, or not even describe themselves as managers, many nurses may be more positive about it, perceiving it as a natural career progression that allows them to combine clinical work with a means to influence how their organisation is run (Bresnen). This may reflect the fact that nurses, and similarly allied health professionals, can find it hard to advance their careers beyond a certain level if they choose to focus purely on clinical practice. Conversely, other professional groups, such as specialty and specialist (SAS) doctors, who often feel marginalised from their medical colleagues, can find it difficult to get on the management ladder, due, in part, to their perceived lack of seniority. Meanwhile, the changing nature of general practice has led to a decline in the proportion of GPs working as GP partners – one of the longest standing clinician leader models.

Changes in leadership approaches and cultures may ease tensions between clinicians, managers and leaders

The presence of reluctant clinician managers, who see themselves, in effect, as shop stewards for their professions, is indicative of the mutual suspicion that still exists in some organisations between clinical communities and leadership teams that have traditionally been dominated by people from non-clinical management backgrounds. Edmonstone has suggested that this owes something to the lingering presence of a command-and-control leadership model in the NHS that has had the effect of constraining the autonomy of clinicians. Conversely, he argues that non-clinical managers, whose loyalties and lines of accountability lie, first and foremost, with the organisation, may consider clinicians who are independently regulated and whose loyalties are split between their patients, professions and employers, as too conflicted to consistently prioritise the needs of the organisation as managers.

Yet there are signs that attitudes may be changing. The adoption of a more collaborative approach to leadership by many provider organisations and system level partnerships, encouraged by a growing evidence base about the benefits of more inclusive and less hierarchical approaches, suggests that a cultural shift may be underway. This shift may help chip away at the division between clinicians and non-clinical managers and encourage the development of shared purpose between them.

Clinician leaders and managers need a stronger training and support offer

There is a clear need for a better training and support infrastructure for clinician managers and leaders. Without this, it is likely that the momentum and opportunity created by the rising profile and stock of clinician leadership and management will be squandered.

With this in mind, the next section explores the learning about clinical leadership from US academic medical centres. Drawing on interviews by the Health Foundation with senior leaders in these systems, we focus on the training, support and career development infrastructures that these centres have put in place for their prospective and current clinician managers.

Clinically-led health care systems: lessons from the US

Many of the top academic medical centres in the US are among the highest performing health care providers in the world. A defining characteristic of some of these centres is that they are almost entirely clinician-led and managed: they include the University of Michigan Health System, the Mayo Clinic and the Cleveland Clinic. Notwithstanding the significant differences between the US health care system and the NHS, these US centres offer important lessons for the NHS.

In common with most NHS trusts, many of these US academic medical centres have a triad management system in place at clinical service level that brings together a medical, nursing and non-clinical management lead. Unlike in NHS trusts though, the non-clinical lead usually has a very tightly defined role that commonly focuses on financial and human resource functions. The responsibility for all operational decisions relating to care planning, delivery and management lies almost exclusively with the clinician leads. And nearly all senior leadership and executive positions across the centres are held by clinicians, usually doctors, many of whom continue to practice clinically in some respect.

Ensure clinical, research and managerial careers are equally respected

One of the most striking features of US clinician-led academic medical centres is their success in ensuring parity of esteem between the clinical, research and managerial career pathways. All three pathways are equally valued and respected, both within the clinical community and across the wider workforce. This stems from managerial positions being well rewarded and having a clear career pathway for prospective clinician managers with appropriate training and development at each stage.

Unlike in the UK, management training is common even at undergraduate level, with some medical students combining their medical degree with a management-related qualification. New clinician managers, meanwhile, are placed on long-term, in-house management training programmes, have access to mentoring and executive coaching, and are given dedicated time for development that according to our interviewees, is seen as sacrosanct by their immediate managers and senior colleagues. This investment is not just about preparing clinicians for management but demonstrating how important clinician leadership and management is to the health system.

For the US-based clinician leaders we interviewed who have experience of working in NHS settings, the contrast can be stark. Doctors who started out in the NHS remember that their primary ambition was, in the main, to become a consultant in a large teaching hospital. If they thought about a management career

at all, then it was to reject it as being too uncertain and difficult to navigate, and too far removed from their medical calling. However, on arriving at their current US organisation, they found their leadership potential was soon spotted and the value to them, their patients and their employer of combining a clinical and management career was strongly impressed on them. The presence of an established management career ladder with steadily increasing amounts of responsibility and rewards, and protected time for management, clinical duties and professional development, was also instrumental in persuading them to become clinician managers.

Clinicians need dedicated leadership and management training and development

Clinician-led academic medical centres recognise that undergraduate and postgraduate clinical training coupled with professional experience is not enough to equip clinicians to become managers. As one senior clinical leader put it, 'They can't just walk out of an operating theatre and start running a service.' They need training in the technical aspects of operational and financial management, among other things, together with development opportunities designed to build their contextual, relational and personal leadership skills. An important goal of such training is to help clinicians appreciate the differences between a clinical mindset, orientated around 'autonomous problem-solving and authoritative decision-making', and a leadership mindset, geared towards inspiring and enabling others to solve problems through collaborative working (Angood).

Another key aim is to ensure that clinicians are cognisant of the financial implications of the operational and workforce decisions that they will have to take as leaders. Knowing how to make the most productive use of fixed assets are seen as key skills, including theatres and equipment and maintaining a staffing ratio that strikes the right balance between safety, quality and efficiency. A clinician leader of a department with a narrow operating margin and limited financial reserves told us that a focus on service productivity and keeping the department in the black was, and had always been, a central feature of his job as a manager and then a leader.

Character is key when recruiting clinician leaders and managers

Significant attention is paid to the recruitment of clinicians with the right personal qualities to be managers and leaders. In our interviews, we heard that many make a point of 'hiring for character' rather than simply according to the weight of someone's clinical or research achievements, with several rounds of interviews and assessments that focus on applicants' attitudes, behaviours and personal qualities. In one system, all staff members are interviewed to find out whom they think among their clinical colleagues would be effective leaders, with a view to identifying a talent pool of future leaders – a labour-intensive task but one credited with helping to build a reliable pipeline of 'servant leaders' who have the trust and respect of their colleagues.

Wholesale adoption of this model is neither feasible nor appropriate

The clinician leadership and management model used by such US academic medical centres is unlikely to be adopted wholesale across the NHS – not only because of the resources required but also scepticism about an exclusively clinically-led model. Many of the NHS clinician leaders we interviewed were wary of substituting one type of uniformity (ie a service largely led by people with a non-clinical management background) with another that is exclusively clinician led. In their view, it is important that NHS leadership is representative of the wide range of clinical and non-clinical professions in the service, and not just those that have historically been the most visible and influential.

This does not mean that NHS providers cannot learn lessons from their US peers, and develop an approach for training and supporting clinician managers and leaders that is tailored to the NHS. Money is undeniably a limiting factor. While many academic medical centres face constraints of their own – with some, for instance, obliged to run at bed occupancy levels that rival those found in many NHS trusts – their ability to finance training and development is generally much greater than that of NHS providers. But not all facets of the academic medical centre approach are dependent on finance. In particular, their highly visible and consistently reinforced strategic backing for clinical leadership and management is one success factor that could easily be replicated. For example, by underlining the value of clinical leadership and management and highlighting clinician leader role models, local NHS organisation and system leaders, national policymakers and professional bodies could help to normalise a leadership and management career among young clinicians.

The need for a multifaceted change strategy

Strengthening and spreading clinical leadership and management should be a priority for national policymakers and local organisation and system leaders. Not only does it make sense from a performance and productivity perspective, but the leadership style of clinicians is well suited to the increasingly collaborative way of working found in the NHS with the advent of integrated care systems and other system-level partnerships. As the US example shows, policymakers and local leaders need to consider the training, development and support needs of clinicians looking at a career in management, and also deal with the practical and cultural barriers that discourage this.

It would be wrong-headed, however, to consider the case for greater clinical leadership and management in isolation. As we saw above, clinician leaders acknowledge that their effectiveness as leaders and managers can be constrained by operational, cultural, political or resource factors beyond their control. For example, it can be much harder to make a difference when a service is locked in permanent fire-fighting mode. So, while important, measures to improve training and encourage more clinicians into leadership and management will not be enough in themselves to ensure that the potential benefits that clinician leaders and managers can bring to the NHS are fully realised.

Instead, a multifaceted approach is needed. This should combine boosting clinician leadership and management with steps to create positive, organisational cultures in which clinician leaders and managers can help to drive the consistent delivery of safe, high-quality care, while maintaining a focus on service productivity and financial sustainability.

One major strategic agenda focused on creating safety and quality-focused cultures is the recently launched NHS Impact approach to improvement, which seeks to embed organisation and system-wide approaches to improvement across the NHS in England. For this reason, it makes sense for policymakers and system leaders to consider the push for greater clinical leadership and management in tandem with the NHS Impact approach.

Clinical leadership and management in improvement-led settings

Clinical leadership and management is likely to be most impactful in contexts that are already receptive to the collaborative and consensus-building leadership style associated with clinician leaders. Such contexts are most likely to be found in high-performing, improvement-led provider organisations and partnerships such as those highlighted by NHS Impact. These organisations and systems are characterised by their commitment to embedding a positive workplace culture focused on learning and building the capacity and capability of all staff to lead and support quality and safety improvement. These traits are usually complemented by an attempt to create a strategic and operational balance between the pressure to deliver against short-term performance targets and the need to secure a space for innovation and long-term improvement to flourish.

Many improvement-led organisations and partnerships have sought to promote greater clinical leadership and management to give their workforces a stake in delivering and improving services and deciding their future strategic direction. A case in point is Surrey and Sussex Healthcare NHS Trust, which was one of the five NHS trusts in England to participate in the NHS partnership with Virginia Mason Institute. Now rated by the CQC as an outstanding trust, in 2010 it was one of the lowest performing trusts in the country. Its then chief executive took the view that one potential path to improvement lay in addressing its top-down leadership approach. This led to a set of values co-produced with front-line staff that prioritised care quality, and a programme to strengthen clinical leadership, designed to give clinical teams the chance to take the lead in tackling quality challenges (Burgess). Senior leaders also adjusted their leadership approach from one focused on 'problem-solving' to one geared to 'problem framing', and empowering and supporting others to identify solutions.

This is not to say that clinical leaders and managers cannot flourish in a less propitious climate, or indeed become the primary driver of sustained performance improvement. But the chances of being able to do so are likely much greater in an improvement-led organisation that places a premium on an open, learning culture and on staff capability building and empowerment. As such, there is a strong case for aligning

national and locally led initiatives to promote clinical leadership and management with initiatives that encourage the development of organisation and system wide approaches to improvement.

Conclusion and recommendations

Strengthening and spreading clinical leadership and management in England will require a concerted effort at national, regional, system and provider level. A set of key recommendations are described below. Some of these measures can be delivered through a change in strategic attitudes and culture and are not resource dependent. Others will require small amounts of extra resource – whether new investment or through existing budgets. In many cases, it is about identifying and spreading good practices already implemented in parts of the health service. The new Royal College of Clinical Leadership will have an important role to play in leading, coordinating and galvanising action at all levels of the NHS.

Our main recommendation is to develop a multifaceted change approach that involves all national and local bodies, such as NHS England and NHS trusts, with a role in training, supporting and employing clinician leaders and managers. This approach should combine a focus on strengthening and spreading clinical leadership and management with steps to create positive organisational cultures in which clinician leaders and managers are equipped and supported to drive the consistent delivery of safe, high-quality care. This approach should seek to do the following:

The profile of clinical leadership and management, and training, support and development

- Ensure that all leaders at national, regional, system and provider level consistently underline the value to the NHS of all management and leadership roles – clinical or non-clinical – and work to ensure that there is diversity of thought and backgrounds at all leadership and management levels.

- Develop high-quality leadership and management training and development opportunities for prospective, new and experienced clinician leaders and managers. These should reflect the NHS's transformation priorities, including leading the service's digital transformation and delivering improved productivity and quality, and address any cultural and practical issues impeding access to them. A blended and closely-aligned approach is likely to be necessary that combines training geared to the local context, led by employers and local partnerships, with national and regional-level offers that allow for economies of scale.

- Strengthen the clinician management talent pipeline in provider organisations and among local system partnerships by identifying clinicians with an aptitude for, or an interest in, management at an early stage. Support their career development through mentoring and coaching, and ensure that there are clear pathways for progression.

- Implement robust recruitment processes for clinician managers and leaders that place sufficient weight on candidates' values, mindsets, behaviours, skills and experience, while ensuring that the competencies required are clearly identified and used to inform selection decisions.

Organisation and system-wide improvement

- Encourage NHS trusts and integrated care systems to prioritise the development of organisation and system-wide approaches to improvement and ensure that they receive the support necessary from their local, regional and national partners to do so. It is crucial that an effective balance is struck between the need to meet immediate service delivery priorities and the long-term challenge of building the conditions, capability and infrastructure necessary for transformation at scale and financial sustainability.

- Ensure NHS trusts and integrated care systems identify their clinical leadership and management capability requirements and put steps in place to address any training and development gaps. Such leadership strategies should have a broad remit, encompassing both system leadership, leadership for improvement, equity and productivity, and examine and reinforce the relationship between them.

- Ensure that any existing local and national strategies to strengthen clinical leadership and management are aligned and integrated with the leadership strategies developed by NHS trusts and integrated care systems as part of NHS Impact.

- Give clinical leaders and managers a central role at NHS trust and integrated care system-level in leading improvement across organisations and systems, recognising their commitment to collaborative leadership and coalition building. It is important to ensure that effective training, support and development opportunities are available to build and embed collaboration skills, knowledge and experience across systems.

This long read was published originally on 26 September 2024 at the following address:
https://www.health.org.uk/publications/long-reads/strengthening-clinical-leadership-and-management