Barriers to doctors successfully delivering leadership in the NHS

Authors: Edward D Nicol[A] and Jenny Cowpe[B]

ABSTRACT

Leadership will be essential to deliver the changes outlined in the *Five year forward view* and to ensure that the efficiencies identified in the Carter Review are delivered. To achieve the scale of savings outlined in these papers, while maintaining the quality and safety of care, all NHS staff will need to be involved in and to take the lead in identifying wasteful practice and procurement and, more importantly, to become the agents of change and architects of innovative and high-quality practice. However, many barriers exist to successful leadership by doctors in the NHS. In this article we present qualitative data from interviews with senior NHS leaders identifying several real-word barriers that need action to maximise the success of the medical profession in leading these changes.

KEYWORDS: Healthcare leadership and management, organisational culture, clinical leadership, education and training

Introduction

The NHS remains a focus of intense scrutiny and debate and, as shown by the 2015 general election campaign, it is a highly politicised topic.[1] During the last parliament, we stated that the NHS appeared to be 'under intense pressure to balance its mission of delivering high quality, safe and cost-effective care against the concurrent need to make massive efficiency savings, at a time of radical structural change'.[2] Although the structural changes are being established, the financial challenges remain acute. The *Five year forward view* outlines NHS England's latest vision for the NHS, including why it needs to change and how it might evolve. In the *Five year forward view*, Monitor, NHS England and independent analysts state that the NHS will face a £30 billion annual funding gap by 2020–21 if no further action is taken.[3] In 2015, Lord Carter of Coles' interim report[4] identified efficiencies and procurement changes that could save upwards of £5 billion per year.

Authors: [A]honorary senior lecturer, Keele Clinical Leadership Academy, Keele University, Staffordshire, UK, and consultant cardiologist, Departments of Cardiology and Radiology, Royal Brompton Hospital and Harefield NHS Trust, London, UK; [B]director, Keele Clinical Leadership Academy, Keele University, Staffordshire, UK

To achieve the changes outlined in these reports, all NHS staff will need to identify areas of wasteful practice and procurement and, more importantly, become the agents of change and architects of innovative, high-quality practices. As stated by Nigel Edwards, the Nuffield Trust chief executive, in response to the Carter Review, 'Diagnosing the problem is the easy bit, getting solutions to stick is much, much harder'.[5] Most NHS staff are aware of substantial inefficiencies and have ideas about how to improve productivity and service delivery, but enabling and leading change within local departments can be challenging, and doing so on an organisational scale or at the system-wide level need is even more difficult.

The *Five year forward view* draws attention to the importance of 'coherent national leadership' and a backing of 'diverse solutions and local leadership in place of further national reorganisation'.[3] However, the focus on local and clinical leadership is not new. Sir Robert Francis argued for greater leadership from within the wider NHS workforce,[6] and echoed Lord Darzi's previous reports,[7,8] which articulated the need for all healthcare professionals to engage with the NHS delivery agenda in tripartite capacity as practitioners, partners and leaders. This systematic approach appears to have 'gained only limited traction' in the intervening years, despite much evidence that increased engagement, especially with doctors, drives up organisational performance and outcomes[9–11] and supports a more stable, loyal and productive workforce.[12,13]

Although McKinsey[14] and others[15,16] have previously published narratives about barriers to doctors delivering leadership in healthcare and Sir Robert Naylor has published a plan to tackle the NHS leadership crisis,[17] little qualitative research has been published in mainstream medical literature on the perceived organisational barriers to doctors particularly delivering this leadership vision. We aimed to capture the views of senior leaders on perceived barriers to the successful engagement of doctors in leadership and to identify potential solutions to these barriers. We present a summary of our data, which we hope highlights some of the biggest challenges to delivering the vision for the NHS.

Methods

The design and methods of this qualitative research have been published previously.[2,18] In summary, the study involved

an initial focus group and then targeted semi-structured interviews with 20 senior staff involved in leadership in the UK healthcare sector. The respondents were selected to ensure balance across the full range of healthcare leadership activity and influence (political, clinical, managerial, educational, medically qualified vs managerially qualified). Respondents included a former health minister, members of the NHS Executive; chief executives of strategic health authorities, primary care trusts and acute trusts; medical directors; deans of medical schools; and other key representatives of the medical leadership arena (such as National Leadership Council members, commentators, commercial and charitable providers of health leadership programmes). Most respondents (75%) were male, 85% were older than 50 years, 90% had more than 25 years of healthcare experience in the UK and 60% were clinically qualified, although not necessarily practising.

All interviews were recorded and transcribed, and observational notes were taken at the time of the interview to capture the immediate thoughts and reactions of the interviewer and provide a basis for reflection. Full transcripts were analysed according to the principles of grounded theory;[19,20] NVivo 8 software (QSR international) was used to assist with coding and the identification of specific themes.

The questions posed covered several major themes: history, culture and changing attitudes towards health leadership; perceptions of clinical leadership; attributes required for success as a healthcare leader; training and education in health leadership and views on the armed forces leadership model as a delivery model for national healthcare leadership. Views on the barriers to achieving successful engagement in, and delivery of, the healthcare leadership agenda emerged across all these interconnected themes. Our study gained ethical approval from the Stoke on Trent Research Ethics Committee (Ref 09/H1204/74). All participants gave written informed consent before participation in either the focus group or semi-structured interviews.

Results

Throughout the focus group and interviews, respondents regularly returned to the practical, real-life barriers, which they felt made widespread and meaningful engagement in leadership by doctors challenging. Box 1 summarises the key themes.

During the interview process, it became clear almost from the outset that any attempt to meaningfully discuss NHS leadership required historical contextualisation to show the barriers that were faced by today's aspiring leaders. Several themes quickly emerged: the history of the doctor's role in leading the health service and the introduction of general management into the NHS after the Griffiths Report;[21] the subsequent (often hostile and negative) culture and attitude among senior doctors in relation to this agenda; antagonism between doctors and other healthcare professionals; subsequent (negative) role-modelling faced by aspiring clinical leaders and the challenges that this presents to the younger generation of doctors who wished to take on leadership roles.

The starting point was usually the introduction of general management after the Griffiths Report[21] in 1983.

> *We are still in the aftermath of decisions that alienated the medical professions; doctors in particular, then abrogated their responsibility and said 'let managers get on with managing and we will get on with our clinical work'* (respondent 1).

Box 1. Ten barriers to successful healthcare leadership for doctors.

1. Negative senior doctors' attitudes towards the medical leadership agenda.
2. Negative senior role modelling.
3. Lack of natural career progression into management and leadership roles.
4. Lack of embedded corporate training within medical curriculums.
5. Too little focus on team leadership and developing followership.
6. Too much focus on theoretical versus practical leadership development.
7. Elite socialisation and autonomous leadership style of doctors.
8. Lack of real-world corporate experience.
9. Lack of robust assessment, feedback and support for medical leaders.
10. Infantilisation of junior doctors.

This opinion encapsulates the perception of a real-world and long-standing division (and animosity) between doctors and managers, which was expressed by most respondents. However, nearly all respondents also acknowledged a recent, perceptible change in culture among the younger generation of doctors and within the wider NHS, with an *'acceptance of the target culture'* (respondent 6) and *'a greater enthusiasm and openness to addressing the more corporate aspects of healthcare delivery'* (respondent 8).

However, many respondents felt that, despite the Griffiths Report being more than 30 years old, the culture and attitudes held by many senior doctors often remained antagonistic, with younger aspiring leaders dealing with senior role models with less than enthusiastic views about clinical leadership. Respondents reported that trainees and junior consultants often faced hostile responses from older colleagues, who saw the drive for greater medical engagement in leadership as *'a cynical attempt to get clinicians to "carry the can" for organisational failings'* (respondent 12), *'a saccharine-coated attempt to get clinicians to take more corporate responsibility'* (respondent 15) or *'a cynical, superficial, window-dressing term'* (respondent 10). These statements give insight into the negative feelings expressed by some senior and influential medical staff on the shop floor and contrast starkly with the perceived desire for engagement from more junior colleagues. This negative backdrop was thought to have potentially prevented individuals from gaining wider acceptance for their ideas.

Several respondents also noted the lack of senior doctors in chief executive positions and commented that many more nurses appeared to naturally *'make the transition from practitioners, through management into senior leadership roles'* (respondent 3). Other identified reasons for this professional

gap included greater financial and professional recognition (that are notably reversed with doctors) and a more natural career structure that allows *'identification and development of these staff into clinical managerial roles at relatively early stages of their professional careers'* (respondent 2). Additionally, several managerial respondents echoed the comment that the *'lack of perceived historical loss of power and influence amongst the older, non-doctor, clinical workforce that also meant that less antagonism existed between senior nurses and healthcare managers'* (respondent 20).

Investment in the right people

Although many respondents acknowledged the increase in investment in leadership within the NHS, they also expressed frustration with the focus on individuals within their professional silos and the lack of multidisciplinary and team training, credible assessment and feedback. They argued that this setup makes selection of the right individuals for further investment difficult and undermines the need to develop the transferrable leadership skills and holistic multidisciplinary focus needed when approaching real-life challenges.

This sentiment was captured best by statements such as *'currently the approach is confused and not joined up, everyone is doing their own thing'* (respondent 4), *'There is a requirement to develop individuals who are capable of expressing the attributes required [to lead] but who are also comfortable in both the clinical and managerial leadership roles'* (respondent 2) *'It is known that poor team working kills patients whilst good leadership defines high-quality care'* (respondent 9), and *'the challenge is to get individuals to understand themselves, their personal skills and attributes and how they play out in interaction with others – ie to understanding how to actually lead service improvement'* (respondent 4).

Many respondents believed that doctors were not always best placed for this challenge because of how doctors are trained and socialised in a way that is peculiar to them as a cohort:

> *Medical students are isolated right at the start, socialised immediately with little meaningful interaction with other healthcare professional students or the wider student body; usually the medical school is even physically located away from the rest of the wider university* (respondent 3).

Additionally, the wider social expectations of doctors and how they are trained to lead does not always bode well for general health leadership positions:

> *Doctors are expected to be good diagnosticians in highly charged environments, with autonomous rapid decision making; taking control, taking charge, stating 'that is my expert judgement and opinion and it is not up for discussion'. However, in management it is a different culture – you are more equal and not top of the hierarchy and you are expected to consult and engage, and listen to others opinions, and take them into account. You have no authority without willing followers. These are two highly paradoxical and contradictory positions, leading clinicians in these positions potentially feeling hugely conflicted* (respondent 3).

Many respondents felt that multidisciplinary-team learning, with much stronger early interaction between all forms of clinicians and their managerial colleagues, was essential from the outset. Such learning would support leaders to *'understand the bigger picture and the interplay between players'* (respondent 14), with focus on *'strategic thinking – a skill set most clinicians do not have'* (respondent 5). It was argued that training should include *'an understanding of the interplay between the hard stuff (contracts and key performance indicators) and soft relationship skills required to lead effectively at higher levels'* (respondent 5). This training might incorporate *'interplay with finance and management training programmes, multi-professional in their approach and delivery, and not just health related but traditional finance and management'* (respondent 4).

Several respondents also emphasised the need for a practical component of higher leadership training to distinguish *'those who say they can deliver versus those who can actually deliver'* (respondent 11). In essence, many respondents felt a need for a *'raw testing ground where the individual has to prove their worth'* (respondent 13) and for potential leaders to *'be able to [show they can] convince colleagues to change, whilst understanding [real-world] negotiation with colleagues'* (respondent 9).

Respondents acknowledged that the desired external interaction and practical components of training would be costly to deliver. Many stated that a robust selection technique would be needed to identify the appropriate individuals for this kind of investment – without it, many felt that current paradigm would fail to deliver.

Leadership – the need for credibility

The issue of leadership credibility, to ensure followership, was raised by many respondents, who identified several pertinent issues about timing and content of training and education in healthcare leadership: the so-called infantilisation of junior doctors (ie the lack of adult–adult engagement within the hierarchy, by contrast with other commercial and public sector organisations such as the military) and a lack of real-world experience.

As previously published,[2] respondents expressed frustration at the lack of organisational and broader healthcare system knowledge (corporate knowledge) among junior medical staff ('appalling', 'very, very disappointing', 'poor') but accepted that this problem was because corporate knowledge was not taught on the (very full and appropriately clinical) medical curriculum. Several respondents stated that even if younger doctors engaged in the corporate agenda they often faced cynicism and hostility and that it did not take long for a negative indoctrination to occur once in the NHS workforce. Engagement and credibility were undermined further by a combination of how junior doctors are treated, a lack of real-world experience in actually leading in a challenging environment and an arrogance perceived by respondents that some juniors, despite having not led in practice (either at all, or without substantial senior sponsorship), gave the impression that they had all the tools to do so, having been on a 'leadership fellowship' or similar.

Many respondents argued that corporate training and better education on the broader issues affecting the NHS should start early on to tap into the enthusiasm and energy of students before the negative role modelling previously described:

'You are sitting on a workforce of trainees who are very bright and become indoctrinated by the least corporate individual, and then you expect them to be a comfy feely team player' (respondent 2). Those proposing an immediate corporate strand in undergraduate medical education argued that *'the evidence would suggest the earlier you do it the more enthusiastic individuals are as they are [more] open to suggestion [and] they are not yet indoctrinated and cynical'* (respondent 3) and *'it is bizarre that medical schools do not induct people into the NHS'* (respondent 7).

> *Exploring leadership concepts with medical students allows them to enter the profession with an open mind, and medical education needs to change to acknowledge the wider NHS context and plant some seeds of interest in the wider system* (respondent 6).

Additionally, several respondents alluded to the pervasive (and often ignored) social hierarchy among doctors and the fact that junior members of the medical profession are *'often treated like children despite often being in their mid-to-late 30s, with families of their own, and often more than a decade of experience'* (respondent 16). Respondent 19 contrasted the treatment of doctors with that of military officers:

> *We infantilise doctors and the contrast with the military at the same age is extraordinary. We do not let anyone prove themselves and we treat our junior doctors like children – not like any other good organisations. BUPA and McKinsey just find it laughable, and yet there are senior clinical leaders who still do not see it.*

The lack of real-world versus theoretical leadership training was also highlighted as a potential barrier to successful translation from perceived to actual leadership capabilities: *'Experience is really important and can't be taught on a course. Experiential learning informs decision making'* (respondent 16), *'Experience is required to be credible'* (respondent 10).

> *All the talking, all the conferences and all the exposure to high-flying political people may lead to overblown self-importance. There is a danger there, perversely creating a situation that leads to individual arrogance in those who have had exposure to very senior health leaders but have not delivered anything themselves* (respondent 13).

There was a feeling among many respondents that an unintended consequence of the clinical leadership agenda, especially when focused at trainee doctors, was that some junior doctors had *'unrealistic expectations as to their broad leadership competence and a mismatch between their own self-belief versus those around them'* (respondent 20). Respondents felt that this issue was largely due to an absence of constructive feedback, and that it also detracted from the achievements of early career doctors who really did show exceptional leadership capabilities, despite their lack of clinical experience.

Real-world assessment, feedback and support

Almost all respondents acknowledged that data were insufficient to assess the outcomes of leadership programmes. They also commented on the widespread *'lack of assessment, feedback and support given to individuals who undertook leadership training'* (respondent 8). There was a perceived dearth of evidence to support investment in leadership programmes, with comments such as *'does it make people competent?'* (respondent 18) and *'I am not convinced you can link [successful leadership] to a course because the confounding variables are so great'* (respondent 4) giving some indication of the anxieties expressed. *'A lack of evidence fuels the agenda of those who wish to knock this initiative'* said respondent 2, and *'it will take a generation to know whether this has been successful'* (respondent 6).

Respondents acknowledged that it was challenging to capture these data, but several interviewees felt that academic assessment based on *'objective and personal feedback would be possible, assessing behaviour changes and outputs using supporting evidence (such as 360 appraisal before and after programmes), and assessing perceived growth in personal domains'* (respondent 19) could provide valuable data to both the individual and funding organisations and start to build up evidence to support the benefit of any investment. It was argued that these issues, and the absolute requirement to develop credible medical leaders who would inspire followership among the whole workforce, *'not just their particular tribe'* (respondent 3), necessitated this type of real-world assessment and feedback.

Discussion

We undertook this research after the Darzi reports[9,10] but before the fundamental changes witnessed in the NHS as a result of the Health and Social Care Act 2012 and the publication of the Francis,[6] Keogh[22] and Berwick[23] reports. However, the senior individuals who we interviewed had clearly already considered much of what subsequently emerged in those publications and nearly all respondents retain senior and influential positions in the new system. Furthermore, we believe that there is little evidence to suggest that our findings are any less relevant to the new NHS.

These qualitative data show many of the issues with medical engagement that need to be addressed if leadership among doctors in the NHS is to become the norm and sufficiently valued. Up-front investment is needed to overcome several barriers and joined-up thinking between the healthcare professions to overcome others; self-reflection and honesty about doctors' potential additional training requirements when applied to the broader leadership competencies that enable successful leadership in today's complex NHS will be necessary to overcome most. The issues we raise in this article are wicked problems [24] – ie they span political, cultural and professional domains and clear and visionary leadership are needed to solve them successfully.

We suspect that much of what emerged from our interviews with senior leaders will be self-evident to people who work on the shop floor within the NHS. However, our results generated several interesting points worthy of further discussion. Perhaps surprisingly, neither financial remuneration nor excessive clinical workloads were major themes of the interviews. Why respondents did not focus on these issues is unclear, because it is often cited as a reason why more doctors do not take up leadership roles.[17] In a small group of senior respondents, it is possible that time and success in the leadership field have

resulted in personal financial compensation and reduced clinical delivery, which have biased the results. By contrast, these results might also reflect the views of a cohort whose motivational drivers are not financial.

Additionally, we noted a seeming paradox of wishing to engage younger doctors in the leadership agenda while they are enthusiastic, driven and motivated, only then to perceive many of the same individuals as subsequently self-important and uppity when they become engaged and involved. Why? Many respondents suggested that doctors in particular should consider more closely the type of leadership skills needed to lead outside a purely clinical role and that success as a clinician does not imply that success in other areas will necessarily follow. Maybe there is insufficient focus on the emotional aspects of leadership in this cohort, or insufficient time is spent exploring notions such as followership? This hypothesis links with respondents who argue that greater real-world assessment of leadership is needed to ensure a return on investment and, crucially, to identify doctors who can gain followership and actually deliver enduring, positive change.

The call for greater leadership assessment in the workplace chimes with the recent joint King's Fund and Faculty of Medical Leadership and Management report[25] and work done by Health Education Kent,[26] whereby all trainees undergo annual leadership assessments as part of their appraisal. Locally, this scheme has led to systematic engagement among the trainee community and 'proved to be a catalyst for junior doctors to seek out and experience leadership opportunities'. It is a potential model that could be used by Health Education England across the country with its remit for all healthcare professionals. However, respondents also clearly expressed the need to support leaders at all levels (especially doctors), who are brave enough to try to lead change, despite the cultural and hierarchical barriers they face. Any scheme must include realistic feedback and ongoing access to support, especially after fellowships or previous out-of-programme leadership endeavours.

Although they clearly believe strongly that history is important, respondents suggested that attitude of doctors towards leadership seems to be changing. An obvious question that arises is how can this cultural change be propagated without being burdened by the past? The implementation of the Griffiths Report remains a hotly debated subject among those who lived through it or just after it, but is it relevant to today's aspiring or emerging leaders? Respondents argued convincingly for the need to breakdown professional silos and ensure that leadership training is multi-professional and holistic. However, perhaps these silos also have value – the medical versus managerial tensions could ultimately result in a more appropriate answer to a problem, one that takes into account both the clinical and managerial arguments. Maybe this tension should be welcomed, with the acknowledgment of the different strengths and approaches that different professionals bring to bear but a greater understanding as to these differences.

So how do we do this? At what stage of doctor's careers should they be actively encouraged and supported to engage in the healthcare leadership agenda, and how do we encourage a more collegiate approach? One approach is the North-West buddy scheme, [27] teaming junior doctors and junior managers early in their careers to break down the professional divide, while delivering real change in the system. This simple approach is purported to be innovative, sustainable and cost-neutral. Participants on both sides report that the improvement in understanding and insights gained were valuable. Maybe the wider implementation of this simple approach with realistic project-based outcomes is a model for the desired workplace-based assessment.

Finally, to which organisation do we expect individuals so called 'corporate' engagement to be towards? This could be the NHS as a whole, the local health economy or the trust in which one works? This is a difficult question to answer and for some may controversially be further complicated by loyalty to any private provider that you may be employed with in addition to your NHS duties.

So where do the results of this study leave us? The one certainty is that the results of this research leave us with as many questions as answers. These clearly need further detailed investigation and provide the basis for serious enquiry into this complex area. This study is limited by its small size and potential bias that that results in. A larger study focusing on a wider cohort, or cohorts, of aspiring, emerging, or established local, regional and national leaders would be illuminating and may be able to answer some of the outstanding questions this research has highlighted.

Conclusion

To deliver the very significant transformational service change and financial savings required over the next 5–10 years, all NHS staff will have to be involved in making changes, no matter how small, to collectively achieve the aim. This research highlights several key barriers to successful leadership by doctors that must be overcome if they are to be the catalysts for this change, while also leaving us with as many questions as answers.

The real challenge is to make leadership the norm for all staff, ensuring they are adequately supported. This requirement needs be addressed and supported locally, with the risk of failure to engage in this agenda being that organisations may ultimately be doomed to fail. If individual organisations start to fail, then the whole system is under threat. We would argue on the basis of this research that it is time to address the leadership barriers of today, to secure the NHS leadership talent of tomorrow. ■

References

1 Pym H. The £8bn NHS political row. *BBC*, 11 April 2015. Available online at www.bbc.co.uk/news/health-32269023 [Accessed 12 June 2015].

2 Nicol E, Mohanna K, Cowpe J. Training and education in health-care leadership: is it time for an NHS healthcare academy? *Future Hosp J* 2014;1:33–40.

3 Stevens S. *Five year forward view*. Available online at www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf [Accessed 5 June 2015].

4 Department of Health. *Carter review of operational productivity in NHS providers interim report June 2015*. Available online at www.gov.uk/government/uploads/system/uploads/attachment_data/file/434202/carter-interim-report.pdf [Accessed 1 July 2015].

5 Triggle N. Simple steps 'could save NHS £5bn'. *BBC*, 11 June 2015. Available online at www.bbc.co.uk/news/health-33071066 [Accessed 12 June 2015].

6 Francis R. *The Mid Staffordshire NHS Foundation Trust public inquiry: report of the Mid Staffordshire NHS Foundation Trust public inquiry*. London: HMSO, 2013
7 Darzi A. *High quality care for all – NHS next stage review*. London: HMSO, 2008.
8 Darzi A. *NHS next stage review: a high quality workforce*. London: HMSO, 2008.
9 West M, Borrill C, Dawson J *et al*. The link between the management of employees and the patient mortality in acute hospitals. *Int J Hum Resour Man* 2002;13:1299–310.
10 Armit K, Roberts H. Engaging doctors: the NHS needs the very best leaders. *Asia Pac J Health Manage* 2009;4:47–52.
11 Atkinson S, Spurgeon P, Clark J *et al. Engaging doctors: what can we learn from trusts with high levels of medical engagement*. Coventry: NHS Institute for Innovation, 2011.
12 Harter JK, Smidt FL, Keyes CLM. Well-being in the workplace and its relationship to business outcomes: a review of the Gallup studies. In: Keyes CLM, Haidt J (eds), *Flourishing: positive psychology and the life well-lived*. Washington DC: American Psychology Association, 2003: 205–24.
13 Salanova M, Agut J, Piero JM. Linking organisational facilitators and work enagement to employee performance and customer loyalty: the mediation of service climate. *J Appl Psych* 2005;90:1217–27.
14 Mountford J. *Clinical leadership: unlocking high performance in healthcare*. London: McKinsey & Co, 2008.
15 Lee T. Turning doctors into leaders. *Harvard Business Review*, April 2010. Available online at https://hbr.org/2010/04/turning-doctors-into-leaders [Accessed 1 November 2015].
16 Lee TH, Cosgrove T. Engaging doctors in the healthcare revolution. *Harvard Business Review*, October 2014. Available online at https://hbr.org/2014/06/engaging-doctors-in-the-health-care-revolution [Accessed 1 November 2015].
17 Naylor R, Dorrell S, Everington S *et al*. Ending the crisis in NHS leadership: a plan for renewal. Available online at www.hsj.co.uk/Journals/2015/06/12/y/m/e/HSJ-Future-of-NHS-Leadership-inquiry-report-June-2015.pdf [Accessed 15 June 2015].
18 Nicol E, Mohanna K, Cowpe J. Perspectives on clinical leadership: a qualitative study of the views of senior healthcare leaders in the UK. *J Royal Soc Med* 2014;107:277–86.
19 Glaser BG, Strauss AL. *The discovery of grounded theory: strategies for qualitative research*. New York, NY: Aldine Publishing Company, 1967.
20 Bowling A. *Social science and grounded theory in research methods in health*. Buckingham: Open University Press, 2008.
21 Health Department of and Security Social. *Griffiths report: NHS management inquiry*. London: HMSO, 1983.
22 Keogh B. *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*. Available online at www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf [Accessed 5 June 2015].
23 Berwick D. *A promise to learn – a commitment to act. Improving the safety of patients in England*. London: Williams Lee, 2013.
24 Grint K. Wicked problems and clumsy solutions: the role of leadership. *Clin Leader* 2008;1:54–69.
25 West M, Armit K, Loewenthal L *et al. Leadership and leadership development in healthcare: the evidence base*. Available online at www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/leadership-leadership-development-health-care-feb-2015.pdf [Accessed 2 May 2015].
26 Hadley L. *Leadership from the ground up*. Available online at http://careers.bmj.com/careers/advice/view-article.html?id=20021943 [Accessed 15 June 2015].
27 Ahmed-Little Y, Holmes S, Brown B. North-West buddy scheme. Available online at http://careers.bmj.com/careers/advice/view-article.html?id=20003342 [Accessed 3 November 2015].

Address for correspondence: Dr ED Nicol, Keele Clinical Leadership Academy, Keele Hall, Keele University, Staffordshire ST5 5BG, UK.
Email: cyprusdoc@doctors.org.uk