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Are we nearly there yet? A study of the English National Health Service as professional bureaucracies

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Abstract

Purpose

This paper explores issues of medical engagement in the management and leadership of health services in the English National Health Service (NHS). The literature suggests that this is an important component of high performing health systems, although the NHS has traditionally struggled to engage doctors and has been characterised as a professional bureaucracy. This study explored the ways in which health care organisations structure and operate medical leadership processes to assess the degree to which professional bureaucracies still exist in the English NHS.

Design/methodology

Drawing on the qualitative component of a research into medical leadership in nine case study sites, this paper reports on findings from over 150 interviews with doctors, general managers and nurses. In doing so, we focus specifically on the operation of medical leadership in nine different NHS hospitals.

Findings

Concerted attention has been focused on medical leadership and this has led to significant changes to organisational structures and the recruitment and training processes of doctors for leadership roles. There is a cadre of doctors that are substantially more engaged in the leadership of their organisations than previous research has found. Yet, this engagement has tended to only involve a small section of the overall medical workforce in practice, raising questions about the nature of medical engagement more broadly.

Originality/value

There are only a limited number of studies that have sought to explore issues of medical leadership on this scale in the English context. This represents the first significant study of this kind in over a decade.

Keywords

Doctors; leadership; medical leadership; performance; professional bureaucracy

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Introduction

It has long been argued that involving doctors in the leadership of health organisations can help improve organisational performance and drive improvement in health systems (Dwyer, 2010; Candace and Giordano, 2009). The engagement of doctors in these sorts of roles is argued to be important because, in the language of organisational theorists such as Henry e.g. Mintzberg (1979), health care organisations are professional bureaucracies and as such front line staff have a large measure of control over the content of work by virtue of their training and specialist knowledge. Consequently, as Mintzberg goes on to argue, hierarchical directives issued by those nominally in control often have limited impact, and indeed may be resisted by front line staff. Professional bureaucracies have an inverted power structure in which staff at the bottom of the organisation generally have greater influence over decision-making on a day-to-day basis than staff in formal positions of authority (Dickinson et al., 2016b). Control is typically driven by professionals who use collegial influences to secure co-ordination of work. Collegial influences depend critically on the credibility of the professionals at their core, rather than simply the power of people in formal positions of authority (Phelps et al., 2016). Organisational leaders therefore have to negotiate, rather than impose, new policies and practices, working in a way that is sensitive to the culture of these organisations (Ham, 2008a).

Appointing respected and experienced professionals to leadership roles is often advocated as a helpful response to the challenges raised by professional bureaucracies (Ham, 2008b). For much of the history of the UK National Health Service, doctors have enjoyed a large measure of freedom to practise in the way they consider appropriate. Successive national governments have struggled to engage doctors in the leadership and management of the health system despite a range of different reform attempts (Dickinson and Ham, 2008). From the mid-1980s most NHS hospitals implemented a system of medical management centred on the appointment of senior doctors as clinical directors responsible for leading the work of different services within the hospital, mirroring developments in other national health systems (e.g. Braithwaite, 2004; Fulkerson and Hartung, 2006; Mo, 2008). Clinical directors combined their management and leadership roles with continuing, but reduced, clinical duties. They usually worked with a nurse manager and a business manager in a directorate management team known as a triumvirate. Evidence on the impact of general management found that a more active management style resulted in which managers were increasingly involved in questioning medical priorities (Flynn, 1991). The extent to which this led to a shift in the frontier of control between managers and doctors is disputed with the balance of evidence maintaining that change was limited and that doctors retained significant autonomy and influence (Harrison and Pollitt, 1994; Strong and Robinson, 1990; Bate, 2000).

A more mixed picture emerged from a survey of clinical directorates in Scotland conducted by McKee and colleagues (1999). This survey found wide variations in the way directorates were constructed and conducted their business. Three major directorate types were identified. The dominant type was described as **'traditionalist'** and this was characterised by a strong focus on operational issues and limited scope for innovation and change. Relationships between clinical directors and clinical colleagues remained embedded in a collegiate clinical network and were based on consensus building and facilitation. The second type was described as **'managerialist'** and was characterised by a business oriented approach more in line with managerial philosophy. Clinical directors in managerialist directorates had direct links with top managers in the hospital and were better placed to influence overall strategy and direction than those in traditionalist directorates. The third type was described as **'power-sharing'** and involved clinical directors working across established specialty boundaries and operating as a team with the business manager and nurse manager.

McKee and colleagues emphasise the overwhelming sense of continuity with 'few examples of Trusts creating a new climate in which clinical directors of the future were being spotted, nurtured or sustained' (p. 110). Furthermore, clinical management was very thinly resourced, with many directorates run on a shoestring. The minority of directorates that were not traditionalist held out the prospect that clinicians could be developed into innovative leaders, but for this to happen: 'More, and more senior, doctors will have to be given the incentive to get involved, the relevance of management will have to be actively marketed and the clinical legitimacy of doctor-managers will have to be safeguarded' (pg. 112). This study reaffirmed evidence from the organisational theory literature relating to the tendency of professional bureaucracies to be oriented to stability rather than change, while also underlining the limited progress in moving from professional bureaucracies to managed professional businesses. Similar conclusions were also reached by Marnoch (1996) and Kitchener (1999).

UK central government has continued to pay extensive attention to this issue, introducing a range of initiatives, new forms of structures and exhorting doctors and managers to work together more collaboratively. This theme took on an even more urgent aspect since the publication of the Francis report (Francis, 2013) into major failings at the Mid Staffordshire hospital which concluded that the disengagement of doctors in management posed serious risks to the quality and safety of patient care. The government's response to the Francis report (Secretary of State for Health, 2013) included a commitment to further assist doctors to take on leadership roles and significant investments are being made in this area. Part of the explanation of the persistence of professional bureaucracies can be found in the work of Friedson (1986) who contends that professional (and especially medical) dominance in health care has been maintained by internal differentiation of roles. This entails a distinction between 'rank and file' doctors providing patient care, a 'knowledge elite' of doctors involved in education and research and an 'administrative elite' of doctors in leadership roles in hospitals and other health care organisations. Members of the administrative elite occupy the hybrid roles referred to above and identify as much with the organisations they work in as the profession in which they trained. A point we would add is that the size and role of the administrative elite varies between health care systems and organisations within these systems.

More than a decade on since the last extensive research into this topic, this paper examines the degree to which professional bureaucracies still exist in the English NHS. There is a growing evidence base that demonstrates a link between doctors in positional leadership, board or chief executive roles with improved organisational performance (Walston and Kimberley, 1997; McNulty and Ferlie, 2002; Ham, 2003; Goodall, 2011; Veronesi et al., 2013; Dickinson et al., 2016a; Loh et al., 2016). However, many of these studies have focused more on performance at the organisational level and less on the operation of teams within organisations.

In this paper we report the qualitative component of a broader research project examining the structures, practices, processes and outcomes of medical leadership. In doing so, we focus specifically on the operation of medical leadership in nine different NHS hospitals. The paper is structured as follows: the first section outlines the methodology underpinning the data reported in this paper; the next sets out an overview of the findings; and the final draws together the lessons of the research. The paper concludes that concerted attention has been focused on the issue of medical leadership and this has led to significant changes to organisational structures and the recruitment and training processes of doctors for these roles. There is a cadre of doctors that are substantially more engaged in the leadership of their organisations than previous research has found. Yet, this engagement has tended to only involve a small section of the overall medical workforce in practice, raising questions about the nature of medical engagement more broadly and the mechanisms needed to enhance these processes.

Methods

This paper reports on one part of a broader research project investigating medical leadership in the English NHS. The overall research comprised three inter-related phases: a national questionnaire survey; in-depth case studies of nine NHS Trusts; and analysis of the relationship between the engagement of doctors in the case study sites and various measures of organisational performance. This paper focuses primarily on the case study component of this research and further detail on the survey and measures of performance analysis may be found elsewhere (Authors, 2013; Authors, 2014). Throughout the research we were interested in understanding how far the clinical directorate model had evolved and the roles and relationships of leaders from different backgrounds. Specifically, we investigated: the professionalisation of medical leadership; the balance of control at the organisational level and within the traditional triumvirates; and, engagement of Consultant Medical Staff at the 'front-line'. Variations in practice between the case study sites were particularly useful in developing these themes.

The nine case study sites involved in the research were selected from those who had responded to the national survey. We employed a purposive sampling approach (Denscombe, 2007) aiming to select sites with a range of different principal organisational structures across a range of criteria such as size, geography, Trust type and budget (See Table 1). For more detail on the formal structures of these organisations, where accountabilities lie and what different resources individuals and teams controlled see Dickinson et al. (2013). As a first stage of exploration, approximately five members of each Trust's executive board were interviewed (n=46). Interviews were semi-structured, following an interview guide which covered a series of different themes around the structure, process and outcome of medical leadership within the Trust, leaving sufficient space for interviewees to discuss the full range of themes they believe relevant to issues of medical leadership. These interviews were recorded. The aim of these interviews was to gain high-level insight into: the structures of the Trust; how doctors were selected, prepared and developed for leadership roles; how effectively management structures operated on a daily basis; and, the strengths and weaknesses of medical leadership within the Trust as perceived by interviewees. As part of this initial round of interviews we asked interviewees to identify clinical units or sub-groups which we could do more in-depth work with in order to complement the board perspective with those closely involved with the delivery of patient care.

Table 1

Following the board interviews we conducted approximately five interviews with different professionals in three different units within each Trust. We aimed to involve a mix of doctors, nurses and managers in each of the units, although the precise mix of individuals varied from unit to unit depending on their particular personnel and characteristics (n=105 total, with breakdown set out in Table 2). The aim of these interviews was to gain an understanding into the operation of leadership within these clinical units and the roles that different professionals play in this process. Again, interviews were semi-structured with an interview guide setting out a broad range of issues to explore, but leaving space for interviewees to delve into a range of related medical leadership considerations. Interviews covered issues such as: how doctors are selected, prepared and developed for leadership roles; how effectively management structures operated on a daily basis; where accountability for decision-making lies; and, the strengths and weaknesses of medical leadership within their units as perceived by interviewees. We were interested ultimately in understanding the balance of power and control in units by exploring issues such as: who is the accountable officer in the units; who has decision-making power over a range of issues; how engaged different professional groups are in terms of the leadership and management of the clinical units; and how the triumvirate interact on a day-to-day basis in the running of the units. Most of

these interviews were conducted on-site at the Trust, with follow up telephone interviews where individuals were not available in person. Again all interviews were recorded.

Table 2

Interviews for this project were transcribed partially. After interviews had been completed recordings of interviews were listened to several times and analysed against a number of themes relating to the three meta-themes of structure, process and outcome. Table 3 sets out the different themes that were examined in the analytical process. Where interviews discussed these themes, components of interviews were transcribed verbatim. A report was compiled for each site that provided a descriptive account of the content of the interviews against the different themes, highlighting where there was particular agreements and disagreement concerning the different factors. Data from the nine sites were then aggregated and the sub-themes cross-compared to analyse the degree of consistency and difference between the sites. Further detail about methodology may be found in Authors et al (2013). In the next section we consider the findings gleaned from the case studies.

Table 3

Findings

As described above, this paper reports on qualitative data gathered from our case studies in relation to the structures, processes and outcomes of medical leadership. This paper extracts relevant data in order to examine the degree to which recent changes in the relationships between doctors and managers might represent a shift of the NHS away from professional bureaucracies and data on the national survey and performance analysis of the Trusts can be found elsewhere (Authors 2013; Authors, 2014). We set out findings here in relation to a number of different themes which explore perceptions of individuals and organisations concerning who the dominant professionals or groups are that have control on a day-to-day basis. We were interested in exploring whether the sorts of patterns of authority and control that McKee *et al* (1999) identified in their research have altered in the fifteen years since this research. In setting out our findings we start with an account of the professionalisation of medical leadership. Following this we move on to explore which professionals were considered to have control within the different organisational structures. Having explored this at the organisational level, we then move on to examine this in terms of the clinical unit level and the interaction of doctors, managers and nurses and then to the degree that doctors at the front line are perceived to be engaged in the leadership of health organisations.

Professionalisation of medical leadership

All of the Trusts were taking steps in terms of talent management and succession planning which was seen as a critical part of moving away from “amateur clinical leads” to more professionalised medical leaders. As a director at site A explained: “We will get more out of it if people really engage with these roles”. Five of the sites (A, B, C, E and I) reported having established development programmes within their Trusts specifically for doctors in leadership roles. Typically, these had been run either in conjunction with a local university or a management consultancy. A number of Trusts (B, E, and F) had development programmes for all consultants, with a view to engaging a wider consultant body. These Trusts tended to have a longer history of clinical engagement, so that clinical leaders had emerged from a workforce already relatively highly engaged, rather than needing to be trained for a managerial role. Others did not have specific internal programmes but offered doctors places on training and development programmes through relationships with regional health organisations or Deaneries (Sites D, G and H). Site D had developed its own leadership academy where it offered training in improvement methodologies.

As part of the process of moving from “amateur” status of doctors in leadership roles, all of the sites had recently gone through a process whereby if they did not have a formalised process for the appointment of medical leaders previously, they had implemented one. Formalisation of the appointment process in most of the Trusts had not in practice generated huge competition for medical leadership roles. As one Director described and was echoed by others in the site, doctors are not necessarily “queuing up for these roles”. For the most part, Trusts were trying hard to make sure that they did manage to generate more competition in future and they were being “ruthless in getting the right people” (Director, Site D).

In terms of what Trusts looked for in medical leaders, rather unsurprisingly clinical credibility was seen as an important factor. Typically, this might mean that candidates for medical leadership roles would need 5-10 years’ experience in a consultant role before they were seen as having sufficient “clout” with their colleagues to be successful in these roles. Aside from clinical credibility, another major factor across all of the Trusts is an ability to think and act in a “corporate manner”, beyond the doctor’s immediate specialty area. As one director explained:

“The doctor traditionally represented the consultants at management and that has changed now. It is now representing a clinical position in the tough choices that need to be made. And then if tough decisions need to be made then explaining that to your colleagues. It’s not a trade union representative on the board and most people get that” (site A).

Beyond these factors, interviewees found it difficult to identify what it was precisely that they looked for in medical leaders. For many they “knew it when they saw it” but couldn’t quite articulate what the important factors are. The majority typically suggested that they are quite similar to those sorts of characteristics that make good leaders in a more general sense, so things like being able to communicate well at a number of levels, being engaging, having the ability to think strategically and being able to make decisions.

Doctors in management and leadership positions are all allocated programme activities (PAs) to support their roles. A standard full-time contract is made up of 10 PAs. In some cases ‘responsibility payments’ are paid as an alternative where doctors are given additional money for the role rather than time within their job plan. We found some degree of variation in terms of the time allotted to medical leadership roles, although in general Medical Directors typically have somewhere in the region of half to the whole of their programme activities dedicated to their leadership role, whereas at the clinical director level (or equivalent) this reduces to approximately 2 with specialty leads receiving 1 PA (if anything at all). In some Trusts there is some flexibility in relation to programme activities at the clinical director level depending on the size and the scope of the Trust, but typically the allocation to this level is relatively marginal.

Across all sites there was a strong sense that medical leadership roles are challenging and tend to take a good deal of time to do well. Many of those in these roles suggested that it is difficult to be precise about how much commitment these roles take in practice as it is not easy to separate this out from other responsibilities, because many management and leadership activities take place “in the margins” of the job. As one doctor described: “The role spills into everything else – my clinical work and my home life” (site A). We interviewed more than one doctor who had formerly had a medical leadership role but had resigned as it overshadowed their clinical role. Where additional PAs were given for a clinical leadership role, often these were added to a job plan rather than substituting for other activities, particularly clinical activities. As an example, a 10 PA job (the standard full-time contract) might become a 12 PA job plan, which clearly suggests that leadership roles are undertaken in addition to a full workload. How much time is allocated to these posts was described as being a decision that goes beyond simply determining how much time such a role might involve. For example, some of the Board of Directors at Site G were clear that they believed that if

the leadership element of a doctor's role goes beyond six PAs a week then there is a risk that they will lose clinical contact and clinical credibility in the eyes of their colleagues. If this is the case, then simply allocating more time to these roles might not be helpful. In this situation the answer then lies in how these medical leaders are supported and the relationships they have with their clinical and managerial colleagues so that they are able to delegate aspects of their roles to others.

Balance of control: organisational level

Of principal interest in exploring whether professional bureaucracies still dominate the English NHS, was the issue of which professionals were perceived to hold the balance of control within the structures of the case study Trusts. We were particularly interested in understanding whether these structures were felt to be dominated by doctors or managers in practice. One way of understanding this is in terms of where formal accountabilities lie within structures. So, for example, where a doctor holds a positional leadership role which is accountable for that component of the structure then we might consider it to be medically-led, formally at least. However, this relationship between formal accountability and the description of the Trust does not necessarily hold in all cases, as further discussed below. Five of the sites described themselves as being strongly medically-led in board interviews (A, B, D, E, and F). Another (G) felt similarly strongly about being led by health professionals, describing itself as clinically-led reflecting the nature of the professional make-up of the Trust. Only one site described itself as a managerially-led organisation (C) and two were described as having an aligned structure in which leadership was shared by doctors and managers (H and I). Table 4 sets out the variety of names that are given to the formalised roles that doctors play within the structures of the Trusts and also an indication of who is the responsible individual within principal organisational units. As this table illustrates, although the size of Trusts ranges significantly within our sample, there is less variation in the number of levels that doctors hold roles at. Regardless of the size of the Trust, there tend to be either three or sometimes four 'formal layers' where doctors hold leadership roles.

Table 4

Most Trusts identified clinical director or divisional manager levels as being the most important driver of medical engagement. Respondents in the main did not tend to view Medical Director roles as being the primary driver of medical engagement, or clinical specialty leads but the level in between these positions in terms of the organisational hierarchy. The primary driver of medical engagement cited in the majority of Trusts was those individuals who occupy hybrid clinician-manager roles.

Those Trusts that described themselves as medically, or clinically, led stated that this had been a deliberate decision on the basis that medical leadership was perceived to be the "key to success" (respondent, B). Respondents at Site A were clear that the hospital is explicitly medically-led on the basis that this should help fully engage doctors in decision-making processes and not have doctors in leadership roles simply as representatives. As a director at site A stated:

"the AMDs [Associate Medical Directors] are not some figureheads we wheel out when we need a doctor. They are genuinely the managers of that directorate and the general managers are junior to them. We could have made them equal, or we could have –like some hospitals do – the general managers in charge and the doctors feeding in sideways. We were quite clear that we wanted the most senior person in the directorate to be a doctor".

Both of the 'aligned structures (H and I) are mental health Trusts. Although the formal accountability in site H resides with the general managers, the structure was reported as being an attempt to: "Match the medical structure with the operational management structure". In Trust I

accountability was held 'jointly and severally' at the operational units, between the general managers and the clinical directors.

Outside of the formalised organisational leadership structures, many of the sites also had a series of 'horizontal' structures which were medically or clinically-led and which developed strategy for clinical issues, for example cancer services or planned care, or addressed specific issues such as updating mortality reporting. These horizontal structures cut across the vertical clinical directorate structure in an attempt to give some consistency in terms of strategic and operational issues across the different units that comprise the hospital. These horizontal structures were also often viewed as vehicles for including a wider range of clinical representation within the leadership of Trusts.

Balance of control: clinical units

One of the features of most of the structures that were described by board members in all of the Trusts was that clinical units were often underpinned by a 'triumvirate'. This term refers to the involvement of doctors, general managers and nurses in the management of clinical units. Although triumvirates were described as underpinning the formal organisational management of most Trusts in our sample, at the clinical unit level interviewees did not necessarily recognise that this organisational arrangement underpinned the practice of everyday management and leadership of their teams. What we more often found was that there is a 'duality' of the doctor and manager in place to the exclusion of nursing partners who on the whole are perceived as more junior and in some structures were more junior in the hierarchy, reporting directly to general managers. What this meant was the effectiveness or otherwise of medical leadership structures was critically dependent on how the duality functioned. As a Director at site G described:

"The structure completely relies on the clinical director and general manager relationship working well. If we got a pairing who couldn't work together then this would be unworkable. All our pairings work, although some work much better than others. Where it works well the individuals have worked out which are their roles and responsibilities".

In the mental health Trusts in the sample (sites G, H and I) triumvirates were explained not to exist because, as one Director at site H explained, "mental health Trusts are different". The rationale offered for this is that in mental health Trusts there are a broader range of professionals present in these organisations who might feel that they have an equal right to have a voice in terms of how services are led and provided. Some suggested that it was therefore easier to limit the crucial relationship to the lead clinician and the manager rather than involve a range of other professionals in addition. Further, many of the managers that we interviewed in mental health Trusts had nursing backgrounds and had gone into management roles in order to progress their careers. Therefore, although nurses may not be formally involved in a triumvirate, a nursing perspective was often reflected by managers with nursing backgrounds. Although some managers in acute trusts had clinical backgrounds this was a relatively smaller proportion than in mental health trusts.

Outside of the mental health trusts, the duality of medical leader and general manager was described as "really" driving organisations. The leadership "duality" was typically described as a partnership. Even where the formal accountability of the general manager to the clinical director was clear, the partnership was widely seen as being crucial to the effective operation of the units concerned. A deputy director at site B explained:

"Formally the Chief of Service is the boss, but sometimes it is the other way round. In terms of who does what within the duality there was a common distinction that general managers would lead on the practicalities of whatever issue they were facing whilst for

clinical directors their role related to coordinating with the medical workforce and 'selling' messages to them."

In thinking about the role of doctors in the leadership and management of the principal organisational units a distinction between management and leadership was often raised. One director (site B) said of clinical leaders:

"They are not managers. They are clinical leaders. I don't expect them to go to a 50-page budget report and show the overspending on sutures. I expect them to be conceptually thinking about the future and making sure the present is appropriately managed, with a team. I am expecting leadership skills not management skills".

Having made this point, clinical directors had different styles and some had a greater interest in getting involved with tasks like detailed budget management that might be traditionally considered more managerial. Whatever structure is adopted it seems that individual responsibilities are negotiated, explicitly or implicitly, within the working of the partnership between clinical directors and general managers. Nurses seemed to have a clearer professional identity across Trusts, whereas doctors tend to be more organised around specialties or directorates.

Engagement at the front line

In many of the sites there was a distinction made in levels of engagement in terms of those doctors that are in formal medical leadership roles and the "rank and file" consultant body who are seen as less engaged in the business of the Trust as a whole. Those in medical leadership roles at a range of levels made sure that they attended regular Trust update meetings but the wider consultant body were less engaged and are often less positive about change or initiatives within their Trusts. This was described in interviews by both those at the board level and also in clinical units as something of an "engagement gap". The engagement gap was compounded in the larger Trusts where their size or the geographical area covered could increase the distance between leaders and followers. Even Trusts that believed they had high engagement of consultant staff acknowledged there was a group of consultants that were not engaged in the corporate affairs of the Trust, perhaps because they had interests in teaching or research, or in professional bodies. What seemed to be important was that the Trust maintained opportunities for engagement, so non-engagement was a choice of the individual consultant rather than a product of the structure or processes of medical leadership.

Some of the executive teams identified the "engagement gap" as an issue but thought of it as a natural part of their journey towards more effective medical engagement. The first phase of this process has been to develop and appoint strong medical leaders and in the next phase to then try and better engage the rest of the consultant body. Even in trusts where there was a strong history and culture of medical engagement, having engagement from all medical staff was understood as being very difficult. As a director at site B explained:

"If you see clinician engagement as triangle, we work well with the 13 divisional directors, and probably 80% well with directorates. It is when you get to the bottom of the triangle that there is always a problem, and we are looking at different ways now of trying to engage with those – who I call the backbenchers".

There was a commitment here to using different ways of engaging staff, but also a realisation that complete engagement was unlikely to be possible and may not be desirable. Although in many of the trusts interviewees suggested that the "bad old days" of doctors and managers being permanently at loggerheads seem to be behind them, this does not mean that all is well for medical leaders. While the case for medical (and clinical) leadership was generally understood across the trusts in our sample, there are still some doctors: "Who think that getting involved in medical leadership is like going over to the dark side" (doctor, site H).

In terms of the impact that this had on outcomes, interviewees often identified that this 'gap' in engagement was problematic in terms of driving improvement in the health system. Interviewees suggested that until doctors were more broadly engaged with the leadership and management of their Trusts peak performance could not be reached. Others, however, saw this as being a part of a journey towards more effective medical engagement. The first phase of this process has been to develop and appoint strong medical leaders and in the next phase to then try and better engage the rest of the consultant body. As one director explained, "Is every single doctor – all 650 of them – engaged in strategy? No I don't think so. Have we got the 10-20% we need to start making the shift? Yes, I think we probably do" (site C).

Discussion and conclusions

What is apparent from the data is that significant efforts have gone into the organisational structuring of doctors' leadership contributions, and the training, development and recruitment of doctors to leadership roles. Despite this, our case studies reveal that whatever the structure adopted, roles and relationships vary as does the perceived effectiveness of medical leadership. There are variations too in the engagement of doctors and in the performance of the services concerned (Authors, 2013). On one level it would appear that the boundaries between professional and bureaucratic ways of organising work are becoming blurred as a greater number of doctors take on more hierarchical roles and this has also been observed elsewhere (e.g. Waring and Currie, 2009). Yet, in practice, many respondents described ongoing difficulties of engaging doctors in leadership and management of their organisations and the ability of doctors to stall or de-rail improvement projects and initiatives.

Returning to the typology outlined by McKee and colleagues (1999) in their study of clinical directorates in Scotland in the 1990s, the research reported here points to a move away from 'traditionalist' and 'managerialist' structures to 'power sharing' arrangements in the current English NHS. We base this claim on the fact that most of the case study sites described themselves as medically or clinically led or having aligned structures in which doctors shared power with managers, rather than being managerially led. The sites also provided some evidence of their structures and processes leading to innovation and service change of a different order to that described by McKee et al in their account of how 'traditionalist' directorates functioned. However, we would not go as far as Cheraghi-Sohi and Calnan (2013) who, in their study of general practice, suggest that the use of a particular target based regime has moved this field away from a professional bureaucracy towards a 'machine bureaucracy' (pg. 58). Our evidence suggests that although roles and relationships have moved on in the English NHS, there is no reason to question fundamentally the argument of Greener and colleagues (2011) about the persistence of established relationships and dynamics between doctors, nurses and managers. To be sure, progress has been made on the journey of involving doctors in leadership roles but the organisations we studied are not yet at the desired destination as articulated by the Department of Health.

In our fieldwork, we heard time and again that the impact of medical leaders depended critically on their personal credibility and their ability to lead peers who were often highly skilled and autonomous professionals. It was for this reason that trust leaders focused on developing doctors as leaders and introducing greater formality and professionalism into the process. To return to Friedson's typology (1986), the 'administrative elite' of doctors in leadership roles has resulted in increasing differentiation between these doctors and the 'rank and file' whose main focus is their clinical work, leading to the engagement gap we noted above. Rather than lessening the power of doctors these changes may have served to increase the powers held by a new administrative elite in the context of more professionalised medical management. This is a pattern that has also been observed by Harrison (2009) in relation to primary care and the normalisation of financial incentive

schemes for doctors, although Calnan and Gabe (2009) suggest that this may be a horizontal, rather than vertical, re-stratification.

As Currie et al (2012) observe 'powerful actors (re)generate or (re)create institutional arrangements in the face of external threats, in a way that can enhance, not merely maintain, their position' (pg. 958). This raises the question of whether the medical professionals in our study are deliberately engaging with leadership roles as a way of retaining their power in the face of external pressures; or whether doctors are demonstrating a new form of professionalism and becoming more accepting of managerial values. Clearly this is a difficult question to answer in a definitive manner, given that the medical profession is vast and there are likely to be aspects of continuity and change across different aspects of the health services (Evetts, 2011). In this study we found that those who took on leadership roles at the middle level of the organisation (e.g. clinical director) were often appointed for their ability to see beyond narrow sectional interests and to represent the entire organisation. These individuals spoke of their desire to see the organisation improve as a whole and to do this they argued it is crucial that the different constituent components of the Trust work together for the greater good, which might sometimes be to the detriment of their own service area. To this extent, it may be the case that these individuals have adopted aspects of managerial values. However, these individuals still believed that clinical credibility was crucial as illustrated by the maximum time allowances that could be taken up by these roles; going beyond this would be seen as going over to the 'dark side'. There was often less competition for service-level leadership roles (e.g. lead clinician) and individuals were often appointed because it was their 'turn'. In this case it is difficult to argue that these individuals had bought into managerial values, but neither did they seem themselves as a part of an administrative elite. There may be an important distinction here between individuals in these roles and their drivers for occupying these positions which may have broader implications for the selection, training and development of medical leaders.

The hybrid roles that medical leaders inhabit continue to occupy a relatively precarious middle ground. Hybrid roles do not have the same status as that attaching to medical leaders who are committed to clinical, research and educational activities, and it is therefore not surprising that our research found that competition for these roles is often limited. Trusts find themselves in a difficult position in relation to issues of training and development for these roles. If they train and develop doctors separately, away from the managers, nurses and other clinicians that they work with on a day to day basis then there is a danger that this further endorses the position of doctors as different or distinct from other professionals. A number of the case studies involved in our research saw multi-disciplinary leadership development as being the only way to break down professional barriers and to encourage closer working between leaders across different levels of the organisation. Yet such programmes run the risk of being perceived negatively by doctors looking to engage in uni-professional development as a way of enhancing their professional practice.

A common theme in our findings is that the journey to achieve medical engagement is by no means at an end. The challenges faced by Trusts and their medical leaders, as summarised above, remain significant, including how leaders can engage followers and how more doctors can be supported to become leaders. Based on the evidence we have gathered, there is no reason to suggest that new organisational archetypes have supplanted the professional bureaucracy as the dominant form in the NHS, notwithstanding the emphasis on managerialism and market based reforms. Our research suggests that the constituent parts of the NHS may be developing different forms of medical professionalism, with clear contrasts between secondary care and mental health. Although central government has often looked to structural solutions to improve health services the evidence presented here suggests that the 'softer' aspects of leadership may be much more important, particularly relationships between individuals within clinical teams.

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Table 1. Overview of key features of case study sites

Case Study	Total Budget (£ million)	Total Number of staff (total head count, not FTE)	Number of Medical consultants	Number of doctors on Trust Board of Directors	Number of doctors on Trust's Management Board
A	193	3300	140	1	5
B	450	6582	358	1	12
C	950	13000	714	1	1
D	507	8743	504	2	8
E	178	4300	223	1	14
F	323	3594	249	3	6
G	150	2000	70	2	5
H	140	3200	64	3	5
I	131.5	2808	86	2	5

Table 2: Individuals interviewed in principal organising units

Case study site	Number of individuals interviewed
A	Doctors 6 Mangers 5 Nurses 3
B	Doctors 5 Mangers 4 Nurses 3
C	Doctors 3 Mangers 3 Nurses 5
D	Doctors 9 Mangers 3 Nurses 2
E	Doctors 3 Mangers 2 Nurses 4
F	Doctors 1 Mangers 2 Nurses 1
G	Doctors 6 Mangers 4 Nurses 2 Psychologists 2
H	Doctors 8 Mangers 3 Nurses 3
I	Doctors 5 Mangers 4 Nurses 3 Psychologists 1

Table 3: Meta themes and themes of data analysis

Meta-Theme	Themes
Structure	Positional medical leadership roles
	Composition of executive board
	Decision-makers within clinical units
	Accountable officers within clinical units
	Formalised power structure
	How clinical units engage with one another
	Strengths of Trust structure
	Limitations of Trust structure
Process	How doctors are prepared for leadership roles
	How doctors are selected for leadership roles
	Characteristics of good medical leaders
	Time commitment of medical leaders
	Resources allotted to medical leaders
	Negative implications of assuming medical leadership role
	Positive implications of assuming medical leadership role
	Balancing of medical and leadership responsibilities
	Operation of the triumvirate
	Roles of different professionals within triumvirate
	Responsibilities of professionals within triumvirate
	Engagement of doctors in unit management
	Proportion of doctors engaged in organisational leadership
	Examples of challenges in daily operation of units
	Changes required in working practices
Outcomes	Organisational performance: quality
	Organisational performance: safety
	Organisational performance: patient experience
	Organisational performance: finance
	Impact of medical leadership on Trust performance
	Examples of clinical units with good medical engagement
	Examples of clinical units with poor medical engagement

Table 4: Formalised structural roles that doctors hold and responsible officers within principals organisational units

Case Study	Number of levels doctors hold formalised structural roles and roles	Responsible officer within principal organisational unit
A	3 – Medical Director, Associate Medical Director, Specialty Leads	Associate Medical Director
B	4 – Medical Director, Chief of Service (Division level), Clinical director, Lead clinicians	Clinical Director
C	4 – Medical Director and Deputy Medical Directors, Divisional Medical Managers, Clinical Directors, Lead Clinicians.	General Manager
D	4- Medical Director, Clinical Director, Director of Education and Director of Research	Divisional Clinical Director
E	3 – Medical Director, Clinical Director, Lead Clinicians	Clinical Director
F	3 – Medical director, Divisional Director, Specialty Leads	Divisional director
G	3- Medical Director, Clinical Director, Associate Clinical Director	Clinical Director
H	3 - Medical Director, Associate Medical Director, Medical Leads.	General Manager
I	3 – Medical Director, Clinical Directors (at 2 different levels)	‘Jointly and Severally’